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**MIGRATION AND SETTLEMENT IN INDIAN, KOREAN
AND CHINESE IMMIGRANT COMMUNITIES IN
AUCKLAND: A PERSPECTIVE FROM THE POLITICAL
ECOLOGY OF HEALTH**

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A thesis submitted in partial fulfillment of the requirements for the degree of
Doctor of Philosophy in Anthropology, The University of Auckland, 2007.

ABSTRACT

This research used tuberculosis (TB) as a lens to elucidate how migration, settlement, local agency and support networks influence migrants' health in New Zealand. The study also examined specific characteristics of TB such as delays in diagnosis and the stigma attached to the disease to gain a broader understanding of TB experience for migrants in New Zealand. The research addressed these aims through the analytical framework of political ecology and incorporation of interviews, participant observation and media analysis. Participants in the research included immigrants from Mainland China, South Korea, and India, and New Zealand health care professionals.

The study found that immigration policies, social discrimination and isolation have created structural inequalities between dominant host populations and Asian migrants in New Zealand. These inequalities compounded settlement problems such as language difficulties and limited employment opportunities, resulting in low income levels and perceived stress for Indian, Korean and Chinese people, which has affected their health and well being.

Transnational policies and experiences of health care systems in immigrants' countries of origin and in New Zealand strongly influenced health seeking behaviour of migrants, along with structural barriers such as lack of Asian health care professionals and interpreting services. Local cultural and biological factors including health cultures and physical symptoms also affected these practices. In relation to TB, structural processes along with clinic doctor-patient relationships and social stigmas created barriers to diagnosis and treatment. Factors that facilitated access to health care in general, and TB diagnosis and treatment in particular, included the use of support networks, particularly local General Practitioners from countries of origin, and Public Health Nurses, along with flexible TB treatment programmes.

This study shows that the incidence and experience of TB is shaped by migration and settlement processes. It also builds upon other medical anthropological studies that have employed political ecology by demonstrating its usefulness in application to developed as well as developing countries. In addition, the study contributes to the growing area of Asian migration research in New Zealand, illustrating that migration and settlement processes are complex and need to be understood as multidimensional, thus demonstrating advantages in approaching them from a political ecological framework.

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TABLE OF CONTENTS

ABSTRACT.....	ii
ACKNOWLEDGEMENTS.....	iii
TABLE OF CONTENTS.....	v
LIST OF TABLES.....	ix
LIST OF FIGURES.....	x
LIST OF ABBREVIATIONS.....	xi
CHAPTER ONE: INTRODUCTION, BACKGROUND AND THEORETICAL OVERVIEW.....	1
Aims.....	1
Tuberculosis in global and local contexts.....	3
Using the term ‘Asian’.....	7
Political ecology.....	8
Political ecology and globalisation.....	11
Habitus.....	14
Immigration and tuberculosis screening.....	15
Transnationalism.....	16
Asian migration to New Zealand and immigration policies.....	17
Settlement policies.....	21
Settlement experiences.....	23
Discrimination.....	23
Language difficulties.....	24
Employment.....	25
Migration, stress and tuberculosis.....	25
Health systems.....	27
India, China and Korea.....	27
New Zealand.....	29
Health cultures.....	30
Stigma.....	31
Social networks.....	32
Summary of thesis chapters.....	33
CHAPTER TWO: PARTICIPANTS AND METHODS.....	35
Setting the scene.....	35
Participants.....	37
Methods.....	39
Participant observation.....	39
Interviews.....	45
Data analysis of participant observation and interviews.....	48
Media analysis.....	49
Ethics.....	50

Conclusion.....	51
CHAPTER THREE: PARTICIPANTS AND SOCIAL CONTEXTS.....	52
Participants.....	52
Immigration history.....	53
Socioeconomic status.....	53
Residential dwellings.....	54
June.....	55
Meeta.....	57
Vishal.....	58
Drezan.....	59
Beginning the migration journey: Why come to New Zealand?.....	60
Migration process.....	63
Settlement in New Zealand.....	64
Language barriers.....	64
Employment.....	67
Racial discrimination: Othering of Indian, Korean and Chinese migrants.....	73
Physical and cultural environments.....	79
Isolation and social networks.....	81
Conclusion.....	88
CHAPTER FOUR: UNDERSTANDING HEALTH, ILLNESS AND HEALTH SEEKING BEHAVIOURS.....	90
Health and illness.....	90
Freedom from illness, function and normality.....	91
Holistic health.....	93
Healthy habits: Diet.....	94
Exercise.....	95
Body weight.....	96
Stress.....	97
Religion.....	99
Health seeking behaviour and practices.....	99
Seeking local GPs from countries of origin.....	100
Alternative healers.....	102
New Zealand's primary health care sector.....	105
Resting, waiting and taking medicine.....	112
Hospital experiences.....	115
Alex.....	115
May.....	116
Sun.....	117
Social networks.....	118
Conclusion.....	120

CHAPTER FIVE: SOCIAL STIGMA AND TUBERCULOSIS.....	121
Stigma.....	121
Tuberculosis: A disease of others.....	123
Tuberculosis: A disease of contagion and death.....	128
Blemishes of individual character.....	132
Gendered stigma.....	134
Coping with stigma, information management.....	135
Social networks.....	138
Conclusion.....	140
CHAPTER SIX: THE TUBERCULOSIS JOURNEY, FROM SYMPTOMS TO CURE.....	141
Tuberculosis life stories.....	142
June.....	142
Meeta.....	143
Vishal.....	144
Drezan.....	145
Symptoms and health seeking behaviour.....	145
Diagnosis.....	148
Diagnosis in Korea.....	151
Reactions to diagnosis and understandings of tuberculosis.....	153
Contact tracing.....	155
Tuberculosis treatment.....	157
Discipline and surveillance.....	158
Barriers and facilitators of treatment.....	160
Public Health Nurses.....	163
Hospital experiences.....	167
Impacts of tuberculosis.....	173
Life after tuberculosis.....	175
Conclusion.....	177
CHAPTER SEVEN: DISCUSSION AND CONCLUSION.....	179
Overview.....	179
Migration status and inequality.....	182
Policy.....	183
Discrimination and stigma.....	183
Access and barriers to health care.....	185
Tuberculosis screening.....	186
Support networks.....	187
Relationships between sufferers and healers.....	188
Conclusion.....	189
EPILOGUE.....	192
Participants: Pros and cons of working with multiple groups.....	192

What would I have done differently?.....	193
Moving on, where to from here?.....	193
Peoples' lives after participation.....	194
Conclusion.....	195
APPENDICES.....	196
Appendix 1: Interview questions for participants with TB.....	196
Appendix 2: Interview questions for PHNs.....	198
Appendix 3: Interview questions for GPs.....	199
Appendix 4: Participation information sheet.....	200
Appendix 5: Participant consent form.....	203
LIST OF REFERENCES.....	205

LIST OF TABLES

1.1	Age-standardised incidence of TB by ethnicity in New Zealand 2000-2004.....	4
1.2	Incidence of TB by country of birth in New Zealand 2000-2004.....	5
1.3	Time between arrival in host country and diagnosis of TB.....	6
1.4	Seven largest Asian ethnic groups in New Zealand 2001-2006.....	21
2.1	Description of participants interviewed in the study (using pseudonyms).....	38
3.1	Participants' paid and un-paid occupations in New Zealand.....	68
3.2	Percentage of unemployment by ethnicity in Auckland, New Zealand.....	70
3.3	Percentage of people aged 15 years and over with a declared personal income of \$30,000 or more by ethnic group.....	71
5.1	TB and migration themes from <i>The New Zealand Herald</i> 1999-2006.....	124

LIST OF FIGURES

1.1	Using TB as a lens to investigate how immigration, settlement and social networks influence migrants' health in New Zealand.....	3
2.1	Community TB presentation to Manukau Indian Association, 2005.....	40
2.2	Evening meal provided after a TANI meeting, Auckland, 2007.....	42
2.3	Indian GP in North Shore clinic, 2007.	43
2.4	North Shore GP clinic, 2007.....	43
4.1	Chinese Medical Centre, Auckland, North Shore, 2007.....	104
4.2	Chinese Healing Centre, Auckland, North Shore, 2007.....	105
4.3	White Cross Accident and Medical Clinic, Central Auckland, 2007.....	109
4.4	Auckland PHO GP Clinic (operated out of a converted dwelling), 2007.....	110
7.1	Interrelationships between immigration, settlement, social networks and health for Indian, Korean and Chinese migrants in Auckland, New Zealand.....	181

LIST OF ABBREVIATIONS

A and E Clinic	Accident and Emergency Clinic
ACMA	Auckland Chinese Medical Association
AIS	Auckland Institute of Studies
ARPHS	Auckland Regional Public Health Services
BMI	Body mass index
DHB	District Health Board
DOTS	Directly Observed Therapy-Short Course
EM	Explanatory model
GP	General Practitioner
HPA	Hypothalamic-anterior pituitary-adrenal cortex system
LTBI	Latent tuberculosis infection
NZIS	New Zealand Immigration Service
NZQA	New Zealand Qualification Authority
PHN	Public Health Nurse
PHO	Primary Health Organisation
SAM	Sympathetic-adrenal medullary system
SAT	Self Administered Treatment
TANI	The Asian Network Incorporated
TB	Tuberculosis
TBD	Tuberculosis disease
TCM	Traditional Chinese Medicine
TKM	Traditional Korean Medicine
WHO	The World Health Organisation

CHAPTER ONE: INTRODUCTION, BACKGROUND AND THEORETICAL OVERVIEW

Tuberculosis (TB) can be seen as a focus point for studying the interconnections among multiple levels of human societies and the complex interrelationships between biology and culture. Infectious diseases such as TB expose the “fault lines” of society (Farmer 1992:9). In the context of migrant TB in Auckland, the incidence and experience of the disease are embedded within broader national and international interactions. Immigrants are exposed to macro and micro level forces such as migration and policies at international, national and regional levels. At micro levels of analysis, links between the processes of peoples’ lives, such as how they adjust to migration and settlement, their social networks, their degree of local agency, their material living conditions and their understanding of health, can also be explored through TB, to identify social inequalities and differential risks of infection.

The recognition of the intertwining roles of political economy, culture, environment and biology are crucial in analysing the occurrence of TB among Indian, Korean and Chinese immigrants in New Zealand as they provide a broader understanding of the complexity of the disease. This research builds upon other medical anthropological studies that have used political ecology by extending its application from less developed to a developed country. It also contributes to the growing area of research on Asian migration in New Zealand and to the study of infectious diseases.

Aims

The primary aims of the research are to use TB as a lens to elucidate how migration, settlement, local agency and support networks influence migrants’ health in New Zealand, and, at the same time, to examine specific characteristics of TB such as delays in diagnosis and treatment, to gain a broader understanding of TB experience for migrants in New Zealand. The study focuses on these aims within the context of TB diagnosis and treatment. Within these aims are more specific areas I will be exploring, including:

- To investigate how New Zealand's immigration policies, immigration experiences and transnational linkages shape the migration experience of Indian, Korean and Chinese migrants in New Zealand
- To explore if or how processes of migration and subsequent settlement in New Zealand influence Indian, Korean and Chinese migrants' health in general, with particular emphasis on the possible relationship between stressors and TB.
- To ascertain how Indian, Korean and Chinese immigrants' support networks and social stigmas influence health understanding, practices and choices in general, as well as seeking medical advice and adherence to the treatment of TB.
- To gain an understanding of the relationship between health knowledges, health practices and other social practices of Indian, Korean and Chinese immigrants in relation to TB.
- To provide a critical examination of the use of political ecology in medical anthropological contexts.

The following diagram (Figure 1.1) provides a visual model of how I will use TB as a lens to investigate how transnational interactions between macro and micro levels influence settlement experiences and the health of Indian, Korean and Chinese migrants in New Zealand. Each of these areas and associated aims will also be discussed below.

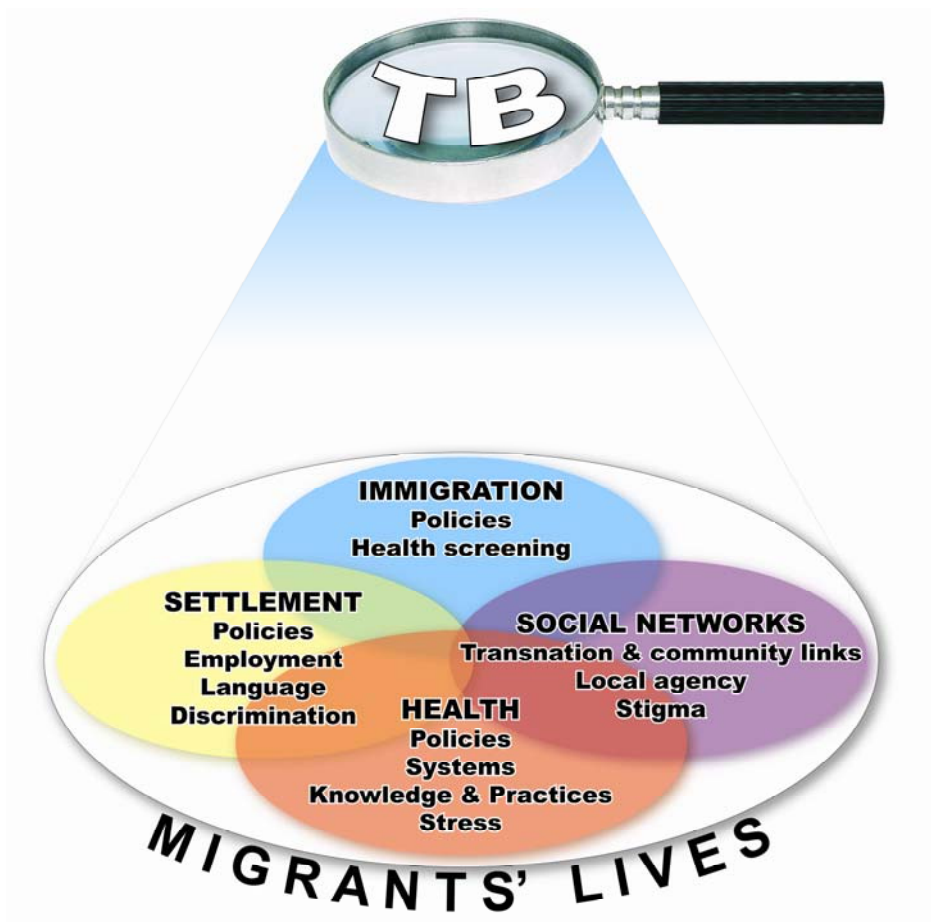


Figure 1.1 Using TB as a lens to investigate how immigration, settlement and social networks influence migrants' health in New Zealand.

Tuberculosis in global and local contexts

TB is an infectious disease most commonly caused by the bacteria *Mycobacterium tuberculosis*. Most people infected with TB (90-95 percent) have latent TB infection (LTBI) where they feel well and are non-infectious (Klovdahl *et al.* 2001:681). However, approximately 5-10 percent of adults infected with the bacteria progress to active TB disease (TBD) (Klovdahl *et al.* 2001:682). This can occur within a short time (four to five weeks of infection) or as a result of endogenous reactivation (Ministry of Health 1998). TB can affect almost any part of the body but most commonly only TB involving the respiratory system becomes infectious (Klovdahl *et al.* 2001). TB is transmitted by air borne droplets thus most TB transmissions occur within confined and crowded environments or by sustained contact (De Zoysa *et al.* 2001).

In 1992, it was estimated that a third of the world’s population (two billion people) were infected with *Mycobacterium tuberculosis* (Bloom and Murray 1992). During the mid-1980s, there had been a global resurgence of TB in developed countries after decades of decline (Klovdahl *et al.* 2001). In 1995, the World Health Organisation (WHO) declared a “global emergency” as more deaths had resulted from TB than any other year in history (Martin 2000:68). TB rates in New Zealand have followed the global pattern with an increased incidence since 1987 (Das *et al.* 2006a, Harrison 1999). The average rate in New Zealand from 1995 to 2004 was 10.3 per 100,000 (Das *et al.* 2006a:1). TB incident rates in New Zealand are higher than those in Australia, Canada and the United States and show wide ethnic and geographic disparity (Table 1.1). Auckland has the highest rates of TB in New Zealand (23 per 100, 000) (Ministry of Health 2003:5).

Table 1.1 Age-standardised¹ incidence of TB by ethnicity in New Zealand 2000-2004 (Das *et al.* 2006a:6)

Ethnicity	Number of cases	Notification rate per 100,000
European	209	1.43
Māori	332	20.46
Pacific Island	359	48.79
Other	939	79.73

Foreign-born people in New Zealand have a TB rate 10 times that of New Zealand-born population (Ministry of Health 2003:2). From 2000 to 2004, the TB rate among foreign-born was 32.3 per 100,000 compared to 3.9 for New Zealand-born (Das *et al.* 2006b). In the Auckland region, in 2001, Asian notifications made up 48 percent of the total, followed by Pacific (21 percent), Māori (14 percent), Other (9 percent) and Europeans (8 percent) (Asian Public Health Project Team 2003:46). Due to the higher rates of TB occurring in people from Asian countries of origin, this study included participants from three Asian countries; India, South Korea and China. TB rates for people in New Zealand who were born in these countries are listed in Table 1.2.

¹ Authors’ age-standardised incident rates to the New Zealand population age structure of the 2001 Census (Das *et al.* 2006a:2).

Table 1.2. Incidence of TB by country of birth in New Zealand 2000-2004 (Das *et al.* 2006b:4)

Country of Birth	Cases	Populations (based on 2001 Census)	Rate per 100,000
India	269	20892	257.5
Korea	55	17931	61.3
China	119	38949	61.1

Although increases in rates of TB in New Zealand are not solely attributable to immigration (Das *et al.* 2006b), the proportion of TB notifications from immigrants has increased from 47.5 percent in 1995 to 76.3 percent in 2005 (Das *et al.* 2006b) and immigrants from high incidence countries have the highest risk of developing TB (Harrison 1999, Martin 2000). Many factors have been reported to affect the disparity in TB rates among different New Zealand populations. These include: socio-economic inequality, over crowding, stress, imported TB infection and differences in local transmissions (Harrison 1999, Martin 2000). Thus, both conditions in the sending country and in New Zealand are implicated. For these reasons it was important to look at transnational relationships within the study.

The highest rates of TB among Asians occur in young adults. Incidence for both LTBI and TBD treatment cases between 1994 and 2002 were highest among people between 25-34 years of age (Auckland District Health Board 2003). There is also evidence to suggest that notified rates of TB for some immigrant groups are higher in New Zealand than in their country of origin (including India, China and Korea) (Ministry of Health 2003). Some possible explanations for this phenomenon are better screening procedures, diagnosis and notification records in New Zealand and also that people may come to New Zealand to seek TB treatment, which is often not available in developing countries (Ministry of Health 2003). It is also possible that the stress of immigration and settlement places those with LTBI at risk of developing the disease.

The increased incidence of TB in New Zealand (and other developed countries) and the high rates of TB among foreign-born immigrants has often been attributed to imported TBD. However, rather than bringing active TB into New Zealand, it appears that migrants develop TBD some time after arrival (Das *et al.* 2006b, Park and Littleton 2007). Time between arrival in New Zealand and diagnosis of TB tends to support this assumption (Table 1.3). In New Zealand, about 25 percent of TB cases were notified within the first year of arrival, which has decreased from 31

percent in 1995 (Park and Littleton 2007). Park and Littleton (2007) suggest that the other 75 percent of foreign-born TB notifications are most likely to be reactivations of LTBI or locally acquired new infections.

Table 1.3 Time between arrival in host country and diagnosis of TB (Centres for Disease Control 2004, Gilroy 1999, Public Health Agency of Canada 2004, Turnbull 2002).

Country	Years between arrival and percentage of TB diagnosis						
	<1	1-2	2-3	3-4	4-5	5-10	>10
New Zealand 2001 (excluding 17% unknown)	26.7		35.9			38.4	
Australia 1997	14	11		17		19	38
Canada 2002	12.4	14.9	7	4.8	3.2	18.8	38.6
United States 2003 (excluding 13.7 % unknown)	20.7		27.9			14.9	36.4

These findings raise several questions (that may not be mutually exclusive) about how Asian people are contracting TB in New Zealand. Firstly, are inadequate TB screening procedures and resulting delays in diagnosis and treatment increasing the rates of imported TB in New Zealand? Secondly, the delay between arrival in New Zealand and onset of TB infection may indicate that settlement in New Zealand results in a stressful high-risk environment causing reactivation of LTBI. Most immigrant TB cases in the United States are the result of reactivation of latent infections and are “likely to be due to the peculiar stresses that they face during migration” (King 2003:48). The relationship between length of time in New Zealand and migrants’ health status has recently become the focus of much research. Reports on Asian health (Scragg and Maitra 2005, Rasanathan *et al.* 2006, Ministry of Health 2006a) indicate that recent Asian migrants in New Zealand are healthy (in comparison to their “native-born people”) but their health deteriorates over time, where disease patterns converge to those of New Zealand’s “host population” (Tse and Hoque 2006:10). This trend has been termed the “healthy immigrant effect” (Tse and Hoque 2006:10) and also occurs for migrants in Canada and the United States (Frisbie *et al.* 2001, McDonald and Kennedy 2004). There have been several reasons proposed to explain the good health status of recent migrants, including immigration selection factors where immigrants tend to be young people from professional backgrounds due to business and general category immigration policies. In addition, immigration health

screening disqualifies immigrants with serious health conditions. The transnational tendency for chronically ill migrants to return to their home countries for treatment may also influence the health status of migrants in New Zealand, as discussed in Chapter Four. Finally, values, lifestyle and holistic health practices have also been suggested to contribute to the healthy immigrant effect (Tse and Hoque 2006). Factors that may contribute to health deterioration for Asian immigrants include low health service utilisation, barriers in accessing health care (particularly in relation to language barriers and lack of awareness) and stress (Tse and Hoque 2006). One aim of this thesis will be to explore how settlement influences migrants' health with a focus on the relationship between stress and TB.

Using the term 'Asian'

The term 'Asian' in this study is applied to the three participating groups (Chinese, Indian and Korean). Currently most health research in New Zealand has included statistics for Chinese, Indian and Korean people under the categories of 'Other' or 'Asian' which is one of the reasons this study refers to TB rates of Asians rather than specific ethnic groups. Although there are advantages in using this term there are also many problematic implications. One of the many difficulties associated with using the term Asian lies in its definition, as the social groups included in this category vary depending on where the term is used. For example, Asian differs in definition between the United Kingdom, the United States and New Zealand (Rasanathan *et al.* 2004). Statistics New Zealand uses the term to refer to people from East, South and Southeast Asia whereas, in the United States, Asian is often grouped with people from the Pacific Islands (Rasanathan *et al.* 2004). The term also lacks specificity, lumping many diverse ethnic populations into one homogeneous category. When used in health research, the term Asian can mask differences in risk factors or susceptibility between populations which can be seen in differences in rates of abortion, diabetes and TB between Chinese and Indian women. Another problem with Asian is that it can reinforce stereotypes of marginalised groups. In New Zealand (and other developed countries) there are national perceptions that TB is a disease of others, particularly in reference to overseas migrants and refugees (Searle 2004). Therefore using Asian in association with TB can perpetuate this stereotype.

However, there are advantages with the term Asian in some research contexts. For many human societies, diseases such as TB carry stigma for patients and their

families (Edginton *et al.* 2002, Rubel and Garro 1992, Sumartojo 1993). Research that associates TB with specific ethnic groups such as Chinese, Indian or Korean can have essentialist implications where such groups may be perceived as being more biologically susceptible to the disease than others. Also, given the sensitive nature of research on TB, naming specific groups can impede participation of communities due to fear of being identified and public reactions. These issues will be discussed more extensively in Chapter Two. Therefore, in this study, Asian will be used as a broad category to include Chinese, Indian and Korean people but at no stage will it be considered as an ethnicity. The research acknowledges the diversity within and between the three groups and, where applicable, will refer to specific groups.

Political ecology

The resurgence of TB in recent years and its persistence among the socially disadvantaged has resulted in a number of studies where explanations have focused on biological, cultural, environmental and/or political-economic factors. Studies of TB that focus on only one of these aspects may provide in-depth knowledge and detailed descriptions within specific contexts, yet they fail to illustrate the complex inter-relationships that operate within and between human communities. Such approaches also ignore the diversity among local and global contexts and processes (Ho 2004). In response to such criticisms, many social scientists are advocating models to study TB that focus on the interconnections among different levels of human societies, with an emphasis on systemic linkages between disease, environment, culture and politico-economic processes (Gandy and Zumla 2003, Ho 2004).

Critical medical anthropology is an approach that seeks to understand health from a holistic, biocultural and political economic approach (Baer *et al.* 2003). This framework has also been extended to include micro level causal linkages at sociocultural and individual levels through applications of interpretive or meaning centred approaches under the critical interpretive medical anthropology perspective. Despite the holistic nature of critical interpretive medical anthropology, Hans Baer (1996:452) has argued that there is also a need for this framework to incorporate environmental influences within its level of analysis through the application of political ecology, where anthropologists must consider the complex relationships between people and their environment when studying disease and thus “must treat political economy and political ecology as inseparable”.

In order to understand how political and economic structures impact on health through the creation of particular environments in which people and other biological organisms interact, this thesis will draw on the theoretical framework of political ecology (Baer 1996, Stonich 1993, Turshen 1984). As was exemplified by Harper's (2002) study in Madagascar, adding an interpretive dimension to this approach will also elucidate people's interpretations of their migration and illness experiences. This illustrates how culturally constituted frames of meaning influence individual's choices and understandings in various transnational contexts.

Political ecology is an approach developed from the social sciences of anthropology and geography, integrating political economy and human ecology into a coherent analytical framework (Mayer 1996). The approach analyses the production of inequality through the operation of world systems and transnational capitalism within global and local contexts (i.e. political economic approaches), while incorporating a bio-cultural approach that focuses on the interaction between societal forces, biology, culture and the environment of human communities in different times and places.

Although political ecology incorporates political economy, it becomes broader in its application for human study by including environmental interactions with health. In this context 'environment' refers to physical and social characteristics that surround individuals such as climate, pollution, water quality, political, social, cultural and economic conditions, rural or urban residence, social networks and the availability of health care (McMurray and Smith 2001). This thesis will build upon the traditional application of political ecology which is grounded in physical dimensions of the environment (Baer *et al.* 1996) by extending its use to social environments, with a focus on support networks. Although 'environments' are often assumed to consist of natural, physical processes, Park and Littleton (2007:9) argue that they are "also the result of human interventions which are themselves the outcome of complex, globalising, historical, political processes." As discussed below, social networks involve biological, spatial and social dimensions. They are influenced by global as well as local political and economic forces. Thus the use of political ecology with its focus on interconnections between these levels of societies will demonstrate relationships between local and transnational environments and health.

From a medical anthropological perspective where health is contextualised within a concept of culture, political ecology can provide insights into "multiple

levels of well-being, illness and disease” (Harper 2002:27). In this sense political ecology can demonstrate how historical and contemporary factors impact on the daily lives and experiences of people, and also how people themselves can influence their environment, thus recognising human agency. Political ecology has been used in a number of research contexts that examine different levels of interrelationships between environments and political and economic dimensions. For example, Allan (2000), Bradnock and Saunders (2000) and Mayer (2000) have focused on physical environmental factors such as sea-level rises, water allocation management and infectious diseases in relation to national and international political economic contexts. These studies have not included local levels of analysis, excluding actions and experiences of people who live within such environments. Recently, anthropologists such as Harper (2002) and Leatherman (2005) have used political ecology within more anthropologically based research incorporating micro levels of societies with an emphasis on daily life events of individuals and acknowledging their agency. Thus, employing a more critical interpretive application of political ecology, rather than purely political economic. This study uses political ecology within a similar ethnographically based framework, emphasising the critical interpretive medical anthropological dimension of political ecology. To illustrate macro-micro linkages between the world system and individual participant’s illness experiences, this thesis will incorporate Arthur Kleinman’s (1980) concept of explanatory models within the broader framework of political ecology. Explanatory models (EMs) provide a “meaning-centered” perspective, where illness is experienced and understood by people at an individual level through culturally constituted frames of meaning (Baer *et al.* 1996:24). The application of an interpretive approach within a political ecology framework will therefore illustrate the interactive relationships between local experiences of illness and broader social, economic and political forces.

A key point of difference between my study and those of Harper (2002) and Leatherman (2005), is the later employed political ecology for the study of developing countries focusing on people facing significant poverty. In contrast, this study was set within a developed country where people were not faced with the same levels of severe economic hardship as those experienced by people in Madagascar and Peru. As well as employing political ecology to assist me to achieve the study’s aims, I also intend to critically examine its application to health within a developed country.

Political ecology and globalisation

In a world globally interconnected, disease does not recognise borders. The geography of the TB pandemic across nations means it cannot be understood solely from a local ethnographic analysis. Therefore a wider global framework has to be employed to understand how different physical and social environments, health care systems and services, patterns of poverty and inequality and cultural understanding of the disease influence TB (Gandy and Zumla 2002, 2003). Inda and Rosaldo (2002) point out that there has been a recent shift in power relations between human communities from classic forms of inequality and dependency stemming from colonisation to the emergence of transnational capitalism resulting from the intensification of global interconnectedness. According to Wallerstein's World Systems Theory, unequal power relations occur between core and periphery regions (Hannerz 2002). However, in a contemporary setting where globalisation and transnational processes operate, the relationship between core and periphery has become more fluid where there is "a continuous circulation of people, capital, goods, images and ideas" (Inda and Rosaldo 2002:20).

Globalisation is characterised by the increased linkages between states and groups in states (McMurray and Smith 2001). The emergence of a global economy and emphasis on liberal free-market economics has led to an increasing divide between those benefiting from, and those disadvantaged by this process, reflected in divergent patterns of health and disease. Although globalisation has led to an increase in technologies including effective TB treatment, other aspects of globalisation are contributing to increased risk of developing TB, particularly in relation to marginalised groups (McMurray and Smith 2001) such as Asian migrants in New Zealand. This phenomenon is particularly apparent when looking at the movement of people between localities. Migration not only involves movement of people but also flows of capital, goods, images, ideologies and disease - "the flow of subjects and objects" (Inda and Rosaldo 2002:5). Migration for many people in New Zealand (and other countries) is not simply a one way movement but involves many global cross-border movements of political, economic and social processes, which has led to the recent term transnationalism (Benton and Gomez 2001, Murata 2001). Transnationalism is defined as "the process by which immigrants forge and sustain multi-stranded social relations that link together their societies of origin and settlement" (Murata 2001:1). A focus on globalisation and transnationalism allows for

the study of movement of populations, capital, commodities, ideologies and disease across space (Tsing 2002).

The notion that TB is transmitted from 'high incidence' countries to 'low incidence' countries may have less utility than a recognition that particular neighbourhoods in different cities are connected through transnational social networks that transcend national borders (King 2003:53).

The process of transnationalism is context-contingent, thus it can only be understood by looking at the physical, social and economic environments of both home and host countries (Morawska 2003). This becomes important when looking at TB in New Zealand and global relationships. In the recent past New Zealand had seen an increase in the growth of transnational Asian immigrants, particularly in relation to foreign fee-paying students (although this has now begun to decline) (Asian Youth Forum 2003). TB rates among these people are also very high and by employing the concepts of globalisation and transnationalism under the framework of political ecology, I can illustrate how the interaction of macro and micro level factors influence migrants' health, particularly in relation to TB. For example, this approach will allow an understanding of how international and national immigration and health policies influence transmission, treatment and knowledge of TB. It can also demonstrate how transnational impacts on employment, economics, social structures and agency can influence an individual's health.

One of the strengths of political ecology is that, unlike other medical ecological approaches that tend to regard human behaviour as the product of socio-cultural systems and natural environments, the framework emphasises the importance of human agency in creating environments (McElroy and Townsend 1985). Political ecology recognises that humans not only comprehend the complexities of their environments but also actively engage in behaviours and decision-making processes that can transform their complex social, political and physical environments, while acknowledging that these contexts are not always of their own choosing (Baer *et al.* 1997). "Individuals respond to a range of lifestyle options and choices available in any community, which in turn, is determined by international relations and global influences" (McMurray and Smith 2001:12). In New Zealand, many Asian migrants have established and belong to cultural groups such as sports groups and churches. These groups often entail activities such as teaching English language to help

migrants adjust to life in New Zealand. Many Asian communities publish newsletters and newspapers in their own languages to keep communities informed of key international and local events and provide a forum for opinions and problems to be voiced. Another important characteristic of political ecology is that drawing from its heritage in anthropology, it is always historically informed (Mayer 1996).

Political ecology provides a useful perspective for medical anthropologists to study infectious disease. Nonetheless, as with all theoretical frameworks, complex and integrative approaches can also contain weaknesses. Critics of such frameworks have argued that they fail to acknowledge the issue of primacy; whether specific factors play a more predominant role than others in disease aetiology (Baer 1996, Vayda and Walters 1999). Vayda and Walters (1999) are critical of the approach claiming that it privileges political economic approaches over other social factors such as human influences on the environment and local decision-making processes. Although they concede that attention to political and environmental influences are often important, they argue it can also result in a reductionistic approach when political ecologists:

Go well beyond asking for or paying more attention to such influences. Problematically, they insist that political influences- especially political influences from the outside, from the so-called *wider* political-economic system- are *always* important, arguably more important than anything else, and should accordingly be given priority in research (Vayda and Walters 1999:168).

However, many anthropologists using the political ecological frameworks have addressed this problem by incorporating the issue of primacy within their research. For example, in his study of TB in Haiti, Farmer (2000) explored primacy in his research and found that economic factors were more influential on compliance to treatment than cultural factors. This recognition of the intertwining roles of political economy, culture, environment and biology is crucial in analysing the occurrence of TB among Indian, Korean and Chinese immigrants in New Zealand, as it provides a broader understanding of the complexity of the disease. Along with political ecology, this study will also draw on the theoretical approach of habitus within the context of settlement experiences and health seeking behaviours of Indian, Korean and Chinese migrants in Auckland.

Habitus

Habitus provides a disciplined approach to examining the interaction of culture and political ecology within individuals and groups in their environment and this provides a vital link in political ecology and theory. Bourdieu's (2002) theory of habitus may also offer a useful framework to understand migration and settlement of transnational migrants. This theory has been applied to other research contexts to illustrate how socially-shared understandings of places and experiences in different physical and social spaces influence peoples' knowledges and practices (Gatrell *et al.* 2004). Habitus can be defined as long lasting schemes, structures of perceptions, conceptions and actions of a person or group of people who occupy similar positions and conditions in social spaces (Bourdieu 2002). They are therefore subconscious frameworks that form "the basis for the perception of the world" (Morris 2002:23). Habitus are long lasting and tend to reproduce themselves but may be changed by historical actions, new experiences, geographical and social spaces. As stated by Bourdieu (2002:31), "In rapidly changing societies, habitus changes constantly, continuously, but within the limits inherent in its original structure, that is within certain bounds of continuity". Central to this theory are the notions of 'field' and 'capital'. A field is social space which is structured through systems of social positions inhabited by tensions and contradictions where associated struggles and competitions generate change (Bourdieu 2002, Gatrell *et al.* 2004) and capital are resources which people take to the field (Hillier and Rooksby 2005). Bourdieu identified three primary forms of transposable capital: firstly, economic including material wealth and concomitant power; secondly, social, where resources are obtained through social networks, and finally, cultural, referring to knowledge and skills (Hillier and Rooksby 2005). Bourdieu also proposed that all these forms of capital can be incorporated within the concept of symbolic capital "when they are perceived and recognised as legitimate" (Bourdieu 1989:17).

Social relationships between people and groups of people occupying different positions are based on their social, economic, cultural or symbolic capital. Therefore, positions within fields such as health and employment are regulated by capital and the ability to change or conserve the field. Therefore, applying the concept of habitus to settlement and health practices of migrants can investigate the interplays between embodied practices and institutional processes that create inequalities (Devine and Savage 2005), and ultimately, affect the well being of Indian, Korean and Chinese

immigrants in Auckland. The following discussion on TB policies will also demonstrate how institutional practices directly impact on different groups of people within New Zealand.

Immigration and tuberculosis screening

Political decisions of governmental authorities on health and other policies can affect the control of TB rates within and between national populations (Antunes and Waldman 2001). This study aims to demonstrate how immigration policies and transnationalism shape the migration and settlement experience of Indian, Korean and Chinese migrants in New Zealand (including their access to provision of health care). Due to the global nature of TB, the WHO and others have argued that responses to the disease must be international in scope, including the collaboration of both developed and developing countries (King 2003). However, as seen in New Zealand's health and immigration policies, responses to TB focus mainly on the concern of protecting New Zealand's borders.

In New Zealand the association of TB with immigrants (and the recognition of ethnic health disparities) and emphasis on targeting immigrants for screening has also had further national and international repercussions by highlighting that it is a disease of 'others'. This study will explore if and how these discourses and policies discriminate against socially marginalised migrant populations and exacerbate stigma surrounding the disease. In New Zealand, emphasis on border control is apparent through TB screening. According to the Ministry of Health (2003) screening benefits public health by reducing the risk of infection to other New Zealand residents and reduces economic costs to New Zealand health services. Although TB screening in New Zealand is important, it cannot prevent TB from entering New Zealand from people who constantly cross borders (such as transnational immigrants) or prevent TB from occurring within New Zealand's borders (local transmissions and reactivation). New Zealand has different entry and screening requirements for different immigrant categories. Until recently, the New Zealand Immigration Service (NZIS) required all people aged 12 years and over (except those with New Zealand or Australian passports, asylum seekers and quota refugees) planning to stay in New Zealand for more than 24 months to have a medical examination and a chest x-ray before arrival (Ministry of Health 2003). Many young people coming to New Zealand on student visas and permits are from countries with a high incidence of TB. In 2001, young

Asian people from high risk TB countries made up a large proportion of student permits and visas issued by NZIS (Chinese-40 percent, South Korea-17 percent, Thailand-4 percent, Taiwan-4 percent, Hong Kong-3 percent and Malaysia- 3 percent) (Ministry of Health 2003:10). Due to the increasing incidence of TB in New Zealand and pressure from the Ministry of Health, the New Zealand Government made changes to TB screening procedures in 2004. These changes have targeted migrants, students and visitors coming to New Zealand in an attempt to prevent imported TB from crossing New Zealand's borders. As of April 2004, the 24-month criterion was reduced to six-months for foreign fee-paying students from high-risk TB countries and later that year was extended to include visitors and workers from relevant countries (Ministry of Health 2004). This discussion has shown that many Indian, Korean and Chinese migrants in New Zealand come as temporary visitors to study in New Zealand, and still have links with their home countries illustrating the importance of transnationalism in the research.

Transnationalism

Recently there has been recognition of the changing practices of migration in response to accelerated globalisation. Increasing global capital accumulation and transfer, increasing speed of communication and affordability of long distance travel are enabling people to cross (and re-cross) geographical, political and cultural boundaries physically, electronically and financially, thus producing a transnational world (Koopmans and Statham 2003). Transnationalism is important when studying TB in Indian, Korean and Chinese migrants as many fall under this category, particularly students who may only stay in New Zealand for the duration of their studies and have substantial links with their home countries. Transnationalism is not a new phenomenon but has seen changes due to rapid advances in communication and transportation which is now "more dense and intense than those that occurred in the past" (Joppke and Morawska 2003:22). Many migrants now engage in "social, cultural and political 'transnational spaces' that transcend or escape nation-state boundaries" (Joppke and Morawska 2003:20). When people migrate from one country to another they take with them ideas, perceptions and practices such as concepts of health, disease and treatment.

Transnational immigrants maintain diverse connections with their countries of origin through people (family, friends and business connections), religion, and

institutions (Joppke and Morawska 2003). However, movement is not a prerequisite for transnationalism. Although many migrants do travel frequently there are also those that travel infrequently but whose daily lives involve contacts and resources from outside their home country (Levitt 2003). Morawska (2003) found that Indian migrants in the United States maintained transnational households with their family in India by sending remittances and regularly exchanging news and making decisions through the internet, phone and videos: “depicting family events on both sides of the world” (Morawska 2003:136). Therefore, transnationalism occurs not only at macro levels but also influences everyday social and economic lives of migrants (Levitt 2003). This study looks at how transnational linkages influence the migration experience of Indian, Korean and Chinese migrants in New Zealand. It will also explore how transnational networks influence health (with a focus on TB) by investigating what, and how, information about health and treatment is exchanged between migrants, and how these networks can create stigma or support that can influence understanding, health seeking behaviour and treatment.

Asian migration to New Zealand and immigration policies

Political and socio-economic conditions not only generate migration and transnationalism from regions with high TB rates but also continue to influence the health and daily lives of immigrants within developed countries. New Zealand’s immigration policies were initially based on discrimination towards Asians and driven by competing economic markets and labour (Bedford *et al.* 2000, Lidgard *et al.* 1998a, McKinnon 1996). New Zealand’s discriminatory policies were strongly influenced by its origin as a British settler colony where legislation and national identity were modelled on its parent state (Pearson 2005). In contrast, later changes aimed to abolish discrimination and promote economic growth through skilled migrants and by enforcing stricter English language tests. To understand the social contexts of migrants’ lives in New Zealand, a primary aim of this thesis will be to understand how history, policy and economics have impacted on local experiences of migrants in New Zealand.

The first large numbers of Asian immigrants to New Zealand were Chinese. Early Chinese migration to New Zealand arose from commercial interests relating to the Otago goldfields during the mid to late 1800s (Fong 1959). Chinese migrants working in New Zealand’s gold fields resulted in the establishment of a distinctive

although small ethnic minority in New Zealand who suffered from social discrimination due to New Zealand's unwritten "White New Zealand Policy" where Chinese were vilified as 'the Asian Peril' and designated as 'undesirable aliens' (Ip and Pang 2005:17, Pearson 2005:27). They were the only people subjected to poll taxes and special permits to enter the country, as well as excluded from all government welfare benefits and prohibited from seeking naturalisation (Fong 1959, Ip and Pang 2005, McKinnon 1996). Anti-Chinese legislation reflected public discourse at this time, as illustrated by the murder of Joe Kum Yung (a Chinese gold miner) in 1905 by an anti-Chinese New Zealander Edward Lionel Terry (McGill 1982). Indians were the other major Asian ethnic group that became established in New Zealand during this era. They first came to New Zealand in small numbers during the later nineteenth century and were generally employed as hawkers of fruit and vegetables (McKinnon 1996:24). In contrast to Chinese who were prohibited from seeking naturalisation, Indian immigrants were entitled to naturalisation as they were classed as British subjects rather than foreigners. However, in 1920, a change in New Zealand's immigration policy meant that Indian immigrants were also restricted. The Act stated that no non-Briton could enter New Zealand without a permit from the Minister of Customs and the classification of British subjects was by parentage, excluding naturalised or colony British subjects (McKinnon 1996:27). No criterion of selection was provided for the entry permits and appeals were not possible (Ip 2002).

After the Second World War, in the late 1940s and early 1950s, a change occurred in immigration patterns in New Zealand. During the 1920s and 1930s New Zealand, Britain and many other countries had experienced a significant decline in birth rates. This population decline prompted policy changes to increase (although still carefully regulate) immigrants into New Zealand. In late 1945, a further change in immigration policy allowed Chinese women and children to come to New Zealand to reunite with family, leading to a growth of indigenous Chinese family units in New Zealand (Ip 1995). In 1948, New Zealand (following Canada and other dominions) established a New Zealand nationality separate from the common British nationality. This resulted in a new Immigration Act stating that all Commonwealth citizens including Indians arriving in New Zealand could acquire citizenship through registration (McKinnon 1996:36) and as a result, in 1952, Indians became the second largest migrant group after Britons.

During the 1950s to 1960s, New Zealand's economy was focused on industrial development of an import-substitution manufacturing base. Labour migration was encouraged to ease the labour demand through a number of work permit schemes and restrictions on tax were relaxed (Beal and Sos 1999, Bedford *et al.* 2000). In 1961, an amendment to the Immigration Act was made where non-New Zealand citizens were required to have a permit before entering New Zealand. The change in Policy only allowed Asians with family connection in New Zealand to be admitted into the country, demonstrating the continued discriminatory policy (McKinnon 1996:41). During the 1970s another major change in New Zealand immigration was influenced by concerns about its low economic performance (high inflation levels and low levels of economic growth), and severe labour shortages (Beal and Sos 1999). The Government created the 'Entrepreneur Immigration Policy' to encourage migration, resulting in a significant increase of migrants to New Zealand (Beal and Sos 1999:52). During this time New Zealand experienced its highest levels of migration for 100 years, 70,000 permanent and long-term migrants were recorded from 1973 to 1974 (Bedford *et al.* 2000, McKinnon 1996:42), although the majority of migrants still came from Britain.

