An Exploration of Health Perceptions and Practices among South Asian Descendants Living in Dunedin, New Zealand

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Abstract

Drawing from critical medical anthropology, post-colonial theory and case-study interviews with nine people of South Asian descent living in Dunedin, this research asks whether there may be a greater demand for medical pluralism than currently exists in the New Zealand health care sector. Among differing cultures are diverse ways in which health and the body are understood. With South Asians among the fastest growing migrant populations, New Zealand is increasingly becoming a multicultural nation. Yet western biomedicine remains the dominant form of health care available. An exploration of the perceptions, experiences and health practices of participants in this research reveals explicit and tacit knowledge that has been passed down through generations. Their narratives reflect a pluralist approach to medicine where traditional remedies are often used as first choice for general health concerns and biomedical treatment is sought for more serious conditions. While most participants are not adverse to biomedical treatment, many indicate a preference for ‘natural’ remedies they perceive to be safe in comparison with pharmaceutical drugs. Some express concerns about what they consider to be a loss of traditional knowledge around health; this they attribute to the high-pressure demands of a modern lifestyle. The use of home remedies provides effective and empowering strategies to attend some of their health concerns, and may be contextualised as a means to negotiate biomedical authority. Traditional health practices are for some an integral part of the diaspora experience and, in the interest of multiculturalism, such concerns should be reflected in the New Zealand health care sector.
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Glossary

**Ajwain**: a seed of the same family as caraway

**Asanas**: postures in yoga

**Ayurveda**: ethnomedical tradition that originates from the Indian subcontinent

**Ayurvedic**: pertaining to Ayurveda

**Caraka Samhita**: earliest known Ayurvedic text from the first century

**Desi ways**: traditions from the Indian subcontinent

**Dosas**: the three humors or in Ayurvedic medicine: *vatta* (wind), *pitta* (bile) and *kapha* (phlegm)

**Gurukula**: one-to-one teacher to student model of training in Ayurvedic medicine.

**Hakim**: Doctor of Unani Medicine

**Kalongi**: (nigella in English) a seed of the same family as cumin

**Ojas**: Sanskrit word meaning vigour or virility

**Puja**: a ritual or act of worship

**Rasam**: a soup or gravy of south Indian origin

**Siddha**: ethnomedical tradition that originates from the Indian subcontinent

**Siddhas**: Indian sages or holy men

**Susruta Samhita**: Ayurvedic text from the fourth century

**Unani**: ethnomedical tradition based in Islamic medicine

**Vagbhata Samhita**: Ayurvedic text from the eighth century

**Vaidya**: Doctor of Ayurvedic medicine
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Chapter 1: Introduction & Research Setting

1.1 Introduction: The Research Premise

Although New Zealand is increasingly becoming a multicultural nation, western biomedicine remains the dominant form of healthcare available. Among differing cultures are diverse ways in which health and the body are understood. Kirmayer (2004, 44) suggests that ‘healing practices address core values and concerns in which individuals and communities have a profound stake.’ Thus, a universal approach to health care that is predominantly dominated by western biomedicine may ‘neglect to meet the interests of different groups in the community’ (Fuller 1997, 154).

The research question central to this thesis ask whether the mainstream New Zealand health care system meets the perceived needs of South Asian migrants, or whether there may be a greater need for medical pluralism than currently exists. Because this thesis relies on small-scale qualitative research, I do not expect to offer the kind of definitive answers that may be deduced from a survey type study. Rather, through an in-depth exploration of the perceptions, experiences and lived health practices of a small cohort of participants in Dunedin, I hope to offer some insight into the field of medical anthropology and contribute to the growing call for cultural competence in the New Zealand health sector.
1.1.1 Demographics of the Study

For this research project, I have drawn qualitative data from semi-structured interviews with nine men and women of South Asian descent whom—apart from one\(^1\)—at the time of the interviews were living in Dunedin. The interviews centre on open-ended questions designed to access both tacit and explicit understandings around health and medicine. The age of participants range from nineteen to sixty-three years old, and origins of birth range from northern to southern India, Malaysia and New Zealand—two participants were second-generation migrants who grew up in Dunedin. The religious backgrounds of participants also vary. Among them are Catholic, Hindu and Sikh; one participant claims to be agnostic and another non-religious. The ethnic category chosen for the study is significant because the latest census figures show that South Asians are currently among the fastest growing migrant populations in New Zealand (Statistics New Zealand 2013).

Funding constraints have limited this research to Dunedin, a city with the second largest population in New Zealand’s south island and home to the University of Otago. Much of the research on ethnic minorities stems from Christchurch or the larger centres of the North Island. Although the South Asian population is small in Dunedin compared with other major cities, Dunedin is likewise rapidly growing in diversity; and this study aims to contribute to the region’s multicultural mapping (see Friesen 2009).

\(^1\) Although Sukhi Turner currently lives in Wanaka, she served as Dunedin mayor for three consecutive terms and made a significant contribution to the community. For more on this, see section 5.3.2.
1.1.2 A Brief Tour of the Chapters

The current chapter of this thesis introduces the research topic and premise; it briefly outlines the contributions of subsequent chapters and offers some insight into the conservative policy of the New Zealand health sector in order to provide some context to the research premise. Chapter 2 offers a review of previous literature relevant to the topic of South Asian migrant health. While international studies contribute ethnographic insight, there is a notable paucity of ethnographic research investigating people’s lived experience of traditional health practices in New Zealand. Much of the New Zealand literature attends rather to the statistical disproportion of health seeking among Asian migrants and potential causes for this disparity.

There is, however, a growing voice in the literature that challenges assimilationist attitudes towards health care and calls for greater cultural awareness and inclusion of culturally diverse practices in the health sector (see for example DeSouza 2005; O’Connor 2007; North 2008). My research aims to contribute to this growing body of literature through talking with people of South Asian descent in Dunedin about the culturally mediated strategies they use to attend their health needs. Although the interview methods that I predominantly rely on do not comply with full-fledged ethnography,² my aim is to help bridge a gap in the literature through offering some reflection on the lived experience of those who agreed to participate in this research.

This thesis does not look in great detail at issues of mental health, which is of central concern in discussions on culture and medicine. Ruth DeSouza, a prominent spokesperson on issues of migrant health, claims that culture is of special relevance in

² I discuss this in greater detail in section 5.2.3.1.
the diagnosis and treatment of mental health because culture ‘strongly shapes how mental illness is understood and treated’ (DeSouza 2015, 33). This is an important observation that warrants further ethnographic inquiry.

I argue that culture also shapes perceptions of the body and physical health, and that ethnomedical practices carry cultural meaning that may not only transcend standardised measures of efficacy but also may challenge distinctions between body and mind. In order to access some of this cultural meaning, in Chapter 3, I look cross-culturally at the epistemological divide between western biomedicine and medical traditions that originated in South Asia. Through the biomedical lens, the body is viewed as a discrete entity that can be acted upon mechanically (see Foucault 1973; Hardey 1998; Langford 2004), while eastern medical traditions tend to acknowledge an interrelationship between the physical body and ‘environmental and climate factors, psychological dispositions, and moral and spiritual states’ (Khare 1996, 838; also see Scheper-Hughes & Lock 1996).

Nonetheless, traditional medicine is practised side-by-side and often syncretically with western biomedicine throughout the Indian subcontinent. Chapter 3 investigates the pluralistic approach to medicine that is popular among doctors and patients alike. The multiple and diverse systems of medicine include folk healing, the traditional systems Ayurveda, Siddha and Unani medicine, homeopathy and western biomedicine. An elaboration of medical pluralism in South Asia is important to my Dunedin research firstly to complicate the notion that migrants move from one distinct paradigm of health care to another when coming to live in New Zealand, and second to highlight the integral relationship between traditional South Asian medicine and the use of folk remedies that are common among my Dunedin informants.
As mentioned earlier in this chapter, South Asians are currently among the fastest growing migrant populations in New Zealand. While previously small in number, New Zealand has had a long and diverse history of Indian migration that can be traced back further than the early British colonial settlement. In Chapter 4, I briefly map South Asian immigration and explain how the multiple waves highlight the heterogeneity of Indo-New Zealanders. I also discuss the growing multicultural trend—as New Zealand has become ‘one of the highest migrant receiving countries in the world’ (Singham 2006, 33)—and some ideals and values that surround multiculturalism. Arguing for an integrative rather than assimilative approach, I reiterate Ananda Chopra’s (2008, 252) assertion that globalisation offers the ‘opportunity to acquire knowledge about other cultures and their medical arts.’

Many critical medical anthropologists are cautious of the pitfalls in using western biomedicine as a benchmark for evaluating other ethnomedical systems, and they turn their analysis to the politics of biomedical authority (see Rhodes 1996). In Chapter 5, I elaborate on the theoretical paradigms that inform my research. Post-colonial theory and critical medical anthropology inform my own critique of the power dynamics surrounding modern medicine, while critical ethnography inspires me take responsibility for personal investment in the topic and use my voice, alongside the voices of participants in my research, in an attempt to inspire social change.

Critical ethnography offers a radical approach to research through advocating a move away from traditional objectivity and encouraging the researcher to be transparent about personal values and research agendas. In Chapter 5, I outline the qualitative methodologies used in this research and—highlighting the importance of a reflexive
approach—I discuss some of the potential pitfalls in representing others through qualitative research.

I have begun this introductory chapter with an outline of my research premise, a brief discussion about the location and demography of the research project and a preliminary tour of most of the thesis chapters. The following section goes on to outline the main findings (from Chapter 6) that have emerged from interviews with participants. Paramount among these findings is that each of the nine participants interviewed demonstrates a pluralist approach to health and medicine, which includes traditional practices that have been passed down through generations.

Medical pluralism is prevalent throughout South Asia, where biomedicine is practised side-by-side—and sometimes syncretic—with traditional medicine. In New Zealand however, the biomedical paradigm is principal. The question as to whether an increasingly multicultural New Zealand calls for greater medical pluralism is central to my research. Thus, it is germane to offer some insight into the New Zealand health care system. This introductory chapter completes with a glimpse into the historically mediated conservatism that tends to live on in New Zealand's medical policy and implicitly marginalise non-orthodox health care practices.

1.1.3 Main Findings from the Interviews

Participants in this study report that they each, to varying degrees, make use of home remedies that have origins in traditional medicine and that have been passed down through the generations. Indeed they each shared with me at least one recipe that was passed down from their mother or grandmother, and from which they have experienced remedial efficacy.
Corroborating much of the international literature on South Asian health practices, the narratives of participants in this research indicate a pluralist approach to medicine. Traditional remedies—including homeopathy—are a popular first choice for general health concerns; and biomedical treatment is usually sought for conditions deemed to be more serious. Although some participants concede that they may at times opt for an over-the-counter medication for fast relief of a debilitating cold, they tend to classify traditional remedies as ‘natural’ and safe compared to western pharmaceuticals that often produce adverse side effects.

While the broad findings in my research tend to corroborate many of the findings from the international literature, in Chapter 6, I offer some further insight into specific areas of difference. Due to my use of open-ended questions in the interviews, some of the participants’ narratives take me down unintended pathways. A rich analysis of these narratives enables me to reach beyond the broad themes I had anticipated, and access unique understandings that reveal tacit knowledge around health.

Several participants expressed concern that the fast pace of modern living has resulted in a shift away from traditional medicine, which does not offer the ‘quick fix’ promised by western medicine. For some, this indicates a loss of tradition. Yet one participant, Rajesh, exclaimed that ‘Indian cooking is the best Ayurvedic medicine.’ Many of the botanical herbs and spices that are used in Indian cooking are essential ingredients found in Ayurvedic pharmacopeia.

Simran and Lila, both second generation migrants, each told me that they view food as important to their cultural identity. They were taught to cook by their mother and grandmother respectively; and they carry on the tradition by cooking mostly Indian food
at home. Several participants divulged specific knowledge about the medicinal qualities of the spices they use in their cooking. Those who had less explicit knowledge still understood that the culinary herbs and spices they used were intended not for flavour alone, but because they were supposed to be good for the health.

Sirisha, who is a computer technician from Hyderabad, demonstrates another unique and interesting way in which she keeps indigenous health knowledge alive. She tells me that whenever her mother or grandmother recommends a remedy, she searches on the Internet to find the ‘scientific reasons’ for its efficacy. She claims that the reasons many people use traditional remedies are rooted in sentiment rather than education. The knowledge she gains from researching online the traditions of her elders serves to validate the efficacy of these traditions.

In my final discussion of the interviews in Chapter 6, I look at how some of the participants’ narratives demonstrate that the use of traditional health practices may offer some autonomy from the hegemony of biomedical authority, and may be contextualised as expressions of human agency.

1.2 Insight into the New Zealand Health Care Setting

All citizens and permanent residents of New Zealand are eligible for publicly funded health services (Ministry of Health 2015). Although there are some private hospitals in New Zealand that offer specialist services to private patients for a fee, public hospital care is free and therefore provides the majority of secondary health services (see Ashton, Mays & Devlin 2005). General practitioners (GPs) provide primary health care; they are the first port of call for most patients. GPs operate privately and charge a fee for their services. These fees are partially subsidised by the government provided the
patient has registered with a primary health organisation (PHO). Further subsidies are available for low-income patients; and after July 2015 children under the age of thirteen became eligible for free visits to the doctor (Ministry of Health 2015a).

General practitioners have the authority to refer patients for specialist or hospital treatment. Patients may however elect to see private specialists to avoid the long wait for subsidised hospital or specialist care, as waiting times are often up to six months (see Anderson 2008). GPs also have the authority to refer patients to a limited number of alternative therapies that are subsidised through the Accident Compensation Corporation (ACC) or government benefits. According to Kate Duke (2005), only doctors who are sympathetic to complementary medicine will authorise these referrals.

1.2.1 Orthodox Medicine

Although there are a variety of traditional medical systems (TMS) and complementary and alternative medicines (CAMs) available and utilised in contemporary New Zealand, the biomedical model of medicine is endorsed by the national health system and remains the dominant modality. The term ‘orthodox’—which implies an authoritative status—may ultimately be used to signify any medical practice that is officially legitimised by the state. Thus, what is considered orthodox will differ depending on context. In New Zealand, orthodox medicine is used mainly in reference to the practices of registered medical practitioners, dentists, nurses, physiotherapists and psychologists who have been trained at state funded institutions (see Miskelly 2006).3 According to Philippa Miskelly (2006, 118), the status of orthodox medicine ‘is due, in part, to the tacit approval it receives from the state, which in tandem with biomedicine supports the

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3 Some orthodox practitioners do however also practise some form of CAM (see Duke 2005).
privileging of science and technological knowledge over the supposedly more metaphysical philosophies underpinning alternative and complementary modalities.’

Miskelly (2006) argues that early European settlers were accustomed to a range of healing options from herbalism and hydrotherapy to chiropractic, osteopathy and more orthodox biomedical practices. Homeopathy was practised widely in the early days and categorised as an orthodox form of medicine. But the status of biomedicine grew as ‘scientific knowledge and technology had become more widespread’ (2006,119). Government support was achieved through increasing standardisation and regulation of biomedical practices coupled with a move for medical doctors to form professional bodies. This also served to increase the popularity of biomedicine over other healing modalities.

Mirroring the British coloniser’s suppression of traditional medicine in India,4 in 1907 the Tohunga Suppression Act was passed in New Zealand. This Act made it illegal to practise Māori medicine for decades (see North 2008). The following year, the Quackery Prevention Act 1908 was passed. Quackery refers to ‘people who pretend to have knowledge or skills that they do not possess’ (Dew 2003, 9). Although the expressed purpose of the Act was to assure quality by introducing regulations and preventing false claims, the inference was that all non-scientific medicine should be considered quackery. Thus the Act effectively marginalised alternative therapies (see Duke 2004; Dew 2003).

Kevin Dew (2003, 30) claims that ‘[b]y 1940 the New Zealand medical profession was homogeneous, organized and a powerful pressure group, with medical knowledge and education having become much more standardized.’ The Otago Medical School, which

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4 See Chapter 3.
was established in 1874, contributed to the overall conservatism of the medical profession. The Medical Practitioner’s Act 1914 had limited overseas trained practitioners—thus supporting those trained at the Otago medical school where students were offered ‘no alternative educational experience that would lead them to question “scientific medicine”’ (Dew 2003, 30).

