



Making Education Easy

Issue 2 - 2012

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Welcome to the second issue of Asian Health Research Review.

Warm wishes to all our readers for a Very Happy New Year!

The population of Asian ethnic groups in New Zealand has increased considerably over recent decades. Their health issues, sources of resilience and diverse experiences are relevant to the communities involved as well as service providers and wider society. Asian Health Research Review is a unique New Zealand publication bringing you the latest research on the health and wellbeing of Asians in New Zealand together with local commentary.

In this issue, we focus on a series of recent publications that provide invaluable insights on the diversity of perceptions, experiences and health needs of Asian people living in New Zealand and some frameworks and promising strategies that rise to the occasion of addressing the challenges involved. We hope you find these studies interesting and useful in your current practice, and look forward to receiving any feedback you may have.

Kind Regards,

Professor Shanthi Ameratunga

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Peri-abortion contraceptive choices of migrant Chinese women: a retrospective review of medical records

Authors: Rose SB et al

Summary: A retrospective review of the medical records of 305 Chinese women, compared to data from 277 European and 128 Maori women, was intended to determine whether Chinese women in NZ were over-represented among abortion seekers, to evaluate the contraceptive choices of Chinese women seeking abortion and to determine the relationship of contraceptive method choice to demographic characteristics. Pre-abortion oral contraceptive pill use by Chinese women was lower than in other ethnic groups, but rates of pre-abortion contraceptive non-use were similar to those of comparison groups, and Chinese women were not over-represented among abortion clinic attendees. Post-abortion rates of oral contraceptive pill use were similar for Chinese and European women (46.9% vs 43.7%), and rates of intrauterine device use did not differ significantly between Chinese and Maori women (28.9% vs 37%), but were higher than in European women (21.7%). In Chinese women, significant predictors of post-abortion method choice were age, parity and previous abortion.

Comment: There is a commonly held notion (supported by some reports) that Chinese immigrant women favour abortion as their contraceptive method of choice and are generally reluctant to use hormone-containing methods. This study challenges these relatively simplistic representations of Asian women's preferences and contraceptive choices. Based on assessments at a large public hospital abortion clinic (the sole provider for the Wellington region), the research indicates that there were far more similarities than differences between Chinese women and their European and Māori counterparts, with regard to presentation rates at the clinic as well as use of contraception before and after abortion. Following clinic-based counselling, Chinese women were as likely as Māori women and more likely than European women to choose effective hormone-containing methods. The findings suggest that rather than presuming the 'problem' of unplanned pregnancies among Chinese women lies in culturally-mediated attitudes and fears, attention should focus on addressing the barriers and vulnerabilities that prevent access to information and effective methods of contraception in this community.

Reference: PLoS One 2012;7(6):e40103

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3387017/>

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Asian Health Review

Independent commentary by Professor Shanthi Ameratunga.

Professor Shanthi Ameratunga has a personal chair in Epidemiology at the University of Auckland. A paediatrician and public health physician by training, Shanthi's research focuses on trauma outcomes, injury prevention, disability and youth health. She is the Project Director of the Traffic Related Injury in the Pacific (TRIP) Study, a collaboration with the Fiji School of Medicine, funded by The Wellcome Trust and the Health Research Council of New Zealand.



Disclaimer: This publication is not intended as a replacement for regular medical education but to assist in the process. The reviews are a summarised interpretation of the published study and reflect the opinion of the writer rather than those of the research group or scientific journal. It is suggested readers review the full trial data before forming a final conclusion on its merits.

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Markedly different clustering of CVD risk factors in New Zealand Indian and European people but similar risk scores (PREDICT-14)

Authors: Perumal L et al

Summary: This study compared the cardiovascular disease (CVD) risk profiles of 8,830 Indian and 47,091 European patients aged 35–74 years in primary care in the northern region of NZ extracted from the PREDICT decision support program. A greater proportion of Indian patients lived in more deprived areas compared to Europeans and had a 2- to 4-fold greater burden of diabetes across all age groups. They also had a lower proportion of smokers and a lower mean systolic blood pressure. The CVD risk factor profiles suggest similar age-adjusted Framingham 5-year CVD risk scores; however, national rates of hospitalisations and deaths from CVD are higher in the Indian population than in the European population suggesting an underestimation of CVD risk in Indians by the Framingham risk equation.

