eCALD®

Caring for Asian Children

Supplementary Resources

Disclaimer

Information within this resource may be freely used provided the source is acknowledged. Every effort has been made to ensure the information in this resource is correct. Waitemata District Health Board and the authors will not accept any responsibility for information which is incorrect and where action has been taken as a result of the information in this resource.

Published: June 2018, by Waitemata District Health Board, eCALD® Services.

Authors:
Dr Sharon Wong and Dr Bobby Tsang
(Paediatrians, Waitemata DHB)

Dr Annette Mortensen and Sue Lim
(eCALD® Services, Waitemata DB)

Website: www.eCALD.com

Suggested citation:

Waitemata DHB, eCALD® Services (2018). *Caring for Asian Children.* Auckland: WDHB, eCALD® Services. Retrieved from: http://www.ecald.com under Resources/Cross Cultural Resources section.

Waitemata District Health Board
Best Care for Everyone

eCALD®

This resource is available as an e-book and a PDF version via www.eCALD.com.
Updated: 28th June 2018

Table of Contents

Introduction

The *Caring for Asian Children: Culture and Health – A Resource for Health Providers* is written for health providers caring for Asian children and young people and their families.

The Auckland region is super diverse with more than 200 ethnic groups settled in the region. Asian peoples are the second largest ethnic group (23 percent or 307,230 people) in the region (Statistics New Zealand (SNZ), 2013). For the Asian population the most represented level 2 ethnicities in Census 2013 were Chinese and Indian, each accounted for over a third of Asian ethnicity responses (Walker, 2014). Twenty-one percent of the Asian population in the Auckland region was born in New Zealand (Walker, 2014).

For Waitemata DHB, Asian births have increased by 50 percent over the past six years, and are projected to increase similarly, over the next 12 years. As a proportion, Asian births are expected to rise from 29% to 32% of all births in the Auckland region by 2025 (Auckland DHB & and Waitemata DHB, 2015). In 2013, 37 percent of the Asian population was under the age of 25 years (Walker, 2014). The younger age brackets have a much higher proportion born in New Zealand (Walker, 2014).

In Auckland, 1 in 3 people are likely to identify with an Asian ethnicity in 2038, up from about 1 in 4 in 2013 (SNZ, 2015). At the national level, by 2038 the Asian population will make up 21 percent of the population, compared with 12 percent in 2013 (SNZ, 2015).

Language, culture and unfamiliarity with New Zealand health and social services are major barriers for Asian families accessing services for their children and young people. In Census 2013, thirteen percent of the Asian population spoke no English.

Refugees to New Zealand from Asian backgrounds come from: Vietnam, Laos, Cambodia, Afghanistan, Sri Lanka, Burma, Bhutan and China. Paediatric refugees have complex medical and psychological needs (Rungan et al., 2013).

Culturally competent care for Asian children and their families is central to the provision of quality, equitable and responsive services. Cultural competence includes health practitioners developing cultural awareness, sensitivity, knowledge and skills.

Being aware of the barriers to accessing health services for Asian families, and how to overcome these, is helpful in ensuring that families remain engaged with service providers and with the treatments and interventions prescribed. As well, being familiar with Asian family values, traditional health beliefs and practices, perceptions of health and illness and expectations of healthcare, will reduce cultural conflict between families and practitioners. Gaining skills in cultural assessment including: assessing cultural views, behaviours, practices and expectations; and the ability to negotiate a culturally and mutually acceptable outcome, will improve service uptake, treatment compliance, patient experience and reduce misunderstanding and disengagement.

What this resource aims to do

This resource aims to provide information and strategies to enable health providers caring for Asian children to respond more effectively when working with Asian families.

It will help health providers to:

- Gain an understanding of the knowledge, skills and attitudes needed for culturally competent practice when working with Asian children and their families.
- Be more aware and have more knowledge of the cultural practices and beliefs of Asian families in respect to birth, postnatal care, health and illness, child disability, child and adolescent mental health, grief and death and dying and the impact of these on providing healthcare services.
- Gain skills to work effectively and broach sensitive issues with CALD children and families.
- Apply cultural assessment tools in practice.
- Know how to find and use resources to work with CALD children and families.

Purpose

The purpose of this resource is to provide an overview and perspective on Asian children and their families including, their health status, health needs and the socio-cultural issues affecting Asian children's health in New Zealand. The resource offers a general guide with strategies on how to be culturally effective and responsive to Asian families when caring for their children.

Who this resource is for

This resource is for health providers who are involved in caring for Asian children and their families in primary, community, mental health, and secondary care settings. The resource complements the CALD Cultural Competency Training Programme provided by WDHB eCALD® Services (for more information go to www.ecald.com). *NB CALD in this resource refers to culturally and linguistically diverse groups from Asian backgrounds.*

It is highly recommended that the viewers of this resource will have completed the CALD 1: Culture and Cultural Competency course available via www.eCALD.com.

It is expected that viewers of this resource will:

1. **Have completed CALD 1: Culture and Cultural Competence**
2. **Additionally, it is highly recommended that the readers of this resource will:**
   - Have completed CALD 2: Working with migrants (Asian) patients *[course].*
   - Have completed CALD 3: Working with refugee patients *[course].*
   - Have completed CALD 4: Working with Interpreters *[course].*

- Have completed CALD 9: Working in a mental health context with CALD clients *[course].*

Additional valuable information on working in a culturally competent way with migrants, refugees and interpreters can be found in the following courses and supplementary resources all available via www.eCALD.com under Resources.

- CALD 5: Working with Asian mental health clients *[course].*
- CALD 7: Working with religious diversity *[course].*
- CALD 8: Working with CALD families - Disability Awareness *[course].*
- *Supplementary resources with culture-specific information, case scenarios, tips, guidelines and approaches to supplement the above courses:*
  - Cross-Cultural Resource for Health Practitioners working with CALD clients-patients *[pdf].*
  - Ayurvedic Medicine *[video].*
  - Working with Religious Diversity *[HTML object].*
  - Working with CALD families - Disability Awareness *[HTML object].*
  - Working with Asian mental health clients *[HTML object].*
  - Working with Middle Eastern and African mental health clients *[HTML object].*
  - CALD Family Violence Resource for Health Practitioners: Working with Asian, Middle Eastern and African women *[pdf, HTML object].*
  - Maternal Health for CALD Women: Resource for health providers working with Asian, Middle Eastern and African women *[pdf, HTML object].*

Scope

This resource focuses on the Paediatric care for Asian children from birth to their fifteenth birthday, and their families.
The resource does not cover the following topics:

- Screening for partner abuse and child protection in Asian families as this is covered in the *"CALD Family Violence Resource for Health Practitioners: Working with Asian, Middle Eastern and African women" accessible via eCALD.com under Resources/Cross Cultural Resources section.*
- Common mental health issues or presentations amongst CALD child and adolescent such as depression and anxiety; problem gambling; internet game addiction; drug and alcohol abuse; eating disorders; post-traumatic stress disorder (PTSD); sexual identity and suicide risk under the mental health section. These topics will be covered in another resource called "*Caring for Asian, Middle Eastern and African Children Resource for Health Providers" which is being developed and yet to be published.*

Additionally, some topics are not covered in more detail in other resources eg:

- Female Genital Mutilation (FGM) and cultural perspective relating to postpartum practice, infant care and infant feeding are covered in greater detail in *the Maternal Health for CALD Women Resource for Health Providers: Working with Asian, Middle Eastern and African women"*
- Disability issues are covered in more depth in the *CALD 8 Working with CALD Families: Disability Awareness* course and supplementary resource.

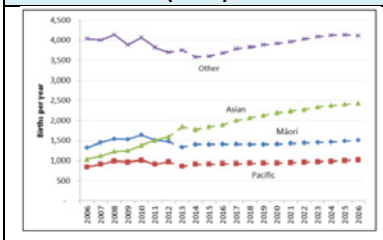
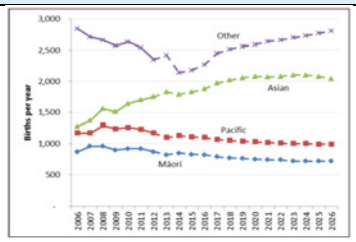
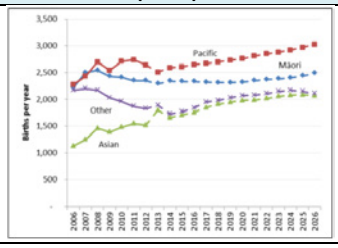
Topics discussed in this resource include:

- Current demography, health determinants, health service utilisation and key health status.
- The importance of providing culturally competent care for Asian families and what is involved.
- Concepts of culture and cultural competency.
- How to improve cross-cultural communication with Asian families, e.g. how to address parents and grandparents, language and cultural issues, and how to implement cultural awareness-assessment-negotiation techniques.
- Understanding Asian cultures including: the importance of family, religious traditions, duty, value, respect for authority, views of health and illness and traditional treatments.
- How to elicit information about cultural and ethnic identity, explanatory health beliefs, use of traditional medicines, traditional child rearing practices, views about disability and mental health etc.
- Guidelines and tools on how to improve communication and engagement with Asian families, as well as cultural assessment tools.

Background

The Asian population in the Auckland Region was over 402,000 in 2016 representing 23% of Auckland's total population (Statistics New Zealand, 2015). The most predominant Asian ethnicities in the region are Chinese (38.5%); Indian (34.6%), Korean (7.2%) and Filipino (7.0%) peoples. Close to a quarter of Asian peoples in the Auckland region have lived in New Zealand for less than 5 years (Walker, 2014).

Asian, populations have a much younger age structure than European populations, with relatively high proportions at the child and childbearing ages, and low proportions at the older ages (Statistics New Zealand (SNZ), 2015). In the last decade, there has been a significant increase in births to Asian women in the Auckland region. The following graphs show the Auckland region's birth numbers and projections to 2025 by ethnicity (Auckland & Waitemata DHB, 2012).

WDHB – Asian births are expected to rise from 21% (2012) to 32% (2025).	ADHB – Asian births are expected to rise from 29% (2012) to 32% (2025).	CMDHB – Asian births are expected to rise from 18% (2012) to 22% (2025).
		

Annually the New Zealand government accepts a UNHCR mandated refugee quota of 750 places. In 2018, this number will increase to 1000 quota refugees per annum. Refugees also arrive as asylum seekers and through the refugee family sponsored category. A quarter of refugee populations are under the age of 15 years (McLeod & Reeve, 2005). Refugees to New Zealand from Asian backgrounds come from: Vietnam, Laos, Cambodia, Afghanistan, Sri Lanka, Burma, Bhutan and China. Pediatric refugees have complex medical and psychological needs (Rungan et al., 2013). Refugee children are at risk of developmental and mental health problems due to their refugee experiences of trauma, violence and deprivation and of migration stressors on arrival in New Zealand (Rungan et al., 2013).

To begin with, having knowledge of the current demography, health determinants, health utilization and key health issues of Asian children will enhance service planning and development. The next sections will address: the socioeconomic status of Asian populations; the health status of Asian children; child health in refugee populations; and caring for Asian children.

Socio-economic status

The Auckland Region Asian population has a higher level of education than the Auckland total but a smaller proportion of adults earning over $30,000 and households earning over $50,000. The Asian population has about the same level of home ownership as the Auckland total, a higher rate of unemployment, and a lower rate of people on the unemployment benefit (Walker, 2014).

Summary of the health status of Asian children

Below is a summary of the health status of Asian children of the data presented under Appendix 3.

Mortality	There were no significant differences between the infant mortality rates of the three Asian groups examined and European/Other infants (Mehta, 2011). There were no significant differences in the rate of deaths from all causes among Auckland children aged 0 to 14 years belonging to the three Asian groups as compared to European/Other children (Mehta, 2011).
Child (0-14 years) Potentially Avoidable Hospitalisations	Across the Auckland region, Chinese boys aged 0 -14 years have a significantly lower rate of potentially avoidable hospitalisations (PAH) as compared to European/Other children, but there were no significant differences between the PAH rates of Indian, Other Asian and European/Other boys. Among girls aged 0 to 14 years, Chinese girls had a significantly lower PAH rate as compared to both European/Other and Indian girls, and a lower rate as compared to Other Asian girls although this difference was not significant. There were no significant differences in the PAH rate of Indian, Other Asian and European/Other girls across Auckland (Mehta, 2011). The top three causes of PAH among children from each of the ethnic groups examined were ENT infections, dental conditions or asthma. The PAH rates for both dental conditions and asthma among Other Asian and Indian children were significantly higher than among their European/Other counterparts (Mehta, 2011).
Low Birth Weight	In all areas examined, a greater percentage of Indian babies born between 2008 and 2010 had a birth weight below 2500 grams as compared to European/Other babies. The proportion of Chinese and Other Asian babies with low birth weight was similar to European/Other babies in all areas except ADHB, where a greater percentage of Other Asian babies had low birth weight as compared to their European/Other counterparts (Mehta, 2011).
Immunisation	Chinese, Indian and Other Asian children had similar or higher rates

Coverage

of being fully immunised at two years, and five years of age, as compared to European/Other children. Chinese children had the largest proportion of fully immunised children at both two years and five years among all the ethnic groups examined (Mehta, 2011).

Oral Health

Auckland Regional Dental Service data regarding oral health in five year olds and eight year olds indicates that a lower proportion of Chinese, Indian and Other Asian five year olds across the three DHBs had caries-free teeth as compared to European/Other five year olds. Chinese five year olds had the worst oral health of the ethnic groups examined. Although the proportion of Asian eight year olds that had caries-free teeth was lower across the three DHBs than for European/Other eight year olds, the differences across the ethnic groups examined were small (Mehta, 2011).

Among Auckland children between 2008 and 2010, Other Asian children had a significantly higher hospitalisation rate for dental conditions as compared to European/Other children. Indian children had a slightly greater rate of dental hospitalisations and Chinese children had a similar rate as compared to their European/Other counterparts (Mehta, 2011).

Youth health

Asian students participating in the Youth '07 survey mostly reported positive family home and school environments, positive and rewarding friendships and adult relationships, and about 40 percent noted the importance of spiritual beliefs (Parackal et al., 2011). However, most Asian students, did not meet current national guidelines for adequate intakes of fruit and vegetables or daily physical activity, and were less likely than NZ European students to report using contraception. The prevalence of smoking had decreased among Chinese students but not among Indian students compared to the 2001 survey, and Chinese and Indian students were less likely to be current drinkers or to binge drink than their NZ European counterparts. Mental health problems, particularly depression, were a particular concern among the Asian secondary school student population, and while most Asian students reported good health, a number of barriers to accessing health care when required were noted, including lack of knowledge of the health system, as well as cost and transport issues (Parackal et al., 2011).

Lifestyle

Asian Health in Aotearoa in 2011 - 2013: trends since 2002-2003 and 2006-2007 (Scragg, 2016).

- **Nutrition**
  - The pattern of food security in the households of Asian children was similar to that for European & Other children, while Māori and Pacific children had poorer food security.

  - The proportion of Asian children eating breakfast at home every day (a protective factor against obesity) increased from 2006-07 (79%) to 2011-13 (91%).
  - All Asian ethnicities, along with Māori and Pacific, had lower proportions of people eating the recommended daily number of serves of fruit and vegetables (≥5) than Europeans.

- **Physical activity**
  - Asian children generally had similar patterns for method of transport to school, and for hours of TV watching, as European & Other. These patterns have changed little from 2006-07 to 2011-13.
  - Adults from all three Asian ethnic groups, along with Māori and Pacific, were less likely to be physically active than European & Other. Activity levels for Asian men and women have changed little over the three survey periods from 2002-03 to 2011-13.

- **Smoking**
  - South Asian, Chinese and Other Asian women were less likely to smoke tobacco than European & Other women, while the prevalence of current smoking in men was similar for all three Asian ethnic groups combined and European & Other (both 17%).
  - There was no change in the frequency of tobacco smoking by Asian men or women over the three survey periods from 2002-03 to 2011-13.
  - The percentage of children that lived in a house where people smoked inside was similar for all ethnic groups, aside from Māori and Pacific who had the highest levels.
  - The percentage of adults that lived in a house where people smoked inside was lower among South Asians (4%) and Other Asians (3%), compared to European & Other (7%).
  - Smoking inside the houses of all three Asian ethnic groups has decreased from 2006-07 to 2012-13 in households of both children and adults (6% to 2%, and 10% to 4%, respectively, for all Asian ethnic groups combined).

- **Body size**
  - South Asian, Chinese and Other Asian children had similar prevalences of overweight and obesity to European & Other

children.
  - Mean BMI of South Asian, Chinese and Other Asian children did not change between the 2006-07 and 2011-13 survey periods.

- **Acculturation**
  - A longer period of residence in New Zealand by Asian people was associated with increased likelihood of being an alcohol drinker, while other lifestyle variables were not related to duration of time lived in New Zealand.

- **Chronic Disease**
  - The most common chronic diseases in New Zealand children of all ethnicities were asthma and eczema.
  - Eczema was more common in children of all three Asian ethnicities (17% combined), and also in Māori (21%) and Pacific (20%) children, compared to European & Other (13%).

Child health in refugee populations

In Rungan et al's (2013) study of refugee children arriving in New Zealand, more than half (53%) were from Asia (53%) including: Myanmar (40%), Bhutan (10%), Afghanistan (8%), Nepal, Sri Lanka and Bangladesh (each contributing ≤2% of the sample). The Auckland Regional Public Health Service (ARPHS), Refugee Health Screening Service assesses the health of all newly arrived refugees. The findings of the 343 children screened, were that:

- The most common infectious diseases were latent tuberculosis (15%) and parasitic infections (15%).
- In those older than 1 year old, who had rubella and measles serology information, immunity was found in 50% and 59%, respectively.
- Hepatitis B immunity was found in 68% of children.
- Complete vaccination certificates were available for 66% on arrival to New Zealand.
- Vaccinations were administered to 73% of children while at the Mangere Refugee Resettlement Centre.
- Iron deficiency and vitamin D deficiency were the main non-infectious diseases found and were present in 33% and 12%, respectively.
- The total requiring referral for further medical assessment or support was 58% with 19% requiring referral to more than one service.

NB *Appendix 1, 2 and 3 provides more information on current demography, health determinants, health utilization and key health issues of Asian children.*

Caring for Asian children

In this resource, the term '**Asian'** refers to the collective set of Asian ethnic groups, who although not homogeneous in nature, share certain value orientations, health beliefs and practices. These groups represent many diverse cultures, languages, religions, socio-economic status, education levels and migration experiences (Ho et al., 2003). Asian Peoples in New Zealand come from countries in West Asia (Afghanistan and Nepal), South Asia (covering the Indian sub-continent), East Asia (covering China, North and South Korea, Taiwan, Hong Kong and Japan), and South East Asia (Singapore, Malaysia, the Philippines, Vietnam, Thailand, Myanmar, Laos and Kampuchea) (Mehta, 2012)).

'Asian' groups include every category of immigrant: skilled migrants; refugees; those on temporary work visas, foreign fee-paying students on fixed term visas; and New Zealand-born Asians (third and fourth generation New Zealanders).

New Zealand-born Asians and 1.5 generation Asians (who were born overseas and relocated to New Zealand at a young age) are generally more acculturated to New Zealand culture, than newcomers. Within a family, the degree of acculturation may vary between the younger generation and the older generation or between those who have longer residence in New Zealand and those who are new arrivals.

There is increasing interethnic marriage and relationships in New Zealand society (Didham & Callister, 2014). Rates of interethnic marriage are significantly higher in Asian populations in the 1.5 generation and among the New Zealand born than in the overseas born (Didham & Callister, 2014). Maintaining ethnic belonging is central to the identity of many Asian women in interethnic marriages or relationships. Being in a cross-cultural marriage does not preclude the pressure from family and community to observe traditional birthing, postnatal and parenting/grandparenting practices. New Zealand born and 1.5 generation women may be living with mothers or mothers-in-law who have an expectation that their daughter or daughter-in-law will follow their cultures' traditional child rearing practices.

Traditional Asian culture is very (extended) family oriented with a high priority placed on family, unity, dignity, respect, spirituality and humility. There are significant differences between Asian collectivist and western individualist views about decision-making, family structure, gender roles and parenting.

Asian cultures, religions and languages have a significant impact on health beliefs and practices, influencing the way in which Asian people explain their health and illness, and how they respond to and access health services. Cultural backgrounds also influence patient's and family's behaviour, family structure, decision-making, child rearing practices, caregivers' roles, dress codes and dietary preferences.

Cultural groups have different ways of understanding illness and will attribute different causes to the origin and symptoms of their sickness. How illness is explained is strongly influenced by families' cultural/religious backgrounds. To a large degree, these values also define the acceptable symptoms of the illness as well as the behaviour, expression and role of the sick person. Health beliefs are often complex and may change overtime with acculturation. For some Asians, after a long period of settlement in New Zealand, there may be little or no reliance on traditional practices. Some families will revert back to traditional

health practices when they find that illness is not responding well to Western medicine. Younger Asians who are New Zealand born or the 1.5 generation may not hold any traditional health beliefs and practices. To assess acculturation levels and to avoid stereotyping, individual assessment is essential.

Migration to a new country with a totally different culture may require a long period of adjustment. Racism and discrimination in New Zealand make the process of adaptation more difficult for migrants (Scragg, 2016).

To provide culturally competent care for Asian children and their families, it is recommended that health providers consider the following:

- Having knowledge of the current demography, health determinants, health utilization and key health issues of Asian children will enhance service planning and development.
- Becoming familiar with Asian cultural values, beliefs and practices, and the influence of these on families' responses to health services and decision-making processes.
- Understanding the impact of migration and the 'refugee' experience.
- Acknowledging and showing respect towards traditional health beliefs and practices, even though you may disagree with the practices. It is best to work alongside families and negotiate a mutually and culturally acceptable outcome. *This approach is most likely to build trust and rapport between the health practitioner and the family.*
- Avoiding assumptions that extended family and community support networks are available.
- Showing genuine concern and providing practical support to Asian families especially those who are unfamiliar with the New Zealand health system eg sourcing suitable health and social services/networks. This is particularly helpful when the family you are working with have limited English language skills.
- Being mindful of the potential intergenerational issues that can occur between the young patient and his/her family members especially with their older family members.
- Being aware of interethnic marriages and potential conflicts over traditional child rearing practices and decision-making between family members.
- Understanding the influence and role of grandparents who may be the primary care-giver of the child or young person.
- Assessing health literacy and English and native language fluency. *Provision of information about diagnosis, services and treatment in the client's language.*
- Using professional interpreters. *NB: not using children or family members to interpret.*

Caring for Asian Children: Cultural Competency

> *"Cultural competence refers to an ability to communicate and interact effectively with people of different cultures. It is not just about knowing another person's culture. In the healthcare setting it is about understanding how cultural differences impact on the consulting relationship and being able to adjust your behaviour to accommodate these differences for the best patient outcomes. Competence involves the capacity to function effectively as an individual within the context of the cultural beliefs, behaviours and needs presented by patients and their families."* (Waitemata DHB eCALD® Services, 2016a).

Cultural competence comprises four components:

- Cultural Awareness
- Cultural Sensitivity
- Cultural Knowledge
- Cross-Cultural Skills

Cultural competence definitions and standards are also prescribed by professional registration bodies such as the Medical Council of New Zealand; the Royal New Zealand College of General Practitioners; Auckland Region Allied/Public Health/Technical MECA; Nursing Council of New Zealand; the Aotearoa New Zealand Association of Social Workers (ANZASW) and others.

Why the need for cultural competence?

Cultural competence refers to an ability to communicate and interact effectively with people of different cultures. It is not just about knowing another person's culture. In the healthcare setting it is about understanding how cultural differences impact on the consulting relationship and being able to adjust your behaviour to accommodate these differences for the best patient outcomes. Cultural competence comprises four components: cultural awareness, sensitivity, knowledge and skills.

Asian communities bring their own health beliefs, values and practices which at times conflict with western models of health care and practices. Our cultural background determines our reactions to health and sickness and influences our health behaviour. These differences can sometimes be difficult to understand. By understanding the cultural dimensions of individualism and collectivism, power distance, uncertainty avoidance and masculinity and femininity from both our own and other cultural perspectives, we can begin to recognise where the differences lie and adjust our behaviour accordingly so that we can assist the Asian children and families we work with effectively. It may be difficult to engage and to maintain effective cross-cultural interactions with families without understanding their cultural expectations of health care and health practices.

Developing cultural competence

Cultural Awareness

Being culturally aware of your own and others values is a step in becoming culturally competent. It is easy to be ethnocentric, using one's own values and way of life as the standard for judging others. Becoming culturally competent means examining your biases and prejudices, developing cross-cultural skills, "having a willingness to recognize and accept that there are other legitimate ways of doing things, as well as a willingness to meet the needs of those who are different " (Cartledge et al., 2002).

Cultural Sensitivity

> *'Part of being culturally competent is being culturally sensitive. Cultural sensitivity begins with recognition that there are differences between cultures. These differences are reflected in the ways that different groups communicate and relate to one another.' (Krapp & Cengage, 2002).*

Cultural sensitivity involves having the ability to recognize cultural differences as well as similarities, without assigning values (ie better or worse, right or wrong) to those cultural differences. It includes being non-judgmental and having an enquiring attitude. It also involves not making assumptions based on appearance or generalised information, but to understand your client's or patient's cultural values and health beliefs as an individual eg enquiring about your client's degree of acculturation or who makes the decision in the family for health care for the children. Making assumptions about cultural norms or behaviours can lead to stereotyping and less than optimal cross-cultural interactions.

Cultural sensitivity also requires the qualities of openness and flexibility to adjust your behaviour to accommodate these differences for the best patient outcomes.

Cultural knowledge

> *"Cultural knowledge requires the familiarisation with selected cultural characteristics, history, values, belief systems and behaviours of the members of another ethnic group." (Adams, 1995).*

Cultural competency is not about learning everything about a specific culture. It is better to learn about the values of collective cultures and to learn some of the more common cultural beliefs and practices of the groups you serve rather than to try to learn a list of practice 'do's and don'ts for caring for patients from some cultural groups. This latter approach can be reductionist and can lead to stereotyping and the oversimplification of your client and their culture.

By understanding the cultural dimensions of individualism and collectivism, power distance, uncertainty avoidance and masculinity and femininity from both our own and other cultural perspectives, we can identify potential areas of difference so that we can work with our clients effectively. Without understanding the client's cultural expectations of health care and their health beliefs and practices, it is difficult to engage with families, maintain effective cross-cultural interactions and to achieve culturally and mutually acceptable care for children.

Cross-cultural skills

Cross-cultural skills refer to the ability to implement cultural awareness, sensitivity and knowledge in practice effectively in the cultural context of the child and their family, and the needs/issues they present with.

It involves, being competent with:

- Addressing language barriers in clinical encounters (knowing how to use interpreters is essential). You can learn how work with interpreters by undertaking the following training which is available on line: *CALD 4: Working with Interpreters* (Waitemata DHB, eCALD® Services, 2017d).
- The Cultural-Awareness – Assessment – Negotiation Technique (Campinha-Bacote, 2011), which involves:
  - Being aware of the ethno-medical beliefs of the clients/family/ communities you serve.
  - Assessing the likelihood that a particular patient may act on these beliefs during a particular illness episode.
  - Negotiating between biomedical and ethno-medical belief systems.
  - Emphasizing common goals (eg helping your child to get better), while acknowledging differences.
  - If necessary or possible, incorporating non-harmful remedies in the treatment plan.
  - Not assuming that the family knows how to use the NZ Health system.
  - Referring to available culturally appropriate support services when required.

Checklists for effective cross-cultural communication

The following points present a checklist for effective cross-cultural communication with patients/families from cultural backgrounds different to your own.

Checklist for Cross-Cultural Communication	
Pre-interview checklist	• Do you know what *culture* your client is from? • Do you know what *language and/or dialect* they speak? • Can you *greet* your client in their language? • Do you need an *interpreter*? • Do you know the *acculturation* level of your client? (NB: Be aware that an individual within each cultural group or family may differ in their levels of acculturation to New Zealand society. For example, some members in a family or a cultural group may hold very traditional beliefs whereas others may have western beliefs and practices, many will have (a sometimes conflicting) mix of both. It is important that practitioners do not assume every Asian /refugee /migrant person holds traditional views. When making a diagnosis, treatment recommendations and assessing the need for cultural support for the client, consider to what degree the client is acculturated (ie holds western views versus traditional views).
During-interview checklist	• **Assess spoken and written English/native language** fluency**.** • **Engage interpreters** where there is low English proficiency. • **Address the client appropriately.** • **Explain your role** to your client. • **Speak clearly** and **slowly.** • **Avoid jargon.** • **Simplify** the form of the sentence or question. • **Pause** and take time to explore any issues that need clarifying to ensure you are understood before continuing. • **Periodically summarize** and encourage feedback to check understanding. • **Note differences in meanings** of words (eg "Yes"). • Be aware of the **client's level of understanding**. • **Respect** others' beliefs and attitudes. • Take note of **non-verbal language.** • Find out whether **eye contact** is acceptable or not. • Find out what kind of **physical touch and examination** is expected and acceptable. • **Assess health literacy.**
Cross-cultural interviewing	• Be non-judgemental, avoid stereotyping and ethnocentrism. • Listen.

Checklist for Cross-Cultural Communication	
checklist	• Be observant (especially when there are conflicts between verbal and facial expression (non-verbal)). • Be aware of one's own tendency to 'project'. • Tolerate difference. • Respect differences. • Be flexible. • Be empathic. • Use available tools effectively ie: - Know how to access telephone and face to face interpreting services; when is it more appropriate to use a telephone interpreting service or a face to face interpreting service, and most importantly know how to work with interpreters effectively over the phone or face to face to achieve the best outcome (e.g. pre briefing interpreters, structuring an interpreting session, post briefing). - Know what culture-specific resources are available and how to access these and work with the relevant cultural staff to achieve the best outcome. - Know what language appropriate materials are available or need to be translated for clients to achieve better understanding for clients.

Guidelines for working with interpreters effectively

The following points offer useful guidelines for health practitioners when communicating with non-English speaking clients through an interpreter.

Guidelines for working with interpreters effectively	
Pre-brief the interpreter: before the session	• Allocate extra time for the interpreting process. • Provide a brief introduction of your role and service. • Explain the objectives / purpose of the session. • Obtain cultural background information or ensure that appropriate cultural greetings and etiquette are followed. • Establish the mode of interpreting - consecutive or simultaneous. • Confirm the use of the first person throughout the session. • Clarify any specific terminology to be used and ask the interpreter if they understand it. • Prepare the interpreter for difficult issues or tense topics. • Inform the interpreter if you plan to talk about a sensitive or controversial issue. Advise the interpreter that you will inform the patient or family through them that what is said is not the opinion of the interpreter but

Guidelines for working with interpreters effectively	
	your own. • Remind the interpreter of the confidentiality protocol.
Briefing: at the start of the session	• Greet and direct the patient or family member(s) to a pre-arranged seating arrangement. • Introduce yourself and explain the roles of the professionals present. • Introduce the interpreter and her/his role (ie she/he will be interpreting for both you and the patient and family members, and that the interpreter will not be expected to give her/his opinion during the session). • Assure the patient of confidentiality. It can be helpful to the patient to know that both professionals are bound by a clause of confidentiality under a Code of Ethics. Conditions under which confidentiality cannot be maintained (for clinical safety) can also be explained at this time. • Establish with the patient that everything said in the session by all parties will be interpreted. • Familiarise the patient with the mode of interpreting (ie consecutive or simultaneous) to be used. Ask the patient (and family members) to pause after three short sentences for the interpreter to interpret. • Explain that if the session involves sensitive or controversial issues, the opinion given is yours rather than that of the interpreter.
During the session	• Do not enter into direct conversation with the interpreter. • Do not ask the interpreter for their opinion. • Use short sentences. • Pause at regular intervals for the interpreter to assimilate and interpret. • Allow the interpreter to interpret after every 3-5 sentences. • Allow enough time for the interpreter to convey information.
Debrief: after the session	• Ask for a de-briefing with the interpreter to clarify any cultural issues, interpretation of words or concepts.

Cultural competence continuum

> *"Cultural competency is a developmental process, which requires an individual to pursue ongoing education, to develop approaches based on cultural considerations, to seek ongoing mentoring and supervision of cultural practice in order to advance along the cultural competence continuum" (see more about the Cultural Competence Continuum via eCALD.com). (Cross et al., 1989).*

A range of evidence-based eCALD® cultural competency training and resources are available via www.eCALD.com to support health practitioners to develop CALD cultural competencies.

The following section provides an overview of Asian traditional family values, health beliefs and practices and offers communication tips and tools on how to engage with Asian families.

You can learn more about cultural practices by completing CALD Cultural Competency Training and viewing the supplementary resources such as the *Cross-Cultural Resource for Health Practitioners working with CALD clients* (incudes communication tips, traditional family values, health beliefs and practices of 7 Asian cultures*); CALD Working with religious diversity*: (includes principles of Confucianism, Taoism, Folk Religion, Buddhism, Traditional Chinese Medicine) and *Maternal Health for CALD Women: Resource for Health Providers working with Asian, Middle Eastern and African Women* (includes traditional birth, postnatal and neonatal care beliefs and practices, neonatal intensive care and cultural profiles including infant feeding and helpful tips for engaging with parents and grandparents).

Caring for Asian Children: Culture and Health

> *"Culture is an integrated pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious, or social group" (Cross et al, 1989, p7).*

This section provides an overview of traditional Asian family values, health beliefs and practices. It outlines the values of collective cultures, how culture influences explanations of health and illness, and how Asian communities respond to health and sickness, their behaviours, attitudes and health seeking patterns. ***NB*** *The information is generalized and is intended to highlight cultural differences and to enhance cultural understanding for health providers.*

Suggested culturally appropriate approaches and tips are offered throughout the section to improve cultural responsiveness to Asian families.

Traditional family values

The following compares Asian traditional family values (across most Asian cultures) with Western family values.

Asian	Western
• Family is the unit of society.	• Individual is the unit.
• Extended family.	• Nuclear family.
• Dependence and infirmity is more natural.	• Independence valued with illness needing to be eradicated.
• Decisions made by family, tribe or community as serves the collective interest best. Traditionally fathers and sons are seen as heads of household and decision makers.	• Decisions more often made by the individual or nuclear family.
• Traditionally (and currently still common) sons are valued over daughters.	• Generally similarly valued.
• Shame at 'failures'.	• Guilt at 'failures'.
• Honour, duty and filial love towards parents and family are very important.	• Individual rights.

Asian	Western
• Child rearing is oriented towards accommodation, conformity, dependence, affection.	• Child rearing oriented towards individuation, intellectualisation, independence, compartmentalization.
• Religion plays an important role in symptom formation, attributions (God's will/karma) and management.	• Attribution of illness and recovery is seen to be self-determined, and psychological symptoms are attributed to weakness of personality, thinking patterns etc.
• Marriage partners often need approval from family, or are arranged by families, and for some families an astrologer will be consulted.	• Marriage partners more often self-chosen.
• The health practitioner is seen as the authority and highly respected.	• Doubt in doctor-patient relationship.
• Informed consent is a family decision.	• Informed consent an individual decision.
• Seniors/elders highly respected.	• Elderly viewed much as any other age group.
• Honouring of ancestors	• Ancestors not usually a factor.