### 1.2.2 CAMs & TMS—Crossing Paths

Despite legislative attempts to thwart the practice of alternative therapies, Duke (2005) asserts that they never went out of fashion in New Zealand; and by the end of the twentieth century, numerous orthodox medical practitioners also used some form of CAM. In 2003 the Ministerial Advisory Committee on Complementary and Alternative Health compiled a comprehensive list of CAM modalities practised in New Zealand (see Duke 2005, 15). Ayurveda is one of the seventy items listed. Other modalities range from therapies as general as ‘massage’ or ‘herbal medicine’ to therapies as specific as ‘colon hydrotherapy’ or ‘iridology’. There are also more obscure titles such as ‘primal healing’ and ‘paramedical aesthetics’. Duke estimates that around ‘one in four adults in NZ utilise some form of CAM therapy’ (2005, 15).

Miskelly (2006) attributes the popularity of CAMs in contemporary New Zealand to neoliberal values, which promote and reinforce self-responsibility and patient autonomy:

> Contained within neo-liberal discourse and the rhetoric of individualism is the inference that individuals should embrace autonomy and exercise freedom of choice. This is particularly pertinent to the health sector and the choices individuals are now faced with in regard to the range and types of modalities on offer, as well as their own health-related behaviour. The neo-liberal environment encourages individuals to question and challenge traditional bastions of authority. There is now a continual
appraisal and critique of the way biomedicine delivers health care and a manifestation of this questioning is also seen through the increasing use of alternative and complementary therapies. (Miskelly 2006, 114)

Although a compelling analysis, Miskelly (2006) neglects to address where diversity in health care options may be of value to an increasing multicultural society. The global movement of people and knowledge through migration may also be responsible for the increasing prevalence of CAMs by creating ‘demand for alternative health care in the country of settlement’ (North 2008, 8). Many of the healing modalities that are considered complementary or alternative to western biomedicine are in fact traditional medical systems, deeply rooted within a cultural matrix; ‘traditional Chinese medicine (TCM) … and Ayurvedic medicine are categorised as CAM in New Zealand and other western countries, although they are regarded as mainstream in China and India respectively’ (North 2008, 3).

The categorisation of TMS into the broad CAM category indicates that, in the West, these modalities share in common a marginal status to biomedicine. Yet these modalities also appear to share some common traits. The rhetoric around CAM as a holistic alternative to biomedicine (see Miskelly 2006) mirrors the reputation of eastern medical traditions, where diagnosis and treatment tend to acknowledge an interrelationship between body, mind and environment (see Khare 1996). Similarly, these modalities tend to acknowledge the heterogeneous nature of people, often catering treatment to the individual instead of prescribing for the condition.

I have identified some parallels between the attitudes expressed by CAM users and those expressed by participants in my research who use traditional herbal remedies. A New Zealand study (Chan & Whitehead 2007) found that, like many of my informants,
CAM users are concerned with adverse side effects of pharmaceutical medications. As with proponents of traditional South Asian medicine, CAM users advocate its benefits in ‘maintaining health and preventing illness’ (2007, 39). The theme of self-responsibility, argued by Miskelly (2006) as quintessential to CAM users in New Zealand, also arose during my interviews with participants in reference to the use of traditional herbal remedies. Ray, for example, confided in me that he always relied on his mother and regrets that he had not paid greater attention to the preparation of home remedies because he wishes to be more self-reliant.

When I had asked Sirisha what comes to mind when she thinks of the word ‘health’, her response was thus:

Frankly, I never think of the word ‘health’. Well because you consider my mother, grandmother, everyone—we never went to any hospital or anything, ninety per cent, until there is an emergency. We never faced any emergencies. And most my family is very healthy. We don’t use most medicines. Generally the common health problems are like cold, cough, flu, like that. We use only the home remedies, not medicines or anything.

1.2.3 Status, Stigma and Subsidies

Nicola North (2008) interviewed immigrant doctors practicing non-western medicine to find that unanimously they have experienced a significant loss in status due to the marginal position of traditional medicine in New Zealand compared with their country of origin. Finding a position that aligns with one’s skill level or qualification has been noted as a common struggle for skilled migrants to New Zealand (see Bandyopadhyay 2010). North (2008) asserts that immigrant doctors who practise non-western medicine are doubly disadvantaged because not only do they find themselves stigmatised as immigrants, but also because their field of practice is itself marginalised.
Media representations further stigmatise the status of indigenous medicine and practitioners. A 2015 news item reveals a recent trend of Indian ‘witch doctors’ extorting money from ‘vulnerable kiwis’ by promising unrealistic outcomes through prayer (Rutherford 2015). Although the unmasking of this scam is important to Indians in New Zealand, the media portrayal runs the risk of conflating folk magic with traditional medicine, and contributing to the stereotypes and stigma surrounding unorthodox forms of healing.

The peripheral position of CAMs and traditional medicine in relation to western biomedicine impacts not only the status of its practitioners, but also impacts access to subsidised health care for patients who prefer non-biomedical treatment for chronic conditions. Visiting a private CAM or traditional medical practitioner can be costly and, as I mentioned above, only a limited number of CAM modalities are subsidised through ACC or government benefits:

> The Accident Compensation Corporation (ACC) subsidises acupuncture, chiropractic, and osteopathy services provided by specified providers. Work and Income NZ (WINZ) will also subsidise certain alternative treatments for those who are receiving disability allowance if the treatment is seen as beneficial to the recipient. There are also some traditional Maori practices, which are funded through Maori health provider organisations. (Duke 2005, 13)

With the acceptance of Māori medicine—which is granted some authority in New Zealand through bicultural politics\(^5\)—an alternative therapy modality can only warrant government subsidy if it has been evaluated by experts to meet the criteria of an ‘evidence-based’ medicine (Dew 2003, 152). In New Zealand, medical efficacy is measured by the guidelines of biomedical science, which involves clinical trials that are

\(^5\) For more on bicultural politics, see Chapter 4: section 4.
randomised, double blind and placebo-controlled. The ideal conditions necessary to carry out such trials are unrealistic even for many biomedical therapies; thus a consensus of ‘experts’ is often relied upon to determine what passes as evidence-based medicine (Dew 2003, 109).

The experts authorised to grant credibility to alternative therapies are not however practitioners of those therapies but inevitably they are members of the biomedical community. Dew (2003) discusses in detail the politics behind the limitation of CAM in New Zealand, and explains how those modalities that have achieved enough status to be partially subsidised by the government have done so through aligning themselves in some way with biomedical principals.

Acupuncture is one such practice and a pertinent example because the treatment stems from traditional Chinese medicine (TCM), which—along side Ayurveda and Unani medicine—is considered by Charles Leslie (1976, 2) one of the three ‘great tradition’ medical systems. Similar to the way in which Ayurveda was reinvented in India as a symbol for national identity, TCM was reinvented ‘during a period of nationalism marked by idealism and pride in China’s ancient philosophy and cultural heritage’ (Hsu 2008, 465). As with Ayurveda, TCM’s claim to scientific validity relies on its alignment with biomedicine.

Unlike Ayurveda however, acupuncture is now widely practised throughout New Zealand, both through private clinics and with GPs and physiotherapists adding needle treatment to their repertoire (Dew 2003). Acupuncturists have their own section in the

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6 For more on this, see Chapter 3: section 2.

7 For more on this, see Chapter 3: section 6.1.
yellow pages of the 2016 Otago phone book; there are thirteen listings, two of which are specified as physiotherapists. On the other hand, a South Island wide search led me to only three Ayurvedic clinics in Christchurch, two of which appear to be no longer operating.

Although there has been much controversy about the efficacy of acupuncture in the medical community, many argue that ‘its evaluation by scientific trials showed its effectiveness for a number of conditions’ (Dew 2003, 61). It is notable however that although acupuncture has been granted adequate status for government subsidy in New Zealand, the whole system of TCM has not been embraced in the same way.

1.2.4 Current Legislation

Dew (2003, 30) asserts that the medical establishments of both New Zealand and Australia are ‘very conformist’ compared with those of the United States, Canada, and Britain, where homeopathy and other CAMs are afforded greater acceptance. In 2011 the Australian and New Zealand governments announced they would be working towards a joint therapeutic products regulator, which would standardise the regulation of orthodox medicine and CAM products between the two countries. There was concern from many CAM users that this treaty would create greater restrictions and further limitations on natural health products in New Zealand (Ellena & VonTigerstorm 2006). The project was abandoned in 2014 because it was decidedly too costly for both countries (Dutton & Coleman 2014).

Meanwhile, in 2011, two bills were introduced to New Zealand parliament as replacement for the Medicines Act 1981. These were the Medicines Amendment Bill, which was passed through parliament and became an Act in 2013, and the Natural
Health Products Bill, which is still making its way through the legislative process (see Medicines Amendment Act 2013; Ministry of Health 2015b). Natural health products had previously been regulated under the same legislation as orthodox medicine, but the proposed bill contextualises them as ‘low risk’ in comparison to biomedical products, implying they should require separate regulations (see Natural Health Products Bill 2011, 1).

The purpose of the Natural Health Products Bill is to regulate natural health products and traditional medicines; this means both restricting and permitting the products’ entry into the country, and regulating the types of claims made on their labels. The bill grants the Director General of Health the role of gatekeeper for these purposes. Herbal Ayurvedic preparations are among the products governed by this bill. While the rationale is to assure these products are safe for human consumption, some of the language used in the commentary supplied with the bill suggests that an ulterior motive is to police natural health products for their ‘clear scientific evidence of efficacy’ (2011, 2). The assumptions that reveal themselves through this legislation reinforce the hegemony of biomedicine in New Zealand, and are reminiscent of earlier legislative attempts to marginalise the practise of traditional and alternative therapies.

1.3 Summary

Traditional medicine falls under the umbrella of CAM in New Zealand as it does in most western nations. Although complementary and alternative medicine is popular among doctors and patients alike, the health care system is discriminatory against unorthodox medical practices that have not passed the gold standard for scientific testing. New Zealand medical policy thus restricts access to health services that resonate with the
core values of culturally diverse people. This access is restricted either through legislative policy that limits the importation of traditional preparations or by a refusal to subsidise most traditional health care treatments, contributing to their unattainability for many.

The Dunedin locale of my research is significant because the Otago Medical School has had a lasting impact on the conservative politics of orthodox medicine in New Zealand. Because each of my participants report varying levels of support for indigenous remedies that have been passed down from their South Asian ancestors, and many state that they would visit Ayurvedic doctors and homeopaths were they more accessible, I propose there is cause to re-evaluate the medical conservatism that restricts access to unorthodox health care on a governmental level.

Biomedicine is likewise the singular dominant medical paradigm receiving government subsidy in most western countries—and access to traditional medicine is often limited. In the following chapter, I explore some of the international literature that investigates the health practices of South Asians living in various diasporic contexts. A pluralist approach to medicine that is similar to my own findings can be traced throughout the literature. The popular use of traditional remedies among South Asian migrants can in turn be traced back to the Indian subcontinent where traditional medicine and biomedicine are both supported on state and national levels.
Chapter 2: Literature Review

2.1 Introduction

This chapter provides a review of international literature investigating the use of traditional health practices by South Asian migrants, and a review of ethnographic studies investigating the pluralistic use of traditional and modern medicine in South Asia. Because there is a paucity of ethnographic research looking into the use of traditional medicine by South Asian migrants to New Zealand—which indicates a need for such a study to be undertaken—the New Zealand literature included in this review centres more broadly on Asian migrant health issues. The priority of much of this literature lies mainly in identifying risk factors for disease or mental illness, and understanding reasons for a perceived deficit in health care utilisation. A review of this New Zealand literature is necessary to provide context and highlight some of the particular challenges faced by South Asian migrants to New Zealand.

The international literature—mainly from North America and the United Kingdom—offers some insight into the lived health practices of South Asians in diaspora. A general finding in this literature is that their informants commonly demonstrate a pluralist approach to medicine similar to that of people living in South Asia. Although visiting a traditional doctor (*Vaidya* or *Hakim*) may not be as accessible for South Asians in diaspora, these studies have found that many continue to use traditional folk remedies in conjunction with western medicine. Folk remedies consist of culinary spices, herbs or minerals based in Ayurvedic pharmacology. The literature agrees that home remedies are generally a first choice for familiar or chronic health concerns, but for more serious health problems South Asian migrants will tend to turn to conventional medicine.
While a pluralist approach may be common to South Asians at home and abroad, a leading UK study found that South Asian migrants in Glasgow rarely speak of their use of home remedies with their doctors (Bhopal 1986). More recent studies in Canada report that some respondents feel patronised or ridiculed when they disclose their cultural practices with health professionals (Bottorff et al. 2001; Hilton et al. 2010). Isabel Dyck (2006) refers to traditional and indigenous medicine—in the context of migrant experience—as subjugated knowledge in tension with dominant ideology; and Ann Hilton and colleagues (2010) assert that the more integrated into mainstream society, the less likely are their respondents to rely on traditions from the homeland.

While much of the New Zealand literature agrees that processes of migration and cultural factors—such as language barriers or perceived stigma around health problems—pose a risk for physical and mental illness, the proximate cause for this disproportionate risk is often attributed to the perceived under-utilisation of health care facilities among migrant Asians. A weakness of much of this literature is the tendency to aggregate multiple ethnic groups into a single category of ‘Asian’, contributing to an unclear picture of the diverse needs of heterogeneous ethnic groups (see Leckie 2015; De Souza 2006; Rasanathan, Ameratunga & Tse 2006; Rasanathan, Craig & Perkins 2004). Still, many of the barriers to health care explored by New Zealand scholars align with the international literature. These include language difficulties, stigma around mental illness, discrimination, and social isolation. Further barriers include limited ethnic diversity among health professionals in New Zealand and limited understanding among migrants as to how the health system works.

In an attempt to redress the disparity of health care among Asian migrants in New Zealand, there is a growing initiative to insure cultural competence among health care
workers (Scragg 2016; Mehta 2012; Ngai, Latimer & Cheung 2001). Yet the dearth of ethnographic inquiry into the health needs as perceived by migrants themselves reflects an implicit expectation for minorities to assimilate into the established system. Ethnographic research in Canada found that migrants have their own strategies of coping with distress, which include the use of home remedies and traditional practices (Bottorff et al. 2001).

There is however a growing voice in the New Zealand literature that challenges assimilationist attitudes towards healthcare, calling not only for greater cultural awareness in the health sector, but for greater inclusion or support of cultural health practices (see for example De Souza 2005; O’Connor 2007; North 2008). In an exploration of the maternity and post-natal practices of migrant Goan women in New Zealand, Ruth DeSouza (2005) notes that her informants struggle to fit in with the ideology of a health system that does not support their cultural needs.

This concern is central to my own research, which has been driven by the question as to whether there may be a greater need for the support of medical pluralism within New Zealand health policy. An exploration of the extent to which South Asian migrants broadly rely on traditional health practices—which is the focus of this thesis—can offer some insight into this question. Through inquiring into the lived experience and strategies people have for attending their health needs, this thesis fills a gap in the New Zealand literature and contributes a New Zealand perspective to the international literature. Because this research is limited to the South Island due to funding constraints, there is room for further studies to cover greater New Zealand.
2.2 A Review of the International Literature

There are a number of interview-based studies conducted internationally that focus on health practices of South Asian migrants. While the majority of this research comes out of North America and the United Kingdom, an extensive search has revealed two early papers addressing Indian health practices in Malaysia (Colley 1978; Heggenhougen 1980), research conducted in Fiji in the 1980s (Singh 1986; Gill 2010), and two more recent papers looking broadly at the use of Complementary and Alternative Medicine (CAM) among South Asians in Singapore and South Africa (Lim et al. 2005; Singh, Raidoo & Harries 2004).

Frederick Colley (1978) asserts that Malaysian Indians rely on a variety of practices including ‘classical Indian medicine, some European medical concepts, folk remedies and spiritual healing’ (1978, 84). He interviewed 16 middle-class housewives of diverse Indian origin and religious background. All of them used traditional home remedies and believed these to be ‘better than western medicine’ for treating general health concerns (1978, 92). In Malaysia—as in other postcolonial third world countries—western medicine dominates the official health care system; yet many people continue to rely on a range of traditional practices. Harald Heggenhougen refers to Malaysia as ‘an ethnically pluralistic society’ (1980, 236) which, he asserts, to some extent explains the medical pluralism. The leading ethnomedical systems—themselves having internal variations—include local Malay folk healing, Ayurveda, and Chinese medicine (see Heggenhougen 1980).

