HEALTH AND WELL BEING: A SOCIAL AND CULTURAL PERSPECTIVE

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Preface

One of the most essential aspects in life for anyone in any society and culture is health and wellbeing. It is the indispensable base on which happiness is based. A Vietnamese proverb says that metaphorically good health is gold as health and wellbeing are precious and inseparable. Thus this book is about this important aspect of life: health and wellbeing.

The book includes the following special features:

- It focuses on the social and cultural aspects of health and wellbeing in current societies and cultures. Traditionally health research has placed great emphasis on physical and clinical aspects such as diseases, medical treatments and rehabilitation. With an increasing interest in population health, particularly in the current context of globalization, the sphere of health research has been expanded to cover also social and cultural factors which not only affect health conditions of individuals and communities but also are determining health factors in some respects.
- It attempts to provide insights on health and wellbeing across cultures as to a great extent health concepts and practices are culturally constructed. Health professionals nowadays are very likely working with patients, colleagues, and communities of diverse cultural backgrounds whose assumptions, beliefs, and practices in relation to health and wellbeing are different and potentially lead to miscommunication and possible conflicts in dealing with health issues.
- It not only provides up-to-date research findings on social and cultural aspects of health and wellbeing, but is also an informative discourse in which meaningful voices are heard and different stories are told. They may come from the chapter writers reflecting on their research journeys, from individuals whose quality of life was affected by health conditions, and from institutions which provide healthcare services.
- Finally the book includes authors of different professional and cultural backgrounds who have profound life experiences as well as research expertise in health and wellbeing. This diversity provides the book with insights from different perspectives, personally, professionally and culturally.
The completion of this book owes a great deal to the many contributors. I would like to express my gratitude to Nova Science Publishers for its professional guidance, enthusiasm, and encouragement. I am indebted also to the chapter authors for their contribution to this book. Last but not least, I would like to express my deep appreciation to the Board of Reviewers for their help in enhancing the quality of this book.

Quynh Lê
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Part I

Health Concepts and Health Care
Chapter I

Emotional Intelligence and Intercultural Health Care: Concept and Experience

Quynh Lê

Abstract

Emotion and intelligence are traditionally treated as mutually exclusive. While intelligence is ranked at the top scale of intellectuality, emotion is normally associated with weakness, irrationality, and destructivity. The mind should be strong and free of emotional interference. However, this negative view of emotion has been strongly challenged by scholars in various academic disciplines. The concept “emotional intelligence” has been developed to indicate the significant role and function of emotion in daily encounters as well as in intellectual activities. Emotional intelligence has recently received great attention in research, particularly in health science as emotion is deeply embedded in health issues. From an intercultural perspective, there are cultural values which affect the perception of the nature of emotion and its role in human cultures and societies. This factor can lead to problems facing migrants living in a new cultural environment.

Keywords: emotional intelligence, emotional health, feeling, affective communication, intercultural health

Introduction

For many people, emotion is an emotional issue which should be avoided in public communication. Though it is commonly accepted that emotion exists in human mind and behavior, it tends to be associated with negative views and attitudes among the masses. Recently emotion has received great attention from educators, health professionals and
academic researchers. This leads to the recognition of the significant role that emotion plays in human development, social interaction, and health care. Since the concept of emotional intelligence was introduced, interest in this concept among different professionals of different perspectives has lead to a comprehensive examination of the role of emotional intelligence in individuals and professions. As emotion, semantically and behaviorally, is deeply affected by culture, there are challenges facing health professionals working in an intercultural discourse.

**Emotional Intelligence and the Academic Discourse**

Traditionally, there are three fundamental aspects of education: intellectual, physical and moral. Intellectual development tends to focus on cognitive aspects such as the ability to generalize, synthesize, and categorize. The Bloom taxonomy has been used as a basis for promoting cognitive skills (OfficePort Educational Site, 1997).

- **Knowledge**: arrange, define, duplicate, label, list, memorize, name, order, recognize, relate, recall, repeat, reproduce, state.
- **Comprehension**: classify, describe, discuss, explain, express, identify, indicate, locate, recognize, report, restate, review, select, translate.
- **Application**: apply, choose, demonstrate, dramatize, employ, illustrate, interpret, operate, practise, schedule, sketch, solve, use, write.
- **Analysis**: analyse, appraise, calculate, categorize, compare, contrast, criticize, differentiate, discriminate, distinguish, examine, experiment, question, test.
- **Synthesis**: arrange, assemble, collect, compose, construct, create, design, develop, formulate, manage, organize, plan, prepare, propose, set up, write.
- **Evaluation**: appraise, argue, assess, attach, choose, compare, defend, estimate, judge, predict, rate, core, select, support, value, evaluate (OfficePort Educational Site, 1997).

Emotion and intelligence first appear to be mutually exclusive in the sense that emotion implies lack of intelligence. According to Picard (2002), for a long time people have kept emotions out of the deliberate tools of medicine and science. Since the introduction of the term multiple intelligences by Gardener (1983) and emotional intelligence (EI) by Mayer and Salovey (1990), the concept of emotion has become important in academic disciplines such as psychology, education and health and has been used in professional contexts to provide some insights into human interaction in different social discourses.

The concept of emotional intelligence is derived from extensive research and theory about thoughts, feelings and abilities that, prior to 1990, were considered to be unrelated phenomena. Today, emotional intelligence attracts growing interest worldwide, contributing to critical reflection as well as to various educational, health and occupational outcomes. (Akerjordet & Severinsson, 2007, p. 1405)
Emotional intelligence is now recognized as an important aspect of leadership. Woo (2007) gives the following six universal and timeless characteristics of great leaders: ability to share a vision, surrounding oneself with great people, ability to coach other team members, ability to focus on perfection, develop emotional intelligence and ability to train effective leaders. Wiegand (2007) points out that emotional intelligence has potential for improving safety-related efforts and other aspects of individuals' work and personal lives. Oginska-Bulik (2005) argues that emotional intelligence, which is “an essential factor responsible for determining success in life and psychological wellbeing, seems to play an important role in shaping the interaction between individuals and their work environment” (p. 1967).

According to Fernandez-Berrocal and Extremera (2006), emotional intelligence has generated “a broad interest both in the lay and scientific fields. Since the development of the concept, research on EI is increasing exponentially” (p.1).

In health research, emotional intelligence has become widely researched in various areas such as medical training and health care. Austin, Evans, et al. (2007) point out that there is considerable interest in the attributes other than cognitive ability that medical students need in order to be professionally successful, with a particular focus on empathy and emotional intelligence. Brewer and Cadman (2000) confirm that emotional intelligence enhances the effectiveness of the health students and patient outcomes.

A study was conducted to measure how well students in computer science and information systems coped with stressful situations and their levels of emotional intelligence. The researchers then examined the effects of these intrapersonal factors on their grades, based on a series of questionnaires designed to measure coping strategies and emotional intelligence. More than 600 undergraduates at more than 20 institutions in the United States participated in the study. The results showed that although students’ emotional intelligence was not directly linked to academic success, students with higher levels of emotional intelligence had more self-efficacy. The implication is that computing curricula might need to be redesigned to include emotional intelligence training, which is a learnable skill (News-Medical.Net, 2008).

Emotional intelligence should start with health education. According to Roberts (2010), “the concept of emotional intelligence is gaining increasing precedence in the nursing literature, with particular emphasis placed upon its importance for various aspects of the nursing profession and the demand for greater attention to be given to its development in the education of nurses” (p. 236). There are strong arguments and research evidence to endorse this approach. An appreciation for the emotion work required of nursing staff suggests that caregiver education should address the skills of emotional intelligence (Ruckdeschel and Van Haitsma 2004). It is pointed out by Walsh (2009) that the development of emotional intelligence through clinical supervision and reflective practice is of significant benefit to both health care and discipline staff.

According to Mayer and Salovey (1997b), emotional intelligence covers four main aspects which are included in the ability model of emotional intelligence:

- accurately perceive emotions in oneself and others,
- use emotions to facilitate thinking,
- understand emotional meanings, and
- manage emotions.
Mayer and Salovey (1997a) give a detailed description of the four aspects as follows:

- **Perceiving emotion**: It is about nonverbal reception and expression of emotion. Facial expressions, such as happiness, sadness, anger and fear, are universally recognizable in human beings. The capacity to accurately perceive emotions in the face or voice of others provides a crucial starting point for more advanced understanding of emotions.

- **Using emotions to facilitate thought**: It is the capacity of the emotions to enter into and guide the cognitive system and promote thinking. Thus, emotions prioritize thinking. Having a good system of emotional input, therefore, should help direct thinking toward matters that are truly important.

- **Understanding emotions**: Emotions convey information: happiness usually indicates a desire to join other people; anger indicates a desire to attack or harm others; fear indicates a desire to escape; and so forth. Each emotion conveys its own pattern of possible messages and actions associated with those messages. Fully understanding emotions involves the comprehension of the meaning of emotions, coupled with the capacity to reason about those meanings.

- **Managing emotions**: Finally, emotions often can be managed. We may want to remain open to emotional signals so long as they are not too painful, and block out those that are overwhelming. In between, within the person's emotional comfort zone, it becomes possible to regulate and manage one's own and others' emotions so as to promote one's own and others' personal and social goals.

The four aspects given above by Mayer and Salovey (1997a) indicate that emotion permeates various functions of our cognition, interpersonal communication and interaction. There are various factors which could affect those four aspects or skills in dealing with emotion such as gender, personality, social status, cultural background, life experience and worldview (Bellack, 1999; McMullen, 2003). In discussing emotion, we tend to focus on the negative aspects such as anxiety, stress, sorrow, etc. and pay less attention to the positive aspects of emotion. Humor, for example, is most important to our emotional health as it brings happiness and relaxation.

Emotional intelligence tests (Queendom.com, 1996b) have been produced to measure emotional intelligence. However the reliability and validity of EI tests are questionable as the scores gained from the tests do not reflect emotion in real life. They are just like written driving tests which are cognitively based whereas in real life, handling our emotion is quite different.

There are many problems in devising and interpreting emotional intelligence tests from an intercultural point of view. The following questions (with responses from 1 to 5) used to measure emotional intelligence are heavily culturally determined (Queendom.com, 1996a):

- I panic when I have to face someone who is angry.
- I feel uneasy in situations when I am expected to display affection.
- I feel uncomfortable when I am expected to console others.

Studies in sociolinguistics (Kramsch, 1998; Meyerhoff, 2006) and intercultural communication (Cameron, 2001; Scollon & Scollan, 1995) give comprehensive insights into
Emotional Intelligence and Intercultural Health Care: Concept and Experience

the intricacy and complexity of communication in social and cultural contexts. For instance, giving and receiving compliments reflect strongly interpersonal relationship and cultural influence. Social and cultural factors such as age, religion, gender, social status, professional experience, etc., determine what, how, when and why emotions are displayed and interpreted. Miscommunication easily occurs due to a lack of intercultural awareness (Cherniss, 2002; Lopes et al., 2004).

Emotional Health and Intercultural Awareness

The term emotion is a linguistic stereotype in Australia which assigns negative connotations in daily interaction. The adjective emotional when attached to a person or event, implies irrational, reactive or temperamental qualities, and therefore does not deserve critical consideration. In this stereotype, men who are very emotional in a discussion often show aggressive and abusive acts, while women often exhibit the crying behavior of desperation. Emotion is heavily gender-stereotyped in music lyrics, poetry, literature and the mass media. Female drivers are stereotyped as high-risk in causing accidents due to their emotion as they can easily lose their calmness and become frantic in times of danger which requires confidence, clear thinking, and firmness. Emotion is often used to blame for a sudden fall in a share market. People sell their stocks on the basis of fear, mainly reflecting a herd mentality, not on careful scrutiny. Thus, emotion is negatively associated with unpredictability, irrationality, and a lack of intelligence.

The term “aggressive emotion” is also used widely, particularly in sporting competition, to describe the physical behaviour of players. For instance, players throw tennis rackets onto the ground of a tennis court or football players hurl racial abuse at other players. Aggressive emotion is opposite to passive emotion, which is often manifested in crying, fearful or nervous behaviors.

As emotion is closely linked to health, a new concept and field called “emotional health” has been introduced.

Emotional health can best be described as a state where you are in control of your thoughts, feelings and behaviours. You feel good about yourself and your relationships and can keep problems in perspective. Emotionally healthy people can still have emotional problems and mental illness, but they have learned of ways to cope with stress and problems and know when to seek help from their doctor or counselor (Australian Government Department of Health and Ageing, 2004).

As emotion is an important aspect of health, the emotional life of people reflects their health. Happiness, calmness, freedom from anxiety are essential in building a healthy life. In Vietnamese, the well-known proverbs used by parents and teachers to teach their children are:

- Sức khỏe quý hơn vàng bạc. (Health is more precious than gold.)
- Ăn được, ngủ được là tiên. Không ăn không ngủ mất tiền thêm lo. (To eat well and to sleep well are happy fairies. No good sleep and no sound sleep cost money and bring worries.)
In many Vietnamese New Year greetings and birthday wishes, emotion and health are often included as they are important in Vietnamese cultures. For example:

- Năm mới chúc bạn đời dão súc khỏe và yêu đời mãi mãi. (For New Year, I wish you good health and an endless love of life.)
- Chúc em một cái Tết vui vẻ và dão súc khỏe. (Wishing you Merry New year and a healthy life.)

Emotion reflects the inner world of people. For some, it is hard to talk about emotion as it belongs to their private world. Not all cultures view privacy in the same way. In Western cultures, individuality is very important. Each person is entitled to their own privacy. Children are introduced to the concept of privacy at an early stage in their childhood. They are taught to respect other people’s privacy and they also expect others to respect theirs. In Asian cultures, the division between the public domain and the privacy of individuals is not always clearly prescribed.

In Vietnamese culture, privacy is not a secret world of individuals (Le, 2005). Friends, neighbors, colleagues, and family members are very open in sharing their emotions. The boundary between inner world of emotion and the outer world of human relationship is not clearly established. Thus health issues and emotional life of individuals are closely linked. When a family member is sick, this could create emotional unrest in the whole family and circle of friends. They often offer help to the patients by contributing money and care time. This offering is about care and responsibility, not an act of charity.

However there are also problems of collective responsibility about the emotional wellbeings of individuals and their families. The pressure imposed on individuals could cause some anxiety and unhappiness on those who want to live with their own emotion. For example, they are expected to show harmony and happiness in the family, particularly when living with in-laws, even though the feelings are the opposite. Suicide can be the result of frustration, loneliness and stress on individuals when their lives are emotionally disturbed (World Health Organisation).

In Vietnam, mental illnesses caused by emotional disturbance are numerous. However, there are no proper studies and official statistics to demonstrate this health phenomenon. The problem is exacerbated when people with mental illness are viewed as social outcast and are cruelly treated as an object of ridicule in the community. Derogatory emotional language is used such as ‘đồ điên’ (You are mad), ‘đồ khùng’ (you are mad and stupid), or a combination of ‘điên điên, khùng khùng’, ‘nhà thương điên’ (hospital for mad people) etc. This is the reason why families with members having mental illness tend to hide them from the neighbourhood so that they are not looked down by the outside world.

In traditional Chinese medicine, emotions and physical health are intimately connected. Sadness, nervous tension and anger, worry, fear, and overwork are each associated with a particular organ in the body (Wong, 2008b). For example, irritability and inappropriate anger can affect the liver and result in menstrual pain, headache, redness of the face and eyes, dizziness and dry mouth.

According to Wong’s (2008a) *Understanding Emotions in Traditional Chinese Medicine*, there is a close association between body organs and different types of emotion. For example:
- **Spleen**: Emotions - worry, dwelling or focusing too much on a particular topic, excessive mental work
- **Lung**: Emotions - grief, sadness, detached.
- **Liver**: Emotions - anger, resentment, frustration, irritability, bitterness, "flying off the handle".
- **Heart**: Emotions - lack of enthusiasm and vitality, mental restlessness, depression, insomnia, despair.
- **Kidney**: Emotions - fearful, weak willpower, insecure, aloof, isolated.

Emotion cannot be blamed for human problems. It needs to be recognized as an aspect of intelligence from the Western point of view and be treated as an important aspect of wisdom, from the Vietnamese perspective. In Vietnamese culture, emotion and rationality are not mutually exclusive. The term ‘chữ tình’ is an important concept. ‘Tình’ is not simply translated as ‘love’ but embodies human spiritual enhancement and the power of the intellect. The Vietnamese use the root term ‘tình’ (love) to express their profound philosophy of ‘living with others’ in connection to the mind and the heart. The following key terms are widely used in literature, philosophy, moral teaching and interpersonal communication: ‘tình đời’ (life love), ‘tình người’ (humanity love) ‘tình bằng hữu’ (love friendship), ‘tình đời đen bạc’ (dark and bright way of life). They are symbolic of Vietnamese spirituality in which emotional health is embedded.

In intercultural health care, it is important to take a patient’s emotional intelligence into account as it is strongly rooted in the personal and cultural background of the patient in his/her dealing with sickness, health care environment such as hospital, ambulance, surgery room, and health care workers.

A Vietnamese elderly lady told her visiting friend in a hospital:

> You know, sister, this hospital is like a luxurious hotel. When my children talked me into going to a hospital, I was so scared. I once visited a public hospital in Saigon, I told myself that I would never want to be in a hospital. I’d rather die than to face a horrible scene like that in the hospital. But here, I feel so good. Everyone is so friendly. I can read, write and watch TV. I don’t feel lonely here. (Private correspondence)

In Vietnamese culture, medical professionals are not only medical experts but also a symbol of high social status and power. When interacting with medical professionals, patients are reluctant to share their emotions. The lack of interpersonal communication can lead to poor health care treatment and management.

In Western health care, suicide is treated as a complex and sensitive aspect of health which is closely linked to emotional wellbeing. It is an important aspect of emotional health. An Australian study (De Leo & Klieve, 2007) shows that there is a link between mental health and emotional health. Among patients with psychotic disorders, committing suicide is the major cause of premature death. Between 10 and 15% of patients with schizophrenia would eventually die by committing suicide, and the rate of suicide among them has been reported as increasing. Lifetime suicide attempts are common in 18–55% of individuals suffering schizophrenia. Approximately 2–12% of all suicides are attributable to schizophrenia, and in studies investigating samples of inpatient suicides, as many as 76% of the cases have a diagnosis of schizophrenia.
Care for suicidal patients is one of the most complex health care situations that only well-trained workers are allowed to work with the patients. It is not only a very complex medical condition but is also a serious emotional health problem.

One of the worst things a physician has to face is the suicide of a patient. The common reactions experienced by physicians who have gone through such an event are disbelief, loss of confidence, anger and shame. The suicide of a patient can trigger feelings of professional inadequacy, doubts about one's competence and fear for one's reputation. In addition, physicians confront the enormous difficulty of dealing with the family and friends of the deceased. (World Health Organisation)

Treatment and care of suicidal patients vary among communities, cultures and nations (Adelman, 2006; Freshman & Rubino, 2004; Kerr, 1973; Meyer, Fletcher, & Parker, 2004). In developing countries, the care and treatment of suicidal patients are affected by lack of resources, religion, cultural attitudes and political interference. In Vietnam, for example, if suicidal patients are treated with suspicion by medical authorities, their health suffers. Australia is a land of cultural diversity. There are people of different cultural backgrounds. It is virtually impossible for health workers to be aware of all different cultures and how these affect the communication with, understanding and treatment of the patients. One of the solutions is to employ health professionals who share the same or similar cultural backgrounds with the patients. Such people need to be culturally “bilingual”. This shared cultural background helps them to understand their patients’ emotional health.

**Conclusion**

From Decartes, one of the greatest French philosophers: “I think therefore I am” (*Je pense, donc je suis*). This represents a long tradition of emphasis on the fundamental role of thinking or reasoning. However French people often say: The heart has its own reasons that reasoning cannot understand (*le coeur a des raisons que la raison ne connaît pas*). The two statements indicate the dual relationship between emotion and thought. Emotion is no longer viewed as irrelevant to the intellect. It plays an important role in human life. In health care, emotional health has been taken seriously. Patients do not just bring to health services their sickness, most importantly they bring along their emotional life in which sickness is embedded.

**References**


Chapter II

Education, Health and Wellbeing

Dawn Penney

Abstract

This chapter adopts a socio-critical orientation in focusing on the linkages between education and health and wellbeing. It stresses the key role of education in enhancing young people’s understandings of health and wellbeing and influencing their capacity and desire to pursue ‘healthy lifestyles’. Discussion highlights, however, the need to problematise both the understandings and opportunities that are developed in and through education, via the formal, informal and ‘hidden’ curriculum in schools. The chapter therefore specifically explores (i) issues associated with curriculum, pedagogy and assessment in Health and Physical Education (HPE) and (ii) intended and incidental learning about health and wellbeing that occurs across the curriculum and throughout schools. HPE, the wider curriculum and whole school environments are all shown to play a critical role in shaping young people’s understandings of, and attitudes towards, health and wellbeing, and as representing avenues through which particular discourses may be reaffirmed or challenged. Challenges and opportunities for teachers seeking to embed discourses of inclusion and equity in Health and Physical Education, and tensions between socio-critical discourses and dominant health messages in contemporary western society, are discussed. A theme that runs through the chapter is the significance of the body in HPE and education more broadly. The chapter therefore discusses teaching and learning in HPE, and young people’s experiences in and of schooling, as embodied pedagogy, highlighting the implications of pedagogic practices and experiences for young people’s current and prospective future health and wellbeing.

Keywords: health and physical education, pedagogy, curriculum, assessment, body, equity.

Introduction

For better or worse, education has a profound impact on young people’s understandings of health and wellbeing. Most people will have some vivid memories of their school life,
relating to experiences and relationships within and/or beyond the formality of the classroom. Those memories highlight the complexity and scope of schools as contexts of learning. This chapter draws attention to the intended and unintended learning that occurs in and through schooling. It considers the many ways in which young people’s capacity and desire to pursue ‘healthy lifestyles’ is shaped in schools, by the formal curriculum, pedagogical and assessment practices in Health and Physical Education (HPE) particularly, but also by other curriculum experiences, and amidst school life more broadly. An extensive body of literature now recognises the significance of schooling as embodied pedagogy; influencing how young people think and feel about their bodies, their health, and their current and prospective future lives (see for example, Evans, Davies & Wright, 2004). Searching questions have thus been posed for HPE professionals, challenging them, for example, to consider whether their curricula “leave pupils feeling valued, included, competent, comfortable and in control of their bodies [and] health; or feeling neglected and alienated from their corporeal selves” (Evans & Davies, 2004, p.42).

In exploring these issues, this chapter seeks to bring to the fore a concern for inclusion and equity and consider the ongoing challenges facing educationalists who seek to counter dominant yet prospectively damaging discourses of health and wellbeing. Readers are reminded that schools are a significant, but not the only, nor necessarily the most influential, site of young people’s learning about health and wellbeing. This chapter emphasises, however, the critical role that education and particularly HPE has to play in seeking to promote health and wellbeing for all young people. To that end, the body is central to the analysis and discussion presented. Underpinning the focus on the body is a holistic conceptualization of health and wellbeing, encompassing physical, social, emotional and spiritual dimensions, and a recognition that understandings of health are socially and culturally constructed and value laden. ‘Bodily health’ is therefore understood as not merely physical, and furthermore, not a neutral concept. Positive health and wellbeing is related as much to whether or not one feels comfortable in and with one’s body as it is to physical characteristics of the body that may frequently be associated with health. As I discuss further below, whether or not such a perspective is actively reaffirmed in and through various aspects of schooling and school experiences, will have a fundamental bearing upon the understandings and attitudes that young people develop in relation to their own and others’ health and wellbeing.

**Everybody Matters: The Body in Education**

The first day attending school is a day that can give rise to both excitement and trepidation for children. Changing classes or moving to a new school can similarly be events that children may look forward to or face with considerable anxiety. In part, those feelings will relate to how children feel about themselves and more specifically, their bodies. Society and schools can be harsh, quick to label those who do not appear to fit with stereotypical and/or dominant expectations as deficient and/or problematic. Size, shape, skin colour and other physical features are all inherently part of children’s identities; their lived identity and also the identity that others immediately see, ‘read’ and form opinions on the basis of. To this day, my memories of school years are of being acutely aware that I was short and small.
Those physical characteristics went a long way towards establishing an identity amongst peers. At times I felt vulnerable, at others, inadequate. Yet early in my school life I also discovered that I had some physical characteristics in my favour. I was reasonably agile and quick, such that I was often able to evade others in playground games such as British Bulldog. Speed, agility and coordination in the context of physical activities such as netball and hockey served over time to define me (at least in some contexts) as notably able. At the age of 9, another factor came into play that would have a bearing upon my feelings of health and wellbeing at school. I was acutely short-sighted and like many children wearing unflattering National Health Service thick-lensed (milk-bottle) glasses, was destined to be ridiculed. The lesson learnt from my experiences remains vivid. Physical appearances matter greatly in schools and in life. They influence others’ reactions towards you, whether or not you are deemed to fit in with a community, how you will be judged and in turn, how you will feel.

In comparison to many other children I was probably lucky. Amidst the contemporary dominance of discourses of overweight and obesity, more and more children must be feeling that their bodies are socially unacceptable, the focus and subject of others’ critical gaze. Furthermore, as indicated, in some physical education and sporting contexts, I was able to enjoy some sense of ability and achievement. I remain acutely aware, however, that such feelings are far from assured as a consequence of participation in physical education and sport in schools. In my view it is vital that all children leave school confident and happy with their bodies and with both the desire and capabilities to maintain all aspects of their health and wellbeing. In pursuing that end, I begin by looking specifically at the learning area of HPE, exploring the various messages about health and wellbeing that can be communicated in and through curriculum, pedagogy and assessment. In the second part of the chapter, I turn attention to intended and incidental learning about health and wellbeing that arises across the curriculum and also beyond the formal curriculum. This part of the chapter recognises that other learning areas variously connect with issues of health and wellbeing, sometimes by design and sometimes inadvertently, and that significant learning can also occur elsewhere in school environments. I identify contexts and mechanisms through which powerful messages about health and wellbeing may be communicated and variously understood by children, which may or may not align with the understandings that we wish to promote.

HPE Curriculum: What is being Taught and Learnt about Health and Wellbeing?

What children learn from the school curriculum in general and PEH in particular derives not only from its content but also from the manner and mode in which it is organized and then provided and how learning is interpreted, assessed and displayed. (Evans & Davies, 2004, p.46)

Evans and Davies’ (2004) comment indicates several important points in relation to curriculum and learning that hold true across education as a whole, and in considering HPE specifically. First, it is important to acknowledge that curriculum design necessarily involves selection of content and thus, choices about the skills, knowledge and understandings that are
deemed worthy of inclusion in a school curriculum or not. Secondly, how teachers then approach teaching and assessment, the learning environments that they seek to create and the learning relations that feature in those, will all also have an important impact on what is learnt by whom in HPE about health and wellbeing.

This section thus acknowledges that HPE curriculum has long held an explicit connection with health agendas and more specifically with ‘schooling bodies’ (Hargreaves, 1986) in particular ways. Kirk’s work (1992, 1993) in particular has revealed the ways in which historically, physical education curriculum and pedagogy has aligned with discourses of health that were dominant at the time, amidst specific social, political and economic contexts. Perhaps the most vivid illustration of these connections is the adoption of the Ling system of Swedish Gymnastics in the early part of the 19th century in Britain and Australia, with its appeal being the focus on developing bodies and citizens that would be fit and disciplined, prepared to meet national economic and military needs (see Kirk, 1992, 1993). As Hargreaves (1986) and Kirk (1992, 1993) highlighted, discourses of health embedded in physical education have, over time, also served as a powerful means of expression of gender, class and cultural discourses relating to bodies, their capabilities and appropriate form.

HPE curriculum is not then, value free, but rather, its content in itself reflects judgments by curriculum authorities and teachers about what skills, knowledge and understandings relating to health and wellbeing it is important for children at various ages and stages of education, to learn. While regimented drills and exercise may no longer be a core element of the HPE curriculum, its content nevertheless retains a regulatory function in relation to children and young people’s bodies. Furthermore, the content represents a particular stance in relation to issues such as how children should think about health, wellbeing and their bodies. In the content that is included and/or privileged but also, through what is marginalized or excluded from learning, different HPE curriculum can be seen to reflect varied social, cultural and historical contexts, dominant values and particular health discourses. HPE curriculum will serve simultaneously to reaffirm particular perspectives on health and wellbeing, and to deny or marginalize other ways of thinking about these issues. In critiquing the National Curriculum for Physical Education (NCPE) in England and Wales, Penney and Harris (2004) highlighted that as a text the NCPE portrayed and positioned the body “as something to be appropriately prepared for physical activity; to be tuned through structured and progressively more demanding physical activity” and also “as the responsibility of the individual” (p.99). As they pointed out, a highly functional view of a body essentially divorced from emotion, society and culture, runs contrary to messages of inclusion in education. Arguably, to engage with inclusivity, HPE curriculum needs to acknowledge (and not in a tokenistic sense) diversity in terms of different bodies and different values relating to health and wellbeing. Penney and Harris (2004) identified that in the NCPE health was similarly positioned as socially and culturally neutral, “to be gained and positively maintained through participation in physical activity; to be understood and evidenced by changes in/to the body” (p.99). In the NCPE the compatibility and relationship between ‘fitness’ and ‘health’ was not questioned. Developing knowledge and understanding about the physical benefits of physical activity, and movement skills to participate in activity, were a key focus for a curriculum seeking to develop children’s interest in and ability to pursue this vision of fitness and health throughout
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life. The NCPE arguably illustrated a tendency in many physical education (PE)\textsuperscript{2} curricula internationally, to view content associated with participation and performance in various physical activities as compatible with learning about health and ‘for’ a healthy lifestyle. As numerous commentators have observed, the multi-activity model, comprising units of work relating to various activities, remains the dominant curriculum model for physical education internationally, particularly in secondary schooling (Crum, 1983; Locke, 1992, Penney & Chandler, 2000). Amidst the dominance of that model and the associated privileging of sport discourses in physical education, there are dangers that learning about bodies and health lacks a holistic orientation and retains a narrow focus, on establishing and maintaining fitness associated with participation, performance and some aspects of physical health.

HPE as a learning area in many states within Australia and in New Zealand, has provided contexts in which holistic and socio-critical discourses of health and wellbeing have been able to be embedded and expressed to varying extents in curricula. Personal development, interpersonal relationships, issues of identity, the health of communities and the environment have variously been acknowledged as legitimate and important areas of skills, knowledge and understanding that should feature in HPE curriculum. Several of these areas have been shown to open up the possibility of questioning (rather than simply accepting) what it is to be healthy and what it means to establish and maintain health and wellbeing in particular social and cultural contexts. Perhaps more importantly, some curriculum developments have clearly signaled that such questioning is an important element of HPE, the emphasis being that socio-cultural knowledge and understandings variously relating to health, wellbeing, physical activity and sport, should be addressed in and through the HPE curriculum.

The ways in which such knowledge and understandings can and should be embedded in HPE curriculum remains a matter of debate internationally and represents a notable challenge for curriculum writers and teachers. As Penney and Jess (2004) suggested, arguably “the relevance and purpose of the activities being advocated and enshrined in policies and curricula have been left inadequately explored” (p.276) in relation to particular curriculum intentions. From their perspective, if PE or HPE is to effectively engage with “whole not partial lives” (original emphasis), we need curricula that address “‘more and different’ skills, knowledge and understanding than is currently the case” (p.276), and a move away from the prevailing focus on skills, knowledge and understandings for participation and/or performance in established, physical activities or sports. There are arguments then for HPE curriculum design and content to give more prominence to the different dimensions of health that underpin health and wellbeing and similarly, to address gender, class and cultural differences in both the meaning of health and wellbeing and the behaviours that are associated with establishing and maintaining health and wellbeing.

As indicated, some developments have moved in these directions with curriculum frameworks certainly enabling an emphasis on holistic and inclusive health and wellbeing to come to the fore, even if not explicitly foregrounding those interests in the official curriculum design. Notably, in 2007 ‘Health and wellbeing’ (HWB) (rather than HPE) was adopted as a learning area in the new Tasmanian Curriculum. The stated aim of HWB was “to assist students to become resilient, responsible, active and healthy people” (Department of

\textsuperscript{2}This reflects that physical education is the established subject in the curriculum in England and Wales, differing from the situation in many states and territories in Australia and in New Zealand, where physical education is incorporated within the learning area of HPE.
Three strands provide the organisational framework for content: (i) understanding health and wellbeing; (ii) skills and concepts for movement and physical activity; and (iii) skills for personal and social development. This structure is intended to emphasise physical, mental, social, emotional and spiritual dimensions of health and wellbeing and their inter-relationships. Yet, while curriculum developments such as this are undeniably important in requiring and/or enabling particular content to feature in HPE, the ‘official curriculum’ always remains something destined to be expressed and experienced in many and varied ways in different schools and classes, and most of all, by different children. As the quotation above from Evans and Davies (2004) emphasised, how content is enacted in pedagogy and assessment in a particular setting with all its inherent complexities (including the physical environment, the composition and dynamics of the class and grouping strategies employed) has a fundamental bearing upon what any individual student will learn from their lived experience of HPE. ‘Learn’ in this instance needs to be associated with how students’ experiences in HPE shape their thinking about matters such as what they regard as a healthy body, how they feel about their own body, and what characteristics and behaviours they see as defining healthy lifestyles. Teachers’ pedagogy is thus a powerful mediator of learning opportunities, experiences and outcomes. In relation to the interests central to this chapter, it will send powerful messages about ‘whose bodies matter’, whose bodies and what abilities are valued within and beyond HPE. Through actions and words teachers will signal, often very publically, their recognition of these things and furthermore, that invariably, a direct association being made between ‘body’, ‘effort’ and ‘ability’ in HPE (Evans, 2004). All too often perhaps, body shape and size are read and interpreted as defining not only the abilities that children possess in HPE but also, those they are capable (or not) of developing. Furthermore, those readings may well be through gendered and/or culturally biased lenses, with pedagogy both expressing and reaffirming particular social and cultural ideals and values.

At issue here is “how young people feel when they hear and see that they are not the right shape, size and weight” (Evans et. al., 2008, p.7) to have a valued place in an activity, a team, school and wider society. While the most obvious example to spring to mind here may well be the prospect of a large child being ‘read’ as fat, lazy and/or lacking in physical abilities, other types of body may similarly be deemed inadequate amidst sometimes harsh, stereotypically laden, contexts of HPE teaching. For example, we can certainly question how boys of small stature feel about their bodies and in and of themselves, amidst a culture that may well celebrate stereotypical masculinity in and through sporting activities that demand and celebrate a particular kind of physicality, and invariably, sexuality (see for example, Clarke, 2002; Keyworth, 2001). Tinning (2010) recounts a physical education lesson in which “Year 8 boys of all shapes, sizes, and sexual development were displayed immodestly in all their fleshiness by the brevity of their swimming uniform” (p.131), while lining up, shivering, before very publically attempting a forward somersault dive from a board, with little by way of instruction or guidance. From the lesson described, there seemed little prospect that many of the boys would have gained any sense of enjoyment of movement and physical activity, extended their movement skills, or enhanced their confidence in their own developing bodies.

However, teachers never solely define pedagogical environments and relations. Students are active players in determining the values that will typify a HPE environment and whether or not, that environment will be felt to be an inclusive environment, irrespective of one’s shape, size, ethnicity, gender and physical abilities. For many students, pressures and feelings
of bodily inadequacy may come as much from peers as from teachers in HPE. Classmates may be both harsh and explicit in their judgment of bodies and ability in HPE settings, quick to condemn and perhaps failing to see value in diversity. Amidst the dominance of idealised images in the popular media and widespread condemnation of bodies that are deemed to pose a critical health risk not merely to the individual, but also to society, a clear challenge in HPE is to provide learning environments within which everybody feels safe, secure and valued. Students, not merely teachers, need to understand and respond to that challenge.

A final consideration to address in relation to HPE lessons is assessment. Assessment, and particularly, summative assessment, sends a powerful signal in terms of what skills, knowledge and understandings really matter. Furthermore, the focus and format of assessment will point directly to who has the ability to succeed in HPE (or not). Formal assessments in HPE can variously offer all children an opportunity to demonstrate many and varied abilities or in contrast, mean that many children once again feel inadequate and/or publically humiliated. Bodies are on display in HPE, to teachers and to peers. Assessment tasks and settings need to therefore be designed to support rather than jeopardise the development of bodily confidence and positive embodied identities.

**Learning beyond HPE**

In this second part of the chapter, the emphasis is that learning about health and wellbeing is by no means confined to formal HPE lessons. Several other learning areas, including science (and most obviously, biology and/or human biology) and studies of society and the environment (SOSE) will variously include content that addresses aspects of health and wellbeing and that specifically looks at bodies. Probably the most important point to state here is that this content, just as that in HPE, will either reaffirm or challenge dominant, potentially narrow, images and understandings of health and wellbeing. Arguably, subjects or learning areas other than HPE have an equally important role to play in supporting children to develop understandings of health as multi-dimensional and as socially and culturally constructed. Teaching that is directly concerned with ‘the human body’ and/or characteristics of the body in relation to physical health (for example, aerobic fitness and cardio-vascular health) can, for example, either ‘disembody’ these issues, isolating physical health and portraying health as ‘value free’, or it can be taken as an opportunity to reaffirm a holistic view of health and wellbeing and to illustrate the interplay between health and social and cultural values. In part as a result of choice of content, but also once again, as a consequence of the particular pedagogical approaches adopted by teachers and the relations and environments created in classrooms, students learning about their bodies in science, or about changes in human bodies across time and cultures in SOSE, will come to feel either more or less comfortable about and ‘in’ their own bodies. Being ‘different in some way’ will be either felt to be ‘OK’ and furthermore, entirely normal, or as something that sets them apart from others, such that whatever it is (e.g. being short, tall, thin or fat relative to peers) becomes a source of anxiety, self-consciousness, self-doubt.

Other areas of the curriculum and particularly the arts, also present settings where bodies and bodily capabilities are ‘in focus’, on display and/or where students may be encouraged to express and develop greater understanding of emotions through movement. Drama and dance
are, for example, contexts in which aspects of mental, emotional and spiritual wellbeing can be creatively explored, and/or where particular health issues (such as drug-taking) can provide a focus for teaching and learning in and through movement. The challenge once again will be for teachers to shape and support an environment in which students feel comfortable, confident and able to express their emotions and developing identities without fear of ridicule.

It should already be apparent that many aspects of a school day and school environments have the capacity to impact upon students’ personal health and wellbeing and to shape their understandings about health, wellbeing, healthy bodies and healthy lifestyles. While classrooms present a formal focus for learning, as indicated, they are also sites of unintended, incidental learning. Furthermore, they are not the only site of learning in schools, a point that has been reflected internationally in health policy and in the development of ‘Health Promoting Schools’. As McCuaig (2006) explains, the Health Promoting Schools (HPS) framework recognises the individual and collective potential for (i) curriculum, teaching and learning, (ii) school organization, ethos and environment, and (iii) school partnerships and services, to support the achievement of positive health and education outcomes for students. Looking beyond teaching and learning in the classroom, the HPS framework thus prompts school communities to critique the physical and social environment of the school from the perspective of all students’ health and wellbeing. From this perspective,

The physical environment should provide a safe, stimulating and fun place in which to learn, work and play. The social environment should encourage caring, respectful relationships and participation in school decision making and should be free from discrimination, harassment and intimidation. (McCuaig, 2006, p.61)

Achieving such environments is by no means easy, yet this is a crucial way in which schools can influence the social and emotional wellbeing of children. Physically and socially, parts of school environments can prove threatening and fearful for some children and young people. While the dominant forms of bullying may have changed with technological advances, school playgrounds remain a prime site for either ‘direct’ acts of bullying or for less overt but still potentially very damaging behaviours that serve to marginalise and exclude some students, sometimes simply because their bodies and/or physical abilities are deemed ‘not to fit’ with stereotypical norms. Just as is the case in HPE lessons, there can be both pleasure and pain in the interaction of the physical body and social space (lisahunter, 2006).

Another area of schools that have been an explicit focus for health promotion initiatives, and in which messages about health and healthy lifestyles are communicated, are school canteens. In 2008 the World Health Organisation (WHO, 2008) released a School Policy framework for the implementation of the WHO Global Strategy on Diet, Physical Activity and Health and called upon member states to “develop and implement school policies and programmes that promote healthy diets and increase levels of physical activity” (p.1). In Australia, schools have been recognised as a key site in the framework proposed to tackle the reported obesity crisis (Commonwealth of Australia, 2003), with canteens a focus for interventions directed towards changing eating behaviours and enhancing students’ understandings about ‘healthy eating’. For example, the ‘Cool Canteen Accreditation Program’ (Cool CAP) in Tasmania was established with the premise that:
The formation of healthy eating behaviours is part of each child's education. Although eating behaviours will go through a number of stages during childhood, habits established early in life are said to be long lasting. Children need guidance to help them select a healthy diet and have healthy attitudes toward food. (Tasmanian Schools Canteen Association, (TSCA), n.d.)

While initiatives such as this may be well intentioned, there is also a need to acknowledge that measures designed to regulate and re-shape food choices may add to some students’ feelings that their bodies and eating habits are the focus of constant monitoring - at school, at home, amongst family and peers (Evans et al., 2008). As Shilling (2010) explains, in the context of relentless and public monitoring and evaluation “against the fit, trim active and healthy ideal” (p.161), “corporeal excellence joins academic excellence as a metric circulating between and among teachers and pupils, and against which children are classified” (ibid., pp. 161-162). Evans et al.'s (2008) research has illustrated the potentially damaging impact that the dominance of contemporary discourses celebrating thinness, and demonizing both fatness and many food choices, can have on the health and wellbeing of young women. Their work highlights that schools have as vital a role to play in addressing the risks of eating disorders as they do the risks of obesity. It also provides a reminder of the need to recognise that ‘healthy eating’ and ‘healthy eating behaviours’ are, like health, matters that are far from value free but rather, inextricably linked to particular social and cultural values, which accord some bodies greater status and social acceptance than others.

**Conclusion**

Pedagogical work is done if an individual gains some knowledge (comes to know), either consciously or subconsciously, as a consequence of engaging in a pedagogical encounter which has as its purpose the passing on of certain knowledge/understanding … thinking about pedagogical work helps take the focus off specific pedagogical practices and helps us focus on what is understood by the learner as a result of some pedagogical encounter. (Tinning, 2010, p.20, original emphasis)

Tinning’s (2010) emphasis is that intention is fundamental for pedagogical work to be done, while acknowledging that the outcomes of a pedagogy may not necessarily (nor for all students) match the intent. This chapter has reaffirmed the latter point and aligns with Tinning’s view that it is critical that we foreground “the consequences of pedagogy” (p.19, original emphasis). Discussion has also sought to highlight, however, that students will ‘come to know’ much about bodies, health and wellbeing, amidst encounters within schools that do not necessarily feature pedagogical intent. In doing so, they may grow in bodily confidence and develop a positive sense of wellbeing, or develop feelings that instead are characterised by self-doubt, insecurity and inadequacy. Furthermore, it is crucial to also keep an appropriate sense of perspective and to therefore recognise the many other avenues through which children and young people ‘come to know’ about bodies, health and wellbeing. In contrast to the scope and intrusiveness of the media and internet, messages conveyed in and through schooling may seem in danger of proving insignificant. In conclusion, however, I come back to my firm belief that Health and Physical Education as a learning area and HPE teachers have a vital role to play in shaping students’ knowledge, understandings and feelings about
health and wellbeing. As Tinning (2010, p.136) states, “all pedagogical encounters in physical activity are at their core bodily encounters. The pedagogical work of PE will always have an embodied dimension and that will often be the most significant thing that young people take from PE”. The challenge for PE/HPE teachers, and for schools more broadly, is to ensure that all young people take something positive from their embodied experiences and encounters of lessons and daily lives in school.

Acknowledgments

Thanks go to Professor John Evans for his longstanding collegiality, friendship and inspiration to think differently about PE and HPE.

References


Chapter III

Uncovering the SES-Health Myth: How Modern Society Undermines our Achievement of Optimal Health

Susan A. Korol

Abstract

This chapter examines existing research on health advantages and disadvantages predicted by educational achievement and socioeconomic status (SES). While already established health disadvantages of low SES groups are well-known, health psychologists have largely ignored addressing broad social and economic etiological factors in generating theories and interventions. The influences of broader social and cultural influences on health are examined more closely in an effort to identify barriers to achieving better health across the population. Health challenges of marginalized groups are discussed alongside less dramatic psychological risk factors in higher socioeconomic groups. The psychological-physical health relationship among high SES group members is discussed in an attempt to uncover illness-prone psychological characteristics required by many high status occupations valued in modern culture. It is argued that personality and behavioural characteristics required to achieve status, power and “success” in the context of a competitive, individualistic culture virtually eliminates any possibility of achieving optimal health. The broader cultural environment is explored in an attempt to identify health risks and protective factors at the sociocultural level. SES and health are discussed in an effort to identify culturally-rooted problems that act as health risk factors in all SES groups. Consequently, it is proposed that population-based health improvements will require shifts in modern values from individually-oriented goals to more community-oriented sources of satisfaction and fulfilment.

Keywords: SES, health advantages, health psychological theory, personality, individualism, community interventions, education.
Introduction

This chapter examines existing research on health advantages predicted by educational achievement and socioeconomic status (SES) in an attempt to uncover broad cultural influences that undermine the achievement of “optimal health” across populations. Identified health disadvantages of low SES groups appear to be the result of a number of associated variables including lower levels of educational attainment, access to healthcare, availability of health-promoting lifestyle factors, occupational hazards, and greater economic stress (see Steinbrook, 2004; Grzywacz et al., 2004). Not surprisingly, alongside poorer health outcomes observed within socially disadvantaged populations is the widely accepted notion that people in higher socioeconomic groups enjoy additional health benefits associated with better educations, incomes and psychosocial supports (Taylor & Seeman, 1999; Coburn & Pope, 1974). Although a crude understanding of health and SES is of enormous value in shedding light on the problems faced by low SES populations, of equal importance is the development of solutions that will best serve all members of society. At first glance, it appears as if our health solutions lie in narrowing the gap between low and high SES groups, as proposed by many health researchers (see Marks, 2004; Marks, 2002; Marks, 1996; Murray, 2004). However, it is also essential that we identify additional health challenges faced by higher socioeconomic groups in our attempt to develop a model of optimal health. Given the proliferation of reductionistic theory and research that appears to be guiding the evolution of the field of health psychology (Campbell & Murray, 2004; Stam, 2002), an understanding of the broader social, cultural and economic influences on health does not appear to be on the horizon. However, the critical psychology movement offers some hope in its insistent appeal to broaden our perspectives on health in an attempt to further our understanding of health in the context of economic, political and cultural influences (Marks, 2008; Murray, 2004; Stam, 2002).

On the extreme end of the SES spectrum, the psychological-physical health relationship among high SES group members is discussed in an attempt to uncover illness-prone psychological characteristics and behaviour patterns required by many high status occupations. While personality variables have been a central focus in studying health behaviours, vulnerabilities and protective factors (Lee et al., 1990; Denollet, 2009; Kaplan, 1992), they have rarely been considered from a perspective in which cultural influences may promote and reinforce behaviour patterns that have been identified in the etiology of disease. Some personality and behavioural characteristics required to achieve status, power and “success” in the context of a competitive, individualistic culture, virtually eliminate any possibility of achieving optimal health. Community participation and social solidarity has offered valuable benefits in improving health by offering already established buffering effects against stressors and in promoting health-enhancing behaviours (Campbell & Murray, 2004). Consequently, in order to improve health status at a population level, modern values must be shifted from individually-oriented goals to more community-oriented sources of satisfaction and fulfilment. This shift in values requires a disposal of competitive approaches socially and professionally, toward more collaborative approaches. Furthermore, shifts from materially-based sources of satisfaction to more people and relationship oriented sources of satisfaction will additionally produce more positive health outcomes.
Limitations of Traditional Health Psychological Approaches

Considered a relatively new sub-discipline within the field of psychology, the emergence of health psychology developed out of a growing desire to better understand the relationship between psychological processes in the promotion of health and in the development of illness (Taylor & Sirois, 2009). Long before health psychology was recognized as a valid sub-discipline a mere forty years ago, health professionals and scholars widely accepted that psychological mechanisms and behaviours are at play in the etiology of illness and in predicting good health (Poole et al., 2007). In 1946, the World Health Organization (WHO) issued a definition of health as “a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1948; cited in Poole et al., 2008, p.3) This definition of health assumed that it be understood as a holistic concept, which included a consideration of more than physical indicators. Currently, although definitions of health appear to universally resist its definition as a purely physical absence of illness, critics of health research claim that it is most often conducted from reductionistic, biomedical frameworks (Stam, 2002). Additionally, these frameworks are often limited to narrow research questions about physical illness to the exclusion of how social contexts affect health and illness. Despite the recognition of a need for multidisciplinary perspectives within the field, mainstream health psychological approaches have relied on traditional scientific methods of inquiry that inherently ignore broader social, cultural and economic forces that impact health status (Murray & Chamberlain, 1999). While many individual determinants of health have been uncovered and appropriately fill the pages of health psychology textbooks, concerns related to how social and political influences bear on individual health status and lifestyles continue to be voiced (Campbell & Murray, 2004). The resulting limited perspectives have provided few solutions in the prevention of illness and the promotion of health (see Murray & Poland, 2006; Murray, 2004). The most widely used approaches in the field focus on cognitive and behavioural interpretations of health behaviours often related to beliefs and perceptions of desirability, risk and vulnerability to negative health outcomes (Azjen, 1985). And while the health psychology literature cites cognitive and behavioural theories in predicting behaviour change (see Azjen, 1988), substantive empirical evidence indicates that despite large changes in individuals’ intentions, only small to moderate changes are observed in behaviours (Webb & Sheeran, 2006).

The tendency to burden the individual with the responsibility to care for his/her health is problematic on several fronts. This perspective assumes that individuals have ultimate control over their health, while focusing little attention on influences such as poverty and marginalisation as playing roles in health status (see Steinbrook, 2004). It further ensures the avoidance of broader cultural and social variables that have been implicated in health and illness, which inevitably perpetuates an approach to health research that is individually-focused with the best possible outcomes involving only the promotion of behaviour changes that are unlikely to be sustainable or to offer the hope of improved health at the population level.
The Critical Health Perspective

Murray (2004) draws interesting parallels between the emergence of the field of health psychology in the 1970s and 1980s in the West and their correspondence with a reduction in public expenditures on health and social services. These cuts were observed alongside a strong promotion from the field of public health for individual self-responsibility. Concurrently, the development of the field of health psychology similarly focused on individually-rooted psychological causes of illness and determinants of health.

The field of critical health psychology emerged as a reactionary movement against biomedical explanations of health behaviours, out of a growing sense that these interpretations were of limited value. Marks (2006) argues for the use of a wide-angle lens from which health behaviours ought to be framed from a broader perspective by viewing social, economic and political forces as inextricably linked to health. He further criticized the consistent failure of health psychology to deal with social inequalities and their relationship to health status, claiming that health can only be understood from within the social, political and economic forces that influence it (Marks, 1996). While a wealth of research in fact supports the observation that discrepancies in social status lead to poorer health outcomes (Steinbrook, 2004; Grzywacz et al., 2004), we are left with the view that those members of society in high SE brackets enjoy better health status. Crudely speaking, this appears to be the case but upon close examination, just how high SES groups enjoy their improved health status must be deconstructed. Individuals in high SES groups similarly suffer the adverse effects of the environments to which they are exposed, namely those produced by occupational stresses (Cobb & Rose, 1973; Karasek et al., 1981).

While health researchers have largely pursued studies into the roles of personality variables, doctor-patient communication, and stress reduction techniques in the management of illness and in the promotion of health (see Poole et al., 2007; Taylor & Sirois, 2009), broader perspectives on health have been largely ignored. In particular, while the role of SES in predicting health status is noted in much of the literature, little attention has been given to how cultural value systems are fundamentally implicated in the development and the perpetuation of illness. While disadvantages in access and education have been identified in explaining the relationship between low SES and illness, very little discussion has been focused on remedying disparities in socioeconomic status across populations.

Critics of the mainstream health psychological approach argue that explanatory frameworks that have traditionally been relied on to understand health and illness patterns lack explanatory power and are to a large extent, merely descriptive (Marks, 2008). Such frameworks rely on cognitive descriptions of why people engage in healthy and unhealthy behaviours with little explanation of what factors give rise to certain health beliefs. Some critical health psychologists have suggested that theoretical frameworks and research within the field have been far too reductionistic in nature and offer few solutions in reducing illness within the broader population. The tendency to ignore social factors implicated in the etiology of disease has been met with increasing frustration, especially as we witness a resurgence of interest in community-oriented practices within other sub-disciplines in the field (Campbell & Murray, 2004). As forms of social exclusion are key determinants of health, Marks (2006) has been active in criticizing the consistent failure within the discipline of health psychology to deal with social inequalities and their relationship to health status. And while these
discrepancies in health status are commonly cited in the literature, health psychologists have been accused of being conspicuously absent from any discussion on social inequities or in offering solutions to remedy some of these causes of ill-health in society (Marks, 2004). Crudely speaking, the relationship between SES and health appears to be quite clear-cut, with the privileged in society enjoying better access to health promoting activities (Lynch et al., 1997), more opportunities for leisure, and better availability of psychosocial supports (Shields & Martel, 2006) this appears to be the case but upon close examination, just how high SES groups enjoy their improved health status must be addressed.

**SES and Health**

The relationship between SES and health has been widely studied, with an overwhelming body of evidence confirming essentially that the poor in our society have poorer health than their wealthier counterparts (Steinbrook, 2004). A number of reasons have been suggested to explain disadvantages members of our society face in achieving positive health outcomes. Factors such as inadequate housing, sanitation, access to health services and environmental hazards have all been proposed in explaining noted disparities in health status between low and high socioeconomic groups (Grzywacz et al., 2004). The poor have a higher incidence of chronic disease, obesity and diabetes (Taylor & Sirois, 2009).

In contrast to the health disadvantages faced by low SES groups are some health advantages enjoyed by higher SES groups. Results reveal that members of these groups have a reduced risk of most illnesses across the life span (Shields & Martel, 2006). High SES group health advantages have been explained as a result of access to a broader array of psychosocial supports, which lead to better health status. Furthermore, Warren et al. (2004) identified high levels of education, higher wages and greater occupational status as being predictive of better health outcomes.

Apart from the obvious discrepancies in income between high and low SES groups, education and health are also positively correlated. In fact, some research suggests that education is the single strongest predictor of health status (Winkelby et al., 1992). This observation has been explained in terms of education-promoted behaviours, particularly lifestyle choices such as diet, exercise and hazard avoidance that promote health. Simply put, a well-educated individual will more likely engage in health promoting behaviours, and self-maintaining activities (Lynch et al, 1997). In fact, Warren et al. (2004) found that individuals from higher socioeconomic strata exercise more, are less obese and don’t smoke as much as their lower SES counterparts (Cobb & Rose, 1973; Karasek et al., 1981). Also troublesome is the growing body of literature that identifies early childhood social disadvantage as one of the most highly predictive measures of future health status. SES disadvantages that have their roots in childhood result in more health problems throughout individuals’ lives and are more likely to be in low SES status in adulthood (Warren et al., 2004).
Occupational Predictors of Health

While a broad perspective on SES and health reveals obvious advantages among those in higher SES groups, occupational environments have been implicated in presenting their own risks, in blue collared and white collared environments. As the workplace environment plays a significant role in our everyday lives, much research has examined the role of workplace environments on stress. Studies have been mostly focused on unveiling adverse effects of workplace stress, job control, social support in the workplace and competitive workplace environments (see Johnson & Hall, 1988; Karasek et al., 1981). Similarly, heavy workloads and occupational stresses have been of interest to health researchers (House, 1974). Despite a strong body of literature that supports the concept of control in the workplace in mediating against workplace stress (Bosma et al., 1997), job-related stress is also noted in white collar environments, independent of sense of control (Bourbonnais et al., 1996). For example, air traffic controllers are often noted for the stressful nature of their jobs and the deleterious health effects of that stress on their health has been studied for decades (Cobb & Rose, 1973; Karasek et al., 1981. The very nature of their work ensures enormous responsibility and decision-making control. In spite of this they continue to suffer increased rates of stress-induced hypertension compared with the rest of the population. Higher rates of hypertension and coronary heart disease observed among air traffic controllers are quite likely the product of a chronically stressful work environment in which mistakes are understood to translate to potential loss of life. It is very unlikely that small manipulations to bring about higher degrees of employee control would have significant effects on air traffic controllers’ overall stress levels. This specific workplace environment offers a clear example of how workplace stress within a high pace environment reduces ones’ ability to achieve positive health outcomes – in spite of high SES status.

Another exception to the SES-health myth involves women in management positions who appear to experience more stress-related symptoms off the job than their white collared male and blue-collared female counterparts (Frankenhauser et al., 2006). These results are only surprising when variables are isolated and results are interpreted outside their broader familial and social contexts. While these results may be interpreted by suggesting that women have fewer innate abilities to act as managers, we might also explore women’s competing roles in their modern lives and the burden that may be represented by them. Results like these can help us identify more realistic practical life solutions that include the creation of more inherent stress-reduction infrastructures.

Social Support and Health

The buffering role of social support is well established in the health literature (see Larocco et al, 1980; House et al., 1988; Dressler, 1991; House, 2001). Within the context of the work environment, we must consider the value of social support. It has been postulated that an availability of social support in the workplace acts as a buffer against cardiovascular disease (Johnson & Hall, 1988). Despite the current health research focus on personal control as a buffer against the effects of workplace stress, evidence indicates that a lack of social support within a high control environment increases chronic disease risk, namely
cardiovascular disease (Johnson & Hall, 1988). In general, poor social support is considered to be a health risk, and the relationship between low levels of social support and CHD has been noted (Kop & Gottdiener, 2005).

While the value of social support both within and outside of the workplace continues to show a strong buffering effect in the promotion of health, modern work environments do not always encourage collaborative efforts. In fact, many work environments operate within frameworks that promote competition for promotional purposes, which inevitably foster alienation and stress among co-workers.

Of particular interest are data indicating the increased incidence of coronary heart disease in industrialised countries. Explanations that have been offered to explain this discrepancy note that social and geographical instability in these regions may account for higher rates of CHD (Yusuf et al., 2001). Furthermore, individuals who undergo more frequent changes in geographic regions, occupationally or socially, are also at increased risk in developing heart disease (Kasl & Berkman, 1983). While modern global societies continue to be promoted both in business and from a social perspective, potential health consequences associated with constant displacement ought to be examined more closely.

**Personality Characteristics and Health**

Personality factors have long been studied within the field of psychology and in health in an effort to shed light on individual differences in susceptibility to specific diseases such as cancer and coronary heart disease. While personalities continue to be “typed” in an attempt to establish such correlations, the most widely studied health personality type appears to be that of the type A. People who exhibit type A personality patterns, characterised by impatience, highly driven, somewhat aggressive, rushed character traits, have been identified as being at increased risk for heart disease (Poole et al., 2007; Haynes et al., 1980). These observations are of interest in examining the relationship between SES and health given evidence pointing toward the type A personality as better in job performance, particularly in management type roles (Lee et al., 1990; Kirkcaldy et al., 2002). In spite of identified associated risks in developing cardiovascular disease, the type A behavioural style remains the one that is of performance value in modern organisational settings.

Recently, the type D personality has become the subject of research attention and has been identified as the most vulnerable personality type in the development of cardiovascular disease (Denollet, 2009). The type D personality type describes a behavioural pattern characterised by a tendency toward internalising negative emotions and refusing to express them in social interactions. Further evidence was found in the predictive power of type D in a recent study following CHD sufferers over five years. Denollet et al. (2006) discovered that among patients with cardiovascular disease, a combination of stress and type D personality increased the risk of suffering a major cardiac event.

In contrast to the more illness-prone personality types, the type B personality style rarely gets attention, possibly since it has been somewhat construed as the boring cousin of the charismatic type A. In his article entitled, *Social health and the forgiving heart*, Kaplan (1992) argues that some specific components of type B personality styles, such as forgiveness, compassion and wisdom, are virtues that not only benefit society as a whole, but
are individually protective from a health (heart) perspective. As Friedman and Ulmer (1984, cited in Kaplan, 1992) note;

Although millions of words and thousands of pages have been spent describing Type A behaviour and type A men, relatively little attention has been given to men exhibiting type B behaviour. Like almost all the researchers writing on this subject in the past, we have tended to describe the make type B negatively – as an individual who lacks the traits of a Type A man. Such a description is unfortunate because in a very real sense it is the Type A, who should be said to lack type B qualities. (p.3)

**Conclusion**

This chapter explored existing research on health advantages and disadvantages predicted by educational achievement and socioeconomic status. While historically health psychologists have shied away from a deep exploration of broader social, economic and cultural determinants of health because of its limited scope in theory and in research practice, health psychology offers few solutions in addressing more culturally-rooted health risks. If we continue to view health and SES simplistically, we may unwittingly propose solutions that inherently offer new health risks to already-vulnerable populations. As previous research identifies work-related stress as a source of potential ill health, such flawed solutions may entail the promotion of education and higher income jobs with more control over one’s work environment. This potential solution is flawed in assuming an infinite availability of jobs that offer sufficient control. Furthermore, competitive environments and limited availability of social supports within work environments must be addressed in developing potential health-promoting solutions. Instead we must consider an adoption of more community-oriented approaches to improve health at a population level. Campbell & Murray (2004) argue for participatory social engagement and involvement in health initiatives and in communities to promote health. The involvement of community members in participation in forming solutions to their health problems holds much more promise than individually-oriented perspectives that have stood in the way of addressing health problems (Schumaker, 2001).

The concept of empowerment is central in community-oriented interventions in health promotion. Empowerment links individuals with their strengths, and promotes natural helping systems that encourage more fundamental and sustainable social changes (Zimmerman, 1995). Of equal importance in promoting health is fostering of a psychological community. This promotes belonging among community members, in various forms of communities, and has been shown to produce a subjective sense of well-being among community members (Davidson & Cotter, 1991).

Health challenges of marginalised groups must be viewed from a perspective that acknowledges the cultural roots that lead to their disadvantaged status. Furthermore, health risks factors affecting those in higher socioeconomic groups must be examined at the level of culture by identifying their origins. Rather than separate high and low socioeconomic groups into “haves” and have-nots”, we must consider solutions that benefit all members of society. If, in fact, narrowing the gap between high and low SES groups offers a solution in fostering
community cohesion and in abandoning value systems hinged on competitive objectives, we must not shy away from considering making fundamental changes in our social structure.

References


Uncovering the SES-Health Myth: How Modern Society Undermines…


Abstract

Communication is traditionally about sending and receiving a message. The sender is seen as taking an active part in initiating a message and the receiver takes a passive role in receiving it. However, it is much more complex than this simple definition of communication in terms of transmission. It requires the participants to take an active part in the meaning making process of communication. Miscommunication can easily occur in intercultural communication due to the interference of the first culture on the second one as culture is strongly embedded in various aspects of intercultural communication. This is clearly shown in the use of cultural stereotypes and metaphors by migrants which reflect their views and attitudes in their acculturation into a new cultural environment. In the health area, migrants’ stereotypes and metaphors can give health professionals some insights into the minds of migrants about their making sense of the health concepts and issues in their new land.

Keywords: metaphor, meaning, health communication, interpretation, concept, culture.

