Asian Public Health Project Report
February 2003

Compiled by the Asian Public Health Project Team to assess Asian public health needs for the Auckland region

Disclaimer: This report is the result of the work of the Asian Public Health Project Team and is not necessarily the opinion or policy of the organisations represented on the Project Team.

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Foreword

Representatives from the Asian community in Auckland approached the Ministry of Health's Public Health Directorate in 2002 requesting that the public health needs of Asian people be considered in developing public health strategies. The Asian Network and the Auckland Regional Public Health Service were keen for health agencies to assess the public health needs of Asian people and subsequently foster programmes and interventions that would start to address some of these needs.

The Ministry of Health facilitated the establishment of an Asian Public Health Project Team in 2002 to oversee an initial health assessment, and this report contains the results of the work undertaken by the Project Team. The Project Team included representatives of the three Auckland District Health Boards, the Asian Network and the Auckland Regional Public Health Service.

The purpose of the report is to compile available information on Asian public health needs to assist decision-makers, programme planners and other interested parties to better respond to the increasing public health needs of Asian people living within the Auckland region.

The report attempts to provide a comprehensive view of Asian people's public health needs within the Auckland region, but there has been limited research in this area and a key finding is that the needs of Asian populations and the more specific needs of the many sub-populations will require further and ongoing research.

The scope of this report is confined to some broad recommendations and starting points. Given that there is limited public health funding for Asian-specific initiatives, mainstream public health providers will be encouraged to use the information in this report as a catalyst to develop activities and programmes that are more sensitive to the key Asian populations within the Auckland region.

Another limitation is that there has been no analysis of primary, secondary or tertiary health care needs of Asian people. The focus has been on public health or needs best addressed through a population-wide approach rather than treatment of specific diseases or illnesses.

The Project Team is to be congratulated for the collaborative way it went about compiling this report, and the Ministry of Health looks forward to an ongoing association with this group as recommendations are implemented.

Bruce Macdonald
Ministry of Health

February 2003

Executive summary

The Asian Public Health[1] Project involved a collaborative Project Team[2] undertaking an assessment of public health issues facing Asian communities in the Auckland region. The resulting report provides the first comprehensive local analysis of Asian health status and underlying issues. The research included analysis of hospitalisation and death data, a literature review, a health service and resource stock-take, key informant[3] interviews, and four consultation meetings with Asian communities.

The project arose from increasing concern that the public health needs of Asian communities in the Auckland region are generally overlooked, despite growing numbers of Asian peoples. The project highlighted many gaps in our understanding as there has been little research in this area to date. The report provides a guide for future development of public health action to address Asian health issues, and identifies areas for advocacy.

In summary, the key findings of the report include the following points.

The Asian population is diverse and increasing

About 65 percent of all Asian people in New Zealand live in the Auckland region, with the current Auckland population being over 146,000 people. The Asian population is made up of extremely diverse ethnic sub-groups, but overall it is the second largest population group in the Auckland region, making up about 12.5 percent of the population. Within the Auckland region, Chinese are the largest Asian group with about 45 percent of all Asian people, followed by Indian (27%) and then Korean (9%). The Asian population is expected to continue to increase mainly through further immigration.

Most Asian people are young and middle-aged adults

As 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. The generally young age structure of the Asian population partially explains the overall good health status of the population group.

Many Asian people are well-educated, but have lower than average incomes

Nearly one-third of Asian people have a tertiary education but, overall, Asian peoples have worse than average unemployment rates (7.4% in 2001) and most 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.

The Asian population has diverse health issues

Overall health status for Asian people is good, but a range of health issues have been identified including a number of significant areas of concern.

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, and the six leading

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1 Public health in this report refers to actions which promote wellbeing and prevent ill health before it happens.

2 The Project Team included representatives from the Asian Network, the Auckland Regional Public Health Service, the Ministry of Health, Auckland DHB, Counties-Manukau DHB, Waitemata DHB and the Asian community within the Auckland region.

3 Key informants included a range of people, mainly Asian health practitioners or professionals working with Asian communities.

causes of preventable hospitalisations are angina (heart pain), gastroenteritis, respiratory infections, road injuries, dental conditions and asthma.

Both the consultation meetings and key informant interviews found that mental health (eg, language barriers, social isolation, under-employment and stigmatisation), cardiovascular disease and diabetes (eg, lifestyle changes around diet and physical activity) and sexual health (eg, very high abortion rates) are leading health issues along with communicable diseases (eg, high rates of TB), and traffic injuries.

Asian communities want better access to health services that cater to their needs

Consultation meetings and key informant interviews were useful in assisting to define health issues, identifying difficulties or barriers in accessing health services, and exploring possible strategies to address public health issues in Asian communities within the Auckland region.

A range of solutions was put forward by participants at the consultation meetings, and by key informants. These focused on reducing language barriers and cultural barriers through the provision of interpreters, recruitment of more Asian health professionals, and the development of more culturally-sensitive services.

There is community support for enhancing mainstream services, targeting of resources and ensuring that service development involves Asian communities through partnerships and other mechanisms.

Asian communities are ready and willing to participate in improving their communities' health

Asian communities in the Auckland region appear to be generally cohesive, have a strong sense of culture, identity and belonging, and an eagerness to participate and integrate in mainstream service delivery. Asian networks are already reasonably well established, and some successful initiatives are underway that provide a foundation for improved Asian peoples' health in the future.

Recommendations focus on building Asian community infrastructure, providing direction for advocacy, and enhancing mainstream providers

The Asian Public Health Project Team will continue to meet for at least a further 12 months to oversee implementation of a comprehensive range of recommendations. A key focus of the recommendations is enhancement of services provided by mainstream public health providers to better meet the diverse needs of Asians within the Auckland region.

The Project Team considers priority should also be given to improving access to health services by Asian communities. Many health providers do not provide services, or health education resources, appropriate for Asian communities. For example, lack of English language proficiency is a key issue for new immigrants, and this impacts on access to health care, employment prospects, income levels and other factors which determine health status.

Resourcing existing Asian community organisations is seen as one way of facilitating ongoing advocacy around these issues.

Asian Public Health Project Team

February 2003

Introduction

This report is the result of the work of the Asian Public Health Project Team. Some individuals carried out specific tasks that fed into the overall report (see acknowledgements on page 82). The project aim was to prepare a report to assist the Ministry of Health, District Health Boards, Public Health Providers and others to assess and respond to Asian public health needs in the Auckland region.

A Project Team (see Appendix 1) was established to oversee the project and carry out six main components of work as follows:

- Profile of Asian demographic and hospitalisation data.
- Assessment of health need – summarise available data and issue reports.
- Literature review of international approaches to Asian populations within non-Asian countries.
- Stock-take of existing services, resources and organisations.
- Consultation (community representatives) and key informant interviews (GPs and other service providers).
- Options for enhanced Asian public health.

Project objectives

1. To provide an up-to-date Asian demographic, health utilisation and hospitalisation data profile focusing on the Auckland region.
2. To compile and summarise available public health related reports pertaining to Asians living in the Auckland region.
3. To carry out a literature review of international public health approaches to Asian populations within non-Asian countries.
4. To carry out a stock-take of current personal and public health services, resources and organisations within New Zealand focusing on the Auckland region.
5. To undertake consultation with the Asian community (amongst four main groups: i. Chinese; ii. Indian Sub-continent[4] including Indian; iii. Korean; and iv. South-east Asian[5] including Cambodian, Vietnamese and Japanese) and approximately 15 key informant interviews within the Auckland region to determine key public health issues.
6. To develop suggested options for public health to address identified Asian needs within the New Zealand context.

The definition of Asian used in this report is based on the categories used in the census (see Appendix 2). Ethnicity (Department of Statistics, Census definition, www.stats.govt.nz) 'is the ethnic group or groups that people identify with or feel they belong to. Thus, ethnicity is self-perceived and people can belong to more than one ethnic group. Ethnicity is a measure of cultural affiliation, as opposed to race, ancestry, nationality or citizenship. An ethnic group is a social group whose members have the following four characteristics:

- share a sense of common origins
- claim a common and distinctive history and destiny
- possess one or more dimensions of collective cultural individuality
- feel a sense of unique collective solidarity.'

[4] Indian Subcontinent (or South Asia) includes seven countries which are members of SAARC (South Asian Association for Regional Cooperation), namely: Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka.

[5] Made up of ten countries which are members of ASEAN (Association of Southeast Asian Nations), namely: Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar (Burma), Philippines, Singapore, Thailand and Vietnam.

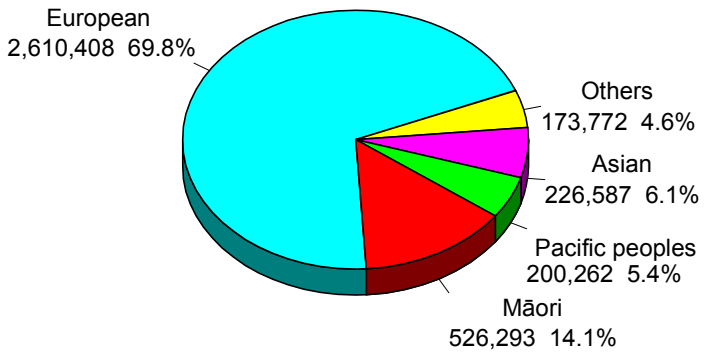
1. Demographic profile of the Asian population

This section outlines the demographic profile of the Asian population in the Auckland region with reference to the national picture. More detailed breakdowns are provided in Appendix 3 (detailed tables of age and gender breakdowns by the Auckland region and three District Health Boards) and Appendix 4 (detailed maps of Asian population concentrations by District Health Board in the Auckland region). All figures are for the latest census (6 March 2001) and relate to the category 'usually resident' unless otherwise stated.

Population by ethnicity in New Zealand

The latest census records that there were 3,737,322 people who usually lived in New Zealand on 6 March 2001. Chart 1 shows the breakdown of the population by ethnic groups in New Zealand. About 70 percent of the population was European. 14 percent of the population was Māori, 6 percent was Asian and 5.4 percent was Pacific peoples. Note that 'Others' includes those who did not specify their ethnicity.

Chart 1: Population by ethnic group in New Zealand (Census 2001)



Total=3,737,322

In total, there were 226,599 Asian people in New Zealand in 2001. Table 1 shows the number and percentage Asian population by District Health Board (DHB). About 65 percent (or 146,103) of all Asian people in New Zealand lived in the Auckland region (namely Auckland DHB, Waitemata DHB and Counties Manukau DHB).

Table 1: Number and percentage of Asian population by DHB, 2001

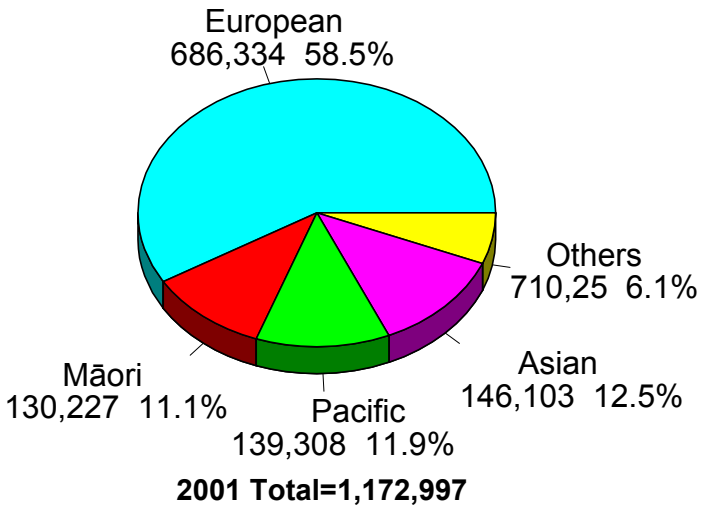
DHB	Number of Asian	% Asian
Auckland	63,243	27.9
Counties Manukau	42,498	18.8
Waitemata	40,362	17.8
Capital and Coast	18,411	8.1
Canterbury	18,105	8.0
Waikato	10,503	4.6
Hutt Valley	7,260	3.2
MidCentral	5,349	2.4
Otago	4,929	2.2
Bay of Plenty	2,847	1.3
Hawke's Bay	2,607	1.2
Lakes	2,025	0.9
Northland	1,620	0.7
Nelson Marlborough	1,497	0.7
Southland	1,371	0.6
Taranaki	1,365	0.6
Wanganui	807	0.4
South Canterbury	678	0.3
Tairawhiti	477	0.2
Wairarapa	438	0.2
West Coast	207	0.1
NZ	226,599	100.0

Population by ethnicity in the Auckland region

There were 1,172,997 people who usually lived in the Auckland region in 2001. Chart 2 shows the breakdown of the population by ethnic groups in the Auckland region. 60 percent of the population was European. 12.5 percent of the population was Asian, 11 percent was Māori and 12 percent was Pacific peoples. Note that 'Others' includes those who did not specify their ethnicity.

Both Asian and Pacific peoples form greater percentages of the Auckland region's population, with people from European backgrounds being a smaller percentage than the national figures. Māori also form a slightly smaller percentage than the national figures.

Chart 2: Population by ethnic group in the Auckland region (Census 2001)



Asian population in the Auckland region

There were 146,103 Asian people living in the Auckland region with 43 percent living in the Auckland DHB, 29 percent living in Counties Manukau DHB and 28% living in Waitemata DHB (see Figure 1).

Figure 1: Asian population figures by District Health Board

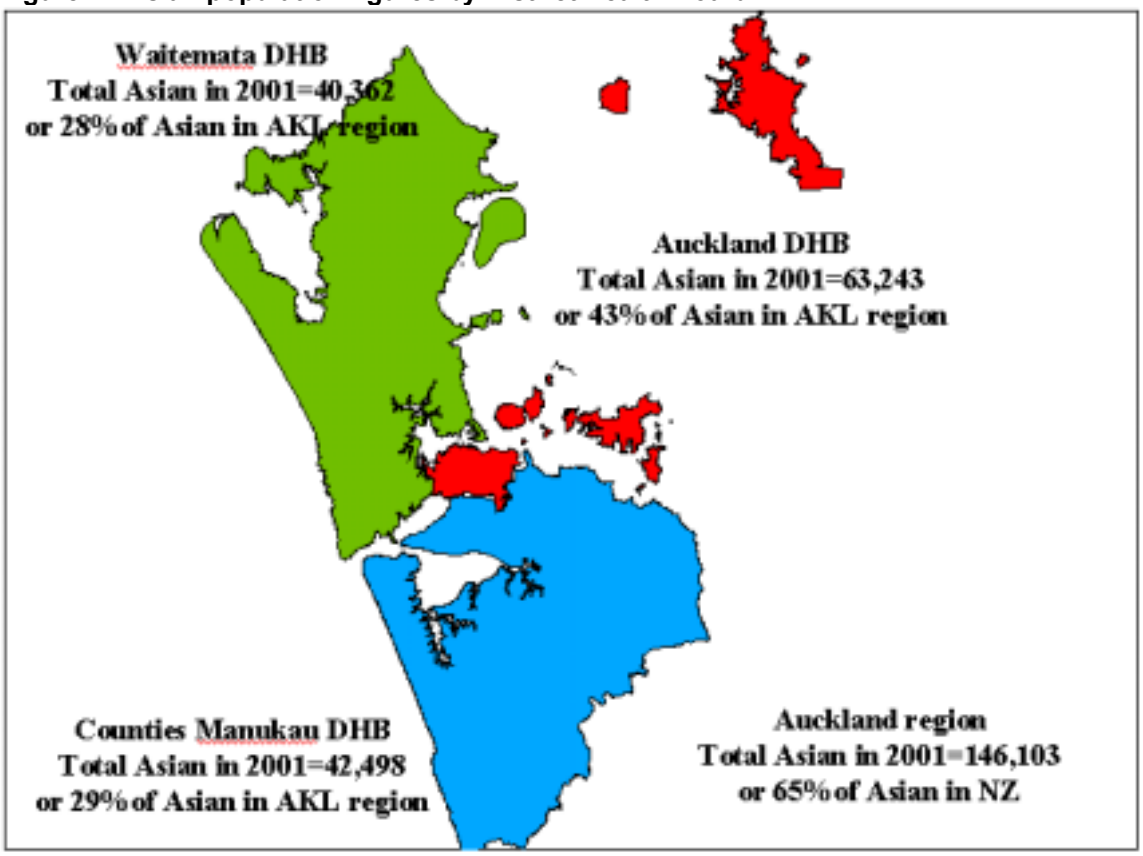


Table 2 shows the number of people identifying with different cultural groups among Asian people in the Auckland region. Note that the sum of this table is not the number of people but the total number of affiliations recorded as people can choose to affiliate with more than one group. Chinese was the largest cultural group identified (45%), followed by Indian (27%) and then Korean (9%).

Table 2: Number of Asian population by culture group, Auckland region 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%

Age structure of the population by ethnicity

Chart 3 shows the age structure of the population in the Auckland region by ethnicity. The Asian population had the highest percentage of young people (15-24 years) while Māori and Pacific populations had high proportions of young people aged 0-14 years.

Chart 3: Age structure of the population by ethnicity for the Auckland region (Census 2001)

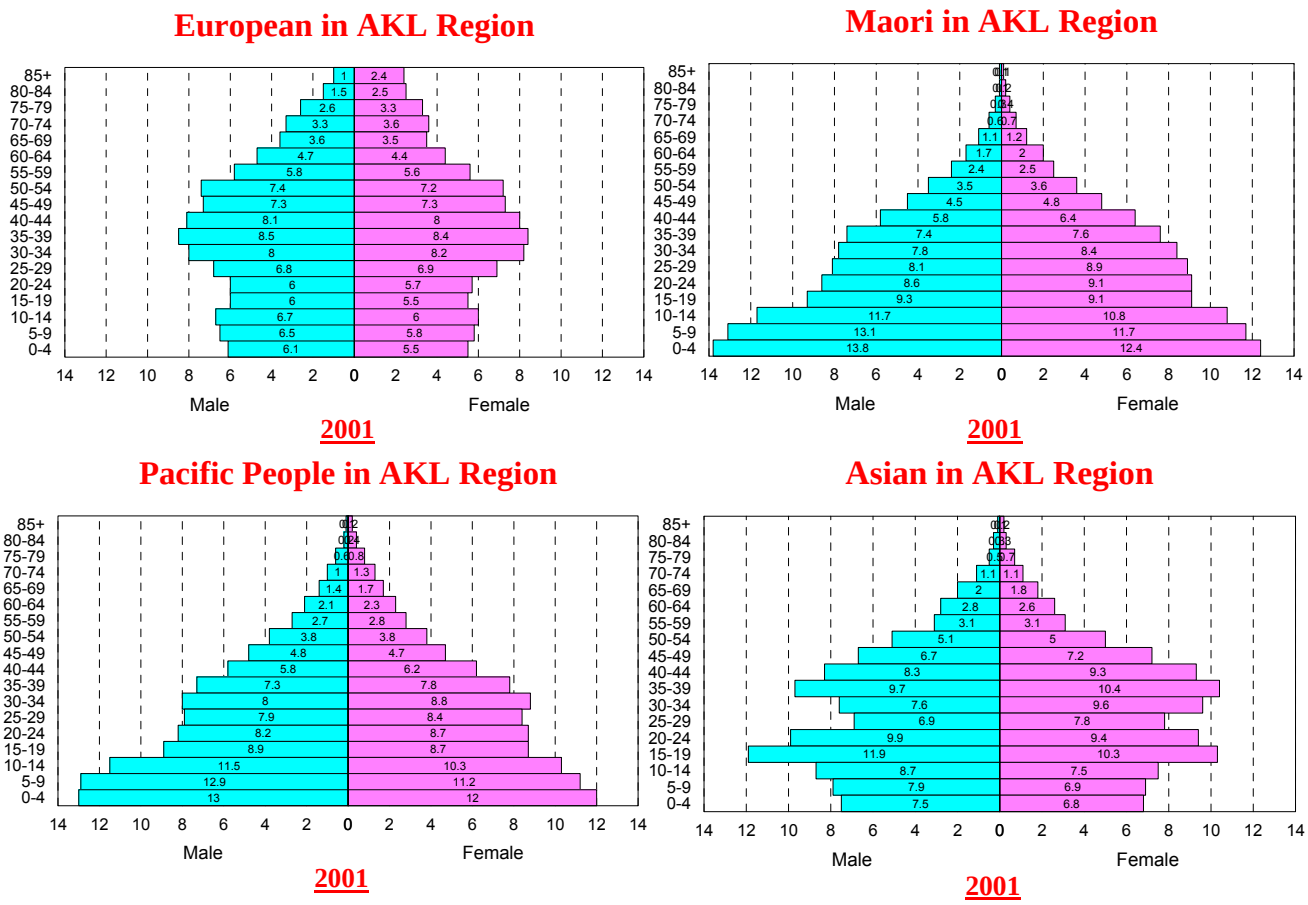
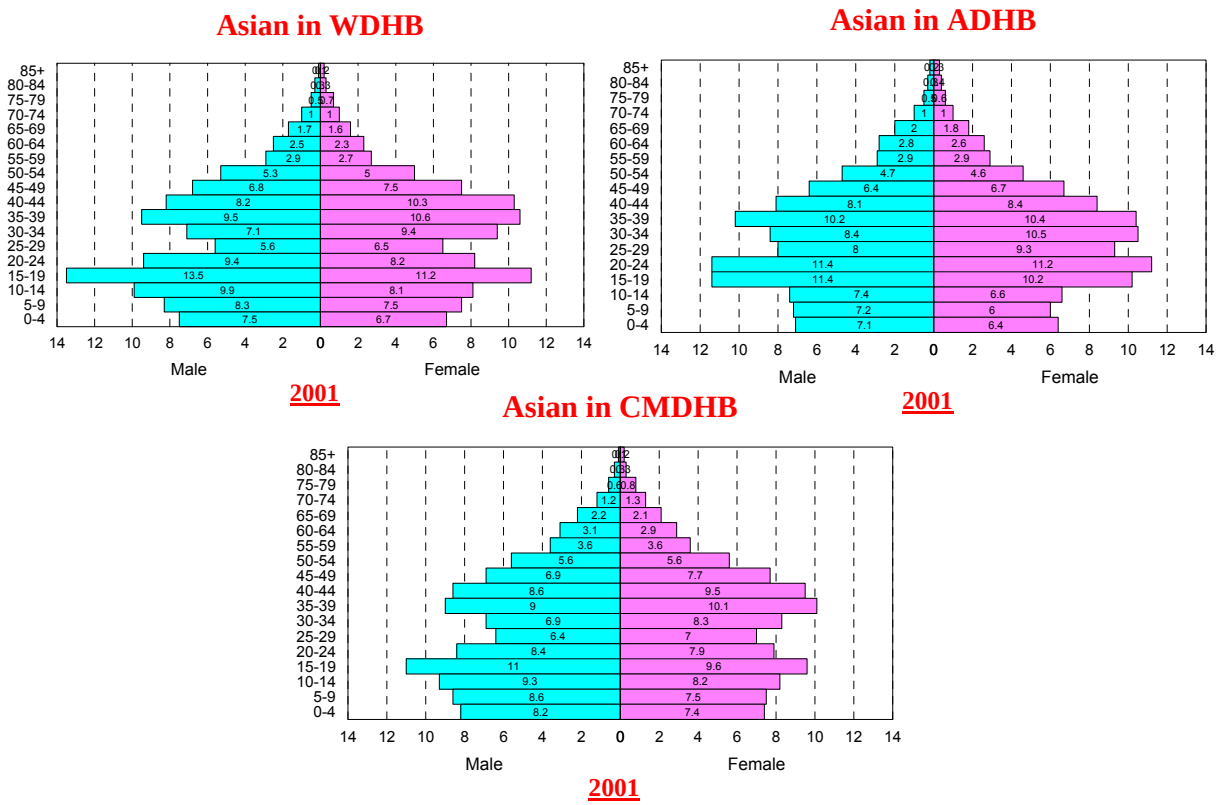


Chart 4 shows that the age structure for the Asian population is different in each of the three District Health Boards within the Auckland region. The Auckland DHB has more 19-24-year-olds than either Counties Manukau DHB or Waitemata DHB. Auckland DHB and Waitemata DHB have more 15-19-year-olds than Counties Manukau DHB.

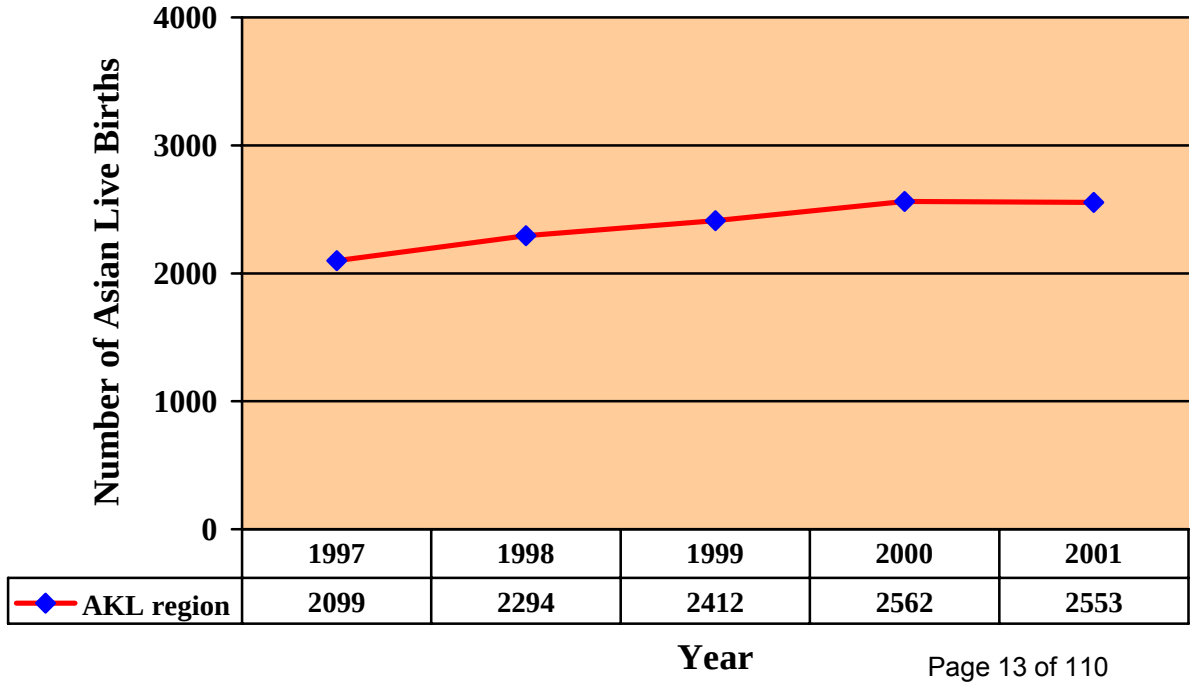
Chart 4: Asian population structure for the three DHBs within the Auckland region (Census 2001)



Live births for Asian people in the Auckland region

There were an approximate average of 2,499 Asian babies born annually in the Auckland region between April 1997 and March 2001. The number of Asian births consistently increased from 1997 to 2000.

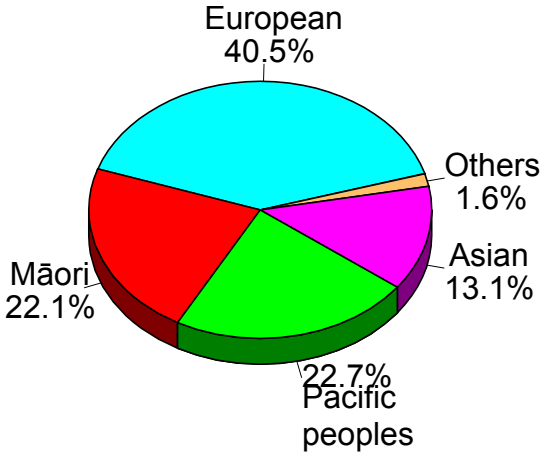
Chart 5: Number of Asian live births in the Auckland region from April 1997 to March 2001



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.

Chart 6: Percentage of live births by ethnic group in the Auckland region (April 2000 to March 2001)

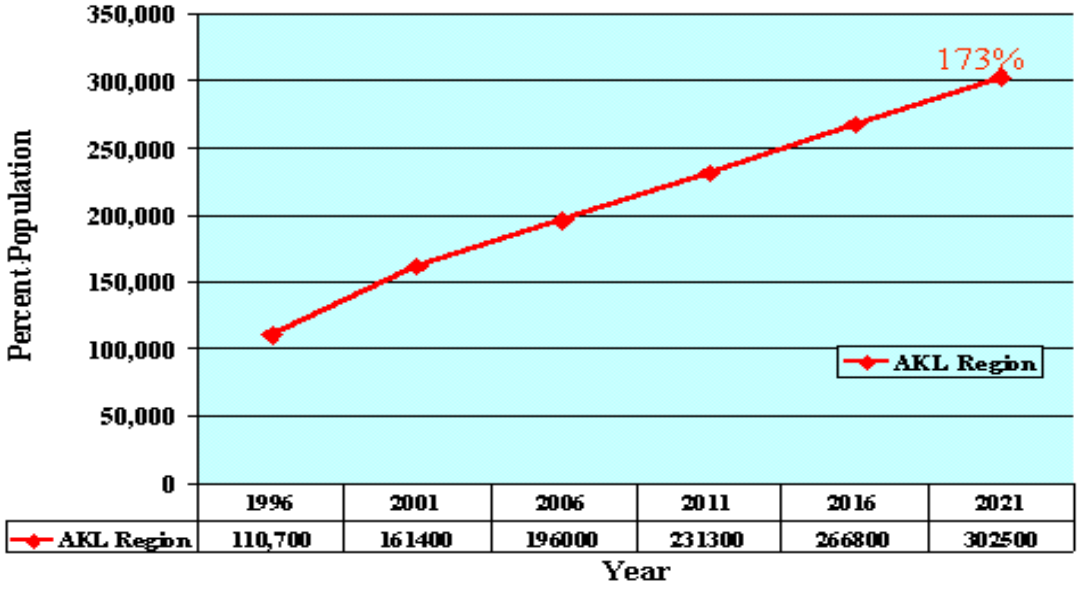


Total births=19,541

Population projection

Chart 7 shows the future growth of the Asian population in the Auckland region based on the 1996 Census[6]. The number of Asian people in this region is expected to grow by 173 percent (or about 190,000 Asian people) by the year 2021.