Comment: Routinely available health statistics have established that South Asian communities in New Zealand experience higher rates of hospitalisation and death due to CVD. This is incorporated into the national CVD risk assessment guideline with the recommendation that people of South Asian ethnicities are screened 10 years earlier than their NZ European counterparts. This study, based on the PREDICT cohort screened in primary care, is one of very few in the country to have assessed the CVD risk profiles in a South Asian group and identified important differences in the risk profile, relative to European people. A finding of particular note is the very high influence of clinically recognised diabetes in the predicted CVD risk among Indians – a finding that is supported by other studies demonstrating the disproportionately high impact of diabetes and its complications among South Asian communities. There are obvious imperatives to consider effective community-based strategies to reduce the burden of diabetes, as well as identify and manage this condition alongside other CVD risks in health care settings. Of note, this study also highlighted a significant problem in obtaining equivalent information for South Asian communities more generally, as there is no single ethnicity code that includes the groups involved.

Reference: *Aust N Z J Public Health* 2012;36(2):141-4
<http://onlinelibrary.wiley.com/doi/10.1111/j.1753-6405.2011.00808.x/abstract>

Waitemata DHB cultural responsiveness to its Asian, migrant and refugee populations – cultural competence concepts and initiatives

Authors: Lim S et al

Summary: This paper discusses the benefits of cultural competence and responsiveness to their ethnic minorities in health organisations in general, and focuses on the Waitemata DHB responsiveness to Asians, migrants and refugees in particular. It outlines resources available to health professionals when dealing with cultural and linguistically diverse populations and various support service groups established by the Waitemata DHB to support ethnic minorities when accessing health services in the region.

Comment: This is a District Health Board that has been at the forefront of the agenda of promoting and supporting services that are culturally responsive to Asian, migrant and refugee communities. What is particularly remarkable about this report is the attention provided to the concepts and principles of best practice in the field, the thoughtful assessment of both the successes and current gaps in services available, and the articulation of a comprehensive set of goals that should motivate work in this space. It is clear that 'cultural competence' is a journey across a continuum, embedded in organisations that aspire to this as an essential approach to achieving high quality equitable services, and championed by managers that accept the role of duty bearers. In a context where we have much to learn, there is no time like the present to share models, frameworks, promising strategies, and experiences indicating what works and could work.

http://www.fmhs.auckland.ac.nz/soph/centres/cahre/docs/2012_Conference_Proceedings.pdf

Chinese peoples' perceptions of colorectal cancer screening: a New Zealand perspective

Authors: Bong G and McCool J

Summary: This qualitative study examined the attitudes and perceptions of 25 Chinese immigrants in New Zealand (mean age 56 years) towards colorectal cancer screening. The perceived acceptability of a national colorectal cancer screening programme was high; however, other cancers, such as breast or skin cancer, were perceived to be more relevant and serious, thus reducing the perceived priority of colorectal cancer screening. Chinese participants paid close attention to 'body balance' and were proactive in seeking medical advice and prioritised preventive health measures. The patient-GP interaction was also considered highly influential in the patient's decision to seek screening. The study suggests that close attention to cultural determinants of screening uptake would be helpful to ensure equitable service and outcomes during the introduction of a colorectal cancer-screening programme.

Comment: All participants in this study were born in Asian countries (e.g., China, Hong Kong, Taiwan, Malaysia and Singapore) and the majority (n=19) had not undergone a screening test for colorectal cancer. It is important to recognise that while sociocultural perspectives are relevant to all aspects of healthcare, these are particularly important in the context of screening programmes, which essentially aim to engage people when they are feeling well. The intention here is that early detection (and subsequent management) would reduce the risk of morbidity and death from a condition (such as colorectal cancer) that had not yet declared itself. The extent to which screening programmes are accessed therefore taps into fundamental concepts of health and wellbeing, access to information and health services more generally, and comfort and trust in interactions with mainstream health systems. Each of these dimensions can involve particular challenges for people of differing cultural backgrounds from the mainstream, and especially so for immigrant communities. These are issues that deserve explicit attention when implementing new and current screening programmes.

Reference: *N Z Med J.* 2011;124(1331):29-38
<http://journal.nzma.org.nz/journal/124-1331/4579/>

Auckland Regional Settlement Strategy Migrant Health Action Plan



Making a healthy difference to the community



A Community Partnership

The Asian Health Review has been commissioned by the Northern DHB Support Agency (NDSA) on behalf of the Auckland Regional Settlement Strategy Migrant Health Action Plan Programme which represents Waitemata, Auckland and Counties Manukau District Health Boards.

