The Health of the Chinese Community in Dudley

A Report on

A Health & Lifestyle Needs Assessment

Carried Out In Autumn 2007

On behalf of the Dudley Chinese Community Association

在2007年秋季進行的

健康及生活模式需要評估報告書

Dudley Metropolitan Borough Council

得利華人會 DUDLEY CHINESE COMMUNITY ASSOCIATION

NHS Dudley

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SUMMARY

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Section 2 Outlines the methodology employed in carrying out the research with particular reference to the development of a bilingual tool, the sample frame used and the process of analysis.

Section 3 Presents the survey findings with regard to response rate and demographic profile of respondents. Interpretation of quantitative and qualitative data on health issues related to physical activity, healthy eating, alcohol and smoking, emotional health and wellbeing and access to services is discussed in sub sections respectively.

Section 4 Discusses results of the survey in the context of national guidance and key health promotion messages. The section concludes with key recommendations for each of the health improvement programme areas of physical activity, healthy eating, alcohol and smoking, emotional health and wellbeing and more generically, in relation to access to health and social care services.

Section 5 Describes progress made on health-related work after the study and evaluates an outcome as a result of the partnerships developed during the research process; delivery of the Expert Patients Programme in Cantonese for the Chinese Community in Dudley.

Section 6 Provides a list of references used and **Section 7** includes the appendices as relevant.

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1 INTRODUCTION & BACKGROUND

This health and lifestyle needs assessment of the Chinese community in the borough of Dudley was undertaken in November 2007 on behalf of the Dudley Chinese Community Association (DCCA) by the Public Health Directorate of Dudley Primary Care Trust (DPCT), in partnership with staff from the Race Equality & Communication Service of Dudley Metropolitan Borough Council (DMBC), who were supporting the organisation.

The DCCA (see Appendix 1) was officially launched on 8 September 1997, in the presence of the Mayoress of Dudley, Councillor Mary Hill, together with other officials from Dudley Metropolitan Borough Council. The objective of the Association was to encourage the Chinese community to get involved and participate in social, educational and most importantly, cultural activities. The DCCA aim to support their community by:

- Promoting friendship and reducing isolation
- Supporting and caring for the community and their families
- Promoting the facilities available for social care

1.1 Rationale

The Chinese community are well established in Dudley Borough but there is very little local information available on their specific health related needs.

Over the years, the Health Inclusion Programme within Public Health (DPCT) and colleagues from the Race Equality & Communication Service (DMBC) have worked with local minority ethnic communities to identify and support their health and social care needs respectively. The strong relationship established through this network of workers working with minority ethnic communities has enabled community groups and organisations to express their needs in an informal way.

The DCCA expressed a need for information about their community's health and lifestyle so that they could better represent the needs of the community and use this knowledge to apply for funding to further develop support through their own organisation.

From the public health perspective, the health improvement programmes related to physical activity, nutrition, smoking cessation, alcohol, mental health promotion and community health improvement all expressed a need for more information about local specific minority ethnic groups so that needs could be better planned and integrated and uptake improved.

The local authority interpreting service found that the social care support they provided to clients from minority ethnic communities often resulted in supporting issues related to access across primary and secondary health care provision. This was further evidenced by the Chinese Community Centre in Birmingham (see Appendix 1) who reported that they regularly received requests from members of the Chinese community in Dudley, mainly to provide interpreting support for their local hospital and GP appointments, thus indicating a lack of awareness amongst the Chinese community of services available in the borough of Dudley.

1.2 Aims of the Project

These factors determined the need to carry out a basic health promotion needs assessment, with two specific aims:

- To develop a baseline of information on health and lifestyle issues related to the Chinese community in the borough of Dudley
- To identify specific needs with regard to communication, access and information

1.3 National Picture and Context

In the UK 7.9% of the population belong to non-white ethnic groups (National Statistics: 2001 Census Data). Of these, 5% are Chinese (which is 0.4% of the total UK population) and this makes them the fourth largest minority ethnic group in the country, after Asian or Asian British (50%), Black or Black British (25%) and Mixed (15%), respectively.

Chinese people in Britain come from mainland China, Malaysia, Hong Kong, Singapore and Vietnam and use a diversity of languages such as, Cantonese, Mandarin and Hakka. Earliest communities were established here over a 100 years

ago when Chinese seamen settled in the dockland areas of major seaports like Liverpool and London, changing their trade to the laundry or catering business. During the war these communities dwindled but, after the 1948 British Nationality Act, many Chinese immigrants came from Hong Kong and were later joined by their relatives and friends. Since the 1950's, there has been a steady increase of Chinese people, reflective of the political and global changes affecting their countries of origin (i.e. the arrival of 'boat people' from Vietnam in the 1970's), to make up the diverse Chinese community we know today in Britain.

Over the years, some research studies have highlighted key issues and identified health related needs relevant to the Chinese community in this country.

Health and Lifestyle

Inequalities between ethnic groups have been well established over the years and we know that people from minority ethnic groups are generally more deprived and that the health experience of different groups is not the same (APHO 2007). However, with regard to the Chinese ethnic group, some of the determinants of health indicators highlight some positive aspects:

HEALTH INDICATOR	**FINDINGS RELATED TO CHINESE ETHNIC GROUP**
National Statistics Socio-Economic Classification	Have the highest percentage of full-time students
Eligibility for Free School Meals (FSM)	One of the groups with lowest eligibility for FSM
Educational Attainment	Achievement is highest of all minority ethnic groups
Ill Health	Have the lowest *'not good'* health in every region of England

Sproston & Mindell (2006) explored the key findings related to the health of minority ethnic groups from the Health Survey for England in 2004. With regard to the Chinese ethnic group they found that:

- Self-reported cigarette smoking prevalence was 21% for Chinese men and 8% for Chinese women which was lower than the general population at 24% for men and 23% amongst women respectively.

- More than 50% of Chinese men and more than 65% of Chinese women did not drink at all in the week prior to the interview. Virtually all minority ethnic groups are more likely to be non-drinkers and drink alcohol less often than the general population (only 8% of men and 14% of women in the general population are non-drinkers).

- The number of people meeting the physical activity recommendations in 1999 and 2004 showed a slight increase amongst the Chinese men from 23% to 30%, compared to a decrease in Chinese women from 18% to 17%. Interestingly, with regard to physical activity amongst 2-15 year olds, Chinese boys (38%) were less likely to have been active at the recommended levels compared to 69% of boys in the general population who exercised at the recommended level.

- In relation to nutrition, the proportion of people eating five or more portions of fruit and vegetables per day was highest amongst Chinese and Indian, men and women. The lowest fat intakes were amongst Indian, Chinese and Black African men, and more Chinese and Black Caribbean men and women said they rarely or never add salt at the table.

- Chinese men (55%) and women (64%) were the most likely group to have ever used complementary or alternative medicines, indicative of the higher use of Chinese medicines and acupuncture among this community. Compared to the general population (3% of men and 4% of women), 44% of Chinese men and 52% of Chinese women had used Chinese medicine.

A cross-sectional study of the Chinese community in Glasgow (Liao & McIlwaine1995) found that language difficulties was the main barrier for Chinese people to make effective use of services and to benefit from health education and health promotion programmes. 59% of the 493 respondents needed an interpreter to

see a doctor and 82% used family members or friends to interpret for them. It was found that the community underused health services and mainly had a non-active life-style, with a low rate of cigarette and alcohol consumption.

Isolation has been identified by workers working with the Chinese community as a key issue (Parish 2000; Chan 2002). To avoid competition, Chinese restaurant and take-away owners tend to locate to areas with few other Chinese people. Therefore, many Chinese people, particularly the elderly, are most likely to have been involved in the catering trade working long hours, having displaced mealtimes and living without contact or support from family members, hence experiencing isolation. This social exclusion is further exacerbated by language difficulties, which also limits their access to mainstream health service provision. The cultural and social differences across generations challenge the myth that families offer a high level of support to older members. Chinese young people have grown up in a social environment that champions individuality and self-expression and this can often conflict with the traditional group values and expectations held by their elders.

Concepts, Beliefs and Values

A qualitative research study into the health beliefs of the Chinese community to explore social representations of health and illness (Gervais & Jovchelovitch 1998), found that traditional Chinese medicine, cultural identity and traditional social values strongly influenced how the Chinese community perceived health-care and utilised services.

The notion of balance and harmony between body and soul at an individual level, and between the individual, social, natural and supernatural levels, was used to explain the nature of health, the causes of illness, and identify solutions. Health was seen as a state of balance of opposing forces or conditions (hot/cold; yin/yang), and illness was perceived as an imbalance. In Tao philosophy, Yin represents “cold, darkness, tranquillity and femaleness” whereas Yang denotes “heat, light, heaven, movement and maleness”.

This conceptual system shaped their thinking around foods, classifying them as either ‘hot’ (yang) or ‘cold’ (yin) or ‘neutral’ (yin-yang). This belief categorises foods

as ‘hot’ or ‘cold’ according to whether the foods have a heating or cooling effect on the body, and does not refer to the physical temperature. A balance of hot and cold foods is desirable to help the body maintain a state of harmony, and an excess in either is seen to be the cause of ill health. ‘Hot’ foods referred to spicy, oily, calorific, high-protein, strongly-flavoured and red, orange or yellow in colour foods such as, meat, herbs, wines, ginger, brown sugar spices and oils. ‘Cold’ foods were defined as bland, watery, crisp, fresh, and green or white in colour, for example, fruit, Chinese cabbage, honey, watermelon, white sugar and tea. ‘Neutral’ foods included rice and wheat noodles.

The core values of Chinese culture encompass 3 key tenets: a respect and belief in the family as the most important unit of social and individual life; a compliance with hierarchy in terms of gender, age and social status; and exercising of self-discipline, hard work and high moral standards. The cultural dimensions of food, family and language, therefore, provide the foundation for gaining and using knowledge about health and illness, thus suggesting that health information will be used in different ways by different parts of the community. Although these broad representations of health and illness directly relate health with lifestyles, social networks and the environment, they do not take into account any preventive health measures.

For health promotion to be effective for the Chinese community, the study recommended specific actions such as:

- Using the notion of balance and harmony in framing health messages
- Educating the community about preventive measures such as screening
- Ensuring health promotion material respects the traditional social roles
- Seeking out the views of the community in a proactive way

Mental Health Needs

In a comprehensive review of Chinese mental health in Britain, Yee & Au (1997) highlighted all aspects of mental health care issues faced by the Chinese community and offered practical approaches to more effective working. The messages for professional workers working with clients from the Chinese community included challenging their own assumptions and ways of working, actively seeking advice and support from the community resources available, and adopting some of the practical

approaches cited as good practice. They recommended that training and employment of Chinese speaking mental health professionals at all levels would be the most important contribution that could be made to improving mental health care provision for the Chinese community.

In terms of Chinese carers of people with mental illness (Yee & Au 1997 Chap 6), the main issues were again a lack of awareness of what services are available, and difficulties with language and access to interpreters. In addition to this, the assumption that the Chinese community like other minority communities, have extended families, is not congruent with the reality of Chinese carers having no-one to turn to, to enable respite from caring.

A study of Chinese people with mental health needs in England (Li, Logan, Yee, & Ng 1999) identified the barriers they experienced in accessing appropriate support from the NHS. 71 people who had mental health conditions ranging from three months to 47 years duration were interviewed and almost three-quarters of the sample had problems in seeking help, with the most common barriers being identified as language difficulties, a lack of knowledge about services available and a lack of access to bilingual health professionals.

For many, the impact of mental illness resulted in unemployment and social exclusion with 55% saying they did not find their families' supportive. They cited family problems, poor physical health, life events, loneliness, isolation and societal pressures as the causes of their mental health disorders. Even though there was a common perception amongst the respondents that mental illness was a product of fate, they felt that self-help and greater awareness through information would have helped them. The discrimination they experienced was attributed to the stigma associated with mental illness and the limited knowledge in the community, thus indicating a need to promote a better understanding of mental illness amongst the Chinese community. The study concluded that 'effective communication' determined satisfaction and effectiveness of services received, and therefore recommended training staff to understand the mental health needs of the Chinese community and ensure access to health advocates.

1.4 The Chinese Community in Dudley

Dudley Borough is home to a culturally diverse population that has seen many different profiles of its community developing over the years. In the early 90's, 4.5% (1991 Census Data) of the population were from black and minority ethnic communities, mainly, Pakistani, Indian, Bangladeshi, African, Caribbean, Yemeni and Chinese respectively. Dudley also has a distinct Gypsies and Travellers community. Later, people seeking asylum/refuge settled locally, followed by economic migrants, thus reflecting the impact of current global changes.

At present, **6.3%** of Dudley Borough's population belong to black and minority ethnic communities with 3.5% of them being Chinese, which is 0.22% of the total local population (DMBC Census 2001 Publication No:1).

The Chinese community in Dudley is relatively smaller than other minority ethnic communities and have often been perceived as a 'quiet' group due to their nature.
In the past, this was most probably because they did not know how to participate or voice their rights and did not know where to go if they had a problem or an issue they wanted to discuss with the authorities. This is further exacerbated by the fact that the Dudley Chinese Community Association (DCCA) does not have an established community centre as yet, operating instead from a temporary venue. Now that the community have learned to voice their opinions, the public have became more aware of this 'quiet' group and have realised that this minority group has been neglected in different ways.

The majority of the Chinese people in Dudley are from Hong Kong and they speak Cantonese, while there are others from Mainland China and they speak Mandarin. The people from Mainland China are mainly from the South of China, such as Fujian and Canton. The dialects they speak may vary depending on the region they are from. As well as from China, there are some people from Malaysia and Vietnam. This clearly illustrates the complexity of communication needs within the community which will need to be addressed.

With regard to employment, the majority of the community are still in the food business, such as Chinese Takeaway, Restaurant, Chinese Grocery Shop and

Supermarket. In the past two decades, the Chinese have become more integrated into mainstream society, so, therefore, the younger generation are in all sorts of professions, such as doctors, accountants, solicitors and pharmacists.