Introduction

In health, it is expected that linguistic precision is one of the most important factors in health communication and treatment of illness. Thus lack of linguistic precision could lead to problems in health due to miscommunication. However, linguistic precision in health communication is not easily maintained in an intercultural discourse in which people of different cultural and linguistic backgrounds interact. Migrants who come to a new cultural
environment bring with them their cultural values and attitudes which are different from those of the new environment. In the health area, migrants may attach different meaning to health concepts and issues in their interaction with health workers of an English background. This is clearly embedded in their cultural stereotypes and cultural metaphors. This chapter examines some sociolinguistic aspects of intercultural miscommunication, with a focus on the health context.

**Miscommunication in Intercultural Interaction**

Globalization has its positive and negative impacts linguistically, socially and culturally. When people of different cultures interact, they create the world together but also encounter problems of intercultural interaction. Miscommunication is a common phenomenon. It can bring people together and enrich mutual understanding and respect whereas it can also create disrespect and hostility.

In the contemporary world of international and intercultural professional communication, the differences between people are considerable. People are in daily contact with members of different cultures and other groups from all around the world. Successful communication is based on sharing as much as possible the assumptions we make about what others mean (Scollon, 1995).

Two interrelated fields, sociolinguistics and pragmatics, offer interesting insights into the communicative behavior of speakers of different socio-cultural backgrounds. A fundamental principle of intercultural interaction is that language and communication cannot be divorced from its socio-cultural context. The same speech act may have different linguistic forms and social functions depending on the context of situation. For instance, how to say goodbye in Vietnamese is not a simple speech act. The Vietnamese word “sorry” (xin lỗi) can be problematic to foreigners as its usage varies sociolinguistically and this often leads to misunderstanding for foreigners. Vietnamese speakers do not say the word “sorry” readily unless they really want to apologize. From the Vietnamese viewpoint, English speakers overuse the word “sorry”. In intercultural interaction, English speakers may consider Vietnamese speakers impolite, unconcerned or uncaring; whereas Vietnamese speakers may misinterpret English speakers as over-polite, artificial, or overly concerned about trivial matters. Kearins (1985) observes similar greeting in Aboriginal tradition. Formal greetings such as “good morning” or “hello” were not used in the past by the Aboriginal people. This does not mean that greeting does not exist in this culture. Argyle (1982) points out that most cultures have a number of forms of polite usage, which may be misleading. They may take the form of exaggeration or modesty. Americans ask questions which are really orders or requests (e.g., would you like to...?). Vietnamese speakers tend not to disagree with their overseas friends as to Vietnamese maintaining social harmony is more important than indulging in trivial conflicts and their expressions of agreement or disagreement may not be linguistically explicit.

For some, communication seems to develop naturally in the process of enculturation. Just like walking and talking, communication is caught, not taught. It grows as a result of constant social interaction. Human beings are born with a drive to communicate. Young babies show signs of communication even when their mother tongue has not been developed.
Communicative ability is enhanced through daily interaction. Communication can be a simple or complex task depending on the communicative discourse. Communicative failure is not a rare event which only strikes in abnormal situations. It is a common phenomenon in our daily interaction, verbally or non-verbally.

The communication process involves at least two participants. Miscommunication often occurs due to our failure to receive the intended message in the communicative process. The word “intended” is emphasized here as it is a key factor in assessing communication success. A smile can be interpreted differently as a sign of happiness or contempt depending on the intention of the sender. Miscommunication occurs when the receiving end fails to capture the sender’s intention. It is important to point out that in effective communication, it is important to capture not only what the speakers say, but also what they mean. Human communication includes many instances of mismatch between linguistic form and underlying meaning or function, which accounts for miscommunication.

The discussion of linguistic mismatch leads us to the question of ambiguity in communication which is one of the main causes of miscommunication. Linguistic ambiguity is universal in human languages. As linguistic ambiguity accounts for miscommunication and communication breakdown, it is important to develop some strategies to handle it. Scollon (1995) states:

The point we want to make is that ambiguity is inherent in all language use. There is no way to get around the ambiguity of language. What is most important is to recognize that this is the nature of language and to develop strategies for dealing with ambiguity, not try to prevent it from developing (p. 10).

Linguistic ambiguity refers to more than one interpretation underlying a linguistic form. It can occur at various levels including phonological, lexical and syntactic. Phonologically speaking, the most common miscommunication taking place in interacting with speakers of different linguistic backgrounds is caused by pronunciation and intonation. Another aspect of linguistic ambiguity is lexical ambiguity. As it is impossible for every single concept to be lexicalized, a word can have different meanings, for examples, bank, table, sister, party, etc. It is worth pointing out that if the context of communication is clear, misunderstanding caused by linguistic ambiguity can be minimized. Though phonological and syntactic ambiguities can account for some miscommunication, it is the structure of discourse which tends to be the primary concern. In legal language, special attention is given to proper referencing to avoid discourse ambiguity. A widely-used device in legal language is nominal repetition. In other words, the same noun is repeated many times. The joint work of Halliday and Hassan (1976) on cohesion is a great source for unpacking textual ambiguity.

**Communication Barriers in the Health Context**

Many studies have been conducted on health issues relating to migrants. Some studies cover different areas and ethnic groups. For instance, Talamantes (2001) studied health care for Southeast Asian American elders (Vietnamese, Cambodian, Hmong and Laotian). Ailinger and Causey (1995) examined health concepts of older Hispanic immigrants. Nelson

According to Carballo and Nerukar (2000), cultural background plays an important role in predisposing some immigrants to some diseases such as depression, chronic anxiety, and neuroses. Alcohol and drug abuse may also be used as coping responses that expose migrants to other health problems such as HIV/AIDS. Seijo et al. (1995) conducted a study on language as a communication barrier in medical care for Hispanic patients. They pointed out that communication is essential in understanding and improving the health of Hispanic people in America. Similarly, Flores et al. (2000) emphasize the importance of language and culture in pediatric care when they conducted case studies in the Latino community.

The study of language in its social context tells us quite a bit about how we organize our social relationships within a particular community. Addressing a person as “Mrs,” “Ms”, or by a first name is not really about simple vocabulary choice but about the relationship and social position of the speaker and the addressee. Similarly, the use of sentence alternatives such as “pass the salt”, “would you mind passing the salt”, or “I think this food could use a little more salt” is not a matter of simple sentence structure; the choice involves cultural values and norms of politeness, deference, and status (Wolfram, 2006).

Conversation between health professionals and migrant patients can be problematic due to a mutual lack of intercultural awareness. Le (2006) conducted a study on intercultural health and communication. She argues that conversation analysis provides useful ways to understand how a conversation works in a social context and how it varies among cultures. It is a complex language activity which is based on conversational principles or maxims. A conversation has a framework involving patterns of turn-taking, initiating and terminating verbal moves. Le highlights this aspect using the following example:

- Doctor: Good morning Tu
- Patient: Good morning Dr Clinton
- Doctor: Please sit down.
- Patient: Thank you, Doctor
- Doctor: What I can do for you today?
- Patient: Doctor, I need antibiotics for my sore throat.
- Doctor: Let me have a look and see what I can do for you.
- Doctor: I don’t think you need antibiotics, Tu.
- Patient: Doctor, I need it badly, Sir.

This short sample of conversation or doctor-patient interaction reveals a number of interesting cultural issues about practical intercultural communication problem.

- Addressing in a health context: Addressing reflects the role and status of the participants. The doctor addresses the patient by the first name as he knows Mr Tam well and wants to give Tu a friendly and informal atmosphere. Both of them are approximately of the same age; whereas Tu still addresses the doctor by his title, which is common in a doctor-patient genre. Vietnamese migrants tend to use Mr and Mrs in addressing others in a formal context such as “I am Mr
Tam‖ or ―I am Mrs Thu‖. Words such as surname, family name, first name, last name and Christian names can be confusing to some migrants. In Vietnamese and Chinese, first name is the family name. A married woman in Vietnam does not officially use the surname of their husband. She keeps her maiden name.

- Health professional roles: In Vietnam, an antibiotic is not a prescribed drug. It can be bought at any chemist and there are no specific instructions on how it should be used. It indicates the different ways in which health workers’ roles are perceived in different cultures. In Vietnam, chemists can play the role of “a daily or family doctor or nurse”. People go to the chemist to ask for advice on how to treat their sickness. Problems arise in the Australian context due to migrants’ different perception, expectation and attitudes towards health workers.

The nature of interaction between patients and health workers is culturally governed. It is important to know about the norms and values that underlie interaction in an intercultural discourse. Lie (1995) supports this view as he points out:

What, then, do we know about the norms and values that govern physician patient or nurse patient interactions in other countries? The answer is that we know surprisingly little, and much of what we appear to know is based on studies of questionable relevance (para. 7).

**Cultural Metaphors and Stereotypes in Health**

Scientific language advocates the use of precise language in communication. However, human communication is full of metaphors. In Greek, metaphor means carrying something across. A hospital can be described metaphorically as a home by some patients and as a prison by others. Through metaphors, one can understand the real meaning and attitudes of the metaphor users. Lakoff (1980) states:

Metaphors may create realities for us, especially social realities. A metaphor may thus be a guide for future action. Such actions will, of course, fit the metaphor. This will, in turn, reinforce the power of the metaphor to make experience coherent. In this sense metaphors can be self-fulfilling prophecies (p. 146).

Metaphors are not mere matters of words, but fundamentally they act as mechanisms for understanding and experiencing one thing in terms of another (G. Lakoff, 2002; G. Lakoff & Johnson, 1980). Zwaan (2009) argues that language is for communication; however the language used in discourse can hide meanings or “paint a different picture” of what is really happening. Participants in a discourse cannot help but introduce personal biases, because of their social and cultural backgrounds and because of their particular motivations for engaging in a discourse. Using metaphor can provide imaginative, interesting, and sometimes misleading associations which can hide the real issues and distort the power plays which are at work.

Migrants coming to a new country bring with them their cultural metaphors in the interpretation of their experiences in a new cultural discourse. From the Vietnamese
perspective, teachers are not those who teach students in schools. Metaphorically, they are perceived as “parents” whose responsibility is not confined to the intellectual development of the students. A teacher is expected to be a moral leader, a role model, and a knowledge transmitter. Doctors are not just health care workers. They are metaphorically seen as saviors who should receive great respect not just from their patients but the community in which they live. Students and patients are therefore discouraged to challenge their teachers and doctors. This is a reason why in Vietnamese, the word “thầy” can be used to refer to teachers and doctors.

Words in health care such as sickness, death, life, healthy, disorders, treatment, etc., may be metaphorically perceived differently by migrants of different cultural backgrounds. Lack of metaphor awareness in intercultural communication can lead to misinterpretation and negative attitudes not just in the health domain but various other domains.

Tran (2000) points out that many migrants and refugees come to the West with empty hands. Some have built up their new lives with great success, conquering big to obtain peace, security and prosperity; while others are still very empty-handed. However, regardless of their success stories or otherwise, they came to their new cultural environment with a heavy luggage of metaphors, particularly for the elderly people. These metaphors have enriched their lives in a new cultural environment. However, the cultural metaphors that they brought from their cultures to the new homeland could also create some pain, despair, and sometimes destruction.

Le and Le (2004) conducted a study on intercultural health metaphors. According to the authors, a metaphor indirectly or implicitly indicates our perception and attitudes, particularly in relation to social values. If a hospital is perceived metaphorically as a home, this metaphor brings with its positive features held by the metaphor users such as warmth, care, security, kindness, etc. On the contrary, if a hospital is perceived as a clinical factory, it reveals negative images and feelings such as cutting the flesh, indifference, fear, cool bloodiness, etc. The study attempted to understand the cultural meaning that Vietnamese migrants used to interpret and value health concepts and issues in terms of their Vietnamese metaphors applied in the Australian context.

Apart from metaphors, cultural stereotyping is another source of miscommunication in intercultural interaction. Klineberg (1982) argues that the term “ethnic stereotypes” are “pictures in our heads” that we have had the impression that we know what “they” are like even before we actually meet them. The existence and nature of stereotypes determines our perception and judgment of others. We tend to assign some distinctive values to people of different cultures and on this basis we form our action, thought and communication. Problems arise when we try to put everyone of a culture in the same basket and treat them according to our cultural stereotyping. Chinese people tend to be stereotyped as “good with business”, French men as “romantic lovers”, English people as “cool and remote”, and Australians as “easy going”. The greatest danger of stereotyping is that it discourages us from discovering for ourselves the uniqueness of each individual that we meet in a context. It provides a “ready-made” mode of behavior for us to use in interacting with “foreigners”. Holms (1985) points out the danger of social stereotyping:

Women in many societies are perceived through a haze of stereotyped expectations when they speak. Whatever women say, or don’t say, can be used against them as evidence of their deficiencies. This is true not only in the popular imagination but also in the halls of academia (p. 25).
Overgeneralization is a starting point of stereotyping. The difference is that stereotyping carries with it an ideological position. Characteristics of the group are not only overgeneralized to apply to each member of the group, but are also taken to have some exaggerated negative or positive values. These values are then taken as arguments to support social or political relationships in regard to members of that group (Scollon, 1995). There are many potential sources of cultural stereotyping and among them language reflects cultural stereotyping very deeply. Our language contains a variety of expressions which suggest the presence of specific psychological traits in particular ethnic groups. In English, we find such ethnic stereotypes as “Dutch treat”, “Chinese puzzle”, “Jew him down”, “to take French leave” (Klineberg, 1982). In language, jokes and anecdotes also reflect cultural stereotyping and they are abundant in many cultures. It is important to distinguish common custom and traditional values each culture has from cultural stereotyping. For instance, in Vietnamese culture obedience and respect for teachers and older members in a family are valued as Confucianism has permeated Vietnamese culture for centuries. This is cultural awareness, not stereotyping. Cultural awareness is therefore essential in intercultural interaction.

In the area of health care, stereotyping does exist. It is not an uncommon communicative behavior among people of different cultural backgrounds. Some migrants may stereotype nurses as being female. Hospitals are stereotyped as a place for people with illnesses. Thus people go to hospitals when they are sick. Very few will go to hospitals for normal check-up. Similarly psychiatrists are stereotyped as specialists for mentally ill patients. People are reluctant to see a psychiatrist for fear of being labelled as “mentally sick”.

While stereotyping in health is a source of miscommunication, euphemism poses a similar problem. It is a polite way of saying something which is unpleasant and embarrassing. Human beings are also social and cultural beings. Different cultures require their language users to use language to show politeness and respects. Euphemism is one aspect of linguistic politeness. The opposite of euphemism is dysphemism.

According to Cumming (2003), the definitions of "euphemism" and "dysphemism" presuppose that there are three words for a thing in different registers: polite words (genitals, intellectual disability, hearing impairment), neutral words (penis, mentally ill, hearing loss, and impolite words (prick, deaf and dumb, mad and crazy). In the health discourse, inappropriate use of descriptive words about body parts may not only cause serious communication breakdown but can cause embarrassment. Migrants with limited English may not be aware of the use of non-discriminatory language strongly advocated in Western countries. They may use words such as “mad and crazy” for people with intellectual disability, “deaf and dumb” for people with hearing impairment.

As Le and Chiu (2009) pointed out, migrants come to a health service bring along their cultural metaphors about health which strongly influence the ways in which they perceive health workers, accept or reject certain health service delivery, and therefore situate themselves in a new health environment. Effective communication with these patients by health workers who understand the patients’ cultural metaphors could contribute a great deal to their adaptation to a different health care environment and to the collaborative relationship between health care providers and their clients.

Cultural competence is important in health interaction. According to Margareth and Iraj (2006), the cultural characteristics of any given group may be directly or indirectly associated with health-related priorities, decisions, behaviors, and/or with acceptance and adoption of health education and health communication programs and messages. Thus, it is important for...
health workers to have some intercultural awareness or cultural competence training to deal with health in a multicultural discourse. Cultural competence is not confined to one’s own culture.

Cultural competence begins with the recognition that we all were born, raised and live in social, educational and organizational cultures. These cultures shape our assumptions, beliefs, values and behaviors. When we interact with others, the similarities and differences between our cultural expectations often make the interaction both more interesting, and more challenging. In a health setting, these challenges must be met if we are to provide equitable, appropriate and accessible services to all our clients (NSW Health Department).

Another important issue about culture and health is the emergence of youth as a discourse. Young children and adolescents constitute a new category of membership in society. Their beliefs, values, life styles, and behaviors can differ greatly from their older generation. The generation gap can create a communication gap between children and adults, particularly in an intercultural context. Thus, some parents may not have great influence on educating and guiding their children in dealing with a rapidly changing world which is full of health-related problems such as HIV, drug, smoking, alcohol, depression and obesity. Without the influence and security of their home, young migrants can become an easy target of abuse, particularly those who cannot adjust to a new language and culture or those who have gone through traumatic experiences in their home countries.

**Conclusion**

In a traditional health discourse, great attention has been given to the clinical aspects of health such as medical treatment, health facility, and access to health resources. While it is undeniable that these aspects are crucial in population health, it is also important to recognize that health is socially and culturally embedded and constructed. Health concepts are therefore viewed and interpreted differently by people of different cultural backgrounds. In an intercultural health context, miscommunication occurs due to the lack of awareness and appreciation of the cultural heritage and identity that newcomers bring to a new environment. From the perspective of health care providers and policy makers, intercultural communication awareness should be valued and translated into practice to ensure that migrants are not excluded from participating meaningfully in health care and they are not at the mercy of the dominant culture. Otherwise, health care can become a discriminatory discourse.

**References**


Chapter V

Volunteers: Reflexive Social Agents

Christine Stirling

Abstract

Community participation is increasingly seen as a valuable addition to service provision. But we lack adequate understanding of what links individuals to community participation and how this influences community participation. In this chapter I outline a Reflexive Social Volunteer Agent model as an explanation of volunteering. The model uses a critical realist framework to incorporate the concepts of reflexive individuals, interests, agency and identities to understand volunteer involvement with health services. The model outlined will be useful for health services and policy makers that desire to generate or harness community participation for services.

Keywords: community participation, volunteers, identity, interests, critical realism, health services.

Introduction

Volunteers are an important link between our cultural, social and health workforce worlds. This chapter follows Tilly & Tilly (1998, p.32) by defining volunteering as the act of ‘providing unpaid effort to parties to whom the worker owes no contractual, familial, or friendship obligation’. It is the unpaid effort of volunteers that leads them to be considered a hallmark of community participation where trust and networks form an important part of these social contributions (Onyx & Leonard, 2000). But while there has been a great deal of research looking at individual motivations to volunteer, or social reasons for volunteering, there has been little work explaining how volunteers’ individual motivations link with social and cultural factors. This chapter will describe a ‘Reflexive Social Volunteer Agent’ model for understanding how social and cultural factors interact with individual motivations to ‘create’ volunteers. The model is based on research undertaken with ambulance volunteers in Australia and New Zealand (Stirling, 2007).
A comprehensive explanatory model of volunteering is important if we are to foster and sustain volunteer workforces. Volunteers have played a significant, though often unrecognised health role in Australian and New Zealand societies since colonisation. They provide services, and associational and self-help groups through the non-government sector, the government sector and the private sector. In the year 2006, more than a third of Australians volunteered, contributing over 713 million hours (Australian Bureau of Statistics 2006). The health sector has many examples of volunteer workers, from acute ambulance services through to palliative care, and in 2000 there were more volunteers than employees in Australia’s community services sector (Australian Institute of Health and Welfare, 2003).

The ‘Reflexive Social Volunteer Agent’ model draws on a critical realist paradigm. Critical realism offers a stratified meta-theory that acknowledges both the effects of pre-existing structures, such as roles, and the ability of actors to intentionally bring about change (Archer, 2000). Volunteering needs to be understood as influenced by both these factors: pre-existing structures, including social entities like collective identities, and the ability of people to intentionally bring about change, that is agency (Archer, 2000). Without an approach that addresses both society and agency, we will only ever understand half of the volunteering equation.

The chapter begins by exploring current theories of volunteering, and then explains the model.

Current Explanatory Theories of Volunteering

Motivations, prosocial behaviour, and social networks have formed the backbone of explanations of volunteering. Motivations are a psychological explanation of volunteering and one of the strongest themes in the current knowledge base about volunteering.

Motivations – A Psychological Explanation of Volunteering

Since Lord Beveridge’s report The Evidence for Voluntary Action (1948) psychological explanations of motivation have dominated thinking about why people volunteer. The general trends in motivational theories have been reflected in the volunteer literature with altruism and egoism commonly used as explanations of volunteer motivations (Van Til, 1985; Yeung, 2004) with the extent of the mix varying according to overarching societal discourses. Hence it was generally accepted that people were naturally concerned for the common good (Marwell & Oliver, 1993) until after the middle of the 20th Century when volunteer motivational literature began relying on prevailing economic ‘rational man’ theories as an explanation of collective action (Stretton & Orchard, 1994). Economists argued that volunteers benefited from the process of volunteering by gaining some individualistic reward and were driven by incentives such as money, social status and social acceptance (Olson, 1965). Any other motivation than incentives or coercion was considered irrational.

Rational man explanations of volunteer motivations were, however, softened by the functional explanation offered by Clarey, Snyder and others (1991; Clary et al., 1998). Using the Volunteer Functions Inventory survey instrument, they showed that six functions can
explain volunteer motivations: values, understanding, social, career, protective and enhancement (Clary et al., 1998). Using the functional approach, altruism is considered to be a valuable benefit for the individual volunteer because they are able to act on a value that is important to them. Other important functions highlighted by the theory were enhancement and social functions, which help individuals to develop a sense of achievement, reputation, new skills, and self-approval for doing the right-thing (the ‘warm-glow’ syndrome). Volunteering also offers social contact by affiliation with groups, friendship, social meetings, and being part of a team. Career and protective functions are also likely to be provided by similar benefits of volunteering, with an increase in social networks and strengthening of social participation skills (Clary et al., 1998). While these new functional explanations of motivation give greater depth to understanding volunteering, they still fail to adequately engage with social explanations of volunteering.

Prosocial Behaviour – Altruism and Socialisation

Sociological theories argue that volunteering is a form of prosocial behaviour and group behaviour. They place volunteers in a broader social context where group norms influence behaviour. Altruism, a form of prosocial behaviour which is “intended to benefit another, even when this risks possible sacrifices” (Monroe, 1996 cited in Knox, 1999, p.477), is seen as fundamental to the ethos of volunteering. Cultural, psychological, evolutionary and personality theories have all been used to answer questions of why people are altruistic. Reciprocity is a key sociological explanation for altruism, based on the idea that altruism is maintained in society because altruistic behaviour is rewarded, and non-altruistic behaviour punished by a large portion of the population (Gintis, 2003). This reciprocal type of altruism is believed to have provided evolutionary benefits to humans (Penner, Dovidio, Piliavin, & Schroeder, 2005). Initially, evolutionary approaches supported the argument that altruism was really based on self-interest and harsh judgements of altruistic behaviour were common in the 1970s, “What passes for cooperation turns out to be a mixture of opportunism and exploitation … Scratch an altruist, and watch a hypocrite bleed” (Ghiselin, 1974, p.247 cited in Gintis et al., 2003, p.154).

However, others argue that not all reciprocity can be explained by self-interest, and propose that ‘strong reciprocity’ is a predisposition to cooperate with others that spreads through the internalisation of norms and provides evolutionary benefits (Gintis, 2003). This theory is based on the idea that cultural and social norms are passed on over generations by the internalisation of norms. There is support for the socialisation link to volunteering as the link between cultural norms and volunteering has been shown in many studies. For example, studies have found strong links between religiosity and volunteering (Fisher & Schaffer, 1993; Wilson & Musick, 1997; Wuthnow, 1998) and differences in gendered volunteer roles (Australian Bureau of Statistics, 2006). These prosocial explanations of volunteering still fail to capture the full extent of the context of volunteering and cannot therefore support a comprehensive explanation of volunteer motivation.
Social Networks – Resources and Social Capital

Alexis de Tocqueville first suggested the connection between volunteers and civil society in his 1830s study *Democracy in America* (De Tocqueville, 1953), believing that America’s democracy was strengthened because its citizens were frequent joiners of associations. The role of non-profit organisations in recruiting and mobilising citizens as volunteers is believed to have a mediating effect on both the private sector and the public sector, while creating avenues for participation and representation in our society (Almond & Verba, 1989; Minkoff, 2001).

It was the argument that participation in society and the building of networks secures economic and resource benefits that popularised Putnam’s version of social capital (Putnam, 1993, 2000). In his theory, individuals develop the ability to cooperate and feel involved in the public sphere through group association, which in turn improves society’s effectiveness. Shared understandings of reciprocity and responsibility create trust amongst groups which eases the way for future cooperative actions, making them increasingly efficient. This, essentially economic, argument for the benefits of voluntary associations generated substantial global policy interest in social capital (See for example Fukuyama, 1995; World Bank, 1999).

Social capital causality is, however, not clear. For instance, it is possible that in secure societies people are more trusting and therefore more likely to associate (Norris, 2001), and that social capital is most productive in strong communities (Onyx & Bullen, 2000). This link to the ‘dominant status model’ has been supported by many surveys and multivariate studies, showing that those with higher socio-economic status are more likely to volunteer (Brown, 1999; Smith, 1994). The extra resources available to those of higher socio-economic status, including education, skills and money, are believed to facilitate their volunteering. Higher education with a resultant higher income is likely to result in increased resources of time, money and skills that are needed by non-government organisations (NGOs). The linking of resources to volunteering brings structural conditions into the volunteer explanatory framework, but leaves out individual and social motivations.

The Reflexive Social Volunteer Agent

While all of the key theoretical approaches discussed above contribute to our understanding of volunteering, none alone can factor in all known influences of volunteering. A critical realist approach can, however, provide a basis for an explanatory theory of volunteering that allows all of these elements to play a role. Critical realist researchers consider both individuals’ actions and structures (which include social norms) as related but separate entities, with their own properties and causal efficacy. Bhaskar (1989) partly explained this interaction between individuals and structures as the transformational principle, which states that though society would not exist without humans, social structures pre-exist the actions of those humans present now. Critical realists assert therefore, that social structures have “their own powers, tendencies and potentials …” (Archer, 1995, p.106) and actors are always operating in a pre-existing context. In terms of the volunteers, the structures existing within society that influence their motivation to volunteer, have been constructed...
over time and pre-date the current volunteers. These understandings are central to the Reflexive Social Volunteer Agent model. Following are the key elements of the model, based on the work of Margaret Archer (2000, 2003).

The Reflexive Individual

The model begins by understanding that people are thinking individuals who prioritise their concerns through internal reflexive conversations with themselves (Archer, 2003). Individuals’ concerns will include a vast range of interests such as physical well-being, practical worldly achievements, emotional relationships and social self-worth. Reflexive deliberations allow individuals to make decisions and act to pursue these interests. Interests are best understood in a manner that moves away from both a narrow focus on the material interests that are based on “what we need to survive, thrive or excel” (Archer, 2000, p.175). Instead, interests need to incorporate the concept of a people who engage in a range of emotional concerns, along with practical and natural conditions in the world. Emotions are elevated in such a framework to acknowledge their importance to individuals. This does not mean we ignore the ‘vested interests’ that are inherent in any situation of finite resources, where groups and individuals must struggle for a share of the resource distribution (Archer, 1995).

Life Chances – The Physical, Social and Cultural World

Every individual’s interests will be influenced by the socio-cultural world around them. The world into which individuals are born and then engage is a stratified world where all is not equal, and so we have the “stratified social subject” (Archer, 2000, p.259). This means that individuals’ concerns and agency are embedded within a pre-existing cultural and structural world. The stratified world in which individuals live will mean that life chances and interests will differ for individuals and groups as factors such as personality, families and neighborhoods exert different influences. This means that people’s internal conversations will be reflections of the context of their life situation.

Agency

Reflexive deliberations will lead individuals to make evaluative decisions based on their interests and life situations, which in turn will lead to action based on these decisions. This means the thinking individual has agency and is central in dealing with the present and future through internal conversations (Mutch, Delbridge, & Ventresca, 2006). Archer’s approach to agency closely matches Emirbayer and Mische’s (1998), who define agency as engagement by actors that is influenced by “habit, imagination, and judgement” and that both “reproduces and transforms structures” (p.970). For Archer (2003), the internal conversation is the point of interaction between structure and agency.
Volunteer Identities

- There are three levels of identity and they are important in the interplay between agents and the real world: Personal identity, is the individuals’ self-concept that derives from interaction with both cultural and structural elements of the real world (Archer, 2000). Factors like morals and emotions form part of an inner conversation that helps us develop a personal identity which remains largely part of our own image of who we are and what we value.
- Social identity, on the other hand, is the individuals’ “self-concept that derives from his knowledge of his membership of a social group” (Tajfel, 1978, p.63). Life chances influence the developing self and the choices made in terms of social identity, which is the identity individuals present to the outside world.
- Collective identity of volunteers is the “shared definitions of a group that derives from members” common interests and solidarity and outlasts the individuals membership (Taylor and Whittier, 1992 cited in Klandermans, 2000,p.163). A collective volunteer identity involves recognising oneself as belonging to various groups and not others, and seeing the world from these perspectives.

Joining Collectives

Volunteers can now be understood to engage with organisations because their interests and life-chances prompt them to do so. They do this because they are agents who have interests which they partly meet through collective identities. Through collectives … “‘people confront problems which are interest-related … [they] confront problem-ridden situations in relation to these wider interests (which are rooted in their life chances)” (Archer, 2000, p.286).

Applying the Explanatory Framework

Volunteers need to be understood as a diverse group of individuals with some collective interests based around their volunteer roles and any other shared life circumstances, such as their location. Volunteer interests may include collective interests such as resources for delivering local services. Other more personal material interests include career opportunities, social capital and status. Other interests such as self-esteem reflect more emotional concerns, but even material interests, including economic, social and cultural capital, should not be considered purely in resource terms as such an interpretation returns to a rational man view of volunteer interests. Instead, the complexity of interests uncovered should be understood in terms of individuals’ fulfilling their personal identities in a reflexive and emotionally connected manner.

Volunteer’s commit to volunteer service because the volunteer identity represents an opportunity for them to meet prioritized interests within their particular life situation. However, the individual can only base their judgment on dominant and publicly available representations of the particular volunteer role they have chosen, such as an ambulance
volunteer. So therefore, while the individual may see an opportunity to meet certain interests through taking up the volunteer role and identity, the role may not prove to enable them to meet their particular interests.

What happens within the volunteer experience also becomes extremely important to the continued involvement of the volunteer. The volunteer experience may prove to meet the interests of the volunteer with a resultant happy balance until such a time as the individual’s situation changes or interests are re-prioritised. Or the volunteer experience may prove to not meet the volunteer interests, at which point the individual may exit the organisation, or may discover other interests which are prioritised and the individual may continue to volunteer. Any mismatch between public representations of volunteer identity and reality may be evident in a quick turnover of volunteers within organisations.

Changes to dominant public representations of volunteers will, over time, work to change the composition of the volunteer workforce. Promoting volunteers as ‘good citizens’, as ‘agents of change’ or as ‘staff’ creates new representations of volunteers which will attract individuals with different prioritised interests to the services. In a similar manner, governments can also, over time, influence who contributes as a volunteer. If policies and discourses create shifts in general societal values to the degree where collective concerns fade as a normative value and more individualist commitments come to the fore, then there may be a dwindling pool of collectively focused volunteers from which services can recruit, and a growing pool of individually interested volunteers. Governments can also influence social conditions to the point where individuals need to re-evaluate their priorities to focus on matters other than collective interests, say for example, earning an income if economic conditions deteriorate.

Archer’s (2000) framework provides a fuller understanding for how volunteers combine individual and collective interests at the volunteer organisational interface. The individual reflexively assesses and adjusts prioritised interests which are enacted and reflected through identities. The Reflexive Social Volunteer Agent model allows a linking of previous volunteer explanatory frameworks with a contextualised explanation of cultural and structural conditions. The multiple motivations uncovered by previous studies can therefore be seen in a more holistic light as the model facilitates linking between the influences of the individual and society.

While Olson’s (1965) rational man is clearly shown to be too shallow an interpretation of volunteers, so too is the functional approach to volunteer motivations (Clary & Snyder, 1991; Clary et al., 1998), though both theories have important relevance for volunteers. Volunteer’s commit to volunteer service because the volunteer role represents an opportunity for them to meet either one or several interests that they have prioritised within their particular life situation. The difference here with the rational man world view (Olson, 1965) is that there is no reason to believe that the decision to take on a volunteer role needs to be economically rational, as any economic focus would depend completely on the individual’s stratified situation and the interests that the individual had prioritised. The key difference with the functionalist approach (Clary & Snyder, 1991) to explaining volunteering is that the socially stratified situation of the individual is brought into prominence and the focus moves beyond the individual to encompass the influence of cultural and structural conditions of society on volunteer motivations.

Equally, because the volunteer is understood to be socially stratified in this explanatory framework, the literature that emphasises the role of social norms in prosocial behaviour
(Gintis, 2003) can be incorporated without social conditioning being given undue prominence. The developmental and reflexive understanding of individuals proposed by Archer (2000) can be used to explain how family and group norms of altruism influence the development of personal identity which may become a prioritised interest that is sought through volunteer work. The use of interests and identity work as an explanatory framework also places this study apart from the work of Grube and Piliavin (2000) who focus on roles and identity. They suggest volunteers develop a ‘volunteer role identity’ where the role becomes part of the volunteer’s personal identity and that this development is necessary for sustained volunteering. While roles are an important aspect of the stratified world, all interests cannot be subsumed within roles.

Conclusion

This model moves beyond a methodologically individualist account of volunteering to capture information about how individual and collective interests underpin individuals’ engagement in volunteering. Collective concerns influence the way that volunteers prioritise interests, with the result that their actions will not always be rational from a self-interested perspective. These findings could lead some to claim that neo-liberal policies are successful in that they increase citizen participation in services, and they do not undermine collective norms and values. The assumption of a collective goodwill that underpins communitarian citizenship theorists (Etzioni, 1993; Stretton & Orchard, 1994) also finds some support from these findings. However, neo-liberal and communitarian proponents need to be able to incorporate a more complex citizen with multiple, and competing interests, into their theories.

References


Chapter VI

Self-Identity and Risk-Taking in Adolescents

Derris Wood, Penny Allen and Quynh Lê

Abstract

This chapter presents an overview of theories on the development of self-identity and self-concept during adolescence. While there is a large volume of research in this field, little is known about the impact of risk-behaviours on the formation of self-identity. The dominant perspective within the adolescent risk-taking literature is the problematic model, where risk-taking is viewed as a threat to adolescents’ physical health, psychological and social well-being, and future life roles. Undoubtedly, risk-taking in relation to tobacco, alcohol and cannabis has the potential to cause considerable harm. The health effects of risk-taking in relation to these substances are discussed in this chapter. It is also noted that a normative perspective may help to elaborate the ways in which adolescent encounters with these substances can promote development of the self.

Keywords: adolescents, self-identity, risk-taking, tobacco, alcohol, cannabis.

Introduction

Much of the literature on adolescent development is dominated by the ‘storm and stress’ model (Hall 1904 in Santrock (2008)), where adolescence is problematised and characterised as a period of upheaval, turbulence and mood swings. Adolescence is also often viewed as a time full of insecurities and a period when individuals search for acceptance. However, adolescence does not always necessarily imply crisis. It is also a time when individuals learn to cope with change, develop relationship skills, explore alternatives and make choices about their lives. Adolescence is also a period of considerable personal development and increasing autonomy. However, with autonomy comes increasing exposure to potentially harmful risks.
This chapter presents an overview of theories on the development of self-identity during adolescence and perspectives on adolescent risk-taking. The health consequences of risk-taking are discussed with reference to tobacco, alcohol and cannabis use.

**Development of Self-Identity in Adolescence**

The self is defined by Rice and Dolgin (2002) as, “that part of one’s personality of which one is aware” (p.182). Rice and Dolgin (2002) suggests that individuals are made up of six different selves; 1) who they are, 2) the people they think they are, 3) the people others think they are, 4) the people they think others think they are, 5) the people they want to become, and 6) the people they think others want them to become.

Self-concept differs from the self in that it is, ‘the conscious, cognitive perception and evaluation by individuals of themselves; it is their thoughts and opinions about themselves’ (Rice & Dolgin, 2002, p. 182). Self-concept is a collection of beliefs about oneself, it is also a developing awareness of who and what one is, of self-perceived physical characteristics, personality traits, social roles and statuses. It is often referred to as a ‘global identity’, while Erikson (1968 in Rice and Dolgin (2002)) uses the term self-concept to refer to the individual’s ego identity.

Cognitive abilities develop during adolescence which facilitate advanced thinking, reasoning and rationality (Moshman, 2004). These, in turn, provide a foundation for the development of the self, which coincides with the development of self-concept. (Heaven, 2001) While self-identity evolves throughout life (France), the central developmental task of adolescence is formation of a coherent self-identity (Rice & Dolgin, 2002). Adolescence is a critical phase of identity formation as individuals, for the first time, have attained the level of physical, cognitive and socio-emotional development necessary to assess and synthesise identities to construct a path towards adult maturity (Marcia & Carpendale 2004 in Santrock (2008)). This involves individuals asking themselves, and resolving, critical questions such as, Who am I? What am I all about? What am I going to do with my life? What is different about me?

Erikson’s theories on the development of the self are the most influential in the field and were the first to appreciate the psycho-social nature of identity, with a recognition of the important role of the community in shaping self-identity (Kroger, 1989). Erikson (1950, 1968) described adolescence as the fifth out of eight developmental stages of life. During each of these stages, individuals face a potential crisis of identity which they must successfully resolve. The term crisis is used in this context to refer to a critical point in development where the individual either achieves growth in identity formation or experiences identity confusion. However, modern theorists have argued that identity formation is more gradual and less cataclysmic than Erikson’s term ‘crisis’ implies (Santrock, 2008).

While the development of self-identity is complex, Erikson (1950, 1968) identified personality and role experimentation as central components of this process. Individuals experiment with different roles and personalities throughout adolescence and begin to differentiate their concept of the self into different situations and relationship contexts. In this way adolescents generally have a ‘real’ self and multiple ‘ideal’ selves for specific relationships or social situations. The real self is mostly presented to family while an ideal or
even false self may be projected in peer group situations or interactions with the romantic
interests. Parents play a key role in shaping self-concept during early adolescence, while
friends become a social mirror, an important source of reflected self-appraisals, during later
adolescence (Bessant, Sercombe, & Watts, 1998; Santrock, 2008). During this process
adolescents become aware of potential contradictions in their differentiated selves. This is
overcome by adjusting their self-concept to ensure consistency between internal and external
perceptions of the self (Rice & Dolgin, 2002). Resolving these contradictions allows
adolescents to construct a general theory of the self, (Harter & Monsour 1992 in Santrock
(2008)) while adolescents who do not resolve this identity crisis suffer identity confusion.

Erikson’s (1950, 1968) theories were later elaborated by Marcia (1980, 1994 & 2002 in
Santrock (2008)) who described four stages of development self-identity. The initial stage,
termed identity diffusion, precedes identity crisis. In the second stage, identity foreclosure,
individuals commit to a particular self-identity without exploring other possibilities. In this
stage self-identity is adopted from models imposed by parents. During the third stage, identity
moratorium, the individual is exploring different self-identity possibilities and is in the midst
of identity crisis. This crisis is resolved in the fourth stage, termed identity achievement,
when the individual makes a commitment to a particular self-identity. Santrock (2008) and
Kroger (2006) note that this approach has been criticised by other theorists for distorting and
overly simplifying Erikson’s concepts of crisis and commitment. Despite these criticisms,
many modern theorists have utilised Marcia’s four-stage model in their research into
adolescent self-identity formation.

Self-identity is composed of many different facets, including career, political affiliations,
spiritual beliefs, relationship status, intellectual identity, gender, sexual identity, cultural or
ethnic identity, interests and hobbies, personality characteristics and body image (Santrock,
Independence, yet moderate connectedness, emotional warmth, shared affection and an
acceptance of individuality provide a foundation for the development of self-identity. Parents
who have a democratic, firm, concerned, flexible yet consistent parenting style, and who
encourage adolescents to participate in family decision-making, have been found to
encourage identity achievement, while permissive, intrusive or controlling parenting styles
complicate and delay the process of identity commitment (Dusek & McIntyre, 2006; P. F.
Rice, 1996; Santrock, 2008). Culture and ethnicity also importantly inform self-identity, with
adolescents from minority backgrounds often developing bicultural or multicultural selves
appropriate to specific contexts. Self-identity is also importantly informed by self-esteem
which, in turn, is influenced by parental and peer approval, physical appearance, skills, and
academic and personal achievements.

A large volume of studies have explored the physical, social and psychological harms
associated with youth alcohol and drug use. However, there is a dearth of research on the
impact of adolescent drug and alcohol use on the development of the self. One of the few
studies conducted on this topic found adolescent substance abuse impairs the ability of
adolescents to successfully develop self-identity, constructive peer relationships and
individual autonomy (Baumrind & Moselle, 1985).
Theoretical Perspectives on Risk-Taking in Adolescence

Despite a vast literature on the subject of adolescent risk, few authors provide a definition of the term. While risk may be technically defined as, ‘a probability describing the likelihood of a future event, given a certain condition or set of conditions’ (Fraser, Richman, & Galinsky, 1999, p. 131), in this chapter the term will be used to describe any activity, event or behaviour which has an uncertain or potentially harmful outcome.

It has been argued that risk has evolved from a historically neutral concept to a negative, or inherently repugnant, concept in modern society (Yates, 1992). Indeed, theorists have described contemporary society as a ‘risk society’, where a sense of danger and anxiety is pervasive (Beck, 1992). While risk is perceived as a negative concept, it is important to understand risk within the context of specific situations and to appreciate that risk is often necessary for self-development.

Kelly (2006) suggests that the excessive focus on ‘youth at risk’ in modern society is a product of the dominance of neo-liberalism, with its expectation for the emergence of an ‘entrepreneurial self’ during adolescence. A sense of vulnerability to risk may also have been encouraged by rapid economic, technological, political and cultural changes which have resulted in changing family dynamics, a lack of job security and a shift away from the welfare state.

Biomedical and psychological deterministic models dominate theories of adolescent risk-taking in the psychological, public health, and sociological literature. While the biomedical paradigm views risk-taking as a product of biological dysfunction, psychological theories consider the existence of negative traits in social background, psychological variables or behavioural systems as predisposing young people to risk-taking. This problematical perspective focuses on the negative consequences of risk behaviours with little or no attention given to the positive role risk can have for individual learning and the development of a young person’s sense of self (France).

An alternative perspective proposes that adolescent risk-taking is a normative and critical phase of developmental necessary to gain autonomy and achieve a sense of self and individual identity. Engaging in risk behaviours also allows adolescents to explore their environment and test their own limits to develop competence in essential life skills. This allows teenagers to grow towards independence.

Factors Associated with Adolescent Risk-Taking

A plethora of studies have sought to describe factors which either protect against or promote risk-taking in adolescents. This literature has consistently found adolescents with low levels of protective factors who are exposed to high levels of risk in their immediate environment are more likely to engage in potentially harmful risk behaviours.

Protective factors that assist teenagers to avoid harmful risk-taking include strong social support in the form of parental, family and friendship networks, and higher levels of community involvement (Abbott-Chapman, Denholm, & Wyld, 2008). Firm yet warm and
loving parenting styles act as a deterrent against risk-taking. (Steinberg, 2001) Cohesive family relationships can also make peer relationships less salient, further insulating adolescents against risky behaviours.

Conversely, parenting styles which are characterised by a lack of supervision and a failure to set limits can reduce barriers to risk-taking. Parents can also model risk behaviours themselves, such as drug or alcohol dependence, (Hoffmann & Cerbone, 2002) which results in increased levels of potentially harmful risk-taking among their adolescent children. However, parental provision of small amounts of alcohol in a family atmosphere can help to initiate dialogue on responsible alcohol consumption and moderate risky drinking.

It is important to note that while parental influence plays a major role in shaping engagement in risk behaviours, this is mediated by neighbourhood socio-economic factors, such as poverty and social disadvantage, school characteristics and peer relationships (Cleveland, Feinberg, & Greenberg, 2010; Frohlich, Potvin, Chabot, & Corin, 2002). Family unemployment, low educational achievement and low life expectations are also correlated with higher levels of adolescent risk-taking (Plant & Plant, 1992).

Peers and friends play an important role in the development of the self they are also highly influential in either promoting or inhibit risk-taking. Peers can play an important role alongside other sources of social support in protecting teenagers against harmful risk-taking. However, teenagers who rely solely on peers for advice and support have higher levels of risk-taking. (Abbott-Chapman, et al., 2008) Shared propensities toward risky behaviours can influence adolescent peer selection and thereby increase engagement in risk behaviours. For example, friendships with peers who smoke or drink has been consistently identified as one of the strongest factors which predicts smoking and alcohol consumption in adolescents (Alexander, Piazza, Mekos, & Valente, 2001; Go, Green, Kennedy, Pollard, & Tucker, 2010; Hawthorne, 1997; Wen, Van Duker, & Olson, 2009). However, psychosocial maturity and assertiveness reduce the influence of risk-taking peers (Clark, 2004).

Peer group membership plays a fundamental role in shaping the type and level of risk-taking engaged in by teenagers by providing models of risk behaviour. Impulsiveness and recklessness are strategies used by some adolescents to gain approval or prestige among peers and avoid social rejection or labels of not being ‘cool’. Peer groups can also act as a vehicle for the acquisition of risk reputations, which confer status yet further risk-taking pressures, on adolescents.

A review of previous research reported that childhood abuse, inadequate parental monitoring and support, inconsistent discipline and conflict with parents may predispose adolescents to engage in risk-taking (Clark, 2004). Risk-taking among adolescents may also be a mechanism for coping with psychological distress. (Bonomo, 2003) Other research has described personality variables, such as impulsiveness, extraversion, sensation-seeking, aggressiveness, achievement motivation, venturesomeness and orientation to authority as either promoting or inhibiting risk taking (Gerra et al., 2004).

While infrequently discussed in the literature, hedonism, or the pursuit of enjoyment, is an important factor explaining the propensity of some adolescents to engage in risky sex, alcohol or drug use. Hedonism is tied to the normal human desire for self-medication and the wish to obtain certain psychological states such as euphoria to oblivion. Drug and alcohol intoxication also expresses a need among some individuals to experience other dimensions and to be, albeit temporarily, removed from the pressures of the world. Many discussions of adolescent risk-taking fail to consider a normative search for pleasure as a factor which leads
to engagement in risk-behaviours. However, sensation-seeking and hedonism are undoubtedly important explanatory factors of recreational drug use and binge-drinking.

Curiosity and a desire for new experiences is another significant factor in the initiation of drinking and drug use. Neuroscience research indicates that a greater motivation for novel experiences, coupled with an immature inhibitory control system in adolescents, may lead to a predisposition to engage in risky behaviours (Chambers, Taylor, & Potenza, 2003).

Religious values and commitment have also been found to play an important role in inhibiting risk-taking, (Abbott-Chapman & Denholm, 1997) while the illegality or perceived danger of a particular behaviour also acts as a deterrent (Abbott-Chapman, et al., 2008).

### Potential Health Risks of Tobacco, Alcohol and Marijuana use in Adolescents

Whether adolescents engage in alcohol and drug use due to peer pressure or a normal desire to experiment and push boundaries, there are concerns that these behaviours may result in serious health consequences. The following sections provide an overview of research into the health consequences of tobacco, alcohol and cannabis use among adolescents.

**Tobacco**

Data from the Australian Bureau of Statistics National Health Survey 2005 indicates approximately 10% of 15–17 years old smoke cigarettes or other tobacco products (Muir et al., 2009). This proportion increases with age 27% of 18–24 years old smoking on a daily basis.

Adolescents often incorrectly assume that infrequent smoking does not lead to addiction. However, research suggests that even monthly smoking is sufficient to establish nicotine dependence (Doubeni, Reed, & DiFranza, 2010). Furthermore, early initiation of smoking is associated with continuation of smoking in later adolescence and heavier smoking in adulthood (Doubeni, et al., 2010).

Despite a common misconception among teenage smokers that the risk of developing, or dying from, a smoking-related disease is minimal, both light and heavy smoking in late adolescence increases the risk of adult mortality (Neovius, Sundstrom, & Rasmussen, 2009). The immediate health effects of smoking among adolescents include shortness of breath, wheezing and productive coughing (Arday et al., 1995). Several studies have also described an association between smoking and poor mental health outcomes, (Boys et al., 2003; Chang, Sherritt, & Knight, 2005; Ilomaki et al., 2008) poorer subjective health ratings and more frequent overnight hospital stays in adolescents (Johnson & Richter, 2002). Adolescent smokers have also been reported as using a greater number of medications and accessing health services more frequently compared to their non-smoking peer (Holmen, Barrett-Connor, Holmen, & Bjermer, 2000). Smoking is also associated with behavioural problems and poor educational attainment (Conwell et al., 2003).
Alcohol

Australian National Health and Medical Research Council (NHMRC) guidelines recommend persons under the age of 18 years should avoid drinking alcohol completely and that the safest option for children and teenagers aged 15–17 years is to delay the onset of drinking for as long as possible. (National Health and Medical Research Council, 2009) However, a 2005 national survey of secondary school students found 86% of 14 year olds had tried alcohol, 70% of 17 year olds had consumed alcohol in the past month and 49% had consumed alcohol during the past week (White & Hayman, 2006a). Alarmingly, 10% of 12 year olds also consumed alcohol during the week prior to the survey. The quantity of alcohol consumed by adolescents is also a cause for concern. The survey indicated 11% of 15 year olds and 21% of 17 year olds engaged in binge drinking (more than six standard drinks in any day for men and more than four for women) during the previous week.

Early alcohol initiation is associated with increased risk of lifetime alcohol abuse and alcohol-related harms in both adolescence and adulthood. Research suggests that individuals who start drinking between the ages of 11-14 years have the greatest risk of developing an alcohol abuse disorder (DeWit, Adlaf, Offord, & Ogborne, 2000). One study found 40% individuals who start drinking at age 14 or younger have adult alcohol dependence disorders compared to 10% of those who begin drinking at age 20 or older (Grant & Dawson, 1997). Earlier initiation of drinking is also related to more frequent and higher quantity alcohol consumption in adolescence, and greater risk of unsafe sex, injury, violence, or driving while under the influence of alcohol (Andersen, Due, Holstein, & Iversen, 2003; Ralph Hingson, Heeren, Winter, & Wechsler, 2003; R. Hingson, Heeren, Zakocs, Winter, & Wechsler, 2003). The National Strategy for Young Australians (Commonwealth of Australia, 2010) notes that adolescents aged 15-19 years had the highest hospitalisation rates for acute intoxication among all age groups and that large numbers of young people are drinking at levels which place them at risk of serious health consequences, including liver damage, sexually transmitted infections and unwanted pregnancy. Additionally, adolescents who abuse alcohol have been found to have increased serum liver enzymes levels, in addition to oral, abdominal, cardiopulmonary, abdominal and musculoskeletal abnormalities (Clark, Lynch, Donovan, & Block, 2001).

Cannabis

A national survey of Australian secondary school students found 18% of students surveyed had used cannabis at some time in their lives. This proportion increases with age, from 5% of 12 year olds, up to 32% of 17 year olds (White & Hayman, 2006b). Approximately 10-11% of students aged 15-17 years had used marijuana in the past month and approximately 6% of the same age group used marijuana during the week prior to survey.

There is a general misconception that cannabis is not addictive, however a cannabis withdrawal syndrome has been described as occurring in adolescent cannabis users (Budney & Hughes, 2006). Signs and symptoms of this syndrome include headache, nausea, sweating, anxiety, appetite change, depressed mood, irritability, restlessness, and craving.

Young people who use marijuana users often underestimate the risks associated with the drug. However, cannabis use in adolescence is associated with poor mental health outcomes,
including depression, (Rey, Sawyer, Raphael, Patton, & Lynskey, 2002) and psychotic symptoms, such as thought disorder, delusions and disturbance of visual perception (Malone, Hill, & Rubino, 2010). Adolescent marijuana use increases the risk of developing schizophrenia and lowers the age of onset of the disease (Malone, et al., 2010). Other health effects of cannabis include motor vehicle crashes, impaired respiratory function and cardiovascular disease.

## Conclusion

As with the adolescent risk literature more generally, the focus of much of the research on adolescent risk-taking in relation to tobacco, alcohol and cannabis has been on negative consequences of these behaviours. While it is evident that tobacco, alcohol and cannabis use in adolescents has the potential for serious health outcomes, much is still to be learned about the positive contribution to self-identity through the development of risk assessment, peer negotiation and personal reflexivity skills in adolescent encounters with tobacco, alcohol and cannabis. In order to further knowledge in this field, future research should encompass the normative perspective. Embracing the normative perspective will allow researchers to learn more about the variables which assist adolescents to successfully negotiate tobacco, alcohol and cannabis risks, whilst avoiding a simplistic focus on protective factors. The normative perspective also circumvents the implicit moral judgements manifest in much of the current research on adolescent risk-taking.

## References


Social Impacts of Closure of Maternity Services in Rural Areas

Ha Hoang, Quynh Lê and Rosa McManamey

Abstract

Childbirth is both a universal biological and a uniquely individual event. The physical process of childbirth is similar for everyone, but each birth experience is not. Women can have a less positive birth experience when women’s needs in maternity care are not meet. In Australia rural communities have experienced an on-going loss of maternity services for more than a decade forcing thousands of rural and remote women to leave their community and familiar places to distant centres to give birth. As place is not just referred to a geographic boundary, people attach meaning and emotion to place. The loss of obstetric services in rural areas has had major social impacts on rural communities ranging from poorer outcomes for mothers and babies, family disruption and costs associated with travel and accommodation, the physical and other impacts of long travel, the risks including roadside birthing and the sustainability of rural communities.

Keywords: social impacts, closure of maternity units, rural areas, maternity services, rural communities, place attachment.

Introduction

As a universal though uniquely individual event, the physical process of childbirth is similar for everyone while each birth experience is not. Birth experience can often change a woman’s sense of self (1991, 1992). Women with a positive birth experience perceived that they accomplished something important, that they were in control, and that the birth experience contributed to their self-confidence and self-esteem (Simkin, 1991). However, research has shown that women can have a less positive birth experience when women’s
needs in maternity care such as the need for family and community support (Hoang, Le, & Kilpatrick, 2009), the need for continuity of caregiver and the need for community and belonging (Kornelsen & Grzybowski, 2005) are not met. Studies have found that one of the most important factors that affect women’s experience of birth, especially for women in rural areas, is geographical location (Kornelsen & Grzybowski, 2005; Roach & Downes, 2007). This factor is significant in Australia where rural communities have experienced an on-going loss of maternity services for more than a decade. In particular, half of the small rural maternity units across Australia have been closed in the past 12 years forcing thousands of rural and remote women to leave their community and familiar places to distant centres to give birth (RDAA, 2006).

**Background**

Australia has a high quality health care system, rating well internationally and provides high standard health care services to its people (Australian Institute of Health and Welfare, 2008). The Australian Department of Health and Ageing (2008) recognised that Australia is one of the safest countries in which to give birth or to be born. Statistics proved that Australia made significant progress in improving the safety of pregnancy and childbirth during the last decade. In particular, in 1936, there were 600 maternal deaths per 100,000 live births. By 1950, this had dropped to 109 per 100,000 live births and, by 1980, this figure had dropped to below 10 per 100,000 live births (Australian Bureau of Statistics). Furthermore, the number of fetal/stillborn deaths, neonatal deaths (to 28 days) and infant deaths (to 1 year) in Australia has significantly reduced from 3,364 a year to 864 over the 40-year period between 1966 and 2006 (Australian Bureau of Statistics).

Despite strong record of safety and quality, maternity care in Australia is not meeting the needs of all Australian women especially for rural and remote women (Alston et al., 2006; Department of Health and Ageing, 2009; Roach & Downes, 2007). Rural and remote families experience higher rates of maternal deaths (Kildea, Polack, & Barclay, 2008); rural women have significantly higher rates of neonatal deaths and remote women have higher rates of foetal deaths (Australian Institute of Health and Welfare (AIHW), 2005). The Department of Health and Ageing has recently conducted ‘the maternity services review’ (the Review) to address a range of issues including health inequalities of people living in rural and remote areas and acknowledged that:

While our system delivers to most Australian women, access to quality maternity services and positive outcomes from pregnancy, this is not uniform, as some parts of Australia and some population groups experience poorer access and outcomes. As with health care services more broadly, the difficulties faced by many Australians in accessing necessary services in rural areas has been highlighted to the Review Team. Similarly, the poorer access and outcomes for Indigenous mothers and babies were identified by many as the most pressing national issue. (Department of Health and Ageing, 2008, p. 22)

There has been a sharp decline in the number of rural communities across Australia providing local maternity care. Half of the small rural maternity units across Australia have
been closed in the past 12 years forcing thousands of rural and remote women to leave their community or place to distant centres to give birth (RDAA, 2006).

Community, Place and Sense of Place

A place is not just referred to as a geographic boundary but is seen as more than the sum of its material characteristics; it was the centre of meanings, intentions and felt values, the focus of emotional attachment and the site of felt significance (Pred, 1983). Humanistic geographers have been studying the ways in which people attach meaning to place. Manzo (2005) suggests that it is not simply the places themselves that are significant, but rather what can be called ‘experience-in-place’ that creates meaning. Place attachment is also stronger for settings that evoke personal memories, and this type of place attachment is suggested to contribute to a stable sense of self (Twigger-Ross & Uzzell, 1996).

Sense of Place

Place attachment involves an emotional connection to a particular place (Manzo, 2005; Mesch & Manor, 1998). Humanistic geographers express place belongingness in emotional terms such as ‘‘love of place,’’(Tuan, 1974). Other researcher Relph (1976) defined place attachment as the authentic and emotional bond with an environment that satisfies a fundamental human need. The literature on displacement when individuals must leave their places for different reasons gives further evidence that attachment to a place is grounded in emotion. When individuals must relocate to a new place, some choose to preserve the bond by selecting locations that are as similar as possible to the old place (Michelson, 1976). In the event of displacement, researchers have found that displacement results in feelings of sadness and longing (Fullilove, 1996). Francaviglia (1978) documented the rebuilding of a town that was devastated by a natural disaster. The destruction gave planners the opportunity to fix planning problems that had existed prior to the disaster. However, local residents and businesses used their power to override the post-disaster zoning maps that had been proposed. Eventually, the new town looked much like it had before the disaster. These suggest that recreating a familiar town proved more important than addressing planning defects.

The research on place attachment has focused on its social aspect. People are attached to places that facilitate social relationships and group identity. Scholars (Woldoff, 2002) assume that attachment to a place means attachment to those who live there and to the social interactions that the place affords them. Therefore, part of social place bonding involves attachment to the others with whom individuals interact in their place, and part of it involves attachment to the social group that the place represents. This latter type of attachment, and recognition that the place symbolizes one's social group, is closely aligned with place identity (Twigger-Ross & Uzzell, 1996).
Health Geography

The main contribution of humanistic geography was not its attempt to construct a rigorous phenomenological geography but rather the sensitizing of researchers to everyday attachments people form with place (Cloke, Philo, & Sadler, 1991). The same observation might be made of health geography, however researchers have paid little attention to the understanding of place within medical geography as an experienced zone of meaning and familiarity (Kearns, 1993). Kearns and Joseph (1993) sought to locate sense of place studies within a much broader understanding of the intersection between people, places and social processes. Mohan (1998) critiques that the significance of this research is that it focuses on the complex interplay between place, health and social process. Sense of place is mobilized as a way of exploring the emotional attachments between people, place and sites of health care. This interrelationship is described through reference to the positioning of health care services within the individual and collective imagination of the communities under study. Thus, ‘commonplace’ elements within the built environment, such as hospitals and schools, are seen to hold important symbolic properties (Kearns & Joseph, 1997). Further, the symbolic value attached to such buildings is seen to impact upon the sense of belonging and well-being that individuals feel (Kearns, 1998). Returning to the current issue of closing of rural maternity services in rural areas, the section below explores its impacts on the community in the context of place that has been discussed.

Social Impacts on Rural Communities

As discussed above, people attach meaning to place which has an impact on the sense of belonging and well-being that they feel. When local maternity services cease to provide pregnant women with services they need, women are forced to travel to another place to give birth. This negatively affects the well-being of mothers and their babies who have to leave their familiar environment, their community and their family to travel to a larger centre to get obstetric services (Kornelsen, Moola, & Grzybowski, 2009; Nesbitt, Connell, Hart, & Rosenblatt, 1990; Sontheimer, Halverson, Bell, Ellis, & Bunting, 2008).

Adverse Outcomes

Nesbitt and colleagues (1990) conducted an investigation on the perinatal outcomes of women who left their local communities for obstetrical services in a rural area of Washington state. Their study discover that women from these communities had a greater proportion of complicated deliveries, higher rates of prematurity, and higher costs of neonatal care than women from communities where most patients delivered in the local hospital. These negative outcomes may be a consequence of the increased stress-physiological and psychological-associated with travel and parturition in unfamiliar settings which interfere with the normal process of labour. A Canadian study (Kornelsen, et al., 2009) on intervention rates and outcomes between women who live adjacent to maternity service and women who have to
travel for this care also found the geographical effect on the well-being of women. Women from outside the hospital local health area (LHA) had an increased rate of induction of labour compared with women who lived within the hospital LHA. Rural parturient women who have to travel for care are 1.3 times more likely to undergo induction of labour than women who do not have to travel. Their analysis demonstrated that women had increased rates of induction for logistical reasons. Further, loss of rural obstetrical services not only has a negative impact on the well-being of mothers but also neonates in communities. Sontheimer and colleagues (2008) examines the relationship between loss of local obstetrical services and pregnancy outcomes. They found that rates of low birth-weight neonates originating from service areas of hospitals that had ceased birthing services were significantly increased compared to data before hospital obstetric closure. Low birth weight infants may be at increased risk for morbidity, mortality and negative impact on long-term quality of life.

Research has also demonstrated a various adverse effects associated with travel for rural parturient women, which include stress; financial loss; separation from spouse, children and community; and lack of continuity of care (Kornelsen & Grzybowski, 2005; Roach & Downes, 2007). In their article ‘Caring for Australia's most remote communities: obstetric services in the Indian Ocean Territories’ Roach and Downes (2007) explored the birthing experiences of women who lived in the most remote and isolated area in Australia. As on-island birthing ceased, women are routinely flown to the mainland for ultrasound scanning and for delivery. Women face the considerable financial, logistical, social, cultural and spiritual difficulties as a consequence of having to leave the islands to deliver their babies. Families can suffer financial hardship through lost income, and large additional expenses such as airline tickets for family members, accommodation and childcare cost.

Community Sustainability

The loss of maternity services not only releases a number of adverse consequences for mothers and babies but also affects on the sustainability of rural communities (M. Klein, Christilaw, & Johnston, 2002). As health professionals stop providing maternity care, women from less central communities must travel a distant centre to get that care. As discussed this may lead to the increased frequency of small premature infants and maternal and newborn complications. These complications dramatically escalate health care expenditure. On the other hand, it is impossible for midwives to provide care in such communities because midwives need physician and institutional back-up to practise. Health care providers and the community suffer the loss of skills related to reproductive and women's health due to the absence of maternity services. Farmer and colleagues (2007) suggest that health professionals would deter from moving to a community where health services are downgrading. Further, their investigation has discovered the influence of health care services on social and economic vulnerability of rural communities. Maternity units have been seen as a sign to businesses of a thriving community and considered important in encouraging younger residents to remain and younger in-migrants to move to rural areas. Scottish surveys have revealed that rural people invest strong feelings of pride in local services, linking their community’s identity to their ongoing existence (Hope, Anderson, & Sawyer, 2000). Existing residents of the community may try to move because of the lack of health care services. In addition, the local hospital is an important employer, sometimes the largest employer, in a small community. Its
downgrading or closure has a significant impact on the socio-economic vitality of the community (RDAA, 2006). Therefore, the community itself becomes dysfunctional and unstable as Klein and colleagues (2002) recognised that maternity and new born care are lynchpins for sustainable communities medically, socially and economically.

