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Migrants' perceptions of health promotion messages in rural Tasmania

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Short title: Migrants' perceptions of health promotion messages in rural Tasmania

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Abstract

Asian migrants living in rural Tasmania experience a social and cultural environment dissimilar to larger Australian cities. This study investigated Asian migrants' lived experiences, their intercultural views with a focus on health risk behaviours within the challenge of a new rural environment. Certain health risks were identified and possible social and cultural connections. This exploratory study used a qualitative approach focussing on the personal experience of the Asian migrants living in rural Tasmania, Australia. Interviews were conducted from October – December 2011 with 36 Asian migrants residing in rural Tasmania, recruited through purposive sampling. Sub-populations such as Asian migrants residing in less dense culturally and linguistically diverse communities, including Tasmania, continue to maintain health and health risk beliefs from their culture. Migrant sub-population selectively adapted to their new environment, with longer term migrants acquiring western health conditions. The research provided insights about Asian migrant's views regarding non-communicable health issues in less dense culturally and linguistically diverse communities. In addition to adding to existing knowledge, the study provided some specific insights for better understanding of the relationship between health, risk and society and hopefully for improving primary health care access and delivery of care in rural and other small communities where sparse and less cohesive culturally and linguistically diverse communities exist.

Keywords: Asian migrant; risk, health risk; lived experiences; behaviour; rural context

Introduction

Immigration has shaped and enriched Australian society over the past two hundred years with over one-quarter of Australia's current population born overseas (Australian Institute of Health and Welfare, 2010). Throughout Australia's history, various culturally and linguistically diverse groups migrated to Australia at particular periods. For example, after the Second World War Australia experienced an influx of European immigrants. Many Asian populations, including post-war refugees, migrated to Australia in great numbers throughout the 1970s and 1980s when immigration policies were relaxed (Orb, 2002, Gray *et al.*, 2007, Castles and Miller, 2009). Tulloch and Lupton (2003) explain the migration or movement of people is a human reaction to risk and can be caused by technological changes, economic pull and push factors, war, disease, famine, and natural disaster.

Regardless of the motivations of migration, contemporary policies have enthusiastically supported family-centred migration, which has perpetuated large and robust culturally and linguistically diverse communities to exist in large Australian cities (Kouris-Blazos *et al.*, 1999, Gray *et al.*, 2007). This phenomenon has contributed to on-going cultural traditions and lifestyles which have preserved many health beliefs, health risks, health promoting behaviours and socio-cultural norms (Bécares *et al.*, 2009, Stafford *et al.*, 2010b). As such, individuals share similar views on risk to those with similar identities or cultural groups (Tulloch and Lupton, 2003, Williams and Baláž, 2012)

This article critically examines the concepts and issues of cultural health issues, intercultural challenges and adaptations to a new cultural and linguistic environment through the lived experiences of Asian migrants in Tasmania.

Tasmania is a small island off the south east coast of mainland Australia and has a social and cultural environment, which is different to large Australian cities. Tasmania lacks the large, dense and dynamic culturally and linguistically diverse communities which allow cultural traditions, health risks beliefs and experiences to thrive more easily (Gray *et al.*, 2007, Stafford *et al.*, 2010b). Asian migrants in Tasmania constitute only 1.3 per cent (n=6153) of the total population (n=476,481) (Australian Bureau of Statistics, 2006). As such, 56.5 per cent (n=3478) of this diverse demographic live in Hobart, the capital city (Australian Bureau of Statistics, 2006). This inner regional centre contains over half of Tasmania's population though it is not classified as a major metropolitan city (Australian Institute of Health and Welfare, 2011). The remainder of the Asian migrant population are scattered across Tasmania, often in isolated rural areas (Australian Bureau of Statistics, 2006).