Chart 7: Estimated Asian population growth for the Auckland region 1996 to 2021



[6] Note that using 1996 census data, the projected number for Asian people in 2001 was 161,400, higher than what was actually recorded in the 2001 census (ie, 146,103). The reason was that the immigration from Asian countries slowed down between 1996 and 2001 as shown in the immigration tables. However, the net migration of Asian people (27,000) into New Zealand between 2001 and 2002 was the highest recorded in the period. If this trend continues, the Auckland Region will experience even higher growth in the size of the Asian population by the year 2021 than was originally projected.

Immigration (national figures)

The three tables below outline immigration, departures and net migration figures for the last six years (1996/97 to 2001/02) by country of origin.

In the last six years on average nearly 69,000 people per year have arrived in New Zealand, indicating that their stay will be permanent and long term. This includes an annual average of over 22,000 (32%) from Asian countries. During the same period, on average there were nearly 66,000 people per year indicating that their departure from New Zealand will be permanent and long term. This includes an annual average of nearly 7,000 (10%) people leaving for Asian countries.

Note: All figures for years ending 31 March, source: Statistics New Zealand.

Chart 8: Immigration from Asia and all countries to New Zealand between 1996/97 and 2001/02

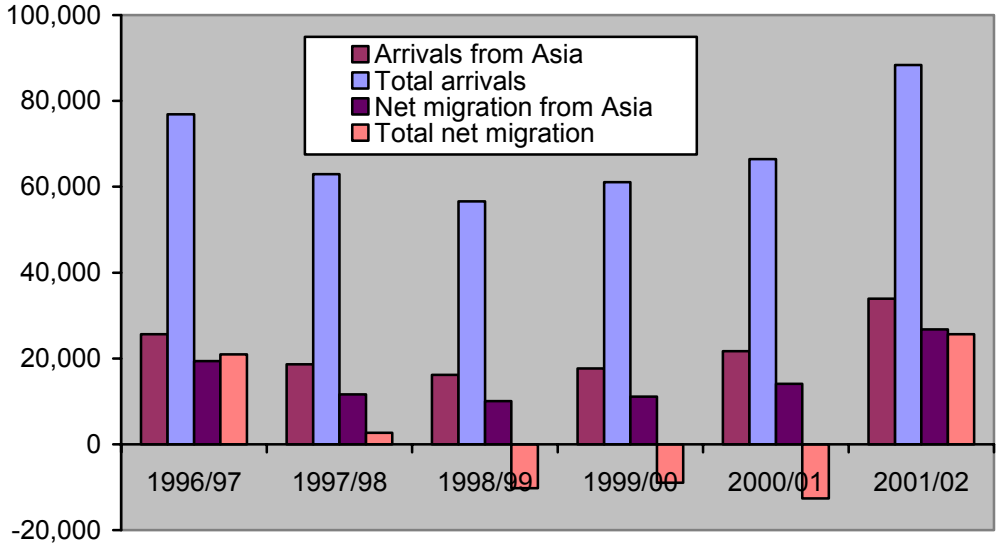


Table 3: Permanent and long-term arrivals to New Zealand between 1996/97 and 2001/02

Country of last permanent residence	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02
Australia (includes External Territories)	12,548	11,433	10,271	10,594	10,811	12,695
Other Oceania and Antarctica	5,446	4,725	4,360	4,256	5,200	5,308
Asia	25,610	18,598	16,195	17,649	21,683	33,956
Canada	1,381	1,131	885	978	907	1,082
United States of America	2,958	2,622	2,399	2,512	2,544	3,033
South Africa	2,648	2,689	2,382	2,363	2,402	3,315
United Kingdom	14,575	12,693	12,082	14,996	14,163	17,748
Ireland	339	280	323	366	514	895
Other Countries (includes Not Stated)	11,391	8,757	7,683	7,375	8,241	10,333
Total	76,896	62,928	56,580	61,089	66,465	88,365

Source: Statistics New Zealand

Table 4: Permanent and long-term departures from New Zealand between 1996/97 and 2001/02

Country of next permanent residence	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02
Australia (includes External Territories)	24,623	26,106	30,372	35,428	42,419	28,783
Other Oceania and Antarctica	4,369	3,608	3,018	2,414	1,812	1,863
Asia	6,223	6,984	6,167	6,532	7,632	7,208
Canada	807	920	1,030	961	1,163	1,166
United States of America	2,634	2,961	3,033	3,101	3,499	2,898
South Africa	154	230	200	235	199	202
United Kingdom	12,386	14,142	16,861	15,709	15,450	14,314
Ireland	252	400	420	569	1,003	1,050
Other Countries (includes Not Stated)	4,500	4,870	5,678	5,127	5,888	5,246
Total	55,948	60,221	66,779	70,076	79,065	62,730

Source: Statistics New Zealand

Net migration to New Zealand from all countries averages nearly 3,000 per year over the last six years. Asian countries lead net migration figures with an average of over 15,000 people per year followed by net migration from South Africa of an annual average of over 2,000 people.

Table 5: Permanent and long-term net migration for New Zealand between 1996/97 and 2001/02

Country of last permanent residence	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02
Australia (includes External Territories)	-12,075	-14,673	-20,101	-24,834	-31,608	-16,088
Other Oceania and Antarctica	1,077	1,117	1,342	1,842	3,388	3,445
Asia	19,387	11,614	10,028	11,117	14,051	26,748
Canada	574	211	-145	17	-256	-84
United States of America	324	-339	-634	-589	-955	135
South Africa	2,494	2,459	2,182	2,128	2,203	3,113
United Kingdom	2,189	-1,449	-4,779	-713	-1,287	3,434
Ireland	87	-120	-97	-203	-489	-155
Other Countries (including Not Stated)	6,891	3,887	2,005	2,248	2,353	5,087
Total	20,948	2,707	-10,199	-8,987	-12,600	25,635

Source: Statistics New Zealand

Summary of demographic data for the Asian population

In 2001, about 65 percent (or 146,103) of all Asian people in New Zealand lived in the Auckland region. The Asian population is the second largest population group in the Auckland region making up about 12.5 percent of the population. Within the Auckland region, Chinese was the largest Asian cultural group identified (45%), followed by Indian (27%) and then Korean (9%).

The Asian population is expected to increase significantly over the next decade or so. Around 2,500 Asian live births are recorded each year in the Auckland region and this number shows an upward trend, but immigration is the primary driver for Asian population growth with net migration averaging over 15,000 nationally in the last six years.

Less than 5 percent of the Asian population is older than 65 years. Over half of Asian people in the Auckland region are between the ages of 25 and 65 years, while around 20 percent are 15 to 24 years and another 20 percent are 0 to 14 years.

2. Socioeconomic status and the health of Asian people in the Auckland region

This section outlines various socioeconomic indicators for Asian people in the Auckland region based on 2001 census data and other research data.

There is some data on various determinants of health (ie, root causes of health) that pertains to Asian people. Much of these data are more recent as various agencies have started to recognise that it is important to acknowledge the impact of an increasing proportion of Asian people in various communities, especially in the large urban centres. For instance, the Asian population category was not identified as a discrete group in the 1996/97 New Zealand Health Survey, so there is little information available on lifestyle factors. A repeat of this survey was carried out in 2002 and included sampling of the Asian population.

Generally high education levels, but employment and income issues

There is evidence to suggest that many Asian people have a high level of educational attainment. However, there is also evidence that unemployment (especially Vietnamese and Cambodian, but not usually Japanese[7]) and under-employment (ie, obtaining a job that has a significantly lower status or skill level to that previously held in their country of origin), 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 often, but not always relate to language barriers. Low proficiency in English, unemployment and other issues have been associated with poor adjustment to life in New Zealand (Abbott et al 2000).

Asian immigrants have a significantly higher level of tertiary education compared to other New Zealanders with various studies reporting that around 30 to 50 percent of newer Asian immigrants have some form of tertiary qualification compared with around 15 percent for New Zealanders as a whole (Ngai et al 2001).

Statistics cited in various reports show that Asian people tend to have an unemployment rate similar to Māori and Pacific peoples, ie, higher than the population as a whole. Combined with the stress of migration to a culturally different country, difficulty finding employment and under-employment can create significant social, economic and health problems for Asian people (Abbott et al 2000). For example, it has been noted that:

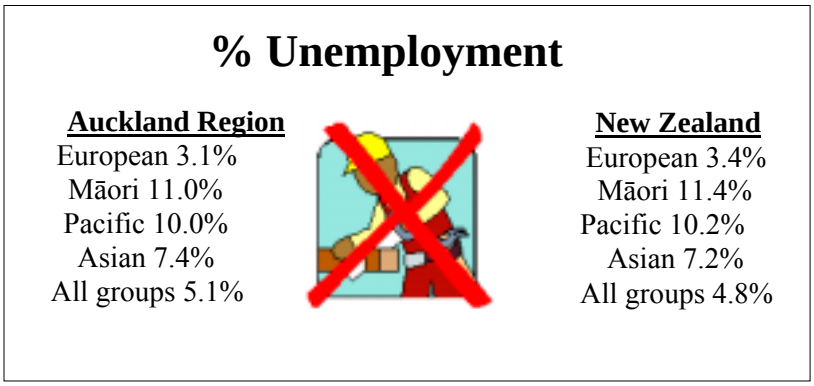
- there are gender differences with Asian women generally being more adaptive than Asian men (Kudos Organisational Dynamics Ltd 2000)
- unemployment and under-employment contribute to mental illness, general stress and family stress, especially marital stress (Kudos Organisational Dynamics Ltd 2000)
- this stress is sometimes a factor in contributing to other issues such as problem gambling, domestic violence, suicide and loss of confidence, especially for men but which also can impact on women's health (Wang 2000)
- few Asian people are employed by central and local government (Kudos Organisational Dynamics Ltd 2000) and related social services (Wang 2000)
- unfulfilled employment expectations lead to a return to country of origin or further immigration (Kudos Organisational Dynamics Ltd 2000)
- major improvements in adjustment to life in New Zealand occur within the first year and plateau out beyond this period (Abbott et al 2000).

From the 2001 census, just over 5 percent of people aged 15 years and over in the Auckland region were unemployed in 2001. The percent unemployed for Asian was 7.4 percent,

[7] Noted in the report by Kudos Organisational Dynamics Ltd (2000).

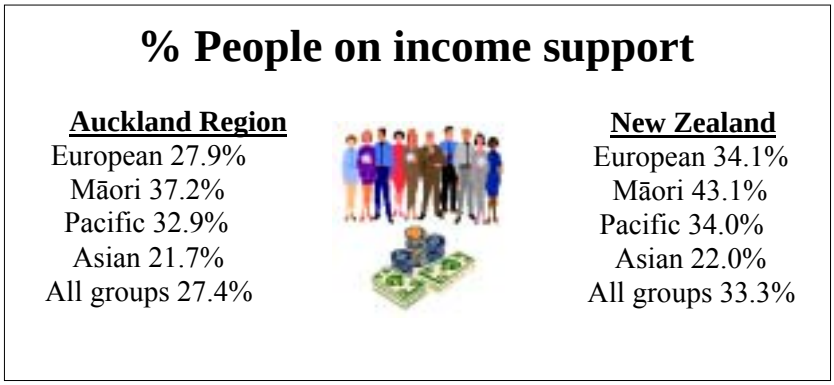
slightly higher than the rate for Asian people nationwide. Maori had the highest percentage of unemployed among the different ethnic groups in this region.

Figure 2: Unemployment figures by ethnic group (Census 2001)



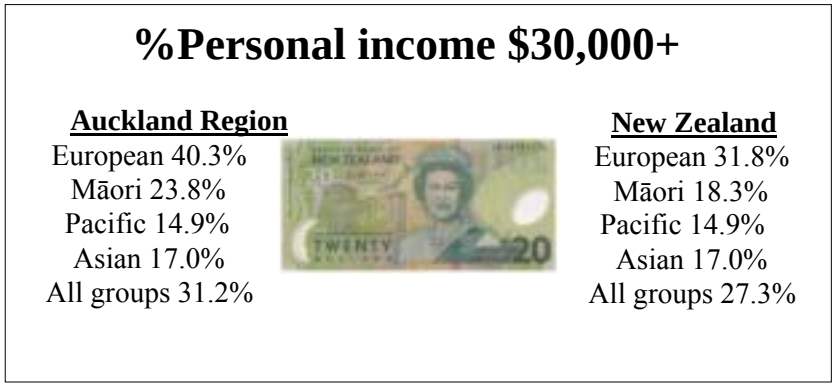
About 28% of people aged 15 years and over in the Auckland region received income support. Asian people had the lowest percentage (21.7%) of people on income support while Māori had the highest percentage (39%).

Figure 3: People receiving income support by ethnic group (Census 2001)



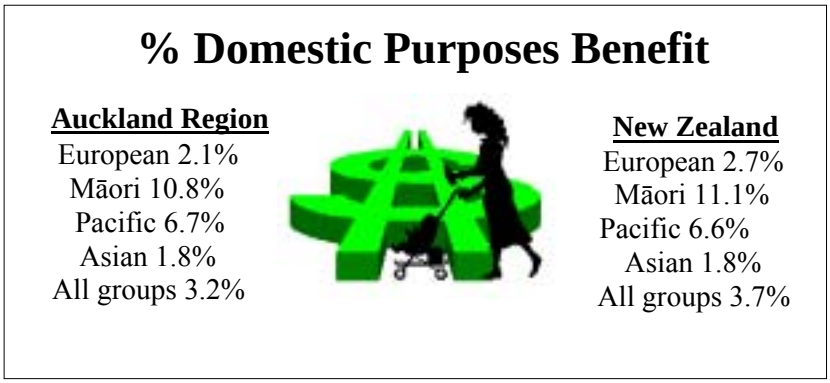
Just 17 percent of Asian people aged 15 years and over in the Auckland region had income of $30,000 or more compared with 31.2 percent for the whole population. Pacific peoples had the lowest percentage of people with income over $30,000 among all ethnic groups.

Figure 4: People with personal income of $30,000 or more by ethnic group (Census 2001)



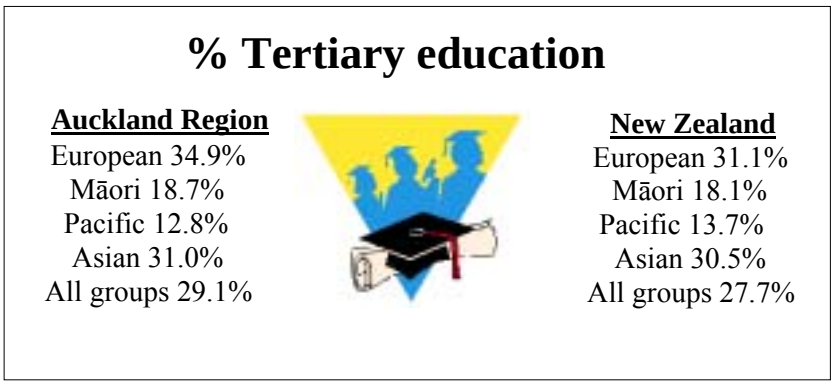
Only 1.8 percent of Asian people aged over 15 years old in the Auckland region received the Domestic Purposes Benefit, the lowest percentage among all ethnic groups. Māori followed by Pacific peoples had the highest percentages of people on this benefit.

Figure 5: People receiving the Domestic Purposes Benefit by ethnic group (Census 2001)



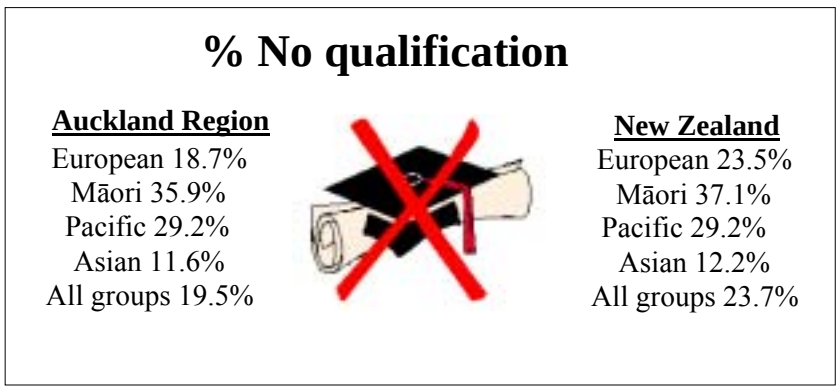
Tertiary education includes all formal qualifications after high school, and 29 percent of people in the Auckland region had tertiary education. Europeans had the highest percentage of people with tertiary education, followed by Asian people. Pacific peoples had the lowest percentage (about 13%) of those with tertiary education in this region.

Figure 6: People receiving tertiary education by ethnic group (Census 2001)



The Asian ethnic group had the lowest percentage of people with no qualification compared with any other ethnic groups.

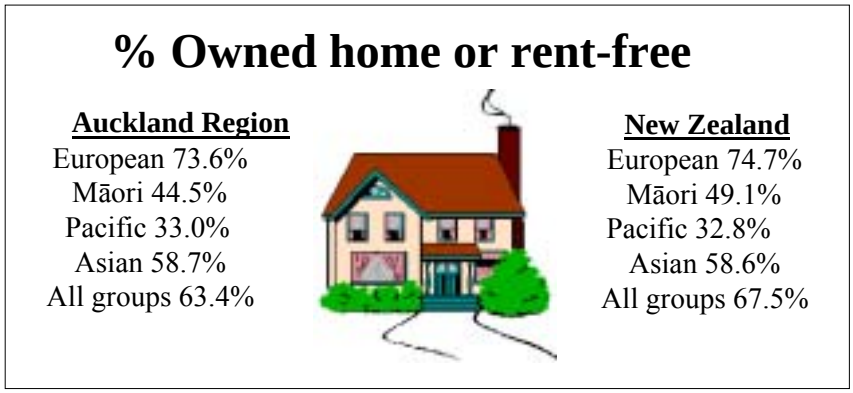
Figure 7: People with no qualification by ethnic group (Census 2001)



Housing and transport

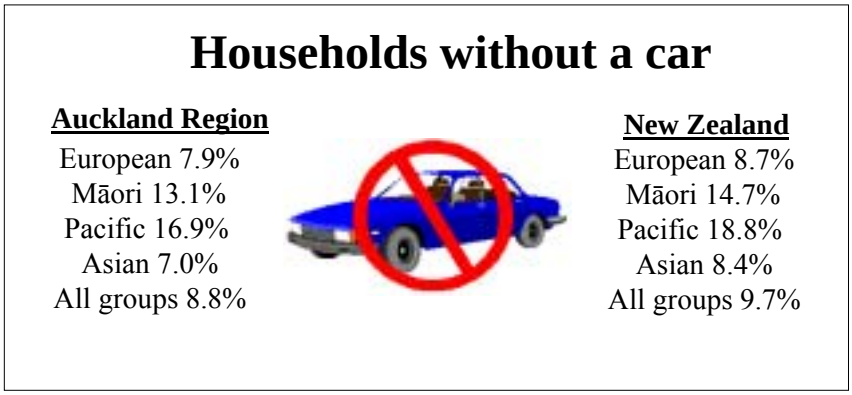
Sixty-three percent of households in the Auckland region either owned their own home or occupied it rent-free compared with 68 percent nationwide. Europeans had the highest percentage (74%) of people who either own their own home or occupied it rent-free, followed by Asian households.

Figure 8: People who own their own home or live rent-free by ethnic group (Census 2001)



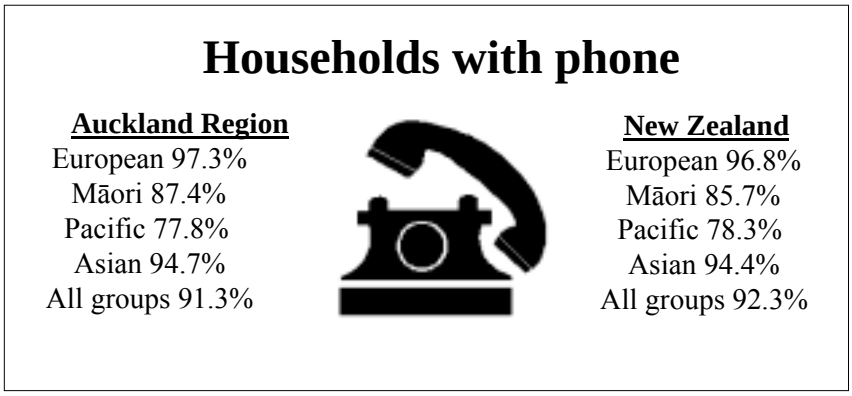
Asian households in the Auckland region had the lowest percentage of households without a car (7%) while Pacific households had the highest percentage (17%).

Figure 9: Households without a car by ethnic group (Census 2001)



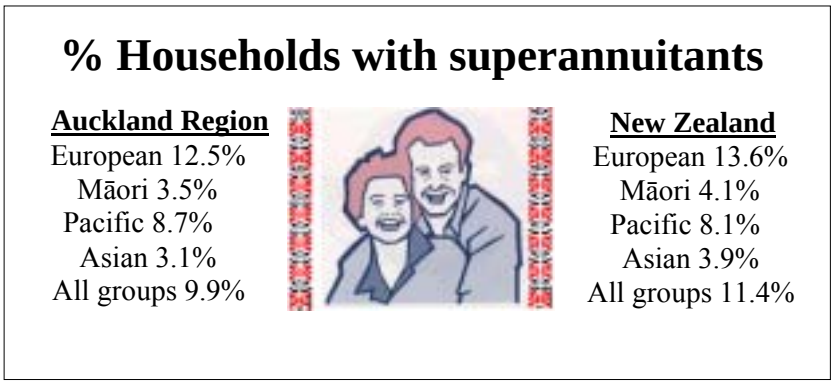
About 91 percent of the households in the Auckland region had a telephone. The European ethnic group had the highest percentage of households with a telephone (97%), followed by Asian households (95%).

Figure 10: Households with a phone by ethnic group (Census 2001)



The Auckland region had a lower percentage of households with superannuitants than for the country as a whole. Asian households had the lowest percentage (3.1%) of superannuitants.

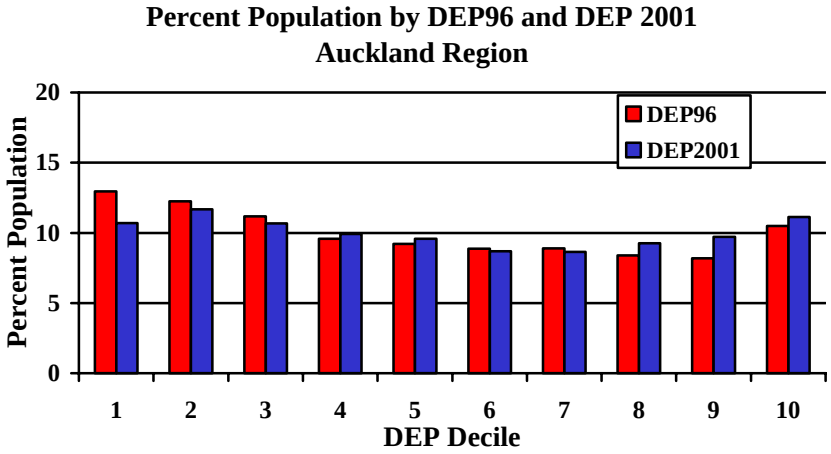
Figure 11: Households with superannuitants by ethnic group (Census 2001)



Population deprivation index figure for the Auckland region

DEP2001 is an index of deprivation, combining nine census variables from the 2001 census that reflect aspects of material and social deprivation. This index applies to an area rather than to individual people. The scale of deprivation ranges from 1 to 10 where 1 represents the least deprived areas and 10 the most deprived areas in New Zealand (Note: opposite to the decile rating used for schools, where 1 is most deprived and 10 least deprived). The charts below show the numbers of people in the Auckland region by DEP2001 decile compared with DEP1996. In general, there was a decline in percent population in the least deprived areas and an increase in percent population in the more deprived areas. About 30 percent of the population in the Auckland region lived in the more deprived areas (deciles 8-10) in 2001 compared with 27 percent for 1996.

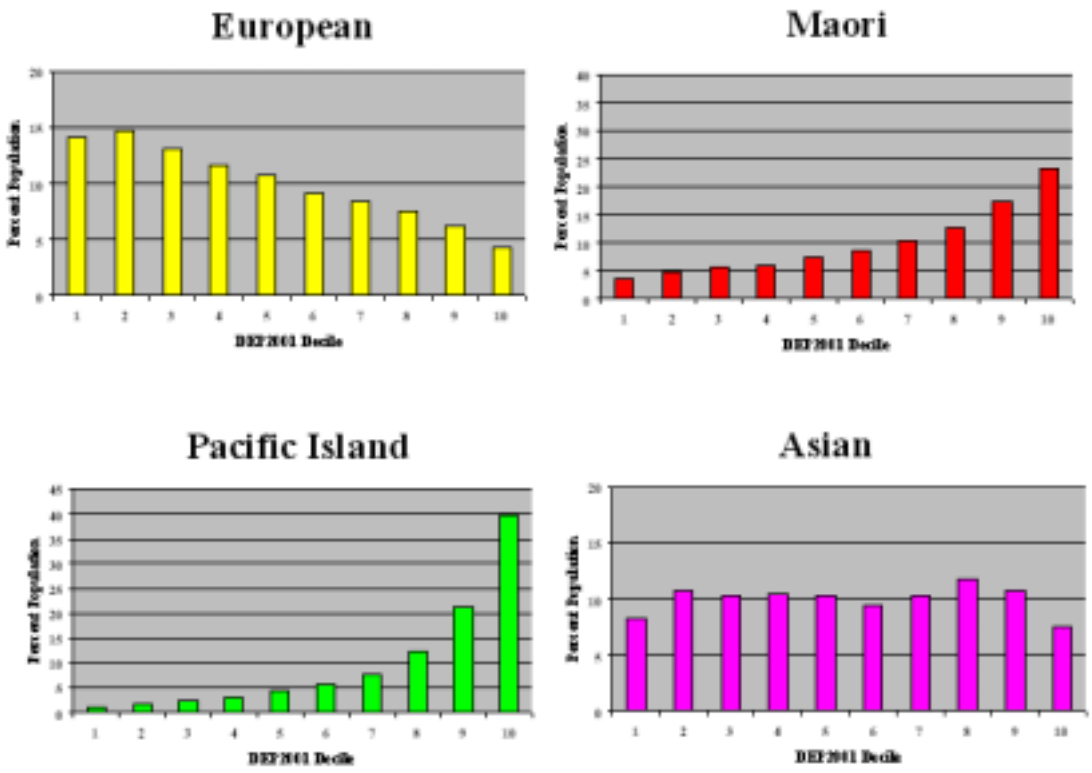
Chart 9: Percentage of population by DEP96 and DEP2001, Auckland region (Census 1996 and 2001)



When broken down by ethnic group, about 73 percent of Pacific peoples and about 51 percent of Māori in this region lived in deciles 8-10 compared with 18 percent for European and 30 percent for Asian populations in the year 2001. As the result of changing the wording of the ethnicity question in the 1996 census, the comparison of DEP96 and DEP2001 by ethnicity was not possible.

Chart 10 shows that for the Asian population deprivation is relatively evenly spread across deciles 1 to 10, whereas Māori and Pacific peoples have a skew towards the most deprived scales of 9 and 10. Europeans have a skew toward the lower deprivation scales of 1-4.

Chart 10: Percentage of population by DEP2001 by ethnicity, Auckland region (Census 2001)



When broken down by DHB, Asian people in Waitemata DHB had the lowest percentage (20%) of the population who lived in more deprived areas (decile 8-10) compared with 34 percent for Asian people in Auckland DHB and 33 percent for Asian people in Counties Manukau DHB in 2001.