Immigration policy changes in New Zealand during the mid-1980s and economic developments in Asia during this time were the catalysts leading to the first significant increases in the number of Asian migrants coming to New Zealand. In 1986, a new policy was established where selection of immigrants was directed towards personal merit and personal contribution to New Zealand without discrimination. These changes saw an end to the traditional country preference system which had underlined previous policies since the 1840s (Bedford *et al.* 2000, McKinnon 1996). The policy also placed emphasis on encouraging migrants with professional, technical and entrepreneurial skills to New Zealand in the hope of increasing business immigration (Beal and Sos 1999, Lidgard *et al.* 1998b, McKinnon 1996). At the same time in Asia, a growth in economic development led to an increase in the affluent middle class population and a potential pool of migrants keen to travel and settle overseas: "Dissatisfaction with the quality of life in these countries, particularly for children, had begun to act as a 'push' to those who could afford to move" (Lidgard *et al.* 1998b:1). The shift in policy in New Zealand and economic growth in Asia led to a decrease in European and American migrants and an increase

in Pacific Island (22 to 37 percent) and Asian (20 to 31 percent) migrants (McKinnon 1996:46).

In 1991, further administrative changes were made to New Zealand's immigration policy. The new immigration policy introduced a points system where immigrants were selected on their skills and money for investment in order to attract skilled workers into the country (Bedford *et al.* 2000, Lidgard *et al.* 1998a). The general objectives driving the change were aimed at increasing New Zealand's human capital rather than meeting shortages in the labour market (Lidgard *et al.* 1998a, McKinnon 1996). From 1991 to 1995, the net rate of Asian migrants to New Zealand had significantly increased. From 1986 to 1991, Indians and Chinese were the two largest Asian communities in New Zealand, while the fastest growing group of Asian migrants were Koreans (Beal and Sos 1999, Lidgard *et al.* 1998a, McKinnon 1996:46).

The most recent changes to New Zealand's immigration policy were implemented during 2002 and included the introduction of talent visas (as a part of the 'Work to Residence Programme'), stricter job search, business investment criteria and English language requirements. The level of English language requirements was raised for many migrant categories (General skills applicants from 5 to 6.5, business applicants from 4 to 5). The new English requirements mean that immigrants would be expected to be able to speak and read English well enough to study at university (Dalziel 2002). These requirements affected job search visa criteria where applicants had to obtain an average score of 6.5 as well as qualifications required for job occupations (Dalziel 2002). Further changes relate to criteria demonstrating how an immigrant's business can benefit New Zealand by promoting economic growth and a reduction for length of stay on visas and permits (initial multiple-entry from 3 years to nine months). The Immigration Minister at this time stated that these changes were designed to improve employability and settlement prospects for immigrants in New Zealand: "all the evidence shows that migrants are able to settle far more successfully in New Zealand if they can communicate better in English" (Dalziel 2002:1). However, the changes were also influenced by political, public and media attention on migration issues in New Zealand, following an anti-immigration campaign by the New Zealand First political party.

Although New Zealand is currently facing declines in Asian migration, the so-called 'Asian ethnic group' is New Zealand's fourth largest ethnic group (Table 1.4)

after European, Māori, and Other Ethnicity, totalling 354,552 people (9.2 percent) in 2006 (Statistics New Zealand 2007).

Table 1.4 Seven largest Asian ethnic groups in New Zealand 2001-2006 (Statistics New Zealand 2007).

Seven Largest Asian Ethnic Groups in New Zealand 2001–2006 Censuses			
Ethnic group	2001 count	2006 count	Percentage change 2001–2006
Chinese	105,057	147,570	40.5
Indian	62,190	104,583	68.2
Korean	19,026	30,792	61.8
Filipino	11,091	16,938	52.7
Japanese	10,023	11,910	18.8
Sri Lankan	7,011	8,310	18.5
Cambodian	5,268	6,918	31.3

While New Zealand actively encourages overseas migrants to come to New Zealand, emigration has also been influenced by push factors for immigrants. Recently, for many Asian societies (such as Chinese and Korean), the push factor for transnational migration has been to gain financial and scholastic capital through English education (Benton and Gomez 2001, Murata 2001). Other reasons for immigration include: stress-free surroundings, a more relaxed and peaceful lifestyle, a clean unpolluted environment, low crime rates, advice from family and friends, employment, business and political reasons (Auckland Institute of Research 1996, Lidgard 1996).

Settlement policies

Recently, there has been a debate surrounding multicultural and assimilationist approaches to immigration and citizenship policies of migrants into host countries (Koopmans and Statham 2003, Patchen 1999). During the 1960s and 1970s, many developed countries such as the United States, Australia, Germany and New Zealand adopted the concept of assimilation into mainstream policies and discourse (Koopmans and Statham 2003, Mulgan 1989, Spoonley *et al.* 2003). Assimilation assumes a homogeneous stance and requires migrants to undergo full conversion to

the dominant national culture by adopting the language, social practices, values and culture of the host country (Koopmans and Statham 2003, Mulgan 1989). However, assimilation is problematic as it does not allow for preservation of distinct, cultural identities thus denying ethnic and cultural differences (Mulgan 1989). In contrast, multiculturalism recognises or even facilitates the right of migrants to maintain their ethnic or religious practices supporting diverse cultures within societies. This concept has also been criticised as having the potential to create disunity by emphasising ethnic differences leading to stereotypes and discrimination (Mulgan 1989).

Although New Zealand leans more towards cultural multiculturalism, adopting multicultural policies is a complex issue relating to the historical and contemporary relationship between Māori and Pakeha (New Zealanders of European descent). New Zealand's current legislation and policies are based around a bicultural nation, Pakeha and Māori. New Zealand's bicultural nation and policies are based on the concept of equal partnership between Māori and Pakeha, centred on the Treaty of Waitangi² (Mulgan 1989). Although New Zealand's bicultural approach has had a long and contested history (Mulgan 1989, Spoonley *et al.* 2003, Vasil 2000), in 1975, Māori rights were officially recognised in legislation and the Waitangi Tribunal was established to investigate any breaches of rights and recommend ways to resolve them (McHugh 1991, Spoonley *et al.* 2003). It has been suggested that multicultural concepts may deny recognition and status of Māori people in New Zealand where, despite bicultural legislations, most political and social institutions are dominated by Pakeha (Mulgan 1989, Vasil 2000).

Although settlement experiences are influenced by immigration policies they are complex in nature, involving many other social and economic factors. Joppke and Morawska (2003) and Levitt (2003) argue that adjustment to host countries is a non-linear, complex and variable process and successful settlement depends on a number of factors involving both migrants and host countries.

² The Treaty of Waitangi was a contract between Māori and the British Crown signed in 1840 that continues to act as a constitutional document guaranteeing rights for Māori in relation to sovereignty, land and other resources. Interpretation and constitutional use of the Treaty is a contested issue in New Zealand and these debates are too broad to examine within this thesis.

Settlement experiences

Discrimination

Migration to New Zealand and subsequent settlement can be a traumatic experience for many Indian, Korean and Chinese immigrants, as they have to cope with many changes such as learning a new language, and settling into a different school or employment system and culture. Not only are the local customs and language different from their own but they are often separated from family, friends and close community support networks.

Several studies have found that discrimination against Asians, particularly stereotyping and rejection by locals, are major concerns for Asian immigrants (Abbott *et al.* 2000, Asian Network Inc. 2003, Bedford *et al.* 1995). Discrimination can have many effects on health and specifically on TB. It often leads to lack of access to health care and social services as well as creating stress for individuals (King 2003). It should also be recognised that many Asians report that stereotyping happens both ways and migrants also stereotype against host communities (Asian Network Inc. 2003). Many Asian migrants have reported being victims of verbal abuse in public areas such as supermarkets, roads and schools stating that “Go back to your own home” was a commonly repeated phrase (Lidgard 1996:35). Some of the common stereotypes directed towards Asians include: Asians are always plotting something, all Asians are Chinese, Pakeha culture is being threatened by Asian customs and Asians always stick together. The stereotype that ‘Asians always stick together’ was troubling to many youths as they felt that their current situation as students limited their involvement within New Zealand community events and therefore reinforced the stereotype (Bedford *et al.* 1995). For example, cramped flats and lack of amenities such as cafeterias and exercise areas at educational institutions encourage students to use public spaces in large numbers. Language barriers also affect the ability of many young Asian people to participate and communicate within the local community. For this reason many young Asians often chose to share a flat or house with other young people of a similar ethnic background.

Most Chinese students because of language barriers usually isolate themselves from local communities. After one or two years study at a University, some of them still don't know the customs or culture of NZ society. Some newly arrived students don't even answer their door. They don't talk to their neighbours and they aren't involved in any community activities (Sun 2003).

Stereotyping and discrimination towards Asians in New Zealand may also be related to their lack of familiarity, understanding and information about New Zealand's culture which are vital factors needed for settlement and adjustment into host societies (Asian Network Inc. 2003). In this thesis I will explore how discrimination of Indian, Korean and Chinese immigrants is expressed through national media and personally experienced in daily contexts, as well as how it impacts on settlement experiences and health.

Language difficulties

English proficiency is a major factor in migrants' settlement and participation in New Zealand society. A large proportion of Asian immigrants cannot speak or have a limited ability to speak English including: Vietnamese (31 percent), Cambodian (29 percent), Chinese (21-28 percent), Korean (21-28 percent) and Japanese (17 percent) (Asian Public Health Project Team 2003:40, Campbell 2001:3). Not only does English language influence education, employment, income and health but it also impacts on facets of everyday life, such as information and entertainment through television, newspapers and radio stations (Asian Public Health Project Team 2003, Campbell 2001). These limitations hinder the ability of immigrants to participate in political and social affairs.

Lack of English competency can create a two-way barrier for health services between patients and health care providers where miscommunications could impact on the descriptions of symptoms or the understanding of diagnosis and treatment (Asian Public Health Project Team 2003). Lack of interpreters, Asian-speaking health professionals and information in Asian languages have also been identified as key problems for Asians accessing New Zealand health services (Asian Public Health Project team 2003). Although all district public hospitals and public health services in Auckland have trained interpreters available free of charge to patients with English language difficulties (Waitemata DHB 2007), migrants may not know how, or where, to access these services. Also, this service does not extend to primary care such as General Practitioners' clinics. This study will explore if and how language difficulties influence settlement in New Zealand and health seeking behaviour for Indian, Korean and Chinese immigrants in Auckland.

Employment

Due to immigration policy changes giving preference to highly-trained, educated migrants from middle-class backgrounds, immigrants in New Zealand differ in these aspects from previous groups of Asian migrants. Asian immigrants have a significantly higher level of tertiary education than other New Zealanders. Despite their high levels of education and professional skills, many Asian immigrants suffer from high unemployment and underemployment because they are unable to work in their chosen professions (Asian Public Health Project Team 2003, Beal and Sos 1999, Lidgard *et al.* 1998b). Although being granted residence based on qualifications approved by New Zealand Qualification Authority (NZQA), immigrants' qualifications were not recognised in areas such as medicine, dentistry, veterinary practice and engineering. Many migrants felt they were misled by the points system as the points awarded to them on educational qualifications did not mean they were accepted by New Zealand's professional bodies (Beal and Sos 1999). These findings illustrate a major gap between New Zealand's immigration policies and New Zealand's efforts to meet migrants' settlement needs. Although the New Zealand Government actively seeks Asian migrants to New Zealand, they often receive limited information and support once they come into the country and may become victims of discrimination. Employment difficulties can result in economic and social pressures on people, acting as stressors that can directly and indirectly affect their health. This will be another aspect of settlement explored in this study.

Migration, stress and tuberculosis

Stress is a process that occurs when external conditions (including emotional, social and physical), are so prolonged and excessive they require functioning beyond habitual levels of activity, resulting in bio-behavioural, physiological and social responses (Goodman *et al.* 1988, McElroy and Townsend 1985). Although stress is a normal part of life, when environmental pressures or stressors are excessive and prolonged, the body's defences can become exhausted and a person may develop psychological and physical symptoms such as depression, immune deficiency and hypertension (Flinn and England 1995, Goodman *et al.* 1988, Sapolsky 1990). The relationship between stressors, biology and behaviour is complex. McDade (2003) argued that stress must be understood within local ecologies including physical, cultural, economic and political contexts.

Socio-cultural factors such as lack of social support, language barriers, unemployment, underemployment and subjection to discrimination can result in chronic stress particularly for subgroups that have the least power within a society (Baer *et al.* 1997). These interrelated forces in New Zealand have had major health impacts such as depression (Asian Public Health Project Team 2003). Impacts of settlement stressors on Asian migrant health have recently become the focus of much research (Abbott *et al.* 2000, Asian Youth Forum 2003, Koo 2004, Mak and Neil 2006, North *et al.* 2004, Sobrun-Maharaj 2006, Ward and Lin 2005, Ward 2006) which has found significant impacts on social and mental well being, resulting in loneliness and depression. In a study of young Chinese migrants in New Zealand, psychiatric morbidity associated with adjustment problems was found to occur in almost 20 percent of participants (Abbott *et al.* 2000:43).

Stress can affect the body directly through the interaction of the limbic system and basal ganglia on the sympathetic-adrenal medullary (SAM) system and the hypothalamic-anterior pituitary-adrenal cortex (HPA) system, particularly in relation to the production of the hormone cortisol (Flinn and England 1995). Chronic stress can also damage health through the constant mobilisation of glucose-causing atrophy and fatigue to tissues (Sapolsky 1990). Stress can also affect the body indirectly. Excessive stress can increase anxiety and vulnerability to illness which is a risk factor for TB. Stressed individuals are also more likely to engage in behaviours that increase health risks for TB including drinking excessive alcohol, taking drugs and smoking cigarettes (McMurray and Smith 2001). Chronic stress experienced by migrants must be treated as a serious problem as it can lead to more severe health issues by compromising an individual's immune system and therefore increasing their susceptibility to infectious diseases such as TB (Gandy and Zumla 2003, McMurray and Smith 2001). Although this study will not directly measure the physiological impacts of migration stressors on immigrants' health, it does aim to identify factors of settlement that immigrants perceive as stressors and also illustrate how Indian, Korean and Chinese migrants understand, embody and cope with stressors.

Health systems

India, China and Korea

For humans, health is greatly influenced by socio-cultural factors such as health systems and culture-specific explanatory models of illness (Kleinman 1980). All human societies create health systems consisting of culturally-constructed frames of meaning, beliefs and practices directed at promoting health and alleviating disease (Baer *et al.* 1997). These systems are highly varied and some are more systematic than others, demonstrating that disease is as much of a cultural construction as a biological entity. The coexistence of different health systems or medical pluralism is also common among societies where different systems may coexist in a cooperative or competitive relationship with one another (Bayer *et al.* 1997:9). Health systems, as with all cultural constructions, are also affected by political, economic and environmental factors. Indian, Korean and Chinese migrants who come to New Zealand may have had experience with health systems and beliefs that are very different to those practised in New Zealand. These experiences, beliefs and practices will influence how they understand TB and seek medical advice and treatment. This study will elucidate how Indian, Korean and Chinese migrants' previous experiences with health care systems influence their understanding and maintenance of health along with health seeking behaviours in New Zealand.

In South Korea health care is largely privatised and run like a business through the national health insurance programme (Kwon 2003, Oklahoma Medical Research foundation 2006). Since 1977, when the policy was implemented, people are required to have health insurance and almost all health care facilities are for-profit entities or owned by physicians. India's health care system includes both public primary health centres and private facilities (The World Bank Group 2006). However, it has been suggested that public health care facilities in India are inadequate, providing poor quality treatment and most people who can afford it turn to private health care organisations (Deogaonkar 2004). In China, the health system is also based on a medical insurance system and public hospitals function much like for-profit entities. There has also been a recent increase of private health care facilities (Blumenthal and Hsiao 2005).

Medical pluralism is also common within these three countries. In India a complex relationship exists between Western biomedical health systems and traditional Indian systems of medicine that have been strongly influenced by

globalisation, politics and economics. Indian health systems, although complex and variable, have been categorised into two general streams, one is an 'oral folk stream' and the other a 'codified classical stream' (Shankar 2001:1). Although each stream differs in certain aspects they are not mutually exclusive. The folk stream is generally practised by lay people (farmers, shepherds and housewives) and, because it is ecologically and ethnic community specific, occurs in diverse and variable forms. There are around a million folk healers based in India's rural communities. They often have no legal status but are held in high social respect within their communities (Shankar 2001: vii). Folk healers are more common in rural areas of India and this may be due to health beliefs and the cost of transport to health centres (often located in urban centres) and medicines (Bodeker 1989). The codified stream of medical knowledge includes systems such as Western biomedicine, Ayurveda, Siddha, Tibetan and Unani and is differentiated from oral streams by their emphasis on theoretical foundations, formally acknowledged status and institutionalised educational systems. Most practitioners of these medical systems, unlike folk healers, are based in urban centres and are licensed, recognised and registered under the State Government's Indian Medicine Practitioners Act (Shankar 2001:2).

Healing is an integral part of Chinese culture; the basic concepts of Chinese thought are employed to all aspects of their society such as their physical and social environments, diet, behaviours and health systems, practices and beliefs (Ho and Lisowski 1997). There are two forms of Chinese medicine that have traditionally coexisted, those of a high-order form that entail theoretical practice such as Traditional Chinese Medicine (TCM) and a low-order form which encompasses folk practices and magico-religious approaches (magicians, shamans, sorcerers and priests) (Bodeker 1989:66). Presently, medical pluralism is evident in China's health system where practitioners of TCM work alongside biomedical doctors in hospitals, medical schools and research institutions (Ho and Lisowski 1997). China has also had a long influence on medical systems and knowledges in Korea stemming back to the sixth century AD when TCM was introduced to Korea (Ho and Lisowski 1997:31).

Korea has a dual medical system where biomedicine and Traditional Korean Medicine (TKM), which focuses on herbal medicines, are independent services, yet both are legally recognised by the Government and included under the national insurance system (Hye Kyung Son 1998). Despite this dual policy, since Korea's independence from Japan in 1945, state health policies have actively encouraged

biomedical services while suppressing use and practice of TKM, significantly impacting on its health care system. For example, in 1990, only 10 percent of registered doctors in Korea were practitioners of TKM (Hye Kyung Son 1998:262).

New Zealand

Since the late 1980s, New Zealand has undergone four different restructures of health care delivery (resulting from pressure to restrict health care expenditure) (Gauld 2003). These reforms were focused on three key areas, including changes from competition to cooperation, contractual arrangements of purchasers and providers and centralised versus local decision-making (Ashton *et al.* 2005). New Zealand's health care is divided into three levels. The first is 'primary care' considered as patients' first point of contact and includes community nurses, General Practitioners (GPs), physiotherapists and optometrists. Next are 'secondary-care' services which are centred on standard public hospitals and include general medicine, surgery, paediatrics and obstetrics. Finally there are 'tertiary' services which include hospitals that provide more advanced services than secondary-care hospitals such as urology and neo-natal intensive care. In addition to District Health Board (DHB) publicly managed health care services, New Zealand also has independent, private health care services such as White Cross medical clinics. Presently in New Zealand, secondary-care and tertiary services in public hospitals (those managed by DHBs) are free for New Zealand citizens and permanent residents; in contrast, primary-care practices charge for their services. Primary care services and private tertiary facilities can also be accessed through private health insurance.

Currently the primary health care system is based around Primary Health Organisations (PHOs) which are formal not-for-profit groups of primary-care providers (GPs, physiotherapists, nurses, health managers and others). They are funded through DHBs on a capitated basis according to the number of enrolled patients. This policy was implemented to improve access and provision of primary health care by encouraging patients to use PHOs as their first point of contact within New Zealand's health care system (Gauld 2003). PHOs are required to be responsive to local community needs and receive a set amount of funding from the government which is based on the numbers and characteristics of people enrolled with them (Ministry of Health 2006a, 2006c). Once patients have enrolled with a PHO they may then be eligible for cheaper health care services (currently depending on their age,

socioeconomic status and health problems) as long as they attend the primary care provider with which they are enrolled. Adam (2003:45) identified a number of barriers in accessing PHOs including: cost of services, language and cultural barriers. Scragg and Maitra (2005) also found that Asian people are less likely to have a health practitioner or consult with health care professionals than Māori, Pacific Island or European New Zealanders.

Medical pluralism also operates in New Zealand. Within the Auckland region there are many non-biomedical healers such as TCM and Ayurvedic practitioners who operate through different health care systems to those of Western biomedical practices. Many Asian migrants in New Zealand seek non-Western medicine (in either New Zealand or their home countries) when they become sick (Asian Public Health Project Team 2003).

Differences in health systems, health beliefs and practices between New Zealand and immigrants' home countries can play an important role in TB diagnosis and treatment. Immigrants may not know how New Zealand's health care system works or may not be familiar with treatments or healer-patient relationships. As 66 percent of TB cases in Auckland are diagnosed through GPs rather than screening or contact tracing (Thornley and Wall 2003), these barriers to health care services can lead to delays in TB diagnosis.

Relationships between patients and their health care providers such as hospital-based clinicians, community-based GPs and Public Health Nurses (PHNs) have also been found to influence TB patients' treatment experiences (Searle *et al.* 2007). McMurray and Smith (2001) state that healer patient relationships also differ between health systems where most biomedically-trained doctors (unlike non-biomedical Chinese and Indian healers) focus on cure rather than prevention, tend to be highly technical and are often unable to cater to the cultural or social needs of patients and are, therefore, often remote to Asian patients. This study will explore how these relationships influence patients' access to health care, understanding of health systems and treatment of TB.

Health cultures

Health knowledges and practices have often been cited as a key determinant in both creating barriers to and facilitating successful TB treatment (Ho 2004, Ito 1999). Understandings of health or health cultures are used to interpret symptoms giving

them meaning and direction for treatment (Rubel and Garro 1992). Some studies have found that health cultures associated with TB are juxtaposed with biomedical knowledge about disease and conclude that traditional beliefs may create delays in diagnosis, barriers to treatment and increase social stigma (Ito 1999). In contrast, other research has demonstrated that non-biomedical beliefs and practices have positive effects on patient compliance and treatment and are thus complementary rather than inimical to biomedical TB treatment (Ho 2004). For example, Ho (2004) found that for Chinese immigrants in New York, TCM was taken to reduce the side effects of their biomedical TB treatment and, as a result, increased patient compliance. Health cultures and practices are also relative to other determinants of health such as class, income and education (Ito 1999). In a study of Chinese residents in Houston, a large number sought TCM for chronic illness, while biomedical medicine was used for many acute illnesses. Most residents sought homemade remedies and around half used both TCM and biomedical medicine. The study demonstrated that class was a key factor in medical treatment. Upper and middle classes were more likely to use biomedical medicine, while lower classes were more likely to use self-treatment and TCM (Asian Public Health Project Team 2003:49). This example highlights the importance of using an integrative model such as political ecology to study TB among Indian, Korean and Chinese immigrants and the relationships between socio-economic variables, cultural practices and health. This research will aim to gain an understanding of the relationship between health knowledges, health practices and other social practices of Indian, Korean and Chinese migrants in New Zealand.

Social stigma surrounding TB has also been shown to influence health cultures, diagnosis and TB treatment (Edginton *et al.* 2002, Rubel and Garro 1992, Sumartojo 1993). Therefore, stigma will also be addressed in this research.

Stigma

Stigma has been defined as an attribute that creates differentness among people, discrediting and preventing them from social acceptance (Goffman 1963). For Asian people stigma operates at many levels from local group perceptions to national discrimination. A common stereotype held by the New Zealand public is that TBD is a disease of new immigrants, not New Zealanders (Searle 2004). This conception may have arisen from and appears to be perpetuated by media reports and presentations.

For many human societies there is considerable secrecy and stigmatisation associated with TB (Edginton *et al.* 2002, Sumartojo 1993). The beliefs and attitudes of many Asian cultures about the causation of TB can lead to family rejection and loss of friends and family. In Chinese and Korean cultures, TB is seen as a disease of ‘dirty’ people while in India it is attributed to excessive behaviours such as sexual intercourse, smoking and alcohol consumption (Asian Public Health Project Team 2003, Rizvi 1991). The social stigmas attached to TB among some Asian cultures can prevent individuals from seeking treatment and taking prescribed medication as this reaffirms that the individual has the disease (Asian Public Health Project Team 2003). This research will explore social stigmas associated with TB and how these influence the TB diagnosis, treatment and experience of Indian, Korean and Chinese migrants. As stigma and broader health and settlement processes are related to social relations and networks, this will also be an area investigated within the study.

Social networks

Social networks are sets of people connected together by social relationships such as neighbours or church groups (Scott 1992). They involve complex bio-cultural interactions which include transmission of infectious disease such as TB, the flow of social information, local knowledge systems and can also function as support systems (Klovdahl *et al.* 2001, Klovdahl *et al.* 2002). As social networks occur over time and space, mapping such interactions within places and time frames can elucidate disease transmission patterns, sources of information (or misinformation), support systems and stress factors associated with Indian, Korean and Chinese migrants.

To cope with stressors, many Asian migrants have established and use a variety of social support groups, mainly voluntary organisations such as ethnic groups, sports groups and churches (Auckland Institute of Research 1996, Beal and Sos 1999, Lidgard 1996, Sedgwick 1998). Many of these groups are based on shared regional origins, language or religion and occupation. There are also many Asian student groups in New Zealand that provide information, support and cultural activities such as the New Zealand China HuBei Student Association. The membership of a Presbyterian church was shown to be common for Taiwanese and Korean immigrants. Lidgard (1996) states church is an important facet of migrants’ lives in spiritual, social and cultural contexts. Many churches provide liaison services between new immigrants and their host societies, seminars on New Zealand culture

and, in some cases, help in providing employment and accommodation (Beal and Sos 1999).

Support groups and networks in Asian communities are also examples of agency where they provide a forum to advocate public action, such as protesting against barriers to immigration and access to health care. An example of the importance of support networks and agency for Asian migrants can be seen through a recent (2005) collaborative TB awareness project that was focused on the Indian community in Auckland. The project was implemented by The Asian Network Incorporated (TANI) and Auckland Regional Public Health Services (ARPHS). Within the project Indian community members were key actors throughout the process using their extensive local networks to disseminate TB information to the community through culturally appropriate services. One of the key principals of effective public health promotion is that of community involvement. Kerr (2000) argues that communities are often overlooked in health promotion, yet, their inclusion, sponsorship and guidance are vital for successful health programmes. However, community involvement in health networks and promotion may also be influenced by the local power, agency and social structure of communities. This study aims to ascertain how support networks and local agency influence the seeking of medical advice and adherence to TB treatment by exploring what and how information about TB and treatment is exchanged between migrants, and how these networks can create the stigma or support that influences treatment.

Summary of thesis chapters

The second chapter will provide a brief description of the people with whom I worked, how they were recruited and will then outline the methods used within the study. Included in this chapter will be a discussion of limitations surrounding the research methods. The third chapter looks more closely at participants and their social contexts. It explores their migration journeys and settlement in New Zealand including settlement problems and coping strategies. In Chapter Four, I explore peoples' understandings and experiences of health, illness and health seeking behaviour with an emphasis on the barriers faced and factors that facilitated these experiences. Chapter Five focuses on social stigmas surrounding TB and how these influence health seeking behaviours, along with coping strategies used to minimise the impacts of stigma. In Chapter Six, I provide an overview of peoples' experiences

with TB, focusing on aspects that facilitated or created barriers to their diagnosis, treatment and coping with the disease. The final chapter of the thesis briefly reviews and summarises key findings and discusses their theoretical implications. In addition, it will identify areas where future research is needed.

CHAPTER TWO: PARTICIPANTS AND METHODS

Introduction

During this research I worked with a diverse group of people who ranged from recent immigrants to members of formal organisations. The majority of participants were immigrants from India, Korea and China, although this did vary within the different contexts of interviews and participant observation. Aside from the many people I encountered during participant observation, I also interviewed 29 people (Table 2.1). Participants included people who had TB, people without TB and health care professionals. They were recruited through health care professionals and local community networks. The study employed an ethnographic approach including semi-structured interviews and participant observation (Emerson *et al.* 1995) and media analysis (Lupton 1994). These methods allowed me to explore connections between public discourses and private practices and experiences. This chapter will discuss how each of these methods was used along with their strengths and limitations.

Setting the scene

Initially when I began my research in 2003, I set out to study 'young' Asian immigrants (between the ages of 16 and 35) living in Auckland, New Zealand. The study was to focus on how young transnational students felt about living in New Zealand, as well as to explore their perceptions of health in general with a focus on TB. My rationale for this was that most Asian immigrants in Auckland were young (Asian Public Health Project Team 2003:13) and the highest rates of TB among Asians occur in young adults (Auckland District Health Board 2003). The next step was to decide which groups to work with. I wanted groups that had large populations in Auckland and high TB rates, to ensure enough people would agree to participate and also to gather as much information on experiences with TB as possible. At this stage I approached PHNs from ARPHS for advice as they have extensive personal and professional experience with working with many ethnic groups in the context of TB treatment. In collaboration with PHNs, I decided to include immigrants from Mainland China, South Korea and India as they were the three largest groups in Auckland and people from each of these groups were being treated for TB at that time. However, for reasons that will be elaborated on below, I soon broadened the age

range of participants to include any migrant from India, China and Korea over the age of 16.

Once I had decided to work with people from India, Korea and China, I then began to seek advice about how to create social networks within the communities. This process involved enlisting the aid of three community 'cultural advisors'. Working with cultural advisors not only aided in establishing networks but also helped overcome barriers associated with my 'outsider/stranger' status as a South African-born New Zealand citizen of European ancestry. Anthropologists often struggle with problems related to insider and outsider status when studying people from their own or other societies and difficulties occur in both contexts (Agar 1980). Being an insider, or studying one's own society can provide a comprehensive view with understandings of cultural values and systems and pre-existing social networks (Fahim and Helmer 1980). However, insiders may also face restrictions due to cultural expectations of their informants and when gathering commonly shared knowledge. In contrast, outsiders such as myself have inherent ethnocentric biases which influence understandings and interpretations of ethnographic fieldwork, yet our outsider status may also allow us to observe patterns that are more noticeable to us than those immersed in social situations. Naples' (1996) work in rural Iowa demonstrated that people hold multiple statuses other than ethnicity including their age and gender. Therefore, people often shift from insider to outsider status within societies: "Outsiders and insiders are not fixed or static positions; rather they are ever-shifting and permeable social locations" (Naples 1996:83). As will be discussed further, my age, occupation, gender and language skills did influence my fieldwork. On several occasions I found myself shift from 'stranger/outsider' to 'friendly/insider' status.

The three advisors became invaluable to my research, not only helping me make contacts within the three groups but also helping with practical advice. For example, the first time I was invited to a prayer meeting at a Hindi temple, I had no idea what to wear. Would jeans be too casual or was this an occasion for a skirt? I also did not know what to expect. Should I provide koha (gift or donation)? Where would I sit? Do I take my shoes off at the entrance? Worried, I called my Indian advisor (who himself regularly attended temple meetings) and was provided with answers to all my questions as well as the assurance "It'll be fine". My Korean and Chinese advisors worked within health care sectors, one with Auckland's DHB and

the other, as a GP. Their health care roles enabled them to advise me about social stigmas surrounding TB, health care practices and behaviours within the specific groups they worked with. They also provided contacts with health care associations such as the Auckland Chinese Medical Association (ACMA), the Korean Health and Wellbeing group and other GPs from the groups with whom I was working.

Participants

Unlike most ethnographic research that focuses on one group of people based on their geographic location, ethnicity, religion, age or gender (Agar 1980), this research worked with three groups of people who were diverse in terms of languages, religion, age and gender. The only commonalities of participants (excluding health care professionals) were their status as immigrants and geographic location in Auckland. While working with such a diverse range of people enabled me to identify commonly experienced difficulties associated with migration, settlement and health experiences, it also limited my ability to determine differences experienced within the groups.

As previously mentioned, during participant observation I worked with many Indian, Korean and Chinese people in a number of different social contexts, which will be further discussed below. In addition to many conversations with these people, I also interviewed 23 Indian, Korean and Chinese migrants and six health care professionals (Table 2.1). They varied in their gender, age, occupation and time spent in New Zealand (an extensive discussion of the social contexts of participants' lives is provided in Chapter Three). Interviews included people who have, or have had TB (TB participants), family members of people with TB and people who do not have TB (Non-TB interviews) and health care professionals (HCP interviews). I worked with people with TB and those who had TB in the past to gain an understanding of transmission, stigma and issues surrounding diagnosis and treatment (See Appendix 1 for interview question outlines). I included family members of people with TB to ascertain how the disease impacts on family structures, how families influence social support and stigma and also to gain broader contexts of TB experiences for patients. I also included people without TB (who were not family members) in the study to gain an understanding of migration and settlement experiences, health beliefs and practices in general, and to investigate how stigma around TB is created and maintained in each group. Interviewing health care professionals (GPs and PHNs) gained their

perspectives on immigrants' understandings of New Zealand's health care system and factors that facilitate or create barriers to accessing health care and treatment with a focus on TB. The interviews also addressed if and how language and cultural factors influence communication with patients and TB treatment (Appendix 2 and 3).

Recruitment of people and problems with the number of participants in the study will be discussed within the following sections of this chapter.

Table 2.1 Description of participants interviewed in the study (using pseudonyms).

Pseudonym	Description of participant	Most recent year of TB treatment	Ethnicity	Gender	Age
Drezan	TB	2005	Chinese	Male	< 20
Meeta	TB	2005	Indian	Female	30-40
Vishal	TB	2005	Indian	Male	20-30
Bina	TB	2004	Indian	Female	< 20
Sachi	TB	2004	Indian	Female	30-40
Bhadrak	TB	2004	Indian	Male	20-30
Ari	TB	2004	Indian	Male	20-30
Yul	TB	2002	Korean	Male	20-30
June	TB	1997	Korean	Female	50-60
John	TB (LTBI) (Family member)	1997	Korean	Male	< 20
May	TB	1989	Korean	Female	30-40
Li	Non- TB		Chinese	Female	20-30
Tom	Non- TB		Chinese	Male	20-30
Alex	Non- TB		Chinese	Male	20-30
Jaya	Non- TB		Indian	Female	< 20
Megan	Non- TB (Family member)		Indian	Female	50-60
Dani	Non- TB (Family member)		Indian	Female	40-50
Madhu	Non-TB (Interpreter)		Indian	Female	30-40
Dependu	Non- TB		Indian	Male	50-60
Tushar	Non- TB		Indian	Male	20-30
Jin-Ho	Non- TB		Korean	Female	50-60
Kim	Non- TB		Korean	Female	30-40
Sun	Non- TB		Korean	Female	50-60
Chris	HCP (GP)		Pakeha	Male	50-60
Mary	HCP (GP)		Korean	Female	30-40
Priya	HCP (GP)		Indian	Female	30-40
Janette	HCP (PHN)		Pakeha	Female	40-50
Sarah	HCP (PHN)		Pakeha	Female	40-50
Heather	HCP (PHN)		Chinese	Female	20-30

Methods

Data collection methods in the study included participant observation, semi-structured interviews and, media analysis. Each participant (with the exception of those included in participant observation contexts) was given an information sheet (approved by the Auckland Ethics Committee) outlining a description of the study and key contacts and then signed a consent form before participating (Appendix 4 and 5). Participant information sheets were available in English, Mandarin and Korean languages. Mandarin translations were done by the Public Health Protection Interpreter Service (associated with ARPHS) and independently checked for translation and clarity by a Mandarin speaking colleague of mine in the Anthropology Department, University of Auckland. The Korean translation was done by a Korean colleague and checked by a Korean GP. As most Indian informants did not have English language difficulties I did not translate information sheets into Indian languages. For the one Indian woman who had English language difficulties, the information sheet was verbally translated by an interpreter.

Participant observation

Participant observation was a crucial method in the study. This method involves ethnographers “getting close” to people, observing and participating in their daily routines and lives (Emerson *et al.* 1995:1). Participant observation enriches anthropologists’ abilities to describe accounts of events from first hand experiences. It also provides additional sets of information as people often behave differently in different contexts. For example, descriptions provided in interviews may differ from observed behaviours (Agar 1980). By employing both interviews and observations, ethnographers are able to supplement each information source. As participant observation focuses on both observing and engaging in direct, personal involvement with communities, it can include a spectrum of positions from complete observation to complete participation (Jarvie 1969). Ellen (1984) emphasises the importance of researchers’ participation roles in ethnographic studies where specific ‘roles’ or ‘jobs’ create professional and useful images of researchers, allowing for familiar interplays between ethnographers and their hosts. It has also been suggested by Jarvie (1966) that researchers who focus on observation risk becoming ‘strangers’ to people they work with, while participating in community events and roles changes this stranger/outside status to that of a friendly/insider. Such roles often depend on the

ethnographers themselves as well as the people they work with. For example, Paul Farmer is an attending physician and anthropologist and his role as a practising doctor in Haiti provided him with the opportunity to gather information from clinics and patients through this familiar medical role (Farmer 2004). I also actively participated in many ethnographic contexts of this research. When I approached the ACMA, I was asked to give a presentation of my research proposal at one of their meetings. I have also actively participated in many events with The Asian Network Incorporated (TANI) including a TB education and awareness programme.

In 2005, ARPHS in collaboration with TANI implemented a project to raise awareness of TB among Indian communities in Auckland. TANI recruited two paid volunteers from each of 10 Indian associations to attend training programmes. PHNs and other health professionals from ARPHS conducted the training programmes. Following the completion of their training, volunteers then disseminated basic information about TB to their communities through presentations. I was asked to be a general facilitator in this project (working with TANI on the project proposal, recruiting community members, helping PHNs with training and community members with presentations) (Figure 2.1). This gave me an excellent opportunity to observe community members' knowledge and attitudes about TB in the context of both training sessions and community presentations as well as to explore health promotion, Indian networks and local agency.



Figure 2.1 Community TB presentation to Manukau Indian Association, 2005.

Participant observation has been applied in different ways within ethnographic research. Some researchers fully immerse themselves within a different cultural context, learning local languages and living among people for long periods of time. For example, Harper (2002) spent a year living in a small village in the south-eastern region of Madagascar studying health and illness of Tanala people. In contrast, other researchers do not immerse themselves and live with the people they work with but still apply a hands on approach to participant observation. Rapp's (1999) study of social impacts of amniocentesis in America was based on participant observation in various medical and private setting such as counselling sessions, diagnostic laboratories and private homes. My fieldwork was similar to that of Rapp. Although I live in the same city as the people with whom I work, I did not live in their homes, nor learn Korean, Indian and Chinese languages. As I was working with three groups of people who spoke a diversity of languages, and had a limited time to complete my doctoral thesis, a full immersion approach to participant observation was not possible. As a result, I was more distanced from participants and unable to observe as many daily life events within private contexts as I would have using an immersion approach.

Before I could begin participant observation I had to establish contact with community members. Establishing a rapport with informants is a critical and ongoing component of ethnography (Spradley 1979:78) where a basic sense of trust must be established to allow "for the free flow of information". Initially these contacts were made through my cultural advisors and then these connections snowballed, enabling participant observation in a number of social contexts. Some of the first organisations I approached included TANI, the Auckland Institute of Studies (AIS) St Helens, and the ACMA. By becoming involved in these formally structured organisations, I was able to make less formal networks and create friendships with many people leading to participation in a number of social events (Figure 2.2). For example, AIS hosted a series of Chinese movies to celebrate the Chinese New Year in 2004. Attending the movies allowed me to meet many Chinese people in Auckland and led to invitations to dinner, and the ability to participate with people in their daily domestic spheres of life. Likewise, Indian and Chinese cultural advisors at AIS invited me to student groups, clubs and events where I was able to meet students, form friendships and become involved in less formal social activities. These daily social contexts included

going shopping at local malls, going to the beach or on bush walks, having dinner or coffee and watching videos in their homes (or mine).



Figure 2.2 Evening meal provided after a TANI meeting, Auckland, 2007.

My roles as observer and participant also allowed for many opportunities to engage in casual conversations or ‘informal interviews’ with people. Participant observation was critical to understanding how migration and settlement experiences such as language barriers and isolation influence the everyday lives of migrants in New Zealand. It also allowed me to gain first hand experience of how social networks operate for migrants in Auckland, particularly how information about health (including TB) is exchanged and what health knowledges and practices are used by migrants.

I also observed, where consent was provided, in clinical settings with GPs, PHNs and TB patients. These observations included meetings with GPs in their clinics (Figures 2.3 and 2.4), homes or with associated organisations, attending nurses’ meetings and workshops at Greenlane Hospital, and home treatment of TB patients by PHNs. This allowed me to understand how relationships between patients and health care providers influence patients’ attitudes to health, TB and treatment. It

also gave me insights into how these relationships can act as important support networks for patients.



Figure 2.3 Indian GP in North Shore clinic, 2007.



Figure 2.4 North Shore GP clinic, 2007.

My interviews with TB patients created an opportunity to get to know them and their families (although this did vary due to social stigmas surrounding the disease). I became very close to two TB patients in particular, Meeta, an Indian woman, and June, a Korean woman. Both women invited me back to their homes for social visits after our interviews were completed and these visits became regular events. My close relationship with Meeta and June led to meeting and getting to know their families and gaining first hand experience of the social isolation they faced as immigrants and TB sufferers.

Although participant observation is a critical research method in ethnography there are also be problems that arise with the method. Language was a problem I encountered when meeting and participating in events with Korean and Chinese people (most of the Indian people I interacted with spoke English). I found that there were times when I was unable to follow conversations or activities (such as watching Chinese movies) due to my inability to speak in Korean or Chinese languages. Although I was lucky enough to make friends with many community members who acted as 'informal translators' for me, there were still situations where language

limited my ability to understand and describe events. For example, I was having dinner (consisting of pizza and fries) with four Chinese people; I became engaged in conversation with two of the young women when the two men began laughing loudly. Startled, Sarah, one of the young girls asked the boys in Mandarin what they were laughing at. They replied in Mandarin and their response sent the two girls off into a state of hysterical laughter. Not speaking Mandarin or being privy to the joke made me very aware of my language barrier in this situation. Language also limited my interactions with June when I visited her. Initially, I used an interpreter for our TB interviews, but during my social visits we would often have to rely on her son John to act as an informal interpreter between us. When John was not at home we would often counter communication limitations by resorting to physical gesturing to try and clarify meanings to each other. Another problem with using community members as 'informal translators' was that I had no way of knowing that what they were telling me was actually what had been said and had to rely on trust and observations of non-verbal behaviours to substantiate comments.

A further problem with participant observation is consequential presence, where the ethnographer's presence can affect how informants talk and behave (Emerson *et al.* 1995:3). Therefore, my presence as a female English speaking Pakeha may have altered the behaviour of people with whom I worked. For example, during the first evening of AIS's Chinese movie event, I was the only Pakeha present. I distinctly remember a Chinese man approaching me and asking (in English) are you Chinese? 'No' I replied. He then asked if I spoke any Chinese languages to which I also replied 'No'. Looking perplexed he then enquired why I was watching a Chinese movie (the movies did not have English subtitles). Jason, one of my Chinese friends from AIS, then decided to have some fun by telling the man "Oh she's here cos she's looking for a Chinese husband", a joke I would have to put up with over the next three evenings.

I found that with many young Indian, Korean and Chinese students my student status enabled us to build a rapport where we would discuss the subjects we study, the educational institutions we attend and associated difficulties. However, being known as the 'TB girl' did led to situations where people were more likely to discuss topics such as health, medicine and TB in my presence. Also, in other contexts, my age, sex and status as a student became a disadvantage. I often found I was limited in my ability to speak with many Indian men (particularly older men) or was expected to

answer questions but not ask them. For example, I was asked by TANI to assist in a community TB presentation, where my role was to facilitate the presentation and set up technical equipment. I asked permission from the organisation to bring my father (who had contacts with members of the organisation through his hockey club). They agreed and my father came to help me in my role. However, the organisation's chairman did not address me nor the young male Indian presenter (who was also a student) and directed all instructions and questions to my father (who I might add is not a health care professional). Impacts of gender on ethnographic research are common in anthropology. Abu-Lughod (1986:16) found her status as a 'woman' and 'adopted daughter' in Bedouin society restricted her ability to participate with men, yet also enabled her intimate access "in the women's world". Due to my inability to participate in such 'male' contexts, most observations of gender in this thesis are focused on women and young men (who were mostly students) and do not portray the impacts of migration or health experiences for married men.

Interviews

In total, 33 interviews were conducted with 29 participants (if permitted, I conducted follow up interviews with people). Ten interviews were conducted with people who had TBD and one for LTBI (who was also a family member of a TBD participant). Non-TB interviews incorporated a cross section of 12 immigrants from India, Korea and China including three family members of TB patients and one interpreter. I also interviewed six health care professionals (three GPs and three PHNs). One of the greatest limitations of this study was the small sample of TB participants and inclusion of only one Chinese TB patient. Due to this problem, the study can not represent the diversity of issues faced by immigrant TB patients, nor address individual differences between the three groups. Despite these limitations, the research can still illustrate experiences common to TB patients and establish a framework for future research on TB studies within Indian, Korean and Chinese immigrants in New Zealand. Difficulties recruiting TB patients also exemplify the extent to which social stigmas influence the lives of TB sufferers (which will be discussed below and in Chapter Five).

