CHAPTER 1: INTRODUCTION

When I discussed the topic of my thesis with some of my Hong Kong Chinese friends with backgrounds in health care, their responses really shocked me. Their first question was: “What does physical activity mean?” The second question was: “Isn't it boring to study older Chinese people?” That indicated that they regarded the study of the preventive health behaviour of older Chinese people from Hong Kong who are living in Australia and their patterns of physical activity as “uninteresting”, “nothing special”, and had the belief that “older people’s problems are more or less all the same”. In any case I was told, “old people usually exercise because they have so much time”. Some suggested that I should study something “more meaningful”.

Two questions immediately came to my mind. Should older Chinese people have the right to experience health equity and equality? If my friends were right about their exercising because they have plenty of time, why did studies show that there were still many sedentary or physically inactive older Chinese people in Australia? I also thought it ironic that many of those who criticised my topic of study were themselves largely physically inactive.

1.1 Growing old

It is a truism that ageing is a natural part of life and a normal phase of human existence. Nonetheless, it is not always easy to define who exactly we are referring to when we talk about “older people”, since the term can have a variety of meanings. The meaning of “old” also varies with the stage of development of the observer. For example, young children might think of someone aged 60 or more as being very old, while the
contemporaries of a 60-year-old might think of them as merely middle-aged (Koo & Rowling, 1999, p. 134). Moreover, being old depends not only on the characteristics of the individual but also on the attitudes and needs of the culture within which they live (Aiken, 1978; New South Wales Department of Health, 1989).

A chronological definition classifies “older people” as those who have passed through late middle age and are over 60 (Kempton, Gardner, Beurden, Williams, & Sladden, 1992). However, it could also be argued that it is incorrect to define 60-year-old people as “older” since especially nowadays, they tend to be as active and alert as those who are twenty or even thirty years their juniors. In terms of health status, it is usual to consider “older people” from a biological perspective rather than a chronological one. Speechley and Tinetti (1991, p. 50) divided older people into three groups:

- The “young old” are those who live a normal active life and who tend to be under 75;
- The “middle old” are those between the ages of 75 and 80 and who, while having some functional impairment, can live independently if assisted in some activities; and
- The “old old” are those who are usually so frail and disabled that they need institutional or constant nursing care, the majority of these being over 80.

The chronological definition is used in this study. Adopting 60 as the referential age of “older” people recognises the importance of ensuring that they are able to experience a healthy and independent life. Similar to the definition of “older people”, the attitudes toward old age and the role played by older people in the community also vary considerably with time, place and person. Ageing needs to be understood as a long-term process of change for both individuals and populations. Older people make a great contribution to society in different ways, including support for their families as well as the performance of voluntary work and participation in other productive activities. However, the process of individual ageing has also come to be represented in negative
terms, with growing old being commonly seen to be characterised by physical incapacity and a loss of independence. Most media tend to portray people over working age as living in states of frailty and poverty, creating “ageing-phobia” among the young and older community (Tsang, Liampittong, & Pierson, 2004, p. 52). Only a minority are represented as enjoying high levels of independence and achievement (Hendricks & Hendricks, 1981, p. 15; New South Wales Government, 1998, p. 14).

Although this negative image of older people is in fact quite misleading, it is true that apart from exceptional individuals such as Nelson Mandela, older people tend to lack opportunities to participate in political or social decision-making, and their economic influence is limited by their low incomes. Those who provide services for older people sometimes overprotect their clients and may create dependency. However, as pointed out for instance in a paper by the South Western Sydney Area Health Service (1990), the younger generation of Australian-born people do not appreciate the positive and productive aspects of older people and their potential contribution to the society. This attitude is less prevalent among younger people of non-English-speaking background (NESB), whose cultures tend to have a higher regard for old age and the elders in the community. However, in some groups such as the Chinese, these cultural values have been reported to be diminishing in importance due to their assimilation into the dominant culture, which leads young people to regard respect, let alone reverence for their elders, as being old fashioned (Cheng, 1997, p. 40; South Western Sydney Area Health Service, 1990; Tang & Fisher, 1992).

“Adding life to years, not years to life” (Department of Health, 2004, p. xvii).

“How are you?” is probably the most commonly asked question when people meet each other. “Fine, thank you” may also be the most common answer. Even though the
majority of older people report their health as excellent or very good, there are many different ways in which health can be conceptualised. Successful ageing can be described as a combination of three elements: survival (longevity), health (lack of disability), and life satisfaction (happiness) (Palmore, 1987, p. 654). Over the past few decades, average life expectancy has been increasing in Australia, reaching 76.5 years for males and 82.5 for females. By 2050, it is anticipated that life expectancy will reach 83.3 years for males and 86.5 years for females (Department of Immigration and Multicultural and Indigenous Affairs, 2003b, p. 4). However, of critical concern is whether longer lifespans will be associated with health and wellbeing or with handicaps or disabilities (Duckett, 2000). It has been found that:

- In the general population, 95% of persons aged over 65 suffer from at least one long-term medical condition and that those who do not exercise or who engage in low levels of exercise experience the most illness (Lewis, Szabo, Weiner, McCall, & Piterman, 1997, p. 1). This is the age group likely to be responsible for the great bulk of the increased costs of Medicare by 2051 (Cooper & Hagan, 1999, p. 25);

- The disability rate increases steadily with age, rising from 41% among those between 65 and 69 to 92% among people 90 years and older. The most commonly reported needs were help with health care, transport and property maintenance (Sainsbury, 2004, p. 8);

- People aged 65 years and over comprised 30% of all hospital separations (1.5 million separations) and 48% of all patient days (11 million days) in 1995–96 (Australian Institute of Health and Welfare, 1998, p. 69). In 1999–2000, there were 1.9 million hospital separations (Australian Institute of Health and Welfare, 2002a). As noted above, by 2051, this age group will continue to be responsible for the majority of projected increased hospital separations (Cooper & Hagan, 1999, p. 17); and

- More importantly, in 1999-2000, the Commonwealth Government spent around $5 billion on residential aged care, home and community care, respite and support for carers. Expenditure on the health needs of this group accounts for 24% of medical
services, 31% of pharmaceutical services and 35% of acute hospital services (Ageing and Aged Care Division, 2002, p. 2).

Undoubtedly, the practice of health maintenance and illness prevention behaviours can significantly reduce morbidity as well as increase functional status in persons of all ages, but these practices are particularly efficacious among older persons. Prevention is clearly the best “cure” for disease, and moreover and most importantly, it is a cost-effective method of decreasing the enormous financial outlays for health care (Australian Institute of Health and Welfare, 1998). The evidence indicates that many older people can remain in relatively good health, and only in the last year or two before death do they use a high level of health services (Australian Bureau of Statistics, 1995). Adequate physical activity, a healthy lifestyle and taking foods that complement a person’s constitution are all important aspects of health maintenance (Arcury, Quandt, & Bell, 2001).

In all countries and cultures, food, lifestyle and health traditions are commonly the key points of health maintenance. As Arcury et al. (2001) identified, maintaining a healthy diet is also important; people from different countries may have similar but also some different beliefs about health maintenance and illness prevention. Spector (1996) designed a guideline to facilitate communication and caring for culturally diverse people. As will be seen from Table 1.1 below, these guidelines list various methods for health maintenance and illness prevention used in different countries.
Table 1.1: Examples of Selected Health Traditions from Different Countries

<table>
<thead>
<tr>
<th>Nation</th>
<th>Maintain health</th>
<th>Prevent illness</th>
<th>Restore health</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>Always clean the floor; use Chinese herbs.</td>
<td>Drink ginger tea to prevent the flu.</td>
<td>Colds and coughs: scratch the back with a coin; drink herbal teas.</td>
</tr>
<tr>
<td>England</td>
<td>Take cod liver oil daily.</td>
<td>Get lots of fresh air; wrap up warmly.</td>
<td>Coughs and congestion: put formaldehyde crystals in a plastic bag and place on the chest.</td>
</tr>
<tr>
<td>Italy</td>
<td>Eat chicken soup, get lots of sleep; wear a camphor bag around the neck.</td>
<td>Children should wear a pouch with raw garlic around neck to keep unhealthy children away.</td>
<td>Colds and coughs: put warm to hot red brick wrapped in wool cloth on the chest; inhale very hot water with turpentine.</td>
</tr>
<tr>
<td>Japan</td>
<td>Children: massage naked body every morning (even in winter).</td>
<td>Gargle with salt water; sleep well, eat good things, and exercise.</td>
<td>Asthma attacks: <em>yaeto</em> usually burned on upper back and shoulders.</td>
</tr>
<tr>
<td>Ukraine</td>
<td>Eat chicken soup; drink vodka.</td>
<td>Eat healthy food; bundle up in cold weather; drink vodka.</td>
<td>Colds and coughs: use cupping; drink vodka.</td>
</tr>
</tbody>
</table>


Over the past three decades, increasing interest has been shown in the study of the links between health and physical activity. Irrespective of the ethnic groups targeted, extensive research has provided strong support for the health benefits of regular physical activity.

Numerous studies report that being physically active is linked to longevity (Blair et al., 1996; Chan et al., 1996; Curfman, 1993; Department of Health, 2004, p. 22; Dwyer & Briggs, 1983; Finucane et al., 1997; Folsom, Prineas, Kaye, & Munger, 1990; Ho, Woo, Chan, Yuen, & Sham, 1996; Ho, Woo, Yuen, Sham, & Chan, 1997; Hong et al., 1994; Kannel & Sorlie, 1979; King, Taylor, & Haskell, 1993; Morabia & Costanza, 2004; New South Wales Department of Health, 1996; Nied & Franklin, 2002, p. 419; Northern
According to these studies, participation in regular physical activity is reported to lead to a two-fold decrease in the risk of coronary heart disease, a three-fold decrease in the incidence of stroke, and a 30% reduced risk of developing hypertension. In addition, physical activity includes decreasing the risk of developing non-insulin-dependent-diabetes-mellitus, and lowering both total blood cholesterol and triglycerides. Regular physical activity also enables older people to elevate their immune response and prevent breast, prostate and colon cancer. It could also delay the onset of osteoporosis, osteoarthritis and rheumatoid arthritis, prevent falls and bone fractures by improving muscle strength, functional capacity, gait, balance and reaction time. Other benefits include preventing obesity or reducing body weight, relieving symptoms of depression, anxiety and other mental or psychological disorders, increasing opportunities for social contacts as well as maintaining physical function and preserving independence in older people (Department of Health, 2004; New South Wales Department of Health, 1996; Northern Sydney Area Health Service, 1996; Public Health Association of Australia Inc., 2004, pp. 1–2; Rousseau, 1989; U.S. Department of Health and Human Services, 1998). Everybody can experience these benefits regardless of their age, race or ethnicity, such as older Hong Kong Chinese people (Ho et al., 1996; Ho et al., 1997; Hui & Nagi, 1997; Wong, Wong, Pang, Azizah, & Dass, 2003; Woo, Ho, & Yu, 1999; Woo, Ho, Yuen, Yu, & Lau, 1998).

According to the National Physical Activity Guidelines for Australians (Commonwealth Department of Health and Aged Care, 1999) and other current reports (Armstrong, Bauman, & Davies, 2000; Centres for Disease Control and Prevention and the American
substantial health benefits may be gained from an accumulated 30 minutes or more of moderate intensity physical activity on most and preferably on all days of the week. Moderate intensity physical activity is activity that increases a person’s heart rate slightly but does not result in their being out of breath. The benefit can be achieved even if the activity is started later in life by previously sedentary people. Examples of exercise include walking, cycling, swimming, washing the car, heavy housework, or playing doubles tennis or badminton.

However, the terminology adopted in the study of health and physical activity has not always been consistent and people may also have different perceptions. Physical activity, as defined by Caspersen, Powell and Christianson (1985), consists of three elements: (1) any bodily movement produced by skeletal muscles; (2) resulting energy expenditure which varies from low to high; and (3) a positive correlation with physical fitness. In this definition, physical fitness is a set of attributes that people have or achieve that relates to their ability to perform physical activity. Sometimes physical activity is referred to as “habitual physical activity” (HPA) and a subset of activities within HPA includes exercise and sport (Biddle & Mutrie, 1991). Although the distinction between HPA and exercise is not always so clear-cut and philosophers have argued long and hard over the word “sport”, Caspersen et al. (1985, p. 127) define exercise as “planned, structured, and repetitive bodily movement done to improve or maintain one or more components of physical fitness”.

Physical activity can be further categorised into incidental physical activity, unplanned physical activity, occupational physical activity, leisure-time physical activity or
recreational physical activity (Armstrong et al., 2000; Dishman, Washburn, & Heath, 2004; New South Wales Physical Activity Task Force, 1998). Armstrong et al. (2000, p. 54) defined incidental or unplanned physical activity as the forms of physical activity undertaken at work and home, and also activity in which people take part as they go about their day-to-day lives, for example, using stairs or performing domestic tasks. Leisure-time physical activity refers to sport and recreational physical activity, including a range of activities conducted specifically for enjoyment, social, competitive or fitness purposes, performed in leisure or discretionary time.

No matter how physical activity is perceived, its health benefits among older people are well established and the promotion of physical activity among this group has been demonstrated to be a potentially cost-effective public health measure (American College of Sports Medicine, 1998). Research shows that the majority of health problems associated with ageing have the potential to be successfully prevented by physical activity (VicHealth, 1996). However, a recent report has shown that patterns of physical activity among older people did not show significant change between 1997 and 1999 (Armstrong et al., 2000). Other research has demonstrated that almost half the total population of New South Wales (NSW) failed to meet the recommended levels for physical activity (energy expenditure) and almost one in eight adults are totally sedentary (no physical activity) (Bauman et al., 1996, p. 61; Booth et al., 1993; Finucane et al., 1997; Levy, 1997; New South Wales Department of Health, 1996, p. 9; New South Wales Physical Activity Task Force, 1998; Northern Sydney Area Health Service, 1996; Public Health Association of Australia Inc., 2004, pp. 1–2). This proportion was higher in females than in males (Armstrong et al., 2000).
More importantly for the purpose of this research, people who did not have English as their first language, or spoke a language other than English at home, were less likely to have expended adequate energy during physical activity than people who spoke English at home. Moreover, people born in a non-English-speaking country had a higher proportion of their number reporting no activity than those born in Australia or in other English-speaking countries. In other words, if a language other than English was spoken at home, the respondent was also more likely to have been sedentary (Armstrong et al., 2000; Bauman et al., 1996, pp. 61–64).

**Patterns of physical activity in Australia**

Physical inactivity is a major health issue for Australia, with almost half the population being insufficiently active for a health benefit (Public Health Association of Australia Inc., 2004, pp. 1–2). Several studies have been conducted to evaluate the effectiveness of different physical activity programs in Australia. All these studies demonstrate successful program strategies in encouraging older people to participate in regular physical activity. In summary, the components of these physical activity programs include walking groups (Fisher et al., 1998; Jones & Owen, 1998; Women's Health in the South East, 1997); gentle exercise classes (Bagnall, Monk, Gimson, Saul, & Farmiloe, 1998; Peel, Cartwright, & Steinberg, 1998); serial mass media campaigns (Owen, Bauman, Booth, Oldenburg, & Magnus, 1995) and participating in the activities of a Wellness Centre (Hahn & Smith, 1995). Other activities include aquarhythmics, *tai chi* or *yoga*, while information efforts include classes, exercise expositions and information booklets (Butler & Chin, 1992; Koo & Rowling, 1999; Piper, 1996, 1997a, 1997b; Swalwell, 1997).
These community-based programs address barriers such as inaccessibility and knowledge deficits about participation in physical activity. They place emphasis on accessibility, convenience, cost-effectiveness, awareness raising, knowledge enrichment, and skills improvement. Social support includes involvement with families, nearby friends and neighbours and the companionship of congenial others. Positive images of older people were promoted by utilising older people to lead groups of their peers. Notwithstanding the existence of these programs, older people of Chinese-speaking Background (CSB) still have very limited participation in physical activity or the practice of other Western preventive care. This situation is a result of attitudinal and social determinants such as negative thinking about physical activity, language difficulties, access problems, insufficient family support, financial hardship, social isolation, illiteracy, and cultural blocks (Abbott, Wong, Williams, Au, & Young, 2000; Eyler et al., 1998; Woo, Ho, Sham, Yuen, & Chan, 1995).

Barriers vary cross-culturally, and also between individuals and each cultural group (Lewis et al., 1997). The ethnic Chinese in Australia are a good example. People of CSB represent the world's largest ethnic group (Yip, 2003, p. 21). When about 1.9% (344,319 persons) of the Australian population was speaking Chinese (Australian Bureau of Statistics, 2001), it was easy to overlook the diversity of cultures among them (Monash University, 2004a, p. 1; University of New England, 2001, pp.1–2). Ethnic Chinese living in Australia may have been born in or emigrated from China, Taiwan, Hong Kong, Singapore, Indonesia, Vietnam, Cambodia, East Timor or Thailand and should not be treated as an homogeneous group since they have different cultural backgrounds and needs (Martin, 1999; Reid & Trompf, 1990).
Chinese people from Hong Kong have been described by various authorities as being socially, culturally, economically, and politically distinct from the Chinese from all the above-mentioned countries (Abbas, 1997; Martin, 1999). That distinctiveness is of course, due to Hong Kong's history over the last 150 years, during most of which it was a British colony. Over that time, it was the site of close cultural contact and intermingling between Chinese and other cultures, something which is reflected in the health beliefs and practices of Hong Kong Chinese, who in general display an eclectic, idiosyncratic and pragmatic response to illnesses. Although one needs to be careful to avoid implying homogeneity in the cultural experiences of any two members of a given culture (Choy, 2003, p. 248), it can be said that both Western and Chinese medicine are employed in their health maintenance, especially in dietary practices. Food remedies with their specific health concepts play an essential role in the Hong Kong Chinese health practice. Chan and Quine (1997, p. 75) also point out that migrants from Hong Kong and China demonstrate different patterns in utilising health care services. However, to date there has been little research on the preventive health behaviours of older Chinese people in Australia who have migrated from Hong Kong. There is a lack of understanding of the beliefs and practices of this particular group, who experience problems that are additional to those of Australia’s ageing population in general. This thesis seeks to fill the gap in knowledge about the preventive health practices and particularly the attitudes to physical activity among older Hong Kong people living in Australia in the belief that the research and findings will help health promotion efforts by those who are concerned for the wellbeing of all elderly inhabitants of Australia.

1.2 Rationale for this study

Effective health promotion for ethnic minority groups is not just a matter of language. It also involves taking into account issues related to gender, class, education and culturally
based belief systems (Saini & Rowling, 1997, p. 324). Other research (Kendig et al., 1996a; Ma, 1999b, p. 25; Pyong, 1995, p. 43) has also revealed that socioeconomic status-related factors such as class differences, education, occupation, and poverty have direct impacts on the health of individuals. Ethnic groups that are characterised by low income, little education, and ethnic segregation often show decreased awareness of preventive health measures. This also reflects a decreased ability to access health care because ethnicity and SES create differential life experiences that lead to differences in value preferences (Berkanovic, 1973; Ma, 1999b, p. 26; Stein & Fox, 1991).

Notwithstanding, by encouraging older Hong Kong Chinese people to actively participate in preventive health behaviour, their functional independence can be enhanced with a concomitant reduction in the incidence of morbidity and mortality (Chou, Chow, & Chi, 2004; Hong Kong Sports Development Board, 2002; Neid & Franklin, 2002; Wong, Wong, Pang, Azizah, & Dass, 2003). Most importantly, this group could continue to make a contribution to society rather than being a financial burden to family, caregivers, health care services as well as the whole community.

Physical inactivity is a major risk factor for a range of pathological conditions including cardiovascular disease, diabetes, some cancers, obesity and falls among the elderly (Department of Health, 2004; Public Health Association of Australia Inc, 2004; US. Department of Health and Human Services, 1998). However, as will be demonstrated in this study, older Chinese people generally have a low rate of participation in physical activity of any kind. The reasons for their failure to participate in this kind of preventive health behaviour forms an excellent case study of those factors and trajectories that impact on the health of older Hong Kong Chinese people resident in Australia. Knowledge about attitudes and specific barriers that limit the participation of older Hong Kong Chinese people in physical activity can indicate how culturally appropriate
preventive programs can be designed for them. It can also contribute to structuring precise and valid instruments for measuring or evaluating preventive health behaviours, including participation in physical activity. It can, in addition, be used as a starting point for exploring ethno-specific strategies for the development of health promotion programs for other ethnic groups in the future.

Using physical activity participation as a case study, the research aims to explore the following questions:

- What are the health beliefs and preventive health behaviours of older Hong Kong Chinese people?
- What is their knowledge about and attitudes towards physical activity, and what are their patterns of participation in physical activity?
- Can physical activity be shown to play an important role in the preventive health beliefs of older Hong Kong Chinese people?
- What are the determinants which influence older Hong Kong Chinese people's participation in physical activity and how do these determinants influence their participation?

1.3 Summary of the chapters

This thesis consists of seven chapters. The introductory chapter outlines the negative image of older people held by society in general and the impacts of their health problems on themselves, their families and the community as a whole. It then moves to a discussion of how older people can obtain substantial health benefits from preventive health behaviour such as physical activity. Lastly, it emphasises the heterogeneity of older Hong Kong Chinese and the need for information on their problems in relation to preventive health behaviour.
Chapter 2 describes the historical background of Hong Kong. It highlights the impact of British rule on the Hong Kong Chinese's cultural beliefs and argues that this has resulted in the formation of a unique culture among Hong Kong people. The way in which three major Chinese traditional philosophies, those of Confucianism, Taoism and Buddhism, are integrated in the daily lives of the Hong Kong Chinese is described. Lastly, the discussion elaborates on how the three Chinese philosophies are integrated into Hong Kong Chinese health beliefs, health-seeking practice and their preventive health behaviour. The role of food in Chinese culture, which strongly affects Hong Kong Chinese people's priorities in preventive health behaviour, is also explored.

Chapter 3 focuses on the clash between Chinese and Australian cultures. This clash raises the physical, cultural, and social problems that older Hong Kong Chinese people encounter in Australia which hinder their participation in and utilisation of preventive health care services. This chapter highlights how the complex interweaving of past experiences with the Hong Kong health care system and the current experiences in the specific context of Australia's health care system might impact on preventive health behaviour. This chapter also explores relationships between the Theory of Planned Behaviour and the principles of Confucianism, Taoism and Buddhism, in order to conceptualise the study topic and facilitate data collection and analysis.

The methodology adopted for this study is described in Chapter 4. An ethnographic approach involving interviews, participant observation and case studies was the main research method employed for collecting the data. Case summaries and typology are used to facilitate data analysis. Also outlined are the techniques used to maintain rigour in data collection and analysis. Eight steps of an audit trial are set out before the chapter concludes with an exploration of the ethical issues and difficulties posed by the study.
Two findings chapters report the research findings which help to answer the research questions above. Chapter 5 shows the informants' patterns and concepts of physical activity as well as describing six states of physical activity/exercise (PA/Ex) among the informants. Six case summaries from the informants further elaborate the relationship between these six states of physical activity. Chapter 6 provides information on the cultural and health beliefs as well as the preventive health behaviour of older Hong Kong Chinese people. It also delineates the determinants influencing their participation in physical activity and explains how these determinants impact on their attitudes and intentions in this regard.

All the findings mentioned in Chapters 5 and 6 are then further discussed in Chapter 7 through the lens of Chinese traditional philosophies and the Theory of Planned Behaviour. The methodologies, the theory applied and the limitations of this study are also discussed. Lastly, the conclusions of this study and recommendations for promoting preventive health care among older Hong Kong Chinese people are made.
CHAPTER 2: CHINESE BUT NOT CHINA - THE UNIQUENESS OF HONG KONG

Chinese culture, like all other cultures, is not static and has a dynamic and evolving nature, especially in the modern era, which is profoundly characterised by rapid change (Choy, 1998). In this chapter, the identity of Hong Kong Chinese and the historical background of Hong Kong are briefly sketched. The three major Chinese philosophies of Confucianism, Taoism and Buddhism are then described. Finally, discussion turns to how the “theory of yin/yang” and faith in the “five elements” is integrated into the health beliefs and preventive health behaviours of the Hong Kong Chinese.

2.1 Identity: Chinese or Hongkongese?

The metropolis of Hong Kong is well known as one of the world's leading economic and financial centres. Situated at the southeastern tip of mainland China, its total area is about 1,100 square kilometres. In mid-2003, the population was around 6.8 million (Census and Statistics Department, 2004; Yau, 2003c). Many Westerners and even some Chinese hold the misconception that all Chinese, whether they are from Hong Kong, mainland China, Taiwan of any or the states of southeastern Asia, share the same cultural beliefs and customs (Choy, 1998, p. 218; Yau, 2003c, p. 105). However, while geographically a part of China, Hong Kong is not China and it has a culture distinct from that across the border (Wei & Li, 1996). As Yau (2003c) stated,

Hong Kong has its unique culture, which is often ignored or denied by many people including both Westerners and Chinese. Culture is dynamic and ever changing. It is also shaped by political, social and economic changes. Thus, the taken-for-granted view on the uniformity of Chinese culture across all Chinese communities is a fallacy (p. 109).
In 1842, Hong Kong was ceded to Britain in the Treaty of Nanjing (Wei & Li, 1996). Over the next one hundred years, many people, wanting to escape poverty in China, emigrated from their birthplace to Hong Kong. A more restrictive immigration policy was adopted after 1949 in an effort to stem the flood of immigrants from mainland China and also the effects of the Cold War. The creation of these barriers between Hong Kong and mainland China encouraged the emergence of the so-called “Hong Kong ethos” or “Hongkongese identity” (Baker, 1983; Wong, 1996, pp. 109–111). As Bond (1993) pointed out:

Hong Kong is a cultural nerve-centre, its people surrounded by an endless stream of influences, needing to position themselves somewhere in this flow. In a “borrowed place” in “borrowed time” what identity will be assumed by a borrowed people? How do Hong Kong Chinese perceive themselves? (p. 3)

The correct answer to that question is disputed. While on the one hand Kwok (1994, p. 111) asserts that Hong Kong is not a Chinese city, on the other hand Chan (1993, p. 483) holds that Hong Kong is very Chinese. Such differing opinions probably stem from different conceptions of the meaning of “Chineseness” (Mathew, 1998, p. 25; Wong, 1996). While more than 97% of the Hong Kong population are ethnic Chinese (Chan & Lee, 1995, p. 83; Kwok, 1994; Lau, 1997, p. 2; Wei & Li, 1996, pp. 16–17), they nonetheless exhibit a very strong indigenous identity which they call *heng¹ gong² yen⁴*, that is, a Hong Kong-oriented awareness which is usually but clumsily encapsulated in the term “Hongkongese”. This is one result of the way they took the idea of their British rulers of “Hong Kong as apart from China” and reworked it on their own terms (Bond, 1993, p. 4; Lau & Kuan, 1988; Mathews, 1997, p. 8; Mathews, 1998; Wong, 1996, p. 105; Yau, 2003c, p. 107).

Hong Kong people are often stereotyped as money-minded and it is true that some have the means to choose materialism as the basis for their lives and identities. Because they
saw the acquisition of wealth as giving them the freedom to do anything they wanted, they developed a mode of living and an outlook different from that of people from mainland China (Mathews, 1997, p. 10; Wei & Li, 1996). One example of these differences emerged from Mathews' study (1997) in which he found that while people in urban areas of mainland China tend to spend most of their leisure time at home drinking tea and watching television (TV), most Hong Kong people prefer to use their leisure time by going to movies or dining in restaurants (Mathews, 1997, p. 10). While some characterise themselves as more Westernised and others as more traditionally orientated, most Hong Kong people cherish their distinct identity and are proud of their reputation for “cleverness and diligence”, of Hong Kong's status in Chinese society as well as in the world economy.

Nonetheless, it should not be thought that there is cultural uniformity within the Hong Kong community itself. Although their national awareness is much stronger than their ethnic awareness, there is no obvious or overt clash between the local identity of Hong Kong people and their Chinese identity. Instead, these characteristics tend to be complementary, harmonious, and symbiotic. Survey findings showed great sociodemographic differences within the population. Females were more likely to identify themselves as Hongkongese than males. The more educated people were also more inclined to call themselves Hongkongese rather than Chinese. Similarly, people who were born in Hong Kong were more likely to see themselves as Hongkongese (Lau, 1997, pp. 5–7). Morikawa (1991, pp. 2–4) has argued that Hong Kong is distinct from other Chinese societies around the world. This author maintains that there is very little that can be regarded as Chinese tradition in the life of Hong Kong people. As Lauh Bing, the Deputy Director of the New China News Agency in Hong Kong before 1 July 1997, commented: “Most Hong Kong people do not understand Chinese culture … they do not
have deep feelings toward the country and the race … They have received a different education from the mainland Chinese, which leads them to biased ideas about things in China … ” (1996, p. 9).

However, Yip (2003, p. 20), who classified all Chinese communities on the basis of their different exposures to traditional mainland Chinese culture, defined Hong Kong people as a Chinese community in a bicultural society. It is difficult to define exactly what Hong Kong Chinese culture is without oversimplifying and falling into a narrow-minded and stereotyped definition of Chinese characteristics (Cheng, 1997; Kong, 1989). While in terms of language, values and ideologies, Chinese culture seems to be the dominant culture among most Hong Kong Chinese, nevertheless, as Hong Kong has evolved as a “hybrid community”, its inhabitants have also developed a “mixed sense of identity”. Mathews (1997, p. 3) described being “Hongkongese” as having a “Chineseness plus” identity with three clusters of meaning: “Chineseness plus affluence/cosmopolitanism/capitalism”, “Chineseness plus English/colonial education/colonialism,” and “Chineseness plus democracy/human rights/the rule of law”. Indeed, it should also be emphasised that not all Hong Kong Chinese accept and subscribe to a similar set of prescribed characterisations, since each individual is often enmeshed with other systems such as the political background, socioeconomic class, gender and education (Yeo & Meiser, 2003, p. 300).

Interestingly, their Chinese heritage does seem to set the fundamental behavioural code and moral base of everyday interaction for the people of Hong Kong (although the imperatives of modernity supplement this original framework). The foundation of Hong Kong thinking about health, illness and daily living is to be found in the philosophies of Confucianism, Taoism and Buddhism. To understand Hong Kong society, it is necessary
to recognise not only this Chinese cultural heritage, but also how that has evolved and been transformed beyond its original cultural context.

2.2 Traditional Chinese beliefs and values: Confucianism, Taoism, and Chinese Buddhism

Allinson (1989) stated that,

Every Chinese person is a Confucian, a Taoist, and a Buddhist. He [sic] is a Confucian when everything is going well; he [sic] is a Taoist when things are falling apart; and he [sic] is a Buddhist as he approaches death. (p. 15)

The culture founded on these teachings is practical because they deal principally with day-to-day life, and life has to be practical (Han, 1945, p. 3). These philosophical and religious roots have been integral parts of the Chinese culture for over two thousand years (Monroe, 1995, p. 69; Shih, 1996, p. 209; Wei & Li, 1996, p. 84). People growing up in a Chinese family will, consciously or unconsciously, be socialised into the ideals of these three philosophies (Yeo & Meiser, 2003, p. 304).

Confucianism – “The Five Right Relationships and Five Main Principles”

Strictly speaking, Confucianism is not considered to be a formal religion but is rather a moral philosophy, characterised by its strong emphasis on ethical and moral values. Confucius (hung7 jì2) (born 551 BC) concentrated on the present life. He enunciated a humanistic and rationalistic philosophy that explicates the principles of proper behaviour (Han, 1945; Su, 1967; Wei & Li, 1996, p. 84; Yeo & Meiser, 2003, p. 304). Confucianism has had a tremendous impact on how the Chinese live their daily lives and forms the core of Chinese thinking and behaviour (Chu & Caraw, 1990; Monroe, 1995, pp. 77–78; Su, 1967; Wei & Li, 1996, p. 84).
In Confucian ethics, everyone has a specific place within a family and within society at large. These relationships were set out by Confucius under the “Five Right Relationships”, the ng' len'. In these terms, one's conduct is shaped by one's position and relationship to other people. Four of the relationships are family oriented: father–son; elder brother–junior brothers; husband–wife; children–parents and ancestors (filial piety). The last includes obedience to the rulers. This social hierarchy lays down an order in the human community which, Confucius maintains, reflects that of the universe (Hwang, Liu, Han, & Chen, 2003, p. 52; Kong, 1989, p. 32; McLaughlin & Braun, 1998, pp. 5–6; Monroe, 1995, pp. 78–79).

Filial piety (hao' sem') and paying homage are important practices in Confucianism because they reflect this continuity and the laws of nature (Chu & Caraw, 1990, p. 66; Kong, 1989, p. 32; Monroe, 1995, pp. 78–79). Confucianism stresses that an individual's responsibility lies in one's duties: first to one's family, then to neighbours and finally, to the community (Da, 2001, p. 66; Kong, 1989, p. 32; Monroe, 1995, pp. 78–79). Confucian ethics has as its goal helping a person to understand and become aware of what is good and just, and strive to satisfy the expectations of peers, elders and society. Being an ideal person involves self-reflection, self-restraint, good-heartedness, responsibility and respect for elders. Da (2001, p. 67) pointed out that filial piety is not actually a one-way relationship. Reciprocal caring relations are an outstanding feature of the Chinese family. Parents invest time, resources, and sacrifice individual interests to care for their children. Therefore children are expected to obey and look after their parents and seniors. Filial piety helps maintain the harmony of the family and its patriarchy and lineal structure, while also sustaining the social system at large.
Moral families produce moral children, therefore an ideal family must have honour and respect for grandparents, parents and all blood relatives, and more importantly, the highest honour must be paid to deceased ancestors. To dishonour the family is the greatest sin of all, a sin so black as to warrant suicide. Only individuals who have achieved these virtues are considered fit to raise a good family and assume administrative responsibilities in society and government. Under its general principles, women in the old days were constrained by the “three rules of obedience” (sam' chung') and the “four virtues” (sei' deg'). The former required women to be obedient to their father before marriage, obedient to their husband after marriage and obedient to their son after the death of their husband. The four virtues (sei' deg') encouraged women to cultivate themselves in morality, modesty, diligent work and proper speech. Women however, were excluded from public activities and labelled as “domestics”. They had no right to education while men, being the heads of families, were given the exclusive power to take decisions (Da, 2001, pp. 65–66; Engels, 1972; Wong & Reker, 1985).

In addition, there are principles of yen', lei', zung' sen', deg', and wên'. Yen', meaning love and virtue, is the greatest. It denotes an innate quality that motivates people to have respect for all humans and for all of nature, animate and inanimate. If the government is just, then the citizens will behave accordingly (Cheng, 1974, pp. 180–182; Han, 1945, p. 9; Monroe, 1995, pp. 77–79; Wei & Li, 1996, p. 84). Lei' (respect, politeness) is the way humans should communicate with each other and also in their social relationships. It prescribes how people are to speak to each other, how to use the proper words and how to avoid the use of obscene and demeaning words and gestures. Lei' also includes the doctrine of “the golden mean” or zung' yung'. Zung' means “not being inclined to any side and without excess or deficiency.” Yung' means to be normal or constant. Taken together, zung' yung', in daily life means that which is balanced and normal—“the Right
Path”. The doctrine of the golden mean or zung⁴ yung⁴ conceives goodness as a state of equilibrium as well as a state of harmonisation. Equilibrium is a state of relative rest in which all emotions are unaroused. The state of harmonization in contrast, is a state of relative motion in which emotions are aroused in such a way as to satisfy the good purposes of the growth of life. The important thing is to do the right thing in the right way (Cheng, 1974, pp. 187–189; Monroe, 1995, p. 79). The famous Golden Rule, “What you do not wish to be done to yourself, do not do to others,” is a part of the zung⁴ yung⁴ (Han, 1945, pp. 7–8).

Zung⁴ sen⁴ (loyalty), the third principle, defines yen⁴ as being primarily a term to explain the correct relationships among human beings, and then finding the accurate words to express these relationships. Such terms as “the supreme good” or “true manhood,” or the “ideal gentlemen” would be the examples of good yen⁴ (Cheng, 1974, pp. 180–182; Monroe, 1995, p. 79). The fourth principle, deg¹ (virtue), refers to the art of government. Deg¹ sets out the way a good ruler can command the respect of his subjects. The good ruler desires peace. People are treated with charity and compassion, although they are not mollycoddled (Cheng, 1974; Monroe, 1995, p. 79). The final principle is wén⁵, the study and practice of the arts of peace. A nation that loves the beauty and the aesthetic values found in art and poetry and music, will find it easier to pursue peaceful international relations. A moral nation becomes a model for other nations in a mutual search for peace (Han, 1945; Monroe, 1995, pp. 79–80).

**Chinese Buddhism – “The Four Noble Truths”**

Buddhism was and is a major part of Chinese religious life as well as philosophical thought. It was introduced into China along the Silk Road by Indian merchants in the second century BCE (Cheu, 2000, p. 2; Kong, 1989, p. 41; Monroe, 1995, pp. 113–114).
In most parts of China, the Buddhist philosophy or doctrine absorbed Taoist and Confucian aspects whilst another type of Buddhism is practised in Tibet (Cheu, 2000, pp. 9–10; Ferroa, 1991, p. 69; Kong, 1989, p. 42). A central focus of Buddhist doctrine is the attainment and maintenance of a clear, calm, state of mind, undisturbed by worldly events. Mercy, thriftiness, and humility are the three treasures of Buddhism. Cause and effect (yen' and guo'), sometimes calls the law of karma, is the principle that encourages people to do “good” and “right” and to receive “good” in return (Chen, 1996; Howley, 1999, p. 103; Wei & Li, 1996, p. 85). According to the anonymous author of a website entitled Karma (2004, p. 1), in Buddhist teaching, the law of karma means that “for every event that occurs, there will follow another event whose existence was caused by the first, and this second event will be pleasant or unpleasant according to whether its cause was skilful or unskilful”. A skilful act is one that is not accompanied by “craving, resistance or delusions”, while an unskilful act is one that is accompanied by any one of these. According to the law of Karma, responsibility for unskilful actions is borne by the person who commits them.

Buddhist philosophy lays down the “Four Noble Truths” which lead to enlightenment and which also explain the sources of human suffering, while the “Eightfold Path” outlines the actions required to eliminate such suffering. The first “Truth” is that suffering and pleasure are essential elements in all of human existence. Suffering is universal and is found in all of life from birth until death. The second “Truth” is that suffering and pain are caused by the desire for personal fulfilment or selfish desire. If a person learns to tolerate all the painful experiences caused by disease, they will receive a better reward in heaven after death. The third “Truth” is the cessation of desire. If all selfish craving is eliminated, then the person has achieved nirvana, the supreme goal for every human. The fourth “Truth” is escape from suffering that will come if one follows
the “Eightfold Path” to nirvana (Kong, 1989, p. 39; Monroe, 1995; Shih, 1996, p. 211), which leads to deliverance from self. It requires a person to strive to attain the following goals:

- Right knowledge, which means, acceptance of the Four Noble Truths;
- Right thought or aspiration;
- Right speech, avoidance of obscenity and words that demean others, of gossip and lies;
- Right behaviour or conduct, which includes no stealing, sexual immorality, drunkenness, or murder;
- Right effort, having the necessary willpower to do right actions;
- Right means of livelihood, to do honest work faithfully. This includes refraining from prostitution, selling drugs, alcohol, meat, armaments or engaging in slavery;
- Right mindfulness, what we are and will become is determined by our thoughts; and
- Right concentration, or the practice of correct meditation and yoga. Concentration is a quality of mind control by which all external distractions, feelings, and sensations are divested from the mind (Kong, 1989, p. 39; Monroe, 1995, pp. 113–114).

In addition, the human body is composed of states of mind and matter that are impermanent and experience a continuous process of change (Bowman & Singer, 2001, pp. 460–461). The goal of each Buddhist is to attain spiritual purification and enlightenment through self-denying thoughts and deeds in order to achieve nirvana, a state of nothingness, a permanently happy state in heaven and a supreme happiness found in the wisdom and peace of Buddha. If one persists in the attainment of this goal, eventually one will be released from the cycle of death and re-birth and so reach nirvana (Kong, 1989, p. 40; Monroe, 1995, pp. 113–114; Shih, 1996, p. 211).

A Buddhist who sets out to attain enlightenment and the spiritual goal of nirvana must also observe the “Five Precepts”. These are abstinence from taking life; taking what is
not given; illicit sexual pleasures; lying and taking intoxicants (Kong, 1989, p. 39). In addition, six main principles of social behaviour are laid down for the individual.

- Similar to Confucian philosophy, children in a devout Buddhism family are expected to “worship” their parents every day by performing duties in the way of love, respect and physical assistance;
- Pupils are required to respect and be obedient to teachers and should study seriously, while the teacher has an obligation to train and shape the pupil properly;
- Love between spouses is considered sacred or religious; husband and wife should be faithful, respectful and devoted to each other; the husband should secure the wife's comfort and position, while the wife should look after household affairs;
- Relations between friends, relatives and neighbours should be characterised by hospitality and charity and they should speak pleasantly and agreeably to each other, work for each others' welfare; be on equal terms, avoid quarrels, help when the other is in need and not forsake one another in times of difficulty;
- The employer should assign work to employees according to capacity and ability, while employees should be diligent, obedient and honest to their employer and their work; and
- The laity should look after the material needs of the religious with love and respect; while the religious should impart knowledge and learning to lay people and lead them on paths of goodness and away from evil-doing.

(Cheu, 2000, pp. 9–10; Howley, 1999, p. 61–62)

**Taoism – The “Way” or “Tao”**

Taoism was founded by Lou î Sen³ and did not begin as a religion (Wei & Li, 1996, p. 84). Taoism is a philosophy of withdrawal or “let-it-be”. It is a return to the state of nature when individuals led a simpler life free from the structures and judgement of society. According to its teachings, everyone should learn how to live in harmony, free from stress. Taoism teaches that all phenomena in this world are in a perpetual state of flux, and that everything is constantly changing. The central teaching of Taoism is “The Way” or “Tao”. “Tao” also represents the natural order of the world. The Taoists believe that there is constant interaction between the natural and supernatural. They stress that
there were no differences between spiritual and material realities or between heaven and earth (Kong, 1989, pp. 27–28; Lassiter, 1995; Monroe, 1995, p. 73; Wei & Li, 1996, p. 84; Yeo & Meiser, 2003, p. 306). Taoism emphasises the need to live in harmony with nature and that humans should follow the rhythms of heaven and earth to achieve a state of balanced tranquillity.

As the religion developed, it became associated with the tradition of shamanism and magic. Taoists believe in supernatural beings and attempt to communicate with gods and spirits through magical practices. They use charms and spells, meditate and have a vegetarian diet. It is their belief that these practices can help them gain longevity or immortality and be at one with the universe (Kong, 1989, p. 27; Koo, 1989c, p. 52; Wei & Li, 1996, p. 84). In its popular form, Taoism can be classified as a religion with three levels of comprehension (Monroe, 1995, p. 74). At the most philosophical level, Taoism attempts to define the ultimate reality of existence. Reality is that which is behind all of creation, and the place to which all creatures return after death. Tao is the creative force for all of creation, that which energises all substances and all of life. Tao is spirit, infinite and eternal, hidden but always present and is always within the human person (Kong, 1989, p. 28; Monroe, 1995, p. 74; Wei & Li, 1996, p. 84).

At a lower level Taoism is the expression of the mystery of nature. Life and death move in cycles, just as the sun rises and sets and the seasons come and go. Taoists find no value in striving to find ultimate, absolute values for good and evil, or right and wrong. All values are relative. Life and death are not opposite states of being, for death is only the continuation of life (Chen, 1996, p. 211; Monroe, 1995, p. 74; Shih, 1996, p. 211). Two competing energies, yin and yang, are found in all things. Two fundamental forces govern the creation and the working of the universe. Yang is masterful but with justice, it
is the active, positive, aggressive or male principle while *yin* is the passive, negative, merciful, and gentler or female principle of the universe. Combined, the *yin* and the *yang* created the universe and made it work (Jovchelovitch & Gervais, 1999, pp. 251–253; Monroe, 1995, p. 74; Wei & Li, 1996, p. 81). These two forces are always in a state of interaction, but also always seeking to find a state of balance. When the two forces are in balance within the human personality then the perfect, ideal human will exist. Excess of either energy is harmful (Chen, 1996, p. 18; Kong, 1989, p. 27; Monroe, 1995, p. 74). This will be further discussed in Section 2.3.

At a third level, a human level, Taoism is “The Way” to a good life or “The Way” of the perfect human. It teaches that humankind should live in harmony with all other beings, human or non-human. Pure spirit can be known only when the physical human body is purified of all sensual desires, desire for wealth and power, of pride and also of fear. Perfection is attained only by that person who suppresses all desires, masters their emotions, becomes totally unselfish, and lives a clean life (Kong, 1989; Monroe, 1995, pp. 75–76).

To conclude, Taoism resembles Confucianism in that both are concerned with the cultivation of human character and in their understandings of the purpose of human existence. Both Confucian and Taoist philosophy emphasise the importance of maintaining physical, emotional, and social harmony by way of protecting health and also community, and social relationships. They also emphasise family values. Both teach the importance of respecting all living things and maintaining harmonious relationships with them, although Buddhism and Taoism also emphasise that all phenomena in this world are in a perpetual state of flux, and that everything is constantly changing. It is important to note that these three philosophies are not mutually exclusive because in
reality the many Chinese people often subscribe to more than one belief system (Yeo & Meiser, 2003, pp. 306–310).

2.3 Understanding Chinese health beliefs and preventive health behaviour – the “Theory of Yin/Yang” and the “Five Elements”

Chinese health beliefs and practices as well as traditional Chinese medicine (TCM) are also greatly influenced by Taoism, which emphasises balance and harmony between the mind, body, and emotions and one's nature or environment. According to the theory of \textit{yin/yang}, all phenomena are naturally grouped in pairs of opposites which are also complementary–heaven and earth; sun and moon; night and day; dark and bright; negative and positive; cold and warm; inside and outside; movement and stasis; feminine and masculine. They represent the Chinese conceptions of nature and are fundamental to Chinese understandings of the natural sciences (medicine, astronomy, calendrical science, geography and agriculture) as well as of social behaviours. The forces of \textit{yin/yang} formulate the \textit{qi}, which is classified into human, heaven, and earth \textit{qi}. \textit{Qi} is the transcription of a Chinese ideogram, which has many meanings. For examples, \textit{qi} can mean “life force”, “gas”, “air” “breath”, “odour” and much more (Liu, 1997, p. 3). In sum, \textit{qi}, called “vital energy” in the West; is “the source of life” and is defined as “the energy circulating in the human body”, which is related to health and longevity. Three main sources of body energy identified by the Chinese are (1) \textit{jìng}–sexual energy; (2) \textit{qi}–physical energy; and (3) \textit{zèng}–spiritual energy. Health is a product of a sufficient accumulation of these three energies and its presence encourages their smooth flow in the body (Gascoigne, 1997; Koo, 1984; 1989b, p. 221; Ma, 1999b, p. 105).

In medicine, the concepts of \textit{yin/yang} are used to categorise both anatomic parts and physiological functions. They are divisible and interdependent. They also counterbalance each other. For instance, heart, liver, spleen, lungs and kidney are \textit{yin}. Stomach, gall
bladder, large intestine, small intestine, bladder and “warmer” functions (the lymph system) are *yang*. Other examples of *yang* include the abdomen/back, lower body/upper body, bones/surface skin, sinews/body hair, *qi/blood* and agitation/moderation (Chen, 1996, p. 2; Ferroa, 1991, p. 65; Liu, 1997, p. 133; Shih, 1996, p. 209) (See Table 2.1).

Table 2.1: Examples of Matters Classified According to *Yin/Yang*

<table>
<thead>
<tr>
<th>Yin</th>
<th>↔</th>
<th>Yang</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phenomena group in pairs of opposites:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Earth</td>
<td></td>
<td>Heaven</td>
</tr>
<tr>
<td>Night</td>
<td></td>
<td>Day</td>
</tr>
<tr>
<td>Moon</td>
<td></td>
<td>Sun</td>
</tr>
<tr>
<td>Darkness</td>
<td></td>
<td>Brightness</td>
</tr>
<tr>
<td>Inside</td>
<td></td>
<td>Outside</td>
</tr>
<tr>
<td>Stasis</td>
<td></td>
<td>Movement</td>
</tr>
<tr>
<td>Negative</td>
<td></td>
<td>Positive</td>
</tr>
<tr>
<td>Femininity</td>
<td></td>
<td>Masculinity</td>
</tr>
<tr>
<td>Cold</td>
<td></td>
<td>Heat</td>
</tr>
<tr>
<td>Water</td>
<td></td>
<td>Fire</td>
</tr>
</tbody>
</table>

**Main anatomic parts and physiological functions:**

“Five *zong* viscera”:

| Heart                    | Stomach            |
| Liver                   | Gall bladder       |
| Spleen                  | Large intestine    |
| Lungs                   | Small intestine    |
| Kidney                  | Bladder            |

“Warmer” (the lymph system)

**Others:**

<table>
<thead>
<tr>
<th>Abdomen</th>
<th>Back</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower body</td>
<td>Upper body</td>
</tr>
<tr>
<td>Bones</td>
<td>Surface skin</td>
</tr>
<tr>
<td>Sinews</td>
<td>Body hair</td>
</tr>
<tr>
<td><em>Qi</em></td>
<td>Blood</td>
</tr>
<tr>
<td>Agitation</td>
<td>Moderation</td>
</tr>
</tbody>
</table>

**Symptoms of diseases:**

| Cough with a heavy chest | Fever   |
| Rheumatic pains         | Rash    |
| Dizziness               | Sore throat |
|                         | Hypertension |
|                         | Infection  |
|                         | Upset stomach |
|                         | Venereal disease |

**Presentation of pulses:**

| Deep | Floating |
| Slow | Rapid    |
| Rough| Slippery |

Source: Adapted from Ferroa, 1991, p. 65; Shih, 1996, p. 209.
In other words, Chinese health beliefs are based on a holistic or macrocosmic view, which takes into account the mental, physical and social factors conducive to health and emphasises the importance of environmental factors in increasing the risk of illness. Natural phenomena and the social and physical environments, which involve emotions, taste, seasonal conditions, colour, climatic changes, and directions, among others, influence all parts of the body. A state of wellbeing means both a coordinated and integrated way of living and a balance in the physical, emotional, social, and spiritual development of a person, a family, and a community (Chen, 1996, p. 2; Gervais & Jovchelovitch, 1998, p. 31; Kwan & Bedi, 2000, p. 296; Kwan & Holmes, 1999, p. 296; Lee, Schwarz, & Mak, 1993, p. 364; Lim, Schwarz, & Lo, 1994; Ma, 1999b, pp. 102–107; Shih, 1996; Yau, 2003e, p. 128).