Chart 11: Percentage of Asian population by DEP96, Waitemata DHB (Census 2001)

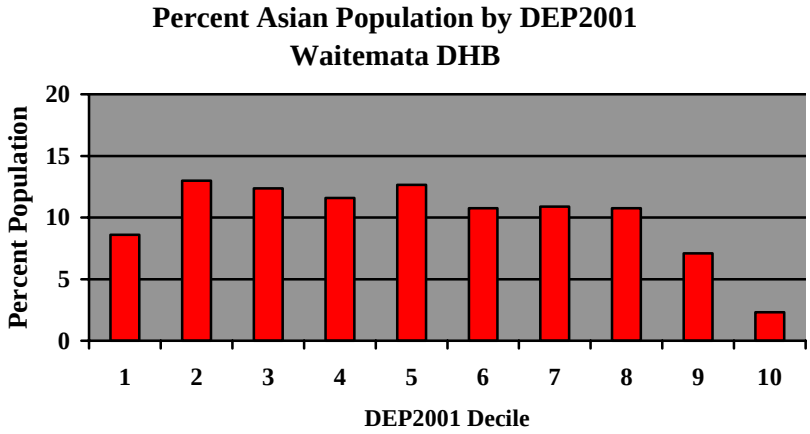


Chart 12: Percentage of Asian population by DEP96, Counties Manukau DHB (Census 2001)

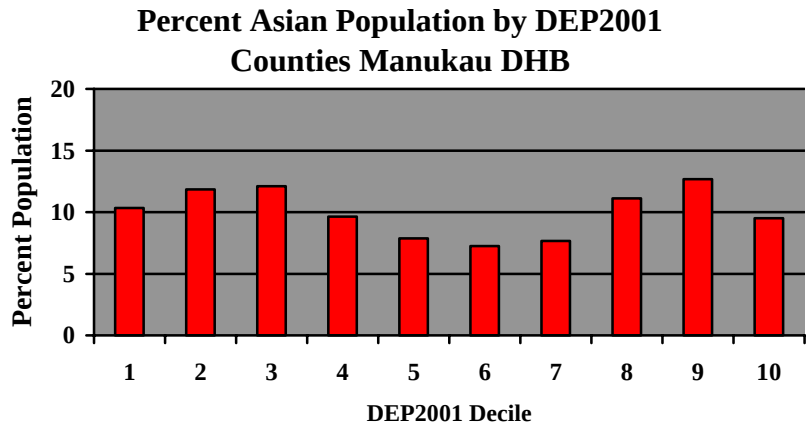
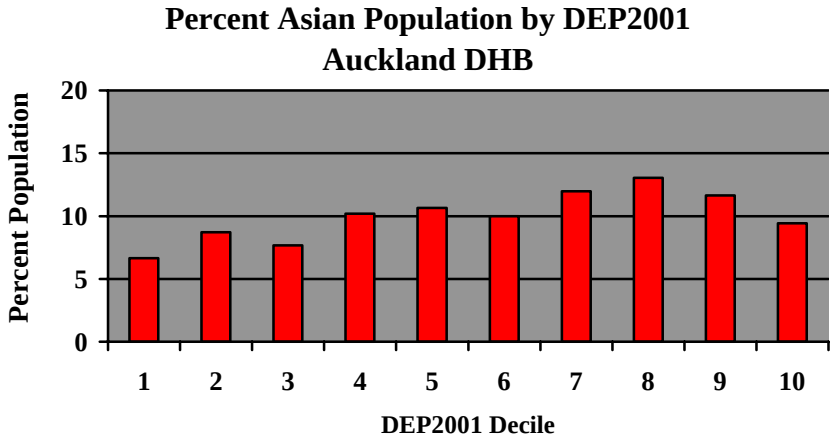


Chart 13: Percentage of Asian population by DEP96, Auckland DHB (Census 2001)



Summary of socioeconomic data pertaining to the Asian population

In 2001, 7.4 percent of the Asian population were unemployed in the Auckland region (slightly higher than the rate for Asian people nation-wide) compared to just over 5 percent for all people aged 15 years and over, 11 percent for Māori and 10 percent for Pacific peoples.

About 28 percent of people aged 15 years and over in the Auckland region received income support. Asian people had the lowest percentage (21.7%) of people on income support while Māori had the highest percentage (39%).

Asian unemployment and income support rates are lower than Māori and Pacific peoples. Just 17 percent of Asian people aged 15 years and over in the Auckland region had an income of $30,000 or more compared with 31.2 percent for the whole population, 24.8 percent for Māori and 14.9 percent for Pacific peoples.

Asian people aged over 15 years in the Auckland region have the lowest percentage use of the Domestic Purposes Benefit among all ethnic groups. Māori followed by Pacific peoples had the highest percentages of people on this benefit.

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%). Pacific peoples had the lowest percentage (about 13%) of those with tertiary education in this region. The Asian ethnic group had the lowest percentage (12%) of people with no qualification compared with any other ethnic groups.

Sixty-three percent of households in Auckland region either owned their own home or occupied it rent-free compared with 68 percent nationwide with Europeans having the highest percentage (74%), 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%).

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.

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.

3. Health status of Asian people in the Auckland region

This section summarises New Zealand Health Service (NZHS) data that pertain to the Asian population in the Auckland region (ie, the Waitemata District Health Board, Auckland District Health Board and Counties Manukau District Health Board data combined).

All data are latest available at the time the report was prepared.

In the Auckland region, Asian people make up a similar proportion of the population to Maori and Pacific peoples but have a lower proportion of hospital discharges and significantly lower proportion of deaths. This is partially explained by a generally younger demographic created through population increases by immigration. These figures are further expanded in this section.

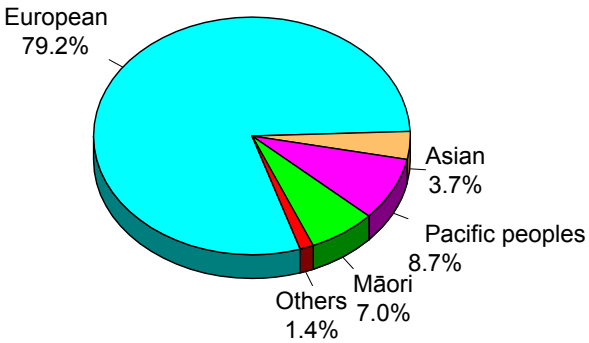
Table 6: Summary of deaths, hospitalisations and population figures by ethnic group within the Auckland region

	Deaths (2000/01)		Hospitalisations (2000/01)		Population (2001)	
	No.	**%**	**No.**	**%**	**No.**	**%**
European	17,569	83%	128,708	62%	686,334	62%
Māori	1,534	7%	26,795	13%	130,227	12%
Pacific peoples	1,603	8%	33,970	16%	139,308	13%
Asian	540	3%	16,659	8%	146,103	13%
Total (exc Others)	21,246	100%	206,132	100%	1,101,972	100%

Deaths by ethnicity and age group in the Auckland region

In total there were 6,789 deaths in the Auckland region between April 2000 and March 2001. About 4 percent of the deaths were among Asian people.

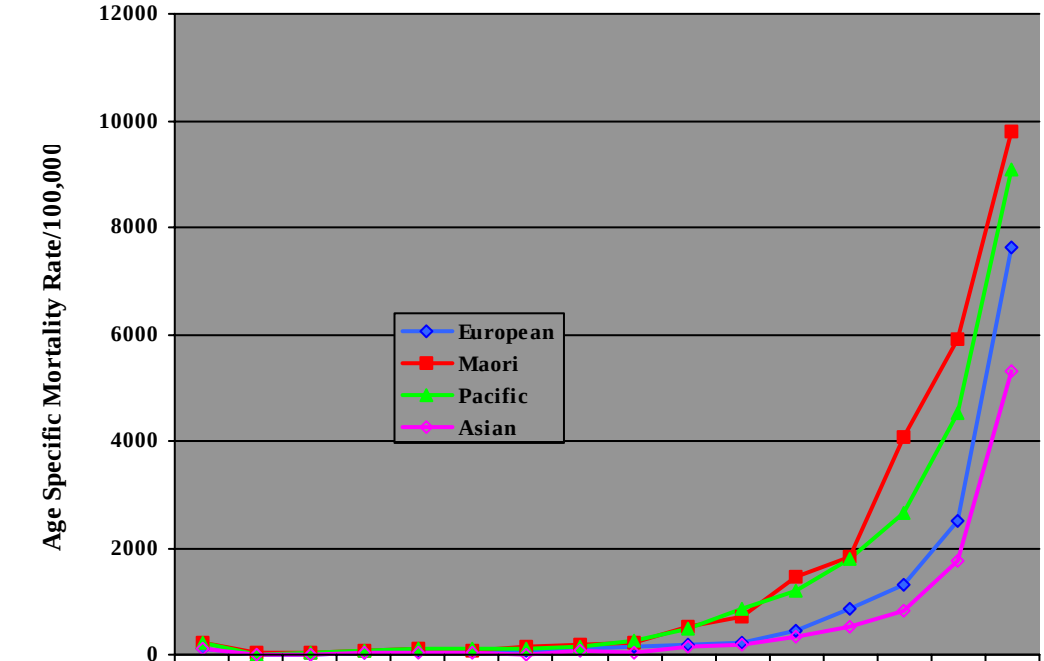
Chart 14: Number of deaths by ethnicity, Auckland region, April 2000 to March 2001



Total deaths=6,789

Chart 15 shows the Age Specific Mortality Rate (ASMR) for all ethnic groups in the Auckland region. Europeans had the lowest ASMR among young people while Asians had the lowest ASMR among older people. Māori had the highest ASMR among all ethnic groups in the Auckland region.

Chart 15: Age Specific Mortality Rate by ethnicity, Auckland region, April 2000 to March 2001



	0-4	5-9	10-15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
European	101	7.1	18.4	22.9	62.3	57.3	70.1	94.8	139	203	238	460	854	1318	2509	7622
Maori	217	24.8	20.5	75.1	121	71.9	161	184	238	512	715	1445	1850	4067	5903	9783
Pacific	224	6	53	73.6	118	97.1	111	162	265	483	876	1200	1788	2648	4515	9074
Asian	106	9.3	8.5	24.8	49.6	37.1	15.9	68.1	38.9	148	203	354	510	825	1774	5319

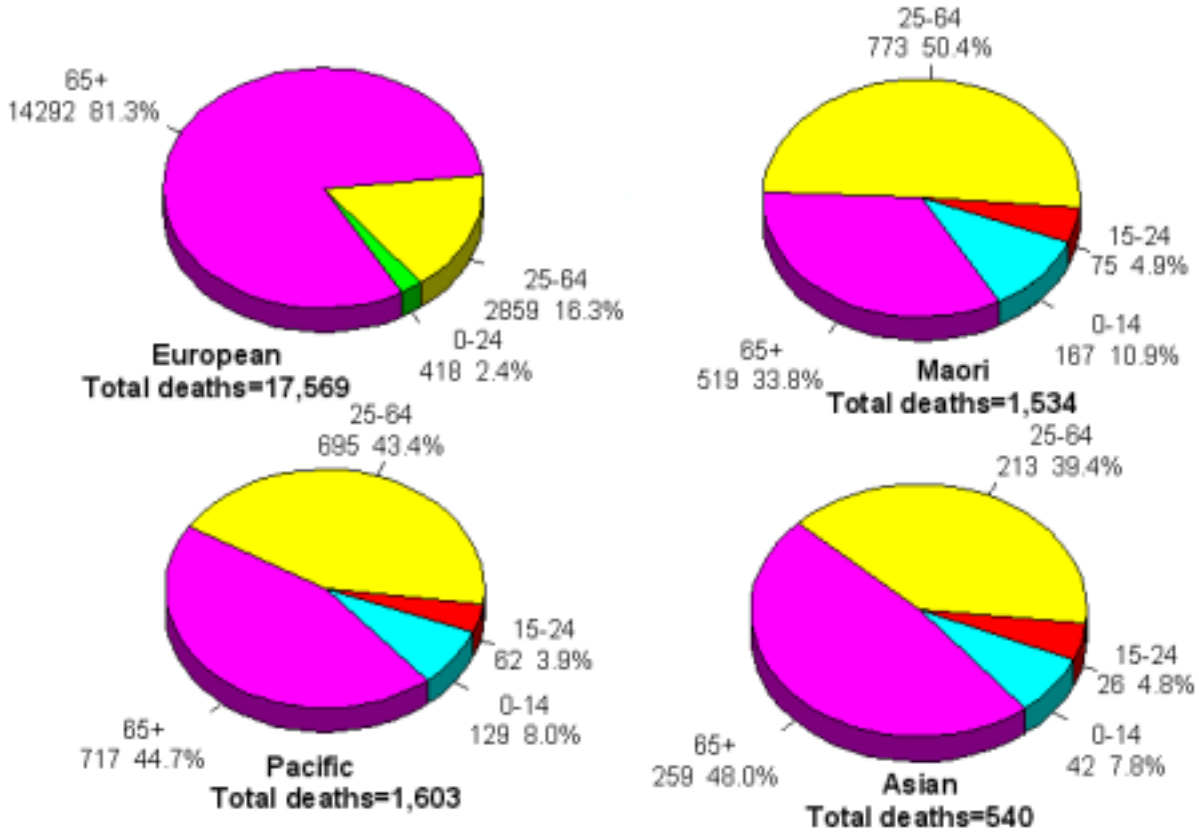
Age Group

Overall deaths by age group and by ethnicity in the Auckland region

Chart 16 shows the numbers of deaths by age group for four ethnic groups in the Auckland region between April 2000 and March 2001. The vast majority (81%) of the European population die aged 65 years or older, while 48 percent of the Asian population, 45 percent of Pacific peoples and 34 percent of Māori die aged 65 years or older.

More young (0 to 14 years and 15 to 24 years) Maori (10.9% and 4.9% respectively), Pacific peoples (8% and 3.9% respectively) and Asian (7.8% and 4.8% respectively) people die than the European population (just 2.4%).

Chart 16: Deaths by ethnic group in the Auckland region, April 2000 to March 2001



Deaths by major causes by ethnicity in the Auckland region

Between 1996 and 1998, the three leading causes of death for Asian people in the Auckland region were cancer (156, 29%), ischaemic heart disease (96, 18%) and stroke (42, 8%). These three leading causes of death were the same as Europeans, Māori and Pacific peoples.

The three leading types of cancer death for Asian people in the Auckland region were lung cancer (23, 15%[8]), large bowel cancer (19, 12%), and leukaemias (16, 10%) and are the same as for the European population. Other leading types of cancer deaths for Asian people in the Auckland region included stomach (13, 8%), liver (13, 8%), breast (10, 6%) and brain (8, 5%). Asian people appear to have slightly higher proportions of stomach and liver cancers than the European population and other ethnic groups.

Other leading causes of death for the Asian population in the Auckland region include motor vehicle crashes (34, 6%), diabetes (27, 5%), circulatory system diseases (24, 4%) and injury and poisonings (21, 4%). Diabetes and motor vehicle crashes are also key leading causes of death for Māori and Pacific peoples, but not for European people.

Full tables of deaths by major causes (including a breakdown of different cancer types) and ethnicity in the Auckland region and by the three District Health Boards are included in Appendix 5.

[8] Note percentages for the cancer figures are the percentage of cancer deaths, not overall deaths.

Major causes of death by age group for Asian people in the Auckland region

The leading cause of death for Asian people in the Auckland region varies according to the different age groups.

0-14-year-olds

In total, 42 Asian 0-14-year-olds died between 1996 and 1998 in the Auckland region. The leading cause of death was birth defects with 15 (36%) deaths. This was followed by 8 (19%) from perinatal conditions, 5 (12%) from cancer, 4 (10%) from motor vehicle crashes, 4 (10%) from Sudden Infant Death Syndrome (SIDS) and 2 (5%) from nervous system conditions.

15-24-year- olds

In total, 26 Asian 15-24-year-olds died between 1996 and 1998 in the Auckland region. The leading cause of death was motor vehicle crashes with 13 (50%) deaths. This was followed by 5 (19%) from suicide, 3 (12%) from other injuries and 1 (4%) from cancer. Motor vehicle crashes, suicide and other injuries were also the three leading causes of death for 15-24-year-olds from European, Māori and Pacific populations.

25-64-year-olds

In total, 213 Asian 25-64-year-olds died between 1996 and 1998 in the Auckland region. The leading cause of death was cancer with 78 (37%) deaths. This was followed by 39 (18%) from ischaemic heart disease, 16 (8%) from motor vehicle crashes, 15 (7%) from injury and poisoning, 9 (4%) from stroke, 9 (4%) from suicide, 7 (3%) from digestive system conditions, and 7 (3%) from diabetes. Cancer and ischaemic heart disease were also the two leading causes of death for 25-64-year-olds from European, Māori and Pacific populations. Motor vehicle crashes and injuries and poisonings accounted for a higher proportion of Asian people compared to the other ethnic categories, while circulatory system conditions accounted for a lower proportion.

Between 1996 and 1998, 22 people died from drowning, 6 of these (27%) were Asian.

65+-year-olds

In total, 259 Asian 65+-year-olds died between 1996 and 1998 in the Auckland region. The leading cause of death was cancer with 72 (28%) deaths. This was followed by 57 (22%) from ischaemic heart disease, 32 (12%) from stroke, 20 (8%) from diabetes and 18 (7%) from circulatory system conditions. Cancer, ischaemic heart disease and stroke were also the three leading causes of death for 65+-year-olds from European, Māori and Pacific populations.

More detailed breakdowns are included as Appendix 6.

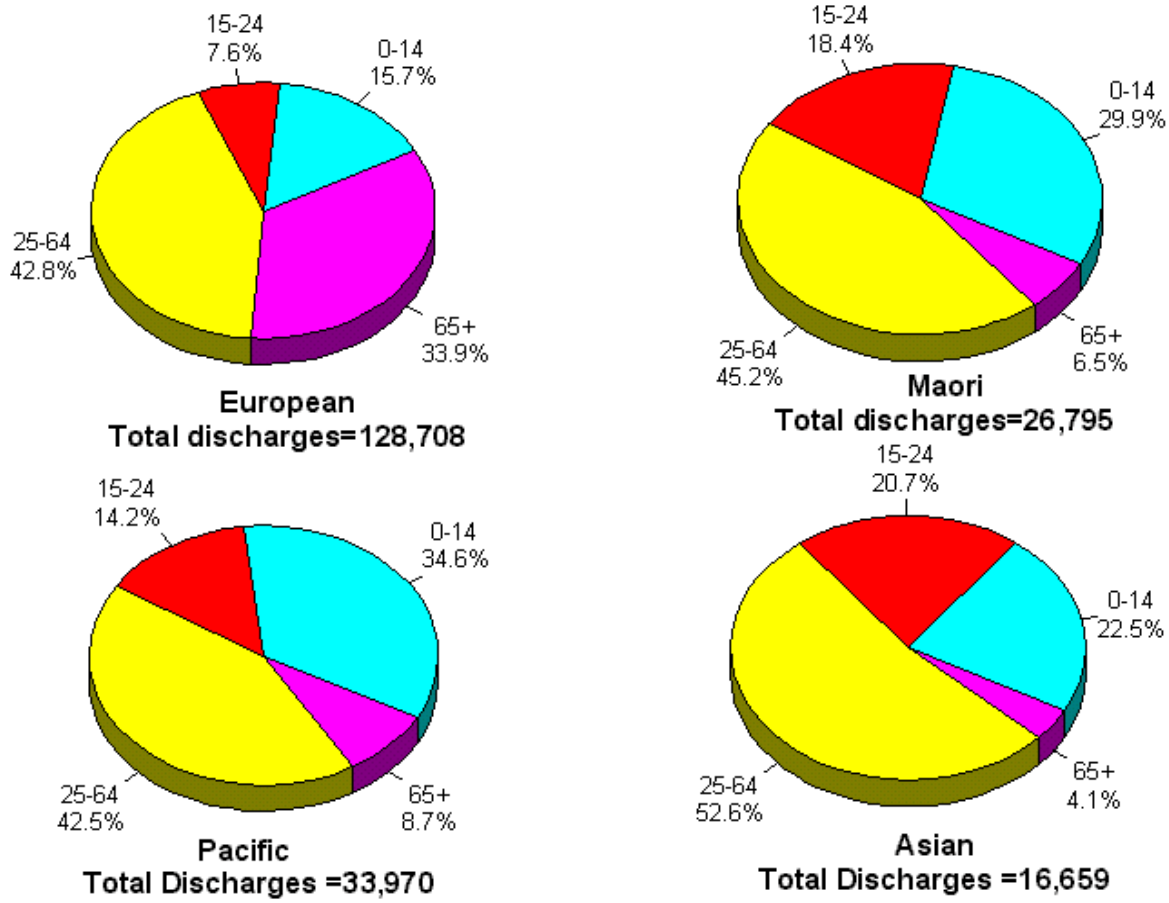
Hospital utilisation of Asian people in the Auckland region

The following data include people who were normally resident in the Auckland region and were admitted and subsequently discharged from hospital (ie, stayed at least one day) between July 2000 and June 2001.

Number of hospital discharges by age group and by ethnicity in the Auckland region

Chart 17 shows the number of discharges by age group for four ethnic groups in the Auckland region between July 2000 and June 2001. In total, there were 206,132 hospital discharges in the Auckland region for 2000/01, including 16,659 (8%) Asian people. The Asian population had the smallest percentage of 65+-year-olds discharged from hospital. The majority of Asian people discharged from hospital were in the 25 to 64 year age group (53%) followed by the 15 to 24 year age group (21%).

Chart 17: Number of hospital discharges by ethnic group in the Auckland region between July 2000 and June 2001



The top ten discharge categories vary by age group and ethnicity. Tables of the top ten discharge categories by ethnicity are included in Appendix 7.

Top ten hospital discharge categories for 0-14-year-olds by ethnicity in the Auckland region

The top ten hospital discharges for Asian 0-14-year-olds in the Auckland region in 2000/01 were:

- dental extractions and restorations (207, 5.0%)
- gastroenteritis/other digestive system diagnoses (181, 4.4%)
- viral illness and fever (168, 4.1%)
- ear, nose and throat (ENT) (147, 3.6%)
- otitis media and upper respiratory tract infection, laryngotracheitis, nasal trauma and deformity (127, 3.1%)
- fracture, sprain or strain (126, 3.1%)
- bronchitis and asthma (123, 3.0%)
- respiratory infections or inflammations (68, 1.7%)
- red blood cell disorders (63, 1.5%)
- injury, trauma to the skin, subcutaneous tissue and breast (60, 1.5%).

Top ten hospital discharge categories for 15-24-year-olds by ethnicity in the Auckland region

The top ten hospital discharges for Asian 15-24-year-olds in the Auckland region in 2000/01 were:

- delivery (305, 18.2%)
- preterm labour and antenatal admission (117, 7.0%)
- abortion (79 4.7%)
- poisoning or toxic effect of drugs (70, 4.2%)
- abdominal pain or mesenteric adenitis (69, 4.1%)
- injury, trauma to the skin, subcutaneous tissue and breast (65, 3.9%)
- inflammatory bowel disease (55, 3.3%)
- menstrual and other female reproductive system disorders (43, 2.6%)
- fracture, sprain or strain (39, 2.3%)
- mental disorder, drugs and alcohol (34, 2.0%).

Delivery and preterm labour were also the two leading categories of hospital discharge for other ethnic groups in this age group. Abortion discharge figures for Asian 15-24-year-olds reflect other statistics showing a high rate for the Asian population.

Top ten hospital discharge categories for 25-64-year-olds by ethnicity in the Auckland region

The top ten hospital discharges for Asian 25-64-year-olds in the Auckland region in 2000/01 were:

- delivery (2111, 23.0%)
- preterm labour and antenatal admission (505, 5.5%)
- chest pain/angina (396, 4.3%)
- abortion (347, 3.8%)
- gastroscopy for digestive disease (312, 3.4%)
- postpartum and post-abortion diagnoses (230, 2.5%)
- abdominal pain or mesenteric adenitis (196, 2.1%)
- respiratory signs and symptoms (195, 2.1%)
- respiratory infections or inflammations (179, 1.9%)
- inflammatory bowel disease (171, 1.9%).

Asian people aged 25 to 64 years were discharged from hospital for similar reasons to other ethnic groups, especially birth and chest pain/angina. Most commonly, they were discharged for gastroscopy for digestive disease than others.

Top ten hospital discharge categories for 65+-year-olds by ethnicity in the Auckland region

The top ten hospital discharges for Asian 65+-year-olds in the Auckland region in 2000/01 were:

- chest pain/angina (132, 7.9%)
- lens procedures (91, 5.4%)
- gastroscopy (73, 4.4%)
- cerebrovascular disorders (69, 4.1%)
- circulatory disorder (58, 3.5%)
- malignancy/neoplasms (56, 3.3%)
- respiratory infections or inflammations (55, 3.3%)
- chronic obstructive airways disease/interstitial lung disease (49, 2.9%)
- rehabilitation/aftercare musculoskeletal system and connective tissue (49, 2.9%)
- heart failure and shock (39, 2.3%).

Potentially Avoidable Mortality (PAM), 1996-1998

Potentially Avoidable Mortality is one of the analyses for measuring health improvement. It analyses the causal structure of health outcomes at the level of diseases and injuries by classifying these codes into avoidable and unavoidable categories. The concept of avoidability means responsiveness to health sector interventions (through prevention, early diagnosis or treatment). Based on this definition, all deaths after the age of 75 are considered unavoidable.

The table below shows the numbers and percentage of PAM between January 1996 and December 1998 for the Asian population compared with the total population in the Auckland region. As with the total population, of all the deaths among Asian people during this period, 69% of them could theoretically have been avoided.

Table 7: Number and percentage of Potential Avoidable Mortality by Asian ethnicity and the total population in the Auckland region between 1996 and 1998

	Asian population	%	Total population	%
Non-PAM	121	30.8	2,974	30.6
PAM	272	69.2	6,736	69.4
Total deaths	393	100.0	9,710	100.0

Table 8: Number and percentage of leading Potential Avoidable Mortality for Asian people in the Auckland region between 1996 and 1998

PAM	Asian	%
15 Ischaemic heart disease	68	25.0
20 Motor vehicle crashes	34	12.5
16 Stroke	19	7.0
10 Lung cancer	18	6.6
32 Diabetes	16	5.9
27 Suicide	16	5.9
05 Hepatitis and liver cancer	15	5.5
08 Colorectal cancer	14	5.1
42 Stomach cancer	11	4.0
11 Breast cancer	10	3.7
54 Congenital anomalies	7	2.6
26 Drowning	6	2.2
38 Asthma	5	1.8
55 Birth trauma and asphyxia	4	1.5
19 Sudden Infant Death Syndrome (SIDS)	4	1.5
02 Tuberculosis	2	0.7
48 Leukaemia	2	0.7
13 Alcohol-related conditions	2	0.7
28 Other infections	2	0.7
33 Epilepsy	2	0.7

Potentially Avoidable Hospitalisations (PAH)

The concept of avoidability can be extended from fetal to non-fetal outcomes. A Potentially Avoidable Hospitalisation (PAH) indicates the occurrence of an injury or severe illness that could, theoretically, have been avoided.

The table below shows the number and percent PAH between July 2000 and June 2001 for the Auckland region. Of all the discharges during this period, 24 percent of PAH for Asian people could theoretically have been prevented compared with 26 percent for the total population in the Auckland region.

Table 9: Number and percentage of Potentially Avoidable Hospitalisations by Asian ethnicity and the total population in the Auckland region between 2000/01

	Asian	%	Total Population	%
Non-PAH	12,153	76.0	141,580	73.5
PAH	3,839	24.0	50,924	26.5
Total discharges	15,992	100.0	152,904	100.0

Table 10: Number and percentage of leading Potentially Avoidable Hospitalisations for non-Asian and Asian people in the Auckland region between 2000/01

PAH	Non-Asian	%	PAH	Asian	%
Angina	6,938	14.7	Angina	680	17.7
Respiratory infections	4,302	9.1	Gastroenteritis	399	10.4
Cellulitis	3,616	7.7	Respiratory infections	303	7.9
Gastroenteritis	3,484	7.4	Road traffic injury	262	6.8
Road traffic injury	3,283	7.0	Dental conditions	220	5.7
Asthma	2,801	5.9	Asthma	198	5.2
Ear, nose and throat infections	2,785	5.9	Cellulitis	175	4.6
Dental conditions	1,842	3.9	Tuberculosis	141	3.7
Chronic obstructive respiratory disease (CORD)	1,671	3.5	Sexually transmitted diseases	124	3.2
Suicide	1,572	3.3	Suicide	120	3.1
Epilepsy	1,527	3.2	Ear, nose and throat infections	117	3.0
Ischaemic heart disease	1,255	2.7	Kidney urinary infection	107	2.8
Skin cancer	1,199	2.5	Epilepsy	105	2.7
Kidney urinary infection	1,118	2.4	Ischaemic heart disease	104	2.7
Sexually transmitted diseases	1,067	2.3	Stroke	86	2.2
Stroke	841	1.8	Peptic ulcer	60	1.6
Diabetes	750	1.6	Hepatitis and liver cancer	58	1.5
Recreation injury	707	1.5	Diabetes	57	1.5
Congestive heart failure	688	1.5	Chronic obstructive respiratory disease (CORD)	56	1.5
Poisoning	642	1.4	Recreation injury	54	1.4

Summary of death and hospitalisation data

In total, 540 Asian people died in the Auckland region between 1996 and 1998. As with other ethnic groups, the three leading causes of death for Asian people were cancer (156, 29%), ischaemic heart disease (96, 18%) and stroke (42, 8%). In total, 16,659 Asian people were discharged from hospital in 2000/01 in the Auckland region.