(Waitemata DHB, eCALD® Services, 2016f).

Family Structure

In this section, additional information about Asian traditional family structures, family-based decision-making, gender roles, parenting, intergenerational and other cultural expectations are provided. The suggested cultural approaches or considerations are included to expand health providers' cultural understanding and to enhance engagement with Asian families.

In New Zealand, Asians who have extended family members usually live together as a single-family unit, which includes grandparents, parents, children, as well as the families of parental uncles. With increased mobilization to urban areas, this structure is slowly moving towards that of the nuclear family comprised of parents and their children.

- The grandparent's role in raising the children is a highly valued link to culture, religion and heritage.

- For traditional Chinese families with multiple sons, the parents or grandparents usually choose to live with the eldest son, while for traditional Indian families the choice usually is to live with the eldest son or the one with more financial capability.
- Asians value family ties and have strong filial love, respect for seniors, loyalty and honour as well as duty to the family.
- It is a traditional Asian belief that children have to give a lot of respect to parents and take care of parents when they get old. Some Asian older people may be more dependent on their children's care when they are unwell. They may be reluctant to do exercise or help themselves in daily activities. There may be the dilemma of dependence and interdependence. *For this reason, the process of and purpose of rehabilitation needs to be carefully explained by health practitioners. .*
- Because of the close-knit family structure, a family can expect many visitors when a family member is in the hospital.

Suggested approaches:

- *Explore family dynamics and relationships.*
- *Find out who is the primary caregiver for the child.*
- *Explore the level of acculturation of the family members and their service expectations.*
- *Ask the client if he/she has family or community who can help in practical ways when he/she returns home.*
- *Ask how many visitors would be expected to visit the child.*

Decision-making

- The father or the husband is usually the decision-maker for bigger family issues. However, mothers are usually the main caregivers of the children and older persons.
- Some Chinese and Korean mothers may have difficulties with taking on the role of making decisions on serious health matters for their children, because their husbands are working in their homeland. While they may have to be the main decision-makers they may still need to discuss decisions with their husband first. This may lead to a lot of stress.
- Because of the value placed on interdependence and privacy in Asian cultures and the desire to *"save face"*, family issues including healthcare decisions, are frequently discussed within the immediate family before seeking outside help.

Suggested approaches:

- *Establish the main decision-maker(s) for healthcare matters (including informed consent).*
- *For communication, convey information to both (father or the husband or the*

mother of the children or caregivers of the children or older persons) to avoid communication breakdown.

- *Find out if there is anyone overseas that needs to be contacted for healthcare decisions.*

Gender roles

The roles of Asian men and women are distinct. Women manage the home by keeping all finances, family, and social issues in order. Women are more passive and men typically are the bread-winners and managers of issues requiring interaction with individuals in the community, eg health care. This type of behaviour implies that men have a dominant and authoritative role because they are the primary point of contact with society. However these roles are beginning to change among educated Asians and among immigrants in progressive or permissive societies.

Suggested approaches:

- Ask who the primary care giver is for the child and who is responsible for decision making.

Parenting and grand-parenting

- In many Asian cultures, parents expect their children to be obedient, well-disciplined and to achieve high academic qualifications. Therefore Asian parents employ a "training" mode of upbringing, organizing children to attend different tutorials or interest groups, even after school and during holidays.
- Failure to meet expectations (eg academic) brings shame and *"loss of face"* to the child and the family.
- Some parents are concerned about their children losing their native language ability and being unable to maintain traditional values. Children may be stressed by their parents' traditional expectations and face conflict between eastern and western cultural values and peer group norms.
- In most instances in Asian communities, the whole family is involved in the care of the children. Grandparents play an important role in rearing children.
- For grandparents who do not live with the couple, they will come before the birth and stay to help out for the first few months to several years after the birth of the child.
- Children often sleep with parents from the time of birth to early childhood. If the grandparents are part of care taking, the children may be as attached to the

grandparents as to their parents. This may cause some attachment issues between the child and their parents.

- Respect for elders is highly valued and children, including grandparents, older siblings, teachers, and family friends. The discipline of children is thought to come naturally. In some families, a child is responsible for many of the adult tasks, such as finance, legal forms, and interpretation/translation. Children from refugee backgrounds in particular may be responsible for adult tasks including the care of younger children.
- China's one child policy was introduced in 1979. This has resulted in the development of the *4-2-1* problem. This refers to the first generation of law-enforced only children becoming parents themselves. The adult child has two parents and four grandparents. Consequently, some Chinese parents and grandparents may over-indulge their only child or grandchild resulting in a child who may lack self-discipline and the ability to cooperate with others. The Chinese media refers to these traits as the "*little emperor syndrome*". (Wikipedia, 2017). The impact of the one-child policy may result in some Chinese young couples having limited parenting skills.

Suggested approaches:

- *Assess parents' views about the importance they place on the child's education and the child's ability to cope with parental expectations of high achievement.*
- *Assess the child (if he/she can speak for himself/herself) on their own to determine stressors and issues (eg cultural identity issues, educational expectation, etc). Explain to the parents the importance of assessing the child on their own (if parents are not comfortable to have their child assessed without them).*
- *During an invasive procedure, ask the child for their choice for support: grandparents or parents – or better, both.*
- *Advise parents/grandparents against using their children as interpreters.*
- *Assess the effects on the child of having adult responsibilities.*
- *Explore the couple's parenting skills and encourage parenting education or incredible years' education. (If grandparents are involved as primary care givers, encourage them to attend parenting education programmes together with the parents).*

Intergenerational and interethnic family relationship issues

There are increasing interethnic marriages and relationships in New Zealand society (Didham & Callister, 2014). Rates of interethnic marriage are significantly higher in Asian populations in the 1.5 generation and among the New Zealand born than in the overseas born (Didham & Callister, 2014). The term 1.5

generation in this resource refers to people who were born overseas and relocated to New Zealand at a young age.

It is important to remember that maintaining ethnic belonging is central to the identity of many Asian women in interethnic marriages or relationships. Being in a cross-cultural marriage does not preclude the pressure from family and community to observe traditional birthing, postnatal and parenting/grandparenting practices. New Zealand born and 1.5 generation women may be living with mothers or mothers-in-law who have an expectation that their daughter or daughter-in-law will follow their cultures' traditional child rearing practices.

Traditional practices during birth and the postnatal period are used worldwide in countries and regions such as China (Lau, 2009), Myanmar (Kokanovic, 2011; 2012), Korea (Kim, 2015), India (Goyal, 2006; Wells & Deitsch, 2014) and beyond. When families migrate, traditional birth, postnatal and parenting practices are challenged by western models. Older family members in New Zealand are likely to maintain traditional beliefs and parents may struggle with a lack of decision-making power (Lau & Wong, 2008).

Specific postnatal traditions differ by ethnicity, but they are all generally female-oriented with family-centric support networks aimed at ensuring the mother and baby's health. Typically, during the first month after birth the woman is under the care of her mother or mother-in-law who helps to restore her health and strength as quickly as possible after birth, for example, by providing her with good nutrition, taking care of the older children, and doing the housework.

Postnatally, the traditional practices of rest, abstaining from housework, having a good diet, and avoiding fatigue and stress are intended to support lactation. In traditional cultures, the first month is of fundamental importance to the survival of the new mother and her baby, therefore the postpartum period is as important as the pregnancy.

Cultural expectations and conflicts

Older family members' expectations of what constitutes healthy practices in the postnatal period may conflict with the advice women receive from their midwives/Well Child Tamariki Ora (WCTO) nurse and other child health service providers (Guo, 2013).

Older family members who support the woman often experience culture shock as their experiences of pregnancy, childbirth, postpartum and child rearing may not be understood by maternity service providers (Guo, 2013).

In Guo's (2013, p.309) study of migrant Chinese mothers in New Zealand, a midwife successfully included older family members by providing the kind of support that was acceptable to the woman and her husband. During a postnatal home visit, the midwife asked the woman and her husband how the woman's mother would help them during the postpartum period. The couple was worried that the woman's mother would expect the woman to observe the practice of the 'sitting month', and that she would be making decisions about breastfeeding and how they should parent their baby.

To overcome the potential cross-cultural communication barriers between herself and older family members, and to avoid conflict between the grandparents and parents, the midwife recommended that the parents interpret what was being discussed for the grandparents:

> *I can actually sit here with you guys and baby and your mum and dad and you can translate for me. And sometimes when I have you translate for me they kind of like get to understand a bit more about how things are for you here. Okay? (Guo, 2013, p.310)*

By doing this, the older family members felt included and they had an opportunity to understand the roles and practices of New Zealand maternal and child health services. Most importantly, the older family members felt respected and involved in decision-making rather than being excluded from the communication between the midwife and the couple.

Suggested approaches:

- *Recognise that there may be components of traditional practices that migrant women wish to follow or to adapt, and that these practices may be helpful for the woman and her baby.*
- *Health practitioners can act as cultural mediators. Health practitioners can discuss the need to include extended family members when engaging with parents. Family harmony can be maintained by acknowledging the important role of older family members and the relationship between the care-giver and the extended family, and by including them in decisions about the child's care. Additionally, health practitioners can act as mediators between older family members and parents. The cultural practices that sound useful can be considered by parents and can be modified to ensure that the older family members feel accommodated.*
- *Connect women to networks of other women of the same ethnicity. When women are unfamiliar with the New Zealand maternal and child health system, networking with other migrant women is helpful, in particular when women have limited English language skills. For example, Asian communities often access online forums to share ideas and perspectives on childbirth and parenting. For first-time mothers, the role of maternity-care/WCTO service providers is critical in linking women to child health services and supports, for example, some Plunket groups offer 'coffee groups' for specific ethnic groups in order to encourage networking and support for new mothers.*

The following case study illustrates the intergenerational issues and conflicts between a young Indian couple and the child's paternal grandparents about child rearing practices. The case study provides a question for viewers to consider and reflect on. *Discussion and suggested approaches for this case can be found under the Case Studies section.*

Case Study 1: Neonatal care and intergenerational issues (Indian)

Jayanti is a 1.5 generation New Zealand trained registered nurse. She and husband Shri are from Mumbai. Jayanti and Shri have a 3 year old son, Narayan, and a five month old daughter, Nirmala. The couple has their own ideas about neonatal care practices, leading to arguments with the child's paternal grandparents who live close by.

The couple speaks Marathi at home. They practice the Hindu faith, attend cultural and religious events, and are strongly connected to their extended family and community. Jayanti and Shri place considerable importance on maintaining their language and cultural and religious practices. However, in the area of child rearing they want to do things "the Kiwi way".

Shri's parents are a very supportive and are very involved in helping with the children. However, Jayanti is determined to be much more firm with her mother-in-law about deciding on child rearing practices for her baby daughter, following the experience of her insistence on controlling every aspect of Narayan's upbringing.

Nirmala has been a very unsettled baby and Jayanti has successfully used the strategies offered by the Well Child/Tamariki Ora nurse. This has resulted in Nirmala sleeping overnight since she was 2 ½ months old. Jayanti's mother-in-law is highly critical of Jayanti's parenting style, which she considers to be too tough.

Question: As the Well Child/Tamariki Ora nurse, how will you support Jayanti and Shri to manage their baby's unsettled sleep patterns?

Discussion notes are available under the "Case studies – discussion notes" section (p.119).

Gender preference

China's preference for sons stretches back for centuries China's one child policy has exacerbated the problem and produced disparity in the sex ratio at birth. In the past two decades, the advent of ultrasound scans has allowed people to abort female foetuses, although sex-selective abortion is illegal.

In Indian society , there is a similar preference for sons rather than daughters (Branigan, 2011). Gender preference issues may lead to a female infant being neglected.

Suggested approaches:

- *Ask the couple about the family's gender preference and views if there are concerns with the care provided to the female child. If there are neglect issues, make every effort to explain the neglect and abuse concerns and the serious consequences of these to ensure that the couple are aware. Take action if there are signs of child abuse, following DHB protocols.*

The following case study illustrates the issue of gender preference in a Pakistani family with signs of child neglect. The case study provides a question for viewers to consider and reflect on. *Discussion and suggested approaches for this case can be found under the Case Studies section.*

Case Study 2: Gender Preference (Pakistan)

Background

Asal is a 30 year old pregnant woman who presents to hospital during her third trimester seeking midwifery care. She and her husband have 4 female children aged between 2 and 12 years. Asal, her husband and their oldest daughter are migrants from Pakistan. The family settled in New Zealand 8 years ago. Asal's husband is currently unemployed and the family struggles financially. English is a second language. This is Asal's 4th pregnancy since arriving in New Zealand.

Current Pregnancy

When Asal presented to the hospital, during her antenatal assessment she received a pregnancy ultrasound scan and was advised (with an interpreter) that she was having a girl. Upon receiving this information Asal said she did not want another girl.

Asal did not attend any further follow-up antenatal appointments and was admitted when she went into premature labour. Her baby was born 5 weeks early.

Upon delivery, Asal refused to have contact with her baby and she discharged herself without the baby. The baby needed to remain in hospital for 5 weeks. During this time Asal did not want any contact with her baby telling nurses that this was because the baby was a girl and "she did not like her baby". Other members of her family did not visit.

A number of nurses recorded in the patient's medical record that they were concerned about the lack of emotional care that the baby was receiving from her mother and other family members.

Asal and her family were difficult to engage and assess when staff made attempts to meet with them. The staff made provision for the availability of interpreters. Antenatal staff made the assessment that Asal was tired and overwhelmed by the birth of a 5th child and was possibly suffering from postnatal depression. A referral was made to mental health services. Mental health services had the same difficulties engaging with Asal and her family. Follow-up postnatal visits by the midwife were also difficult.

Discharge of Baby

After 5 weeks the baby was well enough to be discharged home with her parents and siblings. A discharge meeting was held with the parents, an interpreter, mental health services and a well-child provider. It was felt at this meeting that there were no child protection concerns and that there were enough services involved to support the family in the community.

Re-admission of baby into hospital

After 2 weeks post discharge, the baby was re-admitted to hospital in a seriously malnourished and neglected state.

Child Protection Indicators and Red Flags:

- During pregnancy
    1. Once the baby had been identified as a girl – it appeared that this was an

unwanted baby.
2. Asal did not attend follow-up antenatal appointments.

- Postnatal
  1. Asal did not want to hold or care for her baby directly after birth.
  2. Asal discharged herself as soon as possible post-delivery.
  3. Asal refused to have any further contact with her baby and stated she did not like her baby.
  4. The baby did not receive any skin to skin contact, nurturing, emotional connection/attachment or family involvement.
  5. Health professionals were concerned about the mother's lack of emotional attachment to her baby.
  6. Asal was deemed to be suffering from postnatal depression, to be shut down and was not responsive to her baby.
  7. Asal had other stressors, 4 other children to care for at home, no extended family support, financial difficulties.

Question 1: How could health professionals have done a better job of assessing Asal's situation, as well as protecting and supporting her and the baby?

Discussion notes are available under the "Case studies – discussion notes" section (p.120).

Traditional health beliefs and practices

In general, health providers should be aware that traditional practices and beliefs are **dynamic** and that they **change** considerably after resettlement. In some cases, there may be little or no reliance on traditional practices. In others, illness will result in a reverting back to more traditional practices, especially as it becomes apparent that Western medicine does not have all the answers. Younger people living in New Zealand may not have any traditional health beliefs and practices. It is vital to make assessment of health beliefs and practices on an individual basis.

Asians tend to be 'holistic' in their view of health. 'Life Force' balance or 'Body Balance', religious, spiritual and supernatural factors, as well as physical / environmental, social, economic, mental, and hereditary factors are seen to be interrelated and interdependent in influencing health. People from rural areas may follow more traditional lifestyles and health treatments than people from urban areas (due to a lack of knowledge about modern medicine). Economic status and education (which can vary greatly among people from the same country) are also significant factors. Cultural variations may also be marked between generations. Each of the cultural sections that follow provide details of the health beliefs and practices specific to that culture (Waitemata DHB, eCALD® Services, 2016f).

Humoral/Body Balance

In this section, some of the traditional beliefs and natural remedies practiced by traditional Chinese, Indian, and Korean families in New Zealand are discussed.

The belief in body balance is similar to homeostasis in that there are external influences, which can affect your health. The four main elements are wind, heat, dampness and toxins, which can exist in every type of activity, environment or food. If the body has an excess of any one of these elements, or a disruption of internal harmonies, it can lead to ill health. For example, western medicines are believed to have a heat nature to them. To counter this, patients may take herbal teas or medicines to reduce the effect of heat in their bodies.

Usually alternative medicines or treatments are used to target the root cause of a disease or to re-establish body balance. The types of alternative treatments used are:

- Daily diet, herbal teas, herbal tonics/medicines, supplements.
- Homeopathy, relaxation.
- Qi Qong, Tai Chi.
- Acupuncture, acupressure.
- Traditional Chinese Medicine or Ayurvedic Medicine.

Yin-Yang

Yin-Yang is about believing in two opposing forces consisting of five material agents. These opposite forces either produce one another or overcome one another cyclically and constantly. Therefore all opposites of experience, such as health and sickness, wealth and poverty, can be explained in reference to the temporary dominance or one principle over the other. Since no one principle dominates eternally, that means that all conditions are subject to change into their opposites.

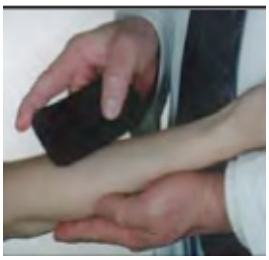
Qi Qong

(*Chi Kung*) The name means to cultivate energy or to do energy work. It is an integration of physical postures, breathing techniques and mental focus all of which are aimed at easing or increasing the flow of chi, or directing chi to specific systems or organs within the body. It is sometimes classified as a marital art, and can have medical and spiritual effects.

Acupressure

It is a form of touch therapy that utilises the principles of acupuncture and Chinese medicine. In acupressure, the same points on the body are used as in acupuncture, but are stimulated with finger pressure (or a blunt tool) instead of with the insertion of needles. It is used to relieve a variety of symptoms and pain.

Scraping

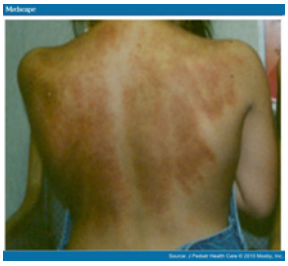


(Scraping Sand) Scraping was a popular treatment around 3,000 years again in rural areas of China. The technique was slowly forgotten with the advance of modern medicine, but is still sometimes practiced by housewives.

The theory behind this treatment is that scraping will re-activate the body's healing mechanism in order to help clear any blockages due to dead blood cells and debris from accident areas and to allow proper circulation. Scraped areas are chosen according to acupuncture points and affected sites.

This treatment is used for physical discomforts such as headaches, joint pain, muscle aches and even bloating. (It may leave marks on the body, not to be assumed a result of physical abuse).

Coining



Coining (gua sha), is a traditional Chinese medical treatment in which the skin is scraped to produce light bruising. Practitioners believe *gua sha* releases unhealthy elements from injured areas and stimulates blood flow and healing (Wikipedia, 2016).

Gua sha was transferred and translated into Vietnamese from China as *cạo gió*. This term translates roughly "to scrape wind", as in Vietnamese culture "catching a cold" or fever is often referred to as *trúng gió*, "to catch wind". *Cạo gió* is an extremely common remedy in Vietnam and for expatriate Vietnamese. There are many variants of *cạo gió*. Some methods use oil balm and a coin to apply pressure to the skin. Others use a boiled egg with a coin inserted in the middle of the yolk. The egg is wrapped in a piece of cloth and rubbed over the forehead (in the case of a fever) and other areas of skin. After the rubbing, the coin is removed from the egg and will appear blackened (Wikipedia, 2016).

The following case study illustrates how a nurse applied culturally appropriate techniques to resolve a cultural conflict with the mother of a child who was admitted to the Emergency Department with high fever and was practicing the traditional *"coining treatment"*. The case study provides a question for viewers to consider and reflect on. *Discussion and suggested approaches for this case can be found under the Case Studies section.*

Case Study 3: Coining- Resolving cultural conflict through negotiation (Vietnamese)

(Campinha-Bacote, 2011)

Mrs Lee is a 28 year old Vietnamese woman who brings her daughter, Leah (age 2 years) into the Emergency Department because "she is sick."

A nurse assesses the child and notes that she has an elevated temperature (39.4° C) with slightly pulse and respirations. After a nursing assessment and diagnostic workup it was found that Leah had a bacterial infection that required an antibiotic. On physical examination, the nurse is concerned to see several symmetrical, striated, and abrasive marks on the back of the child. She is concerned that this may be child abuse, and also that the skin breaks may complicate the child's bacterial infection.

The nurse asks Mrs Lee how the child received these marks and the mother readily responds, *"I did it."* To rule out potential child abuse, the nurse takes a patient-centred approach and conducts a cultural assessment.

First, the nurse asks Mrs Lee to explain what she thought was wrong with her daughter Leah.

Mrs Lee says, "She was very hot and crying and I brought her here because I want her to get all the help she can to get better fast." The nurse then asks Mrs Lee what kinds of treatments she has tried for this problem. Mrs Lee becomes very defensive and asks, *"Why are you asking me all these questions."* The nurse responds by saying that she wants to learn more about Leah and how she is cared for. Mrs Lee reluctantly states, *"I used cao gio; I think you call it coining in English."*

Although, the nurse has heard and read about the practice of coining among Southeast Asian peoples, she clarifies with Mrs Lee, her understanding of her values, beliefs, and practices. She asks Mrs. Lee to explain coining. Mrs Lee responds, "I get some oil and rub Leah's back with it and then I rub a small coin down the middle of her back until I see a little blood under the skin."

The nurse further asks what is/are the expected result or results of coining. Mrs Lee adds, "*Coining takes away the wind that is causing her fever."*

Next, the nurse asks Mrs Lee if she has sought help or advice from people other than healthcare professionals, such as people from her community.

Mrs Lee answers, "Yes! There is an elder in our community who sells the oil for the coining. I think he says it has winter green, or eucalyptus, or peppermint oil in it. I really don't know, but my family trusts him." After conducting this cultural assessment the nurse feels confident that the marks on Leah's back are not child abuse, but rather the culture-specific practice of coining.

The nurse continues the cultural assessment by explaining her perception of Leah's problem to Mrs Lee.

The nurse explains that Leah has an infection that needs to be treated with antibiotics and that any open wounds can increase the chance of the infection getting worse. Further, the nurse remarks that she is concerned that the skin abrasions caused by the coining may increase the chance of more infections. Mrs Lee abruptly interrupts the nurse and remarks, *"I am not going to stop my coining! She won't get better if we just give her your medicine!"* The nurse demonstrates respect for Mrs Lee and acknowledges the differences between their two perceptions regarding treatment of Leah's illness by telling her that the coining is being done to help Leah and that their common goal is to get Leah better.

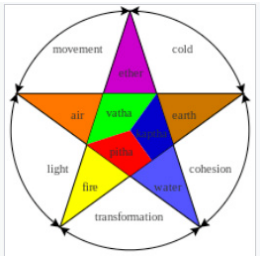
The nurse focuses on recommendations that involve Mrs Lee as an active participant in negotiating a mutually acceptable treatment plan. Mrs Lee is firm in the belief that coining is the only way that Leah's fever will go down. After several recommendations by the nurse and several non-acceptances of these recommendations by Mrs Lee, they finally agree that in addition to complying with the nursing and medical discharge plan, Mrs Lee can rub the coin lightly on Leah's back, making sure not to cause any redness, bleeding, or break in the skin. Mrs Lee states, *"I'll give this a try."*

Question 1: Identify the culturally appropriate techniques that the nurse used to resolve the cultural conflict with Mrs Lee without compromising medical and nursing guidelines?

Discussion notes are available under the "Case studies – discussion notes" section (p.122).

Ayurvedic Medicine

Restores and maintains the balance of the 3 elements in the body (aspects of the Life Force) referred to as *doshas: pitta, vatta,* and *kapha*. The rhythms of the pulse as well as clinical history and observation are used in diagnosis. Herbs, oils, dietary management, detoxification, and some massage regimes are included in treatment.



This medicine system is traditional in India and there are a number of practitioners in New Zealand (including Westerners who are being locally trained).

The following case study illustrates how a nurse applied culturally appropriate techniques to resolve a cultural conflict with the mother of a child who was admitted to the Emergency Department with high fever and practicing Ayurvedic treatment. The case study provides a question for viewers to consider and reflect. *Discussion and suggested approaches for this case can be found under the Case Studies section.*

Case Study 4: Humoral/Body Balance (Ayurveda)

Shanti presents at the Emergency Department with her daughter Saroj (age 18 months). She reports that her daughter has had a fever, runny nose, and a cough for the last 2 days. Saroj has a temp of 39.5°C and she is dehydrated because she is not drinking much fluid. It's a hot day but she is dressed in a jumper, hat, leggings and socks and wrapped in a blanket. The doctor on duty explains that they need to get Saroj's temperature down quickly.

The doctor unwraps the child, gives her an ice-block and asks the nurse to give her antibiotics and an IV drip. The family follows *Ayurvedic* traditional medicine principles and in this practice to maintain body balance cold foods are not consumed during a cold/fever. Herbal remedies are preferred for treating coughs and colds and for restoring health.

The family objects to the ice-block as they think that this will make her cold and the fever worse. The emergency nurse explains that cold drinks will help Saroj because they will lower her temperature. The family strongly objects to this recommendation.

The nurse respectfully acknowledges Shanti's concerns and enquires about Shanti's traditional practices and the reasons for her objections.

The nurse realises that Shanti's objections are because of her strong traditional beliefs. The nurse acknowledges Shanti's beliefs and practices, and emphasizes their common goal which is to reduce Saroj's fever. She then explains the immediate need to reduce Saroj's temperature to avoid the child's temperature continuing to spike which may lead to serious consequences.

The nurse finally manages to get Shanti to agree with the recommended approach and asks her to monitor Saroj to make sure that her temperature is back to normal. The nurse also suggests to Shanti, that once Saroj recovers, she can provide the necessary traditional Ayurvedic herbal remedy to restore her health.

Shanti says *"thank you I will stay with Saroj and monitor her progress. I agree that it is most important to manage Saroj's temperature and to get her well first."*

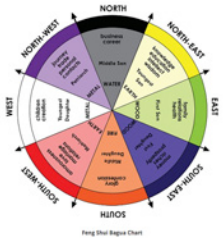
Question 1: What techniques did the nurse use to resolve the differences in beliefs and practices with Shanti to achieve a culturally appropriate outcome?

Discussion notes are available under the "Case studies – discussion notes" section (p.124).

Environmental/Metaphysical

In some Asian culture there are strong beliefs in fate or predestination and therefore the use of techniques such as Feng Shui, Palmistry or fortune telling is common. The purpose of these techniques is not only to increase or bring good luck to a person, but also to find out how to avoid bad luck and to enhance health, wealth and prosperity.

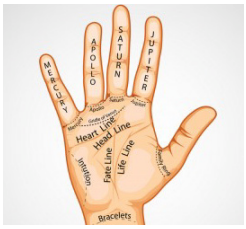
Feng Shui



(*Fong Shway*) Feng Shui is a Chinese philosophy about the relationship between humans and their environment. It is about how everything is connected and affects your well-being. It is believed that the practice of *Feng Shui* can help to enhance your good fortune.

http://megafengshuishop.com/feng-shui-bagua-formula.

Palmistry



The beliefs about Palmistry are similar to western practices, where the lines on the palms of the hand can predict a person's fortune, attitude, health, character, marriage, fortune, etc.

http://psychiclibrary.com/beyondBooks/palmistry-room/

Superstitions

With those who believe in fate, there are a lot of superstitions around what can bring you bad luck. For example, the number 4 for Chinese and Koreans has the same connotations as the number 13 for western cultures. The main reason is that the pronunciation of the number is very similar to the pronunciation for death in the respective languages. Therefore there are many buildings without a 4th floor in countries that use these languages.

Some remedies that are used to avoid bad luck are changing your environment, changing the directions of windows or doors, using charms or talismans to ward off evil spirits, carrying out specific acts. For example a lot of Chinese people will have number plates with 8 because the number 8 sounds like the word for lucky in Chinese languages/dialects.

Spiritual and religious beliefs

Asians have very diverse religious belief systems. Religious beliefs are not universal among all Asians. In the healthcare setting, it is helpful to have a basic understanding of the individual patient's chosen religion and how the person practices and lives out that faith. The following are the religious affiliations identified by the following Asian groups in New Zealand (Mehta, 2012)

- Chinese: 57% no religion; 21% Christian; 13% Buddhism.
- Indians: 56% Hindu; 16% Christian, 13% Muslim, 10% Other religion, 3% no religion.

- Sri Lankan: 24% Christian; 42% Buddhist; 26% Hindu; 3% Muslim; 3% no religion
- Koreans: 71% Christian; 5% Buddhist; 19% no religion.
- Japanese: 11% Christian; 18% Buddhist; 61% no religion
- Cambodians: 74% Buddhist; 8% Christian; 12% no religion.
- Vietnamese: 50% Buddhist; 26% Christian; 20% no religion.

The following are some aspects of the religious/philosophical belief systems which impact on Asian health beliefs and behaviours:

- **Confucianism** is a religion/philosophical system, which emphasizes devotion to parents, family, friends, and ancestral worship. Also central to Confucianism is ethicality and the maintenance of justice and peace.

- **Taoism** is a philosophical/religious system which advocates harmony, simplicity, and selflessness.

- **Buddhism** is a religious and philosophical system based on the teachings of Gautama Siddharta (also spelled Siddhartha), the Buddha (in Sanskrit, "The Awakened," "The Enlightened"). The branch of Buddhism most commonly practiced by Koreans is Mahayana Buddhism, or the "greater vehicle," which also is practiced in Korea, Vietnam, China, and Japan.

  The teachings of the above three religions/philosophical systems are quite similar in some ways, teaching three different routes to the truth, new beliefs grafted onto old beliefs, harmony with nature, acceptance of what life brings. Thus a patient believing in this teaching may feel that they have to accept what life brings to them.

- **Hinduism** teaches the law of behaviour and consequences in which actions in past live(s) affects the circumstances in which one is born and lives in this life (Karma).

  A Hindu patient may feel that his or her illness is caused by karma (even though there may be complete understanding of biological causes of illness).

- It is not uncommon for Koreans to encompass several spiritual views into their religious belief systems. Among the religious views embraced by Koreans are Confucianism, Shamanism, Taoism, Buddhism, and Christianity. Shamanism is a belief in good and evil spirits which can be influenced by Shamans, ie religious/spiritual practitioners with a special relationship or insight into the spirit world.

- The shamanistic health practice of healing the body and soul is called *hanyak* in Korean, which is the use of herbal medicine to create personal harmony. Shamans are consulted as a last resort for treatment or spiritual options. Although shamans provide profound spiritual services to people, they are considered part of the lowest class by Koreans.

Suggested approaches:

- *Assess, acknowledge and respect traditional health and religious beliefs and views about health and illness; health seeking behaviours and treatments. Negotiate a mutually acceptable outcome and integrate the traditional practices or beliefs which are not harmful. Traditional practices can be beneficial for improving patient outcomes when incorporated into the patient's treatment or recovery plans.*
  If the beliefs and practices are harmful or impact on the child's health or development, it is important to explore the reason(s) for the practice/belief and to make every effort to explain serious consequences to the family in a way that they understand. ***NB*** *Some Asian families are not familiar with what may be considered child neglect or child abuse in New Zealand.*

The following case study illustrates a parent's religious and cultural perceptions about food and the value of having "pale skin" and how the GP responded to the parent's views. The case study provides questions for viewers to consider and reflect. *Discussion and suggested approaches for this case can be found under the Case Studies section.*

Case Study 5: Religious beliefs (Hindu)

Mrs Shukla presents with her 2 ½ year old son Rajiv, who has a persistent cough and recurrent chest infections. This is her third visit for a chest infection this winter.

Rajiv looks pale and sickly. The GP tests him for anaemia and Vitamin D. He asks about his diet. Rajiv is cared for by his grandparents as his parents work long hours in their business. Rajiv is fed on whole milk (blue top milk) 3 times a day as he will not eat any solids.

His blood tests show him to be anaemic and to have severe Vitamin D deficiency. The GP recommends that Rajiv is introduced to solids including red meat to increase his iron levels.

The GP prescribes Vitamin D for Rajiv and for Mrs Shukla.

Mrs Shukla says that they are vegetarian and would not feed their child meat. The GP suggests that Mrs Shukla introduces eggs. Mrs Shukla says that it is against her religion (Hindu) to eat eggs and that her parents in law would object strongly.

The GP consults with a colleague who practices the Hindu faith, who suggests that the family introduce *rajma* (a curry made with beans or lentils). Foods such as kidney beans, dahls and lentils are rich in protein, folate and iron and will replenish Rajiv's iron stores.

Mrs Shukla says that her 6 year old Sanjay was also pale as a toddler but "came right" when he was older. In consultation with a colleague, you find out that having children with pale skin is highly valued in Indian culture, which may have provided a disincentive for the family to consider that their child was unwell and lacking in essential micronutrients.

Question 1: How could the GP have intervened earlier to have prevented Rajiv's anaemia and severe Vitamin D deficiency?

Question 2: What health education messages will be important for Mrs Shukla to ensure that her son's health improves?

Question 3: What could the GP do to improve his cultural awareness, knowledge and skills?

Discussion notes are available under the "Case studies – discussion notes" section (p.125).

Additional information is available in the following supplementary resources accessible via www.eCALD.com.

- *Supplementary resource: CALD Working with religious diversity: (includes principles of Confucianism, Taoism, Folk Religion, Buddhism, Traditional Chinese Medicine).*
- *Supplementary resource: CALD Working with CALD clients: Disability Awareness (Disability in Islam cultures, some African and Asian cultures).*
- *Supplementary resource: CALD Working with Asian Mental Health Clients.*
- *Supplementary resource: CALD Working with Middle Eastern and African Mental Health Clients.*
- *Supplementary resource: CALD Family Violence Resource for Practitioners: Working with Asian, Middle Eastern and African Women.*
- *Supplementary resource: Maternal Health for CALD Women Resource for Practitioners: Working with Asian, Middle Eastern and African Women.*

Asian perceptions about health and illness

Expectations of a perfect baby

- In the second generation of the One Child Policy in China, four grandparents and the two 'only child' parents await the delivery of a baby, creating a demand for a perfect outcome (Hellerstein et al., 2015).
- Asian community attitudes and beliefs towards babies with impairments, and the impact on parents and families, are explored in the Disability section of this resource.

The following case study illustrates the expectations of a perfect baby and how the parents reacted and responded towards the news that their baby had a cleft palate. The case study provides a question for viewers to consider and reflect. *Discussion and suggested approaches for this case can be found under the Case Studies section.*

Case Study 6: Birth defects (Chinese)

Jinjing Xu arrived from Shanghai with her husband 5 years ago. She is pregnant for the first time. Mrs Xu has a scan at 25 weeks of gestation. The scan reveals that the baby is a girl and that she has a cleft palate. Jinjing and her husband are determined to terminate the pregnancy. There is a lot of pressure from Jinjing's mother-in-law in China who expects a grandson and a perfect baby.