Migrant beliefs are influenced by their culture and how their new environment is observed and conceptualised (Lê and Lê, 2005, Ma *et al.*, 2008, Chen *et al.*, 2009). Migrants also identify and understand health and health risks within their own cultural values and norms which are transferred as they migrate. These beliefs and cultural meanings can cause confusion and distress in the early years after migration; however health and health risk beliefs of migrants do change according to gender, age, education and the length of time they have lived in their new country (Salant and Lauderdale, 2003).

Asian migrants' health needs and their perception of health and health risks are not well understood in the less ethnically dense communities, such as Tasmania (Daly *et al.*, 2002, Lê and Lê, 2005, Biddle *et al.*, 2007b). Their views on health risks and modifiable behaviours such smoking, alcohol, physical engagement and diet have the potential to be different to their large and densely populated mainland Australia

counterparts according to Landrine and Klonoff's (2004) operant theory of acculturation. They further explain migrants, who reside in large cultural communities or groups have lower levels of social integration into the host country and a greater propensity to maintain culturally-normative behaviours through cultural positive and negative reinforcement, such as laws, religions, myths, rituals, icons, symbols and social norms (Salant and Lauderdale, 2003, Landrine and Klonoff, 2004). Conversely, migrants who do not reside in large cultural communities have less cultural reinforcements and have a greater propensity to adopt the behaviours of the dominant society. As such, this has the potential to explain the difference between the health attitudes, behaviours, morbidity and mortality among migrants in large cultural communities and those who continue to live in small, sparse and marginal culturally and linguistically diverse communities.

Asian migrants in Tasmania have been observed to maintain many traditional views and practices. They often face with language, cultural barriers and increased confusion and anxiety especially as they enter the unfamiliar territory of health and the health care system (Hoang *et al.*, 2009, Terry *et al.*, 2011). Nevertheless, an insight into the health risks of this heterogeneous population in Tasmania remains absent with a paucity of research especially in the rural context. This observed gap has been highlighted within the literature where very little research exists regarding health and the health risks of Asian migrants in rural communities. It is anticipated that the insights gained from this qualitative study presented in this paper will enhance the understanding of the lived experiences of these migrants. It will provide an improved understanding of primary health care and wellbeing issues faced by Asian migrants in other less dense community contexts.

Methods

Aims

The aim of the study on which this paper is based was to examine the views and perceptions of Asian migrants live in rural Tasmania with regard to health risk. Firstly, the study identified common themes through the lived experience of health risks with specific attention to factors such as smoking, alcohol, food and vegetable consumption and physical engagement. Secondly, the study examined how these health risks are manifested by this cohort within the Tasmanian context. This study not only provides insight into how Asian migrants in rural Tasmania perceive and deal with their lived experience of health risks, but also provides implications for enhancing health and wellbeing of this population. The study can open windows for future research nationally and internationally.

Study design

The study used an exploratory research design to comprehend what is occurring among the relatively small number of Asian migrants in Tasmania. This is to create a better understanding of key primary health care and wellbeing issues faced by Asian migrants in less dense culturally and linguistically diverse communities (Babbie, 2007). In addition, the purpose of an exploratory research design is to develop the feasibility and methods to undertake larger and more extensive research (Babbie, 2007).

This study adopted the qualitative approach to investigate and analyse the lived experience in health risks of Asian migrants when living in Tasmania. Like all qualitative research, this study does not provide evidence for generalisation to other similar populations. Its strengths lie in presenting the uniqueness of real life experiences of people in different social contexts and providing some deep understanding of the

multiplicity of human existence which cannot be captured in evidence-based generalisation of quantitative research. .

This study deals with the key conceptual notions and frameworks which underlie social research, involving acculturation, discourse practice, and meaning making. It examines the conceptual and socio-cultural problems facing migrants in a new cultural environment. Words and expressions in their native language such as ‘patient’, ‘medical advice’, or ‘patient’s right’ may have different meanings in English as word meanings are heavily embedded in their cultures and it is possible that their understanding of ‘equivalent’ English words can be influenced by language interference . In addition, their level of English literacy will interfere with their understanding of health concepts and issues in English communication. In relation to discourse analysis, it provides insights about social identity, hegemony, power relationship and social capitals which may facilitate or hinder migrants in their new life experiences. Access to health care, for instance, will depend a great deal on the discursive practice in a new cultural environment. Through the lens of phenomenology which emphasizes the significance of real life experience of individuals, this study examines how Asian migrants make sense of the new social and cultural realities in terms of health practices in the context of Tasmania.