There were variations in the leading cause of death and hospitalisation for different age groups of Asian people. Of the 42 children aged 0 to 14 years who died, the leading cause of death was birth defects with 15 (36%) deaths, followed by 8 (19%) from perinatal conditions, 5 (12%) from cancer, 4 (10%) from motor vehicle crashes, 4 (10%) from Sudden Infant Death Syndrome and 2 (5%) from nervous system conditions. Leading hospitalisations for this age group included, dental extractions and restorations (207, 5%), gastroenteritis/other digestive system diagnoses (181, 4.4%), viral illness and fever (168, 4.1%), ear, nose and throat (147, 3.6%), otitis media and upper respiratory tract infections, laryngotracheitis, nasal trauma and deformity (127, 3.1%), fracture, sprain or strain (126, 3.1%) and bronchitis and asthma (123, 3%).

Of the 26 young adults aged 15 to 24 years who died, the leading cause of death was motor vehicle crashes with 13 (50%) deaths, followed by 5 (19%) from suicide, 3 (12%) from other injuries and 1 (4%) from cancer. Leading hospitalisations for this age group included delivery (305, 18.2%), preterm labour and antenatal admission (117, 7%), abortion (79 4.7%), poisoning or toxic effect of drugs (70, 4.2%), abdominal pain or mesenteric adenitis (69, 4.1%), injury, trauma to the skin, subcutaneous tissue and breast (65, 3.9%) and inflammatory bowel disease (55, 3.3%).

Of the 213 adults aged 25 to 64 years who died, the leading cause of death was cancer with 78 (37%) deaths, followed by 39 (18%) from ischaemic heart disease, 16 (8%) from motor vehicle crashes, 15 (7%) from injury and poisoning, 9 (4%) from stroke, 9 (4%) from suicide, 7 (3%) from digestive system conditions and 7 (3%) from diabetes. Leading hospitalisations for this age group included delivery (2111, 23%), preterm labour and antenatal admission (505, 5.5%), chest pain/angina (396, 4.3%), abortion (347, 3.8%), gastroscopy for digestive disease (312, 3.4%) and postpartum and post-abortion diagnoses (230, 2.5%).

Of the 259 older adults aged 65+ years who died, the leading cause of death was cancer with 72 (28%) deaths, followed by 57 (22%) from ischaemic heart disease, 32 (12%) from stroke, 20 (8%) from diabetes and 18 (7%) from circulatory system conditions. Leading hospitalisations for this age group included chest pain/angina (132, 7.9%), lens procedures (91, 5.4%), gastroscopy (73, 4.4%), cerebrovascular disorders (69, 4.1%), circulatory disorder (58, 3.5%), malignancy/neoplasms (56, 3.3%) and respiratory infections or inflammations (55, 3.3%).

Overall, the six top potentially avoidable deaths for Asian people in the Auckland region are ischaemic heart disease (68, 25%), motor vehicle crashes (34, 12.5%), stroke (19, 7%), lung cancer (18, 6.6%), diabetes (16, 5.9%) and suicide (16, 5.9%), while the six leading causes of preventable hospitalisations are angina (680, 17.7%), gastroenteritis (399, 10.4%), respiratory infections (303, 7.9%), road traffic injury (262, 6.8%), dental conditions (220, 5.7%) and asthma (198, 5.2%).

4. Assessment of health need

This section summarises available data and reports that directly pertain to Asian health within New Zealand, including DHB needs assessment reports, an Auckland City Council report, and other reports provided by the Project Team. It also includes a summary of issues from overseas literature.

There have been a number of studies pertaining to Asian health carried out in New Zealand, particularly within the Auckland region, but focusing on health care (eg, Holt et al 2001; Ngai et al 2001) as opposed to public health need. Other studies have 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). Some information gleaned from these studies pertain to public health.

It appears from these reports that 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.

A search of international literature for public health approaches to Asian populations within non-Asian countries was carried out by the Auckland Regional Public Health Service (ADHB). Information was gathered through Medline and websites accessed in June 2002.

Asian populations have immigrated to various countries. Information was found on Asian immigration to the United States, Australia, UK and Canada, in which Asian populations make up between 3-6 percent of the total population.

A diverse population with diverse needs

The Asian population is extremely diverse and is made up of many different ethnic backgrounds with an increasing proportion of new immigrants, and a small but steady flow of refugees (quotas of around 700 per annum over the last two decades or more). Asian population growth within New Zealand is predominantly fuelled by further immigration. The diverse and changing Asian populations within New Zealand means that it is difficult to generalise the needs of the Asian population as a whole. Where possible, specific research or data for more specific ethnic groups is presented.

New immigrants are likely to have different health needs to Asian people who have been born in New Zealand or who have lived here for some time. A key difference is that new Asian immigrants often have a lack of English language competency. Lack of English creates a two-way barrier within health and other settings (refer to Holt et al 2001 for a summary of findings from various reports).

Lack of English language competency has been identified by a number of authors (Holt et al 2001; Kudos Organisational Dynamics 2000; Walker 2001; Wang 2000) as the key barrier to accessing health and other services for new Asian immigrants, and is likely to be a key factor in poor adjustment to New Zealand (Abbott et al 1999). A number of deficiencies in immigration practices and health and social services have been criticised for failing to reduce this barrier. For example:

- Immigration policies and practices, eg, a relatively open policy coupled with a lack of appropriate resettlement programmes (Kudos Organisational Dynamics Ltd 2000; Wang 2000).
- Unavailability (eg, high cost) of language courses (Holt et al 2001).
- Lack of interpreters and information in Asian languages relating to health and other services (Kudos Organisational Dynamics Ltd 2000; Wang 2000; Ngai et al 2001).

At a macro level, health status amongst Asian people is generally similar to New Zealanders of European descent and therefore superior to Māori and Pacific peoples. One reason for this, as noted by the Auckland and Waitemata District Health Boards' health assessment reports, is that most Asian people are recent immigrants who have to have a good health status to be accepted for immigration. As noted, there is some diversity in health status between different Asian ethnic groups, and as population growth has arisen through recent immigration of mainly younger adults, there is yet to be a significant proportion of aging Asian people.

This diversity across religion, language proficiency and education is well summed up in a recent report on Asian mental health (Ho et al 2002):

> *"Asians in New Zealand are very diverse in religion, culture, language, education and socio-economic experiences. In 2001, half of the Chinese people said they had no religion, one-quarter were Christians and nearly 1 in 7 were Buddhists. Within the Indian population, Hinduism is the most common religion whereas amongst Koreans, a majority said their religion was Christianity. In the case of Cambodians and Vietnamese, Buddhism is the most common religion.*
>
> *Lack of English language proficiency is a fundamental problem facing recent Asian immigrants. Within the Cambodian and Vietnamese groups, one in three men who had been resident in New Zealand for under 10 years could not speak English or Maori, while the proportions amongst women were even higher (47% and 38% respectively). In the case of Chinese and Korean recent immigrants, between 22% and 28% could not speak English or Maori. Across ethnic groups, Indians had the lowest proportion of recent immigrants with no English or Maori (8% for males and 14% for females).*
>
> *There is considerable variation in education within the Asian population. Across ethnic groups, Indian recent immigrants were the most well-qualified, with 30% of men and 26% of women reporting that they had a university degree and/or higher qualifications in 2001. The incidence of university qualifications amongst Chinese and Korean recent immigrants ranged between 13% and 23%. In the case of Cambodian and Vietnamese recent immigrants, only very small proportions (between 0% and 5%) had a university qualification (p.5)."*

Asian refugees have greatest health needs

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. This programme was assessed in 1997 (Reeve 1997).

Auckland Healthcare figures indicate that a total of 769 quota refugees came into New Zealand for the year ending March 2002. Of these, only 131 (17%) came from Asia - all from Myanmar (Burma). As refugees from different countries have different problems (Soloman 1997), it is hard to generalise as to whether Asian refugees have more or less health problems than those from the Middle East and from Africa. Also, refugee sources vary from year to year, depending on where wars and conflicts occur. When refugees leave the Mangere Refugee Resettlement Centre, they blend into the general community and no separate data are collected on their health status. Therefore, it is difficult to assess the true impact of any refugee data in relation to Asian public health needs. This is not to say that refugees do not have significant public health needs and that health authorities need to continue with developing appropriate services for this diverse and changing population group.

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

Cancer

Cancer is a leading cause of death for Asian people in New Zealand.

Reported in the US[9], breast cancer is the most common cancer among Chinese, Filipinos, Japanese and Korean women while cervical cancer is the most common cancer among Vietnamese women, with the latter more than two and half times the rate of any other ethnic group. South-east Asian women tend to present themselves with late and severe cancer and are less likely to follow up with treatment.

In the US, lung cancer is the most common cancer in Chinese, Korean and Vietnamese men while prostate cancer is the most common cancer in Filipino and Japanese men.

Also reported in the US, it has been found that overseas-born Asians do not utilise cervical or breast screening as frequently as mainstream populations. (Strong et al 1998; Taylor et al 2002). Unfamiliarity with western culture and the biomedical concepts of prevention, the perception that gynaecological examinations are embarrassing and the lack of English proficiency are thought to have contributed to low levels of screening (Carey Jackson et al 2000).

[9] http://www.apiahf.org/programs/cancerfacts.html

Overseas, the following have been used to improve screening levels:

- Culturally- and linguistically-appropriate interventions (Taylor et al 2002)
- Co-ordinated public health education and post-screening support in Asian languages (Yu et al 2001), home visits and presentations at small groups by bicultural workers, barrier-specific counselling, language videos and tailored logistic assistance in terms of transport and interpretation (Carey Jackson et al 2000)
- Sharing screening knowledge to ethnic groups to be passed on to their people (Sadler et al 2001).

Also, a respect for different beliefs, values and perceptions is important in cancer prevention (Ishida 2001).

Smoking

Overall tobacco use by Asian people in New Zealand is comparable to the whole population (around 25%), but many more Asian men smoke compared to Asian women.

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 Māori, and 21.8 percent of girls and 25.3 percent of boys for Pacific peoples.

In the US, Asian Americans (and Pacific peoples) also have the lowest smoking prevalence; 13.7 percent compared to a general prevalence of 24.1 percent in the 1998 estimates (CDC 2000). However, the smoking prevalence of some ethnic subgroups is very high, 35.8 percent in Korean men, 72.8 percent of Vietnamese men and 28.1 percent of Chinese men in Oakland[10]. It is possible that this is similar in New Zealand.

An overseas study (Chen et al 1999; Rissel et al 1999) found that acculturation (adopting less traditional behaviours, loss of native language, etc) seems to have a negative effect on Asian youth smoking (ie, more smoking) even though the rate of smoking is lower and the age of onset of smoking is later when compared to the mainstream population. Internationally there is concern for increasing rates of smoking amongst Asian communities (http://www.hsph.harvard.edu/organizations/bdu/summary.html).

Targeting of a specific Asian group with an anti-smoking programme has been found to be successful[11]. The smoking rate of Vietnamese men fell by 6 percent in a three-year campaign in San Francisco and Oakland between 1993 and 1997. The campaign included:

- Vietnamese language media and billboards using culturally-appropriate messages
- specific health education material distribution (brochures and videos)
- activities targeting physicians, youth and businesses.

In the United Kingdom, 44 percent of Bangladeshi men compared to 27 percent of the general population smoke. In addition, 19 percent of Bangladeshi men and 26 percent of women chew tobacco; the rate increases to 56 percent in women over 55 years. Also South Asian men and women are 38 percent and 43 percent more likely to die from heart disease than the general population. Only a third of Asian men succeed in giving up smoking when compared to 54 percent of men in the general population. In the United Kingdom, a specialist tobacco helpline in a variety of languages and adverts in the South Asian press and specialist radio stations were launched to coincide with Ramadan 2001[12].

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10 http://www.cdc.gov/tobacco/sgr/sgr_1998/sgr-min-fs-asi.htm; http://www.pslgroup.com/dg/33506.htm

11 http://www.pslgroup.com/dg/33506.htm

12 http://news.bbc.co.uk/hi/english/health/

Coronary heart disease

A study in England and Wales (McKeigue et al 1988) showed that immigrants from the Indian subcontinent have a higher morbidity and mortality from coronary heart disease than the general population.

Hypertension and diabetes were found to be two to three times higher among South Asians compared to whites in Britain (Cappuccio et al 1997). This is probably due to insulin resistance syndrome associated with a pronounced tendency to central obesity (McKeigue et al 1991).

Similarly, in the US, immigrant Asian Indian men are shown to have high prevalence of coronary heart disease, non-insulin dependent diabetes mellitus, low HDL cholesterol and hypertriglyceridaemia (Enas et al 1996). Diseases of the heart and stroke are also the leading causes of death amongst Asians in the US[13].

There is an apparent increase in cardiovascular deaths among Asian migrants who have lived in Australia for more than 10 years (Hsu Hage and Wahlqvist 1993).

Diabetes

Overseas studies show that most diabetes reported within Asian populations is type 2 diabetes. In many cases, it is related to obesity and hyperlipidaemia. Compliance with 'Western' dietary advice is poor, probably due to language and cultural barriers (McAvoy and Donaldson 1990).

In the US[14], Hawaiian Japanese have a higher rate of obesity and double the prevalence of diabetes compared to Japanese in Japan. For many Asian Americans, the diet in America is higher in calories and fat and lower in fibre than their countries of origin. Prevention is achievable through diet and exercise promotion.

The incidence of gestational diabetes is significantly higher among women born in the Indian subcontinent and other Asian countries as compared with women from Northern Europe or the Americas (Beischer et al 1991).

Kieffer, Martin and Herman (1999) argue that more effective identification, treatment and follow-up of immigrant mothers with diabetes during pregnancy may require:

- special attention to language and sociocultural barriers to effective care
- systematic surveillance of the prevalence and impact of diabetes during pregnancy for immigrant and non-immigrant women, particularly in racial and ethnic minority groups
- detailed studies on the impact of acculturation on diabetes to increase understanding of the epidemiology of gestational diabetes.

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13 http://www.americanheart.org/downloadable/heart/1014746484488FSO3ASO2WEB.pdf.

14 http://www.niddk.nih.gov/health/diabetes/pubs/asianam/asianam.htm

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.

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 Māori (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 Europeans (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).

Osteoporosis

It is reported in the US that Asian American women are at particular high risk of osteoporosis due to relatively lower bone mass and density, smaller frames and lower intake of calcium when compared to other population groups[15].

[15] http://www.4woman.gov/faq/Asian_pacific.htm

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 Māori, 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 Statistics[16], 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)[17].

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 taskforce[18] 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.

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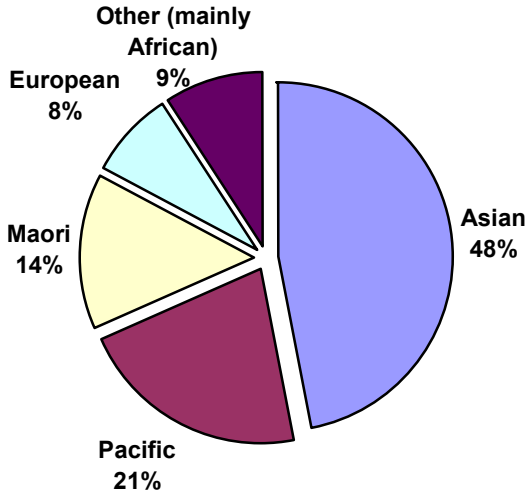
16 http://www.4woman.gov/faq/Asian_pacific.htm

17 http://www.aapihp.com.hepbtf/eulerslides/intro.htm

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

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.

Chart 18: Percentage of TB cases reported to the Public Health Office by ethnic origin in 2000 (n=196)



Overseas reports[19] 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).

Mental health

Research on recent Chinese immigrants to New Zealand showed that the level of mental health problems is similar to the population as a whole, but that factors such as rejection by locals, being aged 26-35 or over 45 years and low English proficiency were found to contribute to those who experienced problems (Abbott et al 1999). Again, there is some diversity within the Asian population group, with some sub-groups experiencing greater problems, while others experience less.

In another Auckland study, Wang (2000) identified *"crisis, safety, cultural shock, scared about being unaccepted by their peers, loss of personality identity in human growth and development process, loss of cultural identity etc"* as key issues facing Chinese adolescent immigrants.

[19] http://www.4woman.gov/faq/Asian_pacific.htm

The Mental Health Commission has recently carried out a literature review and a series of consultation meetings relating to Asian mental health (Ho et al 2002). Key conclusions in the draft report include:

> "Until recently, the mental health of Asians in New Zealand has received very little public and professional attention. A popular belief has been that Asians are extremely well adjusted, as reflected in their low rates of crime and divorce as well as high educational and occupational attainment. This brief literature review challenges the stereotypes of extraordinary well-being and mental health amongst Asians.
>
> Two themes dominate recent mental health related research on Asians in New Zealand. One focuses on their adaptational problems, mental health status, and factors contributing to or hindering their successful adaptation and mental health. The second theme concerns the utilisation of mental health services by Asians, especially the barriers preventing their access to services. Based on the findings from the research review, the following recommendations are developed to promote mental health in Asian communities and improve cultural responsiveness in mental health services. In addition, four groups that experience a high risk of developing mental health difficulties are identified for further research (p. xi)."

Ho et al (2002) provide recommendations for promoting mental health in Asian communities as:

- increasing public support for cultural diversity
- providing extensive information before and after migration
- improving access to English language education
- encouraging and supporting the development of community support programmes.

Ho et al (2002) also provide recommendations on high-risk groups requiring further research:

- Women.
- Students.
- Older people.
- Refugees.

Overseas studies indicate that many Asian people are unfamiliar with depression and its treatment and complain about physical symptoms, resulting in under-recognition and under-treatment. Younger Asian women studied in London are vulnerable to increased rates of attempted suicide (Bhugra et al 1999).

Overseas researchers state that the low levels of utilisation of mental health services may be attributed to:

- inadequate and inappropriate resources for responding to the needs of Asians (Ma 1999)
- cultural values of shame and family name - the belief that the admission of emotional problems and the inability to work out one's own problems arouses shame and reflects poorly on the family name (Sue 1980).

Overseas research has suggested that strategies to assist Asian mental health include:

- improved recruitment of Asians into health care professions, improved training and research in an increasingly diverse society (Iwamasa and Hilliard 1999)
- enhancing cultural identity and recognising that minority groups may need to rely on their own subculture for psychological and social support for positive mental health especially in high school settings (Yee and Lee 1977).

Other mental health issues identified in New Zealand include problem gambling and alcohol abuse.

Problem gambling

Problem gambling has been identified as an issue for the Asian community within New Zealand (eg, Wong 2000). Problem gambling is recognised as a public health issue and is often associated with other addiction problems (eg, tobacco, alcohol and other drugs) and depression. Problem gambling can also lead to other social problems such as criminal activity, family breakdown and lost productivity (Korn and Shaffer 2000; Volberg and Abbott 1994).

There is some evidence to indicate that the impact of problem gambling on the Asian Community is greater than that on other ethnic groups, or at least equal to other New Zealanders (Wong 2000). Part of this may be due to the apparent popularity of gambling amongst Asian people and that a disproportionate percentage of Asian people gamble (Abbott and Volberg 1991). A SkyCity Population Study carried out in 2001 showed that 26 percent of those who visited the main gambling floor of the SkyCity Casino in 2001 were Asians, and of those who played at the tables, 54 percent were Asian people. In a study by Wong (2000), new Chinese immigrants appeared to be at greater risk of problem gambling than more longer-term resident Chinese people.

Various issues have been identified that may contribute to problem gambling amongst Asian people. Asian people are generally new immigrants from countries without casinos, and experience relatively high unemployment and social isolation, including poor access to social support and treatment services (Wong 2000).

It has been noted that Asian people are under-represented in research in mainstream problem gambling studies (Department of Internal Affairs 2000).

Alcohol and other drug abuse

Data pertaining to Asian alcohol and other drug (excluding tobacco) use is generally not available. Alcohol harm has been identified as an issue in a Waitemata DHB survey (Ngai et al 2001).

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).

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.

Under-utilisation of health care

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.

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.

Strategies to improve Asian health suggested by international literature

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

- offering culturally-sensitive and appropriate health services
- providing appropriate health education and resources
- providing medical interpretation and translation service
- acknowledging different cultural 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) and reorienting health services
- recognising multi-ethnic culture and collect disaggregated data, utilise over-sampling and allocate more funding for specific studies (Srinivasan and Guillermo 2000)
- researching collaboration between universities, community-based organisations and ethnic communities (Chen et al 1997)
- supporting community advocacy and raising community awareness

- including cultural issues and ethnic health components in the training of health professionals (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)
- setting specific national targets on ethnic health with appropriate funding and resource allocation.

Resources for Asian health from overseas literature

Australia, the US and the UK all have various public health resources available in Asian and other languages.

In Australia, the NSW Multicultural Health Communication Service acts as a clearing-house for all health-related multilingual resources. Resources may be accessed online (http://www.mhcs.health.nsw.gov.au/), by fax, or are obtainable as hard copies through a number of health providers around the country. A total of 295 resources are classified under 33 different categories and available in 43 different languages. The website is updated every month and resources are downloadable in .pdf format.

In the US[20], the White House Initiative on Asian Americans and Pacific Islanders was established in June 1999. The initiative addresses the concerns of Asian Americans and Pacific Islanders (AAPI) in a variety of areas, including health, education, labour, small business, housing and economic development. The initiative was a spin-off from the research initiative carried out by the US Department of Health and Human Services since 1997.

AAPIs are recognised as the fastest-growing ethnic group in the US. The great diversity and a high proportion of immigrants and migrants with lack of English proficiency have resulted in the need for culturally-competent health services.

A comprehensive programme to address health disparities involves the following:
- Appropriate and useful data collection.
- Enhancing health service access and utilisation.
- Community participation.
- Health funding and research.
- Addressing priorities.
- Collaborating approaches.
- Strengthening partnerships with AAPI community organisations.
- Workforce training and AAPI representation in all levels of decision-making.

In the UK, infant mortality rate is used in health status monitoring. Infant mortality is highest for children of mothers born in Pakistan.

Mainstream targeting initiatives[21] to improve the health of ethnic minorities include:
- Intensive parenting programme.
- Anaemia prevention through good nutrition.
- Parenting styles and child-rearing practices.
- Maternity and child care.
- Sure Start programme which targets areas with high ethnic minority populations.
- Training pack for health practitioners - exploring health practitioners' awareness of cultural issues, attitude and behaviour, awareness of racism and stereotyping, etc.

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20 http://www.omhrc.gov/OMH/Asian%20Americans/2pgAAPI/whatsnew10.htm

21 http://www.doh.gov.uk/healthinequalities/index.htm

Health needs assessment conclusions

Literature from overseas highlights similar issues for Asian public health as the New Zealand data. Countries such as Australia, the US and the UK which have Asian population levels of around 3-6 percent have also established various programmes or strategies to improve Asian public health.

Some specific issues such as tobacco use appear to be very ethnic-specific and there appears to be value in specific targeting of programmes that address people from high-risk ethnic backgrounds. The appropriateness of this approach needs further investigation within the New Zealand context.

The overseas literature provides better coverage of the more general health priorities (such as heart disease and stroke prevention, cancer prevention, diabetes prevention, and mental health promotion) for Asian people than New Zealand research. However, a number of research reports have been carried out that focus either directly or indirectly on public health issues for Asians within New Zealand, most notably the recent literature review initiated by the Mental Health Commission on Asian Mental Health. Despite this, the data and research on Asian public health within New Zealand are quite sparse reflecting the recent increases in Asian populations and increased mainstream concern for Asian health.

A key issue identified in New Zealand research relates to new immigrants and English language proficiency. English language proficiency impacts on access to health care and the determinants of health, especially employment and income prospects.

New immigrants have a range of public health needs, some of which are ethnic specific, for example, prevention and treatment of tuberculosis, while similar health issues to the overall population (eg, heart disease, stroke and cancer) are also encountered. However, effective delivery of public health programmes to Asian communities is much more complex, and innovative strategies that are culturally appropriate will require significant investment of resources.

Overseas studies indicate that effective public health for Asian people requires the development of culturally-appropriate programmes. There is value in seeking ways of extending nutrition, physical activity, healthy lifestyle programmes and other health promotion programmes for key Asian population groups.

Better research of the health issues facing Asian communities within New Zealand will also be required, and future major public health monitoring should consider the inclusion of an Asian population category or sub-categories.

5. Stock-take of existing services/resources/organisations

A stock-take of existing services, resources and organisations was carried out by the Auckland Regional Public Health Service (ADHB) and translation services in hospitals.

Networks were used to identify existing personal and public health services, resources and organisations for Asian communities within New Zealand with a focus on the Auckland region. Resources from Public Health Units nationally were searched, but all resources were available within the Auckland region.

Services (see Appendix 8) and Resources are listed in alphabetical order as follows:

Auckland Chinese Medical Association[22]

The Auckland Chinese Medical Association is an association of New Zealand registered medical practitioners of Chinese descent. Ever since its inception in 1988, it has played a very active role in providing community services to Auckland's Chinese population. The Association regularly organises health fairs to disseminate health information to the community, takes part in community functions by providing free health checks, and gives health talks on Chinese radio stations as well as on request to different sections of the community. It funds research related to Auckland's Chinese population, publishes, and regularly updates, a list of Chinese-speaking GPs and specialists, and translates health pamphlets into the Chinese language. The Association acts as a bridge between mainstream health providers and members of the Chinese community to ensure that their health needs are met.

Auckland Regional Public Health Service (ADHB)

This includes the following specific services:

Hepatitis B Screening Programme

This Ministry of Health-funded programme aims to identify Māori, Pacific peoples and Asians who are chronically infected with the hepatitis B virus and offer them counselling and ongoing follow-up checks, whilst free vaccinations are offered to those who are not immune. The Northern region Hepatitis Consortium, which runs the programme in Auckland and Northland, utilises GPs to conduct the screening and follow-up. The Consortium works closely with the Auckland Chinese Medical Association as well as individual Asian providers, and has drawn very good response from the Asian community despite the relatively small amount of money spent on publicity amongst the Asian populations.

[22] Information provided by Dr Wilson Young (7/8/2002).

Chinese food safety initiatives[23]

The Food Section of the Auckland Regional Public Health Service, through the efforts of Lily Ma, have produced Chinese food safety pamphlets, and also disseminated food safety messages on Chinese radio stations and newspapers. They have participated in Chinese health fairs, and have conducted educational talks in Chinese on food safety to the general public as well as the industry. Relevant articles in the public health quarterly publication, *Imported Products Advice*, have been translated into the Chinese language for the benefit of the food industry. At the request of the Ministry of Health Food Programme, Lily has also translated some of their national media releases into the Chinese language.

Smokefree promotion[24]

Ongoing tobacco retailer education to dairy and other outlets on current legislation is carried out in addition to addressing workplace complaints in Chinese restaurants and cybercafes. There is plan to further promote smokefree in the Asian community.

World Smokefree Day 2002 displays were set up at the Auckland Badminton Association and the Glen Innes YMCA, clubs where there is a high Asian membership. Smokefree drink bottles were donated to each club to be used as prizes. Both clubs were presented with a 'Certificate of Acknowledgement' for their active support and commitment to World Smokefree Day 2002. A smokefree article was placed in the main Chinese newspaper, the *New Zealand Chinese Herald*. A similar message was also broadcast on Chinese radio.

Action on Smoking and Health (ASH)[25]

ASH has a small selection of Asian resources that feature Jackie Chan, a well-known US celebrity. The resources have the caption 'Striking back against tobacco' on them. They include posters (large and small), desk top promos, fans, rulers, stickers, mouse pads, videos and CD interactive games. It has a collection of Asian news clippings in its archives (national and international). ASH communicates regularly with overseas Asian tobacco control groups and receives newsletters and publications.

Asia Pacific Centre for Community Health and Development Research, Auckland University of Technology[26]

The Asia Pacific Centre for Community Health and Development Research was established in 2001 and brings together research in child health and development, physical activity and exercise promotion, migrant and refugee health, and health of adults and older people. The emphasis of this research centre is to study topical health and developmental issues with a view to capitalising on the unique resources of our country and region and improving health and social outcomes. The main focus will be on studies that contribute to understanding how cultural, economic, environmental, social and other factors impact on community and development.

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23 Information provided by Dr Wilson Young (7/8/2002).

24 Excerpts from: World Smokefree Day 2002 by the Auckland Regional Public Health Service compiled by Marilyn Burton, June-August 2002.

25 Information provided by Nicola MacDonald (13/8/02).

26 Information provided by Vivian Cheung (30/7/2002)

Asian Health Support Service (Waitemata DHB)

The Asian Health Support Service provides the following services to WDHB mainstream services:

- Asian Health Volunteer Service.
- Waitemata Asian Translation and Interpreting Service (WATIS) – 24 hours 7 days a week for
  - interpreting services for all languages
  - health information translation.
- Chinese Call Centre/Support Line (Mandarin and Cantonese) – 9 am to 4.30 pm.
- Chinese Needs Assessment Service.
- Chinese Diabetes Support Group.
- In-Service Cultural Perspective Workshop

Waitemata Asian Translation and Interpreting Services (WATIS):

The Waitemata Asian Translation and Interpreting Service (WATIS) is an in-house service with a 24-hour 7-days call centre that co-ordinates interpreting requests. Its mission is to facilitate quality and cost-effective interpreting and translation services for mainstream services (within the Waitemata district) for the purpose of helping to bridge language barriers between Asian clients and health service providers.