If consent was given, interviews were recorded with a digital audio recorder, otherwise hand written notes were employed (only one person did not consent to his interview being digitally recorded). All participants were given the option of using an

interpreter for interviews and eight people chose to have an interpreter. I used interpreters from Auckland's Public Health Protection Interpreter Service as they are trained, qualified interpreters who specialise in health focused contexts. The interpreters did not only verbally translate interview questions and answers but also acted as cultural interpreters. For example, Kate, a Korean interpreter would advise me to "take your shoes off when you go into their home, it is rude if you don't" and pulled me aside after an interview where I had run out of time and declined the refreshments offered stating "No, sit, eat and drink otherwise you will insult her [our host]". In these instances having interpreters who shared similar backgrounds with participants allowed me a greater understanding of social contexts and practices. After several interviews using interpreters and informal discussions with them about their experiences interpreting for immigrants in hospitals and other health contexts, I realised they were also key actors in immigrants' health experiences so began to include these discussions in my field notes and conducted a formal interview with an Indian interpreter.

Each interview was between 30 minutes and an hour and a half in duration. TB and Non-TB interviews took place in a number of venues of the participant's choice (discussed below). Interviews with PHNs took place at Greenlane Hospital and GPs were interviewed in their clinics or homes. All interviews were semi-structured using the life story approach. The life story approach does not focus on one aspect of a person's experience but on continuous events that influence their lives (Agar 1980, Angrosino 2002). It allows for in-depth narratives that represent complex and varying life events experienced by individuals applying a "holistic stance to social reality" (Ortiz 1985:100). Kleinman's explanatory models (EMs) were also employed as an analytical framework for interviews. EMs are notions about sickness episodes and treatment from all members engaged within the process (patients and healers) where they explain and make sense of an illness. Kleinman (1980) emphasised that EMs of disease are constructed by both sufferers and healers alike and, by exploring the interaction between EMs of both patients and health care professionals, an analysis of clinical communications can be achieved. Medical practitioners' EMs can illustrate how they understand and treat disease while patients and families' EMs provide understandings of how they make sense of disease and choose and evaluate particular treatments. Thus, employing EMs is a useful tool for medical anthropologists to understand cultural and social structures that influence interactions between health

care providers and patients. Another strength of applying EMs as an analytical framework to study disease is that power relations between health care systems and sufferers of TB can be identified and compared within specific community and clinical contexts. Although EMs are a useful method they must also be applied with caution. Kleinman (1975: 645) found that EMs “may be and often are ambiguous and changing, and they may contain contradictions and various degrees of logical development”. EMs of patients should not be treated as rational models based on theoretical knowledge, rather patients base their EMs on personal experiences located within embedded knowledge (Mol 2002). For these reasons, Mol (2002) suggests interviews should be based on what people do and their illness events rather than their cognitive operations or ‘thinking’.

Recruitment of Non-TB participants was through community networks matching as far as possible characteristics of the TB group. For TB interviews contact was initially made through PHNs from Auckland DHB. PHNs briefly described my research to patients and asked them if they were interested in learning more about the study. If they agreed, the PHNs would then pass their contact details on to me. I would then contact the patients and invite them to participate in the research.

PHNs informed me that many patients did not wish to know more about the study, particularly Chinese and Korean patients. I also found that for many of those who did agree, once I contacted them they did not want to be interviewed (five people I contacted did not wish to participate in the study) or did not turn up to arranged interviews (this occurred three times). In an attempt to find out why so many patients did not want to be involved in the research I consulted with PHNs. Their advice was that stigma, trust and language barriers may have been key issues. To help resolve these problems, I contacted three Korean GPs and asked for their help. They offered to help recruit people who were patients of theirs. They felt that this would overcome language barriers and they were also able to ensure patients of the confidentiality of the research. Despite their help, I still faced similar difficulties getting patients to participate and was only able to interview four Korean people who had TB.

Although interviews were a valuable research methodology I encountered a number of problems that need to be acknowledged and addressed. When using interpreters in interviews there is always the danger that questions and answers may not be accurately translated, potentially distorting people’s narratives. Aside from

translation problems, the presence of a stranger (interpreter) may make people feel uncomfortable given the stigma surrounding TB, particularly if the interpreters are from the same ethnic community as the participants. All the interpreters I used in the study were trained to deal with confidentiality issues and would verbally restate this at the beginning of each interview. Also, rather than the interpreter's presence being off-putting to people, many appeared to enjoy having someone to communicate with. On three separate occasions, TB participants invited the interpreter to stay after the interview for refreshments and informal conversation. One of the interpreters I worked with established a close relationship with Meeta, an Indian woman with TB. She helped Meeta with immigration problems and accompanied her to clinic appointments (as a friend, not a paid interpreter). Participants were also assured (verbally and in written form on their information sheets) that all interview material was confidential and were given the option to pull out of the research at any stage.

Another potential problem with interviewing people who had TB in the past is their narratives and descriptions may be influenced by the long time delay between their diagnosis and the time when I interviewed them. All of the Korean people I interviewed had TB in the past (between 3 to 14 years earlier) and two of these experienced TB in Korea. Despite these delays I found their recollection of events such as diagnosis, treatment, hospital stays and reactions from other people were vivid and detailed.

Data analysis of participant observation and interviews

The primary aim of data analysis for research is to “find meaning in the information collected” (Minichiello *et al.* 1990:247) through coding, discovering themes and propositions. All interviews and field notes were transcribed and entered into a QSR (N6) software programme where they were coded under broad conceptual themes such as ‘language difficulties’, ‘support networks’, ‘diagnosis’ and ‘treatment’ (these themes had been identified through interviews and transcriptions). Each of these themes was then re-analysed into sub-themes based on similarities or differences (of ideas, experiences and events). For example, under the theme ‘treatment’ would be a sub-theme ‘number of pills’ as this was the most common problem experienced by TB patients. This technique enabled me to see both variations in experiences and shared similarities

Media analysis

Media analysis is another method that was used in the study. As “we now live in a media saturated world” (Askew and Wilk 2002:1) media messages and texts (from press, Internet and television) can be employed to investigate embedded ideologies, politics and economics (Askew 2002, Gunther 2000, Jensen *et al.* 1991). Media are sources of social control and are also controlled by social, cultural and political elites (Gunther 2000) and can therefore reveal how power structures and relationships are generated and expressed (Lupton 1994). Media also provides stereotyped representations of mainstream discourses (Gunther 2000) such as those surrounding immigration, immigrants and disease. Lupton (1994) used media analysis of text to understand the construction of knowledges and epistemologies of AIDS in Australia. Like Lupton, I applied media analysis to local and national New Zealand newspapers to elucidate discourses on immigration, settlement, health and TB.

Media analysis can be applied through many quantitative and qualitative techniques (Bertrand and Hughes 2005, Gunther 2000). I employed a qualitative method of discourse analysis. This approach treats language and meaning of text as social, cultural and political constructions focusing on “the choice of words, the figures of speech and the style as well as the subject matter” (Lupton 1994:28). I used specific key words (such as ‘Asian’, ‘immigration’ and ‘tuberculosis’) to search for media text articles and then based my analysis on content, looking at social themes and discourses. I applied discourse analysis to *The New Zealand Herald* as it has the highest circulation in the Auckland area (Statistics New Zealand 2000) and other local Auckland newspapers such as *The Aucklander* and *The North Shore Times*. I used Auckland newspapers as they were able to give detailed descriptions of local, Auckland contexts. I obtained articles from *The New Zealand Herald* from an online electronic data base (www.nzherald.co.nz) covering the period from January 1999 to June 2007. Articles from *The Aucklander* and *The North Shore Times* were collected from hardcopies (as a North Shore resident I receive these newspapers weekly) over the period of January 2004 to June 2007.

As media is also used by Asian migrants in New Zealand as a networking tool where local newspapers are used to communicate, advertise and voice key community issues and events, I also included local migrant newspapers and newsletters including *Migrant News* and *The Asian Network Incorporated News*. I obtained hard copies of these sources from TANI covering the period from March 2004 to May 2007. These

sources established how local media counters national perceptions, illustrated how migrants feel about immigration policies and investigated key settlement issues in New Zealand. Due to my inability to read Chinese, Korean or Indian languages my media analysis was restricted to English sources which limited my ability to gain many local sources of knowledge.

Ethics

Ethics approval was granted for the study by the Auckland Ethics Committee in 2003 and was renewed in 2004 and 2005. There are several ethical issues that need to be acknowledged and addressed in the research. The study used PHNs and GPs to recruit participants. Most patients have a trusting relationship with their health care providers and a potential problem in this study was that people may have felt obligated to participate in the research when asked by health care providers. The patients may have felt they would have let their nurses or doctors down by not participating or may have felt compelled to participate because of the perceived 'powerful/authoritative' position of their health care providers. To try and avoid this occurring in the research I advised people that participation was their choice and choosing whether to participate or not would not affect their relationship with health care providers. Participants were told this orally before each interview and it was also clearly written on their information and consent forms.

Due to the stigma surrounding TB in these communities, identifiability and confidentiality were key areas of concern for people. All interviews took place in environments of the participants' choice. Generally most interviews with people with TB or who had had TB in the past took place in their homes, the University of Auckland or my home. However, some people were very sensitive about being associated with the study, not wanting family, friends and neighbours to know about the interviews and their TB status, so interviews took place in public places such as cafes, malls and McDonalds. Even when people allowed me to interview them in their homes, it was often carefully planned to avoid raising the suspicion of others. An example of this occurred with an interview with Vishal, a young Indian man with TB. He told me he would be interviewed in his home, only if I parked my car down the street away from his house and came carrying a clipboard. He told me if I was seen by anybody to tell them I was conducting a survey.

Chinese, Indian and Koreans make up relatively small populations in Auckland, therefore the potential identifiability of small groups was a concern for me in the research. All personal information relating to participants was kept confidential and codes were used in place of participants' names on interview transcripts. Pseudonyms were also employed in transcripts and later writing. All data that may identify people such as spatial locations, schools, work places and specific ages have also been omitted, changed or generalised throughout the thesis.

Conclusion

During this research I worked with a diverse number of people from recent immigrants to members of formal organisations. Participants were recruited through health care professionals and local community networks but there were problems with the number of TB participants included in the study. Despite my efforts to encourage people with TB to participate by using a number of health care professionals and reassurances of confidentiality, social stigma still led to an unavoidably small number of participants. However, to help counter this problem, I employed a number of different strategies to gain information on understandings and experiences of TB. These included participation with TB education and awareness programs, interviews and participation with family members of people with TB, other community members without TB and health care professionals. The study employed a number of qualitative methods including semi-structured interviews, participant observation and media analysis. Each of these methods are valuable to qualitative research, yet all contain problems and limitations that have been specifically addressed in the context of this study.

CHAPTER THREE: PARTICIPANTS AND SOCIAL CONTEXTS

Then I realised that the problem, you know, coming to foreign countries is a bit, you know, it's very risky and people, you know, take risk and [to] take risk is no[t] always positive, you know, sometimes you may lose. (Dependu, Indian man in his 50s).

Introduction

The primary aim of this chapter is to provide a description of the people with whom I worked, including their immigration background, settlement experiences and current daily life context in New Zealand. Exploring the social contexts of Indian, Korean and Chinese migrants' lives in New Zealand also provides insights into relationships between New Zealanders and non-New Zealand migrants. 'Othering' or racialising people into socially constructed groups such as 'Asian migrants' underlies the creation and reproduction of inequality (Schwalbe 2000) and can have significant impacts on migrants' lives. Social inequality and other settlement problems can result in stress, where individuals experience a reduction in health status (Berry *et al.* 1987). This chapter will illustrate how political, economic, social, cultural and physical aspects of environments act as stressors for migrants in Auckland. These transnational and local contexts have important implications in understanding immigration experiences in New Zealand including health and TB.

Participants

The participants in my study were a diverse group of people (Table 2.1). Although they were all migrants from India, South Korea and China, they differed in gender, age, occupation, immigration history and length of time in New Zealand. The findings in this chapter are primarily based on the number of people I formally interviewed, supplemented by information from participant observation and informal interviews. The majority of people came to New Zealand with other family members. However, six students from China and India came to New Zealand alone. Participants came from a variety of backgrounds within their countries of origin, although most were

from cities with the exception of three people from rural areas of India and two from small towns in China. Most young people had been students in their countries of origin, others worked in professional fields such as practising doctors, librarians and school teachers. All the Korean women and one Indian woman were housewives. Most people described themselves as healthy in their countries of origin. Only three Korean participants personally experienced serious periods of ill health (two had experienced TB and one had cancer).

Immigration history

Immigration history also varied between those who had emigrated directly from their countries of origin and others who migrated through several countries before arriving in New Zealand. Three people (two Indian and one Korean) migrated from their countries of origin to Australia, Zambia and United Arab Emirates respectively before coming to New Zealand. Participants had been in New Zealand from two to 48 years, although most had been in New Zealand for fewer than five years. People who migrated to more than one country or who had been in New Zealand for longer durations, tended to experience fewer settlement problems than those who had recently emigrated directly from their countries of origin. For example, Dependu, an Indian man in his 50s, emigrated from India to the United Arab Emirates before migrating to New Zealand. He felt his previous experiences with migration and settlement helped him prepare for life in New Zealand, particularly in relation to finding a job, home and social networks. This finding is consistent with other immigration studies in New Zealand which have found that immigration history and other aspects of migration preparation and experience aid in settlement and adjustment to new countries (Kim 2006).

Socioeconomic status

The socioeconomic status of informants was difficult to measure. I did not ask interviewees about their income levels, so had to use indirect methods to assess deprivation. Following Crampton *et al.* (2000), I used indirect variables to measure deprivation. These included the number of people in full-time employment, access to a home phone (or cell phone), ownership of a vehicle, level of qualification, household

occupation (based on the number of people and bedrooms) and home ownership. These measures revealed great diversity among participants, although young people, particularly students, had higher levels of deprivation. Only eight participants engaged in full-time employment. Those unemployed or working part-time were housewives and students. As will be discussed below, the study found that many migrants found it difficult to find skilled jobs in New Zealand. All interviewees had access to a home phone or cell phone. Most people owned their own car but seven people did not. Most of these were again students or part-time workers. All participants held secondary school qualifications and a further 13 held tertiary qualifications. Although participants were highly qualified, qualifications held by migrants in New Zealand may not be a useful measure of deprivation given their lack of recognition by New Zealand employers and other social factors influencing employment (discussed below). Only two people, both students, had to share a bedroom with someone other than their spouse and most people did not own their home. Of the nine that were home owners, most were older people (from their mid 30s to 50s).

Residential dwellings

Participants lived throughout the Auckland region. Nine people resided in rental properties and a further nine either owned their homes or lived with family members who owned a home. For example, Bina, a young Indian girl in her late teens, lived in her parents' home with her brother and paternal grandparents. Her parents owned the home which was a large, two storied house with a self-contained unit where she resided. Household composition varied from those living with one other person to living with eight others. Young people were more likely to move homes more frequently and live in lower standard housing with more people than older participants. Drezan, a Chinese student in his late teens, changed accommodation every six months: "Yeah, yeah. Normally half a year, change one address, one place [laughs]. Normally, ah half year I go back to China. Before leaving New Zealand I just, ah yeah, just ah, finish renting then when come back to rent another place again, yeah".

Jaya, a young Indian student in her teens, flatted with eight other students in a small three bedroom home in central Auckland. Her flat had one bathroom, she shared

one small bedroom with another girl, the second bedroom was shared by a couple and the third by three girls, while her other two male flatmates slept in the garage. Another young Indian couple with a young child rented a small one bedroom unit in West Auckland and found the unit to be “damp and cold”. Confined living conditions such as these promote infectious respiratory diseases such as TB where most transmissions occur with crowding and sustained contact (Beyers *et al.* 1996, De Zoya *et al.* 2001, Klovdahl *et al.* 2001). As I will discuss in Chapters Four and Six, participants attributed illness such as asthma and TB to damp, cold housing conditions. Although four people lived in homes that were small and crowded, potentially posing risks for TB transmission, the majority of people resided in comparatively large homes where they did not share bedrooms with people other than spouses.

These descriptions have provided a broad overview of interview participants. To enable more detailed accounts of the people with whom I worked, I next provide four short life stories of people with TB. These descriptions will give a brief background of their life before coming to New Zealand and the social context of their experiences in Auckland up until their diagnosis of TB (which will be discussed further in Chapter Six).

June

June is a Korean woman in her 50s, who migrated to New Zealand with her husband and son years 14 years ago. She has experienced three episodes of TB during her life time, two in Korea and one in New Zealand. Along with TB, June also has asthma, diabetes and chronic neck and shoulder pain. June came from a wealthy family in Korea but had difficulties completing her schooling due to her on going illness experiences. Despite these problems, she graduated with a degree from a Korean University in her early 20s, but her poor health prevented her from engaging in full-time employment. Not long after graduating, she married a Korean man and became a housewife and mother. June described her life in Korea as lonely. Due to the lethargy and pain associated with her illnesses, she experienced a fairly isolated social life, where she was unable to leave her home for long periods of time. Aside from her parents, June said she only had two close friends in Korea. Her social isolation was also compounded by the social stigma of her TB experience. Her husband’s parents did not approve of her marriage to their son

because of her previous TB episodes and she described her relationship with them as “troubled and stressful”. As June’s son Tom began to approach high school age, she and her husband decided to emigrate from Korea to a Western country to provide him with a good education and “better life”. The social tension between June and her in-laws was also a significant factor in her wanting to leave Korea:

Anneka: Right, ok and what made you decide to leave Korea?

June: Because of the children, my only son, cos of my only one son, and cos, I had trouble with you know, my family in-law [s]. So I want to, you know, be free of that stress, yep.

June’s husband was a research scientist and managed to organise a transfer to New Zealand through his employers in Korea. June described the transfer and migration process to be relatively simple due to her husband’s qualifications and pre-arranged job in Auckland. When the family came to New Zealand, they joined a local Korean church and through these connections were able to find a home and school for Tom. Despite the ease of migration June found settlement difficult in New Zealand, where she faced more social isolation than in Korea. June had limited English language skills and, other than people from her church, had no social networks. To help overcome these problems, she enrolled as a part-time student in an English class to improve her language skills and to meet people in Auckland. However, after three months in New Zealand, she began to lose weight and felt tired and “lacking in energy”, so she was unable to continue her course and often unable to attend church. June put her symptoms down to menopause and sought medical attention from local GPs and TCM healers. The following year, her health continued to deteriorate and she was diagnosed with diabetes. At this stage, June said she was confined to her home and, when her health allowed, would fill her time with domestic duties, gardening and reading. In early 1996, June and her husband bought a new house in Auckland. The home was a large four bedroom house with a substantial section. June found this to be a very busy period of her life, where she was focused on decorating, cleaning and establishing a garden. Not long after moving into her new home, June began to experience persistent coughing, fevers and lethargy. These symptoms progressed to the point where she began to cough up blood. At this stage June realised

she was suffering from another TB episode and, as will be discussed in Chapter Six, her TB experience in New Zealand compounded her pre-existing social isolation and settlement difficulties.

Meeta

Meeta is an Indian woman in her 30s, who migrated to New Zealand in 2003. Meeta came from a small rural town in India where she lived with her parents. Meeta's father suffered from paralysis and was bedridden, her mother spent much of her time caring for her father, and Meeta was the sole income earner for the family. Meeta taught full-time at a local school and would supplement her income with private tuition for students after school hours. Along with paid-employment, she also helped her mother with domestic duties and looking after her father. In 2002, Meeta's family was approached by an Indian family in New Zealand looking for an Indian bride for their New Zealand-born son:

It took a long time to get married. He [her future husband] had been there [India] three times. First off, ah his sister had been there and decided 'Yes, I had been a good girl; I'll look after my husband'. My husband had been there, and second time, he decided 'Yes I can marry this girl'.

In 2003, Meeta married her husband in India. He then returned to New Zealand and later left for Australia (where he had found a job). Meeta could not immediately join him in New Zealand as she had difficulty getting permanent residency. Meeta discovered that there would be an 18 month wait for permanent residency so decided to come to New Zealand on a work visa, arriving in Auckland in late 2003. As Meeta's husband had moved to Australia for work, she resided with her mother- and sister-in-laws in a large three bedroom home in central Auckland.

Meeta found life in New Zealand to be "a struggle", particularly in relation to language as she does not speak English. Along with language barriers, she felt insecure living with people she did not know well, and encountering cleaning appliances she had no previous experience with, such as dishwashing machines, washing machines and dryers. She also faced difficulties finding employment due to her language difficulties. Meeta told me she was so worried that she would not be able to pay her bills and that her

work visa would expire that she spent much of her time “crying in worry”. After two months, her sister-in-law helped find her a job in a local retail shop that was owned and managed by an Indian friend of theirs. Meeta enjoyed her job as she was working with many other Hindi speaking people so she was able to communicate freely and form social networks. However, after several months of working, Meeta began to feel sick. She experienced fevers, night sweats, a lack of appetite, weight loss and coughing. Like June, when Meeta began to cough up blood she suspected she had TB. She was worried that, if her family found out, they would send her back to India and her husband would divorce her. Due to these fears, Meeta tried to hide her symptoms. She wore loose clothing to mask the weight loss and would go to her bedroom when she had to cough so nobody would see the blood. Despite her attempts to disguise her illness, Meeta’s family were aware that she was not well. Megan, Meeta’s sister-in-law with whom she lived, told me that she was worried about Meeta’s health as she was not eating and was constantly coughing. She told Meeta to see a doctor and, when she had not sought medical attention, Megan took her to a Hindi-speaking GP who diagnosed her with TB.

Vishal

Vishal is an Indian man in his 20s, who came to New Zealand two years ago. Vishal came from a city in India where he and his wife lived with his family. Vishal described his family as “wealthy”. He held a postgraduate degree and worked within his specialised area in India. Not long after he married his wife they decided to immigrate to a Western country to gain overseas experience. Initially, they considered migrating to the United States but decided New Zealand would be a better option due to the quicker migration process. Vishal had no problem being accepted into New Zealand due to his qualifications, young age and good health. However, his expectations of life in New Zealand were not met. After migrating, Vishal found a three bedroom home to rent in the city, joined a local mosque and began to seek employment. At this stage, Vishal’s wife became pregnant so he was keen to find a job as quickly as possible. He spent six months trying to find work in his area of expertise with no luck, as he said employers told him he did not have the experience needed to work in New Zealand. Unemployment was difficult for Vishal. He had used most of his savings and was worried about the future of

his family. He sold his car and moved into a small, two bedroom flat in central Auckland, and finally found a low-paying job in a petrol station. Vishal's son was born later that year and he said he felt "very stressed" due to his employment, economic and housing situation. He decided to enrol part-time in a tertiary institution to gain New Zealand recognised work experience and qualifications. Eighteen months after arriving in New Zealand, and being under constant stress, Vishal began to feel unwell. He noticed swelling on his neck and experienced lethargy, pain and fevers, the beginning of his experience of extra pulmonary TB.

Drezan

Drezan is a Chinese man in late teens, who migrated to New Zealand three years ago. Drezan came from a large city in China where he attended school and lived with his family. Drezan's father had told him from a young age that he would be sent overseas to study when he was old enough. When Drezan was 16, his father decided to send him to New Zealand to learn English and attain a Western education. His father employed an immigration consultant who organised his student visa, school and accommodation. When Drezan first arrived in Auckland, he said he felt lonely, missing his family and friends in China. He also struggled with English language, New Zealand food and was subject to bullying from New Zealand students. They would taunt him about his language skills, threaten to beat him and often tell him to go back to China. Initially, Drezan did not want to stay in New Zealand but was afraid of his father's reaction, so stuck out the first six months of his education then returned to China through his school break. This was to become a regular pattern for Drezan, who spends six months at a time in New Zealand studying, and then returns to China between semesters and over summer breaks, reflecting the transnational nature of many international students in New Zealand.

When Drezan returned to Auckland for his second semester, he found accommodation through a Chinese newspaper and flatted with other young Chinese students in the city. Currently, he lives in a small one bedroom city apartment with another Chinese student (who sleeps on a mattress in the living room). After two years in New Zealand, he found English less of a problem and developed a taste for New Zealand

food but still experienced harassment from New Zealand-born students, and also had difficulty finding a part-time job.

Although Drezan's family pay his tuition fees and for his flights to China, he is financially responsible for his accommodation and living expenses, so it was important for him to find employment. Drezan said initially New Zealand employers told him his English skills were not good enough to gain him employment in Auckland. However, Drezan managed to find a number of part-time jobs in fast-food restaurants and internet cafes through his Chinese friends. Due to the harassment he faces from New Zealanders, he told me most of his friends are Chinese. Along with study and work, Drezan leads a fairly busy social life playing snooker, computer games and attending local night clubs with his friends. Around two years after coming to New Zealand, Drezan developed a pain in the left side of his chest. The pain gradually became worse and started to affect his study, work and sleep. In 2006, he was diagnosed with pulmonary TB.

As these narratives have shown, the people with whom I worked were diverse in terms of their geographical, occupational and linguistic backgrounds. Despite these variations, the following discussions on migration and settlement experiences will also demonstrate similarities in their experiences in Auckland.

Beginning the migration journey: Why come to New Zealand?

It has been suggested that Asian migrants, particularly Chinese and Korean, come to New Zealand to gain financial and scholastic capital through English education (Benton and Gomez 2001, Chang *et al.* 2006, Murata 2001). Other reasons include a more relaxed and peaceful lifestyle, a clean unpolluted environment, low crime rates, advice from family and friends, employment, business and political reasons (Auckland Institute of Research 1996, Lidgard 1996). My research supports these findings. I identified four main reasons why the migrants with whom I worked chose to come to New Zealand. These were better employment opportunities and life style, education, environmental reasons and friends and family. Most people came to New Zealand for better employment opportunities and life style:

Mm, cos lot[s] of people living there [China], maybe just one reason.
And, um, I think most ah important reason is we want to change our

circumstances there. Um, especially I have worked in my original Government work branch for ten years, but I don't feel that um, mm, mm I can get better, so I want to change. And find other opportunities in another country (Tom, Chinese man in his 20s).

Education was a major push factor for migrants to come to New Zealand. Nine people came to New Zealand on student visas for education purposes and two others who came on permanent residency visas also undertook study. Of the nine who came on students visas, all were young, between their early teens and mid-twenties. Parents were key actors in these decisions: two Chinese students and one Indian student did not choose to come to New Zealand, but followed their parents' decision to send them here. Migrants came to New Zealand not only to increase scholastic capital but also because they preferred New Zealand's education systems over those of their county of origin:

My Father was not quite happy about the Chinese way to study because um, we usually study about 12 hours per day and we have another four hours of homework. And, um, and there's a chance to um graduate to university, it's um quite hard. It's ah about ah only 20 percent [of] the high school student[s] can go to university. So um, my Father thought maybe we [I] should move on to another country (Alex, Chinese man in his early 20s).

A common theme from these narratives relates to Bourdieu's (1986, 2002) concept of cultural capital which refers to people's knowledge or skills. Bourdieu suggests that cultural capital can be acquired through institutional forms, such as education. Cultural capital (as well as other forms of capital) affects peoples' positions in various social fields and social interactions (Hillier and Rooksby 2005). Gaining cultural capital through education, English language and professional employment skills is an influential factor for Chinese and Korean migration to New Zealand and other Western countries (Benton and Gomez 2001, Murata 2001). As suggested by Murata (2001:61): "The ideal young [Chinese] man is also a wealthy scion with the same profile of having studied abroad, is sophisticated, worldly and transnational". Migration strategies focused on gaining cultural capital illustrate how experiences in different places influence knowledges and practices and have the potential to modify people's habitus (Gatrell *et al.* 2004). Yet capitals are differentially valued in different fields which have their own sets of power relations. Although cultural capital gained through migration may increase

migrants' economic and social positions in their home countries, in New Zealand this is not necessarily the case and may conflict due to the different habitus of migrants and New Zealand-born, as will be further elaborated.

Four people came to New Zealand on recommendations from friends and family or because they had family in New Zealand. Peter, a Korean GP, told me, when he decided to emigrate from Korea, he wanted to live in an environment where he could enjoy semi-retirement. He had two friends in Korea who had previously lived in New Zealand and told him it was a beautiful, quiet country. On their recommendation he and his family came to New Zealand for a holiday and decided to settle here. A few years later, he opened a clinic and continued working as a GP in Auckland. In general, most people like Peter did not obtain official information about coming to New Zealand but relied on information from friends and relatives who had lived, still live here or had visited. Three people from China and Korea came to New Zealand for environmental reasons: "So I want to, um, wanted to live, you know, quiet place, less population. I heard from lots of people that New Zealand has [is] cleanest in terms of air and also, um, that the air is clean, no pollution and less population" (Jin-Ho, Korean woman in her 50s).

Two Korean women came to New Zealand because their husbands were transferred here from Korean companies. Kim, a Korean woman in her 30s, had moved to Auckland three years earlier. Her husband was transferred from his company in Korea to New Zealand where he worked for a further year before being transferred again to Australia (where he will be working for two years). Rather than move to Australia with her husband, Kim and her two children decided to stay in Auckland, where her children could continue schooling in New Zealand until the whole family returns to Korea. For many Indian, Korean and Chinese people, New Zealand was not their first country of choice. Australia, the United Kingdom, the United States and Canada were preferred options. They came to New Zealand because it was cheaper, had an easier and quicker immigration process or because it was the first country to accept them:

[New Zealand] was an easy option, easy option at that time [2000] and I um, cos to go overseas um I thought of Australia and New Zealand were the best options. Um but in terms of um, no time of, I mean less time of migration process, and um yes, I chose New Zealand (Bhadrak, Indian man in his 20s).

Migration process

The official migration process and settlement in New Zealand begins with an application for a migrant visa. Ten participants came to New Zealand on permanent residency visas, two on business visas, nine on student visas (although one of these has since applied for permanent residency) and two on work visas (one of the two is currently applying for permanent residency). People had mixed experiences with immigration processes; some found the experience relatively easy and others experienced difficulties. The latter included language barriers and delays in the process. English competency made filling out application forms and passing the English language test difficult, particularly for Chinese and Korean migrants: “Problem was yeah, I had to prepare all the documents from Korea. Yes was English problem” (May, Korean woman in her 30s).

Although people acknowledged that New Zealand’s immigration system is quicker than that of other countries, six still experienced delays in the process. Acceptance of immigration visas was variable for participants, ranging from six weeks to 18 months. Four people experienced delays in paper work and found this to be a stressful experience:

I apply in I think February, and um, I can get my visa six months later in August. Oh um not very happy (about the wait). Cos um, the, the, so far you feel ‘Oh is my visa ok’. Cos um already to go two months, three months, four months and you don’t know. ‘Oh can’t get my visa’ or at that time you may think ‘Oh maybe I try another country’ because I, maybe that will be easier. Or so with everything I was very, very worried. Yes because ah, the immigration service did not provide anything back about your application and you don’t know anything, you just wait, it’s about six months, it’s quite long time” (Alex, Chinese man in his 20s).

Nine people felt their immigration process was relatively easy. Many factors helped to facilitate their experience including their educational background, help with English language, use of immigration consultants and companies or employers arranging the process. Five participants (three Indian and two Korean) felt that the process was easy due to their educational background: “It was quite easy because I was studying engineering um at University so getting an admission in New Zealand was, wasn’t difficult for me. Um visa process was quite easy because I come from an educated family

and um, a very engineering background. So it was good for me” (Bhadrak, Indian man in his 20s). May, a Korean woman in her 30s, asked her local Korean University to help with English language documents and two Chinese students employed immigration consultants. Two Korean women’s husbands were transferred from Korea to New Zealand by their respective companies. The companies arranged everything for the families including immigration visas, travel and accommodation. After arrival in New Zealand, migrants then began the process of settlement including finding a home, school, and job.

Settlement in New Zealand

To illustrate how settlement in New Zealand impacts on migrants’ health, the following discussion will review settlement experiences with a focus on aspects that created barriers to settlement and factors that facilitated this process. I found that participants did not receive much settlement and advice from the New Zealand government or agencies but did find support from local networks. Despite these support networks, migrants still faced many settlement issues in New Zealand including: language barriers, employment problems, cultural and environmental issues and isolation. These categories are not mutually exclusive and often interrelate and influence each other, as will be discussed throughout the chapter.

Language barriers

People with whom I worked varied in their English language skills from those who were competent in written and oral skills, to those who had limited ability (where I needed interpreters to communicate). Eleven people experienced English language problems that affected their ability to find a job, understand social and legal systems and socialise with others. One of the biggest problems that limited English posed to migrants were socialising and performing basic tasks such as grocery shopping:

Yeah language here was a big thing for me, hard. With the family it was not the language problem, but when I was going out, for example shopping, or just to talk with another person at that time, I had a language barrier. Yeah interaction was the main problem for the language barrier (Sachi, Indian female in her 30s).

As previously discussed, June had a restricted social life in both Korea and New Zealand due to her on-going health problems. She also found it difficult to make friends and socialise in New Zealand because she could not clearly communicate with others. June enrolled in an English language course, but found that it did not help her situation. She felt this to be an ongoing problem as she believed she needed to make “Kiwi” friends to learn “everyday Kiwi English” but could not due to her language ability:

I had limited um ability in terms of speaking English because I learned English at school [in Auckland], that was all. When I went to school and learned English, ah it was not a practical English like you can use in a everyday conversation or anything, quite formal, the readings from books and writing. We can speak the simple everyday English but not in depth. Cos I have a few Kiwi friend[s] and some Japanese friend[s], but it’s kinda limited, ah um friendship with ah Kiwi friend because of the um barrier of language...Because the problem is, [it is] hard to make the friend because ah, you know, to increase my English level, cos I just stayed home, don’t meet Kiwi friend. If I meet Kiwi friend and we talk and you know, talk about something and I can learn more. But I just stay home; I think that is the problem.

English barriers were more of a problem for Korean and Chinese participants; only two Indian people could not speak English fluently. However, Indian people still experienced language difficulties in relation to New Zealand accents and colloquialisms: “Ah yeah, in the beginning because ah our pronunciation. And our way of talking and New Zealand way of talking is quite terrible [laughs]. Like in the beginning it is quite hard to ah, to understand like you know? Because of the accent and everything” (Sachi, Indian woman in her 30s). There were also notable differences between younger and older participants in language barriers. Although younger people initially found English difficult, after a time it became less of a barrier. In contrast, for older participants, language continued to be a barrier, even after ten years of living in New Zealand. This could be because younger people had more contact with English. For example, two Indian students and one Chinese student in their teens lived in student hostels and with a home-stay family. I found these young people to have very active social lives, going to the movies and parties with ‘Kiwi’ friends and engaging in local cultural and sports groups. Another reason for variations in English abilities could relate to changing immigration requirements.

New Zealand's immigration policies surrounding English language requirements have undergone many changes over the last decade and these have influenced visa applications and employment opportunities for immigrants. In the early 1990s, immigration policies were directed towards attracting skilled migrants to invest in New Zealand and, as a result, the net rate of Asian migration increased significantly (Beal and Sos 1999, Lidgard *et al.* 1998a, McKinnon 1996:46). In 1995, as a consequence of the significant increase of immigrants to New Zealand at this time, further changes were made including more stringent English language requirements to control the number of immigrants approved for entry. These changes among others led to a decline in residence visa applications from 1996 to 1998, prompting further changes to language policies to counter immigration declines. In 1998, pre-existing language bonds were replaced with cheaper pre-purchase English language training (Ip 2000). In 2002, more changes were made to New Zealand's immigration policies, where language requirements were again a key focus and stricter requirements were implemented. These policy changes have led to variations in English language competency among Asian immigrants in New Zealand, depending on when they came to New Zealand, and under which immigration visa they entered.

Participants also used a number of strategies to counter English language barriers. Five people (one Chinese, two Indian and two Korean) would use family members as 'informal English translators'. This strategy would limit non-English speaking participants' social activities as they could only go shopping or go to the doctors when family members were available to take them. Four people engaged in volunteer work and joined 'Kiwi' churches to increase their English language abilities. Religious groups and cultural groups were also used by people to help with language skills and provide social environments where people could meet and engage in social activities without language barriers.

As previously mentioned, cultural capital was a strong push factor for Indian, Korean and Chinese migrants to come to New Zealand. Language is a form of cultural capital as it is a skill often acquired through formal education (Bourdieu 1986). This type of cultural capital can also be transferred into economic, social and symbolic capital through the advantage it offers in employment and thus material profits. English also

provides immigrants who wish to extend their social networks with an opportunity to engage with people outside of their own communities and therefore affects their social capital. Language and communication can also be classed as forms of symbolic capital as they can legitimate recognition and relative power of individuals through social communication (Bourdieu 1989, Hillier and Rooksby 2005). Although many Indian, Korean and Chinese migrants came to New Zealand to gain cultural capital, their English language difficulties have led to decreased economic and social capital in New Zealand by creating barriers to employment and social networks. The following discussion will review employment problems immigrants faced and associated economic costs.

Employment

The people with whom I worked engaged in a variety of paid and un-paid occupations (Table 3.1) which were not mutually exclusive categories as most students worked part-time and some housewives undertook study. Fourteen people engaged in either full-time or part-time employment, 12 were students and six women described themselves as housewives

Table 3.1 Participants' paid and un-paid occupations in New Zealand.

Pseudonym	Occupation	Full-time or Part Time	Gender	Age
Li	Student/Housewife	Part-time (student)	Female	20-30
Tom	Student/Factory worker	Part-time (student and worker)	Male	20-30
Alex	IT worker	Full-Time	Male	20-30
Drezan	Student/ Fast food restaurant worker	Full-time (student), Part-time (worker)	Male	< 20
Bina	Student	Full-time	Female	< 20
Jaya	Student	Full-time	Female	< 20
Meeta	Fast food restaurant worker	Full-time	Female	30-40
Sachi	Teacher	Part-time	Female	30-40
Megan	Retail	Full-time	Female	50-60
Dani	Business owner	Full-time	Female	40-50
Madhu	Interpreter	Full-time	Female	30-40
Bhadrak	Student/ IT worker	Part-time (student and worker)	Male	20-30
Ari	Student/IT worker	Full-time (student), Part-time (worker)	Male	20-30
Vishal	Student/ Service station attendant	Full-time (student), Part-time (worker)	Male	20-30
Dependu	Business owner	Full-time	Male	50-60
Tushar	Student/Factory worker	Full-time (student), Part-time (worker)	Male	20-30
May	Housewife/Student	Part-time (student)	Female	30-40
Jin-Ho	Housewife	Full-time	Female	50-60
Kim	Housewife	Full-time	Female	30-40
Sun	Housewife	Full-time	Female	50-60
June	Student/ Housewife	Part-time (student)	Female	50-60
Yul	Real Estate	Full-time	Male	20-30
John	Student	Full-time	Male	< 20

Despite their high levels of education, seven people with whom I worked could not find employment in their qualified fields of expertise. These included areas in medicine, engineering, library science, education, accounting and business:

Ah, it was a little bit difficult because we, ah, my husband and myself was, ah, a little bit, quite a huge amount in ah in India but only here in money wise and getting a job in our best, own field. Like my qualification and my husband's qualification, the job was totally different... Yeah, finding a job in that area and particularly, totally different. Ah no, no, for the immigration purpose our degrees are at par, but for getting a job they

[New Zealand employers] said 'No it is not'. Yeah, yeah, particularly my husband, he is the ah, doctorate from the number one institute from India which is recognised in US too, but in here, [in] New Zealand, they say 'No'. So it is quite frustrating (Sachi, Indian woman in her 30s).

For many immigrants, not being able to find employment in their areas of expertise has meant either undertaking re-qualification and having to pay full fees, taking up menial work or leaving New Zealand (New Zealand Citizens Advice Bureau 2000). Li, a Chinese woman in her 20s, was a practising doctor in China who was unable to find a job in New Zealand. Because Li wants to stay in the medical field she is now training to be a nurse in New Zealand. Five people had to change their career choice to find employment in New Zealand. Three young male participants (one Chinese and two Indian) who held postgraduate degrees from their country of origin had to take low-paying jobs in factories, gas stations and fast food restaurants:

I find a full time job in a factory. So I, but ah, um the wage is not so high, just a basic wage. Ah about 10 dollars an hour, I work from about eight o'clock, ah, about eight hours, so that's 40, 40 hours a week. But it's lowest, lowest work, ah lowest in the wage (Tom, Chinese man in his 20s).

Employment difficulties faced by migrants highlight gaps in New Zealand between immigration requirements and settlement policies. As discussed in Chapter One, in 1991, New Zealand introduced a points system to attract skilled workers into the country to promote economic growth, giving preference to highly-trained, educated immigrants. (Bedford *et al.* 2000, Lidgard *et al.* 1998b). Nearly one-third of Asian people in New Zealand have a tertiary education and Asian immigrants have a significantly higher level of tertiary education compared to other New Zealanders (Asian Public Health Project Team 2003). Despite their high levels of education and professional skills, many Asian immigrants suffer from high unemployment (Table 3.2) and underemployment (obtaining a job that has a significantly lower status or skill level to that previously held in their country of origin) because they are unable to work in their chosen professions and face discrimination (Asian Public Health Project Team 2003, Beal and Sos 1999, Lidgard *et al.* 1998b).

Table 3.2 Percentage of unemployment by ethnicity in Auckland, New Zealand (New Zealand Census 2001).

Ethnic group	Auckland region	New Zealand
European	3.1 %	3.4%
Maori	11.0%	11.4%
Pacific	10.0%	10.2%
Asian	7.4%	7.2%
All groups	5.1%	4.8%

Although recent policy changes now require immigrants to receive registration from appropriate professional bodies before they enter New Zealand (Lidgard 1996), this does not assist immigrants who arrived prior to the change, nor does it address issues of discrimination. Many Asians feel they face racial discrimination when seeking jobs in New Zealand, where “Employees are chosen on race rather than qualifications” (Lidgard 1996: 31). A study by Chang *et al.* (2006) found Korean migrants in Christchurch attributed unemployment to anti-Asian feeling, discrimination and racism. People with whom I worked encountered similar reactions from New Zealand employers:

When I looking for a job employers ‘We’re sorry we can’t help’. They look for experience. But if I didn’t find a job, how can I get local experience? Yes, it’s quite bad. Yes, yes because they don’t think Chinese experience is suitable here. And in many, in many employers’ mind they think China is a poor country, that it’s not as advanced as Western countries (Tom, Chinese man in his 20s).

Language was also a barrier to finding employment. Some migrants were not able to meet the English language test requirements needed to work in their qualified field: “My major is um, is Arts in China. And my wife ah, she was a doctor and she has studied medical science, but because of the language can’t meet the criteria for doctor, so she can’t find a very relative job [job as a health care professional]”. However, as previously mentioned, many participants spoke English language fluently and still could not find employment. Viewing employment as a field in which the social status and relative power of people positioned within it depend on their capital (Bourdieu 1989), it is evident that, in New Zealand, language proficiency of migrants does not qualify as symbolic capital. Although English proficiency is an institutionalised form of cultural capital, it is

not recognised as a ‘legitimate’ form of capital by New Zealand employers, who dominate this field and define what is valued.

Isolation from friends and family also affected peoples’ opportunities to find employment. For example, three female participants found that lack of family and friends available for childcare meant not being able to find a job. Social capital is the accumulation of actual or potential resources of social groups which provides members with capital (Bourdieu 1986). In New Zealand, migrants’ lack of social networks reduces their social capital, and in turn, reduces their economic capital.

Unemployment and underemployment experienced by Indian, Korean and Chinese migrants in New Zealand are reflected in their income levels. Only 17 percent of Asian people aged 15 years and over living in the Auckland region had an income of \$30,000 or more (Table 3.3) compared with 31.2 percent for the whole population (Asian Public Health Project Team 2003:21).

Table 3.3. Percentage of people aged 15 years and over with a declared personal income of \$30,000 or more by ethnic group (New Zealand Census 2001).

Ethnic group	Auckland region	New Zealand
European	40.3%	31.8%
Maori	23.8%	18.3%
Asian	17.0%	17.0%
Pacific	14.9%	14.9%
All groups	31.2%	27.3%

Underemployment of migrants in New Zealand has reached national attention. Excerpts from national newspapers depict highly skilled migrants working in low paying positions: “A scientist from India who became a cook in KFC” (Tan 2006a), “One friend of my Chinese wife was a lecturer in mathematics, now she fills up shelves in Pak ‘n’ Save; my wife, a graduate in teaching, works as a reliever in childcare centres for \$10.25 an hour” (Bol 2006:A11). Media articles such as these depict reality for many Indian, Korean and Chinese migrants in New Zealand.