Data collection

All participants were interviewed in a public place in English by one interviewer for at least half an hour.. Though English was used in the interviews, the interviewer occasionally asked the interviewees to clarify their understanding of some English words whose meanings may show different conceptions due to cultural differences. The participants were recruited through purposive snowball sampling of known contacts, social and employment networks. Inclusion criteria were individuals who have an Asian

background, have migrated (first generation migrants) to and obtained citizenship or permanent residency in Australia and are residing in rural Tasmania. Asian migrants who were on student visas or had refugee status were excluded from the sample, as their views and experiences would be extremely contrasting to those who have chosen to live in Tasmania permanently (Pernice, 1994, Guerin and Guerin, 2007).

The term 'Asian' is confusing due to the many and diverse ethnicities it entails. However, for the purpose of this study, it encompasses individuals from East Asian, Southeast Asian, and South Asian regions who were grouped together in this study due to the very small numbers living in Tasmania. Out of the 42 Asian migrants identified in the north, south and northwest of Tasmania, 36 agreed to participate in the interview.

The interview consisted of questions relating to demographic background, the participant's views and the differences observed in his/her home country and in Tasmania. This included questions relating to their own cultural health beliefs and behaviours including their view of health risk factors, such as smoking, alcohol, physical engagement, diet and the environment, both before and after migration. For example, 'Have your view and understanding of health issues changed since you came to Australia?' and 'Please share with me some misunderstanding or confusion about health issues facing you in your new life in Australia.' The final questions related to what could be done to improve the participant's health condition in Tasmania such as 'Please give your suggestions for how to help migrants to understand health issues and to improve their healthy living in Australia.' More in-depth questions were asked throughout the interview to gain greater insight into each participant's lived experience of and adapting to rural Tasmania and including issues or concerns which may have been raised, for example, 'If you are asked to give advice to new migrants on how deal with health issues and potential health problems in Australia, what would you tell

them?’ and ‘In what ways should your Australian friends, local community and health organisations do to help you to deal with health issues in Australia?’

A challenge to the recruitment process was snowball sampling which often proved ineffective. Those Asians living in Tasmania for more than 10 years whom the researcher first approached stated they did not know anyone or knew very few from an Asian migrant background. This further highlighted the disconnectedness of less cohesive culturally and linguistically diverse communities especially those living in Tasmania for longer periods (Gray *et al.*, 2007, Stafford *et al.*, 2010b). In addition recruiting male participants was challenging, as this demographic group cited work commitments and language barriers to inhibit participation. It was difficult to recruit and obtain participants with certain Asian communities such as the Bhutanese, although several attempts were made.

Ethical approval for the research was provided by the Social Sciences Human Research Ethics (Tasmania) Network prior to conducting the interviews. Each participant gave written consent to participate and to be voice recorded prior to their interview.

Data analysis

The voice recordings were transcribed, imported, coded and analysed using QRS-NVivo v8.0 software. The analysis attempted to reflect the identifiable themes and patterns of living and behaviour of participants’ experiences of health risks in their homelands including now in Tasmania (Van Manen, 1990). However, there is interplay between the emerging themes from the data and those embedded in some of the questions.

Demographic characteristics of the participants

The participants spoke varied degrees of English and were from 13 Asian nationalities. The average age of the participants was 40 years (range 19 to 72). They had resided in Australia for an average of 12 years and 9 months (range 7 months to 41 years) and consisted of nine males and 27 females. Eighteen of the 36 participants were married to Australian born partners who were of European origins with the remainder being single or married to a partner who was Asian and born overseas as outlined in Table 1.