Similarly, illness may be categorised according to *yin/yang*. Illness is viewed as an imbalance or disequilibrium of these forces. An imbalance in the *yin/yang* within the body causes illnesses and discomfort. Pulses may similarly be categorised. Deep, slow and rough pulses are *yin*, whereas floating, rapid and slippery pulses are *yang* (See Table 2.1). Other than ranking body energy in quantitative terms, there are also qualitative distinctions of body energy in terms of a “hot”/“cold” or “wet”/“dry” polarised scale. To maintain good health, one should try to keep these forces in balance (Ferroa, 1991, p. 65; Koo, 1984, p. 757; Lim et al., 1994, p. 364; Shih, 1996, p. 310).

Apart from the theory of *yin/yang*, the theory of the five elements is also treated as a foundational explanation of health and illness phenomena. It stresses the premise that all phenomena in the universe are the products of the movement and mutation of five qualities: metal, wood, water, fire, and earth. Similarly, the various organs and tissues can be categorised by the five elements. First, the attribute of metal is ascribed to the
lungs (which are believed to be connected to the large intestines). Second, wood is ascribed to the liver (connected to the gall bladder). Third, water is ascribed to the kidneys (connected to the bladder). Fourth, fire is ascribed to the heart (connected to the small intestines), and fifth, the attribute of earth is ascribed to the spleen (connected to the stomach). As mentioned earlier, the heart, liver, spleen, lungs and kidney constitute the five zong⁶ viscera. The gall bladder, stomach, large intestine, small intestine, bladder and “warmer” (the lymph system) are six fu² structures (Guo, 2000, p. 56; Lee et al., 1993, p. 2; Shih, 1996, p. 210; Yau, 2003e, pp. 133–134). They are further illustrated in Table 2.2.

Table 2.2: Classification of Natural Phenomena According to the Five Elements

<table>
<thead>
<tr>
<th>Element</th>
<th>Metal</th>
<th>Wood</th>
<th>Water</th>
<th>Fire</th>
<th>Earth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colours</td>
<td>White</td>
<td>Green</td>
<td>Black</td>
<td>Red</td>
<td>Yellow</td>
</tr>
<tr>
<td>Climatic factors</td>
<td>Dryness</td>
<td>Wind</td>
<td>Cold</td>
<td>Heat</td>
<td>Dampness</td>
</tr>
<tr>
<td>Seasons</td>
<td>Autumn</td>
<td>Spring</td>
<td>Winter</td>
<td>Summer</td>
<td>Late summer</td>
</tr>
<tr>
<td>Flavours</td>
<td>Pungent</td>
<td>Sour</td>
<td>Salty</td>
<td>Bitter</td>
<td>Sweet</td>
</tr>
<tr>
<td>Five zong⁶ viscera</td>
<td>Lung</td>
<td>Liver</td>
<td>Kidney</td>
<td>Heart</td>
<td>Spleen</td>
</tr>
<tr>
<td>Six fu² structure</td>
<td>Large</td>
<td>Gall</td>
<td>Urinary</td>
<td>Small</td>
<td>Stomach</td>
</tr>
<tr>
<td>Sense organs</td>
<td>Nose</td>
<td>Eye</td>
<td>Ear</td>
<td>Tongue</td>
<td>Mouth</td>
</tr>
<tr>
<td>Tissues</td>
<td>Skin &amp; hair</td>
<td>Tendon</td>
<td>Bone</td>
<td>Vessel</td>
<td>Muscle</td>
</tr>
<tr>
<td>Emotion</td>
<td>Grief</td>
<td>Anger</td>
<td>Fear</td>
<td>Joy</td>
<td>Pensiveness</td>
</tr>
</tbody>
</table>

Source: Adapted from Guo, 2000, p. 56; Lee et al., 1993, p. 3.

2.4 Balance and harmony: Health as a world view

In its famous definition, the World Health Organization has laid down that health is not simply the absence of disease but “a state of complete physical, mental and social wellbeing” (World Health Organization, 1986, p. 73). But this view is open to differing cultural interpretations. The concept of illness is also culturally determined, indicating the social recognition that a person is unable to carry out daily duties appropriately, and that action must be taken to remedy that situation (Hwang et al., 2003, pp. 69–70). Definitions of what constitute both “health” and “illness” vary not only among cultural groups and social classes but also between individuals, and can be interpreted in terms of
personal experience and expectations. People learn from their own cultural and ethnic backgrounds how to be healthy, how to recognise illness and how to treat illness (Chen, 1996, p. 2; Ferroa, 1991, p. 65; Shih, 1996, p. 209). According to Kendig et al. (1996b), the main criteria of health among older Australians included keeping physically or socially active, the absence of disease and an ability to maintain independence. It also involved having a positive mental outlook and healthy lifestyle. The most important actions which could be taken to improve health were engaging in physical activity (particularly walking), healthy eating, participating in social activity, and having healthy living habits and positive attitudes.

In terms of Western concepts, it is believed that nature can be overcome and manipulated to generate benefits for humankind. In contrast, the Chinese believe that in order to create health and prosperity, people need to live in harmony with heaven and earth in order to maintain the “triad bonding” of heaven, earth and people (Yau, 2003e, p. 130). Thus, the notions of balance and harmony are central to Chinese conceptions of health and illness. In fact, the traditional Chinese concept of health is multifaceted or multidimensional and is integrated into the society's overall value system. This value system is reflected in the Chinese people's daily living, and also represents the cosmic interplay between heaven (nature), earth (self) and humanity (others). It emphasises that if illness is to be avoided, it is important to maintain harmonies across the three systems and subsystems, which include,

- Heaven (nature) – harmony with nature, including time and space;
- Earth (self) – harmony with self, internally and externally; and
- Humans (others) – harmony in social relationships which include not only the living, but also those in the supernatural world (Yau, 2003e, p. 132).
Because of their holistic perspective, many Chinese believe that human interaction with nature is important. Human life, illness, and death are part of the universe and can be influenced by every aspect of the universe. The Chinese often view both physical and mental health as the consequence of an individual's moral conduct in the social context. Self-care plays an essential role in Chinese health practices. Although cultural concepts of self-care are not unique to the Chinese, the degree of their elaboration in Chinese health culture is indeed noteworthy. The three Chinese philosophies, especially the theory of yin/yang, can be seen as constituting the framework for preventive health behaviour.

For the body to maintain appropriate balance, one must make every effort to adapt to the internal and external factors that can cause energy imbalance. The internal factors include one's hereditary proneness to having a yin- or yang-dominated personality, age, poor diet, infections, accidents, fatigue or excess of any one of the seven moods (joy, anger, anxiety, obsession, sorrow, fear, and horror). External factors include weather, geographic locations, seasons, temperature, environmental irritants, germs, wind, cold, heat, moisture, dryness, and fire (Gervais & Jovchelovitch, 1998, p. 32; Ho, 1985; Ma, 1999b, p. 108). Therefore ingestion of, contact with or experience of any of these external elements can affect a person’s equilibrium. Congenital factors and personality also make each individual more susceptible to one of these extremes (Gascoigne, 1997; Koo, 1984, p. 757; 1989b, p. 221; Reid & Trompf, 1990).

Above all else, a Chinese person seeks equilibrium. According to the Taoists, excessive mental, emotive and cognitive activities will lead to illness and are the source of all illness. In order to achieve equilibrium and harmony, all things should be done according to natural law (Hwang et al., 2003, p. 67). In addition, since each emotion is linked to a
particular internal organ, an excess of an emotion may adversely affect the flow of qi in the body. For example, since grief is regarded as the emotion of the lung, a bereavement or separation may lead to respiratory symptoms such as pneumonia or bronchitis (Gascoigne, 1997; Koo, 1984, p. 757; 1989b, p. 221; Reid & Trompf, 1990). To avoid illness and maintain good health, extreme emotions of sadness must be moderated if not avoided altogether. Containing desire and mediating excess are the foundation for preserving and refining life. Therefore Taoists propose an emptying of the thoughts, the dispelling of worry and living simply with no desires, so as to preserve qi. While this seems to be a passive life philosophy, it is seen as a proactive method for maintaining health (Gervais & Jovchelovitch, 1998, p. 32; Ho, 1985; Ma, 1999b, p. 108; Yau, 2003e, p. 131). The consequence of this philosophical tradition is that Chinese people take great care to conceal their emotions. If they feel compelled to express their feelings, they usually do it in what is seen as a socially acceptable way (Hwang et al., 2003, p. 67).

As far as external factors are concerned, instead of taking remedies such as antibiotics to eliminate noxious microbes from their bodies, people are advised to learn to maintain their health and avoid getting sick. Orifices such as the mouth, the nostrils, the vagina and the anus, are regarded by Chinese people as points of special vulnerability through which germs, bad spirits, the wind or other illness causing agencies can penetrate the body to cause physical or mental disorder. For example, eating “rotten” food may result in stomach upsets and vomiting, which require simple treatments with medicinal herbs and special diets (Koo, 1984, p. 758). These beliefs about the need for equilibrium and harmony, the links between emotions and avoidance of extremes, all shape how older Chinese people make sense of health and illness and act to manage or treat it. However, belief systems are also influenced by other factors. Ho (1985) found that people born in China or outside Hong Kong and those who had their education in the Chinese-type
schools, were likely to have stronger affiliations with the Chinese culture and traditional concepts, and could be expected to have stronger traditional beliefs about the value of food in health and illness.

**Hong Kong Chinese views on the aetiology of illness**

The principles of *yin/yang* strongly influence Chinese people's health concepts and preventive behaviour (Chen, 1996, p. 211; Monroe, 1995, p. 76). In this study, it is posited that the Taoist way of life and the principle of *yin/yang* provide a key to understanding the health beliefs and the preventive health behaviour of older Hong Kong Chinese. Although very little research has been conducted on their health beliefs and preventive health behaviours, Yip (2003, p. 20) noted a highly diversified practice of traditional Chinese concepts of physical and mental health among Chinese communities as follows:

- Sub-ethnic groups within Chinese communities;
- Exposure to and experiences of traditional Chinese culture;
- According to individual age, sex and educational background; and
- Exposure to and experience of non-Chinese culture, especially global Western culture.

In a pluralistic society like Hong Kong, where British colonial rule resulted in the importation of many Western practices, Chinese people retained many of their traditional religious, social and cultural customs. But the juxtaposition of the latest in modern technology and the retention of traditional ways, means that the health beliefs of Hong Kong people are complicated. Thus, for instance, many Hong Kong Chinese people still believe that inherited and environmental factors can affect the balance of *qi* and blood (Koo, 1984, p. 758).
Among their causation theories is that rheumatism/arthritis (fung' seb') is due to exposure to cold and wetness and measles to the release of “poisonous” (duk') energy which entered the body before birth. In addition, they believe that diabetes results from eating too much sugar, and gallstones from long-term consumption of foods contaminated with sand or dirt. Haemorrhoids are associated with eating too many “hot” foods; peptic ulcers with foods that are hard to digest or which are “irritating” (fad'). Severe exercise after a meal causes appendicitis, too frequent sexual intercourse causes impotence because of the general assumption that the amount of sexual energy (jing') is limited and is directly related to health (Chau, Lee, Tseng, & Downes, 1990; Ho, 1985; Koo, 1987, pp. 406–413) (See Table 2.3)
### Table 2.3: Hong Kong Chinese Views on Disease Aetiology

<table>
<thead>
<tr>
<th>I. Due to or affected by excess ‘hot’, ‘cold’, or ‘wet’</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Excess ‘hot’</strong></td>
<td><strong>Excess ‘cold’</strong></td>
</tr>
<tr>
<td>Acne/pimples</td>
<td>Asthma</td>
</tr>
<tr>
<td>Conjunctivitis</td>
<td>Bronchitis</td>
</tr>
<tr>
<td>Constipation</td>
<td>Cold extremities</td>
</tr>
<tr>
<td>Cough</td>
<td>Diarrhoea</td>
</tr>
<tr>
<td>Haemorrhoids</td>
<td>Dysmenorrhoea</td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
</tr>
<tr>
<td>Irregular menstruation</td>
<td>Excess ‘wet’</td>
</tr>
<tr>
<td>Nightmares</td>
<td>Osteoarthritis</td>
</tr>
<tr>
<td>Nose bleeds</td>
<td>Rheumatism</td>
</tr>
<tr>
<td>Skin rash/allergy</td>
<td></td>
</tr>
<tr>
<td>Sore throat</td>
<td></td>
</tr>
<tr>
<td>Dark/sparse urine</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. Due to or affected by the accumulation/penetration of “poison”</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accumulation of &quot;hot-poison&quot;</strong></td>
<td><strong>Penetration of &quot;wet-poison&quot;</strong></td>
</tr>
<tr>
<td>Colds</td>
<td>Skin allergy/rash</td>
</tr>
<tr>
<td>Cough</td>
<td>Dark/sparse urine</td>
</tr>
<tr>
<td>Ear humming</td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III. Due to or affected by insufficient or blocked energy</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insufficient energy</strong></td>
<td><strong>Blocked energy</strong></td>
</tr>
<tr>
<td>Anaemia</td>
<td>Gallstones</td>
</tr>
<tr>
<td>Baldness (premature)</td>
<td>Headache</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Insomnia</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Stroke</td>
</tr>
<tr>
<td>Impotence</td>
<td></td>
</tr>
<tr>
<td>Menorrhagia</td>
<td></td>
</tr>
<tr>
<td>Irregular menstruation</td>
<td></td>
</tr>
<tr>
<td>Premature ejaculation</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
</tr>
</tbody>
</table>

Source: Koo, 1984, p. 763.

Illness may also be seen as punishment for offending the gods, demons or spirits, or for performing dishonest deeds. Other causes are poor *fung seu* (the impact of both the natural and manmade environment on the fortune and wellbeing of inhabitants) and cosmic disharmony. The latter results when the combination of a person's year, month, day and time of birth, (known as the “eight characters”), clash with those of another person in their family. Accidents are caused by displeasing a deity, or by black magic and sorcery, the effects of which may be counteracted by the use of charms and expiatory
or exorcism ceremonies performed by Buddhist priests (Lee, 1992, p. 16; Queensland Government, 2003, p. 4; Yau, 2003e, p. 141).

2.5 Between two worlds: Western and Chinese medicine

People often use their cultural beliefs and values as points of reference for decisions about health care (Kleinman, 1980). Hong Kong Chinese people have been described as “situation-oriented” because their health-seeking and preventive health behaviour is determined by the situational context of their problems and their expectations of help available under those circumstances (Yau, 2003b, p. 232; Yeo & Meiser, 2003, p. 307). Some research studies have also found that Chinese people tend to be crisis-oriented in their use of Orthodox Western medicine (OWM), which means that they turn to this kind of medicine only when their health condition becomes dire (Chan & Chang, 1976; Frank-Stromborg & Olsen, 1993, p. 93; Kleinman, 1980). This is because many retain a deep-rooted faith in their own medical tradition and they thus have an eclectic, idiosyncratic and pragmatic response to illness. Many will obtain treatment simultaneously from both Chinese and Western-style general practitioners when they get sick, with visits to the former mainly to seek tonics in order to build the resistance to disease (Department of Health, 2004, p. 33; R. Lee, 1980; R. P. L. Lee, 1974; Wong, 1998).

The literature presents contradictory viewpoints about the role of Western and Chinese medicine in the management of illness. In traditional Chinese culture, this depends on the severity of the complaint and the degree of urgency of the problem. In Guo's study (2000) on the health beliefs and health-seeking behaviour of older Chinese people in Flushing in New York, the informants tended to use metaphors to express their opinions on health. They often used three terms to express their health problems: mou' běng (an
abnormal condition) or xiù mou béng (a small problem), daì mou béng (major problems) and mì daì mì sei mou béng (in-between problems). Those with acute or life-threatening symptoms will be sent immediately to the general practitioner (GP) or to the emergency department of a hospital for Western medical care. But when the problems seem to be minor, various dietary treatment methods are commonly used in the home. Only when food remedies have failed, are Western or Chinese style practitioners consulted (Kasteler, Kane, Olsen, & Thetford, 1976; Lee, 1980; Tang, 1998; Wong, 1998). Lee (1974) found that most Hong Kong people prefer the Chinese to a Western medical approach because they believed that traditional Chinese herbal medicine produces fewer side effects and it treats the disease itself rather than merely the symptoms. Most keep certain Chinese remedies in their homes for possible self-treatment (Cheung, Cho, Lum, & Yau, 1989; Lee, 1974, p. 2). Apart from herbal medicine, the other two main areas of TCM traditional Chinese Medicine are acupuncture (with the use of needles), acupressure (with the use of massage) and moxibustion (the burning of herbs at the acupoint sites) (Ferroa, 1991, p. 64; Pankhania, 2003, p. 34).

A different view of the role of OWM is presented in the more recent writing of Leung (1998, p. 154). He explained that Hong Kong Chinese tend to seek Western medical help first when they experience minor health problems, since it seems more convenient to take the ready-made drugs than to undertake the time-consuming process of brewing herbal tea or using special diets. In addition, OWM is viewed as more “scientific” and modern by most. However, when OWM fails to cure chronic illness and cancer, they are inclined to consult traditional Chinese medical practitioners. Another survey found that traditional Chinese medical practitioners were more likely than their Western counterparts to provide detailed explanations to their patients about the nature of their
illness (Wong, Yu, Liu, Lee, & Lloyd, 1997, p. 368). In their treatments, traditional Chinese medical practitioners mainly used the notion of the interruption or blockage of qi as the basis for their diagnosis and treatment of illness, as well as for promoting health and preventing illness (Ludman, Newman, & Lynn, 1989, p. 1122; Ma, 1999b, p. 120). There is currently no normative practice in terms of use of TCM or OWM. Health-seeking treatment and illness prevention behaviour is influenced by knowledge and experiences of both systems of health care. The most common dietary method of treating various symptoms or ailments is to drink certain types of herbal teas or soups to alleviate particular problems and re-establish the body's energy equilibrium (Koo, 1984; Reid & Trompf, 1990). Sometimes exotic items such as dried snakes, lizards, frog and animal horns are used to add potency to medicinal brews. For example, patients are treated with scrapings of rhinoceros horns to treat fever or with tiger-bone wine to alleviate aches and pains (Ferroa, 1991, p. 65; Koo, 1989b, pp. 221–224).

“Food is medicine, medicine is food” (Guo, 2000, p. 123)

In Chinese health culture, prevention is predicated on the necessity for balance and harmony in health behaviours, lifestyle, emotion and daily diet (Ludman et al., 1989, p. 1122; Ma, 1999b, p. 120). Avoidance of illness can be accomplished by living modestly and in harmony with the microbiological environment (Gervais & Jovchelovitch, 1998, p. 32; Ho, 1985; Ma, 1999b, p. 108; Yau, 2003e, p. 131). Notwithstanding their differences, Chinese living in a variety of countries have similarities in their beliefs about health maintenance and illness prevention. Over the last few decades, numerous researchers have studied Chinese migrants' health beliefs, preventive health behaviour and health-seeking behaviour in different countries (Chan & Chang, 1976; Chan & Quine, 1997; Cheng, 1978; Gould-Martin & Ngin, 1981; Guo, 2000; Kwan & Holmes, 1999; Ma, 1999a, 1999b; Martin, 1999; Phoon & Macindoe, 2003; Prior, Huat, Chun, &
Bloor, 1997; Queensland Government, 2003; Tang, 1998), including that of the Hong Kong Chinese in Australia (Martin, 1999; Phoon & Macindoe, 2003; Tang, 1998). These studies have shown that in some respects, the preventive health practices of Chinese people were very limited, for example, as far as dental care and having Pap smears were concerned (Department of Health, 2004, p. 28; Gervais & Jovchelovitch, 1998, p. 3; Kwan & Bedi, 2000; Kwan & Holmes, 1999). But it should be remembered that it is common for Hong Kong Chinese people to combine Western and Chinese concepts of health maintenance and illness prevention (Department of Health, 2004, p. 33; R. Lee, 1980; R. P. L. Lee, 1974).

For Hong Kong Chinese people, the first necessity for correcting energy imbalances is having an adequate diet. Food plays a very important role in Chinese culture, not only for social reasons but also because of its perceived effects on physical and mental wellbeing (Frank-Stromborg & Olsen, 1993; Karmi, 1996; Koo, 1984; Satia-Abouta, Patterson, Kristal, Teh, & Tu, 2002; Yuan & Liu, 1992). As Koo (1989b) stated,

> If the body is seen as a battery where various physical, sexual, and mental activities drain it of energy, then foods of a tonic nature are able to “recharge” it with energy (p. 221).

Food is the most commonly used method to manipulate the quantity and quality of personal body energy. TCM is taken not just to relieve a symptom or cure an illness but also to improve bodily functions and to prevent illness (Ferroa, 1991; Koo, 1984, 1989b; Pankhania, 2003, p. 34). In general, Chinese herbal and dietary treatments are almost always practised together. Over hundreds of years the belief that foods are like herbal remedies, and herbal remedies are like foods, has reinforced the importance and use of home remedies in family health care practices (Guo, 2000, p. 115). However, food remedies have always been primary because they are seen as more “natural” and
“balanced”, thus causing fewer negative side effects, although they are slower to take effect (Koo, 1984; Reid & Trompf, 1990).

The belief in their health-giving properties means the selection of foods and the timing of meals are an important means of manipulating energy in order to increase health levels (Gascoigne, 1997; Koo, 1989b). The subtropical climate of Hong Kong means that heat, humidity and air pollution are very common for most months of the year. These climatic factors could also partially account for the fact that the food classification system and its use in health care seems to be more complex and popular among the Hong Kong Chinese than those from other parts of China (Koo, 1989b, p. 227).

Foods can be divided into three categories—the “cooling”, the “warming” and the “tonics”. Cooling foods include cucumbers, watercress and fruit, the “warming” include garlic, peppers and chives while the “tonics” include red date, shark fin, and wild duck. Three other food categories which need mention are the “poisonous” (*duk*), “irritating” (*fad*), and “stimulating” (*qi gig*) foods. “Poisonous” food tends to be evident in the allergic reactions and skin eruption (such as measles) they cause, and they are linked with “wet-poisonous” (*seb duk*) or “wet-hot” (*seb yid*) foods like shellfish. “Irritating” (*fad*), foods can disturb the normal flow of body energy by causing it to be expended too much or too quickly in certain parts of the body, and too slowly in others. “Stimulating” (*qi gig*) foods increase the forced expenditure of body energy, resulting in exhaustion of the body’s reserves. In many cases, the “irritating” and “stimulating” properties of foods are combined, such as in coffee. As many foods fit into the different categories, they need to be eaten in proper balance, taking into account the seasonal variations and the individual's body constitution, temperament and state of health. The maintenance of proper balance is paramount in the achievement of harmony and the concomitant health

There are numerous studies on the health or dietary beliefs of Hong Kong Chinese (Chau et al., 1990; Department of Health, 2004; Guo, 2000; Ho, 1985; Koo, 1982, 1984, 1987, 1989a, 1989b, 1989c; Kwan & Holmes, 1999; Lee et al., 1993; Ludman et al., 1989; Martin, 1999; Whittemore et al., 1990; Yuan & Liu, 1992). Such beliefs are unaffected by migration. Chau et al. (1990, p. 2) indicated that Chinese older women who had migrated to San Francisco were more likely to select foods according to their attributes of “hot” (yid) or “cold” (leng) in order to maintain equilibrium. Other studies also found that food plays an important role in the maintenance of body equilibrium in the health beliefs of Chinese people living in Western countries (Chang, 1974; Lee et al., 1993; Ma, 1999a, 1999b). Although many Hong Kong Chinese are familiar with Western concepts of nutrition based on the material properties of foods, these are combined with Chinese methods of dietary manipulation in a complementary role in disease prevention. The strength of these beliefs means that the use of various traditional food remedies has not declined among Hong Kong Chinese people in Australia, even though Westernisation and modernisation are dominant in their new living environment. Guo (2000, p. 123) argued that Chinese people, especially the elderly, have strong tendencies toward the maintenance of their traditional health beliefs and practices. Indeed, the older generation of Chinese Australians probably retain an unquestioning respect for their traditional practices since they perceive them to have been successful in the past (Lee, 1992, p. 16).

In their study of 379 Chinese people from various countries, including Hong Kong, Ludman et al. (1989, p. 1124) found similar beliefs in blood-building foods. Although knowledge and understanding of the ancient philosophical yin/yang underpinnings of this
belief was poor among all groups studied, the most recommended foods were often of the appropriate *yang* nature. That indicates that while these Chinese groups used food as a preventive health strategy, they did not consciously link it to Taoism. This is probably due to these practices being ingrained in their behaviour (Ho, 1985, p. 233). Koo (1984; 1987; 1989b) has demonstrated the strength of the belief in the principle of “like helps like” and using “poison to fight poison” in the treatment and prevention of disease. Types of food or herbal methods for treatment of various illnesses are summarised in Table 2.4.

**Table 2.4: Dietary Treatments of Illness in Hong Kong Chinese Culture**

<table>
<thead>
<tr>
<th>Food type</th>
<th>Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. Based on energy properties:</strong></td>
<td></td>
</tr>
<tr>
<td>“Cooling” foods (e.g. bananas, carrots, celery, cold drinks, cold water, honey, white sugar, sugar cane, water chestnuts, watermelon, wintermelon)</td>
<td>Acne or pimples, constipation, cough, haemorrhoids, hypertension, measles, nose bleeds</td>
</tr>
<tr>
<td>“Warming” foods (ginger and brown sugar soup, hot tea, yellow onion soup)</td>
<td>Colds, diarrhoea</td>
</tr>
<tr>
<td>“Tonic” foods or wines (patented herbal preparations; naturally grown chicken; soups of animal flesh, liver, fish or fowl; red dates; shark fin; seaweed; wild duck)</td>
<td>Anaemia, cold extremities, diabetes, dysmenorrhoea, fatigue, hypertension, impotence, premature ejaculation, tuberculosis</td>
</tr>
<tr>
<td><strong>II. Based on material properties:</strong></td>
<td></td>
</tr>
<tr>
<td>Soft-textured food</td>
<td>Peptic ulcer</td>
</tr>
<tr>
<td>Calcium-rich foods (e.g. beef soup bones)</td>
<td>Broken bone</td>
</tr>
<tr>
<td>Foods with sugar or glucose</td>
<td>Fatigue, liver disease</td>
</tr>
<tr>
<td>Nutritious, vitamin-rich foods</td>
<td>Anaemia, baldness, dandruff</td>
</tr>
<tr>
<td><strong>III. Based on cultural principles:</strong></td>
<td></td>
</tr>
<tr>
<td>Pig’s brain with walnuts</td>
<td>Headache</td>
</tr>
<tr>
<td>Penis and /or testicle of sea otter, deer, etc.</td>
<td>Impotence</td>
</tr>
<tr>
<td>Ginger</td>
<td>Tinnitus, stroke</td>
</tr>
<tr>
<td>Crocodile meat</td>
<td>Asthma</td>
</tr>
<tr>
<td>Snake gall bladder wine</td>
<td>Osteoarthritis</td>
</tr>
<tr>
<td>Human placenta</td>
<td>Asthma, bronchitis</td>
</tr>
<tr>
<td>Black beans</td>
<td>Baldness, ear humming, headache, nosebleeds</td>
</tr>
<tr>
<td>Peanuts</td>
<td>Impotence</td>
</tr>
<tr>
<td>Wine</td>
<td>Insomnia, premature ejaculation</td>
</tr>
<tr>
<td>Rice congee</td>
<td>Diarrhoea, dark/sparse urine</td>
</tr>
<tr>
<td>Milk</td>
<td>Constipation, peptic ulcer, insomnia, stomach ache</td>
</tr>
</tbody>
</table>

Source: Adapted from Koo, 1984, pp. 759–760; 1989b, p. 224.
Consuming pig's brain with walnuts to treat a headache exemplified the “like helps like” principle, while the use of snake gall bladder wine to cure osteoarthritis typifies the “poison to fight poison” principle. This is because gall bladder is reputed to have anti-poison properties which counteract the “wet-poison” of osteoarthritis (Koo, 1984, p. 760). Another study showed many older Chinese people believed that using pork bones or chicken feet to make soup strengthens the bones, not realising that soup prepared with bones contains high amounts of fat and cholesterol (Department of Health, 2004, p. 24). Traditional health-promoting techniques have become commercialised; nowadays it is possible to buy pre-measured popularly consumed herbal soup mixtures in supermarkets instead of having to get these potions in a Chinese herbal shop (Koo, 1989c, pp. 54–55).

Koo (1984) interviewed 50 Chinese families in Hong Kong in 1981 about their use of food to treat and prevent disease. He found that in order to prevent illness and promote recuperation after it has occurred, similar specific foods would be prescribed or proscribed by the majority of Hong Kong Chinese people (See Table 2.5).
According to Table 2.5, prescriptive rules for illness prevention indicated how traditional concepts have been integrated with OWM, although the influence of Western ideas was less apparent in the proscriptive ones. The dietary prescriptions which stressed the consumption of vitamins, minerals, protein or high-fibre foods were using concepts borrowed from Western nutritional science which indicates that these have been absorbed into Chinese nutritional concepts, based on the energy effects of foods. The proscriptions emphasised that the problems arising from excess “cold” (lêng⁴), “hot” (yid⁶), “wet” (seb¹) or “poison” (duk⁶) energy could be avoided by consuming foods falling into the opposite classifications and reducing those of the same nature. Usually

<table>
<thead>
<tr>
<th>Dietary method (prescriptions)</th>
<th>Symptom/Abnormality</th>
<th>Dietary method (proscriptions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calcium-rich foods; Foods with vitamin C; tonic foods, wines, herbs</td>
<td>Broken bone, sprains</td>
<td>(not mentioned)</td>
</tr>
<tr>
<td>Nutritious foods, especially those with vitamins; vegetables</td>
<td>Diabetes</td>
<td>Reduce sugar, salt, and oily foods</td>
</tr>
<tr>
<td>Regular eating habits (quality, quantity, and timing); vegetables; herbal tea/soups that are “cooling”</td>
<td>Hypertension</td>
<td>Reduce meat and fatty food; reduce stimulating food; stop/avoid drinking alcohol</td>
</tr>
<tr>
<td>Vegetables and fruits; herbal tea/soup that are “cooling”; drink more water</td>
<td>Haemorrhoids</td>
<td>Avoid “hot” and “irritating” foods, stop/avoid drinking alcohol</td>
</tr>
<tr>
<td>Nutritious food, especially those with vitamins; observe food hygiene; drink more water/soups; sugary foods or those with glucose</td>
<td>Liver diseases</td>
<td>Avoid/reduce raw or “cold” foods; stop/avoid drinking alcohol</td>
</tr>
<tr>
<td>Foods with Vitamin C, especially fruits</td>
<td>Skin allergy</td>
<td>Avoid “hot-poisonous” foods, reduce stimulating foods</td>
</tr>
</tbody>
</table>

Source: Adapted from Koo, 1984, pp. 762–763.
meat was among the foods that needed to be reduced, especially beef or pork because they were believed to be “heavy” and “coarse” in nature—“heavy” because of the concentration of fats, and “coarse” because of their association with the polluting effects of blood-culture (Koo, 1989b, p. 221; Yuan & Liu, 1992, p. 293). A recent survey also showed that some older people in Hong Kong avoided eating beef because they believe that it contained “toxins” (Department of Health, 2004, p. 24).

2.6. Summary

Hong Kong Chinese are generally regarded as being quite distinct from the Chinese of mainland China economically, politically, socially and culturally. Nonetheless, the beliefs systems of Hong Kong people cannot be divorced from their cultural genesis-point in China. Traditional belief systems have not disappeared but have merely metamorphosed into different forms while their ends are accomplished through other means. In conclusion, it should be said that Confucianism continues to have a pervasive influence on Chinese behaviour because of its detailed rules and regulations for social interactions. Taoism gives a basic perspective on life and health while Buddhist philosophy has provided the additional attitudes towards life described above and has many prescribed external rituals for life events. The overlapping and interrelated values drawn from Confucianism, Taoism and Buddhism constitute the fundamental lineaments of Chinese tradition embedded in the collective culture and also in the individual personhood of the people of Hong Kong, even though their exposure to Western culture makes them distinct from other Chinese. However, facing the uncertainty of socio-political changes over the last few decades of the twentieth century, many Hong Kong Chinese have chosen to settle abroad in a diaspora which has caused many specific cultural and health conflicts. These issues will be discussed in the next chapter.
CHAPTER 3: IMBALANCE AND ADAPTATION BETWEEN CHINESE AND WESTERN CULTURES

Chinese migrants from Hong Kong have been settling in Australia for more than 150 years. Studies have found that in general, despite the diversity in country of origin and socioeconomic status (SES), Chinese families in Australia retain something of their original cultural beliefs (Chu & Caraw, 1990, p. 6; Crain, 1997; Mak & Chan, 1995, p. 94). The new climate, housing, dietary habits, clothing, patterns of sleep, timing of meals and pace of activities they have experienced (Choy, 2003, p. 245) has induced many physical, social and cultural changes among them (Shuval, 1993). This chapter investigates how older Hong Kong Chinese people living in Australia have been affected by those changes. The chapter will also investigate how the changes have influenced the preventive health behaviour of this group and the barriers they have raised to participation in preventive health programs.

3.1 Physical and environmental changes

During the early 1980s, emigration from Hong Kong to Canada, the United States, the United Kingdom, Australia and New Zealand was on the rise, probably in response to the imminent return of sovereignty over Hong Kong to China (Choy, 1998; Mar, 1998; Skeldon, 1994; Wei & Li, 1996, pp. 67–68). One result was that from the mid-1980s until 1993, Hong Kong was one of the main sources of migration to Australia (Mak & Chan, 1995). The peak occurred in 1991 with the arrival of 13,451 immigrants. This represented 11.1% of Australia's total immigrant intake for this period (Pe-Pua, 1996). Although there is a lack of systematic statistical information about Hong Kong Chinese who have migrated, the most recent Australian census, that of 2001, recorded that a total of 67,080 Hong Kong-born persons were living in Australia. They have mainly settled in
Victoria and NSW, Sydney being the most favoured site of settlement. The distribution by State and Territory showed that NSW had 37,590, followed by Victoria (16,030), Queensland (6,710) and Western Australia (3,530). The age distribution showed that 4.1% were 65 and over. As far as religious affiliation is concerned, the 2001 census showed that 11,340 persons were Western Catholic, 7,560 were Buddhist and 4,390 were Baptist. The remainder stated that they had no religion (Department of Immigration and Multicultural and Indigenous Affairs, 2003a). Studies have also indicated that one in 20 Sydney families speaks a Chinese language at home (Department of Immigration and Multicultural and Indigenous Affairs, 2003a; Mar, 1998; University of New England, 2001, pp. 1–2).

Numbering 2.4 million, people aged 65 years and over constituted around 12% of the Australian population in 2001. However, this number is projected to be 5.4 million in 2031, comprising around 27% of the total population (Australian Institute of Health and Welfare, 2002b, p. 188). Those aged 85 years and over made up 1.4% of the total population in 2002. It is estimated that in 2051, this group will represent between 6% and 9% of the total population, and in 2101, between 7% and 11% (Australian Bureau of Statistics, 2003, p. 2). While in NSW the total population aged 60 years and over increased from around 670,000 in 1991 to the 1,020,000 in 1996, the population of older people of CSB in NSW also grew from 10,500 in 1991 to 18,379 in 1996. The major birthplaces were China and Hong Kong (Australian Bureau of Statistics, 1998; Ethnic Affairs Commission, 1998). Although demographic data about Chinese migrants from Hong Kong was not well detailed, it could be deduced that these two older Chinese groups accounted for around 15,350 out of 1,020,000 (1.5%) older Australian population in NSW. As shown in Table 3.1, there was a somewhat smaller proportion of older Hong Kong-born people (5.3%) compared with the total China-born older population (20.3%).
The proportion of older women in both these Chinese groups was higher than that of older men and this trend increased with age (Australian Bureau of Statistics, 1995).

Table 3.1: Age-gender Profiles for Selected Birthplace Groups in NSW in 1996

<table>
<thead>
<tr>
<th>Key Facts</th>
<th>NSW</th>
<th>China-born</th>
<th>Hong Kong-born</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>6,038,696</td>
<td>65,490</td>
<td>38,886</td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-64</td>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>120,000</td>
<td>1,700</td>
<td>400</td>
</tr>
<tr>
<td>Female</td>
<td>125,000</td>
<td>2,000</td>
<td>350</td>
</tr>
<tr>
<td>Total</td>
<td>245,000</td>
<td>3,700</td>
<td>750</td>
</tr>
<tr>
<td>65-69</td>
<td>Male</td>
<td>110,000</td>
<td>1,600</td>
</tr>
<tr>
<td>Female</td>
<td>130,000</td>
<td>1,800</td>
<td>250</td>
</tr>
<tr>
<td>Total</td>
<td>240,000</td>
<td>3,400</td>
<td>500</td>
</tr>
<tr>
<td>70-74</td>
<td>Male</td>
<td>90,000</td>
<td>1,200</td>
</tr>
<tr>
<td>Female</td>
<td>120,000</td>
<td>1,400</td>
<td>200</td>
</tr>
<tr>
<td>Total</td>
<td>210,000</td>
<td>2,600</td>
<td>350</td>
</tr>
<tr>
<td>75 and over</td>
<td>Male</td>
<td>125,000</td>
<td>1,400</td>
</tr>
<tr>
<td>Female</td>
<td>200,000</td>
<td>2,200</td>
<td>250</td>
</tr>
<tr>
<td>Total</td>
<td>325,000</td>
<td>3,600</td>
<td>450</td>
</tr>
<tr>
<td>Aged 60 and over</td>
<td></td>
<td>1,020,000</td>
<td>13,300</td>
</tr>
<tr>
<td>% of the population</td>
<td>16.9</td>
<td>20.3</td>
<td>5.3</td>
</tr>
<tr>
<td>aged 60 and over</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Adapted from Ethnic Affairs Commission, 1998, pp. 32–33.

**Can older Hong Kong Chinese people enjoy greater longevity?**

During the past few decades, research has identified a number of chronic diseases among older people in Australia (Australian Institute of Criminology, 2004; Australian Institute of Health and Welfare, 1998, 2002b; New South Wales Department of Health, 1989, 1995; Public Health Division, 2000a; Teshuva, Stanislavsky, & Kendig, 1994). The main causes of death were diseases of the circulatory system, cancers and diseases of the respiratory system. These three main categories together accounted for about three-quarters of deaths among people aged 65 and over (Australian Institute of Health and Welfare, 2002b, p. 191). Other common health problems included arthritis, vision loss, hearing loss, cardiovascular disease, incontinence, osteoporosis, foot problems, diabetes mellitus, respiratory diseases, dementia, depression, dental problems, falls and injuries, disability and handicap. Obviously, avoidable conditions arose from causes such as
inappropriate use of medications and insufficient physical activity (New South Wales Department of Health, 1989; Public Health Division, 2000a).

Owing to the stringent health requirements for immigration, most migrants enjoy good health, or at least better health than the Australian-born population. This is known as the “healthy migrant effect” (Australian Institute of Health and Welfare, 2002b, p. 191). Migrants generally have higher life expectancy, lower death rates and hospitalisation rates, as well as a lower prevalence of certain lifestyle-related risk factors (Australian Institute of Health and Welfare, 2002b, p. 191; Mathers & De Looper, 1994; Queensland Government, 2003, p. 4). Research has revealed that in comparison with Australian-born people, Chinese men and women have significantly low age-standardised mortality rates (SMRs) from malignant neoplasm of the respiratory system. They also have significantly low SMRs from diseases of the digestive system, the musculoskeletal system and circulatory system, although there is a moderate level of mortality from other heart disease among men. The Hong Kong Chinese have a particularly low SMR from accidents, poisoning and violence (Donovan, d'Espaignet, Merton, & Ommeren, 1992; Koo & Rowling, 1999; National Health Strategy, 1993; Reid & Trompf, 1990).

Mather and De Looper's study (1994) also showed that, in general, Asian-born people aged 65 years and over (including those Chinese-speaking people born in China and Hong Kong) have a longer life expectancy than the Australian-born. The reasons are not clear. Details of malignant neoplasm and other diseases among older Hong Kong migrants are unavailable. However, while Mathers and De Looper's study (1994) showed that Hong Kong migrants had fewer health problems than their Anglo-Celtic counterparts in Australia, other research (Guo, 2000, p. 45; Janes, 1990; Kuly, 1990) has suggested that migrants, especially those who move to Western urban centres from non-Western
settings, in fact do suffer from several health problems. The following comparison of SMRs among older people born in Australia, Hong Kong and China were extracted by Koo and Rowling (1999, p. 38): (See Table 3.2).

**Table 3.2: Comparison of the Level of SMRs among Older People for Selected Causes of Death and for Selected Birthplaces: Australia, China and Hong Kong**

<table>
<thead>
<tr>
<th>Causes of death</th>
<th>Australia</th>
<th>China</th>
<th>Hong Kong</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant neoplasm</td>
<td>High –</td>
<td>High –</td>
<td>High –</td>
</tr>
<tr>
<td>Male: Colorectal</td>
<td></td>
<td>Male: Digestive</td>
<td>Male: Nasopharynx</td>
</tr>
<tr>
<td>Prostate</td>
<td></td>
<td>Nasopharynx</td>
<td>Low –</td>
</tr>
<tr>
<td>Female: Breast</td>
<td></td>
<td>Peritoneum</td>
<td>Female: Breast</td>
</tr>
<tr>
<td>Moderate –</td>
<td>Low –</td>
<td>Low –</td>
<td></td>
</tr>
<tr>
<td>Lung</td>
<td></td>
<td>Female: Breast</td>
<td></td>
</tr>
<tr>
<td>Pancreas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diseases of the circulatory system</td>
<td>High –</td>
<td>Low, except</td>
<td>Low, except</td>
</tr>
<tr>
<td>Ischaemic Heart Disease</td>
<td></td>
<td>Male: Rheumatic</td>
<td>Male: Rheumatic</td>
</tr>
<tr>
<td>Disease</td>
<td></td>
<td>Heart disease</td>
<td>Heart disease</td>
</tr>
<tr>
<td>Cerebrovascular</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Diseases of respiratory system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diseases of Digestive system</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>Moderate</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Accident, poisoning and Violence</td>
<td>Moderate</td>
<td>High –</td>
<td>Very Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Female: Motor vehicle</td>
<td></td>
</tr>
</tbody>
</table>


With the exception of heart disease, older men and women born in China and Hong Kong generally reported somewhat lower levels of serious-chronic, chronic, recent and minor illnesses than those born in Australia. The prevalence of reported disability and handicap was also significantly lower when compared with those born in Australia. Severe handicap levels were also lower for these ethnic groups (Mathers & De Looper,
Additionally, older people from Hong Kong made significantly less use of hospitals and were less likely to visit GPs. With regard to risk factors, obesity, alcohol consumption and smoking were much less common, while average levels of systolic blood pressure were lower among older Chinese people than among the Australian-born population (Donovan et al., 1992; Koo & Rowling, 1999; Mathers & De Looper, 1994; Reid & Trompf, 1990).

Apart from the results of applying a selective migration policy – the “healthy migrant effect” – the causation of health differentials between Australian-born older people and those who have migrated from Hong Kong is complex. Mathers and De Looper (1994) postulated that age, gender, marital status, living arrangements, income, education and lifestyles would be the major factors associated with the poor health of many older people in Australia. There are also variations in the health status of migrants according to birthplace, age, socioeconomic status, English language proficiency and satisfaction with their jobs and lives in Australia (Australian Institute of Health and Welfare, 2002b, p. 194).

Despite the generally good health status of older Chinese people, analysis of data also suggests that their mortality rates increase with length of residence and exposure to the traditional Western lifestyle in Australia. Thus there is a delay of 15 to 20 years before their mortality rates approximate those of their Australian-born counterparts (Donovan et al., 1992; Frank-Stromborg & Olsen, 1993; Mathers & De Looper, 1994; National Health Strategy, 1993; Young, 1986). This indicates that their health status is significantly impacted upon the degree to which they have adopted the culture and behaviour of Western society. Mathers and De Looper's study (1994) also found that men and women born in China and Hong Kong were more likely to report fair or poor
health compared with Australian-born counterparts and that their preventive health measures were very limited (Department of Health, 2004, p. 28; Gervais & Jovchelovitch, 1998, p. 3).

Previous studies have also found that people born in China or Hong Kong were more likely to suffer greater oral health problems. The majority did not know the causative factors of and preventive methods for avoiding caries and gum diseases (Department of Health, 2004, p. 28; Kwan & Bedi, 2000; Kwan & Holmes, 1999; Lee et al., 1993; Lind et al., 1986; Teshuva et al., 1994). Their awareness of women’s health issues was also very low. For example, they have been shown to have low participation rates in and poor knowledge of mammogram and Pap tests (Donovan et al., 1992; Mathers & De Looper, 1994; Reid & Trompf, 1990). In addition, they had comparatively lower rates of participation in physical activity than those born in Australia (Donovan et al., 1992; Hong Kong Sports Development Board, 2002; Woo, Leung, Ho, Lam, & Janus, 1998).

Changes in their physical environment also impact on the health status of older Chinese people after migration. With an overall population density of around 5,700 per square kilometre (ranging between 26,180 per square kilometre in the metropolitan area and 2,790 per kilometre in the rural area (Wei & Li, 1996, p. 62), Hong Kong is one of the most densely crowded cities in the world. In contrast, Australia is a country with an area of 7.68 million square kilometres and a population of 19.5 million. The centre of Sydney had the highest population density in Australia, that being around 4,000 people per square kilometre (Australian Bureau of Statistics, 2004, p. 1), which means that it provides a much more spacious and quieter environment and even in the cities, has more fresh air compared with Hong Kong (Wikipedia, 2004).
The studies by Martin (1999, p. 12) and Choy (1998, p. 164) found that the majority of Hong Kong Chinese felt their quality of life had improved since coming to Australia. Here they enjoyed including better living standards, a more relaxed lifestyle and more freedom of individual expression. However, some Chinese from Hong Kong enjoyed its highly urbanised, crowded, efficient and busy lifestyle with all its hustle and bustle, and found thinly populated Australia too quiet, slow, boring and backward (Mar, 1998). They felt that while life in Australia was more stable, it was dull. They were never lonely in Hong Kong because they had many friends and there was much more nightlife. In contrast, they felt insecure in Australia, afraid to open their doors to strangers, they feared the likelihood of serious injury in criminal violence on public transport or while walking in poorly lit streets at night (Koo & Rowling, 1999; Tang & Fisher, 1992). Mar (1998, p. 64) constructed the following list of perceived binary place-characteristics among Hong Kong migrants in Sydney:

<table>
<thead>
<tr>
<th>Hong Kong</th>
<th>Sydney/Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>Big</td>
</tr>
<tr>
<td>Dense</td>
<td>Spread-out</td>
</tr>
<tr>
<td>Noisy</td>
<td>Quiet</td>
</tr>
<tr>
<td>Uncertainty</td>
<td>Security</td>
</tr>
<tr>
<td>Danger (crime)</td>
<td>Less dangerous</td>
</tr>
<tr>
<td>Compulsion</td>
<td>Freedom</td>
</tr>
<tr>
<td>Dynamic</td>
<td>Backward</td>
</tr>
<tr>
<td>Fast</td>
<td>Slow</td>
</tr>
<tr>
<td>Sociability</td>
<td>Isolation</td>
</tr>
<tr>
<td>Stimulation</td>
<td>Boredom</td>
</tr>
<tr>
<td>Necessity</td>
<td>Freedom</td>
</tr>
<tr>
<td>Vitality</td>
<td>Retirement</td>
</tr>
<tr>
<td>Government, economic-liberal</td>
<td>Regulated, taxed</td>
</tr>
<tr>
<td>Urban, cosmopolitan</td>
<td>Rural</td>
</tr>
<tr>
<td>Compressed space, convenience</td>
<td>Space as emptiness, distance</td>
</tr>
<tr>
<td>Chinese</td>
<td>“White”</td>
</tr>
</tbody>
</table>

Source: Mar, 1998, p. 64.

As well as the physical environment, language presented many challenges. Although English is the working language of the international business world even in Hong Kong,
the older generation of Hong Kong Chinese still conduct their business and social conversations in Cantonese (Wei & Li, 1996, pp. 60–61). Their lack of skills in both written and verbal English causes great difficulty for the successful settlement of older Chinese people. Of the 60,160 Hong Kong-born who, according to the 2001 census, spoke a language other than English at home, 16% either did not speak English at all or did not speak it well (Department of Immigration and Multicultural and Indigenous Affairs, 2003a, p. 3). More importantly, studies have shown that a large majority of the older population of CSB experienced difficulties in expressing themselves in their second language, English.

Although some studies found that English language proficiency does not predict use of services (McPhee et al., 1997; Ying & Miller, 1992), their lack of English-speaking skills made accessing mainstream health and welfare services such as Centrelink, the police, GPs and hospitals difficult for many Chinese migrants. Thus, unlike other users of health services, older Chinese people face the double disadvantage of not knowing what services exist and not speaking English well enough to seek appropriate access to preventive health services. Isolation and lack of knowledge and information about preventive services available was also identified by Gonzalez, Haan, and Hinton (2001, p. 953) as an issue. They often have out-of-date information because they may not speak English well enough to ask questions. In addition, their low education and literacy levels militates against effective and appropriate health message conveyance (New South Wales Department of Health, 1991). Many older Chinese people, especially women, are unaware of preventive health messages or services because they cannot read (Ganguly, 1995). More importantly, some older Chinese people thought that their capacity to learn anything new was worse than that of young people (Department of Health, 2004, p. 14).
Previous studies have reported that many older Chinese people were restricted to the knowledge available from speakers of their own languages, often Chinese-speaking GPs, which limited access to a wider range of services (Chan & Quine, 1997, p. 75; Ma, 1999b, p. 13; Martin, 1999, p. 13; New South Wales Department of Health, 1991). If the health professionals have acquired some background about cultural differences in their training, the culture of older Chinese people who have migrated from Hong Kong may have an entirely different “style” of verbal communication from that with which they are familiar. The important messages may not be conveyed or may be communicated in such a manner that the other person fails to understand the importance of what is being said (Tirrito, Nathanson, & Langer, 1996). In this sense, the language barrier deprives older Chinese people of the benefits of hearing health messages and support which could facilitate their engaging in preventive health behaviour.