The Migrant Health Action Plan is available on this website: <http://www.ssnz.govt.nz/publications/AuckRSS.pdf>

The pervasive effects of racism: experiences of racial discrimination in New Zealand over time and associations with multiple health domains

Authors: Harris R et al

Summary: To examine the prevalence of self-reported racial discrimination and associations with multiple health measures, data from the 2002-03 (n = 12,500) and 2006-07 (n = 12,488) New Zealand Health Surveys were analysed by logistic regression. Reported experience of racial discrimination increased from 28.1% to 35.0% between the two time points among Asian peoples, but remained relatively unchanged for other ethnic groupings (Māori 29.5%, Pacific 23.0%, European 13.5%). The experience of racial discrimination was negatively associated with all health measures including mental health (SF36 mental health scale, psychological distress, doctor diagnosed mental health condition), physical health (self-rated health, SF36 physical functioning scale, cardiovascular disease) and health-related risk factors (smoking, hazardous drinking) except excess body fat. There was also an apparent dose-response relationship, with those reporting multiple incidents of racial discrimination experiencing a higher risk of negative health outcomes.

Reference: *Soc Sci Med.* 2012;74(3):408-15

<http://www.sciencedirect.com/science/article/pii/S0277953611007143>

Ethnic discrimination prevalence and associations with health outcomes: data from a nationally representative cross-sectional survey of secondary school students in New Zealand

Authors: Crengle S et al

Summary: To analyse the prevalence of ethnic discrimination by health professionals and police, and ethnicity-related bullying, 9107 secondary school students participated in a nationally representative survey in 2007. Logistic regression indicated that there were significant ethnic differences in the prevalence of discrimination and students experiencing discrimination were less likely to rate their general health as excellent, very good or good (OR 0.51; 95% CI 0.39-0.65). They were also less likely to report feeling safe in their neighbourhood (OR 0.48; 95% CI 0.40-0.58), and more likely to report binge drinking in the past 4 weeks (OR 1.77; 95% CI 1.45-2.17). Ethnicity stratified associations indicated those reporting ethnic discrimination were likely to have adverse outcomes for depression, cigarette smoking and self-rated school achievement.

Reference: *BMC Public Health* 2012;12:45

<http://www.biomedcentral.com/1471-2458/12/45>

Working together: Racial discrimination in New Zealand

Author: Statistics New Zealand

Summary: To assess whether New Zealanders feel racially discriminated against, Statistics NZ analysed data from the New Zealand General Social Survey (n = 17,271). One in ten adult (>15 years of age) respondents (the equivalent of 343,000 people) reported experiencing discrimination (being treated unfairly or had something nasty done to them because of the group they belong to, or seem to belong to) of some type in the previous 12 months, and 6% of respondents believed the reason for them being unfairly or unfavourably treated was racial discrimination. The highest levels of discrimination were reported to occur in the employment setting and Asian people reported the highest levels of racial discrimination.

Reference: *Statistics New Zealand* (2012)

<http://tinyurl.com/bcl9bmn>

Comment: It is difficult not to despair of one theme that recurs with monotonous regularity when reviewing publications on Asian health in New Zealand. That is the silent and insidious scourge of racial discrimination. Many qualitative studies have explored and exposed both the impact and underlying issues that are part of the lived experience in this context. Discourses of stereotyping, professional biases, and implicit and explicit prejudices apparent in interactions at all levels of society abound. Here, we highlight just three major quantitative analyses published in 2012: two led by leading Māori health researchers at The University of Otago (Drs Ricci Harris and Donna Cormack) and The University of Auckland (Dr Sue Crengle), and the other published by Statistics New Zealand. While these publications focused on racial discrimination in the New Zealand population in general, each identified Asian peoples as being at particularly high risk in several domains.

Investigating data from New Zealand's National Health Surveys (population-based surveys of adults (15+ years), Harris and colleagues found that the proportions of Asian people reporting racial discrimination had significantly increased from 2002/03 to 2006/07 while remaining reasonably constant in the other major ethnic groups. Analysing data from the nationally representative Youth'07 survey of over 9000 secondary school students, Crengle and colleagues noted that Asian students were significantly more likely than their NZ European peers to report ethnic discrimination by health professionals and police, and as in the previous such survey in 2001, Asian students reported the highest rates of bullying related to their ethnicity. Both these studies established that the experience of racial discrimination was strongly associated with a range of negative health outcomes. Statistics New Zealand examined data from the NZ General Social Survey (15+ years) and noted that Asian people reported the highest levels of racial discrimination in any setting. Racial discrimination was most commonly noted to occur in workplaces, with migrants reporting this experience more often than those born in New Zealand.