In China, late termination and abortion is acceptable. Abortion clinics are government-funded and termination of pregnancy services are available on request for women except in cases of sex-selective abortion. Despite this policy, sex-selective abortion continues to be prevalent and practiced because it is not easy for the Chinese government to regulate the practice and son-preference in Chinese families persists. In many cases the couple can pay, when having an ultrasound or will try to pay to be told the sex of their child (Hesketh et al, 2005; Junhong, 2001).

Question 1: How could giving the results of the scan to Mr and Mrs Xu have been better managed?

Question 2: What do you think are the implications of having a baby with a 'cleft palate' for the parents and grandparents?

Question 3: What is the role of grandparents in the decision-making to terminate the pregnancy?

Question 4: Is the gender of the child a factor in Mr and Mrs Xu's determination to terminate the pregnancy?

Question 5: How would you support Mr and Mrs Xu through this difficult diagnosis?

Discussion notes are available under the "Case studies – discussion notes" section (p.124).

Babies head

- Some Asians, especially Hmong people, believe that touching a baby's head draws out the soul or spirit. If the spirit leaves the child, the child will get sick. It is also believed that making a fuss over a child will draw attention to the baby and the child's spirit might be stolen as a result of this. (Livo et al., 1991).
- Hmong are ethnic groups from the mountainous regions of China, Vietnam, Laos, Myanmar and Thailand. (Wikipedia,2017).

Suggested approach:

- *Precautions should be taken, unless it is required for medical reasons. For example, newborn hearing testing equipment is placed around the head of the newborn. An explanation about the procedure and risk must be provided to parents (and grandparents) to avoid refusal or non-consent for the testing.*

Birth and postnatal care

Each family may have different rites and taboos regarding birth, and postnatal care.

Birth

- For many Asian women coming to maternity wards may be their first experience in a New Zealand hospital. They may not know what to expect and may be confused and frightened by the unfamiliar care and environment. Most Asian women would like to have a female relative, usually their mother or mother-in-law, with them during their birth.

Suggested approach:

- *Explain the services and ask about the woman's expectations and needs during birth.*

Postpartum practices

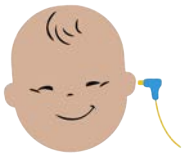
- Traditional postpartum practices are influenced by the belief that they help women rejuvenate, rehabilitate, recover and regain their energy. The practices are believed to prevent the ailments of old age such as: poor vision, digestive disorders, uterine prolapse, back pain, aching joints, headaches, varicose veins, wrinkling of the skin and premature aging. It is generally believed that postnatal women require a lot of rest and should be relieved of household chores for a month (30 days) or more after the birth. Women are not expected to exercise. During this period, new mothers are not allowed to shower or shampoo. Traditional Chinese women must observe stringent dietary restrictions eg they are expected to eat "*yang*" foods, which are neutral and warm and

are beneficial for restoring the body to its natural balance of "*yin*" and "*yang*". All foods must be cooked and served hot including water. Some of the special soups or foods may have a strong smell that may not be appealing to westerners.

Suggested approach:

- *Find out before the birth what the family requires, identify any specific-cultural requirements, acknowledge and respect families' practices and offer culturally appropriate support eg offer the woman other options such as warm or hot water to sponge herself with if she is not showering.*

Newborn Hearing Testing



- Newborn hearing testers need to be aware that some cultural practices or beliefs may impact on the uptake of newborn hearing screening.
- Asian women observing traditional postpartum practices may spend most of their time resting after the birth of their baby.
- Some Asian women are not happy with any intervention that involves their babies' head and are unfamiliar with the newborn hearing testing programme and the benefits.
- Some grandparent(s) who are with the new mother may refuse newborn screening even though the mother agrees to the procedure.

Suggested approaches:

- *It is important for Newborn Hearing Testers (NHT) to complete the newborn hearing test before the woman is discharged.* ***NB*** *Asian women who are observing traditional postpartum practices strictly may be expected by their mother or mother-in-law not to leave the house during the postnatal rest period. Asian women may refuse to come into the hospital for newborn hearing testing after they have been discharged.*
- *Ask the midwife to remind the mother about the screening. Preparing the mother for the NHT visit to the birthing suite to do the newborn screening will make it more acceptable to carry out the procedure while the woman is resting in her room.*
- *Explain the screening process, the risks and benefits of the screening to the new mother (and the grandparent(s) who may be involved in the care of the newborn).*
- *Providing screening information in the client's language is helpful or engaging an interpreter when explaining the screening process to non-English speaking women or grandparents.*

Hearing Loss and Hearing aids

- Some Asian families are reluctant or may refuse to let their child, who has been diagnosed with a hearing loss, wear the prescribed hearing aids because it makes the child's disability visible.

Suggested approaches:

- *If a parent refuses to let their child wear the prescribed hearing aids, health practitioners need to explore the reason why and explain the impact of the hearing loss on the child's development. Explain that it is mandatory that their child wear the hearing aids and that not allowing a child to wear hearing aids may be considered child neglect. The consequences may lead to a referral to the Ministry for Vulnerable Children (MVCOT, formerly Child Youth and Family services).* ***NB*** *Asian parents may not be familiar with the NZ definition of child neglect or the seriousness of a referral to MVCOT. All efforts must be made to encourage the family to cooperate and to explain the consequences to ensure compliance.*

Infant care

- Traditionally, Asian women are considered weak and 'toxic' during this period, as evidenced by the presence of postpartum discharge. Postnatal discharge or lochia is thought to be contagious and for that reason other women are discouraged from coming into contact with it. It is a belief that the follicles expand during birth, leaving the new mother weak and vulnerable to "cold", "air", "wind" or "rain", and thus she is discouraged from going out of the house. In some cases new mothers are not expected by their mother or mother-in-law to leave the house during the postnatal rest period. The mother will not therefore visit their newborn who is in the Neonatal Intensive Care Unit. This may be misunderstood by nursing staff as poor maternal bonding with the newborn.
- Some Asians believe that praise should never be given to a newborn as this invites the attention of demons and ghosts who may steal the child because of his/her desirability. Their preference is that the baby be referred to with unfavourable words such as *"you are ugly"*. This is common among Hmong an ethnic group from China, Myanmar, Thailand, Vietnam) (Franklin, 2005).
- Some Muslim and Hindu families also keep a lamp burning throughout the night for seven days to drive evil spirits away from their newborn babies. (Franklin, 2005).
- The 'Mongolian blue spot' (a bluish pigmentation) is common at birth amongst Indo-Chinese and other Asian babies, and persists until the age of 18 months or two years.
- Some babies may be over-wrapped and sleep in a prone position.

- Some babies may be separated from their mother for at least the first 24 hours, to allow the postpartum mother to rest.
- For some, grandmothers, particularly the father's mother, are often very involved with the new baby and the new mother's recovery. Their authoritative position should be acknowledged when caring for the mother and the baby, during teaching sessions.
- Babies in some Asian cultures may not be named for 1-3 months. For example, in Chinese culture, the baby may initially be given a nickname to be used until a formal name is given. A child's formal name is usually picked by its grandparents traditionally. A baby's naming ceremony is very important because Chinese people believe that one's name can influence everything that happens in life. How this ritual is celebrated depends more on each specific family than on traditional rules.
- Some may not like to have a baby crying too much or some may not like to leave the baby lying on a bed too much. So Asian mothers/ grandparents may carry their infant quite often rather than leave their baby crying as this is considered neglect or bad parenting. It is common for the parents to have the baby "rooming-in" in their bedroom and this practice may persist until the child is more than one year old.
- Many Asian women who are urbanised and live in big cities in Asia are not familiar with benefits of breastfeeding. There is much anxiety and stress about breastfeeding. Some mothers believe that formula provides more nutritional content than breast milk and will supplement breastfeeding. Additionally, for some families, the grandparents are the primary care giver.

Suggested approaches:

- *Explain to the woman the benefits of breastfeeding and bonding while the newborn is in the neonatal intensive care unit. Explore the potential reasons for the woman refusing to visit the newborn (avoid assuming the mother has bonding or child neglect issue).*
- *Explain to the woman what is expected from them for the care of their newborn, when the newborn is under intensive care.* ***NB*** *they may not be familiar with service expectations.*
- *Explain to the mother (and grandparents) that breast milk is sufficient for all their baby's nutritional needs. .*

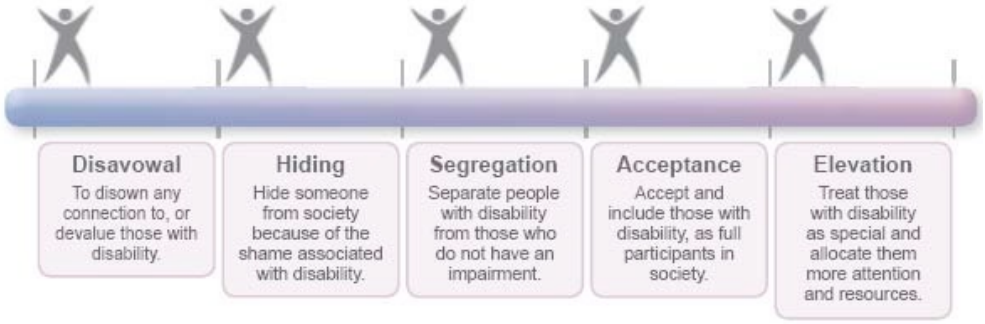
Male Circumcision

- Circumcision is performed on all male Muslim children. The timing of this varies but it must be done before puberty (Queensland Health and Islamic Council of Queensland, 2010).
- Additionally, circumcision is common in the Philippines and South Korea; for 13% in Thailand (Castellsague et al., 2005; Gopal, 2009]; and between 17 to 20% in some regions in China (Ben et al., 2008; Sullivan et al., 2009; Yang et al., 2009).
- NB Female Circumcision is illegal in New Zealand. *For further information see the Maternal Health for CALD women: Resource for Health Providers working with Asian,*

Middle Eastern and African Women (Waitemata DHB, eCALD® Services, 2016g pp 40-41).

Child Disability

- Disability carries stigma in most cultures. Attitudes towards treatment, care, opportunities and inclusion for children with disabilities and their families can vary considerably in Asian communities compared to New Zealand policy on disabled rights and entitlements (Hasnain et al., 2008; Ministry of Social Development, 2016; Pinto & Sahur, 2001).
- The different explanations Asian cultures have for the causes of disability (eg shame, karma, curse and punishment) and community attitudes impact on how families care for children with disabilities. This can range from disavowal, hiding, segregation and acceptance through to elevation – treating people with impairment as special (Waitemata DHB, eCALD® services, 2016d).



- Beliefs about keeping children with impairments outside public view, coupled with cultural/religious explanations about the causes of disability can affect the extent of care and support accessed and accepted by a family (Galloway et al., 2003; Kim-Rupnow, 2001; Liu, 2001; Wang, Michaels & Day, 2011).
- The stigma associated with disability, a lack of disability services in countries of origin and settlement issues can leave Asian families isolated, stressed and difficult to engage with (Galloway et al., 2003; Kim-Rupnow, 2001; Liu, 2001; Wang, Michaels & Day, 2011).
- To improve families' knowledge, understanding and acceptance of services, involve a cultural case worker (when available) to liaise with and support the family (Harris, 2004, Goode, 2003; Mortensen, Latimer & Yusuf, 2014).
- To ensure engagement, include a Cultural Case Worker and / or an interpreter in consultations from the outset, and identify and include the key decision maker and caregiver/s for the child in every session.

- Where possible, provide information in the family's language, give clear explanations of roles and services, and take time to explain why different services and professionals are involved.
- Remember that not all people belonging to the same culture will subscribe to the culture's ascribed beliefs; some may hold traditional explanations yet follow mainstream medical interventions, whilst others may have rejected cultural explanations altogether.

The Islamic perspective on disability
(Waitemata DHB, Child Women & Family Services, 2013)

- There are a number of aspects of Islam that are helpful for families coping with disability. Muslims believe that everything that happens in life, whether good or bad, is from Allah. This is understood as fate (qadr) and acceptance of fate is an important part of a Muslim's daily life
- Having a family member with a disability can be seen as a test of faith, an elevation or higher rank in piety or an opportunity to acquire sustenance (rizq) by caring well for a person with a disability.

Cultural perspectives on disability in Muslim communities in New Zealand
(Waitemata DHB, Child Women & Family Services, 2013)

- Cultural views often differ significantly from the Islamic perspective of disability. Stigma and shame in the community are big issues that families face.
- The causes of disability may be viewed in many different ways, for example: the result of the sinful actions of the parents or of ancestors; a curse from God; a source of shame; a blessing; or a test of faith.
- According to some cultural views in home countries, disabled people are sometimes perceived as having the power to "infect" others with the same affliction and are therefore avoided.
- Cultural views of disability vary among different cultural groups within the Muslim community. In many home countries, the word 'disability' means physical disability. An intellectual disability or mental health issue is not seen as a disability. A child with an intellectual disability might be labelled 'crazy' or considered possessed by a 'jinn' (spirit). This difference in terminology can cause confusion for parents.
- Disabilities acquired through accident or war may be seen as more acceptable than congenital impairments. In some cultures, people with disabilities are hidden from the community.
- In New Zealand, the understanding and attitude of many Muslim community leaders towards disability, particularly those working in the health or social services sectors, has changed, as have the attitudes of those who have lived in New Zealand for some time. However, other members of the community, and particularly older family members tend to hold traditional cultural views about disability and they are also often the decision makers.

Further information on Muslim perspectives on disability are available from: Waitemata DHB, Child, Women & Family Services (2013).Working with Muslim Families and Disability. Auckland: WDHB Child, Women & Family Services. Retrieved from: www.ecald.com/Portals/49/Docs/Toolkits/Toolkit%20Muslim%20Families%20Disability.pdf.

Suggested approaches:

- *Become aware of the different explanations regarding disability (eg karma, punishment, witchcraft or curse).*
- *Use an interpreter and / or a Cultural Case Worker to assist engagement with the family, especially for the first meeting and assure confidentiality.*
- *Explain your role to the family.*
- *Identify the decision maker.*
- *Identify the main caregiver.*
- *Work with the family and understand their goals.*
- *Explain that there may be other practitioners involved in the child's care (and what their roles are).*
- *Explain how the New Zealand health system works for their family.*
- *Provide translated information on how to use New Zealand health and disability services (see Resources section).*

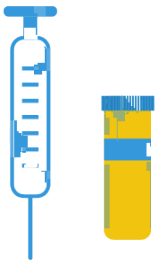
Working with Muslim families with a child with a disability

- *Building trust is most important in order to engage the family and should be the main focus of early encounters. The family is a very important part of a Muslim's life, so it is important to include the extended family.*
- *Decision-making: Find out who the decision maker is and include this person in discussions early on if possible. Sometimes the decision maker lives offshore. Also find out who is the main carer, and include the decision maker and the main carer in the development of care plans.*
- *Avoid making generalisations and stereotyping people. It's best to ask if you don't know.*
- *Remember that the family's goals for their child with a disability may be different from the goals of health and disability services. You may be able to understand the family's expectations better by asking how the situation would be managed in their home country. A good approach is to learn what the family's goals are and support these while negotiating to have the service's goals agreed to as well. Health services may not have been available in their home country or they may have been organised differently, so how services work may need to be explained (sometimes many times).*
- *Because disability support services may not have been available in home countries, parents may not understand their purpose. They may need help to understand the roles of agencies eg Needs Assessment and Coordination Service (NASC) and of practitioner role eg Speech Language Therapist (SLT). Remember to explain your role and the role of others involved in treatment, therapy or care. Be prepared to do this more than once.*
- *Disability support services are sometimes refused because the family expects*

to care for the family member themselves. It might be helpful to remind the family that it is alright to accept support from others.

- *It is good to acknowledge that any religious methods of treatment (as long as they are within New Zealand law) can work well alongside western methods, and that any form of treatment is from Allah.*
- *Finding a culturally appropriate carer can be difficult. It is not unusual to find that a family has been assessed as eligible for carer support, but cannot find anyone to take up the role. Using individualised funding can be helpful in employing a language matched/ culturally appropriate carer.*
- *If offering a respite care service, be sure that religious requirements are accommodated. The provision of halal food and provision for prayer are two important considerations.*
- *Participation and inclusion of disabled children in activities and in the community is an issue for some families. In the Auckland region there are CALD disability support groups available. Further information can be found on the eCALD® services website: www.ecald.com/news-updates/news/cald-child-disability-newsletters and the Disability Connect website: http://disabilityconnect.org.nz/.*

Medications



- Some Asian families hold beliefs that any kind of medication taken continuously has side effects (Stewart & Das, 1997).
- However, on the other hand, when parents/grandparents are seeing a GP or a specialist, many will expect something tangible, like a prescription or an injection, as part of western treatment. This is often a standard practice in their countries of origin. Just talking can be seen as a waste of time and money (especially if they are paying for the service).
- Traditional Asian families would consider Western medicine as useful in acute situations, and traditional treatments are useful for address underlying causes and longer term health. Some clients may use western and traditional treatments concurrently and the possible interactive effects of medicines may need to be assessed.

Suggested approaches:

- *If no prescription or intervention is being offered to the patient, explain the cause of the illness and the reason for no intervention or medication prescribed. Offer practical help or health tips where possible to keep the client engaged.*
- *Assess whether clients are using western and traditional medications/ treatments concurrently.* ***NB*** *questions could include:*
  - *What do you think caused this illness?*
  - *How do people from _____ usually treat this illness?*
  - *What have you done already to cope with / treat this illness?*

- *What other medications are you taking?*
- *Who prescribes your other medications?*
- *What do you do when you run out of medication?*
- *Can you access similar source/s of help here in New Zealand?*

Festive seasons

- There is a belief that taking medicine or brewing medicine on the first day of the Chinese New Year will result in the person getting ill for a whole year. For some traditional Chinese families when family members are sick, they may break their medicine bottles in the belief that this custom will drive the illness away in the coming year.
- Some Asians may not attend scheduled medical appointments during festive seasons for the same reason.

Suggested approaches:

- *To avoid non-attendance by patients who believe in such taboos, confirm with CALD patients that the appointment date suits them and reschedule if it coincides with any festive seasons.*
- *To confirm appointments with non-English speaking patients, ask for an Appointment Confirmation Service from an interpreting service to assign an interpreter to contact the patient to confirm the appointment date and time over the phone. Also remind the patient to cancel the appointment with the service if they are unable to attend (advise them to ask an English speaking family member or friend to contact the service if they can't speak English).*

Food

- Asians have specific food requirements when sick (due to Body Balance beliefs, and to cultural dietary norms differing from western ones.
- Chinese people prefer hot meals and hot drinks when they are sick eg hot tea, clear soup.
- Rice is standard for every meal for Indian families. Meals are usually served with sambhar, rasam (thin soup) and dry curried vegetables. Indian women after birth prefer traditional food called "katlu" or "panjiri", which provides a "hot effect" for restoring energy. Many Hindus have a vegetarian diet and will not eat any foods with meat products eg yoghurt which contains gelatine.

- For Koreans, rice is the main staple along with vegetables and small amounts of meat. There is no preference for hot meals and hot drinks when unwell.
- Some Asians may avoid certain foods (eg egg, beef or seafood) after an operation.
- Asians may like to have pasta (with soup), porridge with vegetables and a small helping of pureed meat or fish.
- Rice culture is popular in Asian countries whereas bread culture does not give patients feelings of adequate nutrition or an adequate meal. Hard rice is not enjoyed by Asians when they are unwell. They prefer soft rice cooked in a rice cooker.
- Asians may avoid oil/butter/cheese when sick.
- Asian families/friends may cook food for patients, whenever possible.
- Asians may prefer home-made baby food eg congee rather than the ready-made baby food (cereal/ jar food).
- Asians may feel that being on a drip will not give them enough nutrition and begin to feel weak after a few days if not fed by mouth.
- Islam has rules about the types of food which are permissible (halal) and those which are prohibited (haram). The main prohibited foods are pork and its by-products, alcohol, animal fats, and meat that has not been slaughtered according to Islamic rites. While most prohibited foods are easy to identify, there are some foods which are usually halal that may contain ingredients and additives that can make them unacceptable. For example, foods such as ice cream may contain pork by-products such as gelatine, which is considered unacceptable.

Suggested approach:

- *Consult with families about their food preferences and any special requirements (eg halal, vegetarian, etc) for their children or young person. They are usually happy to advise and/or supplement hospital food when necessary.*

Surgery and treatment

Asian people have different perceptions, habits and taboos towards illness, eg some Asian families view surgery as a major big trauma.

- Some Asians may consider chemotherapy toxic and harmful for the child, and may seek alternative treatments.
- After diagnosis is provided, if information about treatment is not provided in a timely manner, some Asian families may take their child back to their homeland for further investigation or treatment.
- Western medications are believed to have side effects and to compromise general health.

- The caregiver for the child in Asian families may take time to consider options, or talk to their husband/father of the child and to older family members.
- Asians may avoid bathing or showering when recuperating from surgery as they are afraid of getting cold.

Suggested approaches:

- *Provide clear explanation of diagnostic tests, surgery or treatment options, process, timeframe and consequences, in the client's language.*
- *Assess health literacy and language proficiency and use professional interpreters. (Avoid using the sick child or family members to interpret).*
- *Seek feedback from families about the information provided to ensure comprehension.*
- *Offer the option of sponging the child with warm water, if the family refuse bathing/showering after major surgery.*

Rehabilitation

Generally Asians have a smaller body build and believe that they need a longer recovery time. They traditionally have a lot of rest when ill and are careful not to over exert themselves when in recovery. Concepts of rehabilitation and exercise may be new to some clients.

Suggested approaches:

- *Ask families about their concept of recovery or rehabilitation.*
- *If their concept does not include physical activity, explore and negotiate culturally and mutually acceptable activity that could be incorporated into the recovery plan for the child.*
- *Explain the benefits of the rehabilitation process for the child's recovery and development and seek feedback from the family about what activity would be considered acceptable and monitor the child's progress.*

Protective Charms

Vietnamese, Cambodian, Thai and Laotian cultures may have protective charms for children in the form of string bracelets or necklaces.

Suggested approaches:

- *Explain to the parents the need to remove the charms for the procedure or treatment. Usually the parents will be happy to do so. They may need to pray before the charms are removed.*
- *During emergency situations, if the charms are in the way and the parents of*

the child are not available to ask for permission, it is culturally appropriate to remove and put the charms aside, then return and explain to the parents the medical reasons for the removal, when they arrive.

Paediatric Palliative Care

- The challenge of providing compassionate end-of-life care is compounded when cultural differences occur and there are language barriers.
- Ethnicity and religion influences the acceptability of withdrawal of intensive care treatment (Warrick, Perera, Murdoch & Nicholl, 2011). For example, Muslims believe the deliberate taking of life is unacceptable and some believe that the 'premature termination of life through acts of omission' is also against their teachings (Gatrad, 2008). Spiritual leaders may offer support to parents and advice to clinicians with decision-making.
- In Asian cultures, it is the duty of parents to do everything possible to prolong the life of their baby/child.
- Family members' views may be in conflict with medical views regarding what constitutes the optimum quality of life and end-of-life treatment or care.
- Children in New Zealand with a life-limiting illness die in hospital with a significant influence resulting from ethnic background, diagnosis and referral to the paediatric palliative care (PPC) service. A PPC service was established at the Starship Children's Hospital in Auckland. This small multidisciplinary team provides care across the hospital to home continuum in greater Auckland, and advice to other healthcare services nationally (Chang et al., 2013).
- Asian children are more likely to die in hospital compared with New Zealand European children. (Chang et al., 2013)
- Asian families are often unfamiliar with advance care plans. They may be reluctant to discuss end of life care for their child, based on the belief that acknowledgement of their child's impending death may be self-fulfilling.
- Families often choose not to openly discuss death and dying with their child for fear that this will damage his or her hope, causing a poorer prognosis. This can cause conflict between the healthcare team and the family, particularly when the child is an adolescent or young person.

Suggested approaches:

- *Insights into the cultural beliefs which influence family's preferences about where a child dies will enhance the end-of-life care planning for Asian families (Chang et al., 2013).*
- *At the end of a child's life, the focus needs to be on quality as defined by the family, not the provider. Supporting parents so that they can fulfil their traditional role as care-givers, protectors, decision makers, providers of love and physical tenderness, and instillers of faith requires an individualised*

approach to end-of-life care. Respecting beliefs, customs, and traditions with a focus on preserving the integrity and sanctity of the parent–child relationship is of utmost importance in paediatric palliative care (Wiener et al., 2013).

- *When working with Asian families **who may not have advance care plans or may not be familiar with advance care planning:***
  - *Offer families the opportunity to discuss end of life care and advance care planning with a professional interpreter. A list of Interpreting Service Providers can be found on this site http://www.ecald.com/Resources/Migrant-and-Refugee-Services/Services-by-Provider#interpreting or check your DHB/service's policy on how to access interpreting services. Advance care plans provide shared goals of treatment between family and healthcare professionals that can guide treatment during a period of deterioration and end of life care.*
  - *Avoid using words such as 'death' and 'fatal illness'. (Tse et al, 2003)*
  - *An alternative which may be less threatening is presenting issues to parents in hypothetical terms to determine levels of comfort with planning for end of life care for their child (Wiener et al., 2013).*
  - *Consider referring to, or obtaining advice from the paediatric palliative care team.*
- *If family **choose not to discuss end of life care,** contingency plans need to be made in case the child arrives at emergency department in crisis to avoid confusion.*
  - *Contact the child's general practitioner, primary paediatrician, paediatric team members and emergency department staff with a clinical update and plan.*
  - *The child should be assessed and stabilised in the first instance (Paediatric and Child Health Division of the RACP, 2008).*
  - *Discuss the child's condition and prognosis with the family.*
  - *Negotiate goals of treatment and discuss management options with the family.*
- ***If there is a conflict with medical views** eg the family want to fulfil their duty as parents by prolonging the life of the child:*
  - *Listen respectfully and hear the values and views of family members.*
  - *Demonstrate awareness and understanding of the family's need to do their very best for their child. It is important to offer advice with empathy and compassion and to help reduce the family's feelings of anguish about potentially not fulfilling their obligation to do the best for the child from their perspective.*
  - *Explain your concerns about initiating treatment aimed at prolonging life eg causing suffering to the child with little or no benefit,*

prolonging the dying process, the possibility that ventilation may not be able to be weaned.

- *Negotiate a management plan with the family that includes symptom management, psychosocial emotional and spiritual support. This may include a short trial of treatments aimed at prolonging life e.g. antibiotics, non-invasive ventilation. If necessary seek palliative care, ethical and medico-legal advice.*

- *When **spiritual/religious support** is needed:*
  - *Identify any spiritual/religious support the family are already accessing and whether they would like referral to additional services.*
  - *If so, ensure that the spiritual/religious leader to be contacted is compatible with the family's faith (eg Sunni versus Shia, Catholic versus Pentacostal).*
  - *With the consent of the parents and caregivers, access appropriate spiritual /religious support through the spiritual organisations listed on relevant websites.*
  - *If the child is cared for in the hospital, where possible the religious contact should be arranged through the DHB chaplaincy service.*

Expressions of grief: loss of a child

Expressions of grief usually include:

- Personal feelings - sadness, anger, guilt, anxiety, and helplessness.
- Physical sensations - shock, hollowness in the stomach, tightness of the chest, weakness of the muscles.
- Cognition - confusion, disbelief.
- Behaviours - sleep disturbances, crying, social withdrawal.

- However Asians may express their grief differently. This will be influenced by many factors including cultural and religious backgrounds.
- In addition to crying, grieving people may shout, bite their hands and fingers, tear out or cut their hair, jump, rock backward and forwards, or sit in a corner with their eyes closed. In some cultures, grieving people may attempt to vomit. Self-harm is an extreme psychological reaction (eg people may cut their veins or attempt suicide), and is a pathological reaction to grief.
- In some cultures, people mourn for their deceased children less than they mourn for deceased adult relatives. In most societies, women are expected to mourn longer and deeper than men. Men are expected to be strong and not to show their emotions (Queensland Health - Multicultural Services, 2009).

Suggested approaches:

- *If the couple is distressed, source and refer them to language appropriate psychological support or grief counselling service (if available).*
- *Try to elicit potential reasons if the couple refuse psychological support.*

- *If needed and where available, refer him/her or them for a psychiatric assessment.*
- *Encourage early contact with the general practitioner or other health professional.*
- *Where available, if the couple is in a state of denial, reassure them that mental health support is available to them.*
- *Respect their decision not to seek mental health support, as many people prefer coping with grief in a personal manner.*
- *If available, provide printed information (eg booklet, pamphlet) about grief, preferably in the woman's or couple's own language.*

Child and adolescent mental health

Introduction

Migrant children and young people are at risk of mental health problems for a range of reasons. The first is that the migration process causes stress, not only because migration entails extensive loss of family and friends, culture and community, but also because migrants have to adapt to a new cultural environment, often including different social norms, values and standards and a new language (Berry, 1990).

Secondly, intergenerational conflict between children, parents and grandparents due to the incompatibility between the home culture and the host culture, is common. Asymmetric acculturation within families is a pattern in which children acquire the host country culture and language much faster than their parents and grandparents, resulting in conflict and stress in migrant families (Matsuoka, 1990; Potocky-Tripodi, 2002).

Thirdly, the impact of racism and discrimination on the mental health of Asian, migrant and refugee youth is documented in a number of New Zealand studies (Ameratunga & Horner, 2011; Scragg, 2016; Wong et al., 2015). Belonging to a coherent and supportive family culture protects against the development of mental health problems (Hackett, Hackett & Taylor, 1991; Harker, 2001).

Refugee children and adolescents face the same issues of cultural adaptation and intergenerational conflict as do migrant children (Hyman, Vu & Beiser, 2000). They are as well vulnerable to the effects of the refugee experience pre-migration, most notably exposure to trauma and loss. Particular groups in New Zealand refugee populations constitute higher psychological risk than others, namely those with extended trauma experience and unaccompanied or separated children and adolescents (Ministry of Health, 2012). A number of risk and protective factors either moderate or exacerbate poor psychological health including: family cohesion, parental psychological health, individual dispositional factors such as adaptability, temperament and positive self-esteem, and environmental factors such as peer and community support (Stevens & Vollebergh, 2008).

Children and young people's mental health may be impacted both directly and indirectly from these processes. As children are migrants themselves, the migration stressors mentioned may apply to them but they may as well have to cope with inadequate support from their parents owing to their parents' preoccupation with their own migration stresses (Hicks et al., 1993). In the early settlement phase, migrant and refugee families may be confronted with financial hardship, unemployment and housing problems.

Common mental health issues of Asian children and adolescents
Among the common presentations of children and adolescents from Asian backgrounds to Child and Adolescent Mental Health Services (CAMHS) are: mood disorders (depression, bipolar disorders, self-harm, suicidality); anxiety disorders; obsessive compulsive disorders; psychosomatic disorders; stress-related and adjustment disorders; posttraumatic stress disorder; attention deficit hyperactivity disorder (ADHD), developmental disorders, autism spectrum disorder, psychotic disorders, eating disorders; sexual identity issues; internet addiction disorders (IAD) and drug and alcohol addictions (Kirmayer et al., 2011).

A new resource *Mental Health in Asian, Middle Eastern and African Children and Young People* is being developed to discuss these common mental health issues and cultural influences in greater detail.

This section will focus only on cultural perceptions, practices and expectations of services, cultural considerations when assessing children, issues relevant to refugee children and adolescents and intergenerational conflict. A tool for assessing CALD children is provided with questions to explore cultural and ethnic identify and explanatory models of illness.

Cultural perceptions, practices and expectations of services

In Asian countries, all forms and degrees of mental illness and intellectual disability are grouped together and described as 'crazy ' by the general public. Due to this, there is strong stigma attached to mental illness in Asian countries.

- Asian parents may feel ashamed and may hide their children with mental illness from friends or their community.
- Some families may seek alternative or traditional assessment and treatment including spiritual guidance and intervention, or delay Western treatment until the illness becomes acute or severe and is too difficult for them to manage eg the child is self-harming or harming others.
- Stigma may also result in the refusal to use professional interpreters by Asian families who are not familiar with interpreting services and who have concerns about the confidentiality of interpreters.
- There is strong resistance to continuous medication or treatment especially when families feel the side effects of drugs are affecting the child. *Close supervision and support to ensure medication compliance is necessary.*
- Asian families tend to have high expectations when they access the public health system eg hospital or mental health services. They may feel that the family has no further responsibility once the child is in the care of the health services. Their lack of

participation in the recovery plan for the child may be due to their limited knowledge of the mental illness of their child, or their unfamiliarity with the notion of the need for family involvement to support the child or young person to recover. *Psycho-education and close liaison is necessary.*

- Asian clients tend to somatise their mental illness. For example, they will say they have a headache or stomach pain rather than saying they suffer from depression or other mental illness.
- Language barriers and cultural complexity prevent adequate diagnosis and treatment for Asian migrants and refugees. Presentation of mental health symptoms and acceptance of treatment is challenging in cross cultural psychiatric practice.
- Migrants and refugees may not seek psychological services or attend psychological sessions when referred. They may agree but may not turn up for the appointments.

Assessing Asian children and adolescents

(Waitemata DHB, eCALD® Services, 2010)

In traditional Asian families, children are highly valued and protected. They are taught to be quiet, humble, shy, polite and deferential. Emotional outbursts are discouraged and conformity to expectations is emphasized. Failure to meet expectations brings shame and loss of face to the child and the family, so parents are often reluctant to accept that there is a mental health problem. Generally parents do not express affection or praise for fear of encouraging laziness (Kramer, et al., 2002).

Adolescence has little meaning in most Asian cultures as individuation has no value and seeking an identity outside the family is discouraged (Kramer, et al., 2002). However, after migration the adolescent faces the significant challenge of bridging opposing expectations in a new culture, and this often becomes a cause of intergenerational conflict. While individualism is attainable for migrant Asian adolescents, individuation is not a likely option (Ehthnolt & Yule, 2006).

Assessing children and adolescents is best done in a semi-structured way in order to establish rapport, engage the child and collect information. This relationship building approach is particularly important at the first interview when parents are usually included. Further interviews may need to be more structured, especially when assessing for diagnostic criteria, medico-legal reports etc.

Rho and Rho (2009) suggest that:

- Having a parent or caregiver present may be useful in the initial interview.
- A qualified interpreter is important and the child should not be expected to act as an interpreter.
- A holistic approach is mandatory when working with children.
- Time should be taken to explain what a mental health worker is and what services are available.
- Care needs to be taken when analysing the results of questionnaires as many scores have a western bias. Allowances must be made for language and cultural differences.

Rho and Rho (2009) remind us that children either internalise (manifesting as depression or anxiety) or externalise (manifesting as disruptive behaviour) their emotions. Aggression and disruptive behaviour are more common in boys, whilst anxiety and adjustment issues tend to be more prevalent in girls. Depression, anxiety and sleep disturbances are common complaints in children, and depression and anxiety is common in Asian adolescents.