Lack of transportation is another barrier to accessing health care services and developing social networks, as most older Chinese people are unable to drive and many are fearful of using public transport because of language barriers (Ma, 1999b, p. 102; Tirrito et al., 1996). When they really need to seek medical help or to go for other appointments, they ask either church volunteers or their children to drive them to the health facilities. If the older people must depend on relatives, neighbours, or friends for transportation, they often must conform to the schedules of their helpers and may be extremely time restricted. Thus, once their health improves slightly, they may not return for further necessary treatment (Ma, 1999b, p. 102). The implication is that not only are there fewer opportunities to experience social gatherings in a familiar environment and surroundings, but there is also less ability to participate in preventive health behavioural activities or health promotion programs (South Western Sydney Area Health Service, 1990; Tirrito et al., 1996).
Studies have also shown that many older Chinese people state that they cannot take part in health promotion activities simply because their lack of mobility inhibits their ability to reach the service centres (Tang & Fisher, 1992; Wentworth Area Health Service, 1992). Difficulties are sometimes increased by the location of service centres (such as at the top of a hill), the long distances they would have to walk to reach the centres and inconvenient times (programs were held at night). Bad weather may also militate against participation (Piper, 1995; Tang & Fisher, 1992; Wentworth Area Health Service, 1992) because according to their cultural beliefs about health and illness, “wet” and “wind” penetrate the head and joints, causing headache and rheumatism (Tang & Fisher, 1992). Thus the new environment they experience in Australia causes feelings of insecurity, social isolation or physical restriction (Tang & Fisher, 1992). Encouraging and maintaining mobility is considered to be crucial in the promotion of health and wellbeing of older people but limited mobility, whatever the cause, tends to have devastating effects when it leads to inactivity, social isolation, inability to access services and eventually, loss of independence. All these elements have the potential to influence health behaviour (Ma, 1999b, p. 14).

### 3.2 Cultural difference

In Hong Kong's familial relations, the concept of filial piety, or the respect and devotion children are expected to have for their parents, is still embedded within the collective consciousness and everyone will act accordingly. A strong sense of obligation and responsibility to one's family is still cherished as a Chinese virtue. Emphasis is on mutual dependence and family responsibility for individual members. Family life is hierarchical and carefully preserved (Cheng, 1997, pp. 39–40; Monroe, 1995, p. 78; Rook, 1987; Wei & Li, 1996, pp. 189–190). Love and affection are expressed through actions in fulfilment of one's responsibilities and obligations, but not through words. Due to the emphasis on
family, personal actions reflect not only the individual but also the entire family, including past, present and future generations. Many Chinese people still subscribe to the idea of a society where in principle, older people will be respected and parents have a great influence on the daily affairs of their children, both before and after they are married (Lau, 1997, p. 10; Wei & Li, 1996, pp. 105–106; Yau, 2003a; 2003c, p. 105). It is a child's duty to look after his or her parents until their death. In other words, filial piety consists of much more than merely affectionate regard but also involves succour and support for parents. Family loyalty and solidarity provide its members with great comfort and support (Bowman & Singer, 2001; Cheng, 1997, pp. 39–40; Ferroa, 1991, p. 54; Monroe, 1995, p. 78; Wei & Li, 1996, pp. 189–190). However, there are still strict gender-related roles. Hong Kong women are still expected to carry a major nurturing and caring role in the family, while the husband/father normally assumes the role of breadwinner (Kwan & Chan, 1986, p. 233).

Political changes after 1997 raised new social issues that could threaten the foundations of the traditional family structure and its values. Due to the uncertainty about Hong Kong's future, many members of the suspicious and pessimistic middle classes and intellectual groups moved overseas, creating “astronaut families”\(^1\). Facing a new environment, older Hong Kong people have to cope with a different set of values in their adopted country. When their customary categories of experience no longer seem relevant or applicable, their behaviour often becomes “unusual” (Mak & Chan, 1995; Mar, 1998).

As Yeo (2003) pointed out:

\(^1\) In the “astronaut families” one partner, usually the husband, is left behind in Hong Kong for work and/or financial reasons, while the rest of the family migrates to a Western country to escape from the uncertainties after 1997. The term comes from the idea that the partner who stays behind is like an astronaut travelling between the earth (Hong Kong) and another planet (the country of migration) in a space shuttle (Yau, 2003a, p. 118).
In Western culture, there is an emphasis on assertive coping, which is aimed at improving an individual's skills in changing the environment. Chinese culture emphasises collectivism in which the person has to accommodate to the requirements of the community through attitudes and changes in behaviour. (p. 307)

The concept of “self” in Chinese culture is different from that in Western culture (Yeo & Meiser, 2003). The Western emphasis on individualism places importance on individual self-fulfilment and achievement. In contrast, for Chinese people, the “self” is viewed through the lens of values derived from Confucianism, Taoism, and Buddhism. In Confucianism, the concept of “self” emphasises reciprocity and fulfilment of the duties such as filial piety. It exists as part of the community and is subsidiary to community needs (Lee, 1989; Yeo & Meiser, 2003, p. 310). In Taoism, the “self” is also linked to yin/yang principles. Therefore striking a balance between yin/yang is believed to be of fundamental importance in the life of an individual (Chen, 1996; Ferroa, 1991; Liu, 1997; Shih, 1996; Yeo & Meiser, 2003, p. 311). As explained in Chapter 2, Buddhism focuses on the law of karma (cause and effect) and compassion. According to this philosophy there is no distinctive “self”. Having an ego/self means the person has desires and attachments to persons, places and objects, and such desires inevitably lead to suffering (Yeo & Meiser, 2003, p. 311).

Findings of previous studies (Hsu, 1967; Lin, Tseng, & Yeh, 1995, pp. 9–10) which have analysed the character and lifestyle of Chinese people, indicate that the “Chinese personality” is characterised by respect for authority, conservatism, dependence, obedience, compliance, caution, diligence, patience and conformity to one's role. The typical Chinese tends to be introverted, fond of tranquillity, emotionally reserved, habituated to self-restraint, considerate, and socially overcautious (Hsu, 1967; Lin et al., 1995, pp. 9–10). In addition, Chinese people value family life and the needs of the family take precedence over the needs of its individual members (Cheng, 1997, p. 41; Hwang et
Many traditional Chinese beliefs and values are in direct conflict with those of the West and there is concrete evidence of significant cultural differences between Chinese and Australians. Chiu & Tan (1985, p. 253) compared the perceived social characteristics of general Chinese and white Australians (See Table 3.4). Some of the contrasting values they pointed to are: family-centred life versus individualism; respect for authority and older people versus questioning of authority; parent–child-centred relationships versus husband–wife-centred relationships; an indirect communication style versus a direct communication style (Cheng, 1997, p. 40).

<table>
<thead>
<tr>
<th>Chinese people</th>
<th>White Australians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low profile stance</td>
<td>Preferring a low profile</td>
</tr>
<tr>
<td>Upwardly socially mobile</td>
<td>Increasingly middle class (&quot;implosion&quot; of class structure)</td>
</tr>
<tr>
<td>Non-ghetto—&quot;centrifugal&quot;</td>
<td>Suburban</td>
</tr>
<tr>
<td>Conformist, middle class</td>
<td>Conformist, conservative</td>
</tr>
<tr>
<td>Materialistic orientation</td>
<td>Hedonistic orientation, self-absorbed</td>
</tr>
<tr>
<td>Strongly driven toward personal success</td>
<td>Preferring personal satisfaction to success</td>
</tr>
<tr>
<td>Avoiding partisan politics (&quot;middle-of-the road&quot;)</td>
<td>Politically polarised</td>
</tr>
<tr>
<td>Non-controversial, non-provocative, non-involved, uncommitted</td>
<td>Do-it-yourself attitude</td>
</tr>
<tr>
<td>Family-centred</td>
<td>(Missing)</td>
</tr>
<tr>
<td>Quietly competitive</td>
<td>Easy-going and noncompetitive</td>
</tr>
<tr>
<td>Collectivism</td>
<td>Individualism</td>
</tr>
</tbody>
</table>

Source: Adapted from Chiu & Tan, 1985, p. 253.

Cheng (1997, p. 40) has argued, however, that many Chinese traditional values erode after migration. Family ties may become a double-edged sword. Many older parents sometimes live in their adult children's homes. Conflicts between parents and adult children are increasing as the children become more Westernised and take on the values of Australian society. Due to the frequent dependence of elderly Chinese on adult children and grandchildren, there has been a decline in parental authority and filial piety, creating a stressful situation for older Hong Kong Chinese (Mar, 1998). They feel distressed by their adult children’s and grandchildren’s acculturation in Australian
society and their apparent lack of respect for their elders. Moreover, in moving to Australia, older women face a process of increasing domestic obligation, since they are often expected to look after children and grandchildren and do the housework (Mar, 1998, p. 11; Martin, 1999). As a result they become housebound and unable to take part in social activities or preventive health activities, while their ability to establish contacts or communication with others outside their household is limited (Jayasuriya, Sang, & Fielding, 1992; Tang & Fisher, 1992; Tirrito et al., 1996). They find themselves faced with a need to learn new norms and values, and to abandon or adapt their old ones. Shuval (1993, p. 684) argued that the cultural gap between the places of origin and destination determines the amount of learning that must be undergone. All these factors create problems for many adult migrants who have an established and fairly inflexible set of values and behavioural repertoires (Furnham & Bochner, 1989, p. 194). This trans-generational impact tends to precipitate a mental crisis which may then lead to depression, loss of meaning in life, and the realisation that earlier dreams they had of their new country have collapsed (Abbott et al., 2003; Mathers & De Looper, 1994; National Health Strategy, 1993; New South Wales Transcultural Mental Health Centre, 2000).

The cultural conflicts older people experience cause feelings of impotence due to their not being able to cope with their new environment. Feelings of a loss of control lead to depression and impairment of mental or physical functioning (Choy, 1998; Furnham & Bochner, 1989, p. 181; New South Wales Transcultural Mental Health Centre, 2000; Oberg, 1960). More importantly, from the point of view of this thesis, the stress and strain caused by their encounter with cultural differences can influence their preventive health behaviour and utilisation of health care services. In addition, unemployment in Chinese culture usually led to loss of status, especially for men. This norm has impacted
badly on older Chinese people from Hong Kong who often experience an inability to find work after migration. Consequently, they frequently find themselves alone and unable to attain enough support to resolve critical issues. This may lead to them wanting to return to their home country (New South Wales Transcultural Mental Health Centre, 2000, p. 37).

It takes time to understand new norms and values and to decide whether to adopt new ones or abandon or modify the old (Abbott et al., 2000; Choy, 1998, pp. 213–214; Shuval, 1993, p. 684). Chinese migrants may confront difficulties, misunderstandings and confusion of roles and self-identity stemming from cultural differences. A clash of values can cause anxiety, nervousness, powerlessness, feelings of meaningless and normlessness, stress and strain, lack of self-confidence, distrust of others and mild psychosomatic complaints (Choy, 1998, pp. 127-128; 2003; Furnham & Bochner, 1989, p. 194). Moreover, some studies (Ajzen, 1988; Dishman, Sallis, & Orenstein, 1985; Rhodes, Courneya, & Bobick, 2001; Schnurr, Vaillant, & Vaillant, 1990; Tang & Fisher, 1992) have indicated that personality traits influence people's preventive health behaviour, including participation in physical activity. Extraversion tends to be positively associated with participation in and adherence to physical activity patterns, while introverted characteristics are more resistant to exercise (Blumenthal, Williams, Wallace, Williams, & Needles, 1982; Brunner, 1969; Lobstein, Mosbacher, & Ismail, 1983; Massie & Shephard, 1971; Rhodes & Courneya, 2003; Rhodes, Courneya, & Bobick, 2001; Young & Ismail, 1977). The negative image of ageing among older Chinese people and their stereotypical thinking about the irreversibility of physical decline can be regarded as a contributing factor to their frequent unwillingness to participate in health promotion activities (National Ageing Research Institute, 2003;
Yet it is also true that those older Hong Kong people who are influenced by traditional Chinese concepts of health, strive for harmony with nature and in their social relationships (Yau, 2003e, p. 132). They tend to resort to the use of “suppressive harmony” after migration. That is, perceiving the change of environment as a threat to the collective harmony, a symbol of non-endurance and low tolerance for suffering, or a lack of self-sacrifice, they avoid trying to empower themselves to change their oppressive situation (Yip, 2003, p. 23). Mackinnon, Gien, and Durst (1996, pp. 328–335) argue that in the absence of resources and as a means of balancing relationships, some make great efforts to please their adult children by making few demands and seldom asking for physical, emotional, or financial assistance. They do not feel free to take part in the processes of family decision-making. Other studies (New South Wales Transcultural Mental Health Centre, 2000, pp. 33–34; Tsang et al., 2004, pp. 61–62) also revealed that they feared being a burden to their caregivers, and had no sense of contributing to the household. They did not depend on their family physically and financially. In Tsang et al.’s study (2004, p. 64), most older Chinese informants agreed that having low expectations and no worries was the best way to maintain happiness. Their resort to suppressive harmony could potentially influence their preventive health behaviour and usage of health care services. Thus it may be difficult to tailor preventive health services to the needs of older Hong Kong Chinese as their reticence may mean they are perceived to be unmotivated and unwilling to become involved in preventive health behaviour or potential programs (New South Wales Transcultural Mental Health Centre, 2000, pp. 33–34).
3.3 Social conflict

Good social relations and social support make an important contribution to health (Cusick & Quinsey, 1990; Jayasuriya et al., 1992). Additionally, an older person's social networks may provide information and advice about health alternatives (Chi & Lee, 1989, p. 45). They may also influence health status by encouraging compliance with health-promoting behaviours and the cessation of undesirable practices (Crawford, 1987).

According to Wilkinson and Marmot (2003):

Belonging to a social network of communication and mutual obligation makes people feel cared for, loved, esteemed and valued. This has a powerful protective effect on health. (p. 22)

The “Five Right Relationships” and the “Five Right Principles” laid down by Confucius, still provide a strong foundation for the Hong Kong Chinese social order and are also taken to be cardinal rules of conduct, even in informal social interaction (Wei & Li, 1996, pp. 187–188). Proper conduct is expected, especially in relation to status of the subordinate/superordinate type. These ideas encourage people to be self-disciplined and to rely on their own capabilities and resources to solve problems. Hardworking people are often perceived as more trustworthy and respectable (Lau, 1997, p. 10). There is a special regard for the feelings of others as well as a concern for how one is perceived by others. This is referred to as social sensitivity. Taking initiatives, critical comments and the expression of emotions such as anger or pain are suppressed. Communication with others in indirect and roundabout ways are expected in order to “save face” for others (Cheng, 1997, pp. 39–40; Ferroa, 1991, p. 51; Louie, 1985, p. 20).

It is also possible to “give face” to another by overlooking or claiming not to recognise their faults. Reciprocity is another important principle. This means that if a person has done something for you, you are expected to do something for them in return. This transaction is called the creation of credit or \( yen' qing' \). “Reciprocation of greetings,
favours, and gifts” and “You honour me a foot [25 cm], and I will in return honour you ten feet [250 cm]” is a principle ingrained in the minds of Chinese (Gao & Ting-Toomey, 1998, p. 31). In addition, when two Chinese get to know each other, they have established gwan’ hai6 or reciprocity and are obliged to do each other favours. They never say “no” to any request from the other person or outwardly disagree with anything they say or do (Bond & Lee, 1978; Cheng, 1997, pp. 39–40; Ferroa, 1991, p. 51; Queensland Government, 2003, p. 2; Wei & Li, 1996, pp. 187–188).

Social support networks are traditionally divided into the formal and informal. Formal support is provided by social service agencies, while informal support is provided by family members, relatives and friends. In many ways this is the most frequently used type of social support. When they migrated from Hong Kong to Australia, older people were confronted by significant social differences and in coping with that, Martin's (1999, p. 16) study found that they first and foremost turned to their immediate families when seeking assistance, secondly to their extended family and thirdly to friends. This informal social support network involved both the giving and receiving of help (Atchley, 1988; Chi & Lee, 1989, p. 44; Jones & Owen, 1998; Sauer & Coward, 1985). The last resort in seeking help was an ethno-specific worker or leader. When mainstream services were used, they were usually accessed through Chinese GPs or ethno-specific agencies.

A Canadian study showed that most Hong Kong migrants to that country did not have close friends (Morikawa, 1991, p. 11). Studies have indicated that people who migrated to Australia also often began their lives in their new country in very isolated contexts (New South Wales Transcultural Mental Health Centre, 2000, p. 33; Yeo & Meiser, 2003). Gao and Ting-Toomey (1998, p. 15) also commented that Chinese people make clear distinctions between insiders (such as family, relatives, close friends or colleagues)
and outsiders. For instance, because of Confucian values, many Chinese men may feel a need to give most of their attention to their own immediate families. Therefore they do not spend as much time on outside networking as they did when they were younger. Their migration thus often means that older Hong Kong Chinese experience less opportunity for interaction with the wider community because of their close links with their immediate families (Cho, 1990). Thus, as is evident from the title of Mar's study (1998) about Hong Kong migrants in Sydney, the lives of the elderly members of this community can be characterised by the phrase: “Just the place is different”.

Moreover, their new social support networks in Australia may not be able to replace those they had established in Hong Kong. The result is that many Hong Kong migrants experience sudden feelings of social inadequacy and find that they have extremely few sources of social support (Choy, 1998, pp. 132–133). Since in Hong Kong, their only socialising experiences may have taken place in the context of their working lives, these may disappear in their new environment and loneliness may set in. Many migrants have difficulties in learning the social conventions of Australian culture and re-building their social skills to deal appropriately with the new social settings in which they find themselves. Very often even their own children and grandchildren are not able to provide company and support due to work and school commitments (Mackinnon et al., 1996, p. 333). That they have had to leave their fabric of social relationships behind may add to their sense of loss and feeling of deprivation and loss of status as well as a sense of subordination in their new society (Lee et al., 1994; Mackinnon et al., 1996, p. 328; Yeo & Meiser, 2003, p. 307). Despite that, asking for assistance would represent, for some, an admission of failure too cataclysmic to confront. Feelings of fear, suspicion, shame, and depression lead to further isolation and resistance to outside intervention or accepting formal services (Tirrito et al., 1996).
Another important element of social conflict is the question of acculturation. Acculturation could be referred to as the process of psycho-social adjustment and adaptation to a new culture by people from another culture (Graves, 1967). It involves complex learning processes which include the acquisition of language skills, the degree of familiarity with the host culture, and also educational and generational factors (Tran, Tanya, William, & Roosevelt, 1996, p. 150). To a certain extent, the cultural gap or distance between Hong Kong migrants and Australian society determines the quality and pace of the process of acculturation (Choy, 1998, pp. 127–214; Furnham & Bochner, 1989, p. 194).

A study has found that Hong Kong Chinese in Australia have a low degree of identification with their host country (Monash University, 2004a, p. 2). Indeed, many Hong Kong migrants indicated that they would not leave the Territory permanently, but hoped to return after qualifying for foreign citizenship. This was because a foreign passport was perceived as “insurance” against possible political risks in the future (Bureau of Immigration and Population Research, 1995; Mar, 1998; Mathews, 1998). In 2001–02, around 84.5% Hong Kong migrants in Australia returned to Hong Kong on either a short- or long-term basis (Department of Immigration and Multicultural and Indigenous Affairs, 2003b). Of the 50,463 people who departed permanently in 2002–03, around 1,735 (3.4%) were Hong Kong-born and 2,129 (4.2%) were China born (Department of Immigration and Multicultural and Indigenous Affairs, 2004, p. 3). This is significant from the point of view of this study because “insurance” migration and the emergence of the “astronaut” family have probably led to low levels of acculturation in Australia (Mar, 1998, p. 1).
According to Martin's study (1999, p. 11), their failure to settle in or identify with Australia, result in many Hong Kong Chinese continuing traditional practices in order to preserve their Chinese culture. These practices include following Chinese festivals, celebrations, entertainment, language and diet. Other features mentioned were accessing Chinese media including television, videos, music magazines and newspapers; mixing socially with other Chinese people; sending their children to Chinese schools; and marrying within the Chinese community after migrating to Australia. This often leads to resentment among the Australian-born who, as noted in a study of the Department of Immigration and Ethnic Affairs (1986) felt that it was taking a long time for Asian migrants to blend into the local community. This tendency leads to even more social isolation among older Chinese people from Hong Kong, since by clinging to their Chinese or Hong Kong culture, they make their chances of establishing social networks with Australian-born people even smaller.

The existence of racism could also contribute to low levels of acculturation. Studies revealed that most Australians are not racist and reject racism (Department of Immigration and Ethnic Affairs, 1986). However, previous surveys on migrant attitudes in Australia, found some extremely negative stereotypic comments or attitudes critical of Asian migrants. They include the assertion that Asians are only interested in personal gain; only want to mix with Asians; refuse to learn or speak English; and that Australians are superior to Asians (Department of Immigration and Ethnic Affairs, 1986; New South Wales Department of Health, 1991). Other studies (Choy, 1998, pp. 310–311; Martin, 1999, p. 18) indicated that the majority of Hong Kong Chinese had experienced racism in Australia, including verbal abuse and physical assault. It was also evident in other subtle behaviours such as when locals are rude to Chinese people, serve Australians first
in shops, block a Chinese person's path or stare at them. They felt that racism in Australia had increased since their arrival in Australia.

Choy (1998, pp. 310–311) argued that being subjected to racism would cause not only a sense of loss (of face, status, will and dignity), but also fear of further loss and a sense of inferiority. Racism caused many to suffer from long-term unhappiness and grief-like feelings, since their self-respect, self-esteem and self-confidence were affected. As a result Hong Kong migrants lacked a sense of security and of identification with Australia and its people. Their experience and fear of racial discrimination could also be making older Hong Kong Chinese reluctant to take part in local activities (Department of Immigration and Ethnic Affairs, 1986; New South Wales Department of Health, 1991). Since racism made Chinese people feel unwelcome and excluded, it was probably one of the variety of factors which created negative attitudes towards health care services (Jayasuriya et al., 1992) and could also account for the reluctance of older Chinese people to participate in health promotion programs.

The level of acculturation has a significant effect on health status and plays an important role in determining the health behaviour of older Hong Kong migrants. Studies have indicated that the less-acculturated experienced higher rates of self-reported health problems than those with higher levels of acculturation. Indeed, changes in lifestyle associated with acculturation have been related to increased risks of obesity, diabetes mellitus and cardiovascular disease (Tran et al., 1996, p. 163; Yeh, 2003, p. 15). As they attempt to achieve a balance between two cultures, older Chinese people often experience greater psychological distress of a type that leads to deterioration in physical and mental health (Gonzalez et al., 2001, p. 948). The stresses of daily living, lack of fluency in English, forced inactivity, extreme social isolation, boredom, demoralisation,
low self-esteem and different rates of assimilation among family members are the leading factors in the high incidence of depression and other mental disorders, especially among Chinese older women (New South Wales Transcultural Mental Health Centre, 2000, p. 33). McDonald and Steel's study (1997) revealed that suicide rate for migrants of NESB increase dramatically after 65 years of age. The rates of suicide are more closely aligned with the rates in the country of origin than with the rates of the Australian-born (Hassan, 1995; McDonald & Steel, 1997). More importantly for the purposes of this study, the negative emotions resulting from the migration experience could influence willingness to engage in preventive health behaviour.

Koo and Rowling's (1999) review of eleven programs in Sydney designed to prevent falls and promote physical activity found that the barriers to participation among older Chinese people were many and varied. They included factors such as differences between Western and Chinese culture, low English proficiency, difficulties of coping with a new environment, transportation, financial hardship, insufficient family support, social isolation, personality traits, racial discrimination, poor physical health, poor GP–patient relationship and culturally inappropriate programs (which for instance, mixed Mandarin and Cantonese speakers). However, one shortcoming in the programs provided was that they treated all Chinese as a homogeneous group. Liamputtong and Gardner (2003, p. 262) also pointed out that limited English and a lack of social and family networks were important barriers to health service use.

**Contrasts between the Hong Kong and Australian health care systems**

As mentioned earlier, older Hong Kong Chinese are in danger of physical and mental illnesses as a result of migration. The availability and accessibility of health care services in Australia is thus important to them. On the surface, it seems that the Australian health
care system provides many advantages over that of Hong Kong. Here “Medicare” provides “free” and readily accessible high quality health care to all Australian citizens, New Zealand citizens or holders of permanent visas. GPs who “bulk bill” can send accounts for treatment directly to Medicare, which pays them the full scheduled fee. There is no out-of-pocket cost to the patient (Commonwealth Department of Health and Aged Care, 2000; Liamputtong & Gardner, 2003). Other items billed under this system include dental surgery services, diagnostic imaging services, and pathology tests. Moreover, in public hospitals, Medicare-eligible patients receive “free” point-of-service medical and allied health/paramedical care from GPs nominated by the public hospitals, as well as free “hotel services”. In addition, the Pharmaceutical Benefits Scheme provides all Medicare-eligible people with access to effective and necessary prescription medications at a reasonable cost (Commonwealth Department of Health and Aged Care, 2000).

Hong Kong also has a relatively equitable system as everyone from different income levels has equal access to essential health care services provided by the public and private sector (Leung, 1999, p. 2; Wei & Li, 1996, p. 145). However, health care resources are focused on acute hospital care, which has resulted in the underdevelopment of ambulatory and community health care and other long-term care services (Leung, 1999, p. 3; Wong, 1999, p. 237; Yau, 2003d, p. 154). It is difficult to obtain some diagnostic tests and treatments because of limited equipment in public clinics. The outpatient departments of government hospitals are crowded. Because physicians see a large volume of patients, there is little time to communicate with them and even less time for counselling, reassurance, and education. In contrast, diagnostic tests are readily available for patients who can afford private health care at private hospitals or in private physicians' offices (Bennett, Pei, & Ultmann, 1996, p. 5; Leung, 1999, p. 3).
Despite the level of readily available care in Australia, a particular concern is that some Hong Kong Chinese people have lower rates of health service usage in Australia. The reasons appear to involve linguistic difficulties and societal and cultural factors that prevent easy access to the health services available (Martin, 1999, p. 17; Myna, Rissel, Orr, & Wen, 2002, p. 98; Reid & Trompf, 1990). According to Martin's study (1999), access to mainstream health and social services for Hong Kong Chinese was hindered by a lack of information and language barriers that arose at the point of contact with services. However, the reasons for migrants being less likely to use health services than the Australian-born when they are in similar need are complex. As older Chinese people (born in Hong Kong or China) enter the health system with different views and knowledge about what the system provides and how it operates, they may not know the role of different health organizations such as Public Health Units, Multicultural Health Communication Services, and the Ageing and Disability Departments. They also lack knowledge of their rights and obligations within the health system, especially in relation to the use of interpreter and social support services (New South Wales Department of Health, 1991).

Another study showed that there is variation by birthplace in use of and access to health services in NSW. Compared with people born in Australia, people born in China were significantly less likely to consult a GP over a 12-month period (Public Health Division, 2001), were significantly less likely to attend a hospital emergency department (Public Health Division, 2000b), and significantly more likely to report difficulties in obtaining health care (Public Health Division, 2001). One reason for the lower usage is that according to the health beliefs of some older Chinese people, medical checkups are unnecessary when they are asymptomatic because they do not feel ill and they do not
want to know about any hidden diseases they may have. To them, it is pointless to create problems for themselves by undergoing tests, even though they do not cost anything. They lack knowledge of risk factors and believe that if they feel healthy, there is no need to engage in preventive health care (Helman, 1984; Ho, 1994; New South Wales Department of Health, 1991).

In Chinese tradition, a benevolent form of medical paternalism is valued. According to Confucian perspectives, the core of the relationship between GPs and patients is the trustworthiness of the GP (Bowman & Singer, 2001, p. 461). As discussed before in Chapter 2, although older Chinese people seldom see a GP when they have minor symptoms of illness, traditional Chinese believe that a GP is the leader of the health care team (Deeble, 1991, p. 191). A study has revealed that the majority of respondents of CSB reported the primary source of health care service information was the family GP, indicating the importance of the GP as a source of information about health care services and in promoting access to appropriate services (Myna et al., 2002, p. 100). It also indicates the potential role of the family GP in health promotion efforts.

Kai (2003) commented that “everyone has a history. The problem is that in communicating we are often unaware of the effect of our own history and forget that the other person has one too” (p. 60). Very often the expectations of the health professional and the patient of the consultation are at odds, creating problems. This also happens to the relationships between GPs and Hong Kong Chinese patients. Hong Kong Chinese clients who have experienced a different health care system often have different expectations from the health professional. GPs occupy a very prominent position amongst the Chinese community and will always be respected and be listened to (Everingham & Flaherty, 1995).
However, Ho's study (1994) found that some Chinese GPs had insufficient awareness of health promotion programs as a whole. Consequently, they failed to recommend that their patients join health programs, including those involving physical activity. Moreover, when some Chinese go to see a GP, they mainly expect to be given prescriptions for medication rather than obtain preventive health information. Lee (1983) also mentioned that the undergraduate medical curriculum in Hong Kong tended to emphasise advanced, specialised knowledge essential for hospital care and did not pay much attention to primary medical care. The consequent neglect of health education and health promotion by GPs trained in Hong Kong would mean that they were not good sources of health maintenance information for elderly people (Chi & Leung, 1999; Ho, 1994; Kleinman, 1980).

Studies have also found that many GPs lack the training to prepare themselves for working with the cultural, linguistic and religious diversity of Australian communities (Australian Department of Health and Aged Care, 1999; New South Wales Department of Health, 1991; Tirrito et al., 1996). Cultural incompetence among GPs is likely to negatively impact on their understanding of their patients’ attitudes and beliefs about health, illness, coping style, emotional or cultural needs. Even if the GPs have acquired some background in their training, the culture of those born in China and Hong Kong may demand an entirely different style of verbal communication from that with which GPs are familiar. Thus patients may be made to feel ill at ease, even ashamed, when dealing with their GPs (Tirrito et al., 1996). At the same time, many GPs or other health professionals lack the training which could prepare them for working with the cultural, linguistic and religious diversity of Australian communities. Cultural incompetence among GPs will, therefore negatively impact upon their understanding of their patients’
attitudes and beliefs about health, illness, coping styles and emotional or cultural needs (New South Wales Department of Health, 1991; Tirrito et al., 1996). This is also likely to apply to physical activity.

**Physical activity and Hong Kong Chinese**

In the past ten years there has been considerable research interest focused on the attitudes, knowledge, and barriers to physical activity among older people in Australia (Armstrong et al., 2000; Booth et al., 1993; Brown, Fuller, Lee, Cockburn, & Adamson, 1999; Corti, Donovan, Castine, Holman, & Shilton, 1995; Department of the Environment Sport and Territories, 1995; Kirkby, Kolt, & Habel, 1998; Kirkby, Kolt, Habel & Adams, 1999; Kolt, Driver, & Giles, 2004; Lee, 1993; Northern Sydney Area Health Service, 1996). In Australia, research into physical activity revealed that walking is likely to be perceived as the most acceptable form of light to moderate exercise for older people. Other activities included gardening, housework and swimming (Armstrong et al., 2000; Booth et al., 1993; Brown et al., 1999; Corti et al., 1995; Department of the Environment Sport and Territories, 1995; Lee, 1993; Northern Sydney Area Health Service, 1996). The common barriers included: poor health; poor body image; bad weather; laziness; injury; having to look after grandchildren; lack of transport; lack of companionship; lack of appropriate leaders; language; inappropriate and unsafe environments, fear of violent crime; inadequate facilities such as footpaths and street lighting; and lack of interest and motivation.

Perhaps not surprisingly, most of the descriptive and intervention studies on physical activity in the older Australian population have focused on those of English-speaking background (ESB) while neglecting those of NESB (Lewis et al., 1997). Yet research has shown that those from NESB are less likely to be active compared to those born in Australia or born in other English-speaking countries (Bauman et al., 1996; Central

Bauman, Owen, and Rushworth (1990) who investigated various sociodemographic determinants of physical activity participation in Australia, found that women, older people, the less well educated and those on lower incomes were less likely to participate in regular physical activity. Other factors included family income, life satisfaction and lower perceived health status. When Brown et al. (1999) conducted a qualitative research study into the attitudes of older Australians (aged over 60) to physical activity, the majority in the eleven focus groups were mainly from ESB. While 15% were from NESB, their ethnicity was not identified. Given that overseas-born people represent 22% of the total Australian population and that five in every 100 Australians were born in Asia (Monash University, 2004a; University of New England, 2001), this sample was certainly an under-representation of the NESB and demonstrates the neglect of the special needs of these groups.

In recent years, some studies were conducted on physical activity in ethnic communities. A Victorian study indicated that Italian groups linked physical activity with social interaction. They did not distinguish between the terms “physical activity” and “exercise” and did not define incidental activity, such as “housework” as exercise (Iervese, Payne, & Kertes, 1997). Another study in South Western Sydney found that walking and gentle exercise were the most preferred activities among Italian and Greek groups (Davenport, 1999). Northern Sydney Health Promotion (2002) revealed that Italian, Greek and Serbian groups shared similar ideas about physical activity and exercise. Among these studies, many of the major barriers to participating in physical
activity were similar to those for the ESB community. However, there is a tendency to adopt an homogenous view of NESB people rather than adopting an ethno-specific perspective that recognises differing cultural beliefs and practices between and across language groups (Lewis et al., 1997). Despite the number of older people of CSB having grown dramatically over the past decade (Ethnic Affairs Commission, 1998), they seem to have been largely ignored by researchers and providers of physical activity programs or policy makers. There is very little research on the attitudes and specific barriers to physical activity among the older CSB in Australia, especially Hong Kong Chinese.

Lewis et al. (1997) used focus groups to investigate attitudes of elderly ethnic people in Australia and specific barriers to their undertaking exercise programs. The four sample groups of over 65s were of Indo-Chinese, Italian, Jewish and Greek origin. While the researchers reported that all groups considered exercise to be vital part of a healthy lifestyle and a therapy for adverse health conditions, the Indo-Chinese group felt that exercise should not be mentally or physically stressful. They considered gentler activities more appropriate for their age group. Even though Indo-Chinese people were involved in this study, those from this Chinese community were not Chinese-speaking people. Toohey and Taylor (1997) used questionnaire surveys and face-to-face interviews with focus groups to study the issues associated with sport for ethnic women, including Chinese. The most popular physical activity for Chinese-born women was cycling. The common barriers to participation were that they had no time due to family commitments and that they encountered language barriers. However, the age range, the country of origin and the birthplace of this Chinese group were not mentioned.

The National Ageing Research Institute (2003) conducted research on participation in physical activity amongst various older ethnic groups, 17% of whom were older
Cantonese and Mandarin speakers who were born in China or Hong Kong. Focus group results showed that most of the older Chinese viewed physical activity as very important for health. The most common activity included household tasks, walking, and gardening. Many members of the Chinese group reported that they walked regularly and participated in tai chi. Although little research has been done specifically into Hong Kong Chinese people's physical activity pattern in Australia, in twenty-first century, more general research studies in Hong Kong found that three out of four Hong Kong people (76%) of all ages were not participating at a level sufficient to confer health benefits (Hui, 2001). The majority of Chinese resident in Hong Kong were not sufficiently active to obtain health benefits even though one half of the adult population took part in some form of physical activity or sport (Hui, 2001, p. 20; Hui & Morrow, 2001; Hui, Yuen, & Morrow, 1999).

During the period between 1970 and 2004, several quantitative studies were conducted in Hong Kong to explore leisure activities (Chi & Lee, 1989; Chou et al., 2004; Joint Working Party of The Hong Kong Council of Social Service and Tsuen Wan District Advisory Board, 1980; Lee, 1972). The findings suggested that engaging in daily exercise was not prevalent and that watching television (TV) was the most common leisure-time activity. The favourite activities of those who reported that they “often” did exercise were Chinese boxing, taking a stroll, playing ball games, and doing gymnastic exercises (Chi & Lee, 1989, p. 17; Joint Working Party of The Hong Kong Council of Social Service and Tsuen Wan District Advisory Board, 1980, p. 10; Lee, 1972, p. 39). Generally speaking, willingness to participate in physical activity decreased with age (Hong Kong Sports Development Board, 2002; Hui, 2001). In addition, the study found that Chinese people who were sedentary when they are young, did not change their activity level as they aged. If they were somewhat active when young however, they
were more likely to become more physically active as they grew older (Hui & Morrow, 2001, p. 380).

In 2001, the Hong Kong Sports Development Board (2002) reported that 49% of older people aged over 65 participated in some kind of physical activity or sports with various intensity. These activities included walking, hiking, swimming, jogging, exercise and mou⁵ sêd⁶, although what exactly constituted mou⁵ sêd⁶ was not clearly defined. Gardening was not included, as in Hong Kong the amount of land available for this activity is very limited and most people live in a flat or apartment (Hong Kong Sports Development Board, 2002, p. 9). Fu (1993, p. 20) found that older Chinese people in Hong Kong nominated Kung Fu, going for a morning walk or participating in tai chi as their major form of physical activity. However, Kung Fu was not clearly defined in his study. The morning walk, or sen⁴ wen⁶ in Cantonese, is a traditional practice in Hong Kong. It is supplemented by mild physical activity performed in the early morning such as tai chi, Chinese-style calisthenics, and brisk walking. The morning walk is also an important social activity because it enables older people to meet their friends at the same time and in the same place every day (Hui & Morrow, 2001, p. 381). In addition, they were also interested in watching soccer, volleyball, and basketball. As Table 3.5 shows, in the main older people in Hong Kong enjoyed watching ball games rather than participating in them.
Table 3.5: The Top Ten Preferences and Interests of Older Hong Kong People (age=64 ± 9.67 years) Relating to Different Sporting Activities, Expressed in Percentage (N=89)

<table>
<thead>
<tr>
<th>As Participant</th>
<th>As Spectator</th>
<th>Perceived Attractiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Kung Fu</em></td>
<td>Soccer</td>
<td>Soccer</td>
</tr>
<tr>
<td>(24.7%)</td>
<td>(25.6%)</td>
<td>(13.9%)</td>
</tr>
<tr>
<td>Morning walk</td>
<td>Volleyball</td>
<td>Volleyball</td>
</tr>
<tr>
<td>(18.0%)</td>
<td>(9.0%)</td>
<td>(8.9%)</td>
</tr>
<tr>
<td><em>Tai chi</em></td>
<td><em>Tai chi</em></td>
<td>Basketball</td>
</tr>
<tr>
<td>(11.2%)</td>
<td>(9.0%)</td>
<td>(7.6%)</td>
</tr>
<tr>
<td>Walking</td>
<td>Gymnastics</td>
<td>Calisthenics</td>
</tr>
<tr>
<td>(9.0%)</td>
<td>(7.7%)</td>
<td>(6.3%)</td>
</tr>
<tr>
<td>Travelling</td>
<td>Swimming</td>
<td><em>Tai chi</em></td>
</tr>
<tr>
<td>(7.9%)</td>
<td>(6.4%)</td>
<td>(6.3%)</td>
</tr>
<tr>
<td>Others</td>
<td>Basketball</td>
<td>Volleyball</td>
</tr>
<tr>
<td>(4.5%)</td>
<td>(6.4%)</td>
<td>(6.3%)</td>
</tr>
<tr>
<td>Gymnastics</td>
<td><em>Kung Fu</em></td>
<td>Table Tennis</td>
</tr>
<tr>
<td>(4.5%)</td>
<td>(5.1%)</td>
<td>(6.3%)</td>
</tr>
<tr>
<td>Jogging</td>
<td>Calisthenics</td>
<td>Jogging</td>
</tr>
<tr>
<td>(3.4%)</td>
<td>(3.8%)</td>
<td>(3.8%)</td>
</tr>
<tr>
<td>Basketball</td>
<td>Dance</td>
<td>Gymnastics</td>
</tr>
<tr>
<td>(3.4%)</td>
<td>(3.8%)</td>
<td>(3.8%)</td>
</tr>
<tr>
<td>Swimming</td>
<td>Others</td>
<td>Travelling</td>
</tr>
<tr>
<td>(2.2%)</td>
<td>(2.6%)</td>
<td>(3.8%)</td>
</tr>
</tbody>
</table>

Source: Fu, 1993, p. 28.

Low levels of knowledge of physical activity among older people was one of the main factors influencing the extent to which they participated in physical activity. A U.S. study (Eyler et al., 1998, p. 649) found that older American Chinese women did not know that intermittent bouts of moderate-intensity activity such as vigorous housework or “segments” of brisk walking, counted toward their daily quotas of physical activity. If in line with the recommendations of the Centre for Disease Control these activities were included, most older American Chinese women who did not see themselves as “exercisers”, nonetheless had already met the criterion of an accumulated total of 30 minutes exercise on most days of the week. Hui (2001, p. 21), Hui and Morrow (2001, pp. 373 & 381) and Yuen, Hui and Morrow (1999) recorded that physical activity was a very low priority in the lives of older Chinese people and was perceived to have an unimportant influence on health and illness prevention. The possible reason is that current knowledge about the importance of regular physical activity was still low among this group, even though they took part in a higher level of physical activity than the middle-aged group.
In both Australian and Hong Kong studies (Armstrong et al., 2000; Bauman et al., 1990; Hong Kong Sports Development Board, 2000; Woo, Leung et al., 1999), greater degrees of physical activity were associated with higher education levels, while sedentary lifestyles were most likely to be found among poorly educated individuals. Hui and Leung (1999) demonstrated that levels of knowledge of physical activity influenced the degree to which physical activity was practised among Hong Kong Chinese people and was a function of educational level and age. According to a study of the Hong Kong Sports Development Board (2000, p. 2), respondents with higher educational levels were more inclined to participate in sports. Those with only primary levels of education participated least in sport (28%) while those respondents with post secondary levels (66%) had the highest participation rate. Those with no education had a slightly higher level of participation than those with a lower secondary education, the rates being 42% and 39%, respectively.

As well as a lack of knowledge about physical activity, the busy lifestyles of many people in Hong Kong act as a barrier to participation in sport and physical activity. Lack of time was the main reason consistently given for not playing sport or being active (Hong Kong Sports Development Board, 2000). Likewise, the main barrier to participation in physical activity identified in studies conducted in Australia, Hong Kong and other countries was lack of time. This was especially true of women whose days were taken up with household chores. Other common barriers included: poor health; poor body image; bad weather; laziness; injury; having to look after grandchildren; lack of transport; lack of companionship; lack of appropriate leaders; inappropriate and unsafe environments, fear of violent crime; inadequate facilities such as footpaths and street lighting; and lack of interest and motivation (Armstrong et al., 2000; Booth et al., 1993; Brown et al., 1999; Corti et al., 1995; Department of the Environment Sport and
In their study, Morgan et al. (1991, p. 413) found that older women were probably less able to freely select the activities in which they engaged. Men were significantly more likely to participate in outdoor and leisure activities, while women were significantly more likely to engage in indoor activities (mainly housework). In addition, the physical activity level in women was less influenced by variations in mood. Thus, while a dissatisfied or depressed man may decrease his overall activity level, a woman in similar circumstances may be more likely to persevere, particularly in the role of “home maintainer” because of perceived responsibility. Similarly, the Hong Kong Sports Development Board (2000) found gender differences in physical activity levels. People who engaged in no physical activity or sport were more inclined to consider they had poor physical fitness than sport participants and vice versa. Men's physical activity or sports participation was greater than that of women. Men liked to play soccer and basketball whereas women were more likely to participate in swimming and badminton. Housewives were more likely to choose walking. The main physical activity for people with lower education levels was walking while those with a higher education level favoured swimming. Walking was the most common physical activity for the retired and unemployed. Thus it is clear that determinants of health such as gender, education, occupation or lifestyle strongly influenced older Hong Kong people's health beliefs and preventive health behaviour.
3.4 Conceptual orientation

Chapter 2 discussed how the three Chinese philosophies of Confucianism, Taoism, and Buddhism were deeply ingrained in the health beliefs and preventive health behaviours of Hong Kong Chinese. Understanding this philosophical framework is indispensable to understanding this group. This chapter has also discussed the literature on the physical and environmental changes, cultural differences, and social conflict encountered by older Hong Kong Chinese people after migration. Although this research has been helpful in identifying many social and psychological factors associated with regular participation in physical activity, the why and how underlying people's physical activity behaviour is not well understood. The pre-eminence of a belief system in the way of life of Hong Kong Chinese necessitates the formulation of a theoretical framework that accommodates these beliefs. A number of theories, each highlighting different aspects, are used to explain health.

For example, the Theory of Planned Behaviour (TPB) postulates that behavioural intention is highly predictive of an individual's behaviour. The Health Belief Model (HBM) (Becker et al., 1977; Biddle & Ashford, 1988; Janz & Becker, 1984) emphasises individual perception and motivation. Social Cognitive Theory (SCT) posits that there is a reciprocal interaction between psychosocial factors, environment, and behaviour (Baum, 1998; Liou & Contento, 2001; Nutbeam & Harris, 1998). Each of these theories has been questioned. Sheeran and Abraham (1996) and Stroebe and Stroebe (1995) criticised HBM on the grounds that its components have been formulated without definition and without any rules of combination. Sheeran and Abraham (1996) further pointed out that HBM variables are only weakly correlated with behaviour. Similarly, Resnicow et al. (1997) commented that SCT accounts for only small to medium
proportions of variance in behaviour. I have chosen to apply TPB because the critiques mentioned above do not apply to it in any great or significant measure.

The beliefs of the target group have been set out in some detail because they have to be seen as an integral part of the explanatory theory. The experience of “culture-shock”, social conflict, and the physical and/or emotional changes caused by migration combined with their specific cultural and health beliefs, has been discussed because all of these have the potential strongly to influence attitudes towards engaging in physical activity in Australia. Of the theories mentioned above, TPB is particularly useful for exploring physical activity participation because it accommodates all the varying influencing elements described.

**The Theory of Planned Behaviour (TPB)**

TPB is an extension of the Theory of Reasoned Action (TRA) in which the key elements are intention to act involving attitudes, subjective norms and perceived behaviour control. Central to TPB is an individual’s intention or perceived likelihood of performing a given behaviour. Intention is defined as the motivation required to engage in a particular form of behaviour. Therefore the theory postulates that the more one intends to perform a behaviour, the more likely it is the behaviour will occur. The TPB proposes that intention to act is the most immediate determinant of behaviour, and that all other factors influencing behaviour will be mediated through behavioural intention (Ajzen, 1991; Armitage & Conner, 2000, p. 177; Montano, Kapsprzyk, & Taplin, 1997; Nutbeam & Harris, 1998, p. 23) (See Figure 3.1, page 92).

Within this framework, intention is held to be determined by attitudes, subjective norms and perceived behavioural control. These three conceptually independent determinants of
behaviour are theorised to precede and influence intention. These three determinants have a belief-based structure (Vicki, 1998). The first determinant is the attitude toward the behaviour. Attitude is determined by the person's beliefs about outcome or attributes of performing the behaviour (behavioural beliefs). It refers to the degree to which the person has a favourable or unfavourable evaluation of the behaviour in question. In other words, an individual who holds strong behavioural beliefs that highly valued outcomes will result from performing a behaviour will have a positive attitude toward that behaviour (Ajzen, 2002a, p. 107; 2002b; Ajzen & Driver, 1991, p. 188; Dzewaltowski, Noble, & Shaw, 1990; Kmieciak, 1992; Montano et al., 1997, p. 87; Smith & Biddle, 1999).

Each personal attitude is made up of a belief (for instance, lack of physical activity is bad for you) and people may have conflicting attitudes towards a certain health behaviour. Baum (1998, p. 304) stated that these two major factors combine to form an “intention” to behave in a specific way and this intention is predictive of that behaviour. Therefore beliefs and perceptions of normative expectations mediate the link between attitude and behaviour. Changes in beliefs should increase feelings of control and positive attitudes, which in turn should increase intention and behaviour. Rhodes, et al. (1999) stated that “application of TPB demonstrates its usefulness in identifying factors which influence participation in physical activity that may become targets for intervention” (p. 403). Additionally, beliefs about the opportunities to perform a behaviour and the availability of the required resources also provide insight into the complexity of health behaviour. Ajzen and Driver (1991) stated,

People can hold many beliefs about any given behaviour, but they can attend to only a relatively small number, perhaps eight or nine, at any given moment. It is these salient beliefs that are considered to be the prevailing determinants of a person's actions (p. 186).
The second determinant, termed subjective norms, has been defined broadly as perceived social pressure. It is based on the beliefs that important others hold about whether the individual should or should not perform the behaviour (normative beliefs). These subjective norms are acted upon according to an individual’s motivation to comply with other people’s wishes and vary in strength according to the degree to which the individual values social approval by a particular group (Ajzen, 2002a, p. 107; 2002b; Ajzen & Driver, 1991; Dzewaltowski et al., 1990; Kimiecik, 1992; Montano et al., 1997; Nutbeam & Harris, 1998).

The final determinant is perceived behavioural control. While TRA assumes a causal chain that behavioural beliefs and normative beliefs are linked to behavioural intention and behaviour via attitude and subjective norms, the TPB adds one more construct, focusing on perceived control over performance of the behaviour. This extension to the TRA was based in part on the view that behavioural performance is determined jointly by motivation (intention) and ability (behavioural control) (Ajzen, 2002a, p. 107; Ajzen & Driver, 1991; Dzewaltowski et al., 1990; Kimiecik, 1992; Montano et al., 1997; Nutbeam & Harris, 1998).

The TPB is based on beliefs about the perceived ease or difficulty of performing the behaviour and is influenced by skills, opportunities and resources. The easier a behaviour is, the more likely one will intend to perform it. The inclusion of perceived behavioural control as a predictor of behaviour is based on the rationale that by holding intention constant, greater perceived control increases the likelihood that enactment of the behaviour will be successful. It is assumed to reflect past experience as well as anticipated impediments and obstacles. It is recognised that there are many factors beyond the immediate control of individuals, which will shape their ability to behave in a...
desired way. Ajzen argued that an individual’s intentions will become significantly greater if an individual perceives a greater personal control over a behaviour (a concept closely connected to self-efficacy) (2002a) and that this is also mediated by their perceived power in relation to a given situation. Additionally, opportunities and resources bring an environmental dimension to the concept that the existence of facilities and programs to support a particular health behaviour influences a person’s intention to perform that behaviour (Ajzen, 2002a, p. 107; 2002b; Madden, Ellen, & Ajzen, 1992; Montano et al., 1997; Nutbeam & Harris, 1998, p. 24).

