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Challenges for Asian health and Asian health promotion in New Zealand

Agnes Wong, BHSc, BA

Community Programmes Development Manager
St John New Zealand

and

Member, Youth Advisory Panel
Auckland Council

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*P O Box 99 064, Newmarket, Auckland 1149 Level 1, 25 Broadway, Newmarket, Auckland
1023*

Phone (09) 531 5500 Fax (09) 520 4152 E-mail: hpf@hauora.co.nz

Website: www.hauora.co.nz

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Introduction

New Zealand has had an Asian ethnic presence for over 150 years and, in the past few decades, the population has dramatically spiked to far beyond the “ethnic minority” position it once held in New Zealand society. Despite this growing population, discourse on Asian health, including health promotion, is still relatively invisible on New Zealand’s health agenda; its related policies and research. Few community-driven health promotion initiatives have been targeted specifically at the health needs of the Asian population in New Zealand; with the gap more significant in health promotion initiatives for Asian youth. The lack of concern and attention gives the presumption of an absence of health issues and continuation of status quo. However, previous research indicates that there are a number of potentially “hidden” health issues.

Health promoting mechanisms are increasingly utilised as sustainable strategies to improve health outcomes in populations. Such mechanisms seek to motivate people to change their health behaviours for the better. However, when implementing health promotion activities for a specific population, it is pertinent to understand the target audience and the various cultural and historical perspectives they carry that impact on health. Asian New Zealanders bring a new level of complexity and diversity to the health promotion agenda that require further exploration and understanding, before health improving initiatives can be developed.

This paper examines the challenges of Asian health and Asian health promotion in New Zealand, both culturally and in terms of engagement and participation. It provides examples of Asian health promotion in New Zealand and globally, including specifically for Asian youth in New Zealand.

Defining “Asian” in New Zealand

There is no doubt that the Asian population in New Zealand is rapidly expanding, with an increasing proportion of the population who identify with one or more Asian ethnicities. In 2013, 11.8% of the population in New Zealand identified themselves as of Asian ethnicity - a 33% increase since 2006. Statistics New Zealand (2013) projects this to further increase by 3.4% every year for the next decade. Notably, the majority of the New Zealand Asian population reside in the Auckland region (65.1%) and is relatively young (median age 30.6 years); with a high proportion of youth (31.0%) aged between 15-29 years (Statistics New Zealand, 2013).

The framing and discourse surrounding the term “Asian” and its usage in New Zealand introduces a new set of challenges, and provokes large implications from a health promotion perspective. The Statistics New Zealand definition of “Asian” includes people with origins in the Asian continent from the east of Afghanistan and South of Mongolia, Afghanistan in the west to Japan in the east, and south to Indonesia (Ministry of Health, 2006; K. Rasanathan, Ameratunga, & Tse, 2006). This encompasses East, South and South East Asian ethnicities, excluding people from Middle East, Russia and Central Asia (K. Rasanathan, Craig, & Perkins, 2004). In contrast to this broad state-sector definition, frequent colloquial usage of

the term “Asian” in New Zealand specifically describes Chinese and other East and South East Asian ethnicities (K. Rasanathan et al., 2006). South Asians and Indians are omitted from generic discourse. This paper follows the Statistics New Zealand definition of “Asian”, encompassing all the above described ethnicities and geographical area into a broad ethnic grouping.

Defining who is “Asian” in New Zealand raises complex issues when considering health outcomes. There is great diversity and difference between all the Asian ethnicities, and the common aggregation in research does not account for the cultural, language, religion, socioeconomic and migration differences (Ameratunga, 2008; Ministry of Health, 2006; K. Rasanathan et al., 2006). This loose method of ethnicity classification has limitations and fails to celebrate the heterogeneity in the group while masking disparities with an averaging effect (K. Rasanathan et al., 2004). Common stratification in current policy and research disaggregates “Asian” into three ethnic groups: Chinese, Indian and Other Asian; in attempt to reduce the pitfalls of averaging (Ministry of Health, 2006). Attention to the particular health needs of individual ethnicities or communities is required if successful health promotion is to be achieved to improve the health outcomes of the Asian population.

Health status of Asian people in New Zealand

Generally, Asian people have good health that is comparable to the general population of New Zealand (Statistics New Zealand, 2010). However, there is also the impression that people of Asian ethnicity or descent have favourable outcomes on a range of health indicators compared to other major ethnic groups in New Zealand (Abbott & Young, 2006; Ministry of Health, 2006). This health advantage may be accredited to the “healthy migrant effect”, where the health of immigrants is, for a period of time, substantially better than those who are native born to a country (McDonald & Kennedy, 2004). Many migrants have the resources and a higher socio-economic status in their home country in order to be able to migrate. This corresponds with having good health at the time of migration. This supposedly diminishes with increasing length of residence in new country. In the process of acculturation into the new environment, there may be a number of health issues that are less visible in general health statistics and some health issues that are more predominant in certain Asian ethnicities (Ameratunga, 2008). Stereotypes and the “averaging effect” may have boosted the health status of Asians in New Zealand beyond reality; camouflaging important differences in health status between ethnic groups.