### Dilemmas in Australian Rural Communities

The above section has examined the closure impacts of maternity services in rural communities. The question raised is that despite the maternity services in rural areas being vital to parturient women and the communities, rural communities has experienced on-going loss of maternity services. What are the reasons behind the decision to close maternity services in rural areas? The below section will give a discussion on these concerning issues.

Firstly, shortages of health care professionals have been linked with the loss of maternity services in rural communities across Australia (NASOG, 2008), Canada (Goodwin, 1999), United Kingdom (Department of Health, 2003) and United States (Institute of Medicine, 1989). In Australia the maternity workforce as well as health care workforce is faced with existing and worsening shortages. Rural and remote Australia has experienced medical workforce shortages for a considerable period, particularly in terms of general practice services and some specialist services, such as obstetrics and gynaecology (Department of Health and Ageing, 2009). In addition, the ageing of the maternity workforce worsens the existing shortage as the proportion of health professionals approaching retirement age is increasing. Therefore, there has been increasingly difficulty in attracting and retaining workforce to rural areas (NASOG, 2008). This has been the major factor that led to the closure of 130 rural maternity units in rural areas across Australia since 1995 (RDAA, 2006).

Secondly, another contributing factor to the disappearance of rural maternity care in rural communities is safety and quality considerations (RDAA, 2006). The difficulty of recruiting and retaining health providers who are willing to provide obstetric care in rural areas diminishes anesthesia and Caesarean section capabilities. The absence of these capabilities in rural communities raises the concerns on the safety and quality of birthing services (NASOG, 2008). However, some researchers suggest that the closure of local rural maternity care services can cause poor birth outcomes for women and infants (M. Klein, et al., 2002; Nesbitt, Larson, Rosenblatt, & Hart, 1997). Some investigations have hypothesized that low-intervention styles of maternity care offered in small rural settings are optimal for uncomplicated deliveries (Carroll, Reid, Biringer, Wilson, & Midmer, 1994; Nesbitt, et al., 1997). There is also data demonstrating that smaller maternity units deliver excellent outcomes in terms of lower rates of interventions and maternal and perinatal mortality and morbidity (RACGP, 2008).

Finally, the last factor that affects the closure decision is the cost consideration (M. Klein, et al., 2002; RDAA, 2006). From economic perspective, it is not efficient to run maternity services where demand for or the number of patients using services is too low. The cost of running maternity units including salaries for health care professionals, maintaining and upgrading equipments and other expenses may be too large compared to a small number of deliveries in rural communities. Therefore, hospitals, health authorities and health
departments may anticipate savings through closing rural maternity units. However, Rural Doctors Association of Australia argues that this is not cost-effective because of a number of reasons. First, delivery costs are usually lower in smaller hospitals. Secondly, closure shifts costs from the health budget to rural families and communities in the form of transport, accommodation, loss of income due to absence from a farm or other employment and spending diverted from local businesses. Thirdly, closure affects the sustainability of the community. Next, the larger hospitals where mothers have to go to give birth incur increased costs, often without commensurate increases in human or financial resources. Finally, ambulance services face higher costs, workloads and responsibilities, frequently without the increased funds, staff or training needed to cover them. As Klein et al. (2002) emphasise that “cost savings may prove elusive because the decision to close hospitals in smaller communities carries with it health and economic risks” (M. Klein, et al., 2002, p. 1178).

**Conclusion**

The shortage of health workforce, safety and quality concerns, and cost considerations are the main factors which have led to the loss of obstetric services in rural communities. The closure of maternity units in rural areas in Australia has had major social impact on rural communities. It not only affects the well-being of mothers and their babies but also the sustainability of rural communities. The Department of Health and Ageing has conducted ‘the maternity services review’ (the Review) to address a range of issues including health inequalities of people living in rural and remote areas.

The Review received many submissions highlighted the growing impacts on communities and families of a lack of maternity services in rural communities. These included family disruption and costs associated with travel and accommodation, the physical and other impacts of long travel, and the risks including roadside birthing. As one submission emphasises:

> Women in rural and remote areas are no different from their city sisters in having the same wishes, but rarely are these wishes realised. If their preferred option is not available locally, they have to travel away from home, sometimes long distances to metropolitan centres, where they are dislocated from their support structures. They often have significant financial outlays for travel and accommodation. However, like most people who live in rural, regional and remote areas, they are pragmatic, and accept that they need to make some compromises for living in small communities. Nevertheless they have a right to access more options than currently exist for them (Department of Health and Ageing, 2009, p. 24).

The Rural doctors Association of Australia (2009) expressed the view that the situation in rural areas has shown no sign of improving:

> Maternity services in rural areas have been under increasing pressure over the past decade with at least 50% of rural maternity units having been closed down in the past decade alone. Pregnant rural women increasingly have to travel great distances to give birth as more and more rural maternity units have been closed by the state governments…Unfortunately there is no sign that the situation is improving (RDAA, 2009, p. 1).
In recognising the major social impacts on rural communities resulting from the loss of maternity services in rural areas, their provision has been acknowledged as a national priority (Department of Health and Ageing, 2009). It is hoped that by improving maternity services for rural women, those women, their families and their communities will enjoy the same Australian high standard health care as their city counterparts.

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Building Social Capital – A Case Study: Indirect Benefits Associated with a Dental Undergraduate Clinical Placement Program

Rosemary J. Cane

Abstract

Limited access to public dental care in Australia is evident in long waiting lists for comprehensive care, absence of recall, and an increased likelihood of more extractions and fewer preventive services occurring. Public dental services in Tasmania have been constrained by a number of factors including physical isolation from dental schools and the public hospital system, and the lowest national ratio of dentists to population (25.3 dentists per 100,000 population (2003), which was almost half the Australian average (46.9 per 100 000 (2003)). As one strategy for dealing with the dentist workforce shortage and lack of local workforce education, the Partners in Health (formed between the University of Tasmania and the Department of Health and Human Services, Oral Health Services Tasmania), in conjunction with the University of Adelaide launched the Bachelor of Dental Surgery (BDS) Undergraduate Clinical Placement Program in September 2005.

The Department of Rural Health, University of Tasmania, evaluated three of the annual dental undergraduate clinical programs held in Tasmania (2005-2007). The emerging themes were compared to the broad educational and service objectives of the program. The clinical placements took place within public dental services and involved local administrative staff, dental assistants and dentists.

The program was viewed as being a very attractive option for final year students by all respondents, mostly due to the opportunity to increase students’ clinical competence and confidence. From the students’ perspective, identified educational strengths of the program included the “real world” aspects of the program (experiential learning),

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1 This chapter is an updated version of the paper published in Lê (ed.) 2007.
educational input and the approach of clinical supervisors ("prompting"), and engagement with local clinical services staff (building social capital). Increasing the support available to local clinical supervisors (dentists), such as increasing the professional development opportunities with academic staff and extending the role of clinical supervisors to mentoring new graduate dentists, are likely to be among future benefits of the program.

**Keywords**: social capital, experiential learning, clinical supervision, mentoring, dental, clinical skills.

## Introduction

The introduction of dental undergraduate clinical placement programs has been a significant milestone for the dental workforce in the predominantly rural state of Tasmania (Cane & Kilpatrick, 2005, 2006, 2007a), where access to public dental care has been characterised by long waiting lists for comprehensive care, absence of patient recall, a high level of extractions and fewer preventive services (Brennan, Spencer, & Slade, 1996; Spencer, 2004; Stewart, Brennan, & Carter, 1998). As the only Australian state without a dental school, fewer than 2% of the recent dentist graduate population from the five Australian dental schools were attracted to work in Tasmania in 2003 (Partners in Health, 2003). The state’s rurally distributed population (472,795) (ABS, June 2002), low income per capita and the absence of a dental school indicated that ground breaking strategies were needed to address the state’s ability to recruit more dentists and improve access to services (Partners in Health, 2003). In 2003, with 38% of the population dependent on a government pension or benefit being eligible for public dental services (Trewin, 2004), the public sector dentist workforce had fallen to its lowest.

As an outcome of the Partners in Health (PiH) collaboration formed between the Department of Health and Human Services (DHHS) and the Faculty of Health Science of the University of Tasmania (UTAS), the Tasmanian dental undergraduate clinical placement program was introduced in September 2005 (Partners in Health, 2003). Dental undergraduate clinical placement programs may refer to outreach programs, community based programs or extramural placements, which are part of the dental curriculum occurring outside the traditional dental school environment. The programs were similar to outreach programs and were held for six weeks in Tasmania. The service and educational objectives of the program had been uniquely determined by an agreement between the School of Dentistry, University of Adelaide and the Tasmanian state government.

## Evaluation Method

The Department of Rural Health, University of Tasmania (UDRH), evaluated three annual programs, with ethical approval granted by the Social Sciences Human Research Ethics Committee, University of Tasmania. Qualitative methods guided collection and analysis of data, with the application of “grounded theory” (Meadows, Verdi, & Benjamin, 2003; Pope & May, 1995; Strauss & Corbin, 1994) as a basis for developing explanatory frameworks (Strauss & Corbin, 1994). Inquiry included closed and open ended items seeking
the views, expectations and perspectives of the different interest groups: students (pre and post placement), clinical supervisors (pre and post placement), staff (post placement), patients (post placement) and stakeholders (post placement); and the extent to which success was achieved in their terms. The data has been analysed using a standard procedure for coding and data management under separate themes representing the most salient issues. Interpretations of the data are supported by detailed reference to the data upon which those interpretations are based so that the reader is in a position to agree or disagree with the interpretation (Cane & Kilpatrick, 2007b, 2007c). The emerging themes were compared to the service and educational objectives of the clinical placement program, including “enhanced learning opportunities”, “enhanced professional experience”, “improved access to dental services”, “opportunities for the delivery of workforce education”, “building social capital” and “career opportunities” relevant to dentistry. This chapter outlines the research findings related to building social capital and enhanced learning opportunities.

Overview of Tasmanian BDS Clinical Placement Program

The focus of clinical placement is to provide students with a broad range of clinical experiences within a working environment. This gives students the opportunity to take responsibility for patient care, self reflect on their decisions and receive constructive feedback within a supervised environment. During 2005-2007 the Tasmanian dental undergraduate clinical placement program received a small number of students annually, selected from those expressing an interest from the School of Dentistry, University of Adelaide. The students provided a range of supervised comprehensive and episodic dental care as part of mainstream services at two locations, the Northern Dental Centre (NDC) Launceston and the Southern Dental Centre (SDC) Hobart. The majority of clinical time was spent diagnosing, treatment planning and providing comprehensive dental care for patients who were from the waiting list for public dental services. Students also provided services for patients presenting for episodic care, which were most likely to involve planned, simple and minor surgical extractions. Students contributed to the dental care of paediatric and special needs patients requiring treatment under general anaesthesia in sessions at the Royal Hobart Hospital and Launceston General Hospital, with supervision being provided by public sector dentists. Teleconferencing facilities at the two clinical sites were used for weekly tutorials presented by local dental specialists (oral surgeons and a periodontist). Comprehensive care patients were not screened, although some screening for patients requiring planned surgical procedures did occur. Students were given the opportunity to work with dental assistants on a one-to-one basis for all clinical sessions. Local dental practitioners (public and private sector) provided clinical supervision and attended a local training session provided by the dental school. The clinical supervisors did not undertake clinical work during rostered sessions so that full advantage of the opportunity for educational input, such as discussions on diagnosis and treatment planning and patient management, could occur. This process also enhanced the acquisition of clinical skills through student self-reflection, self-assessment, professional guidance and support. Clinical supervisor student assessments were obtained at the completion of the program. The state government fully funded all three programs, including students’ accommodation, travel
and allowances as well as funding nine undergraduate scholarships for either one or two years duration.

The students perceived that the educational experience was “better than expectations” due to the opportunity to provide dental care for a broad range of patients, with the support of efficient and accommodating dental assistants. While on placement in Tasmania, individual student productivity was similar, that is, each student treated a similar number of patients during a similar number of visits and they completed a similar number of items of treatment. In comparison, individual student productivity was more variable for the period of the year (first semester) at dental school. From the technical and administrative perspective, the clinical placement program provided an enhanced opportunity for each student to acquire knowledge and skills related to a similar range of clinical experiences in a “real world” setting. A comparison of individual student operator profiles per item of treatment recorded during the clinical placement program also indicated that students’ clinical experiences were very similar, with an appropriate mix of services. (Figure 1)

![Graph](image-url)

*Source:* Student operator profile EXACT information systems, Oral Health Services Tasmania 2005

Figure 1. Comparative individual student operator profile (items of treatment) during placement (Tasmania, 2005).

The students also perceived that the timing of the program (six weeks at the end of their undergraduate studies) was an appropriate period to consolidate their skills, gain confidence and be away from their home state. The student/supervisor relationship was described as a significant influence on the overall positive learning experience. The clinical supervisors perceived that the educational experience was “better than expectations” due to the sound administrative planning of the program, the broad range of clinical experiences, and the generally high level of patient management skills demonstrated by the students.
The Need to Build Local Social Capital

Over the last decade, dental education has been challenged to develop curricula that address the emerging science, technology and disease patterns associated with an aging and diverse population (ADEA Commission on Change and Innovation in Dental Education, 2006). Internationally, a series of curricula changes have included clinical placements as a means to: 1) redirect dental education to emphasise community health; 2) encourage experimentation with new methods and less expensive forms of dental education; 3) emphasise active learning, critical thinking, and community involvement; and 4) stimulate the development and use of community based providers in the training of dental students (DeCastro, Matheson, Panagakos, Stewart, & Feldman, 2003). This has been matched by a growing demand by dental students for clinical experiences in “real world settings” (Ayers CS) and for the increased use of community based health centres by dental schools for intrastate, interstate and, in a few cases, international placements and student exchange. In Australia, several dental schools have introduced curricula changes that encompassed extended student clinical placements as an integral part of the curriculum. The School of Dentistry, University of Queensland, placed students for the final year at public dental clinics throughout Queensland (Seymour & Walsh, 2001; Walsh & Seymour, 2001). During the final year of the curriculum at the School of Dentistry, University of Western Australia, students undertook a pre-graduation internship that included an optional placement in a rural or remote indigenous community. In the latter case, the placement program was part of a comprehensive strategy to address the shortage of rural dental practitioners in the long term (Bazen, Kruger, Dyson, & Tennant, 2007; Steele, Pacza, & Tennant, 2000).

A common objective of outreach programs is to provide experiences that lead to the development of, “a generalist more aware of and more confident and capable of requirements and the needs of society” (Weaver et al., 1997). In the United Kingdom, the Options for Change document proposed that in future, education for the whole dental team should focus on, “developing the skills needed in practice with an increased use of primary care outreach schemes throughout undergraduate training” (Department of Health, 2000). In a study to evaluate a local community based family dentistry program at the University Dental Hospital of Manchester, Blinkhorn (2002) found that most students considered extramural training developed their productivity, clinical skills, confidence and patient management skills (Blinkhorn, 2002). Educational objectives were met by providing appropriate experience of integrated restorative care, developing a holistic approach to patient care, co-ordinated treatment plans, and confidence in diagnosis and treatment planning (Blinkhorn, 2002). The authors identified the acquisition of skills occurred mostly in time management, treatment planning, integrated patient care, and the treatment of dental emergencies (Elkind, Blinkhorn, Blinkhorn, & Duxbury, 2005).

From an educational perspective, clinical placements offer an ideal opportunity to engage in experiential learning, that is, the integration of knowledge, skills derived through experience, practice and reflection, as a personal construction in which the individual imposes meaning by making connections (Maudsley & Strivens, 2000; Woronuk, Pinchbeck, & Walter, 2004). This theory underpins the educational success of clinical placements through a positive impact on self confidence, motivation, skill development, student role socialisation,
Building Social Capital

The interaction between the supervisor and the student emerged as an important factor of effective supervision. Giving students responsibility for patient care, opportunities to review patients, direction and constructive feedback that are interpretive, focused and practical are notable features of effective supervision (Kilminister, 2000; Manogue, Brown, & Foster, 2001). Irby (1995) identified four key factors that distinguish the “excellent” clinical teacher from other instructors as being “a positive role model of a competent and compassionate health care provider, provides effective supervision and mentoring for learners, employs a varied and dynamic approach to teaching, and is a supportive person” (p. 902). Communicating clear expectations of students’ behaviour and performance, providing practical and helpful “just in time” teaching (commonly known as “prompting”), engaging in discussions on rationales and techniques are other approaches that have been found to be most effective (Henzi, Davis, Jasinevicius, & Hendricson, 2006). These strategies include regular feedback on performance, personal reflection, and absence of lecture based instruction. The students on placement in Tasmania reported that these features were characteristic of the clinical supervision during the placement program.

Mills et al. conducted an extensive review of the literature, clarifying the different levels of involvement that established practitioners could take in student learning by defining the concepts of “mentoring”, “clinical supervision” and “preceptoring” for Australian rural nurses (Mills, Francis, & Bonner, 2005). The authors noted that the evolving nature of mentoring relationships are broad and encompass improved clinical practice, career progression scholarly endeavour and personal achievement.

Clinical supervisory relationships and mentoring rely on the development of a strong sense of mutual exchange and accountability over time. Preceptoring is a method of preparing students for practice using clinical staff who are not academic staff to provide clinical supervision and instruction to undergraduates within the workplace. Preceptoring staff are experienced clinicians who teach, instruct, supervise and serve as a role model as part of a formalised student program (Usher, Nolan, Reser, Owens, & Tollefsen, 1999). Mills et al. (2005) contended that positive preceptorship experiences, “can shape future career decisions and are vitally important for succession planning” (p. 7). Regardless of the approach, the placement program has emerged as a valuable building block in developing social capital in particular within public dental services.

Conclusion

Overall, the Tasmanian dental undergraduate clinical placement program is seen to be a very positive learning experience by all respondents. Internationally, there is evidence that clinical placements play an integral role in enhancing students’ clinical competence and confidence, and will play an increasing role in dental curricula. Locally, evidence is emerging
to suggest that the roles of experienced local practitioners as clinical supervisors, as well as the range of experiences in patient care and provision of support by dental assistants, are likely to be important factors in the success of the program and contribute to the development of social capital within dental services. A number of issues require further investigation, including the extension of supervisory roles into mentoring roles for new graduate dentists with the provision of appropriate training and administrative support, and increasing the opportunities for local clinical supervisors to interact with dental academic staff. In this way, local practitioners are given the opportunity to enhance lifelong learning opportunities while engaged in active practice, and to maximise the rewards for their commitment, especially when the clinical placement takes place in the rural setting.

Acknowledgments

The study outlined in this chapter received support from Associate Professor Sue Kilpatrick, University Department of Rural Health, University of Tasmania, who was the co-author of a number of Reports. The author would also like to acknowledge the cooperation and contributions made by Oral Health Services Tasmania staff and the students participating in the Tasmanian clinical placement program 2005-2007.

References


Abstract

We examine longevity promoting factors from a variety of cross-cultural evidence and conclude that modern occupational environments must be reassessed to promote health in a manner that reduces individualistic values and approaches. An identified occupation that promotes longevity is traditional farming, as it incorporates many lifestyle and social factors that are health-promoting. Longevity and health promoting lifestyles and values associated with traditional farming are examined and provide the foundation for our recommendations to improve modern occupational work environments. We argue that although the universal adoption of farming roles is unrealistic, many of its occupational benefits may be adopted in modern workplaces, and consequently may improve the health of many people.

Keywords: longevity, occupation, diet, exercise, social cohesion, purpose, optimism, health.

Introduction

This chapter reviews existing literature identifying risk and protective factors related to longevity. We identify lifestyle, psychological, social, and occupational factors that contribute to good health and longevity. In the course of this analysis we identify one occupation, traditional farming, that appears to incorporate many protective factors, and is predictive across cultures of exceptional longevity. We then contrast the lifestyles of traditional farmers with occupational environments characteristic of modern western society. We conclude by making recommendations on ways in which modern western lifestyles should change given this analysis.
Characteristics of Longevity-Promoting Environments

Longevity is not evenly distributed throughout the world. Buettner (2008) identified four regions, “Blue Zones,” which enjoy exceptionally high rates of longevity: Okinawa, Japan; Sardinia, Italy; Loma Linda, California (members of the Seventh-Day Adventist Church); and the Nicoya Peninsula in Costa Rica. According to Buettner (2008), these regions house the world’s highest proportion of centenarians, mostly as a result of common lifestyle practices. Despite large geographic and cultural variations between these populations, universal commonalities were observed in their shared values placed on the importance of family, physical exercise, social engagement, tobacco avoidance, and plant-based diets. Other lifestyle characteristics were not universally present across Blue Zones. These include regular alcohol consumption, no time urgency, empowered women (observed both in Sardinian and Okinawan societies), and exposure to sunshine.

Many longevity characteristics noted by Buettner have been identified as health- or longevity-promoting in the research literature. However, in contrast to Buettner’s holistic view of the interconnectedness of his discussed longevity factors, until quite recently, and for apparent practical research purposes, longevity-promoting factors have largely been studied in isolation.

In this chapter, we review evidence for factors contributing to longevity and good health. These factors fall into four broad categories: lifestyle factors (physical activity, diet, productive activities), psychological factors (a sense of life purpose, personal control, optimism, spirituality and religion), social factors (social support, social cohesion, marriage) and occupational factors (work control, occupational stability, productive output and work environment). For each factor, we describe evidence regarding the factor and longevity in the Blue Zones. These data are based on observations and interviews with centenarians conducted by Dan Buettner and colleagues, large-scale studies of Blue Zone centenarians, or large-scale studies of Blue Zone residents. We then review other research examining the roles of these factors in promoting longevity, drawing primarily on large-scale research, particularly research using a prospective cohort design.

We argue that the identified factors associated with health and longevity are interconnected in various ways. Consequently, a holistic view of longevity-promoting lifestyles, including a reassessment of workplace environments, is required to reduce mortality rates in modern western society. Traditional farming practices and lifestyles are used as a longevity-promoting model from which we make our recommendations for modern occupational environmental modifications.

Lifestyle Factors

A consistent lifestyle factor across Buettner’s reports of Blue Zone centenarians is physical activity. For example, Sardinian shepherds walk at least 5 miles each day and Nicoyan centenarians have generally engaged in physical work all their lives (Buettner, 2008). In addition, the Adventist Health Survey found that moderate intensity physical activity was associated with longer lives (Buettner, 2008). Looking beyond the Blue Zones, a
A vast amount of research evidence supports the role of physical activity in longevity. For example, a longitudinal study of Swedish women found that a moderate level of physical activity (4 or more hours per week) predicted a reduced risk of all-cause mortality (Lissner, Bengtsson, Bjorkelund, & Wedel, 1996). A lack of physical activity has also been associated with specific diseases. For example, physical inactivity is a risk factor for heart attacks (American Heart Association, 2010) and stroke. For example, a prospective study of female nurses found that more physical activity (such as moderately brisk walking) is associated with a reduced risk of ischemic stroke (Hu et al., 2000). Women who were consistently physically active over a span of 7 years had less than half the risk for an ischemic stroke of women who were consistently sedentary (Hu et al., 2000). Physical activity is also associated with a reduced risk of other age-related diseases, such as cancer, diabetes mellitus, and osteoporosis (Warburton, Nicol, & Bredin, 2006).

Regular exercise offers health benefits via a number of mechanisms, including weight control, improved cholesterol levels, decreased blood pressure, and improved psychological well-being (see Warburton et al., 2006, for a review). Research also indicates that regular exercise promotes longevity at a genetic level. As cells divide, telomeres (DNA sequences on the ends of chromosomes) become shorter; evidence suggests that shortening of telomeres in certain cells contributes to aging (see Aubert & Landstorp, 2008 for a review). Exercise seems to preserve telomeres. For example, a study of endurance athletes found that whereas telomeres were shorter in older compared to younger sedentary adults, there was no difference in telomere length between older and younger endurance athletes (LaRocca, Seals, & Pierce, 2010). Furthermore, chronic stress is associated with shorter telomere length (Epel et al., 2004), but regular exercise attenuates this effect (Puterman et al., 2010), suggesting one mechanism by which exercise mitigates the negative health effects of stress.

Diet also plays a role in longevity. Buettner (2008) found that the traditional diet across the Blue Zones, and followed by centenarians, was a plant-based diet. These diets emphasized vegetables, whole grains, and legumes; meat was eaten rarely. The centenarians also consistently ate in moderation; indeed, in Okinawan culture there is a saying “Eat until you are 80 percent full” (p. 83). There was some variation within the diets followed by the centenarians. For example, nuts were consumed regularly by the Adventists of California and red wine was consumed regularly in Sardinia.

In research beyond the Blue Zones, considerable attention has been focused on the Mediterranean diet, which consists of vegetables, fruits, legumes, cereals, fish, nuts, moderate amounts of red wine, a high ratio of monounsaturated to saturated fats, but little meat and dairy (Trichopoulou, Bamia, & Trichopoulos, 2009). The Blue Zone diets are very similar to the Mediterranean diet (see Willcox, Willcox, Todoriki, & Suzuki, 2009), for an analysis of the traditional Okinawan diet and comparison to the Mediterranean diet). A recent meta-analysis of prospective studies revealed that following the Mediterranean diet is associated with significant reductions in all-cause mortality, death due to cardiovascular disease, death due to cancer, and a reduced risk of Parkinson’s and Alzheimer’s diseases (Sofi, Cesari, Abbate, Gensini, & Casini, 2008). In a prospective study of Greek men and women Trichopoulou et al. (2009) analyzed the role of individual components of the Mediterranean diet in reduced mortality and found that the following components contributed: moderate consumption of wine; low consumption of meat; and high consumption of vegetables, fruits, nuts, and legumes; and a high ratio of monounsaturated to saturated fats. High cereal consumption and low dairy consumption made a minimal contribution to reduced mortality.
Research beyond the Blue Zones has also confirmed the value of eating in moderation. A recent literature review concluded that there is preliminary evidence that calorie restriction by adult men and women, with adequate intake of nutrients, reduces risk factors for diabetes and cardiovascular disease, and possibly for cancer (Fontana & Klein, 2007). However, the authors caution that, a) the optimal calorie intake has not been determined, and b) calorie restriction can be harmful to some people (e.g., lean people).

A final lifestyle factor that contributes to longevity is engaging in productive activities. The Blue Zone centenarians interviewed by Buettner describe productive lives, in the past and even (in many cases) in the present. These individuals were farmers and shepherds (raising and harvesting plants and animals for food), caring for children, helping their community, etc. (Buettner, 2008). Willcox, Willcox, Sokolovsky, & Sakihara (2007) describe the important role of basho-fu weaving in the lives of elderly women in Kijaha, Okinawa. Basho-fu weaving produces a fine fabric which was traditionally used for local kimonos. During the 20th century it has been used to produce a variety of products and has been recognized as an important intangible cultural property by the Japanese government. Basho-fu weaving provides the elderly women of Kijaha with the respect of their community, gives them a sense of meaning (ikigai or reason for living), keeps them socially engaged, is part of the rhythm of their daily lives, and provides financial income (Willcox et al., 2007).

In the first study to examine the role of productive activities (as distinct from physical and social activities) in reducing mortality in the elderly, Glass, De Leon, Marottoli, and Berkman (1999) found that engaging in productive activities was associated with reduced mortality over a 13 year period in a sample of older Americans. Indeed, engaging in productive activities provided as much protection as social and fitness activities. The productive activities measured were gardening, preparing meals, shopping, unpaid community work, paid community work, and other paid employment. Other research shows that self-perceptions of usefulness are related to longevity - Gruenewald et al. (2009) found that older Americans were at increased risk of mortality if they had either consistently low or declining feelings of usefulness over a three year period.

Thus, various activities and behaviours of individuals are predictive of good health and longevity. In the next section we examine longevity-related factors that are internal to the person.

Psychological Factors

A number of psychological factors are associated with better health and longevity. The first of these psychological factors, having a sense of purpose in one’s life, is closely related to engaging in productive activities, described above. The importance of a sense of purpose has been identified across several Blue Zones. In Okinawan culture for example, roles are very important and suddenly losing one’s role is associated with decline and death (Buettner, 2008). Similarly, in the Nicoya Peninsula in Costa Rica, highly functioning elderly feel needed (e.g. to care for their family) and if they no longer feel needed then they are at increased risk of death (Buettner, 2008). Finally, members of the Seventh Day Adventist Church in Loma Linda, California are encouraged to volunteer, providing them a sense of purpose (Buettner, 2008). Looking beyond the Blue Zones, a three year longitudinal study of older Americans revealed that people who scored above the 90th percentile in terms of having
a sense of purpose were at significantly reduced risk of all-cause mortality relative to people who scored below the 10th percentile (Boyle, Barnes, Buchman, & Bennett, 2009). Thus, longevity is related both to feeling that one’s life and activities have a purpose and to engaging in activities that produce something of use.

A second psychological factor which impacts longevity is having a sense of personal control over life events (also called mastery or self-efficacy). Although a sense of personal control was not explicitly articulated by the Blue Zone centenarians interviewed by Buettner (2008) it is implicit in many aspects of their lives, including their self-sufficiency (e.g., through farming), and their industriousness (they were often energetic and still completed many tasks on a daily basis), and sense of purpose (discussed above). Research beyond the Blue Zones supports a link between a sense of personal control over life events and longevity. A longitudinal study of British adults aged 41 to 80 years found that a high sense of personal control was associated with less all-cause mortality, cardiovascular disease, and cancer (Surtees, Wainwright, Luben, Khaw, & Day, 2006). A low sense of personal control is associated with more illness and less self-initiated preventive care (Seeman & Seeman, 1983). High personal control predicts the use of problem-centered coping, seeking social support (Florian, Mikulincer, & Taubman, 1995) and maintaining physical mobility (Milaneschi et al., 2009). A third psychological factor is optimism. Optimism is the expectation that good things will happen (Rasmussen, Scheier, & Greenhouse, 2009). The centenarians whom Buettner met in the Blue Zones were almost uniformly positive. For example, after meeting a number of Nicoyan centenarians, Elizabeth Lopez, the team psychologist said, “... these people are incredible! They are so positive” (Buettner, 2008, p. 205), or, as Buettner put it, “There wasn’t a grump in the bunch” (p. 259). Optimism predicts longevity (Fry & Debats, 2009). A longitudinal study found that optimism predicted lower mortality and better self-reported physical and mental health 30 years later (Maruta, Colligan, Malinchoc, & Offord, 2000; 2002). Optimism also mitigates perceived stress (Smith, Young, & Lee, 2004).

A final psychological factor is spirituality and religion. Buettner (2008) found that most of the Blue Zone centenarians believed in a higher power. While other researchers have noted positive correlations between individuals’ beliefs in some omnipotent higher force and longevity (see Powell et al., 2003; Riley et al., 1998), research conducted by Klemmack et al. (2007) has more recently revealed a complex relationship between religiosity and longevity. In their study, they compared heavily practising, church-attending participants with those who considered themselves to be moderately and low practising church-attending religious participants. The findings suggested that heavily-practising churchgoers were significantly healthier than moderately and privately religious/spiritual individuals. These results suggest some inherently positive health benefits in strongly religious, practising churchgoers. It appears as though both belief and shared community values have beneficial effects on health. Therefore, the value of community cohesion and sharing of beliefs as well as rituals is underscored. In his book entitled, Religion and Mental Health, Schumaker (1992) argues that the psychological benefits of religion are essentially connected to the ritualistic benefits of worship insofar as religious practices provide cognitive structures that provide answers to universal existential questions that inherently produce anxiety. He argues that the provision of meaning and purpose that is offered by religion helps to reduce existential anxiety and consequently enhances emotional well-being. He further proposes that in addition to providing meaning to one’s life, and the comfort offered through the formation of a relationship with an omnipotent force, organized forms of religion also offer members more
community-oriented psychological health benefits. These include a sense of belongingness and a social identity that is achieved through shared beliefs and communal rituals. In the context of modern society, Schumaker (2001) argues that private religious practices have become increasingly common, replacing more traditional forms of communal worship. Private religious practices, he claims, undertaken in an individualistic context in which beliefs are tailored to fit individual desires, offer fewer benefits than traditional forms of practise. Schumaker claims that individualistic religious practices undermine religion’s classic task of constructing shared forms of meaning within a social setting that lead to social connectedness. In turn, he argues that self-centred forms of worship lead to spiritual restlessness that ultimately limits the social and psychological protective value offered by shared universal truths. The framework described by Schumaker, within the context of health and longevity, would support the notion that individuals benefit most from religious and spiritual practices that are undertaken communally. Thus, the beneficial elements of spirituality and religion seem to flow from the spiritual beliefs, the practice of ritual, and the social community. In the next section we expand on the importance of social factors in promoting health and longevity.

Social Factors – Social Cohesion, Marriage and Community

A growing body of literature has revealed a positive correlation between marriage and longevity (Hu & Goldman, 1990; Rahman, 1993). In fact, it has been suggested that marriage appears to have a significantly stronger predictive value on longevity than socioeconomic status (Gardner & Oswald, 2004). Explanations for the health benefits of marriage are diverse, and may be explained by tangible forms of spousal assistance, including seeking medical assistance when required. Perhaps the most plausible explanation for the health promoting effects of marriage relies on both emotional and practical support provided by spouses. It has been suggested that marriage reduces stress and stress-related illnesses, may increase material well-being, and encourage healthy behaviours and discourage unhealthy ones. Interestingly, marriage is also more predictive of longevity in men than in women (Felder, 2006). This finding may be explained by men’s relatively stronger reliance on their female counterparts to provide them with both care and social interaction.

Protective effects of marriage on health have been observed in broader analyses of social support and social cohesion, and health and longevity. In a study examining quality of life among centenarians, Dello Buono et al. (1998) found that centenarians reported greater satisfaction with their family and social relationships than their younger counterparts. Centenarians in the study had lower rates of both anxiety and depression, and reported fewer health complaints. Berardo (1985) further observed that in her interviews with centenarians, they universally described strong efforts in establishing and maintaining social ties throughout their lives. Additionally, in their interviews with 24 centenarians, Konch, Power, and Kralich (2007) noted the consistent feature of a strong sense of extensive family cohesion as well as frequent contact with loved ones.

When examining longevity and health within the context of modern western society, we must consider how modern lives accommodate or minimize our ability to adopt longevity-promoting lives. In his book entitled Globalization: The human consequences, Bauman’s (1997) analysis of human relationships paints a rather grim picture. He argues that consumer culture and technology have interfered with our ability to form meaningful, solid relationships
as a result of modern value systems hinged on self-centered objectives achieved through competitive means. He suggests that in modern society, the act of consuming has more appeal than relationship formation. Consequently, Bauman suggests that people living in modern society are perpetually engaged in cycles of searching but not finding. Given the importance of family and social cohesion in the promotion of health and longevity, we must reconsider modern value systems and perhaps reassess the importance of accommodating, fostering and sustaining lifelong social connections.

**Occupational Factors**

Given the amount of waking time adults spend in the workplace, it is not surprising that occupational factors are associated with longevity. Job control, for example, influences health. Low control over one’s work is associated with poorer current and future physical health (Wickrama, Lorenz, Fang, Abraham, & Elder, 2005; Wickrama, Surjadi, Lorenz, & Elder, 2008). Level of control over one’s work also affect’s one’s sense of personal control (Wickrama et al., 2008). Research has confirmed also that individuals who pursued a single career path throughout their adult lives are at a health advantage compared with those whose occupational lives have been marked by significant changes in focus (see Moore & Hayward, 1990). Pavalko et al. (1993) also found that individuals who pursued one single career path throughout their adult lives had lower mortality than those whose occupational lives were marked by a series of unrelated jobs. This observation may be a consequence of increased socioeconomic status achieved by those who follow career paths marked by intermittent promotions and increases in salary and stature as socioeconomic status has been found to be positively correlated with longevity (Robert & House, 2000; Williams, 1990). Furthermore, exceptional longevity is also observed among those who rate low on the occupational status scale. In a study examining work and educational characteristics of centenarians in China, Zhenglian et al. (1997) found that the majority of centenarians had very low levels of education (71% of male and 93% of females). Most men were employed in various forms of manual labour, including farming, while the majority of women’s work roles were domestically defined. Other centenarian studies have observed disproportionately high levels of farmers among the oldest of the old (see Gavrilova & Gavrilov, 2007), once again, despite low levels of education and socioeconomic status (Wilkinson, 1996). An interesting occupational feature among the oldest of the old is a profile of industriousness coupled with creativity and output. Both traditional farmers and craftsmen enjoy exceptional longevity (Gavrilova & Gavrilov, 2007), perhaps partially explained by the results borne of the fruits of their labour.

**Traditional Farming Protective Characteristics**

There are a number of reasons why traditional farming is associated with greater longevity. The principal reason, we argue, is that traditional farming incorporates many factors which have been proven to promote good health and wellbeing. Traditional farming is a productive activity - the farmer raises crops and animals, caring for them on a daily basis,
and ultimately harvesting the food which nourishes the farmer and the farmer’s family, friends, and community. Thus, the farmer produces something tangible and life sustaining, which benefits people with whom the farmer has relationships. Therefore, the farmer is likely valued for this produce, in a similar way to the bashu fo weavers of Okinawa. Caring for animals and crops, and thereby nourishing family, friends, and community is a powerful source of sense of purpose for farmers. For example, Tonino (a Sardinian shepherd interviewed by Buettner, conveys the feeling of purpose and productivity which he receives from farming:

“I love my animals and taking care of them... without the animals and the work it takes to raise them... I would have little purpose in life... I like it when my kids come home and they find something that I have produced” (Buettner, 2008, p. 51).

The nurturing aspect of traditional farming, its tangible output (food), and the farmer’s resulting ability to nourish him/herself and the community also enhance the farmer’s sense of personal control. In addition, a farmer has considerable control over his/her work conditions. Although the weather, season, soil conditions, and other factors dictate some aspects of a farmer’s work, fundamentally the farmer has a lot of control over his/her daily work life (e.g., setting priorities, work hours, etc).

Traditional farming also provides access to vegetables (Buettner, 2008), a key element of a longevity promoting diet. Food grown on the farm will also be extremely fresh (at least during some of the year) and minimally processed, enhancing its nutritional value. There is some evidence that access to a garden in an urban setting is associated with increased consumption of fruits and vegetables. For example, a random phone survey of city residents revealed that if one member of a household is involved in a community garden, then other members of the household consume more fruits and vegetables than do members households with no community gardener (Alaimo, Packnett, Miles, & Kruger, 2008; note, however, that causation cannot be inferred from this study). Other research indicates that children who are exposed to gardens through garden-based nutrition programs at school or in the community consume more vegetables and fruits (for a review, see Robinson-O’Brien, Story, & Heim, 2009).

Traditional farming requires daily physical activity, a key longevity-promoting lifestyle factor. Activity is an integral component of farming life, as the farmer plants, weeds, harvests fields, and cares for livestock. Buettner (2008) has also pointed out that it requires a certain range of motion; this is important as it can help to maintain mobility and flexibility.

In their extensive interviews with centenarians, Konch et al. (2007) found that characteristics common among all centenarians included leading a simple life, working hard, eating well, and maintaining a sense of humour.

**Conclusion**

It is not possible for everyone to be a traditional farmer. However, the longevity promoting features of this occupation can be adapted to other occupations and workplaces. We suggest that our efforts will be best put to use by promoting health and longevity through
the adoption of community psychological frameworks and preventive strategies by fostering participatory involvement of employees within the workplace, and by increasing collaborative versus competitive environments, which ultimately increases commitment to the workplace through the creation of meaning and purpose (Moritsugu, Wong, & Grover-Duffy, 2010). We conclude by offering recommendations to employers that could benefit the health and longevity of employees:

1) Employers should facilitate employees’ sense of purpose in their jobs and their own productivity. For example, employers could communicate regularly to employees how employees’ individual efforts contribute to the wellbeing of others within the company or beyond. That is, employees should feel that they and their work are valued and respected by their employer and their community. Employers could also forge relationships between employees and those who benefit from their work (either within the company or in the larger community); these personal relationships would help employees understand the value of their work and feel productive. Employers could also enhance a sense of purpose by arranging employment so that individuals contribute to the development of products from start to finish to emulate the nurturing and harvesting elements of traditional farming. This stands in contrast to the assembly line approach, in which a worker makes only one part of a product, day in and day out. Finally, employers could enhance employees’ sense of purpose and productivity by, where possible, conceptualizing and organizing employees’ work so that they perceive their efforts as producing tangible, practical outputs.

2) Employers should enhance employees’ sense of control regarding their work. That is, employees should have opportunities to make decisions about their work and develop their skills (Karasek & Theorell, 1990). For example, employers could enhance employees’ sense of work control by matching employees with jobs that match their interests and skills. A match between employee interests and skills would also enhance employees’ ability to derive a sense of meaning from their work and pride in their work accomplishments. Possible ways to achieve a good employee-position match include vocational counselling (e.g. interest inventories) and permitting employees to move among positions within the company, so that if an employee discovers that his/her position is not a good match, then the employee can move to another position. Finally, employers could provide employees with a level of independence that matches employees’ preferences and abilities, including flexibility in their work schedule.

3) Employers should facilitate employees’ sense of personal control, both at work and beyond. This can be done indirectly by enhancing employees’ sense of work control (Wickrama et al., 2008) and directly by educating employees about factors that contribute to effective problem-solving and a sense of self-efficacy. Furthermore, fostering a sense of ownership in the workplace/institution will lead to heightened personal control, and a sense of commitment to, and sense of purpose, within the workplace.

4) Employers should try to enhance employees’ sense of optimism. For example, they can promote a positive attitude in the workplace. In addition, when a company faces economic or other difficulties, the employer can help employees
believe that things will improve in the future by communicating the company’s plan to address problems. A sense of personal control contributes to an optimistic outlook; therefore employers can enhance optimism via techniques to improve employees’ perceptions of personal and work control.

5) Employment environments may be ameliorated by fostering collegial relationships and discouraging competitive relations among employees. Performance evaluations should be minimized or preferably eliminated as they foster stress among employees and promote the need for employees to hide deficiencies, rather than to improve weaknesses.

6) Employers should facilitate employees engaging in physical activity on a daily basis. Some employees may be able to achieve this through their work, but in our information-driven society many employees need to achieve it outside work. There are many ways in which an employer could facilitate physical activities in their employees. Some examples are: provide fitness facilities on site, provide memberships at local fitness facilities as a work benefit, provide work schedules which make it possible for employees to engage in physical activity (e.g. “lunch” breaks which are long enough for both a physical workout and lunch) and provide an adequate salary so that employees can pay for fitness-related needs (e.g. sports equipment, gym membership). People are more likely to stay involved in physical activities they enjoy, so it is important individuals have both time and money to enable them to engage in a physical activity that suits them. At a societal level, we should be encouraging physical fitness, for example by building fitness facilities in accessible locations (near work or home) and by making physical activities affordable (e.g. in Canada, a proposed tax credit would enable individuals to recoup some costs associated with physical activities).

7) From a lifestyle perspective, given that individuals spend a good portion of their waking hours at work, it would be hugely beneficial for employees to have easy access to healthy food choices while at work, such as Mediterranean diet options. Minimizing “fast food” options would lead to better food choices both in and outside the work environment. Employers should also facilitate employees providing healthy food for themselves outside work, for example by avoiding excessive work hours (so that employees have time to prepare healthy meals) and by providing an adequate salary, so that healthy food options are affordable.

8) Employers and governments should educate people regarding factors that contribute to longevity.

Author Contributions

The authors contributed equally to this manuscript.
References


In Praise of Meaning: Occupational Predictors of Longevity


Chapter X

Social Determinants of Overweight and Obesity

Quynh Lê, Cecilia Chiu and Au Bich Thuy

Abstract

Though genetics plays a part in an individual’s obesity problem, environmental and social factors are the main causes of obesity. Insights gained from research on the links between these factors and the prevalence of obesity are very useful for developing intervention and treatment policies and programs. Two focuses emerged: childhood obesity and inequality in area-level socioeconomic status (SES). Prevalence of obesity is particularly high in low SES neighborhood, compared to high SES areas. Childhood obesity has a strong relationship with the decline in physical activities. Comprehensive strategies and concerted efforts involving individuals, parents, schools, communities, health professionals and various levels of governments are required to effectively manage the obesity epidemic.

Keywords: obesity, overweight, BMI, socioeconomic status, health behaviors, intervention, treatment.

Introduction

Obesity is a serious threat to population health. It affects every population in the world and the real danger is that, unlike other health-related problems, it cannot be clearly recognized and therefore cannot be eradicated by clinically-based intervention and treatment (Chu, 2005; Colagiuri et al., 2010; Flegal, Carroll, Ogden, & Curtin, 2010; OECD, 2010). The latest trends as will be discussed in this chapter indicate that this health issue does not only affect a certain portion of the population such as the elderly but is also spreading to the younger age groups. Growing phenomenon of childhood obesity has prompted considerable research and review on effective prevention and intervention measures.
Obesity is a condition of excess body fat that results from a sustained energy imbalance. Generally, escalating rates of obesity can be attributed to both a rise in energy intake and a decline in physical and incidental activity (Catford & Caterson, 2003). The Body Mass Index (BMI) is an internationally recognized standard for classifying overweight and obesity in adults. According to the World Health Organization (WHO, 1998), BMI is calculated by dividing the weight in kilograms by the square of the height in metres. Based on WHO (Sarlio Lahteenkorva, Lissau, & Lahelma, 2005) and the Australian Institute of Health and Welfare (AIHW, 2004a) BMI classifications, four groups are identified:

- Underweight (BMI <18.5 kg/m²),
- Normal weight (18.5 kg/m² ≤ BMI ≤ 24.9 kg/m²),
- Pre-obese or moderate overweight (25 kg/m² ≤ BMI ≤ 29.9 kg/m²), and
- Obese (BMI ≥ 30 kg/m²).

The Global and Local Context

According to WHO (2003), globally over 1 billion adults had a body weight higher than optimal, among which 300 million were clinically obese in 2003. In addition, it was estimated that about 17.6 million children under five year old worldwide were overweight. In certain countries, such as the US, there has been a dramatic increase in child and adolescence obesity since the 1960s. The obesity pandemic, according to the WHO, originated and emerged as a health issue in the US and crossed to Europe and the world's other rich nations, and then, remarkably, it penetrated even the world's poorest countries especially in their urban areas (Prentice, 2006). For example, in urban Samoa, more than 75% of the population are obese, while in some cities in China which has a relatively low prevalence of obesity nationwide, the rates could be as high as 20% (WHO, 2003).

Obesity has increased dramatically in the past three to four decades in the United States. In 2008, 68% of the adult population (aged over 20 years) in the US were overweight, of which 34% were obese (Flegal, et al., 2010). In 2008, about 17% of children and adolescents aged 2 to 19 years were obese, compared to only 5% in the early 1970s (Ogden & Carroll, 2010).

Even for countries or regions which are considered as “lean”, obesity is becoming more of a concern. In Taiwan, in the period from 1994 to 1996, there were 10.9% and 13.8% of children aged 12 to 15 years classified as overweight and obese respectively (Chu, 2005). In 2001, 24.1% and 17.2% respectively of male and female adults (aged 20 years and over) were overweight, and on top of that 33.1% and 24.1% were obese according to the WHO-Asian’s criteria (Chu, 2005). In a survey conducted in China in 2002, it was estimated that about 30% of China’s adult population (aged 18 years and over) were overweight and obese (Wu, 2006). However, there was an alarming 28 times increase in overweight and obesity in children aged 7 to 18 years between 1985 and 2000 (Wu, 2006).

According to the Australian Institute of Health and Welfare (AIHW, 2005), in 2001 there were 2.4 million (16%) Australians over 18 years who were obese and a further 4.9 million (34%) were overweight. From 1980 to 1999-2000, for people aged 25 to 64 years, the
proportion of overweight women increased from 27% to 47%, and the proportion of overweight men increased from 47% to 66%.

While the AIHW (2003b) suggests it is difficult to find directly comparable international data, the following can be noted. Among the Organization for Economic Co-operation and Development (OECD) countries, the measured obesity population in Australia ranked fourth between 2005 and 2007 behind the US, Mexico and New Zealand (OECD, 2010).

It is difficult to estimate the costs of obesity to society as it is often understated due to the facts that indirect costs and costs outside the formal health care system (such as weight loss services) are not included in the cost analysis. The analysis also does not include all obesity related conditions. It was estimated that the direct cost of obesity in Australia was A$464 million in 1980-90, which was equivalent to about 2% of the total health care costs (DoHA, 2009). On top of this, more than A$772 million was estimated to have been lost as indirect costs and consumer costs (DoHA, 2009). In 2005, the total direct costs due to overweight and obesity soared to a staggering A$21 billion (Colagiuri, et al., 2010). Given the magnitude of the costs and the economic burden, Australian society should have a financial incentive to tackle this grim health issue.

Obesity Related Health Problems and Diseases

Concerns over obesity are not confined to body weight. Research has long established a link between obesity and major non-communicable diseases. Literature commonly relates obesity with increased risks of high blood pressure, cardiovascular disease, stroke, type 2 diabetes, gallbladder disease, osteoarthritis, and some forms of cancer (Heart Foundation, 2004; Manson, Skerrett, & Willett, 2002). These conditions result in increased morbidity and mortality and thus decreased life expectancy (Choi, Hunter; McNeil & Segal, 1999).

The health risks associated with overweight and obesity have been well documented. Even a 15 lbs weight gain increases a person's risk of diabetes by 50%. In turn, losing as little as 11 lbs can reduce a person's risk of diabetes by the same percentage (Daniels, 2006). In a study by Park et al. (2006) in Korea, the cardiovascular risk factors and mortality associated with greater BMI were higher among the younger than the older non-smoking Korean men. Younger men (aged under 40 years) with greater BMI (≥ 28 kg/m²) were at a greater risk of high blood pressure, high blood glucose, and high total cholesterol than older men. The relative risks for mortality from stroke and from all cardiovascular diseases associated with greater BMI were also higher among younger men and declined linearly with age (Park, et al., 2006).

In children, obesity is associated with short and long-term health consequences, including diabetes, elevated blood pressure, the development of cardiovascular risk factors, and orthopaedic disorders. The most significant long-term consequence of childhood obesity is its persistence into adulthood, along with the numerous associated health risks (WHO, 1998).

For both adults and children, obesity has powerful social and psychological effects, including low self-esteem, depression, fatigue, issues with physical appearance and social acceptance, as well as other psychological problems (DoHA, 2009).
The Socio-Demographic Aspects of Obesity

Increasing rates of obesity across the social and demographic landscape do not translate into equal risk of all groups (Wardle, Waller, & Jarvis, 2002; Xu et al., 2005; Zhang & Youfa, 2004). Comparisons between male/female prevalence of obesity, due to age and cross cultural factors, are context specific. The generalization is that men may have higher rates of overweight and women have higher rates of obesity (Sobal & Stunkard, 1989; WHO, 1998). Robert and Reither (2004) show that 30% of white women, 40% of Hispanic women, and 50% of black women in the US were obese in 1999–2000 but only 28% of white, Hispanic, and black men were obese during the same period. In a cross-sectional survey of representative national samples of Estonia, Finland and Lithuania, self-reported obesity among men and women was 10% and 15% in Estonia, 11% and 10% in Finland, and 10% and 18% in Lithuania respectively (Klumbiene, Petkeviciene, Helasoja, Prattala, & Kasmel, 2004). The results of these studies all fall in line with the generalization.

Research in the areas of gender, age, ethnicity and obesity shows an international consensus of concern and priority in focusing attention on childhood obesity and intervention (Dollman & Pilgrim, 2005; Widhalm & Fussenegger, 2005).

In the Australian context, Australia follows the global trend of having an increasing proportion of its population being overweight or obese. The rate, estimated at 60%, more than doubled from 1980 to 2003 (Cameron et al., 2003). A similar trend was observed among the younger population. In the period from 1985 to 1997, the proportion of children and adolescence being overweight or obese doubled (Booth et al., 2003). The National Health Survey 2007-2008 data shows that 25% of children aged 5 to 17 years were overweight or obese (ABS, 2009).

Social Determinants

Social determinants of overweight and obesity can be broadly categorized into three areas: socioeconomics, environment and behavior.

Socioeconomic Factors

Socioeconomic factors concern mostly with education, income and occupation and a composite index can be calculated based on these values. Literature supports that disadvantage is associated with low socioeconomic status (SES) (O'Dea, 2003). A study by Manios et al. (2005) evaluated the association of overweight and obesity with SES, in a population based sample of Greek adults. The study shows that overweight and obesity seems to be a serious health problem, affecting more prominently people with lower SES. A study by Cecil et al. (2005) confirms the continued increase in childhood obesity in the UK and reveals a role for height-growth limitation in the absence of overall growth restriction, among children from low-income groups. Evidence from studies on socioeconomic status and health in Australia is unequivocal: those who occupy positions at lower levels of the socioeconomic
hierarchy fare significantly worse in terms of health (Dollman & Pilgrim, 2005; Kavanagh, 2006; King, Kavanagh, Jolley, Turrell, & Crawford, 2005).

A group of research looks beyond the demographic aspects of the socioeconomic factors and incorporates a spatial element in their studies. Ecological studies have demonstrated that BMI is higher with increasing levels of area disadvantage (Goodman et al., 2003; Kavanagh, Goller, King, Jolley, Crawford, Ball, et al., 2005). King et al. (2005) conducted a multilevel cross-sectional survey of area-level social disadvantage and overweight/obesity and found that area disadvantage is an important predictor of adult BMI. Malmstrom et al. (1999) conducted a study on neighborhood environment and self-reported health status and concluded that neighborhood socioeconomic environment has an impact on self-reported poor health. Sundquist et al. (1999) examined whether the neighborhood environment would influence intermediate cardiovascular disease (CVD) risk factors, such as obesity and lifestyle factors. The multilevel study shows that respondents living in the most deprived neighborhoods have an increased risk for being a daily smoker, engaging in no physical activity and being obese when adjusted for the individual SES. Many researchers such as Morland et al. (2001) and King (2005) argue that area rather than individual socioeconomic status could be a more important factor contributing to the prevalence of obesity and overweight in particular segments of the population.

In an Australian multilevel study of physical activity participation, consistent with international evidence, Kavanagh et al. (2005) find that residing in socioeconomically disadvantaged areas affects the overall levels of physical activity participation. The NSW Health Department Survey 2004 (Lawson, 2005) also highlights the correlation between wealth and weight, drawing attention to rural and regional areas, where the regional areas account for the top four areas with highest ratio of obese and overweight patients. Availability of fresh fruit and food and the abundance of food outlets in lower socioeconomic areas accounted for 68% of the increase in obesity levels. This study is further supported by findings relating the number of fast food outlets in low socioeconomic areas to the prevalence of obesity (AIHW, 2004b; Turrell, Blakely, Patterson, & Oldenburg, 2004).

A major study using multilevel modelling involving 4913 men and women across Melbourne’s high, medium and low income areas has found significant variations in BMI and physical activity rates between areas (Kavanagh, Goller, King, Jolley, Crawford, & Turrell, 2005). Although the link between low socio-economic status (SES) and high rates of overweight and obesity is well known, this study is one of the largest in Australia to pinpoint the importance of local area as an influence on body weight and physical activities.

Area disadvantage also has a negative impact on childhood overweight and obesity. Veugelers and Fitzgerald’s (2005) multilevel study in the US about the significance of area-level social factors on overweight and obesity reveals that children in high-income neighborhoods are half as likely to be obese as their peers living in low-income neighborhoods. According to a study by Oliver and Hayes (2005), the prevalence of child and youth overweight in Canada is inversely and statistically significantly related to neighborhood SES. Independent effects indicate that neighborhood characteristics directly influence the odds of being overweight.
Environmental Factors

Area-level socioeconomic factors, as have been discussed above, to a large extent are parts of the general environmental factors. Many low SES areas have poor town design and there might be a need for more police attention (Kavanagh, 2006). The NSW Health Department Survey 2004 (Lawson, 2005) also indicates that low SES neighborhoods have more fast food outlet. The Victorian Lifestyle and Neighbourhood Environment Study (Kavanagh, Thornton, Tattam, & Turrell, 2007) examined the socioeconomic environmental factors on health behaviors. The findings reveal that residents living in disadvantaged areas have poorer health and participate in less physical activities. They are also more likely to purchase take away fast food. People living in low SES areas also face more barriers to leading a healthier and more active life, such as lack of support in care of children and poorer health literacy (Kavanagh, et al., 2007).

The general environmental factors affect all walks of life, though some are more prominent on people living in disadvantaged areas. The current environment in developed countries such as Australia encourages excessive intake of food while discourages physical activities. According to Hill and Peters (1998), environmental factors contributing to overeating and physical inactivity include food availability and portion size, high fat diets, advancement in technology and transportation leading to a sedentary life, limited budget spent on promoting physical activities, etc. Environmental influences on physical activities and eating behaviors, for example television viewing or Internet browsing, low levels of physical activity as well as indiscriminate consumption of fast food and soft drinks, are potential factors promoting the obesity epidemic (Hudson, 2005).

Behavioral Factors

The literature on health behavior and obesity strongly associates it with physical activity and diet (Flegal, et al., 2010; Jackson, Howes, Gupta, Doyle, & Waters, 2005; Park, et al., 2006). Higher television viewing time and lower physical activity time are strongly associated with obesity, with television viewing time showing a stronger relationship than physical activity time (Janssen et al., 2005). It is suggested while genetic and environmental factors play a role, the focus on diet and physical activity is primary (Cleland & Schmidt, 2005). Policy driven interventions utilizing physical activities related to obesity in Australia are supported by major public sector research and report (AIHW, 2003a, 2004a; Dixon & Welch, 2000).

Behaviors of an individual are very much shaped by the individual’s socioeconomic status and the environment he or she is in. The relationship among socioeconomic status, environment and behavior has developed to form a vicious cycle. Low income drives people to live in remote and regional areas where costs of fresh food items are higher, which in turn decrease the intake of fresh food. Harrison et al.’s (2007) Healthy Food Access Basket (HFAB) surveys in Queensland indicates that in 2004, the cost of the HFAB was 29.6% higher in very remote areas than in major cities, rendering the less nutritious food more affordable in the remote areas. Poor education leads to poor health literacy and thus a lack of awareness about the harmful effects of unhealthy diets and a sedentary life. The Victorian Lifestyle and Neighbourhood Environment Study (Kavanagh, et al., 2007) confirms that
people in low SES neighborhoods are less knowledgeable about the benefits of healthy foods and physical activity. Poor town planning and lack of outdoor facilities in low SES areas discourages the residents’ participation in physical activities leading to a more sedentary lifestyle. As a result of a sedentary lifestyle, there are fewer demands for facilities for physical activities.

**Interventions, Prevention and Policy**

As mentioned earlier, the most significant long-term consequence of childhood obesity is its persistence into adulthood (WHO, 1998). A US study shows that 80% to 92% teenagers who are obese will remain so in adulthood (Gordon-Larsen, The, & Adair, 2009). In this regard, tackling childhood obesity seems imperative in helping mitigate the rising prevalence of adult obesity in the long term.

Studies show moderate response to interventions in childhood obesity (Doak, Visscher, Rengers, & Seidell, 2006; Ebbling, Pawlak, & Ludwig, 2002; Jain, 2004b; Summerbell et al., 2005). A review of 22 studies assessing the effectiveness of interventions designed to prevent obesity in childhood through diet, physical activity and/or lifestyle and social support do not find enough evidence to prove that any one particular program could prevent obesity in children. Despite that, all programs reviewed in the studies resulted in some improvement in diet or physical activity and the majority of overweight/obesity prevention programs in combination are effective to a certain extent (Summerbell, et al., 2005). Another review by Doak et al (2006) note that physical education in schools and reducing television viewing are two examples of interventions that have been successful in improving BMI in children.

Salmon et al. (2005) studied the trends in children's physical activity and weight status in high and low SES areas of Melbourne and find that in the period between 1985 and 2001 with a significant increase in childhood overweight and obesity, there was a decline in walking and cycling to school and physical education lessons despite an increase in school sport sessions.

All these studies point to the need for more comprehensive intervention and prevention strategies. Multi-pronged approaches are called for to address diet, physical activities as well as the physical and social environment (Doak, et al., 2006). Summerbell et al. (2005) suggest that future research should look at improvements such as the types of foods available at schools and availability of safe places to run and play. Salmon et al. (2005) points out the need to address student participation in school sport and physical education lessons, as well as to improve the inequities in area-level SES. Waters and Bauer (2003) also advocate a family-focused and developmentally-sensitive behavioral management approach that addresses eating habits, incidental activity and television viewing. Prevention of childhood obesity will ultimately require multi-faceted, large-scale interventions.

On the other hand, most obese adults had a healthy weight as children (Venn et al, 2007). Therefore, measures that target the adult population are also of critical importance. To prevent and treat obesity in adults, lifestyle interventions have shown to be effective (Galani et al., 2007; Lemmens et al., 2008). Continued therapies are good for weight maintenance, but pharmaceutical therapies lose their effects after nine months (Glenny et al., 1997). Those who are morbidly obese benefit from gastric bypass surgery (Glenny et al). However, the number
of studies on prevention and treatment of obesity in adults is small and more research is needed before firm conclusions can be drawn (Lemmens et al., 2008; Glenny et al., 1997).

**Conclusion**

In summary, this chapter investigates the intricate relationships between obesity and socioeconomic, environmental and behavioral factors. To combat obesity in Australia in the long term, the following points should be noted:

- Obesity is an epidemic which is not confined to a particular region, gender, ethnicity and age group. It concerns the whole nation.
- Obesity is not just about body weight. It is a serious health risk which needs to be confronted at various levels of governments and health organizations.
- Health behaviors, environmental and socioeconomic factors play important roles in the prevalence of obesity.
- No single intervention program alone has been proved to be effective in preventing obesity. However, all programs show some positive impact on BMI. Therefore, comprehensive intervention and prevention measures involving parents, schools, communities, health professionals and various levels of governments are called for.
- When formulating prevention strategies and treatment programs, more emphases should be placed on children and the socially disadvantaged.

**References**


Part II

Health and Wellbeing in a Global Context
Abstract

Farmers and fishers have always been exposed to the vagaries of climate and global economic forces. However, in recent years there has been an accumulation of factors which are having a particularly severe impact upon rural Australia. The global financial crisis has negatively affected commodity prices and the viability of some rural communities is under threat. There is evidence to suggest that climate change is already impacting adversely on many primary producers and their ability to farm using traditional methods. Furthermore, many parts of rural Australia are still experiencing the effects of long-term drought and associated problems. Together, these circumstances can rightly be conceived of as ‘difficult times’. Psychological wellbeing is often adversely impacted through the stress of such ‘difficult times’. Key areas recently identified in a decline in mental health among farmers include: increasing isolation, ongoing drought, increased government regulations, and a widening of the schism between urban and rural Australians. While there is a body of literature on behaviour around illness in the context of ‘difficult times’, there is little on preventive behaviours in these circumstances.