In TPB, the crucial factors of interest are intentions and perceptions of behaviour control. As long as these factors remain unchanged, the behaviour should also remain the same (Ajzen, 2002a, p. 110). As exemplified in Figure 3.1, perceived control is linked with both intentions and behaviour. This suggests that the determinant is proposed to have a motivational effect on intentions. For example, individuals wishing to participate in physical activity but with little or no chance of doing so (because of insuperable behavioural barriers at the time) are unlikely to be physically active regardless of their attitudes towards physical activity or the social factors in operation (Smith & Biddle, 1999, p. 271). As a general rule, the more favourable the attitude and subjective norms with regard to a behaviour, and the greater the perceived behavioural control, the stronger should be an individual's tendency to perform the behaviour under consideration. Further, Ajzen (1988) argued that perceived behavioural control will accurately predict behaviour only when perceived control closely approximates actual control (this is illustrated by the broken line in Figure 3.1). Perceived behavioural control therefore acts as both a proxy measure of actual control and a measure of confidence in one's own ability (Armitage & Conner, 2000, p. 177; Dzewaltowski et al., 1990, p. 390).
In addition, studies have shown that human beings tend to persist in doing that to which they have become accustomed (Schneider & Shiffrin, 1977; Shiffrin & Schneider, 1977). Ajzen (2002b, p. 107) and Quellette and Wood (1998) also argued that complex behaviours can become habitual with sufficient repetition and practice if they are initially guided by explicit intentions and self-regulation.

In summary, TPB postulates that individuals' intentions may not be strong when attitudes and subjective norms are positive if they believe they do not have the resources or opportunities to perform the behaviour (that is, low control). Thus, perceived behavioural control, attitudes and subjective norms are all postulated as predictors of intentions. Perceived behavioural control will also directly influence behaviour independent of intentions when actual control over the behaviour is low. In other words, actual control predicts behaviour and perceived behavioural control is an indicator of this effect (Dzewaltowski et al., 1990, p. 390). For the purpose of this study, the dimensions of TPB provide a structure for exploring the impact of varying factors on preventive health behaviour among older Hong Kong Chinese people in Australia.
Figure 3.1: Theory of Planned Behaviour (TPB). Nutbeam & Harris, 1998, p. 24; Smith & Biddle, 1999, p. 270.
**TPB in health research**

Over the past decade, a number of theoretical approaches to explaining health behaviour have been developed in order to understand the beliefs and motivations influencing the adoption of preventive health behaviours (Liou & Contento, 2001, p. 323; Nutbeam & Harris, 1998). These have included TPB (Ajzen, 1991; 2002b), HBM (Rosenstock & Kirscht, 1974), SCT (Bandura, 1986), and also the Transtheoretical Model (Prochaska & Diclimente, 1984; Prochaska, Redding, & Evers, 1997). However, the theoretical framework of TPB has been found to be applicable to the widest range of health behaviours (Blue, 1995). For instance, when Glanz, Lewis, and Rimer (1997, p. 27) reviewed all issues of 24 journals in health education, medicine, and behavioural sciences published from mid-1992 to mid-1994, they found that TRA and TPB (66 articles) were among the most commonly used theories, in 497 articles.

TPB highlights the need to understand the beliefs the groups have about the issue, who they see as affecting these beliefs and their behaviour, and what they see as the barriers to taking actions that might promote their health (Nutbeam & Harris, 1998, p. 24). This theoretical framework has been used successfully to predict and explain a wide range of health or other behaviours including problem drinking (Schlegel, d'Averna, Zanna, DeCourville, & Manske, 1992), diet (Liou & Contento, 2001; Sparks, Hedderley, & Shepard, 1992), contraceptive use (Bennett & Bozionelos, 2000; Montano et al., 1997), change of AIDS risk behaviour (Fisher & Fisher, 2000); fall prevention (Aminzadeh & Edwards, 2000), mothers' infant-feeding behaviour (Beale & Manstead, 1991; Janke, 1994), breast self-examination (Powell-Cope, Lierman, Kasprzyk, Young, & Benoliel, 1991), mammography (Montano & Taplin, 1991), and exercising (Ajzen, 2002a; Ajzen & Driver, 1991, 1992; Dzewaltowski et al., 1990; Godin, Valois, & Lepage, 1993;
Hagger, Chatzisarantis, & Biddle, 2002; Hausenblas, Carron, & Mack, 1997; Kimiecik, 1992; Norman & Smith, 1995; Smith & Biddle, 1999; Vicki, 1998). In recent years, the TBP has been used more commonly than the HBM in attempts to examine the relationship of psychosocial factors to dietary behaviours (Liou & Contento, 2001). Of those above studies, most have looked at exercise behaviour. Some researchers have attempted to gain a better understanding of physical activity and exercise participation by using the self-efficacy theory, protection motivation theory, physical activity model and self-regulatory theory. However, the TPB has guided the majority of the research on health and physical activity behaviour (Maddux, 1993).

Despite physical activity having multiple potential health benefits and wellbeing outcomes (Department of Health, 2004; Morabia & Costanza, 2004; Nied & Franklin, 2002, p. 419; Public Health Association of Australia Inc., 2004, pp. 1–2; U.S. Department of Health and Human Services, 1998; Vicki, 1998), as mentioned in Chapter 1 and 2, a low participation rate of physical activity is common among older Chinese people. First, their holistic view of health involving harmony with nature, self and social relationships on earth or in the supernatural world, as well as the balance of yin/yang, assumes a very important role in preventive health measures among this group and may contribute to the low participation rate. Second, the physical, social, cultural and environmental changes and challenges experienced by older Hong Kong Chinese people after migration (Choy, 2003; Shuval, 1993) may influence the likelihood of their participating in preventive health behaviour.
Smith and Biddle (1999) elaborated the value of this theory for understanding physical activity:

The Theory of Planned Behaviour is appropriate for use in the study of physical activity, particularly as physical activity is a behaviour that potentially has many barriers and thus may only partly be under volitional control (p. 271).

In addition, perceived behavioural control is assumed to be influenced by internal factors and external factors. Internal factors include variables such as skills, abilities, and individual differences in willpower. External factors include time, opportunity, or dependence on other people (Dzewaltowski et al., 1990, p. 390). The more a behaviour is influenced by the presence of opportunities or possession of adequate resources (time, money, skills, cooperation of other people), the less a behaviour is under volitional control. These factors may account for people's failure to carry out their intentions (Kimiecik, 1992, p. 194).

In brief, many studies have supported the conclusions that there are strong relationships between intention and exercise behaviour, attitudes and intention, attitudes and exercise behaviour, perceived behavioural control and intention, and perceived behavioural control and exercise behaviour. Some research has shown a moderate or weaker relationship between subjective norm and intention and between subjective norm and exercise behaviour (Blue, 1995; Godin et al., 1993; Hausenblas et al., 1997; Kimiecik, 1992; Smith & Biddle, 1999). Nevertheless, in addressing the determinants of preventive health behaviour among older Hong Kong Chinese in Australia, Ajzen's TPB (1988; 1991) has provided the best explanatory power for the variety of influencing factors involved. Clearly, if perceived behavioural control is an important determinant of intention or behaviour among older Hong Kong Chinese, knowledge of the effects of control beliefs and perceived power on each facilitator or constraint would be useful.
when developing interventions. This theory can be very useful in thinking about what information health providers may need to collect from this Chinese group before a program is developed. It also highlights the need to understand the beliefs of this group about the issue, who they see as affecting their beliefs and their behaviour, and what they see as the barriers to taking actions that might promote their health. Such findings can designate a focus, helping practitioners target those specific environmental factors where control beliefs are most strongly associated with intention or behaviour. Therefore TPB provides a useful theoretical framework for developing a better understanding of factors that influence physical activity among older Hong Kong Chinese people.

### 3.5 Summary

The move from one country to another has great potential to be a stressful event for older Hong Kong Chinese people. They have to adjust their values, customs and lifestyle to the new country as well as adapt to a new social and physical environment. They experience differences in cultural values, changes in their traditional role, racial discrimination and social isolation. They also encounter difficulties in language, acculturation and communication with family and GPs and also in transportation. In other words, leaving Hong Kong represents an enormous loss, including loss of status, loss of power, loss of independence and loss of confidence. All these issues constitute barriers to their participation in preventive health behaviour.

Using knowledge of the three major Chinese philosophies, this group's health beliefs and practices can be clearly understood and explained. However, there is a gap in existing research among ethnic groups in Australia with regard to explaining beliefs, attitudes, and behaviours in relation to health maintenance and illness prevention. There are no reports from studies which have used the TPB in research on individuals of Asian
descent. Given that these determinants are important predictors of preventive health
behaviour, there is a need to know whether they are applicable to older Hong Kong
Chinese people in Australia and also to identify the subjective norms that are an
important determinant of their intention to participate in physical activity. It is for these
reasons that the TPB has been used in this research to frame the study of the target
group's preventive health behaviour. The detailed research methodology is discussed in
the next chapter.
CHAPTER 4: THE NATURAL HISTORY OF MY STUDY

This chapter is divided into three parts. The first discusses the methodology and the research methods used in this study. The second focuses on how the eight methods for enhancing standards of rigour were integrated into the data collection and data analysis, while the last part outlines the ethical issues, difficulties in data collection and the sensitive areas of this study.

4.1 Research design and theoretical frameworks

Knowledge about the social determinants of preventive health behaviour among older Hong Kong Chinese people in Australia is limited. Studies focusing on their health beliefs are also scarce. In addition, as previously described, many research studies treat all Chinese people as an homogenous group. In order to seek empirically rich and holistic data to provide theoretical explanations for the various research questions under study (See Chapter 1, Section 1.2), qualitative techniques were employed. Qualitative research involves studying phenomena in natural settings, attempting to make sense of, or interpreting them in terms of the meanings people bring to them. Qualitative techniques make it possible to gain insight into the informants' participation in preventive health behaviour. Equally important, this approach is useful in the development of concepts and assumptions about the target group as well as collecting data with authenticity and fullness (Denzin & Lincoln, 2000, p. 13; Minichiello, Aroni, Timewell, & Alexander, 2000, p. 9; Neuman, 2000, p. 122; Strauss & Corbin, 1990, p. 19).
As Strauss and Corbin (1990) indicated,

Qualitative methods can be used to uncover and understand what lies behind any phenomenon about which little is yet known. It can be used to gain novel and fresh slants on things about which quite a bit is already known. Also, qualitative methods can give the intricate details of phenomena that are difficult to convey with quantitative methods. (p. 18)

All qualitative methodologies seek to develop deep understandings. In the present study, they facilitate the identification of cultural and health beliefs in preventive health care. Ethnography provided an inductive research approach that gave valuable guidance in this study. It focuses on describing a culture (Spradley, 1979, p. 3) and is a qualitative approach to understanding how people behave in their actions and interactions and how they cope with the social world and relate to others in everyday life (Liamputtong & Ezzy, 1999, pp. 153–154; Spradley, 1979, pp. 10–16). In other words, an ethnographic study involves direct, face-to-face social interaction with “real people” in a natural setting. Liamputtong and Ezzy (1999, p. 156) also argued that ethnography is particularly suitable for the research focused on health beliefs, attitudes, practices and patterns in different social and cultural circumstances. Ethnographic researchers prefer complete authenticity, achieved by means of participation in the interaction under study. Moving from what is heard or observed to what is actually meant is at the centre of ethnography (Neuman, 2000, pp. 345–347). Studies have shown that this approach allows them to ask questions more effectively (Becker, 1963). From detailed examinations of people and their social discourse and the various outcomes of their actions, underlying principles and concepts can be identified (Berg, 1989, p. 53). In this study, in-depth interviews, participant observation and a case study provided data that was triangulated in the data analysis to develop understandings of the varying perspectives of informants. It will be further discussed in Section 4.2.
Grounded theory was used because this research methodology enables unlike phenomena to be compared with a view to identifying similarities. It is formative, relatively inexpensive and a source of rich ideas. Strauss and Corbin (1990) described the approach as one which: “uses a systematic set of procedures to develop an inductively derived theory about a phenomenon” (p. 24). Furthermore, grounded theory guides qualitative research in areas where data and theory interact. It fits into the broader traditions of fieldwork and qualitative analysis (Glaser, 1998, p. 7; Neuman, 2000, p. 146; Strauss & Corbin, 1990, p. 104). Denzin and Lincoln (2000, p. 522) asserted that the strength of grounded theory lies in:

- strategies that guide the researcher step by step through an analytic process;
- the self-correcting nature of the data collection process;
- the method's inherent bent toward theory and the simultaneous turning away from a contextual description; and
- the emphasis on comparative methods.

Strauss and Corbin (1990) commented that the benefits of building theory in this way are that,

formulating theoretical interpretations of data grounded in reality provides a powerful means both for understanding the world “out there” and for developing action strategies that will allow for some measure of control over it. (p. 9)

Whilst the current research did not utilise a pure grounded theory approach (for example, the axial coding in the data analysis was not used), its inductive orientation of theory-building from the data was employed.

As Hong Kong people have their own specific pattern of combined Western and Chinese cultural and health beliefs, symbolic interactionism assisted in developing understandings of the social reality of the health and preventive health behaviour of this
target group. Symbolic interactionism is a theory for discovering new interactions and concentrates more on the face-to-face context of social life. It is based on observation and analysis of human behaviour and interaction. Interactionism views social order as an on-going process. Social process and interaction consist of individuals interpreting each other's behaviour through shared symbols and meanings (Berg, 1989, p. 7; Lee & Newby, 1986, p. 318; Minichiello, Sullivan, Greenwood, & Axford, 1999, p. 47; Neuman, 2000, p. 60; Smelser, 1988, p. 50). In addition, symbolic interactionism compares unlike phenomena with a view to identifying similarities and thereby offers a rich array of sensitising concepts. In examining a given context in order to understand the process of interaction, theorists try to contextualise human behaviour by determining the way it is shaped by cultural, linguistic and contextual factors (Lee & Newby, 1986, p. 318; Smelser, 1988, p. 50). This theoretical perspective has come to be associated with qualitative research because qualitative methods reveal the meaning and reality created by individuals or groups of people interacting in their social worlds (Duncan, Travis, & McAuley, 1995, p. 64).

It is clear from the literature review that the frames of reference used by the target group to define health and to initiate and maintain preventive health behaviour are dependent on their culture, their life experience, and their interpretation of and the encouragement they derive from other people's life experiences (Koo, 1987; Lee et al., 1993; Wong, 1998). Therefore the examination of social phenomena through the conceptualisations and the reactions of informants to their situation, is qualitatively framed (Neuman, 2000, pp. 145–146). After migration to Australia, older Hong Kong people encountered a different health care system which caused various difficulties or behavioural changes. Guidance from ethnography, grounded theory, and the Theory of Symbolic Interactionism enabled theoretical understandings to be built during the data collection
process. This framework allowed for an iterative process of conceptualisation and operationalisation to occur at the same time that data collection and data analysis were in process, thereby allowing for the development of theoretical understandings which were faithful to the data.

4.2 Method

The use of data from multiple methods (or triangulation) reflects an attempt to secure an in-depth understanding of the phenomenon in question and a strategy to add rigour, breadth, and depth to any investigation (Denzin & Lincoln, 2000, p. 1). Using an ethnographic approach enables researchers to obtain a better, more substantive picture of reality by combining several “lines of sight” or triangulating data collection methods. This approach also helps to achieve a richer, more complete array of symbols and theoretical concepts and a means of verifying many of these elements (Berg, 1989, p. 4). Denzin (1978) also supports Berg's recommendation (1989, p. 4) that triangulation be used during research, stating:

I conclude that no single method will ever meet the requirements of interaction theory. While participant observation permits the careful recording of situations and selves, it does not offer direct data on the wider spheres of influence acting on those observed. Because each method reveals different aspects of empirical reality, multiple methods of observations must be employed. This is termed triangulation. (p. 28)

This study is descriptive and exploratory, using a qualitative approach. Processing raw materials into meaningful data involved several steps. For the collection of their views on, and experience of maintaining their health, this study employed a combination of data collection methods, including in-depth interviews, participant observation and case studies. This combination allowed for deeper insights to be obtained (Denzin, 1989) and also developed theoretical understandings of the informants' preventive health behaviour.
**In-depth interviews**

A semi-structured, face-to-face in-depth interview with open-ended questions was employed to explore the preventive health behaviours as well as the attitudes and barriers to physical activity among the target group. This approach created parameters for the interview while also providing opportunities for gaining informants' perspectives, experiences or situations as expressed in their own words. This method is often employed as part of an exploratory study to gain an understanding of the field of study and to develop a theoretical approach (Liampuntong & Ezzy, 1999, p. 58; Minichiello et al., 2000, p. 75; Neuman, 2000, p. 273).

Semi-structured, open-ended questions provided a set of topics within which the informants were asked questions and further probed, elucidating and illuminating the areas of interest to the study. The questions permitted greater flexibility than the close-ended type and provided a more valid avenue for the explication of the informants' perception of reality. This approach also encouraged them to express their feelings and opinions without misleading or distorting their thoughts by detailed framing of questions (Ma, 1999a, p. 17; Minichiello et al., 2000, p. 76; Neuman, 2000, p. 273). In addition I, as a well-trained interviewer (I have taken several courses in this field), also used nonverbal communication and observed the surroundings and informants' response.

Although using the focus group technique is also useful in exploratory research, this method was not considered appropriate in this study because of the following issues:

- Ideally, the group members should be fairly homogeneous in terms of their educational or social backgrounds, otherwise these factors can be a source of tension;
- The responses of the informants may not be independent because the nature of the group setting means they may influence each other;
The evolving discussion and views expressed may come to be directed by a dominant group member (Minichiello et al., 2000; Neuman, 2000, p. 274); and

Some older Chinese people are naturally reticent about making personal disclosures, so they may have found a group setting or environment inhibiting.

As discussed in Chapter 3, Section 3.2, Chinese people generally have passive and introverted personalities. The Chinese concept of “face” can make them even more reticent because of an underlying fear of saying something wrong or something that seems to set them in opposition to the other group members. That is, particular personal and cultural characteristics could have limited their active participation in a focus group.

In addition, when researching attitudes towards falls among older Chinese people for my Master's thesis, I was a participant observer in two focus group interviews, I noted that some hesitated to express their opinions “in public”, while others took a more dominant role. Sometimes, the less vocal informants simply followed what the other people said or when they did express an opinion, it was usually something which was socially acceptable. This experience prompted me to seek a better method of obtaining the relevant information, I found this was best undertaken through face-to-face interviews, as focus group interviews were not appropriate for obtaining authentic and rich data from the informants. Since there was no fear of “losing face” in individual face-to-face interviews, these provided the informants with more opportunities to express their own thoughts and ideas.

**Participant observation**

Participant observation is a qualitative technique in which a researcher directly observes and participates in small-scale social settings and in the informant's home culture. It is a face-to-face direct social interaction with “real people” in a natural social setting (Minichiello et al., 1999, p. 434; Neuman, 2000, p. 345). The purpose of participant
observation is “to describe the culture and lifestyle of the group of people being studied in a way that is as faithful as possible to the way they see it themselves” (McNeill, 1990, p. 64). Participation in this form of interpersonal interaction is part of naturalistic inquiry and was desirable in this study (Happ & Kagan, 2001, p. 190). As I was able simply to observe Hong Kong Chinese people doing and saying things without asking about why they were acting in that way or about the actions of others, the data collected were less likely to be affected by people's faulty memories, poor verbal communication skills or distortions of reality (Minichiello et al., 1999, p. 434).

As noted earlier, I worked as the home nurse for an elderly Chinese man from Hong Kong for three years. In that situation, I could simultaneously directly talk with and observe him, his brother-in-law and his maid. Occasionally, I could also observe his relatives. I was thus able to learn about their life histories, hobbies, interests, habits, hopes and fears. This ongoing close contact with three older Chinese people provided an in-depth experience of their lived worlds. There was plenty of opportunity to acquire insightful information about their attitudes and opinions towards ageing and health, as well as their preventive health behaviour. However, only one of the subjects met the criteria for the sample because my employer was an invalid and therefore did not meet the criterion of independence. The maid was born in mainland China and therefore excluded from the study. The eligible informant, my employer's brother-in-law, was recruited and interviewed for this study. In addition, I was also able, in a nearby park, to talk with and observe four older Hong Kong Chinese people who regularly engaged in physical activity there. Data from all these experiences were recorded by regular and systematic note taking. The information was used to gather preliminary data on older Chinese people's beliefs about health and preventive health behaviour. This preliminary step informed both the interview questions and the interviewer.
Case study

A case study methodology involves the observation of an individual unit such as a community, an event or even an entire culture that is either very representative or extremely atypical. It is used to gain in-depth understanding of the meanings of the informants, focusing on discovery rather than confirmation. The data gathered from a case study is valuable as a preliminary to major investigations because it is intensive and generates rich subjective data. It provides anecdotal evidence that illustrates more general findings and may be valuable in its own right as a unique case (Burns & Grove, 2001, pp. 364–366; Neuman, 2000).

In this study, one key informant was chosen from the total of 22 because that individual was deemed representative of the target group (See Chapter 5, Section 5.4 or Appendix 7p). My employer's brother-in-law was chosen for the three-year in-depth case study because he had changed his health behaviour before and after migration. He was re-interviewed 12 months after the first interview. During the second interview, he was asked in-depth questions about preventive health behaviour and his behavioural change. Although participant observation and interview were both time- and energy-consuming (Seidman, 1991, p. 5), they proved to be invaluable data-gathering techniques for this study.

4.3 Data collection, analysis and the establishment of rigour in this study

Over the last three decades, there has been extensive discussion of the need for and also about different standards of rigour consistent with qualitative research (Beck, 1993; Chiovitti & Piran, 2003; Davies & Dodds, 2002; Glaser & Strauss, 1967; Hutchinson, 2001; Morse, 1999; Sandelowski, 1986, 1993; Sparkes, 2001; R. Whittemore, Chase, & Mandle, 2001; Wolf, 2003). Beck (1993) proposed credibility, auditability and
fittingness as three main components of rigour common to qualitative research in general.

Credibility is related to how clear and faithful the description of the phenomenon is (Beck, 1993, p. 264). It also relates to the trustworthiness of the findings (Carpenter Rinaldi, 1995). Auditability refers to the ability of another researcher to follow the methods and conclusions of the original researcher. It is demonstrated when another researcher is able to follow the audit or decision trail of all the decisions made by a researcher at every stage of data analysis (Beck, 1993; Chiovitti & Piran, 2003, p. 432). Fittingness or transferability is related to the possibility that the research findings have meaning to others in similar situations (Carpenter Rinaldi, 1995).

One of the steps recommended by a number of authors to establish the credibility of a qualitative study is the construction of an audit trail (Burns & Grove, 2001; Chesla, 1992; Lincoln & Guba, 1985; Minichiello et al., 1999; Wolf, 2003). This record indicates that the raw data have gone through a process of “analysis, reduction, and synthesis” (Chesla, 1992; Wolf, 2003, p. 175). I found it helpful in tracing the textual sources of data back to the interpretations and vice versa. In addition, based on Beck's schema, Chiovitti and Piran (2003) have suggested eight checkpoints which can be used to enhance standards of rigour in the course of conducting nursing management, practice and education research using grounded theory. These authors assert that using these eight checkpoints will also enhance the credibility, auditability and fittingness of the research. The following eight checkpoints of research practice were adopted to maximise the rigour of this study.
Specify how and why informants in the study were selected

Chiovitti and Piran (2003, p. 432) stressed the importance of explaining how and why informants were selected for a study. They assert the importance of, among other things, fully describing the sample with regard to gender, ethnicity, age, socioeconomic class, and any other relevant criteria. In addition, according to Byrne (2001, p. 498), because different research strategies can influence sample size and selection, the researchers must thus document the decision-making process involved in the qualitative sampling in order to provide credibility for their research findings.

Snowball sampling, sometimes known as chain referral, which will be described shortly, is one technique. It is recommended for use in situations in which eligible individuals are readily identifiable, know other similar people, the relationship between informants is unambiguous and informants are cooperative. In some cases, recruited samples have closely matched comparable census figures (Rissel & Khavarpour, 1997, p.196). In order to obtain a broad range of perspectives, ensure that informants were selected from a wide range of social groups, and avoid the informants all coming from a similar background, such as the same community centre, the snowball sampling method was adopted in this study. Those who provided contact points for recruiting the initial informants were church pastors, friends' families, neighbours and a physiotherapist's referrals.

As mentioned in previous chapters, it is a mistake to treat all Chinese people as an homogenous group. For this reason, the focus of this study was on older Chinese people from Hong Kong, while older Cantonese-speaking Chinese people who had migrated to Australia from mainland China or Singapore were not involved. In order to recruit suitable informants, the interviewer first of all telephoned four persons who met certain criteria, these being that they were:
• Male or female Chinese aged 60 years and over;
• Cantonese speakers who were born in either Hong Kong or China and had migrated from Hong Kong;
• Physically independent (able to perform basic activities of daily living) non-institutionalised, whether or not they were physically active;
• Resident in Australia for two years and longer (the researcher was interested in the study of permanent rather than temporary residents);
• Living in Sydney (where most of Hong Kong Chinese have settled in NSW); and
• Representative of various levels of SES.

There are two reasons for selecting informants aged 60 years and over. First, in Hong Kong, people face a major turning point in their lives in their sixties when they retire and lose their working ability. Second, it is better to promote physical activity among this group to avoid injury and maintain physical strength and flexibility before they become too frail (Hui & Nagi, 1997; Wong et al., 2003). Those recruited for the study had both higher and lower levels of PA/Ex participation because in order to provide effective and comprehensive strategies for increasing physical activity levels, both those factors that motivated participation in physical activity and those that inhibited it, needed to be explored.

After making the initial contacts, the snowball sampling process began with interviews of four older people in the Chinese community who met the criteria described above. These informants were then asked to provide four names of other older people (with telephone numbers and nature of their relationship) who they believed would also meet the criteria and be willing to participate in the study. Four names were requested because it was anticipated there might be some refusal to participate among the referrals. Immediate family member contacts were discouraged so that links could be made as widely as possible rather than cluster responses. Recruiting informants from only one
organization was avoided as there was a likelihood that these might have been overly influenced by the social activities or information provided within that organization. As well, to ensure that the findings were not based on a narrow section of the Chinese community, the informants were recruited from different demographic areas.

While snowball sampling was used in an ongoing way, it did not prove to be particularly successful, because only ten informants were recruited at the beginning. Some were reluctant to introduce other eligible older people for three main reasons. First, some informants felt it was not a good idea to bother their relatives or friends as they would be reluctant to be interviewed if that involved them disclosing personal and intimate matters. Second, many older Hong Kong Chinese people in Australia have very limited social connections apart from those with their own families or close relatives. Third, some of the suggested people were not available because they were visiting families in Hong Kong for long periods of time. With so many limitations, it was not easy for them to identify other older Chinese people to participate in the study.

These limitations meant there was a danger that a broad sample could not be accessed. Further efforts were thus made through a variety of groups and organizations to access a range of perspectives. Personal connections, crucial to gaining access to older Chinese people, proved to be important for making initial contacts with informants. Other than Chinese organizations such as churches, contacts were also made with the help of health professionals such as general practitioners and a physiotherapist. In this way, an additional 12 informants were recruited. Once contact with them had been established, personal follow-ups involved explaining in detail the aims, objectives, and the procedures of the study, while information sheets and consent forms were also supplied (See Appendices 1 & 2).
The final number of informants recruited was determined by analysis of information obtained from those who had previously participated. This iterative process meant that further instances of the categories were gathered until the relevance and range of categories for the data were “saturated”, that is to say, no new categories were emerging. Using the combination of snowball and convenience sampling methods, theoretical saturation of data was finally achieved with 22 informants.

_Delineate the parameters of the research in terms of the sample, setting and level of theory generated_

Chiovitti and Piran stated that “providing details about the sample and setting characteristics is one way in which a researcher allows readers to assess the fittingness or transferability of the findings” (Chiovitti & Piran, 2003 p. 433). In order to collect data to formulate the interview questions and identify common experiential themes among the target group, three pilot interviews were carried out in Sydney. These also helped to test the questions and gain experience of the administration of interviews. Formal data collection started after these three pilot interviews.

Generally, each interview lasted about 60-90 minutes and was conducted in a private location familiar to informants, usually their homes, in a church or the researcher's home. These locales were chosen to maximise the level of comfort informants might have felt when expressing their thoughts and feelings about the research areas. Most of the interviews took place in the afternoons or evenings. The goal in the interview process was to allow the informants to feel as if they were chatting with a friend in relaxed and unrushed conditions. In accordance with Chinese cultural norms, I treated the older people with great respect (Da, 2001, p. 66) and framed questions tactfully, as it was important not to make informants feel embarrassed or concerned about their privacy. The
interview began with general social conversation to enhance informants’ willingness to provide answers to open-ended questions (Vicki, 1998). The conversation often started with questions about hobbies, children, historical events in Hong Kong or in Australia.

When it came to the actual data collection, each informant was initially asked basic demographic questions about age, sex, birthplace, years lived in Australia, marital status, educational level, SES, language spoken at home and the frequency of social activity. Health-related questions included the frequency and intensity of physical activity, self-reported health status, activities of daily living, smoking status and alcohol consumption. Apart from facilitating the assessment of the fitness of informants to participate in the study, these questions also provided data to facilitate an exploration of the relationship between preventive health behaviour and sociodemographic characteristics (See Appendix 3).

The format of questions specified by Ajzen and Fishbein (1980) was modified for the interview questions. Data collection was structured using the constructs of Planned Behavior Theory: behavioural beliefs, normative beliefs, and perceived control beliefs. For example, to elicit behavioural beliefs, informants were asked to identify the advantages and disadvantages of physical activity. To assess normative beliefs, informants were asked to list individuals or groups who would approve or disapprove of him/her being physically active. To examine perceived control beliefs, informants were asked to identify factors that made being physically active easy or difficult. The refined questions allowed the researcher to establish the context in which the theory and its specific categories were being applied. In order to prevent predetermined theoretical construction, questions on the interview guide were modified depending on the incoming data from the informants.
After the first few interviews, it was noted that certain issues caused informants anxiety. The family was a sensitive area, especially for those who had problems with their family or had relatives outside Australia with whom for political and/or financial reasons, they could not be reunited. Informants were also reluctant to disclose the specifics of their financial situation. An approximate monthly income figure (for example, $200 or $300) was usually given very hesitantly. In most cases, the first time I asked them about the amount of income, they replied, “it is difficult to tell” or “not constant”. When I tried to reconfirm the answer, instead of stating an amount, they would say “just enough” or “enough to meet the expenses”. They also hesitated to disclose the source of their income.

In addition, when informants were asked to rate their SES, some of them tried to evade the question or they replied, “I don't know, it is too difficult for me”. Information obtained from one of the male informants explained this. He did not feel unhappy or offended. He just wondered about the motives for asking the questions about his financial situation, even though the reason for questions had been explained during the interview. Similarly, some informants became tense when hypothetical questions were asked, for example, “What will you do if you get sick?” Either they had never faced this situation and did not know what they would do if it arose, or because they were worried about this situation becoming a reality, they would reply: “I don't know” or requested me to stop talking about “unreal” issues. Indeed, one female informant (Mrs Lim) blamed me when, after the interview, she began to feel sick and suffered a bout of diarrhoea.

The interview sequence of questions was altered as a result of the first few interviews, to minimise the discomfort caused by questions about income, family or becoming ill.
Questions requiring simple answers were always asked first, and then gradually questions of a greater relevance to the study were asked. Personal particulars were elicited at the end of the interviews instead of at the beginning because at that stage informants were likely to feel more at ease as a result of having talked to and established a rapport with me. Hypothetical issues were minimised if the informants refused to answer. Thus it can be seen that discussions with older people required much time, patience, and care.

Based on informants' self-reported information, their sociodemographic characteristics were recorded in detail. Appendix 4 shows the numbers of older Hong Kong people recruited from the Chinese community. The item for gender was assessed by my own observation. Rissel's (1997) scale was employed to assess the acculturation level of the informants (See Appendix 5). However, it seemed to be impossible to plot the graph showing a logical curve. Consultation with Dr Rissel himself indicated that the plotting was not effective as the sample size was small and most informants had only a low degree of acculturation. Nonetheless, by adapting the questions used in Rissel's scale and asking some additional questions, it was possible to assess the informants' level of acculturation. Using adjustments made by myself and also my knowledge of Chinese characteristics, the informants' acculturation levels were classified into three categories: very Chinese-like (that is, a low acculturation level); Chinese-like (a moderate acculturation level) and Australianised (a high level of acculturation).

**Use informants' actual words**

In qualitative research, it is crucial to realise the potential for distorting or inaccurately representing an informant's original meaning of a word, a relationship, or an action, especially when using single words or segments of interview data to describe the
phenomenon (Chiovitti & Piran, 2003 p. 431). This problem was avoided in the following ways. First, given the background of older Hong Kong Chinese people living in Australia, it was decided that in order to enable the informants to express themselves in their own words, it would be appropriate to conduct the in-depth face-to-face interview in their mother-tongue, that is, Cantonese. Doing this was facilitated by the fact that I am Hong Kong-born and can speak both Cantonese and English. The advantage, as Levy (1985, p. 642) suggested, is that people who share similar cultural patterns, values, and problems are more likely to feel relaxed during the interview. Thus communication can be both verbal and nonverbal, allowing for fruitful data collection from the informants, which in turn allowed accurate meanings for every word to be gathered.

A migrant from Hong Kong who had a Master's degree in translation as well as formal training and experience in interviewing attended the pilot interviews in order to provide feedback on the researcher's technique. All the interviews were audiotaped and the interviewer simultaneously recorded in writing each informant's facial expressions. Their particular responses and my perception of them, were also recorded to aid data interpretation. Distortion of informants' words was minimised by tape-recording the interviews, transcribing them and translating them from Cantonese into English. Even though the complete transcription of interviews was time-consuming, verbatim answers to questions provided indispensable raw data for analysis (Vicki, 1998 p. 5). Transcription occurred throughout the data collection, with developing ideas being introduced into later interviews in an iterative manner. Once all the transcriptions were completed, they were re-read carefully to establish where there was consensus and also where there were contrasting views. To ensure accuracy in transcription, the tapes were listened to repeatedly for clarification whenever necessary and checked for accuracy.
against the transcription text. The translated transcripts were each read through at least four times by me and a series of terms and concepts were highlighted. Fluency and familiarity with Cantonese meant that I was well equipped to understand wordings, jargon and indigenous concepts used by interviewees. To minimise bias and ensure trustworthiness, translated transcripts were randomly audited by the bilingual translator. Transcriptions were also provided to my research supervisors for scrutiny.

The varied meanings and contexts in which informants used a word were delineated. For example, the term “physical activity” was found to have different meanings for the informants when it was used either as Tai² Nang⁴ Wool⁶ Dung⁶ (strength enhancing activity) or as Yen⁴ Tai² Wool⁶ Dung⁶ (human body movement). Thus, the term “physical activity” was delineated in terms of the different meanings it had for the informants (this issue will be discussed more fully in Chapter 7), rather than in terms of some arbitrary Westernised view. In addition, there was much nonverbal data collection. Facial expressions, gestures and bodily posture are continually used to “fill out” utterances, as well as conveying meanings when nothing is actually said. Thus the informants' facial expressions, laughter, raised voices, gestures, questioning and so on were noted and subsequently integrated into the index, the analysis and the reporting.

**Articulate the researcher's personal views and insights regarding the phenomenon explored**

During the data collection, my personal views and insights regarding the responses of the informants were kept in a personal file. These helped to record and explain my own opinions of the phenomena observed and to understand how these affected the inquiry (Locke, Spirduso, & Silverman, 1993). This file contained the following information that was used to document the quality of the interview process, data collection and data analysis:
The date, time, duration and setting of the interview;
A brief description of the informant including demographic information;
Reflective comments on fieldwork activities;
How I gained access to an informant and persuaded her/him to be interviewed;
How rapport was established with an informant;
Personal reflection on my perceptions of and feelings about an informant;
The role of the researcher and that of an informant;
The personal experience of doing this study;
How the research might have influenced or affected the content and process of the
interview; and
An evaluation of the processes involved in doing this study such as barriers and
limitations, and also what phenomenon became evident during the interviewing
process.

Adapted from Minichiello et al., 1999, pp. 580–581.

Personal profiles of each case in terms of gender, age, marital status, educational level,
length of stay, acculturation level and health problems were compared for similarity and
discrepancy in order to identify their relationship with physical activity. In addition, a
summarised page was produced for each transcription (See Appendix 6). It mainly drew
from the content of each transcription with sociodemographic data and the summarised
key findings provided. These summarised pages helped me to interpret, compare and link
up differences and similarities between individual cases. Literature was reviewed
continuously during the data collection and analysis in order to identify any current
related research. In addition, conference papers were delivered and poster presentations
were made. This “member checking” by researchers interested in health promotion and
ethnic groups contributed to the exploration of issues.
Let informants guide the inquiry process

In order to ensure that the phenomenon investigated was accurately identified and delineated, informants guided the inquiry process. The questions recorded in Appendix 3 were not asked in a fixed order in the administration of interviews, but were utilised in a flexible manner. Thus, modification of the interview questions, and content areas of the emerging theory, according to incoming information from informants, guided the inquiry process and helped to enhance credibility (Chiovitti & Piran, 2003 p. 431).

As the project progressed, the information sought was modified and shaped by what informants had been saying in the earlier phases of the study. Efforts were made to transcribe and analyse the data collected immediately or as soon as possible after each interview. The excerpt from the data of the pilot interview provided in Table 4.1 shows the code “concept of old” had strong linkage with the intention to engage in preventive health behaviour. Therefore a few items were added to the interview guide, including questions about their ideas on what it means to be “old” and also about “birth, ageing, illness, death” to further pursue this developing concept and to ensure relevant data was obtained (See Appendix 3, Part II). The pilot study proved helpful in enabling me to improve my interview skills and also helped ensure that the actual interviews proceeded smoothly.

Table 4.1: The Excerpt from Data of the Pilot Interview

<table>
<thead>
<tr>
<th>Raw data from pilot interview</th>
<th>Thematic Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>What can I do? I think that</td>
<td><strong>Concept of old</strong> – influences their intention or motivation to engage in preventive health behaviour.</td>
</tr>
<tr>
<td>I am too old. It means poor</td>
<td></td>
</tr>
<tr>
<td>memory, a lot of wrinkles on</td>
<td></td>
</tr>
<tr>
<td>my face, and slow motion.</td>
<td></td>
</tr>
<tr>
<td>You can't climb up and</td>
<td></td>
</tr>
<tr>
<td>down. You must accept it.</td>
<td></td>
</tr>
<tr>
<td>Don't say old, you have to</td>
<td></td>
</tr>
<tr>
<td>accept death as well.</td>
<td></td>
</tr>
<tr>
<td>“Birth, ageing, illness, death” is normal. You don't need and you can't do anything for it (S3, p. 8).*</td>
<td><strong>Attitude towards life</strong> – influences their intention or motivation to engage in preventive health behaviour.</td>
</tr>
</tbody>
</table>

* S refers to informant in pilot interview, p. to the transcription page number.
The interview structure and questions were revised and modified as the study evolved. The emergence of themes of engaging in physical activity and new information also prompted new questions. For example, the environment and their social life significantly influenced the intention and motivations for performance of physical activity. These influencing factors were explored in later interviews.

During the interviews, many informants resident in Australia frequently referred to their experiences in Hong Kong. Most of these informants had a low acculturation level in Australia and some visited their family in Hong Kong every year. It appeared that their concepts, preferences of and attitude towards physical activity continued to be influenced by their experiences in Hong Kong; that is, they had strong cultural and health beliefs that were possibly being continually reinforced by visits to their country of origin.

**Check the generated theoretical construction against informants' meanings of the phenomenon**

During the study, the theoretical construction generated was checked against informants' meanings of the phenomenon in two ways. Firstly, as discussed in previous sections, when codes expanded and gained greater depth based on incoming data from informants, questions in the interview guide were changed. Secondly, codes were checked and verified for their relevance to informants' meanings. For example, as mentioned earlier, concepts of “old”, and “birth, ageing, illness, death”, were consistently expressed in relationship to participation in preventive health behaviour. Therefore questions were asked to refine, develop and revise the emerging theoretical understanding.
Specify the criteria built into the researcher’s thinking

All qualitative data analysis methods involve coding data into themes, then categories, to form conclusions (Jasper, 1994). During the process of data analysis, I consistently asked myself several questions during coding of the transcribed interview and data analysis in order to facilitate and guide my thinking. These questions were:

- What is happening in the data?
- In what context is the code used?
- Is the code related to another code?
- Is the code encompassed by a broader code?
- Are these codes that reflect similar or different patterns?

Adapted from Chiovitti & Piran, 2003, p. 432.

The quality of data analysis depends on repeated, systematic searching of it (Hammersley, 1981). During data coding, notes were made about how decisions had been reached, how the coding process had been conducted and any specific queries raised. Codes were therefore generated from the data, rather than being predetermined. Repeated coding was performed to review interpretations in the light of new data gathered. New codes were generated until no new insights were found. A separate file, including the codes and their definitions, was used to ensure that the use of each code remained consistent. Established coded sections were compared with other similarly coded segments to ensure consistency of application, as well as adherence to the definition of the code. All codes and parts of the coded data were provided to an experienced qualitative researcher and also to my thesis supervisors for comments.

In order to determine the relationship between each code and the overall theory and also to determine if there were any codes that reflected similar patterns, a diagram was drawn for each code and compared with the others. This provided a visualisation of the linkage
and track of each code. In addition, subcategories were linked logically to categories to enable the researcher to think systematically about the data and to relate them to each other in very complex ways. For example,

<table>
<thead>
<tr>
<th>Category:</th>
<th>Category:</th>
<th>Category:</th>
<th>Category:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural belief:</td>
<td>Concept of old:</td>
<td>Health Belief:</td>
<td>Preventive health</td>
</tr>
<tr>
<td>Chinese traditions</td>
<td>Deterioration of physical functions</td>
<td>Concept of health; Concept of illness</td>
<td>behaviour</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Code: Attitude towards physical activity; Motivation of physical activity</td>
</tr>
</tbody>
</table>

**Describe the literature pertaining to each category that emerged in the theory**

Meanings and experiences provided by informants were incorporated into the theory when constant comparisons of data revealed the repeated presence of specific content areas. In order to demonstrate the fittingness of this study, the literature was searched for findings that referred to a similar phenomenon. For example, the interviews revealed that older Hong Kong Chinese people's preventive health behaviour involved both Chinese traditions and concepts of health. In the literature that discussed Chinese philosophies and health beliefs (See Chapter 2), it was noted that there was an interplay between the traditional thought of *zung*/*yung* and the concept of “balance and harmony between mind, body and emotions”. By highlighting similarities between the findings of this study and previous theoretical constructs in the literature, it was possible to show the potential transferability of the phenomenon being explored to the other situations.

**4.4 Typology**

Typology is a type of classification and a way of describing groups of informants displaying different clusters of attitudes, worldviews, or behaviours. It generally consists of a set of descriptive “types” attached to a typical behaviour and/or attitude for each
group (Minichiello et al., 2000 p. 302; Neuman, 2000 p. 521). Typologising was also used in this study to gain a better understanding of the phenomena revealed by the data, which involved grouping ideas and then forming ideal types. Combining two or more unidimensional, simple concepts demonstrated that such an intersection formed new concepts.

Case summaries

Although each transcript file was coded and categorised systematically, they were still too large and detailed to enable a differentiation to become evident between information relevant to the research question and other interesting but irrelevant information. Therefore before typologising the data, case summaries of each informant's interview were produced to condense the relevant information and link the material presented in the transcript to conceptual themes and topics relevant to the research questions asked (Minichiello et al., 2000). All of the case summaries, using informants' own wordings, were written up in similar formats. Each was checked at least twice to identify any distortion of original meanings and also spot-checked by a qualified translator and my supervisor. This made comparisons between cases manageable while it also enabled the similarities, differences and degrees of consistency between informants' accounts to be identified (Minichiello et al., 2000). It became a huge undertaking in terms of time, and while seemingly tedious, ultimately proved worthwhile to inform a later stage of data analysis.

The process of developing a typology

At the outset, all cases were divided into four groups according to gender and levels of physical activity. The groups thus comprised physically active males/physically inactive males, and physically active females/physically inactive females. In order to construct
plausible relationships between cases, within these groups, each case's personal background such as educational level, length of stay, age, occupational status and marital status, was compared for similarities and differences.

The next step involved re-classifying the data relevant to each issue. This was the most complex and time-consuming task in the entire study. The data was cross-classified and compared in terms of a variety of social groupings including age, sex, marital status, family structure, social and economic status, division of housework, etc. All codes were linked up to find possible relationships. This approach forced me to think about what cases had in common and what diversity there was in a group.

Finally, all cases were categorised into groups by comparing the similarities and differences between cases and sets of categories or themes. These included physical activity levels, concepts of, attitudes towards, barriers to and preferences and motivation for physical activity. Also included were concepts of “old”, health beliefs and preventive health behaviour. From their individual features, each case was classified into different degrees of physical activity participation according to specific patterns. Classification was repeated until all cases fitted the groups without any negative instances found. Modified groups were counter-checked by my supervisor.

Four initial states of physical activity participation were classified from all cases. These were labelled as: acceptance of the sick role, practical, functional, and supporter of physical activity (PA)/Exercise (Ex). Their attitudes towards being old, the importance of physical activity and past experiences of physical activity were the major intrinsic factors affecting motivations and intentions with regard to participating in physical activity. However, three outliers did not fit in any one of the groups. After reviewing all case
summaries, it was realised that the perception of being physically active or inactive and life experiences after changing to a new environment were also key factors influencing physical activity patterns. Therefore two more groups were added, giving a total of six, these being: “Inactive”; “Enforced Acceptance”; “Irregular”; “Practical”; “Emerging”; and “PA/Ex Supporter”. In addition, the classifying groups were linked with the conceptual framework in order to investigate their interrelationship. Some interacting factors (that is, intrinsic and extrinsic factors) influencing the intention or motivation for physical activity among these groups were identified. Details will be further elaborated in Chapter 5, Section 5.5.

4.5 Ethical issues

The purpose of qualitative studies is, on the basis of interviews and observations, to describe a phenomenon from the informants' viewpoints. The intention of the researcher is to listen to the voice of informants or observe them in their natural environments (Field & Morse, 1992). To ensure that valid and rich information would be collected, measures were taken to enhance the participation of informants.

An interview usually involves confidentiality, informed consent, and privacy. All the interviews began with an explanation of the purpose of the study, which was approved by the University Ethics Committee. Informants were given a subject information sheet in Chinese with clear explanations for English and Cantonese versions. Informed consent was also obtained. All recorded tapes and records were stored safely. Indeed, the difficulties inherent in this study were alleviated by awareness and use of the well-established ethical principles of autonomy, beneficence, and justice (Orb, Eisenhauer, & Wynaden, 2001). These qualities were achieved in the following way:
**Autonomy:** During the interview, the informants were fully informed of their rights, including the right to be informed about the study, the right to freely decide whether to participate, and the right to withdraw at any time without penalty. Informants were also permitted not to respond to any question which made them uncomfortable. In other words, the informants were able to exercise their rights as autonomous persons to voluntarily accept or refuse to participate in the study (Field & Morse, 1992; Kvale, 1996; Munhall, 1988).

**Beneficence:** In order to protect their identity, all informants were anonymous. However, this strategy might not be enough to protect confidentiality when a study is conducted in a small community in which the informants can easily be recognised. In such cases, circulation of the study results was restricted to me, the translator and my supervisors. Protection of informants' identities also applies in publications. Informants were told how the findings were to be published. Pseudonyms were used in all verbal and written reporting (Orb et al., 2001).

**Justice:** The principle of justice refers to equal sharing and fairness, and in these terms it is imperative to avoid either exploitation or abuse of the trust of informants. For instance, if during analysis I concluded that a concept or a heading in the report could be damaging, then permission to use the concept would be sought or at the least, there would be a discussion of the issues with the informant. Another way of implementing the principle of justice was listening to the voices of members of the group and attempting to ensure that the research process would not burden these already overburdened and vulnerable people (Orb et al., 2001).
4.6 Difficulties and sensitive areas of the study

Many difficulties were encountered during the course of the research and some sensitive areas were identified. Here are some examples.

**Recruitment**

During the recruitment process, about ten people refused to be interviewed. In many cases, they did not turn down interviews in a straightforward manner. “No time”, “I don't know anything”, and “I am not good at talking” were some of the reasons put forward. Sometimes, it was not the potential informants but their family members who rejected the request. They usually made excuses such as: “My parents do not want to be interviewed”, or “My parents are not used to talking to outsiders”. In these cases, it was feared that interviewing the parents or grandparents might “break the harmony” between them and myself and even with their families. This indicates that family members were very influential in the informants' decision-making process. In addition, even some who had agreed to be interviewed, cancelled or delayed the interviews because they had changed their minds or had to visit families and relatives in Hong Kong. That increased the difficulties of sample recruitment and delayed the process of the study. It also reflected the continuing close links between migrants who have settled in Australia with families and friends in Hong Kong.

**Interviewing**

Most of the informants and especially those who were illiterate, were very sensitive about signing the consent form. One woman refused to be interviewed simply because she objected to having to sign the form. A few of the literate informants preferred to give verbal consent or signed the consent form with a fictitious name. One female informant preferred to sign after the interview was finished to avoid any trouble. Tape-recorded
verbal consent was used for those who felt uncomfortable about signing. The informants' reactions to the consent form might reflect that they found it difficult to trust a stranger and were worried about causing any trouble.

Most of the interviews were conducted in the informants' homes. In one case, the informant wanted her daughter with her during the interview because that made her feel more comfortable and confident about answering the questions. In order to avoid her daughter creating negative feelings and breaking the relaxed atmosphere, I politely suggested that she withhold giving personal opinions during the interview. I also tried to draw the informant's attention to me rather than to her daughter.

During the interviews, it was clear that some informants were worried about providing incorrect information from the way they reacted to questions by looking down and meekly saying: “I don't know”, “It is not for me to say”, “Am I right?” or “Did I say anything wrong?” They also responded to some questions by saying “You should know better than me” and “Don't ask me, please tell me straight away”. They seemed to think that they had very little information of any value to impart and often needed to be prompted to elicit their responses. A possible explanation for this is that they worried that because of their low education levels and sense of inferiority, they would say things which were not suitable for the study. Confucian and Buddhist philosophies could be another explanation. In Confucian philosophy, academic and professional activities are valued (Monroe, 1995; Wei & Li, 1996), and thus they showed great respect for me during the interview because I was a PhD student and researcher, and they did not want to “break the harmony”. Buddhist philosophy lays down that the relations between friends, relatives and neighbours should be warm and friendly and that they should help
anyone who is in need (Cheu, 2000; Howley, 1999). For this reason, the informants might have thought that they were obliged to speak pleasantly and agreeably to me.