- WATIS initially launched with services for Cantonese, Mandarin and Korean languages, but was expanded to all languages on 1 July 2002 (including sign language).
- Both onsite and telephone interpreting services are available to facilitate communication between parties.
- A translation service is also available for written health information.
- WATIS is a not-for-profit service that is funded on a fee-for-service basis - fees cover administration and call centre costs.

Chinese Call Centre Support

The Chinese Call Centre Support is available during office hours (9 am-4.30 pm). It provides online assistance to:

- staff for guidance on communication assistance with non-English speaking clients
- Asian clients for simple translation purposes (eg, health information, directions, rescheduling of appointments, etc).

Support for Cantonese, Mandarin and Korean speakers is provided free of charge during office hours.

Chinese Needs Assessment Service

This service is developed and managed jointly by Asian Health Support Service and Needs Assessment and Service Coordination (NASC). Its aim is to promote ease of access for Asian clients to the Needs Assessment and Service Co-ordination (NASC) agency.

- The service provides Facilitated Needs Assessments and Reassessments for Chinese clients over 65 years of age who have a disability and would prefer an Asian Assessment Facilitator.
- The needs assessment process aims to work with the client to identify their prioritised needs arising from their disability, and to refer them to appropriate specialised assessment services.

- Facilitation in Cantonese and Mandarin is currently offered, with translation of support plans into these languages where required.

Asian Health Volunteer Service

The Asian Health Support Service recruits and trains Asian Volunteers to support Asian patients/consumers within the Waitemata DHB district. The volunteers provide emotional and community support to patients/consumers in hospital wards and also in their homes. Volunteers in turn are provided with petrol vouchers for a day's work.

There are four specific roles available for volunteers:

- 'Meeter & Greeter'
- Patients/Consumers Support Person.
- Cultural Advisor/Community Support Person.
- Research Support Person.

Chinese Diabetes Support Group

The Chinese Diabetes Support Group is a combined initiative between Asian Health and the Waitemata DHB Diabetes Team. The group was set up to help Chinese members of the Auckland community with diabetes to better manage their health. It provides a forum for the group to obtain more information about their illness, and also for them to share problems or experiences with other people in the same position.

- Bimonthly meetings are organised by Asian Health for the group.
- Each meeting is focused on a diabetes-related health topic chosen by the group, with a Health Specialist invited to speak on the topic.
- Lectures by the Health Specialists last for an hour, followed by an hour-long question and answer session.
- Meetings are facilitated by Asian Health co-ordinators, who also translate into Cantonese and Mandarin during the lecture and during the question and answer session.

In-Service Cultural Perspective Workshop

Cultural Perspective workshops are run by Asian Health for Waitemata DHB staff. The objectives of the workshops are that participants (post-workshop) will be able to:

- understand the impact of cultural differences in health care
- identify the cultural beliefs and taboos of Asian people
- enhance their skills in communication and trust-building with Asian patients/clients.

Asian Health Support Service handouts

There are several brochures in Chinese and Korean produced by Waitemata District Health Board. These include:

- Service description of the Asian Health Support Service.
- New Zealand Health Care System - a description of inpatient and outpatient hospital care, primary health care (including immunisation) and community-based care available in the country. Support services like the laboratory, radiology, pharmacy, dental care and also hospital translation services are explained.
- Home and Older Adults Services – information on home- or community-based care for assessment, physiotherapy and other rehabilitation.

- Community Child and Family Services - covers the ear and eye clinic, their liaison role between family and school, dealing with growth and development, illness, puberty and stress and the protection of children under these circumstances.
- Women's Health - options for obstetric care and cost, postnatal care, breast-screening, cervical screening and gynaecological services with points of contacts are outlined.

Asian Network Steering Committee[27]

The Asian Network Steering Committee (ANSC) aims to develop a strong and healthy Asian community through advocating and promoting welfare of the community and actively participating in policy-making. Its goals are to:

1. provide an ongoing network to advocate for the wellbeing of the Asian communities in Auckland through:
   - information sharing
   - training opportunities provision
   - policy submissions to central and local government
   - respond to the changing needs of the Asian communities more effectively
2. be a bridge for the Asians with other communities in Auckland.

The ANSC has been actively promoting the public health of Asian communities. This includes initiating and holding an Asian Public Health Consultation Meeting with the Ministry of Health. The ANSC is currently participating in the Asian Public Health Project of the Ministry of Health.

The Asian Network Steering Committee is supported by the Auckland City Council's Community Development Division.

Asian Problem Gambling Services[28]

The Asian Problem Gambling Services operates under the umbrella of the Problem Gambling Foundation of New Zealand, which is a non-profit making organisation. The Asian Problem Gambling Services have counsellors and social workers who speak Mandarin, Cantonese and Korean. It provides a free and confidential face-to-face counselling service, an information hotline (0800 862 342 or 0800 TO BE HAPPY), assessment, crisis intervention and referral to related services, such as budgeting for the Asian problem gamblers and their family members to deal with their problem in relation to gambling issues. The service also views problem gambling from a public health approach, that is from an overall social and collective perspective, such as involving in research and action to reduce harm and suffering and enhance health, wellbeing and the quality of life of the Asian communities. For example, running community educational programmes and sending out promotional material to raise awareness of harm on problem gambling and to prevent such harm from affecting the Asian community.

Three resources are available relating to problem gambling. These include:

- *Problem Gambling Harms Asian People*: a handout in English and Korean providing information on when gambling becomes harmful, signs and effects of problem gambling and contacts for free confidential assessment and counselling. It was produced by the Compulsive Gambling Society of NZ (Inc).
- *Problem Gambling and Your Health*: a handout in Chinese language and Korean that discusses the physical and emotional effects of problem gambling for self-diagnosis or for detection in family and friends. Various helplines are offered for quitting or

[27] Information provided by Kefeng Chu (13/8/2002).
[28] Information provided by John Wong (14/8/2002).

counselling. It was produced by the Asian Problem Gambling Service of the Compulsive Gambling Society of NZ (Inc).
- 'Eight', a gambling screening tool, is available in the Chinese language.

Breastfeeding

A booklet in the Chinese langauge on breastfeeding was published by the Ministry of Health (2001). It promotes breastfeeding as a relationship between mother and infant and describes the benefits and technique of breastfeeding. Contacts for support are included at the back of the booklet.

BreastScreen Aotearoa

A brochure about the free national breast-screening programme offered to New Zealand women aged 50 to 64 years of age (produced by HFA). The resource covers information about breast cancer and mammography, what breast-screening entails and how to enrol in the programme.

The brochure comes in English, Thai, Korean, Vietnamese, Japanese, the Chinese language and some Pacific languages.

Children's seatbelts

A leaflet produced by the Plunket Society on children's seat belts is available in Chinese and Korean and deals with current legislation on car seats for children and the fines incurred when found breaking the law. Types of car seats to be used for infants and children of varying ages are described. A list of Plunket Centre contacts for car-seat rental is available to the public.

Chinese Lifeline

Chinese Lifeline has produced a handout that covers information on depression and stress, the need to seek help and the contact for Chinese Lifeline (managed by Mandarin/Cantonese-speaking trained volunteers) including service hours. Some common situations when the Lifeline is helpful are also profiled. There is also an appeal section for both volunteers and monetary donations.

Chinese New Settlers Services Trust

The Chinese New Settlers Services Trust was established in 1998 as a charitable trust which offers culturally- and linguistically-appropriate services to both Chinese new immigrants and the community. Its aim is to improve the quality of life of the Chinese in New Zealand, and to enable them to participate in and contribute to New Zealand society. It also acts as a bridge between the Chinese community and mainstream society. Currently they have four multi-service centres/clinics in the greater Auckland region (Howick, Manukau City, Mt Roskill and Glenfield) to provide the following services:
- Settlement service - such as information, resource and settlement support.

- Employment service - such as employment English training and Chinese Employment Network System (CENS).
- Social work support - New Zealand-trained social workers providing language support, advocacy, family services support and casework.
- Cultural and educational services - such as English language and New Zealand culture courses for Chinese elderly and new arrivals; New Zealand law and legislation educational workshops for new migrants; Chinese language, art and music classes for local children and youth; Chinese cultural activities and events for local New Zealanders, eg, tai chi exercise.

Diabetes Projects Trust[29]

The Diabetes Projects Trust is working on a project aimed at developing interventions and resources for the prevention of type 2 diabetes in young people in response to an emerging global epidemic associated with overweight/obesity and physical inactivity.

They are intending to introduce three interventions. The first is a comic book, together with add-on leaflets, the second will be an interactive video with a possible complementary teachers/instructors kit, and the third intervention will involve a multidisciplinary five-session programme flexible for different settings.

These are being introduced in sequence. The five-session programme will incorporate weekly one-hour sessions as part of a programme, with each session covering diabetes and related topics such as what diabetes is, risks and complications and how to prevent it with separate sessions on healthy eating, exercise, feeling good about yourself and perhaps a personal story.

The Diabetes Project Trust is very interested in collaborating with other organisations focusing on health promotion and primary/secondary prevention.

Driving Safely in New Zealand

Driving Safely in New Zealand is a brochure produced by the Land Transport Safety Authority printed in various languages (English, French and Japanese) in the one leaflet. It includes information about travelling by road in New Zealand, common road signs and their meanings. It also deals with overtaking, alcohol, seatbelts, driving on rural roads and what to do in case of an accident.

Food Safety

Food Safety is a brochure produced in Chinese by the Auckland District Health Board in collaboration with the Auckland City Council. Under the headings 'Clean', 'Cook', 'Cover' and 'Chill', it details important messages on hand-washing, food-handling and storage procedures. There is a section on how the above procedures limit bacteria growth and food-borne illnesses.

[29] Information provided by Jane Biddulph (12/8/2002).

Hepatitis B Free Screening

Hepatitis B Free Screening is a brochure in English and the Chinese language produced by the Northern region Hepatitis Consortium. It is aimed at Māori, Pacific and Asian populations who have a high prevalence of hepatitis B. It outlines 'First the bad news' then 'The good news' and encourages the target population to visit their doctor for a free screening test for the whole family.

Maternity services

A handout on maternity services is produced by the Maternity Services Consumer Council in the Chinese language. It outlines options and a choice of practitioners for antenatal care, labour and delivery and postnatal care, whether using a midwifery service or independent midwives, GPs and private/public hospitals. There is also a brief outline on whether cost is involved, especially for those who are new to New Zealand. Some information on antenatal classes and the organisations running the programme are available.

Miscarriage

A handout on miscarriage is produced by the Miscarriage Support Auckland (Inc) in the Chinese language. The definition of spontaneous abortion, prevalence, symptoms and signs of miscarriage, common causes and types of miscarriage and effects of miscarriage are explained in the leaflet. The experience of grief and coping with a miscarriage plus a support line are also outlined.

National Women's Hospital

A leaflet in Chinese on the Obstetrics and Gynaecology unit and the neonatal ward at the National Women's Hospital is available. It provides information on each unit. It also promotes antenatal classes in Mandarin or Cantonese. There is also mention of the abortion service at Epsom Day Unit.

Patient rights

Your Rights, a patient rights handout, has been produced in Cambodian, Korean, the Chinese language and Vietnamese by A+ Auckland Healthcare. It deals with the rights of the patient (in terms of religion, culture, etc) and the right to make an informed decision and to give informed consent, even in teaching or research situations. It is based on the Privacy Code of 1993. The A+ mission statement is also included in the brochure.

Regional Alcohol and Drug Services (RADS)

A service description of Regional Alcohol and Drug Services (RADS) is available in the Chinese language. It covers assessment of the severity of addiction, counselling, referral, quit and methadone programmes, specific youth counselling programmes, dual diagnosis, services for Māori and community training programmes.

Shakti

Shakti provides four key services[30]:

Migrant Resource Centre

Situated at 5A Jordan Avenue, Onehunga, Shakti Migrant Resource Centre has been established with the principal aim to guide, advise and assist migrants and new refugees from all nationalities to settle down and integrate fully into New Zealand.

New migrants and refugees may register to attend orientation seminars relating to settlement, referral and advocacy services to all government departments and ongoing support. A drop-in centre is also available for those who require short-term assistance in specific areas. Information and guidance may be sought on accommodation and housing, English Language training, health checks and professional legal guidance.

Women's Education Service

Services offered at 138 Church Street, Onehunga include road safety (free of charge), road code and practical driving classes as well as life-skill programmes, computer and sewing classes aimed at women achieving independence and self-sufficiency.

Asian Women's Centre

Located at 138 Church Street, Onehunga, it provides an information and advocacy service for women and interpreters in 16 languages. A drop-in facility for migrant and refugee women and their children is also available.

Asian Women's Safe House

The Asian Women's Safe House is a telephone counselling service for women of any religious/cultural group who are victims of domestic violence. There is a national helpline and also a direct contact number for Auckland. Counselling is made available in 16 languages.

The Auckland Refugee Health Service: Public Health[31]

The Refugee Health Service aims to protect and promote the health of refugees and people of refugee-like background living in the Auckland region. Each year, approximately 1500 people awarded residency under the New Zealand refugee quota, refugee status and humanitarian migrant programme settle in Auckland. They are frequently survivors of conflict situations, persecution and other human rights abuses. These experiences have important implications for their health status and for the delivery of health care.

These needs are reflected in the Auckland District Health Board's 'Improving the Health of New Migrants Strategy' in the proposed strategic plan for Auckland District Health Board 2002-2007, Consultation document pp 40-44. The Refugee Health Service provides:

- the National Refugee Health Centre located at Mangere Refugee Resettlement Centre for all quota refugees and asylum seekers in detention. The health centre provides comprehensive health-screening and referral
- an asylum seeker clinic at Green Lane Hospital. Asylum seekers receive the same screening as quota refugees including mental health screening and referral

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30 Compiled by Janet Chen (Auckland District Health Board) with brochures from Shakti.

31 Annette Mortensen, Co-ordinator of Refugee Health.

- the Refugee Health Co-ordinator and Refugee Community Liaison Officer who co-ordinate and network regionally with service providers involved in refugee health to identify gaps and develop capacity. Refugee communities are provided with information about available services and how they can be accessed. Work is undertaken with government and non-government agencies to improve existing services and promote new services as appropriate.

The Refugee Health Service provides:
- consultation and support to mainstream health care workers working with refugees
- training for health care providers on refugee health and related issues, and development of resource materials
- liaison between local health services and agencies that work with refugees
- delivering health information to refugees, including orientation to the health system in Auckland
- providing clinical assessments, advice and referrals
- facilitating and conducting research into refugee health needs and service delivery issues
- advocacy at the health policy level and on a case-by-case basis, to promote health equity for refugees.

The Refugee Health Service aims to assist anyone of refugee-like background. This includes recent refugee arrivals and those here for longer times. In addition, some people reuniting with relatives under the Family Reunion Stream have been through refugee experiences. The service also targets asylum seekers living in the community whilst their applications for residency are being processed. Interventions may be individually targeted as well as community based.

Staff have a mix of professional backgrounds including medical, nursing, health promotion, community development, research and administration.
Most of the Service's activities are conducted through partnerships with the wide range of specialised and mainstream health services that help to address the needs of refugees in Auckland. Collaborations with agencies beyond the health system also form an important part of the services function.

The Refugee Health Service can be contacted regarding:
- general information about refugee health
- advice on health aspects of specific cases
- resources for health professionals, community workers and students
- training for health care workers on refugee health issues
- research needs relating to the health of refugees
- group information sessions for refugees about the Auckland health system
- clinical assessments for newly-arrived refugees or for asylum-seekers.

Traditional healers

Prevention is an essential concept in traditional Chinese medicine. It implies health promotion, balance and harmony in health behaviours, lifestyle and diet but does not include medical check-ups, diagnostic testing or screening.

There are many traditional Asian healers operating within the Auckland region and there are indications Asian peoples use both Western and traditional health practices.

Tuberculosis

Two resources are available on tuberculosis in the Chinese language:

- a detailed flyer on tuberculosis (produced by the Auckland District Health Board) in Chinese outlines the occurrence of disease in the Auckland Chinese population, what tuberculosis is, how it is spread, clinical manifestations, treatment, prognosis and prevention. It also covers the cultural aspect of 'shame' that ethnic people may experience with disease

- a booklet produced in traditional and simplified Chinese, containing pictures and simple text. It is written in question-and-answer form. Common public health concerns are addressed which include how tuberculosis is spread, susceptibility of disease, clinical manifestation, treatment and immunisation.

Well Women's Nursing Service[32]

The Well Women's Nursing Service offers health promotion on cervical screening, breast screening, breast awareness and women's health issues such as periods and menopause to the Asian communities in the Auckland region.

It has Chinese cervical screening clinics (free for those fulfilling certain criteria) in Howick, Epsom and Otahuhu, and a Korean cervical screening clinic in Manurewa.

Well Women's Nursing Service employs a Chinese women's health nurse (0.5 position), a Korean women's health nurse (0.25 position), and Indian and Pakistani health promoters on a casual basis.

It also has funding from Sky City and Lotto to translate resources for new migrant and refugee women.

It has set up Women's Wellness Community Groups for Korean, Chinese, Somali, Pakistani, Indian and Arabic women.

The Korean language pamphlets produced and distributed include contraception, osteoporosis, termination of pregnancy, menopause, cystitis and pelvic floor exercises.

The Chinese language pamphlets translated to date are on STDs, contraception (to be developed further by FPA), menopause, stress incontinence, osteoporosis and termination of pregnancy.

A handout entitled *Well Women's Nursing Service – Patient Information,* produced in the Chinese language, relates particularly to cervical screening, checks for sexually transmitted diseases, pelvic internal examinations, breast examination and mammography, and privacy concerns.

[32] Information provided by Ruth Davy (2/8/2002).

6. Summary findings from community consultation meetings and key informant interviews

The Asian Network carried out a series of four community consultation meetings and interviews with key informants with support from the Project Team. A summary of findings from these meetings and interviews is outlined below.

Method

Information on key health issues was elicited through a series of four consultation meetings and key informant interviews during October and November 2002.

Community consultation meetings

The consultation meetings were conducted in order to achieve two main aims. Firstly, the meetings invited Asian communities to express their views on issues particular to their context. Secondly, the meetings sought to build relationships with Asian communities towards developing solutions.

Each of the four consultation meetings was well represented by a wide cross-section of Asian ethnic groups. These ethnic groups included: Chinese; Korean; South-east Asians and Japanese Peoples; Indian Sub-continent and South Asians (see Introduction).

Invitation flyers (see Appendix 9) were translated into various languages and sent out to various communities. These included Asian communities, mainstream health providers, public health service providers and educational institutions, and other interested parties.

The meetings were also advertised in print media and electronic media.

The meetings included an introduction to the project and a brief overview of public health, and focused on gaining participant feedback on three questions:

- What are the main/major health issues experienced by Asian communities?
- What are the barriers to better public health for Asian communities?
- What are some solutions to improving Asian public health needs?

Each meeting was facilitated by a trained facilitator, with written information being presented in English and relevant translations. Interpreters were employed to translate proceedings, and note-takers were representative of the specific Asian ethnic group that was the focus of the meeting.

Feedback forms (including postage-paid reply envelopes) were available for participants who wished to provide feedback on issues in a written form or wanted to provide feedback on the consultation meetings.

Key informant interviews

Sixteen key informant interviews were conducted to identify key health issues, underlying causes of health issues, barriers to improved health, and possible strategies for improved health for Asian communities. Key informants were recruited because of their knowledge, experience and involvement within the Asian community. Most were of Asian descent and all worked closely with Asian communities. The Project Team identified possible candidates and

approved the final list of interviewees. Key informants were selected from various levels and aspects of the health sector including clinicians, health promoters and researchers. The same interviewer conducted the interviews to ensure consistency. Interview notes derived from the key informant interviews were cross-checked with each participant to ensure accuracy.

Key findings

Major health issues, barriers to improved health and possible strategies from the consultation meetings and key informant interviews are outlined below. Generally, the key issues identified in the consultation meetings were also raised by the key informants and they align with the health data presented in Chapter 3 on health status.

Health issues arising from the consultation meetings and key informant interviews

Both the consultation meetings and key informant interviews highlighted that the most significant health issues facing Asian communities are mental health, heart disease and diabetes and sexual health. The consultation meetings highlighted that Asian communities experience difficulties in accessing public health services due to various barriers. Variation of key health issues amongst each Asian ethnic group was not obvious. Common themes are outlined below and listed approximately in sequential order in terms of the number of times mentioned during the four consultation meetings and key informant interviews.

Mental health

Mental health was the most important health concern for Asian communities as identified in the consultation meetings and key informant interviews. Asian communities indicated that the migration experience has produced alarming psychological problems such as depression and stress. Both participants at the consultation meetings and key informants noted that lack of social support, stress induced by migration compounded by disruptions in the family unit (separation), and settlement/integration frustrations with host country conditions contribute to the prevalence of mental health issues. Participants at the consultation meetings also noted that Asian mental health is an issue because of stigmatisation and discrimination (differential treatment in society) and factors such as employability and unemployment, which can induce high stress levels.

Some key informants stated that some new migrants arrived with pre-immigration mental health conditions such as post-traumatic stress disorder (PTSD), which is especially prevalent in refugee population groups.

Asian communities seek more responsive and effective mental health services. Problems include, lack of trained professional interpreters, lack of Asian mental health workers, lack of cultural sensitivity, and lack of campaigns to promote access to and availability of existing Asian mental health services.

Health system

A number of overarching criticisms of accessing and utilising the New Zealand health system were raised during the consultation meetings and key informants interviews. These included: not knowing how and where to access services; not knowing what services are available and whether these services (particularly in mainstream health care) offer Asian-specific health care; lack of co-ordination between health care services; various gaps in health care services

such as the interpreters service; and a lack of diverse representation in the health workforce. Many respondents suggested that information on the New Zealand health system should be made available before migrants leave their homelands, and when they arrive at their new destinations.

Diets and lifestyles, and heart disease, diabetes, and stroke

Another strong theme that Asian communities highlighted in the consultation meetings were changes in dietary habits and changes in lifestyles. Heart disease, high blood pressure and diabetes were three significant health concerns that emerged during the meetings. These three issues are related to poor nutrition and lifestyle choices. The migration experience includes introductions to new foodstuffs that have high cholesterol levels and this is compounded if people are unable to maintain daily physical exercise which is often the case for new migrants.

Key informants also identified coronary heart disease, diabetes and hypertension as major health issues for Asian people. Some key informants remarked that singular risk factors such as high cholesterol levels accounted for coronary heart disease and diabetes. Others suggested pluralistic risk factors such as genetic makeup, diet, lack of exercise, negative lifestyle practices such as cigarette smoking and stress brought upon by migration.

As mentioned in other parts of this report, some participants at the consultation meetings and some key informants commented that the increasing incidence of heart disease, high blood pressure and diabetes are not necessarily attributed to the migration experience. There was some acknowledgement that migrants arriving in New Zealand brought with them these risk factors (eg, smoking and poor diet, such as high salt intake). Some key informants noted that in several Asian countries, health care services are difficult to access, and therefore conditions may not have been treated effectively or previously diagnosed.

Sexual and reproductive health

The next most frequently mentioned health issue noted, by both participants at the consultation meetings and key informants, was related to sexual and reproductive health. The main issues for sexual and reproductive health focused around increasing numbers of unplanned pregnancies and Sexually Transmitted Infections (STIs). There was in addition a special concern for young people because this population group is also experiencing issues relating to growth and development (eg, puberty, peer pressure and sexual identity formation). Key informants noted that most Asian adolescents are not well informed about safe sex practices.

Participants at the consultation meetings also raised concerns regarding Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome (HIV/AIDS).

Participants at the consultation meetings stated that there was either a lack of knowledge of available services, or a community reluctance to utilise existing sexual health services because of language barriers. In addition, support services for Asian communities were considered inappropriate (eg, some interpreters were of the wrong gender). Finally, existing sexual health centres are perceived as lacking cultural sensitivity. In particular, sexual health care has always been a covert issue for Asian communities because of its sensitive nature and it is not generally openly discussed.

Respiratory disease/allergies/asthma

The next most frequently mentioned health issue expressed by key informants was respiratory related conditions. This was less frequently mentioned by participants at the consultation meetings (see Safe environments/allergies below).

Key informants reported that respiratory disease, allergies and asthma are significant health issues for Asian people and that important risk factors are the environment or climate, personal choice such as cigarette smoking or second hand inhalation, and genetic pre-disposition. Key informants highlighted that high asthma levels amongst children in Asian communities required attention.

Infectious disease

Key informants indicated that there appears to be a high prevalence of infectious diseases such as tuberculosis (TB). Poor housing conditions (eg, damp and overcrowded) are often contributors to increasing levels of tropical diseases. However, TB is not the only infectious disease that threatens Asian communities and another concern is the prevalence of hepatitis B and C. Sharing of utensils and poor hygiene also add to the growth and spread of infectious diseases. Participants at the consultation meetings also highlighted a concern around hepatitis B and TB as illustrations of major infectious disease issues.

Alcohol

Alcohol consumption is becoming more prevalent in Asian communities according to participants at the consultation meetings. Participation in consumption of alcohol is viewed as a socialisation process as well as an outlet for particular stressors.

Gambling

Gambling is an emerging problem amongst Asian communities. Participants commented that gambling activity has increased dramatically with most gambling facilities attracting high concentrations of Asian peoples. A possible reason given for this increase in problem gambling was that gambling facilities have become more widespread.

Participants reported that Asians who recognise that they are addicted or are in financial strife seek assistance from health professionals when their problems are unmanageable.

Smoking

Cigarette smoking is prominent amongst Chinese, Korean, Japanese and South-east Asians whereas tobacco chewing is more common amongst Indians. Participants at the consultation meetings noted that smoking is becoming more prevalent amongst younger Asian population groups. Public health programmes for smoking cessation are perceived as not being accessible for Asian peoples because of the content and delivery. Respondents were aware of the health issues associated with smoking such as lung cancer, but simply being aware is not enough. Key informants also noted that smoking is an issue for the Asian community (see Respiratory disease/asthma/allergies above).

Dental services

According to the participants, dental health services are not accessible to Asian peoples, mainly because of a lack of knowledge of available dental services, while others noted that the cost of dental health services is also an issue. This issue was noted by some key informants and participants.

Safe environments/allergies

Participants at the consultation meetings mentioned the importance of high-quality housing, particularly for those Asian peoples who are asthmatic or who have skin disorders. Allergies which induce respiratory problems were also an issue. Some participants highlighted the importance of injury prevention issues such as road safety particularly in driving education where learning the road code is an issue.

Food safety

Participants at the consultation meetings emphasised a concern around packaged foodstuffs that are imported from overseas. Packaged foodstuffs such as tinned food with bogus expiry dates are filling the shelves of local Asian retail supermarkets and groceries. This presents risks to owners of ethnic-specific food outlets and may be hazardous for those who consume the products. Tighter control in terms of regulations and policies should ensure careful monitoring of imported products to safeguard sellers and consumers' heath standards.

Gastric problems

According to some key informants, gastric problems due to viruses or stress are a common health issue for Asian people.

Arthritis

Some key informants identified arthritis and osteoporosis as an important issue especially amongst older people in Asian communities. Older Asian people living in New Zealand may have reduced calcium in their diets and experience differing weather conditions compared to their homelands. This contributes to arthritis problems.

Other health issues

Other health issues identified by key informants included gout, domestic violence, prostate problems, dental health and iron deficiencies, to name a few. For the older population groups: depression; stroke; coronary heart disease; dementia; diabetes and osteoporosis. For women: cervical screening, hypertension and iron deficiency. For adolescents: sexual health and mental health. For children, key informants signalled asthma as the major health issue.

Other issues that emerged during the consultation meetings were domestic violence and consumption of illicit drugs. The migration experience has influenced many changes within traditional culture, with changes in the family unit and gender roles. As a result of these changes, Asian women have learned to cope with childcare on their own and subsequently learned to be independent whilst the partner is away. Similarly, the migration experience has provided an opportunity for some Asian youth to become involved with taking and/or selling of illicit drugs.

Causes of health issues espoused by key informants

Key informants were asked to discuss the causes of key health issues for Asian communities in New Zealand. They identified a range of causes or contributory factors to health issues that focus on the following points.

Migration

Key informants commented that migration plays an important role in the prevalence of health issues outlined previously. For example, migration leads to changes in the family unit (separation of family members), entails a change in social status (unemployment or underemployment), which can cause psychological problems such as stress and depression. There is also often increased access to alcohol and gambling. Key informants pointed out that migration alone does not necessarily cause major health issues such as diabetes, coronary heart disease and hypertension, as some new arrivals bring these conditions from their homelands. Migration (eg, associated stress or lifestyle changes) can act as a catalyst for health issues.