In July 1997, a survey was commissioned by the Dudley Partnership Board and the Dudley Positive Opportunities Fund Committee (Boothroyd & Cowley 1997) to gather information on the needs of the local Chinese community and this included a section on access and provision of health and social care services. The need for interpreters was identified as a key issue, and there was a recommendation for the health authorities to commission further research into the health needs of the Chinese community in Dudley.

In 2002 a primary care health needs analysis with 72 people from black and minority ethnic communities was carried out in Lye (Dudley South Primary Care Group 2002). 19% (14) of respondents were members of the Chinese community who regularly used services in that area. Recommendations overall included provision of interpreting and language support for services and the need for integration of equality and diversity issues, at all levels, in the planning and delivery of health services.

1.5 Summary of Key Issues

The key issues related to the Chinese community as identified through this review of literature are:

- Experience of isolation
- Image of a 'quiet' or invisible community
- Strong traditional and social values
- Inter-generational conflict
- Cultural concepts and beliefs
- Stigma of mental illness
- Lack of awareness/knowledge of services
- Need for language support / bilingual workers
- Lack of cultural relevance in promoting health messages
- Need for training professionals

2 METHODOLOGY

The experience of working directly with the local Chinese community over the years, and the strong relationships established with the workers supporting them, enabled a process which reflected the recommended methodology for carrying out research amongst the Chinese community (Gervais & Jovchelovitch 1998 Section 7.2).

2.1 Method Used

The methods used in this survey process included, using existing organisations for gaining access to the community, piloting the terminology used in the questions in the survey tool, and producing bilingual material with the appropriate written form of Chinese for the targeted community.

A postal survey was carried out over a period of two months from November to December 2007, using a semi-structured, bi-lingual questionnaire, which was self-completing, or could be completed with support from an interpreter. Open-ended questions were included to enable respondents to express their views on specific issues.

Development of Questionnaire

The questionnaire was based on selected questions from a health and lifestyle survey tool which was used in 2004 by Dudley Public Health. These were discussed with the interpreter working with the Chinese community and the managers responsible for health improvement programmes and adapted to suit translation and re-translation to ensure consistency as far as possible. It was developed to be accessible in two written languages relevant to the targeted community. Questions were divided into 6 sections for ease of reading and analysis focusing on the topics of physical activity, nutrition, alcohol, tobacco smoking, emotional health and wellbeing, access to services, and demographic details.

The final version was produced as a bilingual questionnaire in Cantonese Chinese and English (see Appendix 2). The key points in development were:

- Drafts of the questionnaire were piloted with community representatives and health professionals for accuracy, relevance and consistency.
- The layout and structure of questions was checked to ensure appropriateness for translation and re-translation back into English for comments written in Chinese.
- A rating scale for emotional health and wellbeing was developed based on two aspects of wellbeing, namely, life satisfaction and personal development, reflecting the national evidence base on wellbeing indicators which was current at the time of the research study (new economics foundation (nef) 2004).

A covering letter was attached to the front of the questionnaire inviting people to participate, giving a return date and contact details of the three organisations involved. A stamped, self-addressed envelope was provided for return of questionnaires.

2.2 Sample

The sampling frame for the study was the membership database of the Dudley Chinese Community Association, which is the only organisation that represents this community locally. Questionnaires were disseminated to 277 members registered with the DCCA using their mailing out process.

2.3 Analysis

The numerical data was analysed using the Excel statistical package and cross referenced by gender. Confidence intervals were used but the sample was too small to show any significance, hence not included in the findings.

Responses to open questions written in Chinese were re-translated into English by the interpreter who had originally translated the questions. The quotes used in this report may appear to be grammatically incorrect but this is because they reflect the actual spoken language of people whose first language is not English and also reflect the process of transcribing to capture 'real' words and experience.

3 SURVEY FINDINGS

3.1 Response Rate

277 questionnaires were sent out and 124 returned giving a response rate of **44.8%.**

Although the overall response rate is based on 124 questionnaires being returned, there are a number of questions that have not been answered by all respondents.

- If a respondent answered "no" to a filter question, but then answered the next question instead of skipping it, their answers are not included in the results. If it was left blank, but subsequent questions were answered, then these have been included in the results.
- Some questions invited respondents to give multiple responses as relevant and this is reflected in the results.

Hence there may be some discrepancy between total responders for each question.

3.2 Profile of Respondents

112 respondents specified their district postcodes (see Appendix 3). 86% (96) were resident in areas covered by the local authority of Dudley Metropolitan Borough Council, mainly in Brierley Hill, Stourbridge and Central Dudley, although there was some representation from all areas. 14% (16) of the respondents, however, lived outside the borough but, as established members of the Dudley Chinese Community Association (DCCA) participating in the survey, they would be supporting local activity and using local facilities, and therefore have been included in the findings.

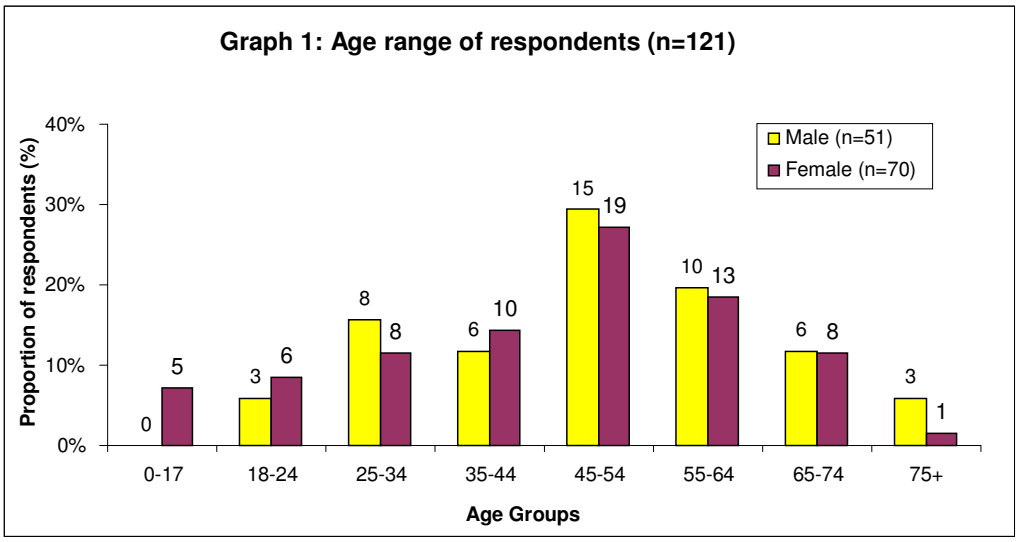
123 respondents confirmed their ethnic group as Chinese and majority of the sample were female (59%) compared to 41% male, thus introducing a slight bias.

With regard to religion, 41% (49) said they did not have a religion, while 36% (43) cited Buddhism and 13% (16) said Christianity. Catholicism was followed by 7% (8) and Tao philosophy by 4% (5).

Age

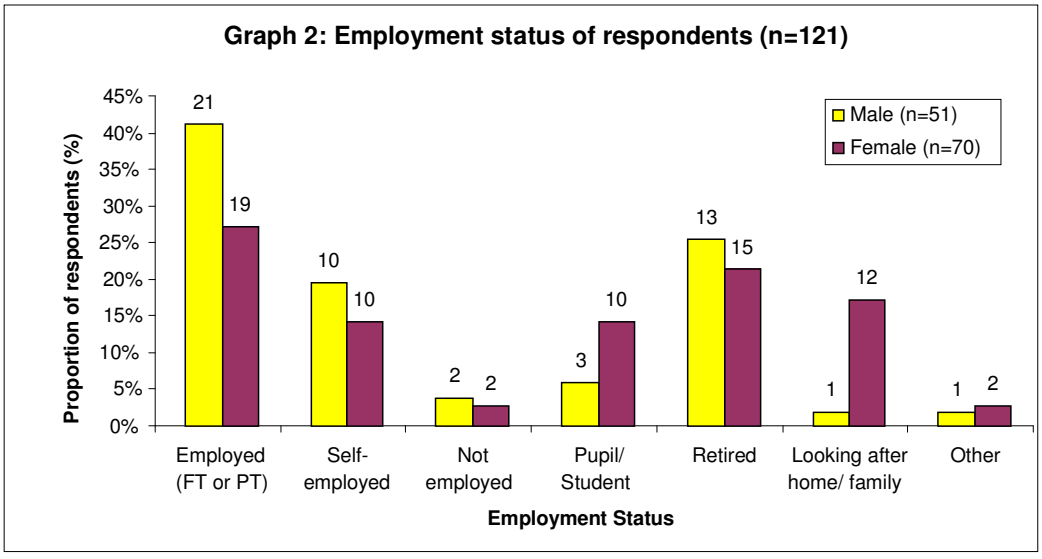
The survey sample reflected a broad age-range of respondents. Of the 121 people who stated their age (see Graph 1), 74% (89) were between 25 and 64 years of age,

with a fairly equal gender representation (39 males and 50 females respectively). Notably, there was no representation of males under the age of 17 years and only one female over 75 years of age.



Employment

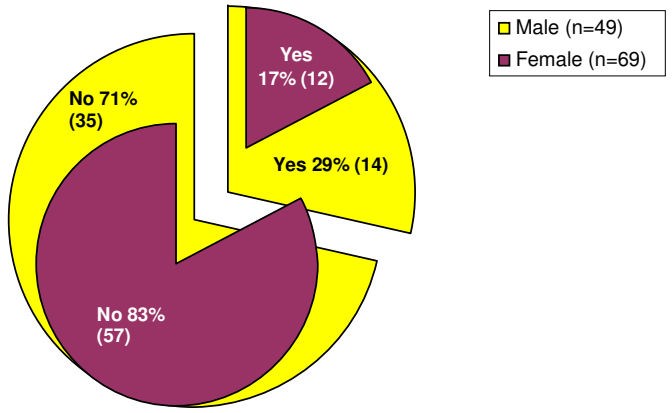
50% (60) of the respondents stated they were in employment (either full or part time), or self-employed (see Graph 2), with not much difference in representation between male and female respondents. Only 3% (4) said they were not employed, 23% (28) were retired, 11% (13) were in education as pupils or students, and 11% (13), virtually all female, looked after the home and family. 2% (3) identified themselves as 'other', specifying, a carer, a Chinese takeaway shop owner, and being unemployed due to illness, respectively.



Limitations to Daily Activity

118 respondents indicated whether they were limited in any way to carry out their daily life activities (see Diagram 1). 78% (92) said they did not have any long-term illness, health problem or disability which limited their daily life activities or work (that is, 83% (57) of females compared to 71% (35) of males).

Diagram 1: Respondents with a long-term illness, health problem or disability, which limits their daily activities or the work they can do (n=118)



Of the 22% (26) who said they did have some limitation (that is, 29% (14) of males and 17% (12) of females), they identified their main health problems as:

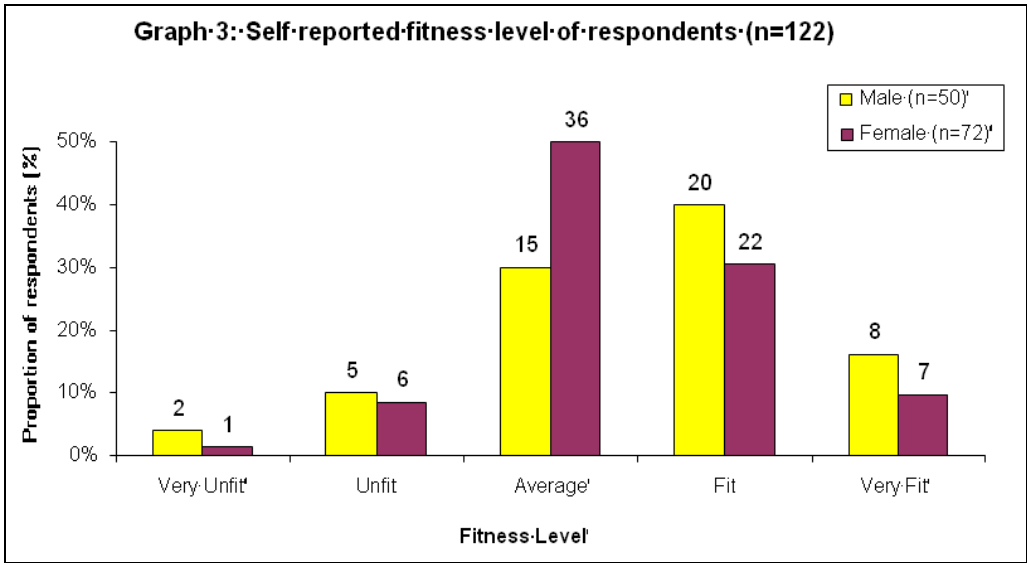
- High blood pressure / cholesterol (13)
- Arthritis (4)
- Heart disease / stroke (3)
- Aches and pains (3)
- Diabetes (2)
- Mental health related problems (2)
- Disability (2)

31% (8) of these respondents identified having more than one limiting health condition.