There have been a number of notable publications in the past decade that specifically focus on Asian health and the challenges and complexities it brings to New Zealand’s health agenda. The Asian Health Chart Book 2006 (Ministry of Health) and Health needs assessment of Asian people living in the Auckland region (Mehta, 2012), both provide in-depth analysis of Asian health outcomes and disaggregate the data into broad ethnic groupings of Chinese, Indian and Other Asian to provide a more accurate outlook on the current health status of Asian population.

A number of key health concerns for the Asian population emerge when it is disaggregated. This includes high rates of cardiovascular disease (CVD), diabetes and low birth weight for Indians (South Asians) and high risk of stroke amongst Chinese (Mehta, 2012; Ministry of Health, 2006). The revelation of key health inequalities for Asians in New Zealand illuminates the challenge when assessing their health status. When the Asian population is considered as a broad group, these health concerns do not appear to be exceptionally high (K. Rasanathan et al., 2006). When Indians are considered on their own, however, they have had the highest rate of self-reported diabetes in comparison to other ethnic groups in New Zealand (Scragg & Maitra, 2005). Despite these rates, there is no current focus on health promotion for Indians and South Asians to reduce the onset of diabetes (K. Rasanathan et al., 2006).

Relative to the New Zealand European ethnic group, the Asian ethnic group as a whole has lower rates of access to health services and health care utilisation, particularly the Chinese (Mehta, 2012; Ministry of Health, 2006). This includes primary care (primary health organisation – or PHO) enrolment, screening services, and access to mental health services, disability support and aged residential care (Jatrana & Crampton, 2009; Mehta, 2012). Stigmatisation, language barriers, lack of cultural competency and education in the New Zealand health system may all have contributed to this.

Furthermore, many Asians in New Zealand are affected by a broad spectrum of complex sociological issues that are beyond personal health and health care. Notably, there are a number of cultural and acculturation challenges that arise for the Asian population, and in particular, the more recent migrants. This commonly includes communication and language barriers, social isolation and distance from friends and relatives, change in dietary patterns and socio-economic status (K. Rasanathan et al., 2006; Salant, 2003; Ward, 2008). A positive consequence of acculturation is the opportunity for migrants to improve their level of English. This therefore, reduces barriers to employment and access to social services, including healthcare, and therefore improving their health in a broader sense (Ministry of Health, 2006).

Asian migrants may also seek a variety of psychological and physical coping mechanisms. The way migrants manage their realised cultural identity and relations with others has significant implications for their health and well-being (Ward, 2006). It is also important to recognise the collectivist nature of the Asian cultures compared to New Zealand Europeans and the common desire for families as a unit to work through health issues and problems together; often before, or as an alternative to, seeking professional help (K. Rasanathan et al., 2004; Tse, Laverack, Nayar, & Foroughian, 2011).

Racism and discrimination are other impacting factors for Asian migrants. The experience of this is associated with a number of adverse mental and physical health outcomes (Crengle, 2012). Generally racism propagates a negative effect on a range of health outcomes, increased risk factors and lowered health service utilisation (Harris, 2012). Asian people are significantly more likely to report unfair treatment from health professionals (Scragg & Maitra, 2005) and globally this is also the case for many other ethnic minority groups

(Crengle, 2012). Racism is reportedly increasingly worse in New Zealand, and evidence suggests that it impacts on structural determinants of health including housing, education and employment (Harris, 2012), creating extra barriers to an already pressured group.

Challenges for Asian health promotion and examples

Health promotion aims to improve the health and well-being of people by empowering them to gain control over their lives and health in a bottom-up approach (Laverack, 2004). This is often implemented in the context of a programme of activity or intervention and focusses on a certain aspect of health. Successful health promotion demands engagement from both the communities and the individuals involved, in order to motivate and drive the behaviour change required (Coburn & Weismuller, 2012).

With the knowledge of who is Asian in New Zealand and key factors impacting their health, health promotion initiatives targeted at specific ethnic groups are key to improving health outcomes for the Asian population. This includes preventative health behaviours like healthy eating and physical activity, and promotion strategies towards specific health issues such as CVD and diabetes. There is also a need for culturally appropriate information for Asian ethnic groups that educates them on the New Zealand health system for informed utilisation and to help improve access to health care (Mehta, 2012).

