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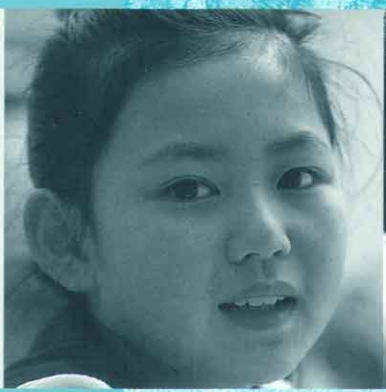
HEALTH EDUCATION AUTHORITY

THE HEALTH BELIEFS OF THE CHINESE COMMUNITY IN ENGLAND



A qualitative research study

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The aims of the present study were manifold. Our explicit and immediate objective had three inter-related dimensions: firstly to explore the structure and content of Chinese social representations of health and illness and to investigate how these shape health practices; secondly to examine how these representations impact on the acquisition and use of new biomedical knowledge; and thirdly to identify the main concerns and difficulties experienced by Chinese people in England when they use various health resources. More generally, we wanted to offset the scarcity of knowledge about the Chinese community and to offer some guidelines, based on in-depth qualitative analyses in order to develop more culturally sensitive policies. The set of representations and practices brought to light in this study illustrates how the Chinese community in Britain makes sense of and relates to issues of health and illness in everyday life. The findings add further support to recent calls from the community to have their needs researched. They suggest both general principles and specific activities through which health-care services and educational campaigns for the Chinese community can be made more effective.

7.1 Main findings

In this concluding section we highlight the findings which relate to our main objectives. We also single out those issues which are of direct import for both researchers and practitioners whose work brings them into close contact with the Chinese community and, more broadly, for anyone interested in the social psychological dimensions of health-related knowledge and practices. Finally, drawing upon this rich research experience, we make a number of recommendations of a methodological nature to facilitate the work of future researchers.

Diversity and unity in the Chinese community

The study highlights both the heterogeneity and the unity of the Chinese community in England. The community comprises three generations, each of them bearers of distinct life experiences. The **older generation** includes the first settlers as well as the parents of the middle generation who later joined their children in England. The vast majority come from the New Territories in Hong Kong. They speak little or no English and live within the confines of the Chinese community. Low integration

and isolation are typical of this group. They hold on to an unquestioned Chinese identity and to traditional understandings of health and illness. The **middle generation** is the most diverse. It encompasses the children of the early settlers as well as newcomers from many Chinese communities. Some members of the second generation are highly integrated in British life (they are fluent in English and are often highly educated professionals), whilst others remain cut-off (they speak little or no English, are often poorly educated and are involved in the catering trade). The former group combine Western and Chinese health beliefs and make full use of NHS facilities. The latter hold on to traditional health beliefs and practices and they are more likely to turn to traditional healers and remedies. Finally, the **young generation** encompasses growing numbers of British-born Chinese (children and young adults) as well as foreign students. All are at least functionally integrated in British society. They speak English and have generally attended English schools. However, for most, reconciling the divergent expectations of Chinese and Western cultures proves a challenge. Their health beliefs and practices reflect this ambivalence and struggle: although they make full use of NHS services, they also combine the latter with traditional health practices.

Researchers, health education agencies, community workers and medical staff ought to recognise this diversity and differentiate between the various segments of the community. This entails becoming aware of the differences in the languages people understand, speak, read and write. For instance, a Chinese person may well speak a particular dialect at home (such as Hakka or Hokkien), but read only Mandarin or Cantonese, and write no Chinese language at all. Sometimes, too, English is the only common language among Chinese people of different national origins. Bearing this in mind, all the material produced for the Chinese community must be bilingual, combining English together with the most suitable Chinese form for the specific target population. This is both an essential mark of respect and a strategic communicational tool. Discrepancies in lifestyles, educational achievements and socio-economic positions must also be acknowledged. Standard, undifferentiated health-care provision is not the royal road to equality of access to health and welfare services. Increased sensitivity to diversity is more likely to result in the efficient use of health resources as well as better community relations. Therefore there needs to be:

- differentiation between sub-groups and profiling of target community;
- sensitivity to linguistic, socio-economic and lifestyle diversity;
- production of bilingual material with appropriate written Chinese form.

Chinese values

The unity found in the Chinese community stems to a large extent from shared values and norms. Indeed, our study corroborates other research on Chinese communities around the world, showing that a number of core values are still very much alive and embody the essence of Chinese culture. These are: first and foremost, the respect and belief in the family as the most important unit of social and individual life; deference for and compliance with hierarchy in terms of age, gender, generation and social role; and the importance of self-discipline, hard work and the maintenance of high moral standards. These values structure the Chinese division of labour both inside and outside the home, placing authority and formal knowledge firmly in the hands of elderly people, men and the educated, and leaving women inside the house responsible for everyday care and the perpetuation of lay knowledge.