In New Zealand, schools tend to make the most referrals to mental health services, where social, interpersonal and family problems are of concern. Referrals made by caregivers are often influenced by culture and the caregiver's perceptions of emotional and behavioural problems.

Culturally consideration when assessing children

- **Parent's expectation of the child's development and behaviour**
  Conducting culturally sensitive interviews with a young child can be challenging, particularly if the parents do not understand why they have been referred. They may be hesitant to disclose details about the child's behaviour at home if they do not know why they are being asked for the information (Rho & Rho, 2009). It is important to understand the parent's expectation of the child's development and behaviour, and whether they see the issue as problematic in their own culture.

- **Child's insight into what behavior is acceptable at home**
  Using culturally sensitive assessment toys and gaining insight into what behaviour is regarded as acceptable at home, can help the clinician to understand the reason for referral. Children may be encouraged to be assertive and outspoken at school, but in the collectivist culture they come from, this may not be acceptable.

- **Parenting style**
  According to Rho and Rho (2009) corporal punishment is commonly used in Asian countries, especially Korea. When children get referred to clinicians by child protection services, it is important to treat the parents in a culturally sensitive, non-shaming way and to explain that in New Zealand alternative forms of punishment are preferred and that corporal punishment is illegal. Normalising the behaviour in an understanding way and providing guidance on alternative forms of punishment like time-out, is very useful to parents. Educating the referring agencies about the need for cultural sensitivity is essential, as well as correcting misattributions like bruising that are caused by cupping and coining, and not by physical violence (see Coining section under Traditional health beliefs and practices: Humoral/Body Balance in this resource). Educating parents through language appropriate parenting programmes such as the Incredible Years Programme (IYP) will assist with developing parenting skills in the New Zealand context.

- **Acculturation and migration experiences**
  Assessing Asian children who are in the process of acculturating can be challenging (Rho & Rho, 2009). These children are navigating their way through developmental milestones in a foreign country, in a foreign language, in a culture that is unfamiliar. Because developmental processes can be disrupted during migration due to

acculturation (as well as pre-migration experiences for some refugees), it can be difficult to assess developmental stages in the context of cultural norms.

Age at the time of migration is an important factor when assessing cultural differences in expression of psychological symptoms (including somatization). The influence of acculturation is more obvious in those adolescents who immigrated at a young age (Chan & Parker, 2004).

- **Suggested assessment approaches**

  Rho and Rho (2009) suggest taking the following cultural factors into account when conducting assessments:

Children:

- *When assessing children's development, it is important to bear in mind that childhood milestones can be culturally based (eg expectations for toileting skills can vary from 4 months to 4 years, ages at which children walk or talk can depend on child-rearing practices etc.).*
- *In many cultures, children are expected to be 'seen and not heard' and may not communicate assertively with adults, whilst in other cultures children are the centre of attention and are accorded many privileges until a certain age. Expressiveness, both vocal and physical may differ significantly across cultures.*

Adolescents

- *It is important to assess whether identity has been established. Emerging independence in adolescence, recognised in Western cultures may not be relevant to other cultures. In holistic cultures where modesty, respect, courtesy and loyalty are valued, independence is usually not valued. Conflict may occur within families, but also within the adolescent who is caught between two cultures and is trying to define themselves, their values and their beliefs.*
- *Sexuality issues, interracial relationships and taboo subjects like homosexuality will need to be explored in a very sensitive way.*
- *If delinquency issues are involved, referral to school liaison teams may be needed. However, parents may need to be educated about the process and this will require careful cultural consideration.*
- *Due to peer pressure to join a new culture, and adjustment difficulties, drug and alcohol abuse may be a problem. Information may not be accessible to parents due to language barriers.*
- *In general, and in Korea in particular (because of conscription factors) age difference between boys is significant with a difference of only one year providing a child status over another. This can often result in bullying*

between boys that seem of a similar age.

Engaging with family

Many Asian children are likely to come from families that are family-centered, with extended members, rather than from nuclear families. ***It is important to ask who the main caregiver and /or decision maker is and to involve them in the process.*** *Our individually oriented care is often not appropriate for clients where families make decisions, and independence and empowerment are not valued in the same way, or are at odds with families' wishes.*

Problems arise in our approaches because:

- *Families are consulted.*
- *There is insufficient understanding about how family structures differ across cultures, and who is included in family boundaries.*
  - *Key family members are not included in consultations and treatment plans and therefore family members so do not support, or may even prohibit proposed interventions. Family members attending the consultations may not fully understand the plans or reasons for them and are unable to convey these to the head of the family. Sometimes the misunderstanding is because of language or lack of familiarity with the medical terminology, at others it may be due to confusion around multiple services and clinicians.*
  - *The key caregiver in the family needs to be included in the consultations. This person is not always a parent, and may also not be the key decision maker. If they are not involved they may not understand or be invested in procedures or care plans.*

Implications for practice

- *Involving parents or family in the assessment of a CALD child is helpful in establishing acculturation rates of the child and parents. Acculturation, and differences in levels between parent and child, are often at the root of a problem, but may not be obvious in the presenting issue.*

Explanatory models of illness

- *Children also have their own explanations for illness, so it is important to explore the child (as well as the family's) understanding of the problem, and their expectations and beliefs about outcomes.*

Issues relevant to refugee children and adolescents

(Waitemata DHB, eCALD® Services, 2010)

In spite of the resilience of children from refugee backgrounds, many experience mental health difficulties that only manifest sometime after settling. In particular, PTSD may present 2-3 years after migration when the child/adolescent has developed trust in their surroundings.

Young refugees are frequently subjected to multiple traumatic events before and during their migration journey. These may include the loss of parents and siblings, extended family, friends, security and homes, as well as witnessing or experiencing extreme trauma. Ongoing stressors within the host country may exacerbate previous stress. Children are also vulnerable to the intergenerational transmission of trauma. The Cambodian and Vietnamese refugees (and some Laotians) who resettled in New Zealand in the 1970s and 1980s were a highly traumatised group and they have tended not to seek mental health intervention for a variety of reasons. A migration history for Southeast Asian children and adolescents who present to mental health services will be important. Some of these children may be carrying burdens of the unresolved issues of their parents and grandparents.

An awareness of relevant risk and protective factors is important. Commonly reported issues include PTSD, grief, depression, anxiety, sleep disorders, somatic complaints, conduct disorders, social withdrawal, attention problems, generalised fear, over-dependency, restlessness and irritability. In New Zealand substance abuse is a problem amongst refugee adolescents, and PTSD, depression and anxiety disorder are recognised as co-morbid features. Despite treatment, reoccurrence is common.

Refugee children are often reticent to discuss past traumas and choose to focus on the future. This should not be discouraged because a future-orientated view has been associated with lower rates of depression in refugees (Beiser & Hyman, 1997).
Some brief pointers for working with Asian children and adolescents are added here to include those children from refugee backgrounds who are from Asian backgrounds (including: Indo-Chinese groups from Cambodia, Vietnam and Laos; Sri Lankan Tamils; Nepali-speaking Bhutanese or "Lhotsampas", and Burmese groups). This serves to remind the practitioner to investigate the client's migration/refugee experience and ethno cultural background and to orient care accordingly.

Suggested approaches:

- *Stigma, 'saving face', absence of Cartesian mind-body dichotomy, somatization, health-seeking pattern, language barrier and reframing are essential concepts to be aware of when doing assessments. Demonstrating an awareness and understanding of these will go a long way towards good rapport and trust with your client, as well as accessing the more subtle factors in a presentation.*
- *A distinction needs to be made between somatizing distress and how distress is reported to others. Explore how clients experience their psychological and emotional distress.*

- *Whether assessing adults or children, understanding their ethnocultural identity, migration experiences and acculturation levels, are essential. Ask about migration experiences and settlement challenges; these are often inextricably linked with the problem.*
- *Milestones can differ, depending on cultural norms and values. When assessing Asian children and adolescents, explore family expectations and perspectives on development and behaviour. Goals for treatment need to be congruent with family's and child's norms.*
- *Problems related to pre-migration trauma may present years after refugees have settled. Knowing your client's migration history can alert you to possible underlying issues at problem presentation. Be alert for cues and explore these sensitively, but do not push clients to speak about issues that may have been dormant for years.*

Intergenerational conflict

Intergenerational conflict, that is, between parents and children, between parents and grandparents, and between children and grandparents, is very common in Asian migrant and refugee families (Potocky-Tripodi, 2002). Intergenerational conflict between parents and grandparents is explored in the section on *'Intergenerational and interethnic family relationship issues'*. This section will explore the conflict between parents and children and children and grandparents.

Intergenerational conflict is due largely to different acculturation rates between the generations, meaning that the different generations adopt the norms of New Zealand society at different rates, resulting in different expectations of behaviour from parents and grandparents (Matsuoka, 1990).

Many Asian families maintain close ties with family members in countries of origin and therefore the concept of family is transnational. Physically distant family members have a significant influence on parenting and child rearing practices, and on decisions about health care and family dynamics.

The following framework is useful for providing a general understanding of the range of intergenerational conflicts faced by most Asian migrant families.

Conflicts across three generations of migrant and refugee families
(Adapted from Pettys & Balgopal, 1998 cited in Potocky-Tripodi, 2002 pp 316-318)

Adolescents	Parents	Grandparents (in NZ and in home countries)
Gender Roles		
Expectations regarding education, work, household tasks, dating, discriminating rules	Decision-making, careers, roles for children, who cares for grandparents?	Expectations of education and careers for children; who will care for them as they age?

Respect		
How much assertiveness is tolerated by parents? How do I respect parents and grandparents and still disagree with them? Am I viewed as aggressive by other members of my migrant community?	How do I encourage assertiveness without losing the respect of my children? How do I be assertive in my career and with New Zealanders? How do I deal with New Zealanders who do not show respect?	How much assertiveness from children and grandchildren should be tolerated? How do I maintain the respect of both my children in New Zealand and in my country of origin?
Power Shifts		
How much influence do aunts and uncles have over me? What role does tradition and religion have in guiding my future? How much say do I have in my own future?	How much influence do my parents have over me? What is my role with siblings? How do I empower my children without losing them to "kiwi" culture?	How can I set different expectations for my children in New Zealand and in my country of origin? What is my role with the grandchildren? What kind of prestige comes from having a family in New Zealand?
Life Cycle		
How does identity change across the life cycle? How do I incorporate the best of both worlds as I mature? How much of my traditional culture do I want? How much of the new culture do I want? What models do I have to learn from? How can I fit in with my peers without showing disrespect to my parents?	How does identity change over the life cycle for me and my children? Have I prepared my children to be ethnic New Zealanders? How do I prove to my parents that leaving my country of origin was a good idea? How do I prove that I will remember my culture and heritage? What role should I play in choosing a spouse for my children? What is my role in helping them find a career? How do I maintain discipline?	How does identity change over the life-cycle? How will aging children and grandchildren maintain their identity? Have I prepared and taught then enough?
Triangulation		
In what way am I caught in the middle between my parents and grandparents and their conflicts?	In what way am I in the middle between my children and grandparents? What must I do to maintain their relationship?	In what way am I caught in the middle between my children and grandchildren and their conflicts?
Westernisation		
What does it mean to be a "kiwi"? How much New Zealand identity do I want to incorporate into my identity? How do I avoid aspects of New Zealand culture while living in the culture?	How much westernisation is unavoidable among children? How do I avoid negative western values (eg individualist values) while living in New Zealand?	How much western culture should be adopted by family living in my country of origin?

Intergenerational conflict related to children and adolescents

The major source of intergenerational conflict is differential acculturation. This is particularly true in relation to migrant children and adolescents. Immigrant and refugee background children learn English and New Zealand culture before their parents and grandparents. Children are often given adult responsibilities and placed in the role of interpreter/translator in relation to dealing with schools; health care and social support services etc. Role reversal may lead to a lack of respect by children of their parents and grandparents. Children will follow the norms of behaviours of their peers which may be upsetting to parents and grandparents.

Parents may be so overwhelmed by the stressors of the migration process that they are unable to provide emotional support to their children and may turn to their children for emotional support themselves (Athey & Ahern, 1991).

- Intergenerational conflict and gender role expectations

  Another source of conflict between children and parents/grandparents may be gender roles. Parents may have gender role expectations for their children that are incompatible with behaviours the children need to function effectively in New Zealand society. For example, parents may expect girls to be quiet, obedient and subservient, whereas assertiveness, initiative, independence and competitiveness are needed in order to achieve in school (Potocky-Tripodi, 2002). When faced with these contradictions, girls may rebel at home. Parents may place more restrictions on the behaviours of daughters than sons, leading to resentment by girls, particularly in comparing themselves to their peers.

- Maintaining parental discipline

  Parental discipline of children is often problematic. The long hours that parents spend at work in order to support their family may lead to children being without parental supervision for long periods (Matsuoka, 1990). Intergenerational role reversals may result in a loss of parental authority over children. Children soon learn that some kinds of discipline eg corporal punishment are considered child abuse in New Zealand and some use this knowledge to threaten to report their parents to the police. Parents should be encouraged to attend parenting programmes, for example Incredible Years Training to learn new parenting practices.

- Intergenerational conflict with grandparents

  Conflicts are likely to arise between grandparents and grandchildren, and also between grandparents and parents, because grandparents may disapprove of the parent's new child rearing practices (Carlin, 1990). For example, conflicts about what language should be used in the home are common. Grandparent's lack of English language ability makes them highly dependent on younger family members, adding to the increased likelihood of conflict.

  Asian cultures place a high value on *filial piety*, which refers to children treating parents with a high degree and respect and taking care of them in their old age (Chang & Moon, 1997). In Asian cultures, older family members are wise advisors. However, this status is

lost, since their life experience is seen as irrelevant to living in New Zealand, leading to a lack of respect by younger people.

Life Cycle Issues

A major developmental task of adolescence is identity formation. Migrant adolescents frequently experience substantial conflict regarding their ethnic identity. For Asian migrant children, the task of forging an ethnic identity is compounded by competing demands from two cultures (Potocky-Tripodi, 2002). Whereas at school and with their peers, children are rewarded for westernising as quickly as possible, at home new habits and behaviours are discouraged.

Adolescent's reactions to ethnic identity conflict may vary. Some may reject one culture or the other, effectively removing themselves from interaction with members of that culture. Some may develop a heightened sense of ethnic/religious pride, often in reaction to experiencing racism and discrimination. Others will experience alternating periods of identifying with one or the other culture and some will selectively choose elements from both cultures to fit their circumstances (Gopaul-McNicol, 1993). This is considered to be the ideal outcome (Potocky-Tripodi, 2002).

- Expectation of academic achievement
  Asian parents have expectations for high academic achievement for their children (Carlin, 1990).
- Some children faced with migration stressors, refugee resettlement, the developmental tasks of adolescence, ethnic identity conflicts and pressure to succeed are at risk of developing mental health problems arising from multiple stressors.

> *Ann An, 19, moved to New Zealand as a child with her parents from China. "If I said I felt fully Chinese I would be lying, because I see myself more as a New Zealander". •Parents want children to carry on their ethnic values and identity. Strict parenting styles may be perceived as being authoritarian. Youth identify more with their peers in a new country than their family. This may lead to complicated relationships and negotiations with their parents. Children balance parents'/grandparent's expectations; and want to be like Kiwi friends. Migrant parents fear losing children to the new culture but want children to have a better life. NZ Herald (May 18th 2016).*

CALD Assessment Tool for Children

(Waitemata DHB, eCALD® Services, 2010)

This tool has been adapted for use with children and adolescents. The following questions are useful for exploring the cultural and ethnic identify and explanatory models of illness with children and their families.

CALD Assessment Tool for Children (adapted from *Benson & Thistlethwaite, 2009; Pal, 2008)*	
A. Questions for establishing cultural and ethnic identity	• Tell me about how you (and your family) came to New Zealand? Do you know why you left your home country? With whom did you migrate? Did you leave any special friends or family members behind? • How is your life in New Zealand? Tell me about making friends here? What differences do you notice between what happens in your house and what happens in your friends' houses? Do you still do lots of things that you would have done in your home country? *(llike eating special foods or having special ceremonies).*
A.1. Questions to explore ethnically shaped developmental experiences:	
A.1.1 *Childhood experiences*	• What are some of the things you remember doing at home *(before coming to New Zealand)?* • Did you go to school before coming here? *(depending on age, explore how many years, primary/ secondary).* • Tell me about any special rituals you have gone through which you can remember (inquire about special rituals or rites of passage). • How are things at home for you? Are Mum and Dad and your brothers and sisters still doing things like they would have done before you came to New Zealand? *(enquire about ethnically prescribed family roles).* • Tell me about the clothes you like to wear now? Has anything changed?
A.1.2 *Language*	• What language do you speak at home? Do you speak the same language with your mum and dad and with your sisters and brothers? What about with your friends? • Did you learn any foreign languages *(that is other than the one you speak at home)* in your home country?

CALD Assessment Tool for Children (adapted from *Benson & Thistlethwaite, 2009; Pal, 2008)*	
	• What language did the teachers speak at your school back home? • What language do you prefer to use when you speak to your friends and relatives? Do you prefer your own language or English? Why?
A.1.3. *Gender issues related to culture*	• What things do you think boys and girls do differently? What do you think about these differences? • Who in the family should make the important decisions? Who makes the important decisions in your family? • Are there things that only certain people in your family are allowed to do? How do you feel about that?
A.1.4. *Age*	• Who is the oldest person in your house? Do they make all the rules in your house? Did they always make the rules, even before you moved here? Does everyone have to listen to them, even mum and dad? How do you feel about that? • What happens if you don't do what they tell you to do? • How was it before you came here?
A.1.5. *Religious and spiritual beliefs*	• Tell me about your religion? Do you go to a church/mosque etc. (if yes continue, if no go to the next section. • How often do you go to the church/mosque/temple? • What is it like going to the mosque/church/temple? • Did you go to a mosque/church/temple before you came to this country? If yes, would you like to go again? • Do you eat any special foods? Is there anything you are not allowed to eat?
A.1.6. *Socio-economic class and education*	• Was your family wealthy before you came here? • What do you think it would be like if you were back in your country now? • How would you describe things now?
A.1.7. *Acculturation process can be assessed by asking.*	• What do you think it means to be a real kiwi? • What helps new immigrants fit in, in New Zealand? • How has it been for you fitting in?
B. Questions to Explore cultural explanatory model of illness	
	• Tell me about some of the things you are finding difficult? • What do you think caused your problem?

CALD Assessment Tool for Children (adapted from *Benson & Thistlethwaite, 2009; Pal, 2008)*	
	• Why do you think it started when it did? • What do you think your illness does to you? • What bothers you the most about how you feel? • Is there something about your illness that scares you? • What kind of treatment / help do you think you should receive? • Do you know how your illness would have been treated if you were still in your home country?
C. Cultural factors related to psychosocial environment and levels of functioning	
	• Do you go to school? Do you learn similar things to what you learnt at school before coming here? • How is school for you? • What do you think about the children at school? • How do you find the teachers? • Tell me about your friends? How do you feel about play dates and sleepovers? What do your parents think about it? • Tell me about the friends you left behind in your country? Do you ever contact them? • Do you play any sports? Or do you have other special activities after school? What do you do after school? • How do you find speaking English at school? • Do you ever meet with people that come from the same country/culture as you do? What do you think about them?

Case Study 7: Psychosocial and familial stress following migration

"The child who sees ghosts every night: Manifestations of psychosocial and familial stress following immigration (Fang, Lee & Huang, 2013) case study demonstrates how the sociocultural factors and cumulative stressors associated with migration experiences can significantly impact on each family member, as well as the family unit as a whole. **This case study can be requested free of charge from your DHB library service or academic provider.**

Brief background of the case
Joey and his parents are first-generation immigrants from a suburban area of Southern China. Arriving in the United States at age 6, Joey had only 1 year of preschool education in China and has received most of his formal education in the United States. Joey has acculturated to western culture, while his parents, who moved in their 30s speak little English and strongly adhere to their traditional cultural values and practices.

The presenting issue in this case, namely ghost-seeing, was understood by the attending clinician from a culturally relevant perspective. Rather than focusing on the boy (Joey) seeing ghosts as the treatment target, the therapist uses Joey's experiences as a vehicle to assess and identify the possible underlying mechanisms for his symptoms.

The case demonstrated successful strategies used by the therapist to engage with Joey and his parents:

- The therapist while empathising with the struggles that Joey and his parents had undergone as migrants, honoured each family member's strengths and commitment to rebuild family cohesion, and focused on assisting the parents to improve their family relationships as well as their work and housing situation.
- The therapist applies cultural assessment skills in making a differential diagnosis.
- The therapist laid out a tentative case formulation and treatment plan during the initial visits, allowing Joey and his parents to have a clearer sense of treatment goals and plans and consequently result in a shared treatment approach.
- With the treatment plan focusing on the family as a whole, both Joey and his parents were supported while working toward positive family changes.

The case formulation includes exploring the following:

- What should the diagnostic formulation be for Joey?
- What other diagnoses could be considered in making a differential diagnosis?
- What culture-specific information will be needed to make an accurate psycho- social assessment of this case?
- What do you know about the cultural explanations for Joey's illness?
- What factors in this case assisted Joey's parent's effective help-seeking behaviour and therapeutic engagement?

Guidelines and Tools

Guidelines for engaging with Asian families

Communication

(Waitemata DHB, 2016f)

Many Asian gestures and greetings differ significantly from Western ones. To develop good rapport and show respect, here are some essentials for greetings and communication.

- Ask clients if they wish to be addressed using a **title and surname**, especially at the initial engagement (premature familiarity may be considered disrespectful eg they may also address the health practitioner as Dr, Madam, Sir to show their respect).
- A **nod or slight bow** is customary.
- **Older people should be greeted first** and last before leaving.
- **Avoid** prolonged or direct **eye contact.**
- **Over-familiar touch** is not appreciated.
  - It is acceptable to **shake hands** with men.
  - **Muslim women** may refrain from shaking hands with men.
  - Preferably use **customary greetings** with women.
  - **When in doubt, a smile and a slight bow of the head will always be appreciated.**
- Using hand **gestures** to summon someone is considered insulting.
- In most Asian cultures it is disrespectful to **touch another's head** (except for medical examination).
- Many Asians will avoid **saying 'no'** as it is considered impolite, so **'yes' may be ambiguous** and may indicate that the listener is paying attention; it does not necessarily indicate agreement.
- Showing **respect,** especially for elders, is appreciated (eg greeting the elders first, the practitioner being on time for appointments and greeting them in their traditional way)
- Showing an **interest** in the culture and practices will likely enhance the relationship with the practitioner, and compliance
- Health practitioners are usually highly regarded and clients may not ask **questions,** and may not answer in the negative as it is considered disrespectful. It would be helpful to invite the client and their family to ask questions, **especially when working through an interpreter**.
- In most Asian cultures **'Saving Face'** is a strong principle and will be used over confrontation or questioning of those in authority. It is also important not to put a person in a position where they will be seen to 'lose face'.
- Ask clients about their **expectations** of the service. *Some migrant families may expect medications, injections, practical help, and solutions rather than just a visit/consultation. For some migrants discussion alone may be seen as a waste of time.*

- Explain the t**reatment process and timeframe,** immediately after diagnosis. *Some Asian clients are distressed by uncertainty and may choose to return to their home country for treatment if they are anxious.*
- Explain **confidentiality and privacy** especially when using interpreters. *Confidentiality becomes an issue in smaller communities or recently arrived groups. Migrants may be reluctant to use an interpreter because he/she knows the interpreter and/or fears that details of the matter will be made public. At the beginning of the interview, reassure the patients that you and the interpreter will respect his/her rights to confidentiality (unless there are serious safety concerns).*
- Explain your **services and roles** clearly and provide **information in client's language.** *Many migrants are **not familiar with New Zealand health and social services, legal rights and policies** eg New Zealand definition of child neglect or family violence or "no smacking" law, and they don't know what services are free of charge eg interpreting service etc. They don't know what they don't know.* Newcomers are not familiar with the routine and practical details of New Zealand health and disability services. They may not understand peoples' roles and who is responsible for what on the ward or in community health and social services. It is most important to provide interpreters or support people to explain what is happening, to answer questions and to discuss any fears or worries with parents/grandparents.
- **Assess health literacy and English language proficiency.** *Do not assume someone who can respond with Yes or No answers understands English or comprehends medical terminology or information. Also do not assume someone can read in English or in their own native language.*
- Use **professional interpreters** where practical: Avoid using a family member or a child to interpret. **NB** Many Asian families refuse the use of interpreting services because they are not aware that it is free of charge, and are not aware of the roles, responsibilities and confidentiality of the interpreters. They may expect interpreters to provide additional support or transport for them. *It is important to explain the roles of interpreters to avoid misunderstanding.*
- **Give instruction**s in a clear, logical sequence so that families understand eg providing **step-by-step instructions or using pictures/visual** information.

Culture and Health-belief Assessment Tool (CHAT)

The CHAT tool can be used in a wide variety of clinical settings, with patients from any cultural background. The questions listed in CHAT are intended to stimulate discussion, giving the physician a greater understanding of the patient's health-belief model, health practices and expectations for treatment.

- What do you think caused your illness?
- Why do you think your illness started when it did?
- What does your illness do to you? How does your illness work?
- How bad (severe) do you think your illness is? Do you think it will last a long time, or will it be better soon, in your opinion?
- What do you fear most about your illness?
- What are the chief problems that your illness has caused for you?
- When you have a problem, to whom do you turn for help?
- For your future care, who would you like to be involved?
- What have you done to treat your illness?
- What kind of treatment do you think you should receive?
- What are the most important results that you hope to receive from treatment?
- Is there anything that might conflict with your treatment regimen?
- Are you feeling uncomfortable or uncertain about what we have decided?

(Adapted from Kleinman et al., 1978)

CALD Tookit

The following Cultural Assessment Tool may be adapted in a variety of clinical settings with children and families from Asian backgrounds.

- How long have you lived here? Do you have many New Zealand friends?
- Did you go to school here? What social activities do you do? (To determine level of acculturation).
- What do you think caused this illness?
- How do people from _____ usually treat this illness?
- What have you done already to cope with / treat this illness?
- What other medications are you taking?
- Who prescribes your other medications?
- What do you do when you run out of medication?
- Can you access similar source/s of help here in New Zealand?
- Tell me about your life in _____? (To determine socioeconomic status in country of origin).

(Waitemata DHB, eCALD® Services, 2016b)

Conclusion

In view of the complexity of social and cultural factors, it would be advisable that health practitioners

- Treat each person as an individual with a unique blend of many influences and circumstances.
- Be sensitive to families' wishes, gestures and feelings.
- Ask the family member(s) about their understanding and views related to their child's illness or treatment.
- Encourage feedback from families about how they feel about existing services, and respect those feelings while remaining client focused, even if there is a language barrier or disagreement.
- Avoid making broad generalizations or assumptions about individuals based on a superficial knowledge of their social or cultural background. People from Asian countries differ in their cultural backgrounds, values and beliefs. It is advisable to view Asians as a diverse group.

Resources

Resources for health providers

The following are cultural and language appropriate information and services available to CALD families.

Services	Description and contact details
Asian Family Services	Asian Family Services provides a one-stop-shop service to the Asian community through culturally and linguistically appropriate face to face and telephone counselling services, social work and peer support for Asian family service users. See website: http://www.asianfamilyservices.nz/. AFS offers services in English, Cantonese, Mandarin, Korean, Vietnamese, Japanese and Thai. An interpreter can be arranged for other languages. All staff are trained counsellors and social workers. Address: 128 Khyber Pass Rd, Grafton, Auckland 1023. Mailing address: PO Box 8021, Symonds St, Auckland 1150 Hours: 9.00am-8.00pm Mon-Fri Phone: (0800) 862 342 or (0800) 664 262
Professionally Trained Interpreters	• DHB staff have access to professionally trained interpreters such as: • Auckland Interpreter Service (ADHB). • Interpreting and Translation Service (CMDHB). • Waitemata Auckland Translation & Interpreting Service (WATIS). • Language Line (National). • Interpreting NZ Service Wellington. • See website: http://www.ecald.com/Resources/Migrant-and-Refugee-Services/Services-by-Provider#interpreting. • All primary care organisations and general practitioners and primary care organisations (eg Independent midwives, Plunket, Birthcare, Family Planning) in the Auckland region have access to free telephone and face to face interpreting services. - Auckland Interpreter Service (ADHB). - Interpreting and Translation Service (CMDHB). - Waitemata Auckland Translation & Interpreting Service (WATIS).
Shine (Safer Homes in NZ Everyday): support and Safe House	Shine offers a national toll-free Helpline (0508-744-633) that operates 7 days/week, from 9am to 11pm, which is staffed by trained professionals. Shine Safety First Advocates in Auckland Central and North shore offer support and advocacy for women and children who have experienced abuse.

Services	Description and contact details
accommodation for victims of domestic abuse	Shine Safe House offers safe and supportive accommodation for women and children on Auckland's North shore. KIDshine offers support specifically for children who have experienced domestic abuse. www.2shine.org.nz.
Wellbeing Charitable Trust (for Chinese families)	A Chinese social media and support service for Chinese migrant families who have: - Issues with managing a newborn after birth. - Feeling isolated during pregnancy or immediately after birth. - Parenting issues. For more information see the website: http://wellbeingtrust.org.nz/. Parents can join the social media support group via: WECHAT: via evachen_118 WEIBO: http://weibo.com/cpsst FACEBOOK: https://www.facebook.com/groups/353392884778592 FACEBOOK: https://www.facebook.com/pages/華人親子服務中心 Contact Person: Eva Chen: Chief Executive Officer Postal Addres: P O BOX 41236, St Lukes, Auckland 1025. Mobile: 022 632 1053 | WECHAT: nzcpsst.
Umma Trust for families from Muslim and Refugee backgrounds	Social and Community Support for families from Muslim and Refugee backgrounds (see website: http://www.ummatrust.co.nz/services/). UMMA Trust provides CYFS accredited social work support for women and families, as well as support groups. To refer a person or family please contract UMMA Trust by email ummatrust@xtra.co.nz or telephone 09 815-0153. Address: 830 New North Road, Mt Albert, Auckland 1025. Hours: 9:30am - 4:30pm Monday – Friday.
Parents as First Teachers (PAFT)	A flexible home based programme which works with parents, caregivers and family from 0-3 years. This programme recognises parents as their child's most important first teacher.
Preventing, Dealing and Complaining about Race-Related Bullying	• All schools have policies regarding preventing and dealing with bullying. • Ministry of Education has published information for schools on how to prevent bullying or dealing effectively with bullying if it occurs on their school. Website: http://www.education.govt.nz/school/student-support/student-wellbeing/health-and-wellbeing-programmes/bullying-prevention-and-response/. • When assault or cyber bullying is involved, it is a criminal matter, police should be notified. Every region in New Zealand has ethnic police liaison

Services	Description and contact details
	officers. Ethnic Liaison officers are advertised on the police website http://www.police.govt.nz/advice/personal-community/new-arrivals/ethnic-liaison-officers • A complaint can be made to the Race Relations Conciliator Office - Human Rights Commission for race-related discrimination and bullying issues: https://www.hrc.co.nz/enquiries-and-complaints/how-make-complaint/.
Midwifery services for Afghan women	Shaqaiak Masomi speaks Dari and is from an Afghani background. ShaqaiakM@adhb.govt.nz. Auckland DHB- Maternity Services.
Disability Connect	Disability Connect offers families with children with disabilities information and advice about the services and supports available to children, young people and their families. The service has cross-cultural support workers and uses interpreters for non-English speaking parents. http://disabilityconnect.org.nz/how-we-can-help/. Contact details: - Phone (09) 636 0351 Facsimile (09) 636 0354 Physical Address - 3B Olive Road (up driveway), Penrose, Auckland 1061. Postal Address - PO Box 13 385, Onehunga, Auckland 1643.
CALD Cultural Case Workers	Some DHBs have cultural case worker roles as part of their Child and Family Services and Child Development Services. Check with local service providers for contact details and referral guidelines.
Translated Information	• You will find a range of translated brochures and information and useful websites. Go to http://www.ecald.com/Resources/Translated-Information. • In Australia, the NSW Multicultural Health Communication Service acts as a clearing-house for all health-related multilingual resources. Resources may be accessed online (http://www.mhcs.health.nsw.gov.au) Multilingual resources and publications are available. Translated resources are in 43 different languages. The website is updated monthly and resources are downloadable in pdf format.
Family Therapy Services for vulnerable	Stand Children Services offer family therapy services for the most vulnerable children/young people aged 0-17 years of age (including unborns) from maltreatment /exposure to chronic trauma and to support their recovery

Services	Description and contact details
children/young people 0-17 yo	from that exposure and enhance their wellbeing. http://standforchildren.org.nz/family-therapy-services.
List of Asian and Refugee services	You will find a list of other Asian and Refugee services information here. http://www.ecald.com/Resources/Migrant-and-Refugee-Services.
Useful websites	• eCALD® Services (2016). *Courses and Resources*. http://www.ecald.com/. • New Zealand Immigration (2016). *New Zealand Refugee Quota Programme*. Wellington: New Zealand Immigration, MBIE. Retrieved from: www.immigration.govt.nz/about-us/what-we-do/our-strategies-and-projects/supporting-refugees-and-asylum-seekers/refugee-and-protection-unit/new-zealand-refugee-quota-programme. Download Refugee Quota factsheets on major refugee groups currently being resettled in New Zealand including: Afghanistan, Colombia. Myanmar, Rohingya, Sri Lanka and Syria. • Cultural Profiles in New Zealand. New Zealand Peoples. http://www.TeAra.govt. • Queensland Health (2016) Multicultural Health. https://www.health.qld.gov.au/multicultural/. • Children's Mercy Family Health Partners (2010) *Cross-Cultural Health Care Resource Guide.* https://www.yumpu.com/en/document/view/11709496/cross-cultural-health-care-resource-guide-childrens-mercy-. • Ethnomed (2016). *Pediatric Patient Education Topics*. Available at: https://ethnomed.org/patient-education/pediatric-health-topics. University of Washington: Harbourview Medical Center. • SPIRAL (Selected Patient Information in Asian Languages) (2016). http://spiral.tufts.edu.