This chapter reports preliminary findings from an exploratory research project that investigates the process by which farmers and fishers achieve and maintain good physical and mental health in the context of ‘difficult times’. The research takes a multiple case study approach, with five Australian sites, each with a different industry base, representing communities undergoing ‘difficult times’. This chapter focuses on two of the sites and data obtained from interviews with farmers in the cotton and sugar industries. It discusses the behavioural choices that they make to maintain good physical health and mental wellbeing. These include choices about nutrition, physical activity, social connections such as participation in community, social or farm-related groups, opportunities for relaxation and regular medical check-ups.

Keywords: stress, mental health, physical activity, nutrition, social engagement
Introduction

Despite there being idyllic notions about rural living, the statistics on health and wellbeing in Australia indicate people living in rural communities experience particular difficulties in the quest to ‘stay healthy’. This is particularly the case in ‘difficult times’ when agricultural industries are subject to the vagaries of adverse weather events and fluctuating commodity prices. Staying healthy in the context of difficult times becomes vital, and the strategies used by farmers and their families can usefully inform health policies and practices. What is evident is that farmers recognise the importance of, and have a variety of strategies to maximise, physical and mental wellbeing. They also recognise that achievement of good health is also linked to being socially connected in local communities, with opportunities to develop off-farm interests and relaxation being important.

Background

Attention to how farmers stay healthy in their everyday lives must necessarily be linked to the work that they do, and the conditions that affect their industry. While there has been a focus in the literature on occupational health and safety (OH&S) generally (Robinson et al., 2004), the uptake of specific behaviours to stay healthy differs between farmers (Dobinson, Doyle, & Wakefield, 2005), and there are differences across industries and states in relation to other OH&S issues (Day & Stathakis, 2004).

It has been noted that health behaviours of individuals were one of the five determinants of rural health status and outcomes (Australian Institute of Health and Welfare, 2008), with other research also suggesting a link between health behaviours and geographical place of residence (Johnson, Ratner, & Bottorff, 1995). Rural people are viewed as being ‘at risk’ more than their urban counterparts, and less likely to engage in preventive health behaviours (Australian Institute of Health and Welfare, 2008). For example, rural people are significantly more likely to report they are regular smokers than their urban counterparts, and rural males are significantly more likely than their urban counterparts to engage in risky or high risk alcohol consumption. The Australian Institute of Health and Welfare (2008) also found that males and females living in rural areas were more likely to be sedentary than those in major cities, and that the difference was particularly notable for men aged 25–64 years. Health behaviours such as alcohol consumption were identified as an integral part of community culture in some rural communities (Humphreys, 2000). The Australian Institute of Health and Welfare (2008) also found that rural people were significantly less likely to consume low fat milk, and less likely to consume the recommended intake of fresh fruit, compared with those in major cities.

There is a consistent finding in the literature that cultural values affect health behaviours and health outcomes for people living in rural areas. Integrated with social and cultural values is connection with the land, and this can be a positive attribute that enhances resilient attitudes amongst rural people (Harvey, 2007; Hegney et al., 2007). There is also an inter-relationship between rural values such as independence and stoicism, and social constructions of gender for both men and women (Gray, 2006; Willis & Elmer, 2007), with some writers discussing how this can be either positive or negative in terms of health behaviours (Fragar, Henderson,
Morton, & Pollock, 2007). For example, those living in rural areas are less likely to believe that they are at risk of illnesses such as heart disease (King, Lane, MacDougall, & Greenhill, 2009) and thus are less likely to adhere to treatment. The intersections between gender identity and rurality suggest that strong adherence to gender stereotypes has implications for wellbeing for both men and women (Harvey, 2007).

Australian research shows that males in outer regional and remote areas were significantly more likely to have high to very high levels of psychological distress, and that males in the 45–64 age group living in regional and remote areas were significantly more likely to experience depression, compared with their urban counterparts (Australian Institute of Health and Welfare, 2008). A recent study of selected South Australian broadacre and dairying farm families (King, et al., 2009) reported that participants over 60 years of age had higher levels of psychological distress and were less resilient than those under 60 years. The same study reported gender differences, in that females from farming families were more likely than males to recover from psychological distress and increase their capacity for resilience. Beyond these studies, there is scant knowledge of the impact of specific rural occupations on stress and mental health.

Some research has identified behaviours and strategies that farmers use to maintain good health. For example, King et al. (2009) noted the importance of medical check-ups, diet and exercise. Humphreys (2000) reported on the importance of relaxation, including socialising, playing sport, watching television and listening to music. The need for strong family relationships was identified by Caldwell and Boyd (2009) and Wickrama et al. (1997). Being connected with the local community is also important (Harvey, 2007; King, et al., 2009). Identification with others who are experiencing the same issues was noted by Caldwell and Boyd (2009) as important, as this means that the local community becomes a source of social support in difficult times. Other research has found that a sense of personal control contributes to positive health-related behaviours (Wickrama, et al., 1997) and that positive attitudes are a frequent coping strategy (Staniford, Dollard, & Guerin, 2009).

The focus on poorer health in rural areas has meant that programs to encourage physical activity and diet, particularly directed at people working in rural industries, have been funded by governments. Similarly, mental health programs have been supported as there has been increased recognition of the mental health problems associated with farming in difficult times in rural Australia. Of particular note are community-based programs, such as Sustainable Farm Families, which offer education, screening and early intervention, including referrals. Participation in the Sustainable Farm Families program has been shown to increase health awareness, reduce indicators of cardiovascular disease and type 2 diabetes, and encourage lifestyle changes to reduce stress (see, for example, Brumby, Martin, & Willder, 2008; Brumby, Willder, & Martin, 2009).

**This Study**

Health actions that rural Australians in agricultural industries take to keep healthy are examined using a case study approach focused on two industries (sugar and cotton). This is part of a broader project looking at ‘staying healthy’ across five different agricultural industries. We identified geographical areas where these commodities are produced and
liaised with local industry representatives to interview those working in the industry. Semi-structured interviews were conducted with cotton and cane growers, and in this chapter we report findings from 20 participants involved with cotton and 13 participants involved in cane production. Participants were aged from their late 20s to over 70 years, with most participants aged in their 50s. Women were slightly younger than men (particularly those from the cotton industry), and participants from the sugar industry were generally older than the majority of participants from the cotton industry. The interviews explored participants’ views of health as well as the specific actions they take to stay healthy, in the context of difficult times.

Findings

The Meaning of Health

For most participants, good health related to being able to function in their daily lives and not being unwell. These definitions of health also incorporated a ‘risk factor’ analysis, that health was about not being overweight, it was about being physically active, and for some participants, about not being stressed in everyday life. The capacity to function in everyday life, and not to be medically unwell, was viewed as enabling choice and control over their lives. Women were more likely to talk about a holistic view of health that incorporated happiness, spiritual values and general feelings about wellbeing.

Participants invariably described their own health as good. This was despite acknowledged health risks associated with increased age (particularly for cane growers); long-term chronic illness, and monitoring of signs or symptoms due to increased risk factors (for example, elevated blood pressure or cholesterol). Medical check-ups were described by most participants as one way they monitored their health (see also King, et al., 2009). A small number of participants discussed the local hospital ‘well person check’, but for many participants their six monthly or annual check-up was related to ongoing health problems, rather than a preventive measure.

Participants’ perceptions of their health status are shaped by their attitudes to health. And it is here that the tenuous balancing act between control or lack of control in difficult times begins to emerge. The capacity to stay in control, even when unhealthy or when farming life is difficult, is due to the emphasis on ‘positive thinking’. Those people who are not able to think positively are viewed as being unhealthy. Participants also drew on explanations for poor health using genetic or biological causal language, where they perceived they could not control health events. As can be seen in the next two sections, achieving good health was about strategies aimed at controlling risk factors and the stress of living in ‘difficult times’.

Physical Activity and Nutrition

When asked about strategies to achieve good health, all participants identified physical activity and nutrition as important, similar to King et al. (2009). A small number discussed their incapacity to undertake physical activity – one cotton grower attributing this to lack of
time, and three cane growers to existing health problems, older age, or caring responsibilities.
The remainder of the participants discussed strategies to undertake physical exercise. There
was a clear difference between how men and women talked about this – for men, exercise
was often embedded in their everyday farm-related activity; for women, exercise was a
conscious strategy that was added in to their everyday life. Illustrative of the men’s responses
are the following:

We’re always sort of active and moving and that so a lot of the times you don’t need to
[undertake additional physical exercise.] (male cane grower)

Basically, I still work physically with my men. And I always say that any person who’s an
irrigator, he actually gets paid to go for his morning walk (male cotton grower).

There was also a belief among some male participants that rural people were more active:
―Being a rural community I think we’re pretty active even though we do sit on a tractor all
day‖ (male cane grower). Further, the physical activity undertaken provided sufficient
‗functional fitness’, leading one participant to state that: “I think I’m as fit as I need to be …
And I don’t think it’s all that necessary unless you really want to be super fit” (male cotton
grower). In discussing the amount of physical exercise undertaken, one cotton grower stated:
“There’s not a real lot of fat farmers, so that sort of says something” (male cotton
grower).

By contrast, women talked about the strategies outside of their everyday life that they
undertook to achieve physical fitness. Several participants discussed going to a gym. As a
group activity, this had social as well as physical health benefits. One participant discussed
how this was her ‘time out’, thus illustrating a widespread view amongst female participants
that exercise was about a healthy lifestyle rather than simply achieving a functional measure
of health:

So we get together and do an hour of aerobics, and then on another morning we have a
walking group for half an hour and then follow on with aqua-aerobics at the local swimming pool.
So I find that this is my time away from the house, businesses, financial, husband stresses –
anything – and that’s my time out for the week (female cotton grower).

Many more women than men talked about the need to go for a daily walk. They also
discussed the encouragement received from family to take up physical activity, for example,
through purchase of home gym equipment or a pet dog.

Similarly, all participants acknowledged the importance of good nutrition for health. A
few participants discussed difficulties with the availability of fresh fruit and vegetables in
rural locations, but for most this was not rated as a problem. Overwhelmingly, the key ideas
that informed ‘good nutrition’ were: a diet based on meat and three vegetables; the need for
smaller portions of food (particularly discussed by cane growers); and the generalised view
that ‘everything in moderation’ was the best approach (particularly discussed by cotton
growers). Home-cooked meals tended to be regarded as healthy, and these were often
contrasted with take away foods that were regarded as unhealthy (and thus a treat when away
from the local area). Some male participants discussed their reliance on their female partner
to provide healthy food choices for them; other participants discussed how they had learnt a
lot about nutrition from programs that had been run in their local area, such Sustainable Farm
Families (Brumby, et al., 2008; Brumby, et al., 2009), that encouraged them to reduce the amount of fat in their diet, to correctly interpret food labels, and to drink plenty of water, particularly as they were involved in outdoors work. Many participants discussed their use of alcohol, but most did not view their alcohol consumption as problematic. Alcohol consumption was linked to social engagement, with the latter being viewed as important in maintaining a healthy outlook, suggesting the importance of understanding the cultural context for health actions and behaviours (also see Humphreys, 2000).

Achieving Good Mental Health

Mental health was inextricably linked to good general health, for most participants. As also identified in the literature (Staniford, et al., 2009; Wickrama, et al., 1997), the importance of a positive attitude was important, particularly in the farming circumstances of uncertainty. Many participants discussed how mental health issues were of greater concern to them than their capacity to achieve good physical health. As one cotton grower said: “I’m actually probably more worried about my state of mind than I am about my physical health … I feel a bit like I’m waltzing on the Titanic” (female cotton grower). This is illustrative of participants’ feelings about not being able to control the conditions under which they worked, including environmental conditions and government policies and procedures. Many farmers discussed the debilitating effects of the drought: “Drought most likely is the biggest source of depression for most people” (male cotton grower). Many commented on the number of suicides among farmers in their communities. Others commented on the impact of government policies and procedures. They felt their mental health was threatened when they were unable to control policies for water rights (of concern for those working in the cotton industry) or had little control over new government regulations in respect of the debated environmental impacts of chemical and fertiliser application (of concern for cane growers).

What emerged from these issues related to stress and mental health was a range of strategies to remain resilient (see also Harvey, 2007). This was expressed differently according to gender. Women discussed the importance of staying positive, men discussed the importance of not worrying. Central to this strategy was the ability to recognise what is controllable and what is not. As one cane grower stated, “well, I don’t dwell on problems with the farm over which I have no control” (male cane grower). Practical ways in which the uncontrollable elements were dealt with included the importance of getting enough sleep, recognising the futility of lying awake at night worrying, as well as having a good relationship with one’s partner. What is needed is a “positive outlook on life, I suppose. I try to really keep a positive outlook on life. I try not to dwell on things greatly” (female cotton grower) and “I am an optimistic person, so you look on the positives all the time. That’d be my strategy, I think, on mental health” (female cotton grower). While this is an admirable strategy that was espoused by many participants, it also brings with it a sense of failure for those who are not able to maintain a ‘positive attitude’. While there was some acknowledgement that staying positive was hard, participants found it difficult to understand those who were not able to do so. For example, with regard to suicide, one participant stated: “When you think about it, they were the ones that were always a bit jittery” (male cane grower) and “it makes you wonder what makes them tick to make them think everything’s that bad you’re frightened to live. It’s strange. It’s just a waste really” (male cotton grower).
Linked with the staying positive theme were ideas about decision making. A small number of participants described how they compartmentalised their decision making to the actual times that a specific decision was required, rather than taking a broad approach to their overall farm strategy (over which they had little control). As one farmer stated: “[I] just do what I have to do and make those decisions as they come” (male cotton grower) and “when I make a decision then I’ll set another date, this is how I get by. This is my mechanism of coping” (male cotton grower). Integral to this decision making strategy was the acknowledgement that a decision made may be wrong, but it was the best that could be made under the circumstances. In terms of health, this limited the ‘stressful thinking’ to a specific period of time, as opposed to an overwhelming feeling of stress that existed all the time. Linked to this view of decision making was the idea that having a plan or an activity was better than just worrying about a problem.

The importance of off-farm interests, relaxation and social engagement were also integral to maintaining good mental health. As found by Humphreys (2000), rural families sought a balance between physical and mental health, by engaging in physical activity (work, individual and organised sport) and taking steps to minimise stress (socialising, playing sport, watching television and listening to music). While women talked about ‘time out’ (as illustrated in their approach to physical activity above), they also discussed the importance of having specific activities such as gardening, reading, horse-riding and social engagement where they were not thinking about the stresses that they and their husbands were experiencing. Shifting the focus of life away from the farm was important: “It’s important not to totally focus on the farm” (male cane grower). Further, “you’ve just got to try and stay active and positive. And I think that’s why being involved in other things you’re not just here sort of feeling sorry for yourself” (female cotton grower). Participants’ off-farm interests ranged from time that they spent out of the local community for rifle shooting events, bush walking and going to the beach, to involvement in social activities in the local community. Involvement in sporting activities, particularly children’s sports, was often discussed, and events and routines such as these can be seen as maintaining a sense of normality in times of difficulty.

**Conclusion**

That good health is a requirement for living and working was evident in responses from all participants. The attribute of a positive attitude and staying in control (see also Caldwell & Boyd, 2009; Stanford, et al., 2009; Wickrama, et al., 1997) was also significant and may explain why, even in the context of suffering chronic illness, all participants reported being in good health.

These findings are suggestive of a commitment to achieving and maintaining good health that is not evident in the literature on rural health, where risk factors, behaviours and poorer outcomes are emphasised (Australian Institute of Health and Welfare, 2008). The importance of gender in understanding different strategies to staying healthy is significant, not only in how men and women view health, but also the actions they undertake in order to stay healthy. While gender is also a key theme in the literature on rurality and health (Alston & Kent, 2008; Harvey, 2007), this research points to the different strategies that men and women see as
important in maintaining good health. For both men and women, physical health and mental wellbeing are inter-linked, and both were at risk during difficult times. An example of this was given by a cotton grower: “People are working farms with less employees so they’re obviously working more. And that has a detrimental effect on health, both mental and physical, that they’re trying to work longer and harder and do much more” (female cotton grower). There was a high level of acknowledgement of the stress of difficult times, but alongside this ran the theme of the importance of acting to reduce stress. Thus, the emphasis on sociability and relaxation were important strategies for health (see also Caldwell & Boyd, 2009; Harvey, 2007; King, et al., 2009). At the same time, the emphasis on maintaining a positive attitude can be seen as both a barrier and a facilitator of good health measures.

The case study approach taken in this study highlights that contextual and cultural factors must be acknowledged in any approach to improving the health of those engaged in rural industries in Australia. While there are similarities across these groups, they are not homogeneous. Demographic characteristics such as age are a factor in understanding the differences between these two population groups discussed here; the different contexts of difficult times in different industries is also an important point for consideration.

**Acknowledgments**

This study has been carried out with funding from the Rural Industries Research and Development Corporation. We wish to thank the cotton and sugar industry associations who facilitated the research in their local areas and the participants who generously gave up their time to be interviewed.

**References**


Chapter XII

Health, Wellbeing and Community Involvement of Older People in Rural Scotland

Jane Farmer, Sarah-Anne Muñoz, Artur Steinerowski and Sara Bradley

Abstract

Involvement in community activities offers a route to achieving one of the five “essential elements” of older people’s wellbeing as identified by McCormick et. al., (2009) – that of “having a role”, i.e. having a sense of purpose, belonging and value within society. This suggests that older people living within remote and rural communities would derive wellbeing benefits from participation in informal helping and volunteering. This chapter uses information from the European Union-funded O4O: Older People for Older People initiative, conducted from 2007-2010, which considered dimensions of older people’s participation in remote, rural communities with the goal of encouraging and studying how older people could help other older people stay living in their own homes and communities for longer. The chapter presents quantitative evidence from a survey of people aged 55 and over in four remote Scottish communities on the relationship between socio-economic characteristics and participation in community activities. Further insights are brought from the analysis of interviews conducted with older people living within the four communities. By taking these communities as case studies, the chapter is able to comment on the relationship between participation and older people’s wellbeing within the rural context.

Keywords: older people; community; participation; volunteering, rurality, wellbeing.
Introduction

Involvement in community activities offers a route to achieving one of the five “essential elements” of older people’s wellbeing as identified by McCormick et. al., (2009) – that of “having a role”, i.e. having a sense of purpose, belonging and value in society. The engagement of older people in remote and rural community activities, including informal helping and formal volunteering (in, for example, community organizations or charities), seems to make intuitive sense from a number of perspectives. Younger older people, such as recent retirees to rural communities, could use their time and skills to support older frailer people to stay living in their own homes and communities. In doing so, both those who give and receive help could benefit in terms of extending their social networks, thereby creating social capital, health and wellbeing. Rural areas may stand to benefit more from volunteering and informal help as there are higher proportions of older people, when compared with urban areas, and it is more difficult to gain access to, and provide, a range of services. Higher levels of volunteering are found in rural regions and there is evidence of greater social capital and stronger networks, trust and sense of belonging, in rural communities compared with urban communities (Fyfe and Milligan, 2003). Rural areas thus apparently show both a need for support for older people and the potential to provide this through community social resources.

The chapter uses information from the European Union-funded ‘O4O: Older people for Older People’ initiative, conducted from 2007-10 in Greenland, Scotland, Northern Ireland, Sweden and Finland. It focuses on data collected within the remote and rural Highland region of Scotland. The O4O project considered dimensions of older people’s participation (both their informal and formal volunteering activities) in their communities with a goal of studying how older people could help other older people to stay living at home. As part of O4O, a questionnaire survey of all people aged 55 and over in four rural communities was conducted. It examined associations between health, demographic variables and participation in community activities. A summary of key findings is presented, alongside evidence from qualitative interviews with older community members. A range of evidence was produced in O4O; here, we consider findings in relation to health, wellbeing and older people’s participation in formal and informal help-giving of various types. Findings are used as an underpinning for comment on relationships between involvement and the wellbeing of older people in rural areas.

Participation and Older People’s Wellbeing in a Rural Context

There is increasing research evidence about associations between physical health, subjective wellbeing and participation (informal and formal volunteering in community activities). As well as cross-sectional international studies, there is longitudinal evidence showing associations between health and participation over time (Lum and Lightfoot, 2005; Luoh and Herzog, 2002). The theoretical foundation is that a sense of community belonging and existence of social capital lead to wellbeing which is then associated with improved health status (Berkman et al, 2000; House et al, 1988; Rowe and Kahn, 1998).
of an individual’s social relationships” has been shown to impact upon health and wellbeing (Fernandez-Ballesteros, 2002) and participation in community activities is one way to increase social interaction. Volunteering has been shown to be related to reduced mortality (Lum and Lightfoot, 2005; Luoh and Herzog, 2002; Sabin, 1993), increased functional ability (Lum and Lightfoot, 2005), improved immune system function (Growald and Luks, 1988), and reductions in stress (Luks, 1988), chronic pain (Arnstein et al, 2002) and depression (Musick and Wilson, 2003).

Intriguingly, studies have shown that ‘givers’ benefit more than ‘recipients’ within volunteering relationships (Brown et al, 2003; Dulin and Hill, 2003; Liang et al, 2001). Considering participation of different age groups, older people have been shown to benefit most (Harlow and Cantor, 1996; Li and Ferraro, 2006; Van Willigen, 2000), partly as their health is more threatened (so they have more potential to benefit and changes are also easier to measure) and partly because people may find a renewed sense of purpose following the loss of longstanding work/family roles (Greenfield and Marks, 2004). While health and wellbeing are related to volunteering, if the volunteer is over-extended (too much volunteering), their health suffers (Schwartz et al, 2003). A volunteer must contribute a certain number of hours before health benefits ensue (Lum and Lightfoot, 2005; Musick et al, 1999).

Here, the relationship between older people’s participation (formal and informal) and wellbeing within remote and rural communities is considered. ‘Rural’ and ‘remote’ have been variously defined and categorised. According to the Scottish Government’s Urban-Rural Classification, the communities in this study are located within a ‘rural’ local authority district because Highland falls within the category of less than 100 people per square kilometre (Skerratt et. al., 2010). In O4O, two of the communities that took part were more than an hour by car from the nearest city (Inverness) and had small populations (between 500 and 700). One community consisted of three small settlements in close vicinity, with a total population of around 1,500. One community was closer to Inverness (six miles), with 1,000 residents. Rural communities have been shown to have higher levels of social capital and volunteering (Onyx, 2000), associated with more traditional, interconnected social relations, the existence of strong and rich social ‘ties’ (Granovetter, 1985) and reciprocity. However, ‘difference’ can be conspicuous in rural communities (Little and Leyshon, 2003) and rural social exclusion can negatively impact on individual wellbeing (Meek, 2007). Internationally, rural areas tend to have higher proportions of older people compared with urban areas. They are becoming ‘more old’ as the trend is for out-migration of young people for employment and education (Giarchi, 2006). In O4O, older people were those aged 55 and over because the Scottish Government use this definition in their plan for older people (Scottish Executive, 2007).
Characteristics of Rural Older People’s Participation

Methodology

Four rural locations in the Scottish Highlands took part in the study. Following ethics committee approval, the O4O Rural Communities Health and Wellbeing Questionnaire was sent by post from each community general practitioners’ (GP) surgery to all registered patients aged 55 and over. In total, 2,462 questionnaires were distributed, with a response rate (following one reminder) of 58% (1428/ 2462).

The questionnaire included health and wellbeing-related questions originating from the SF12 (Quality Metric, 2009), the social capital module of the UK General Household Survey and specific questions for O4O. Measures of informal helping (e.g. giving and receiving ‘favours’ from a neighbour) and formal volunteering (e.g. being on the management board of a local voluntary organisation) were included. Participation was defined by ten ‘participative factors’ including informal and formal activity.

To discover associations with participation, demographic and socioeconomic covariates were included: gender, self-assessed health, age, place of birth, length of stay in the community, employment status, highest educational attainment, access to a vehicle and community of origin.

SPSS 16.0 software and a two stage process of analysis identified which variables influence participation in community activities and the extent of their influence. Initially, chi-square tests were performed for the ten participative factors and individual-level demographic/ socio-demographic variables. Findings allowed examination of the relationship between level of participation and personal characteristics. Those variables that were associated with participation in univariate analyses were then entered into a binary logistic regression model. A ‘forward conditional’ model was used to identify the significant variables and an ‘enter’ model to obtain adjusted odds ratios. Differences were accepted as significant at p < 0.05 for all statistical analyses.

Place, Socio-Demographics and Older People’s Participative Factors

Table 1 shows a summary of the chi-square tests carried out on the ten participative factors included in the study by age, health status, education, length of residence, gender, access to a vehicle and employment. Variables associated with participation are shown – the first five variables represent informal participation and the latter five variables represent formal participation. Non-significant results are blank in Table 1.
Table 1. Summary of Chi-Square Results.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Gender</th>
<th>Health</th>
<th>Age</th>
<th>Origins</th>
<th>Length of stay in the area</th>
<th>Employment</th>
<th>Education</th>
<th>Access to a vehicle</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doing a favour for a neighbour in the past 6 months</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Receiving a favour from a neighbour in the past 6 months</td>
<td>0.045</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.047</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Providing unpaid personal care to someone</td>
<td>0.003</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.038</td>
<td>0.008</td>
</tr>
<tr>
<td>Willingness to use skills to help people in the community</td>
<td>0.007</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td>0.004</td>
<td>0.019</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td>0.002</td>
</tr>
<tr>
<td>Dealing with an emergency in the community in the past three years</td>
<td>0.001</td>
<td>0.003</td>
<td></td>
<td></td>
<td></td>
<td>0.001</td>
<td></td>
<td>0.01</td>
<td>0.007</td>
</tr>
<tr>
<td>Membership of a management committee of a local group</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td></td>
<td></td>
<td></td>
<td>0.008</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Taking part in a community project in the past 3 years</td>
<td>0.046</td>
<td>&lt;0.001</td>
<td>0.001</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Attending a community event in the past 6 months</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td>0.024</td>
<td>0.018</td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
<td>0.003</td>
</tr>
<tr>
<td>Organising a new service in the community</td>
<td>&lt;0.001</td>
<td>0.032</td>
<td></td>
<td></td>
<td></td>
<td>0.004</td>
<td>0.002</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Active membership of a local organisation(s)</td>
<td>&lt;0.001</td>
<td>0.02</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>
Table 1 shows that health, age, education, access to a vehicle and community of residence tend to be associated with both informal and formal aspects of participation. No variables are obviously linked with only informal or formal participation. Willingness to use one’s own skills to help the community was associated with all of the socio-demographic variables.

The socio-demographic variables such as gender, origins (whether an individual was born in the area in which they currently reside) and length of stay in community were infrequently associated with participative factors.

Community of residence was the only variable associated with all participative factors, suggesting that participation behaviours are place-bound. Although all O4O communities are part of the rural Highland region, findings show that community of residence is associated with participative behaviours, i.e. participative behaviours vary by place. Thus, an assumption often made, that rural communities equally possess the social capital essential to enhance their capacity through participation, would be misleading in the case of O4O communities.

Access to a vehicle was associated with all participative factors, except receiving a favour from a neighbour. This suggests that, in remote rural communities, access to a vehicle enables participation.

Educational attainment and self-reported health levels were associated with all participative factors, apart from provision of unpaid personal care. Similarly, age was associated with all participative factors apart from ‘receiving a favour from a neighbour’ (which is likely based more on need and social ‘connectedness’ rather than age) and ‘being an active member of a local organisation’ (which is based on physical and social ability to be active). The nature of the association between participation and these socio-demographic factors is explored in the next section of this chapter.

How Place and Socio-Demographics Influence Participative Behaviours

A second stage of analysis was conducted for each participative factor using variables that were significant in univariate analyses (Table 1). Table 2 shows the adjusted odds ratios and their 95% confidence intervals for four selected participative behaviours. The logistic regression models extracted variables to leave only those variables which were independently associated participative behaviours, as shown in Table 2.

Table 1 highlighted that participative behaviour varies between rural communities. Table 2 shows that community C and community D have the least participation and community A and community B have the most. The regression results show that those living in community A and B are consistently more likely (in statistically significant terms) to be involved in both informal and formal types of participation and those living in communities C and D are consistently less likely.

Table 2 confirms that mobility (access to a vehicle) is positively associated with participation (particularly formal participation that may involve transport to a particular place or venue).
Table 2. Odd Ratios (95% Confidence Interval) and p-value results from logistics models for socio-demographic characteristics and doing a favour for a neighbour, willingness to use personal skills, participation in community projects and membership of a management committee participative variables.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>OR (95% CI)</th>
<th>p-value</th>
<th>OR (95% CI)</th>
<th>p-value</th>
<th>OR (95% CI)</th>
<th>p-value</th>
<th>OR (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doing a favour</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health (poor health)</td>
<td></td>
<td>&lt;0.001</td>
<td></td>
<td>&lt;0.001</td>
<td></td>
<td>&lt;0.001</td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Fair</td>
<td>3.02 (1.55, 5.90)</td>
<td>&lt;0.001</td>
<td>2.55 (1.01, 6.45)</td>
<td>0.048</td>
<td>1.45 (0.65, 3.25)</td>
<td>0.36</td>
<td>1.72 (0.62, 4.77)</td>
<td>0.30</td>
</tr>
<tr>
<td>Good</td>
<td>3.15 (1.71, 5.81)</td>
<td>&lt;0.001</td>
<td>6.55 (2.68, 16.0)</td>
<td>&lt;0.001</td>
<td>2.59 (1.22, 5.51)</td>
<td>0.013</td>
<td>4.28 (1.64, 11.2)</td>
<td>0.003</td>
</tr>
<tr>
<td>Very Good/Excellent</td>
<td>4.14 (2.25, 7.63)</td>
<td>&lt;0.001</td>
<td>8.67 (3.58, 21.0)</td>
<td>&lt;0.001</td>
<td>3.62 (1.72, 7.63)</td>
<td>0.001</td>
<td>5.06 (1.95, 13.1)</td>
<td>0.001</td>
</tr>
<tr>
<td>Community A (Tongue)</td>
<td></td>
<td>&lt;0.001</td>
<td></td>
<td>&lt;0.001</td>
<td></td>
<td>&lt;0.001</td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>B (SWR)</td>
<td>2.51 (1.32, 4.81)</td>
<td>0.005</td>
<td>0.32 (0.11, 0.90)</td>
<td>0.03</td>
<td>0.93 (0.60, 1.44)</td>
<td>0.75</td>
<td>0.92 (0.58, 1.47)</td>
<td>0.73</td>
</tr>
<tr>
<td>C (Ardersier)</td>
<td>0.87 (0.50, 1.52)</td>
<td>0.62</td>
<td>0.20 (0.07, 0.54)</td>
<td>0.002</td>
<td>0.44 (0.28, 0.69)</td>
<td>&lt;0.001</td>
<td>0.56 (0.35, 0.90)</td>
<td>0.016</td>
</tr>
<tr>
<td>D (Lochinver)</td>
<td>0.75 (0.40, 1.41)</td>
<td>0.37</td>
<td>0.20 (0.07, 0.59)</td>
<td>0.003</td>
<td>0.78 (0.48, 1.27)</td>
<td>0.32</td>
<td>1.25 (0.75, 2.08)</td>
<td>0.39</td>
</tr>
<tr>
<td>Age group (85+)</td>
<td></td>
<td>&lt;0.001</td>
<td></td>
<td>&lt;0.001</td>
<td></td>
<td></td>
<td></td>
<td>0.06</td>
</tr>
<tr>
<td>75-84 years</td>
<td>3.31 (1.78, 6.12)</td>
<td>&lt;0.001</td>
<td>2.66 (1.24, 5.73)</td>
<td>0.012</td>
<td>4.16 (1.41, 12.3)</td>
<td>0.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65-74 years</td>
<td>4.43 (2.43, 8.07)</td>
<td>&lt;0.001</td>
<td>5.32 (2.45, 11.1)</td>
<td>&lt;0.001</td>
<td>4.23 (1.46, 12.3)</td>
<td>0.008</td>
<td></td>
<td></td>
</tr>
<tr>
<td>55-64 years</td>
<td>6.08 (3.37, 11.0)</td>
<td>&lt;0.001</td>
<td>16.0 (7.3, 35.9)</td>
<td>&lt;0.001</td>
<td>4.33 (1.50, 12.5)</td>
<td>0.007</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education (No qualifications)</td>
<td></td>
<td>&lt;0.001</td>
<td></td>
<td>&lt;0.001</td>
<td></td>
<td>&lt;0.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>O-levels/Standard Grades</td>
<td>1.58 (0.87, 2.87)</td>
<td>0.13</td>
<td>1.04 (0.70, 1.56)</td>
<td>0.84</td>
<td>1.44 (0.93, 2.21)</td>
<td>0.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highers</td>
<td>3.52 (1.48, 8.41)</td>
<td>0.005</td>
<td>1.35 (0.83, 2.20)</td>
<td>0.23</td>
<td>1.45 (0.86, 2.44)</td>
<td>0.16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HND/HNC</td>
<td>2.39 (0.85, 6.77)</td>
<td>0.10</td>
<td>1.87 (1.08, 3.21)</td>
<td>0.024</td>
<td>1.77 (0.99, 3.16)</td>
<td>0.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional/University Degree</td>
<td>3.08 (1.87,5.07)</td>
<td>&lt;0.001</td>
<td>2.30 (1.67, 3.17)</td>
<td>&lt;0.001</td>
<td>2.52 (1.78, 3.57)</td>
<td>&lt;0.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender (Males)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Females</td>
<td>0.57 (0.37, 0.87)</td>
<td>0.009</td>
<td>1.40 (1.09, 1.80)</td>
<td>&lt;0.001</td>
<td></td>
<td></td>
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<tr>
<td>Vehicle (no access)</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>Access to a vehicle</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>1.85 (1.18, 2.87)</td>
<td>0.007</td>
<td>2.21 (1.30, 3.76)</td>
<td>0.003</td>
<td></td>
<td></td>
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</tbody>
</table>
The finding that some communities are more participative than others in different types of informal and formal participation, suggests that some communities are ‘stronger’ than others in relation to different ways of participating.

Those with access to a vehicle were 1.85 times (95% CI: 1.18 – 2.87) more likely to be involved in community projects and 2.21 times (95% CI: 1.30 – 3.76) more likely to be on the management committee of a local organisation. This emphasises the importance of transport to enable older people’s wellbeing in rural areas. Transport is needed to access these “beyond spaces” (Wiles et al., 2009) outside the home in order to achieve particular kinds of participative activities that facilitate social interaction and sense of belonging.

Regarding level of educational attainment, Table 2 highlights that as the level of qualifications increases, the likelihood of participation concomitantly increases. The highest level of participation was found amongst those with professional skills and university qualifications. This association raises questions about why those with lower levels of educational attainment participate less. If participation facilitates social interaction, with associated health and wellbeing benefits, then what does this relationship imply for the wellbeing of those who perhaps lack the social or cultural capital to ‘join in’? Human and cultural capital appear important to participation; for older people’s wellbeing, there is a need to find ways to include and engage those who have fewer of these assets due to education and socioeconomic status.

Table 2 shows that the relationship between participation and level of self-reported health is one in which those who are healthier are more likely to participate. Those reporting worse health were less likely to participate, but more likely to receive a favour from a neighbour. This relationship is further explored in Table 3.

Table 3 Relationship between Self-Reported Health and Participation.

<table>
<thead>
<tr>
<th>Participation Variable</th>
<th>Least Likely → Most Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Self-Reported Health</td>
<td></td>
</tr>
<tr>
<td>Did favour for neighbour in last 6 months</td>
<td>Poor, Fair, Good, Very Good</td>
</tr>
<tr>
<td>Received favour from neighbour</td>
<td>Very Good, Fair, Good, Poor</td>
</tr>
<tr>
<td>Willing to use skills to help community</td>
<td>Poor, Fair, Good, Very Good</td>
</tr>
<tr>
<td>On management committee of local group(s)</td>
<td>Poor, Fair, Good, Very Good</td>
</tr>
<tr>
<td>Take part in community project in last 3 years</td>
<td>Poor, Fair, Good, Very Good</td>
</tr>
<tr>
<td>Attended community event in last 6 months</td>
<td>Poor, Fair, Good, Very Good</td>
</tr>
<tr>
<td>Active member of local organisation(s)</td>
<td>Poor, Fair, Good, Very Good</td>
</tr>
</tbody>
</table>

The relationship in Table 3 appears to be one where the healthier help the more vulnerable. Despite the potential to produce health and wellbeing benefits from participation, poor self-reported health places restrictions on an individual’s level of participation. Given the potential for wellbeing benefits from participation, focus on how to include those with poorer health is worthy of exploration (although some of the participative factors we studied could be judged to be more active behaviours). In line with findings about health, the regressions show a relationship where the oldest are least likely to participate and the youngest most likely.
The regression modelling findings show the relationship between socioeconomic characteristics and participation to be one where individuals are more likely to participate if: they have access to a vehicle, higher levels of educational attainment (particularly University level), higher self-reported health, and are younger.

Figure 1 shows that for communities B, C and D, those that have the lower overall levels of participation (B and C) also have the higher proportions of people with socio-demographic characteristics associated with low participation (e.g. no vehicle; no qualifications; poor health and over 85 years old) and lower proportions of people with ‘participative’ characteristics (e.g. University qualifications and in the 55 – 64 age group). This suggests that the socio-demographic characteristics of a rural community could predict the level of local older people’s participation. Two applications of this idea might arise: help could be targeted to support those communities where people are more likely to participate; or, initiatives stimulated to support those communities that are less likely to have their own resources. However, community A, which has the highest overall levels of participation is anomalous in that it does not contain the highest proportions of ‘participative’ characteristics (e.g. it has one of the highest proportions of residents without access to a vehicle and the lowest proportion of residents with higher education qualifications). This suggests that there is something about being in community A that generates participative behaviours.

Figure 1. Socio-demographic characteristics that influence participation for each community.
Qualitative Understandings of Rural Older People’s Participation and Wellbeing

Methodology

In July/August 2009, 27 semi-structured interviews were conducted with people aged 55 years and over in the four communities described previously. Most interviewees were selected as people living in the communities who had ‘volunteered’ to participate in aspects of the O4O project, which involved helping to build voluntary organisations in communities to provide basic level services, such as lift-giving or domestic support. A snowball sampling method was used to recruit additional interviewees, with potential participants suggested by the O4O ‘volunteers’. Interview topics included: what the community is like for older people, older people’s needs for basic services, current and future effects of volunteering to provide basic services and feelings about having an active role in the community. Interviews lasted between 20 and 40 minutes and were recorded and transcribed. Transcriptions were coded by theme and managed using NVivo. A large data-set was generated that reflected the range of experiences and backgrounds of older community members and their relationships to their communities. These interviews extend the evidence from survey results, telling about experience(s) of participation and wellbeing. Clearly, interviewees were those who were involved in, or favourable to, volunteering – and their associates in the community. This bias towards those who already participate should be borne in mind when considering the qualitative findings presented.

Perceptions of the Participation-Wellbeing Link

The majority of interviewees had been, or still were, active volunteers and believed in the benefits of formal and informal volunteering for themselves and their communities. A few explicitly stated that they thought volunteering was good for the wellbeing of the volunteer: “we’re healthier as we’re giving out and being part of things, much healthier” (community interviewee 20). Some interviewees stated that voluntary work kept them active and involved in community life and therefore healthy: “It keeps me going, it keeps me alive” (community interviewee 24). Other benefits included getting out of the house, seeing new places, meeting new people, acquiring new interests, using old skills or developing new ones, feeling useful and valued, a sense of satisfaction and using your mind and imagination. One volunteer described getting a “buzz” from helping and another said they got a “sort of well-being factor” (community interviewees 24 and 3). People did not say health was a main motivation; they simply enjoyed contributing: “I just like to help that’s all” (community interviewee 2). For some it was also a duty:

I do feel that if you’ve got your health and strength when you retire ... then you should be able to give something back to your community and do what you can. (community interviewee 9)
Many interviewees had a history of voluntary work including involvement in playgroups or schools, older people’s groups and outings, supporting and developing community buildings and facilities, organising events like the Highland games/village shows, fundraising for different organisations and work for churches. One interviewee said “you move with your children through the volunteering sector” (community interviewee 17). A few said they had been brought up to help others and be active in the community.

Interviewees thought that older people helped each other and that volunteering was important for the well-being and future survival of rural communities. Some expressed doubts about the future of volunteering due to social change and a perceived decline in ‘community spirit’. Several thought legislation requiring, for example, criminal record checks deterred volunteers. Many were pessimistic about the willingness of young people to volunteer and the consequent impact on the future sustainability of their communities. When commenting on their own future as volunteers, some people viewed older age as a point when they would choose to do less so they could enjoy their retirement:

I’m planning on giving up things this year, a lot of things because I’m a bit fed up … it’s a tie really, you’re tied. I don’t have much time to myself and I thought when I retired I would get plenty of time to do my own thing but I can’t. (community interviewee 10)

Given survey findings that showed younger older people took part in a range of voluntary activities, this raises questions about interviewees’ informal ‘definitions’ of both younger people and when they themselves would ‘be older’ (i.e., ‘being old’ is a very vague definition).

Some interviewees regarded participation as a lifelong activity, which depended primarily on their continued good health. This supports survey findings showing decreasing participation with age. Interviewees expected their health and energy levels to decline with age, curtailing their future voluntary activity. All agreed that rural communities had a continuing culture of helping, but some viewed it as the preserve of (a small group of) older people. Some stated a decline in community capacity and self-sufficiency resulting in an increasing reliance on externally provided services. A minority expressed a difference between ‘incomers’ and ‘locals’. There was some resentment about those moving into the area to retire, but who did not apparently wish to contribute to community life:

there are people who come into the area from outside and put down roots, have families. They become part of the community and you can see their children and so on and so forth. There are others who just simply come here to die … it’s a taking relationship … there’s no two way street. (community interviewee 14).

‘Incomers’ were described by some as ‘less self-sufficient’ and more likely to use their car to reach shops and services outside the community. There was a fear that failure to support local businesses undermines community sustainability. This perception may be counteracted by survey results showing that access to a vehicle increases likelihood of participating in local community activities. It was recognised that incoming retirees might need formal support because they lacked local social networks of friends and relatives. This perception exists despite the quantitative findings showing no association between place of
birth and participation, and that length of stay in the community is associated with an increased likelihood of organising a new service.

It was noted that incoming retirees could find it difficult to integrate into the community and be accepted as volunteers even when they wished to contribute:

I’m regarded as an incomer obviously … and there’s very much an attitude sometimes, no not just sometimes all the time, there’s a barrier somewhere that I don’t feel I can break down or get through … I’ve found it difficult first of all to find a way about in the community here, although it’s a very small village. (Community interviewee 18).

An emergent theme was the tension between informal helping and formal volunteering. Some valued giving or receiving without feeling a ‘service’ had to be reciprocated; others thought that rural communities thrived on mutual favour-giving and viewed formalising giving/helping as eroding community wellbeing and social capital.

**Informal Participation and Connectedness within Rural Communities**

An implicit ‘hypothesis’ emerged from several interviewee’s discourses: that there are some rural community residents who are ‘net payers’ into the community, i.e. those who give more than others; and some people who are ‘net recipients’ (i.e. those who receive more than others). This aligns with perceptions of a difference between the behaviour of ‘low-contributing’ incomers and locals who have significantly ‘paid into’ the community over time.

Quantitative findings portrayed a different story. The variables from the O4O survey ‘doing a favour for a neighbour’ and ‘receiving a favour from a neighbour’ might be used as a representation of informal reciprocal participation in the communities. Table 4 shows that the majority of older people in all communities had both given and received a favour from a neighbour in the last six months (81%). Thus, there is a marked overlap between giving and receiving, suggesting high levels of reciprocal informal help and contradicting qualitative perceptions of contrasting payers and recipients.

**Table 4. Overlap between Giving/ Receiving a Favour.**

<table>
<thead>
<tr>
<th>Community</th>
<th>Gave and Received a Favour (%)</th>
<th>Neither Gave nor Received a Favour (%)</th>
<th>Overall level of community participation (rank)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>81.7</td>
<td>7.2</td>
<td>n/a</td>
</tr>
<tr>
<td>A</td>
<td>81.5</td>
<td>6.7</td>
<td>1</td>
</tr>
<tr>
<td>B</td>
<td>90.5</td>
<td>2.8</td>
<td>2</td>
</tr>
<tr>
<td>D</td>
<td>76.0</td>
<td>10.2</td>
<td>3</td>
</tr>
<tr>
<td>C</td>
<td>76.9</td>
<td>9.0</td>
<td>4</td>
</tr>
</tbody>
</table>
Conclusions

In this study, the definition of ‘older people’ was broad. Findings have shown that older people’s participation declines with age and poorer health, and it might be useful to study participation more finely, within narrower bands of older age, to discover more about actual and perceived impacts of different types of participation on health and wellbeing across older age. Similarly, most of the participative factors included, though validated through their use as a battery of social capital questions in the UK General Household Survey, might be regarded as indicating quite active levels of involvement ranging from managing committees to volunteering, to attending local events. Study participants might have been involved in a range of other activities, such as meeting friends and making each other a cup of tea or going for a social walk together. Again, a more fine-tuned study might consider what older people do, and can do, to produce wellbeing for themselves and others if poor health prevents them from ‘more active’ participation.

Findings showed a link between participating in community activities and self-reported health. As health declines, participation declines and help from neighbours and friends increases, suggesting the causal mechanism is health enabling participating. We also found more participation among those with a vehicle and higher levels of education. If participation increases wellbeing, then study is required into how to increase participation for those with poor health, lack of transport and lower education levels in rural areas. Technologies may provide potential options to address these challenges. Qualitative findings showed that community members’ understood participation to be ‘good for their community’ and derived wellbeing from the idea of living in a community that ‘participates’ and includes/maintains “beyond spaces” (Wiles et. al., 2009). There appeared to be a more submerged acknowledgement that participation in community activities might also be good for their own and others’ health. Although research evidence is growing and strong on the benefits of participation, the individual wellbeing benefits of participation perhaps need to be further highlighted to community members by health promoters.

There is a widespread assumption that rural communities are stronger in social capital than urban communities, although the ‘dark side’ of rural social capital has been highlighted by some writers. We found varying levels and types of participation in different communities, with a tendency for this to be associated with residents’ socio-economic characteristics. This aligns with calls for greater understanding of the patchy nature of rural disadvantage and argues for understanding and information about individual communities to underpin initiatives to increase capacity.

Quantitative findings produced a remarkably predictable and consistent story; for example, showing younger and healthier older people were more likely to participate, while older, frailer people were more likely to receive help from others. Qualitative findings revealed the complexity of participating within a rural community where ‘everyone knows everyone else’, highlighting tensions between formal and informal ways of providing assistance and perceptions about ‘net payers’ and ‘net recipients’ linked to tensions around retiree in-migration.

The O4O project commenced with the (apparently rational) notion that, with growing proportions of older people in rural communities, many of them younger in-migrant retirees, there was a role for developing formal and informal helping of the frailer, by younger, fitter,
older people. This was hypothesised as having the potential to release wellbeing benefits for both givers and recipients of services. Study findings show that while there is that potential (indeed, quantitative findings show it is actually happening), the social nuances of living in close-knit communities can interfere with apparently rational schemes for helping.

**Acknowledgments**

The O4O project was funded through the EU Northern Periphery Programme. Thanks are extended to all those who contributed to the project at the Centre for Rural Health and other O4O partner organisations. The research would not have been possible without the contribution of many community members. Assistance with the statistical analysis was provided by Dr. Shona Fielding at the University of Aberdeen.

**References**


Accessing Cultural Expressions of “Being” and Trauma through Phenomenological Investigation with Male African Entrants to Tasmania, Australia

Andrew J. Harris

Abstract

This chapter describes a qualitative research study which was envisaged as a partner to humanistic counselling practice. The study evolved from attempts to assist with the traumatic histories of humanitarian African entrants to Tasmania, Australia. Phenomenological methods were selected to allow for engagement with descriptions of “being” which were outside the scope of prevailing western psychological models. Data collection entailed semi-structured interviews with 16 male African entrants to Tasmania, ethnographic observation at gatherings, and two consensus groups. Major themes revealed in preliminary analysis were: an inalienable responsibility for family; assumptions of collective problem solving as an intrinsic part of community living; and an implied interdependent sense of self. This was contextualised within an immediate sense of community which was explicitly inclusive of all other human community members whether living, ancestral, or yet to be born; the physical environment, animals and plants; and spirit influences. Specific recommendations are made for working with the client groups which were part of the study, and it is concluded that a more complex and inclusive idea of human identity is required for cross cultural counselling practice.

Keywords: cross-cultural psychology, phenomenology, ethnography, trauma, Africa, spirit belief, community identity, African counselling.
Introduction

The study reported in this chapter had its origins in a long-standing desire to engage in phenomenological research as a natural partner to humanistic counselling practice. With many client groups, prevailing western models struggle to account for either the extensive history of attempts by many clients to address their issues (White & Epston, 1992), or for the periodic sense of helplessness and powerlessness on the part of the therapist (Yalom, 1980).

Working with clients in the Phoenix Centre, which in 2004 were mostly of refugee status and African origin, demanded a far-reaching re-conceptualisation of counselling practice. The client group had endured extreme experiences including extreme deprivation, poverty, starvation, multiple loss and dislocation, state sanctioned violence, massacre, rape, and torture. The guiding principle of Phoenix Centre practice was that entrants would require support overcoming the psychological consequences of these prior events as part of their resettlement process.

However, this principle and the related practice models were based on assumptions that operate in urbanised western culture. Most Phoenix clients had grown up in places in Africa where subsistence agriculture was the primary means of supporting life, with oral communication, dance, music, and communal ceremony being privileged.

Many clients were in rapid transition to western society, and for the most part, they sought help to deal with aspects of this transition. Explicit consideration by them of the possible impact of their prior “traumatic” experiences was unusual. Emphasising the influence of putative psychological effects of traumatic history therefore carried the risk of imposing western beliefs on clients. To overcome some of the cultural distance in this work, interviews were held with African staff during 2005-2006 about their own practices in working with their communities.

The transitional nature of the settlement experience also presented challenges to the formal research process which followed these interviews: any effective methodology must be capable of “capturing patterns of social relations, cultural meanings, and identities in the process of their disruption and transformation” (Eastmond, 2000, p68). Ethical requirements were problematic, particularly given the discrepancy in social power between the researcher and prospective participants. MacKenzie et al. (2007) later catalogued these ethical concerns, noting, for example, that participants can be indirectly coerced into studies and consultations which provide no tangible benefit, simply by virtue of their level of need and desperation. A staged formal research study was devised on the basis of the interviews with African staff that could account for these practical and ethical issues.

Methodology

Qualitative methods are recommended for researching complex social phenomena, especially where theoretical formulation is limited (Morse & Field, 1995). Phenomenological enquiry is a central and formative component of qualitative research, and a largely neglected

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1The Phoenix Centre is the Tasmanian service funded by the Australian Commonwealth Government to provide advocacy-based counselling support for refugee survivors of torture and trauma.
Accessing Cultural Expressions of “Being” and Trauma through Phenomenological…

development of modern counselling practice (Giorgi, 1970). The key requirement of phenomenological enquiry, known as the phenomenological reduction, is that the researcher seeks to “bracket” their own assumptions and pre-conceptions of the material to be investigated, seeking a full and accurate understanding of the phenomenon. The researcher’s own reactions and thoughts about the process need to be distinguished as much as possible from this emergent understanding (Spiegelberg, 1960).

Bracketing is not simply an intellectual technique: assumptions and pre-conceptions are represented in language, bodily presence, preferred settings, and innumerable other details of life. To comprehend or even engage with phenomena that may contradict strongly held assumptions requires openness not only to the new phenomena themselves but to new modes of understanding and new modes of living on the part of the researcher (Rowan & Reason, 1981).

Accordingly, the Phoenix Centre service principle - that entrants would require help with traumatic responses - needed to be “bracketed”. Therefore the study did not focus on traumatic responses or symptoms. Instead, respondents were interviewed about methods of counselling or “problem solving” as a way of capturing experiential data. This yielded immediate insights at many levels, including an unexpected benefit of studying transitional phenomena: African respondents frequently offered informative insights into western practices through descriptions of their own adaptation process.

(Now in my work)…If I can leave and it walks properly, then let it go its way. If there is trouble I hold the hand until they are walking. I used to work the African way; but it meant that they wouldn’t be independent by themselves; they come back tomorrow and tomorrow and tomorrow … you will be in trouble if you keep advising them; they will say “X told me to act so” and the trouble will come back to you. (South Sudan, Christian)

As well as contrasting dominant African and western counselling styles, this passage neatly shows how the culture specific issues of personal/group responsibility and accountability are tied together with counselling practice.

Examples of other relevant methodological strategies were:

- The study was limited to male participants to minimise the confounding effects of negotiating gender roles by a male researcher (one female was interviewed to provide perspective on male gender issues)
- Initial interviews were restricted to employed African staff, which minimised the economic power differential and provided implicit acknowledgement of their prior demonstrated interest in improving outcomes for their communities
- Respondents were explicitly interviewed about problems in both Africa and Tasmania, which allowed transitional themes to be more clearly contextualised
- The sample was expanded to include Muslim Africans because religion emerged as a prominent theme in problem solving, and all initial participants identified explicitly with Christianity

The guiding questions were:
What can you tell me about traditional counselling practices in Africa, or other ways people handled problems?

How have you dealt with problems yourself, both in Africa and now in Tasmania?

This layering of questions enabled respondents to make direct or indirect comparisons between their own problem solving attempts and traditional approaches. By being asked about traditional approaches first, respondents were cued to the shifts that had occurred in their own lives, and encouraged to contextualise their difficulties within their history of survival.

Other consultation processes, mostly conducted through agencies working in the sector, were focussed on the settlement experience itself, and from these it was clear that although generally appreciative of the opportunities provided, entrants had problems with work, accommodation, education, racism, and family cohesion (Flanagan, 2007), and encounters with police and other statutory authorities (Campbell, 2007).

There was anecdotal evidence of over-consultation: some respondents reported that they would attend consultations and give voice to their needs; that nothing would change, and they would again be asked what was needed. A partial resolution of this discomforting feature of the work emerged from one respondents’ description of how my unplanned presence at a memorial gathering had encouraged the community:

… you spoke, and shared the pain that people were having … you have lifted up their spirit “oh we have people who can support us, look at this person” … the people that you help, you will always get information from them … (South Sudan, Christian)

The quote highlights the cyclic and potentially recursive nature of such research: simply through my presence at important events, I was seen as a source of support for communities: an answer to my own research question. In order to exploit this finding-in-process, ethnographic observation was explicitly included in the methodology, informed by Lutz (1988). Ethnographic techniques also helped compensate for the primary weakness of the study: that phenomenology is itself a western tradition. Phenomenological enquiry into other systems of meaning is therefore intrinsically recursive. The western-ness of the phenomenological stance might miss, or miss-take, the meaning in an encounter with non-western lived experience. Incorporating ethnographic observation provided the opportunity to witness and experience some of the processes that were being described in interviews, and this also provided many more opportunities to clarify the significance of observed and experienced phenomena.

An outline of the study methodology is as follows:

1) Initial interviews with four male and one female African settlement staff about how problems were handled in Africa;
2) A second round of interviews of an expanded sample of 16 African men including Christian and Muslim respondents, exploring their personal experience of handling problems in Africa and in Tasmania;
3) Ethnographic observation at a range of community and household gatherings;
4) Literature review; and

5) Two consensus groups each comprising five men (not previously interviewed) from the South Sudanese and Sierra Leone communities in Launceston.

Formal interviews were held with men from Southern, Northern and Western Sudan, Ethiopia, Eritrea, Sierra Leone, Liberia, and Egypt, aged from 25 to 65. Men and women from many other African countries also contributed informally in gatherings and at conferences and meetings. The literature review was conducted after the interviews in order to provide a retrospective reliability check.

**Findings**

**Family Responsibility**

The most prominent theme within African male respondents’ reported experience was their felt responsibility for their families, informed by strong community expectations. This was particularly the case for those with children, but was endorsed by all men and was the main area of discussion in both consensus groups. The following statement was compiled from interview responses, reconciled with the literature and discussed with the groups (denoted by the term “Compilation”):

As African men, we have the main responsibility and authority to ensure that our families survive and thrive. We take this very seriously and our families are the most important thing to us. Centrelink pays mothers and children directly, who can be new to this responsibility. When Safe at Home (family violence service) or Child Protection become involved it is a big shock, and causes shame, anxiety, and anger, which can be hard to manage. Often, problems go straight to the police, and Australian laws can exclude the father and stop the community from becoming involved. Also, because they have not grown up here, many African children will misuse the protection that Tasmania’s laws give them, and parents can be wrongfully under suspicion. In African communities, all adults are expected to provide guidance to children, who are required to show respect. (Compilation)

The following quotes from interviews illustrate this theme:

When we split, I (wasn’t permitted) to see my children for three months … because my ex, she thinks I’m going to run away … I don’t like my children (to be) without father and mother. We don’t have to be together, but I have to communicate, work together for the family, for the kids … (Egypt, Muslim)

My mother still alive, my brother, two brothers, two sisters, still living Ethiopia … lot money go away. I can’t buy a house. I can’t buy clothes … because a lot money go away. (Ethiopia, Christian)
In Africa (the police) will charge that boy; if the boy is disturbed, drinking … but here, the child will be in the police car, saying my mother is doing this, my father is doing that, my elder brother is doing so and so to me … (Sierra Leone, Christian)

In order to fully grasp the potency of these issues, they must be viewed within the context of the African sense of self-in-community. The primacy of this theme was demonstrated by the fact that every respondent explicitly referred to intervention and support by experienced community members in a group setting.

"Counselling" in Community

The theme of individualistic vs. collectivistic culture has been prominent in the literature since the 1970s (e.g., Sue & Sue, 1990). Western counselling is seen to have evolved in the context of an individualistic culture, emphasising such values as self reliance, individual goal-orientation, introspection in thinking and feeling, and confidentiality. In contrast, collectivism is held to encourage security and tradition, responsibility to the group, and adjustment to group norms. Like many dichotomies, it can be misleading, carrying the risk of stereotyping both cultures and individuals, and may mask other differences between, and variations within, cultural groups. Furthermore, the individualistic/collectivistic dichotomy is itself a western construct, and may distract from the potentially destructive impact of western colonising practices themselves (Fanon, 1965). This study sought to generate descriptions from the point of view of respondents, within the acknowledged limitations of the English language and western research practices.

The following shows how the relationship between self, community, and problem-solving was construed by the African men in this study.

Most activities are determined by age and gender roles. Important decisions are made together with others, and this means that both positive and negative outcomes of decisions are shared. This provides support when things go badly, and the benefits are shared when things go well. It creates a powerful sense of closeness and trust. For personal decisions, support is mostly provided informally within the family, which is at the core of this community based approach. Marriage and children are vitally important. (Compilation)

In Africa, a particular elder or experienced person, who may be male or female, will counsel by listening very carefully to someone’s problem, to understand it properly, and help find a way out of the problem. This might involve reassurance, suggestions, advice, stories of their own experiences, or explanations of what sort of problem it is. (Compilation)

Sometimes a Pastor, Imam, herbalist, or traditional healer might be asked to help. Serious problems will affect more than one person, sometimes the whole community, and in that case the community or a group of elders may meet to discuss the problem, learn more about it, and involve whoever is needed. (Compilation)

In traditional communities elders make many of the decisions which are then followed by everybody. People may be encouraged or persuaded to follow the community interest, and community support may be withdrawn if they don’t comply. This is a very powerful threat in a strong community. In Tasmania this is not so easy but communities will try to gather together to
work out community problems, and those who have more local experience will often provide guidance. (Compilation)

The following were typical quotes:

If I have a problem with my father, my brother in law, we will sit down, OK what’s happened, dit dit dit dat dat dat … then the eldest in the family, try to fix it: oh you wrong for doing this, you wrong for doing this, you’re right, and then, getting back together … Support, always taking support … (Egypt, Muslim)

There are certain elders in the community that when you see them, you have to calm down, you know, you will definitely calm down … (Sierra Leone, Christian)

People do not want to take a house which is far away from their community group, because when something happens, the first thing they do is they call a person they trust, an elderly person or something … (Ethiopia, Christian)

Impact of Events

The relatively small magnitude of problems in Tasmania compared with Africa was often emphasised, as was the idea that having survived extreme circumstances, entrants could handle the challenges of settlement.

If you compare the situation here, and in Africa, here people are getting paid from government, every fortnight … but in Africa, there are people who doesn’t have anything, completely … what they do, they think like today, what will I eat. The first thing when they wake up in the morning … what will I eat today. Now after completing that task today, tomorrow will be a different task. Now, if you compare, the situation like this one here, I don’t think there is a problem here … there is no problem … (South Sudan, Christian)

In Sudan it’s very hard to fix a problem … (laughs) … like a filter … when water go in a filter, you can’t hold the water, you can’t stop the water … the water can always find some way out … it is like a problem every way … always another problem is coming … (laughs) (North Sudan, Muslim)

I can’t actually remember any problem that I actually solved … now when I look back, and I try to remember what used to happen to me, or the problems I used to face, I can see how horrible it must have been … Yeah it’s unbelievable, it’s unbelievable … when you sort of put things on a scale, and you can’t believe that you used to face these sort of problem … (Eritrea, Muslim)

I was persecuted since I was a child, I was accused wrongly of having weapons … I spent some time in prison, I was still a child … (shows scar on arm)… I was shot in this arm … stayed in gaol for some time … that I think was mainly the reason why I decided to leave the country … Talking about these things is not really upsetting, I’ve been through a lot, this is only a tiny bit of what I experienced, and talking about it, doesn’t cause me discomfort or anything … (West Sudan, Muslim)

Although all respondents had suffered from extreme events over protracted periods of time, few identified negative consequences to their functioning as a result. The sense of loss
and waste was often profound, and this sometimes included the loss of intellectual ability such as concentration or memory. Problems encountered in Tasmania were sometimes seen as unnecessarily provoking memories of times of hopelessness and despair that they had previously experienced.

Yes with time we get used to these things, because if you keep thinking about them you will never achieve anything or step forward … you feel hopeless, but we have to think ahead, think forward. (West Sudan, Muslim)

Generally, problems are simply accepted as part of life. If someone needs counselling it means that their problem is too big or is something new to them. Perhaps they have lost hope for the future, which is common in places like refugee camps, and can happen here if problems pile up. They might be frightened about what they have done wrong to cause the problem. (Compilation)

From guided observations at gatherings, supported by the interviews and the literature review, it also became apparent that problem solving was embedded within routine practices:

African gatherings, whether for a wedding, birth, death, or other important event, will involve eating, speeches, dancing, drumming, music, singing, and rituals. These things remind everyone that we are together and that there is community support for all parts of life. Before a gathering there will be meetings to organise and allocate tasks and collect funds, and the women will prepare and cook the food. There will be lots of discussion about life at these times, sometimes the men and women separately, and sometimes together, with the children playing together. Many problems are dealt with at such gatherings, especially the settlement of disputes and the redefinition of roles; although some problems continue for generations. (Compilation)

One respondent reported a tangible sense of connectedness:

The point is … African way of life is … about being close to other people or connected … there’s that … there’s that … there’s no… nothing; we are still learning actually … to live as individuals, and that’s what we got here. In Africa, your neighbour is your mother … your friend, your brother, and everything … in times of need, your neighbour is the first person to respond … here is a different story. (South Sudan, Christian)

It is difficult to convey the emotional weight with which such things were spoken: the phrase “there’s that … there’s that … there’s no … nothing” suggested at the time that the respondent was at a loss to capture the contrast with Tasmanian culture.