Table 1. Demographic characteristic of the participants

	Participants (n)	Percentage (%)
Nationalities		
- Filipino	11	30
- Indian	6	17
- Chinese	3	8
- South Korean	3	8
- Vietnamese	3	8
- Japanese	2	5.6
- Malaysian	2	5.6
- Nepalese	1	2.8
- Hong Kong Chinese	1	2.8
- Indonesian Chinese	1	2.8
- Singapore Indian	1	2.8
- Sri Lankan	1	2.8
- Thai	1	2.8
Gender		
- Male	9	25
- Female	27	75
Age groups		
- 19 – 29	8	22
- 30 – 39	13	36
- 40 – 49	6	17
- 50 – 59	6	17
- 60 – 69	1	2.8
- 70 – 79	2	5.6
Years of residence		
- Less than 2 years	4	11
- 2 to 5 years	5	14
- 5 to 10 years	10	28
- More than 10 years	17	47
Marital status		
- Married to Australian partner	18	50
- Married to overseas born partner	9	25
	9	25

- Single		
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Schooling was also varied among the participants with 14 attained at least some or all of secondary schooling, 3 completed polytechnic training and 11 completed bachelor's degrees. Notably, 8 completed or were completing their doctoral studies. Most participants were employed, self-employed or studying at university. The exception was 5 Filipinos and 2 Malaysians who were 'stay at home mums' of which 6 had a partner who had employment and 1 had a partner who was not working at the time of the study. The 2 oldest participants are Indian and were no longer working as they had retired several years earlier.

Findings

Health concepts and issues are perceived differently according to a migrants' background and influenced by the depth of their experiences in a new environment (Salant and Lauderdale, 2003, Biddle *et al.*, 2007a). For example, some Vietnamese do not consider smoking, drinking as health risks as these habits are commonly accepted in Vietnam. This was reflected within the study, where the perception of health concepts and issues was varied among all migrants

Smoking as a personal habit and social phenomenon

Smoking was observed within this heterogeneous group as a social and cultural phenomenon. All participants understood that smoking is harmful to health. However the views towards this health issue varied. A number of participants commented that it was a cheap form of entertainment or a means to reduce stress. Many cited its harmful effects by personally observing family members who suffered its debilitating effects. Others cited they had heard that it was bad through western media or from friends, yet

many understood very little about the effects of smoking and passive smoking. One participant referred to smoking affecting each gender differently and another stating smoking affected blood flow.

There is a health risk involving smoking because... it affects the blood flow in the body. (Nepalese participant - – Mr Nischal)¹

Each participant commented and a number were even shocked at the observed cultural differences related to smoking when they moved to Tasmania. They stated that women smoked in more overt and public manners than women from their country of origin, where female smoking remained hidden or taboo. Smoking in their countries of origin was considered a significant social and cultural phenomenon, a masculine activity to be perpetuated only amongst men.

When a little boy is brought up and sees his uncles smoking and his dad smoking, ... he grows up, he thinks it is okay to smoke, but for the girls, my mum is not smoking, and no women around me are smoking and I don't think it is fine for me to smoke. (Chinese Participant - Mrs Lee)

The participants who were from more developed economies, such as Japan, Hong Kong, India and South Korea had a greater understanding of the effects and associated effects of smoking, but also remarked how smoking was becoming more popular among women and increasingly occurring in younger men. They felt this was the influence of western culture with their country becoming more westernised.

Nowadays the trend has changed even the women have started smoking... even the men are starting smoking earlier... so much of the changes in our culture is due to Western culture. They don't take the good thing that is the sad part. (Indian Participant - Ms Aishwarya)

¹ All participants' names used in this paper are pseudonyms.

Overall, none of the participants smoked at the time of the interviews and all participants were aware that smoking was not good for health. A number of younger participants had tried smoking prior to migration yet did not smoke after migration. Conversely the oldest participant in the study started smoking when he migrated to England. His reason for starting was that it was the socially acceptable norm. Nevertheless when he was made aware that smoking was harmful in the 1980s, he was resolved to cease smoking immediately.

