

Asian Children's Health

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Purpose

The purpose of this section is to provide an overview and perspective of Asian people, their health status, health needs and issues affecting their health in the New Zealand context and a general guide on how to work with Asian patients and their families.

Overview

Health providers are starting to realise the growth and diversity of Asian people in New Zealand over the last ten years. There is a greater demand from a spectrum of health providers wanting to know more about Asian people, specifically to learn more about the health and health needs, and cultural perspectives of Asian patients to respond more appropriately and provide more effective health care delivery.

This section aims to provide information and strategies to enable health workers to respond more effectively when managing Asian patients and their families. It will be covering the following topics.

- the current demography
- health determinants
- health services utilisation
- health status
- Key health issues
- Asian culture: importance of family, religious traditions, duty, value, respect for authority, views of health, traditional treatments
- how to interact with Asian patients and their families
- how to involve families, communities and service users
- how to minimise barriers for Asian patients accessing services
- how to use community cultural resources
- how to work with interpreters effectively

The following provides definition of some of the terms used in this chapter to provide clarity.

The term '**Asian**' refers to the collective set of Asian ethnic groups, who although are not homogeneous in nature, share certain value orientations. These groups are very diverse in culture, language, education and migration experiences. (Ho et al, 2003), and they 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, Japan), and South East Asia (Singapore, Malaysia, the Phillipines, Vietnam, Thailand, Myanmar, Laos and Kampuchea). (Statistics NZ 1995; 1999; 2003). See map below.



An Asian person is a person identifying himself/herself as belonging to one of the Asian ethnic groups.

Asians includes every category of immigrant, refugees who have high and complex health needs (notably post-traumatic stress disorder), wealthy business people, foreign fee-paying students on fixed term visas and New Zealand-born Asians (third and fourth generation New Zealanders).

Ethnicity is the ethnic group or groups that people identify with or feel they belong to. It is self determined and perceived. People can belong to more than one ethnic group. Ethnicity is a cultural affiliation, as opposed to race, ancestry, nationality or citizenship. The definition of Asian used in this report is based on the categories used in the census.

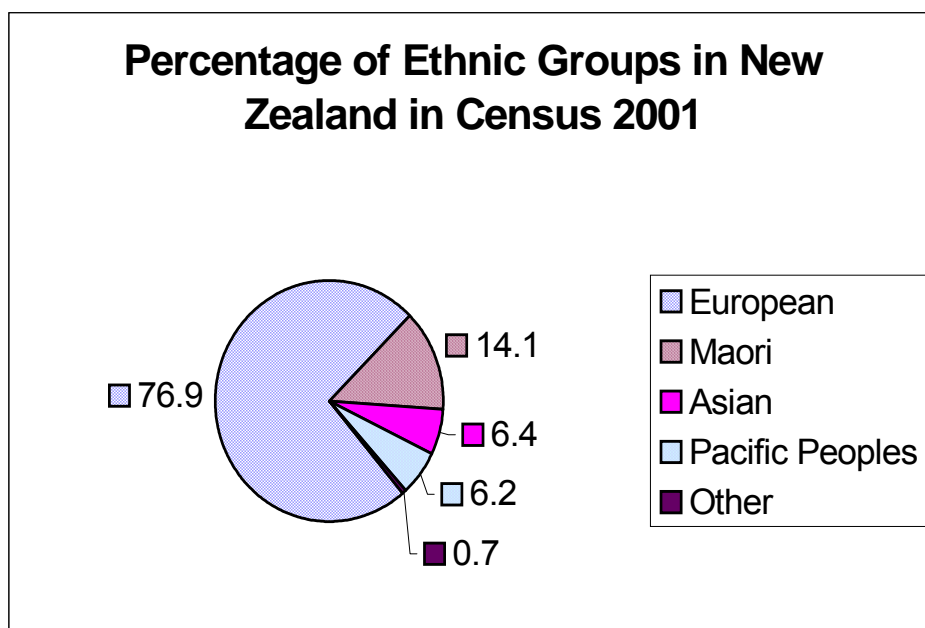
An **immigrant** (also referred as “**migrant**”) is a person born overseas and entered New Zealand under an immigration programme (www.immigration.govt.nz website). Immigration programme comprises of Skilled/Business, Family Sponsored and International/Humanitarian streams. Asian migration usually refers to movement of Asian peoples to New Zealand from other countries rather than internal migration within New Zealand.

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.

Auckland region refers to the districts served by Auckland District Health Board, Counties Manukau District Health Board and Waitemata District Health Board.

Population and Demographics

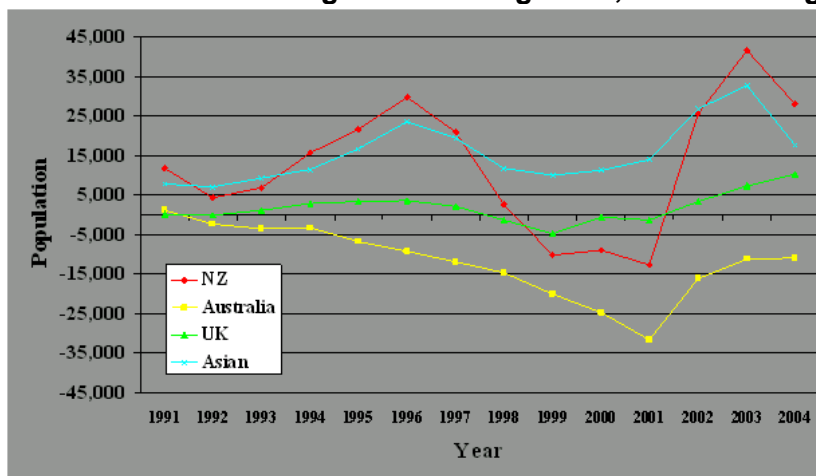
Asian population is growing and increasingly diverse: Asian population is the fastest growing ethnic community in New Zealand. (Ho E, Au S, Bedford C & Cooper J, 2002), and became the third largest ethnic group in New Zealand, the following is a graph showing the proportion in comparison to other ethnic groups.



The growth is largely attributed to the influx of immigrants, international (foreign fee-paying) students and the annual intake of UNHCR mandated refugee quota accepted by the New Zealand government.

Influx of Asian Immigrants: Asian people migrating to New Zealand began in the late 1980s and continued through the 1990s, with a peak in 1995. Between 1991 and 2001 the number of people identifying themselves as Asians has doubled to almost 240,000 or 6.4% of the total population. The figure below shows the net migration into New Zealand between 1991 and 2004, the net gain for Asian has been positive throughout the period though New Zealand as a whole experienced the net migration loss between 1999 and the year 2001.