This traditional social structure has immediate implications. It suggests that actual medical encounters, as well as health education campaigns, are more likely to be successful if they respect traditional roles, at least among the older and middle generations. It also suggests that health information about specific issues, such as nutrition, smoking, the practice of safer sexual relations and so on, will be appropriated very differently by the various segments of the Chinese population. It probably also accounts for the unreasonable demands put on young children to act as interpreters for their parents and to mediate between the latter and the host society.

This collectivist social structure is also evidenced in the widely held view that the community as a whole ought to be self-reliant and to cater for its members. Thus the relative silence of the community should not be interpreted as a straightforward reflection of some unproblematic state of affairs, but rather as the expression of a people proud of its culture and grateful to the host society. Since reaching out for help is often regarded as shameful, it becomes incumbent on British health authorities to initiate contact with the Chinese community and seek out its views. This could be enacted, for instance, through the development of more extensive networks of visiting nurses, or via the provision of self-help facilities for the community. There needs to be:

- awareness and respect of Chinese cultural heritage and values;
- respect of traditional social roles in health promotion material and medical encounters;
- a proactive approach to seek out the views of the community;
- provision of adequately trained interpreters;
- development and use of community resources.

The structure of Chinese health beliefs

Traditional Chinese medicine holds that good living habits are important in preventing disease and maintaining health because they help the organism to keep an internal balance and to adjust to changes in the natural environment. Such notions form the substantive core of the representations found in our study. The binary oppositions between yin/yang, hot/cold and wet/dry are at the centre of a conceptual system used to explain the nature of health and the causes of illness, as well as to identify adequate treatment. Health is conceived as the harmonious balance of these contradictory forces or conditions, while illness is an expression of disruption in this equilibrium. Balance and harmony must prevail at the level of the individual (body and soul), and between the individual, the social, the natural and supernatural domains. Routine and discipline are essential to good living. Thus Chinese health beliefs are deeply entrenched in a world view.

Perhaps we can learn from these all-encompassing representations of health and illness which intrinsically relate health with lifestyles, social networks and environmental conditions. Less individualistic notions of health and illness are only now becoming accepted in the West. The Chinese have much to contribute to current debates about health-care: openness to their ancestral knowledge and practices may result in better quality service provision and sounder health for all. However, the Chinese representations of health and illness do not foster the take-up of preventive health measures. Considerable educational work will have to be undertaken for the Chinese to integrate Western notions of prevention. The task will be greater still when preventive practices, such as cervical smear tests, are also shrouded in cultural taboos. There needs to be:

- openness to the more holistic Chinese approach to health;
- appreciation that traditional Chinese health knowledge is a resource;
- recognition of lay understandings and diagnoses by medical staff;
- use of notions of balance and harmony in framing health messages;
- education about Western medical preventive measures.

Health and cultural identity

It is clear from our study that, for the Chinese, representations of health and illness cannot be separated from a struggle to maintain a Chinese identity and cultural inheritance. Everyday knowledge about health and illness is learned, transmitted and enacted through the most fundamental dimensions of culture: **language**, **food** and **family**. The ancient knowledge Chinese people possess about keeping well is perpetuated in parallel with the perpetuation of Chinese culture itself. This explains why this knowledge will not disappear: to relinquish traditional health beliefs is virtually impossible without fundamentally threatening one's identity as a Chinese person.

Again, this intrinsic connection between health, the entire Chinese way of life, and the personal and social identity of every Chinese person, calls for increased sensitivity and respect. Disregard for the very long tradition of knowledge that Chinese people have about health and illness is experienced by them as disrespect for themselves and for a rich cultural heritage. It should come as no surprise that even young, educated, acculturated, English-speaking Chinese people should seek to keep alive their traditional health knowledge: it is an important resource to maintain, state or reclaim a Chinese identity when other sources of identification are no longer relevant or available. There therefore needs to be:

- recognition of the meaning of health beliefs in terms of identity;
- recognition of health beliefs and practices as expressions of cultural wisdom and history;
- recognition of the importance of Chinese people in the health service and use of Chinese models in health education posters and videos.

The coexistence of Western and Chinese notions of health and illness

Our study suggests that Chinese people can integrate different systems of knowledge and incorporate new information coming from different traditions. This appears to be a function of the Chinese mode of thinking, which itself can absorb and transform new information without losing its essential features. The idea of complementarity between opposites allows for the simultaneous use of different resources; it empowers the Chinese to cope with an alien environment.