8 Although Kuldip Gill’s (2010) thesis was published much later, she conducted her research in the 1980s.
In Fiji, the national health care system is also dominated by western medicine and, similar to the case of Malaysia, there are diverse ritual and herbal-based ethnomedicines utilised by the indigenous and Indian populations (see Singh 1986). But contrasting Colley’s (1978) account of the increasing popularity of traditional medicine among the urban Indian population in Malaysia, Yadhu Singh’s (1986) survey involving 250 Indo-Fijians revealed that while rural villagers showed a vast knowledge of traditional remedies, those who lived in urban Fiji had little experience with traditional Indian medicine. Although Singh’s study was published in the 1980s, Jacqueline Leckie suggested during an informal conversation that the same patterns apply today.

Singh (1986) identifies traditional Indian healers in Fiji as herbalists and spiritualists, implying that traditional Indian medicine was—at the time of writing—limited to local folk medicine. Gill (2010) explains that although her Indo-Fijian informants use remedies and adhere to practices that have their roots in the scholarly system of Ayurvedic medicine, Ayurveda itself is not widely known or practised in Fiji. This differs again from the state of affairs in Malaysia. Colley (1978) explains that by 1972, after traditional Indian medicine had begun to gain greater popularity in urban areas, Ayurvedic practitioners established a professional body in Kuala Lumpur, which—by 1978—was comprised of around 100 members.

Two studies are distinct among the international literature for inquiring more broadly into the use of complementary and alternative medicine (CAM) among South Asian communities in Singapore (Lim et al. 2005) and South Africa (Singh, Raidoo & Harries 2004). CAM has become a common term used to categorise health practices ‘other than those intrinsic to the politically dominant health system of a particular society or culture’ (O’Connor et al., 1997 cited in North 2008, 3). CAM covers a broad range of
modalities with various systems of traditional medicine among them. What is interesting about these two surveys inquiring into the use of CAM among South Asians in Singapore and Chatsworth, South Africa is that many of their respondents state they use CAMs because they are ‘natural’ and they wish to avoid the side effects of allopathic medicine. These reasons for using non-orthodox medicine coincide with reasons provided in the wider literature, by users of traditional Indian remedies.⁹

While the diversity of findings among studies conducted in North America and the United Kingdom depend on the types of questions asked, many researchers have found their South Asian respondents tend to use traditional remedies consisting mainly of culinary herbs and spices as a first choice for general or chronic health concerns (Ahmad et al. 2008; Bhopal 1986; Choudhry 1998; Dyck 2006; Hilton et al. 2010; Rao 2006). Dyck (2006) describes migrant women’s use of home remedies as a convenient first approach to addressing common ailments. She argues that although there may be tension between traditional healing knowledge and Canada’s dominant medical paradigm, biomedical treatment is not rejected by her informants but rather integrated into an attitude of ‘practical pluralism’ (2006, 5). This integrative approach to health practices among South Asian migrants appears commonly through the literature. Another Canadian based study by Hilton and colleagues (2010) found that traditional remedies are used as preventative medicine, to promote health or address common ailments, but for more serious health problems their informants will turn to conventional medicine. In some cases however traditional remedies are revisited when conventional medicine has failed.

⁹ Also, as discussed in Chapter 1, informants to this thesis likewise give similar reasons for preferring traditional remedies to allopathic medicine.
The international literature finds South Asians in diaspora tend to use traditional folk remedies in conjunction with western medicine. Yet an early study in Glasgow by Rajinder Bhopal (1986) reports that respondents rarely spoke of their use of home remedies with their physicians, and tended to view their use of remedies as separate from health care. Corroborating this finding, U. K. Choudhry (1998) and Hilton and colleagues (2010) explore the matter in greater depth. These authors explain how traditional health practices are integrated into the day-to-day lives respectively of their East Indian and Punjabi respondents in Canada. Traditional practices are not limited to herbal medicines and remedies but include diet, spiritual wellbeing and good family relations.

Choudhry (1998) identifies a cultural difference between her respondents and the broader Canadian society; she claims that mainstream Canadians tend to separate activities that centre on health care from other daily activities. To emphasise this point, she upholds that her participants do not use the term ‘exercise’ in reference to health maintenance. When the researcher broaches the topic of exercise in an interview, her informant responds thus: ‘In India we did not talk about exercise, we never gave much thought to it. We remained active by work or walked to the neighbors, to the park in the evening’ (1998, 272).

Hilton and colleagues (2010) however complicate the assumption that South Asian migrants will necessarily have a more holistic view of health than other Canadians because, they assert, the more integrated into Western culture, the less likely are their respondents to rely on desi ways, or traditions from the homeland. Although the authors argue that passing down traditional health knowledge to younger generations functions as a way of preserving culture, much of the literature illustrates how younger
generations tend to facilitate a move away from these traditions or at least bridge a gap between South Asian traditions and western health practices. Dyck (2006, 9) observes children to be ‘significant conveyors of “new” food knowledge.’ They bring home from school messages relating to nutrition and healthy diets. For elder migrant women, especially those who have remained mostly at home or in tight-knit communities, their children who have grown up in the host country are not only a source of information but will accompany them to visit the doctor where they assist in both language and cultural translation (Grewal, Bottorff & Hilton 2005). This demonstrates a shift in roles: from elders traditionally coaching younger generations in health related matters, to the youth in migrant families educating their elders in western ways (Hilton et al. 2010).

Raising the important concern in medical anthropology over biomedical hegemony, Dyck (2006) refers to traditional and indigenous medicine—in the context of migrant experience—as subjugated knowledge in tension with dominant ideology. Although her respondents demonstrate a complex interaction between knowledge systems, the normativity of a biomedical model of health in mainstream society has been noted in the literature to stigmatise divergent cultural understandings and ‘perpetuate an imbalance of power between dominant and minority groups’ (Hilton et al. 2010, 554). This imbalance of power is manifest in the clinical setting where some migrant women in Canada report feeling patronised or ridiculed for using traditional medicine by western health workers (Bottorff et al. 2001; Hilton et al. 2010). The reluctance of migrants to discuss traditional health practices with their doctors (as documented by Bhopal 1986; Choudrhry 1989; Hilton et al. 2010) may thus be attributed in part to fears of disapproval or stigma surrounding traditional practices.

A recent study in London (Jennings et al. 2014) takes a close look at the imbalance of
power between the knowledge of Bengali migrants and authoritative public health messages. The researchers observed health professionals delivering seminars in a top-down fashion at migrant cultural centres. The Bengali informants of this study defer to this expert knowledge and in many cases allow the medical model of nutrition to eclipse their traditional understandings. For example many reiterate that the consumption of ghee (clarified butter) and rice—both staples of South Asian food—should be limited. The seminars focus on negative aspects of Bengali food, like excess sugars, salts, carbohydrates and fats. Community workers outside these seminars echo the same messages, leading many participants to view Bengali food as inherently unhealthy.

Although value can be gained through epidemiological understandings of cultural factors that put people at risk for poor health, this study shows the dangers in oversimplifying correlations between health and diet; Bengali people themselves begin to understand their traditional foods as a risk to their health. No value is given to indigenous knowledge of medicinal properties of herbs and spices used in Bengali cuisine. The one-way delivery of these programs leaves no room for this knowledge to surface and be discussed. The authors reflect how stigmatising Bengali food easily leads to stigmatising Bengali migrants themselves.

Cultural determinants of health risk may—as in the above case—be over simplified and potentially lead to what Joan Bottorff and colleagues (2001) describe as a kind of racist profiling. Yet anthropologists make valuable contributions to epidemiology through understanding cultural beliefs and practices that deter health seeking, which in turn may lead to disparity in health care among migrants. For example, literature focusing specifically on South Asian migrant women in Canada provides insight into how family and community responsibilities tend to come before a women’s own health concerns
(Bottorff et al. 2001; Choudhry 1998; Grewal, Bottorff & Hilton 2005). Choudhry (1998) found that for most of her respondents ‘tradition takes precedence over personal needs. Putting oneself before others is considered becoming westernised and self-centered. Many view women’s independence as detrimental to the family’s welfare, compelling many to remain within traditional boundaries’ (1998, 270).

Choudhry argues that isolation from the larger community limits these women’s exposure to health programs. Decisions around health appear to be negotiated within the family; Bottorff and colleagues (2001) claim that their informants tend to be reluctant to speak of health concern with people outside the family. The authors advise that ‘health service policies that focus solely on supporting and enhancing the health of individual women, without acknowledging the influence of families and communities, are less likely to be successful among South Asian immigrant women’ (2001, 399-400).

Furthermore, Farah Ahmad and colleagues (2008, 115) propose that ‘S[outh] A[onian] immigrant women are at particular risk of acculturative stress’ due to rigid gender roles which pose challenges to settlement and integration. Their study found that loss of social networks upon immigration to Canada is a leading factor their respondents attribute to depression and mental health issues. Similarly, Bottorff and colleagues (2001) found their informants attribute stress and health problems to being cut off from the comforts and familiar ways of their homeland. Their respondents report to have their own strategies for coping with distress—which include the use of home remedies, exercise or yoga and socialising—and although they go for regular check-ups, they tend not to raise mental health concerns with their doctors.

According to Clarissa Giebel (2014), it is mainly in the area of mental health where
services are underutilised by South Asians in diaspora. She attributes the high rate of untreated dementia found among elderly South Asians to a tendency for the family to look after those in distress rather than seeking outside help. This may be due in part to high levels of stigma around mental illness. A Bangalore study which interviewed psychiatric outpatients (Raguram et al. 1996) found that people who suffer depression were concerned about being considered unfit for marriage or being generally ostracised by family and community. The same people however felt no such concern around experiencing physical health problems. The authors conclude that because depression and mental health issues are culturally unsanctioned, South Asians tend to express their distress in somatic terms, through physical pain.

Although epidemiological insight into how culture may impact health can be useful to public health initiatives, this is not the focus to my research on migrant health. I am more interested in employing cultural relativism when looking at health strategies, and asking whether the dominant paradigm of biomedicine meets the perceived needs of South Asian migrants. Bhopal (1986) argues that it is less cultural factors than a lack of mutual understanding between doctors and patients—which he attributes to language barriers—that contribute adversely to compliance with physicians’ advice. A recent study exploring the perspectives of South Asian patients within mainstream health care in the United Kingdom finds that poor communication is often the result of ‘ethnocentric tendencies within the service’ (Abdu, Stenner & Vydelingum 2015, 1).

Arthur Kleinman, Leon Eisenberg and Byron Good (1978) observe that mutual understanding between doctor and patient is key to the efficacy of healing. They attribute the lack of understanding common between doctors and patients not merely to language barriers, but to differences in explanatory models of illness and disease. While
biomedical doctors are mainly concerned with disease categories, which indicate malfunctioning biological processes, the patient is concerned with the lived experience of illness. This experience ‘is shaped by cultural factors governing perception, labelling, explanation, and valuation of the discomfort experience, processes embedded in a complex family, social, and cultural nexus’ (1978, 252).

Laurence Kirmayer (2004) argues that even when medical experts observe symptomatic improvements after treatment, some patients may continue to suffer the illness experience. He uses Kleinman’s (1986) famous example of neurasthenia patients in China who identify their physical and psychological suffering with experiences associated with the Cultural Revolution. Because the biomedical treatment they receive fails to address what the patients themselves believe to be the core issue, it gives minimal relief.

2.3 A Review of the South Asian Literature

Studies conducted in South Asia on the use of health services in both rural (Bhardwaj 1975; Chaudhry, Ahmed & Farooq 2014) and urban (Izhar 1990) settings have found a similar pluralist approach to medicine as found by those studies focusing on South Asian migrants. The literature suggests that home remedies are commonly used by South Asians living in the Indian subcontinent and abroad, and that there is generally a prioritisation of treatment; allopathic treatment is relied on for serious conditions—especially those requiring surgery—and traditional herbal remedies are used as a first approach for general or chronic conditions.

When comparing the findings of research carried out in South Asia with research carried out abroad, it is important to consider the differential access to health services. In most
western countries biomedicine is the singular dominant medical paradigm receiving
government subsidy and there is limited access to traditional South Asian health
services. Ayurvedic medicine falls under the category of complementary and alternative
medicine (CAM) and—where available—clinics are private and consultation can be
costly (North 2008).

Although the degree of governmental support for alternative medicine varies somewhat
between western countries, it is of notable contrast that India supports both traditional
medicine and biomedicine on state and national levels.\(^{10}\) Thus, visiting a Vaidya
(Aryuvedic doctor) or Hakim (Unani practitioner) in urban areas throughout India is
more or less as accessible as visiting a biomedical clinic. In rural areas of India,
traditional or folk medicine is perhaps more accessible and people may need to travel to
larger towns to visit a biomedical clinic (see Bhardwaj 1975). There are mixed reports
as to whether cost is a factor influencing what medicine is utilised in India. The costs
involved in visiting village folk healers are expected to be less than medical clinics; and
herbal remedies can be obtained at a reasonable cost (Ramesh & Hyma 1981). However,
modern standardised and regulated Ayurveda has purportedly been reinvented for the
middle classes (Berger 2008).

According to a 2008 press release, the Pakistani government made efforts to promote
and encourage the use of traditional Unani medicine mainly due to the high costs of
allopathic medicine and its inaccessibility for those in rural areas (PPI 2008). These
efforts align with recommendations of the World Health Organization (2004), which
emphasises the value of indigenous medicine for its cultural heritage and far-reaching

\(^{10}\) For more on this see Chapter 3.
potential to provide health services within rural areas of South Asia.

Ethnographic research conducted in a Punjab village in Pakistan found that villagers tend to 'rely on their traditional methods firstly at home, then the village herbalist and lastly the [biomedical] doctor' (Chaudhry, Ahmed & Farooq 2014, 6289). While locally grown medicinal herbs and substances used in traditional remedies are easy to attain cheaply and higher costs of western medicine may be a factor for greater reliance on traditional medicine, the authors argue that wealthy villagers continue to utilise traditional medicine. A proximate reason for this could be that local healers, who are integrated into the community and familiar with the families' medical histories, tend to elicit more trust than the town doctors. The authors also claim villagers tend to prefer visiting a homeopath to an allopathic doctor because they understand antibiotics to have negative side effects.

A much earlier survey of four rural villages in the Indian Punjab (Bhardwaj 1975) found that most villagers used traditional herbal remedies in the home and demonstrated a pluralist approach—prioritising treatment based on the nature of their ailment. Yet contrary to the findings of the above-mentioned study in rural Pakistan, the majority of Surinder Bhardwaj's (1975) respondents reported to prefer allopathic treatment to visiting traditional healers. Many would need to travel to the nearest town for modern medical treatment. Bhardwaj's (1975) participants were from diverse backgrounds, and he was surprised to find that choice in medicine is not related to levels of literacy or socioeconomic status. His findings support neither the assumption that modern medicine was inaccessible to people living in rural India (even at the time of writing), nor that traditional folk medicine was utilised to a greater extent by the poor and uneducated. He claims that it was a pragmatism driving the villagers' preference, as they
had come to ‘associate modern (angrezi) medicine with quick cure in acute stages of most diseases’ (Bhardwaj 1975, 608).

Further challenging the assumption that the middle classes prefer western medicine, Nilofar Izhar (1990) interviewed patients of a Unani clinic in urban Uttar Pradesh where he found the majority of his respondents were middle class and well educated. He claims that although the interviews were not drawn from a random sample, his findings indicate ‘even high-status persons regard traditional medicine with respect’ (1990, 1141). Demonstrating a pluralistic approach and prioritisation of treatment, many patients attended the clinic to address chronic conditions after being dissatisfied with biomedical treatment. While in general his respondents preferred Unani treatment for its lack of ‘side-effects’, many said they would go to modern hospitals for ‘emergencies, pregnancy, malaria, orthopaedic and heart-related problems where surgery would be required’ (1990, 1140).

Together these studies demonstrate that the tendency to utilise either traditional or modern medicine in South Asia is more complex than economic and demographic considerations alone. Choice of medicine also varies a great deal between provinces, as there is greater support for Siddha medicine in the south and Unani in the north (see Chapter 3). It is also not reasonable to assume that the choice to utilise any particular treatment is based on comprehensive knowledge of the ideologies or distinctive characteristics of the system of medicine. According to Aneeta Minocha (1980, 218) ‘[p]eople's knowledge about medicine and health is actually a total of fragments of beliefs and practices found in diverse systems.’ The pluralistic approach of doctors themselves in South Asia mediates this fragmented understanding of health systems among patients.
Jean Langford’s (2004) ethnography on modern Ayurveda in India reveals a complex intertwining of biomedical and Ayurvedic epistemologies within her subjects. She observes the practices of three Vaidyas (Ayurvedic doctors) who blur the boundaries of modern and traditional medicine to varying degrees. While one of her informants takes a clearly traditional stance in his practice, anatomy—which is central to biomedical analysis—is the ‘bottom line’ for another. The third embraces the modernisation of Ayurveda; he identifies biomedical disease but treats Ayurvedic dosas (humours).