Figure 1: New Zealand Long Term Net Migration, March ending year



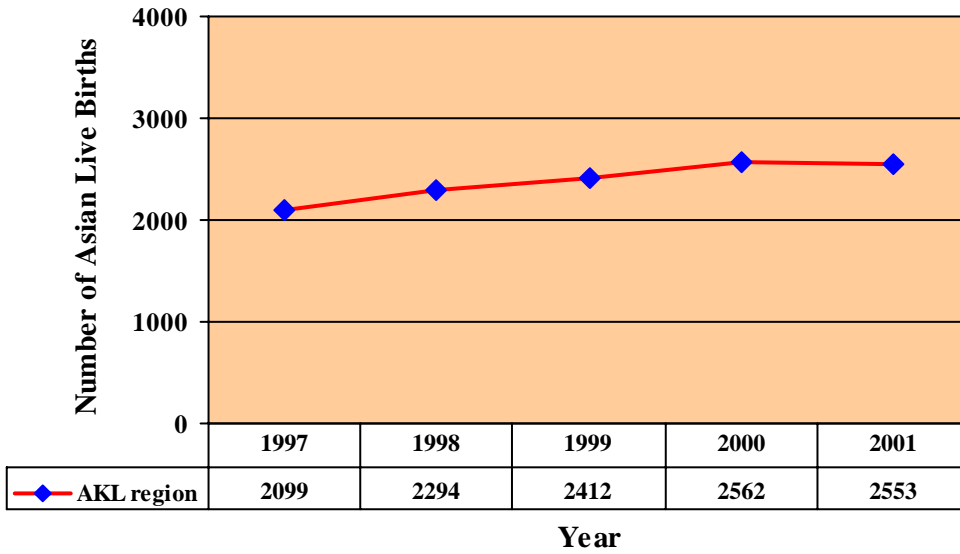
Source: Statistics New Zealand

Influx of Asian foreign fee-paying students: In 2001, New Zealand schools (over 4,000 students from previous year), universities (doubled in the past five years, mainly from China, Malaysia, South Korea and Japan) and English Language schools (from China and South Korea) experienced a huge growth in the number of foreign fee-paying student population (Walsh R, 22 August 2000; Ministry of Education, "Foreign Fee-Paying Students", 2002).

Increase in Asian refugee population: Annually the New Zealand government accepts a UNHCR mandated refugee quota of 750 places. Refugees were also arriving New Zealand as asylum seekers and through family reunification, assessed in accordance with the criteria for refugee status set out in article 1 A (2) of the 1951 Convention. Refugee status applicants who are declined have the right of appeal to the Refugee Status Appeals Authority (RSAA).

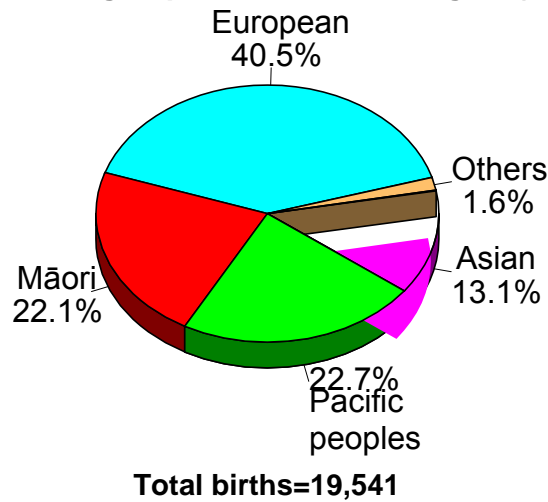
Live births for Asian people in the Auckland region: Between 1997 and March 2001, there was an approximate average of 2,499 Asian babies born annually in the Auckland region. The number of Asian births consistently increased from 1997 to 2000.

Number of Asian live births in the Auckland region from April 1997 to March 2001

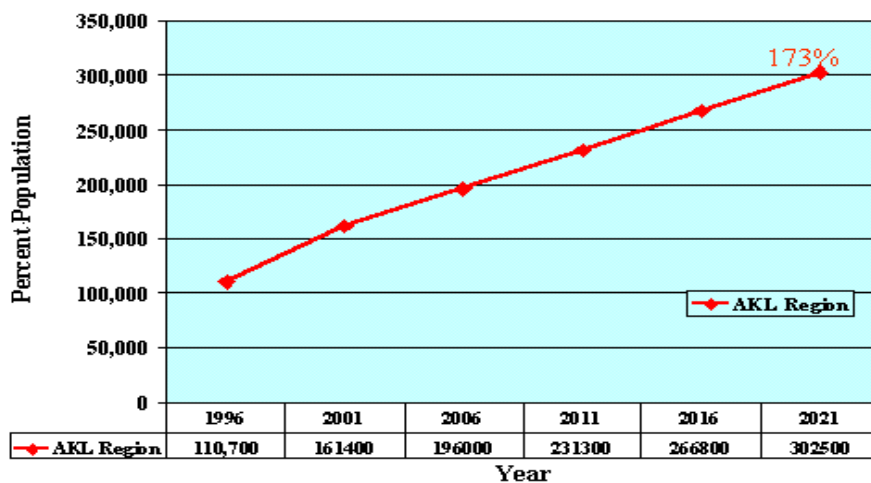


Live births by ethnic group: There were 19,541 babies born between April 2000 and March 2001 in the Auckland region, with 13 percent of them being of Asian descent.

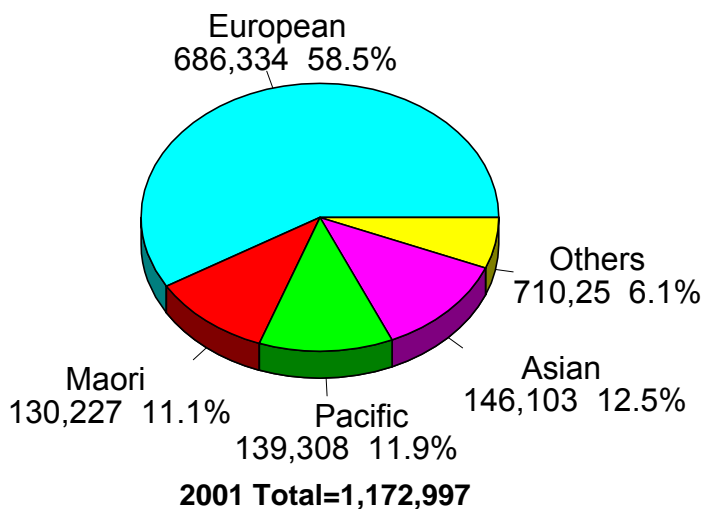
Percentage of live births by ethnic group in the Auckland region (April 2000 to March 2001)



Asian Population Projection: Expected to continue to increase mainly through further migration.^[1], the number in the Auckland region expected to grow by 173% or about 190,000 Asian people by the year 2021. The chart below shows an estimated population growth for the Auckland region 1996 to 2021.

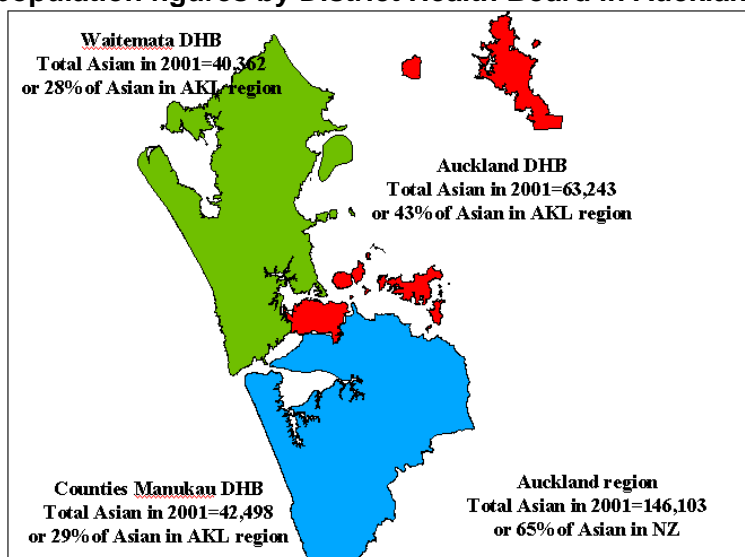


Asians residing in Auckland region: In 2001, Asians made up 12.5% of the 1,172,997 people residing in the Auckland region, and is the second largest population after European, followed by Pacific peoples (12%) and Maori (11%). See chart below.



^[1] The Asian Public Health Project Report. MoH 2003

Asian population figures by District Health Board in Auckland region



Ethnic or Culture groups within Auckland: Chinese accounts for 45% of the Asian population, followed by Indian at 27%, and Korean at 9%. Below is a list of Asian culture group in the Auckland Region (Census 2001).