Problems faced by migrants seeking employment are not hidden but have also been brought to public attention through media as illustrated by these headlines: “Good job opportunities for immigrants just a big fat lie” (Tan 2006c), “Migrant skills go

begging” (Bland 2005) and “The migrant experience: Jobs that shut out migrants” (Middleton 2005). These headlines illustrate public awareness of issues migrants face regarding recognition of qualifications and lack of New Zealand work experience. The media also highlight the range of public responses to migrants’ problems, from extreme views such as “I am tired of the whining that their qualifications are not valued and they are working jobs that are beneath them” (*New Zealand Herald* 2006a:A11) to a headline claiming “Immigrants bring skills and economic sustainability” (Jacobi 2005). There are also differences seen between national newspapers such as *The New Zealand Herald* and local ‘migrant’ media such as *Migrant News* and *The Asian Network Incorporated News*. National media tends to publicise migration employment problems and draws on public opinions and responses. In contrast, local media sources provide advice on these problems, advertise workshops and direct readers to information and help available. For example, in a single issue of *Migrant News* (2006), there were two sections discussing employment problems where articles gave advice on creating curriculum vitae, interview skills and skill assessment (De Boer 2006:4, DeSouza 2006:13).

Difficulties with employment have economic, psychological and physical impacts on people. Low incomes and poverty are key social determinants of many health problems including TB (Benatar 2003, Farmer 1997, 2000). As I discuss in Chapter Four, participants specified employment barriers and low paying jobs as causes of stress and illness:

Getting jobs is difficult. When you come you expect high paying jobs here [New Zealand] like in India, but here even getting a job in a gas station is difficult. In India I would never have done that [worked in a gas station] as I studied engineering to get a job and get paid for it. Here all expectations and no job, you need money to survive and this causes stress. If you can’t get a job and don’t have money you can’t survive... In US and Australia degrees from India get you jobs, but here you can only survive in jobs like Pak ‘n’ Save and groceries. People feel as though they are not getting proper opportunity. They are not good jobs for degrees and money. I have been here for two years and was in stress for not finding good job, and last six months I have been feeling sick (Vishal, Indian man in his 20s).

To counter employment barriers, Indian, Korean and Chinese migrants employed a number of strategies. These included using local community networks such as friends,

family, cultural and religious groups and engaging in unpaid work for experience and volunteer work. Three people found employment through their friends and family: “One of my family members is already working at that place, so she found that there is a place open and through family member only, I came to know of the job” (Meeta, Indian woman in her 30s). Tom, a young Chinese man in his 20s, found work through his church and Carla, an Indian woman in her 50s, was employed through her TANI contacts. Two Indian students in their late teens engaged in unpaid work for local businesses during their semester breaks. They believed that this would provide them with ‘Kiwi’ work experience needed to find jobs once they had graduated.

Racial discrimination: Othering of Indian, Korean and Chinese migrants

Along with discrimination within the field of employment, Indian, Korean and Chinese migrants also experienced national and local forms of discrimination in New Zealand. Successful settlement for migrants depends not only on the immigrants themselves, but also the attitudes, expectations and behaviours of host societies (Sobrun-Maharaj 2006, Ward 2006). Shared attitudes and knowledges or discourses of one group of people towards others create collective identities (Liu *et al.* 2005). Such discourses are often grounded in historical representation and are articulated and maintained through media and everyday language. I used media analysis to gain an idea of how othering of Asian migrants is represented through national mainstream media discourse in New Zealand.

Much New Zealand media focuses on anti-immigration sentiments and key themes associated with Asian migrants include criminal activities, racial discrimination and harassment. For example, from January to April 2007, *The New Zealand Herald* contained ten articles on Asian crime (such as importing and dealing drugs and fraud) and eight articles describing anti-Asian sentiments or racial attacks. In a recent article from *North & South* (a popular mainstream monthly magazine) titled “Asian angst: Is it time to send some back?” (Coddington 2006), Asian migrants are depicted as criminals engaging in murder, extortion, kidnapping, drug manufacturing, importing and dealing, prostitution

and smuggling¹. Reports of Asian criminal activities are common in national and local New Zealand newspapers with headlines such as: “Migrants sold hope in phoney documents” (*New Zealand Herald* 2005a), “Migrants 'defraud' insurers” (*New Zealand Herald* 2005b), “Kidnapping cases hit one a week- Asian students in Auckland are falling victim to kidnap and extortion crimes at the rate of one a week” (Gower 2003) and “Foreign student racket” (*North Shore Times* 2004).

Although these media reports cite specific New Zealand cases of Asian criminal activity, they do not provide comparative data from other ethnic groups to determine how large these problems are in relation to other ‘ethnic’ crimes in New Zealand, providing a false perception of criminal stereotypes of Asian migrants. In contrast to the large number of national media reports focusing on Asian criminal activity, I also found a few reports from local newspapers illustrating how Asians can help prevent criminal activities in Auckland. Articles in *The Aucklander/NORTH EDITION* (Bree 2004:3) and *North Shore Times* (Kiong 2004:16) discuss the benefits that Indian and Chinese migrants can make to their local communities through volunteer and community work with the police. These media reports illustrate the contrasting perceptions of Asian migrants in relation to crime in New Zealand from those who see migrants as criminals who should be sent back to their countries of origin and subjected to stricter immigration requirements, to others who view migrants as a benefit to local communities and play a key role in crime prevention.

Ethnic (Asian) discrimination and harassment is another theme common in New Zealand media. An article in *The New Zealand Herald* highlights bullying of Asian students in New Zealand schools where children were harassed when speaking in their own languages (Walsh 2003). New Zealand Chinese newspaper reporters have also become victims of racial harassment from New Zealand readers, receiving insults such as “Stinking Asian - go back to where you belong!” (Tan 2006b).

Several studies have found that discrimination against Asians, particularly stereotyping and rejection by locals, are major concerns for immigrants (Abbott *et al.* 2000, Asian Network Inc. 2003, Bedford *et al.* 1995). Understanding migrants’ relationships and experiences with New Zealanders was a challenging area of the thesis.

¹ The editor of *North & South* did not give permission for the cover of this edition featuring the headline “Asian Angst, is it Time to Send Some Back” to be used as an image in this thesis.

When asked about such issues all participants told me that they had no problem with ‘Kiwis’ who were described in terms such as “nice, friendly” and “helpful”. However, peoples’ narratives presented quite a different picture of interactions and relationships between ‘Kiwis’ and ‘Asians’. I feel part of this contradiction is due to my ethnicity as a Pakeha New Zealander, where participants may have felt that their experiences of harassment by New Zealanders would offend, insult, or upset me. Harassment therefore may be underrepresented in this study. Other research has found racial discrimination to be widespread among Asian migrants. Ward’s (2006:118) study on young Chinese students in New Zealand reported that 56 percent of students had experienced racial harassment and Chang *et al.* (2006:21) found that most Korean migrants in Christchurch experienced racial harassment.

Three people in the study disclosed to me that they had experienced racial discrimination in Auckland. May, a Korean woman in her 30s, experienced racial discrimination from a real estate agent when looking for a home to rent: “The real estate agent he was ah mean, yeah and ah, the real estate agent, ah he was quite mad at me, and he did a lot of lying. So he wasn’t very nice”. The real estate agent had accused May of using her lack of English competency as an excuse not to commit to renting a home he showed her, when May tried negotiating the rent price he said to her “Oh you people don’t speak the English, but different with money, you can’t do that here, when you gonna know [learn] the Kiwi way”. May said she felt angry and upset with him and changed to another agent.

Sachi, an Indian woman in her 30s, was a victim of racial comments when shopping in a local supermarket with her children. Sachi heard a woman behind her comment: “there’s another muncher, off to get curry with her little munchers”². Sachi said she felt embarrassed and angry that the comment was made in front of and directed at her children.

Racial discrimination, such as that faced by participants in this study, is not directed equally to all migrants in New Zealand. Ward (2006:122) found that New Zealanders tend to favour migrants of European descent and direct bias and discrimination against migrants from Pacific, African and Asian countries. New Zealand

² Curry muncher is a derogatory term for people from South Asia.

has a long history of discrimination against Asian migrants and these biases appear to have escalated during the 1990s due to political and economic conditions. Recognising the growing economic importance of Asia to New Zealand, the New Zealand Government adopted a policy objective in 1993 aimed at tapping into the dynamic Asian centres of capitalism to ensure that New Zealand would be seen as part of Asia by the year 2000. It has been suggested that a social by-product of these policy changes would be that New Zealanders become more familiar with Asian cultures, a social dynamic that would have major social implications on the relationship between New Zealanders and Asian migrants (Bedford and Ligard 1996:25).

Familiarity with Asian cultures and the attention brought to increasing Asian migration resulted in a spate of negative attitudes and racism from the media and political sources (Bedford *et al.* 2000). In 1993, a vicious trend began to emerge where attacks on Asian people were highlighted by the murder of an Indian shopkeeper in Auckland (Leckie 1995). During 1994 to 1995, media labelled the new migration trend as an “Asian invasion” (Bedford and Ligard 1996:3). In 1996, the New Zealand First Political Party used the current debate on immigration issues as a goal of their election campaign, calling for a reduction in the number of immigrants to New Zealand. The anti-immigration political movement in New Zealand is similar to that in Australia, where the One Nation Party was calling for the abolishment of multiculturalism in Australia and used Asian immigration as a primary target in their campaign during the late 1990s (Beal and Sos 1999). In both New Zealand and Australia, the movement against Asian immigration was compounded by the relationship between the majority European settler population and the indigenous people (Beals and Sos 1999).

National identity is strongly affected by historical, political and social relationships. National identities are socially constructed from shared representations of knowledge of that particular group relevant to outsiders (Liu 2005). Thus, to understand group or national identities, one must look at shared knowledges, practices and discourses of that group and also that of the ‘other’. For much of New Zealand’s history Māori have struggled for autonomy under a settler government (Liu 2005). As discussed in Chapter One, it was not until the mid-1970s that Māori rights were officially recognised in legislation with the establishment of the Waitangi Tribunal (Spoonley *et al.* 2003). Since

the 1980s, the New Zealand government has focused on the Treaty of Waitangi and 'Treaty partnership' remaking a bicultural state through legislation changes allocating Māori fishing assets, land settlements and the development of partnership initiatives in the education, welfare, health and justices sectors (Pearson 2005:31). Liu's (2005) study of identity in New Zealand found that biculturalism, and particularly its symbols (such as Waitangi Day and a bilingual national anthem), was an important component of in-group (Māori and Pakeha) identities. Due to New Zealand's focus on a bicultural state, it has never formally endorsed multiculturalism, unlike other British colonial nations such as Australia and Canada, (Pearson 2005). There are also Māori concerns that multicultural policies would subvert their rights and power as equal partners under the Treaty of Waitangi (Zodgekar 2005).

An obvious problem with New Zealand's bicultural stance is that the country is comprised of more than two cultural groups and from this perspective is a multicultural society rather than a bicultural society. New Zealand's ethnic demography will continue to increase and diversify in the future. According to the 2006 New Zealand Census, the Asian group is the fastest growing population in New Zealand, making up 9.2 percent of the total population (which is expected to grow to 15 percent of the total population by 2020 (Rasanathan *et al.* 2006:2277). In Auckland, these numbers are higher. Following Europeans, Asians are the second largest 'ethnic' category making up 18.9 percent of the population (New Zealand Census 2006) and is expected to increase to 34 percent of the total population by 2016 (Rasanathan *et al.* 2006:2277).

Despite debates and tensions created by bicultural and multicultural policies, there is also a growing consensus that biculturalism can acknowledge and include multiculturalism, where partnerships involve all New Zealanders (Ip and Pang 2005, Spoonley *et al.* 2003, Zodgekar 2005) as proposed by Ip and Pang (2005:186):

The bicultural model can accommodate diversity without eroding Maori interest. Similarly, expanding the notion of what a New Zealander is does not mean diluting the idea of a Treaty-based nation. What it implies, however, is that the configuration of a nation's identity in response to its changing population is not set in concrete. Rather, it is a continuous process of redefinition and negotiation.

Othering or racial discrimination is based on real or supposed characteristics such as language, religion, physical characteristics, culture and shared history (Patchen 1999, Said 1991). Although othering creates ascribed categories based on difference, it also creates an experienced reality that influences lifestyle, behaviour, living conditions and socioeconomic status (Marks and Worboys 1997). Othering can influence migrants' settlement in New Zealand through structural barriers such as discrimination from New Zealand employers and in daily contexts where people face racial harassment from their host community. Social discrimination and other settlement barriers can also act as stressors for migrants and affect their health (Berry *et al.* 1987).

Berry's model of stress focuses on the process of acculturation or culture change resulting from continuous contact between two distinct social groups. Although he demonstrates that broader social and physical factors influence peoples' health, I find the term 'acculturative stress' to be problematic. Emphasis on acculturation ignores other biological and broader social factors that influence people's well being and additionally focuses on migrants as individuals, rather than acknowledging the role that host countries and transnational relationships play in health. For this reason, I avoid the term 'acculturative' when referring to stress unless referring to specific cultural aspects. This research supports the finding from a growing number of immigration studies (Chatterji 2004, North *et al.* 2004, Sobrun-Maharaj 2006, Ward 2006, Ward and Lin 2005) that highlight social, economic and political inequalities in New Zealand between the host populations and certain migrant groups such as people from Africa, the Pacific Islands and Asia. Ethnic inequalities such as these are a form of structural violence where inequalities are systematically exerted by particular social groups and orders (Farmer 2004), in this context, the dominant host group- Pakeha on the minority 'others'. TB has been attributed to widening social inequalities in the United Kingdom and other developed nations (Gandy and Zumla 2002a, 2002b, Porter and Ogden 1998) and I argue that it may also affect TBD of migrant populations in New Zealand by impacting on employment opportunities, social isolation and stress of Indian, Korean and Chinese immigrants in New Zealand.

Physical and cultural environments

Along with language barriers, employment problems and racial discrimination, migrants also identified environmental and cultural settlement difficulties in New Zealand. Although New Zealand's 'clean, green and sparsely populated' environment was a pull factor for migrants and many reported enjoying its benefits, others experienced difficulties in adjustment. Jaya, an Indian student in her teens, said New Zealand made her feel insecure. She explained that in Bombay she could walk around the city at any time of the night and feel safe because there were always people around, yet in New Zealand, she did not like walking through the city or using public transport late in the evening: "In Bombay you can catch a bus to anywhere at any time but you can't in Auckland. Me, me and my friends would you know, ride buses as late as two or three in morning [in India] because always there is people and was safe, but you can't here".

Along with a low density population, New Zealand's cold, wet climate was also found to be problematic for three Indian and one Korean participant who had come from warmer countries (or different seasons). Sachi, an Indian woman in her 30s, said that she was not prepared for New Zealand's cold climate, she did not bring warm clothing for herself or her children and her family was not familiar with buying and lighting fires or using gas heaters. Along with the cold, New Zealand's wet weather was also hard for participants to adjust to:

So when my Mum came here she actually totally hated it [laughs] like 'Who'd want to stay here? There's no sun, we haven't seen the sun for like a week, it's just raining and it's just miserable, let's go back to India' and I'm like 'Alright, it'll be warmer there' [laughs]. Yeah the climate was kind of like, it was a big factor (Ari, Indian man in his 20s).

With the exception of Jaya, all participants now feel they have adjusted to New Zealand's cool, wet environment. However, environmental factors were also a key theme in discussions on health (Chapter Four).

Cultural issues were a key aspect of migrants' settlement. Cultural factors that influenced settlement related to lifestyle, food, cultural activities and social networks. When first arriving in New Zealand, five people found everything to be different from their countries of origin: "yeah EVERYTHING is different, like you know?" (Sachi,

woman in her 30s). “Culture shock” was a term commonly used by Korean and Indian participants when describing their settlement in New Zealand.

Lifestyle factors people had difficulty adjusting to in New Zealand included: houses, technologies, food and family structures. Meeta (who came from a rural area in India) found houses in New Zealand were larger and more private where “everyone has own room”. As previously mentioned, she was also unfamiliar with various household technologies (like the microwave and dishwashing machine). Initially the unfamiliar appliances made housework difficult for her as she was unsure how to use them, although now she believes it makes housekeeping easier for her than it was in India. In contrast, two other Indian women from urban areas of India found housework to be difficult because they had always had maids and family in India to help:

In the beginning it was really a struggle for us, everything is new and yeah the working pattern and lifestyle is totally different and ah, we have to manage all housework by our own, and in India back home like, you know, we got ah maids and everybody there to help out back there also. Here [New Zealand] go back for work come home, do all housework again, get ready for the next day (Sachi, Indian woman in her 30s).

Acquiring a taste for New Zealand food was difficult for some people. Meeta found food in New Zealand (including Indian food) to be very different from that of India:

Like even though [there is an] Indian community [here in New Zealand] lifestyle is different in India than in New Zealand. In India we use lots of hot spices and chilli and all the [that sort of] thing, but over here, same Indian people are not using hot spice, Indian curry, masala and all those thing[s]. Cooking matter is different, the food is different.

When Meeta first came to New Zealand her family were worried about her diet as she “would not eat a thing”. She has now acquired a taste for New Zealand food and also performs the bulk of cooking for her family. Adjusting to different food was also identified by three other participants (one Chinese and two Korean): “Certain things hard. Ok the, when um, at the beginning the food is not so good, yeah I didn’t familiarise, don’t like it” (Drezan, Chinese man in his late teens). All four people initially cooked or bought food in New Zealand that they were familiar with, but found that ingredients and recipes

were still very different compared to their countries of origin. Of the four participants who initially found eating New Zealand food difficult, three said that they had now become used to New Zealand food and no longer found it to be a problem: “Because now I live quite long in New Zealand so any food I can eat [laughs]” (Dreza, Chinese man in his teens).

This discussion has illustrated that settlement issues for immigrants are influenced by historical, political and economic dimensions. It is also important to note that migrants are not helpless victims of such structural barriers. Local agency is an important concept within the theoretical framework of political ecology, emphasising the importance of local human action within social and physical environments (McElroy and Townsend 1997). Migrants use a variety of coping strategies to negotiate settlement barriers in New Zealand. The importance of social networks will be the focus of attention in the next section of the chapter.

Isolation and social networks

Family structures and relationships can undergo many changes due to migration and can affect settlement of recent migrants. Isolation from family members, particularly for Indian migrants, affected many aspects of their lives from employment to domestic duties (as previously discussed) and childcare. People from India often came from large extended families where in-laws and siblings would help with domestic work and childcare. Migration to New Zealand often limited such support networks:

[In India] my parents live with me and my children also live with me. So it is a tradition to live together. And when I'm you know, ah, my when my children were young, my parents were taking care of them. Because we were, we go for work at home nobody will be there. So my parents will be taking care. Here [New Zealand] there are lot of people without generations [generations of family with them]. I don't have my parents here, living with me and my wife and my children. So in that case [child care] that is not a possibility (Dependu, Indian man in his 50s).

Three families (two Korean and one Indian) with whom I worked also had family members that had stayed in their country of origin, or resided in another country to work, reflecting the transnational nature of my participants. In all families it was the husband

and father who was absent for much of the time. This family structure put women under a lot of pressure. They experienced loneliness and at times found single parenting to be “worrying”: “Ah it was kind of hard, it’s a bit different but you don’t really have like, because we’ve always actually always been together just you know, just Mum and two kids, is bit hard but we’ve managed to, we were able to manage” (Carla (Mother of Ari), Indian woman in her 50s).

Thirteen people found isolation from friends, family and cultural activities from their countries of origin difficult to cope with when they moved to New Zealand: “It’s not easy, ah because, because of the ah, there not many friends in New Zealand” (Sun, Korean woman in her 50s). Despite initial loneliness many immigrants created local and transnational networks through contact with family in their country of origin, religious activities, volunteer work, employed work and education, sports groups and cultural groups. All participants maintained contact with friends and family in their countries of origin, the most common means of communication being telephones and the internet. They also sustained contact through travel whereby they or their families would travel to meet in New Zealand or their countries of origin.

Religious activities helped establish and maintain support networks and overcome settlement issues such as language and employment barriers. Two Chinese, three Indian and five Korean people regularly attended religious meetings and activities: “And I also meet good people through you know church, yeah. Korean church yeah, that’s right, yes” (Yul, Korean man in his 20s). Membership of, and attendance at religious activities, was not only based around faith and belief but also aided in creating social networks and accessing local facilities. Chang *et al.* (2006) found that Christian churches played a similar role for Korean migrants in Christchurch, providing social networks and practical services such as transport, accommodation, settlement advice and employment. Although most people attended religious activities because of their faith and belief, two Chinese participants and one Korean person attended New Zealand ‘Kiwi’ Christian churches to meet New Zealanders and develop English language skills:

We go to church, yes. The church we go to, we know about the, ah the culture, the Christian culture. Like ah, in many Western countries they are Christian countries. Many people believe in God. So we want to know

more about the culture. And ah, that way we can communicate with the ah, with Kiwis. So yes, they are very friendly and we can improve our English. Yes, and ah, at the same time we can make friends yes, they can help us, helpful, yes. Ah, to many immigrants church is a good place. Ah yes, many Chinese immigrants yes, go to church. And some of them believe in God. Yes after they come here, but before, they, they don't believe in God. You see in China, mm they, we have to believe in commu, communism. Because in much, in much um. Now we have more, have more options, yes. Yes many, many friends of mine have, have, they, they find a job with the help from the church (Tom, Chinese man in his 20s).

During the study as part of my field work I attended religious and social events at various temples and community halls in Auckland. I found these were not just places of religious activity but also functioned as social events where people would catch up with friends, meet new people and were used as forums to advertise and discuss local issues and events. For example, during the 2005 parliamentary election campaign, local political agents would come and present each party's policies and hold discussion groups.

One Korean and one Chinese participant engaged in volunteer work with local organisations which helped them develop social networks, increase their English language skills and learn more about New Zealand culture. Li, a Chinese woman in her 20s, enrolled her three year old son into a local childcare centre when she arrived in New Zealand. Li and her husband Tom believed the childcare environment would help their son develop English language and socialise with other New Zealand children. Once Li enrolled her son she realised that it also provided her opportunities to meet other "Kiwi mums" and develop her language skills. She then began to volunteer at the day care for three days during the week. Li believes that this has not only helped her son but also enabled her to make more friends in New Zealand. May, a Korean women in her early 30s, also became involved in volunteer work with Little Sisters of the Poor. May was encouraged by her local Korean Church to become involved with the charity to develop her language skills and meet other New Zealand women. May works one day a week and said she enjoys meeting friendly people and developing new skills such as "baking scones". These examples demonstrate how establishing social networks creates social capital by increasing economic, cultural and, ultimately, symbolic capital.

Work and education environments were also places where migrants met new people and developed social networks: "Ok in most of the friends of mine now is limited

here to students, yeah my class mates and also some people I work with, doing job with, work mates yeah. Ah most of them are Chinese” (Drezan, Chinese man in his teens). As previously discussed, often migrants would find employment through transnational and local cultural networks and, as a result, would work among people who shared similar cultural backgrounds and languages. For Meeta (who spoke very little English) work provided her with opportunities to meet and socialise with others without language barriers: “Work environment is all right for me because so many Indian people are working in the same area. So working environment is good”.

Twelve people were students at the time of the research or had been students at some stage in New Zealand. Their studies ranged from part-time language courses to post-graduate degrees. Educational institutions allowed participants to meet other migrants and New Zealanders through their various classes: “Oh I make the most friends from all other, other countries like ah, Thailand um Korea, Japan and um German[y]. Yeah lots of friends, quite different, it’s ah, kind natured people” (Alex, Chinese man in his 20s). Some institutions such as AIS have established cultural advisors and groups such as the Sub-Continent group where students from South Asian backgrounds meet regularly to socialise, discuss local or international issues and engage in cultural activities. For some students, sports groups and cultural groups became important sources of entertainment, socialisation and support networks: “I was you know, 15 or 16 [years old] when I was you know, first year student, little bit hard to mix, so, but anyhow, you know, when I play sports like basketball or something like that, you know, I make some good friends” (Yul, Korean man in his 20s).

Two Indian students lived in a student hostel associated with their school and one Chinese man was a home stay student. All three students found their shared living arrangements were helpful, allowing them to meet and socialise with other students. Tushar, an Indian student in his late teens, lived in a student hostel. He told me when he first came to New Zealand he felt alone and confused, missing his friends and family back in India. However, he found living in the hostel helped him meet new friends and through his friends he found and joined a local cultural group. Tushar said the hostel was not only helpful for social networking, but helped in other practical areas of study such as

having access to the internet and computer facilities, finding local places to shop and learning how to use Auckland's public transport.

Alex, a Chinese man in his 20s, was a home-stay student who recently moved away from his care givers to go flatting with friends. He still continues to have a close relationship with his home-stay family, they regularly have dinner together and phone and email each other weekly. Alex told me that living in a home-stay environment was enjoyable because he formed close friendships and was able to develop his language skills:

Oh great, yeah um Peggy and John and the family very nice to me and I really enjoyed it. Yeah and ah, they, they are different because I think, um, they really helped a lot with me and talked talk. We, we often did um sit in long chair [couch] and watching TV programme and we just talk, talk, talk. That's really great yeah. Um, yeah and they just being very nice to me yeah.

Not all students found education facilities to be conducive to making friends. As previously described, Drezan was a victim of verbal harassment. Along with racial harassment, language barriers also prevented students from socialising with other others at school.

Participants were also involved in a wide variety of sports. Ari, an Indian man in his 20s, loved indoor cricket and joined a local University team when he came to New Zealand. Ari said that playing cricket allowed him to meet other young men with whom he shared common interests and soon began to socialise with his cricket friends in other activities such as going to the movies and on holidays:

Oh um I play indoor cricket. Never get sick of it, um I often, I organise movies and things like that, just like I'm a movie buff, every week I try to go to the movies. Yeah so it's like um, I'm always saying 'Oh right this movies out let's go watch it' and um things like that. Um, a lot of us ah did computer systems um so all of us are basically computer savvy. So we can be described as a big, huge mailing list where every body just sends an email, everything is just basically chatting while you're at work on the email [laughs]. And um yeah, so it's like, it's, it's a good group of friends and ah we do like go on trips and stuff like that, explore New Zealand.

Sports were not only a valuable networking activity for those engaged in them but also for other family members. Two Korean women found that their children's sports allowed them to meet other parents and socialise. May, a Korean woman in her 30s, had a daughter who played tennis and a son who played soccer, while June, a Korean woman in her 50s, had a son who is "rugby mad". May said she would always take her children to sports practice and games where, despite her language barriers, she got to meet other parents and become involved in sports related activities such as fund raising events and sports trips.

As the above examples suggest, sports provided more than just recreational activities for people. Golf was a common sport for Koreans, five Korean women with whom I worked regularly played golf in Auckland. I was surprised to learn that golf to these women was not just a leisure activity, but also related to status and business activities. I was told by two women that only very wealthy people can afford to play golf in Korea as the green fees and membership are very expensive with long waiting lists. In contrast, golf greens are cheap and accessible in New Zealand. A study by Chang *et al.* (2006:14) reported similar findings from Korean migrants in Christchurch, where golf "emerged as a key idiom through which the benefits of New Zealand vis-à-vis Korea were expressed". Golf is also used as a social and business activity. May explained to me that she loves to play golf by herself or with her children, but does not enjoy playing it with her husband and his business colleagues. When I asked her why, she explained that her husband and his colleagues play a lot of golf and that, as his wife, she must play with the other wives where, as the youngest woman in the group (usually four men and four women), she must be careful not to outplay the older wives or men (as a sign of respect) which she finds very frustrating.

There are many Asian cultural groups that operate in Auckland. Some of these are large, formal organisations such as TANI and the ACMA, while others are smaller, informal organisations such as AIS's Subcontinent Group. These groups are diverse in their purpose; some are aimed at regional ethnic communities such as The Manukau Indian Association whereas others focus on health issues such the Korean Health and Wellbeing group or are targeted towards sports such as the Auckland Indian Sports Club.

Five participants were involved in local, cultural groups. Four of these had found them through word of mouth or local newspapers and one of the participants founded a cultural group. Dependu, an Indian man in his 50s, found isolation in New Zealand difficult, so founded his own Indian society to help new Indian immigrants. Dependu started his association by going through the phone book and ringing every Indian name (from his home regional area of India) he could find until he had enough people to form an organisation:

When I came in 1994, I was not knowing anybody. I just ah took risk and I came and ah after coming here I called people. Then I realised that the problem, you know, coming to foreign countries is a bit you know, it's very risky and people you know, take risk, and take risk is no[t] always positive, you know, sometimes you may lose. So after realising that, ah I thought of having an association. So we found[ed] a society a little after I come, within six months or maybe one year, a well settled, ah organised society, with that aim. So after that, whoever is coming they will ah, knowing who, who is here and what kind of services and facilities they can avail.

Ari, an Indian man in his 20s, and his family came to New Zealand during the mid-1990s. They found a Tamil community group in Auckland where the family would participate in celebrations and festivals. Ari's father was working overseas at the time and he found that the group was helpful for his family to adjust to New Zealand and maintain their cultural values:

Back in 95? Or ah, I think it was actually 94, 95 around about that time and my Mum actually likes a lot of watching like Indian movies and things like that and they [cultural group] have a whole lot of musicals, dancing and things like that. So she likes, like training up like little kids and you know? Ah doing all these songs based from films, so it's like we did one of those and then basically as soon as that happened everybody's like 'Oh all right, that's it [laughs]. You have to do one every, you know, every so often'. So my Mum's still keen on that, does that quite a bit. But that kind of, I suppose, helped us in terms of um, social settlement, making ourselves known.

Dependu's and Ari's narratives illustrate how migrants actively seek and create social networks in New Zealand. As previously mentioned, there are a diverse number of cultural groups in New Zealand that cater for a host of different cultures and activities.

Along with providing cultural events, festivals, celebrations, social and leisure activities, many groups also provide help relating to specific migrant needs such as employment, language, health and childcare. For example, some Auckland members of the New Zealand Kannada Koota (association of residents from the Karnataka state of India) have organised local community members to look after children of working parents and TANI hold regular community meetings where they provide presentations on diverse issues such as water safety, employment and voting in New Zealand. Such groups demonstrate that local agency not only occurs at an individual level but also at wider group and community levels for Indian, Korean and Chinese migrants in Auckland, creating transnational social fields. These social networks also illustrate how social capital can create other forms of capital in New Zealand and maintain habitus for Indian, Korean and Chinese immigrants within transnational spaces. Warr (2005) also found that social networks of people in discredited neighbourhoods in Australia were used to access and generate social capital. However, it is important to note that for many of the people with whom I worked, social networks were not formed through confined geographic spaces such as neighbourhoods, but also included transnational linkages.

Isolation and loneliness were common experiences for Indian, Korean and Chinese migrants when they settled in New Zealand. Social networks not only provided people with opportunities to meet others (from their countries of origin and New Zealanders) but also offer practical aid with settlement, helping with language, employment and childcare. Support networks, particularly those relating to religious and cultural groups also play a key role in migrants' health seeking behaviour, health experiences and TB, as will be discussed in later chapters.

Conclusion

This chapter illustrated the diversity of the people with whom I worked, demonstrating that migrants came from a variety of different backgrounds and encountered a broad array of immigration experiences. Despite this diversity, they shared similar experiences. The life stories of June, Meeta, Vishal and Drezan, along with other participants, revealed that language difficulties (both real and perceived), employment problems, discrimination and isolation were key barriers they encountered during their

settlement experiences. Their experiences also highlighted the importance of individual and group agency of migrants. Transnational and local community networks facilitated settlement in New Zealand and were used as forms of social capital to counter structural and social barriers in many fields, particularly employment. However, acknowledging the importance of local agency for migrants should not deflect attention away from the high levels of discrimination Indian, Korean and Chinese migrants face from the New Zealand public. Discrimination and other settlement barriers resulted in psychological, social and economic stress for migrants and the relationship between these stressors and health will be a focus in the following chapter on health.

CHAPTER FOUR: UNDERSTANDING HEALTH, ILLNESS AND HEALTH SEEKING BEHAVIOURS

Being sick means you are not one hundred percent fit. Your body is under stress, you're not fit enough to do things. Like if you got a fever you can't go out and work. Even if it's [a] cold, you can't be normal with running nose and headache, you can't use computer and don't feel comfortable (Vishal, Indian man in his 20's).

Introduction

Currently, infectious diseases such as TB remain the major cause of death world wide (Brewin *et al.* 2006, Inhorn and Brown 1997). Understandings of TB are embedded within broader health perceptions and practices. This chapter will explore health understandings and behaviours of Indian, Korean and Chinese migrants in Auckland, New Zealand. People with whom I worked experienced a variety of health problems (other than TB) including stomach pain, indigestion, colds, flu, rashes, diabetes, high blood pressure, broken limbs, asthma, chronic neck, back and shoulder pain, hay fever and headaches. Their understandings of health and health seeking behaviour were affected by previous experiences with health care systems, structural barriers such as language and lack of health care professionals, and social networks.

Health and illness

At its most simplistic, health can be viewed as a continuum ranging from "wellness at one end and illness at the other" (Manderson 1997:25). Yet health is a complex concept and as a result there are many understandings of health, often depending on who is using the term and in which context it is applied. The WHO defines health as "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity" (WHO 2006a). Brady *et al.* (1997) point out the Eurocentric bias of this definition which derives from assumptions about progress, perfectibility and the role of science which are deeply embedded in Western thought. From an anthropological perspective, health is considered a cultural construction and varies in definition and meaning from one society to another (Baer *et al.* 1997). Therefore, health cannot be

defined as a single concept, fact or idea but includes myriad perceptions and images influenced by historical, social and political agendas (Manderson 1997). Just as health can have many different meanings, so too can disease. As this study focuses on health through explanatory models it will avoid the term disease by using the concept of illness. Kleinman (1980) argues that the state of illness is different to that of disease. He defines illness as a unique human condition located within social contexts as a lived experience of symptoms, suffering and seeking treatment. In contrast, disease is a scientific term based on the diagnosis and clinical manifestation of a biological malfunction or deviation from the biological norm. Using this perspective, illness can be viewed as an explanatory concept which is influenced by personal, historical, social, political and cultural factors.

When looking at cultural differences in health, it is important to note that I found more similarities between Indian, Korean and Chinese people than differences. However, there were several health definitions more common to each ethnic group. Medical anthropologists attempt to use indigenous knowledge systems such as perceptions of health and illness to illuminate shared concepts of reality that are grounded in social structure and history, yet variations within knowledge systems must also be recognised and acknowledged as “no two individuals in a given society conceptualize the illness experience or health needs, identically” (Harper 2002:187).

Freedom from illness, function and normality

From participants' discussions with me I identified six main categories of health and illness. These included: freedom from illness, function and normality, holistic health, maintaining healthy habits, stress and religion. Of these, the most common description of health was freedom from illness or 'Having no disease, sickness or problems with your body'. In contrast, illness was understood as pathological or 'Having a disease or disease symptoms'. Health was also described in terms of function and normality where healthy people are able to engage in 'Physical activities and everyday activities' and be 'Ordinary, regular and have a normal life'. Illness was described as a factor that prevented normality or 'When you can't engage in physical/social activities'. There are similarities in definitions of illness between Indian, Korean, Chinese and Pakeha people in New Zealand. In a study of Pakeha in Auckland, Searle (2004:30) found illness meant

the inverse of health or a “lack of wellness” and informants described a sense of loss relating to productivity, physical and mental wellness. This is similar to Indian, Korean and Chinese immigrants’ descriptions of loss in relation to physical activities such as going to work and social activities such as visiting friends.

The most common definition of health for Indian people was ‘Being ordinary, regular and having a normal life’. For many Indian people, status and respect are gained from others’ opinions and it is important to maintain personal appearances to prevent others from thinking badly of you: “Especially Indian communities like this you know? We, many times we, we educate, ah we live for others... So we always worry about you know, other’s opinion. So we want to live you know, so that other ah people will you know, appreciate us” (Dependu, Indian man in his 50s).

Notions of ‘regularity’ are also fundamental components of Indian health systems such as Ayurvedic medicine where health is maintained through the regulation, balance and blending of physical, mental, social, moral and spiritual welfare of individuals (Bodeker 1989:55). The *Tri Dosha* theory of Ayurvedic medicine maintains that human bodies are made up of five elements or *dhatu*s (space, air, fire, water and earth) which are created from food (after digestion) and of waste products which are formed both from food and during *dhatu*s production (Rizvi 1991:60). Therefore, notions of regularity also extend to consumption of food, liquid and bowel movements. Public health campaigns in New Zealand also present images of being ‘regular’ based on conformity to social norms (Manderson 1997). For example, the Ministry of Health (2001, 2002, 2006b) recommends “Regular exercise” and “Regular physical activity” for diabetic people, “Regular three-yearly smears” for New Zealand women and “Regular mammograms” for women aged between 50 to 64 years. Media campaigns that focus on health do influence people’s health perceptions and behaviours as illustrated by Ari, an Indian man in his early 20s:

There’s like this image of the perfect person you know? Like you only eat healthy foods, you follow the [healthy food] pyramid and ah, you do all the exercises everyday and that body would be the ideal. But I don’t think, it’s like people have that in the back of their minds but they just keep ignoring it, ‘Oh my God no, I’m not doing anything that bad, ah it’s all right it’s just the one meal a day it’s not going to help matter’ and yeah... Well ah I think that’s

more[where] the image of the actual healthy person really comes out from and what we actually look at, ah so what I actually think is a healthy person would be something that I'd be marrying based on what I've actually learnt from all these campaigns.

Holistic health

Health and illness were also understood within a holistic sense. All Chinese participants (and one Korean) described good health in relation to the well being of body, mind and spirit, which were not considered separate aspects of the body: "It's um, I think healthy combine both physical and psychological and if I say I'm healthy may be both psychological and physical" (Alex, Chinese man in his 20s). Holistic notions of health have a long history in Chinese medical systems and beliefs and are central to TCM (Croizier 1975). TCM also has a long and influential history in Korea beginning from its introduction from China in the sixth century A.D. (Ho and Lisowski 1997:31). TCM takes a holistic approach to health focusing on the dynamic balance of the whole organism (body, mind, spirit and environment) (Sivin 1987) where the human body is perceived as a microcosm which functions in resonance with the social and planetary macrocosm. However, viewing health in a holistic sense is not unique to Chinese (and Koreans) and also exists among Pakeha and Māori in New Zealand (Durie 2001, MacDonald and Park 2005, Searle 2004).

All Chinese participants (as well as a Korean woman and an Indian man) spoke of the influence of environments on health where climate, pollution and trees were seen as causes of illnesses such as colds, flu and asthma: "I also got a cold... Yes I think because the New Zealand climate. Climate is ah, ah flu could be from. Ah yes, from high temperature to low temperature at night" (Li, a Chinese woman in her 20s). Many people also commented that New Zealand was a healthier environment to live in compared to their countries of origin which were described as "dirty, polluted, crowded, not green, no trees". As part of its holistic approach to health, TCM acknowledges that physical environments such as climate, weather and seasons also affect the behaviour and physiology of humans, "Man's possession of life is completely dependant upon the *Qi*

[*Ch'i*]¹ between heaven and earth and he grows in line with the changes of the four seasons” (Dazhao and Xiaolong 1991:14).

Healthy habits: Diet

Understandings of health and illness also incorporated maintenance of healthy habits (such as diet, exercise and sleep) and notions that age and body weight are important indicators of health, with younger being healthier. According to participants, good diets included eating healthy foods such as fruit, drinking lots of water and avoiding alcohol:

Just drink water, just drink water. So sometimes you, you, if you can't drink you know, half a litre at that time, you can ah have two times, morning, afternoon, something like that.... Food, you must take very simple food. Simple food you know, means ah, not oily, yeah not fatty, not much sugar, not much ah salt. And you should just take simple food and try to take dry fruits. Yes dates and apricots and you know, ah, that sort of thing, dried fruits (Dependu, Indian man in his 50s).

Korean women would consume specific types of food such as acorns and walnuts as dietary supplements to maintain their health. Acorns and walnuts were either eaten raw or cooked as well as baked into cookie type slices. Informants explained to me that both acorns and walnuts have many medicinal properties (such as treating hypertension and asthma) and are good for overall well being. Diet and previous health problems were also seen as causes of illness. Diets high in sugar were thought to cause diabetes (which was termed by one Indian participant as a “sugar problem” disease) and too much alcohol was associated with cardiovascular problems and TB. June, a Korean woman in her 50s, believed that the chronic shoulder and back pain she suffers from was caused by her previous TB infection. As TB is classified as a cold/*Yin* disease in TCM, she also thought that her diet was influencing her illness by consuming too many ‘cold’ foods and consulted a TCM healer to help balance her diet by eating more ‘hot’ foods:

And um she [TCM healer] said you have to eat ginseng all the time. And um she [TCM healer] said ah you know, you, you should eat some food

¹ *Qi* or *Ch'i* are the essence of life and spirit or the body's vital energy (Dazhao and Xiaolong 1991).

and make your body warm like um beef, chicken and walnut ok? Don't, don't eat food that will make your body cold.

There were also gendered differences in dietary practices. More women reported that diet was important to maintaining good health than men. My observations of diet and health related practices among participants also supported this difference. As previously mentioned, Korean women would often use dietary sources to maintain or improve their health but I only observed one Indian male who was strict in his diet and consumption of water because of his concerns about health and beliefs in Vedanta philosophy².

Associations between diet and health are not unique to Indian, Korean and Chinese societies. They are also common among Western societies (Lupton 2003). Although food is obviously necessary to maintain health, notions of what constitutes 'healthy' food and other food beliefs or ethnodietetics differ between cultures. For example, Chinese and Central and South American (Mexican and Guatemalan) societies dichotomise foods into 'hot' and 'cold' categories and a balance between these food types, seasons, weather, life stages and individual constitutions will result in well balanced, healthy bodies (Anderson and Anderson 1975).

Exercise

The most common definition of health for Korean participants was exercise: "So you know, to be a overall healthy person, ah sleep, exercise about half an hour a day so not a big burden on your body and I think yeah" (Yul, Korean male in his 20s). Physical activities that Korean people engaged in included golf, swimming, going to the gym, tennis and rugby. They spoke of engaging in exercise mostly for their health but also used these activities to make social networks for themselves and their children. As discussed in Chapter Three, golf was seen as a popular activity that was related to social networks, business and social status.

It has been found that Asian people in New Zealand have the lowest activity levels among Asian, Pakeha, Māori and Pacific Island New Zealanders (Scragg and Maitra 2005:34). However, physical activity varied with Asian ethnicity with Koreans having

² Vedanta is a branch of Hindu philosophy taught from Upanishad scriptures on dealing with the nature of reality.

the highest prevalence of physical activity (defined as engaging in more than 30 minutes of vigorous physical activity within the last seven days) compared with South-East Asians, Chinese and South Asians (Scragg and Maitra 2005:38). The fact that Koreans feel exercise is an important aspect of health may be why they engage in more physical activity than Indian or Chinese people in New Zealand.

As with diet, there were also gendered differences seen in understandings of health and exercise. Men more commonly reported that exercise was important to maintain good health than women. Gendered differences in health maintenance strategies also occur among Pakeha in New Zealand, where men are more likely than women to describe health within a physical context (O'Connor 2002).

Body weight

Gendered differences were also apparent in understandings of health and body weight, an aspect of health that was only discussed by women. Three women reported that body weight was important to health. For each of these women body weight was not only a symbol of good health but also used to measure health, where the ideal, healthy body is, “not fat, not skinny” (Sun, Korean woman in her 50s). They each described their own ideal body weight and attributed a change in this to problems with their health or life stages such as TB or menopause:

Um usually ah, my body highest weight was 50 to 51 kilos, but after marriage my weight is 46 to 47 [kilos] but after menopause I just dropped my weight, my weight is dropped to 42 [kilos] now at the moment, so I have no energy kind of, I feel very weak, so I couldn't do anything at the moment (June, Korean woman in her 50s).

Associations between body weight and health are also common among Western cultures where they are strongly linked with notions of moral control, self-discipline and attractiveness (Lupton 2003:41). In New Zealand, body weight has become a central notion of public health and concerns about rising rates of obesity and associated diseases such as diabetes have led to an emphasis on exercise and diet. Headlines such as “New Zealand in midst of obesity epidemic says health report” (*New Zealand Herald* 2004) and “Weigh-ins planned for preschoolers to curb obesity” (*New Zealand Herald* 2006b)

provide images of unhealthy bodies. In contrast to concerns about over-weight bodies the media have also drawn attention to eating disorders such as anorexia nervosa and bulimia and health risks of low-body weight. These conflicting messages may impact on women's perceptions of the ideal, healthy body.

Recent studies in New Zealand have also identified associations between body weight and health for Asian migrant groups (Metcalf *et al.* 2006, Rowden and Smallman 2004, Tan and Watson 2004). The New Zealand Asian community has been noted to have high incidence of type 2 diabetes (compared to European New Zealanders) (Rowden and Smallman 2004) and South Asians have been reported to have higher risks of cardiovascular diseases (Metcalf *et al.* 2006). On average, Asian populations have a lower body mass index (BMI) and prevalence of obesity than other New Zealand populations (Metcalf *et al.* 2006, Tan and Watson 2004). However, South Asians have high incidence of being overweight (Metcalf *et al.* 2006) and body weight has also been shown to increase for Chinese female migrants after settlement in New Zealand (Tan and Watson 2004). It has been suggested that the higher prevalence of overweight along with diet, physical activity and other risk factors such as smoking may be related to diabetes and cardiovascular diseases in Asian groups in New Zealand (Metcalf *et al.* 2006, Rowden and Smallman 2004).