3.3 PHYSICAL ACTIVITY

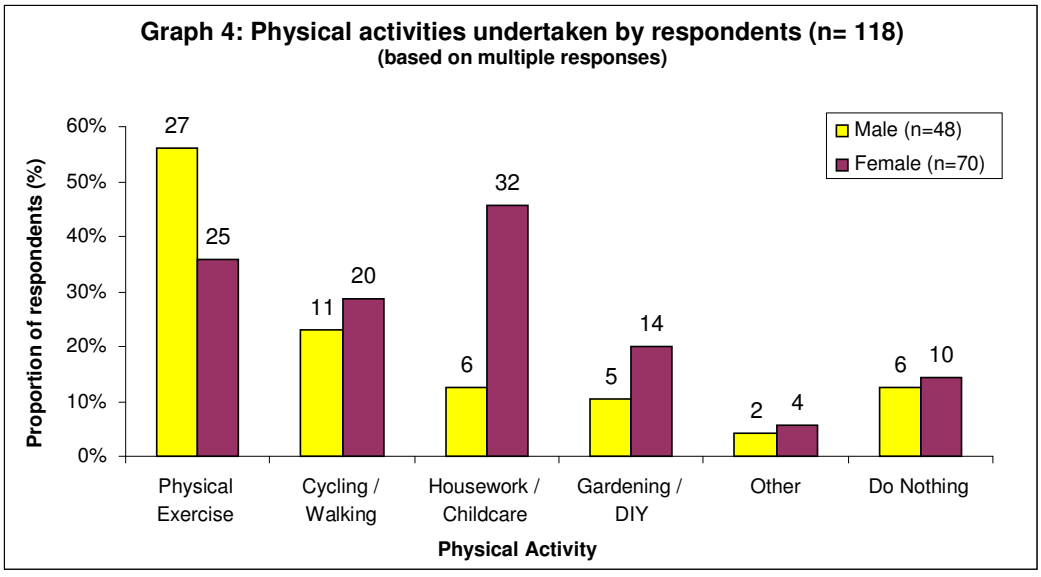
Perception of Own Fitness Level

122 respondents stated what they felt their fitness level to be (see Graph 3). 47% (57) thought they were fit or very fit (56% (28) of males compared to 40% (29) of females). 42% (51) felt their fitness was only average and 11% (14) thought they were unfit or very unfit.



Physical Activity Undertaken

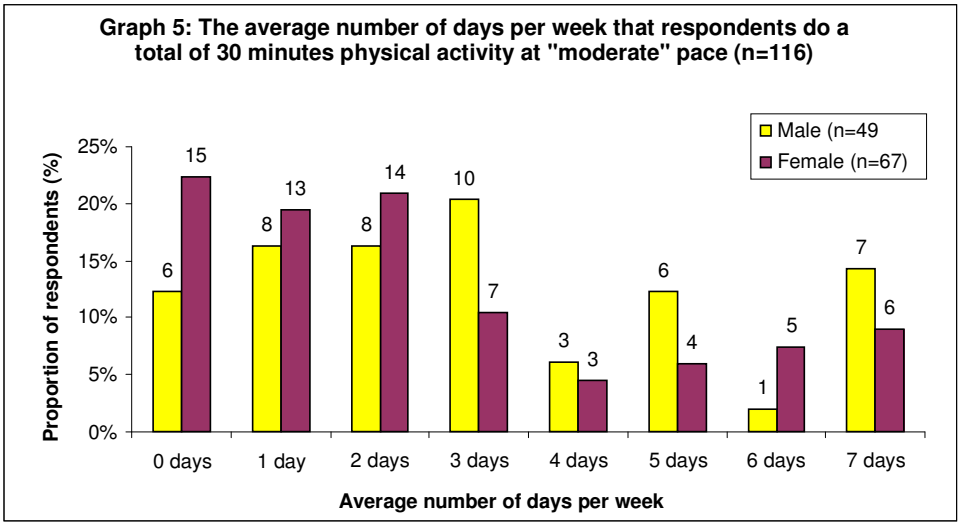
118 respondents stated how they kept themselves physically active (see Graph 4).



Physical exercise was most popular amongst males (56% (27)) and housework/ childcare ranked highest with females (46% (32)). 26% (31) said cycling or walking and this was similar for both male and female respondents. Other types of activity mentioned were golf, gym, jogging, working, and gentle exercise at home. 14% (16) said they did nothing to keep physically active.

116 respondents identified how many days per week, on average, they carried out a total of 30 minutes of physical activity at a 'moderate' pace, i.e. activity that made their heart beat a little faster, their breathing faster and made them feel slightly warmer than usual (see Graph 5). 57% (66) said between 1-4 days and this was similar for both male (59% (29)) and female (55% (37)) respondents. 25% (29) said between 5-7 days (28% (14) males compared to (22% (15) females). 18% (21), mostly female, did not carry out physical activity on any day.

Graph 5: The average number of days per week that respondents do a total of 30 minutes physical activity at "moderate" pace (n=116)



119 responded to the question on whether they felt they did enough physical activity to keep themselves healthy. 48% (57) felt they did, 29% (35) were not sure and 23% (27) said they did not (18% (9) of males compared to 26% (18) of females).

28 respondents further identified the reasons why they did not do enough physical activity (see Table 1), highlighting access, time and cost issues as the most important reasons. 39% (7) of females stated no particular reason compared to one male.

Table 1: Reasons why respondents don't do enough physical activity to keep themselves healthy (n=28) *(based on multiple responses)*

Reason	Total Number of Respondents (n=28)	Male (n=10)	Female (n=18)
Lack of opportunity or facilities	50% (14)	60% (6)	44% (8)
Lack of time	46% (13)	60% (6)	39% (7)
Cost of facilities	39% (11)	50% (5)	33% (6)
Don't know what type of exercise would suit me	39% (11)	50% (5)	33% (6)
No particular reason	29% (8)	10% (1)	39% (7)
Illness / disability	21% (6)	40% (4)	11% (2)
Don't know	18% (5)	20% (2)	17% (3)
Don't enjoy exercise	14% (4)	20% (2)	11% (2)
Other: language barrier / laziness / no need	11% £)	10% (1)	11% (2)

116 respondents identified the factors that would help them to start or become more physically active (see Table 2). The three factors perceived to be most helpful were more information about local facilities and about what to do and safer parks. More females identified individual support and advice as something that would help them than males (17% compared to 6% respectively).

Table 2: Factors that would help respondents to start or become more physically active (n=116) *(based on multiple responses)*

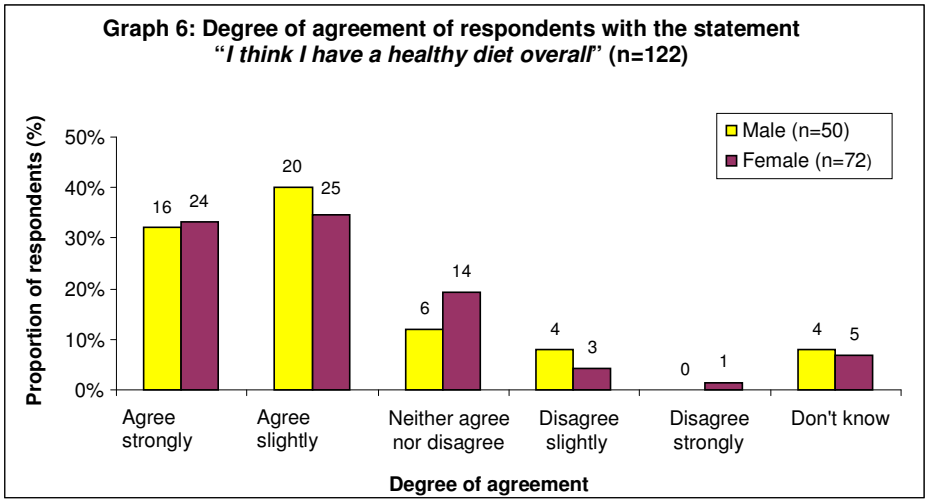
Enabling Factor	Total Number of Respondents (n=116)	Male (n=47)	Female (n=69)
More information about local facilities	44% (51)	43% (20)	45% (31)
More information about what to do	31% (36)	30% (14)	32% (22)
Safer parks	28% (32)	34% (16)	33% (16)
Making streets safer for walking and cycling	22% (25)	17% (8)	25% (17)
Nothing would help	15% (17)	17% (8)	13% (9)
Individual advice and support	13% (15)	6% (3)	17% (12)
Other: a job / more free time / affordable local facilities / more leisure centres / cheaper costs	9% (10)	8% (4)	9% (6)

3.4 HEALTHY EATING

Perception of Own Diet

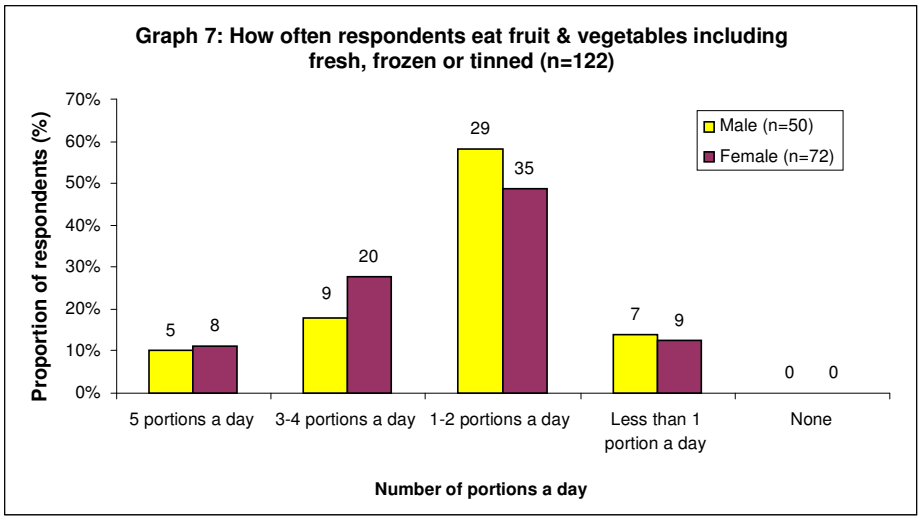
122 respondents stated whether they agreed with the statement *"I think I have a healthy diet overall"* (see Graph 6). The majority (70% (85)) perceived themselves to have a healthy diet to some degree (more males (72% (36)) than females 68% (49)). 16% (20) neither agreed nor disagreed and 7% (9) did not know, hence suggesting a lack of knowledge about what is a healthy diet amongst some respondents. 6% (8) disagreed with the statement thus indicating a level of self-awareness of not having a healthy diet.

Graph 6: Degree of agreement of respondents with the statement "*I think I have a healthy diet overall*" (n=122)



Food Habits

52% (64) of the 122 respondents said they ate between 1-2 portions of fruit and vegetables a day (see Graph 7) and almost a quarter said they ate 3-4 portions (24% (29)). With only 11% (13) eating at the recommended 5 portions of fruit and vegetables a day, which does not reflect the national trend for the Chinese community (See Section 1.3), this indicates a need for promoting healthy eating messages locally.



98 of the respondents identified their reasons for eating less than the recommended 5 portions of fruit and vegetables a day (see Table 3). Access and cost were considered the key issues but interestingly, male respondents identified preparation time as their main reason.

Table 3: Reasons why respondents eat less than the recommended 5 portions of fruit and vegetables a day (n=98) *(based on multiple responses)*

Reason	Total Number of Respondents (n=98)	Male (n=38)	Female (n=60)
Can't get fruit and vegetables I want at my local shop	30% (29)	26% (10)	32% (19)
Can't afford more fruit and vegetables	27% (26)	21% (8)	30% (18)
Time it takes to prepare the fruit and vegetables	24% (24)	29% (11)	22% (13)
Just don't think about it	15% (15)	16% (6)	15% (9)
Don't want to	8% (8)	8% (3)	8% (5)
Don't have facilities to prepare	7% (7)	11% (4)	5% (3)
Don't like fruit and vegetables	6% (6)	11% (4)	3% (2)

Other reasons given were:

"Could not find it"

"Don't know how to count as a 5 portions"

"Health not very good"

"Its enough"

"No time to eat"

"Rare to eat vegetables"

"Teeth no good"

"There is not much Chinese vegetables to select in the supermarket"

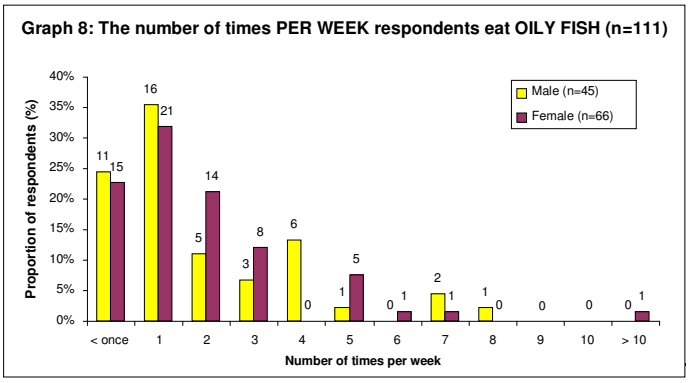
116 respondents stated their use of salt at the table: 51% (59) tasted food first and then occasionally added salt, 36% (42) rarely or never added salt, 10% (12) tasted food and then added salt. Very few (3% (3)) added salt before tasting the food. This finding reflects the national survey findings related to the Chinese community (Sproster & Mindell, 2006) as one of the most likely groups who rarely or never added salt at the table.

With regard to cooking, the 118 respondents who answered this question identified soya sauce (97% (114)) and oyster sauce (49% (58)) as the most commonly used ingredients. There was limited use of monosodium glutamate (13% (15)) and fish sauce (7% (8)).

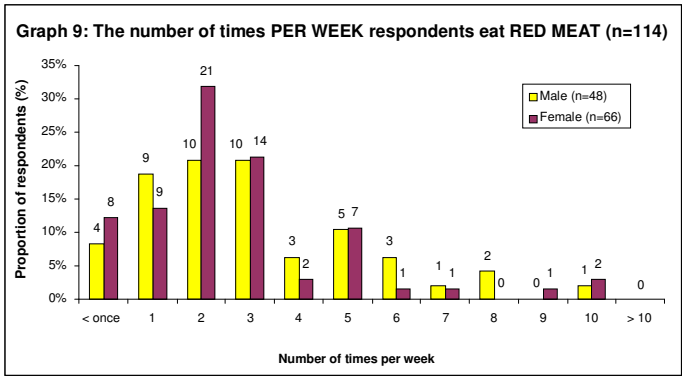
107 respondents stated their daily eating habits in relation to consumption of sugary foods such as cakes, pastries, chocolates and biscuits. 68% (73) consumed these items once a day or less and 32% (34) ate them between 2 – 5 times a day.

Respondents were asked to report on their weekly consumption of key food products such as oily fish, red meat, whole milk / full cream or full cream sterilised milk, full fat cheeses, pulses and processed or ready prepared meals to establish a baseline on consumption of foods that impact on cardiovascular health.

