

ARROGYA

SOUTH ASIAN (INDIAN) COMMUNITY INTERVENTION

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A PARTNERSHIP MODEL.....

- **ASIAN HEALTH FOUNDATION**
 - Project Funder, advocacy, leadership
- **EAST HEALTH PHO**
 - Collaborative Partner, Funding Partner
- **TOTAL HEALTHCARE OTARA**
 - Collaborative Partner, Contractual agreement
- **East Tamaki Health Care (GPs)**
 - Project Deliverer

BACKGROUND

- Asians are the fastest growing population in New Zealand comprising 9.2% of the total population (15% by 2020)
- South Asians are the second largest Asian population in New Zealand followed by Chinese
- South Asians are a high risk group for Diabetes, Cardio Vascular and stroke than any other Asian groups in New Zealand
- Hospitalisation rates for South Asians are higher than any other Asian groups in New Zealand

BACKGROUND

- Health of Asian migrants deteriorated over time
- Transitional people change their food habits and lifestyles as a result of acculturation
- Currently there is no evidence on what type of community interventions are effective
- No recognised infrastructure to deliver Asian services in New Zealand
- Limited workforce capacity to address Asian needs

AIMS OF THE ARROGYA PROGRAMME

- To establish the HEHA needs of the Indian community
- To increase knowledge and change attitude towards healthy eating and physical activity
- To develop a educational tool (food guide)
- To establish an infrastructure with NGOs, PHOs and community leaders to provide Asian services

NEEDS ASSESSMENT

Aim:

- **To explore food habits and dietary changes after migration**
- **To explore what type of resources and community programme would appeal to this audience**

Method:

- **Focus groups, semi structured questionnaire**
- **Telephone interviews to validate the findings of the focus group**

TOTAL HEALTHCARE OTARA (PHO)

Total registered population: 87,000

South Asian Population: 15,000

THO/ETHC

Mainly in South Auckland with a few areas in Central Auckland (12 GP clinics) i.e. Otara, Manukau, Manurewa, Chapel Rd, Papatoetoe, Flatbush, Browns Rd etc. where majority of Indians live in CM.

- Has a high need population with lower socio economics status.**
- Majority of the Indians in CM are enrolled in THO.**
- Indians inherently depend heavily on GPs than other allied health professionals.**
- Most are new migrants with young families.**
- Significant South Asian workforce in the staff**

COMMUNITY LEADERSHIP

- **Reaching Indian Populations**
 - **Gathering around faith based organizations as a routine life style event makes it easy to reach Indians at the Temple**
- **Working as a collaborative partner**
 - **Partnership with the AHF was a new experience, which directed THO towards developing a health promotion programme specifically to Indian population.**
- **Building linkages and community networks**
 - **Through the programme it was possible to make better health practices using the community networks around the temple.**

COMMUNITY LEADERSHIP

- *What was my role as a THO Director and a community leader?*
- *How was it important in the project?*

Issues:

- Working in collaborating with a national Asian advocacy group (AHF) in the project.
- Having a wide Indian population network.
- Challenges in working with Indian populations.
- Having a significant South Asian population in PHO.
- Working in a low socio economic environment.