Freedom from racial discrimination is enshrined in the NZ Bill of Rights and a multitude of international codes and conventions including the UN Declaration of Human Rights. Whether viewed from the perspective of human rights, health equity, or a fair society, the evidence available (these articles are just a fraction) highlights the significant progress yet to be made to uphold these rights for New Zealanders in general, and Asian people in particular.

Health needs assessment of Asian people living in the Auckland region

Author: Mehta S

Summary: To identify the health needs of the main Asian ethnicities in the Auckland region, a health needs assessment was commissioned by the Northern DHB Support Agency on behalf of the Auckland Regional Settlement Strategy Migrant Health Action Plan. The report highlights the misconception that Asian communities have better health status than other ethnic groups in NZ, and that, especially in relation to chronic diseases, some Asian groups have high health needs and disparities in access which appear to be increasing with time. Mental illness, settlement stress and a lack of understanding of the NZ health system are important issues for Auckland Asian communities. The report also analyses health issues not commonly addressed with respect to Asian communities in Auckland, including health of older people, family violence, patient safety and disability.

Comment: The lead author and all involved with this report (including the funders noted above) are to be congratulated for establishing a high-level benchmark for any organisation wishing to understand the needs of the communities they serve. The report digs deep and scans wide to present a careful and thorough analysis of the health needs among the diverse Asian ethnic communities that represent 22% of the Auckland population. In contrast to many standard publications, the detailed analyses and many figures, graphs and maps provide data profiles for Chinese, Indian and other Asian groups, identifying key health concerns for these major groups, and highlighting the value of undertaking more fine-grained analyses beyond "Asian" or worse still, the "other" category. The evidence presented indicates that we would ignore to our peril, the unmet needs relating to the chronic disease burden (e.g., diabetes and CVD risks), concerns relating to mental health and social isolation, and inequitable access to appropriate health and disability support services.

These data are complemented by a wealth of qualitative information provided by health service providers, collectively resulting in clearly articulated recommendations to improve the health of Asian peoples that are likely to be applicable to the country more generally. These include (1) the appropriate recognition of Asian health needs in regional and national health-related policy, planning and monitoring; (2) culturally-relevant health promotion and health-related education programmes focusing on behaviours, attitudes and knowledge that would reduce the risks and unmet needs in chronic diseases and mental health; (3) more targeted health services for Asian people; (4) improved PHO enrolment data and access to primary care for Asian people; (5) reducing cultural and language barriers to appropriate health care; (6) greater collaboration between health services for Asian people; (7) promoting the social capital among Asian communities; and (8) a research that addresses and informs knowledge gaps and opportunities to thrive as members of the increasingly diverse ethnic communities in Aotearoa.

<http://www.waitematahdhb.govt.nz/PlanningConsulting.aspx>

Evaluation of Waitemata District Health Board Child Disability Service Project for Culturally and Linguistically Diverse Families

Authors: Black S et al

Summary: The Waitemata District Health Board Child and Disability Project for Culturally and Linguistically Diverse Families was established in 2009 and was born from the Ministry of Health funded Auckland Regional Settlement Strategy Health Action Plan, which aims to improve access and equity for culturally and linguistically diverse (CALD) families using health and disability services. This evaluation aimed to qualitatively evaluate the project's progress by gathering information on the needs and experience of CALD families who have relocated to NZ with a child with specific health needs. Findings of the evaluation highlighted the difficulties and frustration experienced by CALD families in accessing health services and disability support, and revealed that this is due to lack of knowledge of available health services and the processes for accessing them, as well as the ad hoc fashion in which they are provided. The evaluation also identified the need for support mechanisms to be in place for the two cultural caseworkers (CCWs) whose role is to mediate between those with different cultural backgrounds to effect change that will ultimately lead to better health outcomes for CALD families. The importance of relationship building was recognised as a cornerstone for all work with CALD families. Key potential barriers to access were not meeting the referral criteria or difficulties in navigating the health system, an unwillingness to engage with the project due to stigma associated with disability, and health professionals acting as gatekeepers between the project and families. Key benefits for families engaging with the project were improved access to health and other services, reduced isolation, increased knowledge about a range of issues and an improved living situation. It was recommended that in taking the project forward, the following be considered: staff and their associated skills, acknowledgement of the unique qualities of the CCW role, the provision of accessible and appropriate (cultural) supervision, the potential for staff overload or burnout, the issue of job sizing and engagement of other health staff with the CCWs.