Diet

Key informants further added that migration entails changes in diet as different food is available, or traditional food is less available. Asian peoples' dietary behaviour is often patterned on having meals with high salt concentrations or usage of cooking oil high in fat and, following arrival in New Zealand, there are often increases in fat, calories and protein intake.

Smoking

Key informants noted that cigarette smoking is relatively high in Asian communities, which is another contributing factor to poor health. Cigarette smoking is very common in many Asian countries particularly among the males where it is part of socialisation rituals. Key informants commented that health issues associated with cigarette smoking such as heart disease and lung cancer are causing most concern.

Exercise

Key informants noted that daily walking is common for Asian communities in their homeland, particularly for city dwellers. For example in their homeland, many Asian people rely on public transport and rarely on private vehicles. Sport, recreation and leisure facilities in Asia are popular. However, in New Zealand, Asian peoples are reluctant to use these means of exercise because they feel that some of these facilities are impersonal and competitive.

Stress

According to key informants, the migration and settling experience induces stress and mental health issues. These issues impact on general health and wellbeing.

Other causes

Other causes identified by key informants included alcohol abuse, lack of injury prevention and health promotion programmes for Asian people, poor hygiene, and environmental factors such as poor housing conditions for some Asian people.

Public health barriers identified from the consultation meetings and key informant interviews

Key barriers identified during the consultation meetings and key informant interviews focused around poor access to health services, primarily a consequence of language and cultural

barriers. Other barriers identified by participants at the consultation meetings and key informant interviews were slightly different, partially reflecting the different perspectives of the community and health professionals. These barriers are outlined below listed in approximate sequential order in terms of the number of times mentioned during the four meetings and key informant interviews.

Language

Language was identified as the major barrier facing Asian communities by participants at the consultation meetings and key informants. The language barrier can hamper potential health consumers to access and utilise services. Being unable to communicate effectively can also cause miscommunication and can impact on the quality of health care services in terms of costs, incorrect assessments or intervention, and inefficiencies.

Key informants noted that Asian peoples find accessing health care services problematic because they find it difficult to describe their health problems to the health professionals. Also, Asian peoples find it difficult to understand the process, diagnosis and case management plan explained to them because English is not their first language. This problem is compounded by the scarcity of Asian-speaking health professionals.

Culture

Participants at the consultation meetings noted that variations in interpretations of medical knowledge and practices are not recognised by health care services and health professionals. This was also noted by key informants. Different Asian ethnic groups have different values and beliefs. Traditional medicine and practices are often lost and not acknowledged by Western medicine. Further, the notion of culture extends beyond language differences and emphasises differences in lifestyle and health care priorities. For example, differences in child-rearing practices, different cultural norms and different interpretation of mental health issues can hinder the effectiveness of prevention and intervention programmes for Asian people.

Key informants noted that some programmes in mainstream (Western) health care services recruit Asian participants. However, retention and completion rates are poor because of early dropouts. The main reason for withdrawals is due to variations in cultural perceptions in terms of the aims and practices of these programmes. For example, lack of cultural sensitivity in antenatal classes, and between practice techniques in Asian communities and those taught in mainstream classes. Often the meanings are not shared, values and beliefs are distinctively different, and most programmes are designed for particular groups, memberships and societies that do not fit the Asian paradigm. Consequently, Asian peoples will only access mainstream health care services when their health issues are critical.

Inaccessible health care services

Participants at the consultation meetings commented that mainstream health care services are unable to attract Asian people to use the services because they appear inhospitable. A lack of Asian health professionals in mainstream services means that many services are not perceived as being culturally appropriate. A lack of knowledge of available services and limited promotion through Asian media and networks creates barriers.

A related theme emerged from the key informant interviews where many informants commented that there are differences between the New Zealand health care system and the Asian health care systems back in their homelands. Asian people living in New Zealand may have different perceptions, interpretations, and expectations of health as well as of the health system. Moreover, not knowing the New Zealand health system also poses a significant hurdle for Asian people, as they do not know how and where to seek help when health problems arise.

Health information

Participants at the consultation meetings noted that there is a lack of research on Asian health issues and available resources.

Transportation

Some key informants suggested that transportation is a barrier to Asian people especially for older people.

Cost and resources

Participants at the consultation meetings and key informants stated that the cost of health care service utilisation for Asian communities is another barrier, especially in major health issues where costs and lack of resources might deter usage.

Rights

Key informants highlighted that another cause for major health issues concerning Asian communities is their unfamiliarity with consumer rights. This is an interesting phenomenon because many Asian peoples are unaware that they have rights such as requesting an interpreter when in a public health care centre. So many Asian peoples are reluctant to seek medical assistance and opt for other alternatives such as traditional and medicinal treatment. Currently health promotion work in this area is limited and this is compounded by Asian peoples' non-utilisation of health care services. The net effect of this is that small health issues become significant issues and recovery is slow.

Preconceptions

Another barrier identified by key informants is that there is a misconception that Asian peoples are self-sufficient and have the means to take care of themselves. The reality is that most Asian communities are dependent on public health care service provision. Preconceived notions about Asian communities are a barrier because health care services become reluctant to assist, or assume that Asian communities will somehow cope.

Workforce

The lack of Asian-speaking health professionals was seen as a barrier by participants at the consultation meetings. Migrants who are overseas-qualified health professionals are often not employable because they do not meet the standards set in New Zealand. Participants commented that re-training programmes should be more available so that these bi-lingual/cultural health professionals can register in New Zealand and serve the community. Participants stated that Asian-speaking health professionals would be valuable assets because they can counteract the impacts that arise from language barriers.

Holism

The lack of a holistic approach to health care provision was perceived as another barrier by participants at the consultation meetings. Asian health issues can be related to social, cultural and economic status. Health professionals and health care services often fail to acknowledge factors other than health symptoms in their assessment and treatment. Knowledge of wider factors such as Asian family life and Asian medical practice and

treatment, are essential components in developing a more culturally-appropriate health care system for Asian communities.

Solutions arising from the consultation meetings and key informant interviews

Participants at the consultation meetings and key informants suggested several solutions to improve the current health status of Asian communities focusing on education, resource development, workforce development and service reconfigurations.

Education

Educational strategies to address Asian health issues were the primary solutions expressed by participants at the consultation meetings and key informant interviews. Participants at the consultation meetings stated that an education approach should include the development of Asian publications (such as pamphlets composed in the various languages of the main Asian ethnic groups), greater use of Asian media (such as Asian radio and television) and Asian community outreach services delivering health messages.

Key informants identified education as essential towards developing solutions to Asian health issues, causes and barriers. Health care service providers, health policy-makers and community networks needed to ensure that Asian communities are well informed, have greater access to services and are more responsive to Asian health concerns. Key informants saw benefits in early intervention through community outreach programmes, the use of health promotion programmes, and through intersectoral strategies (eg, between the Ministry of Health and the Immigration Department to improve the migration experience).

Key informants also saw the need for the development of resources such as publications and health promotion materials in the various Asian languages so as to reach Asian communities effectively. Other developments should focus on greater utilisation of Asian radio, newspapers and existing community organisations such as churches or temples to disseminate information such as health facts and health promotion programmes. Organising large-scale events such as open health days, Asian health expos, Asian health conferences, and an Asian health policy interface with Asian communities is important. An investment in initiatives such as Asian mobile outreach units is another suggested innovation that highlights human resources and personalising the delivery of health information to Asian communities. Targeting resources to particular high priority population subgroups such as children, youth and the elderly is considered another effective strategy. Creating an inventory or directory of Asian health professionals and Asian health care service providers for distribution was also considered useful.

The Three Cs (collaboration, consultation and co-operation) approach

Another key theme from participants at the consultation meetings was the need for mainstream agencies and providers to establish relationships with Asian communities. Fundamental to this was formalising partnerships and alliances.

Participants supported the need for an Asian advisory group to be set up to provide advice to health interest groups, government, local authorities, researchers and policy-makers. Respondents suggested this group could be made up of Asian ethnic group representation from the community, health professionals, and government and funder representatives, researchers and policy analysts.

In particular some participants called for the formation of an Asian advisory council for health in each of the local authorities as an essential step in bringing Asian health concerns closer to

local government, businesses and other non-government agencies. This would also enable greater consultation and co-operation with prospective partners.

This approach was also supported by key informants (see Asian Health Council below).

Service reconfigurations

Key informants noted five areas where health service reconfiguration should be considered. Participants at the consultation meetings also suggested the one-stop-shop approach, support groups, an Asian hotline and some form of Asian health council.

i. Asian health centre

Participants at the consultation workshops and key informants noted that an example of a holistic approach was to have a one-stop-shop where all services (primary health care and public health services) are under one roof. Participants stated that this approach would be more responsive and effective for Asian communities. Participants also commented that the centre could act as a venue to collate information for the Asian community and provide public health programmes.

ii. Support groups

Key informants recommended that current health care service providers should consider establishing specific support groups for Asian communities to be facilitated by Asian professionals. Support groups need not be attached to mainstream health services but can be contracted from specialised consultation groups for Asian peoples. Support groups could also provide personal services. This approach encourages closer ties with Asian communities and can be modified over time to suit the dynamics of demographic changes as well as the varying health priorities of Asian communities. Participants at the consultation meetings expressed the need for the establishment of support groups (such as mental health consumers, new mothers, parents groups and older peoples' groups) based in the community.

iii. Asian health council

Key informants (similarly to the participants in the consultation meetings) saw a key ingredient to improve current health care service providers as the establishment of an Asian Health Council as it could provide a channel for Asian health issues and solutions to be heard at higher levels of health administration. Co-operation and collaboration with Asian communities is imperative because it includes a wider range of interest groups such as churches, consumers and practitioners advising on Asian health outcomes. An Asian health council could act as an 'expert' group and provide direct advice to policy-makers, service providers, practitioners and the community on Asian health issues and proposed troubleshooting strategies (short term and long term).

iv. Asian hotline

Participants at the consultation meetings and key informants considered a hotline to provide information on available health services in various Asian languages could assist consumers to access health services at the appropriate time. It would also be easily accessible because language barriers would be minimised.

v. Community support workers

It was suggested that community support workers could provide personal support services such as home visits and transporting to medical appointments for Asian communities.

Funding

Participants at the consultation workshops also called for further funding of Asian-specific health programmes and investment in developing resources. Participants thought that funding could be derived from the government and other state institutions.

Workforce development

Participants at the consultation workshops and key informants felt that there was a need to recruit and train more Asian health professionals. Participants at the consultation workshops also advocated that mainstream health professionals need to be trained on Asian cultural perspectives to improve communication with Asian patients.

Key informants provided suggestions on how to achieve Asian workforce development through the following:

- Providing training and a professional development curriculum for mainstream health professionals on Asian medical knowledge and practices so non-Asian health professionals and practitioners have a greater appreciation and sensitivity towards Asian peoples and their health issues.
- Establishing health policies that include workforce development strategies and recruitment of qualified Asian health professionals to ensure Asian communities are better served.
- Considering innovative recruitment policies such as employment of Asian mentors or elders (eg, recruit through churches or temples) to work closely on matters regarding interpretation, dissemination of information and health promotions work, working within mainstream and community health providers.
- Creating a consultation network of Asian community leaders to be trained on health issues and provide relationship-building interfaces between mainstream health services and Asian communities.

Research

Participants at the consultation meetings noted that research was required into Asian health issues and a key starting point was the generation of Asian health information. This information could then be used for planning, policy development and generally to advance Asian health needs. It was noted that the New Zealand Health Information Service does not provide specific data on Asian communities.

Key informants also highlighted that little is known about Asian health status and research activity in this area is limited. Further research into Asian health issues is needed to provide good information for programme planning and evaluation.

Policy

Key informants recommended that policy should reflect all ethnic groups including Asian, in order for it to be effective and responsive. Most policies absorb Asian interests into labels such as ‘diversity’ and so specific health issues, causes, barriers and solutions are concealed. As a consequence, Asian communities are lost in the paperwork. Policy planning, development, implementation and evaluation should be at central government, local authority, and community levels. Moreover, policy formation should also include ongoing consultation with Asian community leaders, service providers and practitioners. Participants at the consultation workshops called for a national policy to address Asian health needs.

Conclusions from community consultation meetings and key informant interviews

The consultation meetings and key informant interviews were useful in identifying the perceived major health issues, perceived difficulties or barriers in accessing public health services, and possible strategies to address public health issues in Asian communities within the Auckland region. The community participants and the key informants responded very positively to being involved in the project and made significant contributions by offering support and sharing their thoughts with the project team.

Both the community consultations and key informant interviews identified mental health as a leading public health issue. This was related to the migration process and the requirements to adapt to a new country. The other prominent public health issues identified included heart disease, high blood pressure and diabetes. Sexual health was identified as an area of concern, particularly the perceived increase in sexually transmitted diseases and unwanted pregnancies. Many other health issues were raised that have been outlined. Many participants in the consultation meetings commented that language and cultural barriers are the biggest obstacles to better utilisation of health services.

The Asian community and the key informants are keen to effect changes to improve the health of their community. Participants at the consultation meetings commented that education is the most essential component of the solution. Education needs to delivered in a culturally-appropriate manner, rather than in simple language translations. One way of achieving this is by working more closely and in partnership with Asian communities and health professionals. Improved collaboration and involvement of various sectors (eg, government agencies, health service providers, and the community) is seen as an integral part of the solution.

Participants from the community consultation meetings and key informant interviews stressed that many Asian communities are keen to be involved and support initiatives aimed at promoting Asian community wellbeing.

7. Conclusions and recommendations

This report provides a comprehensive snapshot of Asian public health issues in New Zealand with a focus on the Auckland region by compiling demographic, socioeconomic, health status and research data. These data are supplemented by data proactively collected through a series of four consultation meetings and interviews with key informants.

This report will be useful for a range of decision-makers, planners, practitioners and anyone interested in making improvements to Asian population health. This report is a first small step to making Asian health issues more visible. The preparation of this report has helped focus the funding of some initial public health initiatives in the Auckland region aimed at enhancing mainstream services to be more responsive to Asian communities and also provide some resources for Asian communities to become more active in public health initiatives.

Overall, Asian peoples in the Auckland region generally have a good health status, but there are some population sub-groups who have very poor health. There is also a danger that Asian people's current health status will deteriorate if they continue to have difficulty accessing information and services. Asian people, particularly new migrants, face language and economic barriers to improved health status. A number of challenges have been identified in this report and it will be important for public health funders and providers to address these as the Asian population continues to increase.

Overseas studies indicate that effective public health for Asian people requires the development of culturally-appropriate or sensitive programmes. There is value in seeking ways of extending nutrition, physical activity, healthy lifestyle programmes and other health promotion programmes for key Asian population groups.

From the consultation meetings and general working of the Project Team, it appears that there are some strong positive indicators for improving Asian public health. In particular, the Asian communities in the Auckland region appear to be generally cohesive, have a strong sense of culture, identity and belonging, and an eagerness to participate and integrate into mainstream service delivery. Asian networks are already reasonably well established and some successful initiatives are underway.

The following recommendations are made by the Asian Public Health Project Team to provide both specific and general direction for the Ministry of Health, District Health Boards, public health providers and government agencies generally to better address the public health needs of the increasing Asian population within Auckland and New Zealand. The Project Team has agreed to continue for at least a further 12 months to oversee the implementation and monitoring of the recommendations.

Recommendations

The Asian Public Health Project team recommends:

1. Funding recommendations

i. Public health

1.1 That the Ministry of Health, District Health Boards and providers ensure that core public health services address the needs of Asian populations, including cultural training for staff, and development of appropriate resources in consultation with Asian communities.

1.2 That the Ministry of Health amongst others, funds the ongoing development of Asian community organisation/s that can provide mainstream organisations with assistance on cultural input into programme design and delivery around public health issues.

1.3 That the Ministry of Health funds advocacy around Asian public health issues.

1.4 That the Ministry of Health maintains the Asian Public Health Project Team (or similar community partnership) for at least one year to assist with planning, implementation and monitoring the recommendations outlined in this report.

ii. Personal health services

1.5 That health funders and other government agencies ensure there is adequate funding of interpreters, appropriate health education resources (including translations) and culturally-appropriate services for Asian populations.

1.6 That health funders fund initiatives and programmes that add value to the information already provided by the Department of Internal Affairs (for new migrants) to ensure that Asian populations are fully aware of and understand the New Zealand health system, their health entitlements, and their health rights.

2. Policy recommendations

That the Asian Public Health Project Team and the Asian Network advocate for:

2.1 central government agencies, local government authorities and District Health Boards to include the Asian population in policy development, include Asian communities in appropriate consultation processes and ensure Asian community representation in decision-making processes

2.2 central government agencies and other national organisations to acknowledge New Zealand's regional differences (eg, high percentage of Asian peoples in Auckland) within national planning

2.3 immigration policy to include well resourced and supported settlement policies that are integrated with other policies (eg, education, employment, housing and Asian health professional recruitment and registration)

2.4 social policy (eg, housing, employment, education, immigration, child, youth and family, local government) to be inclusive of Asian populations and to align with immigration policy

2.5 government strategies to include targeted interventions for Asian populations (eg, the New Zealand Injury Prevention Strategy, the Responsible Gambling Bill)

2.6 the category 'Other' used in data collection and reporting by agencies to be disaggregated into identifiable ethnic minority groupings (eg, an overall Asian category based on the census definition)

2.7 relevant government organisations (eg, the Office of Ethnic Affairs) to be mandated to carry out regular monitoring, evaluation and auditing of policies to determine appropriate reference to the Asian communities within New Zealand (Note: This role is in line with similar roles carried out by Te Puni Kokiri and the Ministry of Pacific Island Affairs).

3. Health services recommendations

That the Asian Public Health Project Team and the Asian Network advocate for:

3.1 District Health Boards and other health service providers to deliver services that are more responsive, accessible and culturally-appropriate for Asian populations

3.2 health service staff to have access to resources and interpreters in key Asian languages

3.3 health service providers to develop outreach programmes to improve access to diverse communities

3.4 the Ministry of Health, District Health Boards and health services to commence service planning to address the future needs of an increasing Asian population that could reach 20 percent of the overall Auckland population by 2021

3.5 mainstream health services to develop services that are inclusive of Asian populations

3.6 government agencies and non-government organisations to work to raise the awareness of providers around priorities and service delivery issues relating to Asian populations

3.7 health services to utilise the expertise of community leaders to access Asian communities and to deliver health promotion programmes.

4. Community development and community action recommendations

That the Asian Public Health Project Team and the Asian Network support:

4.1 the Asian community to develop appropriate community structures (eg, the development of the Asian Network in Auckland) to promote and advocate for Asian health and wellbeing (eg, encourage mainstream services to be more inclusive of Asian populations)

4.2 the Ministry of Health, District Health Boards and other health services to provide opportunities and funding for Asian communities to mobilise themselves around health issues

4.3 the Auckland Regional Public Health Service to develop and disseminate a directory of Asian health services, information on the health system and access to relevant health information and resources (eg, development of a central information mechanism including a website) to Asian communities in the Auckland region.

5. Health workforce recommendations

That the Asian Public Health Project Team and the Asian Network advocate for:

5.1 the Ministry of Health and District Health Boards to encourage mainstream public health providers to recruit and support staff to fully reflect the ethnicity of the populations they serve

5.2 all health providers to ensure management and staff have a high level of cultural sensitivity and awareness around Asian issues. This might include:

- on-the-job training
- Asian cultural awareness training and workforce development programmes (including undergraduate health professional training)
- access to appropriate cultural expertise
- the development of multi-cultural teams

5.3 central government agencies and District Health Boards to develop policy and programmes to facilitate both recruitment of more Asian health professionals and assistance for health professionals from Asia to gain registration or re-training.

6. Research recommendations

That the Asian Public Health Project Team and the Asian Network advocate for:

6.1 central government agencies to establish a consistent definition of the Asian ethnicity categories based on the census definition for use in data collection by various agencies

6.2 central government agencies and District Health Boards to commence ongoing data collection (especially New Zealand Health Information Statistics, but also other data sets) and reporting using an Asian population category (as opposed to the currently often used 'Other' category) at national, regional and district levels

6.3 research funders and researchers to establish an ongoing research programme relating to Asian health status and gaps in services - the research should:

- focus on established priorities, such as mental health, lifestyle factors that lead to heart disease and diabetes, and sexual and reproductive health
- establish a mechanism to co-ordinate Asian population research.
- encourage the compilation and dissemination of available research
- foster integration of evaluation, research and practice

6.4 central government agencies to establish reporting on inequalities in health and socio-economic status (eg, NZDEP – scale of deprivation) in Asian populations

6.5 research funders to consider research that investigates the role of traditional Asian medicines in New Zealand.

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Martin Dawe of Health & Safety Developments provided overall project management and compilation of the report on contract.

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Appendix 1: Asian Public Health Project Team members

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Appendix 2: Census categories used for Asian ethnicity

4	Asian
40	Asian nfd
400	Asian nfd
40000	Asian nfd
41	Southeast Asian
410	Southeast Asian nfd
41000	Southeast Asian nfd
411	Filipino
41111	Filipino
412	Khmer/Kampuchean/Cambodian
41211	Khmer/Kampuchean/Cambodian
413	Vietnamese
41311	Vietnamese
414	Other Southeast Asian
41411	Burmese
41412	Indonesian (incl Javanese/Sundanese/Sumatran)
41413	Lao/Laotian
41414	Malay/Malayan
41415	Thai/Tai/Siamese
41499	Other Southeast Asian nec
42	Chinese
421	Chinese
42100	Chinese nfd
42111	Hong Kong Chinese
42112	Kampuchean Chinese
42113	Malaysian Chinese
42114	Singaporean Chinese
42115	Vietnamese Chinese
42116	Taiwanese Chinese
42199	Chinese nec
43	Indian
431	Indian
43100	Indian nfd
43111	Bengali
43112	Fijian Indian/Indo-Fijian
43113	Gujarati
43114	Tamil
43115	Punjabi
43116	Sikh
43199	Indian nec
44	Other Asian
441	Sri Lankan
44100	Sri Lankan nfd
44111	Sinhalese
44112	Sri Lankan Tamil
44199	Sri Lankan nec
442	Japanese
44211	Japanese
443	Korean
44311	Korean
444	Other Asian
44411	Afghani
44412	Bangladeshi
44413	Nepalese
44414	Pakistani
44415	Tibetan
44499	Other Asian nec

Appendix 3: Age and gender breakdown of population by ethnicity for the Auckland region and DHB (2001 Census)

Note: All figures from Census 2001.

Table 11: Age breakdown of Auckland region male population by ethnicity

Male	European	Māori	Pacific peoples	Asian	Others	Total
0-4	20,472	8,682	8,787	5,241	2,529	45,711
5-9	21,813	8,253	8,685	5,532	2,352	46,635
10-14	22,251	7,374	7,737	6,042	2,361	45,765
15-19	20,025	5,871	5,991	8,277	2,511	42,675
20-24	20,043	5,418	5,574	6,942	2,670	40,647
25-29	22,641	5,127	5,331	4,797	2,838	40,734
30-34	26,865	4,908	5,421	5,325	3,225	45,744
35-39	28,380	4,650	4,902	6,747	3,207	47,886
40-44	27,240	3,657	3,888	5,784	2,811	43,380
45-49	24,543	2,859	3,258	4,650	2,448	37,758
50-54	24,819	2,175	2,541	3,585	2,250	35,370
55-59	19,278	1,515	1,800	2,169	1,587	26,349
60-64	15,564	1,095	1,386	1,941	1,368	21,354
65-69	11,952	666	954	1,395	1,053	16,020
70-74	11,193	369	705	741	993	14,001
75-79	8,631	192	372	369	699	10,263
80-84	5,169	81	168	186	414	6,018
85+	3,372	63	69	96	276	3,876
Total	334,251	62,955	67,569	69,819	35,592	570,186

Table 12: Age breakdown of Auckland region female population by ethnicity

Female	European	Māori	Pacific peoples	Asian	Others	Total
0-4	19,344	8,340	8,598	5,163	2,412	43,857
5-9	20,541	7,854	8,055	5,238	2,241	43,929
10-14	21,156	7,254	7,368	5,715	2,214	43,707
15-19	19,326	6,108	6,231	7,866	2,283	41,814
20-24	20,061	6,144	6,258	7,182	2,451	42,096
25-29	24,465	6,006	6,003	5,988	2,697	45,159
30-34	28,776	5,661	6,300	7,290	3,165	51,192
35-39	29,655	5,118	5,598	7,932	3,090	51,393
40-44	28,173	4,317	4,416	7,074	2,784	46,764
45-49	25,839	3,201	3,372	5,505	2,343	40,260
50-54	25,278	2,442	2,712	3,807	2,136	36,375
55-59	19,824	1,668	2,034	2,346	1,677	27,549
60-64	15,594	1,338	1,635	1,983	1,419	21,969
65-69	12,480	834	1,236	1,392	1,128	17,070
70-74	12,717	495	912	837	1,065	16,026
75-79	11,655	252	543	522	936	13,908
80-84	8,814	156	300	258	741	10,269
85+	8,385	84	168	186	651	9,474
Total	352,083	67,272	71,739	76,284	35,433	602,811

Table 13: Age breakdown of Auckland region population by ethnicity

Total	European	Māori	Pacific peoples	Asian	Others	Total
0-4	39,816	17,022	17,385	10,404	4,941	89,568
5-9	42,354	16,107	16,740	10,770	4,593	90,564
10-14	43,407	14,628	15,105	11,757	4,575	89,472
15-19	39,351	11,979	12,222	16,143	4,794	84,489
20-24	40,104	11,562	11,832	14,124	5,121	82,743
25-29	47,106	11,133	11,334	10,785	5,535	85,893
30-34	55,641	10,569	11,721	12,615	6,390	96,936
35-39	58,035	9,768	10,500	14,679	6,297	99,279
40-44	55,413	7,974	8,304	12,858	5,595	90,144
45-49	50,382	6,060	6,630	10,155	4,791	78,018
50-54	50,097	4,617	5,253	7,392	4,386	71,745
55-59	39,102	3,183	3,834	4,515	3,264	53,898
60-64	31,158	2,433	3,021	3,924	2,787	43,323
65-69	24,432	1,500	2,190	2,787	2,181	33,090
70-74	23,910	864	1,617	1,578	2,058	30,027
75-79	20,286	444	915	891	1,635	24,171
80-84	13,983	237	468	444	1,155	16,287
85+	11,757	147	237	282	927	13,350
Total	686,334	130,227	139,308	146,103	71,025	1,172,997

Table 14: Age breakdown of Waitemata DHB male population by ethnicity

Male	European	Māori	Pacific peoples	Asian	Others	Total
0-4	9,264	2,724	1,677	1,431	744	15,840
5-9	10,314	2,508	1,620	1,593	816	16,851
10-14	10,512	2,319	1,410	1,905	762	16,908
15-19	9,219	1,815	1,149	2,586	807	15,576
20-24	8,145	1,710	1,086	1,794	750	13,485
25-29	8,814	1,587	1,089	1,083	840	13,413
30-34	11,034	1,608	1,071	1,365	1,017	16,095
35-39	12,258	1,527	1,005	1,812	1,002	17,604
40-44	11,943	1,173	753	1,581	930	16,380
45-49	10,683	876	642	1,305	795	14,301
50-54	10,908	612	492	1,020	747	13,779
55-59	8,406	435	294	555	546	10,236
60-64	6,792	321	222	477	426	8,238
65-69	5,430	168	159	327	351	6,435
70-74	4,962	120	114	183	333	5,712
75-79	3,744	66	60	90	237	4,197
80-84	2,133	27	21	48	156	2,385
85+	1,284	18	15	18	84	1,419
Total	145,845	19,614	12,879	19,173	11,343	208,854

Table 15: Age breakdown of Waitemata DHB female population by ethnicity

Female	European	Māori	Pacific peoples	Asian	Others	Total
0-4	8,958	2,577	1,605	1,419	777	15,336
5-9	9,747	2,451	1,521	1,581	705	16,005
10-14	10,170	2,184	1,443	1,716	780	16,293
15-19	8,922	1,890	1,155	2,376	756	15,099
20-24	7,659	1,776	1,200	1,746	732	13,113
25-29	9,678	1,731	1,179	1,377	849	14,814
30-34	12,189	1,677	1,194	1,998	1,038	18,096
35-39	13,113	1,581	1,116	2,256	975	19,041
40-44	12,624	1,350	885	2,187	963	18,009
45-49	11,277	882	675	1,599	783	15,216
50-54	11,163	699	549	1,062	717	14,190
55-59	8,829	432	384	579	549	10,773
60-64	7,062	375	288	495	486	8,706
65-69	5,625	210	228	330	411	6,804
70-74	5,628	138	159	216	366	6,507
75-79	5,007	63	81	147	297	5,595
80-84	3,564	42	48	63	252	3,969
85+	3,033	24	24	42	204	3,327
Total	154,248	20,082	13,734	21,189	11,640	220,893