In addition, most of the informants used the pronouns ngo5 déi6 meaning “we” instead of ngo5 “I”, or lei5 dei6, the plural form of “you” instead of lei5, the singular form of “you2”. In some situations I needed to clarify whether the opinions being expressed were those of the informants themselves or collective opinions. The use of the latter may be due to the tendency for Chinese people, as in most collectivistic cultures, to stress fitting in with and belonging to the in-group (such as family or work unit). Thus there is a focus on a “we” identity (Gao & Ting-Toomey, 1998, p. 3; Hofstede, 1980). Another explanation is that the informants’ speaking style was meant to avoid any appearance of being opinionated, self-assured or over-confident, which may also stem from Confucian values relating to proper conduct. In behavioural terms, there is a strong belief that the expression of personal opinions is likely to disturb the harmony of the whole (Cheng, 1997; Ferroa, 1991; Louie, 1985). Therefore at all times and in all the interviews, I needed to be careful to differentiate personal points of view from collective ones.

The informants had their own specific concepts of physical activity. In order to ensure the validity and transferability of the data produced by the interviews, I asked all informants to recount their daily routines from morning to night. This enabled an assessment to be made of their physical activity patterns according to the criteria established by the National Physical Activity Guidelines for Australians (Commonwealth Department of Health and Aged Care, 1999). However, in order to avoid misinterpretation and the consequent production of invalid data, I was also careful to

2 In English “you” is used as both singular and plural; the use of “youse” to denote the plural, while grammatically unexceptionable, is inexplicably for non-English speakers, deprecated as being “low class”.

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clarify the meaning(s) of “physical activity” with the informants before starting other interview questions.

4.7 Limitations of the study

The research methodology chosen for the study had several limitations. The first relates to the nature of the recruitment techniques. The 22 informants were recruited (with some difficulty) by snowball sampling. This meant that the sample size was small and the informants were not randomly selected so as to be “representative” of the Chinese population in the statistical sense. Despite these drawbacks, strict criteria were still used in their recruitment process. This group of older Chinese people was deliberately selected and interviews were structured so as to facilitate diversity and contrast in opinions and behaviour.

Another limitation was the problem of searching for relevant epidemiological data for this target group. As mentioned earlier in this study and documented in previous literature (Chan & Quine, 1997; Reid & Trompf, 1990), the geographical origins of Chinese living in Australia varied from mainland China to Hong Kong, Taiwan, Macau, Malaysia or Singapore. However, epidemiological and statistical data about migrants from Hong Kong in Australia were limited and incomplete. Even when data were available, Asian or Chinese migrants were lumped together as an homogeneous group. Their country of birth and origin as well as their age were not clearly listed. It was difficult to access detailed and up-to-date epidemiological information on the health status of older Hong Kong Chinese people and their patterns of physical activity.

Third, this research study only focused on one kind of preventive health behaviour, physical activity. While informants reported that they were taking other preventive
measures such as watching their diet and maintaining mental wellbeing, these were not the focus of the research. Moreover, apart from Mr Chin (9) (See Chapter 5, Section 5.4) whose attitudes and intentions with regard to participation in physical activity changed as a result of personal experience during the course of this research, the rest of the informants were not followed up.

4.8 Summary

This study employed an eclectic approach to the study of older Chinese people from Hong Kong. An ethnographic approach and grounded theory were used in data collection and analysis. Symbolic interactionism helped interpret findings. In-depth interviews, participant observation and the use of a case study technique were the main research methods for data collection. The eight methods of research practice for enhancing standards of rigour put forward by Chiovitti and Piran (2003) were employed to ensure the credibility, auditability and fittingness of this study. Twenty-two transcripts were summarised and typologised for identifying six states of physical activity participation.
CHAPTER 5: FINDINGS I

This chapter presents data gathered during fieldwork using face-to-face in-depth interviews, participant observation and case studies, conducted among older members of the Hong Kong Chinese community in Australia. The presentation of the findings begins with a description of the sociodemographic characteristics of the informants resident in Australia and their participation in preventive health care, mainly physical activity; followed by an exploration of their concepts of and attitudes towards physical activity. Typologies of PA/Ex were developed that helped explain the findings. Six states of PA/Ex participation and intentions with regard to physical activity, as well as their relationships, are explained. Lastly, the possible changes of the six states of PA/Ex participation are discussed. In reporting the findings, verbatim quotes are used from informants. These indicate the name, age and the informant's number and link to the tables in Appendices 7a-v.

5.1 Sociodemographic characteristics

The 22 informants (12 males and 10 females) ranged in age from 60 to 91 years (average 75.5 years). Informants had high rates of marriage or widowhood and a low divorce rate. Most were married (n=18) and living with their spouses (n=18). Three women were widowed and one man refused to give his marital status. Eleven informants had completed secondary school or tertiary education, while of the others, one had obtained a Master's degree and two Bachelor's degrees (two informants). The remainders were unable to read and had not completed primary or secondary school. The comparatively high education levels are probably a result of Australia's selective immigration policies. However, most of the informants reported low English proficiency (12 had low or no
English proficiency). Twelve out of 22 informants could not drive or did not drive after migration. They were reliant on public transport or on family members for transport to take them to, for instance, general practitioner appointments or shopping.

The informants were grouped into four general categories on the basis of their self-reported employment patterns and financial status, these being “paid employee”, “housewife”, “retired”, or “volunteer”. Three informants fell into the category “paid employee” (still working), three were “housewives”, fourteen “retired”, and two fell into the “volunteer” category, since they were occupied in voluntary work. Most had retired after migrating to Australia. Their range of income was from A$150 to A$1,000 per week. The main sources of income were family, pensions and bank savings or investment accounts. However, many of the informants were reluctant to disclose the specifics of their financial situation. With respect to SES, eight informants (four males and four females) reported themselves as falling into a low SES category, nine (three males and six females) as mid-SES, while two males reported themselves as being in the mid-low SES category. Three male informants did not have any ideas about which SES category they fell into, and no one reported they were at the high SES level.

The minimum length of stay in Australia was two years and the maximum was 21 (See Table 5.1). Two informants (Mrs Leung and Mr Yan) had migrated from mainland China to Hong Kong only two years before migrating to Australia. The ages when they first came to Australia ranged from 40 to 79. However, the frequency with which informants visited Hong Kong was important in identifying the influence of cultural factors on their attitudes to and engagement in PA/Ex. Ten out of 22 informants visited their family in Hong Kong every year or every few years.
Among those who had visited Hong Kong after migration, six had stayed there for over six months and up to four years for one of their visits. One female informant had migrated 12 years previously but had only spent around four to five years in Australia. Another two informants (Mrs Su and Mrs Ho) had only been in Australia for around two and a half years. They planned to travel between Hong Kong or mainland China and Australia after obtaining Australian citizenship. Therefore their actual total years of living in Australia were less than their length of stay.

### Table 5.1: Length of Stay and Frequency of Visits to Hong Kong

<table>
<thead>
<tr>
<th>Informant's No.</th>
<th>Name</th>
<th>Age when first came to Australia</th>
<th>Length of stay in years</th>
<th>Number of visits to Hong Kong</th>
<th>Actual total years living in Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mrs Su</td>
<td>66</td>
<td>3</td>
<td>Every year</td>
<td>2.5</td>
</tr>
<tr>
<td>2</td>
<td>Mrs Yiu</td>
<td>49</td>
<td>12</td>
<td>Every year</td>
<td>4.5</td>
</tr>
<tr>
<td>3</td>
<td>Mrs Leung</td>
<td>54</td>
<td>11</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>4</td>
<td>Mr Bek</td>
<td>62</td>
<td>10</td>
<td>3</td>
<td>8.5</td>
</tr>
<tr>
<td>5</td>
<td>Mrs Lim</td>
<td>64</td>
<td>19</td>
<td>0</td>
<td>19</td>
</tr>
<tr>
<td>6</td>
<td>Mrs Lai</td>
<td>79</td>
<td>12</td>
<td>Every year</td>
<td>10</td>
</tr>
<tr>
<td>7</td>
<td>Mr Koo</td>
<td>63</td>
<td>17</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>8</td>
<td>Mr Lee</td>
<td>70</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td>Mr Chin</td>
<td>45</td>
<td>15</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>10</td>
<td>Mr Wai</td>
<td>67</td>
<td>6</td>
<td>1</td>
<td>5.5</td>
</tr>
<tr>
<td>11</td>
<td>Mr Law</td>
<td>72</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>12</td>
<td>Mrs Siu</td>
<td>57</td>
<td>19.5</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td>13</td>
<td>Mr Mok</td>
<td>42</td>
<td>21</td>
<td>1</td>
<td>19.5</td>
</tr>
<tr>
<td>14</td>
<td>Mr Chung</td>
<td>56</td>
<td>15</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>15</td>
<td>Mr Yiu</td>
<td>64</td>
<td>10</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>16</td>
<td>Mr Yan</td>
<td>65</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>17</td>
<td>Mrs Yuen</td>
<td>61</td>
<td>10.5</td>
<td>0</td>
<td>10.5</td>
</tr>
<tr>
<td>18</td>
<td>Mrs Mo</td>
<td>40</td>
<td>19.5</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>19</td>
<td>Mr Wan</td>
<td>55</td>
<td>9</td>
<td>Every year</td>
<td>8</td>
</tr>
<tr>
<td>20</td>
<td>Mrs Chiu</td>
<td>62</td>
<td>10</td>
<td>1</td>
<td>9.5</td>
</tr>
<tr>
<td>21</td>
<td>Mrs Ho</td>
<td>57</td>
<td>3</td>
<td>Every year</td>
<td>2.5</td>
</tr>
<tr>
<td>22</td>
<td>Mr Lau</td>
<td>49</td>
<td>16</td>
<td>4</td>
<td>15</td>
</tr>
</tbody>
</table>

Sixteen informants (eight males and eight females) were classified as “very Chinese” and only six informants (four males and two females) were “Chinese-like”. No informant was classified as “Australianised”. When informants were asked to classify themselves ethnically, all referred to themselves as “Chinese” and “Hongkongese” or  hêng’ gong’ yen’. Mrs Mo, 60, (18) stated:
I don't know how the other hèng1 gong2 yen4 think. Although I migrated to Australia a long time ago, I will never forget that I am Chinese. This is a fact and no one can change it.

**Perceived physical condition**

Most informants in Australia rated their health as “so-so” (six males and eight females) while four males saw their health as “good” or “very good”. Two male and two female informants reported their health as “not good” or “poor”. The majority of the informants reported that they had current health problems, but three male informants reported no current health problems. Arthritis, “bone pain” or fung1 seb1 was the most common problem reported by the informants (three males and five females) and hypertension was the second (four males and three females). Other conditions include diabetes, high blood cholesterol, heart disease, minor stroke, prostate problems, back injury and indigestion.

Three variant forms of mou4 bèng6 (health problems) were used most frequently by informants to describe the degrees of seriousness of a condition, these being xiù2 mou4 bèng6 (a small problem), dai6 bèng6 (big problems) and lou5 yen4 bèng6 (the problems of old age). The leading xiù2 mou4 bèng6 (small problems) were headaches, flu and sore throats. Mostly these were dismissed as not worth worrying about: “It doesn't bother me”, “I can handle it” or “No need to see a GP”. Loss of sleep and indigestion were also common xiù2 mou4 bèng6 reported. Many informants thought that dai6 bèng6 (big problems) as being those that might need immediate hospitalisation or which were life-threatening, such as stroke, heart disease, stomach cancer. Lou5 yen4 bèng6 (the problems of old age) denoted chronic conditions which forced people to seek regular medical attention but were not immediately life-threatening. These included arthritis, high blood cholesterol and hypertension. The use of the terms dai6 bèng6 and lou5 yen4 bèng6 varied somewhat from individual to individual. For instance, some informants treated hypertension as dai6 bèng6 while others saw it merely as a lou5 yen4 bèng6.
**Participation in social activity**

Twelve informants stated that they were “socially active” or “so-so” (seven males and five females), while ten informants stated they were “inactive” (five males and five females). Almost half (n=10) stated that they were “socially inactive”, attributing this to being “not sociable and talkative”. Fifteen informants reported that they engaged in social activity between at least once a month to every day. Seven informants reported having “no”, “little” or “irregular” social activity. However, some had their own interpretation of “social activity” and what it meant to be “socially active”. In the words of Mr Wan, 64, (19):

If social life or social activity means casual chatting, having dinner and fun with friends, I can tell you, I seldom have social activity. Even when I go out three to four times a week; I am not “socially active” because visiting church brothers and sisters is only my job, my duty. I don't have any close friends because I am a church pastor, so I have a lot of restrictions.

**Participation in physical activity**

Among the 22 informants, thirteen reported they engaged in physical activity for at least 30 minutes a day and five or more times a week, while seven informants reported themselves to have “no”, or “little” physical activity. Three informants reported “irregular” physical activity. However, twelve informants categorised themselves as “physically active” or just “so-so”. Nine informants categorised themselves as physically inactive while one categorised himself as totally inactive. Nine of the twelve physically active or “so-so” were male. Seven out of ten of the physically inactive were female.

Similar to their interpretation of “social activity”, the findings revealed that the informants also had their own definitions of what it meant to be “physically active”. They did not merely define “physically active” in terms of the time spent and the number
of days participating in physical activity, but also in the light of performance awards obtained and their contributions to the society. Some of their comments were:

I am not active. Those physically active people are very keen on competition or performance. They sometimes lead the exercise class, it's like an exercise leader. I don't have time to do it. (Mr Yan, 67) (16)

They like exercise very much. They don't only exercise every day, they also encourage people to join exercise courses. (Mrs Yiu, 61) (2)

5.2 Concepts of physical activity and exercise: Is it Tai Nung Wood Dung or Yen Tai Woot Dung?

Informants had their own interpretations and concepts of physical activity, which strongly influenced their participation in physical activity. As the study aims to report the perspectives of informants and some informants used the terms physical activity (PA) and exercise (Ex) interchangeably, the acronym PA/Ex will be used from this point onwards.

The majority (13 informants) thought “physical activity means exercise”. Six informants stated that “physical activity is different from exercise” and three of the informants said, “I do not know what physical activity is”. These varying opinions were spread between self-reported higher and lower levels of PA/Ex participants. In addition, they believed either that physical activity had more health benefits than exercise or that the complete opposite was true. Thus it is clear that this group lacked uniform information about clear definitions of physical activity.

Informants who viewed physical activity as the same as exercise interpreted physical activity as irregular and unplanned body movement. Physical activity contains a broad interpretation of the meaning of exercise as being whatever improved physical function and was beneficial to health. Housework, gardening, heavy lifting, walking, and
shopping, *tai chi* and *qi gong* were the examples they gave. However, 72-year-old Mrs Yuen (17) excluded vacuuming as physical activity because she thought, “this repeated movement may cause back pain”. Similarly, while most of the informants agreed that shopping was a kind of physical activity, Mr Wan, 64, commented,

> Shopping is not physical activity or exercise, but is a kind of labouring, since I have to use my brain to think what I should buy and I am not totally relaxed. (19)

Informants who thought that physical activity was different from exercise had different bases for their beliefs. Some thought that physical activity consisted simply of “body movement in daily living”, so they did not see physical activity as being beneficial to health. They believed that exercise was more beneficial than mere physical activity because they could do it according to their own physical ability. In contrast, Mr Chin, 60, (9) believed,

> Physical activity is comparatively healthier than exercise because physical activity is like a game, it is relaxing and easily accepted. Exercise means spending maximum physical energy to achieve personal targets and people need to learn the skills of ball games or running beforehand.

This comment reflects the belief in the need for low stress and easily accommodated activity. More importantly, this group had different understandings about physical activity, since that can be commonly translated into two different Cantonese phrases: *Tai² Nang⁴ Woot⁶ Dung⁶* (strength-enhancing activities) and *Yen⁴ Tai² Woot⁶ Dung⁶* (human body movement). To Mr Law, a 74-year-old practitioner who loved his physical activity (11), *Yen⁴ Tai² Woot⁶ Dung⁶* (human body movement) meant “stretching exercises, cooking or even washing your face”. However, if physical activity was translated as *Tai² Nang⁴ Woot⁶ Dung⁶* (strength-enhancing activities), it became “a kind of physical training” such as “heavy lifting”. Mr Yiu, 74, (15) also stated that *Tai² Nang⁴ Woot⁶ Dung⁶* meant “all activities performed by people, including social activity”.
It is important for health personnel to understand the distinction between these terms when they talk about PA/Ex or translate English terms into Chinese. The implications for health promotion interventions will be described in Chapter 7. Those informants who did not know what physical activity was, said things like: “I only know what exercise is”. To them, exercise meant running, jogging, walking, housework or in fact any body movement.

Most informants (n=20) thought that mild or moderate intensity PA/Ex was suitable for the people at their age. Some thought that “30 minutes was good enough for older people” while others thought “one hour was best”. As far as exercise frequency was concerned, some said “two to three days a week” and some “at least three to four days or more a week”. In sum, most of the informants thought that “it was good for health to do physical activity every day” because “doing exercise is like eating food or bird's nest3, you have to do it every day to get the benefits”.

**Advantages and disadvantages of physical activity**

While informants had different concepts of physical activity, all could list the advantages of PA/Ex, seeing it as an effective way to improve their physical, mental, and social health. For physical health, the majority believed that “getting moving” could keep the bones, joints and ligaments flexible as well as the figure. They also thought that PA/Ex could improve the metabolism and build up the body's resistance to disease. Mr Yan, 67, (16) believed,

Leading a good life means doing exercise. If you always exercise, you have longer life than the others. If you always exercise, it can strengthen your metabolism and improve the blood circulation. You will feel comfortable. Urination and bowel movements will be smooth. The digestive system will be normal.

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3 Bird's nest is a health-giving tonic made from the nourishment-rich gel secretions which occur in the nests of swifts (Kim Hing Food Industries Pty Ltd, 2003).
In a similar vein, Mr Wai, 73, (10) stated,

I am not afraid of “cold” and “hot”. Physical activity or exercise is helpful for illness prevention because if your body resistance is good, your body is good too. In the end bacteria cannot attack you. In fact, physical activity is a foil for disease and if you do it, you do not need to be afraid of anything abnormal.

Some informants (n=5) used similar metaphors to stress the importance of “getting moving”. Mr Koo, 80, (7) stated,

The body is like a machine. If you don't run it, it will break down. Whether a machine is operated by human being or by fuel, it will break down if you don't run it properly. Take a car as an example; a car will last longer if you can run the engine every morning. This theory also applies to human beings. That's why we need to exercise in the morning.

PA/Ex was also seen as contributing to mental or psychological health. Some informants (especially those reported themselves as physically active or “so-so”) believed that “exercise can increase perseverance”, “make a person feel full of stamina”, “feel fresh and energetic”, “prevent dementia and keep the mind sharp”. Informants also believed that the brain would function better because if they were not sick, people would have no cause for concern, In addition, participation in PA/Ex was perceived as a way to release bad emotions and stress which could cause illnesses. This feeling is reflected in the words of Mrs Yiu, 61:

If you can do each step of tai chi, you feel that you are younger and you have something to kill time. If you don’t exercise and only sit around at home, you will feel very bored. (2)

Mrs Mo, 60, felt that,

Doing exercise can make my life better in the future. I feel fresh and happy when I walk because I am, like, chatting with God. Sometimes, I think about words from the bible. I sing hymns in my heart. (18)

Two informants viewed PA/Ex as an avenue for social contact. They could make friends when they were doing exercise. However, they believed that it still depended on the individual’s personality and they did not treat it as their motive to perform PA/Ex. Only
four informants stated that physical activity had disadvantages such as being time consuming and getting sunburnt. Most of the informants thought that PA/Ex was harmless if people chose the appropriate type of PA/Ex according to their own physical condition.

**5.3 Attitudes towards participation in physical activity**

Although the informants defined physical activity in various ways, all (n=22) believed that participating in PA/Ex was an effective way of improving their health. However, in their attitudes towards physical activity, there are some divergent views between the informants who reported themselves as physically active or “so-so” and those who reported being inactive.

Seven informants who reported themselves as “physically active” or “so-so” believed that people will do PA/Ex spontaneously if they know it is good for health and it is important for them. They did not perform PA/Ex deliberately because it had already become part of their life. They had a sense of emptiness if they stopped participating in PA/Ex. They said, “doing PA/Ex is like eating food”, and “I feel uncomfortable and lack something if I’m not using energy”. Mr Law, 74, believed,

I can do exercise at any time and anywhere because of my willpower. Environment can't affect me, nothing can affect me. (11)

Another informant, Mr Wai, 73, took eating *yum cha* as an example. He said,

When you are used to do exercise, it will become your habit. It's like going to *yum cha*. Once you start going to *yum cha* every morning, your legs will walk to the Chinese restaurant spontaneously. (10)

Although all those who reported themselves to be physically inactive were aware that PA/Ex was good for health, they did not put this awareness into practice. Mr Wan, 64, said,
I know that exercise is good and many people have said so. I don't do it just because I don't want to and because I don't need it. I don't have any motivation. The reason is very simple. (19)

Many physically active or “so-so” informants had a positive attitude towards PA/Ex. Many of them pointed out that they did exercise as a habit. Perseverance supplied them with the motivation to maintain this habit. In contrast, some physically inactive informants had no intention of participating in PA/Ex. They gave different reasons or excuses. The attitudes towards physical activity noted by this group reflected their cultural and health beliefs in preventive health care. These reasons involve many intrinsic and extrinsic factors and will be explored in the next chapter.

5.4 Six states of PA/Ex participation and intention about PA/Ex

The data analysis described in Chapter 4 identified six states of PA/Ex. They were categorised as “Inactive”, “Irregular”, “Enforced Acceptance”, “Practical”, “Emerging” and “PA/Ex Supporter”. Summaries of six case studies that exemplify these states are described below. The full case studies are contained in Appendices 7a-v.

**Inactive: Mr Wan (19): “I will think about doing PA/Ex when my blood pressure can’t be controlled by drugs.”**

Summary: Mr Wan categorised himself as being physically inactive even though he currently walked every day to meet his wife when she finished work. However, he said he walked in order to reduce living expenses and to show his sense of responsibility. Although he accepted that health problems were unavoidable for older people, he did not have any intention of participating in PA/Ex because his blood pressure was still under control. He believed that he did not need PA/Ex now. If he was motivated, he would exercise at the level that could fulfil his physical needs.
**Irregular: Mrs Siu (12): “I don’t know how to sort out my worries and make PA/Ex as part of my life.”**

Summary: “Auntie Siu” suffered from arthritis. She knew that PA/Ex was good for health and arthritis, even though she did not do PA/Ex regularly. She was interested in joining an exercise class in Australia. However, she did not take action because of her introverted personality, her PA/Ex preferences, her worries about her husband, transportation, injury and language barriers. Therefore housework was her only PA/Ex.

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**Enforced acceptance: Mr Chin (9): “PA/Ex is important, but diet, social life, family, entertainment and friends are even more so.”**

Summary: Mr Chin was a lifeguard in Hong Kong when he was younger but he was not interested in continuing this service after migration because, he said, he was too lazy. Another reason was that he had experienced racial discrimination at the hands of colleagues and as a result had hurt his back. After these negative experiences, he lost interest in most things. He believed that diet, social life, family, entertainment and friends were more important than performing PA/Ex. Dosing himself with modified traditional Chinese medicine became his way of keeping healthy, while playing mahjong with friends kept him happy. One year after I first talked with him, he was motivated to do PA/Ex again by a bad cough, his friend's experience of poor health and his GP's advice.

---

**Practical: Mr Lau (22): “I admit that if my health was better, I would not be so enthusiastic about PA/Ex.”**

Summary: Mr Lau did not do regular PA/Ex when he was young. He believed that PA/Ex was good for health because he had experienced its benefits in the past while he saw PA/Ex merely as unpleasant and repetitive body movement. However, he admitted that as a practical person, he was keen on doing regular PA/Ex to keep healthy, especially when his health problems attacked him. He would always stop doing PA/Ex when he felt like it and pick it up again when he needed. When he felt well, Chinese traditional herbal soup was his substitute of regular PA/Ex. When he was feeling unwell, it was a signal for him to restart regular PA/Ex.
Emerging: Mrs Lai (6), “Knowing very well that no one can help me when my legs ache, I have determined not to give up this habit.”

Summary: Mrs Lai loved freedom and independence. She did not ask for longevity but hoped “to die in a comfortable way”. Leg pain, which was caused by the “wet” in her body, was her greatest concern. She ate snake meat and drank blood to demoisturise her body. She was not interested in tai chi or joining a Chinese association. Mrs Lai also followed her daughter’s advice, and exercised on the cobblestones in the laneway outside her room to massage her feet. She enjoyed performing PA/Ex alone because she could start and finish whenever she felt like it. Its benefits made her more determined not to give up this habit.

PA/Ex supporter: “Mr Law (11) stated, “I love doing PA/Ex. I would feel at a loss if I did not perform PA/Ex.”

Summary: Mr Law had loved doing exercise since he was young. He liked constantly moving his limbs and felt at a loss if he did not perform PA/Ex. He sometimes did tai chi and he sometimes walked. Although he stopped cycling and lifting dumbbells after migrating to Australia, he would do push-ups for an hour and would go for an hour’s walk every day. He exercised simply because he enjoyed it and for the sake of his health. He did not find PA/Ex to be a chore and believed that his determination to continue with it resulted from his state of mind.

5.5 The relationship between the six states of PA/Ex participation and intentions regarding PA/Ex

According to the findings and six extracted case studies cited earlier and in the Appendices, the main characteristics of each category of PA/Ex participation and the factors influencing intentions with regard to PA/Ex are typologised in the following table.
Table 5.2: A Typology of Behavioural Intentions with Regard to Participation in PA/Ex among Older Hong Kong Chinese people in Australia and in Hong Kong

Higher level of self-reported PA/Ex participant(s)

<table>
<thead>
<tr>
<th>6) PA/Exercise supporter</th>
<th>5) Emerging</th>
<th>4) Practical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular PA/Ex all long because</td>
<td>No regular PA/Ex when young because of some reasons</td>
<td>No regular PA/Ex when young because of some reasons</td>
</tr>
<tr>
<td>• Interest in PA/Ex since young</td>
<td>↓ Start regular PA/Ex when</td>
<td>↓ Start regular PA/Ex when</td>
</tr>
<tr>
<td>• Positive PA/Ex experience</td>
<td>• Experience old/health problem affecting daily life</td>
<td>• Know PA/Ex importance</td>
</tr>
<tr>
<td>• Know PA/Ex importance</td>
<td>• Positive PA/Ex experience</td>
<td>• Experience old/health problem affecting daily life</td>
</tr>
<tr>
<td>• Aware of the importance of self-care capability (try to delay the ageing process)</td>
<td>• PA/Ex importance</td>
<td>• Positive PA/Ex experience</td>
</tr>
<tr>
<td>• High ability of barrier solving</td>
<td>• Aware of the importance of self-care capability</td>
<td>• High ability of barrier solving</td>
</tr>
<tr>
<td>• PA is part of their life</td>
<td>• High ability of barrier solving</td>
<td>↓ intention/motivation to do PA/Ex when</td>
</tr>
<tr>
<td></td>
<td>• Keep doing regular PA/Ex</td>
<td>• Old/health problem under control</td>
</tr>
</tbody>
</table>

Influencing factors:

- Cultural factors ↔ Attitudes ↔ Perceived social support ↔ Perceived control over barriers
- Cultural factors ↔ Attitudes ↔ Perceived social support ↔ Perceived control over barriers

Lower level of self-reported PA/Ex participant(s)

- 1) Inactive
  - Regular PA/Ex in the past
  - ↓ intention/motivation to do PA/Ex after migration because of
  - Negative life experience due to environmental change
  - Lack of social support
  - Old/health problem not yet affect daily life
  - Use other alternatives to keep healthy
  - ↓ intention/motivation to do PA/Ex regularly with reinforcement of PA/Ex importance

- 2) Irregular
  - No regular PA/Ex when young because of some reasons
  - ↑ intention/motivation to do PA/Ex regularly when
  - ↑ intention/motivation to do PA/Ex when:
  - Know PA/Ex importance
  - Experience old/health problem affecting daily life
  - ↓ intention/motivation to do PA/Ex when:
  - Negative PA/Ex experience
  - Other reasons, e.g. Persistent signs/symptoms of health problem/ family commitment / social support

- 3) Enforced acceptance
  - Regular PA/Ex in the past
  - ↓ intention/motivation to do PA/Ex regularly when
  - Acceptance of old
  - Health problem is under control/not yet affect daily life
  - Negative PA/Ex experience
  - May ↑ intention/motivation to do PA/Ex regularly when needed e.g. old/health problem cannot be controlled
At the top and bottom of the table, physically active and inactive were originally used to describe the informants' physical activity levels. However, as discussed earlier, many informants had different meanings for the term “physically active”. Therefore even though some had met the criteria for being physically active, they reported themselves as physically inactive or *vice versa*. As a result the original dichotomy did not accurately reflect the level of physical activity; for instance, a few informants in the state of “Emerging” reported their participation in PA/Ex as “so-so” or even “inactive”.

As this table is based on informants' meanings when they referred to physical activity, the categorisation was changed from the terms “physically active” or “inactive” to “self-reported level of PA/Ex participation”. That term has been used to accurately reflect the informants' perceived physical activity levels rather than an arbitrary frequency scale that had little meaning to them. In this way, they could report the level of PA/Ex accurately based on their thinking. In other words, the terms “lower and higher level PA/Ex participants” replace the words “physically active or inactive”. Because it is simplistic to categorise informants' participation in PA/Ex simply as physically active or inactive, they have been placed in three subgroups, as follows:

**(a) Those with lower levels of PA/Ex participation**

*Inactive* – this informant had no motivation for doing regular PA/Ex because he was not experiencing any signs or symptoms of health problems, those associated with old age or having had positive PA/Ex experiences.

*Irregular* – while they undertook no regular PA/Ex when they were young because of family commitments or other reasons, they did develop a strong intentions to do PA/Ex but found they could not maintain it for various reasons such as health problems and lack of social support; and
Enforced acceptance – while these informants were physically active in the past, they had, for various reasons, lost any motivation to do PA/Ex after migration. An emphasis on the importance of PA/Ex might motivate them to participate in it.

(b) Those with higher levels of PA/Ex participation

Practical – these informants had no regular PA/Ex when they were young because of family commitments or for other reasons. While they had strong intentions of performing PA/Ex, this would only happen when they experienced signs and symptoms of health problems or of being old;

Emerging – they also did no regular PA/Ex when they were young but they began to engage in it after experiencing signs and symptoms of health problems or those associated with age or for other reasons; and

Physical activity/Exercise supporter – their active participation in PA/Ex since they were young, as well as other reasons, confirmed their determination to continue doing PA/Ex.

Four categories of interacting factors were found to shape these intentions at both levels.

- Cultural factors (cultural beliefs, health beliefs, concepts of age);
- Attitudes (age, health problems, concepts of physical activity, experience of physical activity, awareness of capacity for self-care, life experience, the importance they attached to physical activity, country of schooling, country of origin);
- Perceived social support (family, the health professional, society and friends); and
- Perceived control over barriers (gender, marital status, health problem, life experience, PA preference, environment, language barriers, transport problems, education level, length of stay, acculturation level, ability to overcome barriers).

5.6 The possible changes of the six states of PA/Ex participation

According to the TPB, an individual's perception of his/her control over the barriers to performing physical activity can be expected to have a direct effect on his/her actual
performance. Understanding this complexity of the data, linked with the TPB, helped in the creation of a typology of PA/Ex participation of this group. According to the identified intrinsic and extrinsic factors as well as the significant behavioural change in Mr Chin's case, the six states of PA/Ex participation can be further divided into three main groups based on the following assumptions.

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA/Ex supporter</td>
<td>Irregular (Mrs Siu)</td>
<td>Inactive (Mr Wan)</td>
</tr>
<tr>
<td>(Mr Law)</td>
<td>Practical (Mr Lau)</td>
<td></td>
</tr>
<tr>
<td>Enforced acceptance</td>
<td>Emerging (Mrs Lai)</td>
<td></td>
</tr>
<tr>
<td>(Mr Chin)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Group 1: The states of “PA/Ex supporter” and “Enforced acceptance”**

In Group 1, Mr Chin's intentions with regard to PA/Ex participation were determined by a range of factors, including negative life experiences, lack of social support, and also a lack of awareness of the importance of physical activity. His use of a mixture of Western and traditional Chinese medical remedies influenced his beliefs about the likelihood of PA/Ex resulting in beneficial health outcomes. Therefore laziness became his excuse. A bad cough, his friend's experience of poor health as well as his GP's advice reinforced his intention as far as PA/Ex participation was concerned. In other words, had Mr Chin maintained his regular PA/Ex and overcome the barriers, like Mr Law, he would have moved from the state of “Enforced Acceptance” to that of “PA supporter”. Mr Chin's case provides evidence of the possible relationship between the intrinsic and extrinsic factors and PA/Ex participation that has relevance for those in Groups 2 and 3.

**Group 2: The states of “Irregular”, “Practical” and “Emerging”**

Informants who were classified under Group 2, fell into three different categories of PA/Ex participation. As mentioned in Chapter 5, Mrs Siu, who was classified in the state of “Irregular”, reported she had low PA/Ex participation. Mr Lau, who was in the state of
“Practical”, reported high but irregular PA/Ex participation whereas Mrs Lai, who was in the state of “Emerging”, reported she had high and regular PA/Ex participation. If Mrs Siu's worries and health problems could have been brought under control, that might have increased her perceived control over her barriers to PA/Ex participation. Thus had she maintained regular PA/Ex, she might finally have shifted from the state of “Irregular” to the “Practical” or even “Emerging”. Clearly, perceived behavioural control is still an important predictor of this group's intentions and health behaviour. Understanding the effects of control beliefs on each facilitating or constraining condition could be useful when developing health promoting interventions. The findings in this study can help health promoters to designate a focus and target those specific cultural, social and environmental factors where control beliefs are most strongly associated with intentions or behaviour.

Similarly, health promoters need to design programs or strategies to change the practical concepts of people such as Mr Lau. If his attitudes towards PA/Ex could be altered, his intentions and his participation in PA/Ex would be constant as well. As a result his merely intermittent participation in PA/Ex which occurred only when he encountered health problems, could have become a daily routine. He would thus move to the state of “Emerging”. In contrast, if Mrs Lai, who was in the state of “Emerging”, failed to hold firmly to her intention to do regular PA/Ex due to intrinsic or extrinsic factors, she would move back to the state of “Practical” or “Irregular”. This indicated that the state of PA/Ex is not necessarily fixed. Its dynamic nature means that the factors that positively influence participation in PA/Ex need to be continuously reinforced.
**Group 3: The state of “Inactive”**

Mr Wan was in the “special” state of PA/Ex participation. His health beliefs and concepts of physical activity, together with his bad experience, weakened his intention to perform regular PA/Ex. He believed that nothing would motivate him to do PA/Ex until the advent of something such as dai⁶ beng⁶ (a major health problem). While he did not encounter any difficulties in performing regular PA/Ex, he claimed that his current PA/Ex participation involved fulfilling a traditional Chinese husband's responsibility. Thus he reported himself as totally inactive. His beliefs and evaluations of the positive outcomes of PA/Ex performance might have been greater if his awareness of his capacity for self-care and his susceptibility to health problems were aroused. He might begin walking regularly because he really believed performing PA/Ex was beneficial rather than doing it simply as a duty to his wife. In other words, the possibility was that he would move from the state of “Inactive” to the “Practical” or even the “Emerging”.

**5.7 Summary**

Twenty-two informants were recruited for this study, including 12 males and ten females. The average age was 75.5. The majority had poor English proficiency. The informants had low acculturation levels in Australia and frequently visited family in Hong Kong, resulting in shorter actual lengths of stay in Australia. The informants had their own, various interpretations of social activity and physical activity. While a few were entirely ignorant of the meaning of physical activity, the majority had their own specific interpretations of physical activity and exercise. Although there were divergent views on and attitudes towards physical activity, they all knew about its advantages for maintaining good health. Six extracted cases were selected to typify the six main states of PA/Ex participation from the data: these being “Inactive”; “Irregular”; “Enforced Acceptance”; “Practical”; “Emerging”; and “PA/Ex Supporter”. Cultural factors,
attitudes, perceived social support, and perceived control over barriers were among the intrinsic and extrinsic factors influencing their intentions with regard to participation in PA/Ex. These factors and their relationship with PA/Ex participation will be elaborated in Chapter 6.
CHAPTER 6: FINDINGS II

The three Chinese philosophies of Confucianism, Taoism, and Buddhism are of critical importance in the lives of older Hong Kong Chinese people. The study found that their cultural beliefs led them to maintain specific health practices and preventive health behaviours. The previous chapter described the sociodemographic details of the informants, their patterns and concepts of physical activity, the relationship between six states of PA/Ex and intentions regarding PA/Ex among this group. This chapter examines the cultural, social, physical and environmental factors influencing their preventive health behaviour, using participation in physical activity as a specific example.

6.1 Three Chinese philosophies

As appears from previous research (Crain, 1997; Ma, 1999b; Pyong, 1995), the older Hong Kong Chinese people involved in this study, preserved the core of Chinese traditions and these formed the backbone of their cultural perceptions. The main differences which developed between them and people in Hong Kong appeared to be due to environmental change and as described in the previous chapter, various intrinsic and extrinsic factors influenced this group’s participation in physical activity. The factors described interacted with each other. Before examining that, cultural beliefs influencing the preventive health behaviour of older Hong Kong Chinese people will be discussed.
**Attitude towards life:**

“Birth, ageing, illness and death” (saang¹ lou⁵ bêng⁶ sei²) is a natural process of life. (Mrs Lai, aged 91)

All but one informant felt they could adapt to life in Australia. Their commonly stated belief that “birth, ageing, illness and death” were the natural fate of all human beings may seem to be trite and obvious; however, the way some informants (n=14) held it imbued them with a sense of fatalistic resignation about the course of their lives. These individuals viewed themselves as part of the natural and material world and were thus subject to the same inexorable cycles of birth and death as all other living things. They saw no sense in trying to change the processes of ageing by engaging in PA/Ex.

In significant contrast, those who had higher levels of PA/Ex demonstrated very positive attitudes to this natural lifecycle. Their responses closely connected with their concept of health. Mr Koo, 80, (7) explained this attitude:

> Birth, ageing, illness, death (saang¹ lou⁵ bêng⁶ sei²) is a normal lifecycle, but you don't need to be pessimistic. Even when I get older, I will try my best to maintain my normal life. Of course, you shouldn't compete with other people and show that you are the number one. Just try your best to do everything you can. You can't be too stubborn.

It is also clear that some informants (n=7) were pursuing not longevity but quality of life. Mrs Lai, 91, (6) expressed this view when she said:

> I don't worry. Having one day, living for one day. I don't expect to have a long life. What for? Eating is the most important thing for me. I buy what I like to eat. I like to buy abalone and dried fish tummy. It's also good if my arms and legs don't hurt. Now, I just hope that I have a good death. It would be great to eat until I was full, go to bed and eventually die when I was sleeping. If that came true, I would be very lucky.

However, four informants had integrated this belief with the modern perception that the human body was like a machine and that sooner or later it would wear out. Sixty-year-old Mr Chin demonstrated this belief with this metaphor:
Birth, ageing, illness and death (saang lou béng sei) is a normal process of life. I try to keep myself healthy. If I have any health problems, it is irreversible. Just like a pot and a wok. You cannot use them forever. You will discard them in the rubbish bin one day. (9)

Although Mr Chin and the other informants did not see the structure of the human body as a machine, they believed that nothing could prevent people from getting ill or delaying their eventual death. His negative attitude towards life also reflected his concept of age. Informants sharing such beliefs were usually those who had low levels of PA/Ex participation or had been suffering from multiple chronic health problems for a long period of time. In contrast, the informants who had higher levels of PA/Ex participation believed that “A knife has to be sharpened from time to time to keep it sharp (n=3), or it would rust” and “Life is like a curtain, you need pull it around frequently to keep it smooth”. This belief motivated them to perform regular PA/Ex.

**The concept of age:**

This study demonstrates that the concepts of age or those who are “older people” are not easily definable. This confirms that the definition of old age is to some extent culturally determined. Some informants defined age by measuring years, others assessed it by the state of the individual's physical health or their appearance as well as their capacity to continue fulfilling their social roles. Importantly, these perceptions strongly influenced their health beliefs and preventive health behaviour.

One hundred years old is “old old”, 90 years old is also “old old”. Eighty years old is “old” and so is 70 years “old”. (Mr Yiu, 74)

In their responses to the question of “What does being old mean to you”, some informants defined old by chronological age. Mr Bek, 72, (4) stated:

In Australia, 65 years old is already a stage at which people call you older people or seniors. According to our life development, people have already been classified by different stages.
However, seventy-five-year-old Mr Lee (8) indicated the problem of chronological definitions:

> Take me as an example. No matter how healthy I am, I have to be regarded as old … As the Chinese saying has it, “very rarely can a person reach 70 years old”. But I think we need to consider all factors. Some people in their 50s or 60s look very old whereas some people in their 80s do not feel themselves old.

Their responses reflect the societal stereotype of older people. Indeed, some informants in this study considered themselves to be old not only in terms of a chronological definition, but also because of the state of their physical, mental and social functioning.

*Ageing can cause a hundred health problems, your eyes are blurred, your ears are deaf.* (Mrs Yiu, 61)

As mentioned earlier, the majority of the informants reported having current health problems, and they spontaneously made a direct link between these and ageing. That is, the informants saw discomfort and chronic pain as part of and parallel to the ageing process.

Mr Bek, 72, (4), was a higher level PA/Ex participant. The first time I asked him about his health, he replied, “It is good”. Later, when asked what kind of health problems he has, he said, “I do not have any *dat⁶ bêng⁶* (big problems) yet”. Then in a discussion about what being old means to him, he said,

> Getting old is like this, having a lot of health problems. They are *lou⁶ yen⁴ bêng⁶* (problems of old age). It's unavoidable. I really believe it.

He believed that his health was bound to deteriorate with age and that declining physical fitness was also an indicator of ageing. “I feel that my physical fitness is decreasing every five years”. There was a sense of inevitability about ageing and the body’s deterioration. For example, 67-year-old Mr Yan (16), with no reported health problems said: “Getting old, getting worse. It is the rule”. Whereas Mrs Mo, 60, who suffered from
hypertension and thyroid problems, said: “Psychologically, I am not very old but my body tells me that I am walking the road of ageing” (18). That statement illustrates the sense that ageing is a journey to be endured.

Interestingly, the first sign for many informants (n=10) that they were becoming old was the deterioration of their digestive systems. Mrs Siu, 77, (12) who suffered from hypertension and bone pain (*fung' seb'* ) said,

> When I was young, I could eat more because I could digest the food well. Since getting old, I can no longer digest food if I eat too much.

Furthermore, some informants mentioned that as they became older, their memory was likely to deteriorate gradually and their responses would be slow. More than half the informants tended to restrict their PA/Ex or avoid learning anything new because they felt that they were old. Eighty-year-old Mr Koo for example said: “I can't learn English because I am too old and I don't want to think so much” (7). Health problems such as these had an important influence on informants' motivations for participating in PA/Ex.

> You are old when you have a hunch back and a lot of wrinkles on your face. (*Mrs Su, 69*)

Apart from physical and mental deterioration, being old was defined by changes in appearance. Some informants (n=8) felt that that implied a sense of sadness. Mr Wai, 73, (10) stated,

> Since becoming old, I no longer have any energy and passion. I also have so many wrinkles on my face. They represent the sad experiences in my life. They are the marks of sadness. I am so old, I look very ugly.

This reflects a general negative self-image of some informants resulting from what they saw as their “ugly old face”. Others accepted grey hair as a normal physical sign of old age. Their negative self-image had the potential to hinder the informants from attempting to expand their social circle and seeking social support within the wider society.
**I should seclude myself and not meet anyone. (Mrs Siu, 77)**

Many informants (n=10) were not interested in anything but staying at home or preferred a minimal social life. Their resigned attitudes about avoiding an active life were captured in the words of two of my informants.

Dealing or coping with older people gives rise to complicated thoughts. At my age, I should hide myself. I need to live a secluded existence and not meet anyone. (Mr Wai, 73) (10)

I don't like to have too a busy social life in the church. I prefer a simple social life because I need a lot of energy to deal with human relationships. That is enough for me now. (Mrs Mo, 60) (18)

Only a few informants (n=4) claimed that they continued to have regular contact with their friends and intended to make new friends in Australia. On this score, it is significant that those with higher levels of PA/Ex participation were more willing to develop their social life in Australia. Mr Bek, 72, (4) claimed,

I can make friends anywhere. If people don't know something, I will try to tell them. For example, I have to look after you when I go shopping if I know more English than you do.

**If you can still work, you are not old. (Mrs Yuen, 72)**

Another perception of what it means to be old related to work and retirement. Informants thought they were ready for retirement when they lost their working ability or earning capacity because that made them financially and socially dependent. As Mrs Lai (6), a 91-year-old pensioner stated,

How can I work now? Sometimes, when I go out, some people ask, “Do you want to take care of little kids [for money]?” Yes, I do. But I'm too old for that kind of work. I also need someone to take care of me. Now, I can’t squat. Even when there is money on the floor, I can’t pick it up. I feel bored, very bored. I want to work but no one will employ me. If I was young, I could find a job as a housemaid, I could help people to look after their houses. I am still capable of earning. But who will employ me now?
Although some informants had lost their ability to work, to show their independence they preferred spending money from government sources or their own savings rather than their children's money even when it was available. Mr Bek, 72, (4) claimed,

I seldom spend my children's money. My character is very strange. If they give me money, I won't accept it. My wife doesn't agree with me. She thinks that I should take the money. She is a bit traditional-minded but I am open-minded. I would feel obliged to them or become reliant on them if I took their money.

6.2 Health beliefs and preventive health behaviour

Linked to their concept of being aged was the claim that their new environment in Australia made them feel old. Mrs Siu, 77, (12) stated,

I felt I got older after I came to Australia. That was because of all the procedures I had to undergo when I applied to stay here, such as physical checkups and many other things.

As described in Chapter 2, definitions of what constitutes “health” and “illness” vary between individuals, cultural groups and social classes. Under the influence of Taoism, as well as the practice of Western medicine, Hong Kong Chinese had their specific health beliefs and practices (Ho, 1985; Koo, 1987; Tang, 1998; Yau, 2003e). The study also revealed there was a strong tendency among informants to maintain their health beliefs and preventive health behaviour after arriving in Australia, rather than modifying these to suit their new environment. This was particularly evident in relation to the impact of the new cultural context in their explanations of physiological functioning as described in the following paragraph.

*If I can eat well, walk well and sleep well, I am healthy. (Mrs Su, 69)*

The 22 informants shared similar ideas on “being healthy”. They believed that physical independence, freedom from illness, from pain and medication, as well as having stamina denoted being “healthy”. The majority (n=18) tended to equate “being healthy”
mainly with physical independence; only a few saw social, psychological or mental aspects \( (n=4) \) as being relevant in this regard. Some informants also believed that being able to eat what they wanted, and sleep without interruption as important indicators of good health. They considered the opposite to be the first signs of being old and getting sick, as exemplified in the following statements:

It is healthy if people do not have any illnesses or pain, and do not need to take any medication. Being too fat is not good either. (Mrs Leung, 65) (3)

If you can manage your daily activities such as washing and hanging out clothes, cleaning the house, shopping or cleaning the gutter, I think you should be called healthy. If not, how can you be healthy? (comment from 72-year-old Mr Bek) (4)

A person who can relax, sleep well and has stamina is healthy. (Mr Lee, 75) (8)

In other words, illness, pain and medication, physical dependence, as well as lack of stamina, meant the opposite of being healthy for the informants. There were three explanations of physiological function among informants. These could be classified as (1) Western or “modern” explanations, (2) Chinese traditional explanations, and (3) fatalistic explanations. Some informants exhibited a mixture of ideas about health, while some focused on Western or traditional ways. Figure 6.1 shows the various explanations of physiological functioning.
Chinese traditional explanation: Balance of yin/yang

Western/modern explanation: Good blood circulation

Fatalistic explanation: Innate

Being healthy:
- Free of illness/pain/medicine
- Physically independent
- Full of stamina

- Improve oxygen supply to the whole body
- Increased metabolism strengthens body resistance to bacteria
- Induce sweating & eliminate accumulated waste products
- Improve muscle development & flexibility, resulting in illness and injury prevention
- Without illnesses, people feel happy and have stable emotion

- Nutritional qi nourishes the body and promotes the functional metabolic activities of internal organs & tissues
- Qi (from air) nourishes heart and lungs & promotes the function of dominating blood, vessels, and respiration
- Stable emotion maintains body energy equilibrium & prevent illness
- Harmony with nature maintains health and prevent illness

- A person's fate to have good or bad health
- Depends on luck
- It was not under control

Figure 6.1: Explanations of Physiological Function
First, the majority of informants resident in Australia, especially those who had been educated in Hong Kong (n=12), believed that good blood circulation could improve the supply of oxygen to the whole body. Good circulation resulted in increased metabolism, which could strengthen resistance to bacteria. At the same time, an increased metabolic rate induced sweating, which improved the elimination of accumulated waste products from the body. In addition, good circulation could help muscle development and flexibility, resulting in illness- and injury-prevention. Without illness, people had less pain and worry and that would make them happy and emotionally stable. All such factors eventually made people healthy. This explanation corresponded to their concept of health, Mr Yan, 67, (16) summed up this explanation of health when he said:

Your blood needs to circulate. If you always sit and don't move, your blood circulation will be insufficient. Your body needs blood to supply oxygen, so you need fresh air as well. I believe rheumatism is also the result of the accumulation of waste matter due to lack of movement and poor blood circulation. It's important to keep your blood flowing well in your body. It's conducive to your appetite and a healthy metabolism. If you are healthy, your body is strong enough to resist bacteria.

The Chinese traditional explanation came from those who had been educated or had stayed in mainland China for a longer period of time (n=5). They were more likely to provide an explanation based on physiological functioning, derived from the theory of yin/yang and the five elements. They saw energy – qi – as the source of life and matter, the material manifestation of energy. They believed that nutritional qi, which is extracted from daily food, nourishes the body and promotes the functional metabolic activities of internal organs and tissues. Qi, which is derived from the air one breathes, nourishes the heart and lungs and promotes the function of the blood, vessels, and respiration.

Mr Koo (7), an 80-year-old educated in China with a strong interest in traditional Chinese medicine described this as follows:
Qi means your blood flows freely, and comes from fresh air you breathe and the food you eat. We need to train the qi. If we can keep the qi flowing freely and steadily in our bodies, we will have a good physique and fewer illnesses.