Respondents themselves identified the family responsibility issue as foremost, and the following compilation influenced by Wooding (1995), portrays the complexity of this responsibility:

As Africans we are together with other people and all other things in the world. We are not separate, and whatever affects the community or world, affects us. Depending on the community, the African world might include God, ancestors, spirits, especially of the soil, forests, mountains, and rivers, animals, plants; and other things we can see or can’t see. This is especially true for those of us from villages or small towns, where we rely on agriculture to live and are very close to the natural world. (Compilation)
The notion of community thus emerges as more intimate, inclusive, immediate and active than is routinely understood in the western context. It conjures an idealised notion of a community in harmony: indeed, “Harmony Restoration Therapy” is the name of a modern African psychotherapeutic technique (Oluka, 1995). This sensibility was not universally endorsed; indeed two respondents pointed to a darker side of community life, for example:

People, they didn’t want someone to progress...they just want people to be all the same ... like if I am poor, I don’t have anything … I always go and beg; people want me to remain that way … and if my children start to grow up and prosper, in a different way … they will get rid of all these children who are trying to prosper … they just want to make sure people are all the same. (South Sudan, Christian)

What would be defined in western terms as the men’s “gender role identity” (Pleck, 1981) associated with family responsibility could thereby more accurately be described as an essential and unalterable component of the universe, supported and enforced by all living and non-living things. The impact of loss of role in this context could be devastating:

Before, he lost his home and his livelihood and his safety and his connection with his ancestors, perhaps his family members. Now, he has succeeded in getting to Tasmania but this success has destroyed his life completely. (Sierra Leone, Christian)

In the Sierra Leone consensus group an issue was raised that, although not explicitly addressed, was implicit in many of the interviews. It was agreed that most men would not actively seek help for fear of being seen to be weak and inadequate: again this is consistent with western gender role theory. However, African male entrants were disconnected from the support systems that might have assisted them in fulfilling their role, and were also likely to be experiencing anxiety attached to the possible unknown consequences at ancestral, spirit, and community levels.

The spirit aspect of community was referenced directly by a number of respondents, and is prominent in the African medical anthropology literature (eg Edgerton, 1979; Lambo, 1963).

A place like here, (interview took place in a natural setting) if it were in Africa, will be seen as sacred, because in Africa these are the places where the spirits go and live, you know like the spirits of the sea, the spirits of the forest, and normally we would come here every year maybe after the harvest, and they would come with the elders, and there would be sacrifice, there will be worship and leave some cooked food, thinking that when they go away the spirits will come and take them… (Sierra Leone, Christian)

The loss of access to spirit-based and other protective practices can be a source of profound anxiety, and care must be taken to avoid confounding this with western trauma constructs (LeVine, 2009).
God, Religion and Prayer

For all respondents, God, religion, and prayer were key components of their problem solving strategies. God was portrayed as an active force, intrinsically part of the world and therefore present in community.

How do I know (God helped) … in Africa, I get up and pray, I ask God … I say ay God! You give me the children … I don’t know how to make nobody, you give me, so God please help me, for me and my children, to survive … but before survive, he must give me place what is safe for me and my children. So if I do that from year to year to year to year, and then I see myself in Australia, I feel that God has answered my prayer. That is great! (Liberia, Muslim)

Religious gatherings were valued for the way they brought people together, as well as for the reference to a unifying God: these aspects of organised religion fit neatly with community.

In the camps, you have perhaps 1 cup of palm oil a month, and 2 kg of cornflour. The rebels come at night, you had to hide, you never know if you or your family might be killed. People turned to God in the camps, gathering and praying. I had turned to God before then, and became closer to God … there was more activity of gathering and praying and singing, this brought me closer. (South Sudan, Christian)

This sense of community appeared to be very resilient. Even when the political use of religious difference had been an aspect of the conflict (as in Sudan), the sense of community could be re-established after settlement. The following quote referred to a welcoming party that had been arranged by the Sudanese community for all new and recent arrivals, regardless of nationality or religion.

Here in Launceston, you don’t see any difference between Christians and Muslims, because we are all at the party … there are Muslims there … why is there not a problem? … because we don’t see any problem! … but if it was back in Sudan … they would be a bit aloof … like saying, “Oh God they (Christians) are not clean!” … and then we would not be associated together … (South Sudan, Christian)

Notwithstanding this, many interviews and particularly the South Sudanese consensus group, made references to the pain and enduring inter-group mistrust stemming from religious conflicts.

Recommendations

The following summaries were endorsed as practical responses to support the client group represented in this study:

For men, it is helpful if we get acknowledgement and support for the strength of our commitment to family life. If there is a problem in the family, we will work hard and quickly to fix
it. It doesn’t usually help with African families to leave the father out of the discussion. Also, it is usually helpful to involve other experienced community members. (Compilation)

We need help with our families and community members back in Africa. Keeping our hope alive that they will be safe and we will see them again keeps us positive and active here. We need more help to bring our families here or support them in Africa. (Compilation)

We need to come together and discuss our new lives, our achievements and our problems in traditional ways. Specialists could join our discussions so that we get the right information. Arranging activities which Africans are used to, like working on the land, could bring us together in a more familiar way. Gathering in natural places would remind us of the rivers, rocks, animals, plants and trees that we grew up with, and make us feel a bit more relaxed. (Compilation)

Involving neighbours in our settlement and holding activities that support interaction at neighbourhood level would help develop the sense of community. We also need stronger statements from Australian leaders that racism is not acceptable, and we need effective ways of dealing with it. (Compilation)

Many Africans have beliefs that are very different from those of most Australians, like beliefs in the influence of ancestors and other spirits. These are just other aspects of our community life, and most Africans have seen evidence of them, so they remain important to many of us. (Compilation)

Finally, the following was proposed and endorsed as a way of approaching the issue that is understood in the western framework as “trauma”; the issue that instigated the study.

You have come to a new place, so we need to help you find your way into a new community. You have lost so much. You may have lost some loved ones, and this can be hard to put out of your mind. Also, what you have gone through may make it hard to build a normal life. We can talk about how to put this harm behind you so that you can have a better chance at your new life. (Compilation)

This explicitly incorporates settlement issues in the work on “trauma”: in order to regain a proper order of things, it is necessary that the host country enable the person to attain to the necessary requirements of living, such as employment, safe accommodation, freedom from persecution, and justice.

Conclusion

This study arose from concerns that that western therapy approaches to “trauma” may have been alienating African clients. The idea emerged of a generalised African conception of the world, community and self as being interconnected. Community members take up their respective responsibilities in order to maintain this, act to pre-empt, forestall, or respond to disruptions. Serious problems are problems for the whole community. The findings support the need to re-think ideas of human identity as part of culturally safe counselling practice.
Acknowledgments

Hundreds of African men and women supported this study, in addition to my treasured respondents: I hope I have done justice to their generosity and wisdom. Dr Peg LeVine provided inspirational and patient guidance as I contended with the study’s unfolding perplexities.

References


Chapter XIV

Maternity Care Experiences of Asia Ethnic Minorities in Rural Tasmania, Australia: A Mixed Methods Study

Ha Hoang, Quynh Lê and Sue Kilpatrick

Abstract

When migrating to Australia Asian women bring with them birthing cultural beliefs and practices, many of which are different from the Australian medical and cultural understanding of reproduction. Such cultural differences may result in conflicts between clients and health care providers especially when the migrants have a poor knowledge of English. The research investigated the maternity care experiences of Asian migrants in Tasmania. The barriers that Asian migrants face in accessing maternity care services and the factors that affect their views towards maternity care were also explored.

A mix of quantitative and qualitative methods was employed. Ten women from different ethnic minorities were invited to semi-structured interviews. The qualitative data were analysed using grounded theory. Findings from the interviews were utilised to design a survey questionnaire. Of the 150 survey questionnaires posted, 121 questionnaires were returned. Descriptive statistics and Chi-square tests of independence were used to analyse quantitative data.

Asian migrants followed some traditional practices such as having good rest and eating hot food during the postpartum month. However, they tended to adapt or disregard traditional practices that were no longer applicable in the new environment including the practices of not washing or having a shower. Support is vital for women recovering after childbirth to prevent postnatal depression. Two main barriers migrant women face in accessing health care are language and cultural barriers. Country of origin, partner’s ethnicity, religion and length of stay in Australia are factors that shape the migrants’ views and attitudes towards and experience of maternity care.

Providing interpreting services, social support for migrant women and improving the cross-cultural training for healthcare providers are recommended to improve available maternal care services. The factors that affect migrants’ view on maternity care should be taken into account when providing maternity care for Asian migrant women.
Keywords: Asian women, Australia, childbirth, cultural diversity, health services for migrants, maternity care, reproductive health, barriers to accessing maternity care.

Introduction

For many migrant women, pregnancy and childbirth comprise one of the most important life events. Although childbirth is a universal biological event and similar for everyone, birth experience is not. Birth experience occurs in a cultural context and is shaped by the views and practices of that culture (Cheung, 2002; Jordan 1978; Priya, 1992; Rice, 2000). Whilst cultural diversity undoubtedly contributes to the quality of life in Australia, there are also problems caused by lack of intercultural awareness. Migrants bring their own ‘cultural lenses’ to Australia that may affect their view of the new cultural environment.

Culture refers to the way of living, distinctive knowledge, habits, ideas, norms and values, and language shared by a group of people (Bates & Linder-Pelz, 1987), and differs from one society to another. Reproductive health has a strong connection with culture. Notions of human reproduction, care of the expectant mother and the unborn child, methods of giving birth and post-natal care all vary considerably according to cultural beliefs and traditional practices, although the common aim is to maintain the wellbeing and safety of mother and child.

Cultural beliefs and practices surrounding childbirth have attracted much research (Egwuatu, 1986; Kaewsarn, Moyle, & Creedy, 2003; Kit, Janet, & Jegasothy, 1997; Liamputtong, Parisunyakul, Baosoung, & Sansiriphun, 2005). Liamputtong et al. (2005) provided detailed descriptions of traditional childbirth beliefs and practices relating to dietary and behavioural precautions and preparation for an easy birth among women in Thailand. Kaewsarn et al (2003) conducted a survey of the traditional postpartum practices of 500 Thai women in Thailand. They found the most popular practices after childbirth are sexual abstinence, restricted activity, taking hot drinks, hot baths, food restriction and practices to maintain body heat such as “lying by fire”. These studies focused on the role culture plays in pregnancy, birth and after birth in a particular country. Their findings provide insights for health professionals and assist them to better understand women from differing cultures.

Cross-cultural studies in human reproduction provide another aspect of childbirth research, and the work of Jordan (1978) is a significant contribution to this field. Jordan, an anthropologist, focused on childbirth systems in Yucatan, Holland, Sweden and the USA and investigated a range of biosocial childbirth practices across different systems. Chu (1993) conducted one of the most comprehensive studies on cross-cultural childbirth in China (Taiwan) and Australia, emphasising that reproductive beliefs and behaviour are shaped by cultural, social and individual factors. Her work suggests the potential to improve the services provided for Chinese clients in Australia by raising health providers’ awareness of traditional Chinese models of illness.

A more recent cross-cultural study took a different approach. By exploring “childbirth as a system operating within a specific cultural context” (Shi, 1999), researchers studied the childbirth experiences of some minority ethnic groups living in Western countries. The study found that the women’s traditional birth beliefs and practices are very different from those found in the migrants’ new land. Such cultural differences contribute to misunderstandings between healthcare providers in the host country and migrant patients, and this can affect the
quality and efficacy of the care provided. It has also been determined that a lack of understanding of cultural diversities (Leininger, 1978), racism and racial stereotyping (Bowler, 1993) and lack of knowledge of health beliefs (Chevannes, 2002) affected health professionals’ ability to meet the needs of ethnic minorities. Research in this area has been aimed at helping the health system and healthcare providers bridge the gap between themselves and migrant women by promoting an understanding of migrant women’s cultural beliefs and practices.

In Chinese and many other Asian cultures, following childbirth women are considered to be in a weakened and vulnerable condition and in need of special care for at least a month in order to regain their health (Pillsbury, 1978; Rice, 2000) and be protected from illness. This postnatal care month consists of a set of cultural practices that provide support and special care to the new mother. The cultural perceptions and postnatal healthcare measures are derived from beliefs about the ‘yin–yang’ or hot–cold principle (Chu, 2005). This principle holds that everything in the universe contains two aspects: yin and yang, which are in opposition but also in unison (Spector, 2004). If yin and yang are in balance, one will be in good health; however, if energy is moved in either direction, one becomes ill. In this tradition, during labour and delivery, a woman is considered to be in a “cold state”. In order to restore the balance she should keep warm by not having a bath or washing her hair. Special dietary restrictions assist recovery of the heat and energy. Women should have as much rest as possible and observe certain physical restrictions. The new mother should not leave the house for a period of time after childbirth.

According to the 2006 Australian Census of Population and Housing, Asian women in rural Tasmania account for only 0.3% of the Tasmanian population (Australian Bureau of Statistics, 2006). It is therefore unlikely that healthcare providers are familiar with specific Asian cultural practices. This chapter focused on Asian migrant women’s traditional childbirth practices, barriers to accessing maternal care in rural Tasmania and in factors that affect their view on maternity care in order to provide insights to Tasmanian policy-makers and healthcare professionals, and so improve the quality of available care.

**Methodology**

A mixed method research design with a combination of qualitative and quantitative methods was employed to investigate the childbirth experiences of Asian migrants living in rural Tasmania. Semi-structured interviews were conducted first in order to explore the key issues/cultural factors that were of most concern to Asian migrants. The results of the interviews and the issues addressed in the literature were used to design the survey questionnaire. An ethics application was submitted to, and approved by, the Tasmanian Social Sciences Human Research Ethics Network prior to the data collection process.

**Research Questions**

Three research questions (RQ) were formulated:
RQ 1: How do migrants’ views on maternity care vary after having moved to Australia?
RQ 2: What are the barriers to accessing health care?
RQ 3: How are migrants’ views and attitudes towards maternity care formed?

Sampling and Data Collection: Qualitative Method

The interview findings were addressed to answer the RQ1 and RQ2. The selection criteria for interviews were that the participants were:

- female;
- living in rural Tasmania;
- born in Asia and still sharing Asian cultural beliefs; and
- experienced in birth-giving in Australia, or in her original country and Australia.

Participants were recruited through referral by ethnic community members in Tasmania. Ten Asian women accepted the invitation to participate in an interview: 4 Vietnamese, 2 Chinese, 2 Japanese, 1 Korean, and 1 Filipino. The interviews took approximately 40 min each to complete. Interview questions are on participants’ backgrounds, their maternal care experiences in Australia, cultural beliefs and practices and how they adapted to these in a new environment, and barriers to accessing health care.

Sample and Data Collection: Quantitative Method

The findings from the interviews and issues addressed in the literature were used to design the content of the survey questionnaire, to seek answers to the three research questions. The survey questionnaire sought demographic information and used Likert scale questions designed to reflect the three themes found from the interviews.

Female Asian migrants were recruited with assistance from Ethnic Communities across Tasmania. Of 150 questionnaires posted, one 121 were returned. This represents a response rate of over 80%. Participants’ backgrounds are:

<table>
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<tr>
<th>Characteristics</th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country of origin</td>
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<tr>
<td>India</td>
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<tr>
<td>The Philippines</td>
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<td>20</td>
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<tr>
<td>Thailand</td>
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<td>19</td>
</tr>
<tr>
<td>Vietnam</td>
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<td>11</td>
</tr>
<tr>
<td>Other</td>
<td>21</td>
<td>17</td>
</tr>
<tr>
<td>Length of stay in Australia</td>
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Table 1. (Continued).

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<tr>
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<tbody>
<tr>
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<td>18.3</td>
</tr>
<tr>
<td>Two to five years</td>
<td>54</td>
<td>45</td>
</tr>
<tr>
<td>Over five years</td>
<td>44</td>
<td>36.7</td>
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<tr>
<td>Partner's Ethnicity</td>
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<tr>
<td>Same ethnic background as yours</td>
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<td>54.5</td>
</tr>
<tr>
<td>Different ethnic background to you</td>
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<td>29.8</td>
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<tr>
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<td>15.7</td>
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<tr>
<td>None</td>
<td>19</td>
<td>15.5</td>
</tr>
</tbody>
</table>

Qualitative Data Analysis

The interview data were analysed using grounded theory and thematic analysis. The grounded theory system requires the researcher to constantly analyse and compare newly gathered information before going back to new participants (Strauss & Corbin, 1990). All transcribed material was analysed sentence by sentence and coded for the participant’s meanings. Initial open coding of the data used differing codes, which were then organised into categories. The data were then repeatedly re-analysed to reassess the content and confirm the findings. Three main categories and 6 subcategories were identified. During the analysis, NVivo software version 8.0 was used to organise transcripts, themes and nodes. Quotes were referenced according to the nationality of the informant and given a number if there was more than one participant of that nationality.

Quantitative Data Analysis

The analysis of the survey questionnaire was conducted with the assistance of the computer application Statistical Package for the Social Sciences (SPSS) version 15. Descriptive statistics such as means, standard deviation and ranges were used to describe the collected data. Chi Square tests were applied to analyse the key factors that influenced the respondents’ views on the four questions from the survey that have the largest variations in the respondents’ answers. They are:

- Question 1: Women should have a shower immediately after childbirth,
- Question 2: Women should stay at home for 30 days after childbirth,
- Question 3: Asian women should follow Australian culture in maternity care,
- Question 4: Birthing mothers are best treated by female professionals only.

In this study the word “confinement” refers to the period of 30 days after birth.
Results

Qualitative Results

The three main categories that emerged were labelled (i) “Asian women with traditional practices in the new land”; (ii) “Relationship between support and postnatal experiences”; and (iii) “barriers to accessing maternal care”. The first category was explained by its 6 subcategories: “keeping warm after birth”, “diet in confinement”, “good rest and physical precautions”, “social restrictions”, “no husband present at birth” and “adaptation to the new culture”.

(i) Asian Women with Traditional Practices in the New Land

The Vietnamese, Chinese and Korean women in the study shared similar maternity care cultural practices. In their tradition, the confinement is seen as the most important period for a new mother.

Keeping Warm after Birth

Traditionally, a woman is not allowed to shower or wash her hair for at least a week after delivery and in some cases for a month, in order to keep warm.

I had to follow a set of dietary and behavioural rules during confinement period. I had to keep warm and avoid exposure to wind and could not have showers and wash my hair. (Chinese participant 2)

Diet in Confinement

It is believed that because the mother has lost heat, blood and vital energy during labour, dietary measures help recover the heat and energy.

Vietnamese women should not be served cold food and cold drink when they have a baby. Hot food and warm or hot drink are always good for women after childbirth because they feel so cold after losing blood from birth. (Vietnamese participant 1)

Good Rest and Physical Precautions

During the confinement period, the new mother should have good rest. She should not stand for long or lift heavy objects to avoid uterine prolapse.
One is exempted from housework within a month [after childbirth] so one can rest in bed. One should not walk around much because that will cause the stomach to sag. The new mother also should not keep standing for a long time and lift heavy things to avoid vaginal prolapse because her body is very ‘new’ after giving birth to the baby. (Vietnamese participant 2)

**Social Restrictions**

A woman is advised not to go out for 30 days after giving birth. The ability of the woman to ‘pollute’ after childbirth is one of the reasons she should not leave the house.

According to village tradition, after giving birth a woman is not ‘allowed’ [if living with the in-laws] to stay in the main part of the house as she is still ‘not clean’. (Vietnamese participant 4)

Another reason for not leaving the house during confinement is that the woman is highly vulnerable to a variety of illnesses due to the loss of vital energies and her cold state.

My mother-in-law advised me not to go out for a month [after birth] because I was very weak and easy to catch cold if I let wind enter my body after birth. (Chinese participant 2)

**No Husband Present at Birth**

In Vietnamese and Chinese cultures, women would not have their husbands present at childbirth.

In Vietnam, a husband is not allowed to be with his wife during labour and delivery so he does not know how painful his wife has to go through when she is in labour. Actually in Vietnam a woman is with only doctors and nurses in the labour ward. She might feel very lonely because no one can be there to support her when she needs it most. (Vietnamese participant 2)

**Adaptation to the New Culture**

As relatively recent migrants, seven out of the 10 participating women did not strictly abide by their own cultures practices and adopted practices other than their own.

I found that having a shower and washing my hair after birth was OK for me because I had a warm shower and dried my hair by hairdryer. However, I followed the practices after birth such as having a good rest to recover, eating nutritious meals and hot drink. I found it good for myself when I followed it. (Vietnamese participant 2)

The majority of women strictly observed and followed the physical precautions advised by their mothers and mothers-in-law, such as not lifting heavy objects, because they also believed that they were still weak after birth and that lifting could cause uterine pro-lapse. However, most women found it impossible not to go out for the whole month because they
had to shop and do other things. One woman explained her reason for not following the restriction on leaving home:

I saw no reason for doing that[not going out] as the environment here is very fresh and clean. (Vietnamese participant 2)

Most women in the study said that they had their husband/partner present at the birth of their child despite this not being the practice in their original country.

My husband stayed with me during my labour and I felt supported and especially when my English was not good enough to communicate with midwives and doctors. I felt that now my husband has a great sympathy for women when they are in labour because he witnessed what his wife went through. (Vietnamese participant 1)

Three out of 10 women in the study followed the Australian way of childbirth completely, although they knew about traditional practices:

Although I am aware of the differences, I followed the Australian ways of giving birth and doing baby things. (Japanese participant 1)

(ii) Relationship between Support and Postnatal Experiences

Four women who had a great deal of support from their extended family, husbands, friends and community nurses recovered very well in the month following the birth:

In six families where the husband was the only source of help but could only give a little support due to their work or study commitments, women described their postnatal experience as a contrast to that of the women who received plenty of support:

I was exhausted, teary. I cannot describe it clearly but I felt miserable and isolated. Though I still looked after my baby but I was not happy and did not enjoy it. (Vietnamese participant 1)

Two other women who had experienced childbirth in both their original countries and Australia lacked support from extended family in the new country and that made them feel tired and isolated. One woman said:

I felt lonely, isolated because I did not have many friends and my family is not here. I had only two friends to come to see me when I came back from hospital. It was very different with what I experienced in Vietnam. I did not get any support from anyone. I did all house work and looked after my two children by myself. (Vietnamese participant 3)

Although the sample is small, it appears that support plays an important role in the wellbeing and maternal health of Asian women.
(iii) **Barriers to Accessing Maternal Care**

Lack of English language skills is a reason the new mothers had difficulty in accessing services and information.

I did not go to antenatal classes because my English was not good. When I came to see the midwives, they could not understand me and I could not understand them. (Chinese participant 2)

All participants reported that they received many booklets and brochures from hospitals and healthcare providers; however, most of these were written in English:

I went to hospital to find out the information about health care. They gave me few booklets to read. I did not understand well because my English was not good. I could not read the booklets because they were all in English. (Chinese participant 2)

Language is not the only barrier that prevents migrants from accessing services and the information that should be available to them. Most Asian cultures teach people to be unassertive and inhibited from childhood. Thus, Asian women were often too reluctant or embarrassed to express their needs or enquire about services. As one woman commented:

Because we are Asian we are very reluctant to ask someone for more information. (Filipino participant)

Lack of assertiveness also prevents women from expressing their preferences. They did whatever the health professionals asked them to do, even when this went against their accustomed practices. One woman wanted to follow her mother’s advice by not having a shower immediately after childbirth and she was reluctant to follow the nurse’s instruction:

After my baby was delivered, the nurse asked me to have a shower immediately. I knew I was not supposed to do it but I was reluctant not to do it because I did not want to be against what they told me. (Vietnamese participant 2)

**Quantitative Results**

The survey questions on the views and attitudes towards maternity care held by Asian migrants in rural Tasmania were categorised into five themes namely: Asian women and traditional practices; Support; Migrants and the new culture; Barriers to accessing health care and factors affecting immigrants’ views and attitudes towards maternity care. The first theme was explained by its 5 subthemes: family advice in maternity care, warmth after birth, diet in confinement, rest and physical precaution and no husband present at birth.
(i) **Asian Women and Traditional Practices**

- **Family advice in maternity care**: Most of the surveyed women believed that advice from family members on maternity care is important with 56.67% agreed and 30.83% strongly agreed.
- **Warmth after birth**: Over 65% of the respondents agreed and nearly 29% strongly agreed that women should keep warm after childbirth.
- **Diet in confinement**: The majority of the women (52.10% agree and 39.67 strongly agree) responded that women should be served hot food and/or hot drinks after childbirth.
- **Rest and physical precautions**: Most respondents in the survey agreed or strongly agreed that women should take physical precautions during pregnancy (agree 67.50%, strongly agree 32.5%) and rest after childbirth (agree 58.68%, strongly agree 40.40%).
- **No husband present at birth**: More than half of the women agreed (63.64%) and one third (31.40%) strongly agreed that the husband should be with the woman during labour and delivery.

(ii) **Support**

All the women responded positively to the importance of family support when having a baby (agree 67.77%, strongly agree 32.23%).

The respondents also rated community support as important to the childbirth experience of a woman with 75.00% agreed and 14.05% strongly agreed.

(iii) **Migrants and the New Culture**

A large number of participants (33.88%) agreed to follow Australian culture. However, there was also a significant percentage (41.32%) of women who did not want to follow the host country’s culture and about 21% were uncertain about whether they should follow Australian culture in maternity care.

More than half (57.85%) of the respondents believed that they should follow their own cultures in maternity care, while 20.66% disagreed and 18.18% were not sure whether they should follow their own cultures when living in Australia.

(iv) **Barriers to Accessing Health Care Services**

- **Language barriers**: A significant number of women agreed that language is one of barriers to accessing health information and services. Over 73% of women voted ‘agree’ and 23.94% ‘strongly agree’ indicating their views on the barriers to accessing health care services.
- **Cultural barriers**: Although 14.05% of the respondents disagreed that Asian people are reluctant to express their needs, the majority (66.94% agreed and 15.70% strongly agreed) supported the view that reluctance to ask is one of the Asian cultural characteristics.
- Nearly half of respondents disagreed that female professionals were the best option for birthing mothers. The rest demonstrated their agreement with the gender preference of health professionals in maternity care.

(v) Factors Affecting Immigrants’ Views and Attitudes towards Maternity Care

- **Country of origin**: The analysis indicates that country of origin affects the immigrants’ view regarding whether women could have a shower immediately after childbirth and their countries of origin ($\chi^2 = 47.215$, df $= 3$, p-value $= 0.000 < 0.05$). Country of origin also affects the view that women should follow Australian culture in maternity care ($\chi^2 = 14.560$, df $= 6$, p-value $= 0.024 < 0.05$).
- **Ethnicity of the woman’s partner**: Chi Square test suggests a relationship between the Asian women’s view concerning the practice of staying at home for 30 days after childbirth and ethnicities of their partners ($\chi^2 = 40.354$, df $= 4$, p-value $= 0.000 < 0.05$).
- **Religion**: The Pearson Chi-square value of 9.576 with a p-value of 0.048 suggests, at the 5% significance level, that religion does affect Asian women’s view on whether they should follow Australian culture in maternity care.
- **Length of stay in Australia**: The p-value of the Chi-square statistic of 0.005 ($\chi^2 = 10.529$, df $= 2$, p-value $= 0.005 < 0.05$) indicates that the length of stay in Australia does affect the view on the preference for female professionals in maternity care, at the 1% significance level.

**Discussion**

Many traditional Asian maternity care practices seem unnecessary in modern times and in a developed environment such as Australia. However, these practices have functional purposes, given their historical and social contexts. Further, many Western-trained professionals believe some Chinese cultural practices actually protect and maintain the health of women to some extent (Pillsbury, 1978).

The practice of not washing hair or bathing seems unhygienic today but it was meaningful in certain social contexts, recalling the yin–yang principle discussed earlier. In addition, in the past the water supply may have been contaminated, increasing the risk of vaginal infection if used for washing postpartum (Pillsbury, 1978). However this is obviously not the case in modern Australia and many of the women in the study recognised this.

Most of the women interviewed and surveyed supported the practice of having hot food and drink after childbirth although they may not have known about traditional hot and cold
therapy. According to Western dietary analysis (Tham, 1999), many of the traditional foods prescribed for the new mother enhance the production of red blood cells. In addition, as poor families in the countryside may have once lived without refrigeration, it was safer to prescribe that foods be cooked before consumption to destroy pathogens and so prevent diarrhoea in breastfed infants. In terms of hot drinks, herbal teas can be useful to control menstrual and postpartum bleeding and discomfort, and the traditional teas given to a woman after childbirth may actually have medicinal value (Pillsbury, 1978).

The traditional practice of not leaving a house for the first 30 days after childbirth, and the belief that the new mother is ‘polluted’ and in a socially dangerous state, sounds unreasonable today in Australia. However, the historical and social contexts of the practices offer another meaning. These practices are believed to have offered protection against infection for both mother (e.g., mastitis) and newborn (Dunn, 1978); even today, the majority of Chinese and Vietnamese people live in rural areas where housing and sanitary conditions may present a risk. In these circumstances, the practice of isolating the newborn, the mother and those who come in contact with them may reduce the incidence of infections. However, in contemporary Australia such precautions do not seem practical or feasible and the majority women in this study found they were not necessary in their new environment.

In contrast to disregarding the practice of not leaving house, the women interviewed and surveyed in the study still strongly believed in having ample rest in order to regain their strength. However, new mothers can only observe and follow this practice with the support of family and society. Traditionally, Asian women commonly lived with extended family, such as parents-in-law and siblings, and this enabled their rest after childbirth. However, when they left their relatives and moved to Australia, support from the extended family was often absent. In some cases, even the partner or husband was unable to assist due to his work or study commitments.

In Australia, it has been estimated that up to 10% of mothers experience postnatal depression (PND) (Anthony, 1998; Fettling, 2002). Stern and Kruckman (1983) noted that PND is rare in non-Western countries and this could be related to the traditional practices and family support that allow the mother to rest, relieve her from housework and protect from injury and infection, all of which minimize the stresses of confinement. At the very least, traditional practices suggest it is important for postnatal women to have appropriate support for a healthy transition through this stressful period.

In the present study, the results of the interviews and the survey also indicate a potential relationship between PND and lack of support. The women studied experienced symptoms similar to those of PND, such as loneliness, isolation and exhaustion (Anthony, 1998; Fettling, 2002), perhaps due to a lack of support from their families and the community. When migrant women cannot obtain the support of distant family they must rely on the support of the community in their new country. However, being unfamiliar with the healthcare system, the women were unaware of the many services available to assist them.

Lack of English is seen as one barriers to migrants accessing health care and other services (Documet & Sharma, 2004; Durieux-Paillard & Loutan, 2005; Garrett, Treichel, & Ohmans, 1998). Language barriers also prevent knowledge of services in Australia that do not exist in their original country. Hospital-run antenatal education programs provide a range of information related to pregnancy and childbirth; however, these classes are usually offered in English and without an interpreter. For this reason, the Asian women avoided the classes, and therefore were uninformed about available services and their rights as consumers.
The women in the study received bundles of booklets and pamphlets about maternal care and services but most were in English which they could not read or had difficulty in understanding. Lack of a common language also presented many difficulties for the migrant women in communicating with healthcare providers. The lack of interpreting services compounded this. In addition, cultural differences caused further difficulties and misunderstandings when dealing with the healthcare system.

Most of the women interviewed and surveyed believed in the benefits and health value of their traditional postnatal practices and had observed them to varying degrees. Although they did not complain about different practices in Australian maternity hospitals, some expressed fear for their long-term health when they were, for instance, served cold food and drink or told to take a shower and walk about soon after the birth. Due to their socialized reticence, many were too shy to express their concerns and preferences, or to enquire about support services.

As shown in the results, country of origin, partner’s ethnicity, religion and length of stay in Australia form the migrants’ views of maternity care. Contrary to the views of many midwives who tend to regard Asian patients as a homogeneous group (Bowler, 1993; Kemp, 1985), a patient should be treated individually based on her culture, ethnicity, background and length of stay in the new country.

There are some limitations to this study. Although the researchers tried to select participants from diverse cultural backgrounds, only some Asian countries were represented. Because of this the study may not have encompassed all the traditional practices and issues of Asian women in maternity care. The small number of participants limits the generalizability of the findings. Although this research provides significant insights into the views and attitudes of Asian migrants in rural Tasmania towards maternity care, a larger study is indicated.

### Conclusion

The findings in this study suggest that language barriers are a key issue for women attempting to access the health care they need. It is vital that all migrant women are offered an interpreter, because few of these women are familiar enough with the Australian healthcare system to know about the existence of such services. Interpreters should be easy to access and require less waiting time than at present. Providing printed healthcare information in a range of languages may be another solution to the language difficulties experienced by migrants. Pamphlets or booklets about maternity care should be available in different languages, such as Chinese and Vietnamese. Healthcare professionals and hospital staff should be informed about these resources in order to provide them to migrant women in need.

Cultural barriers may be reduced by staff training in which staff develop a general understanding of and empathy for the issues migrant women deal with. Specific staff trained to improve knowledge of cross-cultural beliefs and practices relating to childbirth will reduce misunderstanding and mismanagement in providing hospital care for many Asian migrant women.

Family and society’s support play an important role in the childbirth experience of rural migrant women. In the absence of close family, migrant women may be assisted by:
increasing their awareness of healthcare services; and encouraging their participation in social
groups.

It is important to take account of these factors in providing health care to Asian women
and in understanding their approaches to maternity care. Recognition of the distinctive and
rich social, cultural and linguistic backgrounds of the clients of health services is necessary to
ensure sympathetic and effective health care (Manderson, 1999).

Pregnancy and childbirth can be the most significant events in a woman’s life. It is
potentially a period of achievement, happiness and fulfillment, but also a time of dependence
and vulnerability. This study provides some insights about the issues and problems facing
Asian migrant women in their childbirth experiences in rural Tasmania. It is hoped that the
findings will contribute to the enhancement of healthcare services for vulnerable migrant
women in rural Tasmania.

Acknowledgments

We would like to express our great appreciation to Asian migrant women in Tasmania,
Australia who participated in the study. Without their willingness to do the interview and
survey, this study would never have been completed.

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Chapter XV

International Students: Their Health and Education Journey

Yun Yue and Quynh Lê

Abstract

International students belong to one type of “sojourners”. According to Paige (1990), international students are defined as individuals who temporarily live in a host country rather than their home country in order to participate in international education as students. They are normally young, well educated, highly motivated and adaptable (Furnham & Bochner, 1986). As a type of sojourners, international students share the same characteristics with other types of sojourners but also have their own features. Living in a new country which is culturally different from their home countries poses big challenges to sojourners. There are added challenges for them as students when they have to cope with a different educational system. The constant pressure of living and studying in a different culture has some impact on their health and wellbeing. This chapter will discuss the health and wellbeing of international students generally and in Tasmania particularly.

Keywords: international students, adjustment, psychological wellbeing, acculturation.

Introduction

In recent years, due to economic development and globalisation, there has been a dramatic increase in the number of international students coming to Australia to further their education. Not only do they contribute financially to Australia, they also bring a diversity of cultures into this country. Therefore, international students have become a significant population group in Australian society. The government, educational institutions and scholars from different disciplines are paying more and more attention to this special population group for a variety of reasons in terms of policy, research, economics, cultural diversity, etc. At
present, there is a great deal of research and literature about international students’ perceptions of their academic challenges and experiences, but less about their physical and mental health. Some pilot research (Axelson, 1993; Bock, 2008; Sandhu, 1995; Sandhu & Asrabadi, 1994; Winkelman, 1994) suggests that international students are a particularly vulnerable group in terms of their health. They are susceptible to physical diseases and psychological problems due to linguistic, cultural and religious differences and barriers caused by environmental transition. The aim of this chapter is to examine the health of international students and identify the adjustment problems that affect their health and wellbeing.

**General Living Factors**

**Diet and Eating Habit**

Diet directly influences one’s health. “A healthy diet should contain all of the required nutrients and sufficient calories to balance energy expenditure and provide for growth and maintenance throughout the life cycle” (Bidlack, 1996, p. 422). Insufficient nutrient intake leads to an accumulation of toxins within the body, resulting in chronic non-communicable diseases (NCDs) (Elmadfa & Freisling, 2005). However, there is little research on international students’ diet. Due to cultural differences, international students may have difficulties adapting to the local food and cooking style. Also, a lack of traditional family support may result in unhealthy nutrition patterns such as skipping breakfast and increased snacking (Ramakrishna & Weiss, 1992). According to Rosenthal, Russell and Thomson (2006), the number of meals per day is an important factor in judging nutritional balance, with students who eat fewer than three meals per day paying less attention to their diet than those who eat three more meals per day. Another factor is the source of student meals. Students who mainly eat home-cooked meals have greater knowledge of their nutritional balance than those who mainly eat fast food.

**Accommodation**

Accommodation is the most frequently mentioned university service which international students specify using (Rosenthal, et al., 2006). The quality of accommodation directly influences international students’ health and wellbeing. According to Ward and Masgoret’s (2004) research conducted in New Zealand, international students mainly live in rental accommodation (43%) or lodge in home-stays (42%). A small percentage stay in hostels (7%), their own homes (3%) or the homes of relatives (4%). Students who live in their own home or that of relatives are most satisfied with their accommodation. Students who lodge in home-stays are more satisfied than those who live in rental accommodation and student hostels. Similarly, Rosenthal et al. (2006) find that students who stay with their family members or partners are most satisfied with their living arrangements, while those living with others are the least satisfied. The research also finds that students with the highest level of
satisfaction with their accommodation have significantly lower levels of stress, depression and anxiety.

Transportation

Apart from accommodation, transportation is another important factor that influences international students’ quality of life in unfamiliar environments. In Williams’ (2007) study, the absence of adequate public transportation or access to a car was problematic for some Asian students, as it was perceived as promoting a dependency on others, which made some students uncomfortable. This indicated that the accessibility and quality of transportation influence international students’ wellbeing. Safety, affordability and public transit service are three factors related to transportation and health. Farhang and Bhatia (2005) state that the high cost of transport, fear of violence, the unreliability of schedules, lengthy transit-routes with multiple transfers and long wait times can cause stress, which has a direct relationship to physical and mental health outcomes such as tiredness, depression and impaired immune response.

Financial Problem

Adequate finances are essential for international students to acquire food and shelter (Khawaja & Dempsey, 2008). The general perception that most international students are wealthy is, in fact, not true (Cadieux & Wehrly, 1986). A review of literature found that financial concerns are commonly identified as one of the greatest sources of stress for international students (Chen, 1999; Mori, 2000; Mullins, Quintrell, & Hancock, 1995), and Galloway and Jenkins’s (2005) data also show that “financial aid” is the most significant adjustment problem for international students. Increasing tuition fees and living expenses are the main sources of financial stress (Chen, 1999). In addition, little or no access to welfare benefits, scholarships and loans, and the considerable responsibility of paying out-of-state tuition may increase international students’ financial pressure (Lin & Yi, 1997). Rosenthal et al. (2006) found that family is the most common source (84.6%) of financial support for international students. Other sources include paid work (28%), their own savings (20.4%) and scholarships (20%). Students who are mainly supported by family are less worried about money than those who are supported by other sources. The authors also found that worrying about finances was significantly related to international students’ levels of depression, stress and anxiety (Rosenthal et al., 2006).
Academic Factors

Inadequate Language Ability

Language barrier is likely to be the most prevalent and significant problem for overseas students (Mori, 2000), especially for those who had little practice in or exposure to English in their home countries (Liu, 2001). According to Rosenthal et al.’s (2006) research, in which 85% of participants were from Asian countries, 24% of the international students reported that they had difficulties with English writing and 22% with fluency in oral English. Ward and Masgore (2004) also report that “making oral presentations” is the greatest academic difficulty that international students face. The other top four difficulties are “taking tests or exams”, “expressing yourself in English”, “expressing opinions to the teacher” and “writing assignments”.

These difficulties caused by inadequate language ability could result in academic failure, which could lead to shame and depression, particularly for those cultures in which “face” is integral to identity (Chen, 1999). Therefore, English language inadequacy is a significant predictor of acculturative stress (Yeh & Inose, 2003) and has deleterious consequences to the psychological wellbeing of the international students (Redmond & Bunyi, 1991; Yang & Clum, 1994).

Unfamiliar Teaching and Learning Style

An unfamiliar educational system is one of the greatest adjustment difficulties for many international students. When learning and teaching styles in the host country conflict with previous educational experiences, it often takes a long time for overseas students to adapt to their new academic environment, and the process of academic adjustment is related to their psychological wellbeing (Arthur, 2004).

According to Hofstede’s theory of cultural dimension, Australian can be defined as a country which is characterised by low power distance, individualism, masculinity, uncertainty acceptance and short-term orientation (Hofstede, 1986, 1991, 1998, 2007; Hofstede & Hofstede, 2005; Nunez, 2003) and its educational style is consistent with these cultural characteristics. Therefore, international students, especially those from countries with different cultural characteristics, may have more difficulties adjusting to the unfamiliar teaching and learning style.

Curriculum Content

Curriculum content is another factor that may interfere with international students’ successful adaptation to their new academic environment. Some examples used in the classroom are derived solely from the host culture and society; therefore overseas students may not fully understand the meaning of examples. They may feel they are being excluded from the classroom and some students even feel like they do not belong in the local academic
context (Arthur, 2004). Ward and Masgoret (2004) examined the issue of cultural inclusiveness in academic context and found that students from different cultural backgrounds feel academically and culturally excluded. Students from China felt the least culturally included, followed by students from other parts of Asia, whilst students from Europe, North America, South America and Australia feel more culturally included. Generally, males reported more cultural inclusiveness than females.

### Socio-Cultural Factors

#### Cultural Value Conflicts

According to Inman, Ladany, Constantine and Morano (2001), cultural value conflicts are cognitive contradictions that are caused by differences between the values and expectations in the host culture and that of an individual’s culture of origin. Values are acquired early in life through family and community, and later through school. Once a value is acquired, becomes integrated into the value system of the group of people. Value systems of individuals are relatively stable but can change based on changes in culture and personal experiences (Straub, Loch, Evaristo, Karahanna, & Strite, 2002). International students, who are living in a different cultural context encounter cultural values conflicts, which can influence their mental health and psychological wellbeing. For example, many African students from Kenyan, Nigerian, and Ghanaian cultures who emphasise communalism, harmony, collectivism and cooperation may experience cultural difficulties when interacting with white American students, who tend to value independence and self-reliance in relationships (Markus & Kitayama, 1991; Swagler & Ellis, 2003). According to Lin and Yi (1997) Asian students are often stereotyped as reserved, quiet and non-assertive, since Asian cultures tend to emphasise the value of harmony, respect, patience and deference. Hence, Asian students would feel uncomfortable when they interact with local people whose cultural values include assertiveness and firm negotiation.

#### Deficient Intercultural Communication Competency

Another factor influencing the degree to which international students adapt to new socio-cultural environments is deficient intercultural communication competency. Besides basic grammatical knowledge, language competency also includes other three components: social linguistic competence (rules of using forms and meanings in various contexts); discourse competence (knowledge of combining forms and meanings to achieve conformed spoken and written discourse); and strategic competency (Liu, 2001). The ability to which international students can adapt to different perspectives due to cultural differences is strongly tied to communication competency. Competency of communication in the host culture impacts upon students’ confidence in adapting to the host culture and the quality of their social interaction. Communication competency also influences international students’ social integration, which refers to the degree to which they engage in the social networks of the host culture (Arthur,
Therefore, deficient social communication competency not only limits the degree of international students’ successful adaptation to the new communication context, but also influences their psychological wellbeing and may result in mental stress. Redmond and Bunyi (1991) examined the relationship between psychological stress and intercultural communication competence among 644 international students attending a university in the U.S. They found that two factors of intercultural communication competence - adaptation and social decentering, accounted for 16% of the variance in amount of stress reported.

**Social Contact**

The extent of social contact within the host society is another factor related to international students’ socio-cultural adjustment. Many pioneer researchers (Heikinheimo & Shute, 1986; Klineberg & Hull, 1979; Sellitiz, 1963) agreed that social contact positively influences international students’ social, cultural, and academic adaptation. Sellitiz’s (1963) interviews with 348 male students showed that close social interaction with local people was related to favourable attitude to American culture and better adaptation. Heikinheimo and Shute (1986) also found that those students who have more social contact with people from the host country have better social, cultural, and academic adaptation. Kilneberg and Hull’s (1979) research had a similar conclusion that international students who made more satisfactory social contact, and established more positive relationships with local people during their sojourn, reported more satisfaction with their academic and social experience. However, according to “sojourner” theory (Siu, 1952) and other researchers (Rosenthal, et al., 2006; Ward, Bochner, & Furnham, 2001), most international students, mainly have contact with people whose cultural background is similar to their own. For example, Rosenthal et al. (2006) found 29.6% of participants have no social contact with Australians within the university, and 39.4% have no contact with Australians outside the university. Only 20% of participants had a reasonable degree of social contact with Australians in either context. Besides, Asian students had more contact with people of similar cultural background and less with Australians than non-Asian students (Rosenthal, et al., 2006).

**Racial Discrimination**

Research has found that a sense of exclusion and alienation among international students is largely due to perceived racial discrimination from the host country (Brislin, Cushner, Cherrie, & Yong, 1986; Searle & Ward, 1990). According to Matsumoto and Juang (2004), discrimination is a perception that one is subjected to unfair treatment on the basis of one’s group membership. Research has reported that international students generally experience racial discrimination in the host social context. For example, Constantine et al. (2005) finds that African students who study in an American university typically perceived Americans to view Africans as less intelligent than themselves, and occasionally report that they also are prejudiced by Black Americans and other international students. Ward and Masgoret’s (2004) research conducted in New Zealand also finds that students from Europe, North America, South America and Australia report the least discrimination, while students from Asian
countries report more discrimination. Additionally, students with less social contact with local people, more contact with co-national friends and poorer English skills report more discrimination.

**Personal Psychological Factors**

**Homesickness**

Homesickness is among the most frequently reported complaints among international students (Hannigan, 2007; Yi, Lin, & Kishimoto, 2003). According to Rajapaksa and Dundes (2002), more than 30% of international university students feel homesickness. Lu (1990) reveals that 95% Chinese students studying in the UK have experienced homesickness. Language skills, cultural differences and gender are correlated with students’ homesickness. “Language proficiency is an important factor both within and beyond the classroom wall” (Hannigan, 2007, p. 63). Students who have lower host country language proficiency may feel more homesick, since deficiencies in the host language lock international students out of academic and social interaction, as a result making them appear to be particularly foreign. The greater the degree of difference between international students’ home and host cultures also increases the likelihood that homesickness will be experienced (Ye, 2005). Research conducted in the United States finds that western European students have the least degree of acculturative stress (Church, 1982), Asian students appear to have greater acculturative stress than European students (Wei et al., 2007), and Middle Easterners and Latin American students usually fall between the two extremes (Church, 1982). Gender is also a variable which accounts for homesickness (Poyrazli & Lopez, 2007; Pruitt, 1978; Ye, 2005; Zwingmann & Gunn, 1983).

**Loneliness**

Loneliness is another psychological burden among international students. According to an Australian study, 65% of international students report that they have experienced loneliness and isolation (Sawir, Marginson, Deumert, Nyland, & Ramia, 2008). Constantine et al.’s (2005) and McClure’s (2007) research focus on African undergraduate students in an American University and Chinese postgraduate students in a Singapore University respectively. Both studies found that loneliness and isolation are common psychological adjustment difficulties for international students.

According to Green, Richardson and Schatten-Jones (2001), young students have a significant negative correlation between loneliness and the number of social contacts. Some research (e.g. Rajapaksa & Dundes, 2002; Sawir, et al., 2008; Weiss, 1973) has reported that women are more likely to be lonely than men, while other studies (Deniz, Hamarta, & Ari, 2005; Poyrazli, Arbona, Nora, McPherson, & Pisecco, 2002) drew a different conclusion, noting that male students have a greater level of loneliness than female students. However,
other research has noted that gender is not significantly associated with loneliness. (e.g. Russell, Peplau, & Cutrona, 1980).

**Depression**

Depression is a common emotional disorder, which causes distress and impairs functioning (Khawaja & Bryden, 2006). Besides academic and social stress, international students have to confront acculturative stress, and therefore they are more liable to depressive symptoms. According to Wei et al. (2007), approximately 30% of Asian international students have indicators of clinical depression. The literature provides many examples of the relationship between demographic factors, such as age, gender, cultural background, host language proficiency, length of stay and levels of depression.

Some studies (Misra, Crist, & Burant, 2003; Rajapaksa & Dundes, 2002) agree that female international students are more depressed than male students. In contrast, Poyrazli et al. (2002) find that male international students have higher levels of depression than female students. Other studies which investigate the relationship between cultural background and depression have reported similar results. Rosenthal et al.’s (2006) study shows that students from Europe and Latin America studying in Australia have the lowest depression levels, while students from Hong Kong, Malaysia, India, and some African countries have the highest levels. Tafarodi and Smith’s (2001) study conducted in the UK similarly report that Malaysian students display more depression symptoms than British students. Additionally, lower English proficiency has a negative correlation with levels of depression (Poyrazli, et al., 2002; Sumer, Poyrazli, & Grahame, 2008; Yeh & Inose, 2003).

**Anxiety**

Anxiety is another common psychological reaction to the external environment. There is limited literature on the topic of anxiety among international students. Only Rosenthal et al. (2006) identify some demographic and situational variables that distinguish international students’ levels of anxiety. For example, younger students are found to be more anxious than older students; single students have higher levels of anxiety than students with partners; and undergraduate students are more anxious than students enrolled in other courses. Additionally, students from Europe, Britain, America and Canada had the lowest level of anxiety, while students from Malaysia, Hong Kong and Africa indicate highest levels.

**Conclusion**

The health and wellbeing of international students has drawn more and more attention in recent years. The discussion in this chapter focuses on key areas such as general living conditions, academic factors, and social-cultural and psychological issues. Each area includes several sub-factors that are closely related to international students’ demographic characteristics, which include age, gender, cultural background, language proficiency, and
length of stay, etc. It is important to point out that international students have made a great
contribution to their host countries, financially and culturally. In return, the host countries
should not only provide a good educational system for them but also care for their health and
wellbeing so that they can have a smooth educational journey in a new cultural environment.

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Chapter XVI

Hepatitis C Knowledge and Beliefs among Culturally and Linguistically Diverse Drug Users

Penny Allen and Lisa Maher

Abstract

This chapter describes a qualitative study of hepatitis C knowledge and beliefs among young injecting drug users from Vietnamese-speaking, Spanish-speaking and Arabic-speaking backgrounds in South Western Sydney. Focus groups with Vietnamese, Spanish and Arabic-speaking participants were tape-recorded and transcribed and transcripts were analysed using Grounded Theory. Findings indicated poor levels of understanding of the hepatitis C virus and its effects on the body. There was also confusion surrounding the terms “negative” and “positive” in relation to hepatitis C testing. Results emphasise the need for health services to engage with drug users from non-English speaking backgrounds to develop culturally appropriate blood-borne virus prevention interventions and increase the uptake of screening and antiviral treatment in this group.

Keywords: hepatitis C, prevention, drug users, CALD, Vietnamese-speaking, Spanish-speaking, Arabic-speaking.

Introduction

Hepatitis C virus (HCV) infection is a major public health problem associated with considerable morbidity, mortality and health-related costs (Gidding, et al., 2009; Razali, et al., 2007). Approximately 278,000 Australians are infected with the virus, with an estimated 204,000 chronically infected (NCHECR, 2008) and at risk of cirrhosis (Thein, et al., 2008), liver cancer (Amin, et al., 2006a) and death (Amin, et al., 2006b). The vast majority of
infections, particularly new infections, occur in people who inject drugs (NCHECR, 2008) with 86% of the estimated 9,700 new HCV infections per annum due to injecting drug use (Hepatitis C Virus Projections Working Group, 2006). Despite the early and widespread implementation of harm reduction in Australia, incidence (approximately 25% per annum) (Aitken, et al., 2008; Maher, et al., 2006) and prevalence (60-70%) (NCHECR, 2009) of HCV among injecting drug users (IDUs) remains high.

Prevalence and incidence of HCV among IDUs from culturally and linguistically diverse backgrounds (CALDB) is even higher. In a prospective study of new IDUs (aged below 30 years or injecting for six or less years) in South West Sydney, incidence among CALDB IDUs was 81 per 100 person-years, compared to 29 per 100 person-years in Anglo-Australian IDUs. Additionally, CALDB independently predicted incident HCV infection (Maher, et al., 2007). While new IDUs shared common risk factors, strong associations were observed between HCV seroconversion and sharing injecting equipment in CALDB, but not in Anglo-Australian, new IDUs. The higher risk profile of CALDB IDUs may be due to high levels of social isolation, limited awareness of blood-borne viruses and lack of engagement with health services (Hellard, et al., 2006; Ho, et al., 2008; Kelsall, et al., 1998; Louise, et al., 1998; Maher, et al., 2001). Despite the fact that they represent a particularly vulnerable and hard-to-reach subgroup of IDUs at high risk of HCV infection, there is a dearth of information on HCV among IDUs from CALD backgrounds. In particular, little is known about Vietnamese-speaking, Spanish-speaking and Arabic-speaking background IDUs living in Australia, although these groups are likely to face language and cultural barriers in accessing mainstream HCV prevention services (Coupland, et al., 2009; Higgs, et al., 2009; Higgs, et al., 2008; Maher, et al., 2009).

Methods

Aims

The study had two main aims. Firstly, to describe HCV knowledge and beliefs among IDUs from Vietnamese, Spanish and Arabic-speaking backgrounds in South Western Sydney, and secondly, to explore knowledge of, and attitudes towards, mainstream and language-specific HCV prevention services.

Qualitative Research Methodology

Health research in Australia tends to be dominated by the use of epidemiological data and quantitative survey methods which emphasise the need for objective “facts” - what, how many and with what frequency? In contrast, qualitative research seeks to explore not simply how many people are infected with a particular virus but - how people are affected, what matters, to whom and why? Qualitative methods are unique in their ability to explore and analyse the relationships between culture and health. They provide rich data on the ways in which meaning is constructed and maintained by individuals and social groups. This
facilitates the social, cultural, structural, economic and physical contextualisation of health knowledge and beliefs. This, in turn, promotes a deeper understanding of the ways in which knowledge and beliefs about HCV, injection risk behaviours and prevention services are constructed and disseminated within and by CALDB IDUs.

Grounded Theory is a qualitative methodology designed to facilitate the systematic analysis of data in order to generate new hypotheses, explanations and interpretations (Glaser, et al., 1967). The methodology is a process rather than a static model of analysis. It essentially allows for the development of theories and understandings through data. Glaser & Strauss (1967) proposed that Grounded Theory involves three principle features: theoretical sampling, constant comparison and the use of systematic coding. Theoretical sampling is purposive rather than random, thereby allowing the researcher to select research participants in order to achieve the greatest theoretical return (Strauss, et al., 1998). Constant comparison involves the systematic coding of data whilst generating a theory. The researcher constantly cross-checks the data coding with emerging categories and theories. In this way, categories which initially seem unrelated may be eventually integrated into a central theoretical framework. The third element of Grounded Theory, systematic coding, is composed of three sub-types of coding: open, axial and selective. Glaser & Strauss (1967) argue that each coding approach should be utilised to ensure rigour and full exploration of the data.

Grounded Theory is a particularly appropriate methodology to explore HCV knowledge, beliefs and risk behaviours among CALDB IDUs which has the potential to “offer insight, enhance understanding and provide a meaningful guide to action” (Strauss & Corbin, 1998, p.12), rather than forcing results into existing models of health beliefs.

Recruitment and Data Collection

Participants were recruited using purposive sampling strategies, including snowball sampling through previous research contacts, and street and social networks. Flyers advertising the focus groups were also distributed by Needle and Syringe Program (NSP) and Drug and Alcohol service staff. Efforts were made to recruit equal numbers of men and women to each focus group.

Three focus groups were held with a total of 33 IDUs. Participants were asked to complete an anonymous questionnaire prior to commencement of the focus group. All participants had English-language skills, although they were encouraged to speak in community languages as arrangements had been made for local service staff to translate the focus group transcripts at a later date. Focus groups were conducted by two experienced ethnographers and lasted a median of 89 minutes (range 84-93 minutes). Bilingual NSP, Drug and Alcohol service staff or health education officers were present during each focus group to assist with translation. Ethical approval for the research was granted by the University of New South Wales Human Research Ethics Committee. All participants provided written consent to participate, and for the focus group interview to be tape-recorded, prior to participation.
Data Analysis

Questionnaire data were entered into SPSS version 12.0.1 (SPSS Inc., Chicago, USA) for descriptive analysis. Tape-recorded interviews were transcribed verbatim in Microsoft Word (Microsoft Corporation, Redmond, USA). Transcripts were then read through while the interviews were played back to check for errors or omissions. After quality-assurance, transcripts were imported into QSR-Nvivo version 7 (QSR International, Doncaster, Australia) for analysis. Transcripts were systematically manually analysed in QSR-Nvivo using open, axial and selective coding methods until theoretical saturation of the data were achieved.

Findings

Demographic Characteristics

There were 16 participants in the Vietnamese focus group, eight women and eight men. Eleven participants were born in Vietnam, four in Australia and one in Hong Kong. Vietnamese was the language spoken at home for 11 participants, English for four and Chinese for one person. Eight had previously received some form of drug treatment and 12 had a history of incarceration. The average age was 21 years (range 17-28) and average age at first injection was 17 years (range 14-21). Eleven participants had been previously tested for HCV, six reported a negative result, three reported a positive result and the remaining two did not know their results. Four participants reported using a needle and syringe after someone else in the past month.

Unfortunately it was not possible to recruit women participants for the Arabic and Spanish-speaking focus groups. From the total of 12 men who participated in the Spanish focus group, four were born in Chile, two in Honduras, two in El Salvador, two in Australia, one in Uruguay and one in Spain. Ten participants reported that they spoke Spanish at home, one English and one participant reported that a combination of the two languages were spoken at home. Average age was 29 years (range 20-41) and average age at first injection was 21 (range 15-30). Eight reported previously receiving drug treatment and four had a history of incarceration. All 12 participants reported being tested for HCV, although two reported that they were tested prior to a test being available and may have confused hepatitis C with hepatitis B testing. Eight participants reported a HCV positive status, three reported a negative result and one did not know his result. Two participants reported using a needle and syringe after someone else during the past month.

The mean age of the five men who participated in the Arabic group was 31 years (range 29-39) and the average age at first injection was 22 years (range 17-25). Two participants were born in Australia, two in Lebanon and one in Kuwait. Three reported Arabic and two reported a combination of English and Arabic as the languages spoken at home. All five men were currently receiving methadone treatment and three had a history of incarceration. Attempts to recruit a non-treatment sample of Arabic-speakers proved unsuccessful. All three participants who reported being previously tested for HCV had a positive result. Two Arabic-
speaking participants reported using a needle and syringe after someone else during the past month.

Focus Group Results Vietnamese-Speaking Group - HCV Knowledge and Beliefs

Knowledge of HCV and routes of transmission were influenced by age and duration of injecting drug use. Participants who had been injecting for several years had increased levels of knowledge compared to those who had recently commenced injecting. Younger participants were confused about the risks of HCV transmission through sharing injecting paraphernalia, sexual activity, kissing and eating utensils. Some younger participants believed that HCV could be transmitted through saliva.

You need a lot of saliva to catch it. (Participant 5, Vietnamese-speaking group)

Most participants, particularly those who were older, were aware of the risks associated with the direct sharing of needles and syringes. During discussion about the risks of transmission through sharing injecting paraphernalia, many older participants agreed that spoons, water and filters could effectively transmit the virus. However, very few younger participants contributed to this discussion.

Of great concern was the common misconception that individuals could infect themselves with HCV through the re-use of their own used needles and syringes. When the group was asked to describe how this occurred, participants explained that blood in needles and syringes became infectious through a combination of exposure to air (which dries and possibly contaminates the blood) and the passage of time. Participants explained that if a person immediately re-used their needle and syringes they would be not become infected with HCV. However, needles and syringes could become infectious with the passage of time.

I used my old syringe, reuse and reuse and reuse alright, I did do that, I don’t share needles but that’s what I did and the virus, and I think it’s very hard to get rid of the virus, you know, it’s very bad, and after every time you use, it’s old and then more old and more old and then it turn into hep C because it’s so old and you’re using it over and over again the virus getting more and more. (Participant 11, Vietnamese-speaking group)

There was considerable debate as to effective methods of needle and syringe sterilisation, with some participants stating that hot or cold water effectively kills or de-activates the virus. While several participants mentioned bleach as important for sterilisation, none explained the method described in hepatitis C prevention pamphlets as most effective, although not guaranteed, for de-activating the virus (two cool water flushes, two flushes with bleach for 30 seconds followed by another two cool water flushes).

Many participants mistakenly believed HCV commonly led to visible symptoms. A jaundiced complexion, yellow eyes and pale skin were thought to be typical symptoms. Only one young person attributed this to hepatitis B rather than HCV.
There was also a great deal of confusion regarding hepatitis C treatment. Some participants believed that HCV could be “cured” through a liver transplant. Other “cures” identified by the group included Chinese herbs and radical treatments such as the removal of infected blood, “you suck all your blood out”. The group did not mention conventional medical treatments such as interferon and ribavirin therapy.

**Spanish-Speaking Group - HCV Knowledge and Beliefs**

During a discussion on the origin of hepatitis C, several participants stated that they believed HCV and HIV were deliberately manufactured by the United States (US) government "in a lab" with the intent of eradicating IDUs in developed countries and entire populations in developing nations. This finding is similar to studies which reported genocidal conspiracy beliefs about the origin of HIV to be prevalent among Hispanic and African-American populations in the United States (Bogart, et al., 2003; Bohnert, et al., 2009; Ross, et al., 2006; Zekeri, et al., 2009).

Could be like with HIV, maybe a bacteria made out of chemicals. That’s what I think ’cause that’s how HIV was invented ... invented by the Americans ... Hep C can be some chemicals as well, put maybe into the drug. (Participant 3, Spanish-speaking group)

Other participants believed that the hepatitis C virus originated in the air and “somehow got into the body”.

If it’s a virus, it has to come from the air, it’s an airborne disease. (Participant 7, Spanish-speaking group)

These participants believed that air could act as a vector for the transmission of hepatitis C, although they were not able to explain how this could occur. Another explanation of the origin of hepatitis C offered by the group was the belief that HCV came from monkeys or baboons. Again, participants were unable to explain how this may have occurred.

One participant believed that all viruses were present in the body from birth and that a person’s risk behaviours determined whether a particular virus physically manifested itself in the body as hepatitis B, HCV or HIV. This participant likened the presence of blood-borne viruses in the body to the presence of pre-cancerous cells in the body.

Hepatitis is inside your system since you’re born, but it depends how you, how you, use the things … You got it in your body, but when you get the things, when you do something wrong … Cancer, hepatitis and AIDS we all got it in the body … it’s already in the body … for me hepatitis is in the body and it all depends on your antibodies, if your antibodies no good for sure you get anything, any disease. (Participant 3, Spanish-speaking group)

After this participant had explained his theory, some of the other participants reinforced his argument. One participant believed that risk behaviours sped up the infection process rather than causing infection.
It [sharing needles and syringes] helps to develop it [HCV]. It depends on what you take to develop it faster, but we all carry it in our body. (Participant 1, Spanish-speaking group)

Similar to the Vietnamese-speaking group, most participants thought that they could infect themselves with hepatitis C if they re-used their own needles and syringes.