Alcohol and health risks in an intercultural discourse

The health risks associated with alcohol were highlighted by all participants in conjunction with smoking. Two participants stated that alcohol was a drug and all other participants noted that alcohol was harmful when it was very strong or drunk in excess. As with smoking, many participants acquired their knowledge of alcohol and associated health risks by observing how alcohol consumption impacted on their family members' health. Many believed it caused liver problems in their home countries, but felt that Australians associated it with poor social behaviour.

Each participant had different behaviours in their use of alcohol, which varied from country to country and within countries. For example, the Korean participants were large drinkers in their home country, citing a culture of heavy drinking. The Filipino participants also saw drinking as part of the culture, but as a lower class habit. A mixed response was observed from the Indian participants. One did not drink due to family tradition; however he acknowledged that Hinduism influencing this tradition. Two others were Hindus and had strong family traditions as well, yet chose to drink occasionally.

Many participants felt that consuming a small amount of alcohol was acceptable. Many alluded to the health benefits of drinking small amounts of wine, however did not

understand why it improves health. These participants just knew alcohol was beneficial as they had read somewhere that science had proved that small amounts of alcohol maintained one's health.

Proper amount of alcohol can maintain health... I read articles a long time ago...It said a glass of red wine gives longer life. (Korean Participant - Mr Dae-Jung)

The younger participants from China and Korea had reduced their alcohol consumptions since migrating to Tasmania. A Chinese participant stated that he had become a Christian since moving to Tasmania and this was why he no longer drank. A Korean participant said that since moving to Tasmania, her friends, work colleagues and roommates were all non-drinkers and so she decided not to drink as well. The majority of participants from China and Korea cited that socio-cultural pressures in their home countries were the main reasons for excess drinking. They did not experience the same pressure once living in Tasmania.

All [the people] have to drink and if you don't, the others will pick on you, and say... you don't respect us... but here you don't have this kind of thing. People drink because they want to... no social pressure. (Chinese Participant - Mrs Lee)

In general, most participants drank very little before coming to Tasmania and their behaviours had not changed after arrival. One participant commenced drinking alcohol after arriving in Tasmania, yet still recognised herself as a non-drinker.

Food and its dietary and cultural manifestations

Health risks relating to the dietary intake of food was a popular topic and participants expressed different views about dietary intake. Many participants had stopped eating rice and a number did not eat traditional foods any longer. The participants who were older were less aware of the benefits of healthy eating, but continued with their cultural

practices or religious observance of healthy eating.

Younger participants were more likely to recognise and articulate the health risks associated with food; nevertheless, their behaviours were paradoxical. Most attempted healthy eating, but were less likely to eat healthily. This occurred, particularly when food consumables such as meat, sweets, chips and other processed foods were available.

When I was in China, my main food is rice and a little bit of meat. Since I came to Australia, beef steak is the main food for me. I used to like frying food, just like barbeque stuff in China... but now I don't like frying food anymore. (Chinese Participant - Mr Chan)

I have more meat because my husband is a local. There always has to be meat. It is a lot of work but that is what happens. When I get anything from the butcher, I cut away all the fat. (Hong Kong Participant - Mrs Wang)

Here... there are very sweet desserts, which I like, but very sweet and the portions are really big. Whenever I go to a party or something, they make massive portion of meat... it's ridiculous. (Korean Participant- Ms Eun Jung)

Many cited the lack of variety in food and familiar ingredients in Tasmania compared to mainland Australia or even their home countries. In contrast, one participant from rural China stated that the variety of food was greater in Tasmania. The participants' views regarding a lack of food variety in Tasmania forced what they felt were poorer food choices. One Korean participant stated that food in Tasmania was often more salty and sweet, yet a Filipino participant stated that it was less salty. Another Filipino stated that there was so much dairy food available that it really affected her health. A Nepalese participant stated that he never had refrigeration until having migrated to Tasmania and yet, 20 years later he continued to refuse to refrigerate

leftover food. In addition, he also said that when he first came to Tasmania, he noticed the difference in the availability of food, which he said was exciting.