In a similar vein, 77-year old Mrs Siu's comment included the environment:

People living in Australia are healthier than those living in Hong Kong because the weather in Australia is not as humid as in Hong Kong. It's not so easy to get “wind and wet” (fung seb) here. Some people said that their “wind and wet” healed after moving to Australia. (12)

Another explanation of physiological functioning had a fatalistic orientation. Those who advanced this idea (n=6), believed that “being healthy” or “being unhealthy” was innate; while some were born with good health, others experienced much illness. In other words, each individual was fated to have good or bad health. Such belief is well captured in the words of 91-year-old Mrs Lai (6) who could not read or write. “Good health means good luck. Health is similar to wealth”. The conversation with Mrs Lai showed that she believed that “being healthy” was not under an individual's control and that people simply had to accept it as their lot. Just as these informants' concept of age affected their health-maintenance behaviour, so their concept of health also strongly influenced their expectation of physical health and the manner in which they undertook preventive health behaviour.

It was evident from the informants' responses that their detailed lore concerning health and illness was influenced by both Western and traditional Chinese medicine. This reflects the fact that the duality of Western and Chinese cultures which they experienced in Hong Kong was reinforced by their experience of living in Australia. This duality strongly influenced the preventive health behaviour among this study group, as exemplified by their participation or non-participation in PA/Ex. As previously described in Chapter 5, some informants appeared not to have a positive attitude towards physical activity, even though some recognised the advantages of PA/Ex and its role as a key
component for health maintenance. Mr Wai, 73, (10) said that he jogs every morning “because I am getting old. Actually, I should have died this year but jogging has prolonged my life”. Another PA/Ex supporter emphasised a holistic approach rather than a sole focus on PA/Ex:

I do tai chi and qi gong every day because they are the most effective way of keeping healthy. I am very concerned about my diet and having enough rest as well. When I was young, I liked playing around. I drank and smoked but I quit all that 30 years ago. (Mr Lee, 75) (8)

Conversely, the informants who reported lower levels of PA/Ex participation were likely to rank diet or other components above PA/Ex as the most important element of health maintenance. Sixty-year-old Mr Chin (9), who saw himself as being in a state of “Enforced Acceptance”, demonstrated this:

Of course, PA/Ex is good for health. But in general, eight out of ten people do not think about doing PA/Ex. Diet has a greater effect on health compared to PA/Ex.

The beliefs of this group of Hong Kong Chinese about health maintenance were strongly interwoven with the fabric of daily life. This is particularly evident in the way that health beliefs were interrelated with their dietary practice. Food remedies were considered to be a “natural” way to keep healthy. Food is therefore a very important element of their Chinese culture, not only for social reasons but also because of its perceived effect on physical, psychological and mental wellbeing. All informants subscribed to the theory of yin/yang but also applied Western ideas in their dietary beliefs and practices. They were very concerned about their diet because they believed, “many diseases come from what one eats”. This belief also strongly influenced motivation to participate in PA/Ex.

Each informant had a rich variety of food remedies at their disposal. Simple, diverse, low-fat and nutritious foods were viewed as healthy. Informants usually ate fruit, vegetables and fish rather than chicken skin, internal organs or other high-cholesterol
food. Spicy or sour foods were also discouraged. Other tabooed foods included those from animals, especially beef, because of the concentration of fats and its association with the polluting effects of blood culture, which were believed to cause skin itchiness or inflammation. This belief is well captured in the following comments:

I don't eat too much greasy food. I seldom eat fat. *Yum Cha* is really bad. I only add a bit more oil when I steam fish. Eating more Vitamin C or orange can prevent flu. Taking some calcium is good for the bones. At our age, the bones are very fragile. (Mr Lau, 65) (22)

Abalone, ginseng, shark fin or *yin* wo [bird's nest] may be very expensive but are worth the cost. However, it is not good to eat these foods every day. My sister died from eating too much tonic food. (Mr Chin, 60) (9)

Drinking a lot of water was considered as being very important for good health. In the words of 74-year-old Mr Yiu:

Water can clear impurities in the body. Water seeps into the blood and goes to the bladder and then the impurities are expelled from the body. Water can wash the inner parts of the body. It is similar to washing a ditch. (15)

In addition, based on the principle of “like helps like” or “poison treats poison” (Koo, 1987), some informants used different dietary methods to treat or to alleviate their particular health problems. Their practices varied from individual to individual. Mrs Lai, 91, (6) with “wind and wet” recounted this dietary practice:

I have had pain in my legs for many years, caused by *fung* seb [arthritis]. When I visit Hong Kong I eat snake and drink its blood to excrete the “wet”. I'm not sure whether my leg pain gets better or not but my friend, a GP who is expert in treating strange and special illnesses, told me that it's good to eat snake for “wet”. Why would I eat it if it is not good?

Some informants (n=6) pointed out that people from different parts of mainland China or other countries have different health status because of their different SES and cultural backgrounds. For instance, some of my informants believed people from mainland China were comparatively poorer than people from Hong Kong. However, my informants saw no link between low SES and poor health. Mr Chin, 60, (9) explained,
The poor people have a very plain diet. The rich people have a very rich and heavy diet. Sometimes, when I go out with Vietnamese friends, I see that they don’t have much knowledge about eating good food and their educational level is low as well, but their lives are longer compared with Cantonese people or other Asians … What they eat is non-greasy or non-fried food, while Cantonese people eat too much greasy or tonic food.

According to the findings, the informants' belief in TCM also reflected their specific health-seeking behaviour in Australia. In the words of Mr Chin (who suffers from hypertension and back injury):

If you lack energy, you will feel better after taking Chinese medicine. Taking Chinese herbs is mainly for health maintenance. I believe in both of them [Western and Chinese medicine]. If I have severe flu or acute illnesses, I get well soon if I see a GP immediately. But after getting well, my body is still very weak. Chinese medicine can help to nourish the qi and regulate my body. It works slowly but effectively. I also take Chinese herbs for preventing the development of a bone spur. Chinese herbs can treat it but the effect is slow. In addition, the one that I am taking now [semen cuscutae] can strengthen the heart and clear the blood vessels. I take these Chinese herbs because they can prevent the hardening and blockage of blood vessels.

Mr Koo, 80, who complained of mild indigestion, said,

According to Chinese medicine, our body can be divided into five zong and six fu. They include heart, liver, spleen, lung, and kidney. People can nourish different parts of the body depending on their needs. Western medicine does not have such a theory and can only offer vitamin tablets as a supplement. (7)

However, the research found that TCM was a very ambiguous and controversial term for some informants. When they were asked whether they subscribed to the use of TCM or the theory of yin/yang, their responses were similar those of 65-year-old Mr Lau (22):

I don't know what yin/yang is and I seldom see a Chinese herbalist for my health problems. But my wife always makes Chinese herbal soup for me to nourish the body or treat excessive “hot”. Is this Chinese medicine?

Although some informants were confused by the term TCM, most of them made use of Chinese herbal soup to maintain the body in harmony with the environment. Moreover, TCM and traditional food remedies have been retained and are forms of self-care among this group of older Hong Kong Chinese people.
In addition, some informants (n=9) experienced *siu mou bèng* (small problems) such as indigestion, high blood pressure, and poor quality of sleep. They believed that emotional experiences like sadness or worry disturb body energy equilibrium, and because they saw unstable emotions as the cause of illnesses, they tried to avoid extreme changes of emotion. Being “open-hearted” and “making fewer demands on the family” were their remedies. They always emphasised that “a person should remain relaxed and should not be nervous or concerned about anything” (Mr Lee, 75) (8). He maintained that in order to maintain good health,

> Your emotions must be stable, and you shouldn't be nervous or angry. Your heart must be quiet without many worries. At this age, we can’t bear any stimulus. If you don't do anything about it, some of the illnesses will be recurrent, such as heart disease … It [worries or anger] affects the *qi*. For a couple, if the husband dies, the wife will also die soon afterwards because of the heart [emotional] problems. When she feels nervous, she will feel pain in her heart. The heart is connected to the lungs. After experiencing this kind of pain, she will die.

Another strategy for health maintenance was having regular physical checkups. As mentioned in Chapter 3, the Australian government provides free health care services for all residents and most of the health services are easily accessible. This encouraged informants to have regular physical checkups and to take advantage of other available health services. Mr Chung, 71, (14) who has been in Australia for 15 years, stated,

> It's free. Why not have a checkup? Why be stupid? The Australian Government pays for it. The Government can afford it more than you can.

In comparing the Australian with the Hong Kong health system, Mrs Siu, 77, (12) (who has been in Australia for more than 19 years) said,

> The social welfare and health care services in Australia are much better than those in Hong Kong. If you have a Medicare card, most of the services are free of charge. It's different in Hong Kong where you still need to pay something and you have to wait for a long time for treatment.

As mentioned earlier, the informants believed that having good stamina was essential for being healthy and was also the key to having a strong physique. According to the
findings, a healthy lifestyle was viewed as important for health maintenance. Inadequate sleep, smoking or alcohol consumption deleteriously affected an individual's stamina and eventually caused illness.

Having enough sleep and fresh air is the most effective way of maintaining stamina. Drinking alcohol and smoking is not good for health. It harms your stamina. Poor stamina influences work performance and daily life, and as a result you can't be healthy or have longevity. (Mrs Chiu, 72) (20)

6.3 The interacting factors influencing attitudes towards PA/Ex

The findings of this study demonstrate that attitudes towards PA/Ex are influenced by the following concepts: age, health problems, concepts of physical activity, PA/Ex experience, the importance attached to PA/Ex, awareness of capacity for self-care, life experience, the influences of country of origin and country of schooling. These have been described previously. What is also important is their interaction.

The findings revealed that when informants felt that when they were old enough, they would start thinking about doing PA/Ex. Increasing age was an indicator for the informants that they should take increasing care of their health. This belief, which was strongly related to their concepts of age and of health, was also one of the key points influencing their attitudes towards PA/Ex, as is evident in the words of 64-year-old Mrs Mo, a housewife in the “Irregular” state:

I do exercise not only because of health problems but because of my age. If I don't do exercise when I can still manage, it will be very difficult to start when one day I can't manage. Now is the right time to be doing exercise. (18)

Although age was regarded as an indicator of the need to do regular PA/Ex, the findings showed that perception of susceptibility to illnesses was another main motivating factor. Some, especially those who reported lower levels of PA/Ex participation, linked health problems with age as a strong motivation for PA/Ex participation.
Indeed, most of my informants (n=15) were motivated to or intended to undertake regular PA/Ex to promote their health when/if they saw themselves as being susceptible to health problems. Otherwise, they did not see PA/Ex being a necessity. The informants would participate in PA/Ex only when they felt that it had an immediate relevance to their lives. Although some informants (n=3) did PA/Ex because they wanted to lose weight or keep fit, their underlying reason was to prevent the emergence of health problems and the physical inconvenience that might be caused by obesity. In the words of two higher level PA/Ex participants:

I have some friends – more than one – who are vegetables. It is very terrible. They have muscle wasting because they do not have any movement. PA/Ex is very important at our age. (Mr Bek, 72) (4)

We need to do PA/Ex at our age, or else we will become very fat. I don't like looking fat. Fat people look clumsy and they are unhealthy. People criticise you behind your back. When I find that my tummy is very big, I will do PA/Ex. When I put on weight or I am too full, I will do housework deliberately. I feel that that burns out the energy and I won’t be so fat. (Mrs Ho, 60) (21)

Regardless of whether informants were higher or lower levels of PA/Ex participants, they would perform PA/Ex in order to maintain health and prevent any physical deterioration. As detailed in Table 5.2, a perception of a deteriorating health condition was a barrier to participation in PA/Ex. However, at the same time, the informants were motivated to participate in PA/Ex because of what they saw as their potential susceptibility to illness. Such thinking reflects the contradictory relationship between their attitudes towards preventive health care and ageing (See Section 6.5).

Although informants' attitude towards PA/Ex could be motivated by their age and health problems, their personal experience of PA/Ex also strongly affected their impression of and perceived barriers to PA/Ex. Positive PA/Ex experiences encouraged the informants to start or maintain it, but negative experiences had the opposite effect. The findings of
this study demonstrate that the informants who reported higher levels of PA/Ex participation were more likely to have had positive experiences of PA/Ex in the past and that encouraged them to maintain it. Sixty-seven-year-old Mr Yan explained his good experience as follows:

Ten years ago, I underwent an operation for excision of the gall bladder. Probably because it was hard for the nurse to find a vein for intravenous therapy, the vein was damaged and blocked. But now, it is recovering because I do exercise every day. If you don't exercise, your health will get worse. Your blood circulation becomes poor, and causes poor metabolism and that causes poor digestive functioning which finally harms your body. (16)

In contrast, the informants with lower levels of PA/Ex were more likely to have had negative experiences, which counterbalanced any good experiences they may have had and Mr Law, aged 74 (11) expressed the view that:

Poor experience would reduce older people's motivation to do PA/Ex. But you will persist with doing PA/Ex when it gives you physical benefits. If it makes you feel better, why should you not do PA/Ex constantly? For me, the time flies if I do PA/Ex and I don't feel comfortable when I sit around doing nothing for long.

In comparison, 60-year-old Mrs Mo (18) said

When I was still young, I ran with my students. But my heart was very uncomfortable after running for a while, so I stopped doing PA/Ex. I tried walking in the street after I migrated to Australia, but I did not feel good because the pathway was on the main road and I breathed in a lot of polluted air. At the same time I did not want to deliberately go to the park just to do PA/Ex. Finally, I gave up.

Mr Wan (64) professed a dislike for swimming because, he said, “I have almost drowned twice at the beach”. (19)

The informants' awareness of their capacity to care for themselves resulted from their attitudes towards age and life. Some, especially those who had higher levels of PA/Ex participation, were more aware of the importance of having physical independence when they were old than those who had lower level of PA/Ex participation, and took action to
maintain their capacity to care for themselves as much as possible. They tried to avoid injury because they believed that no one would be able to help them and they did not want to be cared for by others. PA/Ex was one of the most common preventive health measures they employed. This awareness strongly influenced informants' intentions or motivations to undertake preventive health behaviour. This feeling is reflected in the following comments made by Mrs Lai, 91, (6):

No one can help me if my leg aches. I am old. If I want to carry a bag, I can ask you to do it for me. But if I feel pain in my legs, who can bear the pain for me? It's very difficult to move when my legs ache, but if I don't move them, they will be deadly stiff. When I have time, I move my legs even when I'm sitting. If it's raining heavily, I won't go out because who will sympathise with me if I fall? I have to take care of myself.

However, those who reported a lower level of PA/Ex did not exhibit this same strong awareness of self-care. Mrs Yuen, 72, said:

I don't know, I don't think too much. It's my children's responsibility to take care of me in the future. (17)

It was also found that the informants' awareness of their capacity to care for themselves could also be influenced by their personal life experiences, especially when they migrated to a new country and encountered different cultural, social and environmental conditions. According to the case study in Chapter 5, Section 5.4, Mr Chin's bad experience changed his attitude towards life and as a result he lost interest in most things, even his health. He said:

It's different after I came here [Australia]. I was older and people from other countries such as Lebanese, Spanish, Italians or Europeans, isolated me. They discriminated against me, so I hurt my back. In addition, there were some workers from mainland China. When they were still new, I taught them a lot. When they knew how to do things, they got together and kicked me out. After that, I lost interest in everything. (aged 60) (9)

Mr Chin's story makes it clear that an individual's interest in physical activity could be influenced directly by their life experiences. The result was that he had less awareness of
his capacity for caring for himself, which in turn influenced his preventive health behaviour and motivations.

As mentioned earlier, informants who obtained their education or had stayed in China for a longer period of time revealed stronger Chinese traditional health beliefs than those who had been educated and lived in Hong Kong. The differences in health beliefs and exposure to sports between the two countries could also have influenced this group's exposure to PA/Ex, their concepts of PA/Ex and the importance they attached to PA/Ex, their preference for and their attitudes towards PA/Ex. Mr Chin, quoted above, doubted whether Hong Kong migrants felt a need to have PA/Ex at all.

His views were:

Hong Kong people are the laziest group in Australia in terms of doing PA/Ex. Walking for about 30 minutes is already a big issue to many Hong Kong people, let alone walking fast. People from mainland China are the best at it because many of them are good at tai chi and some even teach it. However, tai chi is not very popular among Hong Kong people while it is widely accepted by people from mainland China. People in Hong Kong are too busy to do PA/Ex. Everyone works hard for a better living standard. As such, they simply cannot afford to think about PA/Ex. It is therefore hard for Hong Kong immigrants to suddenly start doing PA/Ex. Hong Kong migrants, especially those who have investments or came here as skilled migrants do not do PA/Ex at all. Many of these people prefer travelling around Australia to performing PA/Ex.

Mrs Chiu, 72, (20) raised the issue of the availability of an appropriate cultural and physical environment:

Australians like ball games but how can people living in Hong Kong find the space for ball games such as tennis or hockey? It's not available. Many years ago, it was not even common to play lawn bowls in Hong Kong. There are cultural differences and we are living in a different environment. We don't know the rules of an Australian game like rugby. We don't learn it from school or TV. To us it looks like a lot of people fighting together.

In contrast, Mr Lee, 75, (8), who had obtained his bachelor degree in Shanghai, reported the influence of constant involvement in PA/Ex with the support of educational organizations:
When I was young, my health was very good because I liked PA/Ex very much. I knew many kinds of ball games. We had a break in secondary school every day for calisthenics. I studied and played PA/Ex at the same time, especially at the university. The university requested you to learn tennis. I also learned to play basketball, volleyball, soccer, table tennis and even badminton.

He reported that this kind of encouragement made him more interested in participating in PA/Ex.

6.4 The interacting factors influencing perceived social support

The informants in this study relied on three main sources for their social support, these being family, health professionals, the society and friends. Family and friends were a potential source of support for older Hong Kong Chinese people engaging in PA/Ex. However, the informants' responses reflect that this kind of support was mostly absent and therefore that exercising with family was their best motivation. This was mostly not possible because their families were too busy. Mrs Yuen, 72, (17) said, “My daughter has suggested that I have a morning walk, but I do not want to walk alone because it is very boring”. Mrs Leung, 65, (3) was unsuccessful in getting her family involved. “I asked them to do PA/Ex, but they are lazier than I am!”.

Some informants said that they avoided trying to encourage their family or friends to participate in PA/Ex. Mr Yiu, 74, (15) explained,

I won't encourage my family or neighbours to do PA/Ex with me because everyone has his/her own preferences. Everyone's time schedule is different. I don't know whether he/she likes doing PA/Ex or not.

Surprisingly, the family of Mr Wai, 73, (10) discouraged him from jogging every morning. His family wanted him to do something simpler and safer because they believed jogging to be too strenuous for older people. He stated,
My sister always calls me from the United States and says, “You still jog at this age? Don't jog anymore, you should walk. You are too old to jog!”

This response showed that younger people also had their concept of age which influenced the way they either supported or did not support PA/Ex among older people. Some believed that older people should only engage in light exercise. Such attitudes could discourage older people from engaging in PA/Ex.

As far as social circles beyond the family were concerned, only a few informants (n=4) believed that a group of good friends who regularly engaged in PA/Ex, would influence those who did not. Another important factor in this regard is evident in the way that eight of the 22 informants described themselves as being introverted and having a sense of inferiority. Therefore they tried not to bother anyone unnecessarily. This was especially so for those reporting lower PA/Ex participation. Many of the informants had encountered various environmental and cultural restraints that made them incapable of building up their social networks in Australia:

I am very introverted. I don't know English. I don't know how to communicate with the other people. I'm afraid of saying something wrong. I enjoy staying at home and have indoor activity. It is all right for me because I don’t go out. I like quiet. I don’t like being active. I do housework at home, I can spend a whole day for it. (Mrs Siu, 77) (12)

I won't make friends with Mandarin speakers because we come from different places. They live in the place under the control of Communist Party and they have communist education. (Mr Chin, 60) (9)

In addition, a strong sense of independence, autonomy and desire for a secluded life hindered participation in health promotion activities. The majority of informants were not interested in joining exercise classes or other activities conducted by community centres. Among the stated reasons were: “I don't want to have any time restrictions”, “I don't want to socialise with the others in the exercise class”, “I am too old, those people
also do not want me there” or “I don't know how to go there on my own”. Mr Chung, 71, (14) provided some useful comments:

If people just stay there for an hour, they don't know where to go afterwards. It will be better if they [community centres] provided some refreshment and places for chatting. Further, the activities for Cantonese speakers may not suit Mandarin speakers. Chinese people may come from different places from mainland China, Hong Kong, Taiwan and so on. Chinese people from Hong Kong may also feel distant from those from mainland China. It's more difficult mixing with Chinese people than with Western people.

Health professionals could be another potential source of support. The majority of informants (n=19) had great faith in the advice of general practitioners because of their professional knowledge. This means that general practitioners play an important role in providing health information. As Mr Chung, 71, (14) stated, “I believe what the GP and my children tell me because they have much greater knowledge than mine”.

Not all informants agreed about GPs' medical knowledge. Mr Wai, 73, (10) claimed that he did not need them because he did not totally believe what his GP told him and on this score, he was typical of few informants:

I myself know my body very well. I know it better than any general practitioner. I will know if there is anything abnormal. My body is just like a machine, I am the operator of this machine, the operator can know how to operate the machine better than anyone else.

In addition, because of language barriers and cultural differences in Australia, the majority of informants (n=20) preferred to see a Hong Kong trained GP with a Cantonese-speaking background. Therefore such GPs play a very important role in the provision of health information and health education. However, a few informants (n=3) commented that the quality of Cantonese-speaking GPs in Sydney was not very good. Some informants (n=5) mentioned that their general practitioners did not ask whether they participated in exercise or not and seldom encouraged them to do so. Some informants raised a salient point when they said that medical training in the past in Hong
Kong had had a limited focus on primary health care and thus GPs did not provide preventive health information or know the value of social support to wellbeing. Mrs Su, 69, (1) commented,

The GP doesn't tell me anything about PA/Ex or other methods of keeping healthy. He only provided me with information about my health problems or only tells me what I can eat and what I cannot eat.

Furthermore, they also experienced political and financial issues as well. Under “society” we can include the provision of social welfare benefits by the state. As in the case of the health care system mentioned in Chapter 3, the informants thought that the social welfare system in Australia was better than that in Hong Kong. For instance, the discounts and cheap travel available to seniors (residents over 60) encouraged this group to get out of their homes (at the time this research was being done, people could travel all day on any mode of public transport for $1.10). Thus they had greater opportunities to make more contact with society in general and with other people. This enabled them to build up their self-esteem, self-confidence, their capacity to care for themselves and social networking.

Mrs Lai, 91, who was a frequent visitor to the Casino, stated,

Sometimes, I go out for a walk when I feel bored. It only costs you one dollar something for a return ticket. You can go ten times a day if you like. I sometimes go to visit my daughter or I take the shuttle bus to the Casino to play jackpot and I meet some older Chinese people there. Actually, they didn't really want to gamble. They just want to relax in an air-conditioned venue and kill time. But now, I seldom go to the Casino because they charge you three dollars for the shuttle bus. (6)

In addition, those informants with tertiary education were able to obtain health information from books or newspapers. However, there was much less social support for those with lower education levels. Not only was their English proficiency poor, but as a result of not having completed primary school, they even had difficulty in reading Chinese. In addition, only a few informants had access to Chinese TV or radio. Therefore the exposure of these less well-educated informants to preventive health information or
other information relevant to them, such as changes in social policy or social welfare, was limited. In the words of Mrs Lim, 83, who had not completed primary school:

I don't have TV at home as I don't understand English. I had a 2AC [Sydney Australian Chinese radio4] but it broke a few months ago. I don't know how to fix it up. Now, I don't watch TV or listen to radio. (5)

Clearly, factors such as Confucian norms, an introverted personality, feelings of inferiority, environmental, cultural, political and financial restraints as well as specific criteria for making friends, weakened informants' ability to socialise and build up a circle of friends. While this hindered their integration into Australian society, it also resulted in their forging very close connections with their families. Therefore social support from the family is very important for motivating older people from Hong Kong Chinese to participate in PA/Ex.

6.5 The interacting factors influencing perceived barriers' control over PA/Ex participation

Although some informants who had lower levels of PA/Ex realised that it was good for their health, they also encountered many barriers to participation in PA/Ex after migration. The following section explores the interrelationships of the following factors in this regard: gender, marital status, education and acculturation levels, health problems, language barrier, length of stay in Australia, aspects of the physical environment, ability in barrier solving, life experience, and PA/Ex preference.

Gender and marital status: In the responses to the question of “What makes it difficult for you to participate in physical activity?”, the most frequent answer (n=9), especially from females, was: “I don't have time”. They claimed to be too busy doing housework or looking after their grandchildren to do PA/Ex. One important finding is that this Chinese

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4 This Sydney Chinese radio station sells radios at reasonable prices, pre-tuned to its two wavebands, although it is possible to tune into other FM wavebands as well.
group's strong perception of time pressure was linked to their marital status and perception of gender roles.

When I have something to do [housework], I feel pressured because of a sense of responsibility. So I minimise my time for PA/Ex and try to finish the work first. But after finishing the work, I have no interest in doing PA/Ex. Also, I will need to start looking after my grandson very soon. (Mrs Mo, 60) (18)

I don't have time to join an exercise class even though I enjoy it very much. I may join again when my life is changed, for example, when my wife dies. At present, my wife’s dependency greatly influences my daily life. (Mr Bek, 72) (4)

Lack of energy or sheer laziness was another personal barrier to PA/Ex. Most of the informants with lower levels of PA/Ex participation (n=9) stated that they did not do PA/Ex because they were lazy or had no interest in it. They sometimes wanted to do PA/Ex but they felt too tired. Mrs Leung, 65, (3) stated,

Sometimes I do exercise in the park but I am too lazy to go there now. I also don’t want to drive so far if I just am there for just a short time.

Another lower level of PA/Ex participant, 60-year-old Mr Chin (9), pointed out:

Actually laziness is only an excuse. To me, people cannot hold firmly to doing PA/Ex at a fixed time every day. I cannot. I also know that I need to do PA/Ex but I am not interested in it.

However, many informants with higher levels of PA/Ex participation doubted the validity of the laziness excuse. Mr Law, 74, believed that perseverance and personal interest were the key. He commented,

You have to hold firm because doing PA/Ex is good for health. But whether you do it depends completely on the individual's interest. You will squeeze in the time to do PA/Ex if you like it, but you will not do PA/Ex even if someone pushes you. (11)
Mr Bek. 72, (4) suggested:

If the government or any other organizations want this group of older people to participate in PA/Ex, the most important point is to raise their interests in PA/Ex. As far as I am concerned, you must put me in an environment where I can do something together with PA/Ex. I won't just do PA/Ex for its own sake. I need someone to push me.

It was also found that negative emotions and depression caused by changes could be also an explanation for the laziness and lack of interest among some. Many informants who reported lower levels of PA/Ex participation (seven out of ten) stated that they had neither the motivation nor the perseverance and patience to participate in PA/Ex, especially when they were not in the mood. Mrs Chiu, 72, (20) stated, “I don't want to do PA/Ex when I am not in the mood or feel depressed. I lose my interest in it”.

As mentioned earlier, the informants believed that “ageing can cause hundreds of health problems” because of deteriorating physical functions. Many lower level PA/Ex participants, especially females, claimed that they could not do certain kinds of PA/Ex because of their poor physical condition or physical injury. For example, Mrs Siu, 77, (12) asked: “When I feel pain in my legs, how can I move? I look disabled” and Mrs Ho, 60, (21) claimed, “I hurt my knees when I was young. So now I am old, I can’t walk too far or for a long time”. The findings demonstrate a clear connection with informants' health problems and their preferences for PA/Ex.

Walking, *tai chi* and housework were the most common examples of PA/Ex in which the informants were currently participating. Some informants performed more than one kind of PA/Ex. Most (eight males and eight females), including those with lower participation levels of PA/Ex, said that walking was their main PA/Ex because it is simple, suitable, and convenient. These were also the key factors influencing their choice of PA/Ex. *Tai chi* was a popular choice (four males and one female) for men. The women tended not to
like *tai chi*. Women were more likely than men to choose housework (one male and five females) or calisthenics (three females) as their main PA/Ex. Other than walking, men were more likely than women to jog and practise other kinds of traditional Chinese martial arts such as *lug⁶ tung¹ kün¹, hêng¹ gung¹*, and *qi gong*.

However, the preferences expressed by informants indicated that they had very limited choices of the type of PA/Ex in which they were able to participate. These limited choices stemmed from the interaction of factors such as their concepts of age and health as well as from cultural beliefs or the physical environment, all of which raised barriers to their participation in PA/Ex, especially in the new environment in Australia. Many informants preferred to walk alone, the main reasons being that it was awkward arranging mutually suitable times with friends, or that members of their family did not have the time to walk, or simply that they disliked socialising with others. Mr Yiu, 74, raised an interesting cultural issue:

> I won't walk with anyone from the opposite sex apart from my wife. It's related to our Confucian ethical code. It's not right for me to walk with a woman who is not my wife. (15)

Some informants believed that *tai chi* was suitable for older people because “it is slow and it mainly trains the *qi* and Western people also recognise that it is beneficial to health”. However, Mrs Su, 69, said:

> I am old. It is better to do PA/Ex leisurely and without pressure. I don't like *tai chi* because I am too impatient to learn it, even if someone is willing to teach me. I don't want to memorise too many things, it's too complicated and it's not good if I miss one step. (1)

An important finding of this study was that the majority of informants in Australia seldom selected swimming as the preferred activity not only because they could not swim, but also because they thought the aftercare was too troublesome and the chlorine in pool water would damage their hair and skin. Some responses were a direct result of
experience in Hong Kong, where most of the swimming pools are full all the time in summer. This led some informants to believe that a swimming pool is like a public tub and that the pool water was bound to be very dirty. In addition, a few informants were very conservative and felt embarrassed about wearing a swimsuit. This applied even to one male informant. Additionally, as mentioned in Chapter 2, some informants believed that exposure to excessive cold and wetness caused fung’ seb’ (rheumatism, arthritis or bone pain). A rainy day or a humid environment is also commonly seen as “wet” which can cause recurring fung’ seb’ (Koo, 1984; 1987). All these reasons resulted in informants avoiding swimming as a form of PA/Ex.

Morning was frequently chosen as the favourite time for PA/Ex. Mr Koo, 80, (7) thought: “fresh morning air is beneficial to health. If the blood circulation is good in the morning, you will be in good spirits and have lots of stamina”. Also, most of the informants preferred doing exercise on an empty stomach because they believed that it was not good to expend energy straight after a meal.

Although some informants had high educational levels, this did not necessarily translate into having a positive effect on their participation in PA/Ex. Since most of them reported low English proficiency, the language barrier increased their difficulties in acculturating to Australian society and obtaining sufficient social support. In the words of Mrs Su, 69, (1):

I don't know English, I don't know how to talk to them [western people]. Everybody in Hong Kong speaks the same language. [Australia] is different from Hong Kong. It's very troublesome. Sometimes, I get mail but I can't read it. I can only stay at home and do housework.

Apart from language barriers, as mentioned in Chapter 5, the informants had low acculturation levels. The intermittent nature of their stays in Australia and strong feelings
of Hong Kong identity may have discouraged them from integrating into Australian society and made them unwilling to accept new things, resulting in many cultural and social conflicts. More importantly, their low English proficiency and acculturation levels could be factors which minimised their participation in physical activity. This is evident in a statement made by 60-year-old Mrs Mo:

I don't mind doing PA/Ex with Western people but they might not want to do PA/Ex with me. (18)

When I am doing PA/Ex in the corridor, I sometimes meet the “high nose men” [western people] doing tai chi. I just say hello but I don't ask them to teach me. They do their PA/Ex, I do my own PA/Ex. We don't bother each other (Mrs Lai, 91) (6)

Generally speaking, most of the informants (n=21) thought Australia was an ideal place to do exercise when compared with Hong Kong. The new environment directly and indirectly motivated some informants to participate in PA/Ex. They thought the environment in Australia was good, the air fresh, the weather good, while there were trees, flowers and grass everywhere. Some informants, especially those in the higher PA/Ex participation levels, did a lot of walking because there seemed to be so much space in Australia. Mrs Mo, 60 undertook PA/Ex unintentionally:

I live on the sixth floor but there is no lift, so I need to climb up the stairs with no choice. (18)

However, some informants' PA/Ex participation and choices were limited by the change of environment from Hong Kong to Australia. Mr Law, 74, (11) stated,

I do less PA/Ex than in Hong Kong because I don't have the equipment (stationary cycling and dumbbells). I can only walk and do push-ups.

Other changes in their new environment such as lack of transport hindered the performance of PA/Ex. Although a few informants (n=3) said that it would not be a problem for them to do exercise if the transport was available, transportation was a problem for most of the informants. Another important finding is that some informants
(n=7) did not feel comfortable to use the provided transport service because of the Confucian moral code. They did not like to ask for help because they did not want to bother anyone, owe favours or lose their freedom and autonomy because of the fixed times of PA/Ex activities. Therefore some informants would not consider using the transport service even if it had been available. Some other concerns are reflected in the following comments:

My friends have offered to drive me to the beach to do PA/Ex. But if they took me there, I would feel embarrassed and think that I owed them a favour. There's no point in going so far. No, thank you. I prefer walking around my house. (Mrs Yiu, 61) (2)

Even if I use the pick-up service, the vehicle may not pick me up in front of my door. If it is too far from my place, I do not want to walk. If someone only drives me to the community centre but does not drive me back, I will be in trouble because I do not know how to go home … I am also worried about falling down when I get in and off the vehicle. No one would sympathise with me. (Mrs Lai, 91) (6)

Additionally, four female informants were concerned about security problems. They were afraid of going out alone because they thought it was very dangerous. Eighty-three-year old Mrs Lim claimed:

I dare not walk alone in the early morning or in the late evening. I am afraid of drunks and that people will bully me. I am afraid of getting lost … I don't accept lifts because I'm afraid that the lift will break down. If so, I don't know how to go home. I don't know the name of the street I am living in. I don't know how to ask for help. (5)

According to the informants' responses, transport and language problems make it difficult for them to take advantage of the supportive environment provided in Australia which might encourage older Hong Kong Chinese people to engage in PA/Ex. The findings also revealed that the informants' perceived ability to reduce barriers to PA/Ex participation involved their individual personality, the perceived importance of physical activity, their educational level, English proficiency or other intrinsic and extrinsic factors. Their new physical environment, and perceptions of cultural and social
differences weakened informants' perceived ability to overcome barriers, resulting in low motivations for participating in PA/Ex. Compared with the informants with lower levels of PA/Ex participation, the informants with higher levels of PA/Ex participation were more able to reduce the barriers. They did not worry about any problems in performing PA/Ex which may have arisen, because they were confident in using their own ability to overcome the barriers, such as “walking inside or running inside the house”, or “exercising in the hallway”, or “climbing up and down the stairs with the window open” when it was raining. As far as the time problem was concerned, some informants stated that “I can squeeze in time for doing PA/Ex if needed”, or “I can get up a bit earlier”. The possibility of getting lost was not seen as a great problem, in the words of one informant, “I looked at a map before I went walking”. Perceived ability to overcome or reduce barriers was one of the keys for maintaining the preventive health behaviour.

6.6 Summary

To sum up, this group of older Hong Kong Chinese people had their specific attitudes towards life, their concepts of old age and their health beliefs as well as preventive health behaviour. These were all deeply rooted in three Chinese traditional philosophies. Their participation in PA/Ex in Australia involved many intrinsic and extrinsic factors, none of which, individually, could effectively change their behaviour. The summarised relationship of these interactive factors is shown in Figure 6.2. The interaction of these factors will be further discussed in the next chapter.
Figure 6.2: Relationship of the Interactive Intrinsic and Extrinsic Factors and PA/Ex Participation
CHAPTER 7: DISCUSSION

A number of important findings were made in relation to conducting research among older Hong Kong Chinese people. The discussion in this chapter covers, firstly, the methodological issues raised by sampling recruitment and size, the accuracy of SES categorisations, and intercultural communication within the interviews. These are placed within the context of the limitations of the study as well as theoretical discussion. Secondly, there is an exploration of the key findings through the lens of Confucianism, Taoism, and Buddhism. The key factors influencing the informants' attitudes towards PA/Ex participation, their perceived social support and perceived control over barriers to PA/Ex participation are also discussed. Finally, the discussion is turned to the possible relationship between the intrinsic and extrinsic factors affecting PA/Ex participation.

7.1 Methodological and theoretical discussion

In this section, discussion is mainly focused on methods of sample recruitment, the SES of informants, their communication styles and the limitations of this study as well as the theoretical issues encountered in this study.

Recruitment

The traditional beliefs of older Chinese people about proper social interactions created problems for snowball sampling. Rissel and Khavarpour's study (1997) found that the effect of snowball sampling was reliable and recommended its use for other ethnic groups. However, as mentioned in Chapter 4, Section 4.3, this research indicates that snowball sampling is less effective among older Chinese people; informants time and again declined to give names of other likely participants because of a stated wish to avoid disturbing their relatives or friends. This echoes the findings of Wei and Li (1996)
and Yau (2003a) with regard to the emphasis placed on proper social interactions and maintenance of harmony within Chinese culture. In addition, as mentioned in Section 4.6, family members strongly influenced informants' decision-making processes. This indicates that this Chinese group was family-oriented. Further study on these cultural issues might establish greater clarity about effective sampling strategies.

**Accuracy of socioeconomic status (SES) categorisations**

The fact that older Chinese people are reluctant to divulge their financial status means their SES may not be accurately reported. SES classification could help to explain the impact of SES on the informants' preventive health behaviour (Berkanovic, 1973; Kendig et al., 1996a; Ma, 1999b, p. 25; Stein & Fox, 1991), however, as indicated earlier in Chapter 4, many informants were reluctant to talk about their financial status or rate their SES, thus compromising the use of SES factors as variables in the analysis. The lack of clarity in reporting their financial status may have the effect of creating an over-representation of older Chinese people classified as being in low SES brackets. The possible reason might be that Chinese people believe that they should be modest and maintain a low profile. However, as discussed in Chapters 2 and 3, there is a common cultural belief in maintaining familial and social harmonisation. Interviewing showed that this cultural norm was still adhered to by the informants. They did not want to disclose their financial status to outsiders because they saw this as a personal and private matter. Some were retired and reliant on their children for financial support. They worried about how people would see their family's financial status. Thus, disclosing family matters to outsiders involves “losing face” and disgraces the family (Cheng, 1997; Monroe, 1995; Wei & Li, 1996). This “insider/outsider” attitude to disclosure could affect research based not only on questionnaires but also information supplied on census forms. Therefore the SES attributed to informants has to be treated with caution and may
be an uncertain determinant of PA/Ex participation among older Hong Kong Chinese people. As their traditional distinctions between “insider” and “outsider” are still strongly present, future researchers need to take these factors in account in order to obtain other fruitful and truthful data.

**Intercultural communication**

Specific cultural practices in the mode of communication among Chinese people, and also the nature of their interpersonal relationships, have the potential to create difficulties for researchers as they attempt to access personal information (Cheng, 1997; Gao & Ting-Toomey, 1998). As mentioned in Chapter 4, maintenance of social harmony was the main concern of the informants during interview. They were worried about providing incorrect information and they tried to answer questions with collective opinions. The pronoun “we” (ngo‘ déi) was used instead of “I” (ngo’). In addition, this target group's indirect communication style and their practice of using metaphors to allude to hidden meanings also increase the difficulties of data collection. Gao and Ting-Toomey (1998, p. 3) and Hofstede (1980) claimed that for Chinese people, meaning does not stop at words but deepens as one engages further in comprehension and contemplation. That point was supported by the informants' responses which exhibited the typical Chinese-specific communication style, in which “meaning lies beyond words” (yi‘ zoi‘ yin ngo‘).

The informants tended not to take words literally, and to provide indirect answers to the questions. There was frequent use of metaphor in their responses to questions. As reported in Chapter 6, some informants had described the human body as being like a machine, knife, or curtain. This communication style echoes the findings of Guo's research (2000, p. 89) into the health care behaviour of Chinese people living in Flushing, New York. Informants in my study also tended to use metaphors to express
their opinions on health. However, frequent usage of metaphors increased my difficulty in obtaining accurate information. As the informants preferred to answer questions in an indirect way, I needed to clarify what they meant to ensure that I did not miss important data or misunderstand their meanings. Future researchers need to be aware of the communication style of older Hong Kong Chinese people in order to obtain information with accurate meaning.

Furthermore, special precautions should be taken during interviews when asking hypothetical questions, especially those that might have been linked with health or cultural taboos such as getting sick, or death. Mrs Lim's response could be explained by the law of karma in Buddhism, where merely talking about illness or death may cause them to happen (McLaughlin & Braun, 1998). This thinking is similar to that reflected in the old English proverb: “Speak of the devil and he will appear”. I found that this belief was still strongly rooted in the minds of some (although certainly not all) of the informants. While Australians might consider this as mere superstition, her reaction reflects Chinese cultural beliefs which need to be taken into account by future researchers.

**Difficulties of categorisation of PA/Ex participation**

According to the findings mentioned in Chapter 5, the informants' specific perceptions of what it means to be “physically active” and the traditional belief in the need to be self-effacing and modest (Kong, 1989; Monroe, 1995; Yip, 2003) created problems as far as the accuracy of reporting the PA/Ex levels was concerned. For them, being “physically active” meant more than even the amount of time spent on formal PA/Ex, but also needed to include the activities such as the public performance and teaching of tai chi or of sword play. Because they were not involved in such activities, some informants
reported their level of PA/Ex as being merely “so-so”. However, as a result of the terminological confusion described above, it is likely that their views of their own levels of PA/Ex were inaccurate. Based on their own reports on their daily activities, none of the informants were totally sedentary.

Consistent with the findings of previous literature (Armstrong et al., 2000; Bauman et al., 1996; Lewis et al., 1997), in my study more men than women reported themselves to be “physically active” or “so-so”. But while these women possibly engaged in little or no formal physical activity, their traditional role in the performance of domestic tasks means that they were probably extremely “physically active”. Moreover, although few female informants reported themselves as being “physically inactive”, most could be classified as being “active” because, according to the National Physical Activity Guidelines for Australians (Commonwealth Department of Health and Aged Care, 1999) mentioned in Chapter 1, they were involved in mundane but continuous physical activity every day of the week.

Another problem is that while some informants were categorised as being “physically active” at the time of the interview, it turned out that their activity was only sporadic. According to Chapter 5, it is difficult to classify these informants as “physically active or inactive”. For instance, informants who fell into the states of “Inactive” (Mr Wan) and the “Practical” (Mr Lau), both engaged in regular PA/Ex at the time of being interviewed. According to what Mr Wan said, as reported in Chapter 5, he regularly engaged in PA/Ex just because he walked every day to meet his wife at her work. He said, however, that he would no longer do this amount of walking when his wife changed her workplace. This means that while according to his current daily routines he was “physically active”, this was only a temporary state which would come to an end in the
near future, after which he would have to be placed in the “physically inactive” group. In other words, I discovered that I could not rely on self-reported PA/Ex patterns over the previous few weeks as an accurate guideline. This indicates that the methods used to measure the PA/Ex levels of this group and of other older Chinese people, need to be re-examined. More importantly, to increase their PA/Ex level, careful attention needs to be given to their attitude towards performing sporadic PA/Ex, while there is a need to emphasise the importance of continuous PA/Ex adherence.

**Limitations of the study**

In Chapter 4, the issue of the sample size of this study has been raised. Although the sample size of this study is small, the purpose of the research was to focus on understanding the preventive health behaviour of the target population in Australia. Using the lens of Chinese traditional beliefs, an understanding of the determinants of their preventive health behaviours was developed from this study. However, further research could expand the sample size in Australia and compare the results with the behaviour of older people actually living in Hong Kong. This would help to expand understandings about the impact of culture and other determinants of health behaviour.

The difficulty in searching for relevant and updated epidemiological data for this target group indicates the necessity for further epidemiological and statistical studies with more carefully delineated Chinese or other ethnic groups in Australia. Epidemiologists might need to have a basic understanding of different ethnic groups before conducting epidemiological and statistical studies for their preventive health behaviour. This study focused only on PA/Ex. Most of the informants' attitudes towards PA/Ex and behavioural changes were not followed up. Therefore further longitudinal study into changes in the
attitudes and other preventive health behaviour of older Chinese people from Hong Kong may be useful.

**Theoretical issues**

In this study, the TPB helped to explain how informants in different states of PA/Ex participation gained or lost their motivation to participate in PA/Ex through three main predictors, namely attitudes, perceived social support and perceived control over barriers. According to the findings in Chapters 5 and 6, to a large extent, these predictors were strongly influenced by the traditional Chinese philosophies of Confucianism, Taoism, and Buddhism. However, the TPB did not fully account for these important ethical and moral codes. In other words, these need to be strengthened in the TPB for future studies of older Hong Kong Chinese people or other ethnic groups. Effective preventive health services could be promoted among this group by taking into account factors such as the impact of traditional Chinese philosophies and the determinants of health on Hong Kong Chinese's preventive health beliefs, together with the TPB.

**7.2 The impact of Confucianism, Taoism, and Buddhism on PA/Ex participation**

Using Ajzen's TPB (1988; 1991), a framework was created that accounted for the way that cultural, ethical and moral codes, attitudes towards life and concepts of ageing and health developed from Confucianism, Taoism and Buddhism. According to the findings shown in Chapter 6, these belief systems were found to be the fundamental elements influencing the informants' PA/Ex patterns. Moreover, it is clear that cultural and health beliefs strongly influenced the informants' attitudes toward participating in PA/Ex, the way they perceived their social support systems and also the way they perceived their control over barriers to PA/Ex. It was also found that these three determinants directly interacted with each other, influencing informants' intentions with regard to participation.
in PA/Ex and also their actual behavioural change (Koo & Rowling, 2004). The importance of cultural and health beliefs is discussed below.

**Birth, ageing, illness, death**

As mentioned in Chapter 6, the attitudes of the informants towards the life processes of “birth, ageing, illness, death” (saang lou' beng sei’), drawn from the Buddhist tradition and also from Taoism’s “let-it-be” philosophy, exercise a strong influence on their decisions on whether to participate in PA/Ex. Passive and uninterested attitudes towards PA/Ex are probably reinforced by the finding that most regarded the prospect of death with equanimity and said that they did not want to be a physical or social burden for their families. While it would be difficult to change their fatalistic beliefs, health promoters could take advantage of the expressed desire of many informants to have quality rather than quantity of life and to have a “good death” – being able to maintain some degree of quality of life and dignity in the dying process. Their desire to be free of pain and of physical or social burdens as well as having good health could mean that it is more important to emphasise quality of life rather than longevity as one of the chief benefits of participation in PA/Ex. Thus, health promotion efforts among this group should be tailored to their specific beliefs, acknowledging for instance that while “birth, ageing, illness and death” is indeed inevitable, they were not fated to be unhealthy in the last part of the life cycle if they were willing to make an effort to engage in regular PA/Ex.

**Balance and harmony**

My informants echoed the findings of the studies of Palmore (1987) and Kendig et al. (1996b) that successful ageing required a combination of survival (longevity), health (lack of disability), and life satisfaction (happiness). But in adding that they viewed “balance” or “harmony” they were conflating Chinese and Western conceptions about
the essential elements for ensuring long life and wellbeing. Health promoters could emphasise that participation in PA/Ex could contribute to all of these as well as to the physical independence, stamina, freedom from illness and attendant medications and also from pain, which they see as constituting good health. Thus their desire to “eat well, walk well and sleep well” which encapsulates their ideas of physical, social and mental wellbeing constitutes a positive starting point for those who wish to encourage PA/Ex among this group.

At first glance it might seem that the same applies to the informants' belief in healthy diet, the use of TCM, keeping their emotions stable, a healthy lifestyle and regular body checkups as their main ways for health maintenance. But while on this score they are probably not very different from Western people, their faith in specific dietary practices derived from TCM has the potential to discourage their use of other preventive health measures.

Moreover, my informants’ belief, demonstrated in Chapter 2, that mind and body are inseparable entities and that an individual's health is dependent on adopting an integrated and holistic approach that gives equal importance to all aspects of body, mind, emotions and environment, can also be a barrier to their participation in PA/Ex. This would result for instance, from their belief that maintaining good and close familial relations creates a healthy state of mind which is sufficient to maintain their wellbeing. Therefore they would regard participating in PA/Ex as being unnecessary.

Another barrier appears in the discussion of their concepts of ageing set out in Chapter 6, where it was shown that they have a fatalistic attitude towards not only ageing but also health problems such as arthritis, hypertension or diabetes. The informants’ classification
of severity of illnesses into xiū mou² bēng⁶ (a small problem), dai⁶ bēng⁶ (a big problem) and lou¹ yen⁴ bēng⁶ (the problems of old age) reflected the influence of traditional concepts of ageing. These perceptions, as well as their passive acceptance of the sick role, have a negative impact on their physical activity preferences (Koo & Rowling, 2002).

Another belief which needs to be taken into account is that for the informants, it was normal to withdraw from active involvement in the community and to lead a more secluded lifestyle because they saw the negative effects of ageing as a threat to the collective harmony. This constitutes a hindrance to their seeking social support for PA/Ex participation (See Section 7.4). Health promoters therefore need to emphasise to these older people that maintaining their normal social lives and network cannot only provide them with opportunities to make new friends, but also increase their self-esteem and integration into Australian society. In addition, their desire to increase their capacity for self-care and avoid being a burden to their families, as described in Chapter 6, can be used by health promoters to encourage them to participate in physical activity.

### 7.3 Attitudes towards PA/Ex participation

According to the findings indicated in Chapter 6, the positive attitudes towards PA/Ex among informants with higher levels of PA/Ex were due among other things, to the fact that they saw it as being useful in preventing or treating health problems. However, it was also significant that for them, PA/Ex had already become so routine that it did not require much focused attention. They mentioned perseverance and personal interest as the key to their adherence to PA/Ex routines. In other words, it had become part of their daily routines and was seen in the same light as other pleasurable activities such as eating. This could provide a clue as to how to persuade those with low motivation to start
doing PA/Ex or to increase their levels. In most cases, they do know and in fact believe in the benefits of PA/Ex but think that it is not necessary as long as they are healthy. As mentioned earlier, Hong Kong Chinese are crisis-oriented and situation-oriented. The result is that only the onset of severe health problems gives them the motivation for participation in PA/Ex. That was evident in the way that many of the informants in this study mentioned age and particularly health problems as indicators of their need to participate in PA/Ex. It can be pointed out to them that once they become sick, PA/Ex will be far less beneficial and that not only is “prevention better than cure”, but that as the example of regular devotees of PA/Ex indicates, once it has become a regular habit, it is actually highly enjoyable.