The ability to integrate knowledge varies according to age and degrees of acculturation in mainstream British society but it is present throughout our sample. Chinese people will take on new information and either anchor it into their system of thinking about health and illness or allow it to exist side by side with their prior knowledge. This is made possible because, according to the Chinese way of thinking, Chinese and Western health beliefs belong to different realms and therefore do not compete. One believes and trusts in Chinese medicine. Western medical knowledge, by contrast, is grounded in science: it is open to proof and challenge and, by its very logic, challenges beliefs. Rather than turning these systems into mutually exclusive domains, the Chinese reconcile them in order to suit their different purposes and needs. There needs to be:

- awareness of potentially negative forms of anchoring Western medical knowledge;
- use of potentially fruitful forms of anchoring.

The combination of health practices

The feature of Chinese thought discussed above accounts for the finding that Chinese people combine the health resources available to them irrespective of whether they are rooted in Chinese or Western medical traditions. This result corroborates studies conducted throughout the Chinese Diaspora which describe the so-called 'Chinese pragmatism'. Yet we have found that the combination of practices is not random; it is guided by deeply-held health beliefs. Chinese medicine and folk observations are used in everyday life in order to maintain good health and to prevent illness; they are also used to treat minor conditions or ailments for which traditional or folk aetiology is widely endorsed. Moreover, the Chinese believe that their traditional knowledge is better equipped to handle the roots of disease which, in turn, explains why it works slowly. Conversely, the Chinese will use the Western treatment regimen in order to alleviate acute pain, to reduce symptomatology or to cure severe and life-threatening illnesses. In addition, they will draw upon Western medicine when the aetiology of disease is unclear and not established by classical Chinese medicine. Finally, both systems will be used to compensate for the limitations or failures of either; in other words, they are both used as 'last resort' when the other system does not work. This is a general pattern in our sample. There needs to be:

- explicit inquiry from health professionals into simultaneous health practices.

The transmission of knowledge

One of the most important findings of our study concerns the mode in which knowledge is transmitted in the Chinese community. Although language is deeply involved in the transmission of knowledge by virtue of the conceptual categories it carries, it is not actively used in order *to explain* practices and beliefs. The Chinese objectify: they put what they know and believe into action and language, into community rituals of all kinds, which appear as repositories of the ancestral knowledge and wisdom of the Chinese people. They learn by observing what others in the community do mainly inside the home. Mothers and grandmothers are the main agents through which social knowledge is transmitted: prescriptions and prohibitions concerning diet, behaviour and social relations are handed down and learned through their practices. This has serious implications for the understanding of how the Chinese know: their knowledge system is alive in what they do rather than what they say. Anyone researching the Chinese community should be aware that practices are the best means to understand a conceptual system whose origins and principles are often lost to those who, nevertheless, know how to put it to work. This will be

discussed more extensively below, as we turn to methodological issues. There needs to be:

- selection of the most effective agents (women/men, local/national) for health education;
- focus on practices and actual behaviour rather than abstract explanations.

Use of primary health care services

Although Chinese people do make extensive use of Western health resources, a number of factors still impede the full and most appropriate use of NHS resources by them. Lack of information about the functioning of the NHS and the range of services available is still widespread. This is particularly true for services which, until recently, had no equivalent in Chinese cultures, such as social work, and for services which are associated with cultural taboos, such as counselling and psychotherapy. There is an urgent need to produce basic material which describes and explains the British health-care system in a clear and simple way. Inconvenient opening hours for those who are involved in the catering industry, together with linguistic barriers and a shortage of qualified interpreters, also account for the reported under-utilisation of NHS services.

Notwithstanding the overriding importance of such barriers we need to stress the role of cultural differences in determining the evaluation which Chinese people make of Western health services. Our data suggest that, while the level of satisfaction with Western health services is usually high, lack of sensitivity to cultural realities is relatively common and affects the overall appraisal of the services. For instance, foreign-born Chinese patients are used to a different operational system in the delivery of health-care. Their previous experiences shape what are often unmet expectations: consultations without prior arrangements, the systematic prescription of medicines, thorough bodily examinations by doctors, submission to a battery of tests and time dedicated to the patient, are all part and parcel of patient-doctor encounters in Chinese countries. Not surprisingly Chinese people expect similar practices to take place in England. Failure to behave in expected ways leads to frustration and to negative evaluations of health-care delivery in the UK. Moreover, the participants report important differences both in moral codes and norms and in ways of expressing or describing physical pain and psychological distress. These are often misunderstood, thereby impeding full communication. There needs to be:

- production of educational material describing and explaining NHS services;
- anchoring of services with no formal equivalent in Chinese cultures into similar, already-existing services;

- education of health practitioners about different expectations in medical encounters;
- provision of qualified interpreters;
- opening of clinics at more suitable times where there is a large concentration of Chinese people.