I grew up in Nepal eating organic food and... wholesome food. I mean in the beginning you see all this packet food you know, [fast] food and it seems exciting, but I don't think it is that great for general health. (Nepalese participant – Mr Nischal)

Overall each participant attempted to eat healthily, even though they felt their food choices were limited. Most participants' diets had changed since migration. For example, many no longer were eating rice regularly; some were eating larger portions or eating more sweet and processed foods. Consuming western food such as fast food was highlighted as a poor health choice by all and was rarely if at all eaten by any of the participants at the time of the interview. Interestingly, no participant discussed why eating healthily was important or what the consequences of poor eating habits were.

Physical engagement in a new cultural environment

A number of participants highlighted that their awareness and participation in physical engagement only commenced after they had moved to Tasmania. All participants were aware of the health risk associated with the lack of physical engagement, such as obesity or diabetes. Most were engaged in some form of regular or sporadic physical engagement from skate boarding to swimming, tennis and walking.

My view has changed towards sport. In China, I never thought sport as so important, I thought I'm not doing it and no one else is doing it... but now people value sport so much and they think it is so important and it's part of healthy life. If I haven't been walking for two or three days, I feel guilty which I never had when I was in China. (Chinese Participant– Mrs Lee)

The participants felt that a number of factors contributed to increased participation in physical engagement in Tasmania. This related to the environment in which they lived. Many viewed that Tasmania has a greater relaxed lifestyle which allowed them more time to take part in physical engagement. In addition, the physical environment was observed to contribute to the participants' wanting to engage more physically.

In Hong Kong, I did not exercise that much because of long working hours and it is a city. During the weekends, you either go to the shops or restaurants and meet friends. There are not many opportunities for physical exercises. I have considerably more physical activities since I have been here because of the environment here is... so close to nature. (Hong Kong Participant – Mrs Wang)

Inhibiting factors which prevented participants from increasing physical engagement were related to being unaware of what activities are available. This included being unaware of where to go for physical engagement, participating in physical engagement alone, the cost of physical activity participation and the perceived dangers associated with some physical activities such as swimming at the beach.

Environmental impacts on health

Each participant commented on how the place in which they lived affected their health. The majority did not comment on 'place' itself affecting health but rather commented on how the change in environment had improved their health or that they felt healthier since migrating to Tasmania.

Those who moved from more developed countries said it was less congested and this they felt had improved their health. The majority of the participants moved from more developed countries which have heavy industrial works in close proximity to villages, creating air pollution or chemicals in their immediate environment. Others

stated that their home countries and towns had poorly maintained or non-existent infrastructure, which created environmental health hazards, such as unclean drinking water and raw sewage on the streets in the rainy season when flooding occurred.

Tasmania... hasn't been exposed to pollutions and is still very much nature itself and I think this environment helps people to maintain their health. (Korean Participant - Mr Dae-Jung)

Two participants cited various negative issues with the Tasmanian environment which they felt had impacted their health after they migrated. This was highlighted by an Indian participant and a Nepalese participant who said there were an increasing number of cars in Tasmania. Another issue was related to the wood fire smoke pollution which was causing illness in one of the Korean participants.