Bhardwaj (1975) also discusses the eclectic approach of village practitioners in the Indian Punjab who often supply their patients with modern and traditional medicine alike. The villagers in his survey believe injections to be superior to oral forms of medication due perhaps to the well-known success of penicillin. Thus ‘most of these (indigenous) practitioners use modern drugs including injectables freely’ (1975, 609).

Although an in-depth understanding of the distinctive characteristics of each medical system may not drive people’s choice in health care, the research conducted in South Asia indicates that people in both urban and rural settings have similar understandings around the efficacy of modern medicine for serious conditions and traditional medicine for chronic conditions. Rural and urban patients alike also express concerns around the safety of allopathic medicine. These findings are consistent with much of the international literature on migrant health practices where participants speak of traditional medicine as natural, safe and having fewer side effects than drugs used in modern biomedicine (see Bhopal 1986; Dyck 2006; Hilton et al. 2010; Rao 2006).

11 Although the precise regions of India that Langford investigated are not specified in her book, I learned from a personal communication with the author in May 2015 that her fieldwork took place in Mumbai (then Bombay), in Mussoorie (Uttar Pradesh), in Benares, and some in rural Kerala, near Thiruvananthapuram.
2.4 Review of the New Zealand Literature

The studies on migrant health practices reviewed in the previous section address important issues that arise from large-scale emigration from the Indian Subcontinent to various countries in the Global North. William Safran, Ajaya Sahoo and Brij Lal (2008, 1) estimate that by 2008 the Indian diaspora comprised ‘more than 20 million people spread over all continents.’ Yet as Wardlow Friesen (2008) advises that assumptions of a homogenised global Indian diaspora can lead to inaccurate generalisations.

The practices of migrant Indians—and South Asians more broadly—vary based not only on regional, religious and language differences between places of origin, but also based on the specific conditions of the receiving country. This latter point is of obvious importance to qualify a need for investigating the New Zealand context where research into the use of traditional medicine among South Asian migrants is sparse. Elsie Ho and colleagues (2003) acknowledge this lack of research as a critical issue because ‘growing population diversity raises concerns for increased sensitivity to and respect for differences in beliefs and cultural practices’ (2003, xi-xii).

The priority of much of the research on migrant health in New Zealand lies in identifying risk factors for disease or mental illness and understanding reasons for a perceived deficit in health care utilisation (Anderson 2007; Anderson 2008, Ho et al. 2003; Nayar, Hocking & Wilson 2007; Rasanathan, Craig & Perkins 2006; Sobrun-Maharaj, Tse & Hoque 2010). There is a tendency in the majority of this research to use ‘Asian’ as a broad classification, which effectively groups diverse peoples into a homogenous category.
De Souza (2006) points out that the aggregation of Asian peoples in public health research may be deployed for practical reasons due to the relatively small numbers within minority groups such as Indians living in New Zealand. Kumanan Rasanathan, David Craig and Rod Perkins (2004) are concerned that such grouping may contribute to inaccurate generalisations of research findings. For example, the high risks of diabetes and cardiovascular disease among Indians would go overlooked where findings are averaged across a homogenous category that includes people from China or Korea (Rasanathan, Ameratunga & Tse 2006). The aggregation of Asian populations in health research further contributes to an unclear picture of the diverse needs and culturally mediated perceptions and expectations of health care.

Jacqueline Leckie (2015) takes this argument a step further by critiquing the notion of ‘Indian’ as itself a homogenous ethnic category. She reminds us that early settlers from Gujarat and Punjab, along with later immigrants from the subcontinent and Fiji, are among New Zealand’s Indian population. The heterogeneity of place of origin as well as historical flows of settlement reflects the cultural diversity within this population.

Much of the research that focuses broadly on Asian health does attempt to delineate the findings within a breakdown of demographic and ethnic categorisation. In a study investigating cultural risk factors for tuberculosis, Anneka Anderson (2007) looks at how stressors involved in migration impact health for three Asian groups in New Zealand: Korean, Chinese and Indian. She is careful to describe the respective health systems of Korea, China and India; and how cultural understandings might impact health practices. But Anderson (2007, 99) argues that ‘[i]t can be misleading to assume

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12 For more on this see Chapter 4: section 3.
that ‘culture’ alone accounts for particular health beliefs or health seeking behaviours as culture cannot be separated from power relations or broader political and economic factors.’ This observation holds particular strength in reflecting upon diasporic or migrant communities where discrimination and alienation have serious implications on access to resources. Anderson’s research attempts to show how the shared experience—of minority status, discrimination and cultural barriers—between her diverse ethnic groups unites them in terms of health risk factors.

Her thesis provides some insight into understandings of health among Asian migrants, and includes some ethnographic investigation into the use of traditional health practices and herbal remedies. But Anderson’s (2007) main objective is to shed light on the impediments to the use of conventional health care. Noting that Asian migrants are found to be low users of health services in New Zealand, the article published from her thesis (Anderson 2008) explores the main reasons for this disparity in access to primary health care. These include a general lack of awareness around how the New Zealand health system works, impatience with the referral time involved in visiting a specialist, and a preference for visiting doctors from their country of origin (of which there appears to be a shortage).

Amritha Sobrun-Maharaj, Samson Tse and Ekramul Hoque (2010) claim that Asian populations are also underrepresented in using the services of the Accident Compensation Corporation (ACC), which ‘provides comprehensive, no-fault personal injury cover for all New Zealand residents and visitors to New Zealand’ (ACC 2015). ‘(D)espite Asians representing about 7% of the NZ population in 2006, they had only 2% of the 1.4 million injury claims’ (Sobrun-Maharaj, Tse & Hoque 2010, 43-44). The research found that language difficulties, experiences of discrimination and a reluctance
to be seen as ‘begging’—or to be out of work during recovery time—tend to be among the barriers faced by Asians in accessing ACC services.

Furthermore, the authors claim that ‘most [Asians] prefer to follow a culturally traditional health path which focuses on holistic care and treating the root of the problem rather than symptoms ... many cannot relate to the Western system of health care and consider it to be irrelevant to their needs’ (Sobrun-Maharaj, Tse & Hoque 2010, 52). Again, this study aggregates people of diverse ethnic backgrounds into the category of Asian. Research careful to distinguish the heterogeneity of the Asian category is important to the practical implications of the above analysis because ACC will cover the cost of acupuncture—which has gained some evidence-based status—but will not cover for Ayurveda or other traditional medical practices.13

An extensive review of mental health related literature for Asians in New Zealand (Ho et al. 2003) further identifies an under representation of help seeking among Asian migrants for mental health issues. The authors argue that the processes involved in migration pose risks for mental illness. They claim that migrant women especially are at high risk because they are adjusting to the demands of motherhood in a new cultural environment where language is often a barrier and their financial situations often force them to take up unskilled labour. Having social support has been found to protect against mental health problems but migration compromises the support women traditionally receive from social networks. Ho and colleagues (2003) assert that where ethnic communities are not large and well established in the host society, opportunities to develop social networks are limited. The authors cite research that indicates migrants

13 For more on this see Chapter 1: section 2.
who integrate successfully into the host society tend to suffer less mental health problems than those who do not. They offer a useful definition of integration:

Integration refers to the process through which newcomers contribute to the dominant society's social and economic well-being while retaining their own cultural identity. It is a two-way process involving the participation and cooperation of both newcomers and members of the dominant receiving culture. (Ho et al. 2003, v)

Reinforcing the importance of social integration, Shoba Nayar, Clare Hocking and Jan Wilson (2007) follow the processes of acculturation experienced by eight migrant Indian women in Auckland. The study is not longitudinal, thus the inferences made from interviews are more heuristic than chronological. Nonetheless they conclude that successful acculturation tends to contribute to a sense of mental well being; and the research offers a formula to occupational therapists for supporting immigrant mental health help-seekers. This praxis may be helpful for those seeking conventional intervention but neglects to address a prevalent finding that social stigma surrounding mental illness can be a significant barrier for South Asians to seek help in the area of mental health (Giebel 2014; Ho et al. 2003; Raguram et al. 1996).

Ho and colleagues (2003) acknowledge that explanatory models of mental illness differ cross-culturally, thus the way in which assessment and treatment is approached by mainstream providers may be culturally inappropriate to the Asian community. Gregory Winkelmann (2013) argues for a new ‘holistic’ approach to mental and physical health, one that reflects the needs of a multicultural society. He recommends that in order to move forward in New Zealand health practice it is necessary to move away from a medication-centred model towards a model that underlines ‘the importance of the family, social, and cultural domains’ (2013; 87-88). This recommendation indirectly
addresses a concern voiced by South Asian academics in the recent past. Rasanathan, Ameratunga and Tse (2006) were concerned that despite emerging epidemiological findings, health policy in New Zealand fails to consider the specific needs of Asian populations. Reiterating this in her article concerned with aging Indians in New Zealand, DeSouza (2006) argues that neither the long history of Indian settlement, nor the recent growth\(^\text{14}\) of the Indian population is reflected in culturally appropriate health policy and care.

There is however a growing initiative sparked by the Waitemata District Health Board and the Northern Regional Alliance to insure cultural competence among health care workers in New Zealand. An earlier report by Marian Ngai, Sandy Latimer and Vivian Cheung (2001) and two more recent reports by S. Mehta (2012) and Robert Scragg (2016) broadly explore health related risk factors among Asian populations, use of health services, social support systems, cultural differences and barriers to health care. Yet within these reports there is a dearth of ethnographic inquiry into the lived experience and health needs as perceived by migrants themselves. This reflects an implicit expectation for minorities to assimilate into the established system. Culturally mediated understandings of health that differ from the mainstream are viewed as a barrier to seeking appropriate treatment.

DeSouza (2005, 87) argues that ‘there is a need to ensure that knowledge developed from research does not merely replicate dominant or hegemonic views of non-dominant groups.’ In her ethnographic research on migrant Goan women’s experience of

\(^{14}\) This was based on the 2001 Census figures when the New Zealand Indian population was at 62,187. By 2013 this figure had increased to 155,178 (Statistics New Zealand 2013). This significant increase reinforces DeSouza’s (2006) message regarding a need for culturally appropriate health policy in New Zealand.
pregnancy in New Zealand, DeSouza (2005) explores how western knowledge surrounding postnatal and maternity practices eclipses indigenous knowledge traditionally passed down from women elders. Although some of her informants are relieved to replace cultural taboos around pregnancy with new positive associations with childbirth, most struggle to ‘fit in’ with hegemonic western ideology. DeSouza’s informants find little support from health care workers for traditional nurturing practices. While her informants view baby massage essential to the health of an infant, no subsidy is offered to assist with this practice. DeSouza (2005, 94) notes that ‘the universal service that is supposedly provided for everyone, in fact, best gratifies [the values and interests of] the dominant group.’

2.5 Conclusion

Kirmayer (2004, 45) asserts that ‘the appeal to a traditional form of healing which may serve to reinforce a valued ethnocultural identity, may not have this same value for patients who are in transition, caught between cultural worlds, and ambivalent, at times, about both the old and the new.’ Findings in much of the overseas literature suggest that many diasporic South Asians do however continue to rely on strategies of coping with distress that include the use of home remedies and traditional practices. Many of these practices can be traced back to medical traditions that originated in the Indian subcontinent (which I discuss at length in the following chapter).

In this chapter I have explored some of the findings of research on South Asian migrant health practices that have been conducted in Fiji, Malaysia, Singapore, South Africa, North America and the United Kingdom. It is commonly found throughout this literature that South Asian migrants tend to have a pluralist approach to medicine that is similar to
people who reside in South Asia. Although visiting a traditional healer is less easily accessible for those in the diaspora, many still tend to rely on simple remedies that are based in Ayurvedic medicine and have been passed on through the generations. Much of the international literature has also found that traditional remedies are commonly used as a first choice for general health concerns often because they are perceived to be ‘natural’ and have fewer side effects than western pharmaceutical medicine.

Kirmayer (2004, 44) asserts that ‘healing practices address core values and concerns in which individuals and communities have a profound stake’ but he expresses some uncertainty as to whether practices from the homeland retain their value for people living in the diaspora. Inquiry into the extent to which people rely on traditional practices in diaspora does not only help to shed light on this important question, but also provides a valuable contribution to the initiative for cultural competency among western health practitioners.

While the New Zealand literature attends less to the role traditional medicine plays in the lived day to day of South Asian migrants and more to concerns of disparity in health seeking behaviour, there is a growing initiative for cultural competence in the New Zealand health sector and an emerging body of literature that challenges assimilationist attitudes towards health care. This thesis is situated among that growing body of literature, offering some insight into the perceptions and experiences of South Asian migrants who discuss the ways in which traditional health practices are valuable and useful in their lives.
Chapter 3: Practised Medicine in South Asia

3.1 Introduction

There exists throughout South Asia a syncretic and pluralist approach to medicine involving not only the multiple practices encompassed by traditional medical systems and folk healing, but also western biomedicine and homeopathy which were both appropriated during British colonial rule (see Frank & Ecks 2004). This chapter offers some background to each of these systems of medicine and explores the complex and dynamic overlapping and interpenetration of traditional and modern medical knowledge and practice in the Indian subcontinent.

The epistemological divide between Asian and western medical theory is vast (see Leslie 1976), yet traditional medicine is practised alongside western biomedicine in urban India and patronage is often determined by a sort of pragmatic pluralism. According to Langford (2004) the syncretism of practised medicine challenges the enframing of either system as ‘bounded and limited knowledge’ (2004, 26). Traditional healers may refer patients to biomedical specialists or prescribe western pharmaceutics; and traditional therapies are often prescribed for diseases categories established by biomedical diagnosis (Sujatha & Abraham 2009). Modern institutions of traditional medicine foster this syncretic approach.

Although my research centres on the health practices of South Asian migrants in Dunedin, New Zealand, I maintain that an elaboration of practised medicine in South Asia is important for two reasons. First, I aim to complicate any notions that migrants necessarily move from one distinct paradigm of health care to another when coming to live in New Zealand. The biomedical model of health care is hegemonic throughout the
Indian subcontinent as it is in New Zealand; but as I will discuss further, other forms of health care are popular, widely available, and to some extent endorsed by the State. My second objective in this chapter is to highlight the integral relationship between traditional South Asian medicine and the use of folk remedies that are common among my Dunedin informants. This relationship suggests that health related understandings and practices, which have been culturally learned, could be an integral part of the diaspora experience.

In this chapter, I begin to introduce my Dunedin participants and reflect on their varied levels of familiarity with traditional medicine. One of my informants expresses in depth knowledge of Ayurvedic medicine and another expresses a detailed understanding of the syncretic approach taken by medical doctors in India. But what is of particular interest is that even where my informants claim to have little medical knowledge, all of them to varying degrees have some awareness of health remedies that have been passed down through the generations; and all of them to varying degrees continue to make use of these folk remedies.

### 3.2 Folk Medicine

In an early contribution to medical anthropology, Irwin Press (1978, 72) claims that ‘the concept of “folk medicine” is everywhere used, yet nowhere adequately defined.’ He clarifies three distinct meanings commonly attributed to folk medicine. These are: ‘(1) any health system at variance with western, scientific medicine; (2) any health system at variance with a codified, formal, and literate medical tradition ... ; (3) any system of health practices at variance with the official health practice of the community or nation’ (1978, 72). The traditional medical systems of Ayurveda, Unani, and Siddha may be at
variance with western medicine, but each has a codified, formal and literate tradition, and each is to a large extent endorsed by the community and to some extent endorsed by the state. Thus these traditions only qualify as folk medicine according to Press’ first category, which I would argue is an uncritical definition. Not only does this definition reduce a diverse range of ethno-medical traditions to a singular category, but it also renders western biomedicine the ‘superior yardstick of comparison’ (Khare 1996, 837).