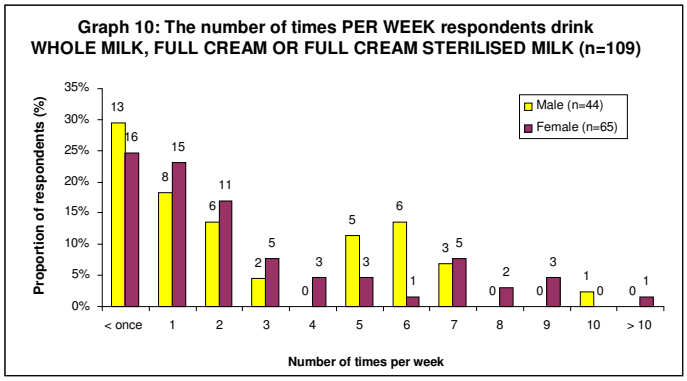
60% (67) of Respondents (n=111) consumed oily fish 1-3 times a week (see Graph 8).



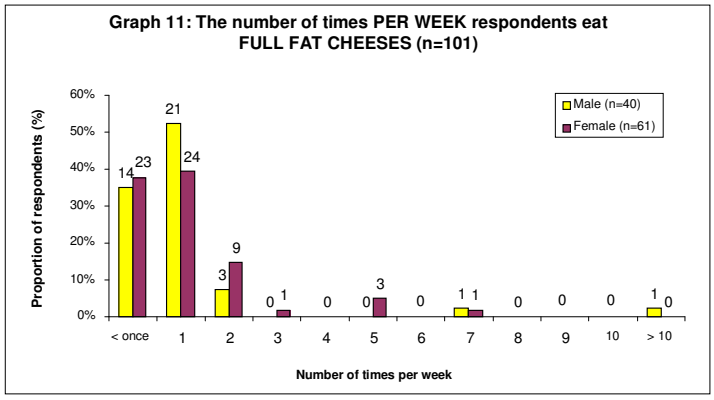
64% (73) of Respondents (n=114) reported eating red meat 1-3 times a week (see Graph 9).



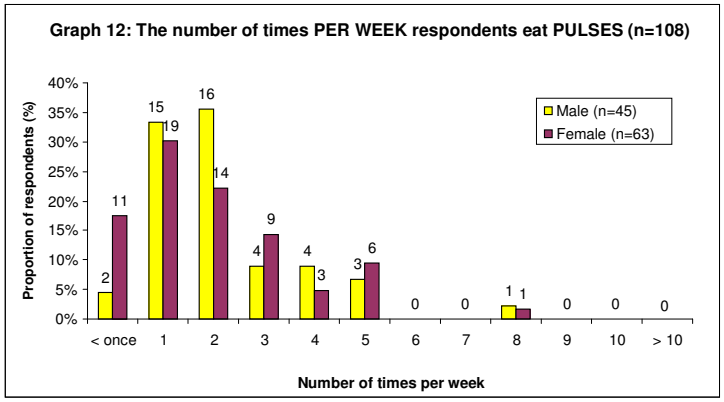
63% (69) of Respondents (n=109) drank whole milk / full cream sterilised milk twice a week or less (see Graph 10).



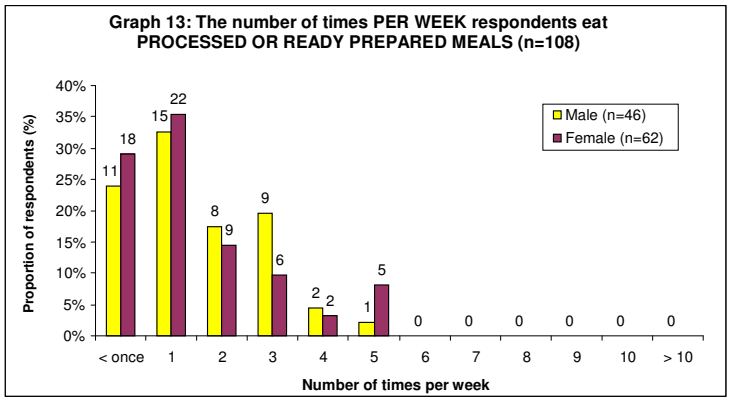
81% (82) of Respondents (n=101) consumed full fat cheeses once a week or less (see Graph 11).



71% (77) of Respondents (n=108) said they ate pulses 1-3 times a week (see Graph 12).



61% (66) of Respondents (n=108) consumed processed or ready made meals once a week or less (see Graph 13).

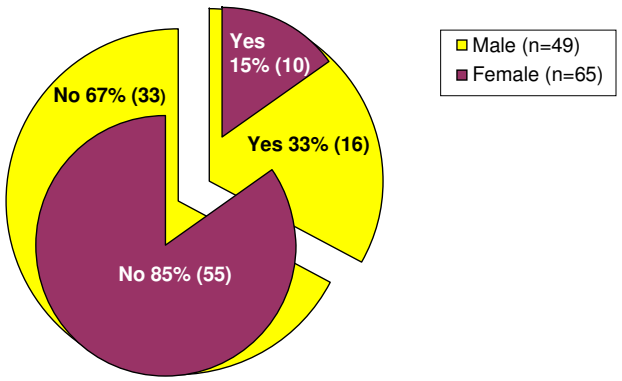


3.5 ALCOHOL & SMOKING

Alcohol Drinking Habits

114 respondents stated whether they currently drank alcohol (see Diagram 2). More females (85%) than males (67%) said they were not currently drinking alcohol. Conversely, more males (33%) identified themselves as current alcohol drinkers compared to 15% of females.

Diagram 2: Respondents who currently drink alcohol (n=114)



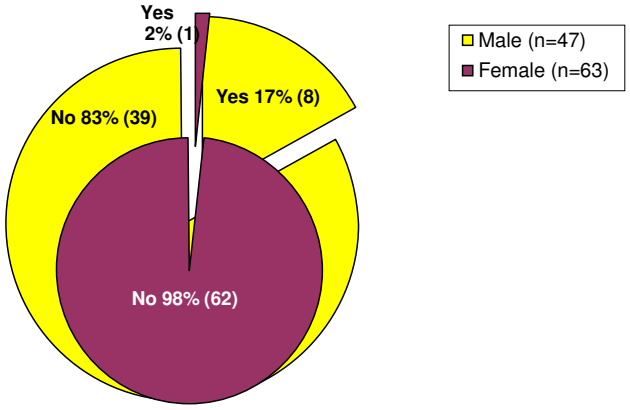
Of the 26 respondents who currently drank alcohol, 46% (12) had had an alcoholic drink on one day in the previous week. 19% (5) said they had not had a drink, 15% (4) said they had drunk alcohol on 4 days and only one male had drunk alcohol on five days. No-one had drunk alcohol every day of the week.

29 respondents stated whether they thought their level of drinking was harmful to their health. 55% (16) did not think their drinking was harmful, whereas 24% (7) did not know. 21% (6) thought their level of drinking alcohol was harmful and they identified their levels of drinking between 1 and 4 days in the previous week.

Tobacco Smoking Habits

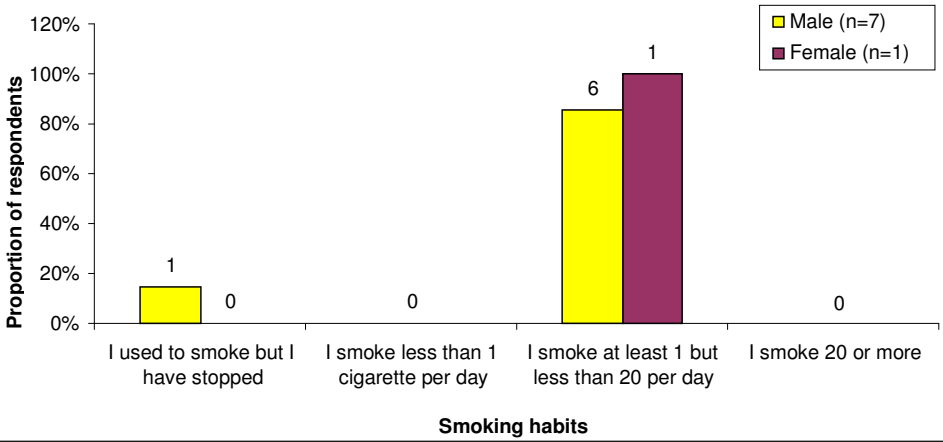
110 respondents indicated whether they smoked any kind of tobacco or not (see Diagram 3). 92% (101) of them said they did not smoke: more females (98%) compared to males (83%). Of those who did smoke, with one exception, they were all male, and had mostly started smoking at 15 years of age or above.

Diagram 3: Number of respondents who smoke any type of tobacco (cigarettes, cigars or pipes) (n=110)



8 respondents identified that they smoked at least 1 cigarette a day but less than 20 per day (see Graph 14). Of the 5 males and 1 female who wanted to stop smoking, 100% (6) had not used any services in Dudley Borough to help them.

Graph 14: Respondents' smoking habits (n=8)

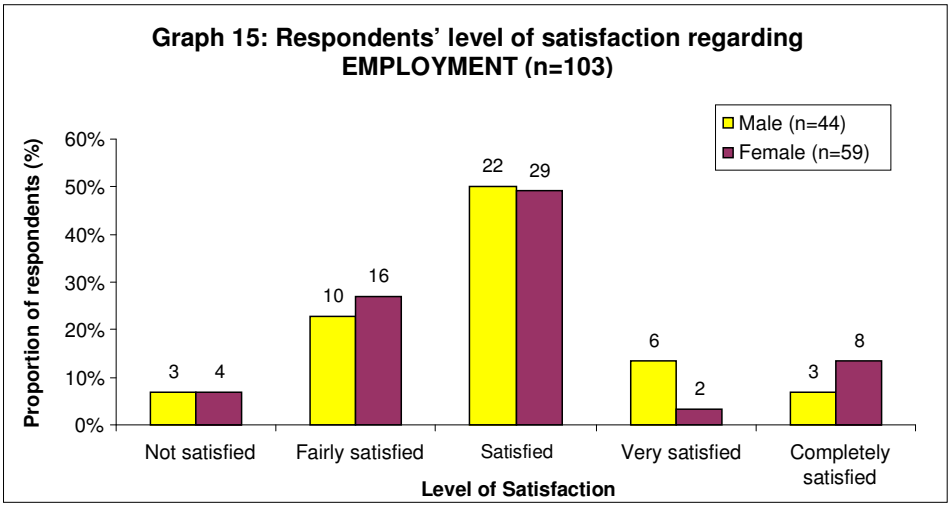


3.6 EMOTIONAL HEALTH & WELL BEING

Life Satisfaction:

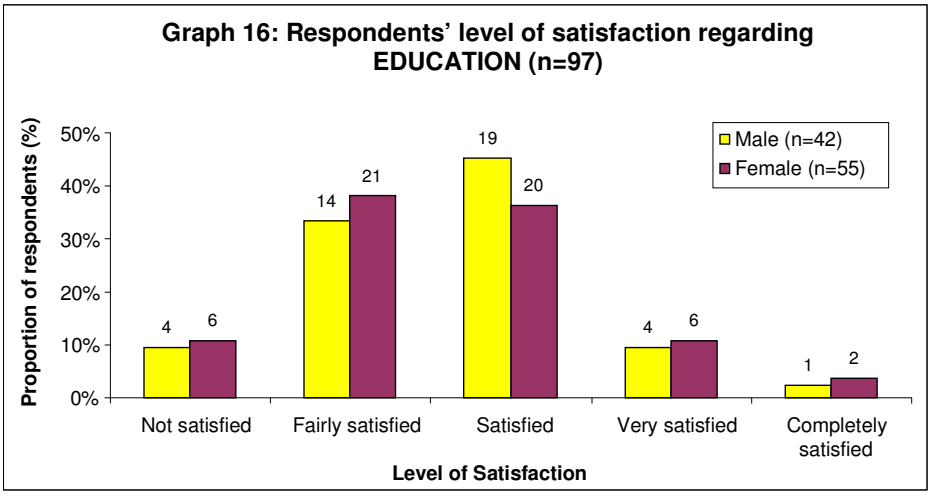
Employment

103 respondents expressed their level of satisfaction with their employment status (see Graph 15). Majority of the respondents were satisfied with their life regarding employment, irrespective of gender (70% (31) of males compared to 66% (39) of females). However, a third of respondents, 32% (33) were only fairly or not satisfied, more females (34% (20)) than males (26% (13)).



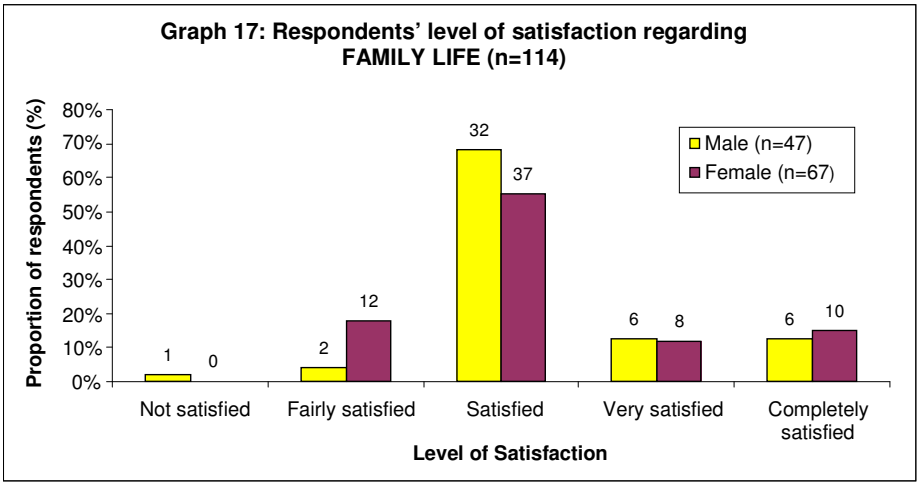
Education

Of the 97 respondents who commented on their level of satisfaction with their education, (see Graph 16), more than half (54% (52)) were satisfied, 36% (35) said they were only fairly satisfied, and 10% (10) not satisfied at all, thus indicating a lack of fulfilment amongst the males (43% (18)), and females (49% (27)).