7.2 Methodological recommendations

In addition to the substantive issues summarised above, general methodological guidelines emerge from our study. Some recommendations are very broad and applicable to any research on the Chinese community; others focus more specifically on health issues. Our intention is not to engage in a detailed methodological discussion but only to communicate the fruits of this research experience to others interested in pursuing further some of the issues discussed in this study.

Let us reiterate, first, that there are both advantages and disadvantages in using researchers who do not share with their subjects a common ethnicity, age, gender, religion, socio-economic background or sexual orientation, for example. Complete matching is no more a guarantee of understanding than complete difference is one of objectivity. Empathy and critical stance can coexist. The respective strengths of both similarity and difference ought to be balanced against one another with a clear awareness of their consequences in terms of the research questions themselves. In this case, non-Chinese researchers worked together with a Chinese research-assistant to maximise the validity of field efforts and to minimise the reactivity inherent in each choice of researchers.

It is also important to emphasize the merits of triangulating, or combining, various methods of data collection and analysis. Again, the research design should reflect the theoretical considerations informing the research process, the practical circumstances structuring its execution, the characteristics of the empirical problem and the kinds of analyses which each method can potentially yield. Here, the research design allowed us to tap into both lay and expert knowledge and to do so at the level of the individual as well as that of the group. We were interested in the structure, content and functions of social representations of health and illness; these are to a large extent taken for granted, so a combination of both lay and more reflexive expert knowledge was necessary.

We used open-ended questions which allowed the subjects plenty of scope to explore their own thoughts and feelings, and to expand on the shortlist of themes singled out beforehand in the interview and focus group schedules; but such a research strategy, alone, cannot provide a sufficient basis for policy makers. It ought to inform, and to help make sense of, large-scale quantitative surveys. Conversely, the limitations of

closed questions and coarse survey methods were also clearly alluded to. One may recall the rationale offered by women for giving up the practice of breast-feeding, or the case of this older woman who claimed, on the one hand, that because of irregular eating times, her 'stomachs were grinding', thereby causing ulcers and, on the other hand, that she did not believe in Chinese medicine at all.

In terms of gaining entry into the community it is best to use existing organisations, associations, community centres, churches, student unions and the like, and to build on initial contacts through snowballing and 'foot-in-the-door' strategies. Again, the diversity which is characteristic of the Chinese community ought to be acknowledged and to inform research practices. In addition, in reaching out to the Chinese population, researchers ought to be mindful of the geographical dispersal of the community: because of its continuing involvement in the catering industry, and in order to avoid competition, the community is particularly spread out across the country. Generally, it is highly desirable to prepare bilingual material, with the most appropriate written Chinese form being selected for the specific segment of the Chinese population targeted.

With respect to health issues in particular, the following methodological recommendations are put forward. First, the terminology used in questionnaires and surveys should always be piloted beforehand because Chinese people may refer to the same medical condition in very different ways. For instance, they may refer to 'arthritis' either by using the English word, or by using the modern Chinese literal translation ('inflammation of the joints'), or again by using the classical Chinese terminology ('wind-damp') which already proposes an aetiology of the condition. Second, the emphasis should always be placed on symptoms rather than on more complex diagnoses. There are already many differences in the ways Chinese people describe their physical condition compared to British people. Greater distortions and sources of misunderstandings can be avoided by reducing the scope for interpretation. Similarly, surveys should focus on practices and behaviours rather than on concepts, knowledge or beliefs which, in any case, can be more adequately explored through open-ended research methods such as interviews and focus groups. Finally, we have learned that it is preferable to avoid references to ill health and to emphasize well being instead because older and less-educated Chinese people tend to be superstitious and to believe that talking about poor health could suffice to bring about disease.

7.3 A final word ...

Researching the Chinese community has been an enriching and rewarding experience. Despite the difficulties associated with accessing lay members of the community, and despite the fact that we are non-Chinese researchers, the people we met were prepared to engage with us and to talk about their experiences in an open and genuine manner. They welcomed us, talked to us and even cooked for us, which in itself is indicative of their desire to state what they think and who they are. We invited them to discuss issues largely taken for granted and often embedded in painful life experiences. They took our invitation up and worked through these issues and experiences with us.

The stability and maintenance of the Chinese belief system owes a great deal to its apparent simplicity and to its ability to make sense efficiently and usefully of complex and diverse experiences. As Anderson writes '... it is simple and it encodes or allows for encoding a great deal of useful information. It is easily taught and easily learned. It does serve as a useful vehicle for storing the collective knowledge of a large group of people' (Anderson, 1987: 334). The Chinese health belief system has survived and also continues to thrive because it is linked to the identity and collective memory of the Chinese people. For all these reasons, health professionals and health education agencies must take seriously the Chinese way of thinking about health and illness.