Culture group	Auckland region	%
Chinese	68,973	45%
Indian	41,700	27%
Korean	13,320	9%
Filipino	6,327	4%
Other South-east Asian	5,988	4%
Japanese	4,224	3%
Sri Lankan	3,996	3%
Khmer/Kampuchean/Cambodian	2,550	2%
Vietnamese	2,244	1%
Other Asian	4,641	3%
Total responses	153,963	100%

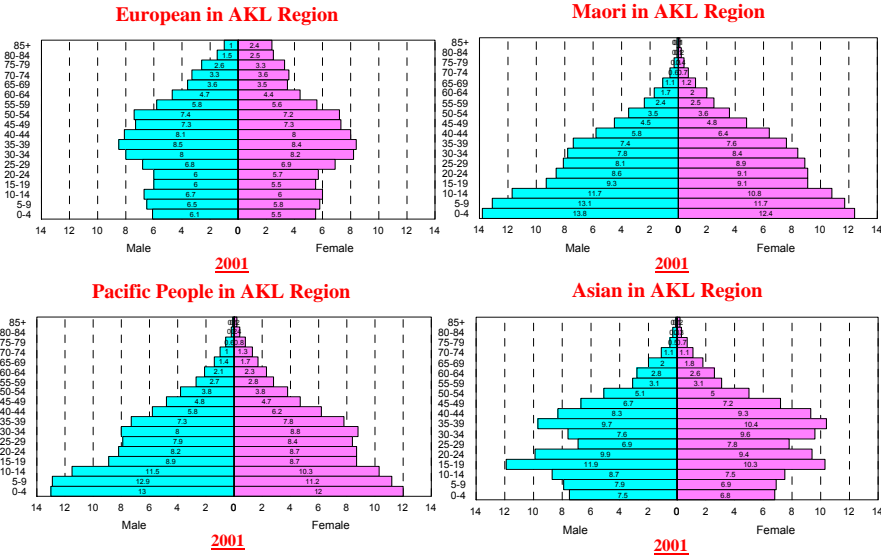
Other Asian Categories of Asian Ethnicity in 2001 Census (from Statistics NZ 2003): not listed above include Burmese, Indonesian (incl Javanese/Sundanese/Sumatran), Lao/Laotian, Malay/Malaysian, Thai/Tai/Siamese, Hong Kong Chinese, Kampuchean Chinese, Malaysian Chinese, Singaporean Chinese, Vietnamese Chinese, Taiwanese Chinese, Bengali, Fijian Indian/Indo-Fijian, Gujarati, Tamil, Punjabi, Sikh, Sinhalese, Afghani, Bangladeshi, Nepalese, Pakistani, Tibetan

Religious Affiliations: Asians in New Zealand are diverse in terms of religious affiliations. In 2001, 30% of the Asian population said they were Christians, 16% were Hindus, 5% Hindu / Muslim and 13% Buddhists (Census, 2001). Chinese people predominantly had no religion, while 25% said they were Christians and 14% were Buddhists. With Indian people, 53% said they were Hinduism, followed by Christianity, Muslim, and only 6% have no religion. Christianity was predominant in the Korean population and Buddhism in the Cambodians and Vietnamese. (Ho E, Au S, Bedford C & Cooper J, 2002)

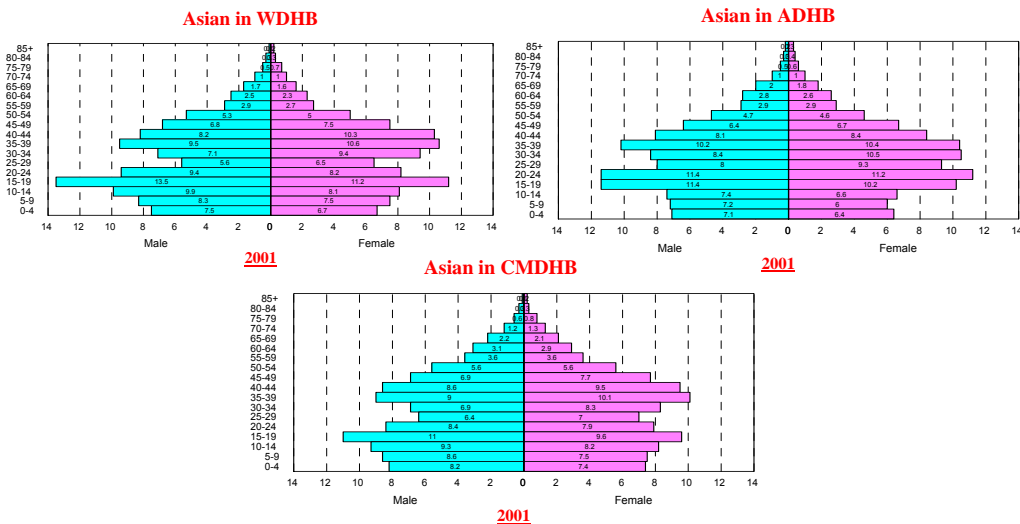
Languages: Asians are also very diverse in the languages they speak. In 2001, 19% of Asian recent immigrants from selected ethnic groups (Chinese, Indian, Korean, Cambodian and Vietnamese), 15 years and over could not speak English or Maori compared to 14% of the overall Asian population and 1% of New Zealanders. Among all recent Asian immigrants who have no English speaking ability, the percentages were higher for the older working age group and people aged 65 years, especially women. The percentage of Asian adults who could not speak English

increases with age. Across the ethnic groups, who could not speak English, the percentages were highest among the Cambodian and Vietnamese groups (Ho E, Au S, Bedford C & Cooper J, 2002)

Age and Sex: Most Asian people in New Zealand are young and middle-aged adults. This is predominantly due to the fact that immigration is the main means of Asian population increase in New Zealand. Only 5 percent of the Asian population in the Auckland region is 65 years or older. Over half of Asian people in the Auckland region are between the ages of 25 to 65 years, while around 20 percent are 15 to 24 years and another 20 percent are 0 to 14 years. (Ministry of Health, APHP Report, 2003)



The chart below shows the age structure for the Asian population is different in each of the District Health Boards within the Auckland region. The Auckland DHB has more 19-24-year-olds than either counties Manukau DHB or Waitemata DHB. Auckland DHB and Waitemata DHB have more 15-19-year-olds than Counties Manukau DHB.



Determinants of Health

“The primary determinants of disease are mainly economic and social and therefore its remedies must also be economic and social”

Geoffrey Rose [The strategy of Preventive Medicine 1992]

Socioeconomic Health Determinants include: (specifically for new Asian immigrants and refugees) poor adjustment to life in New Zealand, low proficiency in English, difficulties with employment including under-employment where skills are not being fully utilised, low income levels; NZDep2001

Socioeconomic data pertaining to the Asian population

Education: Various studies reported that Asian immigrants have a significantly higher level of tertiary education compared to other New Zealanders. Twenty-nine percent of people in the Auckland region have had tertiary education with people of European descent (35%) having the highest percentage, followed by Asian people (31%). The Asian ethnic group had the lowest percentage (12%) of people with no qualification compared with any other ethnic groups.

Unemployment: Even though Asian people have significantly higher level of education, they have worse than average unemployment rates (7.4% in 2001). This is usually amongst Vietnamese and Cambodian, but not usually Japanese¹). Other issues include under-employment, and sometimes limited or no access to relevant benefits are issues for many Asian people, especially new immigrants (Bellringer and Chu 2001; Kudos Organisational Dynamics Ltd 2000). Employment issues do not always relate to language barriers.

Income: Again even with significantly higher level of tertiary education, Asian people have significantly very low income levels (only 17% of Asian people earned over \$30,000 in 2001). These figures are reinforced by qualitative research that indicates many Asian people experience difficulties with employment, including under-employment where skills are not being fully utilised

Domestic Purposes Benefit: Asian people aged over 15 years in the Auckland region have the lowest percentage use of the Domestic Purposes Benefit among all ethnic groups.