Resources for consumers

Topic	Description and website
Maternity Service Consumer Council	• The Maternity Service Consumer Council (MSCC) has information available on maternity care in New Zealand "Choices for Childbirth" translated into 11 languages including: Arabic, Burmese, Farsi, Japanese, Korean and Simplified Chinese. • The resources can be ordered from: mscc@maternity.org.nz or P O Box 21 695, Henderson 0650, Auckland.
Information on postnatal depression	• A booklet "Emotional Health during Pregnancy and Early Childbirth", translated into Chinese, Arabic and Afghan-Dari is available for download from the *beyondblue* website at: www.beyondblue.org.au/index.aspx?link_id=102.944. • Chinese: http://resources.beyondblue.org.au/prism/file?token=BL/0853. • Arabic: http://resources.beyondblue.org.au/prism/file?token=BL/0852. • Afghan-Dari http://resources.beyondblue.org.au/prism/file?token=BL/0854.
Parenting information including children with special needs	• The SKIP website is a tool to help parenting organisations and parents with positive parenting. Strategies with Kids - Information for Parents (SKIP) provides support, information and parenting strategies for parents and caregivers of children up to 5 years old. • The SKIP website www.skip.org.nz has resources in 19 languages including: Arabic, English, Te Reo Maori, Chinese (Simplified), Chinese (Traditional),Cook Island Maori, Farsi, Fijian, Hindi, Japanese, Korean, Nepali, Portuguese, Punjabi, Samoan, Spanish, Thai, Tongan, Vietnamese. • Topics include: Jealousy and fighting, Managing behaviour, Children with special needs, Ages and stages, Tantrums and temperament, Tips on stress etc.
Korean/Chinese videos for parents of children with disabilities	• Seven videos introduce parents to the New Zealand disability sector. • The videos have been recorded in English and produced in three versions with English, Korean and simplified Chinese subtitles. They follow an age-related, progressive format, so that parents can watch them individually or one after another. • They cover a variety of topics on health and disability, education and social supports which families may be eligible for. The videos include power point slides with basic explanations and links to useful websites.

Topic	Description and website
	• The videos are available on YouTube and Vimeo. The YouTube version can be accessed through the Disability Connect website disabilityconnect.org.nz and on the Chinese website www.skykiwi.com.
Disability Connect: Information for Parents of children with disabilities	**Disability Support Guide** • This free support guide is designed to help parents and families of children and young people who have been recently diagnosed with a disability. The booklet aims to help families navigate their way throughout the disability sector, and sheds some light on the roles of the various ministries and organisations involved in the sector including Ministries of Health, Education, Social Development, Work & Income, CYFs and Non-Government Organisations. Included is information on some supports which families may be eligible for. There is also information on disability policy and legislation in New Zealand. • The disability sector can be complicated to understand so this over-arching guidebook may be useful to families regardless of the age of their loved one. • To order your free copy of the Disability Support Guide, please email Disability Connect on admin@disabilityconnect.org.nz , or call us on 636 0351. The Disability Support guide is now available in English, and Simplified Chinese, Korean and Arabic. • English: http://disabilityconnect.org.nz/resources/disability-support-guide/. • Click here for Simplified Chinese version. • Click here for Korean version. • Click here for Arabic version.
Translated Breastfeeding-Beginners Guide Breastfeeding-Grandparents guide	• The Breastfeeding-Beginners Guide is translated into: Chinese/ Mandarin and Thai. • The Breastfeeding- Grandparents Guide is translated into: Chinese/ Mandarin. • Downloadable from: http://www.healthpoint.co.nz/public/maternity/north-shore-hospital-maternity-services-waitemata/im:477656/.
B4 School Check: Information for Parents and Guardians pamphlet	• B4 School Check: Information for Parents and Guardians pamphlet. • Available in English, Arabic, Chinese Simplified, Chinese Traditional, Hindi, Korean, Maori, Samoan, Tongan: Ministry of Health (HP4690). https://www.healthed.govt.nz/resource/b4-school-check-information-parents-and-guardians-%E2%80%93-english-version.
Parents Guide e-	• Parent's Guide e-booklet.

Topic	Description and website
booklet	• Beginnings Guides (USA). • Available in English or Spanish: www.beginningsguides.com/Free-E-Preview.html.

Appendix 1: Asian population and demographics

Overview

Auckland is ethnically super diverse region with more than 200 ethnic groups settled in the region. The ethnic composition for Auckland shows that New Zealand European/Pākehā is the largest ethnic group in the region (59 percent or 789,306 people), followed by Asian (23 percent or 307,230 people), Pasifika (15 percent or 194,958 people), and Māori (11 percent or 142,770 people) The Asian population experienced the highest increase after 2001, from 13.8 percent to 18.9 percent in 2006 and then to 23.1 percent in 2013 (Cain et al., 2016)

In 2013, 37 percent of the Asian population was under the age of 25 years (Walker, 2014). For the Asian population the most represented level 2 ethnicities were Chinese and Indian, each accounted for over a third of Asian ethnicity responses. Thirteen percent of the Asian population spoke no English. The top three languages spoken by the Asian population other than English were Hindi, Mandarin and Cantonese. Twenty-one percent of the Asian population in the Auckland Region were born in New Zealand. The younger age brackets had a much higher proportion born in New Zealand.

Asian Population by Ethnic Group

The tables below show the Asian populations of the Auckland Region DHBs broken down further by more specific ethnic groups. These numbers and proportions are based on total Asian responses (at the level 2 ethnicity level). People can identify with more than one ethnic group so the total of the table is greater than the total of individuals. This gives a good picture of the breakdown of the broad Asian ethnic group. The Chinese and Indian populations were by far the biggest of the Asian ethnic groups in the Auckland Region (Walker, 2014).

Auckland Region
Table 1: Asian Population by Ethnic Group, Auckland Region, Census 2013

Asian Ethnic Group	Total	%
Chinese	118,410	38.1%
Indian	106,557	34.3%
Korean	22,035	7.1%
Filipino	20,562	6.6%
Sri Lankan	6,912	2.2%
Japanese	6,726	2.2%
Cambodian	4,194	1.3%
Thai	4,167	1.3%
Other Asian	21,537	6.9%
Total L2 Asian Responses	**311,100**	**100.0%**

Waitemata DHB

Table 2: Asian Population by Ethnic Group, Waitemata DHB, Census 2013

Asian Ethnic Group	Total	%
Chinese	36,345	39.5%
Indian	21,153	23.0%
Korean	12,480	13.6%
Filipino	9,000	9.8%
Japanese	2,613	2.8%
Thai	1,587	1.7%
Sri Lankan	1,296	1.4%
Cambodian	1,158	1.3%
Other Asian	6,294	6.8%
Total L2 Asian Responses	**91,926**	**100.0%**

Auckland DHB

Table 3: Asian Population by Ethnic Group, Auckland DHB, Census 2013

Asian Ethnic Group	Total	%
Chinese	47,562	40.8%
Indian	38,199	32.8%
Korean	6,150	5.3%
Filipino	6,021	5.2%
Sri Lankan	4,278	3.7%
Japanese	3,231	2.8%
Thai	1,608	1.4%
Cambodian	543	0.5%
Other Asian	9,024	7.7%
Total L2 Asian Responses	**116,616**	**100.0%**

Counties Manukau DHB

Table 4: Asian Population by Ethnic Group, Counties Manukau DHB, Census 2013

Asian Ethnic Group	Total	%
Indian	47,205	46.0%
Chinese	34,503	33.6%
Filipino	5,541	5.4%
Korean	3,405	3.3%
Cambodian	2,493	2.4%
Sri Lankan	1,338	1.3%
Thai	972	0.9%
Japanese	882	0.9%

Other Asian	6,219	6.1%
Total L2 Asian Responses	**102,558**	**100.0%**

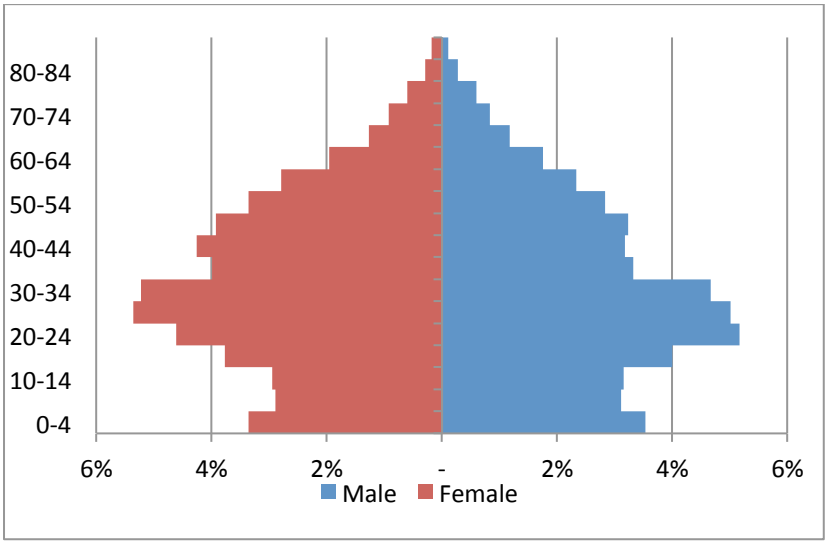
Asian Age Structure, Auckland Region

The population pyramids below give a picture of the age structure of the Auckland Region's Asian population. Over one-third of the population was under the age of 25 (36.6%). Older people aged 65+ years made up 6.3% of the population making the Auckland Region Asian population a relatively young population. The three most represented age brackets were the 20-24, 25-29 and 30-34 age brackets (Walker, 2014).

- For the Auckland Region Chinese population, 35.3% were under the age of 25 and 8.7% were aged 65+. The three most represented age brackets were the 20-24, 25-29 and 30-34 age brackets.
- For the Auckland Region Indian population, 37.1% were under the age of 25 and 5.4% were aged 65+. The three most represented age brackets were the 20-24, 25-29 and 30-34 age brackets.
- For the Auckland Region non-Indian and non-Chinese Asian population, 41.4% were under the age of 25 and 3.6% were aged 65+. The three most represented age brackets were the 15-19, 20-24 and 25-29 age brackets.

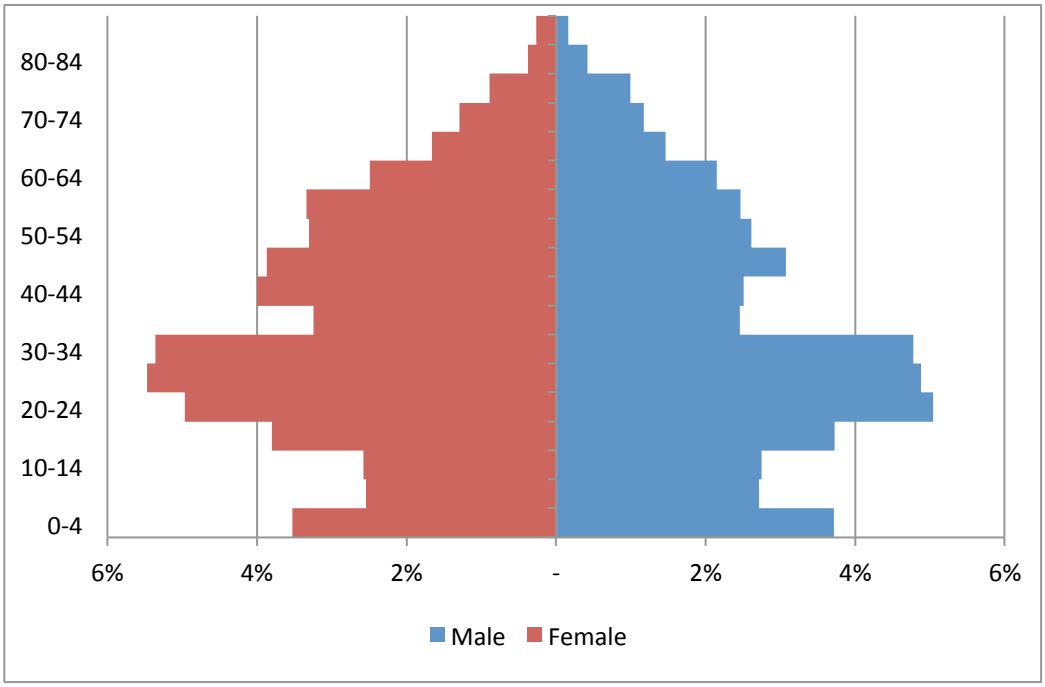
Asian Total

Figure 1: Population Pyramid by Age and Gender, Auckland Region, Asian Total, Census 2013 (Walker, 2014).



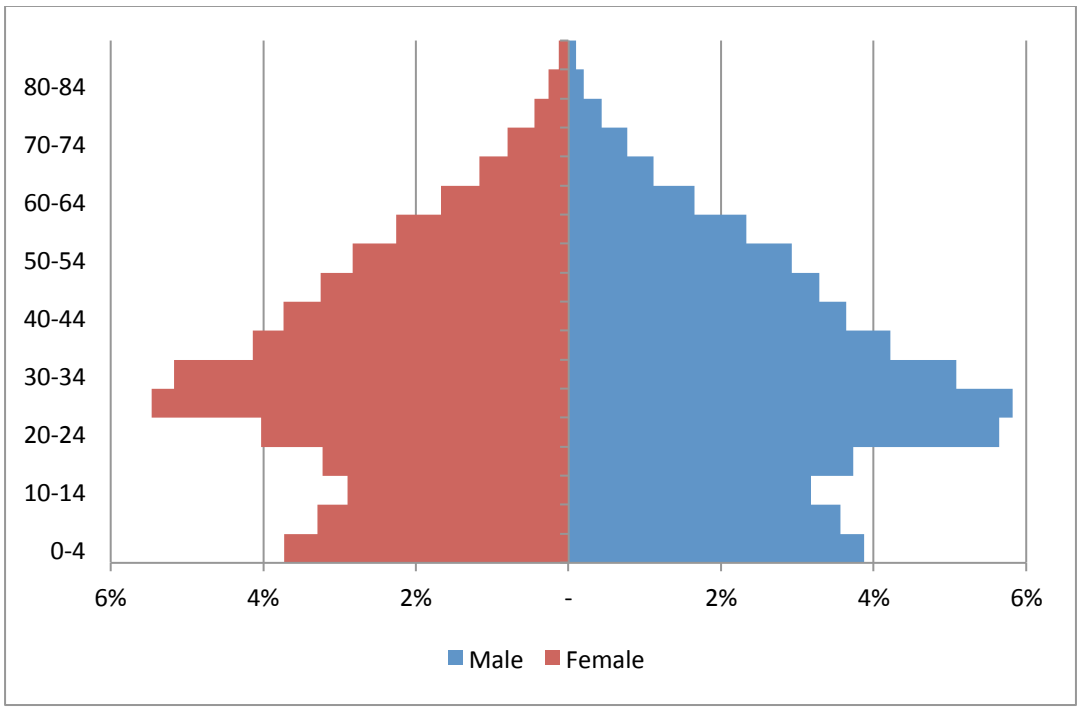
Chinese

Figure 2: Population Pyramid by Age and Gender, Auckland Region, Chinese, Census 2013 (Walker, 2014).



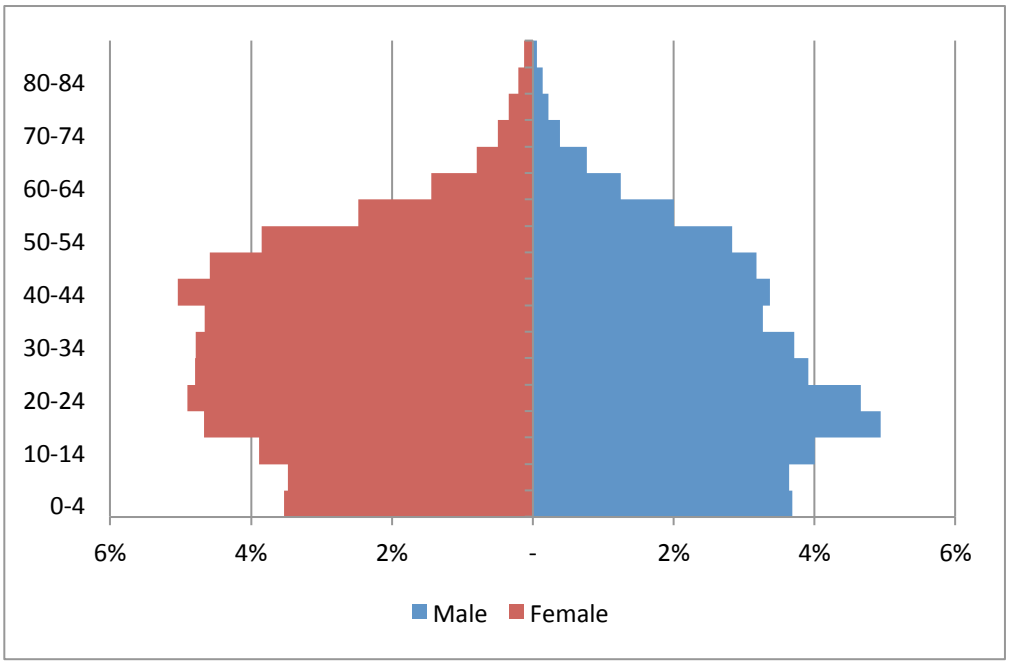
Indian

Figure 3: Population Pyramid by Age and Gender, Auckland Region, Indian, Census 2013 (Walker, 2014).



Other Asian

Figure 4: Population Pyramid by Age and Gender, Auckland Region, Other Asian, Census 2013 (Walker, 2014).



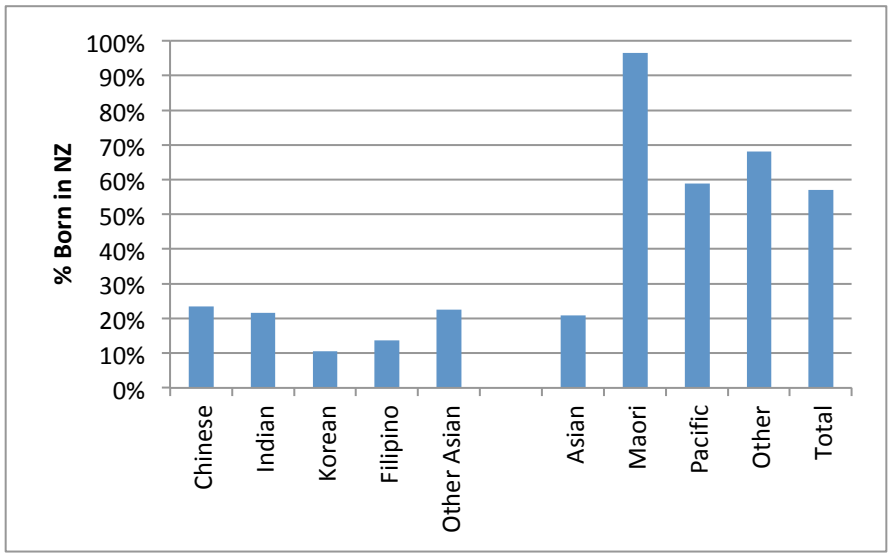
Asian Population, No English Spoken, Census 2006 to Census 2013 (Walker, 2014)

- For the Auckland Region in 2013, 13.4% of the Asian population spoke no English. Counties Manukau DHB had the highest proportion of Asian population which did not speak English (14.4%), followed by Waitemata DHB (14%) and Auckland DHB (12 %).
- Compared to other ethnic groups the Asian population in the Auckland region had a higher rate of people speaking no English (13.0%).
- Among the Asian ethnic groups in the Auckland region, Koreans had the highest percentage of 'No English' (23.4%), while Filipino had the highest proportion of English speakers (only 1.4% with no English).

Asian Population born in New Zealand

- Asian ethnic groups have the lowest proportion of people born in New Zealand (20.9%) when compared with the other level 1 ethnic groups in the Auckland Region.
- Figure 5 shows that among Asian ethnic groups in the Auckland region, Chinese people had the largest proportion born in NZ (23.4%), followed by Indian. Korean had the lowest proportion (10.6%).
- In general the younger age brackets contained a much higher proportion of people born in New Zealand.

Figure 5: Proportion Asian Population born in New Zealand by Ethnicity, Auckland Region, Census 2013 (Walker, 2014).

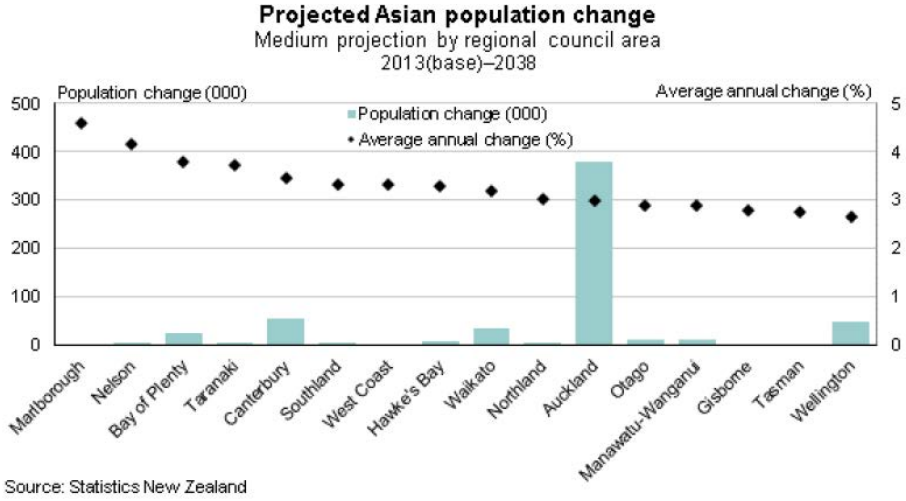


Increase in Asian refugee population: Annually the New Zealand government accepts a UNHCR mandated refugee quota of 750 places. In 2018, this number will increase to 1000 quota refugees per annum. Refugees also arrive as asylum seekers and through the refugee family sponsored category. Refugees to New Zealand from Asian backgrounds come from: Vietnam, Laos, Cambodia, Afghanistan, Sri Lanka, Burma, Bhutan and China.

Projected Asian Population Change (Statistics New Zealand, 2015)

In Auckland, 1 in 3 people are likely to identify with an Asian ethnicity in 2038, up from about 1 in 4 in 2013. At the national level, by 2038 the Asian population is projected to make up 21 percent of the population, compared with 12 percent in 2013 (SNZ, 2015).

Figure 6 Project Asian Population Change, Census 2013 (Walker, 2014).



Births to Asian mothers

For Waitemata DHB Asian births have increased by 50 percent over the past six years, and will increase similarly, over the next 12 years (Figure 7). As of 2012, Asian groups made up 21 percent of the births of Waitemata-domiciled women; by 2025 they are projected to make up 27% (Auckland DHB & and Waitemata DHB, 2015).

Figure 7 Waitemata domiciled birth numbers and projections to 2025 by ethnicity (Auckland DHB & and Waitemata DHB, 2015).

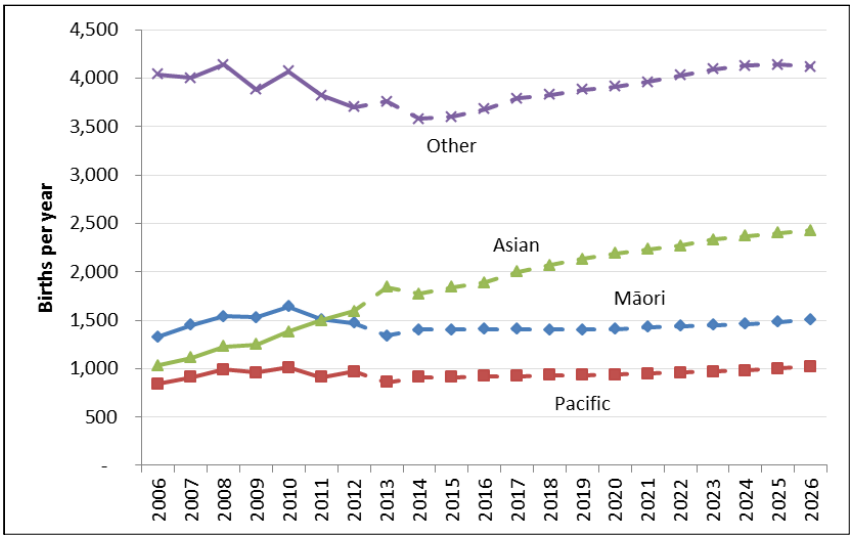


Figure 8 Auckland domiciled birth numbers and projections to 2025 by ethnicity (Auckland DHB & and Waitemata DHB, 2015).

As a proportion Asian births are expected to rise from 29% to 32% of all births by 2025 (Auckland DHB & and Waitemata DHB, 2015).

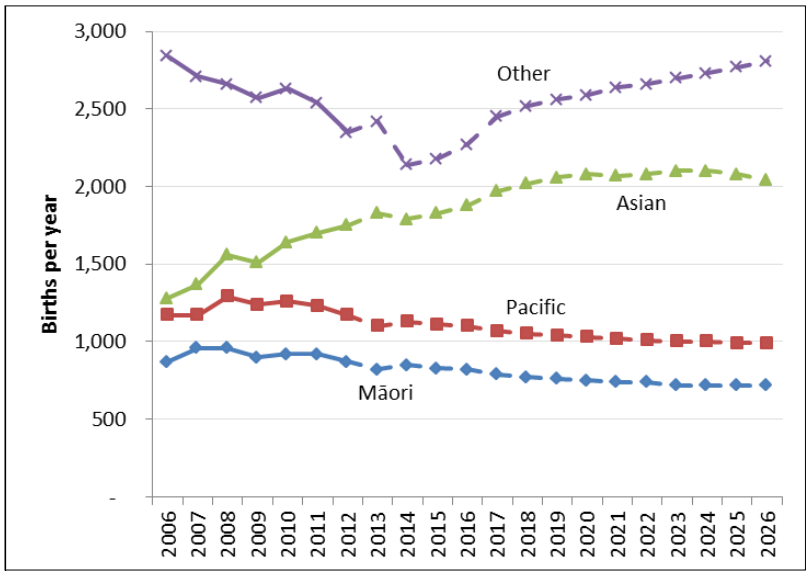
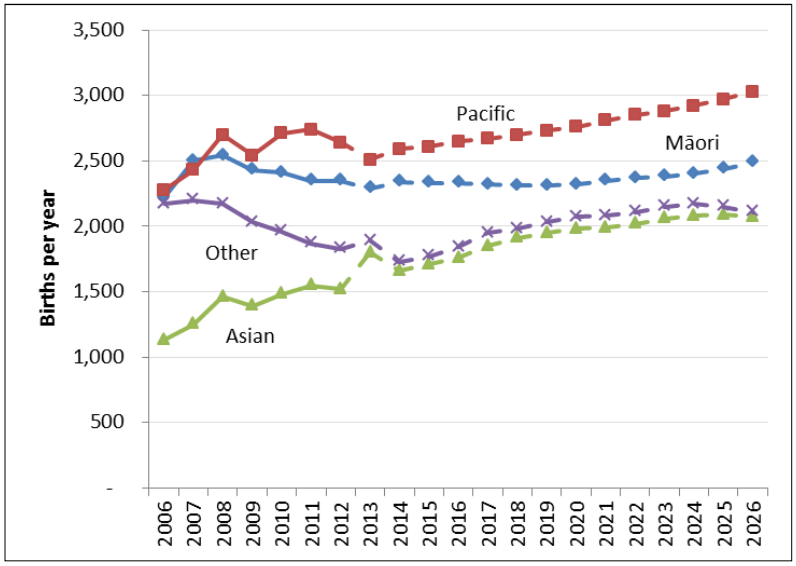


Figure 9 Counties Manukau domiciled birth numbers and projections to 2025 by ethnicity (Auckland DHB & and Waitemata DHB, 2015).

For Counties Manukau, while Māori and Pacific births are expected to continue increasing they do so at a lesser rate than Asian and Other, leading to a small reduction in proportions expected by 2025 (Figure 12). The Asian proportion of births is projected to rise from 18 to 22% (Auckland DHB & and Waitemata DHB, 2015).



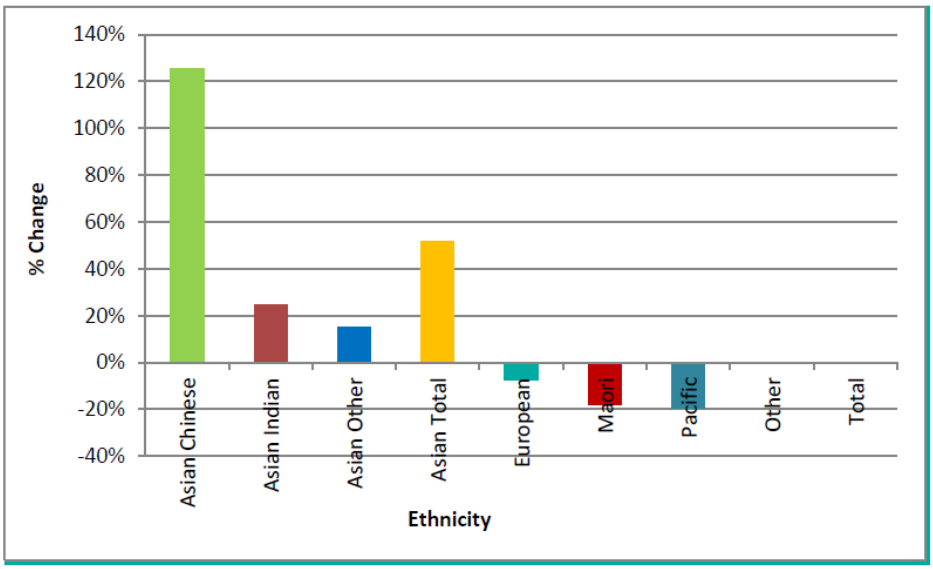
Ethnicity of women giving birth in WDHB

There has been a significant growth in Asian population over both the North and West Waitemata DHB sites, particularly of Chinese and Indian women as shown in Figure 10 (Waitemata DHB, 2014).

Table 5: Ethnicity of women giving birth in WDHB 2013 (Waitemata DHB, 2014).

	NSH		WTH		WDHB	
	No.	%	No.	%	No.	%
Asian Chinese	571	15.3%	197	6.7%	768	11.5%
Asian Indian	137	3.7%	280	9.5%	417	6.3%
Asian Other	314	8.4%	191	6.5%	505	7.6%
Asian Total	1022	27.5%	668	22.8%	1690	25.4%
European	2197	59.0%	1260	43.0%	3457	51.9%
Maori	209	5.6%	413	14.1%	622	9.3%
Pacific	163	4.4%	484	16.5%	647	9.7%
Other	132	3.5%	107	3.6%	239	3.6%
Total	**3723**	**100.0%**	**2932**	**100%**	**6655**	**100%**

Figure 10: Percentage change in ethnicity of women giving birth 2009 to 2013 (Waitemata DHB, 2014).



Religious Affiliations

Many Chinese people follow philosophical traditions such as Taoism which provide a guiding influence in their lives. Of Chinese and Japanese people in Auckland, around 20% are Christian and over 10% are Buddhist (Mehta, 2012). More than 50% of Auckland Indians are Hindu, and other common religions include Islam, Christianity, and Sikhism. The vast majority of Auckland Korean and Filipino populations identify as being Christian, while Buddhism is the predominant religious affiliation among Cambodian and Sri Lankan people across the region. Small proportions of Cambodians and Sri Lankans also identify as being Muslim (Mehta, 2012).

Languages

Asian Population, Top 20 Languages Spoken

The tables below show the top 20 languages spoken by the Auckland Region's Asian population (Walker, 2014). The tables include all of the people who stated each language they spoke, whether as their only language or as one of several languages. When a person reports that they speak multiple languages they will be recorded in each applicable group. This means that the total responses will be greater than the total number of people (Walker, 2014). The top three languages other than English spoken among the Auckland Region's Asian population were Hindi, Northern Chinese (including Mandarin), and Sinitic not further defined (including Chinese). Some variation in top languages is evident between the Auckland Region DHBs (Walker, 2014).

Auckland Region, top 20 Languages Spoken

Table 6: Asian Population by Top 20 Languages Spoken, Auckland Region, Census 2013 (Walker, 2014).

Language	Total	%
English	253,155	82.2%
Hindi	48,243	15.7%
Northern Chinese	37,974	12.3%
Sinitic not further defined	29,916	9.7%
Korean	19,077	6.2%
Tagalog	14,748	4.8%
Panjabi	12,486	4.1%
Gujarati	11,682	3.8%
Japanese	6,324	2.1%
Tamil	4,491	1.5%
Thai	3,594	1.2%
Vietnamese	3,558	1.2%
Urdu	3,531	1.1%
Min	3,528	1.1%
Malaysian	3,402	1.1%
Khmer	3,255	1.1%
Sinhala	3,063	1.0%
Bahasa Indonesia	2,472	0.8%
Malayalam	2,298	0.7%
None (e.g. too young to talk)	8,355	2.7%
Not Elsewhere Included	7,110	2.3%
Other Languages	54,396	17.7%
Top 20 Languages	294,015	95.5%
Total	307,800	100.0%

Waitemata DHB, top 20 Languages Spoken

Table 7: Asian Population by Top 20 Languages Spoken, Waitemata DHB, Census 2013 (Walker, 2014).

Language	Total	%
English	73,965	81.5%
Northern Chinese	11,553	12.7%
Korean	10,920	12.0%
Sinitic not further defined	10,329	11.4%
Hindi	9,186	10.1%
Tagalog	6,408	7.1%
Gujarati	2,718	3.0%
Japanese	2,460	2.7%
Thai	1,374	1.5%
Bahasa Indonesia	1,293	1.4%
Panjabi	1,254	1.4%
Malaysian	1,095	1.2%
Min	1,041	1.1%
Khmer	852	0.9%
Tamil	831	0.9%
Urdu	681	0.8%
Sinhala	606	0.7%
Malayalam	600	0.7%
Vietnamese	363	0.4%
None (e.g. too young to talk)	2,721	3.0%
Not Elsewhere Included	1,983	2.2%
Other Languages	13,857	15.3%
Top 20 Languages	87,276	96.1%
Total	90,780	100.0%

Auckland DHB, top 20 Languages Spoken

Table 8: Asian Population by Top 20 Languages Spoken, Auckland DHB, Census 2013 (Walker, 2014).

Language	Total	%
English	96,531	83.6%
Hindi	16,671	14.4%
Northern Chinese	15,345	13.3%
Sinitic not further defined	12,141	10.5%
Gujarati	6,132	5.3%
Korean	5,109	4.4%
Tagalog	4,329	3.7%
Japanese	2,973	2.6%
Panjabi	2,781	2.4%
Tamil	2,622	2.3%
Sinhala	1,932	1.7%
Urdu	1,815	1.6%
Malaysian	1,500	1.3%
Min	1,422	1.2%
Thai	1,347	1.2%
Malayalam	1,146	1.0%
Vietnamese	1,023	0.9%
Bahasa Indonesia	825	0.7%
Khmer	429	0.4%
None (e.g. too young to talk)	2,748	2.4%
Not Elsewhere Included	2,943	2.5%
Other Languages	22,407	19.4%
Top 20 Languages	109,980	95.2%
Total	115,503	100.0%

Counties Manukau DHB, top 20 Languages Spoken

Table 9: Asian Population by Top 20 Languages Spoken, Counties Manukau DHB, Census 2013 (Walker, 2014).