Table 16: Age breakdown of Waitemata DHB total population by ethnicity

Total	European	Māori	Pacific peoples	Asian	Others	Total
0-4	18,222	5,301	3,282	2,850	1,521	31,176
5-9	20,061	4,959	3,141	3,174	1,521	32,856
10-14	20,682	4,503	2,853	3,621	1,542	33,201
15-19	18,141	3,705	2,304	4,962	1,563	30,675
20-24	15,804	3,486	2,286	3,540	1,482	26,598
25-29	18,492	3,318	2,268	2,460	1,689	28,227
30-34	23,223	3,285	2,265	3,363	2,055	34,191
35-39	25,371	3,108	2,121	4,068	1,977	36,645
40-44	24,567	2,523	1,638	3,768	1,893	34,389
45-49	21,960	1,758	1,317	2,904	1,578	29,517
50-54	22,071	1,311	1,041	2,082	1,464	27,969
55-59	17,235	867	678	1,134	1,095	21,009
60-64	13,854	696	510	972	912	16,944
65-69	11,055	378	387	657	762	13,239
70-74	10,590	258	273	399	699	12,219
75-79	8,751	129	141	237	534	9,792
80-84	5,697	69	69	111	408	6,354
85+	4,317	42	39	60	288	4,746
Total	300,093	39,696	26,613	40,362	22,983	429,747

Table 17: Age breakdown of Auckland DHB male population by ethnicity

Male	European	Māori	Pacific peoples	Asian	Others	Total
0-4	5,682	1698	2532	2133	897	12,942
5-9	5,307	1,539	2,532	2,169	735	12,282
10-14	5,328	1,392	2,316	2,220	753	12,009
15-19	5,115	1,215	1,842	3,435	876	12,483
20-24	7,251	1,392	1,785	3,420	1,101	14,949
25-29	8,775	1,347	1,677	2,409	1,146	15,354
30-34	9,354	1,191	1,779	2,535	1,269	16,128
35-39	8,895	1,125	1,557	3,087	1,206	15,870
40-44	8,082	897	1,272	2,442	999	13,692
45-49	7,272	687	1,071	1,920	828	11,778
50-54	7,185	492	747	1,422	813	10,659
55-59	5,406	354	594	876	570	7,800
60-64	4,239	303	450	837	486	6,315
65-69	3,225	180	357	615	375	4,752
70-74	3,165	93	276	315	327	4,176
75-79	2,658	54	153	159	234	3,258
80-84	1,764	24	72	81	129	2,070
85+	1,257	24	30	54	96	1,461
Total	99,960	14,007	21,042	30,129	12,840	177,978

Table 18: Age breakdown of Auckland DHB female population by ethnicity

Female	European	Māori	Pacific peoples	Asian	Others	Total
0-4	5,274	1,560	2,535	2,109	786	12,264
5-9	4,947	1,434	2,376	2,001	747	11,505
10-14	4,974	1,410	2,184	2,199	660	11,427
15-19	5,181	1,350	1,830	3,372	750	12,483
20-24	7,947	1,617	2,025	3,696	1005	16,290
25-29	9,363	1,518	1,902	3,072	1056	16,911
30-34	9,708	1,317	2,016	3,477	1197	17,715
35-39	9,021	1,152	1,812	3,459	1110	16,554
40-44	8,223	1,014	1,449	2,796	942	14,424
45-49	7,650	816	1,116	2,211	777	12,570
50-54	7,245	585	843	1,521	762	10,956
55-59	5,385	426	642	972	573	7,998
60-64	4,158	363	618	858	456	6,453
65-69	3,306	246	477	597	363	4,989
70-74	3,753	141	348	342	366	4,950
75-79	3,789	90	222	210	336	4,647
80-84	3,141	54	123	123	264	3,705
85+	3,429	39	72	99	282	3,921
Total	106,494	15,132	22,590	33,114	12,432	189,762

Table 19: Age breakdown of Auckland DHB total population by ethnicity

Total	European	Māori	Pacific poeples	Asian	Others	Total
0-4	10,956	3,258	5,067	4,242	1,683	25,206
5-9	10,254	2,973	4,908	4,170	1,482	23,787
10-14	10,302	2,802	4,500	4,419	1,413	23,436
15-19	10,296	2,565	3,672	6,807	1,626	24,966
20-24	15,198	3,009	3,810	7,116	2,106	31,239
25-29	18,138	2,865	3,579	5,481	2,202	32,265
30-34	19,062	2,508	3,795	6,012	2,466	33,843
35-39	17,916	2,277	3,369	6,546	2,316	32,424
40-44	16,305	1,911	2,721	5,238	1,941	28,116
45-49	14,922	1,503	2,187	4,131	1,605	24,348
50-54	14,430	1,077	1,590	2,943	1,575	21,615
55-59	10,791	780	1,236	1,848	1,143	15,798
60-64	8,397	666	1,068	1,695	942	12,768
65-69	6,531	426	834	1,212	738	9,741
70-74	6,918	234	624	657	693	9,126
75-79	6,447	144	375	369	570	7,905
80-84	4,905	78	195	204	393	5,775
85+	4,686	63	102	153	378	5,382
Total	206,454	29,139	43,632	63,243	25,272	367,740

Table 20: Age breakdown of Counties Manukau DHB male population by ethnicity

Male	European	Māori	Pacific peoples	Asian	Others	Total
0-4	5,526	4,260	4,578	1,677	888	16,929
5-9	6,192	4,206	4,533	1,770	801	17,502
10-14	6,411	3,663	4,011	1,917	846	16,848
15-19	5,691	2,841	3,000	2,256	828	14,616
20-24	4,647	2,316	2,703	1,728	819	12,213
25-29	5,052	2,193	2,565	1,305	852	11,967
30-34	6,477	2,109	2,571	1,425	939	13,521
35-39	7,227	1,998	2,340	1,848	999	14,412
40-44	7,215	1,587	1,863	1,761	882	13,308
45-49	6,588	1,296	1,545	1,425	825	11,679
50-54	6,726	1,071	1,302	1,143	690	10,932
55-59	5,466	726	912	738	471	8,313
60-64	4,533	471	714	627	456	6,801
65-69	3,297	318	438	453	327	4,833
70-74	3,066	156	315	243	333	4,113
75-79	2,229	72	159	120	228	2,808
80-84	1,272	30	75	57	129	1,563
85+	831	21	24	24	96	996
Total	88,446	29,334	33,648	20,517	11,409	183,354

Table 21: Age breakdown of Counties Manukau DHB female population by ethnicity

Female	European	Māori	Pacific peoples	Asian	Others	Total
0-4	5,112	4,203	4,458	1,635	849	16,257
5-9	5,847	3,969	4,158	1,656	789	16,419
10-14	6,012	3,660	3,741	1,800	774	15,987
15-19	5,223	2,868	3,246	2,118	777	14,232
20-24	4,455	2,751	3,033	1,740	714	12,693
25-29	5,424	2,757	2,922	1,539	792	13,434
30-34	6,879	2,667	3,090	1,815	930	15,381
35-39	7,521	2,385	2,670	2,217	1,005	15,798
40-44	7,326	1,953	2,082	2,091	879	14,331
45-49	6,912	1,503	1,581	1,695	783	12,474
50-54	6,870	1,158	1,320	1,224	657	11,229
55-59	5,610	810	1,008	795	555	8,778
60-64	4,374	600	729	630	477	6,810
65-69	3,549	378	531	465	354	5,277
70-74	3,336	216	405	279	333	4,569
75-79	2,859	99	240	165	303	3,666
80-84	2,109	60	129	72	225	2,595
85+	1,923	21	72	45	165	2,226
Total	91,341	32,058	35,415	21,981	11,361	192,156

Table 22: Age breakdown of Counties Manukau DHB total population by ethnicity

Total	European	Māori	Pacific peoples	Asian	Others	Total
0-4	10,638	8,463	9,036	3,312	1,737	33,186
5-9	12,039	8,175	8,691	3,426	1,590	33,921
10-14	12,423	7,323	7,752	3,717	1,620	32,835
15-19	10,914	5,709	6,246	4,374	1,605	28,848
20-24	9,102	5,067	5,736	3,468	1,533	24,906
25-29	10,476	4,950	5,487	2,844	1,644	25,401
30-34	13,356	4,776	5,661	3,240	1,869	28,902
35-39	14,748	4,383	5,010	4,065	2,004	30,210
40-44	14,541	3,540	3,945	3,852	1,761	27,639
45-49	13,500	2,799	3,126	3,120	1,608	24,153
50-54	13,596	2,229	2,622	2,367	1,347	22,161
55-59	11,076	1,536	1,920	1,533	1,026	17,091
60-64	8,907	1,071	1,443	1,257	933	13,611
65-69	6,846	696	969	918	681	10,110
70-74	6,402	372	720	522	666	8,682
75-79	5,088	171	399	285	531	6,474
80-84	3,381	90	204	129	354	4,158
85+	2,754	42	96	69	261	3,222
Total	179,787	61,392	69,063	42,498	22,770	375,510

Appendix 4: Asian population within the Auckland region's DHBs

This appendix shows the concentration of the Asian population within the three Auckland region District Health Boards.

Asian population in Waitemata DHB

There were 40,362 Asian people living in Waitemata DHB in 2001. Most of them lived in North Shore City (see Figures 12a and 12b).

Figure 12a: Concentration of Asian population within Waitemata DHB

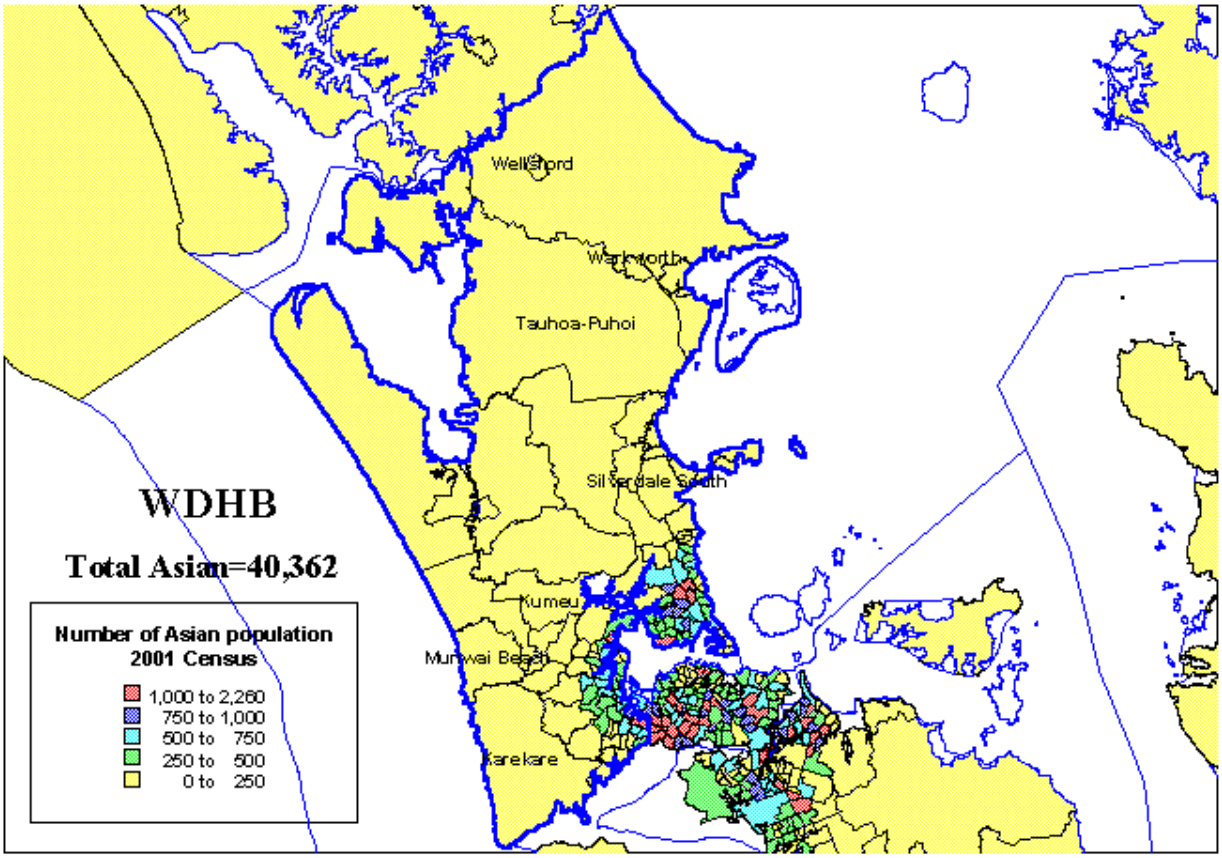

Figure 12b: Concentration of Asian population within Waitemata DHB

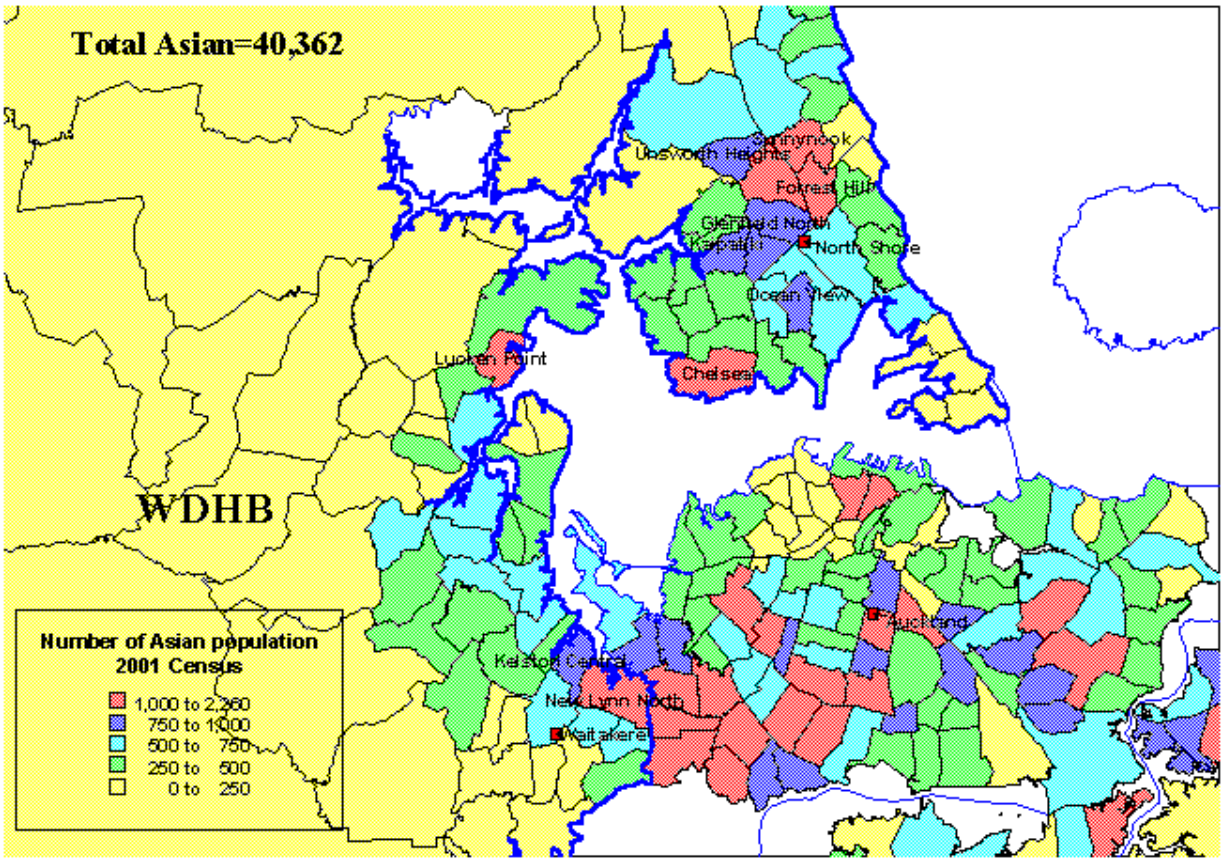

Table 24 shows the number of people identifying with different cultural groups among Asian people in Waitemata DHB. Note that the sum of this table is not the number of people but the total number of affiliations recorded as people can choose to affiliate with more than one group. Chinese was the largest cultural group identified, followed by Korean and Indian people, whose numbers were very similar.

Table 23: Number of Asian population by culture group, Waitemata DHB 2001

Culture group	Waitemata DHB	%
Chinese	17,775	42%
Korean	7,815	18%
Indian	7,602	18%
Filipino	3,009	7%
Japanese	1,431	3%
Other Asian	1,293	3%
Sri Lankan	654	2%
Khmer/Kampuchean/Cambodian	624	1%
Vietnamese	195	0%
Other South-east Asian	2,163	5%
Total	42,561	100%

Asian Population in Auckland DHB

There were 63,243 Asian people living in Auckland DHB. Most of them lived in Meadowbank, Mt Wellington, Epsom, Otahuhu, Mt Albert, Mt Roskill, Blockhouse Bay and around the City.

Figure 13: Concentration of Asian population within Auckland DHB

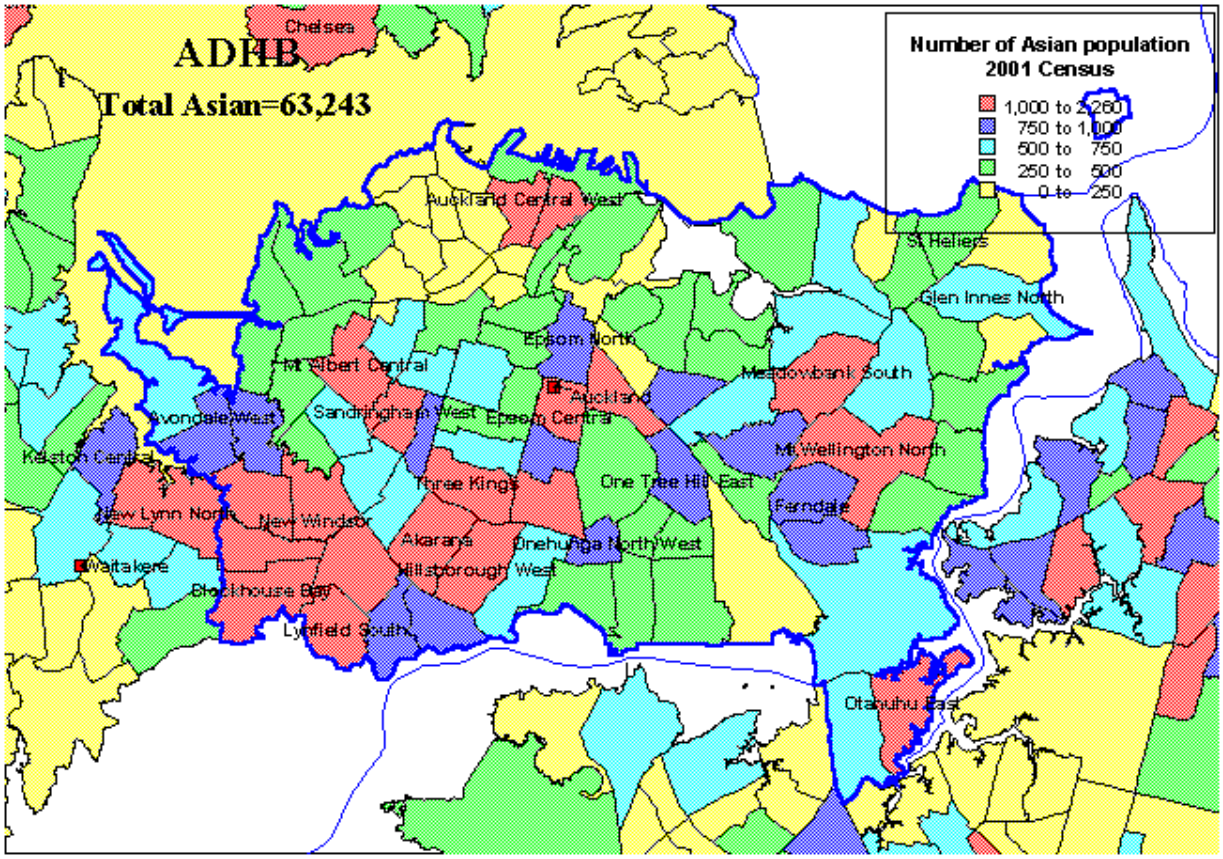

Table 25 shows the number of people identifying with different culture groups among Asian people in Auckland DHB. Note that the sum of this table is not the number of people but the total number of affiliations recorded as people can choose to affiliate with more than one group. Chinese followed by Indian were by far the largest ethnic groups with the number of Korean people a distant third.

Table 24: Number of Asian population by culture group, Auckland DHB 2001

Culture groups	Auckland DHB	%
Chinese	30,282	46%
Indian	19,011	29%
Korean	3,162	5%
Other South-east Asian	2,676	4%
Sri Lankan	2,649	4%
Japanese	2,358	4%
Filipino	1,878	3%
Vietnamese	690	1%
Khmer/Kampuchean/Cambodian	441	1%
Other Asian	2,487	4%
Total	65,634	100%

Asian Population in Counties Manukau DHB

There were 42,498 Asian people living in Counties Manukau DHB. Most of them lived in Manukau City, particularly in Howick and Pakuranga (see Figures 14a and 14b).

Figure 14a: Concentration of Asian population within Counties Manukau DHB

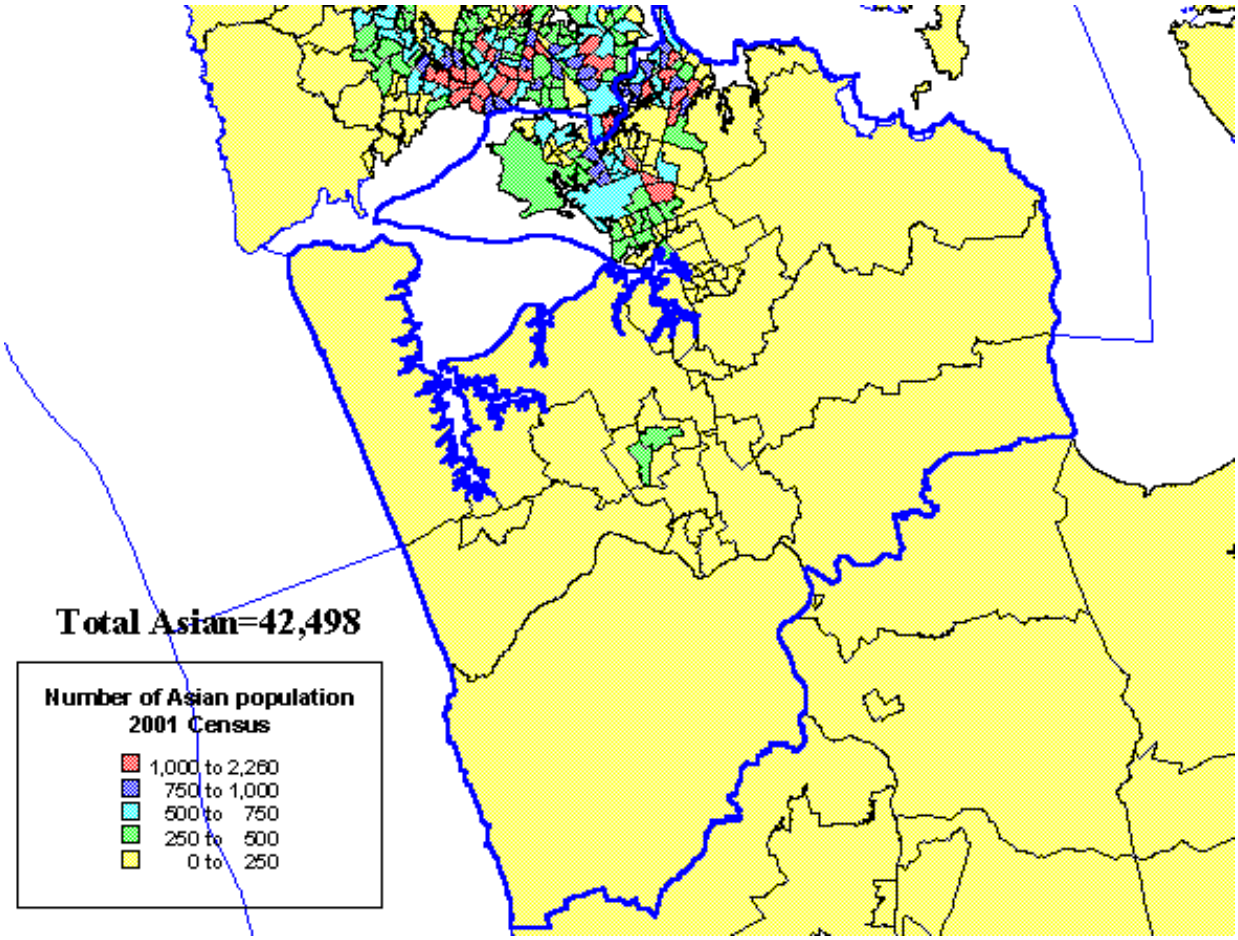

Figure 14b: Concentration of Asian population within Counties Manukau DHB

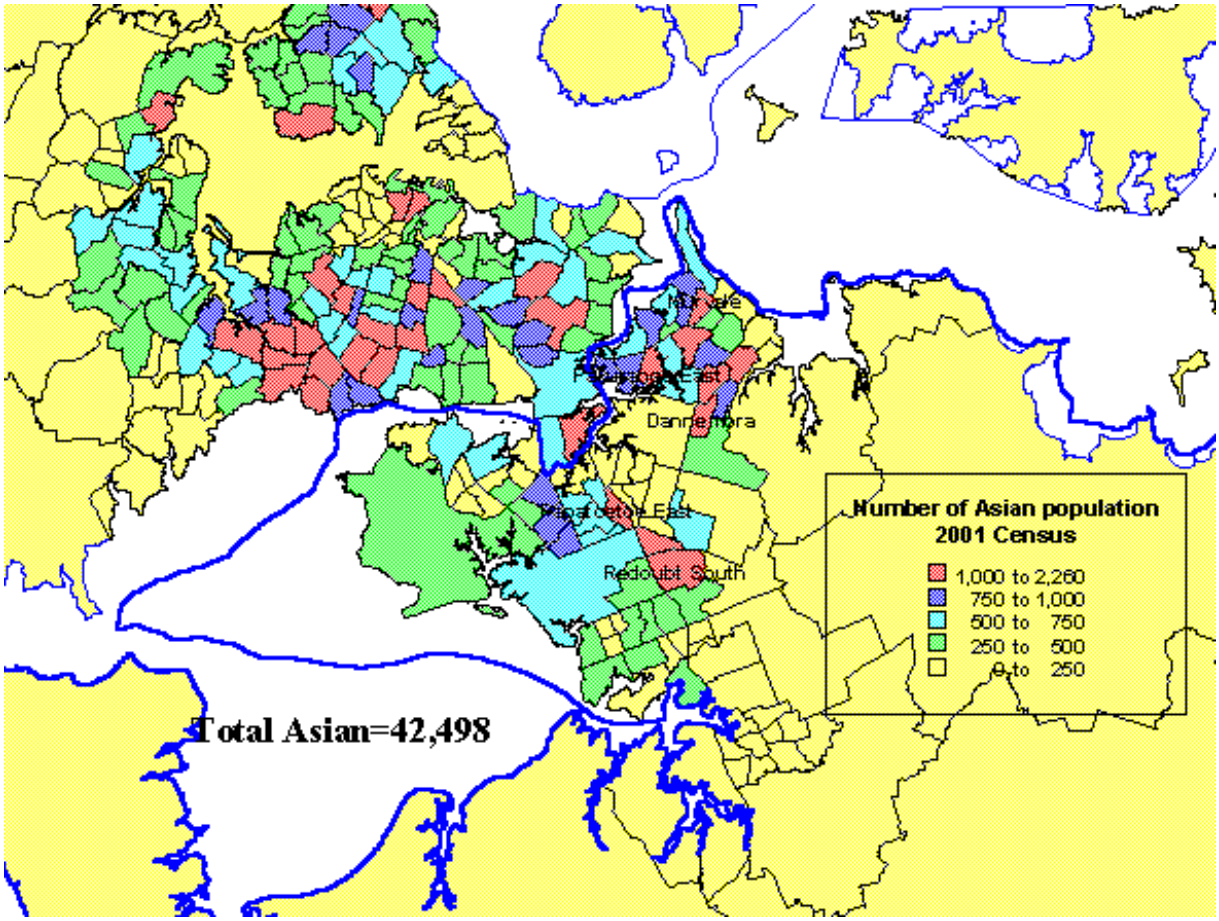

Table 26 shows the number of people identifying with different culture groups among Asian people in Counties Manukau DHB. Note that the sum of this table is not the number of people but the total number of affiliations recorded as people can choose to affiliate with more than one group. As in Auckland DHB, Chinese followed by Indian people were by far the largest groups with Korean people again a distant third.