Charles Leslie (1976, 2), in his introduction to *Asian Medical Systems*, identifies three ‘great tradition’ medical systems that—although share common features which can be contrasted with western biomedicine—maintain their own integrity and have become professionalised to a standard which enables them to coexist in many parts of the world alongside western medicine. These great traditions include Ayurveda, Unani, and Chinese medicine, which respectively arose out of South Asian, Mediterranean, and Chinese civilisations. Leslie (1976) distinguishes these great traditions from the folk medicine of their regions only in that the former have been developed from the latter and cultivated into more complex and civilised systems. For this reason, the line between scholarly and popular (or folk) medicine is blurred (Dunn 1976).

Folk medicine nonetheless falls into a classification distinct from the traditional systems of Ayurveda, Unani and Siddha medicine, and can be defined broadly as local, non-scholarly practices popularly used to treat common ailments (Dunn 1976). Folk practices are not formally learned through documented texts but passed on through oral tradition and therefore ‘characterized by a high degree of shared knowledge between public and practitioner’ (Press 1978, 72). Botanical herbs grown locally may be harvested and used in the home or distributed by knowledgeable elders or herbalists. Folk healers may also be priests, bonesetters, poison healers, birth attendants and
(among others) women of the household. Healing might involve religious rituals or magic, dietary remedies, seasonal health regimens such as fasting, the use of certain animal products and minerals, or various medicinal plants and culinary spices ‘popularly known as grandmothers’ remedies’ (Payyappallimana 2008, 139; also see Shah 1982).

Few of the South Asian migrants I spoke with for my fieldwork in Dunedin expressed much knowledge of the scholarly systems of medicine prevalent in South Asia; yet each are to some extent familiar with the use of medicinal remedies for common ailments. Many follow recipes passed down from their mothers or grandmothers as a first option when feeling unwell. Sirisha, a young woman from Andhra Pradesh who arrived in New Zealand three months before our conversation, provided me with an elaborate list of recipes specific for a number of physical ailments. These recipes had been passed down to Sirisha by her grandmother. Nidia, another young woman from Kerala who has been in Dunedin over seven years, reports that when she has a cold she will resort simply to adding dry ginger and pepper to her coffee; for this is what her mother prompts her to do over long-distance phone calls to India. Reyna, herself a mother of adult children who have grown up in New Zealand, recalls that her own mother was the source of certain medicinal remedies that she has raised her children with. Yet Reyna also makes use folk remedies unconnected with traditional South Asian medicine such as apple cider vinegar, which is popularly used in New Zealand as a digestive tonic\textsuperscript{15}.

Fred Dunn (1976) distinguishes traditional Indian folk medicine from the practices of Ayurveda and Unani in that the latter are more complex systems, which in modern times

\textsuperscript{15} Often recommended by naturopaths, apple cider vinegar is a popular alternative health product (and culinary item) that can be purchased in wholefood stores or supermarkets throughout New Zealand.
have moved away from religious practices and involve formal institutional training. State-sanctioned teaching colleges are located in urban areas and espouse a more universal approach to health than understood by village folk healers, who rely on local knowledge and resources to treat specific local ailments (Berger 2008).

It is arguable whether delineation between the oral traditions of folk healing and the codified systems of Ayurveda, Unani, or Siddha medicine were emphasised as strongly in pre-colonial times as they are today. Acting as advisor to a World Health Organization review of traditional medicine, Dr Sharma emphasised that ‘Ayurveda and similar medical systems can, in no way, be equated with herbal medicine’ (WHO 2004, 8). But Robert Svoboda (2008) argues that Ayurveda, which has come to be appreciated as a modern professionalised medical system as a result of British colonialism, in fact includes the many and varied folk practices of local healers.

While the geo-cultural diversity of folk medicine—which relies on local traditions and ecosystems—is distinct from the more universal (or at least regional) application of the codified systems of medicine, Unnikrishnan Payyappallimana claims that folk practices and codified systems have always ‘closely interacted … in a relationship of reciprocal influence’ (2008, 139). This influence can be found not only through the lived exchange of knowledge in villages where ‘hakims and vaids … practise alongside magicians, exorcists, priests, and snakebite curers’ (Dunn 1976, 154) but also through some of the ancient Ayurvedic texts16 which, according to Payyappallimana (2008), make reference to the importance of acquiring knowledge of medicinal plants from forest dwellers and cowherds.

16 For this example, Payyappallimana (2008) quotes su´sruta (S´u38.10).
3.3 Indigenous Systems

There has been a concerted effort by the World Health Organization (WHO) to promote traditional medicine throughout the developing world in order to ensure affordable health care for all. Indigenous medicine is believed to have a greater potential than western orthodox medicine for ‘wider application at low cost’ (WHO 1978, 13). Although folk medicine is included in the WHO categorisation of traditional medicine, it is apparent from the literature that priority is given to standardised and regulated systems of traditional medicine—where safety and clinical efficacy can be more reliably measured (see WHO 2002).

There are three traditional medical systems in common practise throughout the Indian subcontinent: Ayurveda, Unani and Siddha medicine. Ayurveda and Siddha are indigenous to South Asia, while Unani medicine arrived with the spread of Islamic civilisation. Unani means ‘Greek’ and this system of medicine has its roots in the Mediterranean where it was developed based on the teachings of Galen and Aristotle around the second century (see Leslie 1968; Basham 1976). Arthur Basham claims that the first hospitals were developed in India under Muslim rule and that, if the chronicles of Unani medicine are reliable, ‘Muslim rulers of India did more to develop medicine than their Hindu predecessors’ (Basham 1976, 40). Thus, although Unani medicine has been transplanted in South Asia, it has over time—in the words of Dunn (1976, 150)—‘become indigenous’ and remains popular among the Muslim populations in Pakistan, India and Sri Lanka.

Siddha medicine, which was developed in Tamil Nadu, is a variant on Ayurveda and is popular in many parts of southern India as well as Sri Lanka. While the principals of
Siddha medicine—its diagnostic methods and use of botanical herbs and minerals—are much the same as Ayurveda, Siddha medicine has its own scriptures, which have been recorded in the Tamil language. According to B. V. Subbarayappa (1997), little effort has been made to translate these texts, keeping the knowledge relatively secretive.

Richard Weiss (2008) asserts that modern Siddha practitioners concertedly distance themselves from Ayurveda, claiming a unique and independent system of medicine. In an overview of Siddha medicine, Subbarayappa (1997) illuminates the nature of some distinguishing characteristics and alludes to Siddha as the more mystical twin of Ayurveda. Siddha medicine, Subbarayappa claims, is derived from alchemy and linked to ideas of immortality. This system of medicine had been passed down through sages or holy men known as siddhas ‘who were, and are still, believed to have superhuman powers’ (Subbarayappa 1997, 1841). In addition to the use of herbs, minerals and other organic materials used in Ayurveda, Siddha medical treatment may involve intensive yogic breathing and tantric techniques.

Mystical practices are recommended in the earliest known Ayurvedic text from the first century: the Caraka Samhita (Dunn 1976). But this text also set forth a rational approach centred on diet and the use of medicinal herbs. The second important Ayurvedic text from the fourth century, the Susruta Samhita, elaborated surgical procedures, and the third critical text, the Vagbhata Samhita from the eighth century, continued to reinforce a rational approach to medicine.

The chronology of these texts appears to show a gradual move away from the early religious features of medicine. This however may be confounded by certain omissions in translations of these texts by British scholars who, according to Langford (2004),
endeavoured to ‘facilitate the construction of ancient Ayurveda as empirical as opposed to magical’ (2004, 85). Nonetheless, the reinvention of Ayurveda through standardised institutional training during British colonialism had played a critical role in distancing the medical system from its mystical origins (see Leslie 1968).

The word Ayurveda was originally translated as ‘knowledge of life’ but in more recent times became ‘science of life’ (Langford 2004). Basham (1976, 20) translates Ayurveda as ‘the science of (living to a ripe) age’ and asserts that the word semantically implies that the ‘Indian doctor was concerned not only with curing disease, but also with promoting positive health and longevity.’ Although the popularity of each system of indigenous medicine varies depending on region and historical period, Ayurveda is currently the most widely used indigenous medical system throughout India (Sujatha & Abraham 2009; Ministry of Ayush 2011).

### 3.3.1 Diagnosis and Treatment

Although the three systems of traditional medicine claim unique origins and uphold distinct characteristics, the similarities in practise and theory are notable. All three systems have in common a central focus on the bodily humors. In Unani medicine, there are four humors: blood, phlegm, yellow bile and black bile. In Ayurveda and Siddha medicine there are three humors (or *dosas*: *vatta* (wind), *pitta* (bile) and *kapha* (phlegm). The humors indicate opposing qualities such as hot-cold, active-sluggish, or wet-dry. Health is maintained when these qualities are in equilibrium; illness is caused by disequilibrium (see Leslie 1976).

My informant Rajesh—who has lived thirteen years in Dunedin and whose great uncle had been the principal of an Ayurvedic college in Trivandrum in the 1980s—insists that
Ayurveda is a way of life. ‘Ayurveda’ he states ‘is all about balance. You have to make sure that the balance is maintained.’ While in this instance Rajesh is making reference to the spices used in Indian cooking, Leslie (1976) explains how this idea of balance is fundamental to the epistemologies of Ayurveda, Unani and Siddha alike. Central to these systems is an understand that ‘[t]he arrangement and balance of elements in the human body [are] microcosmic versions of their arrangement in society at large and throughout the universe’ (Leslie 1976, 4). Langford (2004, 28-29) asserts that ‘the idea of dosa bypasses the conceptual split between body and world altogether.’

Ayurvedic theory, more specifically, conceives man to be made up of the elements earth, water, fire, air and either—in both subtle and material forms. Semen, or ojas, is thought to be stored in the heart, and gives the body its vitality (Leslie 1968). The heart, not the brain, is understood to be the seat of consciousness (Basham 1976). In medieval times, reading the pulse had become a common form of patient diagnosis and ‘came to symbolize the art and authority of the Ayurvedic physician’ (Leslie 1968, 562). The efficacy of pulse diagnosis is however disputed by many institutionally trained Ayurvedic practitioners in modern-day India; some accuse pulse healers of being charlatans (see Langford 2004).

The fourth century text, Susruta Samhita, had provided authoritative instruction for surgery and, according to Dunn (1976), surgical practice flourished at that time but withered over recent centuries. Basham (1976) however argues that there are only vague and mythological references to invasive surgery, and that much of the early surgery practised was cosmetic. He explains that a taboo against touching the dead had prevented early vaidyas from dissecting human corpses, thus limiting understanding of anatomy and physiology in traditional Ayurvedic medicine.
Ayurvedic treatment centres on diet, lifestyle and the prescription of herbal medicines. According to Ravindra Khare (1996, 838-839) ‘Ayurveda treats the patient as a whole, as a person, situated within his/her daily social situation and moral position in life.’ Langford (2004) describes one of her informants, an Ayurvedic doctor in India, whose consultations involve listening to his patients’ life stories. A patient suffering from insomnia is prescribed a philosophical outlook on life; a woman suffering infertility is told that her condition will change once she faces her anxieties; and a man who wishes to kick his tobacco addiction is advised to be generous with his money. Langford (2004, 51) writes: ‘Dr. Upadhyay demands of his patients not merely the compliance of taking their medications, but also a complete attention to their actions and mental/emotional states.’

3.4 Biomedicine

Eastern medical traditions, which construe the body as a microcosm of the universe, are often described as holistic because diagnosis and treatment tend to acknowledge an interrelationship between the physical body and ‘environmental and climate factors, psychological dispositions, and moral and spiritual states’ (Khare 1996, 838). This approach can be directly contrasted with the corporeal individualism that Robert Hahn (1982) describes as inherent to the western biomedical approach. In the biomedical view, ‘[t]he human body is held to be a more or less discrete entity in the universe—separately knowable and treatable’ (1982, 233).

Known by many other names—‘modern’, ‘scientific’, ‘allopathic’, or ‘cosmopolitan’ medicine—biomedicine is the official state sponsored system of medicine practised throughout South Asia today. Biomedical theory and practice has its roots in western
civilisation and, although widespread throughout the world today, is native to Euro-American societies (Hahn & Kleinman 1983). Modern biomedicine can be traced back to the Renaissance, when western civilisation underwent a concerted move away from religion and towards science. The scientific biomedical model of treating disease came to represent a rational move away from earlier beliefs about supernatural causes of illness and divine intervention (Hardy 1998).

### 3.4.1 Diagnosis and Treatment

Human biology or, more specifically, physiology is the primary focus of biomedicine (see Hahn & Kleinman 1983). Disease is viewed as a distinct entity that can be identified and located within the body, and interventionist practices are performed in the attempt to eradicate the foreign invaders. While corporal dissection and surgical procedures might be viewed as signature to western biomedicine, diagnosis and treatment often—in contemporary times—rely on the deployment of a number of technologies that no longer involve incision. Technologies routinely used in biomedical practices are too great in number to list here. Some instruments use sound waves or radiographic technologies to offer a ‘window’ into the visceral body (Rapp 2007, 611). They produce a visual representation, which appears on a screen—a mimesis of what lies within—that can be deciphered or interpreted by medical experts.

Some biomedical technologies are considered non-invasive while others are decidedly more overtly invasive. But they share the same purpose: to examine the internal organs, tissue or bodily fluids in order to locate and eradicate the pathogen responsible for

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17 Rayna Rapp (2007) writes specifically about the sonogram but there is a range of biomedical imaging technologies that produce a representation of the internal body that can be deciphered by medical experts. These range from the use of a microscope, to more sophisticated instruments such as X-rays or the Magnetic Resonance Imaging (MRI).
disease. Pharmaceutical medications prescribed by physicians are designed to target these pathogens or to reduce the symptoms of illness caused by disease. Critical medical anthropologists often critique this reductionist approach for its failure to consider the cultural and social impact on health and illness (Rhodes 1996).

Robert Hahn and Arthur Kleinman (1983) argue that although biomedicine is unique due to its efficacy and widespread following throughout the world, it is itself form of ethnomedicine. Despite the preeminent position biomedicine holds on a global level in modern times, biomedical theory and practices have arisen out of a distinctive sociocultural system of ideas ‘founded in a cultural framework of values’ (Hahn & Kleinman 1983, 306). The seventeenth century catholic philosopher Rene Descartes was tremendously influential on modern western thought; his idea of the palpable body as an entity distinct from the intangible mind rendered the soul a subject for theology, and the body a subject for science. This Cartesian duality—separating body from mind, the individual from society, and culture from nature—has become intrinsic to western medical theory. But Nancy Schepfer-Hughes and Margaret Lock (1987, 11) remind us that western ‘epistemology is but one among many systems of knowledge regarding the relations held to obtain among mind, body, culture, nature and society.’

3.4.2 Biomedicine as Cosmopolitan Medicine

Dunn (1976, 135) refers to western biomedicine as ‘cosmopolitan’ to convey that its scope is ‘worldwide rather than limited or provincial.’ With treatments proving largely effective in eradicating disease and extending life expectancy, biomedicine has made valuable contributions to public health worldwide and earned the respect of people in all social classes. In India, as in many other parts of the world, biomedical treatment is
largely government funded, which serves to both legitimise its authority and subordinate other forms of medical practice (Leslie 1976).

As discussed in Chapter 1, health practices ‘other than those intrinsic to the politically dominant health system of a particular society or culture’ (Duke 2005, 11) are broadly categorised in medical discourse as complementary and alternative medicine (CAM). This term itself implies a hierarchy where unorthodox medicine is seen as an alternative or a complement to orthodox medicine. Because western biomedicine is preeminent on a global scale, this term has by default come to represent all health practices other than biomedicine.

For the World Health Organization, the category of CAM only subsumes traditional medicine where its practise has diffused to the West (WHO 2002). But Alex Broom, Assa Doron and Philip Tovey (2009) extend the category of CAM to include indigenous medicine in the context of India, where biomedicine has been appropriated as the dominant national health care system. Yet they concede that because traditional medicine is both politically and culturally sanctioned in India, ‘non-biomedical practices are situated within a much different sphere than CAM in the West’ (2009, 699).