Stress

Stress was seen to be an important factor of health for all participants, although there were gendered and ethnic differences in the ways stress was understood to affect health, was embodied and physically expressed. Only women identified good health with 'Being relaxed/not stressed'. Yet, both men and women experienced stress and often saw it as a cause of illness. Stress and worry associated with day-to-day life activities such as work have also been found to be common perceptions of health among woman in Africa and Madagascar (Harper 2002).

Stress was seen as a primary cause for a number of illnesses such as stomach pain, indigestion, headaches, rashes, diabetes and chronic neck and shoulder pain. Stress for participants related to employment, study, finances, settlement problems and social tensions:

Yeah I, I always think that, that is the healthiest thing I would think you know? No stress, no problems, just calm and peaceful. Yeah no stress or pressure. Cos I think with us [family members] stress is probably been major. Yeah it's a main, major cause for our family because we're all getting it. Yeah because we're all self-employed and you know, we all own our own businesses and everything, so it's pretty stressful you know, owning your business? But that's the only thing, but I mean like when I was stressed out, quite often I'd break out in rashes and all that sort of stuff, it's [stress] physical (Dani, Indian woman in her 50s).

Korean GPs found that stress-related symptoms were common among patients, particularly for recent migrants: "Oh yes, because a lot of the Korean patients that I saw were um, relatively new migrants, um you know? They were presenting with a physical symptom but everything surrounding that physical symptom was to do with the fact that they were recent migrants" (Mary, Korean GP). Migration processes have also been identified as stressors for immigrants in Canada and New Zealand where they have negatively impacted on peoples' physiological and psychological health (Abbott *et al.* 2000, Berry *et al.* 1987).

From interviews and informal discussions with participants and health care providers it was evident that stress was embodied and physically expressed differently among Indian, Korean and Chinese people. I was told by Indian people that, in Indians, stress results in stomach pain and/or a pain in the centre of the forehead. Chinese participants explained that stress causes neck and shoulder pain while, for Koreans, gastric and liver problems were attributed to stress. Kleinman (1980) found that labels and physical symptoms of stress are also different between Chinese and American populations. For Chinese, stress related to the body but, for Americans, it was attributed to psychological illness. Kleinman (1980:76) states that illness categories or labels highlight how members of different groups construct distinctive illness experiences or "culture specific disorders" that reflect societal expectations of how patients are supposed to feel and behave within specific local, social environments. Although stress was embodied differently between the three groups, illness narratives from people illustrated a variety of other ways in which it was physically expressed. Stress was also seen as a cause of illness such as rashes and diabetes which suggests that beliefs around illness causations and symptoms are not fixed and bound within or between cultures but are

variable in nature and caution must be used when applying culturally specific explanatory models and explanations (Garro 2000). It can be misleading to assume that ‘culture’ alone accounts for particular health beliefs or health seeking behaviours as culture cannot be separated from power relations or broader political and economic factors (Harper 2002).

Religion

Religion was a primary theme throughout the illness experience of two participants (one Muslim and the other Christian). Religion was not only seen as a cause of illness (Chapter Five) but was also fundamental to people’s recovery and support during their illnesses. I was told by Korean and Indian community members that some diseases such as cancer were punishments from God/s for immoral behaviours. However, the two participants who attributed their illnesses to religion viewed it as “God’s will” (Vishal, Indian man in his 20s) not as a form of punishment but rather as a test of faith, where their faith in God would see them return to good health:

Ah even though the blood pressure was controlled [by medication] and became normal, my eye[s] didn’t return to normal. So I prayed to God that um, ‘It is up to you whether you cure’ you know, the physical um, you know, face [her eyesight]... I ah, I ah, we prayed, I wasn’t scared because I knew if we prayed it would be all right (Sun, Korean woman in her 50s).

Participants expressed a variety of understandings of health and illness. These were influenced by age, gender, migration experiences, lifestyles and embedded within local systems of knowledge. These understandings were also influential in health seeking behaviours and practices of Indian, Korean and Chinese immigrants.

Health seeking behaviour and practices

When participants first got sick they engaged in a variety of health seeking behaviours such as resting, waiting for the illness to pass or become worse, consulting family members, praying, taking medicine (home remedies, Western medicine from supermarkets and chemists or traditional medicine), consulting healers (accident and

emergency clinics, New Zealand GPs, GPs from their country of origin or alternative healers) or returning to their country of origin for treatment.

Seeking local GPs from countries of origin

The most common response of people when they got sick was to see a local GP from their country of origin. According to Kleinman's (1980) health system classification, GPs fall under the professional sector of health care which includes organised healing professions such as Western biomedicine, TCM and Ayurvedic medicine. Only two Indian participants with whom I worked had New Zealand-born GPs. This could be an artefact of the recruitment method used in the study where some participants were identified through Korean GPs in Auckland. However, Chinese and Indian people were not recruited through Chinese and Indian GPs but were more likely to consult with GPs from their home country than New Zealand-born GPs. Therefore, it is unlikely that this is the only explanation. When asked why people preferred GPs from their country of origin, language and cultural notions of behaviour and health were the most common responses: "So I thought that um, Korean doctor better because I could communicate better... Not really the communication problems, ah but rather their mannerisms, when they deal with the patient, or dealing with me" (Sun, Korean woman in her 50s).

Lack of English competency and cultural differences have been identified as key barriers to accessing health and other services for recent Asian immigrants (Asian Public Health Project Team 2003). Deficiencies in health services such as lack of information, interpreters and Asian health professionals compound language barriers for immigrants (Asian Public Health Project Team 2003). Kleinman (1980:53) demonstrates that translation problems are not just confined to different geographic language groups but are often encountered within medical systems, where different medical languages are used between different health sectors leaving patients to "translate from one language to another".

Participants noted variations in interpretations, values and beliefs of medical knowledges and practices. Local GPs also emphasised the importance of their role for immigrants, not just as doctors but as key support people, interpreters and intermediaries

between patients and other health organisations in New Zealand (such as specialists and hospitals). Mary, a Korean GP, told me that language barriers are not the only reason Koreans seek GPs from their home countries:

Language is number one um, but of course coming very closely to that is the cultural factor. The fact that they are coming to somebody who they perceive knows about their culture, understands you know, not just the language but the beliefs and all the implied stuff, the cultural stuff that they're coming in with... So it is the way people dress, the way they eat, the way they you know, interact with one another, the expressions, traditions, all those things. Ok so from the beginning to the end point you know, there is a whole host of things that you're dealing with apart from the factual medical things you know? It's the way they contact you, the timing, you know, that it's not just themselves that's involved it's the whole family, the family dynamics, the, the, the beliefs about the illness.

Another example of the importance of GPs from home countries for immigrants is evident with different understandings of health beliefs. Many Koreans believe that the liver is central to health care and cite liver problems when feeling tired, anxious or generally unwell. TKM (which has been influenced by TCM) works on the premise that internal organs combine biological and psychological functions. Emotions such as anger, anxiety and sadness are believed to depress the circulation of *Ki* (Korean term for *Ch'i*) causing injuries to the liver (Pang 1990). Korean GPs practising in New Zealand told me that their Korean patients often ask them to examine their livers, or send them for liver tests when their illness may not be related to their livers but they are sensitive and understanding towards their patient's beliefs: "The patient might be coming to me presenting with those [gastric] symptoms wanting their liver checked out but if I went down the path of gastrointestinal investigations then they wouldn't be satisfied you know?"

Divergent understandings of health can also create misunderstandings (and potentially misdiagnosis) in health contexts. Interpreters explained to me that their role, like that of Korean GPs, did not just involve literal translations of languages between patients and healers but also translation of understandings of the body and health, as illustrated by the following quote:

In health care system even the person who knows English in a good ways, that's staying in New Zealand for 15 to 18 years [have difficulties with language]. Everybody think patient know English and is knowing English, but medically that is not the kind of English. For example, one doctor asked a patient 'Do you have a chest pain' and family asked that question because they wanted me to say something. And I kept quiet and family asked 'What does this mean in our language?' And doctor asked again, 'Do you have sharp pain in your chest' and that person did not understand that sort of pain in that communication at all. And then I had to raise my hand and I say 'Excuse me Dr Littleton, ask about this part of the heart, being in Indian, chest can mean middle pain, pain on heavy medicine like a stone of your heart, that sort thing' and that[s] when I asked about pain in this side of heart. Patient said 'Oh yes, sometimes when I climb up stairs I feel very heavy tightening of the heart'. And doctor said, according to his ECG there is some pain like that. So my English is a different area in specialty health, like real medical terminology is different (Madhu, Indian interpreter in her 40s).

Shared understandings of health not only influenced seeking treatment from GPs from countries of origin but also alternative healers. In addition, the types of healers people sought often depended on their physical symptoms and closely related to health cultures.

Alternative healers

Three of the participants in the study consulted with alternative healers when they were sick. All three people (two Chinese and one Korean) went to TCM healers in Auckland. Some family members of Indian participants also saw an Ayurvedic healer. As with local GPs from home countries, participants found TCM healers through word of mouth and through local Chinese newspapers. People would often use both biomedical GPs and alternative healers depending on the symptoms of their illnesses. Understandings and values placed on different types of illness influence people's decisions to respond to illness episodes (Kleinman 1980). TCM healers were consulted for chronic illnesses such as diabetes and cancer, asthma, stomach pain and muscular or skeletal problems such as shoulder, neck and back pain, while biomedical healers were used for colds and flu:

If, if we [I] feel sore in my back, or in ah, in my legs maybe I see Chinese doctor. So they can massage, and they can do some acupuncture or something like that. But they are still ah, heart or stomach or something in

my body maybe I go too. Maybe if I got cold, yes I see the Western doctors (Tom, Chinese man in his 20s).

Li, a young Chinese woman in her late twenties was trained and worked as a biomedical doctor in China but prefers TCM to biomedical medicine. She explained to me that “If you go to a kiwi doctor [New Zealand GP] they just look at one thing such as your heart. But if you go to a traditional Chinese healer they look at all your organs because they know that they all influence each other”. Li’s narrative illustrates that ideas about causes of illness, health beliefs and conceptual notions embedded within health care systems influence people’s health seeking behaviours. Other people would use TCM if biomedical treatment did not help their illness. For example, June, a Korean woman in her 50s, had first tried biomedical treatment for her asthma. When this treatment had no effect she sought TCM. June’s health seeking practices illustrate the variable and dynamic nature of migrants’ health seeking behaviour in New Zealand. Migrants exhibit a large variety of health seeking behaviour and often contest and redefine their health beliefs, perceptions and behaviours depending on their personal experiences and health knowledges.

Health seeking behaviours are influenced by beliefs about illness causation, norms governing choice and evaluation of treatment, power relationships and health care institutions and medical systems (Kleinman 1980:24). When looking at health seeking behaviour it is important to review access to health care, the degree to which migrants are able to communicate and make effective use of services and different values and perceptions immigrants attach to health care service (Marks and Hilder 1997). Health status and access to medical services are influenced by economic changes, national and international policies and institutions, as well as local power relations and cultural contexts where bodies are experienced and made meaningful, as Harper (2002) demonstrated for the Malagasy people in Madagascar.

Kleinman (1980) notes that there are three overlapping sectors of health care in most developed societies: the popular sector, the folk sector and the organised, legally sanctioned healing professions. Although medical systems or health care systems can be viewed through different categories such as folk and professional, it is important to note that these systems do not have fixed boundaries and people often exchange knowledge

from and use multiple health systems (Harper 2002). Through processes of colonialism, modernisation and globalisation, medical systems are no longer nationalistic systems but transnational systems (Alter 2005). Western biomedical systems are now practised in India, Korea and China and TCM and Ayurvedic medicine are practised in New Zealand (Figures 4.1 and 4.2).



Figure 4.1. Chinese Medical Centre, Auckland, North Shore 2007.



Figure 4.2. Chinese Healing Centre, Auckland, North Shore, 2007

New Zealand's primary health care sector

As discussed in Chapter One, New Zealand health care is divided into three levels; primary care, secondary care and tertiary services. Currently, the primary health care system is based around PHOs. In addition to DHB managed health care services, New Zealand also has independent (non-PHO affiliated) health care services such as White Cross medical clinics and independent GPs. All primary care practices charge for their services although there are financial incentives to enrol with PHOs. This policy was implemented in 2002 to improve access and provision of primary health care by encouraging patients to use PHOs as their first point of contact within New Zealand's health care system, and to reduce reliance on secondary public services (Ashton *et al.*

2005, Gauld 2003). There are currently 81 PHOs in New Zealand, 12 of which are located in the greater Auckland region.

Six people in the study were not enrolled with PHOs and attended private accident and emergency clinics (A and E clinics) such as 'White Cross' when suffering from illness. They attended A and E clinics because they did not understand (or were unaware of) New Zealand's PHO policy focusing on PHO affiliated GPs. They also felt that independent health care organisations offered better health care facilities than PHOs and that A and E clinics were more similar to health care systems from their country of origin.

During this research I had two male community members (both students, one Chinese and one Indian) in their late teens, and early 20s, ask me where they should go when they are sick. Neither of these students had heard of or understood New Zealand's PHO policy and both had previously been going to A and E clinics for health care needs. The lack of understanding about New Zealand's health care system is not just confined to Asian immigrants. Chris, a Pakeha GP, told me that many of his New Zealand-born patients also do not understand New Zealand's health care system. Adam (2003:45) identified a number of barriers in accessing PHOs including cost of services, language and cultural barriers. It has been found that Asian people are less likely to have a health practitioner or consult with health care professionals than Māori, Pacific Island or European New Zealanders (Scragg and Maitra 2005). For Indian, Korean and Chinese migrants in New Zealand, it is evident that lack of knowledge about PHOs and their previous experience with health care systems from their countries of origin are also key barriers. Limited numbers of local GPs also creates a barrier to migrants accessing PHOs. In 2001, there were 13, 266 Korean people living in Auckland (Statistics New Zealand 2001:58) but only three Korean GPs practising and one of these was part-time. There are now only two Korean GPs practising in Auckland and, due to high patient loads, they often have waiting lists between one to two weeks:

You know one of my receptionists actually told me that she could have had me working 24 hours a day if I chose to, if I wanted to, because the demand was that great, yeah. Like I used to have like a week at least waiting list to get in to see me for working appointments. Yeah, so um, the

demand is huge for Korean people to seek a Korean-speaking GP yeah (Mary, Korean GP).

The limited number of Korean GPs often means that, if Korean patients need immediate medical attention, they are often unable to attend their GP and have to find alternative health care such as A and E clinics (which are open after hours and do not have an appointment system) or return to their country of origin. With only two practising Korean GPs in Auckland, they are unable to establish formally organised networks such as the Auckland Chinese Medical Association and face many pressures working in New Zealand. The Korean GPs described themselves as “totally overworked and overloaded”; their job not only encompasses health care but also additional roles such as interpreters and intermediaries as the gate keepers for secondary and other health services. For example, Mary, a Korean GP, told me that many hospitals contact people for clinical appointments through letters written in English³ which they do not understand and, as a result, do not make the set appointment times. She would then have to contact the hospital and reschedule appointments and then contact her patients:

Because a lot of communication is initially done in English where a letter gets sent out. Oh the number of times where letters get sent out to my patients [Korean patients] in English and they look at it and they get a mental block and they'd just throw it away in the bin. And so you know, they would DNA [Do not arrive to] their outpatient appointments and I would have to send ANOTHER letter, referral letter, not talking about TB patients but other outpatient appointments where, you know, so 'Please send another letter'. And then I'd have to contact the patient 'Why didn't you go to the hospital? Didn't you receive a letter?' 'No, what letter, we didn't receive a letter'. You know, it was almost a denial kind of thing, they didn't recognise that that letter was a letter from the hospital; they didn't understand the content because it was in English.

Malone's (2003) study on nursing in the United States demonstrated the importance of proximity of care between health care professionals and patients. She identified three types of proximity. Firstly, the 'physical' contact of care; secondly, 'narrative' which involves both knowing the patient and transmitting this knowledge to other health care providers and, finally, 'moral', where nurses recognise patients as

³ This procedure has now changed in some contexts. Waitemata DHB managed hospitals and PHOs now use interpreters to contact people for outpatient appointments if asked by GPs.

‘others’ and act on their behalf. Although Malone discussed these aspects of care in relation to nurses, I argue that narrative and moral forms of proximity also occur for local GPs such as Korean GPs in Auckland. These relationships played important roles for immigrant patients. As the above quote illustrates, Korean GPs would act on behalf of patients as interpreters between them and other health sectors where they not only transmitted but also translated information between the two parties. The additional roles Korean GPs play are time consuming, further adding to waiting times for their patients. This situation highlights how New Zealand’s health care policies do not work for many Korean migrants in New Zealand, not only due to lack of understanding and previous health care experience, but also because of structural barriers such as lack of Korean health care providers and interpreters.

Asian migrants’ experiences with health care systems from their countries of origin are very different to those in New Zealand. As described in Chapter One, health care systems of India, Korea and China operate on insurance based health care and divisions occur between public and private health care facilities (Blumenthal and Hsiao 2005, Deogaonkar 2004). These systems closely relate to power and class divisions which are based on political and economic structures. Insurance based health care and divisions between public and private health care facilities often result in poor access to health care for people within low socio-economic, class and caste backgrounds (Blumenthal and Hsiao 2005, Deogaonkar 2004). These health care experiences influence migrants’ health seeking behaviours in New Zealand. Many people categorised New Zealand’s primary health care services into ‘public’ and ‘private’ practices although, as previously mentioned, all primary health care services operate on a fee-for-service approach. Generally, non-PHO practices such as A and E clinics were seen as private facilities, while local GP clinics and DHB managed hospitals were viewed as ‘public’ services.

Two participants (a Chinese man in his 20s and Korean woman in her 50s) prefer to go to private A and E clinics (Figure 4.3) when they are sick, believing that they will provide better treatment than PHOs:

Probably if I really needed to see a doctor I’d go to private. They have independent financial that’s why. They have to make money and they have

to better themselves. So that's why they react so fast, otherwise they will lose the customer (Alex, Chinese man in his 20s).

Another two people in the study (a Chinese woman in her 30s and a Korean woman in her 50s) told me that they would not go to New Zealand GPs who operate out of small buildings such as converted dwellings (Figure 4.4) as they feel they are “cheap and suspicious”. When I enquired how they judge health care facilities, the answers generally related to the size of the establishment (with bigger being better) and other factors such as “professional uniforms” which are more similar to health care systems in their country of origin:

Yeah, first time I thought that in New Zealand the health system ah wasn't comfortable, ah actually... Yes, yeah in Korea ah, normally we got [go] to the big hospital, there is more staff ah, specialists for health problem. Ah, but in New Zealand you need go GP first, and the GP can be quite small, so I can't trust them. Yes, yes just one doctor in small you know, clinic (Sun, Korean woman in her 50s).



Figure 4.3 White Cross Accident and Medical Clinic, Central Auckland, 2007.



Figure 4.4 Auckland PHO GP Clinic (operated out of a converted dwelling), 2007.

Another difference between New Zealand's health care system and those of India, Korea and China relate to specialists. In India and Korea, health care operates on a user-pays system (Deogaonkar 2004, Kwon 2003, Oklahoma Medical Research foundation 2006) where people seek out 'the best doctors their money can buy' without having to wait for long periods of time. New Zealand's referral system therefore often confuses and frustrates many new immigrants. For some, long waiting times for specialists led to changing GPs and, for others, forced them to return to their countries of origin for treatment. Vishal, an Indian man in his 20s, told me when he is not happy with a doctor he "employs another". This young man had seen five different doctors during his three years in New Zealand. Having spoken to local Indian and Korean GPs in Auckland, I learnt that this behaviour is common in India, Korea and New Zealand and is known as 'doctor shopping'. Doctor shopping is defined as "frequent changes of doctors" (Sato *et al.* 1995:122) and is common in many Asian and Western countries such as the United States and England (Kasteler *et al.* 1976). There are many factors that influence doctor shopping including types of illness, changing perceptions of doctors from respected

professionals to consumer products, social and emotional problems relating to dissatisfaction with care and lack of confidence in doctors and structural factors such as costs of services, inconvenient hours, locations and waiting times (Kasteler *et al.* 1976, Sato *et al.* 1995).

Patients are used to coming from a country where they doctor shopped. ...Mmm we [doctors] are a consumer ah we are a consumerable product basically you know? And so if they [patients] wanted to access a specialist, this GP, that GP, that was within their freedom and their right to doctor shop you know? So if they had more choice than three Korean GPs they would probably end up going to lots, ah ALL of them you know? Depending [on] what ever problem that they had and depending on who they felt was most suitable to help them (Mary, Korean GP).

The concept of ‘doctor shopping’ is in complete contrast to New Zealand’s emphasis on PHOs, where patients can only enrol with one GP practice that is part of a particular PHO at a time. If they seek medical attention from non-PHO providers, they do not gain the financial benefits of reduced service and prescription fees. Some people preferred to seek medical treatment from their country of origin rather than try and adjust to New Zealand’s health care system. Although none of the people with whom I worked returned to their countries of origin for medical diagnosis or treatment, Indian, Chinese and Korean GPs who I spoke with had all experienced patients that had returned ‘home’. Priya, an Indian GP, told me she believed around 50 percent of her Indian patients returned to India for treatment, usually because of long waiting times to see specialists with returning to India a quicker option than waiting and cheaper than purchasing medical insurance in New Zealand:

Anneka: Oh ok so you have quite a few Indian patients that return to India for treatment, how many do you think?

Priya: I have quite a few, about 50 percent...They can’t get into see specialists for four to six months, it’s a long wait and insurance is very expensive, the cost would be cheaper to go to India, it is still cheaper.

Patients would not only return ‘home’ for treatment because of their frustration or confusion with New Zealand’s medical system but for many reasons such as cost of

treatment, long waiting times, belief that their medical services were better and because of greater social support in their countries of origin:

I used to see that happen a lot in my practice [patients returning to Korea for treatment]. Um where you know, especially this waiting list, they couldn't wait and they couldn't afford or if they felt that going privately to solve their medical problem was costly then they would rather spend that money going back to Korea, spend it on the air ticket and have the family support, the medical system that they are familiar with and spend the money there and have their own family look after them in their own language and their own way cultural way and then come back when that was dealt with (Mary, Korean GP).

Resting, waiting and taking medicine

Although seeking healers was the most common response from people when they experienced illness, many would also rest and wait to see if their illness got better or worse and take home remedies. Four people maintained that when you get sick you should rest the body by sleeping and going to bed. Participants said that they would wait between two to four days before they would consult a healer about their illness. People felt that the body would generally heal itself if given time and rest: "Um, have a rest, ah, just ah, how the body can recover quite a lots" (Alex, Chinese man in his 20s).

During this 'resting' period people used medication. This medication included a variety of 'home made' medicines, medicines brought from their countries of origin and store bought Western medicines. Eleven people with whom I worked used alternative medicines and Korean GPs estimated that at least 50 percent of their patients also use alternative medicines. Kleinman (1980) classifies 'home made' remedies such as herbal medicine under the folk sector of health care. The folk sector comprises non-professional and non-bureaucratic medical specialists (Kleinman 1980:59). The folk sector is also often blurred in practice, mixing many components from professional and popular health sectors. Special teas were common among Korean and Chinese participants. I sampled one such tea that was used for colds and respiratory problems when visiting a Korean woman suffering from a cold. The tea was made with quinces, honey and ginseng and served hot. Persimmons were also commonly eaten by Korean people for stomach upsets and diarrhoea. One Indian woman made her own herbal remedies from recipes that were passed down to her from her grandmother:

Oh me and my husband we just take our um, ah house medicines like which we believe in. [Like] the, like herb, ah herbs and that type of thing. If it gets too bad then we prefer to go to the doctor... Oh yes because we ah use a lot of spices and stuff so we, we got most of the things at home. And we know that, how to take that, so that way we just take that and it, it will help. Because my grandmother and my mother they, they used to do the same stuff, so we, we come to know [how to make medicine] through them (Sachi, Indian woman in her 30s).

Other medicines used to self medicate were purchased from supermarkets and chemists and brought from home countries of participants. Jin-Ho, a Korean woman in her 50s, brings TKM with her to New Zealand or gets her father to send her the medicine from Korea. She told me she does not trust Western medicine and finds TKM works better than TCM:

I Yeah, even I can see, I can ah, you know, easily see what's the difference [between Chinese and Korean herbal medicine], [it is] very clean, Korean one is very clean. Also [the] effect is, ah, ah stronger than Chinese. I, even colour and sometimes um the shape [of the powder]. Sometimes the shape ah, we can see the shape. But Chinese one is, can make of powder, quite nasty, very nasty.

June, another Korean woman in her 50s, also preferred Korean topical medicine (a brand similar to Tiger Balm⁴) to New Zealand or Chinese brands and would get it sent over to New Zealand. Familiarity was another reason participants would use medicine from their country of origin rather than New Zealand medicines. Drezan, a young Chinese student in New Zealand, would bring Chinese biomedical medicine with him to New Zealand (or get his parents to send it to him). When I asked him why he brought medicine from China rather than take medicine in New Zealand he told me he was not familiar with medicine in New Zealand: "Um actually I don't know much medicine from here [New Zealand]. I don't take medicine from here. Yes I don't know about the medicine from here [New Zealand]".

Exploring health seeking behaviours and illness experiences of Indian, Korean and Chinese migrants in Auckland through the concept of habitus illustrates how

⁴ Tiger Balm is a topical ointment available in New Zealand pharmacies used for muscle pain and associated conditions.

relationships between transnational, political, economic and cultural dimensions influence health understandings and practices. Bourdieu (1984:190) proposed that the body reveals the “deepest dispositions” of habitus as the way people treat and care for their bodies and maintain health reflects their embodied understandings and social conditions. This study has demonstrated that habitus of immigrants from India, Korea and China in the fields of health, are shaped by previous experiences in their countries of origin and are embedded within broader social contexts. For example, holistic understandings of health and notions of balance were common to Chinese participants. These concepts are also key principles of TCM and extend into broader cultural explanatory frameworks such as social relations, politics and philosophy (Bodeker 1989, Ho and Lisowski 1997).

When immigrants are faced with ill health in New Zealand, they have to negotiate with health systems and habitus different to those with which they are familiar. According to Bourdieu’s framework, people are disposed to act in ways that reproduce their habitus and this was evident for immigrants in Auckland. They engaged in health seeking behaviours such as doctor shopping and judging health care facilities on the basis of ‘private’ and ‘public’ values. Seeking local GPs from countries of origin is a further example of how experiences with different social environments change people’s behaviour, where health needs are met within a perceived ‘public’ sphere, yet still conform to habitus in relation to shared understandings of language, culture and health.

Different forms of capital also influenced migrants’ access to health care and illness experiences. Immigrants’ health cultures can be understood as embodied forms of cultural capital that are also based on institutionalised forms of capital such as health systems and objectified goods, such as medicines. In New Zealand, migrants’ health cultures often did not conform to dominant understandings of health, particularly within biomedical sectors. This caused confusion, frustration, suspicion and, potentially, miscommunication between New Zealand-born practitioners and immigrant patients. As with other ‘fields’ in New Zealand such as employment, immigrants’ language difficulties also presented barriers in accessing health care. These limitations along with structural barriers such as lack of appropriate health care providers also influenced peoples’ economic capital. When immigrants were unable to see their GPs they sought

medical attention from A and E clinics or returned home for treatment, facing higher costs in services, prescriptions and travel. To counter these barriers, many people drew on sources of social capital available to them, which will be further discussed below.

Hospital experiences

The previous sections have focused on immigrants' experiences with New Zealand's primary health care sector; this discussion will focus on secondary care services in public hospitals. As hospitals are places where people go or are sent to when something is wrong with their health, they are often associated with competing meanings of fear, hope, threat and anxiety (Lupton 2003). These feelings can be exacerbated for migrants in New Zealand who are less familiar with New Zealand's health care system and organisations. Three participants with whom I worked had experiences with New Zealand hospitals for illnesses other than TB. Of these people, two accompanied friends or family members and one was admitted due to complications with high blood pressure. Their narratives illustrate barriers migrants face in accessing health in New Zealand and their perceptions of New Zealand's health system.

Alex

Alex, a young Chinese man, had a bad experience with New Zealand's health care system which has left him suspicious of our health care facilities. He was out in the city with his Chinese friends when one of them, another young man, fell and sustained a head injury. As the group believed that public hospitals provide poor health service they decided to take their friend to a private A and E clinic. The injured young man then had a long delay before treatment where he was sent from one health care centre to another:

And um, the ambulance took him [pauses] three times from the private clinic to the hospital and the hospital ask him to give [go to] the private clinic and the private clinic ask him to go to the hospital, THREE TIMES. And the, he just um, I don't know what probably is some kind of things that it, he's [his] head is still bleeding and just ah nobody take care of him, this [is] amazing [shakes his head]. And the [pauses], that's amazing. Just um, complete shock. It's like unbelievable, I'm, it's, that's not the ethic way a doctor should do, huh?

Alex was shocked as he expected that private health clinics would provide professional treatment because they were paid for it. He said that in China private health clinics were expensive but would treat every patient. Alex's concept of health care related to a market model, where patients are seen as consumers and purchasers and healers are commodities (Kasteler *et al.* 1976). This understanding of health was common to many participants who spoke of "employing" doctors, and was strongly influenced by their home country health systems. Due to these health care experiences, many people, including Alex, were unfamiliar with New Zealand's social based health system. When I asked Alex why he thought New Zealand was different he thought that there was less competition in New Zealand compared to China and that is why New Zealand hospitals are "so slow to react". Another confounding problem with Alex's experience was language. Although Alex speaks English some of the friends he was with (including the injured man) did not speak English fluently which could have caused confusion for both the patient and health care professionals.

May

May is a young Korean woman in her 30s, who lives with her two children in New Zealand while her husband works overseas. May's daughter plays tennis and while at practice broke her leg. May received a phone call from her daughter's tennis coach informing her that her daughter was injured and had been taken to a local A and E clinic. However, she had trouble comprehending the message and had to wait for her young son to translate the message for her. She informed me that the clinic would not treat her daughter until she arrived:

At the day I didn't know then my daughter's accident. Then ah, she walk to White Cross. And then um, her tennis coach informed me, um then, I didn't, I didn't understand because my daughter was very serious you know? But she [was] just at White Cross. But they waited for my phone [call], they didn't move ah, start, they, they wait for me [White Cross would not treat her daughter until she arrived]. Then when I arrived at ah White Cross and ah my daughter was crying and then, yeah and then at the time they, they called St Johns ambulance and they moved [moved her daughter to Starship hospital].

May's narrative illustrates how language barriers and isolation from family networks can impact on immigrant's health. Her situation of being separated from her husband is fairly common among transnational Korean families and is often referred to as an 'astronaut family' (Lidgard *et al.* 1998b). According to Mary, a Korean GP, transnational families can result in stress and anxiety particularly for women: "those things in itself can be stressful, you see a mum alone in New Zealand trying to raise a family as well as find a way with her limited English, that is just so difficult". Once May's daughter was moved to Starship Hospital she encountered further problems with the health care system. May expected (as did Alex and his friends from the previous example) that New Zealand hospitals would be similar to those in Korea and expected to be provided with a bed to stay with her daughter in hospital. She was shocked to learn that beds were not provided to parents of sick children and attributed this to the difference between private health care systems in Korea and public hospitals in New Zealand. May also experienced delays from hospital staff in response to her daughter: "But even though she (her daughter) pushed the bell, the nurse wasn't there, ah and it was 40 minutes ah 30 minutes, half an hour [before the nurse responded]". May was also shocked that her daughter was discharged after only one night in hospital, claiming that if she was in Korea she would have been treated for at least three or four days: "We stayed in hospital for three or four days that is normal in Korea. But in New Zealand we have operation and same day we you know, just [same] day we have to discharge there. So that is quite a shock. Korean way is better".

Sun

Sun is a Korean woman in her late 50s, who suffers from high blood pressure. Five years ago she began to experience headaches and initially took tablets from the local pharmacy. When her symptoms persisted Sun went to the local A and E clinic to see a doctor and was diagnosed with the flu. A week or so after her visit to the clinic she experienced double vision while driving and had to ring her son and husband to collect her and take her home. Sun then returned to the local A and E clinic and for a second time her condition went unnoticed: "when I visited the ah, the doctor because of flu he didn't check my blood pressure, so I didn't realise that I had high blood pressure". Sun

then experienced another episode of double vision which affected the vision in her right eye: “after I had that episode because of high blood pressure, my, my right hand side of eye um, had a very angled strangely”. Sun then returned back to the A and E clinic for her third consultation where she was diagnosed with high blood pressure and hospitalised. Sun holds the doctor at the A and E responsible for the delay in her diagnosis and found that his overall manner towards her was substandard: “the doctor, emergency doctor service was not very good, unkind. The doctors didn’t take patients seriously. Ah you know, doctors asked questions but not in a serious manner, ah and also the way they ah, skipped patients”.

Sun was in hospital for three weeks where she was treated for her high blood pressure. She found her stay in hospital a “scary” experience as the doctors were rude and she could not eat the food. She did not understand her health condition and found it frustrating that it was not explained to her:

I didn’t like the ah, the mannerisms, the doctors were, ah they were rude and also the food...Oh you know, they [doctors in hospital] don’t take patient seriously, too, ah too busy. Ah well, I, I don’t know about the blood pressure and ask ‘I want to you know, [know] what’s wrong’ but they don’t answer me.

Five other participants I have worked with have found New Zealand food difficult to get used to and Sun found she could not eat the “strange” hospital food. Sun’s husband, children and members of her church would cook her Korean food and bring it to the hospital for her three times a day during her hospital stay. They would also keep her company, join her in prayer and were key support people. When Sun was discharged from hospital she was told by medical staff that she would need a GP due to her long term need of medication and treatment for her condition. She found a local Korean GP through her church members.

Social networks

A key theme that emerged from participants’ illness narratives was the importance of social networks for patients throughout their whole illness experience. Social networks are important to migrants’ health through consultation, resource sharing

and support (Agadjanian 2002, Pescosolidi and Levy 2002). According to Korean GPs, most patients will consult with family and friends about their illnesses before seeking a healer. Four participants I worked with (three Chinese and one Korean) consulted family members for advice about illness when they were sick. In all cases, the migrant's family members were parents who lived overseas demonstrating that to some extent, isolation in New Zealand can be mitigated through transnational networks and technology such as telephones and email. Kleinman (1980:50) refers to this health seeking behaviour as "the popular sector of health care", which includes individuals, families, social and community networks. In this sector, individuals evaluate their illness and treatment through "lay experts" (family or community members) based on popular cultural beliefs and values which may lead to seeking treatment in other folk or professional sectors. Kleinman found that the families of Chinese patients would often decide which type of healer to consult and family members viewed themselves as primarily responsible for making decisions about their families' health care.

Social networks were also involved with resource sharing where family members and friends would provide transport, food and act as interpreters for sick people. Two Korean women I worked with would use their children as 'informal translators' when attending medical facilities. Dependency of migrants on family members or friends for communication and transport, particularly for elderly patients, can also result in barriers to health care as they have to adjust their health needs around the schedules of family members:

I remember in numerous cases of elderly people they would depend on their children, but if their children are working they couldn't come with their health problems and if they were lucky enough to belong to a church group where someone in the church volunteered to bring them in, then they could come (Mary, Korean GP).

Finally, social networks played a key role in providing support to people through their illness experience such as with June, where her church members kept her company and prayed with her during her time in hospital. Community members from religious organisations such as mosques and churches were often key support networks for migrants. For example, some Korean churches in Auckland provide referrals to healers,

transport to medical facilities and interpreting services as well as emotional and spiritual support to members.

As previously mentioned, different forms of cultural capital (existing in embodied, objectified and institutionalised forms) between migrants and New Zealand-born create barriers in the context of health care. As this research has shown, immigrants overcome these difficulties through the conversion or transformation of economic and cultural forms of capital into social capital. In these situations, social networks such as family members, churches and GPs from home countries, provide collective sources and resources of capital to their members through the provision of translators/interpreters, transport, food and emotional and spiritual support.

Conclusion

Indian, Korean and Chinese migrants' understanding of health, illness and health seeking behaviours are embedded within a system of knowledge which is based on previous experience of health care systems from their countries of origin and reinforced by lack of knowledge of New Zealand's health care system. People encountered barriers in accessing health care due to language difficulties, divergent cultural understandings of health and lack of GPs from their country of origin and interpreters. Social networks and use of health care professionals from countries of origin facilitated access to health care and illness experiences. When reviewing health and illness discourses, health maintenance and health seeking behaviours, it is clear that to some extent cultural discourses and health practices do influence immigrants' health in New Zealand. However, these 'cultural' influences related to political and economic structures in both countries of origin and in New Zealand, as well as individual differences in age and gender. Elucidating understandings of health and health seeking behaviour of Indian, Korean and Chinese immigrants in Auckland also provides a basis on which to study diagnosis and treatment of TB which will be the focus of the next two chapters.

CHAPTER FIVE: SOCIAL STIGMA AND TUBERCULOSIS

If they know so and so has it [TB] they do not want to mix with them again because they still think it is a contagious disease. Yes socially they will not mix; they do not want to be infected by the disease (Vishal, Indian man in his 20s).

Introduction

For many cultures there is considerable secrecy and stigmatisation associated with TB (Rubel and Garro 1992, Sumartojo 1993). Disease-related stigmas have significant impacts upon the human experience of illness. Stigma can increase stress associated with illness, contribute to secondary psychological and social morbidity and affect quality of life and physical well being (Fife and Wright 2000). This chapter will explore the processes, effects and influences of social stigmas on the diagnosis and treatment of Indian, Chinese and Korean migrants in New Zealand, demonstrating that stigma occurs at national and local levels and directly affects diagnosis and treatment of migrants with TB in New Zealand.

Stigma

The term stigma was used by ancient Greeks to refer to bodily marks that were designed to expose the moral status of the bearer, signifying that they were a blemished person to be avoided in public places (Goffman 1963). Goffman has been at the forefront of defining and researching the concept of stigma (Predaswat 1992). According to Goffman (1963: ii) stigma is still used in a similar way but is applied more to the sense of disgrace than to the bodily evidence of it. Goffman (1963) defines stigma as an attribute, an undesired differentness that discredits the bearer reducing them from a whole and normal person to a discounted, tainted individual who is prevented from full social acceptance. He further states that attributes of stigma are not intrinsic but embedded in social and cultural contexts where stigma is an interactional process between the 'normal' and the 'stigmatised'. Goffman (1963:14) proposes that there are three types of stigma (that are not mutually exclusive): 1) abominations of the body or various physical deformities; 2) blemishes of individual character such as addiction and homosexuality;

and 3) tribal stigma of race, nation and religion. For Indian, Korean and Chinese migrants in Auckland, TB falls under two of these categories. TB can be both attributed to blemishes of individual character and to a tribal stigma of migrants as will be further discussed.

Although Goffman acknowledges that stigma is embedded in social and cultural contexts his studies primarily focus on the individual in an American context and have thus been criticised as Eurocentric and lacking discussions of cultural, political and historical contexts (Becker and Arnold 1986, Predaswat 1992). Becker and Arnold (1986) state it is necessary to use a holistic framework to understand stigma using social, cultural and historical contexts. They further propose that stigma is universal, but notions of what constitutes stigma vary from one society to another due to differing structures, values and cultural norms. Therefore stigma is a cultural process “and is thus a reflection of culture” (Becker and Arnold 1986:41). They also emphasise the dynamic nature of stigma arguing that cultural definitions of stigma have their own histories that are influenced by social and historical consequences. The processes of stigma are linked to structures of societies:

Social stratification thus dramatically influences the process of stigmatizing certain individuals. Vested interests of those in positions of power and authority are maintained through the institutionalization of stigma, which entails denial of access to economic, political, educational and social institutions (Becker and Arnold 1986:46).

As stigma is embedded within cultural understandings and linked to institutionalised forms of cultural and economic capital it is also an example of habitus. Bourdieu (1984:193) proposed that the body is a social product and can act as a social marker, where it is “perceived as an index of moral uprightness”. Meinert (2004) extended Bourdieu’s theory of habitus in relation to the body stating that the body is not only a carrier of habitus but is also a form of capital: bodily capital. Habitus can therefore illustrate the construction and maintenance of stigma within groups of people, while the effects of stigma can be understood through the concept of bodily capital. The following discussion will illustrate that stigmatising national discourses of TB as a ‘disease of others’ are prevalent in New Zealand, stemming from historical influences and maintained through media and policy.

Tuberculosis: A disease of others

The visibility or salience of undesired attributes are an important aspect of stigma. Much of people's knowledge is gathered from media images therefore it is important to investigate how such attributes are portrayed in mass media (Ferreira *et al.* 2001, Kaperson *et al.* 2001). Diseases such as meningococcal meningitis, SARS and TB in the recent past have triggered intense media coverage and strong public concerns or "socially amplified hazards" (Kaperson *et al.* 2001:9). These concerns can generate powerful signals to society that either a new hazard has appeared or an existing hazard is more severe or difficult to manage (Kaperson *et al.* 2001:9). By way of example, a recent newspaper article recounted:

TB-infected South Korean woman removed at \$278,000 cost - Immigration officials spent almost \$280,000 to avoid a public health emergency by sending home a South Korean woman who withheld information about her highly infectious and untreatable tuberculosis (Johnston 2005).

Socially amplified hazards such as TB being a "public health emergency" send powerful signals of abnormal risk and negative imagery which generate stigma-related effects for people and places. In New Zealand, we can see these effects from media coverage of TB and its related effects of risk-induced stigma for migrants. At the centre of risk-induced stigma is the concept of fear, and I would argue that media images of TB in New Zealand signal fear of TB as a contagious disease and portray it as a mark of racialised difference or a 'disease of others'.

When reviewing media it is important to investigate the extent of coverage, use of language and how factual details are portrayed as these can have large impacts on public perceptions: "The mass media can also play a critical role in dramatizing and framing the risk problem or threat. Particularly important are the extent of coverage, and the 'facts' selected and the language used to characterize the risk" (Kasperson *et al.* 2001:22). TB has recently become a fairly common topic in New Zealand media and a study by Searle (2004:87) revealed that many media articles falsely associate TB solely with immigration promoting "a climate of fear and stigma toward TB and minority groups". My review of articles from *The New Zealand Herald*, a prominent Auckland-based national New

Zealand newspaper from, 1999 to 2006 found 25 articles featuring immigrants, immigration and TB in New Zealand (Table 5.1).

Table 5.1 TB and migration themes from *The New Zealand Herald* 1999-2006.

Theme	N	Percentage
Cause of TB spread and outbreaks	11	44
TB testing and screening	9	36
Cost/burden to New Zealand	5	20
Total	25	100

The majority of these articles (44 percent) attributed the spread of TB in New Zealand to migrants, with headlines and stories such as “Migrant worker triggers TB alert - A seasonal worker is believed to be responsible for up to 20 people in Coromandel testing positive for exposure to tuberculosis” (Thomson and Binning 2003). These articles associated migrants with: “increase in TB rates”, “outbreak” and “spread” of TB and included descriptions of migrant TB cases in terms such as; “warning”, “alert” and “public health emergency”. Articles such as these have led to a common stereotype held by the New Zealand public that TB is a disease of ‘new immigrants’, not ‘New Zealanders’. Although foreign-born people have higher rates of TB than those born in New Zealand, the notion that TB is exclusively a disease of new immigrants appears to be perpetuated by media reports and presentations. Searle’s (2004) research looking at perceptions of TB among Pakeha in New Zealand found that Pakeha tend to view TB as a problem of the ‘diseased other’ and the media were their foremost source of health information. Not all migrants are included among the ‘diseased other’ category. This socially constructed ‘discredited’ community generally only includes immigrants from Africa, Asia and (sometimes) the Pacific Islands. These articles not only perpetuate the stereotype that TB is a disease of migrants but also deflect attention away from TB cases in New Zealand-born, particularly Pakeha, causing “Pakeha TB to be invisible” (Searle 2004:i). Searle’s study on TB in Pakeha found that these notions of invisibility prolonged delays in diagnosis and increased stigma for patients who had difficulty accepting they had a disease of the ‘other’.

Another common theme was TB immigration testing and screening. For example: “Overseas HIV tests tipped for migrants - New migrants could be forced to undergo tests for HIV/AIDS, tuberculosis and other infectious diseases before they leave their home country” (Mold 2002). This headline and others focused on screening imply that infectious diseases enter New Zealand borders from diseased immigrants. Although India, Korea and China are high incidence TB countries (Das *et al.* 2006b) and screening of immigrants is important to prevent imported TB from entering New Zealand, it fails to acknowledge local TB transmissions and potential reactivation of LTBI in New Zealand.