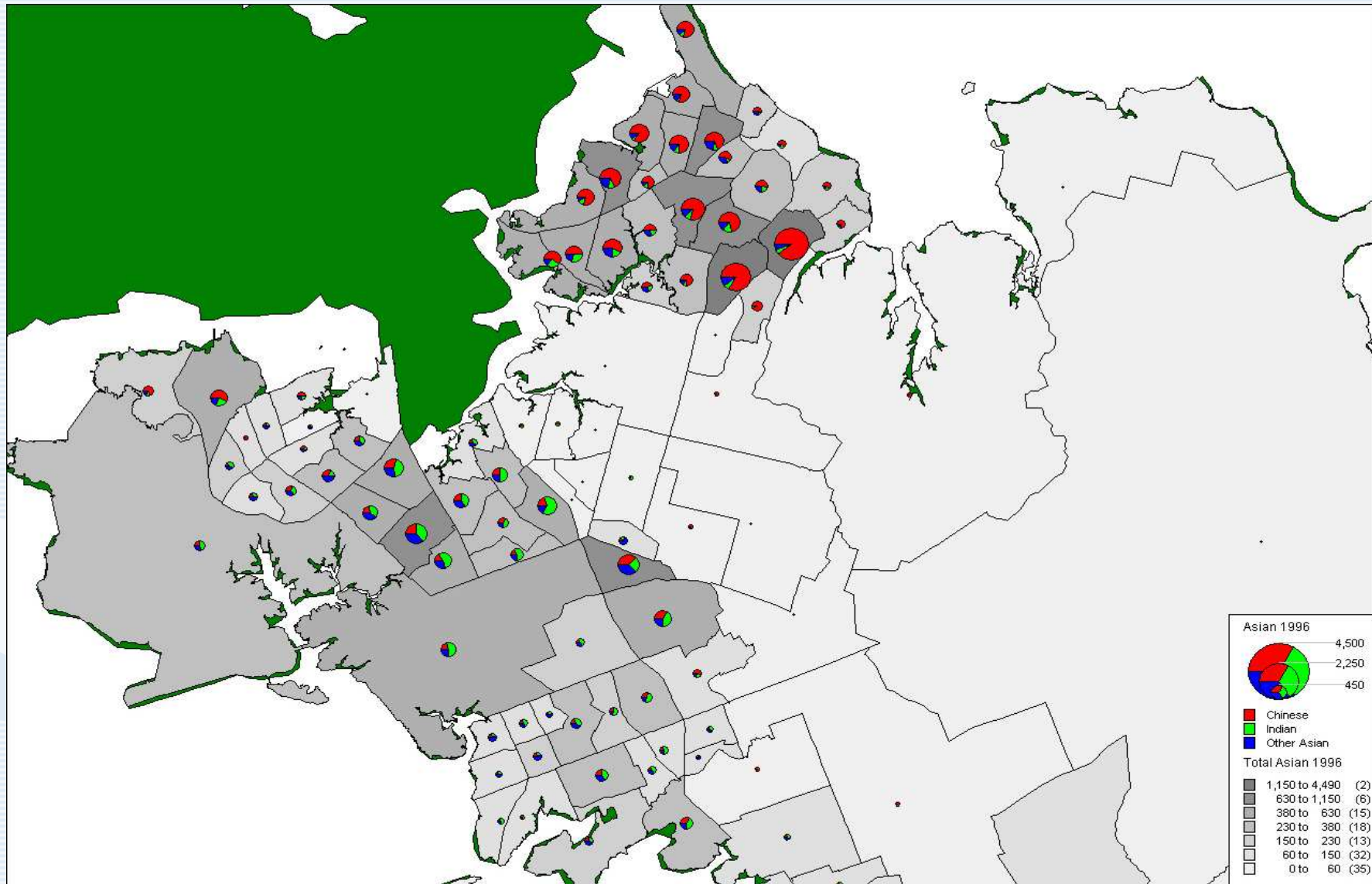
PROJECT CONCEPT & OBJECTIVES

- **Concept (Faith-based interventions):**
- **The temple setting is a good platform to organize and deliver health promotion programmes for Indian people with active community leadership.**

- ***Objectives:***
 - **To improve awareness about healthy eating & healthy activity in a selected Indian population.**
 - **To create behavior changes related to healthy eating and healthy activity through health promotion.**
 - **To test the effectiveness of a health promotion programme (including education tools) targeted to an Indian population using a faith based organization.**