Although it could simply be argued that biomedicine has achieved an exulted position as cosmopolitan medicine due to its efficacy and popularity, I propose that a postcolonial analysis offers a more critical understanding of how an idiosyncratic and culturally informed system of medicine—albeit informed broadly by western epistemology—has come to assume an authoritative preeminence over the domain of medicine on a global scale.
In *The Colonizer's Model of the World*, James Blaut examines the pervasive discourse of ‘Eurocentric diffusionism’ (1993, 1). There exists, according to Blaut (1993), an implicit assumption among writers of European history: that Europe has always been at the centre of cultural evolution and responsible for the diffusion of innovative technologies and so called civilising cultural ideologies. He explains that these writers, who are authorities on their subject, tend to put Europe at the centre of pivotal historic events even in some cases where such credit is not due. For example, surgery—the hallmark for modern medicine—dates back to the fourth century in India (Dunn 1976; Leslie 1968). This is overlooked in many medical history accounts, which implicitly accredit the British with introducing surgery to colonial India (Sujatha & Abraham 2009).

In her critical analysis of this, Langford (2004) describes the celebratory fifty round cannon salute in 1836 ordered by British officials after a group of Indian medical students, headed by Madhusudhan Gupta, dissected a human corpse at Fort Williams Medical College in Calcutta. Although surgery was not new to Ayurveda, this event went down in history as marking ‘the triumph of modern science in India’ (Sujatha & Abraham 2009, 37). The same year, T.B. Macaulay’s *Minute on Indian Education* was released, declaring ‘that all Indian higher education would be conducted in English and modeled on the British system’ (Langford 2004, 5). Blaut (1993) asserts that an unquestioned belief of European superiority served to both motivate and justify the colonial endeavour. It was, in the words of Joseph Rudyard Kipling (1899 [1998]), ‘the white man’s burden’ to civilise colonial subjects.

Eurocentric beliefs do not only inform assumptions that every important invention is born of the West and later diffused or appropriated by the periphery, but these beliefs are also informed by the idea that all that which is born of the West is necessarily
superior to that which is not. This Eurocentric model of diffusionism mediates an aura of supremacy around European culture. I cannot help reflecting here on a conversation in which my informant Rajesh confided his experience of medical Eurocentricism while living in Dunedin.

‘... People are very closed. If you go and tell somebody like about Ayurveda, they say “ah, come on; you are talking crap.” That’s the normal thing I get back from everyone.’

3.5 Homeopathy

There is some dispute as to whether homeopathy was introduced to India as early as 1810 by a German geologist or a British missionary, or by a Romanian physician in 1839 (see Ghosh 2009). Although the practice became popular during British colonialism, homeopathy did not share with biomedicine a link with hegemonic colonial processes. Homeopathy was thus celebrated for being ‘Western and modern without being colonial’ (Bardwaj 1980, 214).

The first school of homeopathy was established in Calcutta in 1881, and students of this school saw the spread of their practice throughout urban India (see Ghosh 2009; Frank & Ecks 2004). After independence from colonial rule, the Indian government began to offer funding for research in homeopathy and to establish committees for its regulation and mainstreaming along side traditional medicine. By 1973, homeopathy had been recognised as one of the Indian national systems of medicine.

The term ‘allopathy’ is commonly used in South Asia in place of biomedicine. Samuel Hahnemann—the German physician who founded homeopathy—coined this term to indicate the fundamental opposition between the principals of biomedicine and homeopathy (Frank & Ecks 2004). While disease, in the biomedical view, represents a
foreign body that can be eradicated by intervention, the central principal of homeopathy is that like is cured by like. This means that ‘homeopathic remedies should produce the very symptoms in a healthy human being which they eliminate when applied to a person with a particular disease’ (Frank & Ecks 2004, 308).

The principals of homeopathy are, on the other hand, more closely aligned with traditional medicine. Both are concerned with nutrition, climate and seasonal change. The vaidya, hakim and homeopath commonly take a detailed case history and emphasise ‘treatment of the whole person rather than of a single symptom in a patient’ (Bardwaj 1980, 210). Perhaps for these reasons many were attracted to homeopathy, which has become the third most utilised system of medicine throughout India after biomedicine and Ayurveda; the prevalence of homeopathy is greater in India than any other country (Gosh 2009).

3.6 Indigenous Systems Reinvented

Western biomedicine had become the official state sponsored system in India under British colonialism, and indigenous medicine struggled to maintain status (Sujatha & Abraham 2009). Although European colonialism has been responsible for reforming the ways of life of people across the globe, it is nonetheless problematic to attribute cultural change to colonialism alone. The diffusion of biomedical clinics and hospitals that occurred on a large scale throughout India during British colonial rule (and persisted after Independence) may not have occurred but for the colonial occupation; yet the ways in which biomedicine was appropriated by the Indian public, medical students and traditional healers is complex and unique.
Biomedicine did not wholesale replace indigenous systems of medicine. Instead, indigenous systems underwent processes of professionalisation mimetic of a western model. Modern institutionalised modes of teaching were appropriated and attempts were made to bind multiple healing practices into a systematic and scientific paradigm that aligned with a biomedical model (see Langford 2004; Leslie 1968).

Although the codified systems of traditional medicine already conveyed a professional status compared with village folk medicine, Leslie (1968) explains how the movement of the late nineteenth century to professionalise Ayurvedic and Unani medicine involved ‘reinterpret[ing] the ancient texts to discover in them the modern theory of the circulation of the blood, the germ theory of disease, contemporary anatomy, the vitamin conception of diet, and so on’ (1968, 567).

Not only was the basic foundation of indigenous medical knowledge reinvented to align with biomedical theory, but the mode of disseminating knowledge was also redirected. Dating back to the fourth century, indigenous healers learned through one-to-one teacher-student lineage or the gurukula model where a small number of students studied under one or two experienced vaidyas (Langford 2004). Below is Leslie’s (1968) description of the archetypical relationship between teacher and student, which prevailed before European teaching institutions became the standardised model for medical education (see Langford 2004).

Traditional medical education followed the pattern, so admired in India, in which the student entered into a deep spiritual relationship with his guru, symbolized by an initiation rite. He joined the household of his teacher and was supported by him through years of apprenticeship. During this time he observed the master diagnose illnesses and acted as a compounder in preparing medications suited to each case. In theory, at least, each individual's illness was unique, varying according to the humoral
character of the patient, astrological conditions, climate, and other circumstances. The large number of variables emphasized the tacit knowledge of the master in grasping and evaluating their relationships, and tacit knowledge was learned by example rather than by exposition. (Leslie 1968, 564)

Although there had been a few large centres for learning prior to the introduction of modern institutions (see Langford 2004), over the later part of the nineteenth century numerous schools of indigenous medicine began to sprout up and were gradually organised in the fashion of biomedical colleges—with classrooms and laboratories, pharmacies, hospitals, and outpatient clinics. The curricula privileged technical over tacit knowledge, and drew from the theories and instruments of western medicine while retaining a central focus on the humoral systems of the body (see Leslie 1968).

By the time India gained independence from Britain, according to Leslie (1968, 569), ‘there were 51 hospitals and 57 urban Ayurvedic and Unani schools with an enrollment of over 3,000 students.’ By 2010 the number of Ayurvedic colleges reached 254, and the nationwide count of Ayurvedic hospitals officially numbered 2,434 with a total bed capacity of 43,914. There were only 45 Unani colleges at 2010, and Unani hospitals numbered 258. Siddha medicine hosted only ten colleges, 270 hospitals in Tamil Nadu and two in Kerala. The nationwide ratio of registered practitioners follows a similar pattern (Ministry of Ayush 2011).

I retrieved the above figures from the Ministry of Ayush website (2011). AYUSH is an anachronism for Ayurveda, yoga, Unani, Siddha and homeopathic medicine, and the government department was established to promote the professionalisation of these alternative therapies. The ministry is committed to ensuring greater financial support for traditional systems of medicine, regulating the quality of teaching institutions and
the safety of drugs, publishing research on the efficacy of treatments and advocating for
the integration of traditional medicine within the primary healthcare sector (Ministry of
Ayush 2011). Originally formed in 1995 as the Department of Indian Systems of
Medicine and Homeopathy, the name was changed to the Department of AYUSH in 2003
(Sujatha & Abraham 2009). In 2014, AYUSH had been promoted to a ministry under the
authority of India’s current prime minister, Narendra Modi, who is reported to be an
avid supporter of yoga and Ayurvedic medicine (Firstpost 2014).

3.6.1 A Symbol for National Identity

Khare (1996) discusses the pluralism of medicine in India—both in practice and in
patronage—as a reflection of a culturally sanctioned, non-competitive ethic. Although
Ayurveda is associated with Hindu tradition and Unani is associated with Muslim
tradition, Khare (1996) asserts that Hindus will visit Unani practitioners and Muslims
will visit Ayurvedic practitioners. Furthermore, South Asian indigenous medical systems
are not discrete but in practice greatly influence one another (Leslie 1968). Yet despite
this syncretism, the figures above show an overwhelming nationwide predominance of
Ayurvedic medicine over Siddha and Unani. Such disparity arguably reflects that the
promotion of Ayurveda as a symbol for national and cultural identity has instigated a
stronger push for its professionalisation—thus availability and patronage—than that of
Unani or Siddha medicine.

Manasi Tirodkar (2008) attributes the popularity of Ayurvedic medicine in
contemporary India to a need for culture remembrance after colonisation—and later
globalisation—has threatened the loss of traditions. Other writers discuss the role
played by postcolonial Ayurveda in re-establishing a sense of cultural or national Indian
identity both through its claims to antiquity and tradition, and through reforming its antiquity to meet the status of a modern bioscience (Berger 2008; Langford 2004; Leslie 1968).

While indigenous medicine represents a unique cultural heritage, intrinsic to its professionalisation is a distancing from the religious, spiritual or magical elements of healing. As mentioned earlier, Siddha practitioners exult the mystical arts, claiming a cultural authenticity, which effectively distances their practice from Ayurveda (see Subbarayappa 1997; Weiss 2008). This to some extent costs Siddha the exulted status offered modern Ayurvedic medicine. The championing of Ayurveda’s status over Unani medicine—according to Rachel Berger (2008)—on the other hand reflects political struggles between Muslim and Hindu identity. Berger (2008) argues that the symbol of national identity so often discussed in the context of Ayurveda’s professionalisation should more accurately be understood in the terms of an urban, middle-class Hindu identity.

It is notable that although my research participants in Dunedin all to some extent rely on home remedies that have been culturally learned or passed down through generations, most do not share an explicit endorsement of any particular system of traditional medicine. The exception is my respondent, Rajesh, who has family in the Ayurvedic medical practice. Rajesh comes from a Christian background, thus his alliance with
Ayurvedic medicine does not neatly fit Berger’s (2008) construction of Ayurveda as a symbol of Hindu identity.¹⁸

Yet Rajesh discussed with me at length his deeply considered thoughts on the relationship between Ayurveda and Hinduism. He asserts that Hinduism is not a religion but a way of life, and that Ayurveda and Hinduism ‘go hand in hand.’ He told me that he often ponders the ways in which Hindu rituals are influenced, ultimately, by Ayurvedic health practice. As an example, he described the puja ritual where a flame of camphor is burned before the deities in temple, then offered to the worshipers who, after cupping their hands over the flame, bring them to brush across their face and hair. Rajesh explained that this ritual was originally designed to facilitate the inhalation of camphor, which is a medicinal element used in Ayurveda; yet most Hindu worshipers are unaware of this purpose, and view the ritual simply as a tribute to the deities.

Similarly, my informant Sirisha (a young Hindu woman from Hyderabad) takes an interest in understanding what she refers to as ‘the scientific reasons’ behind the traditional practices of her grandparents.

I was always interested, actually I asked my grandmother: why are you doing this, and why are you doing that? Like that. But she, they are not educated people so they cannot know the reasons. But whatever they are doing, I started searching why is it useful or not. Is there a scientific reason behind that? So once I started searching I feel very impressed, oh my god, there is a lot of scientific reason. But they don’t know the scientific reasons. But they are doing without knowing.

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¹⁸ Such tidy categories are anyway complicated by the syncretic approach to medicine in South Asia, and also because the traditional systems of medicine fit into a broad indigenous category, which is ultimately coded as Ayurveda (see Berger 2008).
Sirisha described to me a common household practice of sprinkling turmeric at the front doorway of the home. ‘So when I asked the reason’ she tells me, ‘they say it’s our tradition ... we are just welcoming the goddess.’ But Sirisha did her own research and learned that turmeric can be used as an antibiotic. She suggests that this practice must have originated from the knowledge that a barrier of turmeric will assist in keeping insects from entering through the doorway.

The examples above indicate an interconnection between culture, religion and health, and they give some insight into how tacit health knowledge can be passed on through cultural practices. Tirolekar (2008, 240) claims that home remedies are so ‘embedded in the cultural framework’ they are often not considered medical. The dissociation between home remedies and health practices is a theme that has emerged through some of the international literature. Two Canadian studies on South Asian migrant health by Choudhry (1998) and Hilton and colleagues (2010) indicate that the use of herbal remedies are not viewed as separate health related practices, but integrated into the daily lives of their East Indian and Punjabi respondents. Bhopal (1986) reports that such an understanding among his respondents in Glasgow may stand in the way of reporting the use of home remedies to their physicians.

I spoke with a Sri Lankan woman in Dunedin while out one night with friends. When I asked her whether she uses traditional medicine her response was apologetic and—as if explaining why she would not be a good subject for my research—she told me that her father was a medical doctor. I could see that she considered the epistemological divide between traditional medicine and western biomedicine too great to traverse. When I prompted her further, asking whether she ever used home remedies as a child, she took some time to consider and with a brightness in her eye she recalled that whenever the
family got a cold her mother would boil up a large pot of some seed (she could not recall its name) and pour out a cup for each member of the family. The remainder of this pot, she recalled, they would use for steam inhalation by placing a cloth over their head and the pot simultaneously, to breath in the steam and allow it to clear the sinuses.

3.6.2 Compromising Efficacy/Integrity?

The epistemological divide between biomedicine and traditional South Asian medicine is vast; humoral theories are in marked contrast to the scientific methods of biomedicine (see Sujatha & Abraham 2009). Yet the reinvention of indigenous systems through standardising practices and the introduction of biomedical theory and technology into the curriculum of modern teaching institutions have—with some tension—decreased this divide.

According to V. Sujatha and Leena Abraham (2009, 42) ‘efficacy of medicine has come to be defined exclusively in terms of the randomized controlled trial.’ Modern Ayurveda seeks legitimacy through adopting these measures. But Sujatha and Abraham (2009) point out the paradox inherent to evaluating the efficacy of one system with the terms of another; and they insist that the lived experience of relief from symptoms is legitimate evidence of efficacy. Asserting that there is indeed ‘legitimacy outside the laboratory’ (2009, 42), Sujatha and Abraham claim that indigenous medicine should be understood ‘as live and efficacious traditions’ (2009, 36).

Svoboda (2008) further argues that the integrity of Ayurveda is compromised by its commercialisation. He is critical of the aspirations of students in modern Ayurvedic institutions who, he claims, often buy their way in when denied entry to medical school. He sites numerous cases where students use their Ayurvedic qualifications as a gateway
to an allopathic medical practice. The syncretic approach\textsuperscript{19} however, taken by many Ayurvedic practitioners, would make this less a deception than a disposition. Because biomedical theory and disease categories are often a large part of the curriculum of modern Ayurvedic training, a student may leave the school with a degree in Ayurveda but end up using allopathic modes of practice (see Langford 2004).

The reinvention of traditional medical systems to align with the status of modern biomedicine has also impacted the production and distribution of indigenous pharmacopeia. Most herbal medications prescribed by vaidyas or hakims are nowadays mass-produced by Ayurvedic or Unani pharmaceutical companies that supply a number of cosmetic products as well as medicines. Many of these can be purchased off the shelf in dispensaries, grocers or beauty parlours throughout the Indian subcontinent or even abroad (see Bode 2002). Indeed a young man I spoke with who recently came to live in Dunedin from Kerala told me that he had finally managed to locate through friends in Auckland the particular hair oil he had used at home. He claimed to feel energised when using this oil, which contains a combination of medicinal herbs.

Rajesh, who demonstrates a great deal of knowledge around Ayurvedic practices, expressed to me his distrust in modern Ayurvedic pharmacopeia. He describes an elaborate process of preparing a certain combination of medicinal plants taken as a remedy for diabetes. Explaining that the active ingredient in this remedy comes from a poisonous plant, he claims that the traditional method of preparation must be followed to insure that most of the poison is removed. Preparation involves a labour-intensive process of soaking the plant matter in yoghurt and drying it in the sun for several cycles.