You can give yourself hep C. (Participant 8, Spanish-speaking group)

Participants were asked to explain how this could occur and several described how blood could become "dirty" or turn into HCV after a certain length of time outside the body. These accounts were quite confusing and contradictory. It was suggested that the living cells in blood would die after being outside of the body and that the death of these cells could somehow activate the hepatitis C virus.

In general, this group were aware of the potential risk of transmitting HCV through contaminated spoons, filters and water, however not all participants seemed certain of this risk. Some younger participants (who had only recently commenced injecting drugs) and some older participants (who preferred to speak Spanish) did not participate in the discussion of the risk of HCV infection from sharing needles and syringes, spoons, water and filters.

**Arabic-Speaking Group - HCV Knowledge and Beliefs**

Participants who preferred to speak Arabic as a first language contrasted sharply with those who preferred to speak English in terms of their HCV knowledge, with primary English speakers having considerably higher levels of knowledge about HCV. For example, one primary Arabic speaker stated:

I don’t know what it does, or even if I’ve got it, I don’t know … I really don’t know what it is. (Participant 1, Arabic-speaking group)

Participants who stated that they preferred to speak English clearly identified the risks of HCV transmission through the sharing of needles and syringes, spoons and mixing containers, filters and water.

Someone’s going to wash a syringe in a spoon, dump the water out and give you the spoon, there could be still traces of it on the spoon. Then you go and you suck water up from that, and get it [HCV]. (Participant 5, Arabic-speaking group)

After hearing this information, one of the primary Arabic-speakers commented:

I’m scared now, ’cause I’ve been with people, they have Hep C, and sometimes they play with their spoon or something … like they play with their filter in their hand, or clean their fit, and you can forget about it. (Participant 2, Arabic-speaking group)

As with the Vietnamese and Spanish groups, most of the Arabic-speaking participants believed that people could infect or re-infect themselves with HCV through the re-use of their own used needle and syringes. One participant dissented from this surprisingly pervasive
belief. This participant had been an IDU for many years and had acquired considerable knowledge of HCV compared to the rest of the group through his long-term contact with drug treatment services. Another participant, who was knowledgeable about many other aspects of hepatitis C, was unsure whether people could infect themselves through the re-use of their own needles and syringes.

Can you get hep C, from cleaning your own syringe? Just say I’ve got my own syringe, right, I sucked some water out, I’ve used it. But I’ve cleaned it out myself, like say, three or four times with water. Can I get hep C from that? I don’t know. (Participant 4, Arabic-speaking group)

Vietnamese-Speaking Group - HCV Prevention Information and Services

Most of the older Vietnamese participants had been tested for hepatitis C, either while incarcerated or by general practitioners. Some of those tested did not understand their test results, indicating possible problems with the delivery of voluntary counselling and testing (VCT) to this group. Many participants commented that they felt local GPs (within the Vietnamese community) could not be trusted to keep test results confidential. Some participants also stated that the doctor who had tested them had not provided adequate counselling or information about the virus.

I had a test but it’s negative, yeah, and he didn’t say anything about it ... just negative, that’s it, that’s the result. I come back, ask him if I was negative for HIV, AIDS and that ... All he said is just like negative. (Participant 8, Vietnamese-speaking group)

Very few participants were aware of the existence of clinical services offered by a local health service developed to meet the needs of IDUs and not all participants were familiar with the concept of harm minimisation, especially the youngest and oldest participants. However, a small number of participants were familiar with the term and were able to define it.

Harm minimisation means to do all the things that I can do to prevent myself from catching diseases. Things like swabbing myself before using and using clean instruments, not share equipment and if you’re not sure about the purity, using less. Also don’t use alone, just in case you use too much and there’s nobody to look out for you. (Participant 13, Vietnamese-speaking group)

In general, the group had a positive view of NSPs and NSP staff, although they did make some criticisms of the local service. Participants stressed the need for increased sterile water distribution, longer hours, more outreach, public holiday NSP services, the need to install a needle and syringe vending machine in the local area and expanded pedestrian services. Most of the group also believed that HCV prevention services need to employ more bicultural/bilingual workers to improve service utilisation among older drug users with poor English language skills. However, a minority of participants appeared reluctant to be seen by Vietnamese community workers due to concerns about confidentiality within the community. This reinforced the need for workers who are not only bicultural and bilingual, but, above all, are sensitive to the concerns of Vietnamese-speaking IDUs.
Some participants expressed a preference for the ethno-specific outreach NSP service, Indo-Chinese Outreach Network (ICON), due to the discreet, street-based nature of service, the capacity for after-hours service, continuity of relations with core staff, access to and availability of related health services (such as basic first aid) and the fact that clients were not required to provide demographic information. This service had a particular appeal to street-based injectors reluctant to be identified as IDUs within their local community by utilising the mobile van NSP.

Few participants in this group were familiar with mass media HCV prevention resources. Those participants who had read HCV educational pamphlets made suggestions about how these could be improved by including full colour photos and drawings that depict modes of HCV transmission and the effects of HCV on the body.

Spanish-Speaking Group HCV Prevention Information and Services

Although most of the Spanish-speaking group had been tested for HCV, the level of understanding about test results was poor. One participant believed that a negative test result meant “that you've got it”, while another participant thought a positive antibody test diagnosed “you've taken antibiotics”. The confusion surrounding HCV results may stem from the fact that a large proportion reported being tested for HCV while in prison by non-Spanish speaking health workers.

Most participants had seen or read mainstream HCV education resources and these were considered readily available for those interested in learning more about HCV. However, suggestions were also made about the ways in which educational materials could be improved. Participants wanted more information on the symptoms of hepatitis C and long-term health outcomes. Resources which included detailed information, ranging from prevention measures to practical advice on ways in which infected individuals could improve their health, were identified as the most useful. The group also noted the need for a greater range of resources to be translated into Spanish and other community languages.

Arabic-Speaking Group - HCV Prevention Information and Services

Participants who primarily spoke Arabic had limited understanding of HCV testing and the interpretation of results. One participant who was tested for HCV in prison commented:

All the results say hep C but they didn’t say exactly what is it, levels like, she told me. I don’t know ‘cause my English not very good I didn’t understand properly. (Participant 1, Arabic-speaking group)

In general, this group was quite fearful of the hepatitis C virus. Only one participant seemed comfortable and accepting of his hepatitis C positive serostatus. The remaining participants were either unaware of their current status or fearful of the prognosis were they to be diagnosed with hepatitis C infection.
A lot of people won’t have blood tests ’cause they’re scared of finding out they’re gonna have it, I know I am, I know I’m afraid to have a blood test but I don’t think I’ve got it. (Participant 1, Arabic-speaking group)

Participants felt that there was a lack of information on HCV within Arabic-speaking communities. It was suggested that NSPs and drug treatment services offer educational materials produced specifically for parents and non-drug using members of the community.

As with the Vietnamese and Spanish groups, Arabic-speaking IDUs were generally critical of Arabic-speaking doctors. The group believed that the attitude of most Arabic-background doctors reflects the dominant community sentiment of suspicion and intolerance towards drug users. However, the two primary Arabic speakers stated that they would prefer to visit an Arabic-speaking doctor for HCV testing as they would feel more comfortable receiving a diagnosis and treatment information in their own language.

If I go to doctor I go to Arabic doctor, just to see like, maybe I understand better ’cause like some English words I wouldn’t be fully knowledgeable about them, so I’d rather go to Arabic doctor just for things like I’d understand it. (Participant 2, Arabic-speaking group)

Participants recognised the need for Arabic-speaking NSP and Drug and Alcohol workers as the primary Arabic speakers stated that they preferred to speak to staff in Arabic. However, primary English speakers stated that they preferred to speak to health workers in English.

Two participants, both of whom preferred to speak English, were able to identify and discuss recent hepatitis C resources and awareness campaigns. Despite being in daily contact with drug treatment services, participants who preferred to speak Arabic were unable to recall seeing or reading any HCV education resources. English language and literacy were described as essential skills required for accessing mainstream HCV information. All participants recognised the need for a greater range of hepatitis C resources to be translated into Arabic and other community languages.

**Conclusion**

The data presented in this chapter reveal a disturbing lack of accurate information about HCV among IDUs from Vietnamese, Spanish and Arabic-speaking backgrounds. However, it must be noted that the knowledge and beliefs documented among these groups are situated within specific social, cultural and sub-cultural milieus, and that these are not static over time.

All three groups displayed confusion about the routes of transmission and the effects of the hepatitis C virus on the body. Perhaps the most striking example of misinformation can be observed in the belief that IDUs can become infected with HCV through re-use of their own used needles and syringes. This pervasive belief may lower barriers to re-use of other’s used needles and syringes, as the risk of infection from “sharing” is perceived as equivalent to that related to re-use of their own equipment.

Age, age of initiation to injecting and English-language skills influenced HCV knowledge. Older participants who preferred to speak in community languages, and younger recent initiates to IDUs, had poor levels of HCV knowledge, limited exposure to HCV
prevention resources and little contact with health services. This finding indicates the need for HCV prevention efforts to target new initiates and those at risk of initiating injecting in order to prevent the escalation of already high rates of HCV incidence (Maher, et al., 2007).

The findings indicate problems with the delivery of "mainstream" HCV VCT (conducted in English) to CALDB IDUs. Terminology such as “positive antibody” and “antibody negative” perplexed most participants. This highlights the need for improved pre and post-test counselling provided by GPs, drug and alcohol services and prison health services. Participants also suggested that confidentiality of test results needs to be improved among some service providers. These findings emphasise the need to develop and implement culturally appropriate best practice models of VCT for HCV across a range of health care services attended by CALDB IDUs.

Our results also suggest that IDUs from other CALDB may be at increased risk of HCV infection due to language barriers, poor levels of knowledge about the virus and cultural barriers to accessing mainstream services such as NSP and drug treatment. This underscores the need for health services designed to meet the needs of IDUs to stretch the boundaries of service provision to more effectively respond to the needs of CALDB clients.

Traditional models of drug and alcohol service delivery offer little to alleviate the burden of HCV infection among CALDB IDUs and would be greatly improved by changes in structure which allow for greater flexibility in identifying and responding to client needs at the local level. Our experience - of research, harm reduction and service delivery with Indo-Chinese IDUs - suggests that HCV prevention efforts aimed at CALDB IDUs require creative, intensive and sustained responses. A sense of peer ownership is essential and serves to encourage engagement, act as a precursor to meaningful social action and provides a building block for ongoing relationships (Higgs, et al., 2001). To this end, health service managers should be encouraged to identify and develop localised client-focussed responses to CALDB HCV prevention rather than following a prescriptive, top-down approach. The concept of “cultural safety” provides an ideal framework from which to implement such an approach. This concept extends beyond cultural sensitivity to emphasise shared respect, shared values, shared meanings, shared knowledge and shared experiences (Polaschek, 1998; Williams, 1999).

Acknowledgments

We are grateful to the managers and staff of Drug Intervention Service Cabramatta (DISC) and Canterbury Drug and Alcohol Service who kindly provided meeting spaces for the focus groups and helped to recruit participants. Thank you to Carla Calvete and Miriam Marquez from DISC Cabramatta for their assistance in the organisation and translation of the Spanish-speaking focus group. We would also like to thank the research participants who generously shared their beliefs, opinions and personal experiences during the focus groups. The research was funded by the Multicultural HIV/AIDS and Hepatitis C Service (MHAHS).
References


Health and Wellbeing Issues Facing Intermarried Filipino Women in Rural Tasmania

Chona Hannah and Quynh Lê

Abstract

Health and wellbeing are among the most important aspects of life for intermarried Filipino women who left their country to live with their husbands in a different environment and culture. In the process of acculturation into the new environment, their health and wellbeing could be at risk. This chapter reports on a study on the health and wellbeing issues facing intermarried Filipino women in rural Tasmania. The study used interviews as the data collection tool. The interview approach was chosen as it could capture the lived experiences of intermarried Filipino women. The findings of this study identified different health and wellbeing issues facing Filipino women in interracial and cross-cultural marriages. It also provided some insights for health providers about Filipino women’s experiences and concerns in their new lives in rural Tasmania.

Keywords: health and wellbeing, intermarriage, Filipino women.

Introduction

Filipino women are scattered in many parts of the world as migrant workers, students, and a large proportion of them are spouses of residents of other nations. Intermarriage in the Philippines started in its early history when the Malays, Chinese, Spaniards, Negritos and Americans inhabited the country. In fact Filipinos have become a unique blend of all these people. Negritos were the first inhabitants to the country followed by the Malays, who spread throughout the archipelago through intermarriage (Dolan et al., 2006).
In 2000, with regard to the country of birth of Asian-born Australians, the Philippines (123,000) ranked the third, behind Vietnam (174,400) and China (168,100) (Australian Social Trends, 2001). The population born in the Philippines has experienced the fastest growth, with the current population almost eight times that of 1981. Many of the Philippines-born in Australia were women who married Australian men (Australian Social Trends, 2001). In fact in 1989 alone, over 700,000 Filipinas were married or became fiancées to Australians, Germans, Taiwanese and British (National Commission on the Role of Filipino Women, 2004). In Australia, a total of 20,000 Filipino women are married to Australian men, some 90% of whom came through the system of serial sponsorship (National Commission on the Role of Filipino Women, 2004). Like other female migrants, the intermarried Filipino women in rural Tasmania migrated to Tasmania through a fiancée and spouse visa. Some of them came to Tasmania through sponsorship by their family members who are already residing in Tasmania, and the visit could lead to intermarriage if opportunities arise. However their life journeys have not always been smooth as they may encounter different challenges that affect their ways of settling in a new environment as well as their health and wellbeing.

Health and Wellbeing and their Meanings

Health and wellbeing are interrelated. However it is important to distinguish its meaning “since different definitions may result in different conclusions” (Dolan, et al., 2006, p. 7) or understanding. Every individual has their own meaning of being healthy and each culture has its own views and concept of what being healthy means. For example, according to Spector (2004), some see health as the freedom from and absence of evil. Illness, to some, is seen as punishment for being bad or having committed evil deeds (p. 49). This concept is common to traditional Filipino beliefs.

In other instances, Nightingale (1859) explored the health and illness connection with the environment. She believed that “a person’s health was greatly influenced by ventilation, noise, light, cleanliness, diet and a restful bed” (p. preface). However some Italians do not regard illness as a fact of life but as a real piece of bad luck (Legge, 1981). Some believed that life and death were a natural pathway. They also expect that they should die in the natural painless death of old age. Sick persons are the most unlucky ones as they are victims of cruel fate, and for this reason they expect sympathy, understanding, affection and care from relatives, friends and doctors (Legge, 1981).

Eckersley (2007) suggests that human health has multiple dimensions: material, social, cultural and spiritual. People are physical beings with material needs for nutritious food, clean air and water, adequate shelter, physical activity and sleep. They are also social beings who need families, friends and communities to flourish. They are also cultural beings of all species and require cultures to make life worth living. As spiritual beings, psychically connected to our world, health therefore is the ultimate source of human life.

In terms of wellbeing, there is no single agreed conceptualization of wellbeing (Newton, 2007). Most researchers agree about the domains that make up wellbeing such as physical wellbeing, material wellbeing, social wellbeing, emotional wellbeing, and development activity. There are many views of wellbeing based on peoples’ experiences or how an individual embraced it. Some researchers conceptualize wellbeing in two ways: objective and
subjective wellbeing (Ashcroft & Lynas, 2008; Diener, Suh, Lucas, & Smith, 1999). Objective wellbeing refers to the material and social circumstances believed to impact an individual’s or community’s sense of wellbeing. This may include income, housing, educational attainment, access to, and use of, public services and so forth (Ashcroft & Lynas, 2008). While subjective wellbeing is how people evaluate their lives. People can do so in terms of a global judgment such as satisfaction, in terms of evaluating certain areas of their lives such as marriage or work, or in terms of their ongoing emotional feelings about what is happening to them (Ashcroft & Lynas, 2008).

Felce and Perry (1995) describe wellbeing as “(comprising) objective descriptors and subjective evaluations of physical, material, social and emotional wellbeing, together with the extent of personal development and purposeful activity, all weighted by a personal set of values” (p. 60). While Ryan and Deci (2001) treat wellbeing from two general perspectives: the hedonic perspective which focuses on happiness and interprets wellbeing in terms of pleasure attainment and pain avoidance; and the eudaimonic perspective, which focuses on meaning and realization and examines wellbeing in terms of the degree to which a person is fully functioning. These two views have given rise to different research foci and a body of knowledge that is in some areas divergent and in others complementary.

In summary, the following four aspects of wellbeing are very important for the life of intermarried women migrants: physical, material, mental, and spiritual:

- The physical state centres on one’s health and sense of wellness, satisfying physical needs through a healthy lifestyle.
- The material state centres on essential needs such as shelter, food, and financial resources.
- The mental state centres on needs to learn, grow, be recognized and be accepted.
- The spiritual state centres on a person’s religious/philosophical needs and may provide powerful support for values, morals, strength of character, and endurance in difficult and dangerous circumstances.

Each of the wellbeing dimensions has played a vital role in the life of the intermarried Filipino women as to how they will adapt themselves to their new home physically, materially, mentally and spiritually. This means that they have to fully engage themselves in a new life in order to achieve wellness. When all these dimensions work together, there will be a sense of wellbeing and they are more equipped to deal with various problems and stresses in life (What is wellbeing?, 2007).

**What does the Study tell us?**

A qualitative study on intermarried Filipino women in Tasmania was conducted using interview as a data collection tool. Fifteen intermarried Filipino women participated in the interviews. The interviews took place at a place mutually convenient to the participants and the researcher. The interviews were recorded with the approval of the participants. Each participant was interviewed for approximately 40 minutes. The interview questions focused on the health and wellbeing issues encountered by the intermarried Filipino women. The
interview data were transcribed as raw data and later coded for thematic analysis with the aid of Nvivo software version 8.

The following themes emerged from the data analysis: Migration, marital life, social and cultural issues.

**Migration Issues**

Migration means severing the ties with family, friends, and established social networks, departing from traditional routines, value systems, and accepted ways of behaving and having to adapt to new social and psychosocial environments (Carballo & Nerukar, 2001). Migration is one of the main factors affecting intermarried Filipino women’s self-esteem and confidence because they are living in a different environment and different culture. Their identity, self-concept and social role have changed. Being a woman, a migrant, a mother and a wife hold a complex responsibility in today’s world. It is complex because women in this situation embody multiple roles and identities. Each role is quite distinct from the other yet interrelated (Tibe-Bonifacio, 2003).

We are not only a wife and a mother but also a worker, helper, financier, etc. We act like a robot which is very hard on our part. In the Philippines, we always have our families supporting and helping us in many ways. Migration to a new place has made life very hard, particularly in the first few months. (Participant 8)

Filipino women are known for their friendliness and optimism. However in a new cultural environment, they may want to play a ‘wait-and-see’ role.

It is quite hard at first because I am shy and I am hesitant to approach or ask questions to the doctors or any health care professionals. I don’t feel comfortable telling them what I really feel which I think is not good. (Participant 7)

In terms of beliefs and tradition brought along with migration, Filipino wives wanted to inculcate in the minds of their children the strong Catholic faith that they have grown up with.

I believe that God is there for us so there is no need for me to be scared. I leave everything with him. And I always believe that things happen for a reason and that reason is for me to be ready for life’s challenges and that is what I am doing for my kids as well. (Participant 9)

Climate adjustment is another cause of stress because of the cold weather in Tasmania. For the intermarried Filipino women who came from a tropical country, adjusting to the cold weather is one of the major issues affecting their health.

I will never get acclimatized, I think, because I have been here for over 10 years but I am still suffering from cold and flu as well as coughing during winter months. (Participant 4)

When I moved to Tasmania, I started having runny nose, bleeding nose, and hay fever which was so rare for me in the Philippines. (Participant 10)
The new cultural climate also affects intermarried Filipino women’s preferences of food. Their eating habits have changed due to the absence of favourite Filipino dishes, vegetables, and delicacies. Food is a main contributor to everyone’s health. For the intermarried Filipino women, the absence of Filipino food is a challenge because they have to adjust their diet and thus intake of nutrients. Food in Australia tastes differently from the food they have used to. Filipino women tend to socialize together for friendship and food plays an important part in their social gathering.

Here in Australia, they have great food. But of course Filipino food is still different (iba pa rin ang lutong pinoy, kumbaga). Everything is really fresh. (Participant 5)

Other participants said:

I am happy here in Tasmania now, but my first few years was a bit hard. I tried to adjust to the weather, the culture and the food as my husband and his family love vegetables and salad. Every time we have a get together, I'm sort of looking forward to it but at the same time not because I know I will be eating fresh green salad and vegetables. It's just not like me. (Participant 6)

I missed the traditional Filipino dishes. Sometimes I bought Filipino goods from the Asian shops and cooked them but it didn’t taste the same. (Participant 5)

Marital Issues

Marital issues include cultural and spiritual differences, age gap, language barriers, finances and support to the families (back in the Philippines), education, isolation and disappointments and expectation. It is not uncommon for a married couple to have differences or marital issues; however, for the intermarried Filipino women, marital problems are compounded by cultural differences.

Home sickness is also one of the major factors causing marital problems. “Some husbands exacerbate their Filipino wives’ sense of isolation by forbidding them to contact or visit friends and their families, including associating with other Filipinos; forbidding them to work; preventing them from learning to drive (this is particularly problematic in areas without adequate public transportation)” (Allotey, Manderson, Nikles, Reidpath, & Sauvarin, 1999, p. 4).

I feel so homesick and lonely. No families and no friends around. I can’t go anywhere and I can’t drive at all. I have to wait till my husband is available so we can go out together. I feel homesick and very lonely. (Participant 15)

Age plays a part in a relationship. As Thomson, Manderson, Woelz-Stirling, Cahill, & Kelaher (2002) note, Filipino brides are significantly younger than their husbands. In this case, Filipino women rely more on their husbands especially during the early years of their marriages since their arrival (Thompson, et al., 2002).

It makes our relationship a lot better because my husband had a lot of experiences in life and he knows what’s best for our family. That is why I let him decide everything. (Participant 8)
One participant is older than her husband and she could see the age factor in her behaviour and attitude towards her husband:

I have adjusted a little bit since I am older than my husband for two years. He also involves me in decision making, he cannot decide by himself alone. It is also good in a way because I feel that I am a bit superior in some cases and most especially I feel so important. (Participant 11)

In some instances, wide age gaps result in over-dependence of Filipino wives on their husbands which affect their acculturation process particularly during the early years of their migration.

I was not comfortable going out without my husband especially during my first year here in Tasmania. May be it is because that I didn’t know much about the place and didn’t know anyone. Even getting to the groceries, I’d rather wait for my husband so we could go out together. (Participant 4)

These Filipino women came and lived in rural Tasmania with high expectations and certain priorities. Their expectation is one of the reasons for their migration. According to several participants, they thought that Australia is the land of opportunities and they could build a good future with their husbands in Australia. They also believed that because they were educated, they would be able to find work and probably pursue further studies, and have a good access to social services in Australia particularly to health care services.

I cannot deny the fact that before coming here I expected to have a wonderful future as everyone dreams, I supposed. I expected to have a wonderful future because I believed there were lots of opportunities here in Australia in terms of work. (Participant 1)

These expectations affect their health and wellbeing in a sense that most of what they have expected contradicted their actual experiences in rural Tasmania. Thus these expectations could lead to disappointments, confusion and unhappiness.

This is not the life I have expected. I don’t blame my husband but I blame the situations. The sad part is that I have to hide this from my family back home as I don’t want them to worry. It’s hard because when I talk to them I have to pretend that I am happy even though I am not. (Participant 2)

Disappointments affected the mental and emotional wellbeing of the intermarried Filipino women. The participants indicate that aside from their responsibility as a wife and a mother to their children, they also have added responsibilities to their families back home which is also an important part of their existence. The problem is exacerbated if their spouses do not assist them in financially supporting their families in the Philippines.

It will affect you negatively if you hide it from them (husband) but if you are open enough and let them know what you are doing and why you need to do it, then there is no problem. (Participant 10)
Sending financial support to my family back home is often the beginning of our arguments as my husband wonders why we need to do it. But when I explain to him that the money I send is for the education of my younger brother and sisters and knowing that the money I send is from my own pocket, the issue is resolved. (Participant 1)

Another source of their disappointments is education opportunities. Intermarried Filipino women with high educational backgrounds, for example university graduates, may accept their domestic role as devoted housewives in the initial stage of their marriage.

I have a degree, but look at where I am now? If only I have known that this is what I end up with, I should not have gone to a university and got a degree. I feel that the time I spent to get my degree in the Philippines was useless and a waste of time because it is different here. (Participant 4)

However Filipino women aim for jobs which suit their educational qualifications. Some may extend their education by undertaking advanced courses at colleges and universities. There are positive situations in which Australian husbands provide full mental and financial support to their Filipino wives to enhance their academic achievements. However, there are also cases in which conflicts occur between husbands and wives and the conflicts could lead to depression and mental suffering due to a lack of understanding and communication.

I am so thankful to my husband for letting me go to school and pursue my dreams. Now I am working and have my own money. I can help my family and at the same time buy things that I want as well as for my kids. (Participant 8)

Cultural Issues

Cultural differences affect their health greatly for they have not received enough information about healthy lifestyle in a foreign country which requires extensive adjustment. Besides, some still strongly hold the traditional practices and beliefs in a new land.

Filipinos are superstitious, such as: When I am sick I am not allowed to take a shower; to drink cold water and eat cold food because these will affect my tummy. (Participant 1)

With our babies, we are not allowed to bathe them on Tuesdays and Fridays and no cutting of finger nails on that same day. The rest of the days are okay. (Participant 9)

Tradition beliefs and practices have formed migrants’ self-concept and identity. They also become a battle ground for personal and cultural conflicts in a new cultural environment which could lead to health problems to migrants. Carbalo and Nekular (2001) state:

….that culture conflict is a common and serious problem in migration. He further explains, available data suggests that cultural background plays an important role in predisposing some immigrants to some diseases such as depression, chronic anxiety, and neuroses. However, in
general, the trauma and exclusion that all immigrants face increase their risk of behaviours that, in turn, increase their susceptibility to all diseases (p. 5).

Cultural issues are the key factors affecting intermarried Filipino women’s health and wellbeing. The most common cultural issues include: culture shock, stress and depression, loss of family and friends and isolation, loneliness and homesickness, climate adjustment, and eating habits. Due to cultural differences, intermarried Filipino women experience culture shock and this leads them to feeling stressed and depressed. Stress and depression are caused by adjustment to a new cultural environment including the general norms and tradition, values and behaviour of the mainstream Australians.

I am stressed and pressured because I have no family around and looking after my first baby daughter was hard. This was the time that I needed emotional support and guidance from my Mama. (Participant 2)

The intermarried Filipino women are also stressing themselves as to how they should act and interact with the mainstream Australians. It is a challenge for them to acculturate themselves and thinking whether they should retain all their values and beliefs from their home country while adopting the values and norms of mainstream Australians.

Tasmanian culture is very different especially their lifestyle, food, climate and the manner of the people. They are liberated, practical and frank compared to us. We are more reserved and always think about what we are going to say before we utter the words. Actually, we seem to keep what we feel to ourselves than speaking it out openly. (Participant 7)

Most intermarried Filipino women find this a problem when they are sick and during their pregnancy when they would prefer to be treated in their traditional cultural environment.

During my pregnancy I was longing to eat “manggang hilaw” (green mango) with salt and sugar in it. I was also craving to eat “kinason” (any sort of sea shells food) especially in soup, so yummy. But where can I find it here? Fish and sea foods are frozen. They are not fresh and as my doctor told me, it is not good for pregnant woman. (Participant 8)

Social Issues

Social issues include lifestyle, linguistic aspects/English language, health programs, access to health care services and social networking. Australian lifestyle is very different to the Filipinos’ in many ways such as: interpersonal relationship, family bond, personal sharing etc. Intermarried Filipino women find it hard to fit into the lifestyle of the host culture and this affects their health because lifestyle is connected to health.

....a general way of living based on the interplay between livings conditions in the wide sense and individual patterns of behaviour as determined by socio-cultural factors and personal characteristics. The range of behavioural patterns open may be limited or extended by
environmental factors and also by the degree of individual self-reliance. The way in which an individual lives may produce behavioural patterns that are either beneficial or detrimental to health. (p. 229)

The kind of lifestyle intermarried Filipino women have had also affects their views and attitudes towards their health and wellbeing due to different health care programs. Australian programs are mainly biomedicine which is an issue for the intermarried Filipino women especially for those who came from the rural parts of the Philippines with strong attachment to traditional medicine and health practices. They have little knowledge about available resources in terms of access to health care services. According to Asghari-Fard & Hossain (2008) many findings show that migrants have limited access to health services due to being under serviced, language barrier, inappropriateness of the health care system and limited knowledge about the services.

If I am sick I’d rather observe my condition first before consulting a doctor as I am not used to it. As long as I drink a lot of water and have some rest I should be fine. If I am in the Philippines then I would easily get some herbal medicine. (Participant 3)

Social networking is another factor concerning intermarried Filipino women’s health and wellbeing. This involves having a good relationship with the in-laws; networking with the neighbours; interaction with the Filipino community in rural Tasmania and relationship with the family in the Philippines. Strong social networking with others enable migrants to cope with new challenges (Courtright, 2004). People need supportive, positive relationships and social belonging to sustain wellbeing (Ashcroft & Lynas, 2008). Therefore, social networking plays an important role in the life of intermarried Filipino women in rural Tasmania. As noted earlier, Filipino women are strongly family-orientated in the sense that family members support one another mentally, emotionally and financially regardless of age, gender and social status. Thus while Filipino women are living with their children and husbands in Australia, they still want to maintain strong family tie with their families in the Philippines. Support from families and friends and communities helps them solve problems, deal with adversity and maintain a sense of mastery and control over their life circumstances (Smith, 2004). As WHO says “mutual trust and respect in the community protect people and their health (Smith, 2004, p. 71).

Friends are very important in my life here in Tasmania because there are things that I cannot tell my family but with friends it is easy. My friends understand my situation here. Having good friends and being part of the Filipino community makes me feel secure. (Participant 1)

The loss of close family ties or disruption in social support has been identified as a common stressor encountered when migrating to a new country (Bollini & Siem, 1995). The level of social support migrants receive influences the way they adapt to their new country (Barankin, Konstantarea, & DeBosset, 1989). It is important to have an appropriate level of support from family or friends as they are a “source of pleasure and companionship and can buffer stress” (Adams & Blieszner, 1995, p. 7). Thus, migrants who are able to maintain some level of social support with friends and family or can build new friendships will be able to adapt better and experience less stress compared to those who cannot (Jehobo, 2001).
My husband’s family is very supportive. They’re always there to assist me, drive me around the city and help me looking after my kids. My mother-in-law in particular, she taught me how to bake cakes and cook some Australian dishes, which I think is very helpful. Having in-laws like them makes me feel at home with my family. (Participant 2)

In contrast to social networking, there are Filipino women who are “mahiyain” (i.e. socially shy) in nature. They prefer not to socialize with other people apart from family members and close friends which also put their situations in danger especially when living in a new cultural environment. For example, some intermarried Filipino women stay within a violent relationship because of their so-called cultural values “hiya” – they are ashamed of letting outsiders know about what is happening to them and also they are afraid that may cause more possible violence (Abano, 2006).

Conclusion

Health and wellbeing are the two most important aspects to the lives of every individual especially to the intermarried Filipino women who left their country to live with their spouses in a totally different environment and culture. Culture affects the way people live. However, adopting a new culture and living a new culture is not easy for many migrants. It needs skills and emotional intelligence. Skills that are not taught but learned. They are learned through experiencing certain situations that they have never experienced before. Therefore it is where most migrants and intermarried Filipino women find difficulty in their journey of interracial marriage. As a result, they encounter different health and wellbeing issues identified in this study. All these issues strongly reflect the lived experiences of the intermarried Filipino women in interracial marriages and cross-cultural marriages. This study has just opened a few windows on the lives of intermarried Filipino women living in rural Tasmania. Obviously there are more stories about their health and wellbeing which deserve more research attention.

References

Health and Wellbeing Issues Facing Intermarried Filipino Women in Rural Tasmania


Does Culture Affect one’s View of Health Informatics? A Study of the Vietnamese Migrants in Australia

Quynh Lê and Cecilia Chiu

Abstract

Health informatics is playing an increasingly important role in health care. Migrants have been introduced to certain aspects of health informatics directly or indirectly by health authorities, health care services and various migrant communities. However, for some Vietnamese migrants, health informatics is still an unfamiliar subject. This has, therefore, affected their perception about accessing health care services. The objectives of the study are to explore the meaning of health informatics to Vietnamese migrants in Australia, how their culture affects their attitudes towards health informatics and intercultural problems relating to health informatics. The study also investigates the advantages and disadvantages of health informatics in health care services in the eyes of this migrant group. A qualitative study was conducted to find out how health informatics is perceived by Vietnamese migrants. Ten Vietnamese migrants of different gender, age groups, professions and length of stay in Australia participated in this study. The study revealed that the participants’ awareness of health informatics was influenced by factors such as family support, information technology (IT) literacy and the Vietnamese community.

Keywords: health informatics, migrants, culture, health care services, community.
Introduction

Digital technology has permeated many aspects of modern society. Its impacts are seen in various day-to-day activities such as banking, communication and education. The rapid development of digital technology has reached a stage that what was once considered modern technological innovation a few years or even months ago can now become outdated. This phenomenon has increased the power of information and communication technology (ICT) in health and also poses challenges to health informatics and its users, including both health professionals and clients (Curry & Knowles 2005; France 1997; Lewis 2002; Linda 2003).

Australia is a land of cultural diversity. Its population consists of people of different cultural and linguistic backgrounds. Migrants have been introduced to certain aspects of health informatics directly or indirectly by health authorities, health care services, and various migrant communities. However, for some Vietnamese migrants, health informatics remains an unfamiliar territory. It is important for health services to gain an awareness of the way in which Vietnamese migrants understand health informatics and what it can do for them. In pursuit of this aim, a qualitative study with 10 Vietnamese migrants was conducted. This paper examines the issues and problems facing Vietnamese migrants in relation to their views of health care in general and health informatics in particular in the Australian context.

Background

Health is an essential aspect of life and the quality of life depends on the quality of health. This view is embedded in the Vietnamese popular proverb: “Good health is more precious than gold”.

Australia is a land of cultural and linguistic diversity. The number of Vietnamese migrants in Australia has increased markedly after 1975 when the Vietnamese War ended (Migration DRC, 2003). The rapid migration movement started with the intake of Vietnamese refugees in refugee centres in Thailand, Malaysia, Indonesia and the Philippines. Australia has taken a fair share of Vietnamese refugees who overwhelmingly choose to settle in metropolitan areas (ABS, 2006). There are many reasons why migrants prefer to reside in metropolitan areas: job opportunities, closer interaction with migrants of the same cultural background, linguistic factors and family influence. These Vietnamese migrants later transformed the urban landscape of big cities, particularly Sydney and Melbourne. “Vietnamese suburbs” such as Cabramatta, Footscray, Richmond, Bankstown, and Springvale have been recognized as landmarks of the Australian ethnic diversity (ABS, 2006).

Migrants coming to a host country bring with them their cultural heritage and linguistic background. In their acculturation into a new cultural environment, cultural differences and linguistic problems are the main hindrance to their adaptation to the host country (Tai & Lin 2001). Some encounter cultural shocks which turn their dreams of a new life into nightmares while others respond well to the challenges and become successful in their acculturation process (Kreuter & McClure 2004). Vietnamese migrants in Australia encounter similar intercultural experiences. Acculturation is a process in which people of a different cultural and social background adapt to accommodate a new culture and environment. It can be a process filled with confusion, resistance, reluctance and sometimes sufferings. Health
informatics is not a simple concept that can be easily introduced to and readily embraced by society. There are cultural and social issues associated with health informatics (France 1997; Lawlink NSW 2004; MacPherson 2001). In dealing with issues arising from living in a new cultural environment (Akhter 2003), Vietnamese migrants’ views, attitudes and behaviors are often influenced by their cultural background. This can be seen in their understanding and use of health care in Australia.

This chapter reports a qualitative study that was conducted to find out how health informatics was perceived by Vietnamese migrants in Australia. The focus of the study is based on the following questions:

- What does health informatics mean to the Vietnamese migrants in Australia?
- What are the advantages and disadvantages of health informatics in health care services in their eyes?
- How does Vietnamese culture interfere with the Vietnamese migrants’ attitudes towards health informatics?
- What are the intercultural problems in relation to health informatics?

**Health Informatics**

Recently due to the rapid development of computer technology, many new developments in the health area are computer-based (Jadad & Delamothe 2004). The two terms which are commonly used to denote the connection between computer technology and health are e-health and health informatics. Health informatics or e-health is the appropriate and innovative application of the concepts and technologies of the information age to improve health care and health (Health Informatics Society of Australia (HISA)). However, for those who have no concept of e-health or health informatics in their culture and language, these terms may create confusion and worst of all may even prevent users from accessing the health care services they need.

Health informatics operates under key principles covering confidentiality, privacy and security. These three concepts are interrelated and are important in evaluating the success or otherwise of the implementation of health informatics. However, concepts and principles such as privacy, confidentiality and security which govern health informatics have different meanings and values in different cultures and they are perceived differently by users from different cultural backgrounds (Le, M, 2005; Lindenthal, Thomas & Ghali 1985).

According to Le (2007), computer technology offers a range of approaches and strategies to improve security of health data. In health informatics, the two main approaches include restriction of access and anonymization of records. Secured protection of data requires sound physical as well as logical access controls. In brief, logical access controls are mechanisms to protect integrity of the data by limiting the users’ access to information. Users will only be allowed to access information appropriate for them in the system. The logical access controls can be embedded within operating systems, applications, add-on security packages, or database and telecommunication management systems. Logical access control does not limit to electronic access controls. It can be in the forms of policies, procedures and organizational structure. In addition, the subject of control is not restricted to data only. The control covers...
also access to computer software and networks. Encryption is a method for anonymizing patient information held electronically. It is a process by which data are converted into a sequence of alternative characters, by applying a set of rules (or keys) that is capable of both generating the encrypted material and recreating the original information. Another method for anonymizing patient information is the use of separate databases in which clinical information is separated from patient-identifier information. The secondary database retains the non-identifiable patient information, which may be used for a range of purposes.

**Methodology**

Ten Vietnamese migrants were invited to participate in this study. These participants are from different educational backgrounds (health, education, engineering, science and business), 29 to 60 years of age and have been living in Australia from 8 to 25 years. The following characteristics were used to select the participants to cover a variety of background: gender, age, profession and length of stay in Australia. It should be pointed out that only participants with tertiary education background were chosen in this study and structured interview was used. This was a deliberate strategy for two reasons. Firstly, very few Vietnamese migrants are aware of health informatics and as this is a fairly complex concept, migrants of a higher education background may be in a better position to grasp what health informatics means and more forthcoming in expressing their views towards health informatics and health care services. Secondly, the questions asked in the interview are structured to obtain consistency in data collection and data analysis. Ethics application was sought and approved.

The questions used in the structured interview corresponded with the research questions of this study. It is important to maintain a close connection between the research questions and the interview questions to avoid mismatch between data and research questions or research objectives. A disadvantage of this strategy is that the responses of the interviewees are directed by the researcher and there is little room or flexibility for the interviewees to move beyond the structure of the interview. To compensate for this restriction, an open-ended question was added at the end of the questionnaire to provide the interviewees an opportunity to wander beyond the pre-defined interview questions.

The structured questionnaire included the following questions:

- What does health informatics mean to you?
- What are your views about the use of information technology in health care?
- What are the advantages of health informatics in health care services?
- What are the disadvantages of health informatics in health care services?
- In your view, what are the problems about health informatics faced by Vietnamese migrants whose English is very poor?
- How does Vietnamese culture interfere with Vietnamese migrants’ attitudes towards health informatics?
- What are the intercultural problems in relation to health informatics?
- Any other ideas, comments or points would you like to make about health informatics and Vietnamese migrants in Australia?
Findings

Structured interview was used as the method of data collection and as expected the responses of the participants in the interview were in line with the interview questions. This made the analysing work of the researcher easier and simpler in comparison to unstructured open-ended interview data which requires the skill of coding and the ability to infer appropriately and comprehensively from the unstructured data. One of the advantages in using structured interview in this study is that there is an opportunity for comparing the responses among different participants.

The results of the analysis of the structured interview data are grouped below under each interview question, which can be treated as themes.

What does Health Informatics Mean?

The following points are representative of the responses to this question:

- There is a link between health and information technology.
- Health informatics is about the use of computer in health care.
- It is about storing patient information in health data base.
- It is about replacing paper with electronic data in the management of health information.
- Health professionals manage clinical information and make it available when needed.
- Health informatics is a much needed approach to modern health care.

The above items give some idea about how health informatics is perceived. Most of the interviewees demonstrated a good understanding of e-health to a large extent. Despite the fact that one of the interviewees worked in the area of health, all of the responses focus mostly on the obvious, that is, the storage and retrieval of data. In addition, health informatics also means a paradigm shift in how health professionals conduct their services or businesses, a change in delivery channels of health services, tipping of balance between patients and health professionals in the control over patient specific and general health information. It will be interesting to conduct a similar study on local Australians to see if there will be a marked difference in how they perceive the meaning of health informatics.

The Use of Information Technology in Health Care

There was a strong support of the use of IT in health according to the respondents. The following points are representative of the responses to this question:

- Information technology can play an important role in health care.
- Health workers and health professionals should be introduced to health informatics.
For patients, health informatics needs to be introduced to the public to raise awareness so that people know how to make use of it. This is the digital age and health informatics is part of it.

The reasons given in support of the use of IT in health care include: improvement in health care; health care in a modern digital discourse and; benefits to clients, health workers and health professionals. While embracing health informatics and the digital age, the issue of education and training was raised, not just for patients but also for health professionals. The answers rightly imply that awareness, understanding and knowledge about health informatics are conducive to promoting the use of health informatics.

Advantages of Health Informatics

As stated in the previous discussion, there was a strong support of the use of IT in health care. Thus, it was obvious to the interviewees that health informatics has advantages such as:

- Health informatics enhances communication between health services and clients.
- Health informatics saves life.
- It helps access patients’ health files quickly, particularly in emergency cases.
- It helps professionals consult with one another effectively.
- Patients can access their health files.
- It strengthens collaboration among health services.
- Health informatics reduces health risks.
- It saves time and money.

Despite their cultural background, the respondents demonstrated a good understanding of the key advantages of health informatics, namely, improvement in communication; enabling inter-professional collaboration; improvement in speed of service delivery in particular in emergencies and critical situations; health risk reduction; improved efficiency and cost effectiveness; and granting patients access right to their health information.

Disadvantages of Health Informatics

Though the data indicated that there was a strong support of health informatics, it does not mean that health informatics is free from problems. The following disadvantages were identified in the data analysis:

- Jargons and technical terms need to be minimized so that it can be easily understood by ordinary people.
- Privacy of patients could be violated.
Computer security cannot be absolutely guaranteed.
Very few people know what health informatics is about.
Hardware and software need upgrading constantly.
Not everyone has access to computer and the Internet.
It is a disaster if computer crashes.
Computer technology is like magic if managed properly; otherwise it could be harmful and destructive.

Other than an access issue to computer or the Internet, other disadvantages named by the respondents are not restrictive just to health informatics. Privacy, security, user knowledge and training, system or procedure upgrade/improvement, misuse of the system, equipment failures and jargons are also issues faced by the traditional health care delivery models. It is also worth noting that there are also issues about access to physical health care services, think about having to travel miles and miles to get a service, think about having to repeatedly dial a busy hotline to obtain an answer. In general, people have greater trust in what they know and what they use to get in touch with. Therefore, it is not surprising that these issues were raised as health informatics is still a new arena to many.

Cultural Interference with Health Informatics

Health informatics is scientifically based and people orientated. When dealing with people, health informatics is subject to cultural influence. The following issues about cultural interference with health informatics were identified from the data analysis:

Vietnamese migrants prefer to get information about health services from their families, friends and people they know well, not so much from computers and the Internet.

Vietnamese people are used to face-to-face interaction with health services, not through the Internet.

Privacy can be a problem if information is gathered with the help of an interpreter.

Family may unduly put pressure on health services to access their family members’ personal files.

There could be a lack of respect for privacy.

Computer security could be compromised.

It is useless to people who do not understand English.

Changes of addresses and personal information are not passed to the health services timely for data updating.

Vietnamese surnames are limited to about 20 common ones such as Nguyen, Tran, Lê, Pham, etc. This could create problems of mistaken identities.

The information given on the Internet could be culturally inappropriate.
The responses can be broadly categorized into: preferences, privacy/security, communication and cultural. Other than the inherently cultural issues such as surnames and culturally inappropriate contents, other issues raised here in some way or another are also influenced by culture. Vietnamese culture is a very family-oriented culture. It is apparent that families or friends have a fairly strong influence over the choice of how Vietnamese migrants prefer to get information. It is also interesting to learn that families of Vietnamese migrants may put pressure on health services to release information of their family members. Mastery of a second language, in this case English, also plays a part in affecting the participation of the Vietnamese migrants in health informatics.

**Implications**

The results of the study can provide some practical implications for health workers and health services. One can expect that some of the responses are not confined to Vietnamese migrants but are also applicable to migrants of other ethnic backgrounds. In addition, some issues are universal and applicable to even locally born and raised Australians. For example:

- Computer security can be compromised.
- Jargons and technical terms need to be minimized so that it can be easily understood by ordinary people.
- There could be a lack of respect for privacy.
- Not everyone has access to computer and the Internet.
- Vietnamese migrants prefer to get information about health services from their families, friends and people they know well, not so much from computers and the Internet.
- It is useless to people who do not understand English.

If health informatics is the way forward for future health care services, to ensure a successful introduction of the new technology in the existing system across the board, health service providers need to understand how ethnic culture comes into play. Knowledge gained from this study may also be applied to other ethnic groups having similar cultural attributes, such as strong family and community ties.

**Limitations**

The number of samples in this study is small – only 10, and the selection of the samples was skewed towards the higher education end of Vietnamese migrants in Australia, who are in general more proficient in English and more receptive to new technology, systems and ideas and presumably should have better ideas and understanding of health informatics. As such, the findings do not represent the views of all Vietnamese migrants in Australia. In any case, a characteristic of qualitative research is that the data collected is less able to be generalized. In addition, findings from qualitative research are less definitive or concrete than
numbers or pre-defined answers collected from quantitative research. Despite these limitations, qualitative research is better in generating stories or descriptions of emotions and feelings and thus is more appropriate in exploring the influences of Vietnamese culture on perception of health informatics. Even though it may not be appropriate to generalize the results, the findings generated from this “more knowledgeable” group of Vietnamese migrants are still useful in projecting a picture of how other Vietnamese migrants would look at health informatics and how their culture plays a part in influencing their perspective of health informatics. Given that the samples chosen for this study are the better educated, knowledgeable and more liberal members of the community, one could safely assume that issues such as family influence, language barrier and feeling of insecurity facing a new system or initiative would be more apparent in other Vietnamese groups.

**Conclusion**

Health informatics is a manifestation of one of the most innovative developments regarding the use of computer technology in health care. Its role in health care is multidimensional. The rapid development of computer technology will undoubtedly lead to great improvement of health informatics and its effectiveness. However, there are problems regarding the use of health informatics which also deals with perception and human behaviors. This study provides some insights about health informatics in relation to Vietnamese migrants in Australia. Culture plays a part in how Vietnamese migrants look at health informatics and the concerns they may have in embracing this new technology. There is an Asian proverb saying “the water keeping the boat afloat is the same that swallows it”. While culture could be a barrier to participation in health informatics, understanding the cultural influences will be beneficial in helping introduce health informatics to the Vietnamese community. This study provides a starting point for research into issues about health informatics and Vietnamese migrants.

**References**


Part III

Research Methodology
Innovating Community Engagement in Rural Health: A Quali-Quantitative Research Method

Erica Bell

Abstract

This paper aims to explore ways in which an innovative method—a form of Quali-Quantitative Analysis (QQA) developed by Charles Ragin (Qualitative Comparative Analysis or QCA)—can help bring innovation to community engagement methods. The paper first identifies the key issues of internal and external validity that are important to effective community engagement research for rural health. The main challenges (definitional, technical, and ideological) relevant to these issues of validity are explored. The limitations of existing research methods for meeting these challenges of internal and external validity are highlighted. The key steps for delivering the QCA method are explained with reference to a typical situation of researching community views on the nature (attributes and outcomes) of a proposed mental health service. The paper concludes that QCA could help innovate rural healthcare development primarily through the systemacy and robustness it would bring to small-N situations where complex community perceptions need to be captured.

Keywords: community engagement techniques, qualitative comparative analysis, external social validity, rural community participation
Introduction

The Nature and Benefits of Community Engagement

Ideas about research are the result of history and culture, and evolve over time. Although the discipline of rural health is a relatively young discipline, it has developed distinctive approaches to research that set it apart from its more biomedical relatives. Rural health research is frequently characterised by a concern with community engagement—an attention to the needs, experiences and views of local stakeholders. The rationale of such community engagement is manifold.

First, community engagement ideally allows rural health research to achieve external social validity, not simply internal validity. ‘External social validity’ relates to the degree to which research is useful and accurate for its communities of users: often the local rural community, but also sometimes the wider national and international community of policy-makers and practitioners. ‘Accuracy’ in these terms relates to the capacity of research to reflect the needs, experiences and views of the community. ‘Accuracy’ also relates to the extent to which a solution to a health challenge is feasible and supportable in a community. ‘Internal research validity’ relates to the degree to which research is recognised as having rigor and accuracy in research communities i.e. in terms of research genres and protocols. Thus, community engagement has a key role to play in extending the sphere of influence of rural health research beyond research communities into the wider local community of interest (Wagle, 2000).

By helping rural health research achieve external social validity, community engagement allows this research to act as an agent of change. A working definition of community engagement for rural health, developed using existing models (Bell, 2010; Minkler & Wallerstein, 2003) as a point of departure, is as follows:

Community engagement in rural health research aims to address health challenges by reconciling the different experiences and interests of stakeholders in a way that progresses solutions to a specific health challenge. Community engagement in this research creates opportunities for strategic redefinitions of health challenges, sharing of experiences and views, reconciliation of covert and overt opposing agendas and conflicts, and solutions-finding. It does so in a way that documents and makes available the aims, methods, and findings of that community engagement, used as an evidence-base for solutions.

Community engagement thus allows rural research to have an authentic connection to its communities of interest. Through participatory styles of research practice, rural health agencies can work to gain the trust and confidence of their rural communities by using research to build stronger connections between what occurs ‘on the ground’ in communities and policy and practice decision-making. This can be more difficult to achieve in narrow biomedical disciplines where technical knowledge has sometimes been regarded as a prerequisite for effective participation (Levitt, 2003).

Well-delivered, high quality community engagement can help ensure that policy and practice decision-making is robust and defensible. Non-existent or poorly done community
engagement can lead to failed policies and interventions that do not meet the needs of their communities of interest. The latter appears to be more common than the former. Much urban-based policy is made without consulting rural communities affected by those policies, even in societies such as the UK that have mandated participatory styles of research to some extent (Barber, Boote, & Cooper, 2007). Many ethics procedures (and government-funded programs of research) now require researchers to adopt participatory styles of research. However, this is not the same as requiring policy-makers to practice participatory styles of research—the decision to consult or not to consult is often left up to policy-makers themselves. However, researchers can reinforce participatory styles of policy-making by offering evidence-based policy options that are underpinned by high quality community consultation.

Challenges of Community Engagement

Community engagement in research presents a wide range of challenges relevant to achieving internal and external validity.

The first kind of challenge is definitional: for example, defining who to include in any exercise of community engagement and what their roles will be. A diverse range of people may have different kinds of rights to be involved and roles that they may fulfill: rights and roles as experts in the field, as affected groups, as marginalised equity target groups, as influential business sector groups. All these groups will most likely offer different kinds and types of political, financial or practical input important to the success or failure of an intervention. Explicitly or implicitly, every exercise of community consultation is shaped by criteria to do with who has a legitimate right to be consulted and what role they will adopt. These criteria will sometimes be challenging to implement, given that community members exist not as discrete groups but as complex and interwoven networks of interests (de Leeuw, 2001) that do not always have obvious rules for their successful engagement. Definitional challenges can be based on ethical-philosophical positions about rights but they may also be based on rules, procedures, customs, laws and regulations. Definitional challenges need to be met if a community engagement process is to have legitimacy i.e. have external validity.

The second kind of challenge, to do with achieving both external and internal validity, is technical: ensuring that the techniques for engagement permit community members to be seen and heard. Each community member and group will bring different levels of literacy and expertise to the community engagement exercise. The number of community members, the range and complexity of their experiences and views, present considerable technical challenges of data collection and analysis (Cabinet). Thus a critical challenge in community engagement is ensuring that findings about community views are not only accurate, but are supported by a method that can be readily explained to, and supported by, community members. This is particularly difficult in community engagement exercises that require the research findings to include identification of specific areas of community consensus.

The third kind of challenge, particularly relevant to external validity, is ideological: managing conflicting political interests and values. Politics and ideology shape the ways in which the health challenge is understood, how community members engage with that challenge, and the solutions that they bring to the consultation process (Stone, 1989, 2002). Deciphering conflicting political interests and values, and managing them in a way that leads to successful community engagement processes is critical to the success of any solutions
found. Arnstein has suggested that greater levels of community ownership or ‘citizen control’ of a community engagement process can lead to better outcomes for that community i.e. that the greater the degree of community power the greater the quality of the consultation (Arnstein, 1969). However, without careful management, community engagement processes can be ‘hijacked’ by powerful factions within a community that take control of the reform agenda at the expense of other community groups. Careful management of the ideology and politics aspects of community engagement is also important for obtaining the cooperation of diverse community groups important to finding solutions for a particular health challenge.

Practices of community engagement have too often not been accompanied by much scholarly rigour. However, there are some important approaches and tools that have been developed to help bring an empirical rigour to efforts to engage communities. Most of these approaches could be described as ‘action research’ approaches (Gramberger, 2001). Democratic governments in particular have been increasingly active over the last two decades in developing and promoting more systematic approaches to community engagement (Farrell, 2004; Health Canada, 2000). Scrutiny of a wide range of well known action research approaches suggests that they are frequently not defined by a single methodological approach but rather consist of a diverse range of qualitative and quantitative methods that have been adapted to meet the needs of data collection and (to a lesser extent) data analysis of community views (Ellis, Barry, & Robinson, 2007; Minkler, Vasquez, Warner, Steussey, & Facente, 2006; Minkler & Wallerstein, 2003; Taket & White, 1998; White & Taket, 1997; White, Taket, & Gibbons, 1996). For example, the ‘Delphi’ method has been adapted for use in evaluating different kinds of policy options in community-based solutions finding exercises that draw on both qualitative and quantitative information (Franklin & Hart, 2007).

Limitations of Existing Research Methods for Community Engagement

Existing quantitative and qualitative research methods have particular limitations for community engagement.

The quantitative limitations arise from the ways in which variable-driven, big-N statistical methods simplify contextual complexity, reducing it to the singularity of significant variables. Big-N statistical methods allow for generalisations in, for example, community surveys of opinion, but it is often difficult to make those generalisations meaningful once they have been abstracted from their rich local contexts. Research subjects operate in contexts that are criss-crossed by social and environmental relations that are difficult to capture with traditional statistical approaches. Health challenges are embedded with many complex contextual challenges. Thus a key limitation of quantitative approaches is about the information that is lost. This can be seen clearly in the example of sub-groups analysis in classical experimental research paradigms. In these paradigms, information from small groups is too often lost because it lacks adequate ‘statistical power’. Yet complex causality cannot be captured without a means for including such information (E Bell, 2007a). Generalisations about community opinion that are quantitatively robust are of little assistance in meeting the challenges of rural health if they are so broad that they tell us little about the underlying causal factors that shape those opinions. Some quantitative techniques have been designed to help overcome such limitations, notably, decision-analytic modeling aimed at supporting complex decision-making (Weinstein et al., 2003).
The technical qualitative limitations of community engagement relate to the problems of summarising complex language data. The highly interpretive nature of language creates problems of reliability and the small amount of cases often involved makes it difficult to achieve generalisability. A key challenge in analysing qualitative data is to achieve systemacy and rigour, as well as defensibility, in the method for analysis. Since the 1970s many new approaches have emerged to help deal with these limitations, including discourse analysis and other ways of structuring narrative analyses of large amounts of language texts (Davies, 2000; Dingwell & Murphy, 2003; Sofaer, 1999).

Quali-Quantitative Analysis

The Potential of QQA for Community Engagement


Yet despite QQA being included in hundreds of applications across diverse disciplines, it has received very little attention in the disciplines of health. This paper builds on work by the author in previous publications where the potential of QQA in meeting diverse challenges has been explored: for building evidence based holistic clinical practice (Erica Bell, 2006) and for hospital error (Bell, 2007b); for meeting the complex challenges of evidence-based approaches to holistic health challenges such as healthy ageing (Bell, 2007a); for rural crime prevention and the design of community-based interventions (Bell, 2010; Bell & Hall, 2007); as well as for service design (Bell, 2007c). This paper focuses on aspects of this previous work to build an understanding of the usefulness of the method for community engagement in rural health. The generic term ‘Quali-Quantitative Analysis’ or QQA is used here in preference to Ragin’s term ‘Qualitative Comparative Analysis’ or QCA to better convey that what Ragin is offering is not simply another kind of language-based case study approach.

In relation to the limitations of traditional quantitative research, QQA offers a way of capturing contextual complexity by offering a means of retaining the configurational information of individual cases. In relation to the limitations of traditional qualitative research, QQA offers a way of capturing large amounts of language data in a manner that does not sacrifice reliability for rich case-based information. Whatever else it is, QQA is an approach to summarising the configurational attributes of cases that does not reduce these attributes to ‘variable-driven’ generalisations (however generalisable) or narrative generalisations that are not generalisable.

The key text for understanding QQA is Ragin’s 2000 book *Fuzzy-set Social Science* (Ragin, 2000) and allied software (Ragin, Drass, & Davey, 2006). While there are a number of other examples of what might be called ‘case-based methodologists’ (George & Bennett, 2004), Ragin’s work is by far the most sophisticated, well-developed and well-recognised. Readers wanting a general introduction to the field should consult the recent textbook which
offers accounts of the family of methods associated with quali-quantitative case-based approaches (Rihoux & Ragin, 2009).

QQA: Practical Techniques for Community Engagement

Three stages are commonly described by Ragin for implementing the QQA method (Ragin, 2000)—the author has added a fourth stage to do with translating the method into policy and practice, building on her previous work (Bell, 2010):

Stage One: Tabulating and Summarising Cases

In this stage the researcher will need to identify what is the case or unit of analysis, and what are the attributes of those cases that are of interest. This definitional task can involve community members, ideally as members of a reference group. A simple table would be created by the researcher which would identify (as rows) the cases, with column headings identifying the attributes of interest.

The researcher should draw up a preliminary table based on the international literature. For example, if the research project was about determining what kind of local community health facility for meeting mental health needs should be built, the initial table would be developed building upon insights from the relevant research literature, both applied and scholarly. That is, the attributes of interest might be initially defined by systematically reviewing the literature for the best practice attributes of such facilities (what kinds of services they deliver, and so on). Columns could also be added for particular kinds of outcomes being sought from the proposed service, where the evidence supports those outcomes.

The rows of cases could relate then to the planned data collection exercises: one row for each key community stakeholder’s ‘opinion set’ about those attributes. The data collection exercise might involve key community representatives being asked to fill in the table to identify what characteristics of the planned service they wanted to see and their preferences for related outcomes (more than one outcome could be selected). There are a number of options for how responses might be recorded in the table. Community representatives could provide simple ‘yes’ and ‘no’ responses, or they could indicate degrees of agreement. The use of degrees of agreement as responses could involve a number of intervals that had been developed with the reference group, in line with later versions of Ragin’s method (Rihoux & Ragin, 2009).

The number of cases (or community representatives) that can be accommodated this way are several hundred. This should be more than enough, given that most rural community engagement exercises will involve small numbers of peak organisations. Thus, these peak organisations can fill in the table and submit a written report to support their tabulated responses. For situations involving larger numbers, such as the Victorian Bushfires Commission in Australia that involved 1,700 submissions (Teague, McLeod, & Pascoe, 2009), another approach will be required. This might involve tabulation of submissions by panels of community representatives, with tabulations cross-checked by researchers for reliability. In the latter event, each member of the panel would represent a case, with the
possibility of having a small number of panels or a large number— for manageability, as long as the number of panelists did not exceed the limits of a few hundred cases. Issues of generalisability can always be dealt with through standard sampling techniques to select cases.

Upon completion of the tabulation of cases, the researcher would use the software (Ragin, et al., 2006) to ‘minimise’ the information in the table. This would involve obtaining shorthand expressions using a notation system such as Boolean algebra. The point of the shorthand expressions is to summarise configurational information in the table into ‘logical equations’ for a particular kind of desired outcome. Different service outcomes being sought may involve the same or different kinds of logical equations (combinations of service attributes). Conversely, the same service outcome may have different kinds of logical equations or combinations of service attributes.

Thus, the aim of this first stage would be to summarise the views of the community in a way that did not lose information about the particular kinds of service attributes and outcomes that each community stakeholder (represented as a case) felt were important.

Stage Two: Testing ‘Necessity’ and ‘Sufficiency’

The attributes of the service recorded by community members could be described as perceived causal conditions. That is, community members believe that these attributes will (perhaps to varying degrees) lead to particular outcomes achieved by the service.

In Ragin’s method, tests of necessity and sufficiency of causal conditions are critical: “A cause is considered necessary if all instances of the outcome occur with the cause. A cause is sufficient if all instances of the cause occur with the outcome” (Bell, 2010, p. 110).

Thus at this stage of the QQA process, particular perceived causal attributes of services would be identified as being either ‘necessary’ or ‘sufficient’ for particular outcomes. That is, the researcher, working with the stakeholder reference group, would consider the tabulated responses and would identify which attributes were considered necessary by the community to particular outcomes of the service to the extent that community members always recorded that outcome of the service against that attribute. The researcher would also identify which attributes of the proposed service were considered sufficient by the community to the extent that every community participant (or peak organisation) had recorded that attribute with that service outcome.

Using such an approach, quite complex perceptions in the community can be captured. For example, it may be that the community engagement exercise suggests that there are single attributes that are perceived as neither necessary nor sufficient to particular service outcomes. It may be that a particular outcome is perceived as being achievable through two different kinds of combinations of service attributes.

Stage Three: Further Validating the Results

The third stage would involve developing ways of testing the results achieved thus far. In a community engagement research exercise of the kind described, this stage would involve examining whether and how the findings had produced simplification of complex causality.
The causality involved here relates to whether the attributes of the service really are linked to the outcomes in the way the community stakeholder data suggest. Another kind of simplification that the researcher needs to be vigilant about is whether the findings of the research exercise have simplified community perceptions.