**Confusion over the meaning of physical activity**

This study found that another factor in negative attitudes towards PA/Ex participation stemmed from the lack of an accurate understanding of what constitutes physical activity. As described in Chapter 5, physical activity tended to be a confusing and complicated term. However, it should be noted that to the informants, PA/Ex means something that is (1) beneficial to health; (2) free of pain; (3) energy consuming; (4) relaxing and easily accepted; (5) does not require a great deal of brain power; (6) is not strenuous; and (7) is appropriate to individual physical condition or fitness (Koo & Rowling, 2003). The inclusion of these main components in physical activity promotion programs would probably make them more effective.

More importantly, some members of the group were confused by the use of two different Cantonese phrases: *Yen⁴ Tai² Woot⁶ Dung⁶* which denotes any movement of any part of the human body, and *Tai² Nung⁴ Woot⁶ Dung⁶* which is exercise deliberately undertaken to improve physical strength. That confusion discourages some from participating in
PA/Ex because when it is mentioned, they see it as only as Tai Nung Woot Dung (Koo & Rowling, 2003) or formal exercise, which they might believe to be inappropriate for themselves because of their age or for other reasons. However, Yen Tai Woot Dung, which very often involves simply the performance of mundane, everyday household tasks such as sweeping, hanging out washing, weeding, making beds, vacuuming and so on, is an equally effective form of physical activity. What is important is that those who are largely sedentary begin performing some Yen Tai Woot Dung of this kind and in encouraging them to do so, health educators need to make it clear they are not advocating the performance of Tai Nung Woot Dung, formal exercise, because that would probably put their hearers off attempting any PA/Ex at all. It is also important to encourage those who are already involved in the performance of Yen Tai Woot Dung tasks to maintain their levels of activity. Applauding them for what they already doing might change their attitudes towards PA/Ex and encourage them to do more. Therefore appropriate Chinese wordings need to be used carefully to denote the full range of what is meant by “physical activity” and to make it clear that it does not necessarily involves formal exercise.

7.4 Perceived social support

Perceived social support from significant others was also an important determinant that influenced the group's intentions with regard to participating in PA/Ex. Thus, whether they attempted to engage in PA/Ex or not was found to be dependent, at least in part, on the approval or disapproval of their immediate family members (Koo & Rowling, 2004). According to Chapter 6, it was found that family and GPs could play a very important role in encouraging the PA/Ex among the targeted Chinese group. In addition, fully utilisation of social welfare and mass media could also help. We need to discuss each of these in turn.
Family

As demonstrated in Chapter 2, the tendency of this Chinese group to put family relationships before all others means that they could receive positive encouragement from their families to participate in PA/Ex. Indeed, during interviews, most informants said that their best motivation for performing PA/Ex was to do it together with their families. However, although families verbally encouraged informants, some received no practical support because their family members were too busy or too unmotivated to engage in PA/Ex with them. Consequently, some informants received little social support and heard fewer health messages from their families. This finding supports the notion that social influence should not be overlooked as a predictor of behaviour, even though some studies mentioned in Chapter 3 indicated that subjective norms have a weak relationship with exercise behaviour (Blue, 1995; Godin et al., 1993; Hausenblas et al., 1997; Smith & Biddle, 1999). Therefore families should be encouraged to give priority to educating their older members about how to develop positive attitudes towards PA/Ex. Attention should also be given to ways of correcting wrong ideas about such activity and encouraging the maintenance of regular PA/Ex.

General Practitioners (GPs)

It was found that family GPs also constituted a major source of encouragement for participation in PA/Ex. However, according to several informants, some GPs only provided health information focused on immediate health problems and seldom mentioned or supplied information about preventive health measures. A first step in remedying this situation would be to educate or persuade Hong Kong-trained GPs to pay more attention to preventive health care because as argued earlier, the past undergraduate medical curriculum in Hong Kong has tended to emphasise advanced, specialised knowledge, essential for hospital care. It paid little attention to primary medical care
issues. Nonetheless, health promoters should fully utilise Hong Kong-trained Cantonese-speaking medical GPs in health promotion programs as they have the same culture and language as older Hong Kong Chinese, who accord them special cultural authority. Future research on the impact of GPs' support in PA/Ex participation is warranted.

**Society**

An additional source of encouragement could be through social welfare supports and mass media. The findings in Chapter 6 confirm previous research (Guo, 2000; Koo, 1987; Kwan & Holmes, 1999, p. 458; Tang, 1998) indicating that unless they were experiencing a “dai⁶ bêng⁶⁶” (major problem) or acute illnesses, many informants were not willing to seek medical help. This indicates that Chinese people have different expectations of the primary health care services compared with other ethnic populations and make very limited use of preventive care (Gervais & Jovchelovitch, 1998). However, in Australia one saving grace is the “free” medical services which can be obtained under Medicare. This encouraged some to see a GP more often. Availability of cheap transport for seniors could encourage at least some older Chinese people to make more social contact with others and with society in general. Thus, the availability of these “free” GP consultations and the willingness of some informants to make greater use of cheap transport provide a window of opportunity which could be used by health promoters to encourage more preventive health care measures such as PA/Ex.

Moreover, the tendency of some informants to prefer staying at home to watch TV or listen to radio could provide an opportunity to promote PA/Ex participation. The SBS TV channel, Chinese cable TV and Chinese radio stations (for example, 2AC or 2CR) could play an important role in delivering preventive health messages in Chinese in order to arouse awareness of the importance of PA/Ex among the study group. For example,
GPs could be invited to give health talks on TV or radio. However, the SBS channels are not able to broadcast relevant information frequently and not all Chinese families have hired specific Chinese cable TV (TVBJ) or purchased a pre-tuned Chinese radio. Thus, health promoters need to tackle this problem and increase the broadcast of Cantonese health message through the SBS TV channel in order to provide more preventive health information. Simultaneously, the discounts and cheap travel available to seniors should be maintained to encourage their contact with other people and integration into Australian society.

7.5 Perceptions of control over barriers to PA/Ex

According to Chapter 6, these barriers could be classified as arising from many intrinsic and extrinsic factors. They include gender, health problems, marital status, PA/Ex preferences, life experience, acculturation levels, length of stay, physical environment, educational level, language barriers, transport problems, and abilities to overcome barriers. Some of these factors overlapped with those influencing informants' attitude towards PA/Ex and perceived social support.

Ajzen and Driver asserted, on the basis of their research, that a person will expend more effort to engage in a particular form of behaviour when his/her perception of control over that behaviour is high (Ajzen & Driver, 1991, p. 188). The barriers most frequently noted in this study group were lack of time, lack of interest, laziness, having no companionship, language and transport difficulties, feelings of insecurity and injury. Other main barriers specifically found from this study include limited choices and being old.
**Acculturation levels**

Indeed, their feelings of control over their ability to participate in PA/Ex can be reduced to one key factor, namely a cultural clash with the new environment, resulting from their low acculturation levels. Low acculturation level increases the impact of barriers to PA/Ex participation. Frequent visits to and prolonged stays in Hong Kong probably hindered any attempts the informants might have made to integrate into Australian culture. Thus it is vitally important for health promoters to understand the impact of the patterns of family visitation in Hong Kong Chinese and the reasons for the establishment of the “astronaut family”. Further research on this issue is needed.

One factor which also deserves attention and study can be found in the history of two informants, Mrs Leung (3) and Mr Yan (16) (See Chapter 5, Section 5.1) who had in fact undergone two migration experiences, first from mainland China to Hong Kong, and then from Hong Kong to Australia. Their time in China and their education in Chinese schools might have imbued them with stronger affiliations to Chinese culture and concepts of health maintenance than those who came directly from Hong Kong (Ho, 1985, p. 244). Mrs Leung always visited her relatives in mainland China whenever she returned to Hong Kong. The multiple geographical and jurisdictional origins of people like herself seem to complicate their cultural and health beliefs ever further and possibly this is true of anyone who has lived in several countries before migrating to Australia. These issues were not deeply explored in this study, but further investigation might be able to elucidate its effects and importance.

**Lack of time and interest**

Female informants in particular reported that lack of time, lack of interest and laziness were the greatest barriers to engaging in PA/Ex. This may be due to the fact that, as
research has shown (Da, 2001; Engels, 1972; Wong & Reker, 1985), many female informants were still constrained by the “three rules of obedience” and “four virtues” \( (sam' \text{ chung } sei \text{ deg'}) \). They labelled themselves as “domestics” and the “home maintainer” and were kept very busy by what they saw as their familial duties. In interviews they constantly stated that looking after family and doing housework were their top priorities. Mrs Siu (12) (See Chapter 5, Section 5) who was in the state of “Irregular”, was a good example, just about all of her time being absorbed by managing the housework and caring for her husband. From my personal observation and informants' nonverbal responses, to a certain extent, helping with the housework and caring for others might provide them with self-respect, independence and happiness after migration, making them feel not only that they were maintaining the harmony of the family, but also that they were fulfilling a meaningful role (Rook, 1987; Tsang et al., 2004; Wong & Reker, 1985).

But while they saw their household duties as a barrier to PA/Ex participation over which they had very little control, in fact this could be turned to advantage by culturally aware health promoters. Health promoters should be aware of the Chinese cultural beliefs and the values attached to family duties when they design preventive health services or health promotion programs. Instead of urging older Chinese women to interrupt their daily housekeeping routines, it can simply be pointed out to them that housework is a useful form of PA/Ex. In order to ensure an awareness of the benefits of their everyday chores, they could be encouraged to wear a pedometer to measure the amount of walking they do around the house every day. The ideal, according to PA/Ex promoters, is to walk 10,000 steps a day (Monash University, 2004b; The University of Queensland, 2005); if an older Chinese “housemother” and her family find that she is not achieving this target in the
course of her routine duties, it will be easier to encourage her to make up the deficits by taking short walks outside the house in streets or parks.

**Cultural limitation on PA/Ex participation**

Similar to current research findings in Australia (Armstrong et al., 2000; Brown et al., 1999) walking, *tai chi* and housework were the most common examples of PA/Ex in which the informants were already participating. However, according to the informants' responses, perceived poor mental functioning caused by ageing influenced their choice of PA/Ex participation. Some, especially female, tended not to practise *tai chi*. Although they knew of its benefits, they thought it was complicated and that the movements were hard to memorise (despite there being some simple forms of *tai chi* which are easy to learn). Thus, strategies for promoting *tai chi* should be devised when encouraging this form of PA/Ex.

Because informants' behaviour was still rooted in and bound by Confucian ethical and moral codes, most of them preferred to exercise with people of the same gender or exercise alone. This applied especially to people with spouses, who were very careful not to exercise with members of the opposite sex. Some informants also worried about performing PA/Ex with Chinese people from mainland China because of different cultural and political backgrounds. In addition, swimming was not favoured by most informants because of various factors such as an inability to swim, their aversion to swimming in a “public tub” mentioned before, exposure to excessive coldness and wetness, but particularly because of their modesty concerns about wearing swimming suits in public. This means that the cultural background and moral codes of this group should be carefully considered before promoting activities such as walking groups and aqua-aerobics (Koo & Rowling, 2002).
This issue could also apply to programs and campaigns. As mentioned in Chapter 6, the informants raised the issues about the difference between the sports culture of Hong Kong and Australia. One example would be the “Rusty Tin Man” campaign produced by Active Australia to celebrate the International Year of Older Persons in 1999. While it aimed to encourage older Australians to become more physically active, it might actually have had the opposite effect on some of my informants if they had seen it. The TV ad (supported by other printing materials) portrayed a sedentary “Rusty Tin Man” (See Appendix 8), becoming more energetic as a result of participating in activities such as tai chi, walking, canoeing, dancing, swimming, riding bicycle and playing golf or tennis. However, as discussed elsewhere, some Hong Kong people dislike tai chi, and moreover because the ad seemed to equate “physical activity” with formal exercise, it would very likely have “turned them off”. In addition, some informants rejected PA/Ex because it seemed that it would have to be undertaken in a social setting with other people, something precluded by their concept of age and also the Confucian ethical code. They were also not familiar with some sports such as golf because both the topography and dense urbanisation have always made this pastime well-nigh impossible in Hong Kong. Therefore greater use of the underlying understanding of Chinese people is needed in the design of programs which aim to encourage PA/Ex.

**Transport**

The fact that older Chinese people inevitably have problems with transport and getting around and often have to rely on either family members or friends for transport raises problems of reciprocity (See Chapter 6). As reported in Chapter 3, “reciprocation of greetings, favours, and gifts” are all perceived as very important relational values in Chinese culture. According to the principle of (*yen⁴ qing⁴*), a person needs to return any favours they have received. The reluctance of older people to put themselves in that
position means that lack of their own or public transport makes it difficult or impossible for them to travel even short distances to venues where they can participate in PA/Ex. The use of phrases such as “I don't want to bother anyone”, or “I don't want to owe any favours” reflected their strong cultural beliefs in social harmonisation and the principle of reciprocity. Health promoters need to take account of this aspect of culture, since it also inhibits utilisation of services such as free transport pick-ups. Clearly an in-depth understanding of this group's beliefs will maximise the design of appropriate health promotion messages.

7.6 Conclusion and recommendations

Although my research base comprised only a small target group, the significance of the study lies in the fact that it was the first of its kind. As such, it has some important implications as far as stimulating awareness of this particular Chinese community is concerned and also for current health promotion paradigms. It could provide a basis for ongoing and effective action to understand the patterns of participation in preventive health behaviour among older Hong Kong Chinese people in Australia.

That said, it must be admitted the recommendations in this chapter may be too ambitious because it may not be worthwhile and cost effective to invest money, time and personnel to cater for only one ethnic group. It may also be impossible for health promoters to design various types of physical activity programs for older Hong Kong Chinese people classified in the six states of PA/Ex. However, the determinants influencing this group's low PA/Ex participation might be similar to those of other ethnic groups. Thus the determinants described in this study could form a research guideline for investigation of the preventive health behaviour of other ethnic groups in Australia. Similarly, although there may be different and more numerous states of PA/Ex participation in another
Chinese community, the findings of this study can inform health promoters in Australia about the specific beliefs about preventive health care among Hong Kong Chinese and provide direction for the design of appropriate interventions and research for different states of behavioural intentions. All of this justifies the recommendations which are made below.

**Understandings of health**

Health is more than simply “health care” (Liamputtong & Gardner, 2003, p. 3). As should be clear from the material presented in this thesis, it also involves various cultural, social and environmental factors. My findings demonstrate that the preventive health behaviours of my informants could be divided into macrocosmic and microcosmic aspects. The macrocosmic include society as a whole, the environment and the social welfare system, while the microcosmic include the balance of diet, PA/Ex, being open-minded, having regular health checkups and living a healthy lifestyle. They see the maintenance of balance and harmony between all these components as the fundamental principle of physical, mental and social wellbeing.

That my informants had their own unique beliefs about health and preventive health care indicates that they are truly at the crossroads of East and West. While Hongkongese continue to be influenced by British culture, their daily lives and cultural values are still rooted in Confucianism, Taoism, and Buddhism. The same is true of their health beliefs and practices which evidence an admixture of ideas about OWM and TCM. Furthermore, since the health-seeking and preventive behaviours of Hong Kong people are crisis- and situation-orientated, this Chinese group also exhibits idiosyncratic and pragmatic responses to preventive health care.
These responses are affected by their acculturation levels, which tend to be low, resulting in their having a more inflexible set of values than better acculturated Chinese people. The resultant raising of perceived barriers to PA/Ex makes their preventive health practices very much more complex. Nonetheless, it is possible to minimise the impact of some intrinsic and extrinsic factors creating barriers to PA/Ex participation by reconceptualising the meaning of health, illness, and preventive health care in Hong Kong Chinese cultural and socioeconomic terms. That will involve consideration of interrelated factors such as cultural values and health beliefs, age, gender, education, occupation, acculturation levels, living environments, and language.

In order to decrease health expenditure, utilise health care services more effectively and also promote successful ageing for older Hong Kong Chinese people, I strongly emphasise the importance of understanding how cultural factors act on their determinants of health so that we can really address the root of the problems. This will require:

- A greater understanding of this group's specific attitude towards “birth, old, illness, and death”, their concept of age and capacity for self-care;
- Respect for the Chinese cultural heritage and values as well as health and social taboos; and
- Respect for their traditional social roles in health promotion material and medical encounters.

**The importance of culturally specific programs**

In addition, it is necessary to be aware of the typical Hong Kong communication style in order to obtain fruitful information from this Chinese group. The importance and use of the Chinese language must be acknowledged. Many Hong Kong Chinese older people speak only Cantonese and read only a complicated style of Chinese script or, in some cases, are illiterate. Bearing this in mind, all the material produced for older Hong Kong Chinese people should be in Cantonese, not Mandarin. In addition, as explained in
Chapter 5, the different Cantonese terms denoting physical activity, “Tai Nang Woot Dung” and “Yen Tai Woot Dung”, caused confusion. Appropriate Cantonese translations and complex Chinese characters for the term “physical activity” and other promotional material are also needed to avoid distortions and misunderstanding of health messages.

Furthermore, health care workers should preferably be people from Cantonese cultural backgrounds who understand the health and cultural beliefs of older Chinese people with regard to physical activity and other preventive health care. It is also desirable to design Hong Kong-style activities and to establish what are appropriate times for activities conducted by community centres for this ethnic groups. Greater use of interpreters by members of the health profession coupled with cross-cultural awareness training, could also improve culturally sensitive communications and result in better health outcomes. A greater understanding of the use and style of the Cantonese language in Hong Kong in compiling printed health promotion information; and staff development, training and employment of bilingual and bicultural interpreters and health workers will ensure a more effective service delivery to this Chinese group.

**Traditional Chinese Medicine (TCM)**

Without a deeper understanding of the role of TCM in health care practices, Western-orientated health promotion strategies will not be in a strong position to change older Hong Kong Chinese people's preventive health behaviour. In other words, the use of specific Chinese health practices derived from Chinese traditions, such as the role of food and TCM in preventive health care, may be useful in a health promotion perspective. Thus, health education activities should create links to traditions, rather than
simply introduce new concepts and activities in isolation from those traditions. There needs to be:

• Application of notions of balance and harmony and the theory of *yin/yang* in framing health messages;
• A recognition of the holistic but eclectic health beliefs of Hong Kong Chinese and the specific role that food plays in their health maintenance measures;
• Collaboration with practitioners of Chinese medicine; and
• Specific attention to the traditional communication style of older Hong Kong Chinese people when conducting further research on their health beliefs and practices.

The challenge would therefore be to develop culturally sensitive programs designed to create positive attitudes towards PA/Ex among this Chinese group. Standard, undifferentiated health care provision is not the royal road to equality of access to preventive health care services.

**Encouraging PA/Ex participation**

It is important to emphasise the benefits of PA/Ex for the target group and understand their PA/Ex patterns. In this regard it needs to be said that the typology of six states of PA/Ex participation that was developed in the study is not claimed as definitive. Rather, it elucidated the complexity of PA/Ex participation among older Chinese people from Hong Kong. Limitations of time mean that each determinant of health was not fully explored. For instance, attitudes towards life and PA/Ex, perceived social supports and barriers to PA/Ex participation as well as several determinants of health, could only be assessed on the basis of the information introduced by the informants and were not assessed by any scales or surveys. Further assessment and investigation measuring the association between these determinants of health and PA/Ex would prove valuable. It would also be advisable to initiate more research into the differences between the Chinese and Western understanding of physical activity.
**Social supports**

Social welfare supports could be an additional source of encouragement to participate in preventive health services. As seeking assistance outside the family is regarded as a cause of shame and loss of face (Martin, 1999, p. 20), using a family-centred approach, networking with Chinese organizations and Cantonese-speaking GPs and also using Chinese media are important health promotion strategies. Thus, health promoters need to think of strategies which will:

- Encourage families to adopt health strategies for promoting physical activity;
- Provide primary health care training for Hong Kong-trained GPs;
- Establish active consultative mechanisms to involve older Hong Kong Chinese people in program design and health or social policy-building; and
- Facilitate collaboration between intra- and inter-sectoral networking, GPs, Chinese organizations and health promoters for developing appropriate, effective quality services for older Chinese people from Hong Kong.

**A last word**

Finally, while at the time the study was conducted, this Chinese group displayed little intention of participating in PA/Ex, building up culturally specific social and health policies could create a supportive environment to change their attitudes. As in the Confucian doctrine mentioned in Chapter 2, the important thing is “to do the right thing in the right way” (Cheng, 1974; Monroe, 1995). The creation of a favourable external environment in the form of culturally appropriate social and health policies, could form a useful backup for this Chinese group when they feel themselves to be willing and ready to engage in PA/Ex. To move ahead towards successful ageing as individuals and society, comprehensive health-promoting actions, the pooling of resources and expertise from both government and non-government sectors by means of collaborative efforts of people of all age groups are all desirable. There is a need for the health policy-maker to design culturally appropriate elements in the National Health Strategy or the Healthy
Ageing Policy in order to tackle the problems of older Hong Kong Chinese people or other ethnic groups in Australia, because they, as much as any other Australians, deserve it.
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Appendix 1: Subject Information Statement

Disharmony between Chinese and Western views about preventive health: A qualitative investigation of the health beliefs and behaviour of older Hong Kong Chinese people in Australia

Subject Information Statement

Dear Informants,

The purpose of this letter is to enhance the information regarding the study “Disharmony between Chinese and Western views about preventive health: A qualitative investigation of the health beliefs and behaviour of older Hong Kong Chinese people in Australia”.

This study aims to explore the health beliefs, attitudes towards and knowledge about participation in preventive health care. It will also investigate the social determinants involved. Physical activity is taken as a case study. Sixty-minute face-to-face interviews will be conducted in two main parts. Part one focuses on basic demographic questions and health-related questions. Part two will involve open-ended questions related to (i) older Hong Kong Chinese people’s cultural beliefs about life, (ii) health beliefs and preventive health behaviours, (iii) attitudes towards and knowledge about physical activity as well as barriers to participation in physical activity. Interviews will take place in a private location. Informants will be interviewed by a Cantonese-speaking Chinese researcher (Miss Fung Kuen Koo) and all answers will be recorded on tape.

You are assured that information obtained from the interviews will be treated in strict confidence. It will be kept safely in a locked filing cabinet and destroyed after five years. Individual informants will not be identifiable from the data set (no names or personal identifiers placed on the tapes) nor from the results contained in the thesis or in future publications related to the study.

This research study is being supervised by Dr Louise Rowling and has ethics approval. The work will be included in a thesis Miss Koo is completing as part of a PhD degree. The information obtained will not be used for purposes other than those specified in the consent form. If you are (1) a resident who has lived in Australia for two years and longer; (2) aged 60 years and over; (3) a Cantonese speaker (China or Hong Kong-born) who has migrated from Hong Kong; you are eligible to be an informant of the study. Your participation is voluntary. You are free to refuse or to end your participation at any time without penalty and prejudice. You can request that all or any of the recorded tape be erased if you so wish.
If you have any questions, please do not hesitate to contact me (Miss Koo) on 02-93513696 (email: fkoo1433@mail.usyd.edu.au) or my supervisor, Dr Louise Rowling, on 02-93516389 (email: l.rowling@edfac.usyd.edu.au).

If you have any concerns or complaints in relation to this research study, you can contact the Manager of Ethics and Biosafety Administration, University of Sydney on 02-93514811.

I would like to express my sincere appreciation for your help.

Yours faithfully,

Fung Kuen Koo
PhD student of the University of Sydney
Faculty of Education and Social Work
附錄一: 研究調查內容聲明

華人與西人對預防性健康護理的不同看法
就香港來澳華僑長者對健康的看法與行為所進行的研究

研究調查內容聲明

各位朋友你們好:

本人現於悉尼大學進行一項研究，題目為「華人與西人對預防性健康護理的不同看法: 就香港來澳華僑長者對健康的看法與行為所進行的研究」，茲謹此致函詳述有關之研究。

該項研究旨在探討來自香港的澳洲華僑長者對於預防性健康護理的看法、態度及認識，以及影響他們參與預防性健康護理的社會因素。本人將以體能活動作為研究個案。參與該項研究的人士將會接受約一小時的面談訪問，而訪問內容主要分為兩部份：第一部份主要包括基本的人口及健康問題；而第二部份則主要探討：(i)香港來澳華僑長者對於有關生命的信念；(ii)對健康的看法及預防性的健康行為，以及(iii)華僑長者對於體能活動的態度及認識；以及阻礙他們參與體能活動的原因。該項訪問將由華籍研究員古鳳娟小姐以廣州話於私人地方進行，而訪問內容將會錄音。

閣下於訪問中所提供的資料會以保密方式處理，並將妥善鎖於文件箱內，於五年後予以銷毀。錄音帶內將不會收錄閣下的姓名或個人資料，而有關的研究論文及日後發表有關該項研究的刊物亦均不會載列閣下的個人資料。

該項研究由 Louise Rowling 博士提供顧問意見，並已通過道德審批。研究資料將載錄於古鳳娟小姐的博士論文內，並僅用作隨附的同意書上所指定的用途。如閣下(1)於澳洲居留滿兩年或以上；(2)年滿六十歲或以上；及(3)由香港移居澳洲（於中國或香港出生均可），並以廣州話為母語，即可參與這項研究。鑑於參與該項研究乃屬自願性質，故閣下可拒絕接受或隨時退出該項研究而毋須承擔任何責任，亦不會因而受到歧視。閣下更可要求刪除錄音帶的全部或部份內容。

如欲垂詢，請與本人聯絡（古鳳娟小姐 電話：02-93513696；電郵地址：fkoo1433@mail.usyd.edu.au）或該研究顧問 Louise Rowling 博士（電話 02-93516389；電郵地址：l.rowling@edfac.usyd.edu.au）。

閣下如對該項研究有任何疑問或投訴，請致電 02-93514811 與悉尼大學道德及生物安全經理聯絡。

如蒙閣下支持，本人將不勝感激。

古鳳娟

悉尼大學博士研究生
Appendix 2: Consent Form

Disharmony between Chinese and Western views about preventive health: A qualitative investigation of the health beliefs and behaviour of older Hong Kong Chinese people in Australia

Consent Form

I willingly agree to participate in the study “Disharmony between Chinese and Western views about preventive health: A qualitative investigation of the health beliefs and behaviour of older Hong Kong Chinese people in Australia”.

I have been informed that my participation will involve answering questions about health beliefs and preventive health behaviours asked by the researcher (Miss Koo) at a private location and my answers will be recorded on tape. I have been told that my participation is voluntary, and that I am free to refuse or to end my participation at any time without penalty and prejudice. I have also been told that I may request that any or all of any part of the tape be erased if I so wish.

To assure confidentiality, there will be no names or personal identifiers placed on these tapes. The information obtained will be kept safely in a locked filing cabinet and destroyed after five years. Having been informed that my name will not be used, and that the information obtained will not be used for purposes other than those specified in the consent form, I also consent to publication of this study.

I understand that there are no known risks involved in this study and my participation may benefit others in the future.

I understand that if I have any questions, I can contact Ms Koo on 02-93513696 or Dr Louise Rowling on 02-93516389.

I also understand that if I have any concerns or complaints in relation to this research study, I can contact the Manager of Ethics and Biosafety Administration, University of Sydney on 02-93514811.

Signature: _______________________________ Date: ________________

(Print Name: _______________________________)

Researcher: Fung Kuen Koo
PhD student of the University of Sydney
Faculty of Education and Social Work
附錄二：同意書

華人與西人對預防性健康護理的不同看法：
就香港來澳華僑長者對顧護的看法與行為所進行的質化研究分析

同意書

本人同意參與由悉尼大學進行的研究——
「華人與西人對預防性健康護理的不同看法：就香港來澳華僑長者對健康的看法與行為所進行的質化研究分析」。

據本人所知，本人於參與該項研究後，將獲安排進行一項與健康看法及預防性健康護理有關的錄音訪問，而訪問將由研究員古鳳娟小姐於私人地方進行。本人明白參與該項研究乃屬自願性質，故可拒絕接受或隨時退出該項研究而毋須承擔任何責任，亦不會因而受到歧視。本人亦獲悉本人可要求刪除錄音帶的全部或部份內容。

為確保資料得到保密處理，錄音帶內將不會收錄本人的姓名或個人資料，而研究所得的資料亦將妥善鎖於文件柜內，並於五年後予以銷毀。據悉，本人的姓名將不會被公開，而所提供的資料亦不會用作非本同意書所指定的用途；故此，本人同意有關資料可予以刊印。

本人明白該項研究並無涉及任何已知的風險，而本人的參與日後可能使他人受惠。

本人明白如有任何查詢，可聯絡古鳳娟小姐（電話：02-93513696）或 Louise Rowling 博士（電話：02-93516389）。

本人亦明白如對該項研究有任何疑問或投訴，可致電 02-9351 4811 與悉尼大學道德及生物安全經理聯絡。

簽署: ___________________________ 日期: ___________________________

（姓名: ___________________________）

研究員: 古鳳娟
悉尼大學博士研究生
教育及社會工作系
Appendix 3: Interview Questions for Face-to-face In-depth Interview

Part I. Personal details:

- What is your age?
- What is your religion?
- Where were you born?
- What is your language spoken at home?
- When did you migrate to Australia?
- In total, how long have you stayed in Australia?
- How often have you been back to Hong Kong?
- (Probe: For how long?)
- (Probe: For what reason?)
- What is your marital status?
- How many children do you have?
- Where do you live?
- Who do you live with?
- How do you feel about your life in Australia?
- Which year of schooling did you complete?
- Where did you obtain your education?
- How do you rate your level of English proficiency?
- What is your current employment?
- What is your source of living expenses?
- How much is your income?
- (Probe: How much per week/month/year?)
- (Probe: Do you think that it is sufficient or not?)
- What do you think about your socioeconomic status?
- (Probe: Is it high, middle, or low?)
- What do you think about your current health status?
- (Probe: What current or previous health problems do you have? Have you been hospitalised?)
- (Probe: Do you receive any drug treatment?)
- (Probe: Are you totally able to care for yourself?)
- (Probe: Do you smoke?)
- (Probe: Do you drink any alcohol?)
- What is your main transportation?
- (Probe: Do you drive?)
- What is your daily routine?
- (Probe: What do you usually do in a day?)
- (Probe: Do you have any social activity? How often?)
- (Probe: Do you think that you are socially active or inactive?)

For the questions about acculturation level, refer to Appendix 5.
Part II. Cultural belief about life and ageing:

- What is your own viewpoint about life?
  (Probe: Is there anything that influences your way of living?)
- (Probe: There is a Chinese saying, “birth, ageing, illness and death”. What do you think about each stage of life?)
- What do you think about “old”?
  (Probe: What does “old” mean to you?)
- (Probe: What do you feel about “old”?)
  (Probe: What are the differences in your life as you get older?)
- (Probe: How about when you were in your 20s, 30s, 40s and so on?)
- What do you do to cope with this life process?
  (Probe: How about the final part of life?)
- (Probe: In what ways does this thinking influences your beliefs and behaviour about health and illness?)

Health beliefs and preventive health behaviour:

- What does “being healthy” mean to you?
  (Probe: Why do you think so?)
- What do you do to promote health?
  (Probe: What do you do to stay healthy?)
- (Probe: What do you eat to stay healthy?)
- What does “illness” mean to you?
  (Probe: Why do you think so?)
- What do you do to prevent illness?
- What do you do when you get sick?
  (Probe: Do you see a doctor?)
  (Probe: Do you use any other methods? What are they?)
- In Australia, some health promotion campaigns can be seen on TV, posters or heard on radio. What do you think about them?
  (Probe: What kind of program did you join before or currently in Australia?)
  (Probe: Can you tell me your experience?)
  (Probe: What about in Hong Kong?)
- How did you get the health information to keep you healthy?
  (Probe: From where?)
  (Probe: By whom?)
  (Probe: Did you receive any health information before you migrated to Australia?)
  (Probe: Did you receive any health information after you migrated to Australia?)
  (Probe: What was it?)
  (Probe: What do you think about this health information?)
Part III. Physical activity:

- Have you heard about physical activity?
- What is physical activity?
  - (Probe: What does it mean to you personally?)
- What is your opinion about physical activity?
  - (Probe: What are the advantages of being involved in physical activity for you personally?)
- (Probe: What are the disadvantages of being involved in physical activity for you?)
- What kinds of physical activity do you prefer?
  - (Probe: Why do you have these preferences?)
- What physical activity do you currently participate in?
  - (Probe: In what ways do you participate? How often?)
- (Probe: Do you think that you are physically active or inactive? Why?)
- What physical activity did you participate in, in your home country, before you migrated to Australia?
  - (Probe: What has been your previous experience?)
- What reasons are there for you to participate in physical activity?
  - (Probe: What makes it easy for you to perform physical activity?)
- (Probe: Of the people who are important to you, who approves of you performing physical activity?)
- What makes it difficult for you to participate in physical activity?
  - (Probe: Can you tell me your experience?)
- (Probe: Does anyone disapprove of you performing physical activity? Who?)
- What did you do to overcome these barriers?
  - (Probe: Did you experience any difficulties in overcome these barriers?)
- What is your ideal setting for physical activity?
附錄三: 面談訪問的問題

第一部份 個人資料

- 你的年紀有多大？
- 你有甚麼宗教信仰？
- 你在哪里出生？
- 你在家裡說甚麼語言？
- 你在那一年移居澳洲？
- 你在澳洲合共居住了多久？
- 你有多經常返回香港？
  (提示: 逗留多久?)
  (提示: 為甚麼回港?)
- 你的婚姻狀況如何？
- 你有多少個子女？
- 你住在哪裡？
- 你和誰一起居住？
- 你覺得你在澳洲的生活如何？
- 你的學歷如何？
- 你在哪裡接受教育？
- 你覺得你的英語水平如何？
- 你是做哪一個行業的呢？
- 你的生活費來自哪裡？
- 你的收入有多少？
  (提示: 每星期/月/年有多少?)
  (提示: 你認為是否足夠?)
- 你的社會及經濟狀況如何？
  (提示: 屬於高尚階級、中階階級或低下階層？)
- 你認為你目前的健康狀況如何？
  (提示: 你現在或以前有甚麼健康問題？你是否入院接受治療？)
  (提示: 你有否接受藥物治療？)
  (提示: 你是否完全可以自己照顧自己？)
  (提示: 你是否吸煙？)
  (提示: 你是否有飲酒的習慣？)
甚麼是你主要的交通工具？
（提示：你會開車嗎？）

你日常會做甚麼？
（提示：你一天裡通常會做甚麼？）
（提示：你有沒有參與社交活動？多久參與一次？）
（提示：你認為你在社交方面屬於活躍還是被動？）

有關同化程度的問題，請參閱附錄（五）。

第二部分 有關人生與老的文化觀念：

你對生命有甚麼看法？
（提示：有沒有甚麼東西影響著你的生活方式？）
（提示：俗語有所謂「生、老、病、死」。你對生命中的每個階段有甚麼看法？）

你對「老」有甚麼看法？
（提示：「老」對你來說代表了甚麼？）
（提示：你對「老」有甚麼想法？）
（提示：隨著年齡增長，你的生命有甚麼轉變？）
（提示：當你二十多歲、三十多歲、四十多歲，年紀不斷增長的時候，你又有甚麼感想？）

你怎樣面對這個「生、老、病、死」的過程？
（提示：你怎樣面對人生的下半場？）
（提示：這種想法又影響你對健康與疾病的看法及行為？）

健康看法及預防性的健康行為：

你認為「健康」是甚麼意思？
（提示：為什麼你會有這種想法？）

你怎樣使自己更健康？
（提示：你怎樣保持身體健康？）
（提示：你吃甚麼來保持身體健康？）

你認為「疾病」是甚麼意思？
（提示：為什麼你會有這種想法？）

你怎樣預防疾病？
當你生病的時候會怎樣做？
( 提示: 你是否會去看醫生？)
( 提示: 你會否借助其他方法？你會用甚麼方法？)
澳洲有一些電視節目、海報或電台節目會宣傳有關健康推廣的活動。你對這些活動有甚麼看法？
( 提示: 你移居澳洲之前／目前你在澳洲曾參加過哪些活動？)
( 提示: 可否分享一下你的經歷？)
( 提示: 在香港的時候你又參加過哪些活動？)
你怎麼得知有關保健的資料？
( 提示: 從哪裡得知?)
( 提示: 從誰得知?)
( 提示: 在移居澳洲之前，你有否聽到關於保健的資料？)
( 提示: 在移居澳洲之後，你有否收到任何有關健康的資訊？)
( 提示: 這是甚麼資訊？)
( 提示: 你對這些健康資訊有甚麼看法？)
第三部份: 體能活動:

• 你有否聽過體能活動?
• 甚麼是體能活動?
  （提示：對你個人而言，體能活動是甚麼意思？）
• 你對體能活動有甚麼看法?
  （提示：對你個人而言，參與體能活動有甚麼好處？）
  （提示：參與體能活動有甚麼害處？）
• 你喜歡做哪類體能活動?
  （提示：你為什麼喜歡做那類體能活動？）
• 你現在做哪種體能活動?
  （提示：你怎樣參與哪類體能活動？有多經常參與哪類體能活動？）
  （提示：你認為自己是活躍的人還是不活躍的人？為甚麼？）
• 移居澳洲之前，你在原來的地方曾參與哪類體能活動?
  （提示：你在這方面有甚麼經驗？）
• 你為什麼會參與體能活動?
  （提示：有甚麼東西有助你參與體能活動？）
  （提示：你身邊有哪一位對你很重要的人贊成你參與體能活動？）
• 有甚麼東西勸阻你不參與體能活動?
  （提示：可否分享一下你的經驗？）
  （提示：有沒有人不贊成你不參與體能活動？是誰不贊成？）
• 你怎樣排除這些障礙?
  （提示：在排除這些障礙時，你遇到甚麼困難？）
• 你認為一個做體能活動的理想環境應該是怎樣的呢？
Appendix 4: Sociodemographic Table for Older Hong Kong Chinese People Resident in Australia*

<table>
<thead>
<tr>
<th>Informant No.</th>
<th>1</th>
<th>2</th>
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<td>Mrs Leung</td>
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<td>M</td>
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<td>Yes</td>
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<td>North Epping</td>
<td>West Ryde</td>
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<td>Non-drinker</td>
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<td>Hypertension, diabetes, heart disease</td>
<td>Bone pain (arthritis)</td>
<td>Retinal detachment</td>
<td>High blood cholesterol</td>
<td>Leg pain (arthritis)</td>
<td>Indigestion</td>
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<td>Yes</td>
<td>Yes</td>
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<td>Yes</td>
<td>Yes</td>
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<td>Can't drive</td>
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<td>Can't drive</td>
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<tr>
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<td>Inactive</td>
<td>Active</td>
<td>So-so</td>
<td>Inactive</td>
<td>So-so</td>
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</tr>
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<td>Active</td>
<td>So-so</td>
<td>So-so</td>
<td>So-so</td>
<td>So-so</td>
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<td>6 days/week</td>
<td>Everyday</td>
<td>Everyday</td>
<td>Twice a day</td>
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*Items listed in the table are self-reported by the informants except those with + and #
+Item is assessed by researcher's personal observation
#Categorisations are made by acculturation scale, researcher's personal adjustment and the knowledge of culture; see Chapter 4 & Appendix 5 for details.
<table>
<thead>
<tr>
<th>Informant No.</th>
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<td>Name (fictitious):</td>
<td>Mr Chin</td>
<td>Mr Wai</td>
<td>Mr Law</td>
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<td>Chatswood</td>
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<tr>
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<td>$190/week</td>
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<td>Sufficient</td>
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<td>Middle</td>
<td>Middle-low</td>
<td>Middle</td>
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<td>So-so</td>
<td>So-so</td>
<td>So-so</td>
<td>So-so</td>
<td>So-so</td>
</tr>
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<td>Smoking status:</td>
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<td>Nonsmoker</td>
<td>Nonsmoker</td>
<td>Ex-smoker</td>
<td>Nonsmoker</td>
<td>Nonsmoker</td>
<td>Nonsmoker</td>
</tr>
<tr>
<td>Alcohol consumption:</td>
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<td>Social drinker</td>
<td>Ex-drinker</td>
<td>Nondrinker</td>
<td>Nondrinker</td>
<td>Social drinker</td>
<td>Nondrinker</td>
<td>Nondrinker</td>
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<td>Main health problem:</td>
<td>Hypertension, back injury, enlarged prostate</td>
<td>Hypertension</td>
<td>Hypertension, joint pain</td>
<td>Hay fever</td>
<td>Knee pain (arthritis)</td>
<td>Nil</td>
<td>Nil</td>
<td></td>
</tr>
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<td>No. of hospitalisation:</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Once</td>
<td>Once</td>
<td>Once</td>
<td></td>
</tr>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Nil</td>
<td>Nil</td>
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<td>Drive</td>
<td>Can't drive</td>
<td>Drive</td>
<td>Can't drive</td>
</tr>
<tr>
<td>Social activity (self-reported):</td>
<td>So-so</td>
<td>Inactive</td>
<td>So-so</td>
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<td>Active</td>
<td>Inactive</td>
<td>Active</td>
<td>So-so</td>
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<td>2 time/week</td>
<td>Once a week</td>
<td>Twice a week</td>
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<td>2-3 times/week</td>
<td>1-2 times/week</td>
<td>1-2 times/week</td>
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<td>Physical activity (self-reported):</td>
<td>Inactive</td>
<td>Active</td>
<td>So-so</td>
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<td>Active</td>
<td>Active</td>
<td>Active</td>
<td>So-so</td>
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<tr>
<td>No of physical activity:</td>
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<td>Everyday</td>
<td>At least 5 times/week</td>
<td>Little</td>
<td>Everyday</td>
<td>Everyday</td>
<td>6 days/week</td>
<td>Everyday</td>
</tr>
</tbody>
</table>

*Items listed in the table are self-reported by the informants except those with + and #
+Item is assessed by researcher's personal observation
#Categorisations are made by acculturation scale, researcher's personal adjustment and the knowledge of culture; see Chapter 4 & Appendix 5 for details.
<table>
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<th>Informant No.</th>
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<th>22</th>
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<td>Name (fictitious):</td>
<td>Mrs Yuen</td>
<td>Mrs Mo</td>
<td>Mr Wan</td>
<td>Mrs Chiu</td>
<td>Mrs Ho</td>
<td>Mr Lau</td>
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<td>60</td>
<td>64</td>
<td>72</td>
<td>60</td>
<td>65</td>
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<td>F</td>
<td>M</td>
<td>F</td>
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<td>M</td>
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<td>China</td>
<td>Hong Kong</td>
<td>Hong Kong</td>
<td>China</td>
</tr>
<tr>
<td>Years living in Australia:</td>
<td>10.5 years</td>
<td>19.5 years</td>
<td>9 years</td>
<td>10 years</td>
<td>3 years</td>
<td>16 years</td>
</tr>
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<td>No. of visit to Hong Kong</td>
<td>Nil</td>
<td>Visit x 3</td>
<td>Every year</td>
<td>Once</td>
<td>Every year</td>
<td>Visit x 4</td>
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<td>Married</td>
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<td>Nil</td>
<td>Yes</td>
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<td>West Ryde</td>
<td>Lane Cove</td>
<td>Penshurst</td>
<td>Lane Cove</td>
<td>Carlingford</td>
<td>Granville</td>
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<td>Live with wife</td>
<td>Live with husband</td>
<td>Live with husband</td>
<td>Live with family</td>
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<td>Life satisfaction:</td>
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<td>Satisfied</td>
<td>Satisfied</td>
<td>Satisfied</td>
<td>Satisfied</td>
<td>Satisfied</td>
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<td>Bachelor degree x 2</td>
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<td>Hong Kong</td>
<td>Hong Kong</td>
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<td>Good</td>
<td>Average</td>
<td>Average</td>
<td>Average</td>
<td>Average</td>
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<td>Employment:</td>
<td>Retired</td>
<td>Volunteer</td>
<td>Part-time cleaner</td>
<td>Cleaner</td>
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<td>Source of living expenses:</td>
<td>Savings &amp; Superannuation</td>
<td>Husband</td>
<td>Wife &amp; saving</td>
<td>Pension</td>
<td>Pension &amp; employer</td>
<td>Employer &amp; children</td>
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<td>$630/wk</td>
<td>Enough to meet the expenses</td>
<td>$200/wk</td>
<td>$190/wk</td>
<td>$300/wk</td>
<td>$450 wk</td>
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<td>Sufficiency of expenses:</td>
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<td>Sufficient</td>
<td>Insufficient</td>
<td>Insufficient</td>
<td>Insufficient</td>
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<td>Low</td>
<td>Middle</td>
<td>Middle</td>
<td>Low</td>
<td></td>
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<tr>
<td>Physical condition:</td>
<td>So-so</td>
<td>So-so</td>
<td>Good</td>
<td>So-so</td>
<td>So-so</td>
<td></td>
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<tr>
<td>Smoking status:</td>
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<td>Nonsmoker</td>
<td>Nonsmoker</td>
<td>Nonsmoker</td>
<td>Ex-smoker</td>
</tr>
<tr>
<td>Alcohol consumption:</td>
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<td>Nondrinker</td>
<td>Nondrinker</td>
<td>Social drinker</td>
<td>Ex-drinker</td>
<td></td>
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<td>Hypertension</td>
<td>Asthma, uterine fibroid</td>
<td>Bone pain, high cholesterol</td>
<td>Hypertension, arthritis, parkinson</td>
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<td>No. of hospitalisation:</td>
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<td>Nil</td>
<td>Twice</td>
<td>Once</td>
<td>Nil</td>
<td>Three</td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Nil</td>
<td>Yes</td>
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<td>Transportation</td>
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<td>Can't drive</td>
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<td>Drive</td>
<td>Drive</td>
<td>Drive</td>
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<tr>
<td>Social activity (self-reported):</td>
<td>So-so</td>
<td>So-so</td>
<td>Inactive</td>
<td>Inactive</td>
<td>Inactive</td>
<td>Inactive</td>
</tr>
<tr>
<td>No. of social activity:</td>
<td>Irregular</td>
<td>2-3 times/week</td>
<td>No</td>
<td>Once a month</td>
<td>Irregular</td>
<td>Once a week</td>
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<td>Little</td>
<td>No</td>
<td>Little</td>
<td>Irregular</td>
<td>Irregular</td>
</tr>
</tbody>
</table>

*Items listed in the table are self-reported by the informants except those with + and #
+Item is assessed by researcher's personal observation
#Categorisations are made by acculturation scale, researcher's personal adjustment and the knowledge of culture; see Chapter 4 & Appendix 5 for details.
Appendix 5: Modified Questions from Rissel’s Assessment of Acculturation Scale Items (1997, p. 608)

1. What language do you normally speak at home?
   Only Cantonese
   Mostly Cantonese
   English and Cantonese
   Mostly English
   Only English

2. What language do you normally speak with your friends?
   Only Cantonese
   Mostly Cantonese
   English and Cantonese
   Mostly English
   Only English

3. What language do you prefer?
   Only Cantonese
   Mostly Cantonese
   English and Cantonese
   Mostly English
   Only English

4. What language do you read better?
   Only Chinese
   English and Chinese equally
   English

5. What language do you write better?
   Only Chinese
   English and Chinese equally
   English

6. What ethnic group do you identify with?
   Only Chinese/Hongkongese
   Mostly Chinese/Hongkongese
   Australian and Chinese/Hongkongese equally
   Mostly Australian
   Only Australian

7. In what language do you usually think?
   Only Cantonese
   Mostly Cantonese
   English and Cantonese
   Mostly English
   Only English
8. When did you last listen to Chinese radio/read newspaper?
   Within the last 7 days
   Within the last 30 days
   Within the last year
   More than a year ago
   Never listen to Chinese radio/read newspaper

9. When did you last watch Chinese TV/video?
   Within the last 7 days
   Within the last 30 days
   Within the last year
   More than a year ago
   Never watched Chinese TV/video

10. What type of food do you eat most?
    Mostly Chinese
    More Chinese than Australian
    Equal amounts of Chinese and Australian food
    More Australian than Chinese
    Mostly Australian

11. How important to you is it that the Chinese traditions are followed?
    Very important
    Somewhat important
    Not very important
    Not at all important

12. How often do you attend Chinese recreational or religious events?
    All of the time
    Much of the time
    Half of the time
    Not much
    None of the time
附錄五：Rissel及Khavarpour（1997, p.608）用以評估外國移民同化程度的問題（經修訂）

1. 你在家裡通常說那一種語言？
   - 只說廣州話
   - 較常說廣州話
   - 英語及廣州話兼用
   - 較常說英語
   - 只說英語

2. 你和朋友一起時，通常用那一種語言？
   - 只說廣州話
   - 較常用廣州話
   - 英語及廣州話兼用
   - 較常用英語
   - 只說英語

3. 你喜歡哪一種語言？
   - 只說廣州話
   - 較常用廣州話
   - 英語及廣州話兼用
   - 較常用英語
   - 只說英語

4. 你在那一種語言的讀能力較佳？
   - 中文
   - 英文及中文均差不多
   - 英文

5. 你在那一種語言的書寫能力較佳？
   - 中文
   - 英文及中文均差不多
   - 英文

6. 你認為自己屬於哪個種族？
   - 中國人／香港人
   - 較常認為自己是中國人／香港人
   - 既是澳洲人，同時又是中國人／香港人
   - 較常認為自己是澳洲人
   - 澳洲人

7. 你通常用哪一種語言來思考？
   - 只用廣州話
   - 較常用廣州話
   - 英語及廣州話兼用
   - 較常用英語
   - 只用英語
8. 你最近一次收聽中文電台／閱讀中文報章是在甚麼時候？
   在最近7日內
   在最近10日內
   在最近一年內
   在超過一年之前
   從來沒有收聽中文電台／閱讀中文報章

9. 你最近一次看中文電視／中文影帶是在甚麼時候？
   在最近7日內
   在最近10日內
   在最近一年內
   在超過一年之前
   從來沒有看過中文電視／中文影帶

10. 你較常吃哪種食物？
    較常吃中國菜
    吃中國菜比吃澳洲菜多
    吃中國菜和吃澳洲菜的機會差不多
    吃澳洲菜比吃中國菜多
    較常吃澳洲菜

11. 中國傳統於你來說有多重要？
    非常重要
    有點重要
    不太重要
    完全不重要

12. 你有多常參與中國的康樂或宗教活動？
    常常參與
    很多時間參與
    有部份時間參與
    很少參與
    從來沒有參與
Appendix 6: Summarised Page

Interview details:

Name: Ms Chan-P12
Location/setting: Participant’s home in Penshurst
Date: 18/4/01
Reason for selection: Met the interview requirement
Time: Arrived at 4pm, chatted for 30 mins, started at 4:30pm & finished at 5:40pm, left at 6pm
Relationship: Mrs Siu’s mother
Duration: 70mins
Spec. circumstances: Tape-recording permitted

Demographic data:

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<td>Sufficiency of expenses:</td>
<td>Sufficient</td>
</tr>
<tr>
<td>Religion:</td>
<td>Christianity</td>
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<td>Middle</td>
</tr>
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<td>Birthplace:</td>
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</tr>
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<td>Language spoken at home:</td>
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<td>Smoking status:</td>
<td>Nonsmoker</td>
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<td>Country of migration:</td>
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<td>Alcohol consumption:</td>
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</tr>
<tr>
<td>Years living in Australia:</td>
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<td>Health problem:</td>
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<tr>
<td>Marital status:</td>
<td>Married</td>
<td>No. of hospitalisations:</td>
<td>Nil</td>
</tr>
<tr>
<td>No. of children:</td>
<td>1 daughter</td>
<td>Medication:</td>
<td>Drugs for H/T &amp; joint pain</td>
</tr>
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<td>Living area:</td>
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</tr>
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<td>Living status:</td>
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<td>No. of social activities:</td>
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<tr>
<td>Life satisfaction:</td>
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<td>Social activity:</td>
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<td>Acculturation level:</td>
<td>Prefer Cantonese/Chinese food &amp; friends; Mainly Chinese newspaper /TV</td>
</tr>
<tr>
<td>Source of living expenses:</td>
<td>Interest of savings</td>
<td></td>
<td></td>
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</table>

Interview Summary:

Questions

Physical activity’s concept
Don’t know what PA is (running & walking?); Exercise means moving here & there/housework (mopping & cleaning floors, mowing the lawn, planting flowers); Don’t fix time; Move more when feeling well & having energy; Mild is better; Move at any time she wants

Preference
Quiet; Likes doing her own work and doesn’t like a lot of people; Won’t choose swimming (don’t know how to swim, avoid wet and embarrassing to wear swimming suit)

Experience
In H.K. treat walking to the market as exercise; Can’t do lug tung kün (because can’t lift legs up & feel painful); Played balls game when young

Advantages
Bone & joints will be better & move smoothly (become stiff if not moved); Good for health

Disadvantages
Chest discomfort if overdone

Source of information
Doctor gives information only about disease

Motivation
Greater movement for the part feeling unwell; Continue to do exercise when feeling arms & legs are good; Good mood on a sunny day

Social support
Daughter

Barriers
Can’t squat (leg pain); No morning walk (can’t walk far away & leg pain); Boring to walk alone & afraid of getting lost but no one can walk with her (daughter is busy/husband can’t walk); Can’t catch up if walking with others; Nothing available; Can’t speak English; Feel dizzy & easily get tired

Barriers solving
Move in bedroom when feeling unwell; Open the door if she needs fresh air; Move at home

Ideal setting
Quiet; Depending on her own ability; Don’t like people to rush her

Salient point from interviewee: “When I was in your age, if I went to swim, if I wore swimming suit, the people were very conservative”, “even my father-in-law would also blame me”, “it’s so ugly. As a woman, you wore a tight swimming suit, you are so bad”, “they were not so open-minded”.