Language	Total	%
English	82,659	81.4%
Hindi	22,386	22.1%
Northern Chinese	11,076	10.9%
Panjabi	8,451	8.3%
Sinitic not further defined	7,446	7.3%
Tagalog	4,011	4.0%
Korean	3,048	3.0%
Gujarati	2,832	2.8%
Vietnamese	2,172	2.1%
Khmer	1,974	1.9%
Min	1,065	1.0%
Tamil	1,038	1.0%
Urdu	1,035	1.0%
Japanese	891	0.9%
Thai	873	0.9%
Malaysian	807	0.8%
Malayalam	552	0.5%
Sinhala	525	0.5%
Bahasa Indonesia	354	0.3%
None (e.g. too young to talk)	2,886	2.8%
Not Elsewhere Included	2,184	2.2%
Other Languages	18,132	17.9%
Top 20 Languages	96,759	95.3%
Total	101,517	100.0%

Appendix 2: Socio-Economic Status of Auckland Region: Asian Populations

Socio-economic Status
The Auckland Region Asian population had a higher level of education than the Auckland total but a smaller proportion of adults earning over $30,000 and households earning over $50,000. The Asian population had about the same level of home ownership as the Auckland total, a higher rate of unemployment, and a lower rate of people on the unemployment benefit.

Education

Education – No Qualification
In the 2013 Census, compared to the total figure for the Auckland Region, a smaller proportion of the Asian population aged 15 years and over had no formal education (10.8%) (Walker, 2014).

Table 10: No Formal Qualification by Ethnicity, Census 2013 (Walker, 2014).

Ethnicity	% No Education				
	WDHB	ADHB	CMDHB	Auckland Region	NZ
Asian	**9.4%**	**9.0%**	**14.2%**	**10.8%**	**11.2%**
MELAA	9.5%	9.1%	15.2%	10.8%	11.1%
European	15.0%	9.3%	19.5%	14.4%	19.0%
Maori	25.0%	22.1%	34.4%	28.5%	30.2%
Pacific	24.8%	26.2%	28.0%	26.9%	26.4%
Other	11.9%	7.5%	14.2%	11.2%	14.1%
Total	15.0%	11.5%	21.4%	15.9%	19.6%

Education – Bachelor Degree and Above
In the 2013 Census, compared to the total figure for the Auckland Region a higher proportion of the Asian population aged 15 years and over had a bachelor degree or higher (31.1%) (Walker, 2014).

Table 11: Bachelor Degree or Above by Ethnicity, Census 2013 (Walker, 2014).

Ethnicity	% Bachelor Degree and Above				
	WDHB	ADHB	CMDHB	Auckland Region	NZ
Asian	**32.0%**	**35.7%**	**24.6%**	**31.1%**	**31.0%**
MELAA	32.7%	33.3%	27.0%	31.5%	30.0%
European	20.7%	36.4%	14.9%	23.9%	18.6%

Maori	11.4%	18.2%	6.2%	10.7%	9.1%
Pacific	7.7%	8.7%	5.1%	6.6%	7.1%
Other	22.0%	36.4%	16.7%	25.0%	19.9%
Total	21.8%	32.9%	14.8%	23.1%	18.8%

Unemployment

In the 2013 Census, the unemployment rate for the Auckland Region Asian population was 6.0%. . The unemployment rate for Asian People was higher than the Auckland Region and the national total (Walker, 2014).

Table 12: Unemployment by Ethnicity, Census 2013 (Walker, 2014).

Ethnicity	% Unemployed				
	WDHB	ADHB	CMDHB	Auckland Region	NZ
Asian	**5.6%**	**6.3%**	**5.9%**	**6.0%**	**5.7%**
MELAA	9.3%	9.5%	8.1%	9.1%	8.5%
European	3.8%	3.8%	4.2%	3.9%	3.7%
Maori	9.2%	9.7%	12.5%	10.8%	10.4%
Pacific	9.3%	10.1%	10.6%	10.2%	10.0%
Other	3.6%	4.0%	3.0%	3.5%	3.7%
Total	4.6%	5.4%	6.4%	5.4%	4.8%

Personal Income

In the 2013 Census, 38.8% of the Auckland Region Asian population aged 15 years and over had personal income of $30,000 or more per annum. Asian Peoples had a lower proportion in this income bracket than the Auckland Region and national total.

Table 13: Personal Income $30,000+, Census 2013 (Walker, 2014).

Ethnicity	% Personal Income $30,000+				
	WDHB	ADHB	CMDHB	Auckland Region	NZ
Asian	**38.1%**	**38.8%**	**39.5%**	**38.8%**	**38.7%**
MELAA	39.7%	37.9%	37.0%	38.3%	38.4%
European	54.7%	60.6%	54.3%	56.4%	51.1%
Maori	46.1%	44.9%	40.4%	43.3%	39.5%
Pacific	40.1%	35.2%	35.5%	36.3%	36.9%
Other	60.9%	65.7%	60.5%	62.3%	58.2%
Total	50.6%	51.4%	46.4%	49.6%	48.1%

People Receiving Unemployment Benefit

In Census 2013, 2.8% of the Auckland Region Asian population aged 15 years and over received the unemployment benefit. The Auckland Region Asian proportion was slightly lower than the Auckland Region and national total.

Table 14: Unemployment Benefit by Ethnicity, Census 2013 (Walker, 2014).

Ethnicity	% Unemployment Benefit				
	WDHB	ADHB	CMDHB	Auckland Region	NZ
Asian	**2.6%**	**2.8%**	**2.9%**	**2.8%**	**2.9%**
MELAA	6.5%	7.1%	9.2%	7.4%	7.0%
European	1.8%	2.1%	2.0%	1.9%	2.2%
Maori	5.2%	6.7%	7.4%	6.5%	7.2%
Pacific	5.2%	7.0%	6.4%	6.3%	6.4%
Other	2.2%	2.6%	1.9%	2.2%	2.6%
Total	2.3%	3.0%	3.6%	2.9%	2.9%

People Receiving Domestic Purposes Benefit (DPB)

In Census 2013, 1.3% of the Auckland Region Asian population aged 15 years and over received the domestic purposes benefit. This proportion was lower than the Auckland Region and national total (Walker, 2014).

Table 15: Domestic Purposes Benefit by Ethnicity, Census 2013 (Walker, 2014).

Ethnicity	% Domestic Purposes Benefit				
	WDHB	ADHB	CMDHB	Auckland Region	NZ
Asian	**1.2%**	**1.1%**	**1.4%**	**1.3%**	**1.2%**
MELAA	2.4%	2.5%	2.2%	2.4%	2.6%
European	2.2%	1.3%	2.7%	2.0%	2.3%
Maori	7.8%	6.7%	12.0%	9.4%	8.8%
Pacific	5.3%	5.8%	6.7%	6.2%	5.9%
Other	1.3%	1.0%	1.2%	1.2%	1.7%
Total	2.3%	1.8%	3.8%	2.6%	2.8%

Nature of Occupancy of Households

In Census 2013, 38.1% of Asian households did not own or partially own their place of occupancy. The rate was much higher for MELAA households with 60.5% not owning their place of occupancy. People in these households either rented or lived rent-free (Walker, 2014).

Table 16: Nature of Occupancy by Ethnicity, Census 2013 (Walker, 2014).

Ethnicity	% Dwelling Not Owned				
	WDHB	ADHB	CMDHB	Auckland Region	NZ
Asian	**33.3%**	**47.3%**	**32.4%**	**38.1%**	**40.2%**
MELAA	53.4%	71.8%	53.5%	60.5%	61.6%
European	26.8%	35.4%	29.1%	29.9%	29.4%
Maori	50.7%	61.7%	60.6%	57.6%	55.0%
Pacific	58.5%	70.3%	63.0%	64.0%	63.3%
Other	24.0%	35.1%	23.9%	27.2%	27.2%
Total	31.3%	44.3%	40.0%	38.0%	35.1%

Households without a Car

In Census 2013, 4.6% of Auckland Region Asian households had no car available; this was slightly lower than the national and regional total (Walker, 2014).

Table 17: Households without a Car, Census 2013 (Walker, 2014).

Ethnicity	% No Motor Vehicle				
	WDHB	ADHB	CMDHB	Auckland Region	NZ
Asian	**2.0%**	**9.3%**	**1.8%**	**4.6%**	**5.0%**
MELAA	3.7%	13.3%	3.7%	7.4%	7.4%
European	2.7%	5.6%	3.2%	3.6%	4.3%
Maori	6.2%	12.5%	11.0%	9.8%	10.0%
Pacific	5.4%	9.8%	7.0%	7.4%	8.2%
Other	1.9%	4.4%	2.2%	2.7%	3.5%
Total	2.9%	7.6%	4.5%	4.8%	5.2%

Households without Telecommunication Access

In Census 2013, 0.9% of the Auckland Region Asian population in households did not have access to a landline, mobile phone, fax or internet. This was slightly lower than the comparable regional figure of 1.2% (Walker, 2014).

Table 18: Households without Telecommunication Access by Ethnicity, Census 2013 (Walker, 2014).

Ethnicity	% No Telecommunications Access				
	WDHB	ADHB	CMDHB	Auckland Region	NZ
Asian	**0.7%**	**1.2%**	**0.9%**	**0.9%**	**1.0%**

MELAA	0.7%	2.0%	1.0%	1.3%	1.3%
European	0.5%	0.7%	0.8%	0.7%	0.9%
Maori	2.2%	2.6%	4.1%	3.2%	3.5%
Pacific	1.8%	2.6%	2.9%	2.6%	2.6%
Other	0.9%	0.9%	0.7%	0.8%	1.2%
Total	0.7%	1.1%	1.7%	1.2%	1.3%

Households with Telephone Access

In Census 2013, 89.5% of Auckland Region Asian households had a telephone. The Asian proportion was slightly higher than the regional and national figure (Walker, 2014).

Table 19: Households with Telephone Access by Ethnicity, Census 2013 (Walker, 2014).

Ethnicity	% Telephone Access				
	WDHB	ADHB	CMDHB	Auckland Region	NZ
Asian	**91.7%**	**85.9%**	**91.4%**	**89.5%**	**88.3%**
MELAA	87.6%	75.8%	90.3%	83.8%	83.0%
European	90.5%	84.8%	89.4%	88.6%	87.9%
Maori	77.6%	72.2%	67.5%	71.7%	69.9%
Pacific	78.4%	74.2%	71.9%	73.8%	72.9%
Other	90.5%	85.5%	91.3%	89.3%	87.8%
Total	89.3%	83.3%	84.2%	85.8%	85.3%

Households with Mobile Access

In Census 2013, 83.5% of Auckland Region Asian households had mobile phone access; for MELAA the proportion was 81.2%. For both groups the proportion of mobile phone access was slightly lower than the comparable regional and national totals (Walker, 2014).

Table 20: Households with Mobile Phone Access by Ethnicity, Census 2013 (Walker, 2014).

Ethnicity	% Cellphone/Mobile Phone Access				
	WDHB	ADHB	CMDHB	Auckland Region	NZ
Asian	**85.3%**	**82.3%**	**83.4%**	**83.5%**	**83.4%**
MELAA	83.4%	78.4%	82.2%	81.2%	81.1%
European	88.5%	88.3%	87.6%	88.2%	87.1%
Maori	86.8%	84.7%	82.4%	84.3%	83.7%
Pacific	83.1%	79.5%	79.1%	80.0%	81.2%
Other	87.3%	88.0%	88.0%	87.7%	87.2%
Total	87.1%	85.0%	83.9%	85.4%	85.5%

Households with Internet Access

In Census 2013, 88.9% of all Auckland Region Asian households had access to the internet. The proportion of internet access was slightly higher than the comparable regional and national totals (Walker, 2014).

Table 21: Households with Internet Access by Ethnicity, Census 2013 (Walker, 2014).

Ethnicity	% Internet Access				
	WDHB	ADHB	CMDHB	Auckland Region	NZ
Asian	**90.9%**	**88.4%**	**87.6%**	**88.9%**	**88.0%**
MELAA	**89.1%**	**83.2%**	**86.5%**	**86.2%**	**85.8%**
European	88.7%	89.3%	84.6%	87.8%	83.8%
Maori	77.0%	73.4%	61.7%	69.1%	65.2%
Pacific	69.8%	61.7%	57.7%	61.2%	62.0%
Other	90.7%	89.9%	88.6%	89.9%	86.8%
Total	87.1%	85.0%	77.0%	83.2%	80.8%

Household Income

In Census 2013, 58.8% of Auckland Region Asian households had a household income of $50,000 or more per annum. The proportion was lower than the national and regional totals (Walker, 2014).

Table 22: Household Income $50,000+ by Ethnicity, Census 2013 (Walker, 2014).

Ethnicity	% Household Income $50,000+				
	WDHB	ADHB	CMDHB	Auckland Region	NZ
Asian	**58.5%**	**57.4%**	**60.7%**	**58.8%**	**58.3%**
MELAA	56.8%	46.6%	52.9%	51.9%	51.7%
European	71.5%	75.4%	70.2%	72.2%	65.2%
Maori	59.5%	57.8%	49.8%	54.6%	50.0%
Pacific	53.6%	46.4%	45.5%	47.4%	47.8%
Other	71.0%	74.8%	70.7%	72.0%	66.3%
Total	67.0%	65.7%	60.3%	64.4%	61.5%

Heating Fuels Used

In Census 2013, 7.3% of Auckland Region Asian households used no heating fuels (Walker, 2014).

Table 23: Heating Fuel used by Ethnicity, Census 2013 (Walker, 2014).

Ethnicity	% Households No Heating Fuels Used				
	WDHB	ADHB	CMDHB	Auckland Region	NZ
Asian	**6.0%**	**8.6%**	**7.0%**	**7.3%**	**5.7%**
MELAA	3.9%	8.6%	3.2%	5.5%	4.0%
European	2.6%	4.1%	3.2%	3.2%	1.8%
Maori	5.6%	7.9%	9.1%	7.7%	4.2%
Pacific	10.6%	13.8%	15.3%	14.0%	10.8%
Other	3.2%	5.2%	3.2%	3.8%	2.0%
Total	4.0%	6.8%	7.3%	5.9%	3.1%

Appendix 3: Health Status – Asian Children

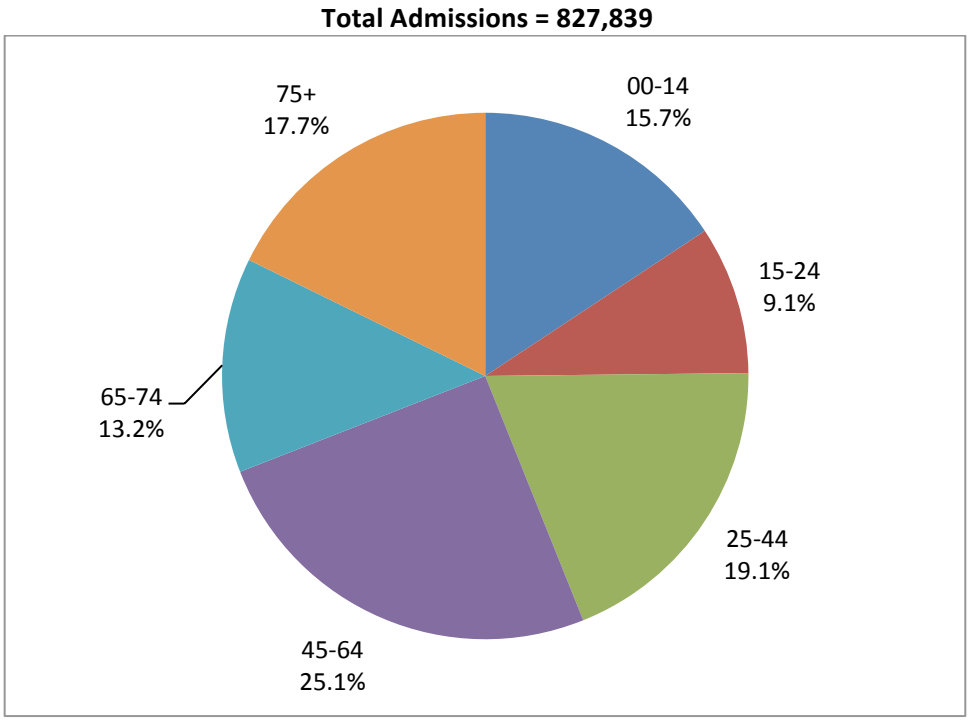
Hospital Utilisation, 2010/11 to 2012/13

The figures below show the number of Medical/Surgical hospital admissions by age group for the Auckland Region broken down by Total, Asian Total, Chinese, Indian, Other Asian (Non-Chinese and Non-Indian Asian). Variation is noticeable between the groups (Walker, 2014). For the Auckland Region Total Asian population in the three years 95,261 people were admitted to hospital. Of these, 9.0% were 75 years and over while 27.1% were young people (0-24).

For the Auckland Region Chinese population in the three years 28,046 people were admitted to hospital. Of these, 14.5% were 75 years and over while 24.0% were young people (0-24). For the Auckland Region Indian population in the three years 40,749 people were admitted to hospital. Of these, 7.3% were 75 years and over while 26.6% were young people (0-24). For the Auckland Region Other Asian population in the three years 26,466 people were admitted to hospital. Of these, 5.9% were 75 years and over while 31.1% were young people (0-24).

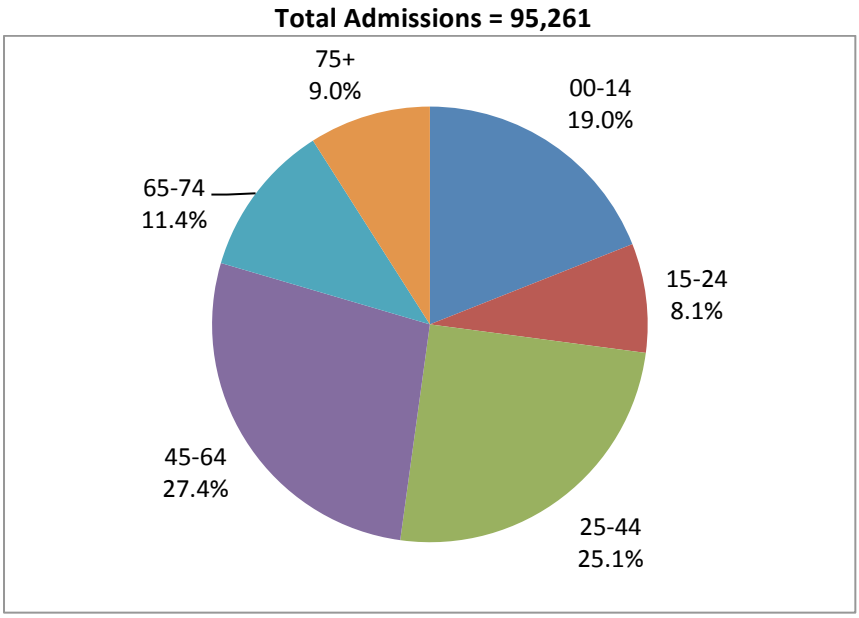
Overall Admissions

Figure 11: Number of Medical/Surgical Hospital Admissions by Age Group Auckland Region Total, 2010/11 to 2012/13 (Walker, 2014).



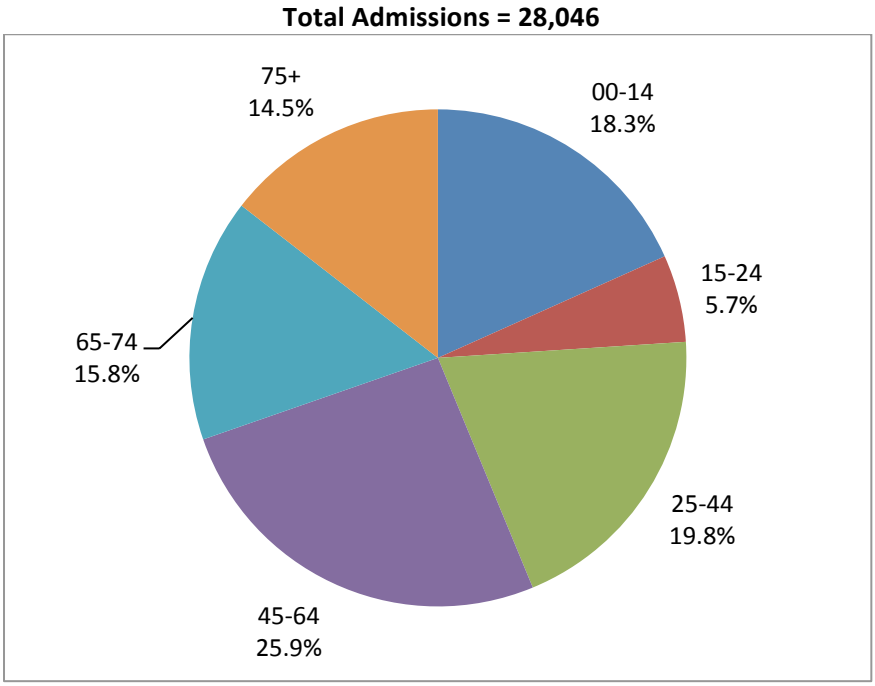
Asian Total Admission

Figure 12: Number of Medical/Surgical Hospital Admissions by Age Group Auckland Region Asian Total, 2010/11 to 2012/13 (Walker, 2014).



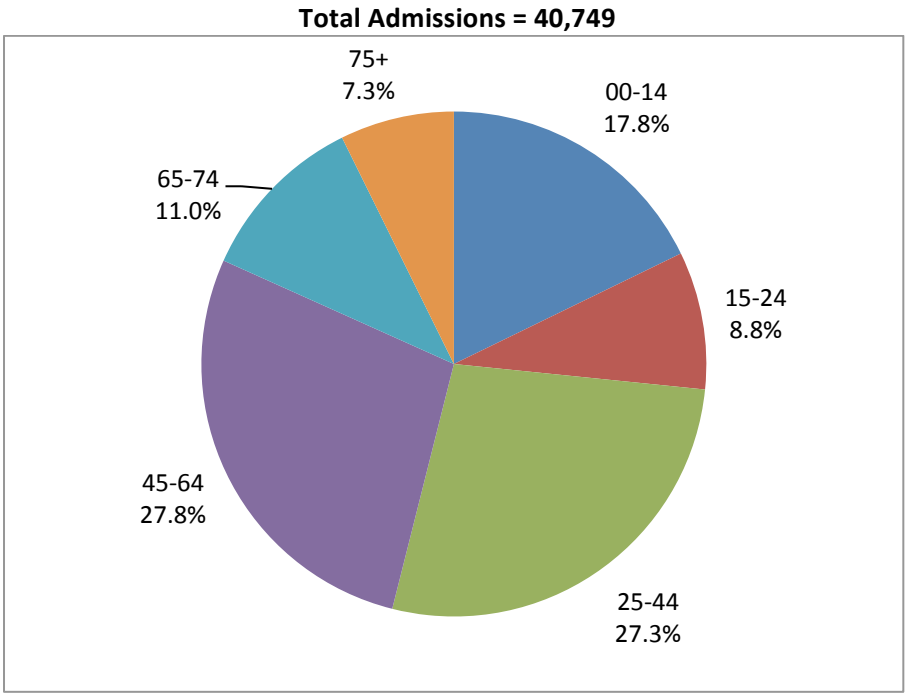
Chinese

Figure 13: Number of Medical/Surgical Hospital Admissions by Age Group Auckland Region Chinese, 2010/11 to 2012/13 (Walker, 2014).



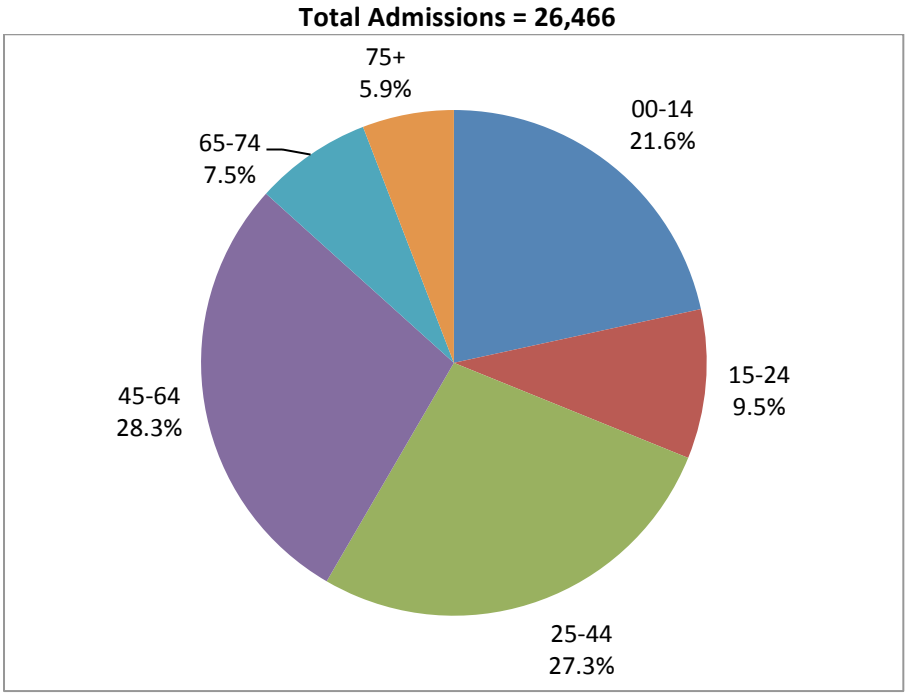
Indian

Figure 14: Number of Medical/Surgical Hospital Admissions by Age Group Auckland Region Indian, 2010/11 to 2012/13 (Walker, 2014).



Other Asian

Figure 15: Number of Medical/Surgical Hospital Admissions by Age Group Auckland Region Other Asian, 2010/11 to 2012/13 (Walker, 2014).



Potentially Avoidable Hospitalisation (PAH), 2010/11 to 2012/13

There were a total of 725,154 acute hospital admissions for patients below the age of 75 years in the Auckland Region in the three years 2010/11 to 2012/13. Of these, 156,079 or 21.5% were considered avoidable (Walker, 2014). For the Total Asian population in the Auckland Region 17.9% of 0-74 year old acute hospital admissions were considered potentially avoidable.

Table 24: Potentially Avoidable Hospitalisations by Ethnicity Auckland Region, 2010/11 to 2012/13 (Walker, 2014).

Ethnicity	PAH Admissions (0-74)	Total Acute Admissions (0-74)	% PAH
Indian	9,330	41,971	22.2%
Chinese	4,453	33,944	13.1%
Other Asian	5,104	29,725	17.2%
Total Asian	18,887	105,640	17.9%
MELAA	3,004	16,586	18.1%
All Ethnicities	156,079	725,154	21.5%

Auckland region total, top ten PAH

The table below shows the top ten causes of PAH for people in the Auckland Region. Angina and chest pain was the most frequent cause of PAH, accounting for 14.0% of preventable hospital admissions.

Table 25: Top Ten PAH Causes for Auckland Region Total, 2010/11 to 2012/13 (Walker, 2014).

PAH Condition	Admissions	% PAH
Angina and chest pain	22,768	14.0%
Cellulitis	18,164	11.2%
Gastroenteritis	13,705	8.4%
Respiratory infections - Pneumonia	10,050	6.2%
Asthma	9,734	6.0%
Kidney/urinary infection	9,367	5.8%
Dental conditions	7,771	4.8%
Respiratory infections - Acute bronchiolitis	7,263	4.5%
CORD	7,205	4.4%
Myocardial infarction	6,702	4.1%
Other PAH	49,805	30.6%
Total PAH	162,534	100.0%

Auckland region Asian total, top ten PAH

The table below shows the top ten causes of PAH for the total Asian population in the Auckland Region. The top three PAH conditions were angina and chest pain, gastroenteritis, and kidney/urinary infection.

Table 26: Top Ten PAH Causes for Auckland Region Total Asian, 2010/11 to 2012/13 (Walker, 2014).

PAH Condition	Admissions	% PAH
Angina and chest pain	3,387	16.9%
Gastroenteritis	2,316	11.6%
Kidney/urinary infection	1,280	6.4%
Asthma	1,270	6.4%
Dental conditions	1,229	6.1%
Cellulitis	1,222	6.1%
Respiratory infections - Pneumonia	1,030	5.2%
Myocardial infarction	923	4.6%
Respiratory infections - Other	886	4.4%
Epilepsy	701	3.5%
Other PAH	5,752	28.8%
Total PAH	19,996	100.0%

Auckland region Chinese, top ten PAH

For the Auckland Region Chinese population, the top three PAH conditions were angina and chest pain, gastroenteritis, and cellulitis.

Table 27: Top Ten PAH Causes for Auckland Region Chinese, 2010/11 to 2012/13 (Walker, 2014).

PAH Condition	Admissions	% PAH
Angina and chest pain	595	12.5%
Gastroenteritis	576	12.1%
Cellulitis	348	7.3%
Dental conditions	325	6.8%
Kidney/urinary infection	314	6.6%
Respiratory infections - Pneumonia	285	6.0%
Asthma	246	5.2%
Respiratory infections - Other	224	4.7%
Sexually transmitted diseases	193	4.1%
Epilepsy	186	3.9%
Other PAH	1,454	30.6%
Total PAH	4,746	100.0%

Auckland region Indian, top 10 PAH

For the Auckland Region Indian population, the top three PAH conditions were angina and chest pain, gastroenteritis, and myocardial infarction.

Table 28: Top Ten PAH Causes for Auckland Region Indian, 2010/11 to 2012/13 (Walker, 2014).

PAH Condition	Admissions	% PAH
Angina and chest pain	1,918	19.8%
Gastroenteritis	1,065	11.0%
Myocardial infarction	660	6.8%
Asthma	619	6.4%
Kidney/urinary infection	582	6.0%
Cellulitis	539	5.6%
Respiratory infections – Pneumonia	481	5.0%
Respiratory infections – Other	403	4.2%
Dental conditions	401	4.1%
Diabetes	352	3.6%
Other PAH	2,662	27.5%
Total PAH	9,682	100.0%

Auckland region Other Asian, top 10 PAH

For the Auckland Region Other Asian population the top three PAH conditions were angina and chest pain, gastroenteritis, and dental conditions.

Table 29: Top Ten PAH Causes for Auckland Region Other Asian, 2010/11 to 2012/13 (Walker, 2014).

PAH Condition	Admissions	% PAH
Angina and chest pain	874	15.7%
Gastroenteritis	675	12.1%
Dental conditions	503	9.0%
Asthma	405	7.3%
Kidney/urinary infection	384	6.9%
Cellulitis	335	6.0%
Respiratory infections - Pneumonia	264	4.7%
Respiratory infections - Other	259	4.7%
Epilepsy	209	3.8%
Sexually transmitted diseases	179	3.2%
Other PAH	1,481	26.6%
Total PAH	5,568	100.0%

Child Health in Refugee Populations

A retrospective audit of all refugee children under 5 years of age was conducted at the Mangere Refugee Reception Centre, Refugee Health Screening Service (RHSS) from the years 2007 to 2011 (Rungan et al., 3013). The largest proportion of refugees was from Asia (53%) including: Myanmar (40%), Bhutan (10%), Afghanistan (8%), Nepal, Sri Lanka and Bangladesh (each contributing ≤2% of the sample). The Refugee Health Screening Service assesses the health of all newly arrived refugees. The findings of the 343 children screened, were that:

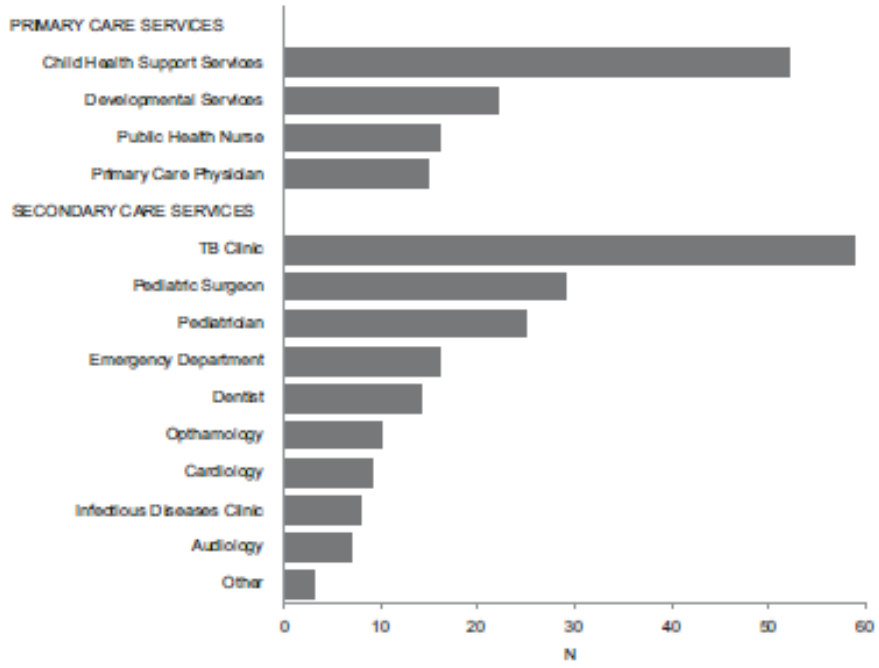
- The most common infectious diseases were latent tuberculosis (15%) and parasitic infections (15%).
- In those older than 1 year old, who had rubella and measles serology information, immunity was found in 50% and 59%, respectively.
- Hepatitis B immunity was found in 68% of children.
- Complete vaccination certificates were available for 66% on arrival to New Zealand.
- Vaccinations were administered to 73% of children while at the Mangere Refugee Resettlement Centre.
- Iron deficiency and vitamin D deficiency were the main non-infectious diseases found and were present in 33% and 12%, respectively.
- The total requiring referral for further medical assessment or support was 58% with 19% requiring referral to more than one service.

Referral

Of the sample, 58% had at least 1 referral to another medical service with 37% made to primary care services and 63% to secondary care services (Figure 16). Of the Asian group, 53 percent required at least on referral:

- Of those referred to primary care services, 50% were referred to health support services.
- 21% were referred to developmental services.
- 14% had specific follow up with a primary care physician.
- Of the secondary services, the most common referrals were to the TB clinic (33%), paediatric surgery (10%) and a paediatrician (9%).
- For those referred to secondary services, 31% required only 1 review whereas 51% required ongoing follow up.

Figure 16: Distribution of healthcare referrals in refugee children (<5 years old) arrivals in New Zealand 2007 to 2011.



Further information on refugee health in New Zealand can be found in the Ministry of Health (2012). *Refugee Health Care: A handbook for health professionals.* Wellington: Ministry of Health. http://www.health.govt.nz/publication/refugee-health-care-handbook-health-professionals.

Health Needs Assessment of Asian People living in the Auckland region (Mehta, 2012).

Child and youth health

This section presents the following child and youth health data:

- Mortality
- Child (0-14 years) potentially avoidable hospitalisations
- Low birth weight
- Immunisation coverage
- Oral health
- Summary Child and Youth Health: *Health Needs Assessment of Asian People living in Auckland* (Mehta, 2012)
- Summary of *Youth '07* findings for Asian students (Parackal et al., 2011)
- Summary of Child Health Findings: *Asian Health in Aotearoa in 2011 - 2013: trends since 2002-2003 and 2006-2007* (Scragg, 2016).

Mortality

Infant Mortality

The infant mortality rate (IMR) is used internationally as an indicator of child health status, and represents the number of children who die in the first year of life, per thousand live births, from all causes. Table indicates that there were no significant differences between the IMR of the three Asian groups examined and European/Other infants.