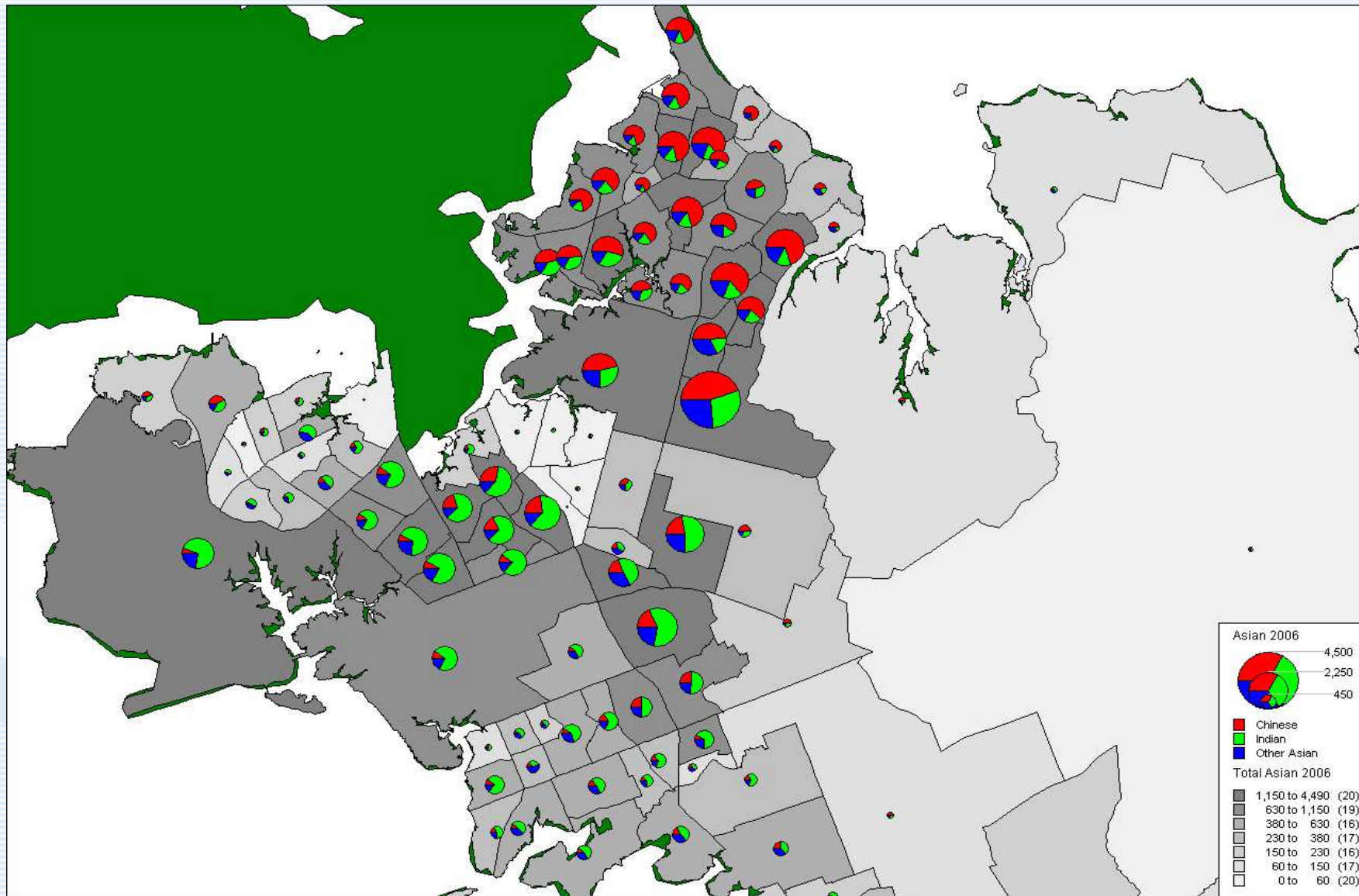
ASIANS POPULATION IN 1996

(SOURCE: G. GALA)



ASIANS POPULATION IN 2006

(SOURCE: G. GALA)



METHODOLOGY

- Self Management Education and HEHA Principles
- Group dynamics (active participation, sharing experiences).
- Community empowerment (knowledge , skills, confidence).
- Social cognitive theory (brain storming, goal setting)
- Motivational discussions, reflective learning, positive reinforcement, active listening.
- Trans theoretical model (pre & post intervention questionnaire, pre-tested by Otago Uni)
- Modified Focus Group Discussions (evaluation)
- External expert assistance (Nutritionist – NHF)
- Weekly two-hour sessions for 8 weeks.

