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**Utilisation of Primary Health Care  
services: the perceptions and experiences  
of South Asian immigrants in Auckland,  
New Zealand**

**By Jessica Vani Tamanam**

*A thesis submitted in complete fulfilment of the requirements for the degree of [Master of Public Health], The University of Auckland, 2016.*

## Abstract

*The South Asian community in New Zealand – comprising of migrants from India, Bangladesh, Sri Lanka, and Pakistan – experience high rates of avoidable morbidity and mortality. This trend raises the question about health awareness, behaviours and health care utilisation among the members of this community. Alongside, it also raises questions about the extent to which New Zealand’s health care system addresses cultural diversities in health care. Focusing on health service utilisation of primary health care (PHC), the first point of access for health care, the present research aims to outline the socio-cultural, economic, and contextual factors that influence or present a challenge for health service utilisation behaviours of South Asian migrants. The thesis draws on Berry’s acculturation and Bourdieu’s habitus theories as explanatory frameworks to understand migrant perceptions and utilisation of health care. The study, located in Auckland, employed a qualitative interpretive research methodology. Fifteen participants from India, Pakistan, Sri Lanka, and Bangladesh, were involved in in-depth interviews.*

*A content analysis of the in-depth interviews revealed two main findings. First, South Asians are influenced by their pre-migration experiences with health care in their home countries, which shape their perceptions of services provided by New Zealand PHCs. These expectations meant that they were most satisfied with health care utilisation when they perceived control over health decisions and were dissatisfied with the PHC when it restricted this ability to freely make choices about their healthcare. Second, the promotion of healthy lifestyles messages and support provided by PHC-level services and society are perceived **to be** inconsistent by South Asians with their ability to live the desired healthy lifestyles. The study recommends that PHC can better support South Asian migrants in their health service utilisation experiences by taking into consideration the particular expectations formed by their pre-existing health knowledge. Further, in order to develop effective health promotion messaging, PHC will need to create partnerships with existing South Asian community groups in ways that promote cultural diversity in messaging and interactions which empower South Asians to experience better health and wellbeing.*

## **Dedication**

I dedicate this thesis to my grandma, Evelyn Megiel who always encouraged me to dream big, work hard, and above all have faith.

## **Acknowledgements**

I would like to first thank the participants of my study for sharing their personal stories of immigration and settlement. Your stories have allowed this research study to yield rich data that aims to further assist health care in developing a culturally competent New Zealand health care sector.

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# Chapter One

## 1. INTRODUCTION

Auckland City, New Zealand's largest urban city is home to the majority of the growing ethnic population, within which a large proportion of migrants are from the Asian continent (Statistics New Zealand, 2013). Since the 1980s consecutive governments have opened national borders attracting Asian migrants with employment opportunities (Bedford, 2000). The employment incentive in the 1970s drove an increase in the percentage of Asian immigrants within society, growing from 6% of the population in 1970 to 16% by the 1981 (Winkelmann, 1999). The South Asian ethnic group is the fastest growing Asian subgroup and is a diverse set of people from the countries of India, Bangladesh, Pakistan, and Sri Lanka. According to the 2013 national New Zealand (NZ) census the percentage of the Asian population has increased by 33% since 2006. 65.1% of the Asian proportion live in Auckland City, with two of the five reported Asian Subgroups being ethnicities from South Asia: Indian and Sri Lankan (Statistics New Zealand, 2013).

Each country's people bring with them their own culture, values and knowledge on health; all important for health systems to account for in order to improve health outcomes (Bhopal, Phillimore, & Kohli, 1991; Cauquelin, Lim, & Mayer-König, 2014). Therefore, by research paying close attention to how specific ethnic minority groups adapt to interacting with different cultures the influences on health service experiences can be better understood post-migration (Sheldon & Parker, 1992). Thus, this thesis focuses specifically on how the morbidity and mortality experienced by South Asians is influenced by their health service utilisation experiences and perceptions, and PHC's ability to promote healthy lifestyles (Rasanathan, Craig & Perkins, R, 2006).

Results from national reports on the health of Asians reveal South Asian immigrants experience higher rates of avoidable morbidity and mortality from Type 2 Diabetes and Cardiovascular Disease (CVD) than any other Asian group (Mehta, 2012; Ministry of Health, 2006; Scragg,

2010; Zhou, 2009). The prevalence of ill health is not the result of a lack of knowledge among South Asians but rather reflects changes in socioeconomic position and the influence of host culture in providing opportunities to live healthy (Bhopal, Hayes, White, Unwin, Harland, Ayis & Alberti, 2002; Chowdhury, Grace & Kopelman, 2003; Nishtar, 2002). Therefore, South Asians experience a complex post-migration experience creating a loss in health status as years since migration progress, a phenomenon known as the healthy migrant effect (HME). The HME explains the role migration plays in exacerbating South Asian susceptibility to CVD and type 2 diabetes causing avoidable hospitalisations and mortality despite health service utilisation (Fennelly, 2007; McGibbon, Etowa & McPherson, 2008; Ministry of Health, 2006). Wong (2015) suggests one of the largest challenges to improving the high rates of ischaemic heart disease IHD, and chronic illnesses experienced by South Asians living in Auckland is the lack of appropriate health services and health promotion activity that strategically and sensitively target this ethnic minority group. This chapter discussion focuses on setting the scene for the rest of this thesis, by identifying South Asian migrants and the role of PHC in preventing ill health and promoting healthy lifestyles. The findings of this thesis will inform health providers on the role PHC plays in supporting South Asian health and their ability to live healthy lifestyles (Gomez, King & Jackson, 2014; Ministry of Health, 2006). Understanding what causes the persisting high rates of avoidable morbidity and mortality among South Asians also sheds light on the role of society and its culture plays in shaping migrant health behaviours (Sheldon & Parker, 1992).

Countries including Canada, United Kingdom (UK) and the United States of America (USA) have been quick to tailor appropriate health promotion programmes and primary health care services to support South Asians in maintaining healthy migrant lifestyles. Both Auckland City and in NZ as a whole are joining the above countries in researching ethnic inequality in health, recognizing the importance of creating and maintain a culturally competent health system (Baum, 2007; King, 2001). The purpose of this thesis is to facilitate awareness within PHC on how South Asian migrant health changes over time as they interact in a new society with a different set of resources, cultural norms, and behaviours (McDonald & Kennedy, 2004). The overall aim of this thesis is to understand the health service utilisation experiences of the South Asians in Auckland City and the role PHC and the sociocultural environment of NZ has in empowering migrants to live healthy lifestyles (Berry, 1997; Walley, Lawn, Tinker, De

Francisco Chopra, Rudan & Lancet Alma-Ata Working Group, 2008; Wilkinson & Marmot, 2003; Williams, Yu, Jackson & Anderson, 1997).

## **1.1. Conceptual frameworks**

The study uses two conceptual frameworks to explore the health service utilisation behaviours of South Asian immigrants. The first is Berry's acculturation theory which focuses on cross cultural interactions. Secondly is Bourdieu's habitus theory which focuses on a migrant's set of resources and skills brought into a society. Both conceptual frameworks allow the study to explore the interactions of South Asians in NZ society, in terms of interactions with culture but also the way in which predisposed skills and knowledge are carried by migrants which challenge health care utilisation experiences.

### **1.1.1. Acculturation**

Traditionally, research on the health and health care behaviours of ethnic minority groups have used an acculturation theoretical framework. Acculturation is defined as the change in cultural behaviours and attitudes between two or more cultures as constant interaction between a minority and a more dominant culture occurs (Redfield, Linton & Herskovits, 1936). The result of constant cultural interaction experienced by both the host society culture(s) and ethnic minority cultures leads to a process where both the dominant and minority cultures shed off traditional cultural behaviours and practices in order to learn and embody new behaviours as an attempt to adapt to their socioeconomic position (Abraído-Lanza, Armbrister, Flórez, & Aguirre, 2006).

The theory of acculturation was developed with regard to the Latino population living in America, whose health and mental status has persistently declined as a result of immigration and responding to the mixture of cultures they experience. Abraido-Lanza, Armbrister, Florez, & Aguirre (2006) research on Latino health found increased acculturation contributed tremendously to an increased prevalence of cancer and poor physical and mental health, caused by an increased exposure and adaptation of risky health behaviours including smoking and sedentary lifestyles. However, diving deeper into the reasons behind the adoption of new behaviours as a result of acculturation creates clearer picture of influencing interactions by



people living in two different cultures. Issues such as lowered socioeconomic position (SEP), language barriers, discrimination, and loss of social kin are all grass root problems experienced by ethnic minority groups shaping their changing health related behaviour (Anderson, Bulatao & Cohen, 2004).

The process of acculturation experienced by ethnic minority groups reveals the inner desire of man to be accepted and that in order to achieve acceptance in a new society one must adapt to new surroundings and expectations in behaviour (Berry, 1997). This drives the motivation of ethnic minority immigrants to acculturate as fast as possible and pick up both negative and positive behaviours such as a negative change in diet but also a positive change in increased utilisation of health services in the most effective way, including utilizing societal sectors such as health care to benefit from society (Redfield et al, 1936).

Acculturation however does not completely explain the migrant's predisposed expectations and knowledge which challenge their post-migration utilisation of health care. Therefore, acculturation should be used in conjunction with Bourdieu's habitus theory. which focuses on explaining the flow of resources and ability to exert knowledge.

### **1.1.2. Habitus**

Pierre Bourdieu, a French Philosopher, dedicated his research to understanding how groups within society observe, organise, and interact within and between each other to form a collective whole. In Bourdieu's (1977) book titled "The Theory of Practice" he explains how society is a space consisting of many fields dedicated to certain aspects of life (pg179). For example, a society has fields dedicated to employment and education all with their own doxa, a set of rules and expectations shaping individual behaviour and position. However, a doxa can be considered more than rules, and rather a set of guidelines structuring both internal and external influences on a field (Pierre, 1989). How an individual or group interacts with a field is not only reliant upon the doxa but also what power they perceive to have in the form of economics, social including behaviour codes and cultural capital such as language. The observation and acquisition of power is important to gain more of the three types of capital: economic, social, and cultural. The mix of these three capitals are seen as skills and knowledge

that form a “habitus”. According to Bourdieu (1977) individuals carry with them a habitus, defined as a “structuring structure, which organises practices and the perception of practices” (pg187). When individuals migrate to another society they carry with them their own habitus, containing their doxa pre-migration. Upon interacting with a new society, the amount and type of capital(s) is converted into symbolic capital, which symbolises their position of power and control over the resources society perceives and attributes to the migrant. This structuring process of capital and doxa on the habitus of a migrant influences the health and wellbeing of migrants as they interact and navigate through the host society (Bourdieu, 1989).

Therefore, a Bourdieuan habitus lens suggests South Asian migrants carry with them their own habitus, shaped by their background such as education, previous employment, family and social networks. A South Asian migrant’s habitus also carries preconceived expectations regarding their utilisation of health care services and ability to live healthy migrant lifestyles, according to their pre-migration experiences. In theory, habitus provides a theoretical framework to interpret the experiences and perceptions of South Asian interactions with PHC and their challenges in living healthy lifestyles.

Bourdieu’s Habitus lens frames this thesis discussion to comprehensively explore factors such as pre-migration social status and interactions with health care, which shape perceptions of health care and thereby PHC’s ability to effectively improve the health issues of South Asian migrants.

Therefore, in accordance with the need to understand how to reduce the high morbidity and mortality experienced by South Asian migrants, this research piece uses acculturation and habitus as the grounding to explore the health service utilisation experiences, and perceptions of healthy lifestyles as possible causes (Rudmin, 2003). Specifically, how interactions with NZ culture expressed through the health system at a PHC-level, the first point of contact with the health system, influences the impact on declining health as identified in related literature (Fennelly, 2007; Kennedy, McDonald & Biddle, 2006; Rasanathan, Ameratunga & Tse, 2006).

This thesis aims to further research on the health related experience of South Asians as an ethnic minority interacting with PHC and society as stated by the Ministry of Health (2006) Asian Chart Book’s recommendation (pg69). It is important health research plays an active role in developing a more multicultural society that is aware of diversity and the importance of a collective NZ identity, by contributing helpful insights for PHC in NZ to provide an inclusive

delivery of care that reaches minority cultural groups (King, 2000; King, 2001; Ministry of Health, 2011).

The following will briefly introduce the main strands of literature needed to lay the foundation for understanding the health care behaviours of the South Asian immigrant group in Auckland City, NZ. Firstly, the discussion will provide a quick overview of the South Asian ethnic minority group. Secondly, the chapter will define and describe the purpose of PHC-level services of the health system. This will conclude with a clear indication on the aims, objectives and outline to this thesis.

## **1.2. South Asian immigrants**

The South Asian ethnic group is a broad term used by New Zealand to categorize people from a region of Asia spanning from Afghanistan in the west to Bangladesh in the east, and from Nepal in the north to Sri Lanka in the south (Rasanathan, Ameratunga, and Tse, 2006). Different developed countries have their own interpretation of what nationalities make up the South Asian ethnic group, for example, in England and Canada the term South Asian is usually reserved for their predominantly large Indian community, whereas in New Zealand and Australia the term South Asian encapsulates all people from the above described regions and extends to include people of South Asian descent who are from South Africa, Fiji, and other parts of the world (Clarke et al, 1990; Leckie, 1998; Vertovec, 1991). For the purposes of this thesis a narrow use of the NZ's definition of South Asian, as peoples from India, Pakistan, Bangladesh, and Sri Lanka is used. This does not include people of Indian descent whose ancestors migrated to Fiji, South Africa, or any other part of the world. Though they may hold some similarities in religion and diet, their experiences and culture are different to the present day cultures of South Asian ethnic minority (Ministry of Health, 2006; Van der Van, 1995).

The majority of South Asians leave their host country in the hope of living a more successful and thriving life overseas in a developed nation (Arnett, 2002; Brown & Foot, 1994; Hong, Wan, No, & Chiu, 2007; Leckie, 1998). NZ as a society has only recently realised the diversity of cultures it is home to, and embraced their immigrant new world identity as separate from its British colony roots. NZ's perceived national kiwi cultural identity first became prominent in the 1980s when the NZ economy started to increase as a result of immigration, forcing New Zealanders to think

about their identity (Gordon, Campbell, Hay, Maclagan, Subury, & Trudgill, 2004; Mitchell, 2003). Immigration to NZ since the 1980s, and especially in the last decade of the 2000s, has rapidly increased as NZ opened up their borders to recruit educated young immigrants from around the world, including Asian immigrants (Bedford, 1993; Trlin, 1993).

This movement of human resource, knowledge, and skill is often referenced in literature as the globalisation of economies and has paved the way for the formation of heterogeneous societies with a diversifying population consisting of immigrants, ethnic minorities, indigenous groups, and the host culture all in one geographical space (Chen, Benet-Martinez, & Harris Bond, 2008).

Therefore, it is important to understand the experiences and perceptions of South Asian migrants in regards to PHC's ability to deliver effective care consistent with their needs, and promote healthy lifestyles with an awareness of their social circumstances.

### **1.3. Primary Health Care: A brief description**

The World Health Organisation (WHO) defines the health system through three main functions. The first is to improve the health of the population they serve; second, respond to people's expectations; and third, provide financial protection against the costs of ill-health (World Health Organisation, 2000). The main function of a health system ultimately aims to improve the health of people and provide them opportunities to flourish, through the principles of equity and justice (Daniels, 2007; Hoag, 2011).

The goal of maintaining a healthy society in order to secure a steady growing economy is a huge driver of health systems (Ministry of Health, 2011). The focus of health systems has naturally been on acute injuries and infectious diseases, dependant on hospital services (Willison, Williams & Andrews, 2007). However, as the majority of the Western World has progressed post-industrialisation, lifestyles have adapted to fit the structural environment of urbanisation, encouraging sedentary lifestyles which caused a shift from acute to chronic illnesses burdening society (Olshansky & Ault, 1986; Omran, 1971; Omran, 2005; Smallman-Raynor & Phillips, 1999). The increase in trade and business relationships between countries has supported the increased burden of chronic illnesses by creating environments that encourage consumerism of health care and other public goods. The increased flow of migration between economies has also formed heterogeneous societies with diverse health needs (De Maeseneer, Willems, De Sutter, Van de Geuchte, & Billings, 2007). The effects of blurred

boundaries between countries has not only led to the formation of heterogeneous societies but has also allowed immigrants to experience improved living conditions, subsequently increasing their average life expectancy usually at the cost of experiencing morbidity (Caldwell, 2001; Olshansky & Ault, 1986; Omran, 1971).

PHC-level services of a health system is designed to prevent illness by promoting healthy management of productive societies among the population it serves (Solar & Irwin, 2007; Walley et al. 2008). Baum (2007) explains that the outcome of creating and maintaining a well-functioning health system is to reduce financial costs associated with illness for the system and its population.

King (2001) defines PHC in the NZ Primary Health Care strategy as:

“Quality primary health care means essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods that is universally accessible to people in their communities, involves community participation, central part of New Zealand’s health system, and first level of contact with the health system” (Pg1).

Therefore, PHC in NZ is core to the health system, designed to actively partner with communities and empower them to manage their health (Mitchell, 2003). PHC in NZ is based on the values of equity, safety, health promotion, and non-discriminatory community level care in accordance with the Alma Ata Declaration, 1978 (King, 2001; Solar & Irwin, 2007).

Little is known in NZ about the post-migration process South Asian peoples experience as an ethnic minority and how changing perceptions influence health behaviours in accessing and interacting with PHC. Present summaries of health needs assessments and national reports on Asian health suggest South Asians usually utilize PHC services once the onset of illness symptoms appear and require management (Mehta, 2012; MOH, 2006; Scragg, 2010; Zhou, 2009). South Asian adults are more likely to access care for their children rather than themselves and place little value on utilising mental health services. Ho (2003) and Sundquist (2001) suggest the ineffective utilisation of PHC services by migrants compared to European counterparts is caused by a web of socio-cultural circumstances shaping coping systems for maintenance health and ethnic identity. A combination of a lack of shared knowledge on the purpose of PHC services as well as the prioritisation of time, finances impacts their utilisation of health care services (Elder, Ayala & Harris, 1999). Reasons for utilising PHC services among South Asians is often only reserved for annual check-ups and child care (Ho, 2003). This is a matter of concern because the lack of continued interaction with PHC services means there are static relationships with providers, and thus a low level of engagement in on-going accountability between the health professional and patient that occurs at PHC-level services. This fragmented relationship becomes more concerning when considering the already pre-existing high levels of chronic illnesses experienced by ethnic minority groups especially among South Asian immigrants (Anand, Yusuf, Vuksan, Devanesen, Teo, Montague and Share Investigators, 2000; Epping-Jordan, Prutt, Bengoa & Wagner, 2004).

A lack proper communication and trust experienced by South Asians with primary health care are one example of the challenges faced by ethnic minority groups causing alienation. South Asian patients felt their health provider did not understand how their culture influenced their deterioration of mental state and health choices (Asanin& Wilson 2008; Campbell, Ramsay & Green, 2001). The lack of trust and connection with primary health care providers is a re-occurring issue in literature and brings to light the need for research on how the health care behaviours of South Asian peoples are a reflection of the structure, shaping their identity and capacity to live healthy lifestyles (Scheppers, Van Dongen, Dekker, 2006). Understanding the possible barriers perceived and experienced by South Asians in accessing and maintaining effective continuous relationships with PHC services, brings PHC in NZ and around the world one step closer to delivering equitable care to the wellbeing of the population as stated in the Alma Ata Declaration (Baum, 2007; Yamin, 2009).

#### **1.4. Aims and Objectives**

The aim of this research is to understand the health service utilisation experiences and perceptions of South Asians. It will focus on the role of primary health care in delivering effective care and promoting healthy lifestyles.

Specifically, this study will:

- A) Map the profile of the South Asian health seeker, namely their health needs, and rationale for using the primary health care system
- B) Outline the socio-cultural, economic, and contextual factors that influence or create a barrier to health-seeking behaviour within primary health care
- C) Understand their perceptions and experiences of health service utilisation interactions with health professionals within primary health care
- D) Examine the capacity of primary health care to promote healthy lifestyles through health promotion activity

Overall, the study uses an interpretive methodology to analyse the data collected through interviews with participants. Participants were recruited through South Asian associations and the university email system and were required to have a basic English skill set and be over the age of 18. Fifteen in-depth interviews were conducted by the researcher face-to-face with

recruited participants. Each interview lasted duration of thirty to sixty minutes and were recorded in MP3 format for transcription. The interpretive approach to collecting and analysing participant experiences gave the study a rich understanding on the role utilisation of health services is perceived to have in maintaining health and wellbeing.

## **1.5. Outline of thesis**

The following outline provides an overview of the key concepts within the chapters and flow of the study discussion.

the literature chapter is an in-depth review of the present data and work on the health care behaviours of the South Asian ethnic minority group within South Asia and internationally. The chapter discusses the perception of migrants to find ethnic identity post-migration, and a society's role in supporting a balance between cultures. There is a tension evident in literature between adopting a multicultural lifestyle and resorting to a more traditional and familiar way of life. This is a result of the resources shaping the habitus of South Asian immigrants to extoll the preconceived benefits of society. From this, the rest of the chapter explores the circumstances brought about by immigration and its translation into the HME and persisting risk of health issues experienced by South Asian immigrants.

Following on from the introduction and literature review chapters, the methodology chapter complements the introduction by setting the foundation for the rest of the thesis to operate. The chapter covers the research design for this thesis. Participant criteria, research approach to data collection, and analysis are all covered in-depth in the chapter discussion, consistent with the wider aims of the thesis to interpret the factors shaping health care behaviours of South Asians with PHC.

The findings from the content analysis interviews are divided into two main analysis chapters. The first chapter is aimed at understanding how PHC may impact the increasing morbidity and mortality experienced by South Asian migrants in NZ. It begins by exploring what defines quality PHC as supposed to what does not by participants. Specifically, touching on the role pre-migration experiences with health care (including consumer environments) have in shaping post-migration perceptions on utilising health care services here in NZ



The second analysis chapter explores the ability of PHC and society to promote effective health promotion messages and programs to South Asians. Part of understanding the health service experiences and perceptions of South Asians within PHC is through realising the relationship social determinants of health have in creating disparities in opportunities to live preconceived healthy lifestyles. Present health promotions are not matching the knowledge South Asian migrants hold on health, or their desire to enact post-migration. The chapter will explore possible ways PHC can better promote healthy lifestyles through equipping South Asians with information relevant to the wider socio-cultural environment of NZ.

Finally, the study will conclude by discussing the findings related to Bourdieu's habitus framework for exploring how health care behaviours are the embodiment of resources and knowledge available and acquired by South Asian peoples, who then attempt to extol the benefits of societal spaces including health care. The conclusion chapter is centred on tying the study discussion and findings into a simple habitus framework for future health system decision planning to meet the health needs and expectations of South Asian immigrant peoples.

## **1.6. Conclusion**

This introduction has covered who South Asian people are, their culture and values, and why knowing their post-migration experience is beneficial to the health system in reaching its goal of effective care for all. The chapter also briefly looked at the definition and functions of PHC overall and in New Zealand as a country. The majority of the conclusion has been dedicated to setting the scene for the rest of the thesis, to explore the relationship between the South Asian community living in Auckland City, NZ and explaining the primary health care level of the health system through the lens of acculturation.

Overall, this chapter has set the foundation for what research areas to reference, the parameters for the thesis to work within and for the reader to understand the specific nature of the research interest: To bridge the gap of expectations and understanding between Auckland's fastest rising ethnic minority group, South Asians, and primary health care, by presenting the experiences and voices of South Asians first and foremost.