Table 30: Age-standardised mortality rate for all causes (per 1,000 with 95% CI) across the Auckland region by prioritised ethnicity among infants (males and females combined), 2006-2008 (Mehta, 2012)

Ethnicity	Number	Rate per 1,000 (95%CI)
Chinese	7	2.0 (0.8-4.2)
Indian	14	3.5 (1.9-5.9)
Other Asian	10	3.4 (1.7-6.3)
European/Other*	73	2.8 (2.2-3.5)

Source: National Mortality Collection; standard prioritised ethnicity.

* European/Other refers to all European, and non-Maori/Pacific/Asian peoples

Child Mortality (0-14 years)

Table presents the mortality rate for all causes among children aged 0 to 14 years. These rates include deaths occurring in the first year of life, and are presented as rates per 100,000 children. For all ethnic groups examined, at least 50% of the deaths occurring among children aged less than 15 years occur in the first year of life. There were no significant differences in the rate of child deaths from all causes among the ethnic groups examined (Mehta, 2012).

Table 31: Age-standardised mortality rate for all causes (per 100,000 with 95% CI) across the Auckland region by prioritised ethnicity among children aged 0-14 years (males and females combined), 2006-2008 (Mehta, 2012).

Ethnicity	Number	Rate per 100,000 (95%CI)
Chinese	14	28 (15-47)
Indian	18	31 (18-49)
Other Asian	12	27 (14-48)
European/Other*	122	31 (26-37)

Source: National Mortality Collection; standard prioritised ethnicity.

* European/Other refers to all European, and non-Maori/Pacific/Asian peoples

Child (0-14 years) Potentially Avoidable Hospitalisations

Table indicates that, across the Auckland region, Chinese boys aged 0 -14 years have a significantly lower rate of potentially avoidable hospitalisations (PAH) as compared to European/Other children, but there were no significant differences between the PAH rates of Indian, Other Asian and European/Other boys. Among girls aged 0 to 14 years, Chinese girls had a significantly lower PAH rate as compared to both European/Other and Indian girls, and a lower rate as compared to Other Asian girls although this difference was not significant. There were no significant differences in the PAH rate of Indian, Other Asian and European/Other girls across Auckland (Mehta, 2012).

Table 32: Age-standardised potentially avoidable hospitalisation rate (per 100,000 with 95% CI) across the Auckland region by prioritised ethnicity and sex among children, 2008-2010 (Mehta, 2012).

Sex	Ethnicity	Number	Rate per 100,000 (95%CI)
Male	Chinese	744	2,607 (2,374-2,889)
	Indian	1,190	3,637 (3,365-3,909)
	Other Asian	947	3,625 (3,347-3,904)
	European/Other*	7,537	3,861 (3,747-3,973)
Female	Chinese	613	2,301 (2,056-2,549)
	Indian	995	3,250 (2,963-3,536)
	Other Asian	692	2,745 (2,487-3,004)
	European/Other*	5,852	3,185 (3,080-3,289)

Source: National Minimum Dataset; standard prioritised ethnicity.
*European/Other refers to all European, and non-Maori/Pacific/Asian peoples

Table 33: indicates that the top three causes of PAH among children from each of the ethnic groups examined were ENT infections, dental conditions or asthma. The PAH rate for both dental conditions and asthma among Other Asian and Indian children were significantly higher than among their European/Other counterparts (Mehta, 2012).

Rank	Chinese			Indian			Other Asian			European/Other*		
	Cause of PAH	No. †	Rate	Cause of PAH	No. †	Rate	Cause of PAH	No. †	Rate	Cause of PAH	No. †	Rate
1	Dental conditions	236	434	Asthma	371	587	Dental conditions	407	773	ENT infections	2,979	788
2	Asthma	221	405	Dental conditions	311	503	Asthma	245	474	Dental conditions	1,659	428
3	ENT infections	135	244	ENT infections	242	388	ENT infections	165	320	Asthma	1,390	366
4	Pneumonia	129	233	Gastroenteritis	217	336	Other respiratory infections	137	278	Acute bronchiolitis	1,096	298
5	Other respiratory infections	129	231	Pneumonia	199	310	Pneumonia	139	272	Pneumonia	1,043	277

Source: National Minimum Dataset; standard prioritised ethnicity.
*European/Other refers to all European, and non-Maori/Pacific/Asian peoples

Low Birth Weight

Low birth weight is defined as a birth weight below 2500 grams. Low birth weight is either the result of preterm birth (ie before 37 weeks gestation) or restricted intrauterine growth. Low birth weight babies are approximately 20 times more likely to die than babies with a birth weight of more than 2500 grams. Low birth weight has also been associated with inhibited growth and cognitive development, as well as chronic diseases such as coronary heart disease and Type 2 Diabetes later in life (United Nations Children's Fund and World Health Organisation (2004).

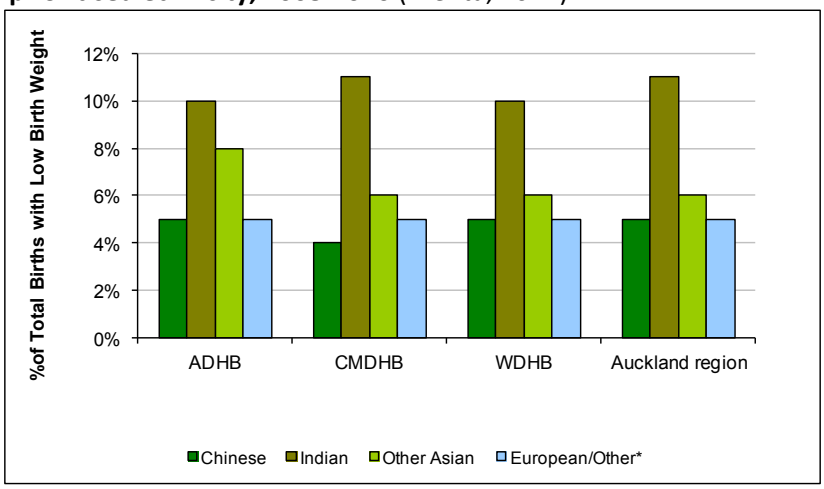
Table 34 and Figure 17 indicate that, in all areas examined, a greater percentage of Indian babies born between 2008 and 2010 had a birth weight below 2500 grams as compared to European/Other babies. The proportion of Chinese and Other Asian babies with low birth weight was similar to European/Other babies in all areas except ADHB, where a greater percentage of Other Asian babies had low birth weight as compared to their European/Other counterparts (Mehta, 2012).

Table 34: Number and percentage of births (males and females combined) with low birth weight (<2500g) by prioritised ethnicity, 2008-2010 (Mehta, 2012).

Ethnicity	ADHB			CMDHB			WDHB			Auckland region		
	No. Of Births <2500 g	Total births	% LBW	No. Of Births <2500 g	Total births	% LBW	No. Of Births <2500 g	Total births	% LBW	No. Of Births <2500 g	Total births	% LBW
Chinese	94	1,796	5%	49	1,183	4%	70	1,505	5%	213	4,484	5%
Indian	167	1,634	10%	210	1,841	11%	96	950	10%	473	4,425	11%
Other Asian	99	1,298	8%	52	945	6%	76	1,271	6%	227	3,514	6%
European/Other*	476	9,537	5%	394	7,690	5%	682	12,740	5%	1,552	29,697	5%

Source: National Minimum Dataset; standard prioritised ethnicity.
*European/Other refers to all European, and non-Maori/Pacific/Asian peoples

Figure 17: Percentage of births (males and females combined) with low birth weight (<2500g) by prioritised ethnicity, 2008-2010 (Mehta, 2012).

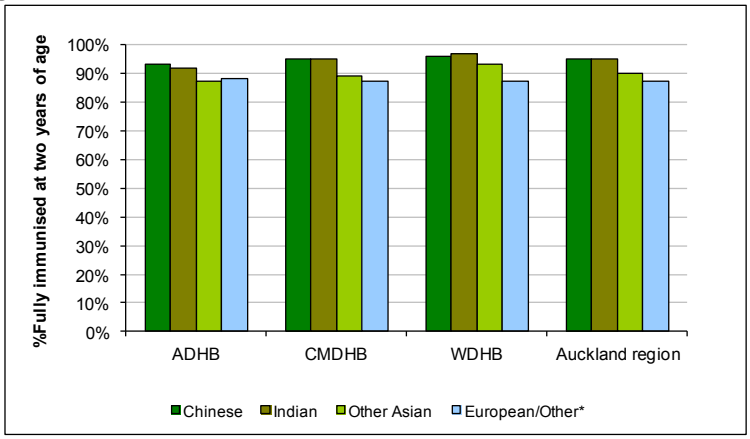


Source: National Minimum Dataset; standard prioritised ethnicity.
*European/Other refers to all European, and non-Maori/Pacific/Asian peoples

Immunisation Coverage

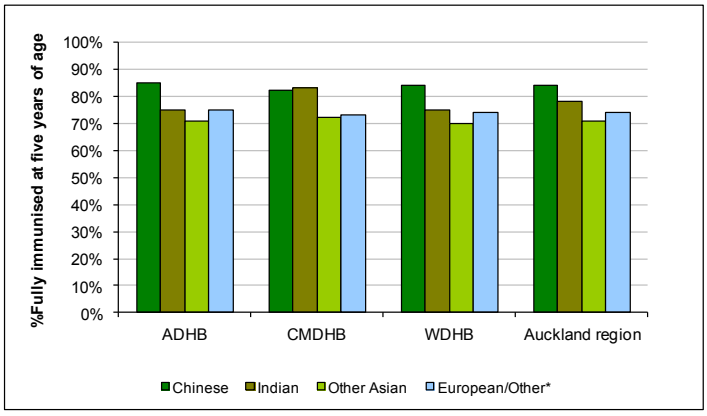
Figure 18 and Figure 19 present data from the National Immunisation Register regarding children who reached two years and five years of age during 2010 and who were recorded as having received all age-appropriate immunisations. These data include children whose parents have elected to opt-off the immunisation schedule or who have declined specific immunisations. (M. Ghafel, personal communication, 2012).

Figure 18: Percentage of male and female children combined who were fully immunised at two years of age, 2010 (Mehta, 2012).



Source: National Immunisation Register; standard prioritised ethnicity.
*European/Other refers to all European, and non-Maori/Pacific/Asian peoples

Figure 19: Percentage of male and female children combined who were fully immunised at five years of age, 2010 (Mehta, 2012).



Source: National Immunisation Register; standard prioritised ethnicity.
*European/Other refers to all European, and non-Maori/Pacific/Asian peoples

All three Asian groups had similar or higher rates of being fully immunised at two years, and five years of age, as compared to European/Other children. Chinese children had the largest proportion of fully immunised children at both two years and five years among all the ethnic groups examined (Mehta, 2012).

The Asian population in New Zealand has the highest immunisation rate of any ethnicity at 96 percent of the population (Pal et al., 2014).

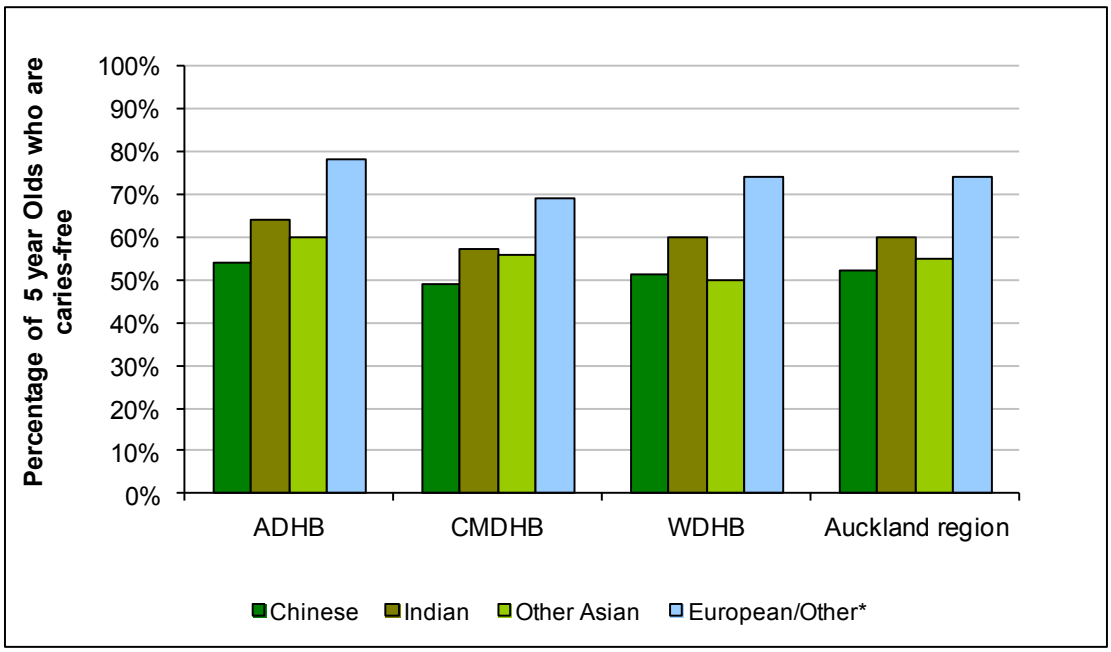
Oral Health

Oral Health in Five Year Olds and Eight Year Olds

The Auckland Regional Dental Service collects data regarding oral health in five year olds and eight year olds. Dentition among five years olds is still primarily comprised of deciduous teeth, while eight year olds have a larger proportion of permanent adult teeth (Mehta, 2012).

Figure 20 indicates that a lower proportion of Asian five year olds across the three DHBs had caries-free teeth as compared to European/Other five year olds. Chinese five year olds had the worst oral health of the ethnic groups examined (Mehta, 2012).

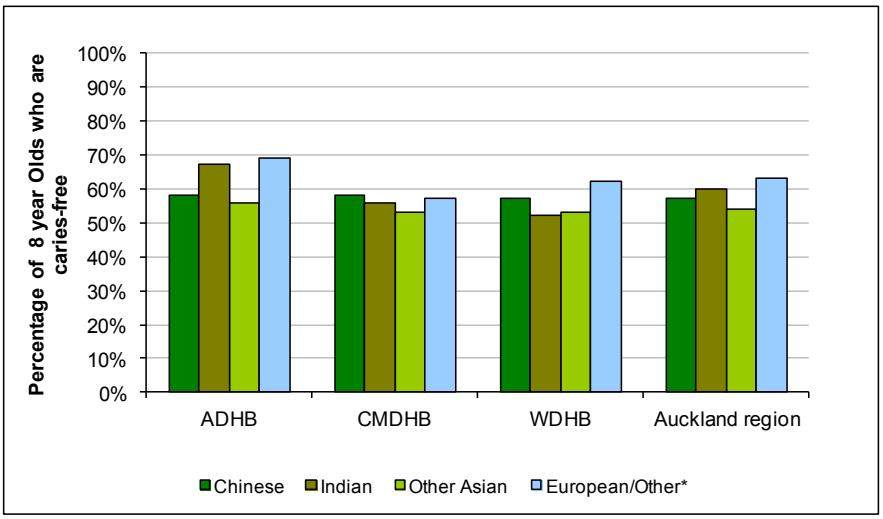
Figure 20: Proportion of five year olds (males and females combined) with caries-free teeth by prioritised ethnicity, 2011 (Mehta, 2012).



Source: Auckland Regional Dental Service; standard prioritised ethnicity.
*European/Other refers to all European, and non-Maori/Pacific/Asian peoples

Figure 21 indicates that while the proportion of Asian eight year olds that had caries-free teeth was lower across the three DHBs than for European/Other eight year olds, the differences across the ethnic groups examined were small. This probably reflects the eruption of some adult teeth with relatively little time for onset of caries, even among those with poor oral health.

Figure 21: Proportion of eight year olds (males and females combined) with caries-free teeth by prioritised ethnicity, 2011 (Mehta, 2012).



Source: Auckland Regional Dental Service; standard prioritised ethnicity.
*European/Other refers to all European, and non-Maori/Pacific/Asian peoples

It is unclear if poor child oral health is more of an issue among Asian migrant children and, if so, whether oral health issues are present on arrival in New Zealand or occur as a result of acculturation. (A. Mortensen, personal communication, 2012).

Hospitalisations for Dental Conditions

Hospitalisations among children are indicated for severe dental conditions, usually to enable tooth extraction under anaesthetic. Table 35 presents the hospitalisation rates for dental conditions among Auckland children between 2008 and 2010. Other Asian children had a much higher rate as compared to European/Other children, and this was a significant difference. Indian children had a slightly greater rate of dental hospitalisations and Chinese children had a similar rate as compared to their European/Other counterparts (Mehta, 2012).

Table 35: Age-standardised hospitalisation rate for dental conditions (per 100,000 with 95% CI) across the Auckland region by prioritised ethnicity among 0-14 year olds (males and females combined), 2008-2010 (Mehta, 2012).

Ethnicity	Number	Rate per 100,000 (95%CI)
Chinese	236	434 (374-494)
Indian	311	504 (444-564)
Other Asian	407	773 (692-854)
European/Other*	1,659	428 (405-450)

Source: National Minimum Dataset; standard prioritised ethnicity
* European/Other refers to all European, and non-Maori/Pacific/Asian peoples

Youth Health

The Youth '07 survey examined the health and wellbeing of secondary school students across New Zealand, including Asian students (Parackal et al., 2011). This section summarises the key findings for Asian students from this survey.

- Youth '07 was a cross-sectional survey conducted in 2007 among a representative sample of secondary school students from across the country. The survey was structured as an anonymous self-report questionnaire that was administered using handheld computers, and included a set of core questions used in the 2001 survey along with new questions addressing emerging health concerns.
- Of the 115 schools randomly selected from a pool of all eligible secondary schools in New Zealand, 96 schools agreed to be involved in the survey. From these schools, 12,549 students were randomly selected and invited to take part, and 9,107 students (or 72%) participated.
- Among these participants, 1,310 students of 14.4% of the total sample identified with an Asian ethnic group (Chinese 537, Indian 365, and Other Asian 408), 76% identified as NZ European, 19% identified as Maori, 13% identified with a Pacific ethnic group and 9% identified with other ethnic groups.

Data for Chinese, Indian and Other Asian students from the Youth '07 survey were analysed separately for a report that was published in 2011 (Parackal et al., 2011). Findings were presented separately for Chinese and Indian students where possible, as these were the two largest Asian ethnic groups in the survey. The following key findings were noted in this report (Mehta, 2011; Parackal et al., 2011):

- **Family life:** Positive family, home and school environments and positive relationships with adults at home and at school were reported by the majority of Asian students.
- **Housing and employment:** Chinese and Indian students, however, were more likely than NZ European students to experience frequent house shifts, overcrowding, and unemployment among parents or other family hardships.
- **Friendships:** Similar to 2001 findings, most Asian students reported positive and rewarding friendships.
- **Spiritual beliefs:** Around 40% identified spiritual beliefs as being important, and a similar proportion attended a place of worship regularly.
- **Bullying at school:** Chinese and Indian students were more likely than NZ European students to report positive feelings about school. Improvement was noted for a number of school safety indicators since the previous survey in 2001, although a small proportion of Chinese and Indian students reported being bullied weekly or more frequently with many identifying their ethnicity as a factor in the bullying. (Refer to Resources Section about where to get help with preventing and dealing with school bullying).
- **Nutrition and Physical Activity:** Approximately 75% of Asian students were not eating enough fruit and vegetables to meet current national guidelines, and 91% did not fulfil current national guidelines to have one or more hours of physical activity each day.

Compared to NZ European students, Indian students reported similar levels and Chinese students reported lower levels of physical activity.

- **Contraception:** Both Chinese and Indian students were more likely than their NZ European counterparts to report not using contraception. The proportion of Chinese students reporting contraception use was unchanged since the 2001 survey but the corresponding proportion among Indian students had declined.
- **Smoking:** Compared to the 2001 survey, the prevalence of ever smoking a cigarette and of smoking weekly or more often had decreased among Chinese students but both indicators remained relatively unchanged among Indian students.
- **Alcohol consumption:** Alcohol consumption was less prevalent among Asian students, with only 35% of Chinese students and 34% of Indian students identifying as current drinkers compared to 66% of NZ European students. Indian and Chinese students were also less likely than their NZ European counterparts to binge drink, although 16% of Indian and Chinese students reported binge drinking on at least one occasion in the previous four weeks. Marijuana use had declined among Chinese but not among Indian students compared to the 2001 survey findings.
- **Access to health care:** Almost all Asian students reported good health. However, a number of barriers to accessing health care when required were reported by many Asian students, including lack of knowledge of the New Zealand health system, associated costs and transport difficulties. Mental health concerns were a particular issue among Asian youth, especially female students. Significant depressive symptoms were reported by 18% of females and 7-8% of male Chinese and Indian students, and these proportions were similar to those noted in the 2001 survey.

Case Studies and Discussion Notes

This section includes all the case studies and discussion notes for the cases.

Case Study 1: Neonatal care and intergenerational issues (Indian)

Jayanti is a 1.5 generation New Zealand trained registered nurse. She and husband Shri are from Mumbai. Jayanti and Shri have a 3 year old son, Narayan, and a five month old daughter, Nirmala. The couple has their own ideas about neonatal care practices, leading to arguments with the child's paternal grandparents who live close by.

The couple speaks Marathi at home. They practice the Hindu faith, attend cultural and religious events, and are strongly connected to their extended family and community. Jayanti and Shri place considerable importance on maintaining their language and cultural and religious practices. However, in the area of child rearing they want to do things "the Kiwi way".

Shri's parents are a very supportive and are very involved in helping with the children. However, Jayanti is determined to be much more firm with her mother-in-law about deciding on child rearing practices for her baby daughter, following the experience of her insistence on controlling every aspect of Narayan's upbringing.

Nirmala has been a very unsettled baby and Jayanti has successfully used the strategies offered by the Well Child/Tamariki Ora nurse. This has resulted in Nirmala sleeping overnight since she was 2 ½ months old. Jayanti's mother-in-law is highly critical of Jayanti's parenting style, which she considers to be too tough.

Question: As the Well Child/Tamariki Ora nurse, how will you support Jayanti and Shri to manage their baby's unsettled sleep patterns?

Reference: Intergenerational and interethnic family relationship issues section (p.26).

Discussion

- It is easy to make assumptions that new parents from CALD backgrounds will follow their traditional childcare practices or, conversely, if they are New Zealand born or the 1.5 generation, that they will adopt the ways of their new country. These assumptions should be clarified as every family is different.
- Parents may choose to retain some cultural and religious practices and decide against others. Many CALD families will be open to family management ideas that may differ from their cultural norms.
- Effective communication between health professionals and parents will determine what support and information is helpful for parents making decisions about child-rearing. This is of particular importance to parents who face potential criticism or sanction from extended family or from their communities for stepping away from tradition.
- Jayanti, with the support of her husband can set boundaries with her mother-in-law. A mutual agreement needs to be reached between Jayanti and her husband and her mother-in-law that they will not discuss how to raise the children.

Case Study 2: Gender Preference (Pakistan)

Background

Asal is a 30 year old pregnant woman who presents to hospital during her third trimester seeking midwifery care. She and her husband have 4 female children aged between 2 and 12 years. Asal, her husband and their oldest daughter are migrants from Pakistan. The family settled in New Zealand 8 years ago. Asal's husband is currently unemployed and the family struggles financially. English is a second language. This is Asal's 4th pregnancy since arriving in New Zealand.

Current Pregnancy

When Asal presented to the hospital, during her antenatal assessment she received a pregnancy ultrasound scan and was advised (with an interpreter) that she was having a girl. Upon receiving this information Asal said she did not want another girl.

Asal did not attend any further follow-up antenatal appointments and was admitted when she went into premature labour. Her baby was born 5 weeks early.

Upon delivery, Asal refused to have contact with her baby and she discharged herself without the baby. The baby needed to remain in hospital for 5 weeks. During this time Asal did not want any contact with her baby telling nurses that this was because the baby was a girl and "she did not like her baby". Other members of her family did not visit.

A number of nurses recorded in the patient's medical record that they were concerned about the lack of emotional care that the baby was receiving from her mother and other family members.

Asal and her family were difficult to engage and assess when staff made attempts to meet with them. The staff made provision for the availability of interpreters. Antenatal staff made the assessment that Asal was tired and overwhelmed by the birth of a 5th child and was possibly suffering from postnatal depression. A referral was made to mental health services. Mental health services had the same difficulties engaging with Asal and her family. Follow-up postnatal visits by the midwife were also difficult.

Discharge of Baby

After 5 weeks the baby was well enough to be discharged home with her parents and siblings. A discharge meeting was held with the parents, an interpreter, mental health services and a well-child provider. It was felt at this meeting that there were no child protection concerns and that there were enough services involved to support the family in the community.

Re-admission of baby into hospital

After 2 weeks post discharge, the baby was re-admitted to hospital in a seriously malnourished and neglected state.

Child Protection Indicators and Red Flags:

- During pregnancy
    3. Once the baby had been identified as a girl – it appeared that this was an

unwanted baby.

4. Asal did not attend follow-up antenatal appointments.

- Postnatal
  8. Asal did not want to hold or care for her baby directly after birth.
  9. Asal discharged herself as soon as possible post-delivery.
  10. Asal refused to have any further contact with her baby and stated she did not like her baby.
  11. The baby did not receive any skin to skin contact, nurturing, emotional connection/attachment or family involvement.
  12. Health professionals were concerned about the mother's lack of emotional attachment to her baby.
  13. Asal was deemed to be suffering from postnatal depression, to be shut down and was not responsive to her baby.
  14. Asal had other stressors, 4 other children to care for at home, no extended family support, financial difficulties.

Question 1: How could health professionals have done a better job of assessing Asal's situation, as well as protecting and supporting her and the baby?

Reference: Gender Preference section (p.28).

Discussion

The following are some issues that could have been further explored or considered:

- Asal was trying to tell health professionals [in her own way] she did not want her baby if it was a girl. However, Asal's comments were dismissed or not taken seriously.
- There did not appear to be any focus on the baby's needs or on how the lack of response from Asal and other family members would impact upon the baby's wellbeing.
- The baby was not identified as being neglected; this could be because her medical and physical needs were being met by health professionals.
- It appeared that the key focus was on Asal's mental wellbeing and other social factors. It would have been valuable to have considered the cultural importance to Asal of having a boy and what an additional girl would mean to her family. At no stage did there appear to be any thought given to seeking cultural guidance or support from a member/health professional from the Pakistani community regarding the importance of gender and how this family could be supported.
- What other pressures were there for Asal, ie from her husband?

Considerations for this cultural group: In South Asian communities having a son is highly important. Sons are seen as future breadwinners, the continuation of a family's lineage, and the inheritors of the family's estate.

Case Study 3: Coining- Resolving cultural conflict through negotiation (Vietnamese)

(Campinha-Bacote, 2011)

Mrs Lee is a 28 year old Vietnamese woman who brings her daughter, Leah (age 2 years) into the Emergency Department because "she is sick."

A nurse assesses the child and notes that she has an elevated temperature (104.0° C) with slightly pulse and respirations. After a nursing assessment and diagnostic workup it was found that Leah had a bacterial infection that required an antibiotic. On physical examination, the nurse is concerned to see several symmetrical, striated, and abrasive marks on the back of the child. She is concerned that this may be child abuse, and also that the skin breaks may complicate the child's bacterial infection.

The nurse asks Mrs Lee how the child received these marks and the mother readily responds, *"I did it."* To rule out potential child abuse, the nurse takes a patient-centred approach and conducts a cultural assessment.

First, the nurse asks Mrs Lee to explain what she thought was wrong with her daughter Leah.

Mrs Lee says, "She was very hot and crying and I brought her here because I want her to get all the help she can to get better fast." The nurse then asks Mrs Lee what kinds of treatments she has tried for this problem. Mrs Lee becomes very defensive and asks, *"Why are you asking me all these questions."* The nurse responds by saying that she wants to learn more about Leah and how she is cared for. Mrs Lee reluctantly states, *"I used cao gio; I think you call it coining in English."*

Although, the nurse has heard and read about the practice of coining among Southeast Asian peoples, she clarifies with Mrs Lee, her understanding of her values, beliefs, and practices. She asks Mrs. Lee to explain coining. Mrs Lee responds, "I get some oil and rub Leah's back with it and then I rub a small coin down the middle of her back until I see a little blood under the skin."

The nurse further asks what is/are the expected result or results of coining. Mrs Lee adds, "*Coining takes away the wind that is causing her fever."*

Next, the nurse asks Mrs Lee if she has sought help or advice from people other than healthcare professionals, such as people from her community.

Mrs Lee answers, "Yes! There is an elder in our community who sells the oil for the coining. I think he says it has winter green, or eucalyptus, or peppermint oil in it. I really don't know, but my family trusts him." After conducting this cultural assessment the nurse feels confident that the marks on Leah's back are not child abuse, but rather the culture-specific practice of coining.

The nurse continues the cultural assessment by explaining her perception of Leah's problem to Mrs Lee.

The nurse explains that Leah has an infection that needs to be treated with antibiotics and that any open wounds can increase the chance of the infection getting worse. Further, the nurse remarks that she is concerned that the skin abrasions caused by the coining may increase the chance of more infections. Mrs Lee abruptly interrupts the nurse and remarks, *"I am not going to stop my coining! She won't get better if we just give her your medicine!"* The nurse demonstrates respect for Mrs Lee and acknowledges the differences between their two perceptions regarding treatment of Leah's illness by telling her that the coining is being done to help Leah and that their common goal is to get Leah better.

The nurse focuses on recommendations that involve Mrs Lee as an active participant in negotiating a mutually acceptable treatment plan. Mrs Lee is firm in the belief that coining is the only way that Leah's fever will go down. After several recommendations by the nurse and several non-acceptances of these recommendations by Mrs Lee, they finally agree that in addition to complying with the nursing and medical discharge plan, Mrs Lee can rub the coin lightly on Leah's back, making sure not to cause any redness, bleeding, or break in the skin. Mrs Lee states, *"I'll give this a try."*

Question 1: Identify the culturally appropriate techniques that the nurse used to resolve the cultural conflict with Mrs Lee without compromising medical and nursing guidelines?

Reference: Humoral/Body Balance section (p.33).

Discussion

- The nurse applied the cultural awareness-assessment and negotiation technique.
- The nurse applied cultural sensitivity and avoided making assumption about the child (Leah) being abused in the first instance.
- Although she had cultural awareness of *"coining"* practices she did not jump to conclusions but instead engaged with Mrs Lee to validate the practice and the value or usefulness of the treatment.
- She demonstrated respect and acknowledged the differences between their perceptions regarding the treatment of the Leah's illness by emphasising the common goals they are trying to achieve.
- She did a cultural assessment to evaluate the likelihood that Mrs Lee will continue her "coining" practice post the discharge.
- She negotiated with Mrs Lee to rub the coin lightly on the child's back to make sure she does not cause any redness, bleeding or skin breaks, to reduce the chance of bacterial infection while Leah is recovering.
- She incorporated non-harmful remedies in the discharge plan to reduce risk to the child.
- She managed to persuade Mrs Lee to alter the coining practice and both the nurse and Mrs Lee reached a culturally and mutually acceptable discharge plan.

Case Study 4: Humoral/Body Balance (Ayurveda)

Shanti presents at the Emergency Department with her daughter Saroj (age 18 months). She reports that her daughter has had a fever, runny nose, and a cough for the last 2 days. Saroj has a temp of 39.5°C and she is dehydrated because she is not drinking much fluid. It's a hot day but she is dressed in a jumper, hat, leggings and socks and wrapped in a blanket. The doctor on duty explains that they need to get Saroj's temperature down quickly.

The doctor unwraps the child, gives her an ice-block and asks the nurse to give her antibiotics and an IV drip. The family follows *Ayurvedic* traditional medicine principles and in this practice to maintain body balance cold foods are not consumed during a cold/fever. Herbal remedies are preferred for treating coughs and colds and for restoring health.

The family objects to the ice-block as they think that this will make her cold and the fever worse. The emergency nurse explains that cold drinks will help Saroj because they will lower her temperature. The family strongly objects to this recommendation.

The nurse respectfully acknowledges Shanti's concerns and enquires about Shanti's traditional practices and the reasons for her objections.

The nurse realises that Shanti's objections are because of her strong traditional beliefs. The nurse acknowledges Shanti's beliefs and practices, and emphasizes their common goal which is to reduce Saroj's fever. She then explains the immediate need to reduce Saroj's temperature to avoid the child's temperature continuing to spike which may lead to serious consequences.

The nurse finally manages to get Shanti to agree with the recommended approach and asks her to monitor Saroj to make sure that her temperature is back to normal. The nurse also suggests to Shanti, that once Saroj recovers, she can provide the necessary traditional Ayurvedic herbal remedy to restore her health.

Shanti says *"thank you I will stay with Saroj and monitor her progress. I agree that it is most important to manage Saroj's temperature and to get her well first."*

Question 1: What techniques did the nurse use to resolve the differences in beliefs and practices with Shanti to achieve a culturally appropriate outcome?

Reference: Humoral/Body Balance section (p.36).

Discussion:

- The nurse was respectful and has an enquiring attitude.
- She did a cultural assessment to understand the client's beliefs and practices and her reason(s) for objecting to her recommendation.
- She acknowledged the common goal of the two treatment perceptions.
- She negotiated with Shanti and involved her actively in the care of the child.
- She incorporated Shanti's Ayurvedic treatment into the care plan for the child.

Case Study 5: Religious beliefs (Hindu)

Mrs Shukla presents with her 2 ½ year old son Rajiv, who has a persistent cough and recurrent chest infections. This is her third visit for a chest infection this winter.

Rajiv looks pale and sickly. The GP tests him for anaemia and Vitamin D. He asks about his diet. Rajiv is cared for by his grandparents as his parents work long hours in their business. Rajiv is fed on whole milk (blue top milk) 3 times a day as he will not eat any solids.

His blood tests show him to be anaemic and to have severe Vitamin D deficiency. The GP recommends that Rajiv is introduced to solids including red meat to increase his iron levels.

The GP prescribes Vitamin D for Rajiv and for Mrs Shukla.

Mrs Shukla says that they are vegetarian and would not feed their child meat. The GP suggests that Mrs Shukla introduces eggs. Mrs Shukla says that it is against her religion (Hindu) to eat eggs and that her parents in law would object strongly.

The GP consults with a colleague who practices the Hindu faith, who suggests that the family introduce *rajma* (a curry made with beans or lentils). Foods such as kidney beans, dahls and lentils are rich in protein, folate and iron and will replenish Rajiv's iron stores.

Mrs Shukla says that her 6 year old Sanjay was also pale as a toddler but "came right" when he was older. In consultation with a colleague, you find out that having children with pale skin is highly valued in Indian culture, which may have provided a disincentive for the family to consider that their child was unwell and lacking in essential micronutrients.

Question 1: How could the GP have intervened earlier to have prevented Rajiv's anaemia and severe Vitamin D deficiency?

Question 2: What health education messages will be important for Mrs Shukla to ensure that her son's health improves?

Question 3: What could the GP do to improve his cultural awareness, knowledge and skills?

Reference: Spiritual and Religious Beliefs section (p.40).