SESSIONS

- Collection of basic data
- Healthy life style
- Concept of HEHA
- Working in families for HEHA
- Changing home environment
- Goal setting & Action planning
- Myth busters
- Label reading & sorting food
- Portion size & regular meals
- Healthy Plate model
- Yoga (practical sessions)
- Art of Living (& meditation)
- Healthy Indian foods
- IHD, CVD, Hypertension, Stroke
- Carbohydrate & fat counting
- Swapping for healthy options
- Moderate exercise at home
- Cooking demonstrations
- Indian food guide, CMDHB LBD posters
- Supermarket sample shopping
- Prevention & Management of chronic diseases
- Maintaining a healthy weight
- When to see help (from GP)

BASELINE DATA

Basic parameters, Ht, Wt, BP, Waist were taken at the outset.

Pretested questionnaire was administered at the beginning and at the end of the programme.

Some participants didn't attend all the sessions (approx 75-80% did).

Modified FGD was done at the end to evaluate.

Basic Data

- Total number = 51
- Age
 - <15 yrs = 20%
 - 15 – 30yrs = 18%
 - 31 – 40yrs = 50%
 - 41 – 65yrs = 10%
 - >65yrs = 2%
- Gender: M:F = 43% - 57%
- BMI: > 25BMI = 41%
- BP: 27% had high BP (>130/90)

QUESTIONNAIRE

Questions/Comments (selected results)	Pre	Post
I don't need to exercise	33%	6%
I am satisfied being an inactive person	21%	18%
I am afraid of consequents if I do not exercise	52%	91%
I believe regular exercise will make me healthy & happy	90%	97%
I believe I can exercise regularly	70%	82%
Regarding eating/exercise I don't need to change anything	48%	25%
I remove unhealthy food from my home	30%	82%
I reward myself for not eating unhealthy foods	42%	70%
I keep things that remind me not to eat unhealthy foods	33%	85%
I don't exercise right now and I don't care	34%	3%
I am finally exercising regularly	61%	85%
I have started to exercise and plan to continue	38%	94%
Instead watching TV, I will go for a walk	40%	85%

LESSONS LEARNED

- **“MYTH,” Asians are educated, rich and healthy?**
- **Health messages need to be made culturally appropriate (i.e. use of oil/sugar by Gujarati).**
- **Building exercises in the daily routine to avoid time constraints (being flexible for busy new migrants).**
- **More visually based & activity related sessions in the programme with clear messages will be effective.**
- **Group size of around 20 would be ideal, including family.**
- **Awareness of language barrier (Hindi/Gujarati).**
- **Data collection (evaluation tool) to be short & simple.**
- **Follow up of the group on regular basis with new inputs.**
- **Culturally acceptable community facilities (Gym, Pools etc)**
- **Need to change the external environment, building supportive environment (ANGELO framework).**
- **Need for culturally & ethnically appropriate workforce.**

CONCLUSIONS

- It is doubtful from the evidence if the national messages on HEHA has reached this population.
- There were clear indications of increased awareness on healthy life styles with the intervention.
- Significant number of participants showed behavior changes towards healthy living (eating & exercise) by the end of the programme.
- Running this programme at the Temple provided the opportunities to attract good cross section of Indian people and to maintain high level of participation. It paved the way for further health programmes (building community expectations).
- Collaborative partnership, community leadership and availability of trained staff (human resources) played a vital role in successful delivery of the programme.
- Sustainability of such programmes depend on availability of funding, community leadership/networks, HP workforce.
- Funding & removing infrastructure barriers at the DHB & PHO level

RECOMMENDATIONS

- More targeted approach with tailored messages.
- Remove territorial boundaries.
- Recognize the diversity within South Asians and cater appropriately (developing culturally appropriate education resource)
- National/Regional strategies need to recognise South Asians as a high risk group
- creating ethnically appropriate workforce
 - Identifying key geographic locations where South Asians reside and develop networks to build local infrastructure
- Use PHOs setting in those localities to serve the South Asian community .
- Train mainstream workers and increase knowledge on Asian cultural concepts

Acknowledgements.....THANK YOU FOR YOUR SUPPORT

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- **Health Sponsorship Council**
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- **Mt Roskill Medical Centre**
- **Roopa TV**