## Chapter two

### **2. SOUTH ASIAN IMMIGRANTS HEALTH AND REVIEW OF LITERATURE**

The problem stated in the introduction chapter of my thesis is the persistence of avoidable health issues reflected as the HME, despite health service utilization among South Asian migrants in Auckland. There is limited evidence on the causation of the trend in NZ, that specifically looks at the role health care plays in shaping health behaviours (Ministry of Health, 2006; Scragg, 2010; Mehta, 2012; Zhou, 2009). Therefore, my review of literature will explore the role of health services and society structures in shaping the habitus of South Asians and the impact habitus has on their ability to extoll the benefits of health services in order to live healthy lifestyles. In this review, I argue that society's response to ethnic migrant groups and their health service utilisation experiences and perceptions s influenced by the acculturation pathway policies and organisational cultures embody i.e. Assimilation and/or diversity. The literature review will first explore what utilisation of health services reflects before dwelling on the impacts assimilation can have on the habitus of South Asians. Lastly, this review will discuss the contrast strategy to assimilation, which is cultural diversity. The argument is that a society based on cultural diversity will reflect it through its health services and thereby create opportunities within and outside of health, across societal spaces, that encourage opportunities for settlement of migrant groups.

Research on the health service experiences of ethnic minority groups can assist NZ in forming a strong multicultural identity (Ashworth, Graham, & Tunbridge, 2007; Van Oudenhoen, Ward & Masgoret, 2006). Exploring the health service utilisation experiences and perceptions of the four main South Asian ethnic groups in NZ is especially relevant to Auckland as the immigrant population continues to grow. The review of literature will support the thesis by exploring the socio-cultural influences shaping health service utilisation and thereby the health of South Asian immigrants (Bogardus, 1928; Jacobson, 1996; Park, 1928).

## **2.1. The use of health services**

The effectiveness of the utilisation of health services at the PHC-level reflects on the health outcomes of the population. This literature review sets the foundation for data analysis by identifying what influences ethnic minority group's utilisation of health services. This review begins with a definition of what utilisation means. Utilisation refers to the behaviour of making use of something in order to achieve an output. In terms of health services, utilization is an indicator of access patients act upon and use to access health services available to them (Rosenstock, 1966). In literature migrant interaction with utilising health services is commonly tied with access to them (Gulliford et al. 2002). The interactions with health services can be determined by a number of factors including the organisational structure of health care services, funding of services, and culture of services. Thomas & Penchansky (1984) frame the utilisation of health services as determined by the ability of health services to meet the health needs of patients. Individuals perceived seriousness of illness, susceptibility of illness, benefits to utilisation, and barriers to health care in regards to their health status. The model states the utilisation of health services is dependent on the individual's desire and perception of agency to access care when needed (Rosenstock, 1974). This is relevant to the thesis topic as South Asian migrant PHC-level service utilisation experiences and perceptions may be determined by a complex set of influences, including the perceived importance of utilising health care, and PHC's ability to accommodate for their migrant needs.

The more value placed by South Asians on maintaining health, the more health service utilisation occurs. However, at the same time, the experiences and perceptions of the health service for South Asians may be heavily dependent on their position in society. Asanin & Wilson (2008) conducted eight focus groups with immigrant populations in Canada Ontario neighborhood revealed that the socio-cultural and economic circumstances of migrant groups challenged their ability to utilise health services in the community. The perceived limited agency, caused by the lack of opportunities provided by policy in society, translated to the experiences of health service utilisation for participants of the focus groups. The health service utilisation behaviours of an individual is dependent on the position they feel they have acquired in a specific societal field as well as their perceived ability to benefit from the field when interacting with it (Veeder, 1975).

Overall the research informs the review that health service utilisation is the interaction between patient and provider services influenced by the wider socio-cultural environment of society. The literature around understanding the factors shaping the health service utilisation experiences and health of South Asians may be strongly tied into their perceived ability to access and benefit from PHC as migrants. Health service utilisation is further explored in this review in connection to society's ability to influence health service utilisation experiences and perceptions. The process of assimilation is connected to the ability to shape health service utilisation experiences of migrant groups, such as South Asians, is discussed in the following chapter.

## **2.2. Assimilative societies role in shaping health service utilisation**

Society's attitudes and organisation of resources can either force migrants to assimilate into host culture, or adapt a multicultural identity. As the previous section discussed, South Asian peoples are educated migrants who carry with them preconceived expectations of migration. The approach society supports ultimately shapes the opportunities migrants have to acquire resources and express habitus influencing health and wellbeing. NZ is known for its fairly multicultural society, eager to provide equality among its resources and opportunities. However, policy values such as equality do not always trickle down into achieving a multicultural society within which migrant habitus can strengthen and develop itself as desired. Trends in health experienced by South Asians, such as the HME and persisting health issues revealed in health reports, are possibly shaped by processes of immigration which then translate into the set of resources shaping habitus. This section will explore the manner in which the wider sociocultural environment could shape interactions with health services and persisting nature of preventable morbidity and mortality among South Asians.

Berry (1997) defines assimilation as one of four acculturation strategies that can be employed by migrant groups and their host societies to manage cultural interactions. Assimilation has been the common strategy of choice in history by societies experiencing cross-cultural interactions. Assimilation of migrant cultures usually occurs when national policies that shape the resources and ability of migrants to embody their culture freely over the host society's culture (Rudmin, 2003). The process of assimilation has been previously successful in the way it influences the ethnic identity of immigrants, by using the migrant's desire to fit in as a lever (Berry et al.

1989). Park (1928) published his ground breaking theory on human migration and the marginal man. The marginal man is considered to be a minority in the population as he shares the beliefs and behaviours of more than one cultural system either through birth, migration, or both. According to Park (1928) and Park (1950) the psyche of the marginal man is often conflicted as he struggles to find a balance between both cultures. The struggle to find a middle ground in cultures can cause high levels of stress from not complexly being submerged in one culture. Stonequest (1937) supports this initial definition of a marginal man, which Park (1928) pg893 explains, and expands on the struggle experienced by the marginal man to find his identity. Both Park and Stonquist develop their theory of a conflicted man by using migrants from Japan and Africa as examples of a marginal man. In summary, it is suggested as much as migrants from Japan and Africa attempt and perceive themselves a part of the European society; they will always be marked different because of their physical appearance acting as a signpost for their cultural differences. This places the marginal man initially in literature concerning intercultural interaction or in other words acculturation in a negative light. Both in their later works however they acknowledge it is through understanding the man of two cultures that civilisation can progress. History is filled with tales of cultures interacting and fusing aspects of each culture to build a strong society.

Simsova (1974) suggests the inner conflict of a marginal man resolves itself when assimilation into one culture happens. The inner conflict experienced by immigrants is shaped by the pressure to assimilate and avoid becoming marginalised. This can be mitigated by creating a supportive culture within which migrants are equipped to express their cultures (Gordon, 1964).

Literature on South Asian migrants suggests that this ethnic group does not resist the idea of assimilation because migration is a perceived positive choice that will result in better lifestyles for them and their families. A brief history lesson on the development of South Asia especially its largest country, India, gives an inside glance into the social motivation for immigration. Around 600BC the South Asian region was comprised largely of the Indian subcontinent. Countries including Sri Lanka, Bangladesh and Pakistan were a part of India and were home to rich dynasties of wealth and power (Kosinski & Elahi, 1985; Majumdr, 2010). However since the separation of Sri Lanka centuries ago, followed by Pakistan and Bangladesh around the time of India gaining its independence, social development has been slow (Thapar, 1990).

Afghanistan and Pakistan have had a turbulent history of unstable governments and politics. Sri Lanka and Bangladesh have developed their economies on agriculture and social welfare (Ollapally, 2008). Since the 1990s India has tried to manage major inequalities in health and social indicators despite rapid economic growth. India has fallen back compared to its neighbours Nepal and Bangladesh in meeting the welfare needs of its population and not just a small elite minority (Drèze & Sen, 2012). The change from the regions historic rich past may shed light on the drive to immigrate to a country not just based on economic wealth, but also for social security and wellness. Therefore, because of the perceived benefit of migration on health and wellbeing on lives, South Asians may already hold the expectation that they should assimilate into host society post-migration. Exploring the motivations to migrate reveals more about the openness to assimilate by South Asians. Regardless of the loss in the symbolic and material capital immigration can have on their lives it is still a common choice made by South Asians and many other ethnic groups (Clarke, Peach & Vertovec, 1990; Wagle, 2013).

Assimilation can exacerbate predisposed susceptibility to illnesses and HME among South Asian peoples. Immigration pressures experienced through assimilative acculturation structures and policies in society reshape the habitus behaviours and ability to benefit from society. As a result of assimilative acculturation the health behaviours of South Asians may determine their health service utilisation experiences. Project Dil, a specifically tailored health promotion program for South Asian ethnics living in Leicestershire England, acknowledged the deterioration in health status experienced as the culture of assimilation began to challenge ability to utilise resources within society including health services (Farooqi & Bhavsar, 2001). The study found that negative behaviours including excessive alcohol consumption, high fat intake, and high levels of stress are suggested to be learned through cultural positions in society. These behaviours add to the already pre-existing high risk of heart disease and type 2 diabetes, as well as other chronic illnesses. Jasso, Massey, Rosenzweig & Smith (2004) illustrate a similar finding about the health of migrants through the assimilation into a host society. Their study suggested deterioration in health experienced by Latino immigrants in America is caused by the embodiment of restricted and controlled lifestyles. It suggests then that assimilative societal policies and structures restrict ability to express cultural identity and live desired lifestyles and can even shape migrant's ability to perceive health services in a positive light (Anderson, Bulatao & Cohen, 2004; Jasso et al, 2004).

Overall, a positive perception of migration may encourage the assimilation of the host society culture but it may also challenge the preconceived knowledge and expectations on lifestyles. These are challenged and complicated by policies and organisational structures (Anderson et al, 2003; Jamison et al. 2006). Though assimilation may be expected and accepted by South Asians, their habitus acts as a strong influence in behaviour resulting in a desire to keep aspects of their own culture intact. The following section will explore the role habitus plays in health service utilisation by reviewing two NZ based studies which have incorporated habitus to explain health behaviours of their migrant groups

### **2.3. Habitus in shaping migrant health service behaviours**

As explained in the introduction chapter of this thesis, Bourdieu's habitus theory provides grounding for encapsulating the experiences and perceptions shaping utilisation of health services experienced of South Asians. Habitus is the predisposed set of behaviours and expectations shaped by an individual's position in society relative to their control over resources and cultural behaviours (Smith, 2003). The predisposed set of resources and behaviours carried by habitus of South Asians is dependent on the host society's ability to accommodate, support, and adaptation of habitus and its behaviours post-migration (Chance, 1965; Ryder, Alden, & Paulhus, 2000). Ryder et al, (2000) explains that immigrant ethnic minority groups have more of a desire to fit in and accomplish success and identity in a new society. Post-migration is a journey of cultural embodiment of behaviours according to continuously shaping journey dependant on the resources in a new society (Redfield et al, 1936).

Habitus can be used to explain the health service utilisation experiences and perceptions of South Asians through understanding the ways in which societies based on assimilation shape positive utilisation and outcomes in comparison to culturally diverse societies. Few studies have used Bourdieu's habitus theory to explain migrant health related behaviours in NZ, however the following will look closely at the two main studies found in NZ literature.

The first is Anderson (2008) study which used habitus as a framework to explain the tuberculosis rates among Indian, Korean and Chinese immigrants living in NZ. The use of habitus allowed Anderson (2008) to map out how the immigration policies of NZ shaped the local agency and ability of immigrant groups to live healthy lives. Predisposed risks to TB were

aggravated post-migration as a result of living in lower socioeconomic positions (SEP). The stress brought about by living in low SEP levels also fed into the ability of participants to express desired control over their own lifestyles, further aggregating dormant TB. Habitus showed the high level of TB among these ethnic migrant groups was a result of the pressure placed on their habitus of resources and skills left unsupported by immigration and settlement policies in NZ. The lack of access to quality employment, housing and other social determinants of health caused inequalities in areas such as health care, thereby, perpetuating TB rates.

Freeman (2012) is another researcher who focuses on migrant health in NZ through a habitus lens. The study explores the health behaviours and experiences of Finnish immigrants through a narrative analysis. The study through employing in-depth interviews with Finnish immigrants concludes the habitus of Finnish people formed prior to immigration is carried over with immigrants and persistently held onto and expressed in NZ. The habitus of Finnish immigrants is challenged post-migration in NZ by their experiences with health care and the assumption they are much like British immigrants. However, participants of the study highlight how their habitus, shaped by their own resources, skills, and understanding of health is relayed in their lay seeking health behaviours when sick. The study informs policymaking and health service delivery agencies to recognise the unique immigration experiences and predisposed understandings of health shaping habitus often left restricted in “post cultural” situations.

Anderson (2008) and Freeman (2012) reveal two similar considerations which can be made by the use of habitus in order to understand the health of migrants. The first is that migrant health is strongly linked to the ability of policies and organisational culture(s) to be inclusive of the habitus of immigrant groups when supporting settlement and delivering services. Second, the health behaviours of migrant groups is predisposed and carried over when migrating to another society. Therefore, policy and services must create environments within which migrant habitus can be expressed and supported to acculturate in a manner which benefits the health of migrant groups. The conclusions made by these two studies inform the literature review that the habitus of South Asian migrants may be strongly influenced by the wider immigration and organisational culture health care services. Therefore the ability of South Asians to express their habitus, including their cultural resources and outlooks on certain issues such as health, may be challenged by assimilative policies that do not encourage diversity. The two studies



express the importance of having a culturally diverse society which provides opportunities for migrant groups to succeed. The following section will take a closer look into what shapes a culturally diverse society and PHC-level services possible role in shaping positive health service utilisation experiences and perceptions.

#### **2.4. Cultural Pluralism and PHC service delivery**

The assimilation section of the review highlighted the negative influences PHC-level services can have when cultural diversity is ignored on the health and wellbeing of South Asians and other migrants. Culturally diverse PHC-level services may be better equipped to support positive health service utilisation experiences and perceptions, thereby causing positive health outcomes for South Asians. As the habitus section argued, a society which takes a culturally diverse approach to policymaking and service delivery is better equipped to improve the health service utilisation experiences and outcomes of South Asian migrants.

Bochner (2013) suggests true integration of minority cultures in a society occurs when values of diversity and acceptance are built into policy and organisational culture. Societies must advocate for the health needs of ethnic minority groups and provide opportunities to be healthy and succeed. Host societies to immigrant groups should be educated to be aware of cultural differences in approaching health; simply mentioning the existence of different cultures does not support a positive acculturation process (Bochner 2013). Berry (2003) and Rudmin (2003) further claim that culturally pluralistic societies are the favoured result of cultural interaction and immigration. Kağitçibasi (1987) suggests that policy level change should include the awareness of cultural integration that can positively impact the experience of a minority group in becoming less isolated. However the more distant the minority culture is from their host culture, the harder it is for them to be integrated into a pluralistic society without issues of discrimination and inequalities in healthcare, education, and living standards.

Perceived racial discrimination by South Asian immigrants in society may influence PHC-level service's ability to accommodate for South Asians and their health service utilisation experiences. The perceived feeling of inadequacy in expressing one's own ethnic identity can be further perpetuated through verbal and physical abuse based of racial differences in society. Often South Asian immigrants and even other ethnic minority immigrants assume experiencing

racial discrimination is a normal part of acculturating into a new culture and subsequently accept any negative remarks made against their ethnic identity in order to be accepted by the wider society (Bhugra, 2004; Rudmin, 2003). Harris et al. (2012) conclude that racial discrimination is embodied physically and mentally throughout an individual's life course even if their social demographic position changes substantially. The effects of embodiment last throughout an individual's life course shaping ethnic minority groups help seeking behaviour and perceptions towards and experiences with institutions including health care, education, employment, and housing. The reception of the host society displayed through sectors including the health sector may also challenge the capacity of South Asians and other ethnic minority groups to feel comfortable in adopting their culture into their host culture (Murray-Garcia et al, 2000).

As the level of cultural distance increases between the minority and dominant the more of a challenge may be perceived to adapt in society (Nesdal & Mak, 2003). Bokestijn (1988) study on intercultural migration and identity suggests that intercultural hostility occurs when there is a lack of communication between cultures with a larger distance in backgrounds and traditions. This can be especially important and related to health systems that serve a diverse set of ethnic backgrounds. PHC-level services that are cautious of their ethnic minority patients perceiving a disconnect between their culture and the culture of the service may experience persistent ill health despite health service utilisation. The literature suggests creating a positive health service utilisation experience and impacting perceptions could be done effectively through creating a PHC-level in the health system that is well immersed in cultural diversity and avoids the discrimination of different cultural outlooks on health issues.

In his early works on the marginal man, Park (1928) brought up the notion of the "other" many host societies may naturally resort to in order to make sense of immigrant cultures. As explained in research by Johnson, Bottorff et al. (2004) the feeling of "othering" can damage the self-esteem and ability of an immigrant to express their own culture, and cause segregation from national services including health care and education services. Korkmaz (2006) discusses the example of North West European countries, including the comparison of Switzerland and Germany with Britain and Canada, to describe the vital role policies have in encouraging and shaping host society attitudes towards immigrants for minority cultures and how this influences their ability to express culture freely. This is why diversity is an integral part of shaping

freedom and equality among people as a lack of it can make adapting into a new society difficult for immigrants (Anderson & Taylor, 2007). The potential for host society and its culture to shape the post-migration process extends beyond first generation immigrants, to their children. A study on second generation South Asian women living in Canada found this to be the case, as the women found trying to find a balance between their freedom in Canadian culture to the restrictions of South Asian culture both stressful and hard to maintain. In the end many of the young women grew to resent their freedom in modern culture because they felt rejected by both cultures (Handa, 1997).

Thus a host society's capacity to embrace diversity culturally is a strong shaper of health behaviours and the settlement process for immigrants from ethnic minorities. Canada is a useful example of a diverse society that has progressed towards multicultural policy overflowing into shaping the attitudes of its people. The country is home to not only a large amount of South Asian immigrants, but other Asian and European nationalities since the 1970s. In a recent national document, the progression towards multicultural policy was noted. It was evident the notion of multiculturalism was not something that happened and was accepted overnight, but a constant working progress since the 1970s which focused on celebrating differences.

Smolicz (1988) approaches the formation and maintenance of cultural pluralism within one society a different way. The author argues that while it is important for both the host and minority cultures to be aware of one another and attempt to fuse cultures for development and identity, it has to be done with caution. If adaptation to pluralism is done rapidly it can lend itself to the process of assimilation instead and create tension for minority groups leaving them marginalised. This was the case for the Aboriginal people of Australia who attempted to keep both cultures but quickly lost their own heritage in the process. Therefore cultural pluralism is best achieved when society agrees on common core values that drive its development for future generations (Smolicz, 1984). Another example of host society's attitudes shaping and supporting the overall habitus of resources and cultural identity is the interaction between Turkish immigrants in the Netherlands. Fons (2003) studied the perceptions of acculturation in the Netherlands between the Dutch majority and Turkish Dutch minority groups and examined the attitudes of both groups under Berry's acculturation lens. The study found that the majority Dutch group were more neutral in their attitudes towards multiculturalism whereas the Turkish minority favoured it more. Another interesting finding was that the majority group seemed to

## Review of literature: Cultural diversity in PHC service delivery

favour assimilation as it was perceived to cause less disruption to their idea of normal. The challenge for ethnically diverse societies, such as New Zealand is to allow immigrant groups to find a balance between the expression of values, resource capital, skills, and identity extolled from both cultures prior to immigration and post-migration (Anderson et al, 2007; Bochner, 2013).

The health service utilisation experiences of South Asians and other ethnic migrant groups is shaped by the ability of PHC and the health system to accommodate for cultural diversity over assimilative policies and organisational service delivery. Given these facts the health system at the PHC-level of care should have the ability to embody cultural diversity through acknowledging and accommodating the socio-cultural influences on health. For South Asian migrants, the literature indicates two main characteristics that may shape their health service utilisation experiences and signals to PHC how cultural diversity can be accommodated to improve utilisation experiences. Below is a close look at the two main society level influences challenging PHC-level services to create positive health service utilisation experiences.

### **2.4.1. Social determinants of health influence on health service utilisation experiences**

The last socio-cultural consideration effective PHC-level services can make and accommodate for, is the relationship between health service utilisation experiences and the role of acculturating to new an initial lowered socioeconomic position (SEP). The social determinants of health (SDH) include living conditions, income level, education, and access to health care (Marmot et al. 2008). The health of an individual is suggested to be influenced by their ability utilise society spaces including health care. Disparities in health can occur commonly among migrant groups as a lack of equal opportunities in SDH influencing their ability to interact with societal spaces as health care in a positive manner (Spencer & Markstrom-Adams, 1990).

Through a migrant's overall health and wellbeing is shaped by their employment status, occupation, education, living conditions, and access to recreation places and basic amenities such as health care (Galobardes et al. 2006). The high rates of persisting illnesses reflected by the HME among South Asian migrants can be related to their ability to extoll the benefits of SDH and thrive in the society they migrate to. Migration is known to lower the socioeconomic position of migrants through unsupportive settlement policies which create a challenge for migrants to live healthy. The effects of ill health and health service utilisation experiences when living in lowered SEP are also embodied into the wellbeing of a migrant throughout their life course (Power et al. 2005; Smith, et al. 1997).

The structural and natural environment where an ethnic minority groups migrates to plays a huge role in their ability to positively acculturate and express predisposed knowledge and skills through their migrant habitus.

A migrant group's acculturation journey and ability to express habitus is suggested to be responsive to the societal structures and values of society. A society that supports the settlement process of migrants through its policies and societal structures and avoids assimilation and marginalisation can change the HME phenomenon (Karlsen, & Nazroo, 2002). Therefore, a culturally diverse society may generate positive health service utilisation experiences as a result of a positive immigration settlement process.

Overall, what the literature shows is that the acculturation path of society strongly shapes their ability to make use of the SDH and express ethnic identity when utilising societal spaces such as health care (Bhopal et al, 2002; Sundquist, 1995). Ethnic minority groups living in low SEP may experience dissatisfactory utilisation experiences and perceptions with PHC-level services (Nazroo, 2003; Williams et al.1997). The process of “othering” where people are deliberately marginalized and discriminated against by policy and organisational culture can be negatively shape the experiences and perceptions of utilising health care by migrant groups (Johnson et al, 2004). When people are given equal opportunities and feel safe with their surroundings adapting to a new culture becomes easier and more beneficial to health as it raises self-esteem and participation in society (Anderson & Taylor, 2007). A lack of cultural diversity acceptance and accommodation by health care can cause illnesses to go unchecked and harder to manage once they health utilisation has occurred (Lamb et al. 2011). Therefore the ability of society to embrace diversity is by policies that support a positive experience of the SDH of ethnic minority groups and their wellbeing.

## **2.5. Conclusion**

The main findings from this literature review are centred on understanding why and how the identity of South Asians as immigrants in NZ can shape their predisposed behaviours and motivations as a part of their habitus to utilise health services. Through this discussion it is evident the health behaviours of South Asians in NZ and around the globe are being constantly crafted by their overall composition of material and social capitals as their habitus attempts to fit into a new society. The trends discussed in detail throughout the literature review have highlighted there is a gap in PHC’s current activity and research concerning PHC’s ability to meet the needs of the South Asian community living in Auckland City, NZ. The changing health illnesses shown by the healthy migrant effect can be shaped by the relationship South Asian immigrants have with the wider socio-cultural environment and PHC-level services. The role of health systems can act as a positive and/or negative influence in shaping and supporting the post-migration and acculturation process experienced by South Asians. Therefore, it is important to mend gaps in delivery and improve the health outcomes of growing ethnic minority groups.