Comment: The families of children living with disabilities and developmental difficulties face a variety of obvious and hidden challenges, while also dealing with a multitude of health concerns. For children and families from Culturally And Linguistically Diverse (CALD) backgrounds, negotiating unfamiliar services that often appear alienating and unforgiving presents a double jeopardy. This report presents an insightful evaluation of a much needed project that has traversed new ground in responding to the needs of CALD communities served by the Waitemata DHB. The cultural caseworker model implemented has successfully addressed several critical needs. However, multiple barriers threaten the realisation of the vision of this innovative model. Resourcing the will to act and gathering much needed practice-based evidence are obvious next steps.

<http://tinyurl.com/azaq4fq>

How to use interpreters in general practice: the development of a New Zealand toolkit

Authors: Gray B et al

Summary: This NZ study revealed limited use of trained interpreters, and a substantial use of untrained interpreters, despite an understanding of the risks of untrained interpreters among clinicians. A review of the evidence on the use of interpreters and existing Australian, US and NZ guidelines was used to develop an evidence-based toolkit for NZ GPs for using interpreters, addressing practice structure, processes and outcomes to improve communication with patients.

Comment: 'LEP' (Limited English Proficiency), CALD (Culturally and Linguistically Diverse) and NESB (Non-English Speaking Background) are just a few of the labels applied to communities at risk of experiencing difficulties due to healthcare that is 'lost in translation'. Appropriate interpreter services can mitigate these risks by lowering the incidence of adverse health conditions; increasing access, use and quality of health care; and improving health status, functioning and satisfaction with services. This paper provides useful insights (summarised in the form of a toolkit) that need to be considered when engaging interpreters in the primary care sector in New Zealand. As with all aspects influencing quality of healthcare, there are critical issues relating to service structures as well as processes employed. These need active consideration in all practice settings, big or small, in large metropolitan regions or smaller communities with just a few 'LEP' families.

Reference: *J Prim Health Care* 2012;4(1):52-61

<http://tinyurl.com/c4yhf9j>

Mental health awareness among imams serving New Zealand's Muslim population

Authors: Shah K and Culbertson P

Summary: In this Auckland District Health Board initiated study, 10 immigrant imams (Muslim clerical leaders) were interviewed about their beliefs and knowledge of mental health in NZ, and their role in providing support for individuals and families within the Muslim community who have mental health issues. Only two of the imams interviewed had some form of qualification relating to mental health and only two had some knowledge about Auckland-based mental health services. However, several were involved in mental-health-related work in the community, giving virtually direct mental health services without being aware of it. In their communities, imams were approached on the following issues: financial stress; depressed mood; issues of settling in to a new culture and a new country; seeking advice and guidance; feelings of isolation (especially in the elderly); mental issues related to physical problems; post-traumatic problems; marital issues among migrants; teenage relationship issues with parents (including drug problems). Two of the main issues raised by imams regarding barriers were their lack of knowledge on available health services and the lack of cultural awareness by health professionals. Other barriers are the cultural stigma and discrimination associated mental health issues, and language issues. Some of the imams felt that translating service brochures into the languages commonly spoken by Muslims would have an impact on educating Muslims about mental health services. The imams indicated a keen interest in participating in mental health training or workshops in order to be better equipped to support and educate their communities on mental health issues and services.

Comment: Drawing on the support of mosques in Auckland, this study explored the perspectives of 10 imams, all of whom were born outside New Zealand. This may explain, in part, their relative lack of awareness of local mental health services, but also their singular awareness and sensitivity to the broad range of mental health concerns experienced by the communities seeking their assistance. There are well-recognised unmet mental health needs experienced by migrants and refugees – communities that face a multitude of challenges in the process of settlement. This paper identifies the substantial mutually beneficial gains that could be achieved when mainstream services are able to communicate and engage more effectively with cultural and religious leaders in Muslim, and indeed, other minority populations.

Reference: *NZ J Counselling* 2011;31(1):87-97

<http://tinyurl.com/agaqck7j>



CALD Cultural Competency Online Courses and Resources

An excellent online training programme in cultural competence and Culturally and Linguistically Diverse (CALD) topics is available for health practitioners.

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For further information and registration details, please visit www.caldresources.org.nz