\textsuperscript{19} For more detail on this syncretism, see the following section in this chapter: 3.7.
of nine times. Rajesh’s previous employer, a lawyer in Kerala, had employed a man full-time to prepare this remedy. The entire process can take up to five months. Medicine claiming the same name and benefits, Rajesh tells me, can be purchased from Ayurvedic pharmaceutical companies, but the lengthy method of preparation is altered because it conflicts with modern modes of production that are modelled after biomedical pharmacopeia.

The Ayurvedic and Unani medicines industry is dominated by three companies, which—in 1997—boasted sales of up to US$600 million (Bode 2002, 184). While the advertisements for medicinal and cosmetic products draw upon mythology and historical imagery, the indigenous pharmaceutical companies celebrate modern laboratory modes of production and scientific methods for testing their products. Maarten Bode (2002) argues that the commodification of indigenous medicines challenges dichotomising distinctions between tradition and modernity. Reaffirming the nationalist argument, he asserts that these products in fact ‘derive their power from a sacred and glorified past as well as from modern science’ (2002, 198).

### 3.7 Practised Pluralism

In this chapter, I have highlighted that multiple and diverse systems of medicine are practised side by side and often syncretically in contemporary South Asia. According to Sujatha and Abraham (2009, 35) ‘[t]he demand for cure and for the care of a growing range of health conditions which elude any particular system of medicine has made pluralism in therapeutic options a way of life.’ Ethnographic studies have found that patients tend to demonstrate a pragmatic pluralism, often using indigenous medicine for chronic conditions and allopathic medicine for more serious problems or where surgery
is required (Bhardwaj 1975; Izhar 1990). Similar results have been found in studies centred on South Asian migrants, where home remedies are often preferred over visiting an allopathic doctor for common ailments or chronic conditions (see Ahmad et al. 2008; Bhopal 1986; Choudhry 1998; Dyck 2006; Hilton et al. 2010; Rao 2006).

Although the epistemology of western biomedicine appears in direct opposition to indigenous medical traditions, the ways in which traditional South Asian medical systems have been reinvented to align with modern biomedicine (as discussed above) begins to blur the lines between modern and traditional medicine. The inclusion of biomedical theory and instruments into the curriculum of institutionalised Ayurvedic training has led to a complex intertwining of biomedical and indigenous epistemologies in practised medicine.

Biomedical infiltration may explain the syncretic approach of a modern vaidya or hakim, but there are also doctors trained in biomedicine who prescribe traditional therapies for allopathic diagnoses. My Dunedin informant Kirit, who was a pharmacist in Surat before he came to New Zealand in 1996, had a number of friends who were medical doctors. He claims that they would often prescribe a seed called Ajwain—which is often used in Indian cooking—for cases of bronchitis or asthma. He also claims that ‘when it comes to diet they just go on the line of Ayurvedas.’ Khare (1996) corroborates this in his description of ‘a modern Indian physician [who] supplements or augments his treatment of illnesses by combining (and recombining) modern medicines and procedures with those patently Ayurvedic’ (Khare 1996, 840).
3.8 Conclusion

Although traditional medicine in South Asia involves multiple practices derived from local, regional and transported traditions, anthropological and medical discourse generally classifies these into two broad categories: traditional folk practices that are passed down orally, and codified medical systems that have in recent times undergone processes of institutionalisation and professionalisation. It appears that much of the distance between the codified systems of Ayurveda, Unani, and Siddha medicine—and also between these systems and traditional folk practices—has more to do with identity politics than epistemological difference in how health is understood and treated. Greater status is allocated those practices that have become professionalised.

Part of my aim for this chapter has been to highlight links between Indian folk medicine and traditional systems of Indian medicine in order to legitimise the use of home remedies as a valid source of indigenous knowledge. Chopra (2008, 252) asserts that globalisation offers the ‘opportunity to acquire knowledge about other cultures and their medical arts.’ Certainly the importance of sharing knowledge and learning from one another is nowhere more crucial than within a multicultural context such as New Zealand.

Although the biomedical model of health care is hegemonic throughout the Indian subcontinent (as it is in New Zealand), the syncretic approach to medicine in South Asia—among medical practitioners and patients alike—is distinct. Biomedicine, indigenous medicine and homeopathy are all popular, widely available and to some extent endorsed by the State. This means that although South Asian migrants do not necessarily move from one paradigm of health care to another when coming to live in
New Zealand, they may find that suddenly their options are limited and that they are forced to conform to cultural standards that do not align with their own understandings.
Chapter 4: South Asians in New Zealand—Migration, Diaspora & Diversity

4.1 Introduction

In this chapter, I discuss South Asian migration to New Zealand and the concept of diaspora as it refers to shared identity and symbolic ties among migrant communities (Cohen 1997; Voigt-Graf 2003). Although this idea is complex and contested due to the heterogeneity of South Asian migrants, my own research has relied on some affinity with that of diaspora among most of the participants. Had my informants not identified with their South Asian ancestry they would not have responded to my call for interviews; and many of those I spoke with expressed sentimental and symbolic ties with traditional practices from their homeland.

New Zealand has had a long and diverse history of Indian migration; historians map three distinctive flows from the early settlers’ period to contemporary times (see for example Bandyopadhyay 2006; Friesen & Kearns 2008; Leckie 1995; Leckie 2007). But the numbers were small until the 1980s when immigration policy loosened racial restrictions and prioritised skilled migration. Latest census figures show that South Asians are currently among the fastest growing migrant populations in New Zealand (Statistics New Zealand 2013).

Not all those counted as South Asian migrants have come to New Zealand from the Indian subcontinent. The second flow of migration saw the beginning of a significant settlement of Indo-Fijians and, according to Robert Didham (2010), many who identify as South Asian in the census have migrated from Malaysia, southern and east Africa and

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20 See appendix 1: participant recruitment poster.
other parts of the world in fewer numbers. This further complicates any notions of a homogenous South Asian community in New Zealand and warrants my brief discussion in this chapter of the hybrid health practices of those whom Carmen Voigt-Graf (2003, 368) refers to as 'twice migrant'.

My research is centred in Dunedin. Although the South Asian population is small compared to other cities of New Zealand, two key Indian presences played a significant role in the Dunedin's history. One can be traced back to the Otago gold fields and the other served three consecutive terms as New Zealand’s first Indian mayor. I was thrilled when the latter, Sukhi Turner, agreed to be interviewed for this research. Apart from Sukhi, who was living in Dunedin from 1973, my research participants arrived in New Zealand—or are descendants of those who have—during the third flow of migration (since the 1990s). Although all of the participants in this research can be categorised as educated and skilled professionals, their varied life stories reflect the heterogeneity of their diverse cultural backgrounds.

Dunedin being a university town may account for the demographics of my sample, yet there is broader evidence indicating that education levels are high among Indians relative to the general New Zealand population (Friesen & Kearns 2008; Statistics New Zealand 2013d). The professional status of my respondents is relevant to my research because it indicates—contrary to popular assumptions—that educated and discerning people value traditional medicine.

**4.2 Diaspora**

Safran, Sahoo and Lal (2008, 1) reported nearly a decade ago that the Indian diaspora was—at that time—comprised of more than 20 million people globally. New Zealand is
one among many receiving countries; and although the Indian diaspora in New Zealand is small in numbers compared with most other host countries\textsuperscript{21}, the latest census figures show that South Asians are among the fastest growing migrant populations in New Zealand (Statistics New Zealand 2013b).\textsuperscript{22} Proportionate to the overall populations of other host countries such as the United States, Canada, and the United Kingdom, the South Asian population in New Zealand is significant.\textsuperscript{23}

Robin Cohen (1997, ix) defines diaspora in the terms of ‘collective identities … link[ed] with … past migration history and a sense of co-ethnicity with others from a similar background.’ Although diaspora was originally associated with the exile, dispersion and a longing for return distinctive to the Jewish people, Lal (2006) asserts that the meaning of words evolve over time. Diaspora has come to more broadly represent ‘dispersed migrants and their descendants with a common ancestral homeland’ (Leckie 2010, 47). Whether employing the narrow or broad interpretation, the concept is uniquely characterised by ‘sentimental and symbolic ties to the ancestral homeland’ (Voigt-Graf 2003, 368).

Both Cohen (1997) and Lal’s (2006) definitions reveal diaspora as a somewhat problematic label to superimpose upon a diverse range of South Asian people in New Zealand. Many writers have grappled with this conundrum (see Bandyopadhyay 2006; 

\textsuperscript{21} For instance, the 2011 United States census recorded a population of 3.2 million who identified as South Asians (CDC 2013), and the 2011 United Kingdom census also recorded a South Asian population of close to 3 million (ONS 2015). In contrast the 2013 New Zealand census recorded a South Asian population of around 176,000 (Statistics New Zealand 2013).

\textsuperscript{22} The Indian population was recorded to be 155,178 at 2013, compared to 104,583 at 2006. This is a 48.4\% increase.

\textsuperscript{23} Those who identify as South Asian make up around 3.9\% of New Zealand’s population, while only around .01\% of the United States population and .05\% of the United Kingdom’s population identified as having South Asian ethnicity as recorded in the recent censuses.
Didham 2010; Friesen 2008; Friesen & Kearns 2008; Leckie 2010) especially considering waves of South Asian migration to New Zealand have been spread across different periods in history; and emigration has been from a diversity of locations not only within the Indian subcontinent but also Fiji, Africa, Malaysia and other parts of the world (see Didham 2010).

Safran, Sahoo and Lal (2008) argue that both the particularities of the host country and connections to one’s homeland influence migrant identities and the diaspora experience. This does not only problematise the image of a homogeneous global diaspora but also implies that it is tricky to allocate shared cultural identity to a heterogeneous group of people with diverse backgrounds—albeit South Asian descent. Didham (2010, 5) asserts that South Asian diasporas in New Zealand can be defined in terms of ‘ethnicities (rather than birth places).’ Friesen (2008) further explains that the idea of ‘pan-Indianness’ is, in contemporary times, nurtured less by identification or links to a common origin and more by ‘new transnational elements’ (2008, 46) such as Bollywood, ethnic associations and the media.

Leckie (1995) also considers that South Asian migrants who arrived in New Zealand from different locations and at different periods in history have built cohesive communities through social and sporting events, religious gatherings and ethnic associations. While the notion of diaspora as shared identities linked with symbolic ties to a common homeland is both complicated and slippery, Leckie (2010, 48) supports the

24 Wardlow Friesen and Robin Kearns (2008, 217) argue elsewhere however that “‘Indians’ do have a political reality based on a shared colonial history’ which tends to unite people from diverse parts of the Indian subcontinent.
concept of Indian diaspora in New Zealand—or rather multiple diasporas—provided they are ‘contextualised within the nation’s history.’

### 4.3 Migration

The heterogeneity of South Asians in New Zealand is considerable due to the historic flows of migration from different parts of the Indian subcontinent and significantly from the South Pacific islands of Fiji. Early Indian migrants arrived from Gujarat and the Punjab between the 1880s and the 1920s (Leckie 2007). These numbers were few because, although British colonial subjects were promised rights equal to British nationals (see Bandyopadhyay 2006), a requirement for English language competency restricted Asian migration to New Zealand. With growing racist sentiment towards Asians, the White New Zealand League put further pressure on the government and even more harsh restrictive immigration policies blocked Asian migration from the 1920s until the 1970s (see Leckie 1985; Tiwari 1980; Trlin 1987).

A second wave of South Asian migration began in the 1980s when New Zealand opened its doors to Sri Lankan refugees, and Indo-Fijians after Fiji’s 1987 military coups (Leckie 1995). Towards the end of the decade, immigration policy had shifted its racial focus to prioritising skilled migration. Therefore, from the early 1990s, according to Friesen and Kearns (2008), the origin and occupational background of South Asian migrants to New Zealand began to represent more diversity than earlier migration flows.

> While the chain migration of earlier periods involved migrants who came from the same region, or even the same villages, the migration systems of the late twentieth century were based on wider dissemination of information and opportunities, so that new Indian migrations involved a more diverse range of occupations and regional origins. (Friesen & Kearns 2008, 216)
These multiple waves of migration highlight the heterogeneity of Indo-New Zealanders. Not only have they come from diverse backgrounds, but also the migration experience would have differed considerably depending on historical conditions, reasons for leaving the homeland and how people were received in New Zealand at their time of arrival.

4.3.1 Early Migration

Although New Zealand’s South Asian population has drastically increased since the 1990s and continues to climb, Indian migration can be traced further back than the early British colonial settlement. There was contact between Māori and the Indian crew of British ships towards the end of the eighteenth century (see Salmond 1997). But the first Indian historically documented to reside in New Zealand was in 1809 when ‘a Bengali deserted the ship City of Edinburgh to live with his Maori wife in the Bay of Islands’ (Leckie 2007, 21). In 1814, three Indian sailors jumped ship near the South Island and settled in Otago (Entwisle 2005). They were among ‘the earliest non-Māori residents of the Dunedin area’ (Leckie 2007, 21). In 1853 an Anglo-Indian from Goa by the name Edward Peters arrived and—although unrecognised for it—‘was the first to discover gold in Otago’ (2007, 21).

A small number of Indian men who were employed as domestic servants had arrived in the South Island around the same time as Peters (McLeod 1986), and there are sketchy records of only a few Indian men in the North Island at that time (Leckie 2007). According to Hew McLeod (1986), it was not until 1890—when two Punjabi brothers arrived via Australia—had South Asian communities begun to take root in New Zealand.
Interestingly, one of these brothers ‘operated as an itinerant herbalist in the central North Island’ (Leckie 2010, 45).

Although recent historic evidence indicates that the presence of Sikhs from the Indian Punjab may have been more extensive at this time than documented by earlier historians (see Singh 2010), McLeod suggests that ‘for practical purposes the history of Punjabi settlement in New Zealand dates from [the Gill brother’s] arrival’ (1986, 54). They initiated what Leckie (1998, 163) refers to as a ‘chain migration’ process. This is a process by which those who have settled in a new place offer sponsorship of passage and resettlement to family relations and others from their home villages.

This process of chain migration is not just one of movement but re-affirms significant relationships and identities. Close bonds were often formed through migration networks but also relationships of dependency or patronage could develop. New friendships also emerged from groups of hitherto unconnected Indian migrants travelling on the same ship to New Zealand or perhaps initially to another destination, such as Australia or Fiji. (Leckie 1998, 164)

A similar but separate and more substantial (in numbers) chain migration from the state of Gujarat developed over subsequent years. The earliest record of this migration flow suggests it began in 1903 (Leckie 1995). But the numbers were still very small in the early days; the 1916 census documents 181 Indians in New Zealand, which increased to 987 within the following decade (Zodgekar 1980, 185).

Kapil Tiwari (1980) attributes the early emigration trend from the Punjab and the state of Gujarat to increasing population and an economic decline from the beginning of the nineteenth century. The Indian settlers in New Zealand worked at labouring or domestic jobs in rural areas and bottle collecting or hawking fruits and vegetables in urban areas.
They tended to work very hard with the aim of sending money home or investing in small businesses. Some managed to open produce shops or lease farmlands for market gardens (see Leckie 1998; Tiwari 1980). It was not until the end of World War II that the wives and other women from the villages joined the Punjabi and Gujarati men who migrated to New Zealand (Leckie 1998). By 1976 there were just over nine thousand Indians living in New Zealand (Zodgekar 1980, 185) and Voigt-Graf (2003a, 144-145) estimates that ‘around 90 per cent ... were Gujarati Hindus originating from a small coastal strip south of Surat’ (also see Leckie 1998).

4.3.2 Twice Migrant

After the racist New Zealand immigration policy loosened its grip in the 1980s, and labour migration was prioritised, the second substantial wave of South Asian migration to New Zealand was comprised of both Sri Lankan refugees and Indo-Fijians fleeing from the 1987 military coups (Leckie 1995). A constant stream of Indo-Fijians has since migrated ‘for economic, social, political or family reasons’ (Didham 2010, 6).

The term ‘twice migrant’ is used by Carmen Voigt-Graf (2003, 368) to describe the plight of Indo-Fijians who have left Fiji for one of the Pacific Rim countries. This term applies not only to individuals or families who have migrated twice in their lifetime but indicates that ‘a second migration can well have occurred a few generations after the first’ (ibid). Indians were brought to Fiji during the colonial period as indentured labourers in the sugar plantations and were later joined by ‘free migrants’ who came mainly from Gujarat and the Punjab (Voigt-Graf 2008, 82). By 1946 the Indian population in Fiji outnumbered Indigenous Fijians, but most recent figures show that
Indo-Fijians now make up around thirty-seven per cent of Fiji’s population (Fiji Bureau of Statistics 2012).