## Review of literature: Conclusion of the literature review

The key point drawn from this review has been the understanding of a South Asian migrant's experiences and perceptions of PHC-level care in context of societies and thereby PHC's ability to accommodate for cultural diversity in needs and values. The review has explored how the health service utilisation behaviours of South Asian migrants can be shaped by their habitus as migrants willing to assimilate in health care services, and the role of acculturation strategies employed by societies and health care. Employing a culturally pluralistic society which embraces multiculturalism may be a better option than assimilation to shape societal spaces including health to embody and embrace cultural diversity (World Health Organisation, 2003).

Overall, PHC service culture needs to be supported by societal structures and organisational culture in delivering health and social services that are equitable, accessible, and effective in positively impacting the health outcomes of ethnic groups such as South Asians. There is an inherent desire within human beings to identify themselves with the habitus of traditions, language, values and diet of host society post-migration in order to be accepted for their own culture (Bottomley, 1998). However, the desire to maintain and adapt ethnic cultural identity in a host culture that does not clearly support habitus of knowledge and resources in capital runs the risk of marginalising cultural groups (Benedict, 1934; Schiller et al. 1992). It is suggested by the review that assimilative policies form negative society attitudes and health care culture only inhibits the ability to support ethnic minorities including South Asians in living their aspirations with good health. A culturally pluralistic society however, can better mitigate and prevent the effects of HME by creating culturally inclusive policies and health care services. Overall, societies can host immigrant cultures and support equality in health and wellbeing by structuring its policy to empower ethnic minority groups in order that they may navigate the health services benefits from the system (Bauman, 1996).

# Chapter three

## **3. METHODOLOGY: AN INTERPRETIVE APPROACH**

The methodology chapter of the study is designed to capture and signpost the main research design the thesis will operate on. The chapter discussion will state the approach to data collection as well as analysis and finish by concluding the main ethical considerations to the research topic.

### **3.1. Research design**

Qualitative research in healthcare is concerned with the lived experiences, social constructs, individual and group interactions, behaviours and changes in lifestyles shaping the health of a population (Strauss, & Corbin, 1990). The research project is a small scale interpretive qualitative study aiming to expand knowledge on the health seeking behaviour of an ethnic minority group living in New Zealand. Employing a qualitative research design will assist discussion to develop a picture of the influences shaping the health service utilisation experiences and perceptions of PHC's ability to deliver quality care and promote healthy lifestyles in a succulent manner.

#### **3.1.1. Methodological consideration: Interpretive Qualitative Research**

The research question is explored through an interpretative approach to qualitative research. An interpretive methodological approach to conducting qualitative research takes a stance that there are multiple realities of what is defined as the truth, compared to the opposite stance which claims there is only one objective truth regardless of circumstance. These multiple realities suggest all individuals and even groups form their own sense of reality and truth based on their cultural background, knowledge skill, and experiences in different situations and on different topics (Green & Thorogood, 2013; Patton, 2005; Ross, 2012). An interpretive approach to qualitative study stems from the phenomenology approach, defined as the study of a phenomenon experienced by groups of people or individually by a person (Taylor, & Bogdan, 1998). The approach is usually preferred over a positivist methodology when conducting a qualitative study because the positivist paradigm in research suggests that there can be and is



## An interpretive methodology approach to research: Conclusion

only is one objective reality and truth (Highlen & Finley, 1996). Max Weber, one of the major influences in sociology suggest the rationale in employing qualitative research, claiming that people who are studied should be treated “as if they were human beings” and not mere objects to mechanically draw information out of (Patton, 2005).

Qualitative research is based on principles of providing insight and depth into the lived experiences of people in order to understand their perceptions influencing other parts of life including health (Holloway, 2005). Listening and understanding the stories told by people adds richness to research and is the pinnacle reason behind the formation of qualitative research (Merriam, 2002).

Despite the well-formed presence of the interpretive approach qualitative research, there is still a slight concern among the different research designs in creating clear distinctions between shaping the foundation of interpretive qualitative study designs. The risk of using the same criteria that quantitative studies would use does not reflect the original intent of the interpretive approach and positivistic criteria, including transferability, credibility, and validity of research designs (Drisko, 1997; Malterud, 2001). Interpretive research therefore, has to be careful not to blur the lines between the two schools of thought, quantitative and qualitative, and what defines the two different paradigms as criteria like validity is hard to achieve when dealing with non-numerical data (Koch, 2006; Sandberg, 2005). The use of them in interpretive qualitative research blurs the differences stated by qualitative schools of thought and therefore suggests the need to form their own criteria for assessing effect (Denzin & Lincoln, 2009).

Confusion in the use of criteria such as transferability may be attributed to the generalization of ideas by interpretive qualitative research which is usually deemed impossible because experience is relative (Drisko, 1997). However, transferability between studies on the same topic can occur, because there is a level of commonality in experiences and values carried by humans. An interpretive approach to research may be unique to the context in which the study operates in and thereby produce participant specific data. However, underlying the lived experiences of participants are common issues, challenges, and views of the world based on cultural background, gender and so on (Flick, 2009). This means that interpretive qualitative research may display traces of criteria belonging to research in general not only belonging to quantitative study designs. Even with an interpretative approach to qualitative study where it

## An interpretive methodology approach to research: Conclusion

is assumed every study may produce different results based on the chosen cohort and their experiences and perceptions on a topic, there is still a level of commonality in data that can be organised into themes (Polit & Beck, 2010). Qualitative studies on the health of South Asians are a beneficial example of using an interpretive qualitative approach to understand the lived experiences of people reflected by the expressions of participants in a specific study. Research on migrant health service utilisation behaviours may yield similar findings through a qualitative interpretive research attributed to similar themes of miscommunication, discrimination, stress of immigration and relationships with health providers (Rahman & Rollock, 2004; Worth et al. 2009). Of course each study is unique and there is a level of information that cannot be transferred to make sense of another immigrant group, but there is also a level of information, especially in the above themes, that help as research to build a strong understanding on the perception and experiences of people and the lives they live through qualitative paradigms relevant for policy and decision makers (Mays & Pope, 2000).

Previous interpretive approaches in qualitative health care research on ethnic minority health provided rich data for researchers, as it allowed studies room to develop pre-existing themes in literature and the formation of new research areas expressed by participants. Florez et al. (2009) used an interpretive framework to understand the Breast Cancer beliefs of Dominican women living in the USA. Dominican women are part of the Latino minority group, who have a long history of migrating to the US and underutilise health care services often influenced by the disparities in social and health conditions experienced. Approaching sensitive experiences of Dominican women through an interpretive framework allowed the interviewers to form a trusted rapport with participants, to gain full understanding of the beliefs shared. An interpretive framework allows the research question at hand to be fully explored providing and expanding existing knowledge on the experiences and perceptions of South Asian health behaviours and interactions with PHC in Auckland City, NZ (Denzin & Lincoln, 2011; Holloway, 2005). Although, arguments against the rigour of interpretive qualitative research exist, it is still a well-used and valid qualitative paradigm and one of the only approaches to assist qualitative studies in exploring and understanding the social lived aspects of the meaning behind numerical data (King et al. 1994). An interpretive framework supports qualitative research in capturing the reality of the different circumstances people groups whose voices may go overshadowed or unexplained by context in quantitative numerical data. Questions in the in-depth interviews are designed on understanding perceptions and experiences appropriate to

the research question. Without this curiosity and expansion of knowledge of understanding the stories behind trends and phenomenon of the Healthy Migrant Effect (HME) cannot be completely helped (Ritchie et al. 2013).

### **3.2. Research approach**

The main form of recruitment was through South Asian associations and the faculty student email system to advertise the study. There is sufficient literature on the positive effects of social support has on immigrant health. The content analysis of participant in-depth interviews acknowledges the ways in which PHC-level services can use social connections among South Asian communities as a lever to gain knowledge on improving utilisation experiences of care and promoting healthy lifestyles. The following describes the avenues used to advertise the study, how interviews occurred, and participants recruited.

#### **3.2.1. Advertising the study**

The study used a recruitment notice as seen in the appendix section to this thesis which stated participants must identify as being from South Asia, speak English, and be over 18 years of age. The study was advertised through the university student faculty system and South Asian associations. Around four to five South Asian associations were contacted and consulted with by me. The main associations in Auckland contacted were the Sri Lankan association, Central Indian association, Bangladesh association, and Pakistan association. Unfortunately, the Indian association was the only one willing to be used as a place for recruitment of participants to occur. The other associations including the Sri Lankan association did respond to consultation where they were briefed on the study and agreed to participation but in the end did not respond to the study when recruitment started. Despite the lack of facilitation from other associations, the email sent out to the faculty recruited almost half of the participants interviewed. Another form of advertisement of the study occurred from participants suggesting other participants who expressed interest in being involved in the study. In the end fifteen participants were interviewed in a semi-structured style face to face with the researcher.

#### **3.2.2. Primary data collection**

In-depth interviews were conducted face to face in a chosen private location that is comfortable for the interviewee and maintains a level of privacy. The main strength of in-

depth interviews is listening and placing value on the participant's experience and helps the researcher to understand South Asian health seeking behaviour as an ethnic minority (Coombes et al. 2009).

Knowledge is understood as buried metal and the interviewer is a miner who unearths the valuable metal... [T]he knowledge is waiting in the subject's interior to be uncovered, uncontaminated by the miner. The interviewer digs nuggets of data or meanings out of a subject's pure experiences, unpolluted by any leading questions. (Pg,139)

The extract above is taken from Legard et al. (2003) who describe the purposes of in-depth interviews through a miner metaphor. The interviewer is described to be a miner who digs little valuable pieces of nuggets describing the interviewee's experiences and unravelling treasured data that is not shared by the interviewer. This is a consistent description of the purpose of in-depth interviews and their use for this interpretive small scaled qualitative study. Each interview with a participant is an opportunity to interact and engage in in-depth conversation on the topic of interest. In-depth interviews are a common tool to use for a qualitative interpretive study in search of understanding the experiences of people (Turner III, 2010). The interviewer creates a safe environment for the interviewees by first summarizing the purpose of the qualitative study and then asking a series of appropriate open-ended questions formatted to encourage participants to share their experiences. Interviews use an interview guide composed of open-ended questions and semi-structured questions based on themes and areas of interest indicated in a literature review. This will help to form a clear picture of the experiences and perceptions of how health behaviours change told by participants while referring to themes indicated in relevant literature (Green & Thorgood, 2014). This metaphor, is applied to the semi-structured questions used in the in-depth interviews of the study.

The interview question guide seen in the appendix section of this thesis, were consistent with key themes found in literature on the experiences of ethnic minority groups in a new society, including themes such as HME and the role society's role in shaping acculturation. The approach to conducting in-depth interviews took a deductive approach in shaping its questions which utilizes existing theories or findings on a topic i.e. Bourdieu's habitus theory for explaining high morbidity rate, to interpret and make conclusions on the study findings. A deductive interpretive approach also encourages the formation of questions that allow room for

participants to express perceptions and experiences based on previous research of the phenomenon the researcher has conducted (Mears 2012).

All in-depth interviews were also recorded via an electronic recorder with the permission of participants to allow the researcher to concentrate and form in-depth conversations with participants.

### **3.2.3. Participant Criteria**

It is important to understand the process of immigration as a major underlying process shaping the experiences and perceptions of immigrants and change in behaviour as one culture interacts with a more dominant culture. Therefore, exposure to health risks including cardiovascular diseases (CVD) and type 2 diabetes observed in existing data sets can be attributed to the immigration experiences of South Asian immigrants in New Zealand accumulating as years since migration prolong (Scragg, 2010). Over time, the effects of immigration begin to accumulate, expressed through perceptions and experiences with certain societal spaces including education and health care services (Leclere, Jensen, & Biddlecom, 1994). As an ethnic minority group becomes more associated with their new host culture, the main goal from both the host and minority cultural groups is to fuse characteristics of each other to form an adapted ethnic identity. However, the success of forming and maintaining a multicultural society that embraces diversity and supports new ethnic minority groups from the continent of Asia and the Middle East is still to be explored and published in NZ health systems literature (Ministry of Health, 2006). The effects of cultural adaptation can lead to the adoption of host society behaviours such as binge drinking, smoking, and change in the traditional diet. At the same time, a lack of support from the socio-cultural of host society post-migration can also lead to negative effects on health, by marginalising oneself from extolling the benefits of society and cultural resources within societal spaces such as health care. Ethnic minority groups can also experience marginalisation from the host society through institutional and self-perceived discrimination that causes isolation, depression, and untreated illnesses (Salant & Lauderdale, 2003). The prominent impact encapsulating the processes of habitus through immigration on the health of ethnic minority groups is described in literature as the Healthy Migrant Effect (Fennelly, 2007; Ministry of Health, 2006). The Healthy Migrant effect explains that the health of immigrants declines the longer they stay in the host society, because of acculturation in diet and cultural behaviours (Rasanathan, Ameratunga, and Tse, 2006) The

## An interpretive methodology approach to research: Conclusion

HME encapsulates the persisting high health risks experienced by South Asians (Fennelly, 2007). Little is known about the role PHC plays in shaping the health service utilisation behaviour and experience of South Asians in NZ the primary health care system. More knowledge about the experiences of the South Asian community in NZ within primary health care increases the depth of knowledge on ethnic minority health and how to improve equity.

Based on the lack of research specifically targeted at understanding the post-migration and processes on the South Asian growing minority in NZ, participants were recruited with specific attention to their age and years since migration.

The original participant criteria as seen in the recruitment notice in the appendixes of the thesis was the following: Participants need to be 18/ and or above the age of 18. Participants must identify themselves as being South Asian (this covers Afghanistan in the West to Bangladesh in the East, and Nepal in the North to the Maldives in the South), Lastly, a basic English skill set as there is no interpreter involved.

As recruitment progressed, participants recruited were consistent with the criteria. For example, all participants were over 18 years of age and had a high level of English oral and written skills. However, participants were recruited based of the four main South Asian ethnic groups: Indian, Sri Lankan, Bangladeshi, and Pakistani only excluding people from Afghanistan and Nepal. The narrowing of participant country origin happened to be consistent with the review of literature which only focused on the four main South Asian ethnic groups and in relation to the active South Asian groups in Auckland.

Overall, the mix of participants the study recruited can be seen below as per their code name, age, and country of origin. The largest proportion of participants came from India and were middle aged 35 and above. Followed by Bangladeshi participants totaling at three, Sri Lankan at 2, and Pakistani at 1. The representation in number of participants is also reflective of the positive and active response from the Auckland central Indian association which facilitated recruitment of participants. The central Indian association was contacted in the same as the other associations were contacted, through phone calls and emails. From the initial set of emails, I was invited to a Bollywood aerobics class at the Mahatma Gandhi center to announce my study and recruit participants. On my first visit I handed out a number of recruitment forms and noted down the numbers potential participants to follow up on through the week. The follow up calls briefed participants on the study once more about the study and confirmed an

## An interpretive methodology approach to research: Conclusion

interview time. At the same time, from my initial visit there were two participants ready to be interviewed the following week, so participant information sheets were given to them. A total of three visits occurred to the center to recruit and interview people. Majority of the interviews occurred at a café after the aerobics class face to face.

The other avenue of recruitment occurred through faculty email. Potential participants responded to the announcement in their mailbox. After a phone call briefing the participant an interview time and participant information sheet was sent for participants to make an informed decision. Participants who responded through the email chose to be interviewed at Grafton campus. The final avenue of recruitment occurred through word of mouth from which three Bangladesh people were recruited in a similar way through phone calls which lead to them being interviewed at their home.

**Table 1: Participants**

Gender	Age	Indian	Sri Lankan	Bangladesh	Pakistan
Male	20-35		Paul		
	35 and above	Jerry Ralph		Andrew	
Female	20-30	Joanna	Tanya	Monica	Isabella
	35 and above	Sarah Lucy Penelope Lotus Sally HR (above 70 years of age)		Matilda	
<b>Total</b>		9	2	3	1
		Total: 15 participants			

**Table 1 participants**



Overall, the participants recruited were also represented by the following waves and generations and waves. The categories of waves and generations is used to assist the content analysis further in the thesis.

**Table 2 participant categorization**

Wave Number	Years of migration
1	1900s-1950s
2	1050s-1980s
3	1980s-2000s
4	2000-2010s
Generations	1 <sup>st</sup> generation – overseas born migrants
	1.5 generation – overseas born children of migrants
	2 <sup>nd</sup> generation – NZ born to migrants

**3.2.3.1 First and second waves of South Asian immigrants:**

The first (1900-1950) and second (1950-1980) waves of South Asian immigrants encapsulate the experiences and adaption of mind-sets allegedly might be well immersed in the host society culture, rooted in their perceived ethnic identity and feel comfortable in expressing it in their society. An indicator of immigrant ethnic minority groups adapting in a positive manner within a host society can be an increased rate of health service utilisation at the primary health care

level (King, 2001; Thomas, 1995). Health service utilisation increase as an awareness of the health system and its services become apparent to the immigrant and a sense of one's own health issues is understood. The effects of discrimination, and cultural pressures increases and becomes evident through the presence of an early onset of chronic illnesses physical and mental (Berry, 1997). The effects of migration on identity and behaviours also become evident over the years the generational differences between parent and child vary in health seeking behaviours (Das, & Kemp, 1997). It is interesting to explore the ways in which health behaviours change and are shaped as ethnic identity also changes based on socio-cultural and material circumstances. South Asian Indians have had a longer history in NZ compared to some of the other ethnic groups and have either completely assimilated into the NZ culture, or have limited their interactions to social enclaves (Buckner, 2008; Leckie, 1998). Participants who have spent a longer time as an immigrant are assumed to have acquired more knowledge about the health system and the culture around them. The in depth interviews hopes to uncover some of the interesting themes that are assumed in literature (Gala. 2008; Leckie, 1998).

### **3.2.3.2 Third and fourth waves of South Asian immigrants**

The third and fourth waves of South Asian Immigrants are categorized in my study as migrating to NZ between the years of 1980-2000 (third wave) and 2000 onwards (fourth wave).

The third and fourth waves of South Asian immigrants arrive through a strict immigration screening process recruiting them for their education and work experience (Bedford, 2000). The fourth wave of South Asian immigrants especially may display a fresher memory of the initial phase after immigration which literature is known to be a whirlwind of sudden change in cultural values. The first five years are an adjustment in diet, living conditions, and socioeconomic position. The immigration process can be stressful and cause high levels of discomfort for all ethnic minority groups whether they are international students or young and old families (Baptiste, 1993; Mori, 2000; Thomas, 1995). Though after two years' adjustments become a common reality, pressure from cultural changes accumulate and is embodied on the health status of high level needs groups such as, women within ethnic minority groups (Csordas, 1994).

### **3.3. Approach to data analysis**

The rich data collected through in-depth interviews that was used to assist this process of building a deeper understanding through analysis in forming common themes consistent with the review of literature in the previous chapter (Vaismoradi et al. 2013).

The analysis started by transcribing the data collected through the MP3 recorded data and notes taken during the interviews. Transcribing data collected into written accounts. During this process, any changes in vocal tone, silences, and mood of the interview are picked up and transcribed alongside the narrative told by the participant. Then, after reading and re-reading the data, familiarizing it in order to write descriptive summaries of interviews were formed. A process of analysis and familiarisation with the content of data allowed thematic descriptions of concepts and patterns to be categorised in to similarities and differences. At the end of the transcription process strong themes on the main findings in data were more apparent (c, 2012).

The study employed the use of content analysis to explore persistent themes in South Asian health behaviour literature studies combined with new themes found through participant expressions during in-depth interviews. Content analysis is a commonly used method in interpretive qualitative studies that is descriptive and interprets experiences. It looks through the data collected and categorizes information into common pre-set themes (Neuendorff. 2002). Information collected has been read through and categorized into themes that represent commonalities that are categorized again until a theory arises out of the picture created. Content analysis involves the steps described above by Ross (2012) including transcribing data as a whole systematically to establish key themes in the experiences lived by people to develop conclusions (Hsieh and Shannon, 2005). Stemler (2001) uses the definition “a systematic, replicable technique for compressing many words of text into fewer content categories based on explicit rules of coding.” Content analysis accounts for multiple themes and their influential factors to be accounted for when summarizing and exploring new avenues during analysis.

More specifically, there are two main approaches to content analysis; deductive and inductive content analysis. Deductive content analysis is used in conducting studies which already have a pre-existing theory that is being furthered in health research. Inductive content analysis is the opposite, it is used when there is no pre-existing theory or in-depth knowledge about the details of a phenomenon and therefore, the purpose of analysis is to create one (Patton, 2005; Taylor, & Bogdan, 1998). Using a deductive content analysis approach is best, referencing common

themes found in international research considering South Asian health to assist in mapping the process of post-migration and the effect it has on behaviour shaping interaction with PHC in NZ (Ministry of Health, 2006).

Content analysis however, is not the most common tool used by researchers concerned with ethnic minority health behaviours. A quick review of literature indicates thematic analysis is the common option. Thematic analysis is very similar in the approach it uses to code themes as content analysis. A key difference between the two approaches is, thematic analysis codes by paragraphs, and content analysis codes the entire piece of information (Ross, 2012). Thematic analysis sifts through data paragraph by paragraph and is more commonly used by researchers who have large amounts of data to analyse. However, in this thesis, content analysis is used to analyse transcripts as a whole to identify similarities and differences in perceptions and experiences of South Asians. A study by Farooqi & Bhavsar (2001) used content analysis to transcribe focus group data into key themes to make conclusions about South Asian attitudes about Coronary Heart Disease in Leicester, England. Content analysis allowed the study to analyse data as a whole in limited time frame and glued themes together to form a narrative. This thesis used content analysis in the same manner to identify key themes in experiences that provide insight into changing health behaviours during post-migration.

### **3.4. Ethics**

The thesis was approved by the University of Auckland Human Participants Ethics Committee on the 29<sup>th</sup> of June 2015 for three years, Reference Number 014913.

Ethics is an important part of conducting a qualitative study in health research. In planning and performing research involving humans and their experiences, information gathered must be valid and reliable. Therefore, the methods employed at each stage of the research process must incorporate ethical principles into its backbone to ensure findings are accurate (Miller Birch et al. 2012). Green and Thorogood (2013) suggests that an effective qualitative study aimed to improve the lives of people is grounded in Beauchamp & Childress (1983) ethical principles of autonomy, beneficence, non-maleficence, and justice. The following are ways in which this qualitative study is founded on these principals.

Autonomy is the recognition of a participant's intellect and respect towards the information they decide to share. To ensure the autonomy of everyone involved is respected, participants

## An interpretive methodology approach to research: Conclusion

recruited were given a participant information sheet summarizing the intentions of the research and how their contributions are used in supporting health in research on Asian health. Briefing potential participants through a participant information sheet also ensured that the principle of beneficence defined as working for the best and good of people instead of causing harm is a principle value throughout the research. After potential participants have read through the participant information sheet, informed consent was collected by briefing the participant on their part to play in the research piece. This is all in the hope of maintaining a non-maleficent agenda especially during the data collection with participants. Thereby, the researcher's conduct was transparent, respectful, and non-intrusive. This principle of non-maleficence and justice another underlying principle are vital in shaping and holding accountable the researcher conduct during the research process. It allows the researcher is to remain balanced in behaviour and empower people to share their stories (Orb, Eisenhauer, & Wynaden. 2001). Throughout the research process the principle of justice is used to make sure the study did not burden participants by making sure there are translated copies of participant information and conformed consent sheets. Even the location of interviews was chosen by participants to allow them to be interviewed when convenient for them and keep their autonomy during the study.

Participant identity will also be kept anonymous and only broad categorical information including the age, gender, years since migration, country of origin, and other SEP factors are used during analysis. Each participant before signing their consent forms were requested to choose a code name of their choice to keep their identity anonymous. Participants were not identifiable and the information they shared was confidentially handled and disseminated. After the interview occurred participants consent form, transcribed interview notes, and any other information with their identity is stored at the university for confidentiality. This is to keep the credibility of the research and value the principles of privacy and ethics described above (Orb, Eisenhauer, & Wynaden, 2001).

Following these ethical principles during the qualitative research process shapes the nature of the researcher and participant interactions, as researchers become aware of the vulnerability participants' show in sharing their experiences (Silverman. 2010).

### **3.5. Conclusion to chapter**

The essence of this methodology chapter has been to outline the methodological framework and tools used to collect and analyse data by. The main positive to this chapter is that it clearly outlines the rationale for using an interpretive qualitative framework for research design and how it influences and shapes the data collected from interviews to make recommendations on at the end of the thesis. It also outlines the participant criteria in detail to feed into the analysis chapters and end outcomes of the study. The division of participants into the three main categories assists the data collection to be specific to each stage of post-migration journey experienced embodied through the habitus: health behaviours and interactions with the PHC care for South Asian immigrants. The logistics of data collection and analysis of data are also covered in detail, ensuring there are no gaps in research design for the thesis. Last, the chapter ends with briefly outlining the processes for ethical conduct of the study. This methodology chapter operates as the control room of the thesis clearly stating all aspects of collecting and analysing data that will assist in forming clear conclusions and at the same time clear up assumptions on the negative health behaviours of South Asians as immigrants, and how it can be changed through understanding their interactions with PHC and society as an ethnic minority group. Overall, the methodology chapter of the study has set out the foundation methodology and research approach used to collect and analyse data. The interpretive qualitative approach to the study recruited 15 participants for in-depth interviews which produced the following analysis chapters to the thesis.

## Chapter four

### **4. PRE-MIGRATION EXPERIENCES AND POST-MIGRATION PERCEPTIONS OF UTILISING HEALTH SERVICES**

Chapter four is the first of the analytical chapters drawing on the interviews. It examines whether the HME and persistent illnesses burdening South Asian is related to the perceptions of GP care and expectations in utilising health care. Overall, the chapter will argue that there is a connection between experiences in utilising health care pre-migration and the expectations and perceptions of PHC care post-migration, shaping the health of South Asians.

Experiences influence post-migration PHC-level service utilisation perceptions and experiences. There are various determining factors in establishing this relationship between pre-migration experiences and post-migration perception, however, the primary cause is suggested to be the social constructions of status and power held in society of my participants, shaping a consumeristic role when utilising health services. The consumerist experience shaping perception is not an unusual finding among studies on ethnic minorities in other countries pointing to the same relationship.

Research on South Asians in the United Kingdom (UK) reveals how the expectations and perceptions of South Asian patients are formed by their experiences as a consumer in utilising health services back in their country of origin. It is suggested patients prefer direct access to specialist care rather than utilizing their general practices (GP) because GP care is perceived to be an unnecessary step towards health (Rashid & Jagger, 1992). Further, Asian patients in the UK are known among health care professionals for needing more time to consult with as a result of the expectations on the quality and quantity of service delivered stressed by patients who feel their needs are not understood (Calnan et al. 1994). Health systems often perceive different health needs to what Asian groups perceive their health needs to be (Hawthorne, 1994; Ngo-Metzger et al. 2004). The literature indicates the South Asian people desire involvement in their health decisions and may experience unmet expectations as a result of experiencing utilisation of health service differently. The theme of fragmented health expectations between South Asian patients and health service delivery is further explored in this analysis chapter

## Pre-migration experiences and post-migration perceptions of utilising health services

along with other identified factors through applying Bourdieu's habitus lens to allow the analysis to identify possible ways health service utilisation experiences and perceptions may change as acculturation post-migration takes place.

Habitus helps shape the picture of migration experiences and perceptions on health service utilisation through providing a framework for which the consumer behaviours of South Asians are shaped by their knowledge on the doxa (codes of behavioural expectations) post-migration. Thus, making the habitus a powerful lens over perceived controlled expression of ethnic identity. The more aligned or similar the set of doxa (behavioural codes) are with an individual or group's pre-migration society, the more capacity is expressed post-migration including utilizing health care services (Singh-Manoux, & Marmot, 2005). Therefore, a change in the overall symbolic capital and identity of an immigrant post-migration shapes the manner in which health is perceived and incorporated (Abel, 2008 Bourdieu, 1985). The discussion will explore how the perceptions and experiences of South Asians are related to consumeristic expectations formed with health care prior to migration and informing post-migration perceptions.

The rest of the discussion is centred on first exploring the tension between pre-migration experiences with health service utilisation, and post-migration perceptions of health care especially primary health care (PHC). The analysis chapter will finish of the discussion with exploring the tension between pre-migration experiences and post-migration perceptions and expectations in utilizing PHC services in relation to consumer habits.



#### **4.1. Pre-migration experiences in utilising health services**

As mentioned in the literature review chapter each South Asian country has its own history, challenges and culture shaping the way the health system operates. For example, the Indian health system has recently been challenged by finding itself lagging behind the world in health care outcomes in the 21st century. Despite having the health care infrastructure and expertise, the growing population demands and consumer culture have coupled together to burden the health care systems ability to improve health outcomes (Gudwani et al. 2012). India has a combination of rural vs urban and private vs public complex health system set on strengthening PHC and universal health care (Forbes India, 2014). Sri Lanka is another dominant South Asian country with an improving health care system. Sri Lanka's health care systems and policies have focused their efforts on achieving the Millennium Development Goals (MDGs) especially for maternal care and child nutrition through improved PHC (Fernando et al. 2000; World Health Organisation, 2014). Bangladesh differs to both India and Sri Lanka since it is comparatively a rural country that has made strides in its social health care policies towards equipping and empowering health care for its population. It faces scarcity in workforce and funds, inhibiting its vision for strengthening health systems. However, Bangladesh is similar to India and Sri Lanka in experiencing the same health burdens (World Health Organisation, 2014). Pakistan the last South Asian country represented by my participants is similar to the other countries in facing the same health burdens of communicable diseases. Health care in Pakistan is challenged by the lack of workforce and politics driving the distribution of medicines and facilities (DeCosta, Johansson & Diwan, 2008; Drèze & Sen, 2012; World Health Organisation, 2013). There is a mix of public and private health care in all four South Asian countries dealing with a co-burden in communicable (CDs) and non-communicable diseases (NCDs) (Murray & Lopez, 1997). Although, there is a viable public health system in each country, it is perceived as being low quality and drives middle class people to access private care service (Ghaffar, Reddy & Singhi, 2004). More recently there has been an explosion of the private health system because of the ability it has to purchase technology to use in delivering specialist health care to the prospering middle class population (Baru, 2003; Sengupta, & Nundy, 2005; Shaikh & Hatcher, 2004). The growth in the middle class population of countries especially India starts to create a divide in what is publicly available which is off poor quality, and what can be afforded through private care creating a consumer health care environment.

## Pre-migration experiences in utilising health services

The knowledge expressed by immigrants' post-migration when interacting with PHC in NZ is the product of developed consumer knowledge and understanding of health care in a different health care environment experiencing a by a double burden in diseases (Grimm et al. 2004; Murray & Lopez, 1997).

Overall, the consumer health care environment South Asian migrants come from is formed through the growing ability of the middle class pre-migration to utilise private health care. Private health care is perceived higher quality than public due to the available choice and power given to patients over social status. The same perception of control in consuming health care is then tried to be replicated post-migration. The following sections of the chapter will further discuss the connection between pre-migration and post-migration interactions with health care, and its role in shaping the health of South Asians.

#### **4.1.1. Private care interactions with shaping experience and expectations**

The primary finding from my data is that private health care is preferred and shapes the consumer expectations of my participants. Private care allows people to access a wide range of choice in services and availability of quality care that the public health care cannot provide to the same capacity in South Asian countries. Participants reflect a level of social status capable of accessing and utilizing private care despite high costs of care lower social status groups could not afford. Therefore, a preference for utilising private care shapes consumerism in health care by people groups who can afford to pay. It also supports the patient in acquiring power over health care interactions using social status as a lever (Dirks, 1989). Consumerism is founded on the ideals of liberalism, evidenced in this study by advocating for the rights of the patient to access effective health care (Wilson, 2010). Though, this may be appealing for patients from status exerting control, consumerism can be induced and happen in excess amounts which further perpetuates existing inequalities in health and society inhibiting beneficial health outcomes (Henderson, & Petersen, 2002; Rashid & Jagger, 1992).

Therefore, social status gives people agency to consume and utilise private care, shaping their overall perceptions on the power they hold within health care settings. The use of social status as a lever to experiencing high quality private care is expressed by Isabella a young female from Pakistan who migrated to NZ when she was a teenager. Her experiences with health care in Pakistan are positive as a result of coming from a high social background which allowed her family to utilise high quality care through the private system. Isabella is an educated young female who throughout her interview expressed her self-dependence in looking after her own health because she perceived PHC to not give her the specialist care she was used to receiving. Below is a quote as expressed from Isabella's interview in which she recalls her experience with private health care in Pakistan. Isabella and her family lived in a good neighbourhood and her family had social status. Consequently, she was able to access high quality private care:

It depends on what area you live in. It is based on the caste system. Get better health care if you are well off. So my memory of the health system is good. Private is the nicer one.  
Isabella, Pakistani Female: YSM>7yrs, twenties.

The focal point of Isabella's quote is the positive consumption of private health care because her family had the social agency and control over care. The desire for control over the access

## Concluding with habitus shaping health service utilisation

and availability of services shapes a positive experience as a consumer in health care expressed by Sarah in the quote below.

I think India is much better because there is a lot of private care. Public is not as good: environment conditions are bad but people still live. Sarah, Indian female: YSM >7yrs, thirties.

Another participant of the study Sarah, a middle class educated female expressed in her interview the above quote highlighting the environment of injuries and illnesses complimenting the availability, quality, and access of private care services provide in comparison to the public health system. Although Sarah's perception of health care in India is positive, it should be noted that not every participant or South Asian immigrant may agree with her. Sarah's perception is a reflection of her social status and agency prior to immigration which supported her to access high quality private care as she desired. Sarah is not alone. The typical South Asian immigrant to NZ comes from highly educated backgrounds that prior to migrating accessed high quality health care without any restrictions.

Though this is true, social status does not necessarily protect from supply induced demand when services push for more services to be used and therefore conduct costly medical bills to be paid by patients. Sarah might reflect a positive experience because she herself was a part of the system as a medical doctor. However, as seen below in Andrew's quote the existence of private care could burden people with unnecessary costs. Another important factor to consider is highlighted in Balarajan, Selvaraj & Subramanian (2011) review of health in India which states that health inequalities in India and much of the developing world are rampant made worse by the out-of-pocket expenditure by patients.

We have facilities where you pay to see the doctor. All private and lots of tests and bills. Therefore, I feel restricted when not given access to secondary care here in NZ by the GP. Andrew, Bangladeshi Male: YSM >7yrs, forties.

Andrew expression above is taken from his in-depth interview which provided the study with a lot of information on the perceptions and understandings on healthcare South Asian migrants may hold post-migration. In his quote, Andrew reveals there is a sense of mourned loss of power and control over health and wellbeing. The feeling of loss of power in accessing all levels of health care when desired is exacerbated when there is a lack of knowledge upon

## Concluding with habitus shaping health service utilisation

interacting with a new health care system operating on expectations formed prior to immigration. Expectations are displayed in Jerry's quote below which highlights both the lack of knowledge on NZ health care but well-formed knowledge on the Indian health system. Jerry also highlights the negative side to private health care, contrasting Sarah's earlier quote on quality. There is a trade-off made by the patient between quality and cost often being exploited by health care.

Problem here in NZ is that government does not put money in health. In India doctors have money and there are a lot of private clinics which put money into infrastructure. But those in India exploit. Even if medicine is not required they will prescribe it. Jerry, Indian male: YSM >7yrs, forties.

There is an awareness of the health care in South Asia exploiting patients by over prescribing medicine and tests, counteracting South Asians' desire to be in control of price and the improvement in their health outcomes (Van der Geest & Whyte, 1991). It is obvious from the expressions explored in this section of the discussion; health care interactions happen in a complex and fast developing environment where information to health is available and control is exerted through social status. South Asian immigrants have an extensive knowledge of motives of the South Asian health care systems and their role in relation to it (Fotaki et al. 2005).

Therefore, there is a tendency to want to replicate the same role and power balance in the NZ PHC, which could almost be considered a coping mechanism to create a sense of norm as their surroundings change. This change and adaptation of habitus is further explored in the following section.

Both Andrew and Jerry's perceptions suggest that South Asian immigrants to NZ may struggle with navigating through the country's PHC and healthcare. These perceptions can be further developed by comparing them with utilising health services in South Asia and NZ. Experiences prior to immigration shaping health care interactions shape the feeling of control in health care supported by a culture of individualism and consumerism. Therefore, adjusting to PHC and interacting with a new health system overall may take time.

## Concluding with habitus shaping health service utilisation

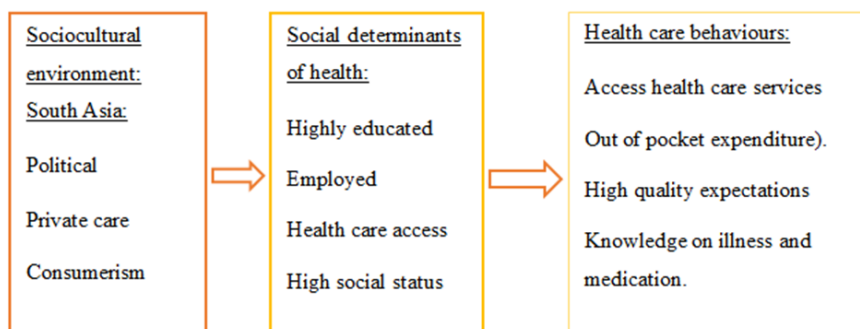


Figure 1 Prior to immigration

### 4.2. Post-migration perceptions on PHC and health behaviours

The data collected from my participants suggests there is a dichotomy of positive and negative perceptions towards PHC GP delivery of care. The combination of positive and negative perceptions is shaped by the lack of appropriate information on the purposes of PHC in NZ. The lack of support informing and supporting health care perceptions and experiences causes participants to operate on predisposed ideals on health care roles pre-migration.

The dichotomy of experiencing perceived satisfaction and/or dissatisfaction in GP care by participants is a reflection of the resources and knowledge acquired through social status prior to immigration.

The three quotes taken from three separate interviews below closely reveal what makes an ideal general practitioner (GP) in PHC-level services.

My GP includes me in the making of my health plan. She advised me on other health services to use including the physiotherapist and chiropractor. I felt this was very holistic. Sarah, Indian Female: YSM >7yrs, thirties.

My GP gives website link to British journal to research and know about illness. Andrew, Indian Male: YSM >7yrs: forties.

The GP used to Google symptoms and causes on the computer so her and her sister could understand why it was happening and how to stop it. It helped educate. Joanna, Indian female: YSM >2yrs: twenties.

## Concluding with habitus shaping health service utilisation

From the above three positive GP experiences, inclusion is a strong desire. The three examples include instances where the GP met the expectations of the South Asian patient(s) by facilitating and providing them with extra resources and information on the wider health system and maintenance of health. Participants expect to have control in their patient provider relationship, and inclusion through the GP facilitating resources and knowledge in decision making. There is an explicit desire to be included by the GP whose role is to facilitate a reflection of the strong supply demand health care environment for those participants who have interacted as consumers in prior to immigration. Therefore, the quotes above not only reveal the role of a “good” GP which is to be a “facilitator” of health decision making, but also suggests the experiences in utilising health care through their social status is transposed post-migration (Benedict, 1957; Dirk, 1989). The ideal of a good GP as a facilitator is far from the traditional balance of power in a patient health professional relationship but is a reflection of the informed patient in an era of health care where patients hold power (Dunn & Dyck, 2000; Gupta, 2000; Hibbard & Weeks, 1987).

Therefore, a GP acting as a facilitator may not be a negative expectation to be met by PHC. Literature on the improving health outcomes of patients has attributed better health outcomes to patient inclusion by GP in decision making and maintenance of their own health (Lefebvre, 2008; Stewert, 1995; Street, Makoul, Arora & Epstein, 2009). Approaches to building long term relationships between health providers and patients are encouraged to be adopted by service delivery side providers (Griffin et al, 2004). Approaches include the chronic care management model, an approach to service delivery for health professionals to incorporate a holistic method in motivating patients to be empowered in the long term management of illness (Barr, Robinson, Marin-Link, Underhill, Dotts, Ravensdale, & Salivaras, 2003). Though, the NZ health system may not be identical to the health systems of India, Bangladesh, Sri Lanka, or Pakistan in terms of power dynamics and choice in health care, it does operate on the underlying principle of empowering the patient (King, 2000). Therefore, the data supports that the role of a GP as a facilitator is not being far from the norm in existing health care values.

The expressions of younger generation participants also indicate a similar expectation in care from their GP. The existence of GP is considered a positive part of care where support is found and long term relationships are established with their health providers.

## Concluding with habitus shaping health service utilisation

It's very cool you get to go to one doctor every time and he knows everything about you.  
Joanna, Indian Female: YSM>2yrs, twenties.

A GP is an advantage because they know you and your family. They know the background and all. Isabella, Indian Female: YSM>10yrs. twenties.

However, because younger participants have acculturated into host society, their ability to extract information and resources on health care is expressed by their agency in health care interactions. Younger participants' "habitus" seemed to vary in comparison to the older generations in terms of displaying cultural capital in knowledge on health care. The desire for a GP to be a facilitator is seen in Tanya's example below where she explains the importance of having a GP who advocates for health issues. The GP's ability to meet Tanya's expectation to facilitate and advocate for health breaks down reserved expectations about PHC.

I lost feeling in my legs and one side of my body. She saw her GP who said it may be shingles. So I saw another GP because one of my legs had stopped moving. The GP ran through all the tests and called neurologists who did not want to be involved in my case because I was not private care patient. So the GP called the on -all neurologist. My GP pushed for tests and was my advocate. I respect her for it. My GP didn't think I was crazy which I loved. I did not have much interaction with my first GP before this case. I am still with my current GP who pushed for my care. Tanya, Sri Lankan Female: YSM>7rs, twenties.

Tanya's experience presents two perceived conclusions: the first, is that the GP's role as a facilitator is important to the patient in feeling confident in depending on the professional for care. Second, perceived expectations of younger South Asians on PHC-level services may be shaped by the level of education in health, and awareness of negative experiences immigrants may have had with PHC. For example, the negative parental experiences with GP care can easily influence and shape the perceived ability of PHC to deliver expected quality of care.

Not very happy with him right now because mum had varicose veins and she wanted to continue treatment from India here (she had her x rays from India) he said no directly. Mum was very upset. However, one day the GP was not there and mum had to see another doctor. The fill-in GP helped the mum out and got treatment done. Joanna, Indian Female: YSM>2yrs, twenties.



## Concluding with habitus shaping health service utilisation

The experience of her mother shared by Joanna is further explains the way in which parental experience may shape younger generation perceptions on PHC but also indicate how GP care can be negatively experienced. Joanna, a young Indian female expresses the disappointment felt by her mother when the GP failed to understand their concerns. It is an example of when the facilitator expectation formed by my participants was not met. A study from the USA on immigrant health in relation to service quality found a direct negative link between poor service health delivery and health status. Immigrant patients were more likely to feel unsatisfied with the quality of health care they received than any other patient group. A huge part of being dissatisfied is similar to the experience shared by Joanna's mother arising from the lack of communication and inclusion expected by patients (Derose et al. 2009). It is an example of the risk to encouraging utilization and long term care health care poses when it chooses to operate on supply side assumptions of what the patient needs, instead of consulting the patient much like Joanna's experience with PHC (Kai, Beavan et al. 2007).

Though, the quotes above indicate a positive perception of a GP as a facilitator, expectation of a facilitator role can cause tension when it is not met. The data suggests participants are happy with their GP care when they facilitate services and negotiate the rest of the system, but at times dissatisfied with the GP's gatekeeper function.

Andrew's perception below affirms the tension experienced between satisfactory and dissatisfactory GP care hinted at by Joanna. In a previous quote Andrew indicated the positive component of the care his GP provides through including him. However, in the quote below Andrew explains how his expectation for the GP to facilitate care was not met.

In our country, doctor would examine the heart with an ECG. Here in NZ I want to take an ECG of my heart. I told the doctors can you refer me or can I take it? But he told me no you're not at that stage. He measured by BP and check-ups cholesterol levels. I want ECG and heart test but he told me by examining BP, sugar, and cholesterol. He said I cannot refer you but if you want to go you can go directly and gave me an address but I have to pay \$100, so I didn't go. Andrew, Indian Male: YSM >7yrs, forties.

Andrew's experience on his unmet expectation in PHC is reaffirmed for him by comparing his experiences prior to immigration with health care as a consumer. The comparison made between health care prior to and post-migration becomes skewed when the patient is not

## Concluding with habitus shaping health service utilisation

provided with information on navigating through the health system (Ho, 2003; Trlin & Watts, 2004). Andrew's perceived dichotomy of good and bad experiences with his GP can be further perpetuated by the lack of support offered to him by PHC in utilising a navigating through the health system. There has been no information provided to Andrew on the role of GPs as gatekeepers causing the perceived tension and restriction to the level of services he expects (Gomez, King & Jackson, 2014).

The concern as GPs acting as gatekeepers is also seen among the younger participants who voice their concern of not being referred to specialist care when needed just as the older generation has voiced above.

GP does not know when to pass on a case. Some doctors have the problem of thinking they know what they're doing but haven't listened to their patients. Tanya, Sri Lanka  
Female: YSM>7yrs, twenties.

Tanya's perception carries a tone of concern in the GP having the control to pass on cases when needed. Her perception on health care provides insight into recognizing the factors shaping social and cultural capital are different for the children of immigrants. For Tanya, her perception of the GP, PHC, and the wider health care system is shaped by her experiences with the education system in NZ where she has been exposed to knowledge and accustomed to behaviours within health care. The interactions her parents have with health care also can shape her perception towards it. Tanya indicates the interactions with health care her parents have may be different to her interactions, and at times she may be the bridge between the health provider and her parents in communicating messages. The role of an immigrant child acting as a bridge between parents and health providers is not uncommon (Valenzuela, 1999). Immigrant children often take on the role of an advocate for their parents when interacting with health providers out of concern for their parent's loss in power to navigate through foreign systems of care (Suárez-Orozco et al. 2009).

My parents are getting aged related illnesses- As a result, go to the doctor but there is a language barrier. Mum or Dad has to practice on her beforehand what they will say. They will break the whole thing down with me first before the go to the GP. Tanya, Sri Lankan  
Female: YSM>7yrs, twenties.

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The role of an advocate is not a reflection of competency in English because the level of written and oral skills needed by migrants to gain entry into NZ is set high (Trlin, Henderson, & North, 2004). It is a more a precautionary method parents seem to use in order to ensure their concerns are heard and the GP facilitates. Children are perceived to know more about the behaviours and expectations of host society and therefore, improve the messages desired to communicate by parents to their health professionals. Therefore, the experiences of parents with health care also have the ability to shape and form own perceptions and expectations with health care.

Both the older and younger generation participants framed their perceptions of PHC-level services as having a problem with a lack of support experienced in utilising health care. Health-related information provides educated South Asian immigrants care on the possible ways in which they can adapt their expectations within a new health system (Kirmayer et al. 2011). Information management can go both ways, between the patient and health professional, strengthening the health system and improving the health experiences and outcomes of South Asian ethnic groups in NZ. Additionally, this helps loosen the grip participants have expressed through their consumer expectations with health care is vital. Aligning information and expectations should put patients at the centre of the relationship (Berwick, 2009; Sabate, 2003; and Schoenbaum, & Audet, 2005). It motivates health professionals to be equipped to handle diverse expectations and needs by communicating messages in a manner that comforts and supports South Asian patients in a broader social and medical setting (Haggerty et al. 2003).

In a nutshell, there is a strong connection between experiences with PHC prior to immigration shaping consumer behaviours attempted to be replicated post-migration. Perpetuating the dissatisfaction experienced by participants in regaining and recreating control in health provider relationships is the health professional hesitancy and lack of knowledge on South Asian patient background and expectations. A qualitative study on the perceptions of health professionals delivering care to ethnic minority patients in the United Kingdom expressed feeling hesitant during consultations, because they did not know what was culturally appropriate (Stone et al. 2005). Health professionals were concerned they may be ignorant to certain issues and this restricted their ability to deliver care and improve patient health. The concerns expressed by South Asian patients regarding the level of care they receive from their GP may be a reflection of the GP not knowing what South Asian patient expectations are of them and their prior knowledge of health (Stone et al, 2005) This then may be the actual

problem, a misunderstanding of each side's knowledge and expectations for each other. Lim (2014) suggests resources such as Cultural and Linguistic Diversity (CALD) should continue to be used as a seed of awareness on equipping health professionals in understanding the wider immigration process of immigrant groups including South Asians. Overall, creating an improved understanding of the immigrant experience can also help PHC deliver long term care centred on the patient consistent with the central governments aims of equity in care (King, 2000; King, 2001). The discussion has explored the dichotomy of a good and bad GP perceived by South Asian participants shaped by experiences with consumer health care prior to immigration. It is clear the expectations and experiences with private care occur through the agency social status allows, extolling the benefits of the system as a consumer. The connection between prior experiences as a consumer patient is carried post-migration especially in regards to expectations when utilizing PHC causing the tension experienced by participants. The conclusion to the chapter discussion will explore the link between Bourdieu's habitus and the connection seen in health care perceptions of South Asian participants.

### **4.3. Discussion and Conclusion**

Bourdieu's Habitus theory suggests individuals or group behaviour in a societal space is the embodiment of a combination of structuring structures. Knowledge and resources are gained through capitals consistent with the behavioural rules (doxa) of societal spaces (Fowler, 1997). Therefore, habitus is the depository of capital, knowledge on behavioural conduct, and social status acquired to, and given by society. The role habitus plays in shaping consumer expectations is an important insight into the health care behaviours of South Asian immigrants. There is a direct link between the health care behaviours of my participants and the social agency they have shaping perceptions and experiences.

In summary, the experiences with health care prior to immigration breed consumer identity in utilising health services. Consumer behaviours are shaped by the wider socioeconomic position of an individual including income level, education, and family social class which feeds into their ability to access standard of health care. The habitus of South Asians as consumers of health care is also supported by their social status which acts as a resource to use when utilizing care. Consumer behaviour grows through patients slowly treading the waters of health care to measure the power they hold and can exert in health relationships. The more capital an individual has the more their habitus is informed and shaped by the power given them to

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externally in society realms including health care. Therefore, participants interviewed explain the manner in which they used social status to utilize private health care which is considered to be of higher quality to public care which is accessed by lower socioeconomic individuals and groups.

Post-migration causes an adaptation of capital now operating in a different society with a different set of expectations and behaviours shifting the ability of immigrants to exert the same benefits status provided in health care prior to immigration. The social determinants of health including income level, under-employment, unemployment, language, and education all challenge the ability of immigrants to maintain the same symbolic capital though habitus changes. Bauder (2003) and Friedmann (2002) make reference to this challenge in both their reviews of immigrant behaviours. Their findings from reviewing migrant habitus reveal a desire to replicate and hold to predisposed ways of behaving within society post-migration. However, in relation to my study, it indicates the consumer expectations of South Asian participants is a reflection of predisposed understandings of health care shaping health care now.

The migrant attempt to hold onto the capital and behaviours shaping their habitus is made worse with the lack of information and support provided by host society on navigating through the health system. This acts as an inhibitor for participants to experience quality health care producing improved health outcomes. The lack of appropriate information to support migrants from the host society acts as an inhibitor for participants to experience quality health care producing improved health outcomes. Bourdieu informs us that habitus—which is the set of capitals, meaning resources, skills, and knowledge adapts to a new society that—shapes ability of migrants to interact and benefit in societal spaces including health care. It is not an easy change, as indicated by the dichotomy of a good and bad GP presented by participants above. The health care expectations of my South Asian participants to utilize and experience care in the same way as they have prior to immigration causes tension. The tension experienced by participants to adapt to new expectations and perceptions of health care despite a change in habitus is highlighted in the quote by Isabella below

The health system in Pakistan is very robust. They don't just tell you here's the medicine for it but tell you how you can change your condition. We come with that expectation and it is a conflict here because here you got to the doctor and they give you an antibiotic

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so a lot of people from our culture feel let down and disappointed with health care here.

Isabella, Pakistani Female: YSM>7yrs, twenties.

Reporting no perceived discrimination when interacting with health care, and preference for GP ethnicity or gender. The desire to consume health care and make the most of health care interactions is displayed in some of my participant's perceptions on accessing care from a GP of the same ethnicity.

I felt like my Indian GP in NZ did not want to go into depth when treating and maintaining health. So I changed GP but European charge is high/ but friend suggested current doctor. Andrew, Bangladesh Female: YSM>7yrs, forties.

For Andrew, the desire to experience good quality GP care consistent with his expectations meant utilizing PHC from a different ethnic GP. He did not feel his concerns were taken seriously by his Indian GP because being from the same culture might cause the GP to overgeneralise or downplay his perceived need in health care. Andrew's perception also reveals how "habitus" in utilizing current capital to acquire information on health care. Though, the European co-payment is higher than the South Asian GP, Andrew's decision to make the shift highlights the consumer background and behaviours of participant health care behaviour. To receive the care, he desired he did not mind paying more. This again, is different to the younger generation of participants who do not hold expectations on GPs and health care providing information on health. Whereas, as indicated in Andrew's perception above, consumerism is acted out through seeking care through the GP, consumerism in the younger generation may be sought individually through other avenues including media.

I used to go to the GP for the common cold but now I do not go because it a waste of money. They give the same medication that I already know. Isabella, Pakistani female: YSM>7yrs, twenties.

Isabella's perception draws similarities to Tanya's perception on utilizing PHC. Both reflect the adapted habitus of expectations and behaviours embodied through being acculturated to a culture of consuming health care through other sources including the internet instead of their older generation who consumed primarily through the health system.

## Concluding with habitus shaping health service utilisation

Bourdieu's habitus lens also informs us that the predisposed expectations on utilising health care services South Asian migrants carry over with them when they migrate should be seen as an opportunity for the NZ health system to provide evidence best practice to its ethnically diversifying population. Lo & Stacey (2008) suggests that immigrants may experience a hybrid habitus where understandings of health interactions are a combination of previously held expectations and newly gained understanding on health care. Their study suggests that in order for health professionals to understand the adapting habitus of an immigrant it is best to provide health professionals with cultural competency information.

Overall, despite the different consumer behaviours between generations and the similarities in what makes a GP good, the habitus of my South Asians patients is comprised of the experiences and perceptions with health care prior to immigration and perceptions of health care post-migration. Applying a habitus lens informs decision makers and service delivery providers especially in PHC on the wider sociocultural factors shaping health care utilization behaviours among South Asians.

This chapter helped inform the study of the connection between pre-migration experiences with health care and post-migration expectations and perceptions when utilising PHC-level services held by South Asians. The second, analysis chapter will focus on the role of PHC and society in promoting healthy lifestyles for South Asian migrants as they acculturate post-migration.

# Chapter five

## 5. PROMOTING HEALTHY MIGRANT LIFESTYLES

Primary health care (PHC) by definition exists to promote healthy lifestyles among the population. The 1978 Alma Ata declaration for PHC incorporates the function of promoting healthy lifestyles as one of PHC's key functions. The World Health Organisation's Ottawa Charter (1986) defines health promotion as the increasing ability of people to achieve a complete state of physical, mental, and social wellbeing by empowering and encouraging people to achieve their goals in life in a changing environment. Therefore, the type of services that health care provides to its population is an essential component to improving the health and wellbeing of people (World Health Organisation, 1986). The ability for the PHC to promote healthy lifestyles is dependent on the health promotion component to services. Whether it be promoting healthy messages on smoking, nutrition, and screening at a community level, or through utilisation of GP clinics for hosting programs, health promotion has an active place within PHC. GPs are usually aware of their health promotion function and advocate for healthy choices among their patients to be made. Promoting healthy lifestyle choices was seen among a group of GPs in Massachusetts as a key part of meeting their function as PHC-level services. Promoting healthy lifestyles also allowed GPs to connect and build long term relationships with their patients (Wechsler et al, 1983). UK's PHC-level of the health system has also displayed itself as a place for the promotion of healthy lifestyles to occur. GP practices became a place for health-related behaviours to be supported through active programs and counselling (Fox et al, 1997).

Kowalczewski (2010) in her Master of Public Health thesis touches on the importance of PHC-level health services to have culturally adaptable health promotion in NZ so it can match the growing ethnic diversity of the population. In her thesis, Kowalczewski highlights how PHC can connect with ethnic patients and improve utilisation of services for ethnic groups when health promotion activity is aware of the social circumstances affecting what is perceived to be important in achieving health for the particular ethnic group. It is suggested in research concerning ethnic minority groups in NZ that there is a gap in the effectiveness of health



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promotion catering to the South Asian community despite this group's growing rates of avoidable illnesses and hospitalisations (Mehta, 2006; Wong, 2015).

The previous chapter was focused on understanding South Asians experiences and perceptions in utilising PHC-level services. This chapter follows on from it, discussing how PHC-level services can cater better for the health service utilisation experiences and perceptions of South Asians in regards to utilisation of health promotion messages and activities. Health promotion is framed as programs and supportive action by the PHC to promote healthy lifestyles to South Asians in my study. PHC is a key platform for health promotion to connect with vulnerable and highly disadvantaged groups through services tailored to meet their specific set of sociocultural pressures and illnesses (Hefford, Crampton, & Foley, 2005; Jatrana, & Crampton, 2009).

The chapter will continue to explore the analysis of data from in-depth interviews with participants through the conceptual frameworks of acculturation and habitus. Using both to underpin discussion broadens understanding of the set of experiences and knowledge shaping the South Asian migrant behaviours within societal spaces such as health care. Acculturation plays an important role in framing the socio-cultural influences on perceptions towards utilising health services and promotion of healthy lifestyle messages and programs. The theory of acculturation may inform the discussion that the habitus of migrants is carried over post-migration and challenged in its ability to be expressed through their socio-economic position.

The content analysis of participant perceptions and experiences with PHC-level services found services may not be supportive of predisposed understandings of health carried through migration. PHC-level services are suggested through the analysis to be supportive of the cultural understandings on health and in promoting desired health promotion messages and programs. not supporting perceptions, and wider systems of social determinants of health failing to support migrant lifestyle desires.

## **5.1. Perceptions of lifestyle**

The previous analysis chapter on the migrant health behaviours has revealed that South Asian immigrants come from educated backgrounds with a strong predisposition for behaving as

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consumers in health care. The finding of predisposed behaviours and outlooks on health care is also consistent with the expressions of South Asian participants regarding living healthy lifestyles. Expressed perceptions of my participants frame the educated consumer habitus formed prior to immigration shaping expectations on how to live healthy lifestyles. However, the post-migration settlement journey is a complicated process causing a change in identity, agency, and knowledge which shape the way preconceived expectations realistically occur.

There is a wider societal adjustment made by South Asians unsupported by society spaces including health care within which the consumer behaviour expectations of participants make navigating through PHC challenging. The data from my study overall reveals PHC does not meet the desire of my participants to be supported in living culturally-appropriate lifestyles. Participants suggest receiving support in making utilisation decisions about health care through culturally- appropriate messaging encouraging healthy lifestyles. For example, Ralph expresses that he did not know how to access support on how to live out a desired lifestyle by the health care system.

I did not have the information and so I had to ask friends and the internet to know. Ralph, Indian Male: YSM>7yrs, forties.

These findings are concerning because they suggest that there is no support from health care provided to immigrants on utilising PHC- level services which the first port of call to health care in NZ should be met. Despite the lack of support in the form of participant- desired information directly from GP services, there are other ways through which society has enabled living healthy lifestyles. Participants were determined to extol the benefits of society in and out of utilisation of health services and, therefore, sought out ways to gain skills and collect knowledge on healthy lifestyles for themselves.

Women and children seemed to interact with societal spaces providing support more than men. Some older female participants described their experiences with Plunket services. The support given from Plunket with information on maternity care and connections formed with other mothers acted as a form of health promotion.

Plunket gave me support especially because I was a young girl with no family of my own and the only woman in the household. I interacted with the European community more and it made things easier. Penelope, Indian Female: YSM >7yrs, fifties.

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Penelope experienced support from Plunket during her pregnancies in the late 1980s and found it helped her find an alternate route to stay connected and find support which would have been the role of other women in the household prior to immigration. Penelope's experience with Plunket gave her a support system and connections with European mothers in the community, which in turn helped her regain the cultural capital she had lost initially after migration to NZ. A study by Desouza (2005) examined the maternity care experiences of a group of Indian women from Goa in NZ. The study found that nurses, especially from maternal services such as Plunket, played a significant role in supporting the women through migration and motherhood. What has set apart services such as Plunket from the ordinary PHC service is the ability to be culturally empathetic to the situations South Asian women face as immigrants away from their social support and in need of health support. Over the years Plunket has created a culture of understanding the background of its mothers and assisting them with maternal care while they acculturate into society (Desouza, 2006).

Younger generation participants also revealed how the education system encouraged an awareness of living healthily. Children are encouraged to live active lifestyles through physical exercise classes, playing sports, and health lessons at school. However, the ability to act out change in home settings is challenged by cultural expectations of children.

Parents wanted me to study instead of play netball. Now as they have grown older they understand being healthy is important and encourage me to go to the gym and eat more fruit. Monica, Bangladesh Female: YSM>7yrs, twenties.

Monica explains how, when she was in school, she joined the netball team because she found it a great way to stay fit and make friends. However, her parents felt it was a waste of time which could be better spent on studying. Again, this is a link back to the habitus of South Asian immigrants seen in the previous chapter which concluded that post-migration perceptions on health care are shaped by preconceived expectations on health care which developed pre-migration. Therefore, Monica's parents encouraged her to spend time studying as they perceived their success to be connected to the success of their children's lives. Immigrant children like Monica may be encouraged to focus on studies because it is perceived as a key to earning high income and then finally living the desired lifestyles preconceived by immigrant parents prior to immigration. The parental encouragement to academically succeed over other activities e.g. fitness, can have negative side effects including obesity that occurs as a result of

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sedentary lifestyles among children. Pallan, Parry & Adab (2012) scoped out the potential for a childhood obesity prevention programme in Bingham, UK among the South Asian community. Focus group analysis revealed South Asian patients were likely to steer children into sedentary behaviours without even realizing it, as a result of time spent on study and religious activities over nutrition intake and physical activity. Pallan et al, 2012 concluded the reason for obesity among South Asian children was due to the cultural expectations of parents for their children to succeed, but also due to the lack of awareness of healthy lifestyles.

We see the recurring theme of a lack of support in living healthy lifestyles challenging South Asians ability to live desired lifestyles and utilise PHC-level services to the fullest. There is an evident gap in the information available to support and equip South Asians through PHC and community services.

To match this unmet desire of support expressed for GPs to be a backbone of support through facilitating patients with access to knowledge and resources to live a healthy life. PHC is seen as a source of information and a resource centre to equip patients on living healthy lifestyles. However, expectations are not met when arriving to NZ and settling, as there seems to be a fragmentation between immigrant expectation of PHC as a place of support and the services delivered by PHC.

Due to the PHC not fulfilling the role of facilitating services and resources allowing South Asians to live the perceived expected lifestyles formed prior to immigration, participants use preconceived information on healthy living to equip oneself to extract the right information. The knowledge of what is needed is displayed in the below quote from Jerry who indicates there is already knowledge on healthy living. Resorting to preconceived knowledge on health also highlights the high level of status and access to information on health experienced prior to immigration by participants.

We try to live a kiwi diet but that won't work with us because our taste buds have changed. We should try change our diet patterns, snacking and smaller proportions with vegetables. Eat early and walk. Jerry, Indian Male: YSM>7yrs, forties.

Participants also highlighted the desire to figure out the resources needed to live healthily in NZ when they felt unsupported by PHC-level services. Ralph, a middle aged Indian male, displays this need to take control over health based on his knowledge of health below. Ralph

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expresses how he has always had a desire to live a healthy life through exercising but could not do so in his hometown. However, once Ralph migrated to NZ he observed the culture of healthy living around him within which people felt free to jog on the grounds encouraging him to do the same.

I was too keen to pick it up because I always wanted to live a healthy lifestyle, but from where I come it was hard. If anyone is going on a run people would make fun of them instead of joining them. We had monkeys and street dogs so it is not that safe. Ralph, Indian Male: YSM>7yrs, forties.

Ralph reveals acculturating to live a healthy lifestyle is seen as departing from living a traditional South Asian lifestyle, especially in terms of diet. There appears to be a perceived undesired trade-off made between cultural diets and lifestyles overcome by the inherent desire to succeed (Das, & Kemp, 1997).

Overall the lack of support from PHC and the wider society challenges the ability of South Asians to live the healthy lifestyles they desire. The rest of the discussion will explore how the utilisation of PHC-level services and wider society supports the desires promote healthy lifestyles for South Asian immigrants.

### **5.2. Health promotion messaging**

Continuing from the previous section, the unmet need in promoting healthy lifestyles by PHC-level services is further explored.

The process of navigating through a new health system is mainly challenged by the lack of appropriate messaging through effective channels to equip and empower South Asian participants. The main issue perceived by participants is the lack of expected information through PHC available to them.

There should be some corner that deals with South Asians and the problems they face... I do take interest in the messages but sometime I feel like it does not apply to me, am I the right person? I check the internet but even then I could not have the right information. How do I do? Ralph, Indian Male: YSM> 7yr, forties.

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Jerry explains in his interview the confusion he faces when seeing health promotion on healthy lifestyles for general society. There is a desire to maintain a healthy lifestyle while sticking to his Indian culture but he often feels there is no support given to him through PHC to do so. Jerry is not the only participant to express the lack of cultural appropriateness that health promotion messages of healthy lifestyles and other issues have in relating to him and his ethnic identity. Monica, a young Bangladesh female, indicated the same issue with the lack of effectiveness in health promotion messages from the system in terms of encouraging cervical screening for women.

There was this ad where Maori women altogether go on this bus for cervical screening but my mum said where are they going? She did not get it because it was not their cultural sense of humour. Messages do not get through culturally to my mum because it is not targeted at South Asian culture. Tailoring of messages would help the older generation of South Asians. Monica, Bangladesh Female: YSM>7yrs, twenties.

Monica's story of her mother's difficulty in relating to the health promotion messages is an indication there is a lack of appropriate tailoring of messages for ethnic minority groups who are just as vulnerable to health issues. The interesting part of Monica's perception however, is the belief that the older generation needs appropriate health messages more than younger generations. It is a reflection of Monica's symbolic agency discussed in the previous chapter, influenced by ethnic identity where South Asian immigrant children attain skills and knowledge on navigating through two cultures, making it easier for them to extol the benefits of PHC and health knowledge.

Both Jerry's and Monica's experiences indicate a sense of confusion on how mainstream messages reflecting a wider society culture are relevant to them as South Asians experiencing an adjustment of cultural identity in the settlement journey, causing a higher risk of health illnesses due to stress and lack of support.

The lack of appropriate messaging is also expressed throughout the analysis of the younger generation (1.5) who highlighted the concern they held in health promotion missing expectations and therefore not supporting health messages for the South Asian peoples of NZ. Paul is a young Sri Lankan male whose habitus is well informed and equipped with knowledge on health through his education in science and immigrant experience. Through his observations over the years on the topic of health promotion Paul concludes the importance of health

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promotion messaging through PHC and society to take a cultural approach in communicating messages on health to ethnic minority groups.

It's nice to have someone similar; although it might not affect me personally because we understand it for some people who are isolated it might not be relevant to them when they see pictures of health promotion... Mainstream approach will work- it is a powerful tool but health promotion needs to have everyone represented in the mainstream approach not just Pacific Islanders. It is a wider issue. So people will understand it is not just one culture experiencing it but is widely experienced...I think for people who are here for a long time their issues are well addressed but newcomers are nervous about getting in there. Paul, Sri Lankan Male: YSM>7yrs, twenties.

Paul's advocacy for culturally appropriate messages by health services contest the perceptions of older South Asian immigrants with a strong educated background to not draw attention thereby accepting mainstream health promotion messaging. The acceptance of mainstream messaging targeted at their cultural groups may be attributed to the perception of immigrants to make the most of their circumstances. Older generation participants such as Andrew however, did not strongly advocate to be represented in mainstream health promotion campaigns. Andrew's perception on health promotion messages is shaped by his social agency and educated status shaping knowledge on extolling most of the messages on healthy lifestyles regardless of whether they are directed at him or not.

It is good because these kinds of posters say you need to do this the poster impacts our mind...Doesn't matter. Andrew, Bangladesh Male: YSM>7yrs, forties.

However, acceptance of broad messages is not the same as not having a desire to receive culturally-appropriate messages on healthy living. There is still an expectation among participants to be communicated to on the topics of healthy lifestyles and even stigmatized issues including depression through culturally-appropriate crafted messages. The importance of PHC and society in crafting appropriate health messages is hinted at in Sally's perception below on the need to change mind-sets of South Asian peoples through commitment.

Mind-set of people saying I have to eat my rice and chapatti. Perception of "whatever happen, happens" Hard for people to change there are some people you cannot convert. They've tried hard in our Indian community: Healthy messages of changing oil, not

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overcooking vegetables, dividing plate. Meetings are advertised. Sally, Indian Female: YSM>7yrs. forties.

Sally explains how there is a perceived need for a change in mind-sets of South Asian peoples which requires investment in time to equip people and support them to find a balance between cultures in terms of behavioural change. Sally's perception also segues into the solutions utilized by participants to seek information and access to resources for healthy lifestyles as the PHC system fails to do so. Participants extract the needed information and support to live healthy lives aspired to through social networks including South Asian cultural associations. The lack of appropriate messages in NZ frustrates attempts to live healthily by South Asians. Health promotion is effective in encouraging positive responses from ethnic groups when messages are clearly tailored to help support them to keep their South Asian identity through healthy methods of cooking traditional food and appropriate desired physical exercise (Netto et al, 2010).

It is also important to note the difference in expectations with health promotion messages through media avenues between younger and older generations of participants. Media routes include TV channels and radio stations which cater to South Asian communities, and can be effective in reaching the wider South Asian population and changing health behaviours in the long run. Media including social media and television is known as an effective lever to bring about both positive and negative behavioural change in its targeted audience (Moorhead, Hazlett, Harrison, Carroll, Irwin, & Hoving, 2013). While media is an untapped avenue for older generations, younger generations utilize media through the internet and social media to form their opinions and behaviours in regards to living healthy lifestyles. Younger generation participants including Monica and Isabella sought out and were influenced by health promotion messages through social networks and the internet as sources.

During my time at university I developed weird eating habits. When I looked at myself I am not happy and I knew I had to change. So I started to research online what I was doing wrong and how I can be healthy. Isabella, Pakistani Female: YSM>7yrs, twenties.

Isabella, a young Pakistani female explained in her interview how she felt so unhappy with herself due to her weight but whenever she went to the GP about symptoms, including



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headaches from dietary intake, she was dissatisfied. Isabella took to social media to explore and find what other people were doing to lose weight.

So that is what they eat to get a body like that. Isabella, Pakistani Female: YSM>7yrs, twenties.

Monica, another young female from the 1.5 generation group expressed in her interview similar thoughts to using media to equip herself with knowledge on how to maintain and improve health. This is contrast to older generation participants who also suggested using media outlets including South Asian radio and television as an avenue for health promotion.

Yes. And I think social media encourages it [i.e.] Instagram... you want to be like them to adopt a healthy lifestyle and gym. Monica, Bangladeshi Female: YSM>7yrs, twenties.

The perceptions of Isabella and Monica suggest the younger generation South Asians may experience and be shaped by health promotion messages through seeking it out, instead of being delivered to. The behavioural norm is to seek out information instead of being delivered it through PHC as older generations have indicated. Therefore, health promotion must account for generational differences in reaching the South Asian peoples, both old and young.

### **5.2.1. Unmet expectations in promoting healthy lifestyles**

Despite the perception of the lack of desired support from PHC in facilitating and equipping participants with the right resources to live healthy lifestyles, there are other ways in which participants take initiative to equip themselves in regards to healthy lifestyles.

The first response seen among participants is to take an individualistic outlook in responding to messages on living healthy lifestyles. There is a mentality among participants, especially earlier waves of South Asian immigrants, to view responding to health promotion messages as an individual responsibility, as seen in Penelope's perception below.

The messages are out there it is up to the individual to incorporate it into their daily lives... I am not sure what new immigrants have in place. I feel the people adopt different now. Back then the way I adopted I went out there and interacted. Now the population is bigger people want to stick to their own culture people and not make an effort to interact with society. Penelope, Indian Female: YSM>7yrs, fifties.

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Penelope's perception above does not only support the individual mind-set of South Asian participants but also the fragmented connection in knowledge and culture between South Asian subgroups. There are a number of reasons why an individual outlook is taken by immigrants on responding to health promotion, but the main reason may be attributed to the disconnect in relationships formed through lack of interactions and exposure to groups within the vast South Asian ethnic group cluster. Thus, post-migration sees a trend of different people groups from across South Asia carrying over those fragmented preconceived perceptions and opinions about other South Asian groups responses to health promotion messages. The perpetuation of assumptions on health service utilisation is particularly evident for earlier waves of immigration who were much more isolated from other ethnic subgroups.

A bit more done on television about how to look after your children i.e. take them to the doctors...Indian girls who are born here are alright, they know what to do, but the ones who come from India, they're the ones who do not know what to do...Also cleanliness among Indian people. Especially South Indians. They have no hygiene and tidiness. HR, Indian female: YSM>7yrs, eighties.

The quote above by HR, a first wave immigrant to NZ from Gujarat India, represents the cultural assumptions made by one culture on another culture, despite the similarities between them. HR's views on the Indian cultures different to her own are specifically tailored towards South Indian shaped by the cultural divide experienced by people in the North and South of India (Barnett, 2015). This cultural divide experienced and ingrained into mind-sets is then replicated post-migration. It is useful for health providers and health promotion activity at a PHC-level to be aware of the fragmentation in diversity expressed by South Asians to avoid over-generalizing messages and recognizing the underlying causes of an individualistic response to health promotion.

The second response utilized by participants is social networks to acquire needed information on health. Social connections and support is a dominant coping system within the South Indian immigrant journey. South Asian associations and community groups are an active place where people of this ethnic group connect and gain information for settlement. Ahmad Driver, McNally, & Stewart (2004) reviewed the coping strategies of Chinese and South Asian women living in Canada. Ahmad et al (2004) found health promotion occurred in an informal manner through social connections instead of formally through services and programs. The study

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reflects the background knowledge on health promotion held by South Asians. Hinting experiences prior to immigration occurred through informal social connections, not through formal programs. Informal health promotion messages occurred in part due to the sociocultural environment South Asians come from, as NCD issues such as CVD are perceived through a medical illness lens instead of the social determinants of health lens, fuelling a different set of health promotion messages to NZ (Ghaffar, Reddy, and Singhi, 2004) Therefore, post-migration presents a learning lesson for the particular ethnic minority group in gaining access to and utilising information through PHC-level services. The case of Auckland Central Indian association acting as a connector between health promotion and South Asian association members is a fantastic example of utilising existing strengths and activity within the community to further build on health knowledge through social activity. Lotus and Sally, both recruited through the Indian association express how the association hosts fitness classes around two to three times a week and regular health classes on the importance of screening, health care utilisation, and healthy nutrition.

My husband was a big part in introducing health classes to the Indian association. It eventually evolved into health message classes because the instructor was utilising funding from ProCare. So they had speakers on diabetes, heart illness, and healthy eating healthy living workshops. Lotus, Indian female: YSM>7yrs, fifties.

The association have different people come in and talk about different health messages. There is a fitness trainer for bolly-aerobics is an advocate for the community and always stresses the importance of health. Sally, Indian Female: YSM>7yrs, forties.

There are benefits to promoting healthy messages in a community setting, as South Asians utilise social capital as a mechanism for adaptation. For example, Asian cookery clubs in Bedfordshire, UK equipped South Asians with skills for healthier food preparation techniques while at the same time fostering connections, and motivated people to take on the messages shared and apply it to their daily lives (Snowdon, 1999). SPROUT is another example of health promotion happening at the community level by South Asian people for South Asian people through creating a playing field where people can come and equip themselves with knowledge on health and nutrition while at the same time be a part of Bollywood-styled fitness classes. Health promotion has the potential to communicate effectively through the right messages utilising pre-existing social networks and further existing health promotion activity to support

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educated South Asian immigrants in attaining their desired lifestyle. Crawford, Ahmad Beaton & Bierma (2015) scoped the screening knowledge of South Asians in the UK. The scope found there is a need to promote health promotion messages around cancer screening indicating the health system could do more to reach this particular ethnic group.

The potential for this path becomes especially relevant when discussing stigmatized issues including depression and domestic violence (Choudhry, 1998). For South Asian women, health promotion messages and programs hold greater value and impact on their health and wellbeing when messages are tailored towards their unique set of immigration experiences including changing gender roles (Ahmad et al. 2009).

Perceptions of participants revealed a mix of saying it is the woman's responsibility to keep herself out of isolation, to also suggesting it was the male spouse's fault, to then suggesting it is the responsibility of PHC to be aware of females presenting distress and link them to the appropriate support.

Have to work and not sit at home. Women need to get involved in social work. It is not our background but we need to adapt. Jerry, Indian Male: YSM>7yrs, forties.

Issues including domestic violence and depression are for the most part seen as avoidable and controlled by the women instead of a wider societal or marital issue (Lauber, & Rossier, 2007). However, the suggestion to seek out social connection as discussed in the previous section is a common coping mechanism for South Asian women. Culture plays an influential role in shaping this perception and is uncommon with the South Asian men. A cross sectional study reported violence against wives by Bangladeshi men (Silverman, Ducker, Kaur Gupta, & Raja, 2007). The study indicated it happens commonly and is directly attributed to the sexual health of their wives. South Asian women who are abused by their spouse are also likely to be cheated on with sex outside the marriage, therefore experiencing a higher risk of sexually transmitted diseases including HIV/AIDS (Silverman et al. 2007). This study somewhat reflects the slight hint of male dominance behind Jerry's statement about women helping themselves. Though what he has said is very true and women do need to keep themselves surrounded with social support, if issues including domestic violence are still occurring it can further drive women into isolation. However, there is a lack of appropriate health messages out there in society attracting South Asians in a manner that is supportive and desired by the ethnic minority group

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(Pescosolido et al. 2010; Parker & Aggleton, 2002). Building awareness of stigmatized issues within the South Asian ethnic groups needs momentum and resources. The *Dimagai Sehat Ki* (Let's talk about mental health) program in NZ is one of the few key support groups tailored for the South Asian community (Ho, 2013). Its aim is to bring an improved and enlarged understanding of mental illness among the South Asian people through creating a network of support services and members within the communities themselves. The program also intends to use the next recommended factor for a model of health promotion which is to utilise media avenues to reach the South Asian communities (Ho, 2013).

The use of social networks to find the support needed to assist promoting healthy settlement lifestyles is a key mechanism used by South Asian participants. Despite holding an individualistic outlook on responding to health messages, social connections are still used to acquire information to make individual choice regarding health.

### **5.2.2. Social connections as a possible solution**

Social connections as mentioned previously in the discussion is a huge lever for health promotion to use and meet the expectations of South Asians. The use of existing social connections is defined by Bourdieu as social capital:

the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance or recognition. (Bourdieu, 1983. Pg.249).

Regaining social capital is a common lever to use among immigrants to gain power through increased access to resources post-migration and establishing a familiar social status experienced prior to immigration (Portes, 2000).

The South Asian immigrants in this sample are highly educated and live well-off lives in their country of origin. However, post-migration factors shaping capital including employment is a challenge to gain. South Asian men and women in this case are forced to be underemployed and underpaid as a result of society barriers (Bauder, 2003; Portes & Sensenbrenner, 1993). Bauder (2005) explored the employment of South Asians in Vancouver, Canada to understand the coping and settlement strategies used by this particular immigrant group for entry into the employment field. Bauder's review of data collected through interviews with South Asian

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immigrants found the use of social networking as a support mechanism but also as a lever to gain access to employment and other socioeconomic determinants of health including housing to be highly valued. Social connection is formed to create some sense of familiarity in social status embodied prior to immigration

South Asian peoples are not the only group of ethnic groups who utilise social connections to rebuild socioeconomic position (SEP). Latino people in the USA who utilise social support as a coping mechanism to rebuild a sense of cultural normal to buffer the stress caused by social inequalities experienced such as loss of economic capital shaped by social environmental drivers (Finch & Vega, 2003).

### **5.2.3. Culturally appropriate health promotion for South Asians**

As well as the health care system's disconnect in promoting culturally appropriate messages in healthy lifestyles for South Asian peoples, there appears to be a lack of support provided by wider society outside of health. The stressful journey of migration comes with a change in identity and socioeconomic position. The places we live, learn, work, and play, in other words the social determinants of health: shape our ability to live healthy lives (Newman, Baum, Javanparast, O'Rourke, & Carlon, 2015; & Westin, 2010). The social determinants of health experienced and society's attitudes towards immigrants shaped by immigration policies play a crucial part in the ability of South Asians to live their desired lifestyles. Society's ability to promote, support, and empower ethnic minority groups including South Asian peoples in attaining the highest standard of life desired through PHC, health promotion, and the physical and social culture of society. As discussed in the literature review, a society that incorporates cultural diversity in its policies and socio-cultural environment is more effective in supporting ethnic minority groups including South Asians settlement journey. The following participant perceptions suggest a society that incorporates cultural diversity in its culture is effective in supporting the perceptions of South Asians to live healthy in relevance to their ethnic culture.

Ward & Masgoret (2008) examine the attitudes of NZ's host society towards immigrants and NZ becoming a multicultural nation. The results of the review showed a positive attitude towards immigrants with little feeling of a threat despite the very real nature of the zero-sum effect which describes the loss of accessible employment through immigration. The ideal of a multicultural society proved to outweigh any concerns in the study. The openness of NZ's host

society towards immigrants and multiculturalism may be due to the positive impact Asian immigrants have on the economy through improved workforce, labour output, and relations with Asian powers including China and India for trade and political alliances (Simon & Lynch, 1999). Therefore, there is a high level of tolerance among the host society towards Asian immigrants in NZ (Bedford, 2000; Pearson, 2000). The word tolerance is used because it represents the conflict of a host society, between embracing cultural diversity and the threat to loss of national identity. However, tolerance of culture is can sometimes not be real acceptance of diversity. For example, a media campaign titled the Asian invasion in the 1990s by the New Zealand First Political Party in their election campaign encouraged the population to not be tolerant of Asian immigrants. The Asian population were targeted and seen as invaders of NZ urging people to not be tolerant or accepting of them (Anderson, 2008; Bedford, 2000). Politicians and media worked together to provide NZ society with an unrealistic picture of concern for political gain (Munshi, 1998; Trlin, 1987). However, as seen above in Simo & Lynch (1999) the majority of NZ society still had positive attitudes towards multiculturalism and immigrants because realistically the “Asian invasion” argument was based on political gain.

Despite research indicating society has an open mind-set towards South Asian immigrants in NZ, South Asian immigrants themselves perceive the feeling of losing social status post-migration attributed to societal attitudes towards them. This is expressed by Lotus, a second wave immigrant who expressed her perception on societal attitudes towards South Asians when she was asked if she has ever felt discriminated against in society. Though, Lotus grew up in NZ she describes feeling inferior to the rest of NZ society despite its belief in being a multicultural society.

I felt inferior to the European and Maori cultures as a child, because in some ways you feel inferior. Something psychological you have to get over... NZ is an immigrant country, but I just went to Canada to visit family and the country is made up of recent immigrants, I felt everyone was on the same basis and level. Whereas, here I feel the Maori and white people who settled a little earlier look upon us like we are invaders. Whereas, in Canada it is like everyone people come in together to make something beautiful. White people have done a good job in setting up the country, but I just hope

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they realize new immigrants are not here to take away but add to the country. Lotus, Indian Female: YSM>7yrs, fifties.

The theme of feeling inferior to the European-Maori identity of NZ society is also expressed by Jerry, a middle-aged Indian male, who explains the inclusion South Asians feel in American society as supposed to how he has felt settling in NZ. His quote reveals the influence the physical and social environment of a society has on the immigrants' ability to live successfully in terms of health and social identity.

Here, South Asians are living a life of depression working two to three jobs, qualified but underemployed. There is discrimination. My brother lives in the United States of America and has an Indian accent but he is very successful because they accept people from other cultures. They have a lot of Latinos. Slowly as New Zealand sees people coming from other countries they will accept migrants have their own country qualifications and can get the job done. Jerry, Indian Male: YSM>7yrs, forties.

Jerry reveals the difficulty experience post-migration as economic capital changes. The Asian Health report also indicted the very same response in data collected, displaying a high level of under-employment acting as a stressor on the ability of migrants to live healthy lives (Ministry of Health,2016). The lack of perceived support from society can also create disparities in health outcomes seen between South Asian migrants and the European population whose socioeconomic position is higher despite both groups being educated (Scragg, 2010).

The perception of inferiority experienced by the participants above might reflect the gap in NZ's settlement policies and instructions including health care's ability to facilitate and provide the opportunities desired by South Asians to live their desired lifestyles.

All in all, the role wider society plays in shaping social identity and agency executed in societal spaces as health care is strong. The healthy lifestyle expectations preconceived prior to immigration are left feeling unsupported and unrealistic upon post-migration participants due to the lack of societal encouragement and equipment to do so. Immigration policies can create a diverse society shaping attitudes towards immigrants. Attitudes of host society can shape the perceived identity of South Asians and therefore, influence behaviours including accessing health care. Factors such as loss of status and connections post-migration are reinforced by a lowered sense of control and power over health and wellbeing for their families. A perceived



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loss in control over lifestyle is applicable to the experiences expressed by South Asian immigrants internationally including America and Canada which have practiced the art of becoming home to societies of diverse immigrant cultures (Light & Bhachu, 1993). A society which incorporates and embraces cultural diversity supports and equips its migrant groups to utilise societal spaces such as health care in a more effective manner.

#### **5.2.4. Approaching South Asians at a personal level**

In summary, the two factors, immigrant identity, and societal attitudes and social support, are interconnected and influence the overall consumer-patient role South Asian immigrants are commonly used to (Jasinskaja-Lahti, Liebkind, Jaakkola, & Reuter, 2006). These are only two of many other sociocultural factors that shape health behaviour but what these two in specific indicate is the influence society has on the journey of acculturation and adaptation.

The physical and social cultural environment of a city such as Auckland can utilise health promotion through a personal approach which identifies the educated consumer behaviours of South Asians peoples, as well as coping systems including social networks as a lever to meet expectation in achieving health and wellbeing within PHC and in the wider society. Employing a personal approach ensures messages are both tailored and delivered through an equity-empowerment lens with an understanding of consumer experiences, cultural values, and immigration pressures.

In that case it should not be general advertisements but more society based. For example, go to the community and put it up on the community board not broad general avenues. Have to us the appropriate avenues. Going to the communities and it is the responsibility of the health care system to go there and reach them. For example, gambling in Auckland: if you go and put advertisement that gambling is bad and we have a helpline that is all fine, but more than that identifying communities who are suffering from it through surveying is much more effective when trying to promote help and services. Help needs to be personally tailored. Sarah, Indian Female: YSM>7yrs, forties.

Sarah advocates for health promotion to first be careful in the approach it chooses to take. Health promotion needs to identify issues and support help through specific avenues. Her argument is reflective of the common mind-set of immigrants' desire to be accepted and not be seen as a problem (Reitz, & Sklar, 1997). Sarah's point above is a valid to point make from the

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immigrant perspective, and if NZ is striving towards becoming an egalitarian society then it should be careful in using population-level health promotion to reach South Asians, because it has the opposite effect of empowerment and equity. Instead for Sarah, it creates a gap between ethnic minority groups and the rest of society, communicating the message that health can solely be achieved by the immigrant, when there is an evidential lack of support from society to do so. Sarah's perception brings to light the fine line between trying to help improve the health of a certain ethnic group as supposed to making them feel further powerless and victimized in a new society (Labonte & Laverack 2001; Leverak & Labonte, 2000). Sarah's equity lens approach on the topic of South Asians being represented in mainstream health promotion can also be picked up on in Paul's perception on mainstream health promotion.

It's nice to have someone similar, although it might not affect me personally because we understand it for some people who are isolated it might not be relevant to them when they see pictures of health promotion... Mainstream approach will work- it is a powerful tool but health promotion needs to have everyone represented in the mainstream approach not just Pacific Islanders. It is a wider issue. So people will understand it is not just one culture experiencing it but is widely experienced...I think for people who are here for a long time their issues are well addressed but newcomers are nervous about getting in there. Paul, Sri Lankan Male: YSM>7yrs, twenties.

Paul expresses the same need as Sarah for health promotion to avoid exacerbating disparities in health through any negative societal attitudes towards immigrants. However, Paul's underlying tone in his perception is not so much through an equity lens like Sarah, but a reflection of his bicultural identity as an immigrant child. There is a desire among younger generations to reflect a bicultural identity grounded in both South Asian and European cultures, however, at the same time, traditional family roles and practices are respected and maintained (Talbani & Hasanali, 2000). The acculturation adaptation experience of South Asian youth is more aligned with integration and therefore the perceptions of health promotion representing their ethnic group in population campaigns may be a reflection of this desire to be a part of both cultures. In Canada, South Asian children were encouraged by their parents to mix with the host society's culture and be a bridge of communication and understanding through the acculturation journey for South Asian immigrant parents (Kurian, 1991). All of this may shed some light into the advocate tone of the perceptions noted above by Paul in saying health

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promotion at a mainstream population level should reflect the diversity of NZ and meet the curiosity of South Asians to live healthy lives.

Epp (1987) “Achieving health for all: A framework for health promotion” states that the role of health promotion activity is to reduce health inequalities. The report argues for a health for all approach to be taken by the Canadian health system which caters to a vast number of ethnic minority groups. Health promotion should further every population group in their endeavours to succeed through equipping them with the right skills to do so, in a non-cohesive way that is culturally desired (Kowalczewski, 2010)

For health promotion to utilise a personal approach through a cultural lens is consistent with the habitus of South Asian immigrants explored in the previous analysis chapter. The cohort of South Asian participants interviewed in my study highlight the high level of education and understanding on what health is held by a typical South Asian immigrant in NZ. A review of health promotion behaviours including healthy eating and physical exercise of Gujarati Indians in the United States of America (USA) found South Asians usually liked to self-educate themselves on healthy lifestyle behaviours including nutrition and health care utilisation before accessing health care (Misra, Patel, Davies, & Russo, 2000). The study indicated there is a level of individual responsibility displayed by South Asian people when it comes to health promotion behaviours before accessing health care services. The study finding contrasts the desire for PHC to promote healthy lifestyles as seen by my participants. However, the health systems of South Asian countries health systems are burdened by communicable diseases, therefore framing health promotion messages on hygiene and so on, instead of healthy eating and physical activity as seen in NZ. Thus, health promotion messages on improving lifestyles is rare to my participants driving a notion of not wanting to be singled out among ethnic groups as having a problem. Thus, in order to sustain a sense of familiarity in surroundings and lifestyles, South Asian immigrants are likely to self-educate in order to maintain a healthy lifestyle.

The mental, spiritual, and physical aspects of us. I would not say I am healthy because I have physical illnesses but I am mentally equipped to handle it. Sarah, Indian female: YSM>7yrs, forties.

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Sarah's expression on her perceived definition of health is one among many expressed by participants, revealing the high level of knowledge held on health. The perception frames the pre-existing knowledge on health lens participants use to perceive health promotion messages a routes post-migration. For Sarah, her equity lens is framed by her predisposed knowledge on health as a trained medical doctor, consumer of health care, and educated mind-set cautious of being felt less powerful because of targeted health promotion.

For Andrew, a fourth wave immigrant from Bangladesh his definition of health is centred on the ability for him and his family to thrive in a healthy environment externally influencing their internal health and wellbeing. Unlike Sarah, Andrew's perception on healthy living signals the motive to migrate to NZ. The lack of healthy environments for him and his family and the knowledge of living better lifestyles outside of Bangladesh motivated him to migrate to NZ. However, the lack of information and support for him and his family to utilise the perceived healthy benefits of living in NZ is an uncalculated challenge for him.

Healthy environment – no pollution, eat healthy food, lifestyle. In our country we have lack of this-health environment. Andrew, Bangladesh Male: YSM>7yrs, forties.

Again, the underlying problem is not a lack of information for the South Asian population in regards to healthy lifestyles but rather a lack of support through connections with PHC and wider social capital in maintaining healthy lifestyles by PHC and social services. The economic progression of South Asia has produced a population well informed and able to make decisions on their own health and wellbeing, migrating overseas for better healthier lifestyles matching their new found expectations on state provision for their livelihoods (Chatterjee, 2008). Therefore, the typical South Asian immigrant in NZ does not arrive nor interact with PHC and health promotion from a place of lack of prior knowledge and information on health illnesses affecting them but rather knowledge on the potential benefits on lifestyle that can be extolled through PHC.

### **5.3. Conclusion**

The analysis reviews the tension experienced by South Asian participants in desiring to live healthy lifestyles but feeling unsupported to do so when utilising PHC-level services. Therefore, participants have revealed the main coping mechanism utilised to acquire information and access to resources in support of living desired lifestyles is through social networks. Whether it be through South Asian cultural associations including the Indian association or through family friend circles, social networks are always a huge component to their habitus. Changing the behaviours of South Asians in regards to prevention can only occur through time and commitment to understanding the wider social status and cultural outlook on life in the long run (Kelly, 2005). There have been attempt to improve PHC's capacity to meet the health expectations of South Asians. PHC attempts include HEHA project by the DHBs which till this date may be the most positive and effective example of health promotion for the South Asian community done right. The HEHA programme implemented a multifaceted health promotion occurring at religious facilities, community centres and other venues South Asian people were commonly known to go to including grocery stores. Through these venues the HEHA team was able to attract and recruit people to partake in the education classes specifically designed to communicate to the South Asian people from a place of cultural understanding of values and immigrant priorities (Sobrun-Maharaj et al. 2011). The reason why HEHA was so well accepted and effective was because of the culturally appropriate programme logic and methodology it built its activity on. It came from a strengths-based approach in identifying existing activity and knowledge among the South Asian communities on healthy behaviours.

Bourdieu's habitus theory informs the discussion of the way in which migrants adapt and make the most of their social status post-migration. Erel (2010) on pg. 643 refers to the adaption of habitus as "migrations specific cultural capital" which encapsulates the adaption and behaviours of migrant groups to meet their own unmet needs through utilising existing capital to acquire more. It supports the findings of this chapter in discussing the ways participants meet the unmet need of healthy living promoted by PHC. The effective use of habitus as a theoretical lens to observe the health behaviours of ethnic minority groups including Indian people is displayed in Anderson (2008) who looks at the experiences of migration and settlement using tuberculosis as an example. The study indicates a similar finding to my study in suggesting that

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there is a gap found within society settlement policies and resources to equip and support migrant groups to maintain health. The loss of support by society and health care causes a loss of economic and cultural capital which is regained through the utilisation of social capital by migrants (Anderson, 2008). Another study on the habitus of Finnish immigrants in NZ also revealed the importance of health care and the potential of wider society policies to either positively or negatively impact the habitus of Finnish people (Freeman, 2012). The study supports my study's finding indicating immigrants bring with them a strong sense of habitus shaped by their identity. The post-migration process however, is almost out of the migrants control because society's ability to cater to their needs is a strong contender in shaping health behaviours and perceptions towards health care (Freeman, 2012).

The habitus of South Asians is therefore shaped by a combination of preferences and knowledge founded pre-migration and continuously shaped post-migration through PHC and society's ability to cater to the habitus of South Asians. The chapter discussion has revealed the lack of appropriate health messaging through effective cultural avenues expressed by participants. It has also discussed the relevant coping mechanisms South Asians utilise including social networks and pre-existing desires to succeed post-migration driving attempts to be healthy. Progress is made towards what factors should be taken into account during planning and implementation of health promotion and even health care services for the South Asian population. The habitus of the South Asian immigrant is well informed and comes from a position of comfortable social status prior to immigration. PHC in NZ must match, and if not, support the habitus of the South Asian as symbolic capital changes according to host society's ability to equip and empower ethnic minority groups to succeed post-migration.

All the key players and activity is present, all that is needed is connectivity and integration of this social capital to deliver health promotion consistent with the expectations of South Asian immigrants. From the current and previous chapters, the analysis of perceptions and experiences of South Asians with PHC indicates the South Asian population is highly educated and aware of healthy practices but there is a lack of support from health care to live out pre-existing desires in health and wellbeing.

# Chapter six

## 6. CONCLUSION TO THESIS

This thesis has looked at the possible role utilisation of PHC-level services has in the persistent growing nature of illnesses burdening South Asian immigrants in NZ. The study aimed to: to understand the health service utilisation experiences and perceptions of South Asians with PHC. The objectives of my study was to: map the profile of the South Asian health seeker, outline the sociocultural, economic, and contextual factors that influence or create barriers to health care, understand the perceptions and experience of interactions with PHC, and examine capacity of PHC to be culturally responsive to diverse health needs. Drawing on the in-depth interviews of my fifteen South Asian participants in Auckland to interpret the experiences and perceptions of South Asian participant's interactions with health care prior to migration and post-migration. The interpretation of participant interviews revealed two main findings. First, chapter four revealed the utilisation interactions with health care prior to migration were embodied as the set of knowledge and behaviours embodied by participants post-migration. Second, chapter five revealed the role of PHC and society in promoting messages on healthy lifestyles is inconsistent with the desired approach and messages South Asians desire to utilise. Overall, chapter four and five discussed the possible ways in which PHC-level services are inconsistent in the service delivery of care to South Asians in light of a change in ability to live healthy in their social circumstances. The study analysis indicates the inconsistency in care provided by PHC-level services can further restrict the ability of South Asians to express their ethnic identity when utilising health care and receive the care they desire.

### 6.1. Study finding implications:

The two main findings briefly mentioned above carry with them implications for the health system and society of NZ. The first finding presented by Chapter four was that the health service utilisation perceptions and expectations of South Asians are heavily influenced by their pre-migration interaction experiences with health care. South Asian migrants tend to carry over predisposed knowledge on health as part of their resources and outlooks that make up their habitus. The finding provides PHC and the wider health system with a key piece to improving

the ways in which service delivery can reach and build long term relationships with this particular ethnic group. The study highlighted the need perceived by South Asians to be recognised as capable of looking after their own health and wellbeing. It also highlighted through this particular finding that because South Asian migrants perceive themselves to be capable and educated in matters of health, the main role of the GP is seen as a facilitator. The role of a facilitator as discussed in Chapter 4 may be not be that much of a tangent of the gatekeeping role PHC-services have. The facilitator role of services and resources in health can act as a component of care during consultations with South Asian patients. Thus, considering the strong sense of control and knowledge of South Asian migrants that supports their habitus. PHC-level services and professionals incorporating the predisposed knowledge and expectations of South Asian patients can also support existing cultural competency resources for health professions in delivering patient centred care to all ethnic groups within their population (Saha, Beach, & Cooper, 2008). The incorporation of predisposed knowledge of South Asian migrants in regards to health improves the overall experience of utilising health care. The improved utilisation experiences ensures South Asian patients are supported in maintaining their health and reduces the disparities in illness experienced.

The second finding from the content analysis revealed the wider function of PHC to promote healthy lifestyles was often inconsistent in supporting the ability of South Asian migrants to live healthy lifestyles through their socioeconomic position. This finding adds to the research on Asian research focused on understanding the HME and health of Asian subgroups as migrants (Salant, and Lauderdale, 2003; Scragg, 2010). The inconsistency between health promotion and the perceived needs in promotion of healthy lifestyles by South Asian migrants may reveal why the health behaviours of South Asians through acculturation decreases. The lack of societal and health service support in living in socioeconomic positions initially post-migration perpetuates the stress and susceptibility to illnesses by South Asians. According to Ruhm (2005) the lowered socioeconomic position status of migrants influences the ability they have to access, utilise, and benefit from health services. Therefore, the study suggests health promotion messaging by PHC-level services should create partnerships with South Asian community groups in order to equip and empower migrant groups ability to extol the benefits of society including health care. For example, the Central Indian Association already holds health and fitness classes, but finds it hard to reach the wider community. Ahmad et al (2004) in their study on health promotion strategies for Chinese and Indian



immigrants found health promotion that utilised social networks to communicate message son promotion of healthy lifestyles were much more supportive to the migrant lifestyle. Effective promotion of healthy lifestyles with culturally relevant messages should utilise existing avenues by creating partnerships that will equip the ethnic group to experience positive acculturation. PHC's partnerships with South Asian community groups insures the function of advocacy and influencing practice of healthy public policy to reduce disparities in health (Baum, 2007; World Health Organisation, 1986).

The importance of valuing the pre-existing knowledge, skills, and overall habitus of South Asians when acculturating post-migration is the key to improving their health outcomes. PHC-level services overall should embrace South Asian cultural knowledge during consultations and go beyond expectations in care by the community to partner with them in creating positive culturally appropriate health promotion messages and programs (Bauman, 1996; Ho, 2015).

## **6.2. Final note on Acculturation and Habitus**

Positive health service utilisation experiences and perceptions of South Asians are suggested to strongly be attached to the acculturation pathways society encourages and supports them to take. The literature review examined how assimilation can restrict the ability of South Asians to express their culture and thereby cause negative experiences with settlement translated into health care interactions. On the other hand, a society which employs Berry's biculturalism strategy which encourages cultural diversity has a much more positive influence on shaping the settlement of South Asians. The acculturation theory helped the argument that the wider societal policies and culture reflected through health services and other areas of society have the power to shape the habitus and overall health of South Asian migrants.

Figure 2 Sociocultural influences on ability to live healthy

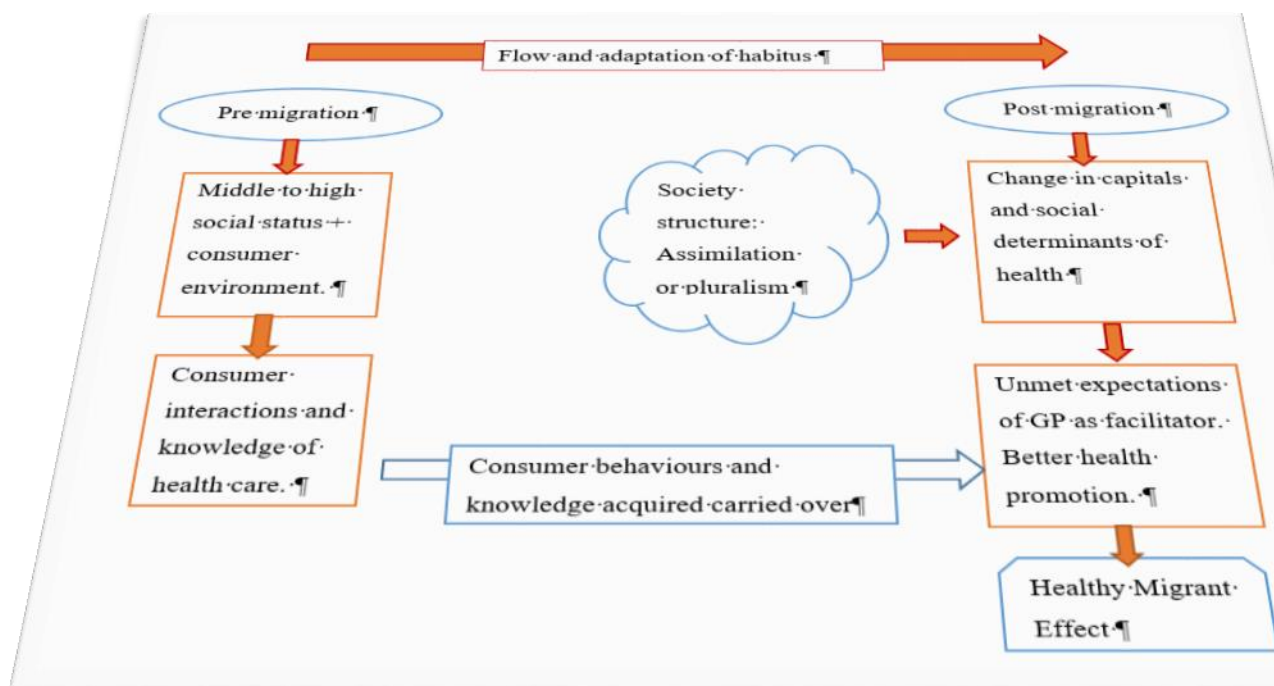
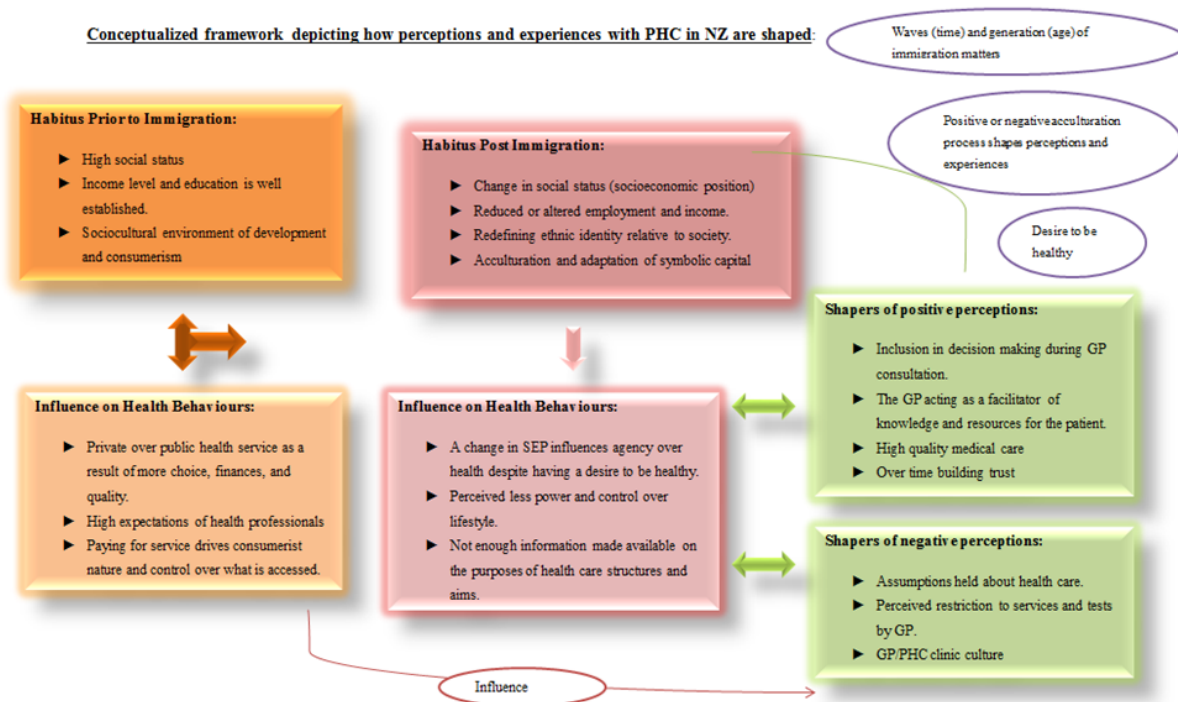


Figure 2 above, highlights the suggested influence sociocultural influences have on shaping the ability of South Asian migrants to live healthy post-migration. For example, the social status of South Asian migrant pre-migration forms expectation on the lifestyles and opportunities host society will provide post-migration. However, the host society's policies and organisational culture has control in shaping the settlement of migrant's post-migration. As the literature review stated, a society that incorporates an assimilative approach to migrants will discourages expression of ethnic identity and restrict the ability of migrants to extol the benefits of society including health care. Whereas, a society that incorporates a cultural diversity approach to its policies and organisational culture creates a socio-cultural environment in which migrants can thrive though improved social determinants of health. All of which, have

the potential to either negatively or positively contribute to the HME and susceptibility of illness bore by South Asian migrants.

Acculturation was also used to identify how the habitus of South Asian migrants determined perceptions of utilising health services at PHC-level. Bourdieu's framework of habitus theory provided a strong framework for understanding migrant resources and skills in relation to acculturative society structures. Habitus seemed to challenge the ability of South Asians to express their ethnic identity through their acquisition of capital. Further participant activity to acquire more capital and/or express consumer control in health provider settings was somewhat left unsupported by PHC culture despite being founded on cultural diversity. South Asian migrant's habitus (resources) changes according to wider society attitudes towards supporting migrants and thereby shaping ability to access health care. At the same the habitus embodied by individuals, in this case South Asian immigrants is immediately identified, judged, and given a place in society through the availability and openness of the culture and opportunities presented in society (Bourdieu, 1977; Bourdieu, 1989).

## Conclusion to the thesis: Final note on acculturation and habitus



**Figure 3 Habitus framework**

Through this habitus and acculturation lens, it is evident connection between the consumer expectations expressed by participants' post-migration are formed through health service utilisation experiences prior to immigration. South Asian migrants experience a change in symbolic capital: economic, social, and cultural as well as overall ethnic identity relative to the rest of the society (Bourdieu, 1989). As stated above the habitus of South Asian immigrants is heavily influenced by the places we live, learn, play, and learn providing opportunities for employment, and social connection shaping perceived agency to express immigrant aspirations and cultural identity (Bourdieu, 1985). The overall change in agency shaped by acculturative policies and organisational cultures then feeds into the expectations and experiences of utilising PHC-level services of South Asians. For example, my participants have highlighted the role their habitus plays in shaping their identity and ability to experience quality health care according to their consumer perceptions of the GP's role as a facilitator to resources in health. Data analysis of participant perceptions and experiences summarized the strong correlation between resources shaping habitus including social status prior to immigration and how status is transferred into the power held by patients in health care settings. Social status acts as a strong lever, empowering participants to utilise health care and asserts control in health provider relationships. The use of social status to access health care, especially privately, is

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supported by the wider sociocultural environment of consumerism in expanding health care systems of South Asian countries. Therefore, South Asian participants display a strong desire to have control over their health especially in health care settings formed by operating as a consumer of health care prior to immigration.

The consumer ideals displayed in the perceptions of my participants indicates, according to South Asian patients, what makes a GP at the PHC-level adequate and at what point does this change. The strong sense of consumerism and control supported by access to knowledge on health fuels the desire for a GP's role to be as a facilitator of care and resources. Therefore, what makes an adequate GP is one who acts as a facilitator to further tests and care at the secondary level. A GP is also considered good over time as trust builds and a level of familiarity builds between the patient and GP. Regardless of the length of time a South Asian patient has been with a GP, if a GP fails to include and facilitate the patient in access and care, it causes disappointment. This is a consistent theme across the South Asian participants interviewed across generations and waves of migration.

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### **6.3. Limitations of the study**

There were three main limitations to the study. The first, is the use of an interpretive approach to the research. An interpretive study design only reveals the partial truth to the issue. For example, the study revealed there is an inconsistency in the messages communicated by PHC regarding health promotion to South Asians. However, employing an interpretive approach only allows the analysis to interpret it according to the perceptions of the participants. There could be more than one interpretation to participant perceptions and experiences of PHC and thereby different conclusions. Thereby, it is important to recognise that the findings of this study is not the objective truth but rather presents a possible truth to the issue explored.

I argue the use of an interpretive qualitative study on the perceptions and experiences of South Asian migrants is valuable research for the health system to consider. Health reports including (Mehta, 2012; Ministry of Health, 2006; Scragg, 2010) in NZ have already set the scene for the need to understand the experiences of South Asians and other Asian subgroups on a personal level in order to improve their utilisation experiences. Thereby, by the study employing an interpretive approach from the ethnic groups side of experiences the study can add richness in understanding to the already existing health data collected by the Ministry of Health. Approaching the study from purely the patient's viewpoints also provides a window into the socio-cultural influences on health that is weak in NZ (Rasanathan, Ameratunga, and Tse, 2006).

Second, the study explored the issue of the HME and illnesses among South Asians despite utilisation of health care from one side only. While the perceptions and experiences of South Asian migrants gives an important voice to ethnic minority groups desired needs in health care, it only has the capacity to focus on one side of the story. The study did not have the time nor resources to sit down with health professionals at a PHC-level and interview their perceptions and experiences on the health of South Asians. Despite this limitation I argue in this study, presenting the voices of South Asian migrants is a key part to understanding how the PHC system can help prevent and manage illnesses in a culturally appropriate way. It is important for the health system to deliver care consistent with the actual expectations of South Asians another migrant groups. Lastly, the use of recruiting participants through the various South Asian association groups resulted in a delay in time to recruit and collect data. The period of consultation, recruiting, and following up with associations limited the time needed to collect

## Conclusion to the thesis: Limitations of the study

data. At the time of recruitment some associations including the Sri Lankan association were not frequently gathering and other associations were not interested. The one South Asian association to respond to my study resulting in participant recruitment was the Central Indian association of Auckland. The Indian association proved to be an active place for my recruitment through the health and fitness classes where participants were happy to be interviewed. The existing knowledge, activity, and desire to be healthy by the Indian Associations proved to be a lever to use for my study, as it yielded participants. The mix in willingness to be a part of the study from the different associations is only reflective of the large diversity and mix of formal and informal structures of meeting in place. In the end regardless of the methodology chapter stating participants would primarily be recruited through the numerous South Asian association groups, word of mouth became the primary lever for me to use. Word of mouth arose as a solution out of the limitation in time.

## **6.4. Conclusion**

Overall, this thesis has set out to understand the persisting growing rates of avoidable morbidity and mortality burdening South Asian migrants, specifically in Auckland city. The findings and implications explored in this final chapter of the thesis reveal there is inconsistency between the way in which PHC-level services are delivered and the desires of South Asians. Participant interviews revealed South Asians are highly educated migrants with a desire to be included in their health decision making by pushing for the role of GPs to facilitate services and treatment. On a wider scale NZ society must consider the acculturation of South Asians and the opportunities it provides for their habitus to be expressed through the set of skills and knowledge migrants arrive with post-migration. This includes shaping PHC to promote messages in living healthy that are relevant to the migrant journey and connect with South Asian communities to empower their aspirations. Research should continue to give a voice to ethnic minority groups including South Asians, informing health care and society on how to create an environment where cultural diversity succeeds and thrives.

## **7. Appendices**

7.1: Participant Recruitment Form

7.2: Interview Guide

7.3 Participant Information Sheet

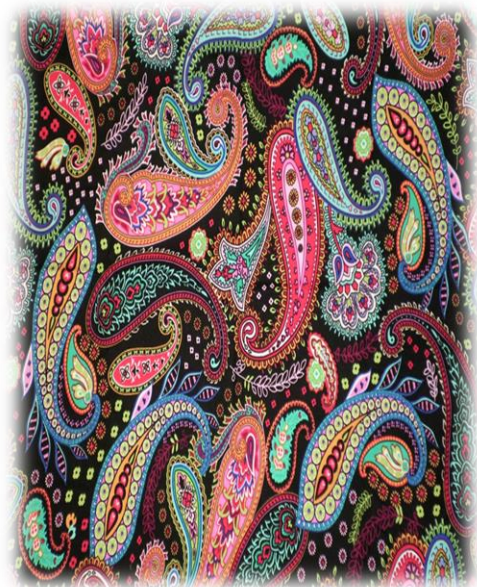
7.4 Participant Consent Form



## 7.1. Participant recruitment form

# PRIMARY HEALTH CARE IN NEW ZEALAND: THE EXPERINCES AND PERCEPTIONS OF SOUTH ASIANS.

Name: Rachel Simon-Kumar (Senior Lecturer at the University of Auckland) Email: [r.simon-kumar@auckland.ac.nz](mailto:r.simon-kumar@auckland.ac.nz)



Hello, my name is Jessica Vani Tamanam and I am a Master of Public Health student at the Faculty of Medical and Health Sciences, University of Auckland. As part of my Masters theses, I am recruiting participants for my research project.

It is a qualitative research study seeking to understand and explore the experiences and perceptions of South Asians with primary health care living in the Auckland Region.

The decreasing health status of South Asians has become a concern for New Zealand health policy and health systems management. Therefore, this research piece aims to provide some insight into the lived experience and perceptions of the South Asian ethnic minority group living in Auckland city. This will bridge the communication gap between providers and South Asian patients accessing primary health care services (i.e. General Practice). This is a step in the right direction towards delivering to deliver culturally appropriate and responsive health care to the needs of everyone in their population.

### What will this study require of you?

There will be one in-depth interview with me (the researcher) face to face for in an agreed location and time for the duration of 30-60 minutes.

Please contact researcher: Jessica Vani Tamanam PH: (021) 1786704 Email: [jtam028@universityofauckland.ac.nz](mailto:jtam028@universityofauckland.ac.nz)

Supervisor details: Name: Rachel Simon-Kumar (Senior Lecturer at the University of Auckland) Email: [r.simon-kumar@auckland.ac.nz](mailto:r.simon-kumar@auckland.ac.nz)

### Participant Criteria:

- Participants need to be 18/ and or above the age of 18.
- Participants must identify themselves as being South Asian (this covers Afghanistan in the West to Bangladesh in the East, and Nepal in the North to the Maldives in the South)
- Basic English skill set as there is no interpreter involved.

Approved by the University of Auckland Human Participants Ethics Committee on 29th of June 2015 for three years, Reference Number: 014913

## 7.2. Interview guide:

Section:	0-2 years since migration	2-7 years since migration	7 and more years since migration
<b>INTRO:</b>	<p>Hello, my name is Jessica Tamanam, I am the researcher to this study and I previously talked to you on the phone. How are you?</p> <p>Thank you so much for being willing to participate in this study and sit down with me for an interview. As explained in the Participant Information sheet and the Consent form you just signed, the aim of this interview is to understand the health behaviours of South Asian people with Primary Health Care. The South Asian ethnic minority group is one of the largest Asian subgroups in New Zealand, and over recent years immigration has increased from this region of the world and culture. Therefore, understanding your experiences and perceptions as a South Asian immigrant with Primary Health care services allows for feedback into the New Zealand health care system, for future improvements in towards health for all. The interview questions are set up to hear your stories involving the health system here and back in your home country.</p>	<p>Hello, my name is Jessica Tamanam, I am the researcher to this study and I previously talked to you on the phone. How are you?</p> <p>Thank you so much for being willing to participate in this study and sit down with me for an interview. As explained in the Participant Information sheet and the Consent form you just signed, the aim of this interview is to understand the health behaviours of South Asian people with Primary Health Care. A large proportion of the South Asian ethnic group in Auckland City have migrated over a decade ago and with this increase in population number, comes a need to understand your health needs and expectations. The aim of this interview is to ask you some simple questions about how your experiences and perceptions of the primary health care system i.e. General Practice has changed from when you initially arrived to now.</p>	<p>Hello, my name is Jessica Tamanam, I am the researcher to this study and I previously talked to you on the phone. How are you?</p> <p>Thank you so much for being willing to participate in this study and sit down with me for an interview. As explained in the Participant Information sheet and the Consent form you just signed, the aim of this interview is to understand the health behaviours of South Asian people with Primary Health Care. South Asians have long had a presence in the ethnic composition of Auckland city. As much as it is important to interview new immigrants it is equally important to consider South Asian immigrants who have settled well into society, and the second generation of immigrant families. The interview today will cover a sample of questions hoping to understand your story and how your perceptions on primary health care have changed over time and influenced your relationships with health care in NZ.</p>
<b>Section A: Profile</b>	<ol style="list-style-type: none"> <li>1. Tell me a bit about yourself and where you come from?</li> <li>2. If you can think back, how did you migrate to New Zealand (if second generation, how did your family?)</li> <li>3. Can you tell me a bit about how you define what it is to be “healthy” and how that may change as you settle into New Zealand lifestyle?</li> </ol>	<ol style="list-style-type: none"> <li>1. Tell me a bit about yourself and where you come from?</li> <li>2. If you can think back, how did you migrate to New Zealand (if second generation, how did your family?)</li> <li>3. Can you tell me a bit about how you define what it is to be “healthy” and how your perception of it has changed over the years?</li> </ol>	<ol style="list-style-type: none"> <li>1. Tell me a bit about yourself and where you come from?</li> <li>2. If you can think back, how did you migrate to New Zealand (if second generation, <b>how did your family?</b>)</li> <li>3. Can you tell me a bit about how you define what it is to be “healthy” and how your perception of it has changed over the years?</li> </ol>

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	<ol style="list-style-type: none"> <li>4. Tell me more about what has influenced your perception on health and health care as you have adapted to living in Auckland city?</li> <li>5. What kind of practitioners did you used to see back in your country of origin and how has it changed since? (If second generation then skip and go to 4).</li> <li>6. What would you define the health system in the country you are from to be like? – disadvantages and advantages</li> <li>7. Tell me about your perception on the health care system here in specific primary health care- what in your view are the disadvantages and advantages to the delivery of care?</li> </ol>	<ol style="list-style-type: none"> <li>4. Tell me more about what has influenced your perception on health and health care as you have adapted to living in Auckland city?</li> <li>5. What kind of practitioners did you used to see back in your country of origin and how has it changed since? (If second generation then skip and go to 4).</li> <li>6. What would you define the health system in the country you are from to be like? – disadvantages and advantages</li> <li>7. Tell me about your perception on the health care system here in specific primary health care- what in your view are the disadvantages and advantages to the delivery of care?</li> </ol>	<ol style="list-style-type: none"> <li>4. Tell me more about what has influenced your perception on health (awareness of health system, change in culture through acculturation)</li> <li>5. What kind of practitioners did you used to see back in your country of origin and how has it changed since? (If <b>second generation</b> then skip and go to 4).</li> <li>6. What would you define the health system in the country you are from to be like? – disadvantages and advantages</li> <li>7. Tell me about your perception on the health care system here in specific primary health care- what in your view are the disadvantages and advantages to the delivery of care?</li> </ol>
<p><b>Section B: Reasons For Use:</b></p>	<ol style="list-style-type: none"> <li>8. Do you find accessing Primary Health Care (i.e. General Practitioner) easy?</li> <li>9. What was your initial feeling after accessing primary health care for the first time? <ul style="list-style-type: none"> <li>- (If you haven't yet, can you shed some insight into possible reasons besides ill health that influence your decision to access?)</li> </ul> </li> <li>10. What are some of the broad reasons for accessing Primary Health Care for you? (I.e. Common cold?).</li> <li>11. When you start to feel sick and need to get better, do you first try a South Asian remedy before accessing the health system (or vice versa)?</li> </ol>	<ol style="list-style-type: none"> <li>8. Do you find accessing Primary Health Care (i.e. General Practitioner) easy?</li> <li>9. What was your initial feeling after accessing primary health care for the first time? <ul style="list-style-type: none"> <li>- (If you haven't yet, can you shed some insight into possible reasons besides ill health that influence your decision to access?)</li> </ul> </li> <li>10. What are some of the broad reasons for accessing Primary Health Care for you? (I.e. Common cold?).</li> <li>11. Tell me a bit about how you think your health has changed as you settle into New Zealand- Are there any specific behaviour changes that has led to better or worse health for you?</li> </ol>	<ol style="list-style-type: none"> <li>8. Do you find accessing Primary Health Care (i.e. General Practitioner) easy?</li> <li>9. If you can think back, what was your initial feeling after accessing primary health care after the first couple of time?</li> <li>10. What are some of the broad reasons for accessing Primary Health Care for you? (I.e. Common cold?)</li> <li>11. Do you feel you access primary health care much more often than you used to before?</li> <li>12. What do you feel, in your perspective has influenced your health over the years the most- whether it be change in lifestyle, behaviours relating to health, or simply an awareness of health?</li> </ol>

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<p><b>Section C: Understand Interaction</b></p>	<p>13. What in your experience, makes your interaction with primary health care satisfactory?</p> <p>14. Do you choose primary providers that are the same culture as you or similar? – could you explain why?</p> <p>15. Do you feel comfortable to speak openly and share information regarding your immigration experiences with your primary health provider?</p> <p>16. Tell me more about your experiences with primary health care services-do you feel your health provider(s) takes time to listen and/or understand your cultural values, traditions, and beliefs?</p> <p>17. Following on from the previous question, what would be the biggest barrier to primary health care you have experienced and would want your health provider to know and understand?</p>	<p>12. What in your experience, makes your interaction with primary health care satisfactory?</p> <p>13. Do you choose primary providers that are the same culture as you or similar? – could you explain why?</p> <p>14. Do you feel comfortable to speak openly and share information regarding your personal social life and stressors such as financial stress or isolation with your primary health provider?</p> <p>15. Tell me more about your experiences with primary health care services-do you feel your health provider(s) takes time to listen and/or understand your cultural values, traditions, and beliefs?</p> <p>16. Following on from the previous question, what would be the biggest barrier to primary health care you have experienced and would want your health provider to know and understand?</p>	<p>12. What in your experience, makes your interaction with primary health care satisfactory?</p> <p>13. Do you choose primary providers that are the same culture as you or similar? – could you explain why?</p> <p>14. Do you feel over the years the content of the information you share with primary health professionals including your doctor has become more thought over and more personal or less?</p> <p>15. Tell me more about your experiences with primary health care services-do you feel your health provider(s) understands your cultural background and hoe your social identity influences your health and wellbeing?</p> <p>16. Following on from the previous question, what would be the biggest barrier to primary health care you have experienced and would want your health provider to know and understand?</p>
<p><b>Section D: PHC Capacity</b></p>	<p>17. Through your experiences with both your country of origin health system and New Zealand’s Primary Health Care system what benefits do you feel you received more back home than here or vice versa?</p> <p>18. When you access primary health care, do you feel comfortable as soon as you enter a clinic, or are there were certain instances where you felt uneasy with the environment and how you were treated differently based on your ethnicity? – was this bad or good?</p>	<p>17. Through your experiences with both your country of origin health system and New Zealand’s Primary Health Care system what benefits do you feel you received more back home than here or vice versa?</p> <p>18. When you access primary health care, do you feel comfortable as soon as you enter a clinic, or are there were certain instances where you treated different based on your ethnicity? –was this bad or good?</p> <p>19. General Practices are now integrated with other primary health services such as the community pharmacist, all under the same roof. Do you find</p>	<p>18. Tell me more about what you think about the health care you receive. Do you feel your health and wellbeing is the result of appropriate care?</p> <p>19. When you access primary health care, do you feel comfortable as soon as you enter a clinic, or are there were certain instances where you treated different based on your ethnicity? –was this bad or good?</p> <p>20. General Practices are now integrated with other primary health services such as the community pharmacist, all under the same roof. Do you find this model of care is helpful and increases your</p>

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	<p>19. General Practices are now integrated with other primary health services such as the community pharmacist, all under the same roof. Do you find this model of care is helpful and increases your experience with primary health care in New Zealand?</p> <p>20. Lastly, do you feel the primary health system responds to your medical needs broadly taking into account your current social circumstances?</p>	<p>this model of care is helpful and increases your experience with primary health care in New Zealand?</p> <p>20. Lastly, do you feel the primary health system responds to your medical needs broadly taking into account your current social circumstances?</p>	<p>experience with primary health care in New Zealand?</p> <p>21. Lastly, do you feel the primary health system responds to your medical needs broadly taking into account your social wellbeing?</p>
<b>Conclusion</b>	<p>Thank you, so much for your time it is really appreciated and I have enjoyed listening to your experiences. I hope this has been of some use for you too and please feel free to provide any last comments on the research topic.</p> <ul style="list-style-type: none"> <li>- Offer MP3 recording</li> <li>- Mention outcome sheet at the end of thesis.</li> <li>- Check you have the right contact details.</li> </ul>	<p>Thank you, so much for your time it is really appreciated and I have enjoyed listening to your experiences. I hope this has been of some use for you too and please feel free to provide any last comments on the research topic.</p> <ul style="list-style-type: none"> <li>- Offer MP3 recording</li> <li>- Mention outcome sheet at the end of the thesis.</li> <li>- Check you have the right contact details.</li> </ul>	<p>Thank you, so much for your time it is really appreciated and I have enjoyed listening to your experiences. I hope this has been of some use for you too and please feel free to provide any last comments on the research topic.</p> <ul style="list-style-type: none"> <li>- Offer MP3 recording</li> <li>- Mention outcome sheet at the end of the thesis.</li> <li>- Check you have the right contact details.</li> </ul>
<b>Specific Questions</b>	<p>If Female:</p> <ul style="list-style-type: none"> <li>- When you first came to Auckland, New Zealand: what did you find most stressful for you as a South Asian woman, and did you feel supported by you husband, family, or even community networks?</li> <li>- How did your perception of health and wellbeing change over time?</li> <li>- If you can think back, do you feel the differences in care you have</li> </ul>	<p>If Elderly</p> <ul style="list-style-type: none"> <li>- Tell me a bit about your story to come to New Zealand (to stay with a child?)</li> <li>- Have you interacted with a doctor or nurse here? What was that like for you?</li> <li>- In your perspective do you see many similarities with how you accessed health care back in your country of origin? Or are there many differences?</li> <li>- If you can think back, do you feel the differences in care you have experienced</li> </ul>	<p>If Second Generation</p> <ul style="list-style-type: none"> <li>- Tell me a bit about how your family came to Auckland, New Zealand</li> <li>- Growing up when you became ill what was your family's go to response- GP visit? Or maybe a South Asian remedy?</li> <li>- Do you prefer a health professional of the same ethnicity as you or different? Or do you feel it is does not matter as long as they are culturally aware of who you are and your background?</li> </ul>

## Appendices two: Interview question guide

	<p>experienced changed your approach to your own health?</p> <ul style="list-style-type: none"> <li>- Do you feel comfortable with a doctor, nurse, or health worker that is from the same place you are?</li> <li>- Can you explain to me a little bit more about how you feel after you have accessed primary health care (Doctor)?</li> <li>- If you can think back to a time where you accessed primary health care. Did you feel the service or health worker understood the role you play in your family and how that affects you and your wellbeing?</li> <li>- Do you feel listened to and treated equally if your family sits in with you during your interaction with the health professional or service?</li> </ul>	<p>changed your approach to your own health?</p> <ul style="list-style-type: none"> <li>- Do you feel comfortable with a doctor, nurse, or health worker that is from the same place you are?</li> <li>- Can you explain to me a little bit more about how you feel after you have accessed primary health care (Doctor)</li> <li>- Do you feel listened to and treated equally if your family sits in with you during your interaction with the health professional or service?</li> </ul>	<ul style="list-style-type: none"> <li>- How in your perspective and from your experience with the health system do you feel the primary health care level can do better to engage the South Asian community in Auckland and improve perceptions?</li> <li>- In your experience, do you often feel in conflict with your parents or family's attitudes towards health i.e health promotion or do you find yourself influencing your family's mind sets on health?</li> </ul>
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## **7.3. PARTICIPANT INFORMATION SHEET**

(Participant copy)

### **Primary Health Care in New Zealand: The Experiences and Perceptions of the South Asian Community**

Researcher: Jessica Vani Tamanam

#### **Introduction:**

Hello, my name is Jessica Tamanam and I am a research student at the University of Auckland Faculty of Medical and Health Sciences. Thank you for your interest towards this piece of research I am doing as part of my Master of Public Health thesis.

#### **Background:**

You are invited to take part in a small scaled interpretive qualitative study on the health behaviours of South Asians within primary health care. Primary health care in New Zealand is defined as the first point of contact for the population with the health system. It is the level of health care tasked as being the gatekeepers to the system through preventative and social medicine at the community level. An important part of this role is to develop partnerships with and engage people groups within the community who may find it hard to access primary health care services or may be unaware of how to use it. At the primary health care level of the system it is important to identify and remove health inequalities experienced by the population and provide accessible effective care for everyone within the population without prejudice. This piece of research is interested in improving the understanding of the different factors that influence the health behaviours of ethnic minority groups within the New Zealand Primary Health Care. There is a lack of evidence to assist the health system and primary health care in tailoring services and medical care to meet the needs of the South Asian population and other ethnic minorities in New Zealand. Previous reports on the health of South Asians migrants have all indicated the settlement is a complex process and simply accessing and utilizing primary health care services plays a huge role in supporting wellbeing and increasing awareness during settlement. However, the structure of service delivery within primary health care can be challenging to ethnic minority groups and can limit the impact of health care. The knowledge acquired through this research will help assist decision makers within primary health care in delivering quality and effective care to the South Asian community within Auckland city. As Auckland continues to grow in diversity the health disparities faced by ethnic minorities become a prominent part of health research in the aim to create a society that is diverse and equitable for all its residents.

This Participant Information Sheet will explain what contribution participants make to the research, and help you decide if you would like to participate.

#### **What is the purpose of the study?**

- To identify the medical and non-medical reasons South Asians seek health care.
- To understand the perceptions and experiences of interactions with health professionals within primary health care

- To understand Primary Health Care's capacity to be responsive to the cultural needs of South Asians.

#### **What are the outcomes of the study?**

- To assist the New Zealand health system and primary health care level of care in delivering quality care to a changing diverse demographic appropriately.
- To provide a voice for South Asian immigrants and settlers regarding their interactions with the New Zealand primary health care level of the health system. This will help policy decision making and evaluations of service delivery for the future embracing ethnic diversity in New Zealand.

The study aims to cover the following:

Is accessing Primary Health Care easy?

How often and for what reason do you access Primary Health Care?

What are the advantages and disadvantages to the New Zealand Primary Health Care system?

#### **What are the conditions for your involvement?**

- This study aims to recruit individuals at or above the age of 18 who identify as South Asian.
- Participants must be familiar with the English language.
- The study will also seek participants who are New Zealand permanent residents, citizens, or on a work visa.
- Participants will take part in one face to face interview lasting between 30-60 minutes.
- The preferred location of the interview is at the University of Auckland, Tamaki Campus. However, if this is inconvenient to the participant than another location will be agreed upon by both the participant and the researcher.

#### **How data is collected and stored?**

- I will collect the data by in-depth interviews face to face with participants. Every in-depth interview will be recorded using a digital recorder in an MP3 format.
- Participants will be given the opportunity to request for their MP3 interview recording and allowed to make any changes and feedback to the research for up to one week after their interview.
- Paper notes taken by the researcher during interviews will be disposed of at the end of the thesis.
- Consent forms will be stored in paper forms by my supervisor for minimum of 6 years at the University.
- A transcribed copy of your interview will be kept on my password protected thesis computer for minimum of 6 years and then deleted.
- Data will not be transferred to a public repository or a third party, and will only be accessed by the researcher.
- Digital recordings will be stored in a MP3 format for minimum 6 years in case of further use during PhD studies. This is because transcription of interviews during content analysis will only be done with sections of the interviews needed for the thesis.

#### **How data is destroyed?**

- After the duration of 6 years of storage time has elapsed, paper copies of consent forms data will be destroyed by the researcher and supervisor.
- Paper forms of Consent forms and transcribed interview data sheets will be stored separately by the supervisor and shredded after 6 years.

#### **What are your rights?**



Participants have the right

- To be involved with the study
- To decide where you want to be interviewed
- To request the digital recording of your interview
- To withdraw from the study at any time till after three weeks post the interview at which point analysis will already be underway.
- To expect confidentiality and anonymity of any information shared on identity

#### **Where does the funding for this study come from?**

The research study is part of a University of Auckland Master of Public Health theses and is not officially funded by any third party.

#### **Anonymity and Confidentiality?**

No item of information revealing your identity will be recorded during the interviews. Your privacy and the confidentiality of information shared are critical to the study. To achieve privacy of identity you will be asked to choose a same sex pseudo code name to hide identity or letting me chose one for you. The thesis will only use broad categories of gender, age, ethnicity, nationality, and years since migration.

If you wish to be interviewed at home, the researcher will be accompanied by a friend for safety purposes. The accompanying person will sign a confidentiality agreement to ensure your confidentiality. The accompanying person will also remain outside of the interview room if the participant is uncomfortable.

If at any point during the consent and interview process you feel the need to withdraw participation out of the study you may do so, but please note that the nature of the study relies on the one in-depth interview and information shared will be kept confidential.

The main language used throughout the research process will be English, and therefore a basic skill set of the language is required.

All in-depth interviews are electronically recorded using a device in an MP3 format to ensure no loss of data and to allow room for the researcher to communicate without interruptions.

There is likely to be cultural familiarity because I am of South Asian descent. However, there will not be any conflict of interest as interviews will only acquire broad information on the experiences of participants and not personal intimate details. Close family members will be avoided but there may be a chance of distant friends being interviews.

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 ext. 83711. Email: ro-ethics@auckland.ac.nz

Approved by the University of Auckland Human Participants Ethics Committee on the 29<sup>th</sup> of June 2015 for three years, Reference Number 014913.

**Researcher Contact Details:**

Jessica Vani Tamanam, Master of Public Health Student, Faculty of Medical and Health Sciences: School of Population Health The University of Auckland, Private Bag Private Bag 92019, Auckland 1142, New Zealand.  
Email: [jtam028@aucklanduni.ac.nz](mailto:jtam028@aucklanduni.ac.nz)

**Supervisor Contact Details:**

Rachel Simon-Kumar, Senior Lecturer at the School of Population Health, faculty of Medical and Health Sciences, University of Auckland. Private Bag Private Bag 92019, Auckland 1142, New Zealand. PH: 3737599 ext: 87645.  
Email: [r.simon-kumar@auckland.ac.nz](mailto:r.simon-kumar@auckland.ac.nz)

**Head of Department:**

Janet Fanslow, Associate Professor  
Department of Social & Community Health  
Faculty of Medical and Health Sciences. Email: [j.fanslow@auckland.ac.nz](mailto:j.fanslow@auckland.ac.nz)  
Phone Number: +64 9 923 6907

## 7.4. PARTICIPANT CONSENT FORM

(This form will be held for a period of 6 years)

### Primary Health Care in New Zealand: The Experiences and Perceptions of the South Asian Community

Researcher: Jessica Vani Tamanam

Email: jtam028@aucklanduni.ac.nz

I have been sent the Participant Information Sheet and have had time to read over it and understand the purpose of the research project. My consent for participation in this research is as follows:

1. I confirm I have read the Participant Information Sheet and asked any questions I have.	<b>YES</b>
2. I agree to take part in this study	<b>YES</b>
3. I consent to the interview being recorded in a MP3 format for the purposes of the research	<b>YES</b>
4. I understand I can ask for the recording of my interview and make changes for up to one week post interview.	<b>YES</b>
5. I understand my participation involves one in depth interview preferably face to face with the researcher	<b>YES</b>
6. I agree the information and views I share on the topic will be presented and published.	<b>YES</b>
7. I understand only the researcher and their supervisor will have access to my personal contact details and information.	<b>YES</b>
8. I consent to my personal identity being used in broad categories i.e. gender, age, and years since migration	<b>YES</b>
9. I understand that data will be stored for up to 6 years for later use.	<b>YES</b>
10. I understand the MP3 recordings of my interview will be stored for up to 6 years in accordance with University of Auckland research regulations.	<b>YES</b>
11. I wish to receive a copy of the study summary outcomes after its completion.	<b>YES</b>
12. I understand I can seek assistance from the researcher should the interview process raise adverse psychological or physical reactions in me.	<b>YES</b>

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Participant Signature: \_\_\_\_\_

#### **Approval:**

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 ext. 83711. Email: ro-ethics@auckland.ac.nz

Approved by the University of Auckland Human Participants Ethics Committee on the 29<sup>th</sup> of June 2015 for three years, Reference Number 014913.

**Researcher Contact Details:**

Jessica Vani Tamanam, Master of Public Health Student, Faculty of Medical and Health Sciences: School of Population Health The University of Auckland, Private Bag Private Bag 92019, Auckland 1142, New Zealand.  
Email: jtam028@aucklanduni.ac.nz

**Supervisor Contact Details**

Rachel Simon-Kumar, Senior Lecturer at the School of Population Health, faculty of Medical and Health Sciences, University of Auckland. Private Bag Private Bag 92019, Auckland 1142, New Zealand. PH: 3737599.  
Email: r.simon-kumar@auckland.ac.nz

**Head of Department:**

Janet Fanslow, Associate Professor  
Department of Social & Community Health  
Faculty of Medical and Health Sciences  
Email: j.fanslow@auckland.ac.nz  
Phone Number: +64 9 923 6907

**Participation Contact Details**

Participant Name:
Phone number
Email
Address

## References

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