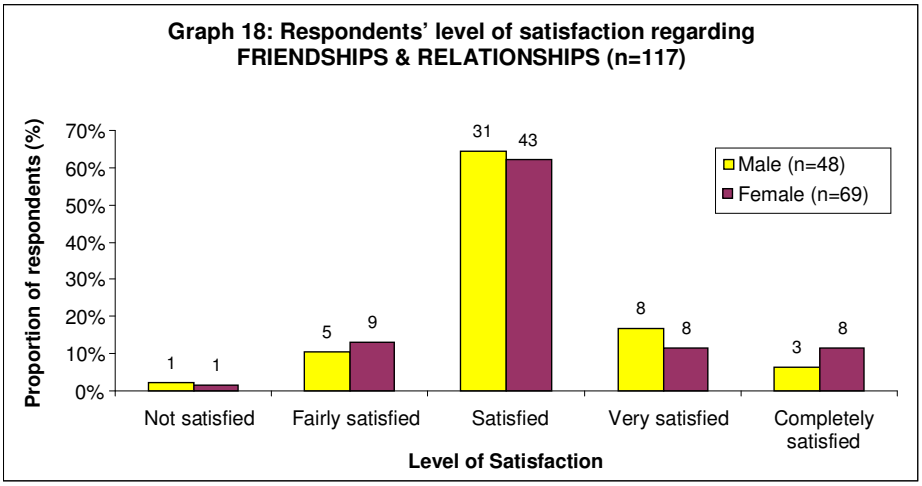
Family Life

114 respondents indicated their level of satisfaction with their family life (see Graph 17), and the majority (87% (99)) were satisfied, very satisfied or completely satisfied. More males (94% (44)) expressed higher levels of satisfaction than the females (82% (55)), although none of the females felt that they were not satisfied with their family life.



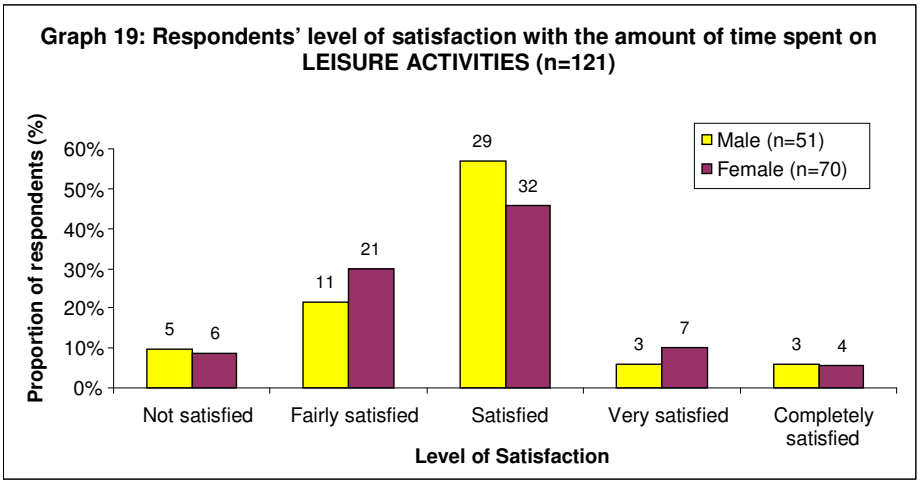
Friendships & Relationships

117 respondents commented on their level of satisfaction with their friendships and relationships (see Graph 18). Most of them were positively satisfied (86% (101)) and this was similar for both males (88% (42)) and females (86% (59)). 14% (10) of females and 12% (6) of males felt only fairly or not satisfied with friendships and relationships in their life.



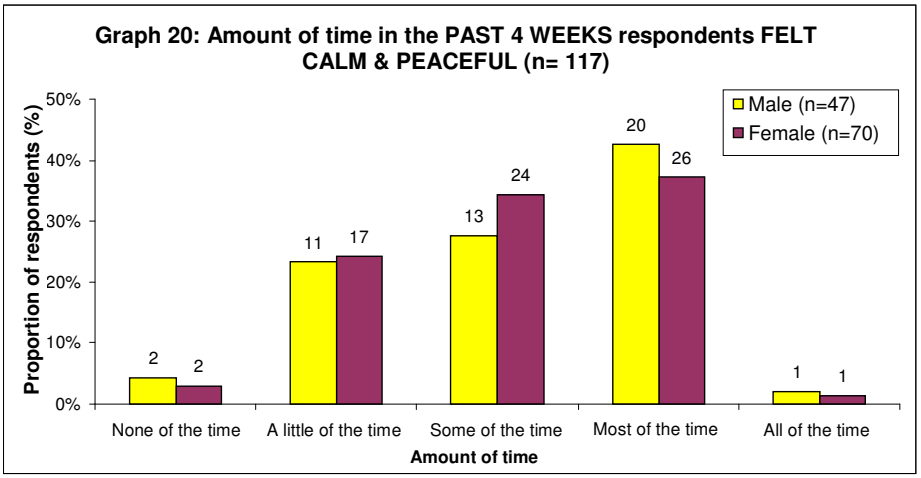
Leisure Activities

121 respondents commented on their level of satisfaction with the amount of time they spent on leisure activities (see Graph 19). Almost two-thirds reported they were satisfied, very satisfied or completely satisfied (64% (78)). A quarter said they were only fairly satisfied (26% (32)) and 9% (11) were not satisfied.



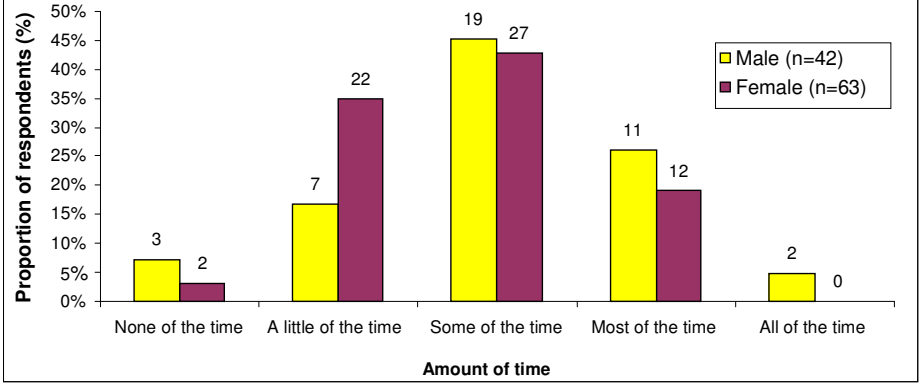
Feelings

117 respondents indicated how calm and peaceful they had felt in the previous four weeks (see Graph 20). It was encouraging to note that 41% (48) said most or all of the time, and 32% (37) said some of the time. However, almost a quarter (24% (28)) said a little of the time or not at all (3% (4)).



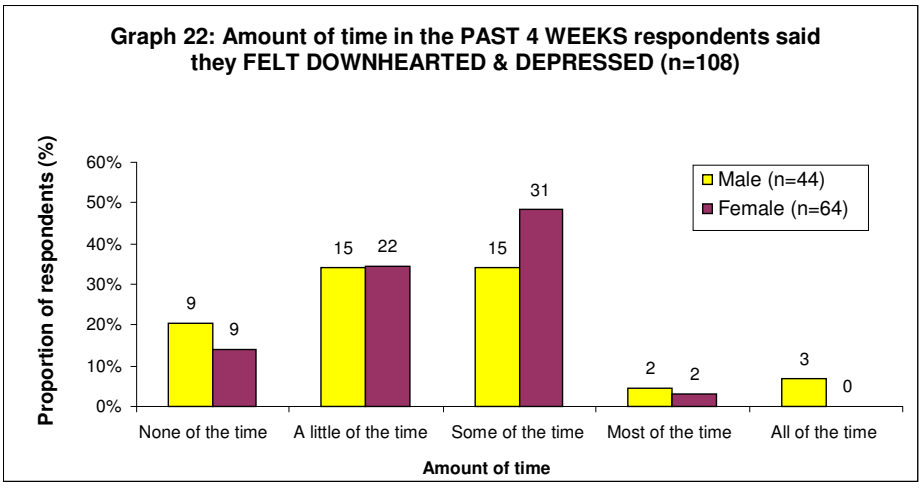
105 respondents indicated how often they felt they had had a lot of energy in the previous four weeks (see Graph 21). More than two-thirds (68% (71)) reported they had had a lot of energy some or most of the time (76% (32) of males compared to 62% (39) of females). However, 28% (29) said it was only for a little of the time and 5% (5), said none of the time.

Graph 21: Amount of time in the PAST 4 WEEKS respondents said they had A LOT OF ENERGY (n=105)



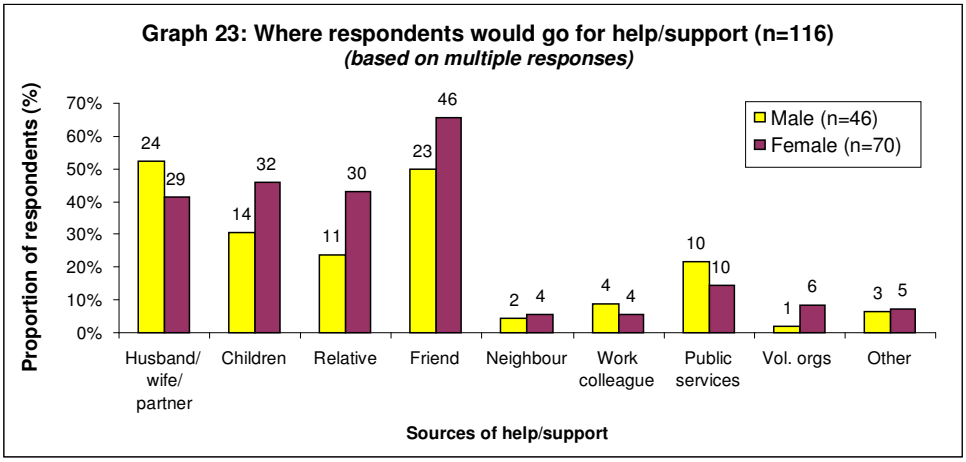
108 respondents expressed how often they had felt downhearted and depressed in the previous four weeks (see Graph 22). 43% (46) said some of the time, 4% (4) said most of the time, and 3% (3) said all of the time. 52% (33) of the females compared to 45% (20) of males felt downhearted and depressed some, most or all of the time. Only 16% (18) said they had not felt this way at all.

Graph 22: Amount of time in the PAST 4 WEEKS respondents said they FELT DOWNHEARTED & DEPRESSED (n=108)



Seeking Help & Support

116 respondents identified where they would go to seek help and support (see Graph 23).



The main sources of help and support identified by respondents were friends (60%), spouses/partners (46%), children (40%), relatives (35%) and public services (17%) respectively (see Table 4). 'Others' identified were: community workers, parents and interpreters.

"I totally rely on the community workers" (male)

"Who can understand me?" (male)

"Want some help from the community workers" (female)

Table 4: Main sources of help and support (n=116) *(based on multiple responses)*

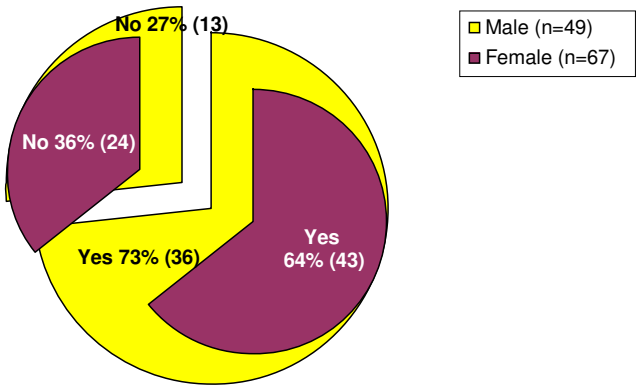
Source of Help or Support	Total Number of Respondents (n=116)	Male (n=46)	Female (n=70)
Friend	60% (69)	50% (23)	66% (46)
Husband/Wife/Partner	46% (53)	52% (24)	41% (29)
Children	40% (46)	30% (14)	46% (32)
Relative	35% (41)	24% (11)	41% (30)
Public Services (i.e. GP, health staff, social worker)	17% (20)	22% (10)	14% (10)
Work Colleague	7% (8)	9% (4)	6% (4)
Other	7% (8)	7% (3)	7% (5)
Voluntary Organisation	6% (7)	2% (1)	9% (6)
Neighbour	5% (6)	4% (2)	6% (4)

Sense of Community Belonging

116 respondents said whether they felt connected to a wider community with 'community' being defined in the questionnaire as *"a specific locality including all the people who live there" (see Diagram 4).*

The majority, (68% (79)) felt connected, but male respondents (73% (36)) did so more than the females (64% (43)). Almost a third of the respondents (32% (37)) did not feel connected to a wider community and this was a higher response amongst females (36% (24), mostly between the age-range of 33 – 48 years) than males (27% (13)).

Diagram 4: Respondents who feel connected to some part of a wider community (n=116)

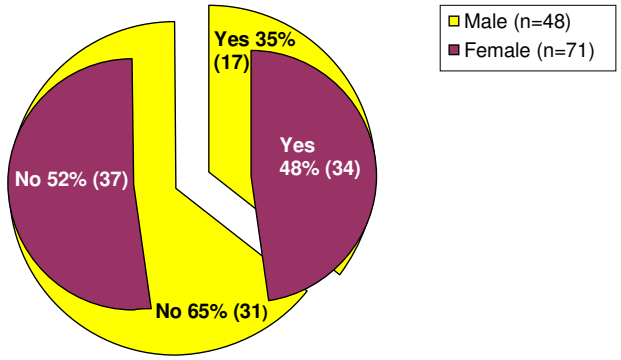


3.7 ACCESS TO SERVICES

Use of Local Services

119 respondents stated whether they had utilised any local health or social care related services in the last twelve months (see Diagram 5). 57% (68) had not, and of the 43% (51) who said they had used these services, almost two-thirds 63% (32) cited health related services such as *"NHS/health services (5)*", *"GP/Doctor (10)"*, *"Dentist (3)*", and *"Hospital appointments (8)".* Social services and interpreters were specified by 7 respondents.