Media articles also emphasised the economic costs of immigrant TB cases and the burden they pose on the New Zealand health system, for example: “Door shut to TB sufferers - A crackdown on migrants who may become a burden on the taxpayer” (Tunnah 2004). Analysis of media has therefore presented a national discourse where migrants are understood to be responsible for bringing TB into the country and spreading the disease at the cost of the New Zealand-born population.

When groups of people are stigmatised in a society they become labelled or ‘marked’. These labels are socially constructed and create a stigmatised category or stereotype (Crocker and Lutsky 1986). For immigrants in New Zealand, this form of national stigma can reduce immigrants’ bodily capital. In this context, simply being a migrant from Africa, Asia and the Pacific Islands becomes a ‘mark’ differentiating them from ‘normals’ through the perceived risk they pose of spreading TB to the New Zealand public. These perceptions can also be described as a form of symbolic violence. Symbolic violence is exerted through symbolic channels of communication, cognition, recognition and emotion (Bourdieu 2001). This form of violence occurs when forms of capital such as bodily capital are not valued in a society and lead to unequal power relationships (Meinert 2004).

New Zealand has a long history of perceiving immigrants with TB as ‘undesirable’ (Bryder 1996, Dunsford 2007). In the late 19th century, once the infectious nature of TB was understood, TB costs were used as a form of propaganda to restrict immigration of British and Asian migrants to New Zealand. In 1903, legislation was

introduced to restrict entry of TB sufferers, primarily targeted at the British (who had previously been encouraged to come to New Zealand for recovery of TB) and Asians (Bryder 1996:465). However, there were still 'ethnic' preferences seen in the restrictive legislations where "British people with tuberculosis were still considered more desirable immigrants than Asians, however healthy" (Bryder 1996:465). Tribal stigma was a category that Goffman used when referring to race, nation or religion where stigma is transmitted through lineages contaminating all members (Goffman 1963). Although New Zealand migrants are diverse in their countries of origin, language and religion, associating TB with migrants reinforces popular stereotypes of migrants as either contaminated or at risk of contaminating the 'normal' others. Here migrants are treated as scapegoats; this model of stigmatised groups suggests that, when a society feels threatened by populations for political, social or economic reasons, they attribute stigmatised behaviours or attributes such as contagion to that population (Predaswat 1992).

These stereotypes, in turn, perpetuate the stigma surrounding TB. Media representation of TB in New Zealand also demonstrate how symbolic violence operates through social structures, social inequality and power relations. As discussed in Chapter Three, during the mid 1990s, media labelled the new Asian migration trends as an "Asian invasion" (Bedford and Lidgard 1996:3) and the New Zealand First Political Party used these debates on immigration issues, including infectious diseases, as a goal of their election campaign to reduce immigration to New Zealand. Winston Peters, leader of New Zealand First Party, promotes stereotypes of immigrants in statements such as "there are many examples of violent crime committed by immigrants and refugees together with the emergence of Third World diseases in New Zealand" (Peters 2003). The emergence of a public debate over the 'Asianisation' of New Zealand, and the Governments' need to manage a surplus of skilled immigrants who had gained entry through the points system, led to immigration and screening policy changes. As discussed in Chapter One, the association of TB in New Zealand with immigrants and emphasis on targeting immigrants for screening led to tighter border control through TB screening.

Despite mainstream discourse that characterises TB as a disease of migrants, I found that many migrants did not internalise this stigma. Goffman (1963) proposed that

one of the most important psychological and social components of stigma is ‘impression management’ whereby people create desired images about themselves to control the conduct of others. Impression management can be applied to the management of personal information about the individual or of interpersonal encounters. When I asked participants who had TB where they got it from, or those without TB how people develop TB, their responses did not reflect those portrayed in the media. Many migrants did not believe that they could develop TB in New Zealand due to the health screening they had to undergo before arrival, as illustrated by the following quote from Alex, a Chinese man in his 20s:

Anneka: Do you know of anyone with tuberculosis?

Alex: No, but if you want to come to New Zealand you must have a, like a health screen and probably nobody has that kind of thing [TB]. So I only know [for] my Chinese friends that’s not possible.

Anneka: Right, it’s not possible for them to come in with it because of that screening?

Alex: Yeah, they have um, a visa programme so you have to have a visa but you won’t have a visa [if you have TB]. You have [to] provide them [with] the x-ray and the health certificate.

In my research I also discovered that, like the New Zealand public who attribute TB to the ‘diseased other,’ this stereotyping also occurs among Chinese and Korean people in New Zealand. Three people with whom I spoke (one Chinese woman and two Korean women) told me that TB was believed to be common among Māori and Pacific Island communities in New Zealand. When asked how they had come across this source of information, I was told they read it in newspaper reports:

I think most Māori family ah, maybe extended family ... ah, live in small house maybe them easy to got [get] this disease. I think Māori and ah Polynesians easy to got [get] this disease (Li, Chinese woman in her 20s).

These narratives demonstrate that othering is not only unique to Western cultures but exists in many human societies. Despite rejecting New Zealand stereotypes or

constructing their own, stigma associated with TB for Asian migrants occurs at local, culturally specific levels.

Tuberculosis: A disease of contagion and death

In my research I have found that stigma surrounding TB for Chinese, Korean and Indian people in New Zealand is something that is hidden and complex, relating not only to understandings of disease causation and transmission but also strongly linked to social values and religion. On the surface stigma surrounding TB is attributed to fear of contagion and death. Fear is a key concept of how and why stigma persists in many cultures (Coleman 1986). All people with whom I spoke understood that TB was an infectious disease. Most people explained to me that people with TB should be isolated from others to prevent the spread of the disease: “So if someone has you know, TB, we have to keep away because it can be infectious” (Sun, Korean woman in her 50s).

Despite this knowledge, the fear of TB remained because of its moral and social implications. When examining the process of stigma associated with TB among Indian, Korean and Chinese people, it is evident that stigma is expressed both directly and indirectly. Direct forms of stigma are expressed through various social structures such as marriage and household composition. I had many informants and health care professionals tell me of women who had been divorced when it was discovered that they had TB or of patients rejected from their homes. Janette, a PHN, told me of one of her patients, a young Indian man who lived with his parents. When he was diagnosed with TB, the family did not want him living with them. Janette explained to the family that because he was taking medication he could not infect others. She told me the family said they understood this and would not reject their son from their home. A few days later, Janette returned to give the young man his pills and discovered he had been moved out of the home into the family’s garage. Despite Janette repeatedly explaining to the family that their son was no longer infectious, and the family stating they understood this, the young man remained living in the garage throughout his treatment process. A quote from Dependu, an Indian man in his 50s, further illustrates how TB can directly influence the social life of sufferers: “Aged people’s children may not visit, if young [a person with TB] may not be getting married”.

Eight out of eleven people with TB did not disclose their TB status due to fear of rejection and isolation from family, friends and communities. Bhadrak, a young Indian man in his 20s, was hospitalised for three months after his TB diagnosis. During this time he did not tell anyone of his disease due to fear of rejection. The only social contacts he had in hospital were with health care professionals. To this day (almost three years after his TB diagnosis) he has still not disclosed the information to his parents (who live in India) for fear of rejection: “I was lost, I didn’t know what to do, I didn’t know what to tell to my family, I haven’t told them yet, that I carry the disease”. Bhadrak’s experience with TB and associated stigma illustrates how these dimensions led to a steep decline in capital. Social capital can impact on bodily capital through care and emotional support (Meinert 2004). For Bhadrak, stigma reduced his social capital and, in turn, led to a low bodily capital.

As discussed in Chapter Three, when Meeta suspected she had TB she tried to hide her TB symptoms and delayed seeking medical attention due to fear of rejection by her family. Her experience demonstrates how social stigmas attached to TB can prevent individuals from seeking treatment and taking prescribed medication. Delays in seeking and receiving treatment have also been found to be common for stigmatised diseases such as TB and leprosy (Predaswat 1992, Rajeswari *et al.* 2005). Direct effects of stigma on people with TB in Auckland are similar to those in India. A study of TB in India by Rajeswari *et al.* (2005) found that fear of others discovering their TB status prevented Indian people from visiting friends and family and disclosing their health condition to friends and even spouses.

Processes of stigma may also be more indirect and constitute ‘social gossip’. As many people were aware of my research area, TB was a popular topic of conversation between community members and myself. Informants would tell me of community members who had had TB in the past (sometimes as long as 10 years ago) or who had recently been diagnosed with TB. I was shocked one day to receive a phone call from an Indian woman asking me did I know that another woman (a mutual acquaintance) had been diagnosed with TB. I was surprised because I gained this information from a member of the community before I was informed of the new TB case by health care professionals. Gossip can have huge impacts on social relationships between community

members. Dependu, an Indian man in his 50s, told me that Indians live for others' opinions and fear that others will come to know of their failings, whether in education, employment or health, can have huge impacts on their social standing in the community. I was often asked by Indian people who my TB participants were and had to constantly explain that I could not divulge this confidential information to ANYBODY. I also emphasised the point that I was interviewing a number of people who did not have TB so not everybody I spoke with in public contexts were suspected as TB participants. PHNs were also often asked for personal details such as "Do you know who this person is?" or "Where was he working, which dairy?" during the TB education programme with Indian community members.

TB is so strongly associated with the notion of contagion that many people do not understand that TB is not always infectious. Observations and participation in the TB awareness programme made me realise that it was understandably difficult for people to understand the differences between latent and active TB, and pulmonary and extra pulmonary TB. The following quote from Madhu, an Indian woman in her 40s, illustrates the powerful relationship that TB has with the idea of contagion for many Indian people:

Ah to people, to Indian people TB means infectious disease. They, they don't know the difference between non-infectious TB and infectious TB and disease. TB means infectious and that's what people think.

On further examination, I also discovered that TB itself to some Indian people means an infectious condition rather than referring to a specific disease. During my participation in the TB education programme, I noticed that TB was often discussed in the same context as HIV. For example, one of the health care professionals gave a presentation on TB and HIV co-infection which led to questions and comments from informants such as: "Some people in India don't see a difference between AIDS and TB" (Sid, an Indian man in his 30s), and "TB stigma in Indians is due to the association between AIDS and TB" (Rose, an Indian girl in her late teens).

The close relationship between HIV and TB may be related to high rates of HIV-TB co-infection in India and understandings of disease causation. Although TB-HIV co-infection rates are highest in Africa, globally, India has the highest absolute numbers of

co-infections with 1.7 million people recorded in 1997 (WHO 2007). From 1992-1996, national HIV associated TB cases in India were 16 per 1000 but these were variable between geographic areas, for example, cases in the Churachandpur District, Manipur state, were 138 per 1000 (Rodger *et al.* 2002: 1). Also, both diseases are believed to be fatal and contracted through unprotected sex: “Um, well I heard if a person is getting TB means she get that by not using condoms and gets everything really, like sleeps with two, three men, that sort of a person is getting TB” (Madhu, Indian woman in her 40s). Nyblade and Bond (2006) also found stigma among people from urban and rural areas of Zambia due to the association between TB and HIV. For Zambian people, two forms of TB existed; the ‘old TB’ which is a curable disease and the ‘new TB’ which was associated with HIV and perceived as fatal. In Zambia, visible signs of TB such as weight loss and coughing trigger TB/HIV stigma. Nyblade and Bond suggest that stigmas surrounding ‘new TB’ are influenced by the reality of TB-HIV co-infection and integration of TB/HIV programmes in Zambia. HIV promotes progression from LTBI to TBD by 5-10 percent for people positive for HIV infection (WHO 2007). In South Africa, people with HIV have a 50 percent lifetime risk of developing TBD and higher TB mortality (Nyblade and Bond 2006:453). Likewise, TB can also result in a more rapid progression of HIV infection to AIDS. Nyblade and Bond (2006:453) suggest that: “TB stigma can no longer be thought of, or addressed, separately from HIV stigma; in effect a new disease stigma has unfolded, namely TB-HIV stigma”.

The biological and social relationships between HIV and TB can also be classed as a syndemic. This term refers to two or more epidemics that interact synergistically contributing to excess disease burdens in populations (Singer and Clair 2003:425). It has also been suggested by Singer and Clair that syndemics are closely related to social conditions such as disparity, discrimination and structural violence. The association between HIV and TB may also influence social stigma of Indian sufferers in Auckland and have important implications for TB diagnosis, treatment and education programmes, despite the rarity of co-infection among New Zealand’s TB cases (Das *et al.* 2006b).

Blemishes of individual character

Stigma is not solely about fear and understanding of disease. For some Indian and Korean people it is attributed to moral conduct and religion. I realised early in the study that there was a strong association with bad hygiene or, more specifically, dirt and TB. At this stage I took comments such as TB is caused from “dirty carpets” and “unclean people who do not brush their teeth”, at face value. However, on further investigation I realised that dirtiness also related to spiritually unclean individuals.

Two Christian Korean women told me that immoral behaviour of “bad people” results in punishment from God in the form of diseases such as TB and cancer. I asked one of the women (Sun, who is in her 50s) where she had heard this information and she told me “it is in the Bible”. I also asked Mary, a Korean GP, if she had heard similar religious explanations about TB or other diseases. Mary told me she had heard from some of her patients that both TB and cancer could be punishments from God. However, although Sun believed “bad people” could be punished by God, she saw her illness (she suffered from high blood pressure) not as a punishment but as a test of faith.

Indian participants also informed me that certain actions such as not fulfilling family obligations, drinking excessive amounts of alcohol and being sexually promiscuous will result in punishment or curses from their God/s or ancestors in the form of diseases such as TB, as illustrated by an interview with Madhu, an Indian woman in her 40s:

Anneka: And what, what kinds of things are attributed to the cause of TB?

Madhu: Um not looking after your family properly, your family you know? And drinking lots [of] alcohol. .. And there are also a number that suffer from cancer. Ah that is the main one, otherwise holding off from your family traditions, you know, not keep happy family life, they are not getting some sort of um, blessings, it is because some God insisted that sort of thing.

A study of TB in India also identified that participants attributed moral causes such as *karma* and God’s curse to TB (Rajeswari *et al.* 2005). Cohen’s (1998) ethnographic study of Alzheimer’s and aging in Indian also found that understandings of illness were embedded within family structures and relationships. In India, Alzheimer’s

was seen as an illness resulting from ‘bad families’ where children neglected their parents with a lack of *sevā* (service to and respect for aged parents) (1988:115). Notions of *sevā* are also central to family structures of Indian migrants in New Zealand, as seen from Dependu, an Indian man in his 50s: “We expect, we expect our children to look after us when we are old. At old age we want ah them, them to look after us, that’s why we invest, we are investing now”. These understandings were also apparent from a group conversation I had with several older Indian women. They told me that when children do not look after their parents, or do not allow them to live with them in their old age, the children may be punished by the gods with bad health.

Another immoral behaviour attributed to TB was that of sexual promiscuity. As previously mentioned, sexual promiscuity is also perceived by Indian people to be the cause of HIV. A study on HIV/AIDS in South Asia by Huda (2006) found that women with HIV were seen as promiscuous and blamed for bringing the infection into their homes, resulting in bad luck for their families. HIV infected women were also ostracised and rejected from their homes. During a TB education course three Indian people made reference to TB and sexual intercourse. Older female community members told me that TB was a disease that women got from ‘sleeping around’ and I have also heard from several Indian people that people with TB (both men and women) should sleep in separate beds from those of their spouse. However, it was also acknowledged that although people should sleep in separate beds and not have intercourse, many men will still “sneak into their wives beds”. People from India would often emphasise to me that beliefs such as these are only held by ‘poor, rural’ people:

For village, um, country sided people; they think TB is like this, you know, very countryside people. Because in [the] countryside, people are very much in knowledge of TB. Like TB can be terrible, you protected from [TB] by looking after family very well, stop drinking alcohol, not sleeping around and it would work (Madhu, Indian woman in her 40s).

However, during observations of TB education programmes, informal and formal interviews, I found that these beliefs were still maintained by educated, middle class people from urban areas of India. Goffman (1963) noted the process of stigmatisation cannot be separated from the concept of morality. Attributing moral transgression to

stigmatised individuals, firstly, reassures that ‘normals’ remain morally pure and avoid punishment and, secondly, helps ‘normals’ to distance themselves from those who are stigmatised and reduces the threat associated with the stigma (Gibbons 1986, Goffman 1963). Goffman (1963:14) classifies this form of stigma as ‘blemishes of individual character’.

By attributing diseases to immoral behaviour the stigmatised become social ‘deviants’ and a ‘blame-the-victim’ ideology emerges within societies (Fife and Wright 2000:52). “People are motivated to believe that others deserve or bring upon themselves the unpleasant events that befall them because the belief that ‘bad things happen to good people’ would lead to unacceptable feelings of vulnerability” (Crocker and Lutsky 1986:103). By applying Bourdieu’s theory of habitus to stigma we can understand how social stigmas are maintained through embodied understandings transmitted through to the everyday practices of socialisation. In this context, stigma is maintained through habitus embedded in social structures and relations such as those relating to sexuality and kinship (Cocker and Lutsky 1986). In this sense, peoples’ experiences of family structures, religion and illness influence their understandings, emotions and social relations towards those with TB and create local forms of symbolic violence. Social violence can directly affect bodily capital through systemic self-depreciation, self-denigration and loss of social and even economic capital (Bourdieu 2001:35).

Gendered stigma

Culturally specific beliefs associated with moral behaviour and TB reinforce the notion of stigma and social isolation of individuals through restrictions placed on the diseased. For example, Indian women with TB are not allowed to have sexual intercourse (or more specifically are to sleep in separate beds from husbands and children), are restricted from contact with children and other family members along with not being able to perform domestic duties such as food preparation:

Indian people believe that when TB is in the home, it is something really bad especially for the women. The stigma is in the home for these people. If mum is having TB she tries not to let children know. TB [is] worse for women because they are main person in family, everybody thinks she

should not cook in these areas and mainly, she won't get [sexual] intercourse. No she won't get sexual satisfaction and always there is insecurity. And then she won't be near the children. So if a person has TB, no good. The woman's whole role really lost (Madhu, Indian woman in her 40s).

When Meeta was diagnosed with TB, her family was also tested through contact tracing and had different reactions to her and her illness. One of Meeta's sister in-laws, Shanti (with whom she had close contact but did not live with), was concerned that Meeta would infect her children with TB. Shanti, like Meeta, came from India to marry a New Zealand-born Indian man. She believed that only dirty people had TB and when Meeta was diagnosed with the illness she stopped all contact with her. Shanti also had three young children who had spent a lot of time with Meeta. Although all three children tested negative to TB through contact tracing, and Shanti was told from Meeta's PHN that there was no risk of them contracting the disease from Meeta, she vaccinated all of her children with BCG and would not let them have any contact with Meeta.

These examples highlight the relationship between stigma and gender. As will be further discussed in the following chapter, I also found that different perceived causes of TB often existed for men and women in Indian groups. For men, TB was commonly attributed to hard work and stress (although this was not exclusive to men) or drinking alcohol, while promiscuity was only attributed to women.

Coping with stigma, information management

Stigmatised individuals develop strategies for dealing with negative values and devalued status that accompanies their stigma (Becker and Arnold 1986). These strategies are influenced by the degree to which the stigma is shared with others in a society and the degree to which it can be 'normalised'. The visibility of stigma is also important in how well individuals cope with stigma as it is often through visual recognition that stigma becomes evident to observers. However, Goffman (1963) proposes that 'perceptibility' is a more accurate description than 'visibility' as conditions such as speech impediments can not be visually seen but are also recognised as tainted attributes. For individuals with a visible stigma, mere contact with others will cause them to be aware of their stigma. Yet, for individuals with TB, the symptoms are not as physically marked as those of other

diseases such as leprosy. Therefore an individual's 'differentness' is not immediately apparent to others and, according to Goffman (1963:57), in this context, individuals manage their stigma and associated relationships with social contacts through information control: "To tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case to whom, how, when and where".

Becker and Arnold (1986:50) propose that life-course experiences shape perceptions of the stigmatised, thus the way individuals counter stigma is "a direct reflection of the broad social and cultural context in which people live". I found that most Chinese, Indian and Korean people with TB develop a strategy that Goffman (1963) terms 'passing'. Passing involves disguising stigma by controlling and concealing personal information about TB, therefore denying their disease because it would discredit them from others.

Seven people only disclosed their TB status to immediate family although two did tell close friends and employers. Only one person did not inform anyone (other than his health care providers) of his illness. Along with concealing their TB status, three people went to great lengths to hide their treatment, meeting their PHNs at times when no one else would be in their home or meeting in parks or car parks to avoid work colleagues, friends and neighbours from observing their treatment. I asked participants what they told their friends, family and employers about their absence from work, bad health or time in hospital. Most people did tell others that they were experiencing health problems but were not specific about the details. One woman told me she followed the advice of her PHN when it came to disclosing her personal information which she felt was a relief:

Julie, my Public Health Nurse, she says to me 'You don't need to tell everybody that what happened exactly, "this is the tuberculosis" or anything like that. If somebody asks just tell them like it's infection in the spine'. So that's how, that's why we don't tell anybody (Sachi, an Indian woman in her 30s).

Other strategies people employed to cope with TB were humour, religion and using Western biomedical knowledge to counter cultural understandings of TB. Ari, an Indian man in his 20s, constantly joked with health care workers, his family, friends and

myself about his TB condition. His use of humour was a coping strategy to deal with his serious health problems and the stigma he faced in his community:

Ah, I told like one or two close friends that I had TB. It was more of a thing like 'Ah you got TB, ah you gonna die' [laughs] kinda thing. It was like, you just make a joke out of it, after a while its like 'Oh ok, ah don't worry about it'. It's like probably the first thing was disbelief like 'Oh sure whatever' you know [laughs] 'Yeah pull the other one'. Yeah and it became a joke, and basically after that, um, it's like they'd take me seriously and then it was like 'Oh ok so what are you doing now?' 'I'm taking medication' 'Oh ok, so you'll be fine then?' [laughs] And that's pretty much about it.

Religion was a key influence in the lives of participants from Korea, China and India, particularly in relation to coping with illness. Vishal, an Indian man who was a Muslim, had isolated himself from friends and family when he discovered he had TB. Despite this isolation he told me that his belief in God helped and that his faith in God would see him through the illness. When he finally told his wife and parents that he had TB, their religious beliefs also acted as a form as support for him "They [his family] said same thing as me, if you believe in God it will be alright".

Six people used Western biomedical knowledge to counter cultural notions of morality and the contagious nature of TB. They tended to emphasise to me that they were no longer contagious because they had been taking their medication and that the cause of their illness was through "TB germs". For example, Vishal, told me that he had extra pulmonary TB and was also on medication and therefore could not infect his family or friends. Despite my head nodding and agreement, he insisted I read medical information he had found that supported this assumption. Participants had collections of TB information pamphlets (from their PHNs) and would tell me of TB websites and medical references where they had gathered information, as illustrated by Bina, an Indian girl in her 20s:

Bina: I went on the internet and I learnt a bit about it [TB] um, and what it is and what it does and stuff like that, and also I got information sheets from Julie [PHN] I think?

Anneka: And how did you find the information sheets?

Bina: Um yep, they were good, um just basic things really, um, what you can do, what you can't do, you know? Like how to kinda get your life back on track and [that] sort of thing, but yeah, no, they were good.

Even though people cited biomedical causations for their illness and understood that they were no longer infectious to others, it was clear that they all still experienced ostracism from their community (by either isolating themselves or becoming isolated from others) and did not disclose their TB status or biomedical explanations to many people in their communities. These are common effects of information control where “Even if the individual succeeds in concealing the past, a sense of stigma is kept alive by knowledge of cultural beliefs about such behaviour as well as by the need to be secretive” (Becker and Arnold 1986:50).

Although TB is a curable disease the stigma associated with TB is more permanent in nature. A study in India by Rajeswari *et al.* (2005) also found that stigma associated with TB is often permanent in nature. As discussed in Chapter Six, two Korean women in the study experienced TB as teens in Korea, and even now, as adult women, suffer long term effects of the disease. May is in her early 30s and still lives with the fear that her TB will return. She told me that as long as there is a scar on her x-ray she still believes she has TB germs in her body. As discussed in Chapter One, June had multiple TB episodes in Korea which led to her in-laws rejecting her, her husband and son from social contact. Her social network is restricted to just her immediate family who migrated to New Zealand and she told me that she is unable to go out and socialise, work or make friends because of her illness and associated stigma. I was told from Indian community members that when a woman has TB, she will always be considered to be “one of those women” who are sexually promiscuous. Therefore, in this case, it is the assumption about the immoral behaviour associated with TB that persists rather than the physical disease itself.

Support networks

Support networks play a key role in how well individuals manage their stigma and provide social capital to buffer low bodily capital of TB sufferers. Goffman (1963:31) terms people who support the stigmatised as ‘sympathetic others’ who consider the

stigmatised as essentially normal despite their discredited attributes and provide instruction, moral support and comfort. 'Sympathetic others' can be separated into two categories, those that share the same stigma and those that are privy to the secret stigma of others (Goffman 1963). I found that support networks varied between people from those who had no friends and family to others that had many.

For immigrants with TB who had family members close to them, their relatives were key actors in the patient's illness and how well they coped with stigma. By way of example, I will return to the life story of Meeta. As discussed above, her two sister-in-laws had very different reactions to her illness. Despite Meeta's fears about being sent home if her family discovered she had TB, her sister-in-law, Megan (whom she lived with), encouraged her to seek medical treatment when she was sick and acted as her translator when possible while she was in hospital. She and Meeta's mother-in-law also brought her Indian food and took turns in visiting her. When Meeta came home from the hospital, Megan made sure she ate, accompanied her to clinic appointments when she could get time off work and offered her emotional support. The support provided to Meeta from Megan and her mother-in-law demonstrates how social capital can buffer low bodily capital. Megan was able to provide forms of cultural and economic capital to Meeta through her ability to translate and through provision of accommodation and transport. In addition, their emotional support also helped ease family tensions between Meeta and Shanti. However, not all migrants have such extensive family networks and are often separated from family and friends overseas.

For migrants who had limited family networks PHNs became central to their lives in helping them with their treatment and support. Goffman (1963:41) describes 'sympathetic others' who are 'normals' but whose special situation has made them privy to the secret life of the stigmatised individual and become accepted by them as 'wise' persons. PHNs fall under this category as they are aware of the individual's disease and generally become accepted by individuals with TB. Rather than a purely medical relationship based around treatment, many people found the support and advice from their PHNs important and helpful in their TB experiences. Bhadrak, an Indian man in his early 20s, had no family or friends around him when he was hospitalised for three months, his only social contact was with health care professionals. He explained to me

that the PHNs “saved his life”, not through their pills, but through their care, friendship and support. As previously mentioned, PHNs were also able to give advice on disclosing health information and helping participants counter social stigma. Patients’ descriptions of PHNs included “best friends, helpful, caring, friendly, fantastic, nice, kind” and “supportive”. It is important to note this aspect of health care provision from PHNs particularly because of the limited social networks many migrant TB sufferers face due to immigration and stigma surrounding the disease.

Conclusion

For Indian, Korean and Chinese migrants in New Zealand, stigma operates at many levels - from national discrimination to local group perceptions. Stigma surrounding TB for Indian, Chinese and Korean immigrants in New Zealand is something that is hidden and complex, relating not only to understandings of disease causation and transmission but also strongly linked to social values, moral behaviour and religion. Stigma is also gendered where different causes and restrictions are seen between men and women. Stigma has significant impacts on TB, creating delays in diagnosis and acts as a barrier to treatment. The following chapter will discuss how factors other than stigma also influence experience of TB, diagnosis and treatment for migrant TB sufferers in New Zealand.

CHAPTER SIX: THE TUBERCULOSIS JOURNEY, FROM SYMPTOMS TO CURE

Well it changed my life completely. The way I was living, ah initially before I had TB, ah well [when] I found out that I had TB um, is completely different to what I am now, life changing experience. Because it completely changes your peoples [social relationships with people] and life you know? Ah every moment of life becomes very valuable to you. And you have some kind of disease that affects your life in terms of everything, um losing friends and work and, um, not being regular. Yes, yes it does affect when you get a big disease like this. Ah yes, that affected the ah working style and, um more my regular life as well, um I couldn't go to work, couldn't study, I couldn't concentrate on anything. Lots of, lot of aspects (Bhadrak, Indian man in his 20s).

Introduction

The primary aim of this chapter is to provide an overview of participants' experiences with TB, focusing on factors that facilitated or created barriers to their diagnosis, treatment and coping with the disease. I will first discuss participants' symptoms, health seeking behaviour and diagnosis. The next section will focus on treatment including any barriers people faced and the role of Directly Observed Therapy-Short Course (DOTS) and medical professionals (GPs, PHNs and specialists) during their treatment. Finally, I will address how TB affected the lives of participants.

This chapter uses material from interviews and participant observation of 11 people who had TB at the time of the research, or who had suffered from TB previously, their family members, interpreters and health care providers. Ten of my participants had TBD and one LTBI. The one person with LTBI was a family member of a participant with TBD and was diagnosed through contact tracing. Of those with TBD, three suffered from extra pulmonary TB and two were first diagnosed and treated for TB in Korea before coming to New Zealand.

Before outlining participants' TB experiences, I will return to the life stories of the four people I introduced in Chapter Three, to provide a personal account of their illnesses.

Tuberculosis life stories

June

As previously mentioned (and further discussed below), June has experienced three episodes of TB, two of these in Korea. In 1996, not long after moving into a new home in Auckland, she became sick. When she began to cough up blood she realised that she was suffering from another episode of TB, yet, despite this knowledge, she waited for two weeks after the first appearance of blood in her sputum before going to her GP. Although she was aware of the seriousness of her illness, June delayed seeking medical attention because she was busy organising the new house and gardens:

Anneka: Ok so you waited for two weeks from when you got sick to when you saw your GP. Why did you decide to go at that time?

June: I came here [new house in Auckland] and then I do the gardening and all housework, that's, that's very hard for me. And you know, in Korea man doesn't help [with] the housework that much and so it, it get very hard here... And um, you know, um, maybe that my personality causing the problem cos I can't, I can't let [leave] the dirty things you know [can't leave dirty housework]? I have to do everything on my own, so that's why.

It was not until June became too weak to engage in housework that she went to see her Korean GP. Her GP sent her for a chest x-ray on the same day which confirmed she had pulmonary TB and she was hospitalised the next day. June spent a month in hospital where she experienced difficulties with the food and encountered language barriers with her doctors. June has diabetes and has to limit her sugar intake, yet in hospital, she was served with jam, jelly and similar sweet foods she could not eat. Along with this problem, she was also unfamiliar with a lot of the food given to her. June's husband and son helped her overcome these difficulties by bringing Korean food to the hospital for her.

When June was discharged from hospital she was placed on DOTS and was treated for a year. June said she felt very weak and "lacking in energy" as well as experiencing neck and shoulder pain which she attributed to TB. Due to her lethargy and pain she was unable to engage in any domestic work which was a great source of frustration to her. June's husband was working full-time and, to help her with the

housework and childcare, he brought her elderly mother over from Korea. June found her mother to be a great comfort and said it “eased my worry” knowing her home and son were being cared for. At this stage contact tracing was undergone in June’s home. Her mother, husband and son were tested and it was discovered her son had LTBI and was also placed on DOTS for six months.

Along with taking her TB medication, June also took alternative treatments for her TB and other health problems to “strengthen” and “protect” her body. After about six weeks of being on medication, June began to feel better and her mother returned to Korea. Due to June’s previous experiences with stigma surrounding her TB (Chapter Five), and health problems, she restricted all social interaction to her immediate family. As discussed in Chapter Three, she already led a lonely life and this was compounded by her TB. In early 1998, June was told she was cured of TB by a hospital clinician. Despite this reassurance, she did not believe her TB was cured (discussed below), and still continues to take TCM to protect her body from TB.

June still lives an isolated life, where her social networks are largely restricted to her husband and son in Auckland, and parents in Korea. Her experience with TB increased her social isolation. She left Korea with her family to avoid conflict with her in-laws due to her TB status. However, her fear of rejection and chronic health problems (which she attributes to TB) limit her ability to leave her home and engage in social interactions.

Meeta

As previously discussed, when Meeta began to feel ill and suspected she had TB, she hid her symptoms and delayed seeking medical attention until one of her sisters-in-law intervened and took her to an Indian GP. Her GP immediately sent her for a chest x-ray which confirmed the TB diagnosis and she was hospitalised on the same day. She spent a month in hospital and was then sent home and placed on DOTS. Meeta’s TB experience had significant impacts on her relationship with her family (Chapter Five) and employment. Meeta lost her job as a result of having to take too much time off work for hospital stays and treatment. She was in New Zealand at the time on a work visa, so loss of her job put her under further stress, as she was worried she would be deported. She

was also concerned that she was financially reliant on others through this period and her mother-in-law put pressure on her to contribute financially to the family. She tried to overcome this pressure by taking over the domestic duties of the house. In addition to these concerns, she felt lonely and isolated while she was not working, as she had made many Indian friends at her work place who spoke the same regional Indian languages as herself.

After several months of TB treatment, and intervention by Megan (her sister-in-law), Meeta was able to find another retail job. Her PHN and interpreter were also able to use their social networks to help her apply for permanent residency (discussed below), so ultimately, she would be able to migrate to Australia to join her husband.

Vishal

As described in Chapter Three, Vishal came to New Zealand with expectations of a good life in New Zealand for himself and his family but faced difficulties with employment. In February 2005, he began to feel sick and noticed swelling on his neck. He sought medical attention from a Pakeha GP and was diagnosed with the flu, given medication and told to rest. After a month, his symptoms had not improved so he went to another doctor (at an A and E clinic) who prescribed him antibiotics. Vishal completed his course of antibiotics and was still feeling ill so again changed doctors, this time to an Indian GP. His GP sent him to a local Medlab for tests and he was told that he may have TB or cancer and was sent to Auckland Hospital for further tests. In June, five months after his symptoms first appeared, Vishal was diagnosed with extra pulmonary TB.

When he was first diagnosed with TB he did not tell his family (in New Zealand and India) of his condition and distanced himself from his wife and child out of fear that they would develop the disease. Despite socially isolating himself from fear of infecting others and also that they would come to know of his health condition, he continued to regularly attend his mosque. He felt that his faith would see him through his illness and it also gave him the courage to eventually tell his wife and parents of his illness. For Vishal, the combination of difficulties seeking employment in a qualified field and TB experience made his hopes of seeking a better life in New Zealand for himself and his family an unmet reality.

Drezan

In 2005, around two years after coming to New Zealand, Drezan began to experience pain in the left hand side of his chest. Initially he thought that because he was young and healthy the pain would go away. Instead the pain increased to a point where he was unable to sleep, work or attend classes. He was taking herbal and biomedical medicine he had brought with him from China for the pain but it was not helping to relieve his symptoms so he phoned his parents in China for advice and they encouraged him to seek a doctor. However, he did not know where to find a doctor so he asked some of his Chinese friends who referred him to a local Chinese newspaper that advertised several Chinese GPs. Three weeks after first experiencing chest pain, he saw a GP.

Drezan's GP sent him for a chest x-ray and he was diagnosed with TB and hospitalised for a month. He found his hospital experience to be lonely and encountered communication problems with medical staff. When Drezan was discharged from hospital he was placed on DOTS. Not long after this, contact tracing was undertaken in his home and school. The contact tracing led to social isolation for him from some of his Chinese friends, who avoided him due to fear of contracting the disease: "Ah friends aren't the same friends anymore, like divorce". However, his educational institution was very supportive to him at this time, managing to keep his identity confidential and offered him reassurance and counselling (discussed below). As well as affecting his social network, Drezan's illness experience and time spent in hospital also impacted on his study where he failed his educational course, having to re-sit it the following semester.

Symptoms and health seeking behaviour

The TB journey begins with the onset of symptoms. People experienced a variety of symptoms but most noticeable were the differences between pulmonary and extra pulmonary TB. Those with pulmonary TB experienced chest pains, fevers, persistent coughing, shortness of breath, weight loss, lethargy, flu-like symptoms (headaches, blocked noses) and two produced blood in their sputum: "Yeah it was that initial cold. Basically it's, it's, it was kind of a reoccurring cold... Um just normal flu-like symptoms you know, blocked nose, headache, um body pain like that, um, and um shortness of breath" (Ari, Indian man in his early 20s). The symptoms described by participants are

commonly experienced by most TB patients in the UK (Bakshi and Ali 1995) and were recognised among the most common indicators of TB seen by the Auckland GPs I interviewed.

The three participants with extra pulmonary TB exhibited symptoms that were localised to areas of infection such as back pain, sore feet and swelling of lymph nodes along with fevers: “I had some bone problems... Couldn’t walk for three months properly... I had a couple of pus sores on my right foot, they were quite big” (Bhadrak, Indian man in his early 20s). The variable nature of extra pulmonary TB symptoms was also recognised by GPs who acknowledged that this often caused delays in diagnosis.

The majority of people attributed their symptoms to colds and flu. Two did not know what the causes of their symptoms were and one believed that muscle strain was responsible for her back pain. Only two people, June and Meeta, suspected that they had TB. Both of these women were familiar with TB. As mentioned, June had suffered from TB previously and Meeta had first hand experience of the disease from her rural home in India.

People engaged in a variety of health seeking behaviours when their symptoms first developed. The majority rested and took home-made, alternative or store bought medicines. All but one delayed seeking medical attention. Sachi, an Indian woman in her late 30s, was the only person who sought medical attention within one day of her symptoms occurring. Sachi was at work engaged in a task requiring heavy lifting when she experienced a “jerk in my back”. One of her work colleagues was worried that she might have strained her back and immediately drove her to her GP where she was misdiagnosed with a muscle spasm, given pain-killers and referred to a physiotherapist.

Aside from Sachi, all other participants delayed seeking healers. All GPs I spoke with in Auckland found that most of their TB patients presented to them some weeks or even months after the onset of symptoms: “Um, well, everyone’s variable of course but, um, ah. When do they usually present? Ah usually some months down the track in terms of symptoms” (Chris, Pakeha GP). Delays in TB diagnosis contribute to increased morbidity, mortality and transmission (Calder *et al.* 2000). Calder *et al.* (2000:483) identified three types of delay that influence length of time between onset of symptoms and start of TB treatment: patient, doctor and hospital. Patient delays are simply “delayed

presentation to a doctor” (Calder *et al.* 2000: 483). One problem with exploring TB patient delays is that there is no established acceptable time interval between onset of symptoms and treatment (Calder *et al.* 2000:484). Calder *et al.* (2000) found that patient delays for TB cases in Auckland did not contribute significantly to total delays (from onset of symptoms to treatment) and were shorter than those reported in overseas studies.

Patient delays of participants varied from one week to six months, with a median delay of 3.5 weeks. As discussed in Chapter Four, there are many reasons that influence health seeking behaviour. Understandings of health or health cultures are used to interpret symptoms giving them meaning and direction for treatment (Rubel and Garro 1992). Understandings of health are also influenced by age, gender and previous health experiences. For the people with TB, there were four key reasons cited for delays in seeking healers, which were not mutually exclusive and included: thinking their immune system would heal their illness, being too busy to see a healer, not knowing how to find a healer and being scared of others discovering they might have TB.

Age appeared to be a significant factor in health seeking behaviour. Five people, all young (under the age of 25), felt that they were healthy and their bodies were able to cope with their illnesses without the aid of medical intervention. Calder *et al.* (2000:483) also found patient delays for people who “hoped their symptoms would go away”:

I thought it was you know, just a common cold and usually your body after a while just gets you know? Like the way I see it is um, if your body usually fixes itself, it’s a lot better than taking medication for it, cos then that way it immunises itself, well that’s the way I think of it anyway (Bina, Indian woman in her late teens).

Being unable to take time out from a busy life schedule was another reason people delayed in seeking healers. Participants were engaged in a variety of occupations including work, study, family, religious and sports commitments. As previously outlined, June delayed seeking medical attention even when she began to cough up blood as she was too busy sorting out her new home to see her GP.

Lack of knowledge and awareness of TB has been found to be an influential factor in patient delay in the United Kingdom (Bakhshi and Ali 1995). However, both June and Meeta were aware of TB and its contagious nature (both believing that they

were suffering from TB), yet both delayed in seeking medical attention. For them, stigma and lack of time were more influential factors in their health seeking behaviour than knowledge of the serious threat of TB to their health.

Drezan also delayed seeking medical attention for three weeks after first experiencing chest pain. His experience illustrates many of the factors that impacted on his health seeking behaviour and delay in seeking a doctor. These included notions of health, unfamiliarity of New Zealand's health care system and the importance of support networks such as friends, family and local newspapers.

After varying time periods, all of the participants with whom I worked did eventually seek medical attention for their symptoms from healers. Generally the persistence of their symptoms, severity of their pain and influence of family members were key push factors that led them to seek attention from doctors. Calder *et al.* (2000) also found that type of symptoms influenced patient delays with patients experiencing coughing delaying seeking medical attention longer than those with chest pains.

Ironically, for Meeta, who was in fear of her family discovering her TB status, it was Megan, her sister-in-law, who finally took her to a local GP out of concern over her weight loss and chronic coughing: "And then when the day before we took her to the doctors I said, you know, because she didn't eat anything and she seemed to be really you know, run down sort of thing and I said 'You'd better go to the doctors, you're sick'" (Megan, Indian woman in her 50s and sister-in-law of Meeta). Parental intervention for two young Indian participants also led them to seek attention from their GPs: "Mum and Dad are like, you know, 'Just get it done [see the doctor] ASAP' sort of thing" (Bina, Indian woman in her late teens).

Diagnosis

After patients sought help from their GPs, diagnosis of TB was the next key stage of their illness. Participants all had different experiences with their TB diagnosis. For some the process was fairly quick, while others experienced misdiagnosis and long delays. Delays in the interval from first consultation with a doctor to the start of TB treatment are classified as doctor delays (Calder *et al.* 2000). There were many factors that influenced these delays including the type of TB from which patients suffered and

seeing more than one GP or doctor shopping. Due to the variations between health care systems in New Zealand and Korea, and length of lapsed time between diagnoses in New Zealand and Korea, the following discussion will only include participants with TB in New Zealand. A separate discussion of experiences in Korea will follow.

The most significant factor that influenced time to diagnosis was the type of TB suffered by the patients. All but one person with pulmonary TB were diagnosed within one day of seeing their GPs. The narratives of these people were all similar. Upon seeing their GP they were informed that they may have TB and were sent for chest x-rays on either the same day or the following day. When their diagnosis was confirmed they were then sent to hospital:

So I went to see doctor... And then he said 'Oh you know, you better get a test done, looks like, you know, TB' so I went to get, you know, a test, somewhere in Manukau I think, Manukau somewhere? Yeah, yeah, so after that, after that they said 'It's TB'(Yul, Korean man in his 20s).

Ari, an Indian man in his early 20s, was the only participant with pulmonary TB who experienced a delay in his diagnosis. Ari had been experiencing flu-like symptoms sporadically for three months. Initially, he and his family attributed his ill health to the damp conditions of their home and New Zealand's cold weather. However, when his symptoms persisted, Ari's mother took him to a local 'Kiwi' GP where he was diagnosed with the flu and given medication. During the next three month period Ari's condition had not improved so he changed GPs in July 2003 (to a local Indian GP) and was then diagnosed with asthma and given an inhaler. Despite his asthma medication, Ari's health had still not improved so he returned to his GP in January (2004) and was sent for a chest x-ray which revealed a lump in his chest and tentative diagnoses of cancer or sarcoidosis¹. Ari was then referred for a CT scan and bronchoscopy. Two days after Ari's bronchoscopy he went to India for a month's holiday and on arrival back in New Zealand in March 2004, learnt that he had been diagnosed with TB.

As with previous narratives, Ari's experience illustrates how complex health seeking behaviours and diagnosis can be. Doctor shopping or changing GPs was common

¹ Sarcoidosis is an inflammatory disease that causes small nodules of immune cells in lymphatic glands, lungs and other organs (Cape 1961).

to many participants with whom I worked (Chapter Four). Doctor shopping has been found to contribute to doctor delays as it increases consultation times and denies GPs opportunities to assess changing symptoms (Calder *et al.* 2000). As with other participants, Ari's family was also influential in his health seeking behaviours. Ari's overseas travel while infected with TB is another factor associated with delays in diagnosis. Three people with whom I worked travelled overseas with TB and in all cases, they were not aware of their TB condition. Travelling overseas was common among the transnational migrants with whom I worked. The emphasis on border control in New Zealand's health policies focusing on TB screening and surveillance does not take such frequent border crossings into account. It also highlights the need for global collaboration in TB detection, management and treatment (King 2003).

In contrast to the generally quick diagnosis of people with pulmonary TB, those with extra pulmonary TB experienced misdiagnosis and doctor delays of between three to seven months. By its nature, extra pulmonary TB is difficult to diagnose and the GPs with whom I spoke acknowledged this. Doctor delays for TB patients in Auckland are problematic; they are longer than those found overseas and contribute significantly to total delays experienced by TB patients in Auckland (Calder *et al.* 2000). However, doctor delays for extra pulmonary TB do not contribute to transmission.