In order to provide effective health promotion strategies that are responsive to the target population, it is important to understand the cultural beliefs, values and social behaviours that help construct the assumptions of health and well-being of the Asian cultures (Ho & Johnson, 2013; Tse et al., 2011). Different cultures have differences in understanding of treatment and the concept of ill-health. For example, the Western biomedical model of health is largely concerned with the anatomical and biological construct of human bodies acting like a machine, whereas in the Chinese culture, traditional medicine's view on health is based on harmony and therefore illness is based on factors both external and internal to the body (Ho & Johnson, 2013).

Successful health promotion strategies also address the motivation and motivators of health that induce behaviour changes in the individual. It is misguided to ignore culture when seeking motivators for health promotion activities. The Asian cultural dimensions are not only collectivist in nature, with a strong sense of group identity, but also hierarchical in nature, have self-regulation and seek for harmony (Coburn & Weismuller, 2012). For Asian people, a strong motivator is the use of negative role models. Asians respond so strongly to the fear and threat of failure seen in negative role models that they act to prevent being the negative role model themselves. Promotion, using positive role models who represent a positive outcome do not have the same effect (Coburn & Weismuller, 2012).

Despite the differences in motivators, a Western model of health promotion is still applicable to people of Asian ethnicities; both in New Zealand and globally. Practitioners are required to be flexible in their approach to establish practices and strategies that account for Asian motivators of health. Cultural competency is of utmost importance; including awareness of

one's culture, recognising cultural differences and the adaptation of one's behaviour to accommodate these differences (Tse et al., 2011). Consideration must also be given to what one constitutes good health, as this too is culturally influenced (Coburn & Weismuller, 2012).

The literature surrounding Asian health promotion is still somewhat lacking, compared to general health promotion, but there is a strong desire for more to become available (Coburn & Weismuller, 2012). Globally, research in the UK, US and Canada has illuminated the potential of targeted Asian health promotion to achieve a healthier community. There are multiple approaches to implementing health promotion activities in the Asian communities; each with their own merits. Some multidisciplinary approaches employ broad engagement with both the community and health professionals, use language-appropriate media channels, peer education programmes and more (Farooqi & Bhavsar, 2001). As multiple sectors become involved, this approach is more likely to be top-down driven. There is a higher chance of placing the importance of Asian health promotion on the health agenda with the recognition and acceptance that activities aimed at addressing ethnic-specific health issues should be included in mainstream service provision (Farooqi & Bhavsar, 2001).

A capacity-building approach is becoming increasingly popular in Asian health promotion. This encourages stakeholders to conduct and maintain health promotion activities and enhance the capacity of the system; adding value and accountability to health promotion activities (Hawe, Noort, King, & Jordens, 1997). This approach often seeks active participation through the entire process to generate power and control over one's behaviour. A capacity-building approach is suited to helping understand the social capital of Asian migrants (Hawe & Shiell, 2000) and their cultural diversity; in order to develop culturally-appropriate health promotion initiatives.

For example, South Asian women have limitations on how they have been socialised, including a lack of knowledge on health risks, language barriers and economic dependency. South Asian women experience an imbalance of power and control; whilst conventional health promotion strategies assume individuals have total control over their own behaviour, and place high value on self-determination and self-reliance (Choudry et al., 2002). South Asian women place a high value on their culture and traditions and uphold family needs before their own. Health promotion activities therefore need to be appreciative of this. A successful relationship between empowerment and health, combined with self-understanding and confidence will empower certain individuals within communities.

In New Zealand, there have also been a number of localised health promotion initiatives that provide sound suggestions on future health promotion initiatives and actions to help address the health inequalities experienced by Asians in New Zealand. Many of these initiatives require strong community support to both raise the profile of the initiative and act as a motivator. Understanding barriers and attributes to ill-health allows for a more comprehensive and productive health promotion strategy. It caters for migration and resettlement issues and removes language barriers, while creating community readiness and building community capacity (Tse et al., 2011). New migrants settling into a new country have little knowledge of local health expectations, education and outcomes. In order to

successfully engage Asian communities in health promotion activities, their voices need to be heard and their capacity shaped and developed by stakeholders with the power to instigate change.

The Mt Roskill HEHA (Healthy Eating, Health Action) project is one of the more successful community-driven health promotion initiatives for South Asians in New Zealand. The programme was implemented in community settings and the South Asian food outlets in the Mt Roskill area of Auckland, New Zealand, with high levels of engagement and a participatory approach (Sobrun-Maharaj, Parackal, Clinton, Fung, & Mahony, 2011). This culturally appropriate and sustainable programme was founded on facilitated ownership, building partnerships with community organisations and businesses, building capacity, increasing knowledge, whilst maintaining cultural autonomy. In the case of Mt Roskill, the South Asian community is diverse in religious affiliation and dietary specifications (Sobrun-Maharaj et al., 2011), hence it was key that future Asian health promotion models support the transition from knowledge to health behaviours that were tailored to the target group.