Diagram 5: Number of respondents who have used local health/social care services in the LAST 12 MONTHS (n=119)



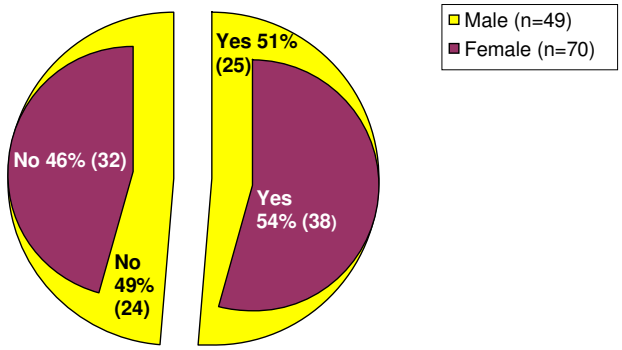
13% (16) of the respondents, mostly male, gave general comments with the main issues being identified as the need for interpreting and language support at the point of access to primary health care and other services, and the need for a centre to provide various activities for the Chinese community:

"I would like to have more social workers and interpreters to help us (Male, age 71)
"Every time when I need to make an appointment to see the GP it took at least a few days. It was too long. If there is more Chinese GP will be good" (Male, age 52)
"The community centre should provide more activities, such as day trips and party" (Female, age 50)
"I hope the Government can fund more to our Chinese community, like housing, social service, learning, relaxing and to find a centre for meeting, health etc" (Male, age 57)
"Arrange more activities for the Chinese within the borough" (Male, age 40)

Interpreting Need

119 respondents stated whether they needed an interpreter to access health and social care services (see Diagram 6). More than half the respondents (53% (63)) said they did, and this was similar for both males and females.

Diagram 6: Number of respondents who require an Interpreter when accessing health & social care services (n=119)

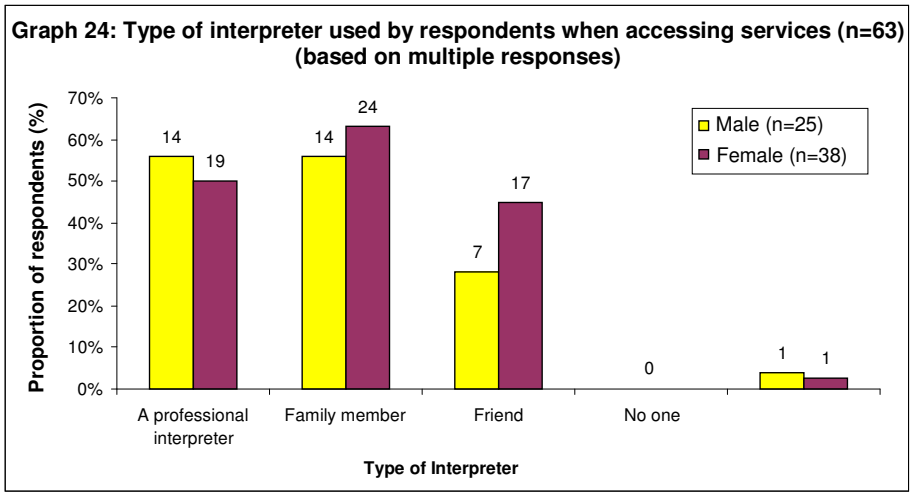


Respondents need for interpreters increased by age-group (see Table 5), 10% (3) of the 0-34 yr olds; 49% (24) of 35-54 yr olds and 90% (35) of those 55 years of age or over, respectively. Older respondents said they needed an interpreter to access health and social services, more than the younger respondents.

Table 5: Respondents need for an interpreter when accessing health and social care services by age-groups (n=117)

Age-Group in Years	Interpreting Need		Number of Respondents
	YES	NO	
0 – 34	10%(3)	90%(26)	n = 29
35 – 54	49%(24)	51%(25)	n = 49
55 +	90%(35)	10%(4)	n = 39
TOTAL	**53%(62)**	**47%(55)**	**N = 117**

Of the 63 respondents who indicated need for an interpreter (see Graph 24), 60% (38) said they relied on a family member, 52% (33) on a professional interpreter, and 38% (24) on a friend. Notably, no respondent said they had no-one to interpret for them. 'Other' was identified as *"contacting the DCCA" or "interpreter/community worker/friends".*



General comments:

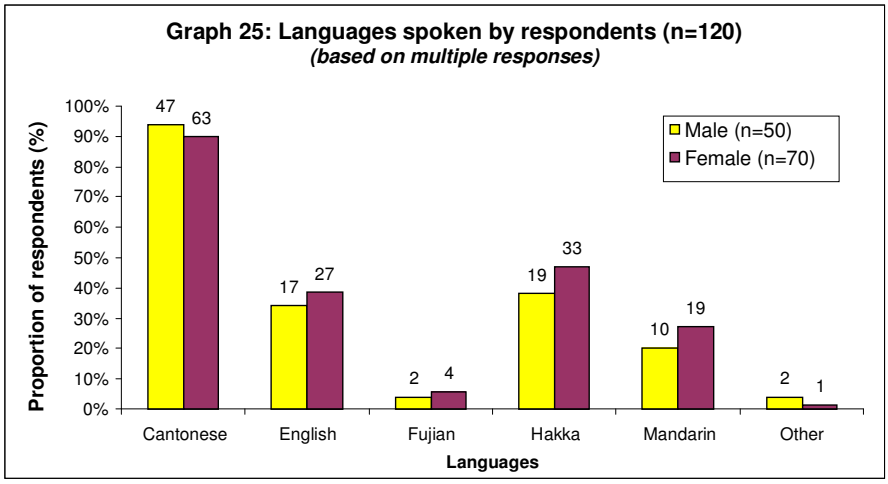
"Regarding the health services, there is a need to have more interpreters. At the moment only hospital will help us to arrange an interpreter. GP do not provide the same services. For the people who could not speak English, very inconvenient, because they have to see the GP first, whatever happens related to health. If GP can provide an interpreter as well would be good" (Female, age 52)

"If there is a 24 hour telephone interpretation services will be good (specially during the evening). In case some emergency happen in the evening, go to A&E/hospital, we need interpretation services. Thank you!" (Male, age 47)

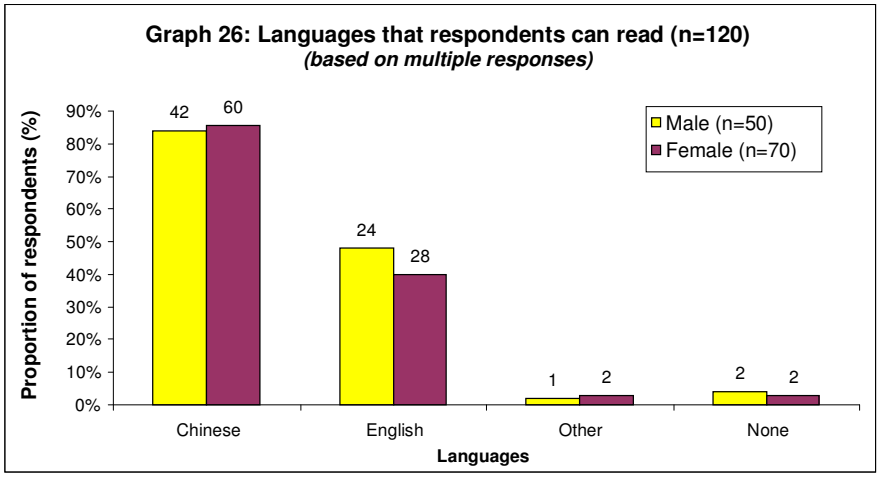
"To show your care of the disability people, needs to be by action not only by saying (word) (mouth)" (Male, age 44)

Literacy

120 respondents identified which languages they could speak and read (see Graphs 25 and 26 respectively). 92% (110) spoke Cantonese Chinese, followed by 43% (52) who spoke Hakka, 37% (44) English, and 24% (29) Mandarin. *'Other'* languages identified were Fujian and Vietnamese.

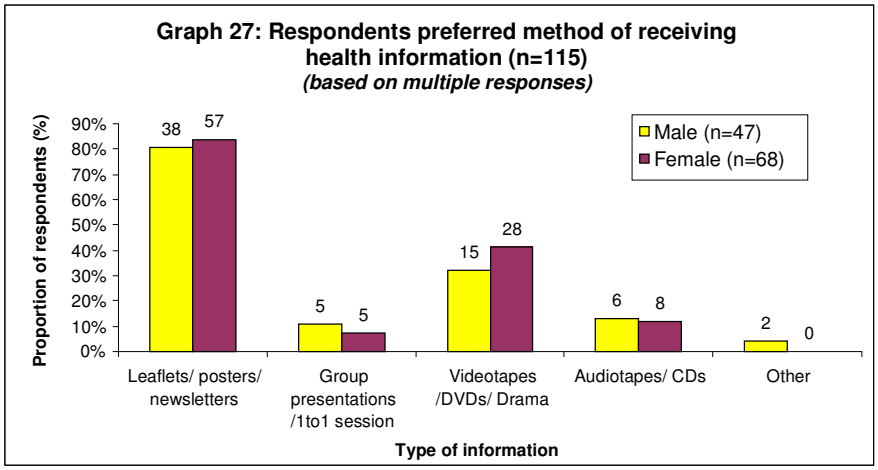


84% (102) could read Cantonese Chinese (see Graph 26) and 43% (52) could read English, and this was similar for both male and female respondents. Other languages identified as being read were Malay, Vietnamese and "*Normal English (not difficult)".* Only 3% (4) said they could not read any language.



Health Information Preference

115 respondents stated their preferred method of receiving information about looking after their health (see Graph 27). 83% (95) identified written material like leaflets, posters and newsletters and 37% (43) stated visual methods like videotapes/DVDs/Drama. Group presentations or 1-to-1 sessions were least preferred. Other individual responses included *"not interested"* and *"television"* respectively.



112 respondents stated what source of information they preferred translated or interpreted into their own language (see Table 6). 84% (95) preferred to receive translated written material and 44% (49) expressed a preference for visual methods, while 17% (19) wanted it in audiotape/CD format.

Table 6: Sources of information respondents would like to receive translated/interpreted into their own language (n=112) *(based on multiple responses)*

Source of Information	Total Number of Respondents (n=112)	Male (n=47)	Female (n=65)
Leaflets/posters/newsletters	85% (95)	81% (38)	88% (57)
Videotapes/DVDs/drama	44% (49)	34% (16)	51% (33)
Audiotapes/CDs	17% (19)	17% (8)	17% (11)
Group presentation/one-to-one	14% (16)	13% (6)	15% (10)
Other *("none", "not interested")*	4% (4)	6% (3)	1% (1)

General Comment:

"More health talk events e.g. diabetes, obesity - the cause and the risk. High blood pressure - the cause etc. Due to the working hours, sometimes unable to attend the event. Written information will be good" (Female, age 43)

4 CONCLUSIONS & RECOMMENDATIONS

4.1 Physical Activity

National evidence shows that active people have a longer life and less risk of developing many diseases such as coronary heart disease, type II diabetes and stroke (*Physical Activity and Your Health* Leaflet, Dudley PCT 2006). Physical activity recommendation for adults is 30 minutes of moderate activity (defined as activity that makes you breathe harder than normal and feel warmer) 5 times a week and for children 1 hour every day. In the UK, seventy per cent of women and sixty per cent of men are not active enough to achieve health benefits and this was also reflected in the findings related to the Chinese community by Sproston & Mindell (2006) who noted a slight increase in Chinese men and a decrease in Chinese women in the numbers meeting the physical activity recommendation in 1999 and 2004.

In this survey, over forty per cent of the respondents considered themselves to be fit (more men compared to women), almost the same number felt their fitness level was only average and the rest perceived themselves as unfit (see Graph 3). Whether this perception is related to the traditional Chinese concept of balance and harmony between body and soul, is something that could be explored further and would be useful in determining the way forward for health promotion interventions.

Most respondents were physically active to a degree with physical exercise popular amongst the men, and looking after children and doing housework being the key sources of physical activity for women (see Graph 4). This echoes the core cultural values of the community in exercising self-discipline and respect for traditional family life and identifies a good approach to encouraging more uptake of physical activity. Outdoor activity such as cycling, walking, gardening, jogging and golf was also undertaken by some, although others clearly did nothing to keep physically active. However, with only a quarter of respondents achieving the recommended level of activity for adults (see Graph 5) there is much need to raise awareness within the community and develop targeted work to promote physical activity health messages.

Many of the respondents were not sure or did not feel they did enough physical activity to keep healthy, especially the women, citing a lack of opportunity / facilities,

time and cost as reasons (see Table 1). Almost forty per cent did not know what type of exercise would suit them – and this gap in knowledge is further supported by the finding that more information about local facilities and what to do would help them to start or become more physically active (see Table 2). More women than men said they would be encouraged to take up physical activity if they had individual advice and support.

In conclusion, the concept of physical activity was valued within both leisure and domestic environments by the community but there is a strong need for greater awareness of the recommended levels, and of the local facilities and opportunities available.

Recommendations:

- To develop targeted work with Chinese women to promote physical activity messages.

- To raise awareness of local facilities for physical activity and promote them in the community to encourage uptake.

4.2 Healthy Eating

What constitutes 'a healthy diet' can be a subjective concept and is dependent on the cultural context of the individual. For example, for people living in poverty, no matter where in the world, *eating well* could mean having enough food to survive each day, for those who live in wealth it could mean having an abundance of food whenever desired, and not necessarily when needed.

The Chinese culture views health as a product of sufficient flow of energy through the body and since food is an important source of energy, the right choice of food and drinks and regular timing of meals are considered integral to good health (Jervais & Jovchelovitch 1998). Nutrition is therefore organised to maintain good health and prevent or cure illness and this is clearly demonstrated by the 'hot and cold' foods concept discussed earlier in Section 1. Most of the people in this survey agreed with the statement that overall they had 'a healthy diet', but there was also indication of a lack of knowledge amongst some respondents and a level of awareness of not having a healthy diet amongst others. This needs to be explored further with the local Chinese community to fully understand their perception of a healthy diet, particularly with regard to traditional beliefs to see how they impact.