Tasmania, you can say it is most beautiful country... except the winter is terrible, not just cold, because of the valley here and the people tend to use wood fire and actually is worse than industry smoke feeling. Actually I feel really terrible even walking outside I can smell and... I tend to react quickly... I can't breathe properly, but I never had that sort of feeling in Korea... it's actually shocking because I live in a rural area, but I still get polluted air. (Korean Participant – Ms Eun Jung)

Discussion

It should be noted here that the paper has a large sample of higher educated participants and this may influence perspectives and conclusions from the data. Smoking and alcohol consumption is not just an individual habit but collective social practices, which are significant social and cultural phenomena. Smoking and alcohol consumption transforms individuals or maintains an individual's social identity. These behaviours provide cultural discourse when collective patterns of consumption are a common feature (Glenn, 2004, Poland *et al.*, 2006). Cigarettes in particular are an important part

of the social and cultural tradition within many Asian countries, such as China and Vietnam where smoking consumption remains acceptable in the male population both in rural and urban communities (Lê and Lê, 2005, Chen *et al.*, 2009).

Behaviours such as physical engagement are also provided by cultural discourse when collective patterns of experience occur (Glenn, 2004, Poland *et al.*, 2006). However within many culturally and linguistically diverse groups in western societies, physical engagement remains limited due to ‘cultural and religious beliefs, issues with social relationships, socioeconomic challenges, environmental barriers, and perceptions of health and injury’ (Caperchione *et al.*, 2009:167). In addition, many Asian cultures have a sociocultural discourse and a view of fatalism over their current and future health (Mellin-Olsen and Wandel, 2005, Lawton *et al.*, 2006, Higgins, 2009). Nevertheless a change of environment necessitates a modification in behaviour. When successful modification in behaviour becomes part of cultural practice, it then is transferred to future generations (Glenn, 2004).

The health risk behaviours and views on health continue to be influenced by a migrant’s cultural or religious practices, language or cultural identity. At times this has been fused with the selective and sometimes obligatory adaptation to their new environment (Rudan, 2006, Zanchetta and Poureslami, 2006, Van Hook and Baker, 2010). In general, all participants were aware of the health risks; however, very little was understood about the effect certain health risks would have on health. Many just knew that health risks were to be avoided to ensure and maintain health.

Nevertheless, the collective social practice such as smoking, alcohol and food consumption, of the studied participants, had altered and so their behaviours had changed after migrating to Tasmania. The health risk behaviours observed in the study include a reduction in consumption alcohol, increase in physical activity and a change

to a more western diet. The findings resemble much of the literature. For example, in other rural and remote regions of Australia, migrant communities continue to be small, and sparse and many cultural health risks beliefs and behaviours also thrive less easily (Fuller and Ballantyne, 2000, Rao *et al.*, 2006, Gray *et al.*, 2007, Stafford *et al.*, 2010b).

In general, many participants in the study were aware of and recognised many non-communicable health risks, yet did not possess the health literacy to interpret or articulate why following or avoiding certain behaviours was better for health (Zanchetta and Poureslami, 2006). This is in contrast to the literature which states Asian migrants in less dense culturally and linguistically diverse communities are less aware of the non-communicable health risk (Gray *et al.*, 2007, Stafford *et al.*, 2010b).

In this paper we have highlighted these communities' awareness that health risks are to be avoided to maintain one's health (Rochelle and Marks, 2010). For example, many did not understand why avoiding smoking, improving a poor diet, drinking small amounts of wine or regular exercise was good for health, they just knew it was good. This reflects many Asian cultures where health is vital and a central feature of the cultural system (Lê and Lê, 2005).

The geographical isolation of Tasmania and the change in place had improved health for many participants (Godkin, 1980, Rudan, 2006). For example, all participants commented on the environment in some way affecting their health positively or negatively. The majority commented positively on how Tasmania's environment, especially the air quality, had improved their health or that they felt healthier in Tasmania. These findings are in contrast to much of the literature regarding the 'healthy migrant effect' where migrant health status is high upon migration which then declines over time. This being attributed to 'the uptake of unhealthy lifestyles including poor dietary habits, smoking, and/or drinking, upon settlement in the host

country... ’ (Newbold, 2005:1360). It must be noted this decline in health has a propensity to be observed over decades, of which nineteen participants (n=19) had been in the country for less than 10 years, which may explain this inconsistency within the findings (Frisbie *et al.*, 2001, Newbold, 2005).