Asian youth health and health promotion

Relatively few studies and policies have focussed on the health of Asian youth and community health promotion initiatives that are specifically for this younger age group. However Asian youth have the potential to be key stakeholders, and remedy this apparent gap. They can do this by initiating health promotion initiatives that are tailored to other young Asians and provide other young people opportunities for engagement and development in New Zealand's health agenda.

Asian youth in New Zealand share a similar health profile to the total Asian population; with good self-reported health and the majority reporting they had no long-term health conditions (Ameratunga, 2008). They have healthy family environments and are less likely to engage in risky behaviours compared to other ethnic groups (K. Rasanathan, Ameratunga, S., Chen, J., Robinson, E., Young, W., Wong, G., Garrett, N., & Watson, P., 2006). Mirroring the total Chinese population, Chinese youth reported not having a usual location for health care and having difficulties accessing health care when it was required. This was particularly the case for more recent migrants - in the past five years or less - and as for those whose English is their second language (Ameratunga, 2008).

Whilst many Asian youth share similar migration and acculturation experiences to those of their parents and the general population, there are increased complexities and diversity. Their awareness of the social consequences of migration are expressed in terms of adaptation, connections and change to their new environment, but they are also highly respectful of their parents' migration experiences, and tend to help them integrate as their attendance at school aids exposure to New Zealand culture. Some migrant Chinese youth have a strong preference for integration; to retain their cultural heritage and to also adopt aspects of the New Zealand culture (Ward, 2006). However, many Asian youth uphold conflicting identities and feelings of neither belonging in New Zealand or their country of origin and there is evidence of

lowered levels of mental health (K. Rasanathan, Ameratunga, S., Chen, J., Robinson, E., Young, W., Wong, G., Garrett, N., & Watson, P., 2006). It is also important to recognise that many young Asians are not recent migrants and share different experiences to those of their parents or those of an older generation.

Meaningful engagement of Asian youth in health promotion initiatives is highly beneficial and has the potential to engender life-long good health behaviours to improve overall health for Asians in New Zealand. Many health promotion strategies in are based on a community empowerment model, which is easily translated to youth-led health promotion strategies (McCall & Shannon, 1999). Young people can be empowered to drive youth health promotion activities when fully engaged in the design, implementation and evaluation of the initiative. There is the potential for them to influence change in policies in procedures, the environment for youth, personal health services and even re-orientate health services, including education and promotion using a medium that is attractive and responsive to the youth of today.

Peers are an important part of the environment in which young people interact, helping shape their attitudes, beliefs, intentions and behaviours (McCall & Shannon, 1999). Peer-led health promotion initiatives, particularly when by someone of similar cultural background, along with culturally appropriate methods, would contribute to the success of youth-led Asian health promotion. The engagement of young people not only generates useful facilitation for communities and individuals, but also provides opportunities for the development and empowerment of youth participants, and benefits to the wider community. These are broadly consistent with New Zealand's Ministry of Youth Development guidelines on providing young people with a voice on matters of relevance and effective youth participation and engagement (Ministry of Youth Development, 2009).

Conclusion and recommendations

When considering health promotion strategies, programmes or activities to ameliorate health issues and inequalities experienced by Asian in New Zealand, a number of challenges and considerations arise. Asian health promotion initiatives appear almost negligible if the sheer diversity of the population is ignored, but when disaggregated into ethnic groups, significant health issues emerge.

The success of Asian health promotion programmes lies with the deliverer to develop and maintain the trust of Asian communities through the duration of health promotion programmes – from inception and development, through to implementation and evaluation s. In the case of Asian youth, youth participation and engagement is necessary to drive this capacity-building approach and connection; for young people, by young people. Respectful mutual relationships are necessary for achieving intended outcomes and improving health and well-being for Asian people.

Successful Asian health promotion strategies and initiatives demand good communication and understanding of the issues as the foundation for community engagement. Community

involvement and engagement drives the building of capacity to make decisions and take culturally appropriate and suitable actions, allow for partnerships to be formed, community needs to be realised and perpetuate sustainability of the programme. It is important that Asian communities are continually legitimised and empowered to drive health promotion initiatives that realise the impact of culturally-responsive community engagement approaches to improve health and reduce future burdens of disease.

Biographical notes

Agnes Wong is passionate about youth participation and Asian health. Her interest in Asian health stems from a summer studentship project undertaken while at university, which focussed on Asian youth health and methods of engaging Asian youth in health policy and research. Agnes played a key role in the development of Royal New Zealand Plunket Society's Asian strategy and was their Asian Strategy Project Coordinator. She currently works as the Community Programmes Development Manager for St John New Zealand, developing and delivering on projects that are committed to driving community health outcomes. Agnes is a member of Auckland Council's Youth Advisory Panel and graduated from the University of Auckland in 2014 with a Bachelor of Health Sciences and a Bachelor of Arts, majoring in Sociology.

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