Over the years, healthy eating messages have been campaigned widely by the government to encourage people to eat well and help maintain a healthy weight and so prevent illness such as heart disease, diabetes and hypertension (high blood pressure). To ensure a healthy balanced diet eating a variety of types of food are recommended (Eat*Well* Leaflet: Food Standards Agency 2008) including healthy eating messages such as:

- Eat plenty of fruit and vegetables (at least 5 portions a day, fresh, frozen, tinned, dried or juiced)
- Eat plenty of bread, rice, potatoes, pasta and other starchy foods (especially wholegrain)
- Have some milk and dairy foods
- Eat some meat, eggs, beans, lentils and other non-dairy sources of protein
- Have 2 portions of fish a week (one portion to be oily fish)
- Eat small amount of foods and drinks high in fat and/sugar
- Eat less salt (no more than 6g a day for adults)

Sproston & Mindell (2006) found that amongst minority ethnic groups, the Chinese and Indian communities were the highest proportion eating 5 or more portions a day. However, in this survey, majority of the people ate less than the recommended 5 portions of fruit and vegetables per day, citing reasons of access; *"There is not much Chinese vegetables to select in the supermarket"* (Female, age 45); cost, and the preparation time involved (see Table 3). With only 11 per cent of the respondents eating the recommended levels of fruit and vegetables (see Graph 7), there is an indication that more health promotion work on healthy eating needs to be carried out to raise awareness in the community in Dudley borough.

Sproston & Mindell (2006) found that the Chinese community were the least likely to add salt to food at the table and this was also reflected in the Dudley survey findings, where people mostly tasted food first and then only occasionally added salt and over a third never added it (see Section 3.4). In contrast, virtually everyone used soya sauce in cooking which is high in salt content, therefore indicating a clear need to raise awareness of the salt content in sauces used in Chinese cooking.

Most people consumed red meat at least 1-3 times in one week and ate less than the recommended levels of pulses (see Graphs 9 & 12) at 7 or more times per week (Dudley PCT Lifestyle Assessment Best Practice Guidelines September 2009).

Consumption of sugary foods such as cakes biscuits and chocolates was generally once a day or less (see Section 3.4) but over a third ate sugary foods 2-5 times a day which do not meet the recommended levels of 0-3 portions per week (Dudley PCT Lifestyle Assessment Best Practice Guidelines September 2009). This reveals a need for raising awareness about the other key healthy eating messages and ensuring a balanced diet.

On a positive note, consumption of full fat milk (twice a week or less) and full fat cheeses (once a week or less) was low amongst respondents (see Graphs 10 & 11) and within the recommended 0-3 times per week (Dudley PCT Lifestyle Assessment Best Practice Guidelines September 2009). This supports the findings by Sproston & Mindell (2006) who found that the Chinese and Indian communities had the lowest fat intakes amongst minority ethnic groups.

Most people in the study ate oily fish at the recommended levels of 1-3 times a week. Processed or ready made meals were reportedly consumed once a week by most people.

In conclusion, the perception of community members generally was that their diet was healthy, but on investigation, did not necessarily practice the national healthy eating guidelines, especially with regard to consumption of fruit and vegetables, meat and pulses. The low fat intake and the consumption of the recommended amount of oily fish is good practice and to be commended but there needs to be awareness raised of a balanced diet overall. Food access has been highlighted as an issue and will need to be considered amongst other social factors when promoting healthy eating messages.

Recommendations:

- To explore the cultural understanding of what a 'healthy diet' means to the Chinese community

- To develop targeted work on raising awareness and promoting healthy eating and healthy cooking messages (i.e. use of soya sauce and salt in cooking)

- To celebrate the positive healthy eating actions currently maintained by the community (i.e. low consumption of fats)

- To address the need around access to fruit and vegetables

4.3 Alcohol & Smoking

The advice on drinking alcohol (*Units and you* Dept of Health 2008) is that men and women should not regularly (i.e. every day or most days of the week) drink more than 3-4 units and 2-3 units of alcohol a day, respectively. Compared to the general population where only 8% of men and 14% of women are non-drinkers, minority ethnic groups are more likely to be non-drinkers and drink alcohol less often. Sproston & Mindell (2006) found that the majority of Chinese men and women did not drink at all in the week prior to their interview.

These findings were also reflected in the local survey with Dudley's Chinese community where alcohol consumption amongst respondents, especially females, was low, with the majority being non-drinkers (see Diagram 2). Of the twenty-six respondents who were current alcohol drinkers, no-one had drunk alcohol every day of the week. Most did not think their drinking was harmful to their health and those that did, drank between 1-4 days in the previous week. Almost a quarter did not know if their level of drinking was harmful, thus suggesting a need for raising awareness amongst the community of levels of drinking and their effects.

Smoking prevalence is higher than average amongst routine/manual occupations and it causes approximately 84,000 deaths every year in England (APHO 2007). Stop Smoking Services have been promoted nationally to encourage people to give up smoking by offering group and one-to-one support (Smokefree Guide Dept of Health February 2009), but monitoring the service by ethnic group has been limited because of a lack of local reliable data on smoking prevalence. However, self-reported cigarette smoking rates amongst Chinese men (21%) and Chinese women (8%) are lower than the general population at 24% for men and 23% for women (Sproston & Mindell 2006).

This study found that smoking tobacco was virtually non-existent amongst females and extremely low amongst males from the Chinese community (see Diagram 3), thus reflecting the national findings. Of the eight who did smoke (7 male; 1 female) they only smoked between 1-20 cigarettes a day. Six had wanted to give up but were not aware of any local services in Dudley borough to help them, and therefore not used any of them:

"I don't know which method is good for me to stop smoking. I don't know how to stop smoking" (Female, age 43)

In conclusion, although alcohol drinking and smoking tobacco do not appear to be major issues for the local Chinese community, there is need for specific support in raising awareness of levels of harmful drinking as a prevention tool and for promoting local services that support people wishing to give up smoking.

Recommendations:

- To raise awareness of harmful levels of drinking alcohol amongst Chinese men.

- To raise awareness of local Quit Smoking Service and other sources of support.

4.4 Emotional Health & Well Being

The importance of mental health and well being is well recognised as equal to that of physical health (Choosing Health Department of Health 2004). We know that:

- 1 in 4 people will experience significant mental illness at some time in their life
- 1 in 6 people of working age will have a mental health problem (mainly anxiety and depression)
- 10% of children have a mental health problem
- One third of GPs (family doctors) consultations involve a major element of mental health

  (Mental Health Foundation 2009)

Evidence shows that poor mental health is associated with unemployment, less education and low income, and can be both a cause and consequence of social, economic and environmental inequalities (Friedli 2009). Over the last 10 years the National Service Framework for Mental Health has supported mental health promotion *"for all"* working with individuals, organisations and communities and there is continued commitment to support this through the *New Horizons* strategy for mental health over the coming years (Department of Health 2009).

Mental health promotion for individuals is about developing resilience and the ability to cope with everyday living. Positive steps to protect mental well being have been identified (NIMHE 2005) which apart from the physical health messages such as being physically active, eating healthily and drinking in moderation, are also about valuing self and others, keeping in touch with loved ones, caring, being creative, learning new skills, getting involved and making a contribution, having a break, talking about feelings and asking for help when needed.

The mental health needs of the Chinese community have been studied with regard to service provision issues and the experience of mental illness (see Section 1) but there is very little evidence in relation to positive mental health and well being. Most studies have looked at life satisfaction as a way of measuring individual well being by capturing information on satisfaction, pleasure, enjoyment and contentment (nef 2004). In this context, the survey explored respondents' self-assessed satisfaction with their employment, education, family life, leisure activities, friendships and

relationships, as a way of gauging how content people were with their lives. It also gained insight into positive and negative feelings experienced at the time of the study, where they sought help when in need, and whether they felt a sense of community belonging.

Personal development has been identified as an important factor in enabling individuals to cope positively with challenges in life (nef 2004). It gives meaning to life and is about curiosity, creativity, commitment, enthusiasm, and challenging and absorbing activities with which we explore the world we live in. Although most respondents in this study were satisfied with their level of employment and education, there was indication of a lack of fulfilment by over a third who were fairly or not satisfied (see Graphs 15 & 16), hence suggesting a need for access to further learning and personal development opportunities.

Reflecting the core values of Chinese culture discussed in Section 1, this survey revealed high satisfaction levels with family life, especially amongst the males (see Graph 17), thus demonstrating the importance attached to the family context (Gervais & Jovchelovitch 1998). Satisfaction with friendships and relationships was also strong amongst the respondents (see Graph 18) and this was further supported by the finding that friends, spouses/partners, children and relatives respectively, were the main sources of support when help was needed (see Table 4). This can be interpreted as a strength within the community and needs to be valued and celebrated. However, less than twenty per cent of people sought help from public services, suggesting a lack of awareness of or confidence in using local health and social care services: *"Who can understand me?"* (Male, age 61).

Managing the stresses and strains of everyday life and events is about maintaining a balance between negative and positive feelings which inevitably impact on self-esteem and the ability to cope. Most respondents reported having felt calm and peaceful most or some of the time in the previous month, with two-thirds saying they had a lot of energy and were satisfied with the amount of time they spent on leisure activities. However, over forty per cent of respondents also reported feeling downhearted and depressed for *some of the time* in the previous four weeks, mainly female, and this would warrant further investigation.

A sense of belonging is very important to feeling valued and also provides the stimulus for contribution and involvement. Generally, respondents felt connected to their wider community which was defined as a specific locality *"including all the people who live there"* (see Diagram 4), particularly the males. However, of the third who did not feel connected, females (all aged between 33-48 years old) felt less connected than males and this may suggest a level of isolation amongst this age-group of women.

The Mental Health Foundation (2009) in their commentary on mental health, resilience and inequalities identify dignity, respect, self-worth, having a positive identity and feeling connected to our wider societal context as essential in helping us to face adversity and the difficulties we all experience in life.

In conclusion, the study population generally reported high levels of life satisfaction and therefore indicate resilience. But there was identified need for personal development opportunities, for greater awareness of public services and the support available, and for developing work with women in their thirties and forties to combat any potential for isolation.

Recommendations:

- To develop learning and personal development opportunities for the Chinese community

- To celebrate family life and achievements within the community and with others

- To raise awareness of the public services and resources available to support mental health and wellbeing

- To develop and establish social participation and networking opportunities for the community, especially women aged 30-50 years to combat isolation and enable greater contribution to the wider community

4.5 Access to Services

The use of health and social care services in Dudley amongst the Chinese community was reportedly low with more than half the respondents not having accessed any in the previous twelve months (see Diagram 5). Of those that did, it was mostly health-related services, with over fifty per cent of respondents saying they needed an interpreter when accessing them (see Diagram 6), mainly relying on family members (see Graph 24).

Dudley MBC has a well-established interpreting and translating service to support diverse local language and communication needs and Dudley PCT provides access to an interpreting and translating service for health professionals such as GP's to support patients/clients needs. Together with the anecdotal evidence from the Chinese Community Centre - Birmingham who had reported that Dudley residents often approached them for interpreting support for their local health appointments, the survey indicated a lack of awareness amongst the Chinese community in Dudley of local interpreting provision, *"…GP do not provide the same services…"*. Where local residents did use the Dudley MBC service, they commended it highly but said it needed to be increased:

"I would like the council to employ more community workers / social workers to help the people who can't speak English…" (Female, age 61)

"Need more interpreters, specially in GP services…." (Male, age 83)

Following the national trend, Dudley will see an increasing older population over the next few years and as the population encompasses communities whose first language is not English, it is likely that the demand for language support will also increase. The majority of survey respondents who said they needed interpreting support were over fifty-five years of age, but there was also evidence of need amongst younger age-groups (see Table 5):

"Due to my English is not very good, I always need an interpreter to assist me and also I do not know what happen within my community locally. If there is a resource/information centre for us, to help us to read the letter or make an appointment will be good" (Female, age 45)

At present, unlike other minority ethnic community groups, there is no established centre for the Chinese community in Dudley and this was reflected in the comments. There was a strong expressed need for a local centre to *"provide more activities such as day trips and party",* and *"for meeting, health etc.".*

Social isolation has already been identified as a key issue for this community (Parish 2000; Chan 2002) and having a designated place that enables sharing of cultural activities and gaining information will go a long way to help promote community well being:
"I wish there is a centre to provide all sorts of activity which will benefit the Chinese community" (Male, age 49)

With regard to communication, the survey revealed a variety of languages and dialects used by the local community including Mandarin, Fujian, Hakka, Malay, Mandarin and Vietnamese. However, the majority of respondents were fluent in both spoken and written Cantonese Chinese with more than a third able to speak and read in English (see Graphs 25 & 26). This level of literacy supported their preference for receiving information on looking after their health in written formats such as leaflets, posters or newsletters (including the format in which they preferred to receive information in their own language - see Table 6):
"…Due to the working hours, sometimes unable to attend the event. Written information will be good" (Female, age 43)

Meeting such communication needs will increase community engagement and contribution as was demonstrated by the research process. By allowing time to develop a bilingual questionnaire and providing access to interpreting support, it enabled positive engagement from people who may not have contributed if the questionnaire had only been in English – many people wrote comments in Chinese which were then translated into English and were valuable in interpreting the results.

In conclusion, the survey findings reflected the key access issues indentified by others (Liao & McIlwaine 1995) namely, under-use of services, language difficulties, need for interpreter to see a doctor and reliance on family members to meet that need.

Recommendations:

- To raise awareness within the community of the local interpreting facilities available from services to support their health and social care needs, particularly for older people.

- To ensure that interpreting provision is considered from the outset in planning and developing health initiatives to prevent reliance on family members.