Other environmental factors which were highlighted by the participants from more industrialised countries were related to prolonged stress through work or home which also affects health and wellbeing. Only one participant had several concerns with local police, government and neighbours. This created great stress and anxiety and this participant still felt a sense of up-rootedness, a sense of not belonging to ‘place’ (Godkin, 1980).

The majority of the participants stated that their views on health had changed since migrating to Tasmania. A number of younger participants had not really thought much about health issues: they stated they had never become sick. However, they recognised they had less illness since moving to Tasmania. Participants from better developed countries, such as Hong Kong, Japan, Malaysia, Singapore and South Korea and one Filipino felt they would be healthier on mainland Australia as there was better or an increased number of options for keeping themselves healthy including maintaining a better diet.

The length of time for migrant views to change is dependent on the individual. A Filipino participant stated that it took over 15 years for her views regarding health risks and health to change and she still felt that she had trouble navigating the health system whereas another Filipino participant stated that it took 3 years for her views regarding health to change. This change coincided with the birth of her first child, whereas other participants were quicker to observe a change in their views about health and health risks.

Each participant had some understanding why they were healthier once moved to Tasmania. This ranged from the change in the environment, acculturation to the lifestyle and adopting the views of the local population. One participant highlighted concisely what many had said throughout their interviews: The greatest change for her was the change in pace and lifestyle when coming to Tasmania. This positive development is helpful to them in coping with some challenges or risks posed by the new living environments.

Future research issues The health risk behaviours of Asian migrants were examined with physical engagement and food consumption highlighted to be the two predominant risk factors greatly influenced by migration to less dynamic culturally and linguistically diverse communities (Mellin-Olsen and Wandel, 2005, Wandel *et al.*, 2008). Migrants participating in more physical activities however found a lack of choice and the inhibitory cost of physical activity participation influenced their behaviour. In addition, migrants were attempting to eat healthily in a number of ways after they had migrated, yet felt their food choices were limited which reduced the ability to maintain this behaviour. These issues provide direction for developing primary health care and wellbeing for Asian migrants in less dynamic and diminutive culturally and linguistically diverse communities.

Future research and primary health care initiatives are required in less dense culturally and linguistically diverse communities. This is to further identify and promote the acculturation of positive health behaviours and reduce the adoption of negative non-communicable health risk behaviours of Asian migrants who live in less ethnically dense communities. The second priority remains to further investigate and improve the health literacy of Asian migrants and their understanding of the health system in a new cultural environment. This may aide and improve migrant populations to develop their

health potential and benefit from healthier decision making after they migrate (Zanchetta and Poureslami, 2006).

In terms of research methodology, it would be a challenge for future research dealing with health risk to move further beyond the traditional structured and semi-structured interviews in such a way that the researchers can comprehensively examine the depth of intricacies and complexities of lived experience of migrants in a new cultural environment such as genuine conversation and narrative construction. However, this approach is useful only when language barrier is not presenting the data collection process.

Conclusion

Research concerning the lived experiences of Asian communities in large Australian cities has received great attention. To date, very little comparable research has been conducted regarding the lived experiences of Asian migrants in Tasmania.

This paper has demonstrated that the health risk beliefs influenced by a migrant's cultural identity had selectively or obligatorily changed with the new environment. In addition the social practices of the participants resembled much of the collective social practice of their new communities. The research provides valuable insights about health risks in real life experiences. The outcomes create a stepping stone for further research by adding to existing knowledge related to the tenet of phenomenology which views the world of lived experience. This is a small study where the findings and conclusions cannot be generalized as pointed out previously in the paper. As a qualitative study, it provides an insight into Asian migrant's views towards certain health risks in less dense culturally and linguistically diverse communities, such as Tasmania. In addition the exploratory research has provided an understanding of the

broader issues regarding the interaction of human lived experience and sociocultural discourses. It is recommended that larger and more extensive research should be undertaken.

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