Sachi, an Indian woman in her 30s, worked part-time at a local school. In November 2003, she experienced back pain at work and was taken to her local GP where she was diagnosed with back strain, given pain medication and referred to a physiotherapist. Despite the physiotherapy and pain medication, her back pain was not improving. In January 2004, she and her family returned to India to visit family where she saw an orthopaedic surgeon who sent her for an x-ray. Sachi's x-ray was 'normal', so again she was given pain medication and returned to New Zealand. By February, her pain was so severe she was confined to her bed and could not work, look after her children or perform any domestic duties: "I was on the bed. Because I couldn't move, I couldn't get up, like I can't sit, I can't like you know? Everything on the bed". At this stage Sachi changed GPs and asked her new GP to refer her to a specialist. In March, she went to see an orthopaedic surgeon and was given an MRI which revealed a TB infection. In March

2004, she was admitted to Middlemore Hospital for surgery and treatment, four months after her initial illness symptom.

People who suffered from extra pulmonary TB all experienced doctor delays, resulting in extended periods of physical and mental suffering. Due to pain and immobility from their disease, participants were unable to work, study or perform domestic duties through their illness periods: “that affected the ah working style and um more my regular life as well, um I couldn’t go to work, couldn’t study, I couldn’t concentrate on anything” (Bhadrak, Indian man in his early 20s). Along with worrying about not being able to work, study or look after their children, they also experienced frustration and anxiety associated with not knowing what was wrong with them. The two participants who experienced the longest delays blamed their initial GPs for their misdiagnosis. Both also changed their GPs: “Because the doctor, ah doctor, my old doctor like ah, I changed my files from that clinic to somewhere else and I, I changed my GP... Yes, yeah his fault” (Sachi, Indian woman in her late 30s).

Two male participants also believed that if they had been treated in India they would not have experienced the delays they did in New Zealand, due to Indian doctors’ familiarity with TB, more direct access to specialists and better quality doctors. However, neither Sachi’s GP in New Zealand or specialist in India was able to diagnose her condition. The following section of diagnosis in Korea also illustrates that delays in diagnosis also occur in countries with high TB incidence.

Diagnosis in Korea

Two women with whom I worked were diagnosed and treated for TB in Korea. Both were young (16 years old) when they were first diagnosed and their narratives and descriptions may be influenced by the long delay between their diagnosis and the time that I interviewed them.

May, is a Korean woman now in her early 30s and living in New Zealand. May’s first memory of TB in Korea is of a cough that lasted for about six months. Initially May’s mother thought she had a cold and treated her with herbal medicine. When her cough did not improve, her mother took her to see a doctor who diagnosed her with a cold and gave her antibiotics. May said that her cough did not improve but, other than her

cough she felt fine, so no further action was taken by her family. Six months after her cough began, May's family went for a yearly medical check-up which included chest x-rays and May was diagnosed with TB and put on medication.

As previously mentioned, June has experienced three episodes of TB during her lifetime, two in Korea and one in New Zealand. She first developed TB when she was at school. June remembers feeling tired and experiencing flu-like symptoms and coughing. Initially her parents gave her herbal teas and went to a TCM healer who gave her herbal medicine and put her on a special diet of 'hot' foods and protein. When her symptoms progressed and she began to cough up blood, her parents took her to hospital where she was diagnosed with TB. June was then sent to a private specialist hospital, similar to early sanatoria in New Zealand, for nine months. She was treated with streptomycin injections for the next two years:

And um, and ah my coughing is getting very severe so I went to hospital and they send me to ah, a isolated place... They gave me medication and give me an injection... Ah it's for the tuberculosis patient, it's like you know, an isolated place in front of the sea and ah, and kind of nice you know? Quite like a home. I didn't know it then but it was very expensive, very expensive place. So the poor people can't get in that um place.

Three years after June's first TB episode (and one year after her treatment finished), she applied to a local Korean university. June's university medical examination discovered that her TB had reactivated (or had not been cured from her initial infection). She had to put her education on hold and was again sent to hospital. She was put on another treatment course that lasted three years including streptomycin injections that caused her side effects:

Yes. I got streptomycin injection and I had a side effect for that so I took some medication for the side effect. I had to take medication for the side effect. I got ah itch, scratch, itchy and a ringing sound in my ear... And I continued you know, sort of taking the medication for three years.

June's recovery was monitored through regular chest x-rays and when she turned 22 (seven years after her first diagnosis), she was told she was cured from TB and able to

attend university. Sixteen years later, when June was 41 and living in New Zealand, she experienced her third TB episode.

May's and June's experiences in Korea illustrate that patient delays and doctor delays also occur in high incidence TB countries such as Korea. One of the main differences observed with their narratives compared to those with TB in New Zealand were that medical check-ups were responsible for both TB diagnoses. Korean GPs I spoke with would often make use of such check-ups. I was told by a Korean GP that the Korean military perform medical examinations on their recruits and will not accept people with TB. To overcome stigma and denial of patients, he would ask his patients "Have you been in the army" as a way of obtaining information about past TB infections. This example highlights how stigma impacts upon peoples' reluctance to reveal their TB experiences (even to health care professionals). It also demonstrates how shared understandings of culture between healers and sufferers (such as stigma and military processes in Korea) can facilitate health provision and care of patients.

Reactions to diagnosis and understandings of tuberculosis

Once participants had been diagnosed with TB they experienced a variety of reactions to their diagnosis ranging from fear of dying to relief. These reactions were influenced by health cultures surrounding TB. Most reactions to their TB diagnosis were shock over how they had contracted the disease and worry and fear because they believed TB to be a fatal disease: "I was worried too much. I was thinking like I was not [going to] survive long and 'Why I got the TB'?" (Sachi, Indian woman in her 30s). Rajeswari *et al.* (2005) found that worry was the most common response of people diagnosed with TB in India, due to social stigma, physical debilitation and fear of loss of income. Some were relieved when they were diagnosed with TB. Ari, an Indian man in his 20s, felt relief because cancer was also suspected: "At first I felt bad in a sense because doctor said 'It could be TB or cancer'. So I was worried in case it was cancer. But when I found out it was TB I was relieved".

The majority of people I interviewed and worked with (including those without TB) described TB as an infectious and fatal disease associated with the respiratory system. TB was also associated with environmental factors such as lack of fresh air, dust,

pollution, crowded accommodation, damp housing and dirty, unhygienic conditions: “Oh you can catch it from you know, dirty things as well. Like my cousin he... He said, ‘Oh you can catch it from the toilet’” (Megan, Indian woman in her 50s). As discussed in the previous chapter, TB is also strongly associated with the notion of contagion and other infectious diseases. Alex, a Chinese man in his 20s, described TB as a contagious disease “Similar to SARS”. I also found for some Indian people, TB is not differentiated from HIV infection.

There were also generational differences in understandings of TB. Older people who were able to share with me their experiences of knowing people who had died of TB were more likely to believe that if you get TB you die: “This was in India, it was quite common in the old days and when the person was suffering from the TB that means he will never recover” (Megan, Indian woman in her 50s). In contrast, younger people still believed it was a contagious disease but understood that it could be cured through medical treatment: “TB is sort of an infection... But if it is diagnosed and treated it can be cured. In the past you were told there is no cure but now we have medicines” (Vishal, Indian man in his early 20s). Younger people acknowledged these generational differences in understandings and some referred to them as ‘older ways’ of understanding TB. For example, as previously mentioned, when Ari was diagnosed with TB he was relieved as he feared it may have been cancer. In contrast, Ari’s mother felt the TB diagnosis was as bad as a cancer diagnosis due to her understanding that TB was also a fatal illness:

Anneka: So when it was diagnosed as TB what was her [Ari’s mother] reaction?

Ari: I think she was, it was, I don’t think it was any less severe from saying that ‘Oh no you know, you’ve got cancer’. You know, it’s like ‘Oh dear’ what’s you know, it’s like also with her I suppose connotations of TB are very similar to the one like of Zambia or India where there is a lot of people dying of disease.

Understandings of TB as a contagious and fatal disease associated with dirt and social stigma helps elucidate the reasons why participants experienced shock and fear when diagnosed with TB. However, having TB did influence people’s understandings of

the disease. Most participants who had TB described their illness in terms of a “germ infection” that could be cured. Unlike people who had never suffered from TB they did not mention causes such as dirt, unhygienic conditions or immoral behaviours. There may be several reasons why people with the disease view it in a biomedical sense compared to those who have never experienced the disease, who see it as a physically and socially unclean illness. TB patients are provided with biomedical information sheets, verbal descriptions and websites about TB from PHNs. These sources of information could have affected their understandings. Patients, as with medical professionals, become experts in their disease. While doctors’ skills are focused on diagnosis and prescribing medication, patients develop knowledge about coping with their disease and medication (Mol 2002). As discussed in Chapter Five, people with TB often use biomedical information and descriptions of TB transmission to counter social stigmas attached to the disease. Therefore, a combination of becoming ‘lay experts’ of TB and the need to buffer social stigmas may lead to different understandings of TB between people with TB experience and those without.

Contact tracing

Contact tracing is undertaken by hospitals and other health care facilities to identify source TB cases, infected contacts who require TB treatment, and uninfected people who may benefit from BCG vaccinations to minimise morbidity and transmission of TB (Ministry of Health 2003). As soon as an individual’s TB diagnosis is established, PHNs (under the guidance of medical officers) will investigate their close contacts, beginning with household members and, depending on conditions of exposure (such as duration, over crowding and ventilation), also their work, school and social environments. Contacts are initially accessed for TB symptoms and, if likely to have been infected, are then given Mantoux tests and, if appropriate, chest x-rays. Contact tracing was carried out for six of the people in the study with pulmonary TB. Only one contact was identified with LTBI. Contact tracing was not done for four participants, three of these had extra pulmonary TB (where infection cannot be spread from one person to another) and one of them was diagnosed in Korea, where she and her family had

undergone chest x-rays as part of a medical examination. She was the only family member with TB.

Contact tracing was a traumatic experience for some people, who said they felt “worry” and “guilt” that others would discover their TB status, or that they may have infected family members with the disease:

You know all my family members didn't know [I had TB], so I said, 'Ok'. I mean, I didn't, probably I asked them [doctors] you know, you know, 'Is it ok to be living with them, you know, my family'? They said 'It's ok' so yeah, they did, they did [the tests], no one else had it (Yul, Korean man in his late 20s).

Contact tracing not only affected participants but also their family members. Ari's family was tested for TB and his sister was identified as a suspected case. She was referred to hospital for a chest x-ray but fear that she may have had the disease delayed her from having an x-ray and created a lot of anxiety for her:

She was afraid to go for an x-ray; I think she only got the x-ray done a few weeks back. So for her it was a lot harder I think. It's like every so often I'd tell her 'Hey have you had the x-ray' and she's like 'No I haven't had time' . . . And she wouldn't listen to, kept putting it off (Ari, Indian man in his 20s).

When Meeta's family were tested for TB they found the experience to be difficult: “At that time they [the immediate family] realised what happened and when they [doctors] say it is not infectious, not infectious for them now, then their reactions were with difficulty, they worry they will be infected too”. As discussed in Chapter Four, one of Meeta's sisters in-law, Megan, who has lived in New Zealand for most of her life, was very supportive of her during this period. In contrast, her other sister in-law, Shanti, distanced herself and her children from Meeta. Unlike Megan, Shanti lived in India for most of her life and the different reactions between the two could be due to variations in understandings of TB in India and New Zealand.

Drezan, was the only person who experienced minimal difficulties with contact tracing. Unlike other participants where contact tracing was confined to their homes, for him, contact tracing was undertaken in both his home and educational institution. The

attitude of the staff at Drezan's school was a key factor in his experience. Drezan said the school helped keep his identity confidential and offered him ongoing support during the process as well as support to other students: "Yeah um they did a good job with the process... [the school was] Um quite supportive because ah they also think [of] other people and their health, yeah. So they quite support to the students". Contact tracing, by its very nature creates a shared experience for all people closely associated with TB patients. Like those with TB, family members experienced reactions of worry and fear. Contact tracing also directly influenced peoples' family interactions, with some like Meeta prevented from having contact with her nieces and nephews. For others, like Drezan, social support and understanding from those involved in the process lessened worry and fear of TB patients. These experiences illustrate that TB influences and affects wider social spheres other than the infected individuals' and cannot be understood solely from an individual perspective.

Tuberculosis treatment

Treatment for TB is a long process usually taking between six to 12 months and involving multiple drugs (Ministry of Health 2003, Sumartojo 1993). During or shortly after hospitalisation (discussed below), TB patients are assessed by medical staff to determine whether they will be placed on DOTS or Self Administered Treatment (SAT). Treatment assessment is based on patient compliance (inability or unwillingness to self administer treatment), type of TB (drug resistant, relapsed/reactivated) and social environments, as illustrated by Sarah, a PHN:

Anneka: And so that's [medication regime] decided between the both of you [medical hospital staff and PHNs]?

Sarah: And also the hospital staff, [they] will say this person's completely disinterested, um, that they've become more trusting you know? And we'll also make a home visit and see whether or not [there is] a home supporter, if it's chaotic, um, what their attitudes are sometimes um and sort of the decision is made with a lot of information really.

SAT involves patients self administering treatment (usually on a daily basis) without the presence of a health care professional. However, SAT is also overseen and

monitored by health care professionals, usually by regular visits from PHNs. The DOTS procedure involves a trained supervisor (usually a PHN) who watches patients swallowing medication for all doses during their course of treatment, ensuring adherence (Ministry of Health 2003). DOTS can be daily or intermittent (usually given two or three times a week). DOTS was implemented by the WHO in response to globally increasing TB rates with an aim to reduce TB globally through committed, standardised care and close monitoring of treatment (WHO 1999).

Research on successful treatment of TB in a global context has illustrated the complexity of factors involved, including behavioural, historical, social and biological (Gandy and Zumla 2002b). Much of this research has focused on individuals in relation to ‘compliance’ of patients but there has also been a recent interest on the role of DOTS health care providers (Gandy and Zumla 2002a, 2002b, Jaiswal *et al.* 2003, Porter and Ogden 2002, Searle *et al.* 2007). Although all DOTS programmes are based on WHO’s strategy, internationally there are variations in programmes in relation to access, delivery, and health care providers (Sumartojo 1993) so caution must be used when comparing international research on DOTS. In Auckland, DOTS venues and times are negotiated between PHNs and patients. They can take place at Greenlane Hospital², and patients’ homes, work places, schools or other places of choice. The flexibility of DOTS seen in New Zealand is not universal. For example, in India, DOTS is only delivered in DOTS centres and chest clinics during working hours and it has been argued by Jaiswal *et al.* (2003) that the inflexibility of the programme affects patient adherence due to having to take time off work and encountering travel difficulties.

Discipline and surveillance

As demonstrated by Craddock (2001:339): “Disease and responses to it are always necessarily political”. Health systems employ various forms of knowledge and control through social and political dispositions. One of the key characteristics of TB treatment, whether SAT or DOTS, is monitoring and surveillance of patients to ensure adherence. This practice can be seen as a form of discipline which, according to Foucault,

² The Communicable Disease Clinic was located in Newmarket, central Auckland until 2003/2004 when it was moved to Greenlane Hospital, south central Auckland.

(1979:136) is a technique of power or social control that coerces bodies, people and populations to be “docile” through hierarchical observation, normalising judgment and examination. For Foucault, hierarchical observation or functional surveillance such as PHNs watching patients swallow their medication is a visible form of power, where rendering people visible makes “it possible to know them and alter them” (Smart 1985:86). Normalising judgment is another form of disciplinary power which operates on penalties or punishments for non-conformity. As previously discussed, TB patients are evaluated or judged on characteristics that will affect their compliance to treatment. If patients on SAT are found to be non-compliant, they are placed on DOTS, where monitoring of compliance continues. If patients on intermittent DOTS miss more than one dose a month, or more than one dose a week for those on daily DOTS, they will be reported to a medical officer of health (Ministry of Health 2003), although, this section is seldom invoked (Medical officer of health *pers com* 2006). The medical officer of health will then meet with them and attempt to resolve difficulties with adherence. However, if these measures do not work, then they can be legally detained for three months under Section 16 of the Tuberculosis Act 1948 (Ministry of Health 2003). Foucault (1979) acknowledges that discipline also operates by gratification through rewards and privileges for conformity. In New Zealand, DOTS programmes provide incentives to patients to improve adherence (Ministry of Health 2003). These include financial and practical incentives such as tokens for food and transport. The third instrument of discipline is examination which combines hierarchical observation and normalising judgment where individuals are classified and judged through written documents and organised into registers and systems rendering each individual as a ‘case’ (Dreyfus and Rabinow 1982, Smart 1985). Compulsory notification of all forms of TB was introduced to New Zealand in 1940 (Ministry of Health 2003). Along with notification to medical officers of health, patient notes of TB patients are also kept by Hospitals, GPs and PHNs. For Foucault (1979:190), examination of people represents a growth of power enabling authorities more knowledge and accumulation of systemic ordering through “the measurement of overall phenomena, the description of groups, the characterization of collective facts, the calculation of gaps between individuals, [and] their distribution in a given population”.

National levels of TB treatment can be understood through Foucault's concept of discipline, where social control is used to encourage, if not legally enforce adherence to treatment. However, the following discussions focusing on individual experience of TB treatment from patients demonstrates that, for them, the care and support of their PHNs along with the flexibility of DOTS affected their treatment process more than observation, surveillance and perceived punishment.

Barriers and facilitators of treatment

All but two of the people I worked with were on DOTS. Of the two on SAT, one was treated in Korea and the other chose to self-administer his treatment. One other participant began her treatment on SAT but, due to factors that will be elaborated on below, was placed on DOTS after six months. Along with prescribed TB medication, two other people also took alternative medicine to relieve their pain and TB symptoms. Sachi, an Indian woman in her 30s, made herbal medicine for her back pain and June sought treatment from a TCM healer. June's healer put her on a diet of 'hot' foods, gave her herbal medicine and moxibustion³. As discussed in Chapter Four, use of alternative medicine was common among the people with whom I worked and often taken along with biomedical treatment.

All participants experienced difficulties with their medication, the most common problem related to having to swallow a large number of pills at one sitting: "But it is 20 tablets in one go. Oh, oh it was ah yuck" (Ari, Indian man in his 20s). Another problem they encountered was having to work their lives around treatment schedules. Practical difficulties with fitting treatment programmes into everyday lives has also been identified as a problem with DOTS in India (Jaiswal *et al.* 2003), although DOTS treatment in India is less flexible in relation to access and timing than that of DOTS in New Zealand.

All the people with whom I worked on DOTS took medication twice weekly. DOTS should be given with food to avoid side effects but this does vary with different types of medication⁴. Most people had to eat before taking medication (although Bina had

³ Moxibustion is a heat therapy using mugwort (*Artemisia vulgaris*) which is rolled into sticks or cones and burned. Moxibustion is often used with acupuncture.

⁴ Rifinah and pyridoxine are best absorbed on an empty stomach, while pyrazinamide and ethambutol are most effective after food (PHN *pers com* 2007).

to eat after her medication while she was on SAT). Three people found having to accommodate their eating schedules around DOTS difficult: “I have to eat with food the medication so I need to eat, cook the food before they [PHN] gets there. I have to take the medication, so whatever food is in the home it [I] just take it, sometimes without cooking” (Meeta, Indian woman in her 30s).

Two people discussed how their treatment impacted on their studies and working schedule. They found it difficult working their two treatment days into their weekly schedules. However, not all participants found fitting treatment into their routines difficult. Four found the flexibility of DOTS helpful for taking their medication. If patients find it difficult to go to Greenlane hospital to take their medication, PHNs will go to their place of work, study or home to give them their medication. These people found that having PHNs coming to them for treatment was easier than having to travel for prescriptions and treatment at clinics, or remembering to take medication:

I actually think that is absolutely amazing the way that they actually come out and give you the medications. I think that was probably the biggest thing that um, I was like ‘Oh ok ah, you mean I don’t have to come in and go out of my way to actually get the medications’. They make it as easy as possible for you. It’s like ‘If you have a problem then ok fine give us a call let us know, let us know’. And you know ‘You can either come in here [Greenlane Hospital] or we will come and give you the medications, which ever’s easy for you’ and its like ‘Ok’ [laughs]. That’s like amazing (Ari, Indian man in his 20s).

There were also notable differences in problems encountered between older and younger participants. Three young people found that not being able to drink alcohol while taking their medication had a major impact on their lives, and one continued to drink alcohol while on medication:

The other thing is with um, with this [medication] you can’t actually go out you know, drinking or anything like that because you know, you’re on this medication and it takes a lot out of you. That’s been one negative thing about it. So um, especially um, when it’s like friend’s birthdays and things like that and you know, just going out generally, like everybody’s drinking. It’s like mmm there’s me in the corner [laughs] ‘I’ll have a coke thanks’ [laughs]. So that’s, in terms of social things that’s a bit of a down side (Ari Indian man in his 20s).

Taking large amounts of medication while patients felt healthy was another issue that arose from discussions with participants. John, is a Korean man now in his late teens, who was diagnosed with LTBI through contact tracing when he was only nine years old. John does not remember much of the process but does recall being confused about why he had to take so many pills when he did not feel sick.

Along with problems associated with treatment, there were many factors that helped facilitate the process for people, and most of these were associated with their PHNs and the DOTS programme. Bina, an Indian girl in her late teens, began her TB treatment on SAT. For the first two weeks she coped with taking her medication daily, but after this it became difficult for her to fit it in with eating and studying so she began to miss her medication. After six months of being on treatment, and missing many days worth of tablets, she was advised by her PHN to go on DOTS. She found DOTS “easier” than SAT, particularly because as she was taking the medication less often (twice a week rather than daily):

So, I mean if I want to go back then I'd definitely go straight on DOTS if I ever got it [TB] again kind of thing. Yeah, and it's a lot easier like to remember. Cos, like every morning, you know, you don't have different things that come up and if you miss in the morning right sometimes it'll be like 'Ok I'll take it in the afternoon'. But it's um, with this it was you have to take it half an hour before you eat and things like that and it kinda got a bit hard. Like cos usually, um, like if I was to go to Uni and stuff I'd wake up if I have it, it would be like having tablets and then breakfast but then I'd have to wake up earlier to have them and you know, it was just, yeah [releases an irritated sigh] Ugh. Miss out on an extra hours sleep or half an hour of sleep. Cos if I miss it and I was to have it at lunch, I have to have it before, like in between classes and then go for lunch after it, there's, yeah, it was a lot harder.

People liked the fact that with DOTS they took tablets less often, only twice a week, compared to daily doses. Vishal was the only participant whom I worked with (who had TB in New Zealand) who was not on DOTS. There were two reasons Vishal did not want to be on DOTS. Firstly, he did not want his neighbours or friends to discover his TB status and, secondly, he felt he was disciplined enough to remember to take his medication regularly. Vishal felt that his regular daily routine aided his medication schedule.

Interviews with, and observations of PHNs revealed that they are aware of many of the barriers their patients faced concerning TB treatment. The three PHNs I worked with would try and collaborate with their patients when organising their treatment schedules, finding times and venues that they could both accommodate. The PHNs were also aware of difficulties patients faced with taking large quantities of tablets at a time and would use various ‘tricks of the trade’ to help this process such as bringing drinking fluids, food and even incentives for patients:

I think that we, in the service, go to great lengths to make taking the medicine easy. We’ve got a young girl at the moment who’s on daily DOTS and she finds swallowing the large tablets really difficult, and the only thing that she will take them with is raspberryade, which is kind of, and she drinks like a bottle, a big bottle of raspberryade each time... Um with children, we try to give them stickers and calendars and to encourage them to remember and to you know, take their medicine. And often um, we have got a system where you can um have a contract with someone where they um, if they’ve been for two DOTS days, they might be given a voucher, a Warehouse voucher, something that they want. .. It’s kind of like a, it is bribery but it’s something to just make it easier to um, to give them some sort of an incentive (Sarah, Pakeha PHN).

The TB treatment process involved challenges for both patients and health care providers illustrating that taking an individualistic approach to reviewing DOTS will not address many important aspects of the process, particularly relationships between sufferers and healers. Having to swallow large numbers of tablets in one sitting and adjusting treatment around life schedules were the two key barriers people faced. Factors that helped facilitate the treatment process were the flexibility of DOTS and the role of PHNs. As PHNs played a central role in participants’ lives, the next section will examine how they influenced the TB experience of participants.

Public Health Nurses

Kleinman (1988:5) has demonstrated that understanding perspectives of, and relationships between both healers and sufferers allows broader understandings of illness experiences: “expectations about illness are altered through negotiations in different social situations and, in particular, webs of relationships”. This discussion will examine

the relationship between TB participants and their PHNs. PHNs became central figures in the lives of the people with whom I worked. Participants first encountered PHNs during their hospital stays and they then became regular and constant contacts throughout their time of treatment. For people on DOTS, PHNs would usually meet with them twice a week. These interactions would usually involve an initial greeting and brief discussion on how the patients were feeling and if they were experiencing any difficulties either with their medication or in general. From my observations of DOTS these conversations were friendly encounters, where patients would take time out to chat with their PHNs about their families, work, study and similar topics. Once PHNs had ‘caught up’ with their patients they would then administer the treatment where they would give the patient a specific number of pills and make sure they had a drink to take them with. The time it took to take medication was variable; during my observations it was a fairly quick process lasting perhaps two to five minutes. However, PHNs informed me that some patients take up to half an hour to swallow all their pills. After the medication had been taken, the PHNs would then ask patients if they had any questions and organise their next DOTS meeting or any other TB appointments.

All of the participants with whom I worked spoke positively about their PHNs describing them in terms such as: “good, welcoming, nice, friendly, genuine, caring, great, helpful, kind” and “fantastic”. There were two roles people perceived their PHNs as key to, that of an overseer of their treatment, and as a key support person. Most Korean participants (and one Indian man) saw their nurses’ role primarily as overseers of their treatment. They would explain that the nurses came to make sure they took their medicine, counted their pills, assessed their health and reminded them of future appointments. These people used terms such as; “job, work” and “duty” when describing their PHNs relationship to them: “And they [PHN], they just counted you know, the date and they checked if I took it [medicine] or not... Ah she was very kind and you know, she was very good at her duty and you know, all that” (June, Korean woman in her 50s). One factor that may have influenced Korean participants’ perceptions of their PHNs was the long delay between their TB treatment and interviews with me. These delays were between three to nine years. During this time people had no contact with their PHNs and this lack of contact may have changed their perceptions. Along with Korean people,

Vishal also viewed his PHN as “doing a good job”. Vishal is on SAT and only sees his PHN twice a month which may also influence his opinion of her.

In contrast to PHNs seen as ‘overseers of treatment’, most Indian people and a Chinese man described their PHNs as key support people. PHNs were not only seen as people who provided and monitored their TB treatment but also as people who offered advice and guidance in other aspects of their life such as helping them with immigration and work related problems. These people used adjectives such as “friendly, helpful” and “best friends” when discussing their PHNs and would often refer to them by their Christian names. All of these people were being treated for TB at the time I worked with them. As previously discussed, Meeta was unable to work and was worried about her work visa. She expressed these concerns to her PHN who helped her resolve the problem. When Meeta was well enough to work again, she found a job in a fast food restaurant where she was in and out of freezers and chillers all day. She found it difficult to cope with the cold and her work uniform regulations did not allow her to wear warm clothing while working. Sarah, her PHN, wrote a note to her employers informing them that due to Meeta’s health condition (TB was not mentioned), she needed to wear warm clothing. As a result Meeta’s employers allowed her to wear a cardigan at work.

People would also consult their PHNs about other illness problems. Drezan developed a cold during his TB treatment and told Janette, his PHN, who advised him to go to his local GP and also brought him medication to help with his cold: “Yeah she [PHN] talk and things, when I got cold she supply my medicine for me”.

Support and advice from PHNs were found helpful by participants. As previously mentioned, there are many different understandings surrounding TB and its transmission. PHNs would verbally provide patients with a biomedical explanation of TB and supplied them with information sheets and pamphlets. People would often use these sources of information to counter stigma associated with TB and felt them helpful to understand why they were sick:

The Public Health Nurses, they are great, quite nice and um they helped me A LOT, um to boost up my energy and um, saving my life actually. Yes, yes they helped me to understand that what is TB. I didn’t know details about the TB, um but they helped ah to know what is TB and what

are the reasons to get the TB, how can it be cured um, they helped me with my medication and I'm still with them. Um they are quite friendly and fantastic ladies. Yes, yes and they have saved my life, that's what I can say (Bhadrak, Indian man in his 20s).

PHNs would also help people get to their clinic appointments at Greenlane Hospital by providing them with petrol vouchers or accompanying them to appointments: "Yeah, well Janette [PHN] comes with me [to clinic appointments] so it feels a lot better than just going in by myself, you know? So no, I like the idea of her being there. Yeah, well she does, so she comes along to ah, um, my appointments with me every month" (Bina, Indian girl in her late teens).

Participant observation of interactions between PHNs and patients made me aware of the impact of environment on relationships. When PHNs came to people's homes they would greet their patients and any other household members present. This social context is vastly different from hospital environments where patients would attend clinic appointments. During treatment sessions PHNs would also ask participants if they had any questions for them. Often questions asked did not directly relate to patients' health, or would come from other family members. During these interactions, PHNs were always friendly and accommodating although it has to be acknowledged that my presence during these appointments would have influenced these social interactions to some extent.

Working with both health care professionals and TB participants could have biased my interpretations of PHN favourably, yet narratives from participants supported the importance of PHNs for people suffering from TB. This interpretation is further supported by Searle's (2004, 2007) research, which also found a positive relationship between Pakeha TB sufferers in Auckland and their PHNs. For participants, PHNs' roles outside of providing TB treatment, such as help with employment, other health issues and attendance at clinic appointments were key support elements of their illness experiences. Searle *et al.* (2007) also found that models of care based on alliances between patients and PHNs facilitated treatment compliance by TB patients.

The importance of caring functions of nurses is a key feature of Malone's (2003) research on nursing. She stated that "Nurses are healers whose activities involve both curing and caring functions, although it is not always easy to separate the two because to

care often *is to cure*” (2003:2317). Her emphasis on the importance of proximity of care was discussed in the context of GPs from home countries in Chapter Four. Moral proximity of care between PHNs and TB patients was also an important aspect of treatment. PHNs acted on behalf of their patients in several social and economic contexts aiding them emotionally as well as financially which positively influenced their overall well being and treatment process. This care relationship also illustrates how PHNs become important sources of social capital for patients in the field of health (and other fields such as employment). PHNs use their resources and networks to increase economic, cultural and bodily capital of their patients. This aspect of care is particularly important for Indian, Korean and Chinese migrant TB patients in Auckland, who often face difficulties with employment, language and isolation compounding their experiences of illnesses such as TB.

Hospital experiences

For patients with active TB in New Zealand, hospitals become a familiar place. Initially patients with active TB are hospitalised (until their treatment renders their TB no longer contagious). Two people with extra pulmonary TB with whom I worked were also hospitalised for surgery. After discharge, they return as out-patients at regular times for check-up appointments with clinicians. Length of hospital stays and frequency of clinic appointments varied depending on the type of TB, and the stage of TB treatment. TB patients I worked with were hospitalised initially between two to four weeks. Overall, they described the doctors and nurses in their TB wards as “good” but experienced many difficulties during their hospital stays.

Three people did not speak English fluently and found language barriers to be an issue in hospital. Meeta (a Gujarati and Hindi speaker) was provided with a Hindi interpreter when she was first admitted to hospital and when she was discharged but, for most of her stay (she was in hospital for four weeks), she was without an interpreter and could not understand what was happening to her. Meeta had to rely on her family members to inform her of her medical situation when they visited her in hospital. June (a Korean speaker) was not provided with an interpreter and also had trouble understanding what was happening around her. Like Meeta, she relied on her husband and son as

intermediary translators between herself and the medical staff. Drezan, a Mandarin speaker, was also not provided with an interpreter and had trouble understanding medical terminology. One of Drezan's ward nurses could speak Mandarin and acted as an interpreter for him:

Anneka: Ok and have you had any language problems [while in hospital]?

Drezan: Probably because at least the language is a problem. Ok just with the medical knowledge not clear, yeah. Ah in the hospital there's a nurse, one nurse, she can speak ah Mandarin yes she can be the interpreter for me. Yes, for the important ah things and ah she come to interpret for me.

Being diagnosed and hospitalised was a traumatic experience for many people and this fear and confusion was confounded for three participants because of language barriers. When viewing hospitals as a field of health, it is clear that language is a form of cultural capital that is not recognised or valued by Western hospital staff. Although formal and informal interpreters were used by patients, there were periods of time where they were unable to communicate their needs or understand those around them and this acted as a barrier to their treatment and created potential for miscommunication and misunderstanding associated with their illness and treatment.

Along with language barriers, hospital food, boredom and feelings of isolation were additional problems people encountered with their hospital stays (refer to Chapter Four for discussion of unfamiliarity of New Zealand food in hospitals). Participants' described their TB ward as "isolated" where people would "wear masks" when they entered their rooms. Patients with active TB are hospitalised in individual low pressure rooms (to minimise spread of infection) and visitors and medical staff must wear masks when in the room (Searle 2004). The hospital environment and time away from work, education, family and friends led to boredom and feelings of being "lost" for people: "Um it was very boring because of the friends, they all have class they, they go to school and for me, it was long [stay in hospital] so I didn't see them" (Drezan, Chinese man in his late teens). Feelings of isolation, boredom and loneliness were more common for people who had no family in New Zealand such as students; PHNs often became central support people for such patients during their hospital stays.

After discharge from hospital, participants would have to come back as out-patients for regular check-ups, usually at intervals of between one to three months. Generally, clinic appointments were found to be problematic for the majority of the people with whom I worked, particularly in relation to language barriers, waiting times, not having their questions answered or explained and strained doctor-patient relationships.

Language difficulties have been highlighted as a key barrier throughout illness experiences for migrants in this research, which includes clinic appointments in hospitals. Although free interpreter services are available for non-English speaking patients in Auckland hospitals, I found many Indian, Korean and Chinese migrants were unaware of these services. Waiting times and interpreter-hospital procedures can also hinder these services. Interpreters work on an hourly basis, and may have several bookings for one day. If a patient's appointment is delayed, this may mean that they lose clinic time with their interpreter or are unable to have an interpreter. Miscommunication between hospitals and interpreting services can also impact directly on patients, when more than one interpreter is booked, or no interpreters are booked as illustrated by a quote from Madhu, an Indian interpreter:

One system is not very good as another one... [Auckland hospital] their system is so much used to over working, is so much less funded for and everything at the same time and so everything not efficient. Like having a separate call centre, there is lots of confusion going on because two or three call centre people are there, they are getting greatest bookings, so for one patient you know, had an appointment on a Monday morning there were three interpreters. So you will get sent home, not going to get the job, not getting paid. Yes, I mean um, when the call centre or the booking schedule, they're not able to find whether an interpreter is available or not, they just guess, they don't tell family coming with the patient to do a translating job, and that makes patient and family so insecure, patient and family don't turn up for appointment. So in that case, they are losing too much amount [of patients]. I explained to my manager, I said 'You think in a day if there are ten patients didn't turn up seeing an appointment, then wasting their time, clinic time, doctor time, everything by not getting that patient seen'.

Despite problems between hospitals and interpreting services, interpreters played important roles in peoples' TB experiences acting as cultural interpreters and as support

people for patients. As discussed in Chapter Four, interpreters would not only translate verbally between patients and health care professionals but would additionally translate ‘medical languages’ in relation to understandings of the body and health. In addition to these roles, interpreters also provided assistance and support to their clients in contexts outside of their paid roles. For example, Madhu had interpreted many times for Meeta during early DOTS sessions with her PHN, during my first two interviews with her and for a clinic appointment. Madhu was aware of Meeta’s social isolation and problems with immigration. She offered to speak to a friend of hers who was an immigration consultant to help Meeta gain residency in New Zealand. In addition, she accompanied Meeta to a clinic appointment (free-of-charge) not only as an interpreter but also as her support person. Joy, a Korean interpreter, told me she had been working with a young man with various health problems and discovered he had to go to court over a legal dispute. Although the young man was appointed a Korean translator in court, Joy came with him to further aid him with any language difficulties and for moral support. Working with interpreters made me realise how important their roles are for Indian, Korean and Chinese migrants in New Zealand’s health care sector. Although they are an important source of social capital for immigrants they do not have the same form of symbolic capital within fields of health as healers. Their roles as interpreters and cultural translators are not as visible or acknowledged as those of PHNs, doctors and other medical professionals for migrant health. However, when possible, I would book the same interpreter for all TB interviews with individuals (and try to book the same interpreter as PHNs had). This method of continuity allowed participants to become familiar with interpreters and may have been a contributing factor in the support relationships between them and TB patients.

Making time for appointments and waiting times were barriers patients faced during their TB treatment. On average, participants attended four clinic check-ups during their TB treatment. These appointments were made by the hospitals during working hours meaning people had to take time off work or study to attend them. Negotiating time away from daily occupations was often influenced by participant’s employers and educational institutions and, as will be discussed later, time away from occupations often had significant impacts on their lives: “Um it was also, it was um possibly a bit difficult

[to get time off work], I have a really understanding manager. So it's easy to actually get the time off to actually, to actually say 'Oh yeah I've got a test' and stuff like that. I mean occasionally it became kind of a joke [laughs], 'Ok you're going for ANOTHER doctor's appointment' [laughs]" (Ari, Indian man in his 20s).

People also encountered long waiting times for their appointments with some waiting up to two hours to be seen by clinicians. Ari, an Indian man in his 20s, likened hospital clinic appointments to production lines: "Oh yeah you have to go to the hospital, you have to sit there, you have to wait. Yeah, it's like time, time delays and things like that, which is understandable because health care you really can't have like yes, no and stuff. You're like a production line".

While most patients attended Greenlane Clinical Centre, some with extra pulmonary TB attended specialist services at other Auckland hospitals. Relationships between clinicians and patients were very different to those of their GPs and PHNs. Clinicians were described by people as "strict, rude, not nice, busy" and "tired". Only one person with whom I worked spoke positively of his experience with clinic appointments. Vishal told me the clinic physician was "good and informative", providing him with several websites about TB. Aside from Vishal, people found that clinicians rushed them through appointments, were "rude" to them, and did not answer questions they had or explain what was happening to them. This was a source of worry and frustration to participants. Sachi had already had surgery on her back during her TB treatment. She was told by one of the clinicians that she may need further surgery which was of great concern to her. At her next clinic appointment, Sachi asked the doctor what was happening but did not receive a clear answer, leaving her "still hanging" and anxious that she will lose more time off work with another surgery. These findings are similar to those of Searle *et al.* (2007:74) who found that Pakeha TB patients were not given opportunities to ask questions in TB clinic appointments due to short consultation times, unfamiliarity between patients and doctors and lack of preparatory time for clinicians.

I found it surprising that most of the participants did not have positive experiences with their clinicians, yet did not blame the doctors for their actions. They attributed busy workloads as the source of their clinicians' behaviours and some even expressed sympathy for the clinicians: "I know that they [are] busy and they are tired, they are sick

of overload, too many patients coming around, so they are not nice, not nice. But it's ok, I can, I can truly understand" (Yul, Korean man in his 20s).

Peoples' perceptions of clinic appointments may have been influenced by a number of factors such as the busy hospital environment and seeing multiple doctors: "But after discharge at clinic when I went back to hospital, was very busy, lots of people ah patients and doctors, the doctors change all [the] time" (Yul, Korean man in his 20s). Participants often saw different clinicians for every hospital appointment, most people saw four different clinicians so were unable to build up any form of relationship with their hospital physicians. Unlike GPs and PHNs, who were often referred to by their names, clinic doctors were described as "Asian lady doctor", "man doctor" and "hospital doctor". Mol (2002) explored differences between various health care professionals and patients in a Dutch hospital through various enactments of the disease atherosclerosis. For example, she found for patients atherosclerosis was a disease that prevented them from walking or visiting relatives, for lab technicians it was a graph produced from a duplex test, while for surgeons it was arteries that contained plaque. Mol's framework of enactment creating multiplicity of disease is useful when viewing relationships between TB patients and hospital clinicians. For TB patients, TB was an illness that prevented them from working, studying and restricted their social lives. In contrast, Searle *et al.* (2007:74) found hospital clinicians enacted TB through chest x-rays, laboratory results and technical aspects of chemotherapy. Therefore, busy hospital environments, lack of continuity and different enactments of TB may be responsible for the difficulties TB patients experienced with their clinic appointments.

Peoples' experiences with hospitals and clinic appointments highlighted many barriers they encountered, particularly in relation to language and problems with interpreting services. Hospital environments invoked feelings of fear, isolation and boredom for participants. As many of the people with whom I worked were transnational migrants and lacked local support networks, these feelings of isolation may have been compounded.

Impacts of tuberculosis

Thus far, this chapter has explored the TB journey of ten people from symptoms to treatment. Before discussing the final stages of this journey (cure and life after TB), I wish to examine the broad impacts that TB had on peoples' lives, these experiences are so significant, they continue to influence people after they have been cured. Impacts of TB on patients are often all-encompassing, affecting their physical health, social, economic and psychological well being (Rajeswari *et al.* 2005). Therefore, TB can be seen not just to reduce bodily capital of immigrants in Auckland, but also their economic, cultural and social forms of capital. This section will not include the effects of stigma on participant's lives as it has been extensively discussed in Chapter Five.

One of the most obvious impacts of TB is the physical pain it causes sufferers. Although symptoms and pain of the disease were variable, for some the pain experienced was so severe it led to immobility and disabilities where people were no longer able to walk, sit or leave their bed. Meinert (2004) found that low bodily capital of HIV-positive people in Uganda negatively transformed their economic and social forms of capital. I also found that TB led to reduction in bodily, economic, cultural and social capital. The pain and lethargy caused by TB prevented participants from being able to concentrate for long periods, impacting on their ability to study, work and socialise. Once patients were diagnosed and began treatment, TB continued to influence their lives. Length of time spent in hospital, taking medication, attending clinic appointments and factors relating to taking medication such as eating routines and not being able to drink alcohol also influenced many aspects of daily lives.

Almost every facet of peoples' lives were affected by their illness including their occupations as paid workers, housewives and students, their social lives and relationships with family members. Six people studied either full-time or part time during their illness and many found it difficult to attend classes and complete their study because of their pain, lethargy and treatment schedules. As previously mentioned, Drezan failed his course as a result of his illness and had to repeat it, costing him time and expenses: "Ok it affected my study, I can't, for long time I can't go to school. Yeah because the pain and also um, because I need to see the doctors so can't go back to school. I failed the exam".

As Meeta's narrative illustrated, TB also impacted on paid employment of participants, which in turn, affected their financial well being or economic capital. In contrast to Meeta (who lost her job), Sachi had an understanding employer who told her she could take a year off work (unpaid) until she recovered from her illness. She was relieved but loss of her income through this time period put her family under financial pressure.

Inability to socialise with others due to pain, lethargy and treatment was also a problem experienced by participants, particularly for young people:

Your whole life's changing you know, it's kinda like it's not like your whole life's changing but aspects of my life were changing. Um such as taking the medication, um, I wasn't able to go out or do things with my friends; I kinda stayed home like cos I was too sick to go out. Like all my friends were like um, out and about and partying and stuff and I kinda got stuck at home (Bina, Indian woman her late teens).

People with TB in India also reported similar constraints on social life (Rajeswari *et al.* 2005). As with employment, social isolation for Indian, Korean and Chinese migrants in New Zealand has already been identified as a key settlement barrier due to discrimination, cultural and language issues (Chapter Three) and TB further compounds these problems, particularly for migrants without close family networks in New Zealand.

Along with socialising among broader networks, TB also influenced relationships within families and has gender specific effects. In many Indian, Korean and Chinese communities there are clear gendered divisions of labour where women engage in domestic duties such as cooking, cleaning, childcare and washing (Rajeswari *et al.* 1999, Rajeswari *et al.* 2005):

And you know in Indian community, ah it is quite common that wife is doing all the housework and men doing, go, go earn money, go back home and wife will make the dinner for the husband and he will eat and such, therefore things happen in ah, Indian communities, it's quite common (Sachi, Indian woman in her 30s).

Physical pain, treatment and cultural restrictions experienced by women with TB affected their ability to perform domestic activities and engage in social networks. Rajeswari *et al.*

(2005:8) found that TB affected the ability to perform day-to-day domestic activities for 50 percent of the women in their study. This was also evident for many of the Korean and Indian women in my research.