Discussion

- Explain to Mrs Shukla that when children are Vitamin D deficient, they are vulnerable to chest and other infections. This means that they have a poor appetite and that therefore supplements will be needed. As well, explain that Vitamin D is needed for children to develop strong bones.
- Mrs Shukla could have been prescribed Vitamin D when she first presented to the practice in her first pregnancy. It is likely that both children were born to a Vitamin D deficient mother. Advise Mrs Shukla that she will need to take Vitamin D supplements routinely.

- Explain to Mrs Shukla that babies and toddlers need iron for good brain development and that it is therefore important to introduce foods rich in protein, iron and folate which are part of the family's traditional diet, such as rajma. Foods such as kidney beans, dahls and lentils are rich in protein, folate and iron and will replenish Rajiv's iron stores.
- Offer Mrs Shukla the Healthy Eating for South Asian People. Check which language her mother-in-law would prefer and offer a translated version as well as English. Available on http://www.ecald.com/Resources/Resources-Translated-Information/ID/1178/Healthy-Eating-for-AsianSouth-Asian-people resource which is in English, Gujarati, Hindi and Punjabi.

Case Study 6: Birth defects (Chinese)

Jinjing Xu arrived from Shanghai with her husband 5 years ago. She is pregnant for the first time. Mrs Xu has a scan at 25 weeks of gestation. The scan reveals that the baby is a girl and that she has a cleft palate. Jinjing and her husband are determined to terminate the pregnancy. There is a lot of pressure from Jinjing's mother-in-law in China who expects a grandson and a perfect baby.

In China, late termination and abortion is acceptable. Abortion clinics are government-funded and termination of pregnancy services are available on request for women except in cases of sex-selective abortion. Despite this policy, sex-selective abortion continues to be prevalent and practiced because it is not easy for the Chinese government to regulate the practice and son-preference in Chinese families persists. In many cases the couple can pay, when having an ultrasound or will try to pay to be told the sex of their child (Hesketh et al, 2005; Junhong, 2001).

Question 1: How could giving the results of the scan to Mr and Mrs Xu have been better managed?

Question 2: What do you think are the implications of having a baby with a 'cleft palate' for the parents and grandparents?

Question 3: What is the role of grandparents in the decision-making to terminate the pregnancy?

Question 4: Is the gender of the child a factor in Mr and Mrs Xu's determination to terminate the pregnancy?

Question 5: How would you support Mr and Mrs Xu through this difficult diagnosis?

Reference: Expectations of a Perfect Baby section (p.42).

Discussion

- When giving the diagnosis to Mr and Mrs Xu, the doctor and LMC would have been better to have given the couple information about cleft palate repair.
- For a pregnant woman, finding out her unborn child has a cleft palate puts her under a lot of pressure from her family. She would be viewed poorly or blamed by her mother-in-law for not taking enough care during pregnancy resulting in the baby having a cleft palate and therefore being considered an imperfect baby.
- Parents face pressures as well, from grandparents expecting the birth of a perfect grandson. Having a granddaughter would upset them.
- While abortion is legal in China, sex-selective abortion is not legal. However, with China's one-child family policy, many will choose to continue a pregnancy only if the fetus is male.
- It is possible that the Xu couple is determined to terminate the pregnancy because of son-preference in their family. The grandparents may have influenced the decision.
- The LMC needs to ensure that:
  - Mr and Mrs Xu understand the process for cleft lip and/or palate repair and reconstruction and also understand that sex-selective late termination is not legal.
  - The parents know that they need to discuss with the grandparents the fact that late termination is not legal in New Zealand and that there is positive news about cleft palate repair.
  - As well, it is good to remind both parents and grandparents that in New Zealand, there is no one-child policy and that there is still another opportunity to have a son later.

Terms Used and Glossary

Summary of terms used and definitions

The following are terms used in this document:

Term	Definition
Asian	People originating from Asian countries including countries in West Asia (Afghanistan and Nepal), South Asia (covering the Indian sub-continent), East Asia (covering China, North and South Korea, Taiwan, Hong Kong and Japan) and South East Asia (Singapore, Malaysia, the Philippines, Vietnam, Thailand, Myanmar, Laos and Cambodia). This definition is commonly used within the health sector and is the basis of Statistics New Zealand Asian ethnicity categories.
Auckland region	The geographical region referred to as the Auckland Region in this report is defined as the combined geographies of the three Auckland metro District Health Boards: Waitemata DHB, Auckland DHB, and Counties Manukau DHB.
CALD	Culturally and Linguistically diverse people from Asian, Middle Eastern and African (MEA) backgrounds.
Ethnicity	Ethnicity is the ethnic group or groups that people identify with or feel they belong to. Ethnicity is a measure of cultural affiliation, as opposed to race, ancestry, nationality or citizenship. Ethnicity is self perceived and people can belong to more than one ethnic group (SNZ, 2005). An ethnic group is made up of people who have some or all of the following characteristics: ▪ a common proper name. ▪ one or more elements of common culture which need not be specified, but may include religion, customs, or language. ▪ unique community of interests, feelings and actions. ▪ a shared sense of common origins or ancestry, and ▪ a common geographic origin.
Families, Family members	These terms refer to the group of people who provide unpaid or paid care, that is they are looking after: • people who are receiving care from the health and disability services provided by DHB provider services, primary health and NGO sectors; or • people who are recovering at home after receiving services from the health and disability services provided by DHB provider services, primary health and NGO sectors.
Health provider,	Roles in health, mental health and disability services providing healthcare services.

Term	Definition
practitioner, clinicians, practitioner, health professional, health providers	
LMC, Lead Maternity Carer	Pregnant women are required to choose a Lead Maternity Carer who coordinates their maternity care. Lead Maternity Carers can be midwives or an obstetrician or a GP with a diploma in obstetrics. LMCs are contracted through the Ministry of Health to provide antenatal, labour and postpartum care.
MEA population	MEA in this resource refers to Middle Eastern and African groups.
MELAA groups	Middle Eastern, Latin American and African groups.
Migrants	People who were born overseas who settle in New Zealand (also known as immigrants).
Neonatal	A newborn baby up to the age of 28 days.
Postnatal (also known as Postpartum)	The period beginning immediately after the birth of a child and extending until the baby is six weeks old.
Refugees	In this resource, refugees refer to people who arrive in New Zealand under one of three categories: • Quota refugees • Family reunification members • Asylum seekers A **Refugee** is defined as "any person who, owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable, or owing to such fear, is unwilling to avail himself / herself of the protection of that country" (United Nations Convention and the 1967 Protocol Relating to the Status of Refugees, 1951). In 1967, the protocol relating to the status of refugees extended this definition to include displaced people who are seeking temporary refugee to escape political and social disruptions.
Children	These terms refer to the group of people who are receiving services from health and disability sectors (ie DHB provider services, primary health services and non-government organisations).

Glossary

The following are abbreviated terms used in this document:

Abbreviation	Description
ADHB	Auckland District Health Board
ARPHS	Auckland Regional Public Health Service
CALD	Culturally and Linguistically Diverse
CMDHB	Counties-Manukau District Health Board
CYFS	Child Youth Family Service now Ministry for Vulnerable Children Oranga Tamariki
DHB	District Health Board
GP	General Practitioner
LMC	Lead Maternity Carer
MEA	Middle Eastern and African
MELAA	Middle Eastern, Latin American, and African
MOH	Ministry of Health
MVCOT	Ministry for Vulnerable Children Oranga Tamariki (formerly Child Youth Family Services)
NHT	Neonatal Hearing Testing
NICU	Neonatal Intensive Care Unit
NGO	Non-governmental organization
NRA	Northern Regional Alliance Ltd (previously NDSA)
NZ	New Zealand
PHO	Primary Health Organisation
SNZ	Statistics New Zealand
WCTO	Well Child Tamariki Ora
WDHB	Waitemata District Health Board

References

Adams, D.L. (Ed.). (1995). *Health issues for women of color: A cultural diversity perspective*. Thousand Oaks: SAGE Publications.

Ameratunga, S. & Horner, J. (2011). 'Asian' and immigrant minority youth in Aotearoa/New Zealand. In *Improving the Transition Reducing Social and Psychological Morbidity During Adolescence: A report from the Prime Minister's Chief Science Advisor* (pp169-177). Wellington: Office of the Prime Minister's Science Advisory Committee. Retrieved from: http://www.pmcsa.org.nz/wp-content/uploads/Improving-the-Transition-report.pdf.

Athey, J.L. & Ahern, F.L. Jr (1991). The mental health of refugee children: An overview. In F.L. Ahern & J.L. Athey (Eds.). *Refugee children: Theory, research and services.* Baltimore: John Hopkins University Press, pp 3-19.

Auckland DHB and Waitemata DHB (2012). *Child Health Improvement Plan 2012-2017. Auckland & West Auckland: Auckland DHB and Waitemata DHB*. Retrieved from: http://www.adhb.govt.nz/planningandfunding/Documents/ADHB-WDHB%20Joint%20CHIP.%20Approved.pdf.

Aydemir, N., Dang, V.T., Snape, D., Baker, G.A., Jacoby, A. & the Crest Study Team (2009). Multiple impacts of epilepsy and contributing factors: findings from an ethnographic study in Vietnam. *Epilepsy Behav,16* (3), 512–520.

Baptiste, D.A. (2005). Family therapy with East Indian immigrant parents rearing children in the United States: Parental concerns, therapeutic issues, and recommendations. *Contemporary Family Therapy 27*(3), 345-366.

Beiser, M. & Hyman, I. (1997). Refugees' time perspective and mental health. *Am J Psychiatry, 154*(7), 996-1002.

Ben, K.L., Xu, .C., Lu, L., Yao, J.P., Min, X,D., Li, W.Y., Tao, J., Wang, J., Li, J.J. & Cao, X.M. (2008).Promoting male circumcision in China for preventing HIV infection and improving reproductive health. (Article in Chinese). *Zhonghua Nan Ke Xue, 14*: 291-297.

Benson, J. & Thistlethwaite, J. (2009). *Mental Health across Cultures. A practical guide for health professionals.* Oxford: Radcliffe.

Berry, J.W. (1990). Psychology of acculturation. In J.J. Berman (Ed.). *Cross-cultural perspectives: Nebraska symposium on motivation 1989* (pp. 201–234). Lincoln and London: University of Nebraska Press.

Branigan, T. (2011). China's great gender crisis. *The Guardian.* Retrieved from *https://www.theguardian.com/world/2011/nov/02/chinas-great-gender-crisis.*

Buwalda , H. (2004). *Basic competencies for mental health interpreters*. Retrieved from www.asylumsupport.info/publications/mlshs/mentalhealth.htm.

Campinha-Bacote, J. (2011). Delivering Patient-Centered Care in the Midst of a Cultural Conflict: The Role of Cultural Competence. *OJIN: The Online Journal of Issues in Nursing, 16* (2), Manuscript 5.

Carlin, J. (1990). Refugee and immigrant populations at special risk: Women, children, and the elderly. In W.H. Holtzman & T.H. Bornemann (Eds.). *Mental health of immigrants and refugees.* Austin, Texas: Hogg Foundation for Mental Health, University of Texas pp. 224-233.

Cartledge, G., Tam, K. Y., Loe, S.A., Miranda, A. H., Lambert, M. C., Kea, C. D. & Simmons-Reed, E. (2002). *Culturally and Linguistically Diverse Students with Behavioral Disorders. Fourth CCBD Mini-Library Series: Addressing the Diverse Needs of Children and Youth with Emotional/Behavioral Disorders--Programs That Work.* USA: Arlington, VA: Council for Children with Behavioural Disorders.

Castellsague, X., Peeling, R.W., Franceschi, S., de Sanjos, S., Smit, J.S., Albero, G., Dia, M., Herrero, R., Muno, N. & Bosch, F.X. (2005). Chlamydia trachomatis infection in female partners of circumcised and uncircumcised adult men. *Am J Epidemiol, 162*, 907-916.

Chan, B. & Parker, G. (2004). Some recommendations to assess depression in Chinese people in Australia. *Australian and New Zealand Journal of Psychiatry*, *38*, 141-147.Chang J. & Moon, A. (1997). Korean American elderley's knowledge and perceptions of elder abuse: A qualitative analysis of cultural factors. *Journal of Multicultural Social Work, 6,* 139-154.

Chang, E., MacLeod, R. & Drake, R. (2013). Characteristics influencing location of death for children with life-limiting illness. *Arch Dis Child, 98*, 419–424. http://adc.bmj.com/content/98/6/419.full.pdf.

Colucci, E., Szwarc, J., Minas, H., Paxton, G. & Guerra, C. (2012). The utilisation of mental health services by children and young people from a refugee background: a systematic literature review. *International Journal of Culture and Mental Health.* DOI:10.1080/17542863.2012.713371. http://dx.doi.org/10.1080/17542863.2012.713371.

Copland, T. (2014). *Japanese.* Wellington: Te Ara - the Encyclopedia of New Zealand. Retrieved from: http://www.TeAra.govt.nz/en/japanese.

Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards A Culturally Competent System of Care,* Volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Cyril, S., Green, J., Nicholson, J.M., Agho, K. & Renzaho, A.M.N. (2016) Exploring Service Providers' Perspectives in Improving Childhood Obesity Prevention among CALD Communities in Victoria, Australia. *PLoS ONE 11*(10), e0162184. doi:10.1371/journal.pone.0162184.

Didham, R. & Callister, P. (2014). *Ethnic intermarriage in New Zealand: A brief update: Research Note*. Wellington: Callister & Associates.

Earnest, J. (2006). Adolescent and Young Refugee Perspectives on Psychosocial Well-being. *International Journal of the Humanities, 3* (5), 79-86.

Ehntholt, K. A. & Yule, W. (2006). Practitioner Review: Assessment and treatment of refugee children and adolescents who have experienced war-related trauma. *Journal of Child Psychology and Psychiatry, 47*(12), 1197-1210.

Fazel, M. & Stein, A. (2002). The mental health of refugee children. *Arch Dis Child, 87:366-370.*

Fleming, T.M., Clark, T., Denny, S., Bullen, P. Crengle, S., Peiris-John, R., Robinson, E., Rossen, F.V., Sheridan, J. & Lucassen, M. (2013). Stability and change in the mental health of NZ secondary school students 2007-2012: Results from the national adolescent health surveys. *Australian & New Zealand Journal of Psychiatry*, *48* (5) 472–480.

Flores, G. (2004). Culture, ethnicity, and linguistic issues in pediatric care: urgent priorities and unanswered questions. *Acad Pediatr. 4,* 276–282.

Franklin, R. (2005). Baby Lore. *Superstitions and Old Wives Tales from the World Over Related to Pregnancy, Birth and Babycare.* Diggory Press. Retrieved from https://books.google.co.nz/books?id=3XWREKracNsC&pg=PA149&lpg=PA149&dq=muslim+praising+babies+-+spirit+take+away&source=bl&ots=3cdn6sDbgs&sig=kiTQy5WnMGrLw098hW_vWOpbk_8&hl=en&sa=X&ved=0ahUKEwjirPungM3RAhVFUZQKHXhoAxsQ6AEIHzAB#v=onepage&q=muslim%20praising%20babies%20-%20spirit%20take%20away&f=false.

Galloway, L. M., Kim-Rupnow, W. S., Stodden, N. J., Stodden, R. A. & Thai, N. D. (2003). Providing effective support services for culturally and linguistically diverse persons with disabilities: Challenges and recommendations. *Journal of Vocational Rehabilitation, 18*, 177-189.

Gatrad, R., Jhutti-Johal, J., Gill, P.S. & Sheikh, A. (2005). Sikh birth customs. *Arch Dis Child* 10:47 AM*90* (6), 560-563.

Gatrad, A.R., Muhammad, B.J. & Sheikh, A. (2008). Reorientation of care in the NICU: a Muslim perspective. *Semin Fetal Neonatal Med 133:*312-4.

Goode, T. (2003). *Getting started…Planning, implementing and evaluating culturally and linguistically competent service delivery systems for children with special health care needs and their families.* Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development. Retrieved from: http://gucchd.georgetown.edu/nccc.

Gopal, R. (2009).Religion, culture and the male cut in Asia. Exchange on HIV/AIDS, sexuality and gender. 3, 14-15.

Goyal, D., Murphy, S.O. & Cohen, J. (2006). Immigrant Asian Indian women and postpartum depression. *J Obstet Gynecol Neonatal Nurs.35* (1), 98-104.

Grant, C.C., Stewart, A.W., Scragg, R., Milne, T., Rowden, J., Ekeroma, A., Wall, C., Mitchell, E.A., Crengle, S., Trenholme, A., Crane, J. & Camargo, C.A. (2014). Vitamin D during Pregnancy and Infancy and Infant Serum 25-Hydroxyvitamin D Concentration. *Pediatrics, 133* (1), e143–e153.

Guo, S. (2013). *Migrant Ethnic Chinese Mothers' Intercultural Communication Experiences with their Maternity-Care and Health Providers in New Zealand*. Unpublished doctoral thesis. Hamilton: University of Waikato. Retrieved from: http://researchcommons.waikato.ac.nz/bitstream/handle/10289/7966/thesis.pdf?sequence=3&isAllowed=y.

Ha, K., Chung, S., Lee, H-S. Kim, C-i. Joung, H., Paik H.Y. & Song, Y.J. (2016). Association of Dietary Sugars and Sugar-Sweetened Beverage Intake with Obesity in Korean Children and Adolescents. *Nutrients, 8* (31). doi:10.3390/nu8010031.

Hackett, L., Hackett, R. & Taylor, D.C. (1991). Psychological disturbance and its associations in the children of the Gujarati Community. *Journal for Child Psychology and Psychiatry, 32*, 851–856.

Harker, K. (2001). Immigrant generation, assimilation, and adolescent psychological well-being. *Social Forces, 79,* 969–1004.

Harris, P. (2004). *Culturally competent disability support: Putting it into practice*. NSW, Australia: Multicultural Disability Advocacy Association of NSW.

Hasnain, R., Shaikh, L. C., & Shawnawani, H. (2008). *Disability and the Muslim Perspective: An Introduction for rehabilitation and health care providers.* Cirrie monograph series. New York: Buffalo University. Retrieved from: http://cirrie.buffalo.edu/culture/monographs/muslim.pdf.

Hellerstein, S., Feldman, S. & Duan, T. (2015). China's 50% caesarean delivery rate: is it too high? *BJOG, 122*, 160–165.

Hesketh, T., Lu, L.X., Xing, Z.W. (2005). The Effect of China's One-Child Family Policy after 25 Years. *The New England Journal of Medicine*. 353:1171-1176. Retrieved from http://www.nejm.org/doi/full/10.1056/NEJMhpr051833.

Hicks, R., Lalonde, R.N., & Pepler, D. (1993). The mental health of immigrant and refugee children. Psychosocial considerations in the mental health of immigrant and refugee children. *Canadian Journal of Community Mental Health, 12*, 71–87.

Hyman, I., Vu, N. & Beiser, M. (2000). Post-migration stresses among Southeast Asian refugees youth in Canada: A research note. *Journal of Comparative Family Studies*, *31*(2), 281-293.

Ip, M. (2015). *Chinese.* Wellington: Te Ara - the Encyclopedia of New Zealand. Retrieved from: http://www.TeAra.govt.nz/en/chinese.

Jackson, K. (2006). *Fates, Spirits and Curses: Mental health and Traditional Beliefs in some Refugee Communities*. Auckland: Refugees as Survivors.

Javier, J.R., Hendriksz, T., Chamberlain, L.J. & Stuart, E. (2013). Cross-Cultural Training in Pediatric Residency: Every Encounter is a Cross-Cultural Encounter. *Acad Pediatr*. 13(6) 495–498.

Junhong, C. (2001). Prenatal Sex Determination and Sex-Selective Abortion in Rural Central China. *Population and Development Review, Vol.27*, Iss.2, p.261 & 269.

Kaur, J. (2012). *Cultural Diversity and Child Protection: Australian research review on the needs of culturally and linguistically diverse (CALD) and refugee children and families*. Queensland, Australia.

Kim, A. (2014). *Pregnancy, Childbirth and Childrearing in Koreans: Cultural Perspectives.* Presentation to the Auckland Regional Maternal Mental Health Training Day held 13th March 2014, Auckland.

Kim-Rupnow, W.S. (2001). An introduction to Korean culture for disability service providers. New York, USA: CIRRIE, University at Buffalo, The State University of New York. Retrieved from: http://www.ntac.hawaii.edu/downloads/products/briefs/culture/pdf/ACB-Vol2-Iss1-Korea.pdf.

Kirmayer, L.J., Groleau, D., Guzder, J., Blake, C., Javis, E. (2003). Cultural Consultation: A Model of Mental Health Service for Multicultural Societies. *Can J Psychiatry, Vol 48, No 3, April 2003.*

Kleinman, A. (1980). Patients and healers in the context of culture. Berkley, CA: University of California Press.

Kleinman, A. (2004). Culture and depression. *New England Journal of Medicine, 35* (10), 951-953.

Kleinman, A., Eisenberg L. & Goode, B. (1978). Culture, illness and care: Clinical Lessons from Anthropologic and Cross-cultural Research. *Ann. Intern. Med 88*, 251-258.

Kokanovic, R. (2012). *Pilot study on postnatal depression (PD) in refugee communities*. Australia: Monash University. Retrieved from: http://profiles.arts.monash.edu.au/sara-niner/files/2012/03/2012-06-beyondblue-Refugee-Mothers-Report-Web-Edit.pdf.

Kramer, E.J., Wang, C.B., Kwong, K., Wang, C.B., Lee, E. & Chung, H. (2002). *West J Med, 176*, 227-231.

Krapp, K. & Cengage, G.(Eds) (2006). *Encyclopedia of Nursing & Allied Health*., eNotes.com. 2006. 1 Oct.

Lau, Y. & Wong, D. F. (2008). The role of social support in helping Chinese women with perinatal depressive symptoms cope with family conflict. *Journal of Obstetric, Gynecologic, and Neonatal Nursing 37,* 556-571.

Liu, G.Z. (2001). *Chinese culture and disability: Information for U.S. service providers*. New York, USA: CIRRIE, University at Buffalo, The State University of New York. Retrieved from: http://cirrie.buffalo.edu/culture/monographs/china.php.

Livo, N.J & Cha, D. (1991). *Folk Stories of the Hmong: Peoples of Laos, Thailand and Vietnam.* Libraries Unlimited. USA. Retrieved from https://books.google.co.nz/books?id=b3MX_MMzDZsC&pg=PA5&lpg=PA5&dq=babies+head+site+of+the+soul&source=bl&ots=JDViK2QucE&sig=tsmgBeOb77y95hJn6SbjEXb-3VU&hl=en&sa=X&ved=0ahUKEwj2u9Xu8szRAhWGmZQKHYMtCk8Q6AEIIDAC#v=onepage&q=babies%20head%20site%20of%20the%20soul&f=false.

McLeod, A. & Reeve, M. (2005). The health status of quota refugees screened by New Zealand's Auckland Public Health Service between 1995 and 2000. *NZMJ, 118* (1224). URL: http://www.nzma.org.nz/journal/118-1224/1702/.

Matsuoka, J.K. (1990). Differential acculturation among Vietnamese refugees. *Social Work, 35,* 341-345.

Mehta, S. (2012). *Health Needs Assessment of Asian People living in the Auckland region.* Auckland: Northern DHB Support Agency.

Ministry of Health. (2012). *Refugee Health Care: A handbook for health professionals.* Wellington: Ministry of Health.

Ministry of Health (2012). *Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand.* Wellington: Ministry of Health.

Ministry of Social Development (2016). *New Zealand Disability Strategy 2016-2026.* Wellington: Ministry of Social Development. Retrieved from: https://www.odi.govt.nz/nz-disability-strategy/about-the-strategy/new-zealand-disability-strategy-2016-2026/.

Mortensen, A., Latimer, S. & Yusuf, I (2014). Cultural case workers in child disability services: An evidence-based model of cultural responsiveness for refugee families. *Kōtuitui: New Zealand Journal of Social Sciences Online*: http://dx.doi.org/10.1080/1177083X.2014.911752.

New Zealand Immigration (2016). *New Zealand Refugee Quota Programme*. Wellington: New Zealand Immigration, MBIE. Retrieved from: www.immigration.govt.nz/about-us/what-we-do/our-strategies-and-projects/supporting-refugees-and-asylum-seekers/refugee-and-protection-unit/new-zealand-refugee-quota-programme.

Paediatrics and Child Health Division of the Royal Australasian College of Physicians. 2008. Decision-Making at the End of Life in Infants, Children and Adolescents: A Policy of the Paediatrics and Child Health Division of The Royal Australasian College of Physicians. Unpublished document of The Royal Australasian College of Physicians.

Pal, S. (2008). *Cross-Cultural Assessment [Questionnaire]*. Auckland, New Zealand: RASNZ.

Pak-Gorstein, S., Haq, A. & Graham, E.A. (2009). Cultural influences on infant feeding practices. *Pediatrics in Review, 30* (3) e11. Retrieved from: http://pedsinreview.aappublications.org/content/30/3/e11.

Parackal, S., Ameratunga, S., Tin Tin, S., Wong, S. & Denny, S. (2011). *Youth'07: The health and wellbeing of secondary school students in New Zealand: Results for Chinese, Indian and other Asian students*. Auckland: The University of Auckland. Retrieved from: https://www.fmhs.auckland.ac.nz/assets/fmhs/faculty/ahrg/docs/2007-asian-report.pdf.

Perumal, L. (2010). *Health Needs Assessment of Middle Eastern, Latin American and African People living in the Auckland region.* Auckland: Auckland District Health Board.

Pettys, G.L. & Balgopal, P.R. (1998). Multigenerational conflicts and new immigrants: An indo-American experience. *Families in Society, 79,* 410-423.

Pinto, P.E. & Sahur, N. (2001). *Working with People with Disabilities: An Indian Perspective*. Center for International Rehabilitation Research Information and Exchange (CIRRIE). Retrieved from: http://cirrie.buffalo.edu/monographs/india.php.

Potocky-Tripodi, M. (2002). *Best practices for social work with refugees and immigrants*. New York: Columbia University Press.

Queensland Health and Islamic Council of Queensland (2010). *Health Care Providers' Handbook on Muslim Patients, Second Edition.* Division of the Chief Health Officer, Queensland Health, Brisbane. Retrieved from: 2010.https://www.health.qld.gov.au/multicultural/support_tools/islamgde2ed.pdf.

Queensland Health Multicultural Services (2009). *Cultural dimensions of pregnancy, birth and post-natal care.* Australia: Queensland Health Multicultural Services. Retrieved from: http://www.health.qld.gov.au/multicultural/support_tools/14MCSR-pregnancy.pdf.

Rho, Y. & Rho, K. (2009). Clinical considerations when working with Asian American children and adolescents. N-h. Trinh., Y. C., Rho., F. G. Lu & K.M. Sanders (Eds.). *Handbook of Asian American Families* (pp 143-166). New York: Humana Press.

Riggs, E., Gibbs, L., Kilpatrick, N., Gussy, M., van Gemert, C., Ali, S. & Waters, E. (2015) Breaking down the barriers: a qualitative study to understand child oral health in refugee and migrant communities in Australia. *Ethnicity & Health, 20*, (3), 241-257, DOI: 10.1080/13557858.2014.907391.

Rungan, S., Reeve, A., Reed, P. & Voss, L. (2013). Health needs of refugee children younger than 5 years arriving in New Zealand. Pediatr. Infect. Dis. J*., 32* (12),e432-6.

Scragg, R. (2016). *Asian Health in Aotearoa in 2011 - 2013: trends since 2002-2003 and 2006-2007.* Auckland: Northern Regional Alliance Ltd.

Scragg, R. (2010). *Asian Health in Aotearoa in 2006-2007: trends since trends since 2002-2003.* Auckland: Northern DHB Support Agency.

Seeleman, C., Stronks, K., van Aalderen, W. & Essink Bot, M.L. (2012). Deficiencies in culturally competent asthma care for ethnic minority children: a qualitative assessment among care providers. *BMC Pediatrics 12*, 47. Retrieved from: http://www.biomedcentral.com/1471-2431/12/47.

Sobrun-Maharaj, A., Nayar, S. & Choummanivong, C. (2010). *Developing culturally responsive services for working with refugee youth with mental health concerns.* Auckland: Te Pou Statistics New Zealand. , 2001. *2001 Census of Population and Dwelling. Data Dictionary.* Wellington: Statistics New Zealand.

Statistics New Zealand (SNZ) (2015). Subnational ethnic population projections 2013 (base)-2038. Wellington: SNZ. Retrieved from: www.stats.govt.nz/browse_for_stats/population/estimates_and_projections/SubnationalEthnicPopulationProjections_HOTP2013base/Commentary.aspx.

Stevens, G. W.J.M. & Vollebergh, W.A.M. (2008). Mental health in migrant children. *Journal of Child Psychology and Psychiatry, 49* (3), 276–294.

Stewart, D.E. & Das, V. (1997). *Migrant empowerment: a case for the health sector*. Culture, Race and Community: Making it work in the new millennium.

Social Policy Evaluation and Research Unit (Superu) (2016). *Families and Whānau Status Report 2016:* Wellington: Superu.

Sullivan, S.G., Ma, W., Duan, S., Li, F., Wu, Z. & Detels, R. (2009). Attitudes towards circumcision among Chinese men. *J Acquir Immune Defic Syndr, 50*, 238-240.

Swarbrick, N. (2014). *Indians*. Wellington: Te Ara - the Encyclopedia of New Zealand. Retrieved from: http://www.TeAra.govt.nz/en/indians.

Trung T. (2014). *Vietnamese*. Wellington: Te Ara - the Encyclopedia of New Zealand. Retrieved from: http://www.TeAra.govt.nz/en/vietnamese.

Tse C, Chong A, Fok S. Breaking bad news: a Chinese perspective. Palliative Medicine 2003; 17:339-343.

Tummala-Narra, P. (2004). Mothering in a foreign land. *American Journal of Psychoanalysis, 64, (2) 167-182.*

Twomey, T.C. (2014). Pediatricians and Pediatric Nurses in the Delivery of Culturally Competent Care: A Scoping Literature Review to Investigate Progress and Issues around Culturally. Diverse Care in Pediatrics. *Pediatr Neonatal Nurs Open J, 1*, (1), 19-25.

Waitemata DHB, Child, Women & Family Services. (2013).*Working with Muslim Families and Disability*. Auckland: WDHB Child, Women & Family Services. Retrieved from: www.ecald.com/Portals/49/Docs/Toolkits/Toolkit%20Muslim%20Families%20Disability.pdf.

Waitemata DHB, eCALD® Services (2016a). *CALD 1: Culture and Cultural Competency.* Auckland: Waitemata DHB, eCALD® Services. Retrieved from www.ecald.com.

Waitemata DHB, eCALD® Services (2016b). *CALD 2: Working with Migrant Patients.* Auckland: Waitemata DHB, eCALD® Services. Retrieved from www.ecald.com.

Waitemata DHB, eCALD® Services (2014c). *CALD 4: Working with Interpreters* Auckland: Waitemata DHB, eCALD® Services. Retrieved from: http://www.ecald.com/Portals/49/Docs/Toolkits/cald-maternal-health.pdf. Retrieved from: www.ecald.com.

Waitemata DHB, eCALD® Services (2016d). *CALD 8: Working with CALD Families, Disability Awareness.* Auckland: Waitemata District Health Board, eCALD® Services.

Waitemata DHB eCALD® services (2016e). *CALD 9: Working in a mental health context with CALD clients.* Auckland: WDHB eCALD® services. Retrieved from: www.ecald.com/Courses/CALD-Courses-Overview/Courses-for-Working-with-Patients#CALD9.

Waitemata DHB, eCALD® Services (2016f). *Cross-Cultural Resource for Health Practitioners working with CALD clients/patients.* Auckland: Waitemata DHB, eCALD® Services. Retrieved from: http://www.ecald.com/Resources/Cross-Cultural-Resources/Toolkits-Manager/type/View/ID/1856.

Waitemata DHB, eCALD® Services (2016g). *Maternal Health for CALD women: Resource for Health Providers working with Asian, Middle Eastern and African Women.* Auckland: Waitemata DHB, eCALD® Services. Retrieved from: http://www.ecald.com/Portals/49/Docs/Toolkits/cald-maternal-health.pdf.

Waitemata DHB eCALD® services (2010). *Working with Asian mental health clients.* Auckland: WDHB eCALD® services. Retrieved from: http://www.ecald.com/Resources/Cross-Cultural-Resources/Toolkits-Manager/type/View/ID/1864.

Walker R. (2014). *Auckland Region DHBs Asian & MELAA: 2013 Census Demographic and Health Profile.* Auckland: Northern Regional Alliance (NRA).

Wang, P., Craig A. Michaels & Matthew S. Day. (2010). Stresses and Coping Strategies of Chinese Families with Children with Autism and Other Developmental Disabilities. *J Autism Dev Disord, 41*, 783–795.

Warrick, C., Perera, L., Murdoch, E. & Nicholl, R.M. (2011). Guidance for withdrawal and withholding of intensive care as part of neonatal end-of-life care. British Medical Bulletin 98, 99–113.

Wells, Y.-O. & Dietsch, E. (2014). Childbearing traditions of Indian women at home and abroad: An integrative literature review. *Women and Birth, 27* e1-e6. Available from: http://www.womenandbirth.org/article/S1871-5192(14)00086-9/pdf.

Wheeler, B., Dickson, N., Houghton, L., Ward, L. & Taylor, B. (2015). Incidence and characteristics of vitamin D deficiency rickets in New Zealand children: a prospective New

Zealand paediatric surveillance unit study. *International Journal of Pediatric Endocrinology* (Suppl 1):P57. Retrieved from: http://www.ijpeonline.com/content/2015/S1/P57.

Wiener, L., McConnell, D.G., Latella, L. & Ludi, E. (2013). Cultural and religious considerations in pediatric palliative care. *Palliat Support Care, 11*(1), 47–67.

Wikipedia (2016). Gua sha. Wikimedia Foundation Inc. Retrieved from: https://en.wikipedia.org/wiki/Gua_sha.

Wikipedia (2017a). *One Child Policy*. Wikimedia Foundation Inc. Retrieved from https://en.wikipedia.org/wiki/One-child_policy.

Wikipedia (2017b). *Hmong people.* Wikimedia Foundation Inc. Retried from Rethttps://en.wikipedia.org/wiki/Hmong_people.

Wishart, H.D., Reeve, A.M.F. & Grant, C.C. (2007). Vitamin D deficiency in a multinational refugee population. *Internal Medicine Journal 37* (2007) 792–797.

Wong, A., Peiris-John, R., Sobrun-Maharaj, A. & Ameratunga, S. (2015). Priorities and approaches to investigating Asian youth health: Perspectives of young Asian New Zealanders. J Prim Health Care, 7(4):282-90

Yang, C., Liu, X. & Wei, G.H. (2009).Foreskin development in 10 421 Chinese boys aged 0-18 years. *World J Pediatr, 5,* 312-315.

Yoon, I. C. & Yoon, H-k (2015). *Koreans*. Wellington: Te Ara - the Encyclopedia of New Zealand. Retrieved from: http://www.TeAra.govt.nz/en/koreans.