The way to deal with these undesirable tendencies to homogenisation and simplification are to devise adjunct tests. For example, to resist the first problem of simplification—to test whether the findings (essentially representations of community views) have simplified the ways in which services shape outcomes—an independent panel of experts in the mental health service field (not involved in the study thus far) could be invited to consider relevant research literature and repeat the steps above. This panel would use, for each row, their consensus opinion about a key piece of literature and the degree of evidence it offers for particular attributes being linked to particular outcomes. The results of this exercise could then be fed back in structured ‘reconciliation’ exercises to the community stakeholder group, research participants and to policy-makers. It may be that this reconciliation exercise will lead to the community concluding that it has missed some important attributes or is wrong about a particular outcome being achievable. Or it may be that the community will decide that the differences between their understanding of causality and that in the literature is a function of important local contextual variables that are unaccounted for in the literature. Either way, an important quality assurance loop has been established.

Resisting the second problem of simplification — to test whether the findings of the research have simplified community perceptions — might involve repeating the exercise above using a random sample of community stakeholders.

Stage Four: Dissemination and Translation

In community engagement exercises for rural health, the dissemination and translation of community views is a critical step. This would involve ensuring that the research findings are well integrated into policy and practice.

In the example above, the task was to develop an agreed set of attributes and outcomes for a proposed health service. The attributes might relate to the governance of the service, its aims, service interventions, location, and funding, and so on. The outcomes might relate to whether the service is aiming at long-term residential support for a particular target group, or perhaps effective short-term crisis intervention, or a combination of both.

Policy-makers can be presented with summaries of the research findings in ways that allow the complexities of community opinion about the proposed service to be known, its proposed attributes and desired outcomes. Decision points and trade-offs can be elaborated as part of presenting the policy options (Bell, 2010).

The translation of the research findings into practice can take another related pathway. The implementation of the service can involve careful mapping of the shorthand expressions, necessary and sufficient service attributes, and related outcomes, onto service design templates and service handbooks for governance.

The concise or summary form in which research data are delivered using Ragin’s method lends itself to a wide range of ways of dissemination and translation into policy-making and practice. The key objective in any such dissemination and translation is not to lose the useful complexity that the method aims to capture. The configurational form of QQA research
findings makes this loss of complexity less likely—a major advantage in a context where much research information from traditional methods does get ‘lost in translation’.

Conclusions

Ragin’s work has been very considerably simplified here to offer broad illustrations of its value for community engagement research, rather than technical detail. This chapter cannot hope to cover the many technical developments Ragin’s work offers. However, the foregoing discussion does offer a basis for suggesting the ways in which Ragin’s method can help innovate community engagement in rural health.

It has suggested that Ragin’s method potentially allows for greater internal research validity because it brings a rigour and systemacy to the task of collecting large amounts of information about community opinion, only imperfectly amenable to summary as significant variables or narrative-driven conclusions. Thus the method has particular value for helping community engagement efforts in rural health achieve a technical sophistication. The possible weaknesses of the method may not lie in how readily and well it can be developed and used. It may lie in the task of explaining the method to those who are unfamiliar with it.

The discussion earlier in this paper also suggested that technical challenges are only one of three kinds of challenges presented by community engagement. How well might the method work for the other kinds of challenges—definitional and ideological? These relate to the challenges of also achieving external validity.

In relation to definitional challenges, how should each stakeholder’s contribution be weighted? Should a stakeholder submission representing only three people be given the same weight as one that represents almost the entire community? The value of Ragin’s method is that it could be adapted for both situations—where all views must be weighted equally or where some greater value should be given to a particular viewpoint or viewpoints. Such weightings too often occur by subterfuge in community engagement exercises, making undemocratic decision-making a likely result. Ragin’s method can be adapted to make such weightings more transparent, perhaps by adding to the columns an additional attribute that could allow for recording of such degrees of representation of a particular viewpoint. The ‘weightings’ attribute of a particular case or community stakeholder opinion could be decided on using fair and explicit criteria, decided participatively upfront.

Ragin’s method could also help meet the ideological challenges of community engagement. This is because the method helps ensure that the findings of community consultations accurately reflect the complexity of community views. That is, the method allows for the configurational complexity of community views to be retained in the final analysis—not eliminated by the simplifying tendencies of traditional quantitative or qualitative methods. It does this in a way that allows community members to be involved in every step of the process of research. That is, the fact that different kinds of views are captured and ‘held’ in the analysis means that it becomes more difficult for difference to be drowned out by volume. Thus the approach has particular value for policy-makers who want to know more about such possibly politically powerful differences i.e. the views that lie on the margins.
Community engagement in rural health is often about ensuring that empirical rigour is brought to a complex situation involving a small number of cases. Developing healthcare for rural communities will rely on this kind of challenge being addressed through innovation in small-N research methods for community engagement. The work of Charles Ragin, one of this century’s most prolific methodologists, offers much that can help meet the need to ensure that not only are rural communities informed about the healthcare they will receive, but they also actively work to shape and own that healthcare.

Acknowledgments

This paper has completed as part of the work of the University Department of Rural Health which is funded by an operating grant from the Department of Health and Ageing.

References


Innovating Community Engagement in Rural Health: A Qualitative-Quantitative Research Approach


Abstract

In population health, data collection presents a great challenge for researchers; particularly when it involves participants from isolated and remote communities. There are many factors which account for poor responses from these communities such as isolation and poor motivation, limited access to and knowledge of information technology, coupled with a general sense of discomfort with the traditional modes of data collection. In turn, this may discourage researchers from involving residents of remote communities in such studies. Healthcare professionals, administrators and policy makers therefore may struggle to identify appropriate evidence from which to plan health programs for rural and remote communities.

This chapter is based on a current research project involving data collection from different localities within a rural municipality in Tasmania. The project seeks to map areas in need of health care services using Geographical Information Systems (GIS) tools.

A survey was developed to collect information on physical health and wellbeing and service utilisation from residents in the Meander Valley municipality, Tasmania. In recognition of the importance of community participation in data collection, the research team worked collaboratively with local communities to ensure an optimal response rate from isolated communities. This chapter summarises strategies and activities employed in the community engagement and data gathering processes, and explore the strengths and weaknesses of each approach. Insights gained from this experience will help enhance future research dealing with data collection in rural and remote communities.
Keywords: community engagement, community empowerment, data collection, population health.

Introduction

In population health, data collection presents a great challenge for researchers, particularly when it involves participants from rural communities. There are many factors which account for poor responses from these communities such as isolation and poor motivation, limited access to and knowledge of information technology, coupled with general discomfiture with the traditional modes of data collection. Data collection in rural communities therefore requires innovative strategies that address some of the identified barriers to engagement. This paper reports aspects of innovative and purposive rural engagement strategies in data collection of a current research project within the Meander Valley, a rural municipality in northern Tasmania. Through data collection process, the benefits of community engagement such as network enhancement within communities, capacity building in collaborative researching, and a deeper understanding of the local communities in terms of their interactive communication processes, values, collective spirit and ways with living, are identified.

Data Collection in Public Health Research

In health, data collection provides a rich source for evidence-based research. Evidence based health care seeks to apply current best evidence from research in the prevention, detection, and care of health disorders (Haynes & Haines, 1998). According to Black (2001), the need to be seen to be making evidence based decisions has permeated all areas of British public policy. This government has proclaimed the need for evidence based policing, and the 1998 strategic defence review introduced evidence based defence. In the health sector, the concept of evidence-based policy has gained ground, and surveys have a strong tradition as an effective data collection method (Macintyre, Chalmers, Horton, & Smith, 2001; Niessen, Grijseels, & Rutten, 2000). The effective use of survey methods presents a number of challenges, particularly when involving participants from rural communities. Most importantly, as Trochim (2006) points out low response rates can render worthless an otherwise well-designed study.

Poor responses from rural communities may be caused by factors such as isolation and poor motivation, feelings of being over surveyed, limited access to and knowledge of information technology, coupled with general discomfiture with the traditional modes of data collection which place little attention to the benefits of actively and meaningfully engaging local communities in data collection. The feedback from community members indicates that generally research is perceived by the local communities as “remote” and “one-sided”. Thus, there is the potential for some mistrust between the researcher and the community in which a study is undertaken. The mistrust may lead to negative attitudes towards participating in any research activities. In turn, this may discourage researchers from seeking to involve residents of remote communities in such studies. As a result healthcare professionals, administrators and policy makers alike may struggle to identify appropriate evidence from which to plan
health programs for rural and remote communities. Public health researchers need to employ effective and innovative activities and strategies to enhance data collection. Diamond et al (2009) goes further to argue that a new paradigm in data collection is needed in public health research. In most traditional methods, the focus is on the researcher as the key player in data collection. This has significant implications for the research including the risk of the marginalising of target participants.

**Community Engagement and Participation in Health Research**

Community participation has received attention in research for a long time, particularly in ethnography research, which places great emphasis on the researcher as participant observer in a community where the research takes place (Silverman, 2001). However, the concept “community engagement” emphasises the collaborative participation of community agents in the research process. The Department for Communities and Local Government in the UK has defined community engagement as “the process whereby public bodies reach out to communities to create empowerment opportunities” and community empowerment as “the giving of confidence, skills, and power to communities to shape and influence what public bodies do for, or with them” (CLG, 2007, p. 12).

As a process, community engagement means working collaboratively with groups of people who are connected by geographic proximity, special interests, or similar situations with respect to issues affecting their well-being. It is a powerful vehicle for bringing about environmental and behavioural changes that will improve the health of the community and its members (Rogers & Robinson, 2004). It often involves partnerships and coalition that help mobilise resources and influence systems, change relationships amongst partners, and serve as a catalyst for changing policies, programs and practices (Jewkes & Murcott, 1996; Oxlund, 1999; Zakus & Lysack, 1998). Community engagement in public health, therefore, stresses the importance of engaging the community in health decision making and improving community participation in health promotion, health protection, and disease prevention efforts (Batangan & Ujano-Batanggan, 1999; Morgan, 1993).

Community engagement strengthens the capacity of communities to take actions that make positive and lasting changes in their community and the lives of citizens. It is about fostering collaboration across the government, voluntary sector and corporate sectors in solving issues affecting the quality of life for citizens in a community.

In 1999 the World Health Organisation published *Community Involvement in Health Development* (Khassay & Oakley, 1999). It set out five key benefits of community involvement:

- coverage and the involvement of more people
- efficiency and the better coordination of resources
- effectiveness as a result of more relevant goals and strategy
- equity through focused provision for those in greatest need
- the growth of self-reliance and local capacity.
According to Whyte (2001), community participation in health research makes good economic, scientific, and moral sense. Community participation in research can achieve more efficient allocation of resources for research by better revealing the full extent of societal demand for various resources. It also strengthens demand for research and interaction between researchers and users can make the conduct of research more efficient. Whyte (2001) argues that community participation also promotes equity by countering the tendency of research to reflect the views of an intellectual elite and enabling national agendas to reflect the interests of local groups.

**The Meander Valley Spatial Health Mapping Project**

Meander Valley is a large and diverse municipality in Northern Tasmania with a population of 18,369 (ABS, 2009). It consists of small to medium townships servicing industries such as agriculture and forestry as well as urban residential areas which form the western edges of the Launceston City municipality.

A survey was developed to collect data on physical health and wellbeing and service utilisation from residents in the Meander Valley municipality, in Tasmania. The focus of discussion in this paper is not the data collection tool itself but some of the ways in which the community was engaged to improve response rate and to enhance research team work between researchers and the community collaborators.

Meander Valley was chosen as the target of the current research due to the following factors:

1) Historically, the University Department of Rural Health (UDRH) and Meander Valley community have worked on a number of initiatives, especially the recent health and wellbeing map project, conducted in 2006 – 2007 (Barrett, Skellern, & Whelan, 2007). This has enabled the UDRH and Meander Valley community have a “clear and shared purpose to the relationship and results-oriented approach to agreed priority areas identified in the community” (Garlick & Langworthy, NA).

2) The Meander Valley community is perceived by State Health authorities as a leading exponent of a primary health care approach and a community development approach to health planning.

3) Several senior health staff within the municipality can be described as boundary crossers. Boundary crossers are defined as people or organisations that have the ability to cross boundaries between community and external agencies (Kilpatrick, Auckland, Johns, & Whelan, 2008).

4) There is strong evidence of trust and a quality relationship having been generated by these prior partnerships, including awareness of each partner’s organisational structure, culture and governance, capacity and constraints (Rudd, 2007). The Manager of a health facility within the Meander Valley sits on the Board of Management of the UDRH.
5) Collaborative research engagement with local communities can enhance awareness of local resources. In the case of Meander Valley, it has high levels of health literacy and optimal population size, distinct health service structure (e.g., core facilities and satellites) and networking, as well as connected IT skills.

6) The involvement of the State Health Service and the Local Government council ensures accessibility of community meeting places that are familiar to residents.

7) Due to its favourable proximity and its dynamics, Meander Valley is perceived as a receptive community for conducting this collaborative research. Pre- and post-data collection meetings with local communities provided opportunities for explanation of the project and feedback. Progressive monitoring and evaluation, and performance improvement are essential for the project. In other words, it includes process and product orientation.

8) The Central North region of Tasmania was chosen on the basis of its variations in socioeconomics, demography, health disparities and access to health services.

**Stages of Engaging Community in Data Collection**

The process of community engagement in this project involved a number of distinct phases with different activities and strategies.

**Phase 1: Consideration of a Community Development Approach**

The Spatial Analysis project aims to obtain data on health service access and utilisation across a range of geographically dispersed communities within the Meander Valley municipal area. The project lends itself well to a community-based participatory research approach based around co-learning and empowerment of participants, particularly in the area of data collection. This is not only helpful to a particular project but also to mutual understanding and respect between researchers and local community for future collaboration in research as well as in implementation of any research recommendations or implications.

Previous research experience with the Meander Valley community suggested that a community development approach would enhance research outcomes. Existing community structures provide a good conduit for accessing the community, this, together with the significant human and other resources in the community were regarded as excellent indicators for community readiness.

**Phase 2: Identification of Potential Collaborators**

Having agreed on a community development approach to data collection the second phase involved “testing the approach” with community leaders. Community leaders are able to mobilise community members in a way that academic project team members cannot. The term “community leader” is broadly used here to refer to any person with some public standing or influence in the community. Furthermore community leaders can provide valuable
advice about the proposed approach and can help identify community members who can support the data collection process. There were three primary data sources:

- The first source comprised people who live outside the target community but have some knowledge and/or experience about the target community such as health professionals and social workers.
- The second source comprised local community agents such as health professionals, pharmacies, schools and community health services.
- The third source comprised public source of information such as Google Earth, phone directory, media, local maps which gave some information about physical and social aspects of the target community such as sport activities, open markets, shops, cafes, restaurants and hotels.

Phase 3: Initial Group Interaction

An important aspect of engaging the community in the data collection process is to draw on previous collaborative experiences with the target community as a means of establishing the framework for the proposed collaborative activities. Using existing community health structures, an information workshop was conducted to present to the established community health body within the municipality an overview of the project and the rationale for collaboration together with details about the project with its envisaged benefits to the community. The desired outcomes of the workshop were to seek interest from the community to participate in data collection. Community stakeholders are viewed as powerful agents for reaching the community at large. From the community perspective collaborations with academic institutions such as the UDRH can provide a high degree of credibility and influence on policy makers through their evidenced based research.

Phase 4: Follow-up Communication and Interaction

This stage involves individual communication and interaction with representatives of the community health body and to encourage their participation and that of their fellow community members in the data collection process. Participants were provided with information on the different ways that they can be involved in the survey process, ranging from providing space for a survey return box (e.g., medical practice, health centres, custom house and councils) to personally recruiting participants to undertake the survey (e.g., social networking).

Phase 5: In-Progress Communication

Regular and consistent communication is needed in order to maintain effective collaboration, it is important to provide opportunities for the research team to provide feedback to the community about the progress of the data collection. It also provides an...
opportunity for the community to clarify or raise comments on any problems or successful approach which were deemed to impede or enhance data collection. For instance, several participants contacted the research team via telephone and email communication with valuable suggestions on how to increase survey return rates.

Phase 6: Feedback Outcomes from Survey Process

One of the main reasons why stakeholders participate in the data collection activities is that they want to make a contribution to a worthy project which could enhance their communities. Thus, it is important to share with them the results gained from the project and any information which could enhance future research as well as maintaining the collaborative spirit. Feedback on previous projects was provided at the initial information meeting, a second meeting was held toward the end of the data collection process and a third meeting is planned to provide more detail about the results to date. It is important to acknowledge and celebrate milestones with the community to ensure continued engagement.

What have we learned from this Project?

Taking into account potential problems facing survey-based data collection in remote communities, the success of this collaborative experience was very encouraging to the research team and the participating data collection community collaborators. The combined strategies also yielded higher than expected response rate from a common survey administration without the use of deliberated strategies. A total of 484 questionnaires were returned (61% response rate) using combined strategies compared to the expected 200 completed questionnaires, based on a typical response rate of 25%.

There were a number of key learnings from each phase of engagement.

Phase 1: Consideration of a Community Development Approach

The decision to adopt a community development (CD) approach to the project research methodology requires considerable planning and should be considered from both an institutional and community perspective. Best practice community development would ensure that the objectives of the study were determined in conjunction with the community: in the case of this study there was community support for the mapping but it was an objective determined in advance by the academic project team.

Whilst CD can enhance the amount and richness of data received it may also raise unrealistic expectations in both the researchers and the community. In the case of this project, there was no formal process developed to ensure that community contribution was monitored and managed. The development of a detailed communication plan would enhance the effectiveness of this process. As a result, although the community support was very powerful there were some areas where return rates were low.
A formal CD plan as a component of the research project plan should have been prepared to ensure that key tasks associated with each stage of the engagement process were followed through.

**Phase 2: Identification of Potential Collaborators**

A critical component in identifying potential collaborators is the existence of some prior history of a positive working relationship. Relationship driven collaborations are more successful than funding driven collaborations as they are forged over a period of time that establishes a framework of trust and mutual benefit. The first step of this study in identifying potential collaborators was the search for information about the local communities in the UDRH’s contact databases and history of collaboration in a number of projects and funding opportunities. It was followed by personal visits and communication with potential collaborators.

**Phase 3: Initial Group Interaction**

Direct interactions with stakeholders and interested parties within the community provide an opportunity to present the research project plan to the community and to outline the proposed community engagement strategy. A critical success factor in the process is the testing of the proposed CD approach with community project advocates prior to presentation to the broader community.

This study’s objectives and methods were determined prior to the community engagement stage, limiting the possible benefits of initial interaction. However, the prior experience of the research team with community leaders enabled early and enthusiastic community engagement in the research process. The community project advocates helped refine the proposed methods to ensure that the approach was practical and achievable from a community perspective.

**Phase 4 and 5: Follow-Up Communication and Interaction / In-Progress Communication**

The project team has followed through on undertakings agreed at the initial workshops, which appears to have helped ensure the continued interest and investment by the community in the project. Not all survey distributors were connected to the project team; in the case of many of those that were, communication was received back through the chain to the project team. It is important that there is a degree of flexibility in the process that will be able to respond in a timely manner to problems experienced at any level in the distributor network.
Phase 6: Feedback and Information Sharing

Acknowledging effort and providing feedback proved to be well received by the community. Aside from wanting to contribute to a project that is perceived to have a positive impact on their community, research indicates that community members participate in community based action research initiatives because they want to be informed on an issue. At the initial information meeting the team announced that the previous study results had been sought and provided nationally and internationally, and this made a strong impression on community members. Community members reported that they valued the ability to share their enthusiasm and celebrate the success of their role. The team were pleased that adequate time and space is created for members to do this.

Suggestions for Future Projects

In this case study, several sources were used to help the research team to gain knowledge and understanding of the physical and social aspects of the target community such as the Internet, phone directory, and local newspapers. Different strategies were used in identifying potential collaborators for data collection, integrating them into the research process, and treating them as meaningful players in the research discourse. The key principle underlying this study was that stakeholders were treated as meaningful and active collaborators in the research journey, not as third party recruiters of participants as normally seen in traditional approaches. Thus, they were valued as “social capital” for a research project.

However, in any successful story, there are always lessons to be learned for future improvement. The following are recommendations for future research involving community engagement, particularly remote communities.

- Adequate time to distribute and collect surveys; in this study the timelines were pre-established by the research team and were not sufficient in many cases
- Making sure the information sheet is clear and concise; a preferred option would be a 1-page plain English sheet with the formal Ethics clearance sheet attached as an appendix.
- Revising the information package to be more “community-friendly”. Technical terms / jargon should be avoided.
- Providing participants a range of options to complete the survey with such as hard copies and an online version.
- Exploring more widely social networking opportunities (e.g., Facebook, Twitter, and sporting clubs).
- Providing support information for the project through timely publicity (e.g., use local media with photos of community stakeholders to promote the project at the first stage of the project).
- Monitoring survey distribution and acting to increase response rates (e.g., using post offices, shopping centres, news agencies for areas with low responses).
- Going back to the communities, thanking and updating them with progress.
- Presenting research findings to the community also assists in research validation.
Before distributing survey, finding out what are other research activities currently conducted in the region for responders to avoid confusion when filling in the survey.

**Limitations**

Engaging local communities in research is an interactive and collaborative process which recognises the important role of stakeholders in research. This study suggests that there were many benefits in engaging different participating community agents in data collection. However, an examination of the data reveals that the study did not target enough young people and male responders, both of which could have been anticipated from previous research.

**Conclusion**

Data collection in the context of remote communities requires innovative strategies to effectively engage participants in the process of data collection. This paper outlines some innovative and purposive rural and remote engagement strategies which appear to have secured a high rate of returned questionnaires. Perceived additional benefits include network enhancement within communities, capacity building in collaborative researching, and a deeper understanding of the local communities in terms of their interactive communication processes, values, collective spirit and ways of living.

**References**


Chapter XXI

Methodological Considerations for Health and Wellness Research with Older Adults

Tony Barnett and Sonia Allen

Abstract

The number and proportion of older adults in society continues to increase. Research with and about older adults is therefore important to grow our understanding of the ageing process and provide evidence on how best to maintain and optimise health and wellbeing in later life from a broad ecological perspective. Research can inform the development of effective strategies to address the many functional, social and health challenges that accompany transitions in later life. This chapter will highlight the demographic changes associated with an ageing society and review some of the changes that are associated with the ageing process, their impact, and how these should influence both the approach to and procedures used in research with older adults. Practical advice is provided on three common ways by which data is collected from older adults in health-related social research: surveys, interviews and focus groups. A number of factors critical to the successful application of these techniques as part of research with older adults are highlighted. Consideration of these in the development of a research plan will ensure that the techniques chosen are more likely to be “fit for purpose” with this group.

Keywords: older adults, ageing, rural health, surveys, interviews, focus groups.

Introduction to an Ageing Society

Globally, populations are undergoing rapid changes in structure. Both the proportion and absolute numbers of older adults has increased. This increase has been attributed to progress in economic wellbeing and advances in public health. Over time, the major causes of death
have also changed. More common at the turn of last century were deaths due to infectious diseases, whereas today, chronic illness, injury, lifestyle choice and degenerative diseases contribute greatly to mortality and the burden of disease associated with ageing (Gray, 2006).

Increased life expectancy and reduced fertility have combined to produce a world in which the number of people who are aged 60 or over will rise from 10% to 21%, around two billion people, by the year 2050 (United Nations, 2003). Over the last century, nearly 25 years of life expectancy has been gained, and in some countries, older adults will outnumber children (Rosenberg & Everitt, 2001).

This demographic change will occur in both developed and developing countries, though the increase will not be evenly distributed (Australian Institute of Health and Welfare, 2008). The most significant change in the short to medium term will occur in developed countries and regions such as Anglo-America, Europe, Japan, Australia and New Zealand (ABS, 2006c), though in the longer term this increase “will be greatest and most rapid in developing countries where the older population is expected to quadruple in the next 50 years” (United Nations, 2002a, p.1).

### Social and Economic Impacts

Whilst ageing is a natural process, as the population ages, it can be expected that there will be increased prevalence of chronic disease and co-morbidity, and functional disability (Orfila et al., 2006). Both reparative processes and adaptive responses decline with age. Ageing is also accompanied by significant life events and changes to a person’s role. The transitions associated with the cessation of paid employment changes to living arrangements, income levels and health, for example, place an increased strain on individuals (Butler & Ciarrochi, 2007; Butterworth, Gill, Rodgers, Anstey, Villamil & Melzer, 2006). This can impact a wide range of support structures and resources (Gartrell, 2003). Sustaining a population in which an increased proportion is regarded as being of “post-employment” age, also raises important economic and social challenges (ABS, 2006c; Grbich, 2007).

The sheer size of the aged population in the next few decades will compel governments to chart new ways to sustain socio-economic development whilst maintaining social stability. As a consequence of an increasing aged population, policy and broader socio-economic debates have occurred around health, housing, welfare, support and transport (AIHW, 2004b; Davey, 2007; National Rural Health Alliance, 2004). A key strategy to sustain an ageing population has been to support “ageing in place” and to extend the time spent by older adults living relatively independently in their own homes whilst also maintaining their quality of life, rather than entering nursing homes or similar supported accommodation (ABS, 2006c; Grbich, 2007).

Many of the “well” elderly, especially those who have resided in a particular area for some time, have well established support mechanisms that can be called upon when needed to sustain their independence, well-being and other attributes of successful ageing. As independent living becomes more difficult however, there is often a need for additional, more formalised, services. Ageing in place can be particularly problematic in rural communities, where population shifts and economic pressures have contributed to a reduction in, or rationalisation of, many support services (AIHW 2004a; Laditka, Laditka, Olatosi & Elder, 2007). For this reason, it has been argued that more in-depth studies to better understand
factors which could influence successful ageing in place especially within a local context are required (Kendig, Andrews, Browning, Quine & Parsons, 2001; United Nations, 2002b).

The Older Adult in Australia

Australia’s population doubled from 1947 to 2005 to just over 20 million, with persons over 65 almost trebling during the same period (Duckett, 2007). Life expectancy in Australia has risen to be one of the highest in the world with more than 2.6 million Australians in 2005 aged over 65 (AIHW, 2008). According to present projections, the proportion of the population over 65 will increase to 18% by 2021 and by 2050, up to 25% of all Australian residents will be over 65 with one third of these over 85 (Byles, Powers, Chojenta & Warner-Smith, 2006; Gray, 2006).

Data from four national health surveys (1989-90, 1995, 2001, 2004-05) demonstrated that whilst the majority of Australians report themselves to be in either good or excellent health, the proportion of people who reported their health to be fair or poor increased with age (ABS, 2006b; Turrell, Stanley, deLooper & Oldenburg, 2006). As found elsewhere, age, especially advanced age, is predictive of health decline, greater impairment and often a reduced capacity for independent living (AIHW, 2004b). A report on ageing noted, “as Australia’s population continues to age, the community faces the challenge of providing policy, programs and services to meet the changing values, behaviours and attitudes of an older population” (ABS, 2006c, p.2).

Women are more likely to survive into old age than men, a characteristic shared by other developed countries (ABS, 2006a). Increased life expectancy, especially for females, however, is not uniform across the population. Indigenous Australians, who comprise around 2% of the population, have a life expectancy around 15-20 years less than other Australians (AIHW, 2006). Socio-economic disadvantage effects health status across cultures and age groups (Grbich, 2007). Three national health surveys demonstrated that, “both males and females from the most disadvantaged areas rated their own health more poorly, and reported a number of long-term illnesses more often than those living in the least disadvantaged areas” (Turrell et al., 2006, p.45). Patterns established by socio-economic factors (social determinants of health) on the life continuum therefore have a significant bearing on health outcomes in later life (Gray, 2006).

Across Australia, the population is generally ageing more rapidly in regional and rural communities than in metropolitan areas. The lower cost of living outside of capital cities and a growing tendency for people to pursue a ‘sea’ or ‘tree change’ has contributed to attracting older people to rural areas (ABS, 2002b; DHS, 2003). This creates special challenges for health care planners and policy-makers, given that outside of major population centres, there may be fewer services, less access to specialist care and fewer health care professionals.

Australia’s expenditure on formal aged care services represents a little over 1% of Gross Domestic Product (GDP). Older people consume more health services than younger age groups and health care spending on those over 65 years is currently four times that per person for those under 25. These costs escalate further for the over 85 age group and are not necessarily concentrated at interventions associated with end of life care (House of Representatives Standing Committee on Health & Ageing, 2005).
Research with and about older adults is therefore important to increase our understanding of the ageing process, and how to maintain and optimise health and wellbeing. Critically, more research is required to better plan and prepare for an ageing population, and increasingly, more research centres are being established to investigate questions related to the ageing population (AIHW, 2004b; Almeida, Norman, Hankey, Jamrozik & Flicker, 2006).

**Approaches to Research with Older Adults**

Within the discourse on ageing, a tension exists between the decline or dependency model of ageing and more positive explanatory approaches (Thomas, 2003). Negative approaches to ageing, characterised by the concept of “ageism”, place undue emphasis on the financial burden of older adults, as well as the assumption that post-retirement is equated with non-productivity, social invisibility and the dominance of pathology (disease states) (Bevan, 2001). Continued participation in the workforce well into older adulthood has, however, been recognised as beneficial to the individual, the community and to the economy (Butterworth et al., 2006). More self-affirming approaches to ageing, characteristic of the “successful” or “healthy” ageing movement, emphasize the positive rather than negative attributes of ageing and value the contribution of older adults to society’s stock of “social capital” (Garlick, Waterman & Soar, 2006).

A challenge for researchers collectively is to investigate how best to support an ageing population in a socially responsible and economically sustainable way that values the potential of older adults and supports their independence for as long as possible (Garlick, Waterman & Soar, 2006). With an ageing population the importance of research activity into the minimisation of dependency and healthy ageing generally has become more important “to ensure that the years added to life are healthy, active and productive and that there is significant compression of disability in later years” (United Nations, 2002b, p.2).

**Conducting research with older adults**

Ageing is a complex process characterised by transition, some loss of functional ability and an increased prevalence of chronic medical conditions. Changes associated with natural ageing include: primary changes, such as vision impairment and hearing loss; or secondary changes, those which ensue from a disease process, for example the onset of dementia can affect recall and cognition. Conducting research with older adults has, therefore, particular challenges which can be related to the physiological changes that accompany the ageing process as well as history and maturation.

Older adults were born in a world very different from that of today and would have seen a great many changes in areas such as transport, technology, life style, expectations and behavioural norms, to name a few. Many would have developed and formed strong familial and other support networks, and experienced both great joy as well as personal loss. The older adult carries with them history, culture, values, a skill set, humour and a wisdom that a careful researcher should both consider and respect when planning their research. Whilst by no
means a homogenous group, older adults are people who have been able (and fortunate enough) to survive.

These factors should be considered when planning to undertake research with older adults, to ensure that the procedures used to collect information maximise participation and that the data collected is reliable and valid. For the “old old” and “very old” especially, fatigue becomes an important consideration and can affect participant recall and ability to engage (Bouma & Ling, 2004). Other factors that should be considered when planning to undertake research with older adults include:

- literacy levels and cultural backgrounds (especially for understanding and obtaining consent);
- when proxies or language translators are used in research then their status, identity and credentials should be verified within the research environment;
- awareness of and respect towards cultural practices, use of appropriate language (delivery, voice tone and intonation when interviewing, potential to offend or to be perceived as patronising);
- where possible, address the person using their preferred name or title; and
- awareness of age and gender differences or mores that may impact on acceptance of the researcher (or the questions asked) and compliance with requests during interviews and focus groups, consider:
  - seating arrangements, lighting, extraneous noise, need for amplification/audio or visual aids (be aware of possible vision or hearing impairments);
  - allowing for polite and appropriate conversation to establish rapport with the interviewee prior to the interview; and
  - careful use of prompts or memory cues (where provided within the research protocol) to encourage recall and maintain focus.

Surveys: Practical Considerations

Surveys typically involve the collection of data through a structured questionnaire. This method is used in research designs that target larger samples and often seek responses to standardised items that focus upon a particular research question e.g. national health and well-being surveys. The advantage of surveys is that data can be collated relatively easily from a large number of people. A major limitation of surveys is the highly structured approach to data collection, which limits both the volume and potential range of responses that can be obtained from participants as there is little lee-way to explore questions or issues in-depth.

It is generally recommended that, where possible, existing measures or tests, which have demonstrated good validity and reliability with similar populations be used rather than creating new ones (Mullin et al., 2000). Where an existing instrument is chosen, the recommended format should also be adopted to assist in maintaining the psychometric properties of the original measure.

The cover page of a survey should include a brief introductory statement about the study, its purpose, instructions and an advance “thank you” for answering the questions (Hansen,
Written instructions should be clear, unambiguous, comprehensible and located where they can be readily referred to. The grouping of similar questions under topic headings or lead-in statements is also recommended as these may “help guide respondents through the topics of a questionnaire and orient them to new topics” (Mullin et al., 2000, p.18).

In developing a new instrument (and in reviewing a previously published one), it is important to be cognisant of a number of design factors. Mullin et al. (2000) recommend that the format of questionnaires adhere to a number of critical attributes: that they be “simple, consistent, organized, natural, clear and attractive” (p.13). It is also important to ensure that items are relevant (not trivial) and are regarded as important by participants.

The language used in each item needs to be appropriate to participants’ level of understanding, as well as congruent with the researcher’s conceptualisation of the underlying construct. Items contained within an instrument should be unambiguous, that is, they should be constructed in such a way that only one interpretation is possible; should not be “double barreled” or contain more than one idea, concept or thought; should avoid using double negatives and words that are emotionally laden, or that may trigger a particular bias in response (Hansen, 2006). Many older adults today left school after 2 or 3 years of secondary schooling (reflecting lower rates of participation in post-compulsory education as well as different employment practices). Consideration should therefore also be given to: use of simple rather than complex instructions (avoid verbosity); being concise and using shorter rather than longer words; adopting sentence structures of ten words or less; using the active rather than passive voice; and emphasising key points through the consistent, though not over use of: italics, bold typeface, capitalisation or underline.

In consideration of the reduced visual acuity in this group, a larger print size should be used. A 12 to 14 point size is often preferable to the more standard 8 to 10 point type (Frank-Stromborg & Olsen 1997). Furthermore, a sharp contrast should be achieved between the print and the background, for example black on white is better than yellow type on green paper. More white space is considered important to reading comprehension and increased spacing between topics can assist respondents to recognise changes between different types of questions and navigate the instrument more successfully (Mullin et al., 2000). Attention to format may therefore contribute to response variability and reduce the tendency for participants to cluster responses at either the upper (a ceiling effect) or lower (floor effect) end of a scale (Castle & Engberg, 2004).

Confusing or graphically complex designs tend to reduce response rates. Consistency in response options for similar looking types of questions e.g. use of either a horizontal or vertically ordered format may better orientate the participant and encourage item completion. Not uncommon with older cohorts, acquiescence bias (i.e., the tendency of respondents to consistently respond positively without fully assessing the content of each item) may be reduced by varying the positive or negative wording effect of items, rather than reversing the order of response options - which can cause greater confusion (see Table 1 for a summary of design attributes).
Table 1. A summary of questionnaire design attributes.

<table>
<thead>
<tr>
<th>Design Attribute</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>General layout</td>
<td>Should be uncluttered and larger font sizes used. Bold face used for topic headings and to emphasise response options. Format of original instrument/s should be used where this is recommended.</td>
</tr>
<tr>
<td>Cover/first page content</td>
<td>Introductory letter should specify title, purpose and importance of the study. Clear, simple instructions provided on how to complete the survey, who to contact should there be a query or complaint. Method of return outlined.</td>
</tr>
<tr>
<td>Graphical images</td>
<td>Can improve visual appeal or used to break-up sections.</td>
</tr>
<tr>
<td>Language and readability</td>
<td>Questions and items should have tested successfully with older adults who represent the target population (e.g., on age, gender, culture, language and literacy characteristics).</td>
</tr>
<tr>
<td>Natural reading flow</td>
<td>Natural (left to right and top to bottom) flow principles should be observed. These may include: text left justified; response options ordered either from left to right or from top to bottom.</td>
</tr>
<tr>
<td>Grouping topics</td>
<td>Group questions thematically under larger font size, bold-faced or italicized topic headings.</td>
</tr>
<tr>
<td>Consistent response tasks</td>
<td>Response tasks (e.g., placing an X in box or circling a number that represents strength of agreement with a statement) should be consistent for questions or items within each topic or sub-section.</td>
</tr>
</tbody>
</table>

Participation and Response Rates

Often, a survey aims to collect data from a sufficient number of participants to allow generalisations or meaningful comparisons to be made with other groups or the population. Putting strategies in place to maximize participation can increase the level of confidence in the results obtained and reduce the effect size (the magnitude of change or difference) required to demonstrate statistical significance (Cohen, 1988).

Typically, with mailed, paper-based surveys, the majority of responses are returned within the first few weeks. Motivation to complete and return a questionnaire can be encouraged through devices such as: reward (a monetary payment or gift), facilitating returns (e.g. through the use of pre-paid envelopes or a conveniently located return drop-box), clearly being able to see how a study can contribute to the participant’s own well-being (relevance), brevity and endorsement of the study by a respected authority. Relevant graphic images, especially on the face page of a questionnaire may also enhance the response rate.

Factors such as a questionnaire’s appropriateness, degree of difficulty and the length of time taken to complete can impact on the probability of it being completed and returned. Some of these factors can be age related. Whilst most researchers may aim for >75% participation rate in highly focused surveys using a well-targeted sample, response rates can vary considerably. For example, at the lower end of the scale, a study about creating a “senior
friendly community” among 4,000 community dwelling residents aged 55+ in the town of Vincent in Western Australia, reported a response rate of only 15% (Boldy, Horner & Anthony, 2006). Low response rates can be attributed to a numbers of factors, including those associated with the particular characteristics of the target population, timing, how the survey was administered or the nature of the survey itself.

An example of an age-related effect was found with the Australian Longitudinal Study of Women’s Health (ALSWH) where the response rate to the initial 24 page mailed survey varied between 54% for the middle-aged sample (aged 45-50) to 36% for the older age group (70-75 years). Whilst older women appeared to be less inclined to participate in a large mailed questionnaire, the follow-up survey three years later achieved a response rate of 90%, which suggests that these women, once recruited, were willing to continue with the study (Lee, 2001). A significant factor which could have contributed to the age-specific response difference may have been the length of the questionnaire – the completion of which may well have been a daunting task for an older person with some degree of visual impairment or motor co-morbidity which may have interfered with their writing ability. Fatigue must also be considered as a factor.

Response Variability: Floor and Ceiling Effects

A floor effect refers to the proportion of the sample who obtains the lowest possible score and the ceiling effect, that proportion achieving the highest possible score. With older adults, a floor effect may come in to play when assessing some areas of functional ability such as “walking one kilometre”. It can be expected that a larger proportion of the elderly will demonstrate less ability in this and related areas, thus the use of an instrument which fails to measure lower end variability in this particular domain would tend to exhibit a floor effect and any deterioration in function or ability for those at the floor would be difficult to detect. In contrast, Castle and Engberg argued that with satisfaction surveys, ceiling effects are more likely, as older adults “tend to use the upper end of a response format” and therefore contribute to a lack of variability in scores (Grbich, 2007). Failing to detect an existing variability will result in a Type II error (a false negative outcome) that is, to accept a degree of homogeneity which is in fact not there. This is true for both floor and ceiling effects and is a consequence of decreased responsiveness of an instrument to the domain or attribute of interest. This is an important consideration when using questionnaires with older participants.

Mode of Administration and use of Proxies

More popular ways to administer surveys include: direct face-to-face (interview of the participant by the data collector); mail (self-administered) and telephone interviews; computer, web-based or texted (e-mediated). Self-administration can produce more favourable ratings of health and wellness than face-to-face interviews (Frank-Stromborg & Olsen 1997), though the use of proxies, or people who complete a questionnaire on behalf of a participant, can also be problematic. For example, in assessing the Quality of Life of residents in aged care facilities in Australia and New Zealand, Byrne and MacLean (1997) found a significant difference in responses from participants on the basis of whether
assistance was provided by the nursing or non-nursing staff compared to those who self-completed the survey. Those who completed the questionnaire unassisted tended to fall midway between the positive nurse-assisted responses and the more negative non-nurse assisted responses. As this and many other studies suggest, caution must be exercised when assistance is provided to collect data as the use of proxies can introduce bias.

**Missing Data and Misunderstandings**

Missing data or non-completion of items can be high in older age groups, especially for self-reported methods of administration. Factors such as reduced concentration, deteriorating eyesight, response burden, and poor understanding of the purpose of the survey or its questions, all contribute to the likelihood of items not being responded to (McKee, Houston & Barnes, 2002).

Face-to-face modes of administration can reduce missing data, are associated with increased costs (e.g. cost of the interview) and invasion of privacy. Telephone administration is also not without its problems as, in the absence of visual cues, hearing impairments may be present which can cause misunderstandings, frustration and low participant response rates with older cohorts. The risk of misunderstandings can be minimised though pre-testing items with people typical of the target population and making modifications accordingly.

**Conducting Interviews with Older Adults**

Gerrish & Lacey (2006, p. 337) claim that conducting interviews is one of the most exciting and fascinating methods for collecting data. Interviews can be conducted in both qualitative, quantitative and mixed method studies (Davies, 2007). An interview is defined as a conversation between two parties, the researcher (interviewer) and the participant (interviewee). The principle of the research interview is to ask the participant purposeful questions, then accurately capturing the response with the intention of investigating a research problem (Bouma & Ling, 2004).

In order to find out what a person thinks and feels, or to get a ‘window’ on reality from the point of view of the participant, it is important to allow the participant time to relate their story as they wish in a safe and comfortable environment (Maltby, Williams, McGarry, & Day, 2010). It is essential that a rapport be established between the interviewer and the participant. The participant should remain central to the discussion, with the interviewer remaining vigilant to recognise and reduce the impact of any power imbalance that may influence the information shared (Nagy, Mills, Waters, & Birks, 2010).

A number of terms can be used to describe the interview, such as: formal or informal, guided, structured, semi-structured and unstructured and the types of questions used e.g. can be closed and open ended (Denzin & Lincoln, 2000). In general, the less structured the interview the more in-depth and flexible the questioning can be (Gerrish & Lacey, 2006; Nagy et al., 2010). In qualitative studies, where the focus is to understand meanings from the participants perspective, the requirement for data collection is broad; structured, semi-structured and unstructured interviews are generally preferred (Gerrish & Lacey, 2006).
A structured interview technique requires questions to be presented to participants in a strict order (Maltby et al., 2010). Responses may be audio-taped, entered into a computer or recorded by hand. In this style of interview, the interviewer’s role is to ask the questions, the participant’s role is to provide the answers with minimal extraneous information (Hansen, 2006). The questions are pre-planned and worded to elicit a relatively narrow range of responses or may require a response involving a fixed choice of alternatives provided by the interviewer. This structured style of interviewing can be conducted face-to-face, by video conference or the telephone (Nagy et al., 2010). The limitations to telephone interviewing is the interviewer’s inability to interpret and respond to observed body language, to make eye contact or to note when a person is becoming distressed and may require assistance (Bouma & Ling, 2004).

With semi-structured interviews, the interviewer uses a number of open ended questions to facilitate and guide discussion within predetermined themes (Nagy et al., 2010). These open ended questions may not be asked in the same way or in the same sequence (Maltby et al., 2010). Semi-structured interviews provide fewer expectations and restrictions on answer formats, allowing the interviewer to guide the conversation using a more natural conversation style (Nagy et al., 2010). The interviewer is required to concentrate on the participant’s responses, noting whether the research issues are being addressed or have to be revisited by posing the question in a different way later in the conversation (Maltby et al., 2010).

Unstructured interviews are more informal and require the interviewer to play an active role in the conversation, prompting the participant to reflect on current interests and concerns pertaining to a research subject. There may be a few pre-determined questions to initiate the conversation, although overall it is the participant who moves the agenda forward. This technique provides flexibility for the participant to discuss unanticipated issues triggered by the research question (Nagy et al., 2010).

Table 2 summarised different interview formats.

<table>
<thead>
<tr>
<th>Type</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| Structured interviews (eg. questionnaire with fixed response options) | Consistency: prescribed questions delivered to each participant in a set order.  
Efficient: less time consuming.  
Less risk of interviewer influence or bias.  
Responses not recorded in the participants’ own words and meaning may be lost.  
Little capacity to accommodate additional viewpoints.  
Researcher-driven constructs used. | Time consuming.  
Wide variation in responses. Large volume of data often collected from each participant.  
Interviewer skill to build rapport with each participant.  
Requires careful marshalling. |
| Semi-structured interviews (eg. the interviewer may use a schedule or short list of open-ended questions to guide the conversation) | Questions, not always asked in the same sequence.  
Researcher has clear intent, but does not wish to limit range of responses from participants. More natural conversation, encourages greater level of interaction. | Participants may raise unanticipated issues.  
May be time consuming. |
| Unstructured interviews (open-ended question/s used to initiate the conversation) | Participant freely discusses topic.  
Responses often recorded in participant’s own words, hence less bias through interpretation.  
Highly contextualised. | |
Some research studies may, at different times, include a number of interview techniques. Generally, it is important to declare which method is to be used with participants so that they are appropriately oriented and attuned to the nature of the study and the researcher’s expectations. This is critically important when seeking information from a group of participants, such as in focus groups, where both individuals and their interactions with one another also have to be managed.

Focus Groups

A focus group is where a group of people are asked about their opinions and ideas on a particular topic, and these are then developed through further discussion and iteration (Maltby et al., 2010). Focus groups usually involve six to ten persons who are likeminded, have similar social and cultural backgrounds or similar experiences, concerns or interest in a topic (Jirojwong & Liamputtong, 2009). It has been suggested that a group format may stimulate greater individual participation over one-to-one interviews and increase a person’s overall contribution (Hansen, 2006). Typically, people who find individual interviews intimidating, culturally inappropriate or where literacy issues are a concern, may be more likely to engage in a focus group (Maltby et al., 2010). Focus groups, however, seldom produce consensus between participants. It is an individual’s exploration and clarification of experience and insights on specific issues that is valued by the researcher during this process (Gerrish & Lacey, 2006).

Focus groups usually engage with a skilled and well-prepared moderator who introduces the topic, sets the scene and facilitates group discussion. Liamputtong (2010) states that the moderator should be “someone with whom the participants feel comfortable and can potentially relate to and with whom they are likely to feel that they can openly disclose information” (p.66).

Focus groups can be conducted in community settings and at times convenient to participants. They can be less time consuming than collecting data on an individual basis, though the moderator may have to initiate different strategies to accurately capture all the information generated by participants. Audio (and video) taping may be used, but multiple voices can sometimes make subsequent playback difficult to interpret. The moderator may use a white board or similar device to summarise data from participants. Note taking is generally best done by someone other than the moderator, who is usually busy facilitating and directing discussion (Maltby et al., 2010). An unobtrusive observer can be used to record conversations, interactions and major points arising from the discussion, as well as record facial expressions, critical events or mood if the research study requires this type of data (Gerrish & Lacey, 2006).

When conducting focus groups with older adults it is essential to consider the location of the venue, the facilities available (e.g., heating, toilets), transport and time of day for commencement and the completion. Careful planning and attention to the environment to ensure the comfort of participants will encourage fuller participation in the process.
Table 3. Advantages and disadvantages of the focus group method (adapted from Liamputtong, 2010, p. 65).

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>To clarify, explore or confirm ideas on a predefined set of issues.</td>
<td>Reluctance of participants to discuss their thoughts in front of others.</td>
</tr>
<tr>
<td>Stimulate individual participant’s thoughts and increase overall contribution.</td>
<td>One or two participants may dominate discussion or intimidate others.</td>
</tr>
<tr>
<td>Can provide a collective perspective on the topic of interest.</td>
<td>It is more difficult to control for confidentiality issues and to manage issues that produce conflict or are distressing to individual participants.</td>
</tr>
<tr>
<td>Allows access to groups that may experience difficulties with more traditional data collection methods such as surveys.</td>
<td>Group dynamics may influence participants’ level of participation.</td>
</tr>
<tr>
<td>Facilitates cultural brokering and use of culturally appropriate strategies.</td>
<td>The success of the focus group is dependent on the skills of the moderator.</td>
</tr>
<tr>
<td>The format can provide safety for marginalised groups to express a ‘voice’.</td>
<td>The monitoring of verbal and non-verbal responses is challenging because of the number of participants.</td>
</tr>
<tr>
<td>A group perspective provides clarification and synthesis of views and opinions.</td>
<td>Moderator bias.</td>
</tr>
<tr>
<td>With similar resources, facilitates access to a larger number of participants than individual interviews.</td>
<td>Considerable preparation is required conducting a successful focus group.</td>
</tr>
</tbody>
</table>

**Conclusion**

As society grapples with an ageing population, there is a growing imperative to conduct research that can help address both the personal challenges that accompany transitions in later life and the broader social, economic and environmental questions that are raised as a consequence of this demographic change.

Whilst many procedures used in research with other population groups can be successfully deployed with older adults, it should be recognised that the ageing process can impact people in different ways. Research designs and data collection techniques should therefore be planned to fit not only with the research question, but also the target population. In this chapter, we reviewed some common ways by which data may be obtained from older adults (surveys, interviews and focus groups). Our broad aim has been to sensitise researchers to some of the factors that should be considered when planning research with this group and to also highlight how these may impact on participation, data collection and interpretation.

A burgeoning interest in research with and about older adults has not always been accompanied by a similar enthusiasm for questions around how best such research should be conducted. Many techniques applied with older adults have not always been “fit for purpose”. Thus, in planning research, attention should be given to not only the impact that ageing has on people, but also to the variety and diversity that exists within this population. The “older adult” is not a homogenous group. Failure to attend to these considerations will frustrate efforts to engage older adults in research at a time, now more than ever, they should be fully consulted and their voices heard.
References


Chapter XXII

Shortcomings in Publicly Available Healthcare Data for Older Australians

Gerard Gill

Abstract

Information technology policy decisions are often made of the basis of analysis of routinely collected health service data. While the data is usually accurate it is often incomplete. Since older individuals are the most frequent consumers of healthcare, understanding their service usage is helpful in planning services. This chapter details some problems in utilising routinely collected Australian data for making decisions about healthcare for older Australians.

Keywords: Australia, health service data, older persons, pharmaceuticals, rurality, socio-economic disadvantage.

Introduction

Australians, by international standards, enjoy excellent health and have good access to effective healthcare when their health becomes impaired. The World Health Organisation World Health Report and Global Burden of Disease publications rank Australia as being the sixth country for highest health adjusted life expectancy, the fourth highest for average male life expectancy and the sixth highest for average female life expectancy (AIHW, 2007; WHO, 2001). Older Australians, those aged 65 or more years, are healthy by international standards. The performance of the Australian healthcare system is monitored by a comprehensive series of statistical records. Since these statistical records underpin the reporting of the performance of Australian healthcare outcomes, it is important that those utilising these statistical reports for comparisons are aware of the potential missing or inaccurate data that may distort the validity and reliability of conclusions based on this data.
The Size of the Older Australian Population

The first area where errors may occur is the calculation of the size of the older Australian population and its demographic characteristics. The Australian Bureau of Statistics (ABS), a Commonwealth government statutory body, is responsible for conducting a census every five years. The data collected in the census is then analysed and reported as soon as possible after the data collection is concluded. Because the data is collected on a single night, the ABS reports this data by location, where the data is collected, and by place of usual residence of the census subjects (ABS, 2007). Therefore, ABS census data should be scrutinised to confirm the data utilised is that of the place of usual residence and not that of the locality of data collection.

Data by place of usual residence is still subject to a degree of incompleteness. Some individuals are missed in the census counting process, because they were overseas temporarily on the census night or may not have received census papers. Shortly after the last formal ABS census in 2006, the Census Post Enumeration Survey, a post census survey, found that the census data did not count approximately 0.5% of Australians over 55 years of age (ABS, 2007).

Databases for those Entitled to Taxpayer Subsidised Services

There are two government insurance schemes that offset the cost of out of hospital medical and some other health services for older Australians; Medicare, administered by Medicare Australia and the Department of Veterans Affairs (DVA) arrangements for eligible veterans and their widowed spouses. Approximately one sixth of older Australians are entitled to treatment under DVA arrangements. The DVA has contracted the payment administration of claims for its beneficiaries to Medicare Australia. Medicare Australia, therefore, administers all government insurance payments for out of hospital medical services to Australians. To facilitate these insurance payments Medicare Australia maintains a database for all Australians entitled to payments under its arrangements and has been contracted by the DVA to maintain a similar database for veterans and war widows entitled to DVA benefits.

All Australian residents who are Australian or New Zealand citizens, or hold or have applied for a permanent residence visa, are eligible for Medicare benefits, following enrolment with Medicare Australia. With enrolment a unique number is generated to enable the identification of those eligible for Medicare subsidies and the individual is given a Medicare card displaying this unique number.

This Medicare card and its number form the basis for determining the entitlement of individuals to access fee-for-service insurance rebates for medical and some other health services, for access to free public hospital inpatient treatment, and for access to subsidised pharmaceuticals under the Pharmaceutical Benefits Scheme (PBS). Similarly, those entitled to DVA benefits have an equivalent card issued by the Department of Veterans Affairs which
entitles them to the same benefits and for most older veterans, a more comprehensive array of additional hospital and health services.

Visitors from the United Kingdom, Sweden, Finland, Norway, the Netherlands, Malta and Italy may access Medicare subsidies for out of hospital services requiring immediate treatment while in Australia, as these countries have a Reciprocal Health Care Agreement (RCHA) with Australia. Tourism Victoria data in 2004 suggest that in that year that only around 60,000 of the international visitors to Australia aged 65 or more years would be eligible for RHCA subsidies (Tourism Victoria, 2004). If all such eligible visitors were enrolled, RCHA enrollees would account for less than two percent of all registrants with Medicare in this age group.

Medicare enrolment data, particularly for those aged 75 or more years, is unreliable. At older ages, there are more individuals eligible for Medicare cards that are recorded in ABS population censuses. The Australian National Audit Office (ANAO) conducted an audit of the Medicare database in 2004. The Medicare database in August 2003 contained 38,285 individuals aged over one hundred and four years who were still recorded as eligible to claim benefits (Australian National Audit Office, 2004a). While the ABS figure for the Estimated Resident Population aged 85 or more years at 30 June 2003 was 289,523, the Medicare database in August 2003 had 734,310 individuals in this age group recorded as eligible to claim Medicare benefits. Incomplete removal of those who have died from the Medicare database was felt to be the main reason for these discrepancies.

Australian residents being treated under DVA arrangements also have a Medicare number and are entitled to claim Medicare benefits should they wish. The proportion of these veterans or their widows who also claim some services under Medicare arrangements, and the number of such services, is unknown.

The DVA treatment population database was audited in the same way as the Medicare database by the ANAO in 2003-4 and the treatment population was found to be up to 2 per cent larger than that actually claiming for services (Australian National Audit Office, 2004b). This overcount reflected the issuing of multiple cards to a small segment of the treatment population.

Therefore, when accessing data held by Medicare Australia for the purpose of examining non-inpatient services for older Australians, it is important that the data:

- includes those treated under DVA arrangements,
- takes into account the over enumeration of older Australians entitled to treatment under Medicare or DVA arrangements and,
- considers the small number of older Australians who was still alive who do not access any Medicare or DVA funded health-care services. Surveys have suggested that less than two per cent of all individuals aged 75 or more years did not see a GP once in a twelve month period (ABS, 2002b; Public Health Division, 2000). The Australian Women's Health Study found comparable figures for older women not accessing healthcare services in a 12 month period (Young, Dobson, & Byles, 2001). A similar study in older men in the ACT from the late 90s suggested that the figure for older men not accessing healthcare services may be up to 10 percent. (Korten et al., 1998).
Data collected by Medicare Australia on Medicare and DVA beneficiaries will potentially encompass almost all primary care claims and specialist, pathology and diagnostic imaging services outside the hospital sector. A small number of primary medical services for direct face-to-face consultations will not be included in Medicare or DVA billing data.

Timing of data extraction from Medicare/DVA databases may distort analyses. There is a delay between the date of consultation and entry of service claims onto the Medicare Australia database (Wilkinson et al., 2003). This is due to delays in the forwarding of claims by patients or medical practitioners, and in data entry once the claim is received. The Medicare Australia and DVA Service Charters require payment to be made to the patient or medical practitioner no more than 16 days after lodgement of claims with the Medicare Australia or DVA. Contact with Medicare Australia and the DVA suggested that 90 per cent of all claims were entered in the database within three months of the date of service.

**Out-of-Hospital Pharmaceutical Services**

PBS arrangements cover subsidised pharmaceutical prescriptions for a specific list of therapeutic agents. There are two levels of subsidies. Those considered to have a low income, and identified by the issuing of a healthcare, seniors or pension card, are only required to pay a small patient moiety for their prescribed medication. The remainder of the population pay a moiety approximately 6 times that of cardholders. The PBS only records data where the Commonwealth is required to pay the dispensing pharmacist a payment to cover the gap between the patient contribution and the Commonwealth listed price for dispensing that medication (Healthcare Management Advisors, 2008). Many medications issued to non-cardholders do not require the Commonwealth to cover the gap and are not recorded as pharmaceutical benefits. Since approximately 85% of Australians over 65 are entitled to a healthcare card, PBS data is reasonably valid for this age group, as the vast majority of dispensed prescriptions attract a Commonwealth subsidy and are recorded. However, a number of pharmaceuticals are not subsidised under PBS arrangements, or are not subsidised for some specific disease states. It has been estimated that approximately 4% of the volume of medicines in Australia are prescribed using non-PBS subsidised private prescriptions. No data is accessible for these prescriptions.

To complicate matters, a trial is under way in some states where patients discharged from public hospitals receive medication on discharge under PBS subsidy arrangements. The cost of these medications is completely subsidised by the Commonwealth.

DVA beneficiaries have all their medication available to them on the pharmaceutical benefits list of approved pharmaceuticals, dispensed to them at the same cost as PBS cardholders. There is also a specialised list of extra pharmaceutical benefits available to DVA beneficiaries. Therefore, DVA data on dispensed pharmaceuticals subsidised by the DVA is complete, but also incorporates other medications not available under PBS arrangements or available for other indications than those approved by the PBS.

To facilitate rapid payment from the Commonwealth, participating pharmacies submit their dispensing data electronically at the time of dispensing. Delays in data entry should be exceptional. The consequence of these pharmaceutical subsidies and the recording of subsidised prescriptions is that:
Shortcomings in Publicly Available Healthcare Data for Older Australians

- the PBS database may not include the dispensing of cheaper medications to non-card holders,
- DVA PBS and Medicare PBS databases are not compatible,
- in some states, but not in others, medication provided to patients on discharge from hospital will be counted by the PBS, and
- delay in dispensing data entry would be uncommon.

Medical Primary Care or General Practice Services

The vast majority of these services are provided by independent private general practitioner contractors who are remunerated on a fee-for-service basis (AIHW, 2008b). Older Australians make little use of accident or emergency services for primary care (ABS, 2002b). Therefore, DVA and Medicare Australia data for general practice fee-for-service payments should reflect accurately the provision of these services.

A long-standing program, Bettering the Evaluation and Care of Health (BEACH), has been examining contacts between Australian general practitioners (GPs) and their patients (AIHW, 1999). The BEACH study recorded in 2000-2002 that one and a half percent of all GP face to face consultations were either not charged or were paid by other funders such as hospitals or workers compensation schemes (O’Halloran et al., 2003). A further one and a half percent of GP patient encounters were indirect, for example by telephone or from relatives or friends of the patient, and would not be recorded in fee-for-service data, as these services currently do not attract an insurance rebate.

BEACH findings suggest that general practice Medicare/ DVA claim data is virtually complete for face-to-face consultations, but lack the ability to indicate the amount of contact which occurs on a non-face-to-face basis.

Medical Specialist Services to Ambulatory Patients

Medical specialist services are available to older Australians, either through public hospital outpatient clinics or private specialist consulting rooms. Under the Australian Health Care Agreement, there is an agreement between the Commonwealth government and the State or Territory governments which controls the Commonwealth subsidies paid to states or territories for the provision of healthcare through public hospitals. Specialist consultations at public hospital outpatient clinics are supposed to be provided without attracting Medicare insurance rebates. However, in practice, a large number of specialist consultations in this environment are billed under Medicare arrangements (Council of Australian Governments, 2007). Medical specialist consultations in specialist private rooms attract insurance rebates under Medicare or DVA arrangements.

Thus there is an unknown degree of overlap between data recorded in the public hospital sector for outpatient attendances and that recorded for private fee-for-service specialist consultations available from Medicare/DVA sources. Hospital data for outpatient attendances
does not differentiate for medical specialist consultations as it also includes attendances where the patient may not see a medical specialist, such as those in hospital accident and emergency departments or outpatient departments where their management is by hospital junior medical staff.

**Hospital Inpatient Services**

Hospital services to Australians are provided via two funding arrangements. All Medicare card holders or DVA beneficiaries are entitled to free treatment as a public patient in the government run public hospital sector. Patients can also elect to be treated as a private patient in the government-run public hospital sector or in the private hospital sector if they are prepared to pay the accommodation charges. Private patients are also entitled to subsidies for the cost of medical services provided on a fee-for-service basis under Medicare Australia arrangements. Private medical insurance is available to cover the costs of hospital bed days and some of the gap between Medicare subsidies and medical fees charged. DVA patients are entitled to either public or private hospital treatment including payment of their attending medical practitioners at no extra charge to themselves.

Data for hospital services are collected in both the public and private sector for most Australian hospitals (AIHW, 2010). This data is often delayed and in the smaller states and territories, may not be complete for the private hospital sector. Because patients admitted to public hospitals under private patient arrangements will be included on the data for public hospitals, but will have their medical services billed to Medicare, combining public hospital data with Medicare data will result in some medical services being counted twice.

Medicare funded services conducted on hospital inpatients do attract a lower insurance rebate. Consequently it is possible to separate Medicare procedure items carried out in hospital from those carried out in community or outpatient settings.

**Diagnostic Imaging and Pathology Services**

In community settings, diagnostic imaging and pathology services attract insurance rebates under Medicare or DVA. Some services are only subsidised when requested by specialist medical practitioners. To avoid the delay caused by having to access a specialist, occasionally the patient may pay privately for these services. No data is available for such privately billed services.

Pathology and diagnostic imaging are ordered through hospital specialist outpatient clinics using hospital facilities. While a number of these services are billed under Medicare/DVA arrangements, not all such services are charged in this way. Therefore, Medicare/DVA diagnostic imaging and pathology services data for community or outpatient patients are incomplete. For inpatients who are private patients in public or private hospitals, the inpatient diagnostic imaging services are rebated under Medicare/DVA arrangements. Because of the different insurance rebates available for inpatient and ambulatory patients it is possible to identify these services.

No good data is available for public patient inpatient diagnostic services.
Dental Services

Dental services are available to older Australians through three mechanisms (AIHW, 2008a). Patients may see a dentist in private practice and pay the charges he or she raises. Private insurance is available to meet some of this cost. The second alternative is to seek treatment from subsidised State or Territory government provided public dental services. There is often a long waiting time for these services.

For a small number of patients with chronic disease, where dental ill-health impacts on their management, patients may have the cost of their dental treatment subsidised under Medicare funded Enhanced Primary Care (EPC) arrangements. This necessitates their GP producing a GP and team care plan and referring them to a dentist for treatment. Medicare holds data for these patients. Due to these fragmented funding arrangements, data for dental services are incomplete, particularly for services in the private sector where no health insurance remuneration applies.

Allied Health

Services such as physiotherapy, psychologists, dietary advice and podiatry are not freely available under Commonwealth sponsored funding.