Housing and transport: Sixty-three percent of households in the Auckland region either owned their own home or occupied it rent-free compared with 68 percent nationwide. Europeans had the highest percentage (74%) of people who either own their own home or occupied it rent-free, followed by Asian households (59%). Asian households in the Auckland region had the lowest percentage of households without car (7%) while Pacific households had the highest percentage (17%). About 91 percent of the households in the Auckland region had a telephone with the European ethnic group having the highest percentage of households with a telephone (97%), followed by Asian households (95%).

Superannuitants: Just under 10 percent of all households in the Auckland region have superannuitants, while Asian households have the lowest percentage (3.1%) of superannuitants of all ethnic groups.

Population deprivation: In the Auckland region, about 73 percent of Pacific peoples live in the most deprived areas (deciles 8-10), followed by Māori (51%), Asian (30%) and just 18 percent for Europeans. The Counties Manukau District Health Board area has the highest percentage of Asian people (34%) living in the most deprived areas (deciles 8-10), followed by Waitemata District Health Board with 33 percent, and 20 percent in the Auckland District Health Board area.

¹ Noted in the report by Kudos Organisational Dynamics Ltd (2000).

Health Status

Overall health status for Asian people is good, but a range of health issues including a number of significant areas of concern were identified by a number of studies pertaining to Asian health carried out in New Zealand, particularly within the Auckland region. Holt et al 2001 and Ngai et al 2001 focussed on healthcare while other studies focused on social services and other issues, such as immigration (eg, Walker 2001; Wang 2000) and the role of local government (eg, Kudos Organisational Dynamic Ltd 2000). In 2003, the Ministry of Health conducted an international literature search to gather public health approaches to Asian population and the report "Asian Public Health Report" was published in 2003.

In these reports, the general themes were:

- Asian people generally have a positive focus on health and wellbeing, seek medical or health advice early, but can have language and cultural barriers in accessing health services.
- The six top potentially avoidable deaths for Asian people in the Auckland region are heart disease, motor vehicle crashes, stroke, lung cancer, diabetes and suicide
- The six leading causes of preventable hospitalisations are angina (heart pain), respiratory infections, cellulitis, gastroenteritis, road injuries and asthma.
- For mental health, the key issues were: language barriers, social isolation, unemployment and under-employment, disruption of family and social networks, pre-migration traumatic experiences, barriers to access, present symptoms as somatic complaints, shame and stigmatisation)
- For cardiovascular disease and diabetes, the issues were around lifestyle changes affecting diet and physical activity)
- For sexual health, the very high abortion rates are leading health issues
- For communicable diseases, the high rates of TB are of concern
- High number of traffic injuries

Asian refugees often have a generally poorer health status (Walker et al, 1998) than other Asians and other population groups. The health status of 'Quota Refugees' (between 1979 and 1997, 75% were from Laos, Kampuchea and Vietnam combined) which includes a proportion of people from non-Asian countries (eg, Iran and Iraq) was studied in 1997 by Solomon. Solomon (1997) found that this group had much poorer health status than the overall population, considerable immediate health needs within the six-week orientation period, and a high incidence of:

- infectious diseases (eg, hepatitis B, HIV infection, malaria, parasitic infections, tuberculosis, STDs, etc)
- diabetes
- post-traumatic stress disorder
- poor nutrition (eg, iron deficiency)
- various women's health issues.

These issues have been predominantly identified by the medical screening programme operating at the Mangere Refugee Resettlement Centre.

Specific public health issues: Leading causes of deaths amongst Asian people are cancer (especially lung, large bowel and stomach), ischaemic heart disease and stroke, similar to the whole population. Common Asian public health issues identified in the local and overseas literature included:

- cancer
- smoking

- coronary health disease
- diabetes
- obesity
- iron deficiency and anaemia
- osteoporosis
- hepatitis B
- tuberculosis
- mental health and depression.

The following are extracts from the Ministry of Health, Asian Public Health Report, 2003 that are useful information for health professionals to know when managing the health of Asian children and for working with their families.

Newborn and child health: An overseas report (McAvoy and Donaldson, 1990) has highlighted that a lack of breastfeeding is common amongst some Asian populations, and this could be due to a variety of reasons:

- A belief that bottle-feeding is modern and superior.
- Concerns about privacy and modesty.
- Communication difficulties with health professionals.
- A lack of support in family.
- A belief amongst Hindus and Sikhs that colostrum is harmful.
- Being misinformed about breastfeeding and infant feeding practices.

Iron deficiency and anaemia: Figures from a study (Schaaf et al 2000) of form 5 to 7 students from eight Auckland secondary schools showed that Asian teenagers have a higher rate of iron deficiency (15.4%) than Europeans (8.3%), but lower rates than Maori (25.5%) and Pacific peoples (20.9%). The rates of anaemia are worse, with Asians having a rate of 15.9 per cent compared with Pacific peoples (12.1%), Māori (11.2%) and European (4.2%).

New Zealand research and data on the nutrition and physical activity of the Asian population is very limited. Apart from the study above, there appears to be no other New Zealand studies that highlight nutritional status specifically for the Asian population.

Chapple (1998) states that the high prevalence of iron deficiency and anaemia in women of South Asian descent living in Britain may be due to:

- Religious and cultural restrictions on certain foods
- Lack of iron in the diet
- Poor iron absorption
- Attitudes to menstruation and menstrual blood.

Chapple (1998) identified that heavy menstrual blood flow is thought to be 'dirty' and 'impure' and a scanty period is perceived to result in abdominal weight gain and pain within South Asian women studied in north-west England. When menstrual blood loss is deemed 'excessive', South Asian women tend to avoid 'hot' foods such as meat, fish and eggs, thus denying themselves a valuable source of iron. The problem may be compounded by not seeking medical help because of the shortage of female general practitioners whom they prefer and poor communication with doctors and other health care professionals.

Iron deficiency and anaemia among British Asian infants/children is also common, probably due to religious and cultural restrictions on certain foods like meat and eggs (McAvoy and Donaldson, 1990).

Hepatitis B: The Hepatitis B Screening Programme was established in the late 1990s as there was increasing concern about the large number of carriers within the Maori, Pacific and Asian populations (Young, 2002). Figures from the Hepatitis B Screening Programme indicate that 7

percent of Auckland's Asian population are hepatitis B carriers compared with an estimated 1-2 percent of New Zealand's population.

A key reason for this is that most new Asian migrants come from countries with high levels of hepatitis B carriage. With the exception of Japan and Singapore, countries in east and south-east Asia have high carriage rates (greater than 8%), whilst countries in the Indian sub-continent have intermediate carriage rates (2-8%).

According to the American Department of Statistics², one in 10 Asian Americans has hepatitis B. A very high prevalence is noted amongst immigrants from Cambodia, Laos, Vietnam and China.

However, increasing hepatitis B screening and vaccination have made an impact on reducing infection or liver cancer in the US (Vryheid et al 2001)³.

Strategies include:

- screening all pregnant mothers
- vaccinating all infants
- catch-up vaccinations of those previously unvaccinated and adolescents
- immunising adolescents and adults who are at increased risk of infection.

Chen, Kuss, McKeirnan and Gleason (2001) report that a taskforce⁴ of public and private organisations in the US has been set up to look into:

- developing and distributing culturally-specific educational material
- supporting a household cluster survey to assess vaccination coverage rates of Asian American and Pacific children
- conducting immunisation and blood-testing clinics at local Chinese schools
- conducting outreach through the media.