Further questions:

- Although she said that she is physically inactive, she moves at home every day. Is she really inactive?
- If tai chi lug tung kün is hard to memorise, swimming is not good, morning walking will get lost, what kind of exercise is good for introverted person? Home exercise?
- What can we do if physically inactive people need to take care of frail family members at home but they don’t want to bother anyone?
Appendix 7a: Case Summary – PA/Ex Supporter: Mr Lee (8)

Mr Lee, a 75-year-old Catholic, rated his health condition as poor because he had many health problems such as arthritis, hypertrophy of the prostate, heart problems, high blood pressure and diabetes. He had once contracted hepatitis and still experienced problems with his liver. He also suffered from insomnia. Luckily, he said, all these health issues had been brought under control because he exercised every day.

Mr Lee was very healthy and active when he was young, especially during his college years. He played table tennis, basketball, volleyball, and football. Mr Lee thought that tai chi and qigong were very effective in improving his health when used together, with the regulation of his diet and sleeping habits. He was concerned about his diet and sleep patterns due to problems with diabetes. His meals included a lot of vegetables and fruit. He normally did qigong and tai chi in the morning and before he went to bed, sometimes even after lunch, each time for 30 minutes. He did it daily, even on rainy days. He said tai chi and qigong did one good, while there were no side effects whatsoever.

In the past, Mr Lee had been very tense and his mind restless. However, after learning tai chi and qigong for half a month, his sleeping difficulties eased and he became very relaxed. He even stopped taking sleeping pills. Mr Lee stated that there were some kinds of massage involved in tai chi and qigong, which served to strengthen one's immune system. He used to catch flu all year round, but after doing tai chi, qigong and massage, this was no longer case. He had kept this practice for the past ten years, and now he did not have to take any medicine. The distortion of his joints was also less serious.

Mr Lee had done tai chi for more than 20 years. His doctor in Australia did not know he was doing tai chi; besides giving him advice on his diet, he did not really encourage Mr Lee to exercise. His family did not interfere with his doing tai chi, as it did not concern money issues. Mr Lee would love to join one or more Chinese associations when he was available. Mr Lee concluded that tai chi and qigong were good for one's health and that one should adjust one's lifestyle to include exercise to stay healthy.
Appendix 7b: Case Summary – PA/Ex Supporter: Mr Wai (10)

Mr Wai, aged 73, was retired and loved doing exercise. Mr Wai liked to say “jogging, jogging, I jog every morning”. He felt his health condition very good because he never had any severe health issues. He had not seen the doctor for more than 20 years and he never took any medicine. He said not many people were as healthy as he was. He believed that he understood his body even better than his doctor. He could feel it when his body felt unwell. His body was like a machine, and he was the operator.

Mr Wai thought exercise had many benefits for his health. His haemorrhoids and rheumatism disappeared after he started jogging. His legs used to cramp at night while he was sleeping, but jogging improved his circulatory system and the situation improved. He broke his finger when he was young, and therefore his blood did not circulate well there. His fingers experienced numbness on rainy days. But after he went jogging, the rheumatism healed and this problem disappeared.

Mr Wai believed that doing exercise was like eating. You had to do it every day to see the result. He said he used to have a very effortless job in Hong Kong, therefore he always had the time to do exercise after work. He chose jogging as unlike tai chi, it did not involve too much thinking or memorising. He also went swimming when he was young, and said it was not hard to learn to swim. He also did gardening and housework. He regarded these activities as exercises. However, he would not force himself to do anything, and thought one should do exercise willingly and happily.

After waking, Mr Wai would go jogging after doing a few minutes of warm-up exercises. He liked doing exercise alone in the morning as the air was fresher. Also, he felt that it was appropriate to exercise all year round, regardless of the season. He would go jogging even if it was very hot outside, as it would make him sweat a lot, which felt good. He was not afraid of any accidents like slipping, therefore he would go jogging even on rainy days. He never caught flu. Mr Wai had been jogging for more than 40 years. He would feel uneasy if he did not go jogging in the morning, and he would naturally feel comfortable after jogging in the morning. He said that just as the earth constantly rotated, people should keep exercising their body.
Appendix 7c: Case Summary – PA/Ex Supporter: Mr Law (11)

It was a rainy day. Mr Law was doing tai chi on the balcony when I met him. Mr Law looked a bit fat but he was strong and cheerful. I could not imagine he was already 74 years old. He was proud of being a sailor when he was young as he had a chance to travel around the world. When we were talking in the sitting room, he could not sit still, and admitted he could not sit at home for long. He liked moving his body all the time and he said he had loved doing exercise since he was young. He sometimes did tai chi and he sometimes took a morning walk because it was cooler and the air was fresher. He immediately demonstrated tai chi for me. He said he would feel at a loss if he did not exercise.

In Australia he did not have any friends close enough to take a walk with him. Most of his friends here in Australia were church members, who he would meet once a week. When he was in Hong Kong, he exercised on the cycling machine for 30 minutes a day and lifted dumbbells. While he believed that such exercise was good for his legs and arms, he never bought this equipment after coming to Australia. Instead, he would do push-ups for an hour, and would go for an hour’s walk every day. This was not a problem for him. Mr Law had read in some magazines that swimming was as good for one’s health as cycling. He was willing to learn swimming if someone would teach him. In a way, he felt ashamed because he did not know how to swim even though he used to be a sailor. Therefore he preferred land activities to water activities.

When it came to his health, Mr Law stated that his health condition was “so-so”. His blood pressure was high, therefore he had to see the doctor regularly and took medication to control his blood pressure. He was overweight, and his doctor said that he needed to lose some weight. He thought losing weight would make him less clumsy. Nevertheless, his doctor never asked him to exercise. He did exercise simply because it was his interest and good for his health. Although Mr Law could not see an obvious improvement in his blood pressure, he knew that doing exercise would be good for his health, especially for the heart. To him, exercising was also good for one’s ligaments and bones. If anyone invited him to exercise classes, he would be quite interested in going, as he thought that it was good for one’s health.

To Mr Law, exercising also had its drawbacks: too much exercise would make one feel tired and over-exercising might damage one’s body. However, for him, exercising did more good than harm to his body. He believed, if he remained immobile all day, he would put on weight. Therefore laziness was never a reason for him to slack off exercising. He believed that one's determination to do exercise all depended on the mind. Environmental factors were not as significant.

Summary: Ever since he was young, Mr Law had loved doing exercise. He liked moving his body all the time, and would feel at a loss if he did not exercise. He sometimes did tai chi and he sometimes walked. Although he stopped cycling and lifting dumbbells after migrating to Australia, he would do push-ups for an hour, and would go for an hour’s walk everyday. He exercised simply because it was his interest and for his health. He did not find doing exercise a problem and believed that the determination to exercise all depended on his mind.
Appendix 7d: Case Summary – PA/Ex Supporter: Mr Mok (13)

Sixty-three-year-old Mr Mok described his health as “so-so”. He did not have severe health problems, except that he suffered from hay fever from time to time and needed to use a nasal spray. Mr Mok had learnt from TV and newspapers that exercising was good for health. Therefore walking and jogging had been his choice since young.

Mr Mok thought that it was convenient to walk or jog because he could do that any time. He liked to do exercise alone as due to difficult time schedules, it was different to find company for this activity. But sometimes, he did play lawn bowls with others. Mr Mok often had meetings in the evenings, at around 7 or 8 pm. Regardless of the weather, he sometimes left the church a bit earlier in order to jog or walk for half an hour. Then, he went to work. Mr Mok would do exercise in the morning if he had enough time to do so. Since he only went jogging when it was light enough for him to see the road, he did not jog at night and so had no safety concerns. Mr Mok would walk when it rained as he would put on a pair of trainers and a raincoat, or used an umbrella.

Mr Mok thought that walking and jogging not only kept him in good health, but helped him sleep well and so to have lots of energy. He thought exercise was psychologically beneficial to him, too. His doctor also asked him to do more exercises. When he was a young man Hong Kong, he always jogged. However, as a 63-year-old, he did not want to take any risks and thought that as he grew older he might prefer to go walking rather than jogging. He pointed out that anyone could get fit if he/she was motivated to do so. The state of the environment did not matter that much. He took himself as an example; he did exercise because it was good for his health and therefore he would continue with it. Although he was very busy, he could still squeeze in time for exercise. He did not experience any barriers to doing exercise. He stated that this determination was driven by his strong belief in the positive impact of exercise.
Appendix 7e: Case Summary – PA/Ex Supporter: Mr Yiu (15)

Mr Yiu was a 74-year-old Christian. He had no illnesses in particular and he rated himself as physically active. He spent 40 minutes on the morning walk almost every day. He thought that morning walk was an exercise that involved movement of the whole body. He could have control over the pace of walking, depending on his mood. If he felt he walked too slowly, he would quicken his pace until he was panting.

When living in Hong Kong, he did the morning walk in the park opposite his house and he usually chose to take ferries to cross the harbour in order to avoid the over-crowded buses and to get more chance to do exercise. After coming to Australia, he still maintained his exercise schedule. Mr Yiu also learnt tai chi because he was still working for the Hong Kong Government where inexpensive tai chi classes were provided by the staff association. He would practice tai chi at home after class and therefore he still remembered how to do it. He felt that it was not particularly difficult.

As western doctors were agreed on the beneficial effects of exercise, he thought that doing tai chi and walking in the morning were sufficient and did not plan to do other sports or physical activities. After coming to Australia, sometimes if it rained, he would stay at home practicing tai chi instead of going out but he preferred walking outside on fine days. However, he usually walked alone because other people could not keep pace with him. However, since he felt that normal walking was too slow and therefore not an effective exercise for him, he needed to walk in a zigzag.

He did not experience any bad effects from walking, which proved his health was good. He thought that a morning walk was an exercise for the whole body. He believed that the human body needs continuous to stimulate blood circulation blood continuously and vigorously. If he sat for too long, that would be unhealthy because the supply of blood, needed to carry oxygen to the organs, would be insufficient. Maintaining good blood circulation was essential for good health. In addition, doing more exercise could build up muscles and enhance the appetite and metabolism.

Mr Yiu understood that some people found it hard to exercise every day in the morning but he thought it would be easier when they kept doing exercise over a period of time, especially in Australia, where the weather in the morning was good and there was plenty of fresh air. He thought exercise should be a self-initiated activity and should be interesting. He would feel himself to be pathetic if one day he found he could not walk because walking had became his ingrained habit.
Mr Yan, a 67-year-old Chinese man, never drank alcohol or smoked. He claimed that he had no major health problems but thought that his health was only “so-so”. Similarly, although he claimed that he was not a physically active person, he had exercised almost every day since he was young. To him, exercise was beneficial to health because “leading life means exercise”.

When he was young, Mr Yan liked running, playing ball games and swimming along the river. He believed that “to get old means to deteriorate”. If people wanted to avoid that, they needed to do exercise. In Australia, people needed money for everything. If he was not healthy, he had to spend a lot of money for health care services. If he had a strong resistance to disease, he could save money. Mr Yan believed that people would live longer if they exercised constantly. Exercise could improve the metabolism or blood circulation, and also improve the digestive system and elimination. Therefore people needed to strengthen their bodies by doing exercise.

Ten years ago, Mr Yan had undergone an operation for excision of his gall bladder in China. Probably because it was too hard for the nurse to find a vein for intravenous therapy, the vein was damaged and blocked. But now because he kept doing exercise every day, the vein was clear again. If he did not exercise, the vein would get worse. This experience reinforced his determination to do exercise. To Mr Yan, the environment in Australia was better than that in China or Hong Kong. There were fresh air, beautiful flowers and grasses everywhere. That was great for his body. He got up in the morning and ran for 30 minutes almost every day. He was not afraid of getting lost because he was familiar with the surrounding areas. He did exercise regardless of whether it was hot or cold, although he would not do exercise outside when it was raining, because that made everything wet and slippery and he was afraid of falling. If the rain stopped, he would go out to do exercise again.

In conclusion, Mr Yan believed exercise had a function of physical adjustment. He did not believe exercise had any disadvantages. He thought that the tips about doing exercise depended on an individual's interest in exercise. If people liked doing exercise, they would squeeze in time for it, otherwise, they would not do it even if someone pushed them.
Mrs Su was a 69-years-old housewife. She had a minor stroke many years ago, and therefore she considered her health as unsatisfactory. She was very careful about her diet. She believed firmly that fish, vegetables, and fruit were good for health, and oil and fatty meat should be consumed as little as possible. Mrs Su had no idea of what the term “physical activity” meant, but she believed that people at her age had to exercise, or else they would experience health problems.

Mrs Su thought that because she was old, her joints would become very stiff if she did not exercise. She believed that the major advantage of exercise was that it maintained the flexibility of her body and joints. To her, doing exercise had no disadvantage and it only had beneficial effects. “Even healthy people have to exercise” was what Mrs Su said. She was worried about putting on weight. To her, being either over or under weight was not good; the best was to be “just fit”. If she was overweight, she would find buying suitable clothes difficult and her movements would be clumsy. What was worse, people would tease her behind her back. Mrs Su knew that exercises were good for her health, much better than sitting in front of the TV. She also knew that she did not have as much physical labour as young people do. All she did was just to go to the market and do the housework. These were not enough and exercise was therefore a must.

Mrs Su started jogging daily after her minor stroke when she was still in Hong Kong. She found her belly big so she also did leg-lifting exercises that she learned from her friends in Hong Kong to keep the fat under control. Since she exercised for about half an hour a day in Australia, she considered herself physically active. In the past, she went to the park near her apartment every morning to exercise with friends, even in winter. Cold weather had never been a problem to Mrs Su as she simply wore more clothes.

Australia was a much better place to exercise than Hong Kong for Mrs Su because it was more spacious and less crowded. Australia had more parks and its air was fresher. She did not need to go far to exercise in Australia and could jog in the front or back yard of her house. Mrs Su usually woke up at about six o’clock and after a cup of tea, she would go out to exercise. Exercising in the morning was a good idea because the air was fresher and she had to go to the market afterwards. More importantly, she would then have enough time to do housework and prepare lunch for her family.
Mrs Yiu was a 61-year-old widow. She had hypertension for four years and a small problem with the thyroid gland. She also suffered from cardiac diseases and diabetes. She needed to take medication to control these problems which made her feel unhealthy. Therefore she was cautious about what she ate. She did not like eating oily or very sweet food because of her diabetes. She explained her poor health was related to her poor financial circumstances when she was young. Mrs Yiu did not want to waste food and so she ate all her children's leftovers, and so harmed her health.

Mrs Yiu doubted if physical activity was the same as exercise. She walked three times around her house every day after her health problems began to appear. She sometimes walked after dinner to soothe her gassy stomach. Because she did not like driving in traffic, she preferred not to do exercise in the park. She liked doing exercise outdoors because it was more spacious and commented that because the air in Australia was fresh everywhere, it made no difference where she walked. Mrs Yiu chose to exercise in the morning because the sun was not too hot and she could do some housework afterwards. After reaching home, she did 15 minutes' warm-up exercise or callisthenics. She said walking and doing housework were older people's normal activities. Other activities were not suitable because she thought she was too old for them.

Mrs Yiu also practiced tai chi which she learned from friends and videotapes. She found it hard to learn initially but she concluded it was not too difficult to learn in general. Her motivation for exercise was her desire to be healthy. She said exercising at her age was not to cure any inherent disease but to maintain her current health status. She believed exercising was good for health. Walking made one feel more relaxed and the bones, ligaments and joints would not be stiff. She heard of the benefits of walking from the radio and TV. Her health knowledge was mainly from the Chinese radio channel. She also exchanged health knowledge with her friends because of language problems. Her children and the doctor also encouraged her to exercise. In general, she thought there were no drawbacks to doing exercise. The best way was to finish all the work and then concentrate on doing exercise.
Appendix 7i: Case Summary – Emerging: Mr Bek (4)

Although Mr Bek was already 72 years old, he thought that he was healthy. His only health problems had been a retinal detachment and had recently suffered from an enlarged prostate. To him, illness was inevitable when one got old. Mr Bek could feel the difference after age 60 but he did not want to be dependent on anyone. He had known more than one friend who was “a vegetable” who needed intensive care and whose limbs were atrophied as they lacked exercise. He did not want to have to rely on others’ help. Physical activity or exercise could keep him healthy and prevent diseases. Keeping his health in a stable condition was good enough for him.

To Mr Bek physical activity meant exercise that consumed his energy and made him healthy. He thought that physical activity or exercise involving body movement could make his joints and ligaments feel better. It also benefited mental and psychological development and helped one to sleep well too. He usually did arm and leg exercises and since it was recommended by nurses, he thought that walking was a good exercise. He believed what professionals told him. He did not undertake regular exercise when he was young, mainly because he needed to financially support his two sons who were studying in Canada. At this stage of his life, however, Mr Bek was able to afford one hour for walking every day.

Mr Bek believed physical activity was necessary and so he would do exercise regardless of the physical or environmental changes. Weather was not an issue for him. He said that the air quality in Australia was better than Hong Kong, both by day or night. Nor was he afraid of cold weather while neither sunny days nor rain would change his exercise patterns. If the weather turned bad, he would open the windows of his house and do stretching exercises. Travelling was not a big problem as he did not have to go far to exercise. Language was also not a problem since he believed the government had provided sufficient language support. But he seldom went out at night because of safety concerns. He returned home in the afternoon and rarely joined evening activities.

He admitted that it would take quite a long time to make older people accept the ideas of trying different kinds of physical activities. He believed the way to keep older people doing exercise was to arouse their interest. He thought that Australia was more resourceful in promoting physical activity than other countries.
Mrs Lim was an 83-year-old widow. She had been living in Australia for more than 19 years. Her health status was reported as “so-so” as she had a problem with her blood cholesterol level. In the years after her marriage in Hong Kong, she was too busy looking after her children to do any exercises. But now she believed that it was not good for her health to sit back and do nothing all day. She said if she stayed at home for one or two days without going for a walk, her legs would feel different. Since she felt it was best if she walked every day, she would go shopping every day or just wander around. She did not take buses because that gave her carsickness. Normally she would walk or take the trains. Although she walked every day, she claimed herself as not very active, but also as not very inactive.

As for Mrs Lim's exercising habits, she would hold on to a bar fixed to the wall at home and move her body for around 20 minutes facing an open window as she thought that would let in fresh air. Sometimes she would lie on bed and do exercises such as kicking her legs. She preferred to stay at home on a rainy day, as the roads would be slippery and taking an umbrella would be troublesome. She would definitely go out when the weather was fine. If it was cold, she would ask seven or eight of her friends to go out with her. They would go shopping together. She was not afraid of cold weather, but when the sun set earlier in winter she would return home. Mrs Lim used to go for walks alone in the morning but she was quite afraid of going out now, especially at night because some drunks gathered at the front door of her building, which scared her. She said she would not know what to do if one of them tried to rob her.

Her solution was to exercise at home, but that was limited to moving her limbs. She said, however, she walked a lot every day, and she regarded walking as a kind of physical activity. Furthermore, doing housework at home was a form of physical activity and therefore it was not a problem for her. She believed that walking had many health benefits. After sitting for too long, her feet would stiffen, which made her walk slower than usual, but she found that if she kept exercising her limbs, she could prevent them from going stiff. Walking fast increased her limbs' flexibility and strengthened her heart and lungs. She was very content as long as she could eat well and walk well.
Mrs Lai, a happy and affectionate old lady, was my friend's grandmother. She gave me a kiss at our first meeting. She lived alone in public housing even though she was already 91 years old. Her doctor had suggested that she should live with family or in an old age home, but she believed that life would not be as free there. To eat and sleep well and “to die in a comfortable way” was her wish. Longevity was not what she was after and she had no wish to live to be a hundred. Although she sometimes felt that she was useless to society, she went through life in a happy-go-lucky fashion and found her present situation satisfactory. She believed that it was bliss to have good health.

During the interview, I saw some cobblestones in a wooden box and some Chinese herbal ointment and pain killers on the table. She told me that they were for relieving her leg pain. She had visited many different doctors and had tried injections and other treatments for her legs, yet the problem had remained unresolved. She explained that as the ache on her legs was caused by the “wet” inside her body, there was nothing doctors could do, and neither medicine nor injections would help. She returned every year to Hong Kong to eat snake meat and blood in order to demoisturise her body. Apart from traditional dietary treatment, everybody Mrs Lai knew was telling her to exercise. When her daughter learned that the old people in her neighbourhood exercised on cobblestones every day and that that had caused their leg problems to disappear, she told Mrs Lai to do the same.

Following her daughter’s advice, she put some cobblestones in a wooden box and walked on them cobblestones to massage her feet. After some time, she began to find the exercise helpful, since she did no longer got cramps and her legs did not ache. Knowing very well that no one would be able to help cure this condition, she determined not to give up this practice. Therefore she kept exercising her arms and legs, even when she was sitting, in an attempt to prevent stiffness. Even when she was in hospital because of pneumonia, she did not stop exercising and having massage, which had won her the approbation of the doctors and nurses. Nevertheless, she had never tried tai chi as she did not see any need for it. She also explained that tai chi was too complicated and serious an exercise for her. She worried that if she could not handle it well she would fall. She always reminded herself not to fall. She said, “The waist, the arms, and the legs are all one could exercise”. There were not many movements an old person could do. Sometimes she would lie on the bed, moving her legs as if she was cycling. What she was doing was enough and anything more complicated was unnecessary.

Although she was a member of Australian Chinese Community Association and also the New South Wales Indo China Chinese Association, she had never taken part in any of their activities even when transportation was provided. It still was inconvenient to her, as she had to walk to the transport anyway and it was difficult for her to get on and off a coach. The pain in her legs and the fear of an accident also made her decide she was better staying home, especially when it rained heavily. She believed no one would sympathise with her or take care of her if she went out and fell.

**Summary:** Mrs Lai loved freedom and independence. She did not ask for longevity but “to die in a comfortable way”. Leg pain, which was caused by the “wet” inside her body, was her greatest concern now. She consumed snake products to demoisturise her body. She was not interested in tai chi or joining a Chinese association. She followed her daughter’s advice, and exercised on the cobblestones to massage her feet. She enjoyed doing exercise alone because she could start and finish whenever she felt like it. The benefits of exercise made her determined not to give it up.
Appendix 7I: Case Summary – Emerging: Mr Koo (7)

Mr Koo was an 80-years-old retired businessman. While he was seldom sick, he experienced small “unavoidable” health problems, such as indigestion and periodic arm pain. Sometimes, he could not sleep. He was currently taking medicine to control his indigestion. Mr Koo's workload in his younger days was too heavy to enable him to exercise much. However, after reaching middle age, he had more spare time to practise tai chi and light callisthenics. He wanted to compensate for his failure to exercise while young by spending more time on exercise, as he did not need to work any more. Thus he started doing exercise some 20 to 30 years previously.

He believed that exercise was good for the circulatory system and for strengthening his body. It could also improve immunity, so he would not be struck down by illness so easily. Psychologically, exercise was also good for his mental health, as it helped to keep him in high spirits and to remain cheerful all the time. In addition, it helped him to have higher endurance in doing everything. He learnt all this from reading books from different sources and had been using them as references. More importantly, while people at his age would often have a humpback, he could still keep his back straight with the help of exercise. This was an undeniable fact.

He noted that many westerners have accepted the benefits of tai chi, aimed mainly at strengthening the foundation-building technique of the lower body and enhancing the qi in the body. He usually practised tai chi in his backyard. He set aside time for exercise every morning. Since he had control over his own time, he said there was no excuse for not exercising. His experience of tai chi was that while it easy to learn, it was difficult to perfect. He taught his wife for one whole year, but although she knew the movements, she did not perform very well. In addition, he borrowed his friend's videotape and learnt hêng' gung', which was recommended by an acupuncturist. He believed that while acupuncture was not able to cure his arm problem, hêng' gung' could.

He mentioned that the natural environment in Australia was very beautiful. Even by just stepping outside his house, he could feel the freshness of the air, which did not differ much from a park. This formed a sharp contrast with Hong Kong. Thus, he spent more time to exercising in Australia than in Hong Kong. In addition, a large awning running alongside his house kept the backyard dry even in wet weather. He did not feel there were any difficulties in doing exercise.
Appendix 7m: Case Summary – Emerging: Mr Chung (14)

Seventy-one-year-old Mr Chung was an embroidery factory owner when he was in Hong Kong. When he was young, he was busy with his business and it was a kind of training to his body, as working occupied all of his time. Therefore he seldom did exercise. However, he believed, his body got used to that kind of training, which contributed to his will power. Thus, he said that he seldom fell ill and he believed that he was born with good health. However, he once tripped over when walking and hurt his leg. He was hospitalised for an operation. The subsequent knee problem annoyed him most.

Despite that he thought he was a physically active person. He considered that the housework he did every day was good exercise. His wife had arthritis and she could not walk well and thus could not do the housework. As a leader of his family, he felt it was his responsibility to take care of all the household chores, which he did after breakfast whenever he was free. For example, he would water his plants and do some gardening. He cleaned his house once a week. Other things that he would do included cleaning the floor and collecting rubbish.

His family did not allow him to walk too much because of his leg problem. Nonetheless, although he reckoned doing housework was a kind of “exercise”, he did not think it was enough, in terms of quantity. He therefore still walked, but with extra care. He believed that this kind of movement stimulated the blood circulation which in turn contributed to a healthy metabolism. If he just sat still after having meals, it was easy to develop a beer gut, but if he did exercise or housework after a meal, he could digest his food better. More importantly, exercising helped him to prevent illnesses.

Exercising was not only beneficial to his health but also for his psychological wellbeing. He, for instance, felt happy and satisfied after doing housework, especially gardening, which he regarded as one of his responsibilities. Many of his neighbours took good care of their front yards and if he did not manage his garden well, he would be teased. There were about ten families living nearby with neat gardens and he did not want to fall behind them. Sometimes when his friends saw his garden, they would praise him for his good work, which gave him a sense of happiness and satisfaction. This is why he wanted to beautify his garden and treated gardening as his responsibility as well as his favourite exercise.
Although 60-year-old Mrs Ho was retired, she worked as a part-time domestic cleaner. She thought she earned quite enough to support herself financially. She described herself as physically inactive because she was a practical person. She often had bone pain and her cholesterol level was on the high side. Although she did not experience big problems in performing physical activity, she only did it after the onset of bone pain.

In her opinion, physical activity was similar to doing sports, that is, moving your body and consuming energy in activities such as doing housework. This was something she had learned from a newspaper. She only rarely went out to do physical activity as she was too lazy to do so. To her, doing housework was not easy at all. It could be very strenuous, leading to muscle pain. Every time she felt herself getting fat or eating too much, she did housework. She found doing housework an effective and convenient way to keep fit and found that it could help consume energy and body fat. She viewed walking to her workplace twice a week as a kind of physical activity too. On her day off, she found it was not very healthy to stay home, and therefore she would push herself to do housework. Sometimes, she walked to her husband's workplace and picked him up for fun once or twice a week. Such walks lasted for around half an hour. She started doing this only a short time previously, but she only did it if she was in the mood, especially when she felt mild bone pain.

She believed that it was good to do physical activity every day. However, it had to be done in moderation. Just like eating yin' wo' (bird's nest), it was no use devouring a large portion of yin' wo' at one time. She thought that being in a good mood was of utmost importance. It did not matter whether physical activity took place indoors or outdoors. Due to her bone pain, many people suggested she should do physical activity. Even her physiotherapist taught her some stretching exercises and gave her a leaflet with pictures demonstrating the ways to do stretching to relieve her bone pain. Thus, she believed physical activity was simply a preventive measure to ward off bone pain and illness. However, she admitted again that she was very practical. She did physical activity regularly when she needed to because that this amount was still good enough to maintain her health and she was confident that she could resume regular physical activity at any time.
Appendix 7o: Case Summary – Practical: Mr Lau (22)

My friend who was a physiotherapist referred Mr Lau to me. Mr Lau was working at hospital as a night shift cleaner. Although he was already 65 years old, he looked younger than his age. He had good body shape and tanned skin. I was amazed by his language ability. He could speak Cantonese, English, Mandarin, Vietnamese, and French. This was because he had lived in Vietnam and Taiwan for many years before migrating from Hong Kong to Australia. His house looked old but he had a big car. He admitted that he was very practical, and only spent money on what he really needed. He told me that he usually drove this car when he went out for work or when he picked up his grandchildren from school.

When it came to his health, Mr Lau admitted that he was also practical. He had been hospitalised three times because of minor strokes. He was also on medication for high blood pressure and high blood cholesterol. Apart from that, he suffered from arthritis, frozen shoulders and Parkinson’s disease. Health concerns were the major reason that motivated him to do exercise. He stated that exercise was the best way to keep him healthy and to prevent himself from becoming more ill. He did not have exercise regularly before migration because he was too busy with his work. He strongly believed that exercise was good because he had experienced the benefits it brought. He became happier and more relaxed. He slept better and he felt more energetic. His frozen shoulders were getting better after doing exercise and physiotherapy. He believed that exercise did no harm and that side effects occurred only when one over-exercised.

Although Mr Lau was busy with his work, when he had time he would go running in the corridor. He also went walking in a park twice a week. He used to walk to the shop, as it was convenient and he could go shopping at the same time. He was not as interested in swimming as he was before because he found swimming inconvenient and there was so much cleanup work. Walking to the shopping mall, compared with going to swim, was simpler and more convenient. He claimed that he did not experience any difficulties in doing exercise, as he was a capable person. He hoped to spend more time exercising when he retired.

When it came to physical activity rather than exercise, Mr Lau had different opinions. He saw physical activity as those activities that involved repetitive movements of one’s body, for example, gardening. He thought that labour at work was also a form of physical activity, albeit an unpleasant one. To him, work activities did not do much good to health. People engaged in this kind of activity had no choice and did it reluctantly. Exercise was not the same. People exercised with an aim and in a leisurely fashion. Unlike physical activity, he enjoyed doing exercise because it was good for his health.

He enjoyed sometimes playing table tennis with his wife as he considered himself introverted and socially inactive. He preferred exercising alone if his wife was busy because it was freer. Surprisingly, he never asked his wife to do exercise. He thought that his wife already did enough physical activity, by which he meant housework.
Whilst Mr Lau was keen on exercising, he believed that doing exercise in a natural and comfortable way was important, and that there should be no rigid requirement as to how often or strenuous the exercise should be. He believed he could stop exercising when he felt like it and pick it up again when he needed to. When he was feeling well, he took Chinese traditional herbal soup to nourish his body instead of regular exercise. However, when he was feeling unwell, he said that it was a signal for him to exercise regularly again. Thus, he exercised only when he thought he needed it, especially when his shoulder pain affected his work. He was quite confident about being able to resume this regular exercise pattern after a break, as he believed the decision as to whether to do exercise or not was all controlled by himself.

**Summary:** Mr Lau did not do regular exercise when he was young. He believed that exercise was good for health because of good experiences in the past, although physical activity was unpleasant repetitive body movement. However, he admitted that he was a practical person. He was keen on doing regular exercise to keep healthy, especially when beset by health problems. He stopped exercising when he felt like it and picked it up again when he felt he needed to. When he felt well, Chinese traditional herbal soup was his substitute for regular exercise. Feeling unwell was a signal for him to restart regular exercise.
I had known Mr Chin for almost three years. He was my employer's brother-in-law and he was also taking care of my employer, who had suffered a stroke. My employer's house was Mr Chin's second home as he had a poor relationship with his wife. I sometimes chatted to him even though he seemed a bit eccentric and was not popular with my employer's family. One morning when I walked into the kitchen, I smelt something strange. I opened the door of the microwave. I found a bowl of milk with two eggs and something like a Chinese herb (fructus lycii), which he believed was good for eyes and that it was nutritious to eat it with milk and egg. Sometimes, he gave me microwave-warmed walnuts as a snack because he said that would be good for my brain.

On another day, when I opened the cupboard, I saw a pot of cooked herbal tea. At that moment, Mr Chin came into the kitchen and told me that it was the herbal tea for treating his back pain. He believed that Chinese herbal medicine could prevent bone spur, strengthen his heart and improve his blood circulation. Mr Chin's back was injured many years ago when he was working in a hospital. Other staff discriminated against him and always asked him to lift the heaviest stuff. After sustaining his injury, he could not see the point of taking anything seriously.

Although he had been a lifeguard in Hong Kong, Mr Chin nevertheless seldom went swimming in Australia. He confessed he was lazy and lacked interest in swimming after he migrated. He had done brisk walking activity in the past but he has stopped doing that. He found a pair of dumbbells in my employer's house but he did not use them. He stated that a person could enjoy longevity if he/she was happy and ate well all the time. He believed that lightly flavoured and simple food was more important to health maintenance than physical activity. While it was useful, diet, social life, family, entertainment and friends were even more so.

Mr Chin was in a hurry every morning. This was the only time he looked excited. He was the member of the Guin Yum Temple which conducted diverse activities. However, he only liked playing mahjong, which he considered a physical activity for his upper limbs. Spending an average of four hours a day playing mahjong was not a problem for him. He found it a lot of fun when he gambled with his friends who were mahjong lovers as well. But his behaviour changed as a result of several factors. Firstly, he developed a bad cough which lasted a year. Secondly, his doctor, told him that there had been an increase of the number of people suffering from stroke. The doctor also advised him not to consume too much fat and sweet food. He began to believe that he was suffering from hypertension because he often dined out when he was in Hong Kong and he had since become very careful about his diet.

The third issue came up one evening when he told me a story in the kitchen before he started his dinner. He had a friend who never took care of his health, ate anything he liked and was addicted to gambling. He ended up having a stroke when he was playing mahjong with Mr Chin, after which he could walk only with the aid of a stick. Mr Chin's comment to a friend was that “bad things always happen too soon, whereas good things are always yet to come”. To him, human bodies were no different from kitchen utensils.
There is bound to be a day when they are worn out and thrown away. He would be very glad if he never needed to walk with the assistance of others or with a walking stick. He surprised me on day when I saw him eating vegetables and fish instead of his favourite, steak. More surprisingly, I found a pair of sneakers and a sports jacket next to him. Instead of playing mahjong, he had obviously just finished brisk walking.

Summary: Mr Chin was a lifeguard in Hong Kong when he was younger but he was not interested in it after migration because of laziness. Another reason was he had experienced discrimination from his colleagues which caused a back injury. As a result of these experiences, he did not take anything seriously. He believed that diet, social life, family, entertainment and friends were more important than performing physical activity. Modified traditional Chinese medicine became his way of keeping healthy, while playing mahjong with friends was his way of keeping happy. One year after I first talked with him, he was motivated to do physical activity again by his bad cough, and his doctor's advice and his friend's stroke.
Mrs Chiu was 75 and had suffered from asthma for 60 years. She had once been hospitalised because of her asthma and fever. She had always needed to use an inhaler when she had an asthmatic attack. Besides, she had a uterine fibroid. Thus she rated her health condition as “so-so”. She used to jog when she was young to keep her healthy and asserted that exercise had more benefits. It could increase lung capacity, improve cardiac function, and enhance the blood circulation, which make one more energetic. She thought she felt in better spirits after exercising although she was unable to explain why. Physical activity, such as walking and climbing stairs, had fewer benefits but still could prevent hardening of the bone. Nonetheless, she stated that she did not do exercise although she was involved in physical activity.

She walked to the shopping mall, cleaned up the leaves in the balcony and sometimes did the vacuum cleaning because her husband was mainly responsible for all housework. She considered these as physical activities because they involved the use of time and repetitive movement. Climbing stairs also took her a few minutes. She admitted that she seldom did physical activity or exercise after migration because she was too lazy. She played games such as badminton with her friends about 30 years previously, although even then she had not been particularly physically active. After migrating to Australia, she had less time for physical activity because she frequently took care of the children of friends.

Mrs Chiu concluded that her decreased amount of exercise was mainly due to laziness which in turn was induced by the relaxed lifestyle of Australia. When she did do exercise, she felt exhausted and panted a lot after walking. She also got bored if her husband did not exercise with her and thus she had no motivation to exercise. Her husband was even more lazy than she was and preferred watching TV and reading magazines to doing exercise. Although the doctor had recommended her to exercise and his advice was repeated by her sisters, they did not exercise either. But she did not blame them as much as her husband, whose refusal to exercise discouraged her, as she needed company while she was doing it. She said she might consider learning *tai chi*, but only if her husband was present.
Appendix 7r: Case Summary – Irregular: Mrs Leung (3)

Mrs Leung was a busy 65-year-old housewife. Her health condition was not good. She suffered from pain caused by a spur in her heel, and also from stomach problems. She also suffered from an inexplicable bone ache in various parts of her body. Although she knew that exercise would be good for her, she did not do it regularly. She described herself as physically inactive.

Nonetheless, she believed that exercising her body regularly would not only make her healthier, but also happier because it would make her relax and be less nervous. She said she was kept busy by her housework and taking care of her children in the past. Therefore she did not know much about exercise. It seemed to her that there were not many activities for older people. For instance, jogging was hard for her at her age. Some people would choose to do gymnastics but not her. She would only exercise her limbs slightly in her backyard when she was free from housework. Sometimes, her daughter would accompany her to swimming. She did not swim a lot; the spa and steam bath were what she really liked. She would not swim alone as it was too boring. She would only go swimming on her daughters’ invitation. Mrs Leung said doing exercise with her daughters would be nice, but her daughters did not have the time. They were even lazier than she, and therefore she had not gone swimming for a year now.

At one stage, she had joined people exercising in the park on Sunday morning. However, because she was quite busy, she had stopped going. She said there were little chance she would go again, as she preferred going for a walk after dinner in the evening before sunset. However, she dared not walk in the dark as it would be dangerous. Also, she would not go out in cold weather or on a rainy day because it was not convenient to carry an umbrella. She believed people of her age would usually have more time to do exercise and while of course it would be best for her to exercise every day but she did not have the time. It would be good if she had the time to do exercise in the morning, only she had to prepare breakfast for her daughters and drive them to train stations. She said she might be more free after her daughters married. If she no longer had to worry about housework and her husband retired, she wouldn’t mind joining exercise classes with her husband in senior clubs. However, that might not be soon.
Mrs Siu was a 77-year-old devout Christian. I usually addressed her as Auntie Siu. Auntie Siu was very sincere but not talkative. She claimed that she was introverted. Whenever I saw her in church, she only sat with her family and went with them afterwards to the supermarket or a Chinese restaurant. She seldom joined other social activities. She would only go out when her daughter could give her a lift. She told me that she had never taken public transport in Australia. She preferred a quiet life and at home would only watch Chinese TV or read a Chinese newspaper. She did not feel bored as time passed quickly when she did the housework. Indeed, the moment I stepped into her house, the neat kitchen and glossy tiled floor really impressed me. The backyard was also well-cared. Most importantly, she did all this on her own.

Auntie Siu had high blood pressure and arthritis and was taking pills for both. She showed me her enlarged and distorted fingers and knee joints which she believed were due to ageing. She felt she had aged a lot in Australia because she “thought too much”. She stated that the pain of arthritis would not be as severe at 60 as it was at 70. She could not squat, as her knees would ache, especially on rainy days. She believed that “wind and wet” caused the arthritis. Therefore she would always kept her bathroom dry to prevent “wet”. Apart from this, she bathed her legs in sunlight and avoided contacting water when the joints ached. She stopped wearing dresses for fear that her legs would catch cold and now she wore trousers all year round. She understood that sitting at home all day long was not good for her health. “A knife has to be sharpened from time to time to keep it sharp, otherwise it will rust” was the metaphor she used. However, she did not do physical activity or exercise regularly, although she would move her limbs slightly after she woke up or when she felt unwell.

When she lived in Hong Kong she had seldom exercised because she needed to look after her husband and children. She was quite interested in joining exercise classes in Australia but there were no such activities in her neighbourhood and she did not know how to get to classes elsewhere. Even if a pick-up service was available, she was afraid the person would drive her somewhere other than her home and she would not know how to get home. She also feared no one could take care of her frail husband but she did not want to bother other people. However, swimming was absolutely not her choice because she could not swim and it was too late to learn swimming at her age. In any case, immersion in water would not be good for her joints.

In addition, she thought it would be very improper for her to wear a swimsuit at her age. In her generation, swimming was not acceptable for young women because that would attract criticism for lack of modesty. In addition, she would not join those classes such as lug⁶ tung⁷ kün⁴ because she could not lift her legs. Nor was she interested in tai chi because she did not have a good memory. She had enjoyed playing table tennis, but she thought that she was too old to play any more. She liked morning walking but she could not walk for long due to the pain in her legs. If she walked alone, she felt it was boring and was also afraid of getting lost. It would be better if her family could accompany her, but that was currently impossible. She thought it would be difficult to interact with people if she joined a walking group because she was like a mute in Australia. She was not sure about the meaning of physical activity, although she knew that exercise was good for her joint pain. Nevertheless, she did not know how to sort out her priorities and make exercise a part of her life. Thus she could only treat housework as her form of exercise.

Summary: Auntie Siu suffered from arthritis. She knew that exercise was good for health and her arthritic condition, but still did not exercise regularly. She was interested in joining exercise class in Australia. However, she did not take action because of her introverted personality, her preferences and her worries about husband, transportation, injury and language barriers. Therefore housework was her only form of exercise.
Appendix 7t: Case Summary – Irregular: Mrs Yuen (17)

Mrs Yuen, a 72-year-old housewife, reported her health condition was 'so-so'. She had rheumatism, a heart problem and high blood pressure. In addition, there was a benign tumour in her parathyroid glands. Occasionally she would suffer from bone pain, but the cause remained unknown. Mrs Yuen seldom went out, as the transportation was inconvenient. She needed her husband or church members to drive her everywhere.

Mrs Yuen admitted she did not have regular exercise when she was young nor did she do any now because she said, there was so much to do and she had so little time to do it. After migrating to Australia, she used to walk back and forth on the pathway near her home for about 15 minutes each morning which she regarded as sufficient daily exercise. She said she would be motivated to do more exercise when she found her girth expanding. She knew that exercising could make her happier and would move her limbs to stretch her ligaments and bones. However, she could not make up her mind to exercise regularly. She would only do a little exercise when her arms or legs ached. Mrs Yuen refused to walk when the sun was strong, or the weather too cold. She also would not go out on rainy days. She eventually stopped walking altogether because it made her “puffed” and the less she did, the lazier she became.

Mrs Yuen had a walking machine at home. She would walk as she watched the news. But now she seldom walked that much. She would try and use it every once in a while, but after stopping for a while, it was hard to get herself to use it again. Her family also encouraged her to do some exercise, but she did not follow their advice. She was not interested in other exercises. Mrs Yuen had joined tai chi classes in Hong Kong but after catching cold after one class, she stopped attending. She also joined some gymnastic classes but she did not know where to find these classes in Australia.

Although there was an indoor swimming pool at her house, she did not go often, as she did not swim very well. In fact, someone did promote swimming classes in Sunday Service a while before, but due to lack of transport, she did not join. She did not want her husband to drive her there, as it would cause him a lot of inconvenience. She realised that she would have loved to go if anyone in the Sunday service had been willing to accompany her.
Mrs Mo was a 60-year-old married Chinese woman who was also a devout Christian. She was a full-time housewife and was involved in part-time missionary work. She suffered from hypertension and thyroid problems. She needed to take drugs regularly lowering high blood pressure. She believed that people at her age usually had some health problems.

However, Mrs Mo believed that exercise was beneficial to health because it increased oxygen consumption. Apart from physical health, she also considered her spiritual life. She felt fresh and very happy when she walked because she seemed to be chatting with God. Sometimes, she would think about words from the bible. She sang some hymns in her heart and so she felt very happy after walking. If she could see or experience the advantages of doing exercise, it could encourage her in the future. She claimed she was physically inactive and only exercised irregularly. However, she believed she could gradually learn to be physically active.

She sometimes walked half an hour to the railway station if she needed to go somewhere to pay bills. When her daughter was on holiday, she would walk with Mrs Mo for half an hour to one hour. Her family liked exercise very much but she did not exercise regularly. If she needed to manage a lot of work, she usually minimised the time for walking. The main problem was the time taken by her church work while she also needed to look after her grandson which usually occupied much of her time.

Many years previously, she had gone running with her students in Hong Kong. She could not take it because this was beyond the limit of her physical capability. While she had done gymnastics for a while, she had hurt her hands. She had also learnt lawn bowling but she hurt her arm which put her off the sport because she needed her hands for doing housework. Some people had suggested that she does tai chi but she felt that she would not be able to memorise all the movements.

While she had learnt to swim when she was very young, she was afraid of water going into her nose. She also had the experience of choking with water which made her give up swimming. But she admitted if her health demanded that she swims once more, she would try again. However, the best motivation for her to do exercise would be when she no longer had any responsibilities. When she had something important to do, she felt pressurised. Because she had a strong sense of responsibility, she preferred finishing the work first instead of doing exercise. After finishing her work, she might be interested in doing exercise. Otherwise, she tended to minimise her exercise time.
Appendix 7v: Case Summary – Inactive: Mr Wan (19)

My friend's husband, Mr Wan, is a 64-year-old minister of religion. He is around 170 cm tall, wears silver-brimmed glasses and has shiny grey hair. He gave me the impression of being a knowledgeable sage. To show my respect, I addressed him as Pastor Wan instead of as Mr Wan.

In the past, he had been the breadwinner in his family but now his job was voluntary, so this responsibility was his wife's, an enrolled nurse whose workplace was far away from home. Pastor Wan felt a bit guilty, so he volunteered to drive her there. After parking the car near the hospital, in order to save petrol, he walked about 30 minutes to the station and took a train home. Before his wife finished her shift, he took the train and walked again to pick up his car and then drove his wife home. He emphasised that this walking was only temporary, claiming that other than that, he did no exercise whatsoever. He followed this routine not only to reduce the cost of petrol and so minimise living expenses but also to show that he took the responsibilities of a husband seriously.

Pastor Wan believed that he did not have good health because his mother tried to abort him but failed. As a result he was weak and was not strong enough to do exercise. He had played soccer when he was young but nowadays he felt breathless after playing soccer for only 30 minutes. Therefore he was happy to be a spectator. As he was the only son in his family, his mother did not allow him to learn swimming when he was young because she was afraid an accident would happen to him. When he grew up, he decided to learn to swim but nearly drowned twice and was luckily to be rescued. After that, swimming was “history” in his life. In addition, especially in his 50 and 60s, the training for being a pastor required diligence and loyalty. This made it impossible for him to spend time doing exercise.

Pastor Wan had suffered from hypertension for four years and needed to take medications regularly. His doctor suggested he walk at a speed of 120 steps per minutes. However, he did not like walking in the street without a purpose. He reported that walking to do shopping was a kind of labouring because people had to use their brains to think what they had to buy and they were not totally relaxed. He was not easily influenced by other people but he trusted his doctor's professional knowledge.

He claimed that his physical condition was good, although he was not as fit as before. His memory was deteriorating and he believed that health problems were unavoidable at his age. He did not have any “dai bing” (major problems). He admitted that he was a practical person. He knew that exercise was good for him but he was lazy and he did not have time to do it. More importantly, his blood pressure was under control, and thus there was no need to exercise at that moment. He could not maintain exercise because his will was not strong enough. He believed he had a strong sense of illness and that if he had any problems, he knew it immediately. If he needed to, no external factors would hinder him from doing exercise. He believed that he would need to do double the requirement because he had a weak physique, but that would be in the future.

Summary: Pastor Wan categorised himself as being physically inactive even though he currently walked every day to pick up his wife. He said that it was only temporary because he walked to reduce living expenses and to demonstrate his sense of responsibility. He accepted that health problems were unavoidable for older people, but he had no intention participating in PA/Ex because his blood pressure was under control. He believed that he did not need to do PA/Ex at that stage. If he was motivated, he would exercise at the level that would fulfil his physical needs.
Appendix 8: Pamphlet of “Rusty Tin Man”

How would you like to get more up and go?

It's never too late to start.

Get out. And get into it.

The people who want to make better living your present job may not	

will tell you all about it. But they will tell you how it can be done.	

Guest to rustic zinc, varnish, paint, primer, gilt, polyurethane, linseed,

melt, and beeswax, in the process of making a good, clean,

tight, and compatible product.