Patients can attend these professionals and pay their full fees. Private health insurance will offer a restricted subsidy for these services. A number of publicly subsidised arrangements also exist to assist patients to meet the cost when accessing such services. In the past, as part of the Commonwealth State Health Care Agreement, State public hospitals were expected to provide such services to community patients. Access to such services is now severely restricted for patients who are not attending state public hospitals. The Commonwealth has provided block grant funding to the Australian general practice network for some service provision in non-hospital settings, particularly for rural and regional areas.

As with dental services, patients with chronic diseases may receive subsidies for a limited number of allied health services from Medicare/DVA if their general practitioner has completed both GP and team care management plans and referred them for these services.

Psychology services funded under Medicare EPC arrangements, up to a maximum of 18 visits a year, are available to patients whose GP has developed a mental health plan and referred them to a registered psychologist.

The wide range of funding arrangements and the blend between salaried and fee-for-service payments makes it difficult to collect reliable comprehensive data on the use of allied health services by older Australians.

DVA beneficiaries have access to a wider range and number of dental and allied health professional services. Good data exists for these services where they are provided in community settings.
Residential Aged Care Facilities

The Commonwealth government oversees and funds the provision of places in residential aged care facilities (RACFs) (AIHW, 2009). Almost all beds in RACFs are provided by private for profit organisations or non-government not-for-profit organisations. Innovative funding arrangements from the Commonwealth government have resulted in many small rural hospitals attracting funding for RACF type patients under what is termed multipurpose centre funding. Some aged care places provided by state governments are not subsidised by the Commonwealth and are not counted in bed provision data. Patients in this category include older patients with long-standing psychiatric conditions residing in longstay wards of state psychiatric hospitals and some longstay patients in smaller rural hospitals not funded as multipurpose centres. Patients in state public or private hospitals awaiting admission to a RACF bed are also not counted in RACF data. Hospitals with patients in this category receive a reduced rate for their stay from Commonwealth or private health insurance funds.

Funding levels for RACF residents are determined by the amount of care they require. A complex supervisory and quality assurance mechanism undertaken by employees of the Commonwealth Department of Health and Ageing exists to ensure that residents of such facilities receive high-quality care.

The Commonwealth makes efforts to ensure that the provision of subsidised RACF places is equitable and matches the needs of the local population. However, the Commonwealth utilises bed licences issued rather than actual beds subsidised in its assessment of the adequacy of RACF bed provision. There is often a delay between the issuing of these licences and the completion of beds in facilities due to delays in building or raising capital to build them. The provision of RACF beds in a locality is based on the number of residents aged 70 years or older. Excess numbers of younger patients requiring admission to RACFs will distort the availability of bed supply.

Admission to residential aged care may be on a short-term respite basis or permanently. Using Medicare or DVA data, it is possible to identify if a patient has been admitted to a RACF when a claim has been submitted for a specific GP RACF attendance item. Medicare/DVA data cannot discriminate if the admission is for respite purposes. Almost all permanent residents will claim these GP RACF items but respite admission residents may not require a GP visit during their stay. The Commonwealth Department of Health & Ageing collects data on these two categories, but there is a very high conversion rate between respite admissions and permanent admission (AIHW, 2009). To further complicate this data, approximately 3 percent of residents permanently admitted to RACFs return to live in the community.

To attract a Commonwealth subsidy for short-term respite or permanent admission to an RACF, it is necessary to undergo assessment by an Aged Care Assessment Team (ACAT) (Lincoln Gerontology Centre - La Trobe University, 2003). These team services are free of charge to assess the degree of disability of older frail Australians using a national assessment tool. The activities of ACATs are recorded in a national database (Lincoln Gerontology Centre - La Trobe University, 2003). Once again, the denominator used for the activity of these teams is the number of local residents aged 70 or older, even though some of the assessments are carried out on younger individuals. While the number of assessments performed by these teams is well recorded in the dataset, it is often difficult to identify how many assessments performed were new referrals, reassessments of existing clients or, in the
past, reclassifications of RACF residents. In recent years the classification of RACF residents has devolved to the RACF staff, again complicating the assessment of temporal trends in ACAT activity.

**Equity**

One of the key principles of the government planning for and provision of health care in Australia is a commitment to equity. In particular, the Commonwealth government budget documents demonstrate a government policy commitment to address health outcome inequalities across the rural and socio-economic spectrum (Commonwealth of Australia, 1999).

**Measures of Rurality**

Three measures have been utilised for the classification of rurality in official statistics (DoHA, 2005). These were the Rural Remote and Metropolitan Area Classification (RRMA) (Department of Primary Industry and Environment & Department of Human Services and Health, 1994), the Accessibility/Remoteness Index of Australia (ARIA) (DHAC, 2001) and the Australia Standard Geographical Classification (ASGC) (ABS, 2002a). All of these measures were designed to classify and order collector districts and statistical local areas employed by the ABS for collecting and reporting census data (DoHA, 2005).

**The Rural Remote and Metropolitan Area Classification (RRMA)**

The RRMA score was constructed around a calculation encompassing the local population, the distance to the capital city, the distance to the nearest other metropolitan centre, the distance to the nearest large urban centre and the distance to the nearest small rural centre (Department of Primary Industry and Environment & Department of Human Services and Health, 1994). Construction of this index utilised 1991 ABS census data and the index has never been updated. It has been extensively used for GP workforce purposes. It classifies localities as belonging to three zones and seven classes (Table 1).

**Table 2. Remote, Rural and Metropolitan Areas Classification.**

<table>
<thead>
<tr>
<th>RRMA Class</th>
<th>Zone</th>
<th>Description</th>
<th>Population Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Metropolitan</td>
<td>Capital city urban centre</td>
<td>&gt;100,000</td>
</tr>
<tr>
<td>2</td>
<td>Metropolitan</td>
<td>Major city urban centre</td>
<td>&gt;100,000</td>
</tr>
<tr>
<td>3</td>
<td>Rural</td>
<td>Large rural centre</td>
<td>25,000-99,000</td>
</tr>
<tr>
<td>4</td>
<td>Rural</td>
<td>Small rural centre</td>
<td>10,000-25,000</td>
</tr>
<tr>
<td>5</td>
<td>Rural</td>
<td>Other rural areas</td>
<td>&lt;10,000</td>
</tr>
<tr>
<td>6</td>
<td>Remote</td>
<td>Remote Centre</td>
<td>&gt;5,000</td>
</tr>
<tr>
<td>7</td>
<td>Remote</td>
<td>Other remote area</td>
<td>&lt;5,000</td>
</tr>
</tbody>
</table>
The Accessibility/Remoteness Index of Australia (ARIA)

ARIA is constructed utilising the distance by road to the nearest centre with a population greater than 250,000, the nearest centre with a population between 48,000 and 250,000, the nearest centre with a population between 18,000 and 47,999 and the nearest centre with a population between 5,000 and 17,999 persons (DHAC, 2001). As it is based on distance alone it is a better measure of rurality but not necessarily of medical resources (Table 2).

Table 3. The Accessibility/Remoteness Index of Australia Classification (ARIA).

<table>
<thead>
<tr>
<th>Classification</th>
<th>ARIA score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly accessible</td>
<td>0.00-1.84</td>
</tr>
<tr>
<td>Accessible</td>
<td>&gt;1.84-3.51</td>
</tr>
<tr>
<td>Moderately accessible</td>
<td>&gt;3.51-5.80</td>
</tr>
<tr>
<td>Remote</td>
<td>&gt;5.80-9.08</td>
</tr>
<tr>
<td>Very Remote</td>
<td>&gt;9.08-12.00</td>
</tr>
</tbody>
</table>

The Australia Standard Geographical Classification (ASGC)

The ASGC is a measure of remoteness for ABS collector districts and statistical local areas (ABS, 2002a). It is an improved version of ARIA but uses slightly different ARIA scores than does ARIA for classification and has no classification equivalent to RRMA and ARIA very remote. (Table 3)

Table 4. The Australia Standard Geographical Classification (ASGC).

<table>
<thead>
<tr>
<th>ASGC</th>
<th>ARIA score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Cities of Australia</td>
<td>0 to 0.2</td>
</tr>
<tr>
<td>Inner Regional Australia</td>
<td>&gt;0.2-2.4</td>
</tr>
<tr>
<td>Outer Regional Australia</td>
<td>&gt;2.4-5.92</td>
</tr>
<tr>
<td>Remote Australia</td>
<td>&gt;5.92-10.53</td>
</tr>
<tr>
<td>Migratory</td>
<td>Offshore, shipping or migratory</td>
</tr>
</tbody>
</table>

Over time all three classifications have been utilised for comparing a variety of health outcomes and service provision across equivalent locations under each classification.

In 2009 the Commonwealth decided that the ASGC would become the sole indicator of rurality. As a consequence it is now difficult to compare historical data for some health measures as the three scales are not compatible.

Conceptually, there is some difficulty in ascribing healthcare accessibility as being equivalent using any of three rurality classifications in different locations ascribed an equivalent ranking. For example, Gundagai in New South Wales is classified using ASCG as inner regional as is Hobart, the capital city of Tasmania. It would be difficult to say that the residents of Gundagai have as ready access to sophisticated healthcare as those in Hobart. Similarly, using the older RRMA classification a number of small satellite towns within half
an hour's drive of major regional centres were classified as RRMA 5, when in fact their residents had as ready access to sophisticated healthcare as the residents of the regional centre classified as RRMA 3.

Postcode is the only indicator of rurality that is readily available from the Medicare/DVA databases. Rurality indicators are derived from ABS census collector or statistical local areas, not postcodes. Data for postcodes usually encompass a number of collector districts and statistical local areas. Some postcodes cover large areas and may encompass a number of localities with differing small area classifications, particularly those close to or situated in larger centres. Postcode data for rurality has therefore potential to misclassify healthcare access difficulties for some individuals.

Australian evidence is conflicting that living outside major capital cities is associated with poorer health outcomes.

In an earlier study, Mathers (1994) using data from the late 1980s compared the health status, health outcomes and service usage of those aged sixty five or older who were living in metropolitan Australia and the same group living in non-metropolitan Australia. While there was a higher rate of adverse lifestyle factors reported from non-metropolitan Australia, and poorer access to medical services, there were few if any differences between mortality rates or self-rated health status between the two localities. There is some evidence that RRMA classification was linked to some health outcomes for older Australians. A higher RRMA classification was linked to a higher prevalence of falls in those aged 65 or older (AIHW, 1998).

A more recent AIHW study found that the mortality rate for those seventy five years and over was lowest for those living in remote locations (AIHW, 2003). Death certification data used in this study indicated that compared with metropolitan areas, rural regions with a lower ranking of rurality than remote regions had significantly higher mortality rates for those aged seventy five or older. The so called healthy survivor effect, with migration to access healthcare or early death of the seriously ill rural dwellers, may partly explain this finding as those aged sixty five years or under in these locations had higher mortality rates (AIHW, 2003).

### Classification of Socio-Economic Status

The ABS produces a number of Socio-Economic Indices for Areas (SEIFA) (ABS, 1998). Like rurality classifications, these indices are derived from ABS census data collected in collector districts and statistical local areas. The most studied measure associated with health outcomes is the Index of Relative Socio-economic Disadvantage (IRSD). The IRSD is a measure of the socio-economic characteristics of a locality derived from average income, education, employment, job skill levels and other characteristics. Areas in Australia characterised as disadvantaged on the basis of their IRSD score have been associated with worse health outcomes for older residents (Glover, 1999) and similar area-based characteristics have been associated with worse health outcomes in international studies (Pickett & Pearl, 2001).

As with rurality, IRSD classification by postcode may not be as sensitive a marker for health outcomes as its use for ABS census smaller areas. Use of such large areas as postcodes increases the danger of misclassifying an individual’s socio economic position on the basis of
their broad geographical residence - the so called ecological fallacy. A study in Western Australia has shown that IRSD score at a postcode level is associated with poorer health outcomes but is not as responsive at identifying poor health outcomes as that IRSD score at a collector district (Hyndman et al., 1995).

Theoretically, the use of the IRSD classification may not represent the true status of older Australians as it is calculated on income, employment, education and skill level of job for all individuals in a collector district. These factors are less likely to be useful in discriminating deprivation levels of older individuals, who are more likely to have lower incomes, are out of the workforce, and are less likely to have attained higher education. It does not capture the past circumstances of older Australian residents with precision. McCracken has suggested that there may be more precise associations with health outcomes if the various individual components of the IRSD are utilised (Mc Cracken, 2001). Studies in the USA have found that highest lifetime educational level and household income have strong associations with health status at older ages (House et al., 1994).

More recently, evidence has emerged in the USA that residing in localities with lower socio economic status does have an adverse effect on health, even for individuals of high socio economic status (Pickett & Pearl, 2001).

This is supported by the previous research of Mathers who found that Australians aged sixty five or more years, living in disadvantaged locations, had more adverse lifestyle habits, made less use of medical services and had poorer health outcomes, particularly self rated health, and mortality (Mathers, 1994). This increased mortality was due to higher rates of death from pneumonia/influenza, diabetes, lung cancer, ischaemic heart disease and cerebrovascular disease. More recently, the Women’s Health Australia Study reported that older women in poor individual circumstances have poorer self rated health as measured by the SF 36 than those in better circumstances (Mishra, Ball, Dobson, Byles, & Warner-Smith, 2002). However, the differences between the highest and lowest tertial of socio-economic circumstances in women aged 70-75 years, 1.5 for physical health component scores of the SF 36 scale and 2.0 for the mental health component scores, were less marked than those seen in middle aged women aged 40-45 years. Again it is possible that the lower differences observed in older women represents the healthy survivor effect.

Health Service usage by Older Australians Across the Rural and Socio-Economic Spectrums

No comprehensive recent studies are available on the medical service usage of older Australians across the rurality or socio-economic gradients. Studies that are available report only Medicare claims, DVA claims, data for all age groups or data for older women (ABS, 2002b; Australian National Audit Office, 2000; Furler et al., 2002; Mishra et al., 2002; Vinson, 2001; Young, Dobson, & Byles, 2000). These studies suggest that those from rural or less advantaged backgrounds continue to have difficulties in accessing certain health services and receive briefer or fewer health care services. The Women’s Health Australia Study found in 1995-6 that there were problems of availability, accessibility and affordability of GP services for rural compared to urban dwelling women (Young et al., 2000). In particular, financial barriers were more common in rural areas due to higher charges by GPs (Young &
Dobson, 2003). Older Australians from rural locations were also less likely to be admitted to residential aged care (Gibson, Braun, & Liu, 2002).

Differing ability to access medical care does matter. A Canadian study demonstrated that increased medical care, particularly general practice care, may ameliorate some of the differences in health outcomes seen in those from more disadvantaged backgrounds or from rural locations (Dunlop, Coyte, & McIsaac, 2000).

Clear, recent Australian data are currently lacking to decide if, over the lifespan, poor access to such services is one of the drivers of worse health outcomes for older persons.

**Conclusion**

This chapter has outlined a number of caveats that exist in the completeness or relevance of current publicly available data in answering questions of healthcare utilisation or healthcare outcomes in the older Australian population. Awareness of these difficulties may prevent those interpreting the data from reaching erroneous conclusions.

**References**


How Well does E-Health Work? A Question of Evaluation

Quynh Lê and Cecilia Chiu

Abstract

Information technology is becoming an integral part of life. All walks of life and all industries have to embrace this new technology to stride into the future. The health care industry is no exception. Many new health informatics or e-health projects or technologies are untested waters. How can we be assured that these new initiatives perform as intended and achieve the desired outcomes? How do we know if e-health as a health care delivery channel is a more cost-effective alternative to the conventional delivery methods? These are questions for the evaluators. This chapter discusses the many different evaluation approaches, types, tools and methods and offers an overview of what should be evaluated for an e-health initiative. It provides an understanding of the evaluation frameworks applicable to e-health initiatives. This is also a practical guide for stakeholders in designing and developing an effective and appropriate evaluation program for an e-health project or technology.

Keywords: e-health, evaluation, stakeholders, health care.

Introduction

Evaluation is an activity which requires a considerate amount of time and resources. A product, process or service is developed for a purpose and thus they all have their own missions to achieve. In other words, they are there because they fulfil a need. For example, a comprehensive cancer care network is established to improve community access to cancer care (NSW Health Telehealth Initiative 2003); a hospital website is developed to provide the public with information about the various services in the hospital and how to access these
services online; a youth e-health program helps educate teenagers about the harms of smoking and alcohol consumption.

Broadly speaking, evaluation has the following functions and purposes:

- There is a need to find out whether the aims and objectives of a service, program, activity, product or design have been achieved or not.
- Evaluation helps to identify the strengths and weaknesses of the subject evaluated. The results of the evaluation can be used as references for improvement.
- Evaluation is useful to health organizations in ascertaining how online health applications are received and perceived in the broad context of health care.

What is Evaluation?

Evaluation is assessing and judging the value of a piece of work, an organization or a service. It is fundamentally about asking questions, and then designing ways to find useful answers. Evaluation is a process which examines the quality and appropriateness of a product or an entity (a piece of work or an organization) or a service such as a training program, a sports project, a community centre, or an e-health software. Evaluation is a goal-orientated task. It takes place in a pre-defined context for a period of time involving certain methods of evaluation.

Without evaluation, it is hard, if not impossible, to know how a product, a program or a service works. For example, how could we tell if a Paediatric Oncology Video designed for clinicians to assist with the management of patients upon returning home (NSW Telehealth Initiative, 2003) is effective and beneficial to its intended audiences? It is thus important for stakeholders such as administrators, developers, participating health professionals to know whether the program achieved its aims, how the participants thought about and gained from the video, what needs to be improved, etc.

Evaluation may take place individually and informally, particularly in self-evaluation. For instance, a teacher evaluates his or her first year of teaching in a rural school. On the other end of the scale, evaluation can be a structured and large scale exercise involving a formal team using a variety of evaluation approaches and tools, for example, an evaluation of a health program for rural people in isolated regions in Australia.

Please note that evaluation is not equivalent to research even though both use scientific methodology to generate information and test the reliability and validity of the data to determine the quality of evidence. One of the main differences between evaluation and research is that evaluation involves making judgment about the value of what is being evaluated whereas research determines the questions you want to ask and how you are going to answer them (Murdoch University, 2004). According to Scriven (1991), evaluation looks for the merit, worth or value of things. Whilst, the conclusion of a research is based on factual results, that is, data collected, observed, measured or calculated. It does not pass on an evaluative judgment. Evaluation very often focuses on an internal situation, such as garnering information and data about a specific program, project or service. The application of the results is restricted to the subject matter evaluated. On the other hand, a research will
generalize the findings from a sample to a larger population or other settings and situations (Priest, 2001).

**Evaluation Approaches**

There are many approaches to evaluation and there is no single correct way to conduct an evaluation. Each approach focuses on different aspects, values or uses of the evaluation. In this chapter, we will discuss three approaches that are more relevant to e-health evaluation.

**Practical Participatory Evaluation**

This approach assumes that evaluation is geared towards program, policy or organizational decision making. Normally professional evaluators will be employed and its primary goal is practical problem solving. This approach builds on the conventional stakeholder-based approach which restricts participations to key stakeholders closest to the program. By involving the key stakeholders (including program practitioners and users), this approach promotes joint ownership, enhance evaluation relevance and thus utilization (Cousins & Whitmore, 1998).

**Transformative Participatory Evaluation**

The primary goal of this approach concerns more about empowerment of the participants. The participants do not only focus on data collection, analysis and dissemination, but also on learning in the process and on actions that may result from the evaluation. The boundary between the participants and the evaluators is thus blurred. The role of the evaluator becomes more like a facilitator. Transformative participatory evaluation and practical participatory evaluation approach differs from each other in their primary goal, yet they have substantial similarities. By soliciting contributions from participants, understanding of the program functions and process will be enhanced and at the same time, the participants will feel empowered to take control of the circumstances and resultant actions (Cousins & Whitmore, 1998).

**Utilization-Focused Evaluation**

The fundamental ideology underpinning this approach is that the subjects of evaluation should be assessed by their actual use and usefulness (Patton, 2002). The focus is thus on the intended use by target users and it eliminates questions that will produce non-useful information. It is a very specific approach with a view to help practitioners make improvements in the program, to help administrators make decisions about future programs and to help the community to make decisions about resources. However, it does not dictate what content, model or method to be used in the evaluation. It is an interactive process
involving the evaluators and the stakeholders in finding and agreeing on the most appropriate content, model, methods or theory to be used for their particular circumstances (Patton, 2002).

E-Health Evaluation

With the rapid development of Information Technology (IT) and its permeation in the various aspects of modern society, e-health is a testimony of the impact of IT on the field of health. The presence of the Internet and the use of other electronic media are commonplace in many health institutions and health services. To some people, e-health is not just an introduction of modern technology to health but also a paradigm shift reshaping thinking and behaviour. The term e-health includes the use of the Internet or other electronic media by the public, health workers, and others to disseminate health related information or services (Wyatt & Liu, 2002). We should not take it for granted that everything would go smoothly with e-health. It is important not to welcome the implementation of IT in health without critical consideration of its effectiveness in a new context. Thus programs and services which involve e-health need evaluation, formally or informally, depending on their nature, scope and social context.

Health informatics which is an important aspect of e-health provides a new way of informing the public and health workers with regard to accessing health services. Many websites and electronic materials have been produced to make health care information and services more readily available to the public. Though this is considered a very innovative and productive development in health care, there are also risks associated with inaccurate information, mismanagement of health data, and IT-based problems. Thus the evaluation of e-health is vital in improving health care, in particular in circumstances when health services rely heavily on health informatics.

As mentioned in the Evaluation Approaches section above, all approaches advocate the involvement of the stakeholders. Hence, user perspective is very important in e-health evaluation. The appropriate level of evaluation depends on the needs of the users. Therefore when designing and developing an electronic health application, user needs, product risks and benefits, program feasibility, and user acceptance to the newly adopted technologies are important issues that need to be evaluated (Gustafson D, Taylor J, Thompson S, & P, 1993; Gustafson & Wyatt, 2004).

What should be Evaluated?

One of the first and most important questions in e-health evaluation is to identify what are the subjects of evaluation. It can be a health informatics program, a shared health database access facility, or a website promoting a health service. Evaluation can cover the whole spectrum or just specific aspects of a product, program or service. Generally an evaluation aims to find out what works and what does not work and make recommendations on how to improve or increase utilization.
User-Friendliness

User satisfaction is the primary aim of e-health evaluation. Users in an e-health program can be the management, administrators, frontline staff, health practitioners, patients or the general public. It is vital to find out how users value the product developed for them when other alternatives are also available. User-friendliness evaluation includes whether the program or software is intuitively designed or easy to use and whether the program addresses the users’ needs. Users’ evaluative feedback, in quantitative or qualitative forms, helps us determine what information needs to be included and prioritize these information to improve user-friendliness of the program.

Usability and Accessibility

Usability and accessibility issues are important when developing an appropriate user interface for different kinds of target users (Gustafson & Wyatt, 2004; Wyatt & Liu, 2002). For example, the interface of an e-health program that provides services such as palliative care, clinical consultation, bereavement support and education will be different from one that discourages teenagers from abusing alcohol and other drugs. The website for teenagers needs to be fun to use whereas easy access to key information is more important to palliative caregivers.

Location of the users and how the users would access the system determine what technology should be used. Thus whether the appropriate technology is used should be evaluated as well. For example, mobile technology should be used for e-health programs for health practitioners on duty in the wards; large size photographs should be avoided and size of files for downloading should be compressed for websites targeted at people in the rural and remote regions as they may not have broadband access.

Accuracy

Up-to-date and accurate information in the system or on the website is pivotal to an e-health program. Inaccurate information not only creates confusion and could be misleading, it also easily renders the system obsolete as users lose confidence in its reliability. Reliability is essential in health care delivery as in an emergency situation, this could be a matter of life and death.

Design, Tone and Approach

As e-health includes the use of the Internet and other electronic media, evaluation generally covers screen design, navigation, written information, visual information, hardware and software support; and HELP facilities. As the Internet is accessible by all, cultural sensitivity needs to be addressed also. For instance, for a multi-lingual website promoting
breast feeding, while it may be fine to use explicit photographs in the English language version, viewers browsing the Arabic version of the website may find it offensive.

Cost Implications

Cost implications are important in evaluating e-health program (Smaglik, Hawkins, Pingree, & Gustafson, 1998). We should consider how e-health programs affect the use and costs of health care services relative to other options. What change has an e-health application made to its end-users in terms of accessing services or support? What is the cost effectiveness of different e-health delivery programs (Eng, 2002; Glasgow, 2007; Gustafson & Wyatt, 2004)? Cost effectiveness and/or cost benefit is highly valued in the decision making process to select an appropriate e-health application.

Evaluation Framework

There is a wide range of evaluation methods used in health services and the approach and tools used will depend on the application (Evers, 2006; Hawe, Degeling, & Hall, 1990; Nguyen, Cuenco, Wolpin, Benditt, & Carrieri-Kohlman, 2007).

All evaluations need to ask and address specific questions, which affects the type of data collection used. Thus, data analysis and reporting of the results are determined by the questions in the scope. The possible questions to be addressed are:

- What is to be evaluated?
- Who is the evaluation for?
- Who are the relevant stakeholders?
- Who will you report the results to?
- What are the benefits and limitations of the project?
- What are the cost implications of the project?
- What are the privacy, security and standards issues?
- How are e-health services performing compared to other service alternatives available?
- What resources (hardware/software/human resources) are needed?

The generic evaluation process of e-health can be described in the following diagram:
Planning an evaluation normally involves the following steps:

1) Identify the purpose of evaluation;
2) Select the questions to be addressed;
3) Select the methods of collecting the evidence (see Methods of Evaluation section);
4) Prepare the documentation: test the questions to ensure they are clear and adequately address the purpose of your evaluation.
5) Conduct activities for collecting the evidence;
6) Analyse the results; and
7) Report the results.

Types of Evaluation

Similar to approaches and methods, there are many different types of evaluations but they could be broadly categorized into formative and summative evaluation. Formative evaluation takes place during the time of implementation and its information is used to shape the activity as it happens. It is more process-focused with an aim to strengthen or improve the object being evaluated. It investigates areas such as program delivery, technology, quality of implementation, procedures and input. Whereas summative evaluation occurs at the end of the implementation phase and information is used to make judgment about its success or failure. In other words, it is more outcome-focused. In addition to the immediate target outcomes, it examines also whether the program has delivered or caused its desired outcome, and the overall impact of the causal factors. Cost benefit analysis is also a key characteristic of summative evaluation. It is not uncommon to have both types in an e-health evaluation.

Under formative evaluation and summative evaluation, there are a number of sub-types respectively (Trochim, 2006).

Formative evaluation:

- Needs assessment – which centres on needs, such as who needs the program? Is the need great? How these needs could be met?
- Structured conceptualization – which helps the stakeholders define the structure of the project, such as technology used, target users, and possible outcomes.
- Implementation evaluation – which examines how well the project or technology is delivered.
- Process evaluation – which investigates the process and procedures in delivering the project.
- Evaluability assessment – which explores how evaluable the project is.

Summative evaluation:

- Outcome evaluation – which assesses whether there is a demonstrable relationship between the intended outcomes and the program or technology chosen.
- Impact evaluation – which evaluates the overall intended or unintended impacts of the project. This evaluation is broader in scope than outcome evaluation.
- Cost-effectiveness and cost-benefit analysis – which investigates efficiency and values of the project.
The way information is presented can significantly affect the perception of the key parties involved in the study. Different types of information appeal to different people (LTDI, 1998). Quantitative measurements may be more useful in demonstrating the achievements of funding organizations and top management, whereas qualitative feedback may be more beneficial to enabling improvements necessary for users of a system. Quantitative evaluations should be supplemented by qualitative studies where users explain what they think when they use the system and how it affects their lives (Gustafson & Wyatt, 2004).

**Methods of Evaluation**

Table 5a. Methods for collecting evidence.

<table>
<thead>
<tr>
<th>Methods</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checklist</td>
<td>Checklist is a brief and introductory way of highlighting the main items to be “checked”. It is useful in screening if the materials gathered fit the defined criteria and for follow-up evaluative tasks. Data gathered can easily be processed and analyzed by database software such as Excel, Access or SPSS.</td>
</tr>
<tr>
<td>Questionnaire</td>
<td>Questionnaire is a list of question items covering various aspects of stakeholder evaluation. It may include multiple choice (close-ended questions) and open-ended questions. It is useful in collecting opinions, factual information and feedback from people.</td>
</tr>
</tbody>
</table>

Table 5b. Methods for collecting evidence (cont’d).

<table>
<thead>
<tr>
<th>Methods</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview</td>
<td>Interview is a direct way of seeking feedback from stakeholders. It can be conducted on a face-to-face or on-line basis. The target of the interview can be an individual or a small group. Confidentiality needs to be maintained. There are different types of interviews: Open-ended – It is a standardized interview and the same set of pre-determined questions is asked consistently across different interviewees by different interviewers. Guided – It is a structured interview. The evaluator has the flexibility to divert from the pre-determined questions and accommodate emerging comments from the respondents. Informal – the discussion will be more free-flowing allowing quicker responses and interactions between the evaluators and the interviewees.</td>
</tr>
<tr>
<td>Focus group</td>
<td>Focus groups are similar to small group interviews. The main difference is that the participants, in most cases, are selected from those interviewed or those who have taken part in a survey, to participate in a more in-depth discussion about their views and experiences. For interview groups, evaluators tend to select a sample population as representative or unbiased as possible. However, for focus groups, participants could be selected based on certain attributes, such as those who hold a very strong view about the subject being research. Focus group participants tend to share similar views or fit into similar profiles.</td>
</tr>
<tr>
<td>Expert review</td>
<td>Expert feedback is important, particularly when a program deals with highly technical health information.</td>
</tr>
<tr>
<td>Tester and user trialing (User Acceptance Test)</td>
<td>It is necessary to pilot-test whether the product matches its intended aims and objectives. It may involve a small group of target users to seek their feedback before the product is finally introduced to the public.</td>
</tr>
<tr>
<td>Observation</td>
<td>The main purpose of observation is to obtain a detailed understanding of the ways e-health applications are used and the problems encountered. The evaluator becomes more involved in actively finding out the facts and issues, rather than having to rely on the inputs, which very often are selective, from the observed subjects. The evaluator plays a role quite different from that in a focus group or interview, which is more a facilitator role.</td>
</tr>
</tbody>
</table>

Source: Adapted from Evaluation Cookbook (LTDI, 1998).
E-health evaluation can be conducted by using a single method or a combination of methods. It may take place as a one-off or longitudinal study and involves simple or complex tools depending on the scale and scope of the evaluation. The information you choose to gather will affect the tools and techniques you adopt, with consequences for the resources you require to successfully complete the study. The following methods can be used for evaluation in e-health:

**Who should be Involved?**

Any health product should have its target users. An evaluation of an e-health program for health workers need to find out what they think and how they feel about the product. Their feedback needs to be monitored during the formative evaluation process. Similarly, an evaluation of a health website for the public needs to identify who are main target users and potential users. Their demographic and socio-economic characteristics need to be taken into account in the evaluation. There is no use to develop a website written in scientific English for migrants who are semi-illiterate in English.

The second group of stakeholders is the administrators and implementers of the e-health product. What are the issues concerning them during implementation? In their views, does it work? Why and why not? What needs to be done to improve the product?

Expert advice is also important in the evaluation. These experts may include IT specialists, medical professionals, allied health workers and even legal experts, as protection of private information and security are among the make or break factors for the success of an e-health program.

**Conclusion**

E-health plays an essential role in the contemporary context of health in general and health care in particular. It builds innovative bridges of information and interaction for health services, health workers and the public. However, one should not take for granted that it is all smooth sailing in e-health. Like many IT-based development, there are problems and risks which need to be examined. Evaluation is an important way to ascertain whether an e-health product works and delivers its intended outcomes and benefits.

**References**


Research Awareness in Intercultural Discourse: A Sociolinguistic Perspective

Quynh Lê

Abstract

Conducting research in a different cultural discourse has many challenges to researchers. As many research concepts and activities such as interview, privacy, meaning, conversation and text are embedded in culture, a lack of intercultural awareness and competence can affect the reliability and validity of a research project. With the emergence of sociolinguistics as a powerful field of study, researchers can incorporate it into their research methodology. This chapter discusses the significance of language in research and subsequently examines how sociolinguistics can contribute to the enhancement of research.

Keywords: sociolinguistics, discourse, intercultural, conversation, interview.

Introduction

While quantitative research use statistics to make sense of human experience and behavior, qualitative research focuses on research as a meaning making process, which needs to take into account the social and cultural context in which a research project is conducted and the participants’ ways of making sense of their lived experiences through “languaging”. With the emergence of sociolinguistics as a powerful field of study, researchers can incorporate it into their research methodology, particularly in cross-cultural research which requires socio-cultural awareness and competence. This chapter introduces some fundamental
concepts and issues related to sociolinguistics and discusses their significance in cross-cultural research.

The Language of Research

Two main factors which characterize research are methodology and the language of research. While a great deal of attention has been given to the methodological aspect of research in the academic research discourse, the language of research tends to be treated as of secondary importance. It is often discussed in terms of written expression, research jargons, graphic presentation and formatting. It can be argued that the language of research is inseparable from research methodology and as a matter of fact is a part of research methodology, not just a presentation of research.

The distinction between qualitative research and quantitative research tends to be described in terms of the methods in which data are collected and analyzed. Each has its own tools to fulfill their functions. For example, questionnaires and experiments, widely used in social science research, are interested in numbers and how they can be used to describe and interpret human behavior and social phenomena. Qualitative research uses tools such as interviews and unstructured observations to collect qualitative data. The follow-up data analysis in qualitative research depends heavily on the researcher’s theoretical orientations such as phenomenology, grounded theory, thematic approach, and constructivism.

It is argued in this chapter that the language of research is inherent in research methodology on the following grounds:

- Research is “languaging”. In other words, it is the process of developing and conducting a research project, from the beginning to the end of a research journey. The ways research questions and objectives are formed reveal an interconnected process of thinking and meaning making. Words to express research aims and objectives such as “investigate”, “examine”, “identify”, “determine”, “understand” are not ordinary words. In fact, they directly denote or imply some aspects of research methodology.
- The language used in the research tools used in data collection and data analysis is also inherent in research methodology. For instance, the different formats of interview (e.g., open-ended, semi-structured, structured) are subject to different ways of “language”. An open-ended interview can be a conversation between two interacting parties; whereas in a formal interview, the language tends to be “sterilized” and directional, flowing from the interviewer to the interviewees. In other words, the former uses what I refer to as “elaborated languaging” and the latter as “controlled languaging”.
- As research is socially (and culturally) embedded in human discourse, to a great extent, research is sociolinguistically determined.

The last statement indicates the role of sociolinguistics in research. This is a new area of interest in current research, particularly in cross-cultural research. Thus it is important to know what sociolinguistics is and how it contributes to enhancing research.
What is Sociolinguistics?

Traditional linguistics focuses on language structure as language is treated as a code and the main role of linguistics is to describe the code in terms of units and construction. Its scope is very limited as it does not go beyond the sentence boundary. The key units are phoneme, morpheme, phrase, clause and sentence. Modern linguistics expands its inquiry not only outside the sentence structure to include text and discourse, but more importantly on the functional aspect of language and its social function (Meyerhoff, 2006; Trudgill, 2000). Thus the interest in language is extended to the relationship between language and its use in society. This is where sociolinguistics plays an important role in research methodology.

As the compound word “sociolinguistics” indicates, it has something to do with society and linguistics, or more precisely it is the intricate link between them. Broadly speaking, sociolinguistics studies language in its socio-cultural contexts. Wolfram (n.d.), writing for the Linguistic Society of America, points out that language is one of the most powerful emblems of social behavior. Communication through language conveys vital social messages about who we are, where we come from, and who we associate with. He states:

The basic notion underlying sociolinguistics is quite simple: language use symbolically represents fundamental dimensions of social behavior and human interaction. The notion is simple, but the ways in which language reflects behavior can often be complex and subtle. Furthermore, the relationship between language and society affects a wide range of encounters - from broadly based international relations to narrowly defined interpersonal relationships. (Wolfram, (n.d.), para. 4)

While structural linguistics and traditional grammar focus on syntax and linguistic rules descriptively and prescriptively, sociolinguistics concerns more about social appropriateness, and not with linguistic correctness. It places great significance on the communicative function of language in use. Sociolinguistics is primarily concerned with communicative competence which enables speakers to function in their speech community. In a simple but illustrative way, it wants to describe the dynamic nature of communicative interaction in terms of “who communicates with whom about what in which social context”. The following examples indicate the nature of this interactive discourse in terms of sociolinguistics:

- A music teacher talked about classical music to his students in a secondary classroom.
- A policewoman spoke to a young driver about traffic violation at a car accident location in the city centre.
- A researcher interviewed a doctor about intercultural health in an interview room at a university.

As sociolinguistics deals with language in its social contexts, there are important implications for research in general and research methodology in particular. The following discussion will examine these implications.
Communication in societies tends to be categorized into different kinds of events rather than an undifferentiated string of discourse. Communicative events have well-defined boundaries between each, and have different behavior norms appropriate for each kind. For example, a telephone conversation is a communicative event bounded by a ring of the telephone as a “summons” and hanging up of the receiver as a “close” (Wooffitt, 2005). Some events are very ritualistic such as a church service or wedding ceremony. Hymes (1974) in discussion of communicative events gives the following components:

- The genre, or type of event (e.g., joke, story, lecture, gossip, etc.).
- The topic or referential focus.
- The purpose or function.
- The setting: location, time, physical aspects.
- The key or emotional tone of the event: serious, formal, informal, jocular.
- The participants: age, sex, ethnicity, social background, etc.
- The message form (e.g., channel: vocal, non-verbal, etc.).
- The message content: what is it about?
- The act sequence: e.g., turn taking.
- Rules for interaction.
- Norms of interpretation: common knowledge, relevant cultural presuppositions.

In research, each task of conducting research, whether it uses qualitative or quantitative methodology, is a communicative event (Bryman, 2008). It is important that researchers are familiar with the communicative nature of an event so that the task is socially appropriate for the social situation and is acceptable to the research participants.

Labov (1972), a pioneer in sociolinguistics, conducted a study on language use in the inner city location where African Americans lived. His study showed that for the research to be valid, the language of research used by his research assistants needed to be acceptable and appropriate to the social context where the African American participants lived. The participant who was perceived as “linguistically deprived” and “cognitive deficit” in an unfamiliar social context could turn out to be an articulated and intelligent person in another context where he felt at home with his environment and the interview event took place in his social environment where he was empowered by his sociolinguistic competence.

In his well-known sociolinguistic book entitled *The Ethnography of Communication*, Saville-Troike (2003, p.102) gives the following advice on ethnographic interview:

- Selecting reliable informants. Often the people who make themselves most readily available to an outsider are those who are marginal to the community, and may thus convey inaccurate or incomplete information and interfere with the acceptance of the researcher by other members of the group.
- Formulating culturally appropriate questions. This includes knowing what is appropriate to ask about, why, and in what way.
- Developing sensitivity to signs of acceptance, discomfort, resentment, or sarcasm. Such sensitivity relates to the first two issues by contributing
information on informant reliability and the appropriateness of questions, and gives an indication on when an interview should be terminated.

- Procedures for data transcription, arrangement, and analysis. These will differ to some extent with the kind of information that is being collected and often with the theoretical orientation of the researcher, whenever the interview is conducted in a language not native to the researcher. However, transcription requires skills in using another orthographic system or a phonetic alphabet (even if a tape recorder is in use).

Data collection through interview is not just a research activity but is a communicative event which requires sociolinguistic awareness and skills to ensure that the collected data, which is the linguistic text, is not only what the interviewee says but what the interviewee really means. Otherwise, the consequent data analysis is based on the interviewer’s version of the text, which does not truly reflect the interviewee’s meaning. This research problem also happens in intercultural research in which translation is required.

**Translation and Textual Authenticity**

One of the problems concerning reliability and validity in conducting cross-cultural research is the use of translation in questionnaires and interviews. As a language is deeply rooted in its culture and any text which is constructed in one language cannot be translated into another language without some loss of meaning. Translated text therefore does not adequately represent the participants’ views and attitudes due to the interference of language and culture in the translation process. Words are heavily coded with cultural values and their meanings are understood only by those who share the same culture (Fairclough, 2003). Words such as “family duty”, “piety”, “social corruption” have their own cultural meanings which will be lost in translation if they are replaced with similar words in a different language. What “family duty” means in Vietnamese is different from what it means in English as the two cultures define “family duty” differently. In Vietnamese culture, the concept “family duty” is embedded in the Confucian ideology. Kinship terms such as aunt and uncle are commonly used in Vietnamese society not only for family members but also for non-family members to denote close interpersonal relationship. Thus translated questionnaire and interview data may not fully capture this cultural aspect. It is essential that data collection should be conducted in the language of the participants.

**Interview and Conversation in Cross-Cultural Research**

Interview is a widely used method of data collection in qualitative research. It provides an opportunity for the researcher to verbally interact with the interviewee; whereas in questionnaires, researchers and participants are faceless. However, as interview is a communicative event which is culturally constructed, researchers need to understand the
cultural discourse of interview. In ethnography research, an interview normally takes place in the form of conversation in which the interviewer and the interviewee are communicative participants. They both need to make the conversation work.

Grice’s theory (1975) of conversational maxims has been widely discussed in sociolinguistics and pragmatics. It is also of great interest to researchers who adopt ethnography as a research approach. Grice (1975) gives the following conversational maxims which are broadly seen as the rules which govern a conversation.

Maxim of Quantity

➢ Make your contribution to the conversation as informative as necessary.
➢ Do not make your contribution to the conversation more informative than necessary.

Maxim of Quality

➢ Do not say what you believe to be false.
➢ Do not say that for which you lack adequate evidence.

Maxim of Relevance

➢ Be relevant (i.e., say things related to the current topic of the conversation).

Maxim of Manner

➢ Avoid obscurity of expression.
➢ Avoid ambiguity.
➢ Be brief (avoid unnecessary wordiness).
➢ Be orderly.

Grice’s theory is a conceptual model about the nature of conversation and it has its universal appeal to researchers who are interested in discourse analysis and conversational analysis. While one can see some of these rules be used in different languages, it tends to be Western culture orientated and it may not apply well in other cultures. Let us examine how Grice’s theory of conversation applies in Vietnamese and what implications should be made for cross-cultural research.

Maxim of Quantity

➢ Make your contribution to the conversation as informative as necessary.
Do not make your contribution to the conversation more informative than necessary.

Vietnamese culture determines how a conversation works and the quantity of “information” in conversation varies a great deal depending on the social contexts. Thus this maxim is vague as it does not give any guidance on how “informative” one needs to be in a conversation. Basically what the maxim says is that “do not talk too much and do not talk too little”. In a Vietnamese conversation, contribution to a talk when interacting with a teacher is different from interacting with a friend due to the social roles assigned to each person. Researchers should be aware of this cultural aspect of engaging in a conversation to avoid miscommunication in interview data collection.

Maxim of Quality

- Do not say what you believe to be false.
- Do not say that for which you lack adequate evidence.

This maxim does not take into consideration the dynamic nature of social interaction in which communicative strategies play an important part. In Vietnamese culture, young children should not openly show disagreement with the respected others, such as parents, teachers and visitors. They are expected to act in harmony with older people to show respect and this could involve lack of adequate evidence or telling white lies.

Maxim of Relevance

- Be relevant (i.e., say things related to the current topic of the conversation).

This maxim may apply well in a formal interview, but in a conversation or informal interview, it can be counterproductive due to its cultural inappropriateness. The notion of relevance is so culturally determined that what is relevant in a social context may not be relevant in other contexts. For example, a conversation with an elderly person in Vietnamese is a winding process which includes many aspects of life to be included. Thus judgment of relevance in a Vietnamese conversation needs to take into consideration of the age and gender of the participants.

Maxim of Manner

- Avoid obscurity of expression.
- Avoid ambiguity.
- Be brief (avoid unnecessary wordiness).
- Be orderly.
This maxim is heavily orientated towards a narrow context of conversation normally found in a formal job interview. This maxim is inapplicable to other social contexts where ambiguity and obscurity play a role in a conversation. Vietnamese culture is greatly influenced by Taoism which treats ambiguity as a quality of communication. While Confucianism emphasizes precise speech and correct wordiness, Taoism favors linguistic ambiguity as it reflects the mystery of nature and life.

Thus, Grice’s theory cannot be universally applied to discourse analysis and research due to intercultural differences. Researchers in cross-cultural studies need to take this into account when conducting ethnographic field work for data collection in a different cultural environment.

Cultural Taboos and Euphemism in Cross-Cultural Research

Taboos have a historical base in religion but gradually they have tended to move from religion to secular use, particularly in relation to themes about sex, politics and race.

Taboos were originally concerned with sacred matters that could not be discussed, but nowadays taboos usually concern things that people are ashamed of. The existence of taboos throughout history has created a need to find words and expressions that enable people to talk about the subjects concerned without feeling uncomfortable or being afraid of hurting another person's feelings. Such words and expressions are referred to as “euphemisms”. (From, (n.d.), para. 1)

Cultural taboos and euphemism are important in intercultural communication. Leech (1981, p.45) defines euphemism as “the practice of referring to something offensive or delicate in terms that make it sound more pleasant or becoming than it really is”. There are different ways to say the same thing. However this variation signals the sociolinguistic factors which govern linguistic politeness. The following examples illustrate the lack of awareness of euphemism in social interaction:

- I am sorry to know that your father died suddenly yesterday. (Euphemism: passed away).
- You should not get too fat. (Euphemism: control your weight).

The use of euphemism is not always reinforced in social interaction. In some social contexts, the use of euphemism strengthens social awareness and collaboration in communication and in other situations it could hinder genuine communication and cause misunderstanding. There are no specific rules for the use of euphemism. Thus, it is important to be aware of the potential problems in interpersonal communication due to the misuse of euphemism. It is important for ethnographic researchers to be aware that taboo topics and their acceptance vary among cultures (Robson, 2002). In the West, topics about royal families attract a great deal of attention of the public and any stories about them can “sell” well in mass media. Whereas, in other cultures, it is a crime to use royal families, spiritual leaders or
politicians as a topic of public entertainment. Researchers should avoid including taboo topics in data collection.

**Privacy and Confidentiality in Cross-Cultural Research**

Privacy and confidentiality are treated seriously in the Western research discourse. They are an important aspect of research ethics. The confidentiality and privacy of all participants are maintained at all stages of the research and in all publications derived from the research findings. These are not only a matter of principle but in practice proper management of data needs serious consideration before a research project is conducted.

However in some cultures which treasure collectivism, personal privacy is treated differently as the boundary of privacy between personal and public domains are not clearly marked. In a family-orientated culture, parents can exert great influence on the personal life of their children such as marriage, career choice and education pathway. In other words, privacy remains the property of a family, not an individual. While good news should be made known to the public such as wedding ceremony, birthday and house warming celebration, bad news such as mental sickness, job loss and marriage breakdown should be secretly kept within the family.

As privacy and confidentiality are valued differently among cultures, cross-cultural research should take this factor into account in conducting research which deals with sensitive issues about the personal views and experiences of individuals as their own personal privacy can be subjected to family control and scrutiny.

**Conclusion**

Traditionally discussion about research methodology tends to focus firstly on the approach which underlies the theoretical and ideological principles based on which a research project is conducted, and secondly on the tools chosen for data collection and data analysis. Due to the influence of sociolinguistics and discourse analysis, more attention is now given to the social and cultural factors which influence research reliability and validity, particularly in ethnographic research. As many research concepts and activities such as interview, privacy, meaning, conversation and text are culturally constructed, it is important for cross-cultural ethnographic researchers to understand how these concepts should be appropriately treated in their research so that the cultural values of the participants and their community are respected and faithfully presented in the research.

**References**

Notes on the Authors

**Penny Allen (PhD):** Dr Allen is a researcher at the Department of Rural Health, University of Tasmania, Australia. She has worked on a range of ethnographic and epidemiological studies in Australia and the United Kingdom. Her research interests are in women’s health and studying health issues from a socio-cultural perspective.

**Sonia Allen:** Sonia’s interests are on ageing in the areas of health, education and community services. She has an impressive publishing record both in national and international journals. Her presentations, public speaking and research activity have focused on service delivery and programs associated with planning for an ageing society. Rurality, policy development, management and ethical issues associated with quality services and end of life care are significant issues amongst others in her portfolio. Sonia holds a joint appointment as Clinical Educator and Researcher Fellow with the School of Nursing and Midwifery and the Gippsland Medical School, Monash University Gippsland Campus, Victoria, Australia.

**Stuart Auckland** is currently the Program Coordinator for the Community Health Development Program Area at the University Department of Rural Health, Tasmania. Stuart holds a combined Business and Agriculture Degree and a Master of Applied Science in Rural Community Development. Stuart has extensive experience in rural community development and has been involved with a range of rural health project and research initiatives. Stuart has presented his work at a number of State and National conferences and forums. His current interests lie in the community health, health mapping, primary health and health impact assessment. He also has a strong interest in rural health partnership structures with communities.

**Rachel K. Baker (PhD):** Dr Baker is an Assistant Professor in the Department of Psychology at Cape Breton University, Canada. She completed her PhD in Psychology at Concordia University (Montreal, Canada). Prior to joining the faculty at Cape Breton University, she was a Postdoctoral Research Associate at the University of Massachusetts Amherst (USA). Her area of research interest is developmental psychology. Her current research focuses on cognitive and language development in children. She frequently teaches courses on introductory psychology, lifespan developmental psychology, and children’s cognitive development.

**Tony Barnett (PhD):** Associate Professor Barnett was trained as a nurse and worked in a number of hospitals in both South Australia and Victoria. Prior to joining the University Department of Rural Health in Tasmania, he held senior positions at Monash and Deakin
universities. His research interests and activities include: clinical practice, rural health and the quality of life of older adults. He is currently working on projects investigating Advance Care Planning in residential aged care facilities and the role of interprofessional learning in the clinical education of health care professionals.

**Annette Barrett:** Annette is the Nurse Unit Manager at the Westbury Community Health Centre, a small rural based health centre in northern Tasmania. Annette was originally one of the first group of tertiary trained nurses in Tasmania and worked in a range of positions in the acute care sector, undertaking a range of further training including her Midwifery and Family and Child Health certificates, and a postgraduate degree majoring in Primary Health Care. Her passion for primary health care led her to transfer to her present position at Westbury 17 years ago where she has focused on the practical application of this approach in trying to improve the health status of the Meander Valley community.

**Erica Bell (PhD):** Dr Bell is the Deputy Director at the University Department of Rural Health, Tasmania, Australia. She has over 40 academic journal and conference papers and presentations in areas of interest to rural stakeholders: adolescent substance abuse, domestic violence and child health, youth crime prevention, healthy ageing and falls prevention, chronic disease, hospital error and medical education reform. Her work in research methods for health policy and practice across these subdisciplines is represented in her book Research for Health Policy published by Oxford University Press in 2009. Erica has a strong record of community engagement work, being the author of 44 applied research reports that have developed policy and practices across health and education specialities and sectors.

**Sara Bradley (PhD):** Dr Bradley has a BA Honours (Oxford University) and a PhD in Social Gerontology (Aberdeen University). Her main area of interest is ageing and older people. Sara has worked mainly in the voluntary sector, in employment, disability and health as well as older people's issues. Sara previously worked for the Centre for Rural Health, United Kingdom in 2001 on ISAAC - International Study of Allergies and Asthma in Childhood (NHMRC) research grant investigating models of public dental services, which involved consideration of workforce education and recruitment. She was a member of the national Dental Workforce Education Committee for the Australian Dental Association. Rosemary was awarded an NHMRC postgraduate public health scholarship to undertake her PhD, which considered visits to GPs for dental problems and the integration of oral health and general health.

**Rosemary J Cane:** Dr Cane graduated in dentistry with honours from University of Sydney in 1977. She spent her earlier years in private and public general practice in Sydney and as clinical undergraduate supervisor at the Faculty of Dentistry, University of Sydney. On moving to Tasmania with her family in 1996, she established a nationally recognised course for dental assistants and worked as clinical tutor for dental therapy upgrade through the University of Adelaide. Rosemary joined the staff of the University Department of Rural Health, Tasmania as a milestone appointment in the absence of a State dental school. Her early work at the UDRH resulted in a National Health and Medical Research Council.

**Cecilia Chiu:** Cecilia is a PhD student currently enrolled at the University Department of Rural Health, Tasmania. She is an early researcher and her research interest is in Geographic Information System, spatial analysis, ageing population and aged care services. As an ethnic Chinese, she is also interested in health issues related to Asian migrants in Australia.

**Jane Farmer (PhD):** Professor Farmer is the UHI Millennium Institute Chair of Rural Health Policy and Management, UK. Jane studies and writes about the social, policy and
management issues of rural health care provision. Her current research interests focus on new ways of providing services to remote and rural areas and involving stakeholders in configuring services. She has had visiting fellowships within rural health care to Australia (Tasmania and Queensland), South Africa and Japan. Her current work is focused strongly on rural health and other service configurations - with a concern to increase, rather than deplete, rural community capacity – and bring together service stakeholders (public, patients, health professionals, managers and policymakers) in decisions. Areas of service configuration currently being studied are: social enterprise, rural community participation methods, new roles in health and service delivery, community wellbeing and the role of services in community sustainability.

**Gerard Gill (PhD):** Dr Gill graduated in Medicine in 1975 from the University of Tasmania. He joined a general practice in a northern suburb of Launceston, Tasmania in 1980, where he continues to practise. He has held national roles in the Australian Medical Association and the Royal Australian College of General Practitioners (RACGP). He holds the Fellowships of the RACGP and the Australasian Faculty of Public Health Medicine. In 2006, he was awarded a PhD from the University of Tasmania with his studies supported by an NHMRC Postgraduate Scholarship. His research interests are in general practice aged care and the rational use of pharmaceuticals.

**Ha Hoang:** Ha completed a Master of Medical Science and was awarded a scholarship for undertaking a PhD study at the University Department of Rural Health, Tasmania. Her thesis is about maternity care services in rural areas of Australia. Ha undertook her undergraduate study in Vietnam and postgraduate study at Griffith University, Australia. She has an intercultural background with work and research experiences in Vietnam and Australia. Her research interests include maternity care and multicultural health.

**Chona Hannah:** Chona is a PhD candidate at the Department of Rural Health, University of Tasmania. Her thesis is on the health and wellbeing of intermarried Filipino women in rural Tasmania. She completed a MEd at the University of Tasmania with a focus on acculturation. She has worked as a college teacher and has presented a number of papers at international conferences.

**Andrew Harris:** Andrew is a registered psychologist working in private practice at The Blue Door counselling service in Launceston, Tasmania. He also holds a part-time position as a Research Fellow at the Department of Rural Health, University of Tasmania. Within the psychology field, he has worked in education, child protection, domestic violence, and torture trauma counselling. He formerly worked as an engineer in the oil and mining industries and in consulting. He is interested in the benefits which accrue from systematically exploring areas of practice and research which are under-represented in mainstream literature. This is an extension of the narrative therapy practice of developing the alternative stories in clients’ lives.

**Lester Jones:** Lester is the Director of Nursing and Manager of Deloraine District Hospital and Community Health Services. He commenced his nursing career in 1977 and has worked in aged care, acute care, community nursing, and in district hospitals in rural settings for the past 14 years. Lester is committed to the principles of primary health care and community development and is an advocate for farming families health and wellbeing. Lester has been and continues to be involved in many local community organisations with a health and wellbeing focus. Lester is a director on the Board of Management of the University Department of Rural health, Tasmania.
**Susan Johns (PhD):** Dr Johns is a Research Fellow with the University Department of Rural Health, Tasmania. She previously worked in the non-government sector, managing a collaborative, regionally-based early childhood program with a primary health focus. Susan’s multidisciplinary research into community capacity building examines partnerships involving the government and non-government sectors, in relation to rural health and education. She has a particular interest in the role of social capital and leadership in rural community development. Susan has presented and published her research findings nationally and internationally.

**Sue Kilpatrick (PhD):** Professor Kilpatrick was appointed Pro Vice-Chancellor (Rural and Regional), Deakin University, in 2009. She has had a career long interest in rural and regional development through education and research. Prior to joining Deakin University, she was Director of the University Department of Rural Health, Tasmania and Director of the Centre for Research and Learning in Regional Australia. She is a member of the Regional Development Australia Barwon South West Victoria Committee, the South West Local Learning and Employment Network Board and the G21 Education Pillar. Professor Kilpatrick has a PhD in the Economics of Education and a Master of Economics in Labour Economics. Her research interests are education and learning in rural and regional Australia, social capital, rural workforce, community participation, learning for primary industry and natural resource management, rural health systems, and community leadership. She has over 150 publications and has received numerous research grants in these areas besides working as a consultant with local communities.

**Sue Korol (PhD):** Dr Korol is Assistant Professor of Psychology at Cape Breton University, Canada. She teaches health psychology, abnormal psychology, clinical psychology and community psychology. Her current area of interest explores social and cultural practices associated with health and longevity. Sue’s research is driven by her passion in examining how cultural values and norms may pose risks or have protective effects on physical and psychological health. Additionally, she is conducting research in palliative care, examining factors that influence choice of place of death from informal caregivers’ perspectives. Her other work positions food rituals and overconsumption as coping mechanisms for modern existential malaise.

**Quynh Lê (PhD):** Dr Lê is the Coordinator of Graduate Research in the University Department of Rural Health (UDRH), Tasmania, Australia. She started as a mechanical engineer in Vietnam and gained a MAppComp from the University of Tasmania, a MEd from the University of South Australia, and a PhD from Curtin University. She has participated in a number of UDRH research projects. Her research enhancing activities include being a co-editor of the on-line international research Journal *Language, Society and Culture* and Assistant Director of the International Conference on Science, Mathematics and Technology Education in Hanoi. She has a wide range of publications in rural health, intercultural health, health workforce issues, social epidemiology and the application of Information Technology in education and health.

**Rosa Maria McManamey (PhD):** Dr McManamey is Honorary Research Associate at the University Department of Rural Health, Tasmania. Rosa graduated in Fine Arts (Hons) from the University of Tasmania. This was followed by a PhD from the Faculty of Education of the same university. She was awarded the 2006 Australia New Zealand Regional Science Association International Post-graduate Award (ANZRSAI) for her PhD thesis. Rosa has been involved in a wide number of research areas in rural health. Her projects relate to social
capital, community engagement, development of rural health teaching sites, arts and health issues related to healing and resilience after natural disasters.

Lisa Maher (PhD): Professor Maher is Program Head at the National Centre in HIV Epidemiology and Clinical Research, NHMRC Senior Research Fellow and Professor in the Faculty of Medicine at the University of New South Wales. She has extensive experience in research, program development and service delivery in North America, South East Asia, Australia and the Pacific. Her research focuses on preventing infectious diseases in vulnerable populations.

Sarah-Anne Muñoz (PhD): Dr Muñoz joined the Centre for Rural Health, University of Aberdeen, in June 2009 as a Research Fellow. Her background is in Human Geography with an MA, MSc and PhD from the University of Dundee, United Kingdom. Sarah-Anne is interested in how different types of rural “spaces” interact with individual and community health and wellbeing. She is interested in bringing a stronger focus on social theory and spatiality into research relating to social enterprise. Her research interests are in the potential of Third Sector Organisations to deliver health services, as well as wider wellbeing, to rural communities. She is interested in the contribution of social enterprise to sustaining rural communities and empowering marginalised and excluded groups.

Karla Peek: Karla is a junior researcher. She began her academic career as an Associate Lecturer at the University Department of Rural Health, Tasmania in 2007 where she teaches within the e-Health (Health Informatics) postgraduate program. Karla has contributed to research into health science student placements in rural Tasmania and primary health approaches to rural health through community engagement. Her research interests include health behaviours and self-regulation.

Dawn Penney (PhD): Professor Penney is Professor of Physical Education and Sport Pedagogy in the Faculty of Education at the University of Waikato, New Zealand. Dawn is recognized internationally for her work in policy and curriculum development in Health and Physical Education. Dawn has led research projects in the UK and Australia investigating national curriculum developments, senior secondary schooling, pedagogy and assessment in physical education. Her publications include Politics, policy and practice in Physical Education (E&FN Spon, 1999); Gender and Physical Education: Contemporary issues and future directions (Routledge, 2002); Sport Education in Physical Education: Research based practice (Routledge, 2005) and numerous academic journal papers.

Artur Steinerowski: Artur is a research assistant at The Centre for Rural Health (CRH), which has operated as a collaborative venture between the University of Aberdeen and the UHI Millennium Institute. Since starting his PhD in 2006, Artur has presented and produced a significant number of journal articles. His latest paper, "Who are the social entrepreneurs and what do they do?", won the Babson Lewis Institute Award for the Best Paper Exploring the Significance of Social Entrepreneurship. The paper will be published in the Frontiers of Entrepreneurship Research in 2009. In November 2008, Artur commenced part-time employment with the Centre for Rural Health as a research assistant on the O4O project: Older People for Older People. Currently he works on the research component of the project.

Christine Stirling (PhD): Dr Stirling is a Registered Nurse and Senior Research Fellow at the Wicking Dementia Research and Education Centre, Menzies Research Institute, University of Tasmania. Her research interests include dementia, workforce and rural health care systems. Christine’s work with rural health workers and volunteers has generated insights into how we can better support health workers in the health system. Her application
Critical Realist approaches to health services research provides a strong foundation for mixed method research. Christine has published extensively on volunteers, evaluation, and research in the community setting.

**Au Bich Thuy:** Dr Au Bich Thuy became a medical doctor and lecturer at the Faculty of Public Health, Can Tho University, Vietnam in 1999. In 2003, she received a Master degree in Tropical Medicine at Mahidol University, Thailand. From 2003 to 2006, Dr Thuy lectured on both public health and Family Medicine and co-founded the Vietnamese Family Medicine Association. From 2006 to 2010, she pursued her PhD on risk factors for cardiovascular disease with the Menzies Research Institute (MRI), Tasmania. Dr Thuy then joined MRI as a postdoctoral fellow and provided support for Vietnam to establish a national surveillance system for risk factors of non-communicable diseases.

**Karen Willis (PhD):** Dr Willis is a health sociologist. She is currently a senior lecturer at the School of Sociology and Social Work at the University of Tasmania, Australia, and an adjunct Senior Research Fellow at Mother and Child Health Research, La Trobe University, Australia. Karen’s research interests are focused on health behaviours and actions, specifically how individual behaviours can be understood with reference to broader social influences. Karen has written extensively on the achievement of best evidence using qualitative methods in public health research.

**Derris Wood (PhD):** Dr Wood was born in Cressy, Tasmania and received her education from a local primary school and the Launceston High School. Her qualifications include a PhD on Adolescence and Risk Taking, a Master’s Degree by Research, a Master of Educational Studies and a Bachelor of Education, all gained from the University of Tasmania. Derris has worked in many aspects of teaching from Kindergarten to Grade 12 and with adults, with an extensive subject range, including English, Social Science, Mathematics and Foreign Languages (French, Japanese Indonesian, German). To complement her language expertise and research experiences, Derris has completed overseas study courses and has spoken at international conferences.

**Yun Yue** is a PhD student currently enrolled at the University Department of Rural Health, Tasmania. Her research interest is physical health and psychological wellbeing related to international students in Australia. As a holder of a Master of Education, she is also interested in linguistic and TESOL issues.
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