Tuberculosis (TB): Harrison et al (1999) note that immigrants and visitors are a significant factor in the epidemiology of tuberculosis in New Zealand, accounting for an increasing proportion of notifications in recent years. This is in part due to a high incidence of TB in many Asian and Pacific countries. Harrison et al (1999) also note that although immigrants to New Zealand are required to have a chest X-ray and medical examination prior to entry to New Zealand that includes checking for TB, there are deficiencies in this overseas medical screening which lead to cases of TB (some quite advanced) entering New Zealand. This is worse with visitors (ie, not people initially seeking residency), who are only required to have an X-ray after two years stay compared to only one year in Australia and Canada (countries with lower rates than New Zealand). Better screening and follow up are recommended.

Anecdotally, the high stigma attached to TB amongst some Asian cultures can lead to people suffering from TB not taking prescribed medication as this affirms that the individual has the disease.

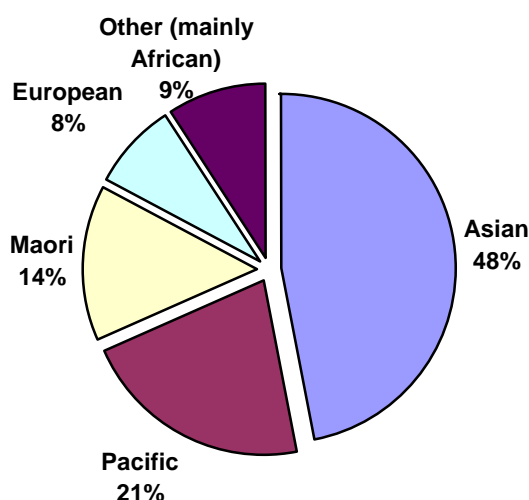
Figures provided by Auckland Regional Public Health Service show that in 2000 there were a total of 196 TB cases within the Auckland region reported to the Public Health Office. Of these, 92 (47%) were Asians, 42 (21%) Pacific, 28 (14%) Māori and 16 (8%) Europeans. Of the remaining 18, one was of unknown ethnicity and the rest from other ethnic groups, mainly Africans. Figures for TB cases for the year 2001 have not been broken down into detailed ethnic groups.

² http://www.4woman.gov/faq/Asian_pacific.htm

³ <http://www.aapihp.com.hepbtf/eulerslides/intro.htm>

⁴ Washington State Asian and Pacific Island Taskforce on Hepatitis B Immunisation

Chart 10: Percentage of TB cases reported to the Public Health Office by ethnic origin in 2000 (n=196)



Overseas reports⁵ of tuberculosis indicate that it is 13 times more common among Asian populations than the overall population, and is especially prevalent amongst those people from Cambodia, China, Laos, Korea, Vietnam and the Philippines.

Overseas researchers report that the incidence of tuberculosis is also high amongst refugees (Marks et al 2001), especially in the first year of re-settlement. The risk is high even after pre- or post-migration screening, emphasising the importance of preventive therapy and follow-up in this group of individuals (MacIntyre and Plant 1999).

Sexual health: A high rate of abortions (Department of Statistics, 2002) has been identified as an issue within New Zealand for Asian people. Latest figures from Statistics New Zealand show that in 2001, abortions accounted for 364 of every 1,000 known Asian pregnancies compared with 226 abortions for every 1,000 pregnancies in the whole population and that little or no sex education amongst new immigrants is a likely risk factor (Gregory, 2002). During 1999/2000, abortion was the leading hospital discharge condition for Asian people in the Auckland District Health Board area amongst the 25-64-year-old age group with 192 discharges or 5.3 percent of the total, and the second leading discharge for the 15-24-year-old age group with 23 discharges of 4.5 percent of the total (Auckland District Health Board, 2001).

Obesity: Most Asian peoples have traditionally been fairly small and slender, but changes in diet and less physically active lifestyles may be contributing to an increase in overweight and obesity in these populations (McGill, 2002). Obesity is a risk factor for diabetes and cardiovascular disease, both of which appear to be increasing for Asian people along with other population groups.

Smoking: From the regular national survey of fourth-form students, Asian students have a lower tobacco use than other major ethnic groups in New Zealand. In 2000, 9 percent of Asian girls and 14.6 percent of Asian boys reported smoking compared to 23.3 percent of girls and 24.4 percent of boys for all ethnicities, 51.1 percent of girls and 33.8 percent of boys for Maori, and 21.8 percent of girls and 25.3 percent of boys for Pacific peoples

Under-utilisation of health care in ethnic minority groups has been reported widely; in Canada (Wen et al 1996; Stephenson 1995), the United States (Davidson and Andersen 1997; Waidmann and Rajan 2000; Ward et al 1993) and Britain (Benzeval et al 1995). It may give the impression of fewer health problems or even absence of needs.

⁵ http://www.4woman.gov/faq/Asian_pacific.htm

However, in a study of Chinese residents in Houston (Ma, 1999), respondents (most had lived for more than five years in the United States) indicated a number of barriers in relation to access to health care:

- Language and communication barriers (75%).
- Culture barriers (73%).
- Different concepts of illness (71%).

A large number sought traditional health therapy especially with chronic illness and regarded Western medicine as effective for mainly acute illnesses. Specific dietary beliefs, health care beliefs and practices, and a different family decision structure may have contributed to the under-utilisation of mainstream health services. This may, in addition, be due to socio-economic issues, systemic barriers (high cost and fragmentation of health care systems), migration factors (new migrants not aware of local systems) and transport difficulties.

Most of the Chinese studied (96%) sought home remedies while about half used both Western and Traditional Chinese Medicine. The upper and the middle classes tended to use Western services while the lower class sought self-treatment and traditional therapy. Interestingly, about one-third travelled to their home country to seek treatment.

For more information on public health approaches to prevention on the above, please refer to the MoH, Asian Public Health Report, 2003

Health Inequalities

Health inequalities in New Zealand are consistently seen whether we measure health by prevalence of risk factors, access and use of services, or health outcomes. There is strong evidence that social, cultural and economic factors influence health and give rise to inequalities. Inequalities in health are unjust and inequitable, avoidable and detrimental to all New Zealanders.⁶

Reducing inequalities is a priority of the *New Zealand Health Strategy*⁷ and a key thread of *He Korowai Oranga – The Maori Health Strategy*.⁸ District Health Boards (DHBs) have a statutory responsibility for reducing health inequalities under the NZ Public Health and Disability Act 2000.

In addition to Maori and Pacific people, Waitemata DHB identified Asian people, refugees and recent immigrants were identified by Waitemata DHB as groups suffering from a disproportionate burden of health inequalities.

[Waitemata DHB, Health Needs Assessment, Bramley et al, 2005]

Challenges for consumers (taken from the studies carried out in NZ)

Access issues: Language and cultural barriers were considered by Asian migrants and refugees as key barriers to accessing health services. Other barriers include lack of understanding of their rights and NZ health system, and a lack of cultural sensitive services.

Challenges for health providers

- **An influx of Asian immigrants, students and refugees**
- **Diversity of Asian population** (culture, language, education and social economic experiences)
- **Dealing with Asians who have limited or no English language speaking ability** – a fundamental problem facing recent Asian immigrants.

⁶ Bramley, D, Riddell, T, Crengle, S, et al (2004). A call to action on Maori cardiovascular health. NZMJ 117(1197). 2004.