The impact of TB on domestic work is made even more difficult for Asian migrants in New Zealand due to their isolation from friends and family. For Sachi, her back pain and immobility was so severe that she was confined to her bed, unable to work, look after her children or perform any domestic duties. She explained to me that, if she had been in India, the effects of the disease would not have been as bad because she had a maid who would have taken over domestic chores and her mother and sisters-in-law would have taken over the running of the house and child care. However, as she was isolated from such support networks, it was her husband who became her sole support person and took over the household duties:

It is strenuous for everybody like my husband, my kids because my situation was, my husband is doing the shift works, kids go to the school like you know? I was in the bed; my husband did EVERYTHING which I NEVER expected [said with a big smile]. Oh yeah and it is ah, like, really ah, I appreciate that. I, I was [laughs] like you know? I was, I never think that he can do that or yeah, but I know that he yes, he can do this now, so yeah, he changed quite a lot after my disease yeah.

It was difficult for me to gauge the effects of TB on men within a family context as most of the male participants in the study were young and not married. For the young men TB impacted on their ability to study and work. It can be generalised that for older married men, TB can have significant impacts on their ability to work and influences their roles as household providers, as demonstrated by research in Vietnam and India (Long *et al.* 1999, Rajeswari *et al.* 2005). These findings not only illustrate the gendered impacts of TB but also highlight how the illness impacts upon many family members creating a shared experience of TB.

Life after tuberculosis

The final stage of the TB journey is being cured of the disease. The majority of people with TB with whom I worked were still being treated at the time of this research; only four Korean participants who suffered from TB prior to this study had reached the

final stage of their journey. They associated several factors with being cured from TB including medical tests (x-rays and sputum samples), cessation of treatment and verbal confirmation from medical practitioners. People's past experience of TB treatment influences their understanding of the disease (Gibson *et al.* 2005). Despite being medically declared as cured from TB, three participants still live under the shadow of their former disease; for them, life has not returned to normal. One Korean man fears his disease and associated impacts will return, while two other Korean women do not believe that TB can be cured.

Yul, a Korean man in his late 20s, developed TB when he was in his late teens. Although Yul has been cured of TB for over three years, he has had a chest x-ray done every year since he completed treatment. Yul still lives in fear that his TB will return and has the x-rays done to reassure himself that he is still free of TB:

After I finished my medication, they [clinicians] check on everything and they said 'Ok now, it's ok'. I have to sit you know, ah chest x-ray, so they were making sure I didn't get it another time, and if I do it will be much more serious, I know this. So I was pretty cautious about getting my x-ray in 2002, yeah. Every year I pay the money, ah 70 or 80 dollars to get it [x-ray] you know, from medical centre or something like that... So I need this [x-rays] to know my life and body is well.

May had TB when she 16 in Korea and, although she was told by her doctor she was cured and passed her immigration medical examination to come to New Zealand, she believes she still has TB because of scarring on her lungs. Like May, June also believes that TB can not be cured. As previously mentioned, June has suffered from three episodes of TB and was told by medical professionals that she was cured after her first two episodes, so it is understandable that she holds these beliefs. She also suffers from diabetes⁵ and chronic neck and shoulder pain and believes that these symptoms were caused from her past TB infections. In June's opinion, the only way to stop the TB from making her sick again, or sicker, is to fortify her body through TCM: "I don't think that it's you know a, it's not cure, you just have a treatment [for TB], doesn't make you

⁵ Positive associations between TB and diabetes have been found, particularly in populations with low socioeconomic status and high incidence rates of both diseases. It has been suggested this co-morbidity occurs from diabetes compromising immunity against *M. tuberculosis* causing higher probabilities of conversion from LTBI to TBD (Perez *et al.* 2006).

cure[d]... I have to protect myself for always you know? I have to keep myself healthy and protecting”.

These narratives illustrate that impacts of TB are so significant that they can result in a persistent fear of the disease returning. Participants’ experiences illustrate how the meaning of illness can influence the life course of individuals as stated by Kleinman (1988: 8): “The trajectory of chronic illness assimilates to a life course, contributing so intimately to the development of a particular life that illness becomes inseparable from life history”. For example, Yul’s TB experience had led him to use yearly chest x-rays as a means of reassurance that he is well and his life remains “normal”. June’s life centres on “fortifying” her body against TB with use of TCM and strict dietary habits. The persistent, if not permanent, effects of TB are also strongly influenced by the stigma surrounding the disease.

Conclusion

Due to the ‘person-specific’ nature of TB experiences, Gibson *et al.* (2005:939) state that generalisations made on ethnicity are risky and must be understood within broader socio-cultural contexts. Illness experiences of the participants I worked with support this perception, as factors such as their migrant status, age, occupation, gender and access to local support networks had greater influences on their illness than ethnicity.

Using Bourdieu’s concept of habitus illustrated how migrants’ cultural, economic and social capital influenced their illness experience within health fields in New Zealand. Their forms of cultural capital such as language and health cultures were not recognised or valued by the dominant group of Western health care professionals. In addition, their reduction in bodily capital led to a decrease in economic and social capital placing them at a further disadvantage. Many, if not most of the people with TB with whom I worked came to New Zealand with hopes of improving their cultural and economic capital (as well as those of their children). However, settlement difficulties instead decreased their symbolic capital in New Zealand. For these people, TB compounded these problems further reducing their hope for a better life in New Zealand.

The various factors that influenced diagnosis and treatment were complex and interrelated including both biological and social variables. Physical symptoms and the

type of TB from which people suffered had significant impacts on their health seeking behaviour, diagnosis and treatment. For example, most people with pulmonary TB believed their illnesses were common colds and flu that did not require medical intervention. However, once they sought medical attention, their diagnosis was quick. In contrast, people with extra pulmonary TB experienced long delays in diagnosis. Health seeking behaviours were also influenced by health cultures such as understandings of immune systems, which were in turn, influenced by age, culture and various experiences with illness and health care systems. Key barriers to participants' diagnosis and treatment included taking time out from busy lifestyles, language difficulties and isolation from close networks in New Zealand. Factors that facilitated TB diagnosis and treatment were support from family, friends and PHNs along with flexible DOTS programmes. Impacts of TB on migrants in New Zealand are broad and long lasting. Aside from physical pain, people also experienced psychological stress, direct economic costs and indirect costs associated with an inability to engage in social activities and impacts on relationships with family members.

CHAPTER SEVEN: DISCUSSION AND CONCLUSION

Introduction

The primary aims of this research were to use TB as a lens to elucidate how migration, settlement and support networks influence Indian, Korean and Chinese immigrants' lived experience and health in New Zealand. At the same time, the study also examined specific characteristics of their TB experiences, such as stigma, diagnosis and treatment. The study used the theoretical framework of political ecology to address these aims and found it to be crucial in its ability to indicate where to look for connections within societies and to demonstrate how these interrelationships influence the settlement, health and TB experiences of immigrants in Auckland.

In this chapter I first highlight and discuss the key findings of the study, drawing attention to its strengths and limitations and identifying areas where further research is needed. Finally, I demonstrate the utility of using TB as a focal point to study human ecologies by drawing on a participant's life history.

Overview

Immigration policies in New Zealand since the mid-1980s have focused on encouraging Asian migrants to New Zealand to increase economic growth and human capital (Bedford *et al.* 2000, Lidgard *et al.* 1998, McKinnon 1996), and many migrants chose to migrate to New Zealand to gain economic, scholastic and cultural capital. However, as this study demonstrated gaps between immigration and settlement policies, along with limited support and social discrimination, actually reduce the economic capital of migrants. Migrants who acquired cultural capital through English language and previous migration and work history still faced settlement barriers, particularly when seeking employment in New Zealand. For many Indian, Korean and Chinese migrants, alternative routes to settlement were sought through social support from transnational and community networks. These resources were used to find employment, help with communication difficulties and provided practical support such as transport, domestic tasks and childcare.

Settlement problems including language difficulties, finding employment, low income levels, social discrimination and isolation, and sometimes problems with adequate housing, place Indian, Korean and Chinese migrants in a marginalised position within New Zealand society. These inequalities compound problems such as language difficulties and perpetuate others such as limited employment opportunities, resulting in low income levels. Political, economic and social inequalities faced by migrants also create stressors which can potentially affect their well being and increase their susceptibility to develop TBD.

This study has shown that ill health creates a whole new set of problems. Immigrants from these three countries are often faced with a health system they have little knowledge or experience of, and structural barriers such as lack of Asian health care professionals, and limited interpreting services. I found that migrants try to adapt by using health practices from their home countries. Transnational and community networks such as parents residing overseas, churches, GPs from country of origin and PHNs also facilitated many aspects of health care.

In this environmental context, TB burdens are exacerbated for immigrants. Not only can the stressors of migration influence conversion from LTBI to TBD, but living in a transnational space between New Zealand and home countries creates two forms of stigma; those in New Zealand and those associated with their countries of origin. In addition, lack of economic and cultural capital make it hard to negotiate New Zealand health care systems and can potentially create delays in TB treatment and diagnosis. The interaction of all these influences therefore leads to negative bodily capital for Indian, Korean and Chinese people with TB in New Zealand.

This research has shown that TB can be seen as a marker of political, economic and social inequalities of marginalised populations in New Zealand. In addition, TB is an important focal point for illustrating how interactions between political, social, biological and cultural factors influence settlement experiences and the health of Indian, Korean and Chinese migrants in New Zealand. (Figure 7.1).

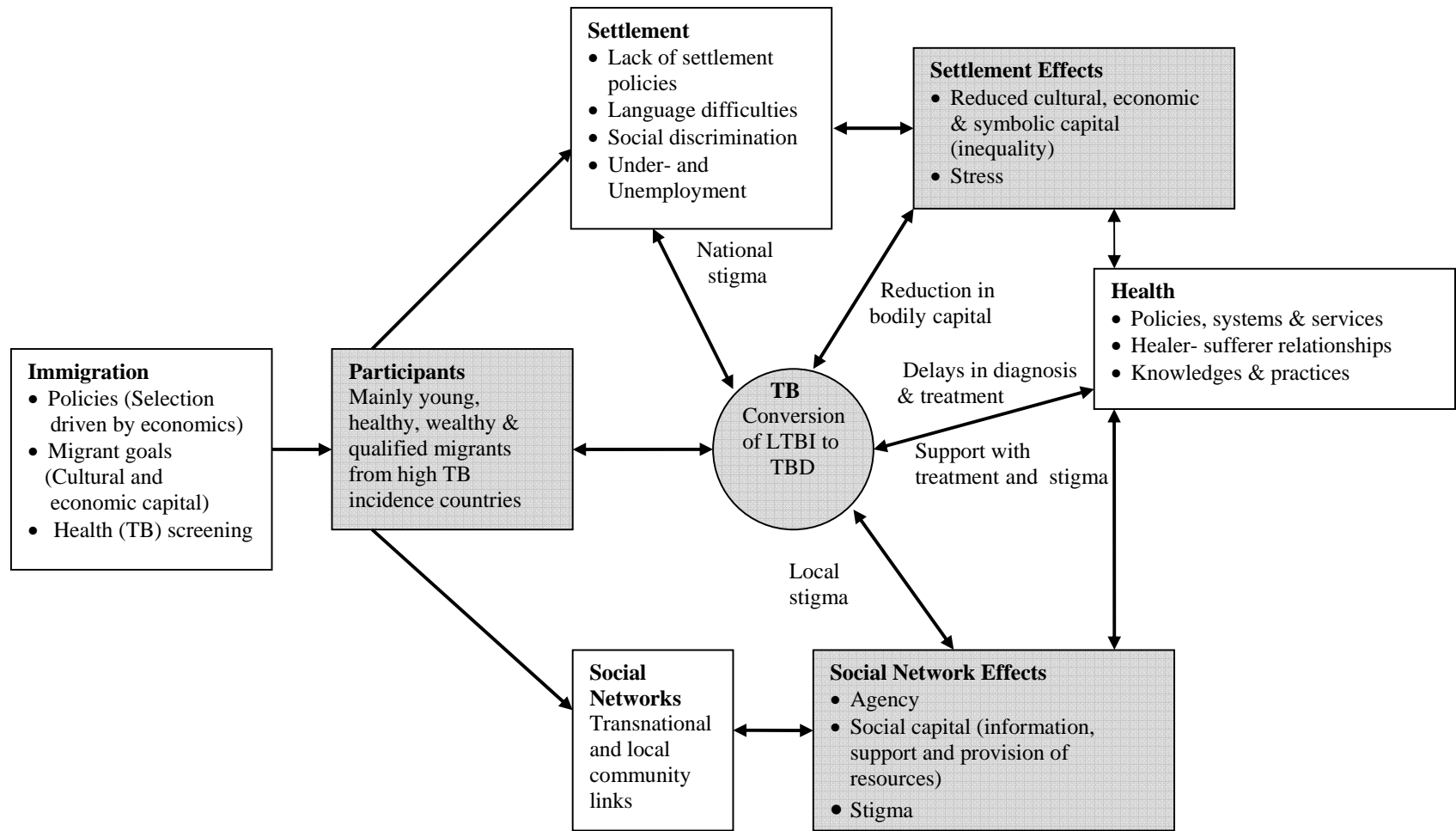


Figure 7.1 Interrelationships between immigration, settlement, social networks and health for Indian, Korean and Chinese migrants in Auckland, New Zealand

As the diagram illustrates, TB can be used as a focal point to demonstrate how immigration, settlement and health experiences of migrants are influenced by policies, national and local services, social discrimination, social networks and cultural understandings such as health cultures and stigma. The following discussion addresses many of these areas more specifically by highlighting the strengths and limitations of the study, as well as implications for further research.

This study was able to identify many difficulties Indian, Korean and Chinese migrants face within settlement and health care contexts in Auckland, which directly and indirectly influence treatment, diagnosis and experiences of TB in New Zealand. Identifying and understanding barriers should only be seen as the first stage of applied research to allow for future strategies to be implemented to overcome or minimise such problems. The following discussion will focus on areas I believe merit more research as well as practical suggestions that can be implemented. However, it is important to note that this study based its interpretations on a small number of participants, particularly in relation to people with TB, and, as a result, may not represent the diversity of problems faced by immigrants or the individual differences between the three groups with which I worked. Despite these limitations, I hope this study will provide a strong framework for future research into migration and health studies within Indian, Korean and Chinese migrant groups in New Zealand.

Migrant status and inequality

Although the suggestions I make relate to many aspects of settlement and health care in New Zealand, most of the difficulties migrants faced were the result of their minority status in New Zealand. Effects of inequalities and minority status on health are not unique to Indian, Korean and Chinese immigrants in Auckland. A study by Lawrence and Kearns (2005) found that social inequalities, economic and cultural barriers also have negative impacts on refugee health in Auckland. Continuing work addressing issues of inequality of immigrants and refugees in New Zealand would lead to improvements throughout many sectors of society. As stated by Porter and Ogden (1998:97), this course of action would then begin “to tackle the cause and not the symptom”.

Policy

There is a large gap in New Zealand policies in acknowledging and aiding immigrants in areas related to health, language and employment. These gaps have been recognised by various sectors of New Zealand society including DHBs and Asian organisations such as TANI, who are currently lobbying for policy changes to meet specific needs of Asian people. Such use of agency in political areas has important implications for Asian and other migrant groups in New Zealand and merits further research. To fully bridge gaps between policy and its impact on daily lives of people, policy changes need to permeate broad sectors of society such as employment markets, schools and local communities. Just as immigrants can exert their agency to produce macro level changes in society, they also have the potential to implement and draw awareness to changes through their social networks that reach local communities, neighbourhoods and groups through informal channels, such as ‘word of mouth’. For these reasons, I recommend that greater use of local Asian networks such as churches and TANI be incorporated within policy planning, implementation and dissemination in New Zealand.

Discrimination and stigma

Mainstream anti-Asian discrimination is another aspect of New Zealand society that greatly influences settlement of Indian, Korean and Chinese migrants in Auckland and ultimately impacts on their health. Although media analysis was able to indicate public opinion of Asian migrants, a limitation of this study was the exclusion of members of the New Zealand-born population. Research with the locally-born would have provided a broader understanding of how discrimination against Asian immigrants arises and is maintained in mainstream public and private contexts. To fully understand how discrimination is produced and maintained in New Zealand, further research is needed focusing on processes and factors that influence ethnic attitudes and perceptions of the New Zealand-born in relation to ‘Others’, particularly in policy making and employment contexts.

Media is a significant source of discrimination against Indian, Korean and Chinese immigrants in Auckland, who have been portrayed as invaders and criminals that

should be sent back to their home countries (Bedford and Lidgard 1996, Coddington 2006). Migrants are also depicted as responsible for bringing TBD into New Zealand (Thompson and Binning 2003). Anti-Asian sentiments focusing on criminal activities and carriers of disease have also been central to political campaigns in New Zealand such as those of the New Zealand First political party. Such campaigns perpetuate these stereotypes and directly influence immigration and health policies. As illustrated by Park and Littleton (2007) from their research on TB in New Zealand, political statements regarding migrants and TB and associated campaigns for policy reforms often do not accord with epidemiological data in New Zealand or overseas. Given the significant impacts that such political statements have on immigrants in New Zealand, there needs to be more accountability, responsibility and recognition of political leaders' actions towards non-New Zealand born populations. Public awareness and education about the impact of stigma directed at migrants needs to be promoted in New Zealand and more emphasis should be directed towards the fact that TB can affect anyone.

Along with national discrimination and stigma, local stigma surrounding TB can prevent people from seeking medical attention and treatment. TB education and awareness programmes have been run by the ARPHS over the last decade with an aim to reduce delays in diagnosis in various migrant communities in Auckland. These programmes were run in collaboration with community members, where, after initial training, members would disseminate information back through their wider community networks. I feel that these programmes also have great potential to increase awareness of New Zealand's health care system, availability of interpreting services and to actively de-stigmatise TB. For health education to be effective in de-stigmatising TB though, it must focus on local, cultural perceptions and understandings of TB within specific cultural groups involving men and women of all ages. These programmes should also acknowledge and build upon coping strategies used by TB sufferers such as using biomedical information, humour, religion and support networks to help minimise stigma surrounding TB. A focus on community development in addition to education is an optimal strategy.

Access and barriers to health care

Indian, Korean and Chinese migrants faced many barriers to health care access in New Zealand, creating delays in TB diagnosis and difficulties with treatment. Health care problems are in themselves complex as they are embedded within political, economic and social structures. As discussed in Chapter Four, New Zealand has suffered four separate restructurings of health care delivery since the 1980s (Gauld 2003). One of the key barriers to accessing health care in New Zealand for Indian, Korean and Chinese migrants was lack of understanding of New Zealand's health care system. Hahn (1999:5) found that inadequate translation of public health knowledges is a worldwide problem occurring across and within national borders and attributes this problem to "the failure of some public health programs to study and take into account the culture and society of the community toward which the program is directed". In Auckland, there has been an emphasis on promoting awareness of New Zealand's health care system. For example, in 2003, Waitemata DHB produced information pamphlets available in many languages together with phone services which provided simple descriptions of primary health care services. However, from my experience working with Indian, Korean and Chinese immigrants, most information obtained about health care in New Zealand is from word of mouth through close networks such as family (often residing overseas), friends and members of social organisations and through local newspapers. I feel that these media can be of great importance to promote awareness of New Zealand health care systems and facilities to immigrants through community workshops and advertisements in local newspapers and community radio stations.

Along with lack of awareness, structural barriers also prevented many participants from attending local PHOs. Addressing structural barriers such as lack of appropriate health care professionals, transport, language difficulties and unsuitable operating times are more challenging. For example, as previously discussed, access and use of interpreting services are affected by hospital structures. Therefore, promoting awareness of these services alone will not reduce additional difficulties such as waiting times which have to be understood within broader secondary health services and national health policies. In addition, although there is a need for more Asian health care professionals such as Korean GPs, simply suggesting employing more people in these roles is not only

naive but also ignores barriers for Korean-trained doctors in achieving New Zealand registration, language difficulties, and perceived differences in understandings of health in non-Korean GP practices. Given the complexities of these problems, and their relationships within wider political and economic structures in New Zealand, there is a need for further research into these areas in order to fully understand and tease apart these dimensions before practical solutions can be addressed.

Tuberculosis screening

In New Zealand, a large focus of TB control is directed at migrant health screening to prevent TBD from entering national borders. Although screening is an important measure to prevent TBD from entering the country, it cannot prevent TBD from entering through people who regularly cross borders and are not screened or local transmissions via people with LTBI. In a recent study of TB in New Zealand, Das *et al.* (2006a, 2006b) found that more immigrants enter New Zealand with LTBI than TBD. This has important implications for detection and diagnosis as LTBI cannot be detected by chest x-rays, yet may reactivate some time after arrival. Due to this pattern of transmission they suggest that primary health care practitioners need to be vigilant for early detection of TB in migrants and refugees. In addition, they also emphasise the need for increased aid and assistance for TB control in neighbouring countries to reduce prevalence of LTBI at national and global levels. International responses to TB have also been a primary aim of the WHO involving collaboration between both developed and developing countries (King 2003). Although international responses and cooperation are the only way to control global diseases such as TB, the task is complex given political, economic and social variations within and between nations. For these reasons, additional research looking at the complexities of diagnosis and treatment of TB in specific, local and international contexts is needed to build upon and improve global TB programmes.

Most migrant TB cases in New Zealand result from reactivation of LTBI (Das *et al.* 2006a). Yet, given that there is nothing inevitable about progression of LTBI to TBD, Park and Littleton (2007) emphasise the importance of understanding environmental circumstances that promote reactivation. This thesis was able to illustrate the important relationship between perceived environmental stressors and illnesses such as TB. There

were a variety of ways that stress was embodied and physically expressed among participants although there were also differences seen between the three groups. Physical expressions of stress were influenced by health cultures, but ultimately, causes of stress for migrants were embedded in broader political and economic processes such as immigration, employment and discrimination. Despite identifying potential causes of stress, I did not directly measure the biological impacts of stressors on health. Further research is needed that focuses on the relationship between stress and chronic and infectious diseases such as TB. Such research would provide further evidence for the hypothesis that migration and settlement in New Zealand results in a stressful, high-risk environment promoting reactivation of LTBI. It would also help to understand underlying factors causing the 'healthy immigrant effect' where Asian migrants' health is good on arrival but deteriorates over time, as disease patterns converge to those of New Zealand's host population (Rasanathan *et al.* 2006, Tse and Hoque 2006:10).

Support networks

One of the limitations of this thesis was that participants were recruited through health care professionals and Indian, Korean and Chinese networks. As a result, to varying extents, all participants were members of existing social networks (although as discussed in Chapter Five, some people experienced very limited social networks). Incorporating people who were members of established networks may have obscured actual constraints on agency and forms of capital experienced by immigrants lacking such networks, particularly new migrants in New Zealand. Furthermore, my close association with health care professionals, educational institutions and organisations such as TANI greatly influenced my perception of the role they play in immigrants' lives. Bearing these limitations in mind, I found that social networks greatly influenced migration and health experiences of Indian, Korean and Chinese migrants in Auckland. I feel that further research into their roles and influences on settlement issues such as employment, child care and effects on health in provision of transport and advice on health seeking behaviour is needed. Such research would lead to broader acknowledgement and utilisation of these networks in addressing problems associated with migration, settlement and health. I further suggest that the concept of support for informal networks be

employed as a method of community development and health promotion and made available to city councils and ARPHS.

Relationships between sufferers and healers

A key theme that came from this research was the importance of relationships between TB sufferers and healers. Supportive roles of local GPs from country of origin and PHNs were seen as factors that facilitated peoples' treatment and TB experience. PHNs roles in particular, aiding their patients in areas of social, economic, practical and emotional support contributed to the physical and psychological well being of their patients. As previously mentioned, New Zealand's health care system has undergone many reforms and restructures. Along with national changes, PHNs in Auckland have also seen local changes (Searle *et al.* 2007). Restructuring which disrupts PHNs relationships with individual patients, patient groups or local areas appears to be detrimental to the rapport and trust typical of most PHN-patient relations. Malone's (2003) study of nursing in the United States found that hospital restructuring affected nurse-patient relationships through reduced proximity. Health reforms in New Zealand have also been found to affect patient care in hospitals. An ethnographic study by Fitzgerald (2004) demonstrated that reforms of hospital systems and resource allocation produced divisions of labour between managers and other staff creating "harried working pressures" (2004:339). She also found different aspects of care between medical professionals where hospital consultants tended to perceive patients as objects and recipients of technical procedures such as x-rays, in contrast to nurses, who embodied a holistic concept of care of both patients and technical work. This study and that by Searle *et al.* (2007:75) also found that TB patients received different aspects of care from hospital clinicians and PHNs, where PHNs "acted as bridges between clients and hospital medical personal to ensure their patient's needs were meet". Given the importance of PHNs roles as carers and curers for TB patients (and patients in general), there needs to be more research on the effects of constant restructuring of the New Zealand health care system nationally and at the local level on the roles of nurses and the relationships between health care professionals and patients.

This research found that New Zealand's health care system has also affected relationships between patients and hospital TB clinicians. As previously outlined, clinicians work under busy conditions, facing conflicts in resource allocations between customer services and medical procedures that do not allow for continuity of care with patients. A limitation of this study was not including observations or interviews with hospital TB clinicians. Therefore, the study is unable to address how these conditions influenced their work or perceived relationships with TB patients, an area where more research is needed.

Conclusion

In summary, this research explored a diverse number of themes including migration and settlement processes, health seeking behaviours and beliefs, social networks and TB diagnosis and treatment for three different immigrant groups in Auckland, New Zealand. Yet the application of political ecology demonstrated that these areas are closely interrelated and strongly influenced by transnational, political, economic, social, cultural and biological factors. To illustrate how these macro and micro level processes interrelate within a single narrative, I conclude with the migration experience of Bhadrak, a young Indian man in his 20s.

Bhadrak held a degree from an Indian University but wanted to continue his education in a Western country so applied for a student visa to study in New Zealand. Given his education, age and wealthy family background he had no trouble migrating to New Zealand and arrived in Auckland in 1999. He found a flat with some other Indian students and completed a two year academic course. After graduation, he successfully gained permanent residency in New Zealand and began to seek full-time employment in his qualified area. Although his qualifications were sufficient to gain him residency in New Zealand, like many other Asian migrants in Auckland, he faced difficulty finding employment due to social discrimination, highlighting gaps between policy requirements and settlement processes for immigrants in New Zealand.

After six months of unsuccessfully searching for employment and having no financial income, Bhadrak was faced with two options - returning to India or taking a low paying job. He was worried that he would face "shame" in returning home, so took a low

paying, part-time job in retail. Bhadrak's difficulties finding employment and experience with underemployment had direct economic costs that influenced his local residential environment, were a cause of stress and, ultimately, may have affected his health. Due to his limited financial situation, he had to change accommodation, moving into a two bedroom flat with two other Indian students. After six months, his employer offered Bhadrak a full-time position which he took, explaining that it was a "safer" option than facing further rejection or unemployment.

Not long after gaining his full-time position, Bhadrak began to feel sick with colds, fevers and pain in his leg. Initially he thought the illness would pass, as he was young and healthy, but the symptoms progressed to a point where he had difficulty walking. Like many other migrants in New Zealand, Bhadrak's health seeking behaviour was influenced by his physical symptoms, health culture and conforming to health practices he was familiar with from his home country. At this stage he sought medical attention. Over the next three months he saw three different GPs, two from A and E clinics and another Indian GP. By this time, Bhadrak could no longer walk unassisted and was unable to work, creating financial hardship. After three months of doctor shopping and misdiagnosis, he was finally diagnosed with extra pulmonary TB and hospitalised for a further three months.

Like many other immigrants with whom I worked, stigma associated with TB, isolation from close networks and the role of PHNs greatly influenced Bhadrak's TB experience. Due to fear of others discovering his TB, he gave up his place in his flat when he went to hospital and stopped all social contact with friends, telling nobody of his illness. His only social contact over this period was with his PHNs. Bhadrak described himself at this time as "totally lost" and suffered from anxiety and depression. He said that, if it was not for his PHN, he did not think he would have survived. With help from his PHNs, Bhadrak found a new flat and another job, yet, to date, has still not informed anyone of his TB and continues to meet PHNs in private settings so nobody can observe his treatment.

When I first invited Bhadrak to participate in this study, despite my assurance that his identity would be kept confidential, he was hesitant and worried that others may discover that he had TB. As discussed in Chapter Two, social stigma surrounding TB prevented

many people with TB from participating in this study, resulting in a small sample size. However, despite his concerns, he chose to participate stating:

I want to go through, um, the interviews, so I can explain to the people who are suffering from this disease, or who ah, will not be suffering from this TB. I hope to help, yeah.

Bhadrak's participation was not in vain. Despite a limited sample size, thanks to him and other participants, I have been able to illustrate how the complex interactions of many levels of New Zealand society and transnational linkages influenced their lived experience in New Zealand, portraying how local ecologies in Auckland can affect health in general and the incidence and experience of TB.

This research builds upon other medical anthropological studies that have employed political ecology by demonstrating its usefulness in application to developed as well as developing countries. It has also contributed to the growing area of Asian migration research in New Zealand, illustrating that migration and settlement processes are complex and need to be understood within transnational, political, economic and cultural contexts. Finally, this study has demonstrated how these complex and interrelated processes impact on health and infectious diseases such as TB.

EPILOGUE

Introduction

By the end of the research process, researchers develop a 20/20 hindsight, realising the strengths and weaknesses of their study's design and methods. In this final section, I will reflect upon my study, discussing its contributions to migrant health, the difficulties I encountered and, if given the opportunity, what I would have done differently in relation to the people with whom I worked and the methods I employed. In addition, I give a brief account of my dissemination plans and future research. Finally, a post-research update of the people with whom I worked will be provided.

Participants: Pros and cons of working with multiple groups

As discussed in Chapter Two, one of the primary aims of this thesis was to understand how shared experiences of migration influence migrants' health in New Zealand, with a focus on TB. To achieve this aim, I included migrants from three different geographic groups as participants in the study. Another reason for including people from these communities was to ensure I would have enough people who currently had (or had previously suffered from) TB. Given the comparatively small numbers of people who suffer from TB in Auckland (Das *et al.* 2006a), the stigma surrounding the illness (Edginton *et al.* 2002, Sumartojo 1993), and the limited time frame available for a PhD thesis, I felt working with only one of these groups would lead to a small number of participants, and therefore limit my ability to understand their experiences. As this research has demonstrated, these factors, particularly stigma surrounding TB, significantly impacted on my ability to recruit participants, and despite including three migrant groups, still resulted in a small number of TB participants. Despite the small sample size, one of the strengths of this thesis was identifying migrants' shared experiences of health and TB in New Zealand, illustrating the significant roles that migration, social discrimination, health experiences as well as related policies play on migrant health. However, a limitation of this method was my inability to demonstrate the diversity of individual experiences of TB within each group (particularly for Chinese)

and interact within the domestic spheres of participant's lives. Given these limitations, and now provided with additional knowledge of the communities with whom I worked, in hindsight, there are several aspects of the research I would have changed.

What would I have done differently?

As previously discussed in Chapters One and Two, during the early stages of my fieldwork I was invited by ARPHS to participate in a TB awareness project among Indian communities in Auckland. Participation in the project proved to be one of the most valuable sources of ethnographic data for my study. It allowed me to create direct, social networks with many Indian organisations and societies, to elucidate their role in health promotion and gain first hand knowledge of people's perceptions of TB and broader experiences of New Zealand's health care system. Had I been aware of this project when I began my research, and how important it would become to my study, I would have changed my research design and only worked with Indian migrants in New Zealand. In addition, I would also have learnt Hindi (which was the most common language, other than English, spoken among my Indian participants). I feel that these approaches would have enabled me to 'get closer' to people, particularly within domestic contexts, better understand the diversity of migration, health and TB experiences of Indian migrants, and allowed a more extensive analysis of local media sources. However, had I only worked with one migrant group, I would not have been able to demonstrate how minority status, social discrimination and migration and health policies influence many migrant communities, creating 'shared experiences'. Therefore, my present study is a valuable platform for further research in each of these communities, where a more traditional one group ethnographic approach could be employed.

Moving on, where to from here?

The most fundamental component of ethnography is the relationship between researchers and participants (Agar 1980). Although my thesis is now completed, where possible, I have continued both personal and professional interactions with many of my participants. As a part of my ongoing involvement with participants, I have also recently begun the dissemination process of my study. To make this research accessible to people

from the three groups with whom I have worked, I have summarised the key finding of the research into a two page document. The summary sheets are available in English and have also been translated into Hindi, Korean and Mandarin. The sheets have been distributed to participants and various community organisations (such as TANI, AIS and ACMA). In addition (and with the help of many community organisations), I have also given public presentations of my work to community groups.

In the future, I wish to continue working with each of these communities in the context of migrant health in New Zealand. Longitudinal, ethnographic research will elucidate community involvement in health promotion, and I am particularly interested in reviewing the long terms effects of the TB awareness project in relation to diagnosis, treatment and stigma of TB for Indian communities in Auckland.

Peoples' lives after participation

Unlike this thesis, which began with an introduction and ended with a conclusion, life for the people with whom I worked continues with various trials and tribulations. For various reasons (such as stigma surrounding their illness, changing homes and contact details, and migrating from New Zealand) I have not been able to stay in touch with all of the people with whom I have worked. For those people with whom I remain in contact, some have faced significant life changes, while others remain facing similar challenges and situations. Five of the people with whom I worked with have since left New Zealand, two have returned to their countries of origin, and three have migrated elsewhere illustrating the transnational nature of many Indian, Korean and Chinese migrants. I am also pleased to note that the two students who engaged in unpaid work for local Auckland businesses, have since graduated from their educational institutions and both found full-time employment. Tushar, was employed by the company for whom he worked voluntarily, and Jaya (perhaps due to her 'Kiwi' work experience) has accepted a managerial role in the commerce sector of a major Auckland company.

For those participants with TB, Meeta, after completing her TB treatment was finally able to join her husband in Australia and maintains contact with her sister and mother in-law in New Zealand. June still suffers from ill health associated with her diabetes and chronic neck and shoulder pain, her social network is still largely limited to

her husband and son (who will soon be graduating from University). Yet, despite these challenges, she is always up for a social visit and cuppa tea from her pesky anthropologist friend, and is keen to go back to school to continue her English studies when her health improves. Finally, Bhadrak has completed his TB treatment and has still not told his family about his TB experience (nor does he intend to). Bhadrak was pleased to receive his summary report of the research and his reaction to this study has been one the most rewarding experiences I have encountered along my research journey.

Conclusion

In conclusion, I found reflecting back on my research aims and methods was a useful experience, providing knowledge I will apply to future studies. I realise now, applying an ethnographic approach to more than one group of people can be advantageous, highlighting shared experiences of migrants in New Zealand. This approach however, also has limitations, particularly in relation to illustrating variations within each group, and elucidating differences between them. After disseminating the results of this study back to the groups with whom I worked, I wish to continue working within the context of migrant health in New Zealand, building upon my strengths and learning from my limitations. In summary, just as TB experiences cease to end after treatment, nor does the research process finish after completion of a thesis.

APPENDICES

Appendix 1: Interview questions for participants with TB

- 1. Where are you from?**
 - Can you describe what life was like there?
 - Home
 - Family
 - Friends
 - Occupation
 - Health

- 2. What made you decide to leave?**

- 3. Why did you decide to come to NZ?**
 - How long have you been here?

- 4. What was the migration process like?**
 - Visas
 - Finding a job/school
 - Finding somewhere to live

- 5. What was it like settling in to NZ?**
 - Language
 - Friends
 - Employment/school
 - Being away from friends and family
 - Finding a home
 - Different culture

- 6. Tell me a little bit about yourself**
 - Where do you live
 - How many people do you live with
 - Occupation
 - Friends/family
 - Hobbies
 - What do you do in your spare time (favourite places)

- 7. Can you describe to me what being healthy means?**

- 8. Can you describe to me what being sick means?**
 - When was the last time you were sick (before TB)?
 - What did you do?

- 9. How would you describe TB?**
 - How do you think people get TB?
 - What does it do to you?

10. Do you think people think differently about TB in NZ compared to (their home country)?

11. Do you know how you got TB?

12. What made you realise you were sick when you got TB?

- How long did it take you to realise this?

13. What did you do when you realised you were sick?

- Where did you go?
- When did you go?
- Why did you go?

14. How did TB make you feel?

15. Did having TB change any aspects of your life?

16. Do you think there is any stigma associated with having TB?

- What were your friends and families reactions?
- Did you tell people you had TB?

17. Can you tell me how your TB was diagnosed?

- Where was it diagnosed?
- When was it diagnosed?
- How was it diagnosed?

18. Were your friends and family also tested for TB?

19. What treatment did you receive for TB?

- What kind of treatment
- How much treatment
- How often do/did you have to take it
- When did you begin taking it
- How long do you have to take it for
- Where do you take it

20. How do you feel about the treatment?

21. Are you still being treated for TB?

- Does this make a difference to you (How)?

22. How do you feel about your Public Health Nurses?

- How often do you see them
- Where do you see them

23. How do you feel about your doctors

- How many have you seen?
- Where do you see them?
- How often do you see them?

Appendix 2: Interview questions for PHNs

1. Background- Job description

- Can you describe your job to me?
- How long have you been a PHN?
- Which area/s of Auckland do you work in (can you describe what these areas are like in terms of socioeconomics and residence)?

2. TB Patients

- How many patients would you see in a week (month or year depending)?
- How many Indian, Korean and Chinese patients have you seen through this time (have you noticed any differences with case numbers)?
- Have you noticed any commonalities with these TB patients (Age, gender, ethnicity, socioeconomic status, occupation, migrants...)?

3. Treatment

- Can you explain the treatment procedure for TB patients (when do you first come in contact with them, how long do you see them)?
- How do patients find taking their medicine (problems, side effects)?
- In your experience, what factors can facilitate or create barriers for patients and their treatment (support networks)?
- Do you know if any of your patients seek alternative treatments (if so what kinds of patients and what kind of treatments)?
- What do you do when you treat patients with English as a second language?
- How do you feel about DOTS (how has this helped or not helped you and your patients)?
- How much interaction do you have with GPs or clinicians of patients with TB?
- What kind of a role do patient's family, friends or wider support networks play in their treatment?

4. Health knowledges

- What are patient's understandings of TB concerning what it is and how you become infected (are these influenced by ethnicity, age, gender...)?
- What kinds of questions do your patients ask you about TB?
- In your experience how does stigma influence the treatment process for patients?
- Do you think there are any factors that influence stigma for patients (support, understanding, age, gender, ethnicity...)?
- What is your impression of patient's understanding of New Zealand's health care system (in your experience are there factors that influence peoples understanding)?
- Is there anything else you'd like to say?

Appendix 3: Interview questions for GPs

1. Background

- Job description
- Where have you practiced?
- History in New Zealand

2. TB Patients

- How many TB patients would you see in a year (or month, week depending)?
- What kinds of patients do you see with TB (Age, gender, ethnicity, socioeconomic status, occupation, migrants ...)
- What kinds of symptoms do patients with TB usually present?
- When do they usually present?
- What could prevent people from coming along and presenting to you?
- How do people react to a potential or positive TB diagnosis?

3. Procedure

- What factors would make you suspect a patient has TB?
- How long does it usually take to confirm a diagnosis?
- What procedure do you follow when you suspect a patient has TB?
- When patients are referred, how do you find they are treated (do you think there are any factors that influence this procedure)?
- How much contact do you have with TB patients post-diagnosis (in relation to their TB and ancillary problems)
- How much interaction do you have with PHNs?

4. General Health

- What are the most common reasons people come and present to you (are these influenced by age, class, gender or ethnicity)?
- Do you know if any of your patients seek alternative medical treatments (if so what kind of patients take alternative medicine and what kind of alternative treatment do they take)?
- Is this a PHO (if so do you find this helpful when dealing with people)?
- Do you think being associated with a PHO has changed your practice? (How)?
- What is your impression of patients understanding of New Zealand's health care system? (In your experience are there factors that influence peoples understanding?)

Appendix 4: Participation information sheet

Participant Information Sheet (Version 1/18/03)

Principal Investigator:

Associate Professor Julie Park
Department of Anthropology
University of Auckland,
Private Bag 92019
Auckland

Phone 3737599 x88589

Name of Study: Tuberculosis in New Zealand

Introduction

You are invited to take part in a study of tuberculosis in New Zealand – past and present. Your participation is entirely voluntary. If you chose not to take part you will receive the usual medical treatment. We will contact you in approximately one week to see if you are willing to take part in this research.

ABOUT THE STUDY

The aim of the study is to find out about the successful treatment and prevention of TB.

We are interviewing people who have had TB in the past and at present, people who have had TB patients in their families or among their friends, health professionals who work in the area, and members of the community. TB patients and their families will be identified by the Auckland District Health Board Public Health Team. Recruitment of community members will be through community networks matching as far as possible characteristics of the TB group

Approximately 100 participants will take part

The study will take place in various venues in the Auckland area.

The time span for this study is four years.

The study will consist of interviews of approximately one hour. People with TB will be asked for up to three interviews; other participants for one. The interviews will be audio-taped. With the participant's permission the audio-tape will be deposited in an oral history archive where it can be accessed by *bone fide* researchers approved by the

Archive management, who will agree to preserve interviewees' anonymity. Other tapes will be destroyed on the conclusion of the study. Where tapes are transcribed, transcripts will also be archived under the conditions described above, with the participants' permission. Otherwise the transcripts will be destroyed after ten years.

BENEFITS RISKS AND SAFETY

The study aims to benefit people with TB and the community through a greater understanding of how TB persists.

The study proposes no risk and the only inconvenience is the time taken for interview.

Participants will be offered a small gift, eg, fruit.

PARTICIPATION

If you agree to take part in this research you are free to withdraw from the study at any time, without having to give a reason and this will in no way affect your health care.

GENERAL

Your GP will be told you are in the study, only if you give us permission to access your medical records.

If you want more information about this study you can access the website at <http://www.arts.auckland.ac.nz/ant/TBProject/TBproject.htm> or contact one of the researchers.

If you need an interpreter, one can be provided.

You may have a friend, family or whanau support to help you understand the risks and/or benefits of this study and any other explanation you require.

During the interview you do not have to answer all the questions, and you may stop the interview at any time.

If you are a health professional taking part in this study, if you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact your professional organisation.

If you have any queries or concerns regarding your rights as a participant in this study you may wish to contact a Health and Disability Advocate, telephone 0800 555 0050.

For Auckland District Health Board Maori Health support, please contact Mata Forbes, RGON; Co-ordinator / Advisor Maori Health Services, Auckland Hospital, Grafton Mobile 021 348432; Tel (09) 307 4949 Extn 7292.

CONFIDENTIALITY

No material which could personally identify you will be used in any reports on this study. During the study the data will be kept in locked University of Auckland facilities.

RESULTS

This study consists of several different components that will be completed successively from 2004-2006. Results of the study can be accessed on the website noted above. For those participants who wish it, copies of the summary reports will be available. The study will also be published in academic and health journals.

STATEMENT OF APPROVAL

This study has received ethical approval from the Auckland Ethics Committee.

Please feel free to contact the researcher if you have any questions about this study.

Anneka Anderson
Department of Anthropology
University of Auckland,
Private Bag 92019
Auckland
Ph (09) 483 7888
027 315 1154
Email aand002@ec.auckland.ac.nz

Appendix 5: Participant consent form

Consent Form (community members and health professionals)

Name of Study: Tuberculosis in New Zealand

REQUEST FOR INTERPRETER (to be included on all consent forms)

English	I wish to have an interpreter.	Yes	No
Maori	E hiahia ana ahau ki tetahi kaiwhakamaori/kaiwhaka pakeha korero.	Ae	Kao
Samoan	Ou te mana'o ia i ai se fa'amatala upu.	Ioe	Leai
Tongan	Oku ou fiema'u ha fakatonulea.	Io	Ikai
Cook Island	Ka inangaro au i tetai tangata uri reo.	Ae	Kare
Niuean	Fia manako au ke fakaaoga e taha tagata fakahokohoko kupu.	E	Nakai
	Other languages to be added following consultation with relevant communities.		

NB: other languages will be added when these are established

I have read and I understand the information sheet dated _____ for volunteers taking part in the study designed to investigate health knowledges and practices as they relate to tuberculosis.

I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.

I have had the opportunity to use whanau support or a friend to help me ask questions and understand the study.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my health care.

I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.

I have had time to consider whether to take part.

I know who to contact if I have any questions about the study.

I consent to my interview being audio-taped

YES/NO

I consent to a copy of the audiotape being lodged in an appropriate oral history archive under the conditions described in the Participant Information Sheet

YES/NO

I consent to my transcript being lodged in an appropriate oral history archive under the conditions described in the Participant Information Sheet

YES/NO

I wish to receive a copy of my transcript

YES/NO

I wish to receive a copy of the summary report

YES/NO

I _____ (full name) hereby consent to take part in this study.

Date

Signature

Full names of Researchers:

Associate-Professor Julie Park, phone 3737599 x88589

Dr Judith Littleton phone 3737599 x87319

Associate-Professor Linda Bryder phone 3737599 x8

Dr Heather Worth phone 3737599 x87042

Associate Professor Robin Kearns phone 3737599 x88442

Anneka Anderson phone 3737599 x88971

Project explained by

Project role

Signature

Date

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