- To make available information in the appropriate written form of Chinese (i.e. Cantonese or Mandarin) in the format of leaflets, posters, or newsletters when promoting health messages to the community. But also to consider the need for specific dialects when arranging interpreting provision.

- For services to make good links with the Dudley Chinese Community Association and engage with the Chinese community.

- To support the establishment of a permanent centre or base for the Chinese community in Dudley.

4.6 Summary of Recommendations

Health Need	Recommendations	Actions By
Physical Activity	▪ To develop targeted work with Chinese women to promote physical activity messages. ▪ To raise awareness of local facilities for physical activity and promote them in the community to encourage uptake.	Relevant Health and Local Authority Services
Healthy Eating	▪ To explore the cultural understanding of what a 'healthy diet' means to the Chinese community ▪ To develop targeted work on raising awareness and promoting healthy eating/ cooking messages (i.e. use of soya sauce and salt in cooking) ▪ To celebrate the positive healthy eating actions currently maintained by the community (i.e. low consumption of fats) ▪ To address the need around access to fruit and vegetables	Relevant Health and Local Authority Services
Alcohol & Smoking	▪ To raise awareness of harmful levels of drinking alcohol amongst Chinese men. ▪ To raise awareness of local Quit Smoking Service and other sources of support.	Relevant Health and Local Authority Services
Emotional Health & Well Being	▪ To develop learning and personal development opportunities for the Chinese community ▪ To celebrate family life and achievements within the community and with others ▪ To raise awareness of the public services and resources available to support mental health and wellbeing ▪ To develop and establish social participation and networking opportunities for the community, especially women aged 30-50 years to combat isolation and enable greater contribution to the wider community	Relevant Health and Local Authority Services
Access To Services	▪ To raise awareness within the community of the local interpreting facilities available from services to support their health and social care needs, particularly for older people. ▪ To ensure that interpreting provision is considered from the outset in planning and developing health initiatives to prevent reliance on family members. ▪ To make available information in the appropriate written form of Chinese (i.e. Cantonese or Mandarin) in the format of leaflets, posters, or newsletters when promoting health messages to the community. But also to consider the need for specific dialects when arranging interpreting provision. ▪ For services to make good links with the Dudley Chinese Community Association and engage with the Chinese community. ▪ To support the establishment of a permanent centre or base for the Chinese community in Dudley.	Relevant Health and Local Authority Services

5 PROGRESS & OUTCOMES

5.1 Expert Patients Programme – *Cantonese Course*

The partnerships established through this research process resulted in the delivery of an Expert Patients Programme (see Appendix 4) tailored to meet the communication needs of the Chinese community in Dudley from 13th October to 17th November 2008. The course was funded and organised by Dudley PCT with support from Dudley MBC and the Dudley Chinese Community Association, and delivered by bilingual EPP tutors from the Chinese Community Centre in Birmingham (CCC-B). Recruitment for the course included offering a taster session opportunity in September and sending out letters of invitation via the local GP to suitable patients. The face-to-face promotional event successfully recruited 13 participants for the course but there was no response from the mail out from GPs, thereby demonstrating the value of personal contact.

The EPP course was held at the Valley Road Youth & Community Centre in Lye, Stourbridge, which is the venue used by the Chinese community for all activities as there is no designated centre for the community. *"In regards to the venue, we felt that the classroom was a bit small to accommodate all 13 participants plus the tutors, and also the ventilation in the room was difficult to control…"* (Course Tutors)

13 people attended and completed the course, 9 were Dudley residents and 3 were out of area funded through Worcester PCT, which also reflects the findings of the research (see Section 3.2). Lunch was provided to encourage retention and made for a positive networking and social opportunity at the end of each session. Therefore retention rates for this course were excellent with 100% completions (defined as attending 4 out of the 6 sessions), thus showing commitment and willingness to learn. In accordance with the Stanford University Licence for EPP (see Appendix 4), the course was delivered from an adapted Cantonese script developed by CCC-B, and supported by handouts in Cantonese. However, the course book was an issue, as the participants wanted to take the book home to read and to learn, but it was difficult for them as their level of English was not as good to comprehend the information given. So for future courses where English is not the first language, then having the course book in the participants' own community language would be more beneficial.

The group were very participative, asked questions and were eager to learn. They picked up the action plan very quickly, and each week their feedback style and information was more relaxed and by the final week the whole group were changing and implementing new ideas. In evaluating the course, the tutors felt that the participants had learnt some new techniques, their thinking of their illnesses had differed and they were more in charge of what they wanted and how they wanted to utilise services.

EPP evaluation is based on self reported changes in confidence to manage aspects of the participant's health condition. The group were positive about the management of their conditions from the very first day demonstrating an ability to manage many symptoms of their long term conditions. Course evaluation showed a noticeable decrease in the burden of common symptoms (i.e. pain, tiredness, difficult emotions, stress, depression and shortness of breath). On a scale of 0-10 with 10 representing all of the time and 0 none of the time it demonstrated a decrease of 12% (n=13); and a marked increase in confidence to work in partnership with health care professionals. On a confidence scale from 0-10, participants showed a mean average of 37% increase in confidence in this area (n=13).

'The EPP is a great advantage for the groups.' (Participant)
'I'm very enjoy this lesson and learn something I never did.' (Participant)

'Most of the participants knew that they are not the only one who has a problem, but will feel reluctant to tell people or ask for help. Therefore, this course means a lot to them, the best part is they can use their mother tongue to ask what they want to know and express themselves without misunderstanding and hesitation'. (Course Co-ordinator)

5.2 Outcomes

The learning from the piloting of this course has informed future developments within Dudley's Expert Patients Programme Service with regard to delivering or commissioning EPP for communities where English is not the first language. With strong links established locally and regionally, joint working is continuing with a Carer's Event aimed at the Chinese community planned for Spring 2010 in Dudley.

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APPENDIX 1

Contact Details of Key Organisations

DUDLEY CHINESE COMMUNITY ASSOCIATION (DCCA)

President: Gary Yiu

Chair: Kwai Sung Yung

Contact Details: C/o PO Box 2922, Brierley Hill, West Midlands DY5 3WY

Telephone: 07733 131229

Email: dcca@hotmail.co.uk

NHS DUDLEY (previously Dudley PCT)

Contact Details: Health Inclusion Programme, Public Health Directorate, 2nd Floor, St. John's House, Union Street, Dudley DY2 8PP

Telephone: 01384 366038

DUDLEY METROPOLITAN BOROUGH COUNCIL (DMBC)

Contact Details: Race Equality & Communication Services, Directorate of Adult, Community and Housing Services (DACHS), Ednam House, St.James's Road, Dudley DY1 3JJ

Telephone: 01384 813400

CHINESE COMMUNITY CENTRE – BIRMINGHAM (CCC-B)

Contact Details: Q-Lorc Centre, 99 Bradford Street, Digbeth, Birmingham B12 ONS

Telephone: 0121 685 8510

Email: cccbirmingham3@hotmail.com

Website: www.bhamchinesecommunity.org.uk

APPENDIX 3

Geographical Areas Where Respondents Lived (n =112)

Postcode	Number of Respondents	Areas Covered (Areas relevant to Dudley Borough)
B62	9	Halesowen
B63	9	Halesowen
B64	6	Cradley Heath
B65	2	Rowley Regis
B69	2	Oldbury
B90	1	Solihull
DY1	14	Dudley town centre and Woodsetton village
DY2	7	Dudley southern area and Netherton
DY3	1	Sedgley town, Lower & Upper Gornal, Gornal Wood, Himley, & Swindon villages
DY4	2	Tipton and south east Coseley
DY5	24	Brierley Hill town and Pensnett village
DY6	5	Kingswinford town and Wall Heath village
DY8	14	Stourbridge town, Wollaston, Wordsley and Amblecote villages
DY9	10	Lye, Pedmore and Hagley villages
DY10	3	Kidderminster
WV12	2	Willenhall
WV14	1	Bilston

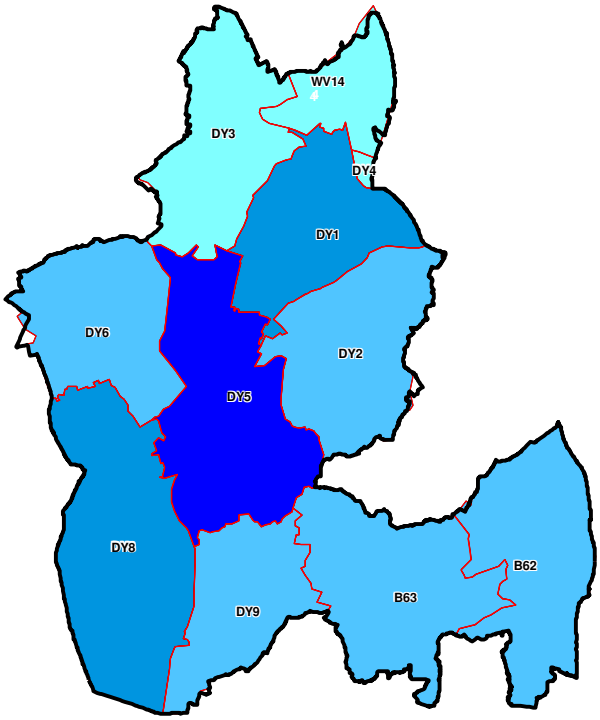

Diagram 1: Number of respondents in each postcode district of Dudley MBC

- 24
- 14-23
- 5-13
- 1-4

APPENDIX 4

Expert Patients Programme Service Specification

1. Introduction

EPP is a self management programme for anyone with a long term health problem. It aims to equip patients with the necessary skills to manage their condition more effectively with a particular focus on the emotional impact that life with a chronic condition can bring.

Over 6 weekly sessions of 2 ½ hours, volunteer tutors (who have conditions themselves) lead participants via a scripted manual though a number of topics including dealing with difficult emotions, fatigue management, communication skills, relaxation techniques etc., whilst implementing and role modelling the core skills such as goal setting, problem solving, being resourceful, decision making and so on.

It also gives patients the opportunity to support and be supported by others in a similar position. From a health point of view it does not replace patient information in other forms but complements medical information or courses by boosting self confidence and empowering patients to feel more 'in control' and less dependant on health professionals. It can help with medication compliance as well as better relationships with health professionals.

2. Background

The EPP course is based upon the Chronic Disease Self-Management Programme (CDSMP) developed and researched over the past twenty years by a team led by Professor Kate Lorig at the Patient Education Research Centre, Stanford University, California.

Plans for the establishment of an Expert Patients Programme in England, were announced in the 1999 Health Strategy White Paper Saving Lives – Our Healthier Nation and later reaffirmed in the NHS Plan of July 2000 which can be downloaded from the Department of Health website.

An Expert Patients Task Force was set up in late 1999 under the chairmanship of the Chief Medical Officer, Professor Liam Donaldson, to recommend a new programme that would bring together the valuable work of patient and clinical organisations in developing self-management initiatives. Task Force members included representatives from the medical profession, non-governmental organisations, and experts in the field of self-management training and research.

3. Benefits of the programme;

The course has been subject to a number of studies world wide which have all pointed to it effectiveness at enabling people living with a long term condition gain a sense of being in control and enabling them to experience better daily health. The course is thus beneficial to patients but also to those in the health care system concerned to meet government targets.

Benefits to patients;
Improved Self Efficacy
Improved communication with Health Care Professionals

Better fatigue control
Lower levels of depression
Improved symptom control
Increased medication compliance

Benefits to wider NHS agenda;
Supports the achievement of government policy initiatives; NSFs, QOF, Health of the Nation, Choice etc...
Reduce usage of both planned and emergency secondary care services
Facilitating greater social inclusion
Targeting health action areas
Building healthy communities
Act as advocates for patient groups
Support the PPI agenda
Increase volunteer capacity.

4. Evidence Base

Recent RCT[1] of EPP showed that the economic benefits of EPP total £451.73 per person per year.
Economic benefits worked out from savings in healthcare services such as reduction in GP usage and hospital in-patient bed days, and reduction in medication usage after EPP intervention.

Expert Patients Programme RCT findings;
Significantly greater self efficacy
Significantly greater energy levels
Significantly greater health related quality of life
50% reduction in use of hospital services
Reduction in costs; 77% probability that EPP is cost-effective
EPP is a useful addition to current services in the care of people with long term conditions.[2]
In addition to such cost savings an increase in self efficacy and healthy behaviours were also reported.

[1] *Economic benefits of Self Care. Commissioning and System Management Analysis Team*. Jeremy Burrows 2007
[2] *Self Care Support Pack*, Department of Health 2007

得利華人會
DUDLEY CHINESE COMMUNITY ASSOCIATION

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Chairman: Kwai Sung Yung 主席:翁桂生

免費 '健康自我管理' 課程
Expert Patients Programme (簡稱EPP)

本會聯同得利基層醫護信託署(Dudley PCT)邀請到伯明翰華人社區中心的梁姑娘及她的同事爲我們以粵語教授 '健康自我管理' 課程.

課程爲期六週, 由10月13日開始的連續六個星期一, 上午十時至中午十二時三十分. 下課後有午膳供應.

Our association work with the Dudley PCT invites Miss Leung and her colleagues from the Chinese Community Centre – Birmingham to deliver the 'Expert Patients Programme' in Chinese Language.

This Six weeks programme start on 13-10-2008 (Monday), 10:00am to 12:30pm, lunch will be provided after the session.

日期Date:

13-10-2008 星期一 Monday/20-10-2008 星期一 Monday/
27-10-2008 星期一 Monday/3-11-2008 星期一 Monday/
10-11-2008 星期一 Monday/17-11-2008 星期一 Monday

時間Time:

上午10:00pm – 12:30pm

地點Venue:

Valley Road Youth & Community Centre, Providence Street, Lye. DY9 8HQ

報名及聯絡Contact:

林姑娘(Winnie) 01384 813400

此課程由得利基層醫護信託署提供, 並特此鳴謝伯明翰華人社區中心及得利種族平等及聯絡服務的協助. This Programme is provided by the Dudley PCT, Public Health Directorate and especially thank you for the support from the Chinese Community Centre – Birmingham and Race Equality and Communication Services, DACHS