⁷ Ministry of Health. The New Zealand Health Strategy. Wellington, Ministry of Health. 2000

⁸ Ministry of Health. He Korowai Oranga Maori Health Strategy. Wellington, 2002

Strategies for health professionals managing Asian children

A number of suggestions to improve Asian health as reviewed from overseas literature (eg, Macbeth and Shetty 2001) include:

- Provision of medically qualified interpreters
- Offering cultural sensitive and appropriate solutions
- Providing appropriate health education and resources
- Acknowledging and learning how to work effectively with Asian patients and families from different cultural and linguistic backgrounds who have different attitudes and beliefs, eg, suffering is inevitable and one's life-span is predetermined (Uba 1992), reinforcing positive traditional dietary habits while encouraging the adaptation of healthy Western food items (Kim et al 2000) by including cultural issues and ethnic health components as part of professional development (eg, Williams et al 1995 reported a failure to use dental services regularly was attributed to language barriers resulting in poor medical histories being taken and poor understanding of the treatment proposed by dental professionals)

We acknowledge the following publications, as helpful references:

- Healthcare Needs of Asian People: Surveys of Asian People and Health Professionals In the North and West Auckland, Ngai et al, 2001
- Literature Review on the Mental Health Issues of Asians, Ho et al, 2002
- New Zealand's Asian Population: Views on Health and Health Services. Wellington: Health Funding Authority
- Asian Public Health Project Report, 2003. Wellington: Ministry of Health, 2003

Asian Culture

This section will provide you with an overview of traditional Asian culture.

When learning about Asian culture, health workers must remember that:

- **Asians** includes every category of immigrant, refugees who have high and complex health needs (notably post-traumatic stress disorder), wealthy business people, foreign fee-paying students on fixed term visas and New Zealand-born Asians (third and fourth generation New Zealanders).
- **Asian groups** are not homogenous and are very diverse in culture, language, religion, education level, and migration experiences.
- Asians have different level of acculturation and **New Zealand-born Asians** are generally acculturated to New Zealand culture

What is Culture?

- Culture encompasses beliefs and behaviours that are learned and shared by members of a group
- It is transmitted from generation to generation through the use of language, symbols and rituals, food and art, etc.
- Many of our cultural influences are unconscious and hidden from individual awareness

What does Culture Affect?

- Beliefs, behaviour, family structure, child rearing, dress, body image, diet, food, caregivers' roles, attitude to health etc.
- Health beliefs are often complex and tend to change overtime.

Summary of main differences between Traditional versus Western Societies

Traditional Society	Western Society
Family and group oriented	Individual oriented
Extended family (not so geographical as before, but conceptual)	Nuclear family
Status determined by age and position in the family, care elderly	Status achieved by own efforts
Relationship between kin obligatory	Determined by individual choice
Arranged marriage with an element of choice dependent on interfamilial relationship	Choice of marital partner, determined by interpersonal relationship
Extensive knowledge for distant relatives	Restricted only close relatives
Decision making dependent on family	Autonomy of individual
Locus of control external	Locus of control internal
Respect and holiness of the decision of the physician	Doubt in doctor patient relationship
Rarely malpractice suing	Common
Deference is god's will	Self determined
Doctor patient relationship is healthy	Mistrust
Individual can be replaced. The family should continue and the pride is in the family tie	Irreplaceable, self pride
Pride in family care for the patient	Community
Dependence on god in health and disease, attribution of illness and recovery to God's will	Self determined
Informed consent (family based)	Individual
Confidentiality (within the family)	Porous
Involuntary admission (family decision)	Individual

(Okasha, 2002)

How religious beliefs may affect health

Asians are very diverse in religions, religious beliefs are not universal among all Asians. In the health care 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. Below are religious affiliations identified by the following Asian groups in New Zealand, 2001. (MHC, Literature Review, 2003)

- Chinese: 50% no religion; 25% Christians; 1/7 Buddhism
- Indians: 53% Hinduism; Christianity, Muslim and 6% no religion
- Koreans: 70% Christians; 5% Buddhists; 25% no religion
- Cambodians: 71% Buddhism; 9% Christians; 10% no religion
- Vietnamese: 50% Buddhism; 26% Christians; 20% no religion

The following are some aspects of how religions affect health:

- 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 way, teaching three different routes to the truth, new beliefs grafted to 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)

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

- In America, it is not uncommon for a Korean to encompass several spiritual views into a religious belief system. Among the religious views embraced by Koreans are Confucianism, Shamanism, Taoism, Buddhism, and Christianity. Shamanism is the belief in good and evil spirits that can be influenced by Shamans, i.e., religious/spiritual practitioners with special relationship or insight into the spirit world.

Suggestion was to ask the patient before implementing any type of spiritual care

Family Structure

In NZ, Asians generally 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.



- Grandparent's role in raising the children is 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 has strong filial love, respect of the senior, loyalty and honor 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. It would need the health professionals to put more efforts to explain the process and consequences of rehabilitation.



- 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. For communication, health professionals should 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
- Some of the 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 with their husband first. This may lead to a lot of stress
- Because of the value placed on independence and privacy in Asian culture and the desire to save face, family issues, including healthcare decisions, are frequently discussed within the immediate family before seeking outside help. Because of the close-knit family structure, a family can expect many visitors when a family member is in the hospital.
- Most Asian women may keep their maiden name even after they got married. It is better to clarify before addressing them as "Mrs"

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, e.g., 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.
- Modesty is highly valued among Asian and are decidedly more comfortable and secure with same-sex care providers. Also see women's health, diet, and other relevant sections.

Parenting

- In many Asian culture, parents expect their children to be obedient, well disciplined and achieve high academic qualifications. Therefore Asians employ a “training” mode, organize children to attend different tutorials or interest groups even after school and during holidays.



- There are parents who do not worry about children’s English level, but worry that they may lose their native language or be unable to keep the traditional virtues. Some children may get stressed from parents’ expectations or face conflict between the eastern and western culture.
- In most instances, the whole family is involved in the care of the children. Grandparents play an important role in rearing the children, and if the grandparents do not live with the couple, they will come before the birth and stay to help out for first few months to several years. The children often sleep with the 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 the parents. This may cause some attachment issues with the child and parents. During an invasive procedure, the healthcare worker may want to give the child a choice for support: grandparent or parent – or better, both.
- Respect is highly valued and children are taught to be respectful of all elders, whether it is grandparents, siblings, teachers, or family friends. Discipline of children is thought to come naturally. In many cases, when a family has recently come from India, a child is responsible for many of the adult tasks, such as finance, legal forms, and translation. The healthcare provider should take note when scheduling appointments that parents/grandparents are advised against using children for translation. The healthcare provider can also assess the effects on the child of having adult responsibilities.

Shame and saving face

- The health care worker may not understand the logic of saving face but must attempt to understand to gain rapport and trust.
- Some Asian women are willing to suffer, if other family members benefit.

Maternity /Babies Care

- Each family may have different rites and taboos regarding pregnancy, delivery, post-natal care. It would always be safe to check with patient or family members about what to do or what not to do.
- Pregnancy: Pregnant Asian women needs special treatment and as much care and rest as possible. She is not expected to be active or to stick to her usual routine. Chinese and Korean women would not like to look at ugly things, and would not sit at the corners of tables. Some traditional Chinese may not allow them to eat some types of food which is believed to be cold (or have ‘wind’) nature.
- Delivery: Many Asian women coming to maternity wards may have their first experience in New Zealand hospital and its routines. They may not know what will happen and may be confused and frightened. Most Asian women would like to have a female relative, usually their mother or

mother-in-law, with them during their delivery. Or else please ask if an interpreter is needed to explain what is going on.