Table 25: Number of Asian population by culture group, Counties Manukau DHB 2001

Culture groups	Counties Manukau DHB	%
Chinese	20,916	46%
Indian	15,087	33%
Korean	2,343	5%
Khmer/Kampuchean/Cambodian	1,485	3%
Filipino	1,440	3%
Vietnamese	1,359	3%
Other South-east Asian	1,149	3%
Other Asian	861	2%
Sri Lankan	693	2%
Japanese	435	1%
Total	45,768	100%

Appendix 5: Major causes of death by ethnicity in the Auckland region

Table 26: Number of deaths by major causes of death and by ethnicity in the Auckland region between 1996 and 1998

Asian			European		
Major ICDs	**No.**	**%**	**Major ICDs**	**No.**	**%**
Cancer	156	28.9	Cancer	4,895	27.9
Ischaemic heart disease	96	17.8	Ischaemic heart disease	4,135	23.5
Stroke	42	7.8	Stroke	1,781	10.1
Motor vehicle crashes	34	6.3	Circulatory system	1,358	7.7
Diabetes	27	5.0	Chronic obstructive respiratory disease (CORD)	993	5.7
Circulatory system	24	4.4	Pneumonia and influenza	686	3.9
Injury and poisoning	21	3.9	Digestive system	519	3.0
Digestive system	18	3.3	Suicide	337	1.9
Birth defects	18	3.3	Injury and poisoning	306	1.7
Suicide	16	3.0	Genitourinary system	291	1.7
Chronic obstructive respiratory disease (CORD)	14	2.6	Diabetes	250	1.4
Infectious and parasitic disease	11	2.0	Motor vehicle crashes	229	1.3
Genitourinary system	6	1.1	Infectious and parasitic disease	112	0.6
Pneumonia, influenza	3	0.6	Birth defects	93	0.5
Others	54	10.0	Others	1,584	9.0
Total	540	100.0	Total	17,569	100.0
Māori			**Pacific peoples**		
Major ICDs	**No.**	**%**	**Major ICDs**	**No.**	**%**
Cancer	420	27.4	Cancer	402	25.1
Ischaemic heart disease	279	18.2	Ischaemic heart disease	259	16.2
Stroke	64	4.2	Stroke	119	7.4
Pneumonia, influenza	19	1.2	Pneumonia, influenza	38	2.4
Motor vehicle crashes	77	5.0	Motor vehicle crashes	53	3.3
Diabetes	84	5.5	Diabetes	101	6.3
CORD	83	5.4	CORD	75	4.7
Suicide	69	4.5	Suicide	41	2.6
Circulatory system	99	6.5	Circulatory system	144	9.0
Digestive system	22	1.4	Digestive system	49	3.1
Genitourinary system	22	1.4	Genitourinary system	29	1.8
Injury and poisoning	59	3.8	Injury and poisoning	46	2.9
Birth defects	29	1.9	Birth defects	27	1.7
Infectious and parasitic disease	16	1.0	Infectious and parasitic disease	32	2.0
Others	192	12.5	Others	188	11.7
Total	1,534	100.0	Total	1,603	100.0

Table 27: Number of deaths by type of cancer and by ethnicity in the Auckland region between 1996 and 1998

Asian			European		
Type of cancer	**No.**	**%**	**Type of cancer**	**No.**	**%**
Lung	23	14.7	Lung	809	16.5
Large bowel	19	12.2	Large bowel	729	14.9
Leukaemias	16	10.3	Leukaemias	449	9.2
Stomach	13	8.3	Breast	438	8.9
Liver	13	8.3	Prostate	351	7.2
Breast	10	6.4	Cervical	222	4.5
Brain	8	5.1	Head	198	4.0
Head	7	4.5	Pancreas	188	3.8
Pancreas	6	3.8	Stomach	187	3.8
Cervical	5	3.2	Melanoma	172	3.5
Prostate	5	3.2	Brain	147	3.0
Kidney	5	3.2	Bladder	127	2.6
Gall bladder	2	1.3	Kidney	91	1.9
Melanoma	2	1.3	Liver	63	1.3
Bladder	0	0.0	Gall bladder	24	0.5
Other	22	14.1	Other	700	14.3
Total	156	100.0	Total	4,895	100.0
Māori			**Pacific peoples**		
Type of cancer	**No.**	**%**	**Type of cancer**	**No.**	**%**
Lung	149	35.5	Lung	90	22.4
Breast	40	9.5	Breast	51	12.7
Leukaemias	34	8.1	Leukaemias	43	10.7
Cervical	25	6.0	Large bowel	28	7.0
Stomach	21	5.0	Stomach	26	6.5
Large bowel	21	5.0	Liver	25	6.2
Pancreas	19	4.5	Cervical	25	6.2
Liver	16	3.8	Prostate	18	4.5
Head	11	2.6	Pancreas	11	2.7
Prostate	11	2.6	Head	9	2.2
Brain	11	2.6	Bladder	7	1.7
Kidney	6	1.4	Kidney	5	1.2
Gall bladder	5	1.2	Brain	3	0.7
Bladder	4	1.0	Gall bladder	2	0.5
Melanoma	2	0.5	Melanoma	0	0.0
Other	45	10.7	Other	59	14.7
Total	420	100.0	Total	402	100.0

Appendix 6: Major causes of death by age group and ethnicity in the Auckland region

Table 28: Major causes of death by ethnicity for 0-14-year-olds in the Auckland region between 1996 and 1998

Asian			European		
Major ICDs	**No.**	**%**	**Major ICDs**	**No.**	**%**
Birth defects	15	35.7	Birth defects	49	23.6
Condition originated perinatal	8	19.0	Condition originated perinatal	45	21.6
Cancer	5	11.9	Injury and poisoning	24	11.5
Motor vehicle crashes	4	9.5	Cancer	23	11.1
Sudden Infant Death Syndrome (SIDS)	4	9.5	Nervous system	21	10.1
Nervous system	2	4.8	Sudden Infant Death Syndrome (SIDS)	19	9.1
Circulatory system	1	2.4	Motor vehicle crashes	11	5.3
Infectious and parasitic disease	1	2.4	Circulatory system	4	1.9
Injury and poisoning	1	2.4	Infectious and parasitic disease	4	1.9
Pneumonia and influenza	0	0.0	Pneumonia and influenza	1	0.5
Others	1	2.4	Others	7	3.4
Total	42	100.0	Total	208	100.0
Māori			**Pacific peoples**		
Major ICDs	**No.**	**%**	**Major ICDs**	**No.**	**%**
Condition originated perinatal	38	22.8	Condition originated perinatal	39	30.2
SIDS	34	20.4	Birth defects	20	15.5
Birth defects	26	15.6	SIDS	13	10.1
Injury and poisoning	20	12.0	Injury and poisoning	13	10.1
Motor vehicle crashes	16	9.6	Nervous system	10	7.8
Cancer	7	4.2	Infectious and parasitic disease	9	7.0
Nervous system	7	4.2	Cancer	8	6.2
Infectious and parasitic disease	5	3.0	Pneumonia and influenza	6	4.7
Circulatory system	3	1.8	Motor vehicle crashes	4	3.1
Pneumonia and influenza	3	1.8	Circulatory system	3	2.3
Others	8	4.8	Others	4	3.1
Total	167	100.0	Total	129	100.0

Table 29: Major causes of death by ethnicity for 15-24-year-olds in the Auckland region between 1996 and 1998

Asian			European		
Major ICDs	**No.**	**%**	**Major ICDs**	**No.**	**%**
Motor vehicle crashes	13	50.0	Motor vehicle crashes	70	33.3
Suicide	5	19.2	Suicide	58	27.6
Other injuries	3	11.5	Other injuries	26	12.4
Cancer	1	3.8	Cancer	19	9.0
Others	4	15.4	Others	37	17.6
Total	26	100.0	Total	210	100.0
Māori			**Pacific peoples**		
Major ICDs	**No.**	**%**	**Major ICDs**	**No.**	**%**
Suicide	31	41.3	Suicide	18	29.0
Motor vehicle crashes	22	29.3	Other injuries	5	8.1
Other injuries	9	12.0	Motor vehicle crashes	17	27.4
Cancer	5	6.7	Cancer	3	4.8
Others	8	10.7	Others	19	30.6
Total	75	100.0	Total	62	100.0

Table 30: Major causes of death by ethnicity for 25-64-year-olds in the Auckland region between 1996 and 1998

Asian			European		
Major ICDs	**No.**	**%**	**Major ICDs**	**No.**	**%**
Cancer	78	36.6	Cancer	1,276	44.6
Ischaemic heart disease	39	18.3	Ischaemic heart disease	438	15.3
Motor vehicle crashes	16	7.5	Suicide	222	7.8
Injury and poisoning	15	7.0	Circulatory system	138	4.8
Stroke	9	4.2	Stroke	127	4.4
Suicide	9	4.2	Motor vehicle crashes	99	3.5
Digestive system	8	3.8	Nervous system	85	3.0
Diabetes	7	3.3	Injury and poisoning	81	2.8
Nervous system	5	2.3	Digestive system	72	2.5
Circulatory system	5	2.3	CORD	55	1.9
Asthma	3	1.4	Diabetes	36	1.3
Respiratory system	2	0.9	Asthma	15	0.5
CORD	1	0.5	Respiratory system	13	0.5
Others	16	7.5	Others	202	7.1
Total	213	100.0	Total	2,859	100.0
Māori			**Pacific peoples**		
Major ICDs	**No.**	**%**	**Major ICDs**	**No.**	**%**
Cancer	250	32.3	Cancer	208	29.9
Ischaemic heart disease	149	19.3	Ischaemic heart disease	121	17.4
Circulatory system	48	6.2	Circulatory system	62	8.9
Diabetes	41	5.3	Diabetes	45	6.5
Motor vehicle crashes	37	4.8	Stroke	40	5.8
Suicide	36	4.7	Motor vehicle crashes	30	4.3
CORD	35	4.5	Injury and poisoning	24	3.5
Stroke	29	3.8	Suicide	22	3.2
Injury and poisoning	28	3.6	Digestive system	20	2.9
Nervous system	17	2.2	CORD	18	2.6
Digestive system	11	1.4	Nervous system	9	1.3
Asthma	8	1.0	Asthma	4	0.6
Respiratory system	1	0.1	Respiratory system	3	0.4
Others	83	10.7	Others	89	12.8
Total	773	100.0	Total	695	100.0

Table 31: Major causes of death by ethnicity for 65+-year-olds in the Auckland region between 1996 and 1998

Asian			European		
Major ICDs	**No.**	**%**	**Major ICDs**	**No.**	**%**
Cancer	72	27.8	Cancer	3577	25.0
Ischaemic heart disease	57	22.0	Ischaemic heart disease	3697	25.9
Stroke	32	12.4	Stroke	1650	11.5
Diabetes	20	7.7	Pneumonia and influenza	673	4.7
Circulatory system	18	6.9	CORD	938	6.6
CORD	13	5.0	Suicide	54	0.4
Digestive system	10	3.9	Diabetes	214	1.5
Infectious and parasitic disease	6	2.3	Infectious and parasitic disease	67	0.5
Genitourinary system	5	1.9	Nervous system	236	1.7
Pneumonia and influenza	3	1.2	Circulatory system	1209	8.5
Respiratory system	3	1.2	Respiratory system	113	0.8
Injury and poisoning	3	1.2	Digestive system	447	3.1
Suicide	2	0.8	Genitourinary system	272	1.9
Nervous system	1	0.4	Injury and poisoning	227	1.6
Others	14	5.4	Others	918	6.4
Total	259	100.0	Total	14292	100.0
Māori			**Pacific peoples**		
Major ICDs	**No.**	**%**	**Major ICDs**	**No.**	**%**
Cancer	158	30.4	Cancer	183	25.5
Ischaemic heart disease	129	24.9	Ischaemic heart disease	136	19.0
Stroke	35	6.7	Stroke	79	11.0
Pneumonia and influenza	9	1.7	Pneumonia and influenza	26	3.6
CORD	47	9.1	CORD	55	7.7
Suicide	0	0.0	Suicide	0	0.0
Diabetes	43	8.3	Diabetes	56	7.8
Infectious and parasitic disease	1	0.2	Infectious and parasitic disease	7	1.0
Nervous system	2	0.4	Nervous system	6	0.8
Circulatory system	48	9.2	Circulatory system	75	10.5
Respiratory system	2	0.4	Respiratory system	4	0.6
Digestive system	9	1.7	Digestive system	28	3.9
Genitourinary system	12	2.3	Genitourinary system	18	2.5
Injury and poisoning	6	1.2	Injury and poisoning	7	1.0
Others	18	3.5	Others	37	5.2
Total	519	100.0	Total	717	100.0

Appendix 7: Top ten hospital discharge categories by age group and ethnicity in the Auckland region

Table 32: Number of hospital discharges by Top Ten DRG Cluster by ethnicity for 0-14-year-olds in the Auckland region between July 2000 and June 2001

European			
DRG Cluster	**Description**	**No.**	**%**
28	Ear, nose and throat (ENT)	1706	8.4
103	Fracture, sprain, strain	994	4.9
75	Gastroenteritis/Other digestive system diagnoses	796	3.9
159	Dental extractions and restorations	700	3.5
148	Viral illness and fever	594	2.9
45	Bronchitis and asthma	508	2.5
31	Otitis media and upper respiratory tract infection (URI), laryngotracheitis, nasal trauma and deformity	476	2.4
108	Injury, trauma to the skin, subcutaneous tissue and breast	419	2.1
40	Respiratory infections or inflammations	359	1.8
46	Whooping chough and acute bronchiolitis	268	1.3

Māori			
DRG Cluster	**Description**	**No.**	**%**
28	ENT	695	8.7
46	Whooping cough and acute bronchiolitis	385	4.8
159	Dental extractions and restorations	369	4.6
103	Fracture, sprain, strain	342	4.3
45	Bronchitis and asthma	315	3.9
107	Cellulitis	276	3.4
40	Respiratory infections or inflammations	272	3.4
148	Viral illness and fever	264	3.3
31	Otitis media and URI, laryngotracheitis, nasal trauma and deformity	258	3.2
75	Gastroenteritis/Other digestive system diagnoses	246	3.1

Pacific peoples			
DRG Cluster	**Description**	**No.**	**%**
40	Respiratory infections or inflammations	693	5.9
28	ENT	664	5.7
46	Whooping cough and acute bronchiolitis	625	5.3
45	Bronchitis and asthma	587	5.0
159	Dental extractions and restorations	496	4.2
75	Gastroenteritis/Other digestive system diagnoses	487	4.1
148	Viral illness and fever	429	3.7
31	Otitis media and URI, laryngotracheitis, nasal trauma and deformity	421	3.6
107	Cellulitis	386	3.3
103	Fracture, sprain, strain	320	2.7

Asian			
DRG Cluster	**Description**	**No.**	**%**
159	Dental extractions and restorations	207	5.0
75	Gastroenteritis/Other digestive system diagnoses	181	4.4
148	Viral illness and fever	168	4.1
28	ENT	147	3.6
31	Otitis media and URI, laryngotracheitis, nasal trauma and deformity	127	3.1
103	Fracture, sprain, strain	126	3.1
45	Bronchitis and asthma	123	3.0
40	Respiratory infections or inflammations	68	1.7
142	Red blood cell disorders	63	1.5
108	Injury, trauma to the skin, subcutaneous tissue and breast	60	1.5

Table 33: Number of hospital discharges for 15-24-year-olds by Top Ten DRG Cluster by ethnicity in the Auckland region between July 2000 and June 2001

European			
DRG Cluster	**Description**	**No.**	**%**
161	Delivery	1112	11.41
163	Preterm labour and antenatal admission	459	4.71
108	Injury, trauma to the skin, subcutaneous tissue and breast	435	4.46
74	Abdominal pain or mesenteric adenitis	394	4.04
103	Fracture, sprain, strain	392	4.02
152	Poisoning or toxic effect of drugs usage	323	3.31
72	Inflammatory bowel disease	294	3.02
134	Abortion	283	2.90
132	Menstrual and other female reproductive system disorders	274	2.81
162	Postpartum and post-abortion diagnoses	256	2.63

Māori			
DRG Cluster	**Description**	**No.**	**%**
161	Delivery	1335	27.0
163	Preterm labour and antenatal admission	522	10.6
134	Abortion	185	3.7
162	Postpartum and post-abortion diagnoses	171	3.5
133	Threatened abortion	157	3.2
108	Injury, trauma to the skin, subcutaneous tissue and breast	146	3.0
132	Menstrual and other female reproductive system disorders	129	2.6
74	Abdominal pain or mesenteric adenitis	108	2.2
103	Fracture, sprain, strain	103	2.1
152	Poisoning or toxic effect of drugs usage	102	2.1

Pacific peoples			
DRG Cluster	**Description**	**No.**	**%**
161	Delivery	1336	27.7
163	Preterm labour and antenatal admission	512	10.6
108	Injury, trauma to the skin, subcutaneous tissue and breast	165	3.4
162	Postpartum and post-abortion diagnoses	143	3.0
134	Abortion	133	2.8
103	Fracture, sprain, strain	113	2.3
107	Cellulitis	94	2.0
45	Bronchitis and asthma	92	1.9
74	Abdominal pain or mesenteric adenitis	92	1.9
133	Threatened abortion	92	1.9

Asian			
DRG Cluster	**Description**	**Asian**	**%**
161	Delivery	305	18.2
163	Preterm labour and antenatal admission	117	7.0
134	Abortion	79	4.7
152	Poisoning or toxic effect of drugs usage	70	4.2
74	Abdominal pain or mesenteric adenitis	69	4.1
108	Injury, trauma to the skin, subcutaneous tissue and breast	65	3.9
72	Inflammatory bowel disease	55	3.3
132	Menstrual and other female reproductive system disorders	43	2.6
103	Fracture, sprain, strain	39	2.3
151	Mental disorder, drugs and alcohol	34	2.0

Table 34: Number of hospital discharges for 25-64-year-olds by Top Ten DRG Cluster by ethnicity in the Auckland region between July 2000 and June 2001

European			
DRG Cluster	**Description**	**No.**	**%**
161	Delivery	7477	13.6
56	Chest pain/angina	2457	4.5
162	Postpartum and post-abortion diagnoses	1855	3.4
163	Preterm labour and antenatal admission	1686	3.1
72	Inflammatory bowel disease	1253	2.3
108	Injury, trauma to the skin, subcutaneous tissue and breast	1197	2.2
74	Abdominal pain or mesenteric adenitis	1186	2.2
69	Gastroscopy for digestive disease	1172	2.1
134	Abortion	1101	2.0
103	Fracture, sprain, strain	1051	1.9

Māori			
DRG Cluster	**Description**	**No.**	**%**
161	Delivery	1613	13.3
163	Preterm labour and antenatal admission	548	4.5
56	Chest pain/angina	467	3.9
107	Cellulitis	289	2.4
108	Injury, trauma to the skin, subcutaneous tissue and breast	264	2.2
134	Abortion	256	2.1
74	Abdominal pain or mesenteric adenitis	241	2.0
45	Bronchitis and asthma	234	1.9
40	Respiratory infections or inflammations	233	1.9
72	Inflammatory bowel disease	223	1.8

Pacific peoples			
DRG Cluster	**Description**	**No.**	**%**
161	Delivery	2746	19.0
163	Preterm labour and antenatal admission	882	6.1
56	Chest pain/angina	523	3.6
134	Abortion	383	2.7
107	Cellulitis	322	2.2
40	Respiratory infections or inflammations	314	2.2
45	Bronchitis and asthma	294	2.0
74	Abdominal pain or mesenteric adenitis	259	1.8
72	Inflammatory bowel disease	258	1.8
69	Gastroscopy for digestive disease	255	1.8

Asian			
DRG Cluster	**Description**	**No.**	**%**
161	Delivery	2111	23.0
163	Preterm labour and antenatal admission	505	5.5
56	Chest pain/angina	396	4.3
134	Abortion	347	3.8
69	Gastroscopy for digestive disease	312	3.4
162	Postpartum and post-abortion diagnoses	230	2.5
74	Abdominal pain or mesenteric adenitis	196	2.1
43	Respiratory signs and symptoms	195	2.1
40	Respiratory infections or inflammations	179	1.9
72	Inflammatory bowel disease	171	1.9

Table 35: Number of hospital discharges for 65+-year-olds by Top Ten DRG Cluster by ethnicity in the Auckland region between July 2000 and June 2001

European			
DRG Cluster	**Description**	**No.**	**%**
56	Chest pain/angina	3117	7.1
102	Rehabilitation/after care musculoskeletal system and connective tissue	2775	6.4
53	Circulatory disorder	1721	3.9
41	Chronic obstructive airways disease/interstitial lung disease	1313	3.0
40	Respiratory infections or inflammations	1271	2.9
20	Malignancy/neoplasms	1246	2.9
69	Gastroscopy	1218	2.8
25	Lens procedures	1209	2.8
9	Cerebrovascular disorders	1153	2.6
104	Perianal and pilonidal procedures	1127	2.6

Māori			
DRG Cluster	**Description**	**No.**	**%**
41	Chronic obstructive airway disease/interstitial lung disease	136	7.8
56	Chest pain/angina	114	6.6
40	Respiratory infections or inflammations	90	5.2
25	Lens procedures	79	4.6
20	Malignancy/neoplasms	68	3.9
55	Heart failure and shock	67	3.9
102	Rehabilitation/after care musculoskeletal system and connective tissue	57	3.3
157	Signs and symptoms	56	3.2
53	Circulatory disorder	41	2.4
43	Respiratory signs and symptoms	36	2.1

Pacific peoples			
DRG Cluster	**Description**	**No.**	**%**
40	Respiratory infections or inflammations	205	6.9
41	Chronic obstructive airways disease/interstitial lung disease	191	6.4
56	Chest pain/angina	163	5.5
25	Lens procedures	156	5.3
9	Cerebrovascular disorders	112	3.8
102	Rehabilitation/after care musculoskeletal system and connective tissue	103	3.5
55	Heart failure and shock	102	3.4
69	Gastroscopy	102	3.4
53	Circulatory disorder	89	3.0
72	Inflammatory bowel disease	83	2.8

Asian			
DRG Cluster	**Description**	**No.**	**%**
56	Chest pain/angina	132	7.9
25	Lens procedures	91	5.4
69	Gastroscopy	73	4.4
9	Cerebrovascular disorders	69	4.1
53	Circulatory disorder	58	3.5
20	Malignancy/neoplasms	56	3.3
40	Respiratory infections or inflammations	55	3.3
41	Chronic obstructive airways disease/interstitial lung disease	49	2.9
102	Rehabilitation/after care musculoskeletal system and connective tissue	49	2.9
55	Heart failure and shock	39	2.3

Appendix 8: Contact list of organisations that provide Asian services

Organisation	Contact Person	Contact Details	Asian Public Health Projects
AMHS (Mental Health Support Service Inc)	Shelley Sha	1 Nile Road, Milford	Community support and education on mental health for the Chinese community.
Amitabha Hospice Service			Offers Auckland-wide practical home help and companionship to anyone experiencing life-threatening illness and their families.
Asia Pacific Centre for Community Health and Development Research, AUT	Vivian Cheung	Private Bag 92006, Auckland 1020 Ph: 9179999 x 7770 Fax: 9179706 Mobile: 021 2125457	Research on Migrant and Refugee Health.
Asian Health Support Service, Waitemata DHB	Sue Lim - Asian Health Manager	Level 1, 15 Shea Terrace Private Bag 93503 Takapuna Ph: 4868953 Fax: 4868924	Asian Health Support Service - volunteers service, Waitemata Asian Translation and Interpreting Service, support line for Asian clients, Chinese Diabetes Support Group, in-service training with Asian health and cultural perspective advice for health professionals.
Asian Network Steering Committee	Vivian Cheung - Chairperson	PO Box 54-022, Bucklands Beach, Auckland Ph 021 2125457	Participating actively in Ministry of Health Asian Public Health Project, public forum on health and social issues, advocacy and policy submissions to central and local government bodies, information sharing through regular newsletters, etc.
Asian Social Services of NZ Inc			Asian Social Services of NZ Inc (ASSNZ) aims to improve the physical and mental wellbeing and enhance the quality of life of members of the Asian community in New Zealand.
Auckland Chinese Medical Association	Dr Wilson Young	C/O Auckland Regional Public Health Service 2 Owens Road Epsom	Health fairs and health checks, health talks on radio as well as requesting community organisations, funds research, translates health pamphlets into Chinese and updates list of Chinese-speaking GPs and specialists, provides a bridge between mainstream health providers and the Chinese community.
Auckland City Council	Community Advisor	Private Bag 92516, Wellesley Street, Auckland 1030 Ph: 09 3539653	Supporting Asian Network and other community projects.
Auckland City Council Road Safety Campaign	Andrew Bell - Regional Road Safety Coordinator	09 3662000 x 7067	Campaign to reduce alcohol-related road crashes and harm amongst Indian and South-east Asian Communities; campaign launch 31 August 2002.
Auckland Indian Association (Mahila Samaj)	Parshotam Govind - President	Home Ph: 09-4190792 Mob: 027 4380711	Health day (health checks - diet, exercise, blood pressure testing, cervical smear and awareness).
Auckland Migrant Centre (Inc)	Mel Fernandez	09 4194437	Various centres in Auckland offering information and advocacy, job search seminars.
Auckland Regional Public Health Service, ADHB	Bob Mack, Janet Chen and Dr Wilson Young	2 Owens Road, Epsom	Hepatitis B Screening Programme, Chinese Food Safety Programme, Smokefree Programme.
CAB, Mt Albert			The Auckland Citizens Advice Bureau has a Mandarin Helpline based in Mt Albert CAB, and has Chinese speaking volunteers/interpreters in most bureaus in Auckland.
Diabetes Projects Trust	Jane Biddulph - Project Coordinator	PO Box 61144, Otara 09 273 9650	Developing resources on prevention of type 2 diabetes in English and other languages.
New Zealand Prostitutes Collective	Kate Dickie - Manager	09 3666106	Intending to develop Chinese resources on safe sex with Auckland Regional Public Health Service, ADHB and other providers.
Problem Gambling Foundation	John Wong - Counsellor	09 5224823	Asian problem gambling counselling and health promotion service.

Organisation	Contact Person	Contact Details	Asian Public Health Projects
Regional Migrant Settlement Services Project	Penny Jorgensen - Regional Coordinator	PO Box 27 367, Mt Roskill	A 'one-stop-shop' to improve access to information and services for new migrants and to co-ordinate migrant settlement and integration services across the region.
Shakti Migrant Centre	C/O Lucia Tang	5A Jordan Avenue, Onehunga	Refugee and new migrant resources, orientation seminars, referral and advocacy, information on accommodation and housing, English language training, health checks and legal advice.
Shakti Women's Health	Lucia Tang	138 Church Street, Onehunga, PO Box 24448 Auckland	Information and advocacy service with interpreters in 16 languages, drop-in centre for women and children, lifeskills training, road code and road safety, telephone counselling for victims of domestic violence.
Shanti Niwas	Indu Bajaj	63 Allendale Road, Mt Albert Ph: 09 8152740 x 723	For Older Adults of Indian Origin - counselling, interpreting and advocacy services, arranging family support, raising awareness on health and community-based care options.
Well Women's Nursing Service	Ruth Davy	216 Manukau Road, Epsom Mobile: 027 2737033	Health promotion on cervical screening, breast screening, breast awareness, women's health issues such as periods and menopause to Asian communities in the Auckland region.

Appendix 9: Consultation meeting flyer (English)

The Asian Public Health Project Team, the Ministry of Health, & the Asian Network Invite you to:

Asian Public Health Project Consultation Meetings

What is public health?

Public Health is about:

- promoting well-being
- preventing ill health.

It is about keeping people healthy and improving the health of populations rather than treating diseases, disorders and disabilities in individuals. It is not about treating people once they have become ill.

Background

There are nearly 150,000 Asian people living in the Auckland Region, 65% of the total Asian population living in New Zealand. Asian people are the second largest population group in the Auckland Region making up about 12.5% of the region's population.

Although most Asian people have good health, as a group they have diverse and unique health needs. They face cultural and language barriers to improved health.

A small number of public health services and programmes have been developed for Asian communities, but there is an increasing need for more to assist these communities to have healthier lifestyles, and to prevent diseases and injuries.

Purpose of Meetings

Health authorities are keen to consult with the main Asian ethnic groups (see below) within the Auckland Region to:

- Determine the key public health issues.
- Seek ways to improve the health of our communities.

We will be asking questions such as:

- What are the best ways to address these issues?
- What are the barriers in your community to people being as healthy as they could be?

Dates of Meetings

The Asian Public Health Project Team, the Ministry of Health, and the Asian Network invite interested parties to a series of meetings at Fickling Convention Centre, 546 Mt. Albert Road, Three Kings, Auckland. Refreshments will be provided. Interpreters will be available specifically for:

- 7 November (Thursday) 5:30pm-7: 30pm: Chinese people
- 9 November (Saturday) 10:00am –12:00pm:South East Asian[1] & Japanese people
- 15 November (Friday) 10:00am- 12:00pm: Korean people
- 16 November (Saturday) 10am-12pm: People from the Indian Subcontinent & South Asian[2]

For More Information (RSVP 4 November, 2002 Monday):

Vivian Cheung,
Ph: 09-917-9999 X 7770 or 021-212-5457
Email: viviancheung@xtra.co.nz

*Flyers available in Bengali, Burmese, Cambodian, Chinese, Hindi, Japanese, Korean, Laotian, Thai, Urdu, and Vietnamese upon request.

[1] Made up of ten countries which are members of ASEAN (Association of Southeast Asian Nations), namely: Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar (Burma), Philippines, Singapore, Thailand and Vietnam.

[2] Indian Subcontinent (or South Asia) includes seven countries which are members of SAARC (South Asian Association for Regional Cooperation), namely: Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka.