Asian Health Review™

RESEARCH REVIEW 10 YEARS
MAKING EDUCATION EASY SINCE 2006

Making Education Easy

Issue 15 – 2016

In this issue:

Abbreviations used in this issue
aOR = adjusted odds ratio
BMI = body mass index
MoH = Ministry of Health
NRA = National Research Advisory

CLICK HERE
to read previous issues of Asian Health Review

Welcome to the fifteenth issue of Asian Health Research Review.

This issue presents the findings of Prof. Robert Scragg's (2016) *Asian Health in Aotearoa in 2012-2013: Trends since 2006-2007* report. This is the third study of Asian Health in New Zealand. While the findings are not in general worse than the findings of the 2010 report – they are not better either. There is a continuing impact from acculturation; broadly, the longer a person resides in New Zealand, the more likely it is that they will be an alcohol drinker; a smoker, obese and overweight. The report also shows that the prevalence of cardiovascular disease and diabetes continues to increase in South Asian populations. The study for the first time reports on ethnic discrimination in Asian populations in New Zealand and I'm ashamed to say that Chinese and Other Asian groups are the most likely, compared to other groups, to have been a victim of an ethnically motivated verbal attack. We need to do better as a society to stop this behaviour. The report provides international studies of Asian population health trends in other comparable migrant nations including the UK, Europe, USA and Canada. Some of these studies will be examined in this issue. A copy of the report can be downloaded from: http://www.ecald.com/Resources/Resources-Publications/ID/1360/Asian-Health-in-Aotearoa-in-2011-2013-2016

For hard copies email Annette.Mortensen@nra.health.nz including your mailing address.

Research Review is ten!! The first ever issues of Research Review were delivered to inboxes in February 2006. Fast forward ten years and we now publish 48 regular reviews to which there are over 160,000 subscriptions. We're grateful to each and every one of you for your support and are looking forward to even bigger and better things over the coming years.

We hope you enjoy this issue and look forward to receiving any feedback you may have.

Kind regards,

Dr Annette Mortensen
annettemortensen@researchreview.co.nz

Dr Geeta Gala
geetagala@researchreview.co.nz

Independent commentary by Dr Annette Mortensen and Dr Geeta Gala

Dr Annette Mortensen has worked to improve the health of newcomers to New Zealand from ethnically diverse backgrounds for the last 15 years. Since 2007 Annette has worked as the Asian, Refugee and Migrant Health Programme Manager for the Northern Regional Alliance on behalf of the Auckland region District Health Boards.

FOR FULL BIO CLICK HERE

Dr Geeta Gala is a Public Health Physician. She leads and advises on many of the cancer projects led by the Northern Cancer Network and is active in advocacy for improvement of Asian health in New Zealand.

FOR FULL BIO CLICK HERE

Northern Regional Alliance – He Hononga o te Raki
Waitemata District Health Board – Best Care for Everyone
Auckland District Health Board – Te Toka Tumai
Counties Manukau Health

The Asian Health Review has been commissioned by the Northern Regional Alliance (NRA), which manages the Asian, migrant and refugee health action plan on behalf of the Waitemata, Auckland and Counties Manukau District Health Boards.

Background to the *Asian Health in Aotearoa* studies

Until the *Asian Health in Aotearoa* reports were published we had very limited information on the health status of Asian populations, although, Asian peoples were over 15% of the Auckland region's population by the time of the first report **Asian Health in Aotearoa: An analysis of the 2002/03 New Zealand Health Survey** published by Scragg and Maitra in 2005. The first report used data collected from over 1200 Asian participants in the MoH funded National Health Survey. The survey provided the opportunity, for the first time, to examine health status in a large representative sample of Asian people, and in particular to examine health status within the separate Asian communities – Chinese, South Asian, Korean and South-East Asian groups. The report can be accessed on the following link

http://www.asianhealth.govt.nz/publications/asianhealthaotearoa0508.pdf

In 2010, the NRA commissioned a second study, **Asian Health in Aotearoa in 2006 - 2007: trends since 2002-2003** (Scragg, 2010). This was the first report to present Asian population health trends in New Zealand. Importantly, this five-year follow up to the first report showed that national data sets under represent the risk factors associated with poor health status in Asian subgroups in New Zealand. The 2006-07 report found inequities in access to health services, notably to primary health services, for Asian people compared to other New Zealanders. The report also identified substantial differences in health status for diverse Asian subgroups. The averaging of Asian groups as a single ethnic group has led to the misconception that all Asian groups have better health than other New Zealand health populations. On the contrary, the analysis of the health of Asian subgroups shows that there is a high prevalence of chronic disease in some groups. Further, the report demonstrates the effects of acculturation by associating the length of residence in New Zealand with declining health outcomes. For example, the obesity prevalence for all Asian people combined increased from 26% in 2002-03 to 41% in 2006-07, using ethnic specific criteria. The report can be accessed on the following link:

http://www.asianhealth.govt.nz/Publications/Asian Health Trends Scragg 2010.pdf

Acculturation and dietary change among Chinese immigrant women in the United States

Authors: Tseng M et al.

Summary: This US study involving 312 Chinese immigrant women in Philadelphia recruited between October 2005 and April 2008, and followed with interviews and dietary recalls until April 2010, examining acculturation and diet over time. Associations, modelled using generalised estimating equations, revealed that increasing length of US residence was associated with a small but significant ($p < 0.0001$) increase in acculturation score of approximately 1% per year, which in turn was significantly associated with increased percentage of energy from fat, energy density of the diet, and sugar intake, and lower dietary moderation score. These changes, however, were small enough that their health impact was unclear.

Comment: (AM) The interactions between migration and health are complex. This American study shows that the impact of migration and acculturation is inconsistent and is conditioned by socio-demographic factors. Specifically, greater acculturation was associated with an increase in energy intake and the percent of energy from fat only, in less educated Chinese women. For women with some tertiary education, there was little change in the percent of energy from fat and a slight decrease in total energy intake with an increasing level of acculturation. Acculturation in the study was measured using the General Ethnicity Questionnaire, using interpreters trained in administering the questionnaire. The findings suggested caution in using length of residence as a proxy for level of acculturation, and showed that length of residence was a poorer predictor of change in dietary behavior than was the acculturation score. New Zealand longitudinal studies of acculturation in Asian populations are rare and much needed to improve both the empirical public health research base and our population level understanding of its implications on Asian population health. Pacific studies of acculturation have successfully adapted the General Ethnicity Questionnaire and New Zealand (NZAccult) Acculturation Scales (Schluter et al. 2011; Port 2014; Skudder 2014; Tautolo et al. 2014). Future studies exploring the impact of migration and health in Asian peoples in New Zealand could learn from Tseng et al.'s (2014) study, and from the methodology successfully used in a number of Pacific longitudinal acculturation studies.

Reference: J Immigr Minor Health. 2015;17(2):400-7
Abstract

Immigration transition and depressive symptoms: Four major ethnic groups of midlife women in the United States

Authors: Im EO et al.

Summary: In this secondary analysis of data from two national Internet surveys of 1054 midlife US women, the relationships between immigration transition and depressive symptoms were assessed. Immigrants had fewer and less severe symptoms than non-immigrants ($p < 0.01$). After controlling for background characteristics, self-reported racial/ethnic identity and immigration status were found to significantly predict depressive symptoms (r^2 0.01; $p < 0.05$).

Comment: (GG) This US internet survey study explored the relationship between immigration transition and depressive symptoms in women aged 40-60 years from four ethnic groups – Hispanic, Non-Hispanic (N-H) Asian, N-H African American and N-H White. The depressive symptoms and the severity were significantly greater in N-H White women when compared to any other ethnic group. Further, N-H Asians had a lower number of symptoms and the least severity scores. Interestingly, immigrants reported a lower number and less severe depressive symptoms than non-immigrants. Is this because immigrants are more likely to be resilient and healthy or there is under-reporting and other confounders? A major limitation of the study is that it included women with English language skills. Hence, findings cannot be generalised to all immigrants. Of note, the association of racial/ethnic identity to depressive symptoms was found to be stronger when compared to the immigration status.

Reference: Health Care Women Int. 2015;36(4):439-56
Abstract

A review on changes in food habits among immigrant women and implications for health

Authors: Popovic-Lipovac A and Strasser B.

Summary: This review examines the factors that alter diet in immigrant women, assesses the consequences for their health, and suggests interventions. Factors included a busy lifestyle, few social relationships, high stress, children's preferences, taste, lack of food security and traditional foods. The factors may result in high fat and sugar consumption, reduced fruits/vegetable consumption, larger portion size, convenience food consumption and lack of activity. These changes increase the risk of chronic diseases including cardiovascular disease, hypertension and type 2 diabetes. Negative impacts increase with time, especially in the USA and Canada, whereas in Europe there are minor negative or even positive impacts. Successful intervention requires a greater understanding of the process and a focus on low-income females because of double discrimination and their influence on family health.

Comment: (AM) A key finding of this review of studies of immigrant women and food habits in the US, Canada and Europe is that women incorporate high fat and sugar snacks, drinks and more fast foods into their traditional diets resulting in negative health impacts including obesity, diabetes and cardiovascular disease. However, the study has limitations in that 'immigrants' are treated as a homogenous group while including those from Hispanic, Asian, South Asian, Pacific, Middle Eastern, Eastern European and other backgrounds. Additionally, the studies reviewed did not analyse men and women separately. Helpfully, Scragg et al.'s (2016) New Zealand study, examines 'Asian' groups and gender separately. The findings are that in Asian populations in New Zealand, the proportion of women who ate fruit two or more times a day was lower for South Asian (53%), but similar for Chinese (62%) and Other Asian (60%), compared to European & Other (68%); and among men was similar for all Asian ethnic groups, compared to European & Other (53%). The proportion of people who ate vegetables ≥3 times/day was reduced in all three Asian ethnic groups, for both men and women, compared to European & Other. Consequently, the proportion of men and women (combined) who ate ≥5 servings of fruit and vegetables per day was lower in South Asian (43%), Chinese (44%), and Other Asians (45%), compared to Europeans (58%). We agree with Popovic-Lipovac & Strasser's (2013) conclusion that immigrant women need tailored culturally and religiously appropriate nutrition education programmes along with facilities for physical activity. See the Association for Nutrition Action (ANA) website for further information on nutrition education and physical activity programmes available for Asian communities in New Zealand http://www.ana.org.nz/our-work/asian-health

Reference: J Immigr Minor Health. 2015;17(2): 582-90
Abstract

A cross-country comparison of knowledge, attitudes and practices about tobacco use: Findings from the Global Adult Tobacco Survey

Authors: Gupta B and Kumar N.

Summary: This analysis of data from the Global Adult Tobacco Survey (2008-10) examined the nature, extent and demographic correlates of knowledge, attitudes and perceptions of tobacco use in adults from low- and middle-income countries. Awareness of the harmful effects of tobacco smoking was relatively high, especially the relationship with lung cancer (>90% in most countries). However, awareness of the harmful effects of smokeless tobacco was relatively low (<90% in most countries except India and Bangladesh), and even lower for the relationship between tobacco smoking and heart attacks (40.6% China, 65.1% India) and stroke (28.2% China, 50.5% India).

Comment: (AM) Gupta and Kumar (2014) find a relatively high awareness about the harmful effects of smoking in India, Bangladesh and China; countries with a high prevalence of tobacco use. However, a high level of knowledge was not found to be a predictor of stopping smoking. In Scragg et al.'s (2016) study, smoking prevalence in men was similar for all Asian ethnic groups (17%) compared to European & Other (17%). There was no change in the frequency of tobacco smoking by Asian men and women over the three-year survey periods from 2002-03 to 2011-2013. There is international evidence that smoking cessation interventions are effective among Asian smokers. An Asian Smokefree Communities pilot run by Waitemata District Health Board found that language, culture and not knowing how to access services are barriers to the use of health services for Asian migrants In New Zealand (Wong et al., 2010). The Asian Smokefree Communities (ASC) pilot-tested a novel Asian-specific service model to address these issues for Asian smokers. Korean- and Chinese-speaking coordinators delivered home-, workplace- or clinic-based interventions to support smokers with cessation and to create smoke-free environments with families. The self-reported quit rate for the 93 cessation clients was 72% at 1 month, 53.8% at 3 months and 40.9% at 6 months. All homes (100%) were smoke-free after the intervention; an increase of 18% from pre-intervention levels. The model could make an effective contribution to smoke-free services for Asian populations in other western countries. The ASC programme is now run by an Auckland PHO, Comprehensive Care. They offer a range of programmes and support for Asian people who want to stop smoking in Chinese (Mandarin and Cantonese), Korean, Hindi and Gujarati languages. Interpreters are also available for speakers of other languages. For more information go to: http://www.comprehensivecare.co.nz/services-and-programmes/addictions/smokefree-communities/

Reference: Asian Pac J Cancer Prev. 2014;15(12):5035-42
Abstract

Time spent reading this publication has been approved for CME for Royal New Zealand College of General Practitioners (RNZCGP) General Practice Educational Programme Stage 2 (GPEP2) and the Maintenance of Professional Standards (MOPS) purposes, provided that a Learning Reflection Form is completed. Please **CLICK HERE** to download your CPD MOPS Learning Reflection Form. One form per review read would be required.

Time spent reading this publication has been approved for CNE by The College of Nurses Aotearoa (NZ) for RNs and NPs. For more information on how to claim CNE hours please **CLICK HERE**.

Poly-tobacco use among adults in 44 countries during 2008-2012: Evidence for an integrative and comprehensive approach in tobacco control

Authors: Agaku IT et al.

Summary: Data from the 2008-12 Global Adult Tobacco Surveys and the Special Eurobarometer 385 (77.1) survey were used to estimate poly-tobacco use patterns in people from 44 countries aged ≥15 years. Poly-tobacco use prevalence ranged from a low of 0.8% in Mexico to a high of 11.9% in Denmark. Across 28 countries, ≥20% of manufactured cigarette smokers also used ≥1 other tobacco product; this proportion ranged from 4.4% in Argentina to 66.2% in India. After adjustment, poly-tobacco use likelihood across all respondents was lower in females (aOR 0.09; 95% CI 0.08-0.11), and in respondents from upper-middle- (aOR 0.53; 95% CI 0.43-0.66) or lower-middle-income countries (aOR 0.64; 95% CI: 0.51-0.81) compared to those from high-income countries. Respondents from South-East Asia had an increased likelihood of poly-tobacco use versus those from Europe (aOR 1.58; 95% CI 1.35-1.85), and the likelihood was higher in respondents aged ≥65 years (aOR 2.10; 95% CI 1.73-2.54) versus those aged <25 years.

Comment: (AM) Poly-tobacco use is highest in India (66.2%). Cigarettes along with chewing tobacco products (or Gutkha) are commonly used in India, Pakistan and Bangladesh. Chewing tobacco users are a population of special interest from a public health perspective in New Zealand, with increasing South Asian populations (Lokhande et al., 2013). The sale of smokeless tobacco was prohibited in New Zealand in 2009. However, chewing tobacco for personal use is not prohibited. Asian adolescents may be unaware of the addictive nature and health consequences from using Gutkha. No research has been conducted in New Zealand on the prevalence, attitudes, practices and appropriate interventions surrounding chewing tobacco/smokeless tobacco. The findings of Agaku et al.'s (2014) study highlight the need for health professionals to ask, in particular, patients from South Asia if they use chewing tobacco and to tailor tobacco cessation counselling and pharmacological interventions to suit their patient's needs. For smokeless tobacco users, nicotine replacement therapy has been proven to help reduce craving and withdrawal symptoms (American Cancer Society, 2014).

Reference: Drug Alcohol Depend. 2014;139:60-70
Abstract

Discrimination and psychiatric disorder among Asian American immigrants: A national analysis by subgroups

Author: Li M.

Summary: This analysis of data from a US nationally representative dataset of Asian American immigrants assessed whether the risk of psychiatric disorder is increased by perceived racial discrimination or language discrimination, or by vicarious racism experiences in the past 12 months. Group-specific logistic regression indicated that perceived racial and language discrimination generated strongly deleterious mental health effects only among Filipinos. While Vietnamese and Chinese were more likely to be affected by vicarious racism experiences, no significant association was found between racial discrimination and mental health outcomes in these groups.

Comment: (GG) Discrimination is a widely accepted risk factor that negatively affects mental health. This US study examined whether perceived racial discrimination, perceived language discrimination, and vicarious (indirect experience of racism through observation or report) racism increases the risk of psychiatric disorder for three different Asian immigrant groups – Filipino, Chinese and Vietnamese. The Filipinos had the highest prevalence of perceived racial discrimination and yet the lowest rate of perceived language racism. Chinese had high rates of perceived language discrimination and vicarious racism whereas the Vietnamese were least likely to have vicarious racial experiences. The study highlights the heterogeneity within the Asian American community that can have variable impact on health status and discrimination experiences across different subgroups. Acculturation and inter-racial contact patterns expose ethnic subgroups to different levels of vulnerabilities, which in turn influence the different forms of racism.

Reference: J Immigr Minor Health. 2014;16(6):1157-66
Abstract

Ethnicity-specific obesity cut-points in the development of Type 2 diabetes - a prospective study including three ethnic groups in the United Kingdom

Authors: Tillin T et al.

Summary: This British study used data from a population-based cohort (1356 Europeans, 842 South Asians, 335 African-Caribbeans; aged 40-69 years), to determine ethnicity-specific body mass index (BMI) obesity cut-points for the estimation of diabetes risk. After a median follow-up of 19 years, diabetes incidence rates were 20.8 per 1000 person years (95% CI 18.4-23.6) in South Asian men and 12.0 (95% CI 8.3-17.2) in South Asian women. In African-Caribbean men and women the incidence rates were 16.5 (95% CI 12.7-21.4) and 17.5 (95% CI 13.0-23.7) and in European men and women they were 7.4 (95% CI 6.3-8.7) and 7.2 (95% CI 5.3-9.8), respectively. The BMI that identified equivalent incidence rates to those in European men and women at a BMI of 30 kg/m² was 25.2 kg/m² (95% CI 23.4-26.6) for South Asians and 27.2 kg/m² (95% CI 25.2-28.6) in African-Caribbeans. Waist circumference cut-points for South Asian men of 90.4 cm (95% CI 85.0-94.5) and for African-Caribbean men of 90.6 cm (95% CI 85.0-94.5) were equivalent to 102 cm in European men. The waist circumference cut-point equivalent to a value of 88 cm in European women was 84.0 cm (95% CI 74.0-90.0) for South Asian women and 81.2 cm (95% CI 71.4-87.4) for African-Caribbean women.

Comment: (GG) Another study supporting the international debate of lower BMI and waist circumference cut-off points for Asians. This UK longitudinal study followed a group of 2500 people from three ethnic backgrounds for 19 years and identified that BMI levels of 25 kg/m² in South Asians and 27 kg/m² in African Caribbeans posed an equivalent risk of developing diabetes to a BMI of 30 kg/m² in Europeans. Similarly, the waist circumference equivalents were lower for South Asians and African Caribbeans. There is a markedly high prevalence of diabetes and cardiovascular disease among the Indians (South Asians) and obesity and metabolic syndrome are key risk factors. The study highlights lowering the BMI and waist circumference cut-offs for the prevention of metabolic risk among South Asians.

Reference: Diabet Med. 2015;32(2):226-34
Abstract