- After the birth, it is extremely important to ensure any religious ceremonies are performed. Please find out before the delivery what the family requires and facilitate the process. Asian women would remain in bed to take rest, do not like to do physical exercise, there are taboos that new mothers not allowed to shampoo and wash for at least a couple of days. Usually Asian women have to take 4 – 6 weeks rest to recuperate after delivery, not to do much household chores and not to get a cold.
- Babies Care: Many Asian women who live in big cities in Asia are not familiar with breast feeding. There is much anxiety and stress on breast feeding. They may want the babies to have supplement. Please explain and pay more attention to the Asian mothers to check if they feel comfortable. The way of babies care are different in Asian families. Some may not like to have baby crying too much or some may not like to leave the baby lying on bed too much. So Asian mothers/ grandparents may carry their babies quite often rather than leave their babies crying, which is considered as neglect or bad parenting. “Rooming-in” their child in parents’ bedroom is quite common, this practice may persist until the child is over 1 year old.
- Please support the mothers by clarifying, explaining and encouraging them .

Traditional Beliefs and Natural Remedies

There are different health beliefs in Asian culture.



- **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 would 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 affect 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

Yin-Yang: The belief in 2 opposing forces consisting of 5 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*) It is an integration of physical postures, breathing techniques and mental focus and can be classified as martial arts, medical or spiritual. The word Qi Qong means cultivating energy. Practices vary from the oft internal styles such as Tai Chi, to external, vigorous styles such as Kung Fu

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.



Blunt tool being used for pressure application.



Scraping: (or *Scraping Sand*) Scraping was a popular treatment around 3,000 years ago in rural areas of China. The technique was slowly forgotten with the advance of modern medicine, but is still sometimes practised 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.

Types of tools used: ceramic spoon, scrapers made of bone, scraping board, tongue depressor.



Scraping of arm

- **Environmental/Metaphysical** - in some Asian culture there are strong beliefs in fate or predestination, so the use of techniques such as Feng Shui, Palmistry or fortune telling is common. The idea with using 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 wealth and prosperity.

With this belief 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.

Feng Shui: (*Fong Shway*) It 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.

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.

- The Indian system of medicine is known as Ayurveda, which means "knowledge of life." Indian medicine mixes religion with secular medicine, and involves observation of the patient as well as the patient's natural environment. More than eighty-percent of people in India rely on herbal remedies as the principal means of preventing and curing illnesses. In the Ayurveda system, the body is comprised of three primary forces, termed dosha. The state of equilibrium between the dosha is perceived as a state of health; the state of imbalance is disease. Upon examination, the Ayurvedic physician finds out the position of the three dosha (Tridosha). Once the aggravated or unbalanced dosha is known, it is brought into balance by using different kinds of therapies. The three dosha are called Vata, Pitta, and Kapha. Each dosha represents characteristics derived from the five elements of space, air, fire, water, and earth. Space represents the ears and is responsible for hearing, speech, and sound. Air represents skin, which is responsible for touch, pressure, and the feeling of cold to dry sensation. Fire represents the eyes, which are responsible for sight, heat, and light. Water represents the tongue, which is responsible for taste, liquids, and hot or cold. Earth represents the nose, hence is responsible for smelling and odor. Each dosha represents certain bodily activities. Vata is responsible for breathing, brain activity, circulation, and excretion. People whose constitution is predominantly Vata tend to be thin, quick thinking, with swift action. When in imbalance they become nervous, anxious, constipated, and insomniac. Pitta is responsible for vision, digestion, hunger, thirst, and regulation of body heat and temperature. When in balance, people whose constitution is predominantly Pitta are intelligent, disciplined, sharp, and contented. When in imbalance they are intolerant to heat, become bald, show short temper, anger and lust; and are prone to heartburn and ulcers. Kapha represents solid structure of the body and lubricating mucous. Kapha types have strong, well-developed bodies, with the tendency not to gain weight, and are mentally cool. When in imbalance they are obese, disorganized, and sloppy; and develop allergies with dull activity, speech, and behavior.
- Shamanistic health practice for healing the body and soul is *hanyak*, which is the use of herbal medicine to create personal harmony. Shamans are consulted as a last resort for treatment or spiritual option. Although shamans provide profound spiritual services to people, they are considered part of the lowest class by Koreans.

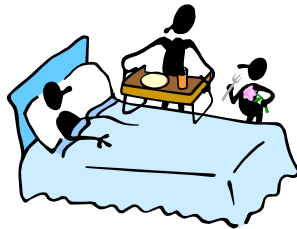
The above are just a flavour of some of the traditional beliefs and natural remedies that may be practised by traditional Chinese, Indians, and Koreans.

Perception of Illness

- As described above, Asian people have different perception, habits and taboos towards illness, e.g. some Asians view surgery as a very big trauma in life and believe it will have side effects to general health. The patient may need to take time to consider, talk to their husband (if patient is a woman), may need a decision from their father (if patient is a child) and health worker need to explain the tests, service options and consequences clearly to help patients (especially those who are new immigrants, and not familiar with health services, system or even health professional roles) to help them make decisions



- Some Asian people have a different body build and beliefs in taking a longer period of rest after an operation, serious illness or delivery of babies e.g. they will stay in bed for a few days after an operation and will not do heavy household chores. It is an Asian belief that if they do not have enough rest after an operation, they will have adverse consequences when they get old. Asian patients with stroke or surgery may have slower progress to therapies as they feel weak, lack energy and feel that they must be cautious and not aggravate their injury.



- Many problems that Asian patients encountered arise because the NZ health service system is so different from Asian countries. Routine and practical details are unfamiliar; Asians may not understand who is who and who is responsible for what on the ward or in the community services. The loneliness and vulnerability become worse if patients cannot speak English. It is most important to provide interpreters or support persons to explain what is happening, to answer questions and to discuss any fears or worries.
- Asian people expect prescription. Many patients feel they have not received proper treatment or have not been taken seriously if they go away from the doctor without a prescription or an injection. However, Asians also resist continuous medication because fear of side effects of drugs. Alternative Asian medicine or treatment is usually sought to keep body balance or look for complete recovery. Therefore lots of explanation and encouragement will be necessary in cases where drugs have to be taken to prevent symptoms recurring or to maintain health.

Daily Living Activities

- Chinese generally do not like to take a bath after an operation or very sick as they are afraid of getting a cold or wind in the body. Offer of self-wash would be good enough to the patients. Especially older people will not have a shower in the morning, as they feel cold. The sick person would need more warm blankets or clothing.
- The sick person would expect taking long rest and being looked after by other family members, the issue of dependence will arise as it comes to the family's responsibility to look after the

sick. Concepts of active rehabilitation and exercise are new to many Asians. Lots of encouragement and explanation to the patient and the family will be necessary.

- It is natural for Asians to express anxiety and suffering when they get sick, it is different from western culture that patients are expected to carry on as normal or to be active or keep cheer up. So some Asian patients may moan or cry when they feel great pain.
- Usually relatives would visit patients and may gather in a big group of visitors. Please be patient with them. It is our public image and we must respect and be courteous to all visitors.



Food

- Chinese prefer hot meals and hot drinks when get sick e.g. hot tea, clear soup.
- Rice is standard for every meal for Indians. It is usually served with sambhar, rasam (thin soup) and dry curried vegetables. Indian women after birth prefers traditional food called “katlu” or “panjiri” after birth which provide a “hot effect” for restoring energy.
- For Koreans, rice is the main staple along with vegetables and small amounts of meat and they have no preference for hot meals and hot drinks when they are unwell.
- Some Asians may avoid certain food (e.g. egg, beef or seafood) after operation.
- Asians, especially older people, may not like to have cold dairy products when they are sick. Please warm up the milk for them if, they prefer it. 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 /meal. Hard rice is not liked by sick Asians, they prefer soft rice cooked in a rice cooker
- Oil/butter/cheese are avoided when sick
- Asian families/friends may cook food for patients, whenever possible please facilitate the different meal times during the day
- Asians may prefer home made baby food e.g. congee rather than the ready made baby food (cereal/ jar food)
- Asians 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. Please allow for some oral feeding as soon as possible so that the patient could feel more comfortable.
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Tissue Release

- It would be desirable to check with patients and their families before surgery. Usually Asians would have a look at the tissue and then let staff manage the disposal. Some people may like to keep “stones”. But as some older people may become distressed at losing part of their

body, family members may decide not to show them the tissue. It is traumatic for Asian women to lose their babies, and family members may decide not to show mothers the aborted foetus. Therefore, individual wishes should be taken into consideration.

Physical Care

- Asian families are cohesive and supportive of each other. Usually family members would like to help the sick in the family, but generally men would not provide personal care to women and would feel embarrassed doing so in public. Conversely Asian women would feel embarrassed and uncomfortable if personal care is provided by male nurses or touched in sensitive parts of their body by male health professionals.

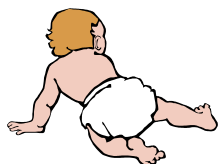


Isolation for Infection Control

- Some Asians may not know about infection control. They would feel very frightened of their isolation and become worried about the seriousness of their illness.



- Asian family members or friends would feel that it is unnecessary or inconvenient when they are requested to wear masks or wash hands when visiting. Therefore the procedures and necessity for infection control should be carefully explained to both the patient and any visitors.
- The information sheet should be translated into different languages to facilitate better understanding.



Disabilities

- The attitudes of Asians towards members with disabilities are a mixture of guilt and particularly caring. They have strong feelings of duty and tend to compensate the misfortune of the disabled member by taking every bit of care to themselves rather than seeking external resources.

- Some Asians may feel ashamed and may hide the disabled child from friends or Asian communities.
- Some parents may reject to send the child away from home, as they are particularly caring and loving towards him/her. They also worry about the cultural difference in the institutes that would make the disabled child uncomfortable, e.g. in food and daily life activities.
- Some parents are not used to reveal their difficulties to the health professionals as they consider it is shameful or it is their responsibility to look after the disabled child. Consistent encouragement will help the family to open up and follow the rehabilitation or training plan.
- Working in two languages and culture add confusion to the disabled child. The language barrier of parents causes more practical problems when they cannot communicate with health workers. Parents may not understand what is being done for the child, or why or what they should do to help. Interpreters and support persons must be involved to help these Asian families.



Mental Illness

- There is strong stigma on mental illness in Asian countries. Patients and families tend not to reveal to friends or colleagues because it would cause “losing face” and bad image.
- There is very little understanding on mental illness. All forms and degrees of mental illness are grouped together and described as ‘insane’ by general public. Most people get general fear about mentally ill people and not like to have mental health services at neighborhood.



- Asians usually do not like continuous medication, so the mentally ill patients may lack of persistence to receive treatment or psychiatric medicine especially when they feel the side effects of drugs. Close supervision and support is necessary.
- Family may believe a stay in hospital will automatically cure the patient, or feel that the family has no further responsibility. For the mentally ill patient, family’s support is most important, so family education and close liaison is necessary.
- Language and culture are likely major problems for mentally ill patients. Asian patients need health workers who speak their language or at least an interpreter or support person who understands something about psychiatry. Without such help, it is impossible to learn anything about the patient, his family, their reactions, states of mind or problems. Therefore any service provider need to train the family and support persons to understand something about psychiatry and how they can observe and help the patient.

- Asian people tend to somatize 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.

Lunar New Year

- Lunar New Year for Chinese, Korean and Vietnamese is usually observed in February. New Year for Indians is usually in April. Asians coming from these countries would not like to meet health professionals for assessment or treatment during the New Year, as there is a belief that it may mean that they will be more likely to get sick throughout the year. It would be better for health professionals to visit Asian client's seven days after the New Year.



Death Practices

- Asians are family oriented, many families may choose not to tell the bad news to the dying relative if they are the elderly or children because of the worries that the elderly or children may give up their hope to live or may be so rejecting/ upset that they could not live peacefully at the remaining period of time. So health professionals better convey the message to the family and let the family make their own decision.
- Asian families would make every attempt to prevent someone from dying and may prefer a dying relative to stay in the hospital so that resuscitation is attempted even at the last minute. Otherwise they would feel guilty at not doing enough to care for the relative. There is a belief that the dying person would like close relatives and friends to accompany and talk to them when death is imminent, even in the unconscious state, for as long as possible. It is love and respect shown to the dying person.
- There are different customs and religious beliefs in Asian countries about death and funerals. Please check with family members what they want staff to do. Family members may have a special mourning period for a few hours after the patient passes away. Please check with the family if they are willing for staff to remove the body.
- Many Hindu patients prefer to die at home and some will go back to India - especially to the sacred city of Varanasi, to die. The idea that suffering is inevitable and the result of karma may result in difficulty with symptom control. Family members are likely to be present in large numbers as death nears. Chanting and prayer, incense, and various rituals are part of the process. After death, healthcare staff should touch the body as little as possible. Ideally, the family should be the only ones to touch the body. A family member should clean the body and this person should be of the same sex as the deceased. After being cleaned, the body is wrapped in a red cloth.
- Koreans would not leave the body unattended, they would wait until someone attends to it. Many Asians would not dress up the dead immediately and let staff bring it to the mortuary, but some Asians would dress up the body while it is still warm.

- Many families may have to call relatives from their homeland to come and arrange the funeral, which could take a longer period. Please be patient and considerate to help these families.

CONCLUSION

Asian culture is very family (extended) oriented which include family, unity, dignity, respect, spirituality and humility. Beliefs and practices about diseases and ill health may be interpreted in relation to “spiritual” experience or encounter.

Asian culture, religion and language have significant impact, influencing the way in which Asian people choose to respond to and access health services. Cultural variations may be marked between generations. Some may still follow traditional lifestyles and health treatments while others are more accepting of a diagnosis than others. Respect for the values and beliefs of Asian people and their families are central to their well being.

Migration to a new country with a totally different culture may require a long period of adjustment. It could lead to psychosocial transitions and possibly culture shock. Discrimination, negative experiences and prejudice all make the process of adaptation in a new country more difficult for immigrants.

It can be easy to build up trust and relationship as long as you indicate genuine concern to them and support them at their pace.

Some general guidelines are suggested below as a reference, but most importantly, check with the patient or his/her family about how they think and feel.

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

- treat each patient as an individual with a unique blend of many influences and circumstances
- be sensitive to patients and families’ wishes, gestures and feelings.
- ask about patient’s health beliefs and practices
- encourage feedback from patients how they feel about existing services, and respect those feelings while remaining customer focused even if there is a language barrier or disagreement.
- do not make broad generalizations or assumptions about individual patients based on a superficial knowledge of their social or cultural background. As people from Asian countries do differ in their cultural background, values and beliefs, thus, it is advisable to view Asians as a heterogeneous group.

Some Communication Tips

- Speak slowly, clearly and in shorter sentences giving patients time to interpret the information in their own mind.
- Simplify the form of each sentence or question. Also use the simple forms of verbs: active not passive.
- When an interpreter is assisting the communication process, please pause at different points to give time for interpretation
- Be careful with using idioms, jargons or jokes. New migrants may not understand.
- Give instructions in a clear, logical sequence so that patients would understand step by step and point by point.
- Encourage them to explain to you what they understood and how they feel. As many Asians have better written and understanding skills than spoken language, usually they just need time to think and respond back from their mother language to a second language. That’s why some patients who cannot speak fluently, can understand and know whether the interpreter has

interpreted properly for them or missed some points. It is useful to ask them to repeat what they understood

- Asians may have the habit of nodding or saying “yes” as recognition of listening to you, but it may not necessarily mean they understand or agree. Therefore it would be useful to ask open ended questions
- Names: It is better to address the patient by their title (Mr/Ms) rather than using their Christian name. In some Asian culture, we put our surname before our given name, it is best to check with your patients on how to address them.