The latest New Zealand census records nearly 11,000 residents who identify as Indo-Fijian (Statistics New Zealand 2013). Yet Didham (2010, 6) notes that as many as thirty per cent of South Asians recorded in the 2006 census were born in Fiji while the actual census figures accounted for less than five per cent. It is difficult to get a true indication of the size of the Indo-Fijian diaspora from the census. The figures are distorted by a reporting bias that Didham refers to as ‘tick-box tyranny’ (2015, 128). While ‘Indian’ is an option explicitly listed for ethnicity on the census, ‘Indo-Fijian’ is not. It would thus be simpler to tick the box available—claiming Indian ethnicity—than to write ‘Indo-Fijian’ in the section marked ‘other’.

An in-depth look at the 2013 census figures reveals that although there were only around 11,000 New Zealanders coded as Indo-Fijian ethnicity, there were close to 33,000 who claimed Indian ethnicity and who were born in Fiji (Statistics New Zealand 2013d). To further complicate things, second or third generation Indo-Fijians may have ticked the Indian ethnicity box and, because they were born in New Zealand, their Indo-Fijian ancestry cannot be traced by the census.

Although Indo-Fijians trace their ancestry to South Asia, their cultural background differs remarkably from those who have migrated from the Indian subcontinent. Voigt-Graf (2008) considers that the cultural distance between them ‘is too great to be narrowed by a shared ethnicity’ (2008, 81). Thus the significant presence of twice-migrant Indo-Fijians further complicates any attempt to generalise Indian diasporic culture as homogenous. The cultural distance between Indo-Fijian and other South
Asian migrants may also offer some explanation as to why my call for interviews with people of South Asian descent attracted no Indo-Fijian respondents for my research.

4.3.2.1 Hybrid Practices

In Chapter 3, I have discussed the plural medical practices that are customary in South Asia. But because there exists a large population of twice migrant South Asians in New Zealand, it is germane to acknowledge some distinctions; the health practices of South Asian descendants who have lived for generations outside the Indian subcontinent are of course somewhat influenced by their local context. I do not have space here for a thorough investigation but look briefly at hybrid practices and some attitudes towards medicine in the context of Fiji and Malaysia. The hybrid medical practices of Malaysia are of particular relevance because two of the participants in my research are twice migrant from Malaysia; and one in particular offers a wealth of personal insight from his life growing up in a Malaysian village. Although none of my respondents are from Fiji nor of Indo-Fijian descent, a brief investigation into the context of Fiji is of some importance because there exists in New Zealand—as discussed above—a significant population of Indo-Fijians.

Writing about the health strategies of Indian women in Fiji, Gill (2010, 84) asserts that ‘notions of good health and well-being based on Ayurveda, ancient yogenic traditions and Hindu religious and philosophical systems, are so intricately woven and knotted into the lives of Indians that they are part of the worldview.’ While the health practices of South Asians in diaspora may be rooted in traditional Indian medicine, there exists in Fiji—and in Malaysia—unique synthesised approaches that are themselves distinct from the pluralistic approach existing in India.
The historic and social contexts, and the ethnic makeup of Fiji and Malaysia differ significantly, yet a hybrid approach to health and medicine is common among South Asian communities in both contexts. According to Gill (2010, 76), Indo-Fijian medicine ‘is a fusion of the folk medical practices of India, vestiges of the ayurvedic system, ... borrowings from Fijian traditions, popular over-the-counter methods of self-treatment, Chinese herbal medicines and European folk traditions.’ The main systems of traditional medicine in Malaysia include Malay folk healing, Ayurveda, and Chinese medicine. Although largely distinct in practice, these ‘systems are interrelated through being part and parcel of a general Malaysian cultural and social situation’ (Heggenhougen 1980, 236).

In Fiji and in Malaysia biomedicine was introduced under colonial rule and remains the government-funded paradigm of national health care. Gill (2010), whose research was conducted in the 1980s, found that her Indo-Fijian informants at first denied the use of traditional household remedies. It took some prompting before they would discuss (and then with marked enthusiasm) the qualities of herbal remedies. Gill (2010) attributes the initial denial of the use of home remedies to stigma associated with traditional medicine, which likely stems from its suppression during British colonialism.

On the other hand, according to Colley (1978), the use of traditional herbal-based ethnomedicine in Malaysia was, by the late nineteen-seventies, becoming increasingly popular among villagers and urban dwellers alike. Traditional Indian medical practitioners had formed an association that rapidly gained membership throughout Malaysia. Judging from Gill’s (2010) report of Fiji and Colley's report of Malaysia, the public attitude towards traditional medicine appeared at that time quite different between the two nations.
Ray is a participant in my research who expounds on his legacy as twice migrant fourth generation from Andhra Pradesh. He grew up in a Malaysian village but moved to the city as a young adult for university. Ray’s mother treated his ailments with herbal remedies throughout his childhood, but he considers that recent generations are moving away from traditional medicine and towards what he refers to as ‘scientific’ medicine:

So like me, I trust on what my parents was saying and carry over the habit. But I think for my kids, it’s quite difficult to say this is the traditional medicine that you are supposed to do because I think probably they don’t trust traditional medicine. They say scientific has more advantage. So the trend is changing. (Ray, Age 33)

Ray’s observations gives cause to ask whether Colley’s (1978) claim to a resurgence of indigenous medicine in Malaysia continues in contemporary times. Ray remembers ‘the old ladies’ in the village who ‘use their plants to make medicine with’ and he attributes the changing trend to a tendency for younger generations to migrate to the cities:

Then we find like the very simple or what do you call the fastest way to access medicine or to get cured. Yeah, it’s the lifestyle in the town. You limit yourself not to explore to what the ancestors used to do.

4.3.3 Recent Trends

The migration of people is one of the foremost processes of globalisation—whether that is a migration from rural areas to the cities for better opportunities in work or education, or migration between nations. Historians consider the third major wave of South Asian migration to New Zealand to have begun in the 1990s and to continue at increasing levels, bringing a diversity of professionals from various parts of the Indian subcontinent (Friesen & Kearns 2008). This is a departure from the early diasporas that were small and homogenous in comparison, consisting mostly of unskilled labourers
who arrived through chain migration from Gujarat and the Punjab (see Bandyopadhyay 2006; Leckie 2007).

Friesen and Kearns (2008, 217) assert that the ‘Indian population of New Zealand is relatively highly educated.’ They suggest this has to do not only with an immigration policy that privileges migrants with higher qualifications, but also a cultural ethic among South Asians—one that favours education. The 2013 census estimates that around 38,500 people of South Asian ethnicity hold a Bachelor degree or higher qualification (Statistics New Zealand 2013d). This figure represents nearly twenty-five per cent of the total South Asian population in New Zealand—and (relevantly) more than thirty-four per cent of the population that is over nineteen years old.

All but one of my own informants have come to New Zealand through this third wave of migration: since the 1990s. Most are either affiliated with the university or in high profile professions. I spoke with several postgraduate students, the wife of one, a university staff member, a lawyer, a restaurant manager and a retired council member and Mayor of Dunedin.

I became interested in whether the education status of my sample reflects South Asians in New Zealand as a whole or whether it is a reflection of Dunedin alone—which is a University town and therefore more likely to attract people associated with higher education. So I obtained customised tables from the 2013 census and found that indeed Dunedin boasts a proportionately more highly educated population of South

25 It is important to consider that my sample may not accurately reflect the Dunedin South Asian population due to self-selection bias, which is further discussed in the methods section.

26 These tables were sent to me via personal correspondence with Robert Didham (Oct 2015).
Asian residents than has been documented for New Zealand as a whole. According to my findings, nearly forty-eight per cent of the South Asian population in Dunedin that is over nineteen years old holds a Bachelor degree or higher qualification.

The education status of my respondents is pertinent to my research because the World Health Organisation implies that the main reason to support traditional medicine is that folk practices are suited to rural, poor and uneducated indigenous people (WHO 2004). Because all of my respondents to some extent make use of traditional home remedies, their relatively high education status serves to both challenge this limiting assumption—in so far as it might be generalised to diasporic communities—and legitimise traditional medicine as something that is valued by educated and discerning people.

4.3.4 Dunedin Context

Census figures show that by 2013 there were 11,427 people who identify as one of the South Asian ethnic categories living in the South Island. While the majority live in Christchurch, of this figure 2,259 were living in the Otago region—and of this figure 1,665 in Dunedin City. These figures have more than doubled since 2001 but still represent a minimal proportion of South Asians living in New Zealand—155,178 recorded in the 2013 census. The majority of these live in the North Island: Auckland in particular (Statistics New Zealand 2013).

Although the Dunedin South Asian population remains comparatively small, it is notable that one of the earliest Indian presences in New Zealand, as mentioned briefly above, is traced to the Otago gold fields in the mid nineteenth century:
Edward Peters, an Anglo-Indian from Goa, arrived in New Zealand in 1853. He became known as ‘Black Peter’ in Otago, where he worked as a farm labourer and gold prospector. He is credited with discovering the crucial gold strains in Tuapeka that attracted Gabriel Read there in 1860. However it was Read who was accorded and rewarded as the discoverer of the first Otago Gold Rush. Peters spent his last years impoverished, dying in 1893 in Dunedin’s Benevolent Institution. (Leckie 2010, 48)

Peters was one among only four Indian men who settled in these early days in Otago, and it was rather the Chinese who had a substantial presence during New Zealand’s colonial period. Chinese migration to Otago began during the gold rush, from 1866, and the population had reached up to 5,000 before the rush ended. Although many returned to China, many also stayed on in Dunedin. They opened groceries and laundries or farmed market gardens and formed a small settlement ‘around Stafford, Hope and Carroll Streets’ (Friesen 2009, 2).

A significant Lebanese community had also established in Dunedin by the end of the nineteenth century (see Farry 2000). But it was not until after immigration policy changed to prioritise skilled migration, in 1987, that the migrant population began to substantially diversify. Prior to this, most migrant newcomers were arriving to Dunedin from the United Kingdom and Ireland. Since 1987 there has been a steady increase in the numbers of people coming from Asia, Africa and the Middle East (see Friesen 2009).

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27 See page 76.

28 During a personal communication in December 2015, Jacqueline Leckie told me there was however a Ugandan Indian refugee family in Dunedin from as early as the 1970s and a small number of Sri Lankans migrated to Otago in the 1980s.
Although there still appears to be more Chinese in Otago than any other Asian group, both the Southeast Asian and the South Asian populations are rapidly catching up.29

More than half of the South Asian population in Dunedin are between fifteen and forty years old (Statistics New Zealand 2013d). This age group is significantly larger within the South Asian community than within the wider Dunedin population. Friesen (2009) attributes this discrepancy in part to the presence of international students attending the university. But it also may be attributed to immigration policy, which privileges younger applicants.

Friesen (2009, 13) uses the term ‘ethnoscape’ to describe the impact on the physical, cultural and political environment made by new migrant populations. It is not only the university that has benefited from the Asian presence in Dunedin, but the city has ‘had the distinction of having two mayors of Asian origin in a row’ (Friesen 2009, 13). Peter Chin is a Dunedin born ‘descendent of one of New Zealand’s earliest Chinese families’ (ibid). He became mayor in 2004; and directly preceding him Sukhi Turner had served three consecutive terms as mayor of Dunedin.

Sukhi Turner was born in the Indian Punjab and migrated to New Zealand with her husband, professional cricketer Glen Turner. Sukhi was New Zealand’s first Green Party mayor. In my interview with her, she told me that she had faced some opposition from those she refers to as ‘the old guard’ who were asking ‘who’s this new immigrant?’ It had been a struggle for her to convince the local business sector that cleaning up the city

29 The 2013 Census Map estimates Chinese make up around 1.9 per cent of the total Otago population, Southeast Asians around 1.1 per cent, and South Asians around 1.2 per cent (Statistics New Zealand 2013a).
water supply was a worthwhile investment; and she said that it was not until her last term in office did she finally manage to get an effective recycling program for Dunedin.

Turner was also the first ‘New Zealander to be awarded the Pravasi Bharatiya Samman Award for the Indian Diaspora by the Indian government in recognition of her work as mayor of Dunedin and more widely’ (Friesen 2009, 13). As mayors, both Sukhi Turner and Peter Chin have contributed significantly to Dunedin’s cultural diversity:

[Chin] maintains that while Dunedin is still conservative in some ways, it has been accepting of its Chinese and other Asian populations for many years, and that since Sukhi Turner became mayor in 1995 there has been a conspicuous ethnic diversification of staff within the Dunedin City Council. Further, he says that one of his favourite activities as mayor is officiating at the citizenship ceremonies in which 30 to 50 migrants become citizens each month. (Friesen 2009, 13)

A noticeable contribution to Dunedin’s increasing cultural diversity is the variety of Asian restaurants. A search through the yellow pages in the 2015 phone book turned up thirty-eight Asian restaurants, twelve of which serve Indian food. There is a mosque and a Buddhist Centre in Dunedin, but no Hindu temple. This is a note of contention for some Hindu residents who ‘believe having their own temple would strengthen the community as a whole’ (Chilton-Towle 2014). My informant, Kirit, told me that a group of up to a hundred people from the Indian community meets for worship once a month at a private residence, and the Otago University Student Association has been known to provide a venue for prayer gatherings.

4.4 Multiculturalism

According to Mervin Singham (2006, 33), ‘New Zealand is one of the highest migrant receiving countries in the world.’ At 2013, around eighteen per cent of the total
population living in New Zealand identified as having an ethnicity other than European or Māori. This figure is estimated to grow significantly by 2025 with ‘[t]he number of people identifying with Asian ethnicities ... likely to exceed the number identifying with the Māori ethnicity from the mid-2020s’ (Statistics New Zealand 2013c).

There is no dispute that migration of peoples to New Zealand from Asia and other parts of the world has, since the 1990s, significantly contributed to growing cultural diversity. Yet there is still some contention as to whether New Zealand can be described as a multicultural nation. Richard Mulgan asserts that ‘multiculturalism’ does not simply indicate a society made up of ethnic diversity but that the term goes further to reflect policy that expressly emphasises ‘minority cultures should be recognised and protected within the framework of the modern democratic state’ (Mulgan 1993, 79).

Although Sekhar Bandyopadhyay (2006, 125) unproblematically asserts that ““multiculturalism” has [since the 1990s] become ... a defining principle for New Zealand’s national identity,’ the official bicultural policy—formalized through Treaty of Waitangi negotiations—complicates a straightforward view of New Zealand as a multicultural nation (see Ghosh 2015; Spoonley 2015; Mulgan 1993). Bicultural policies emphasise mutual entitlement of rights for indigenous Māori and Europeans. According to Mulgan (1993), biculturalism and multiculturalism are—in practise—mutually exclusive because Māori ‘are seen as warranting a degree of recognition and protection, albeit within the framework of the democratic state, that is not accorded to other minority cultures’ (Mulgan 1993, 86).

Gautam Ghosh (2015) and Singham (2006) however both raise the point that the case of New Zealand exemplifies a unique form of multiculturalism precisely due to its official
bicultural status. Singham (2006) acknowledges that Treaty of Waitangi negotiations have been both complicated and challenging, but importantly these negotiations have paved the way for a unique approach to race relations in New Zealand:

> The journey has provided valuable insights into cultural values, identity and our humanity that we may have taken for granted. This experience is invaluable in navigating our way through an increasingly complex pluralistic environment where ethnicity, religious belief and national origin intersect with citizenship, national identity and trade. In many ways, Māori have paved the way for new minority communities. Their journey illuminates the way for others. We can and must, respectfully capitalise on the existence of this vital knowledge and wisdom. (Singham 2006, 34)

The ideal for both biculturalism and multiculturalism is a democratic dialogical negotiation of rights and responsibilities. There is yet some contention as to the measure for social equality where diverse peoples intersect. As Mulgan (1993) points out: the benchmark for determining social disadvantage is most often based on western-centred values and criteria. For example, most of the New Zealand literature focusing on migrant health disparity attends to whether people are effectively assimilating into the existing health system (Anderson 2007; Anderson 2008, Ho et al. 2003; Nayar, Hocking & Wilson 2007; Rasanathan, Craig & Perkins 2006; Sobrun-Mahraj, Tse & Hoque 2010). If the ideals of multiculturalism—specifically ‘the need to give political recognition to ethnic diversity’ (Mulgan 1993, 77)—are to be upheld in New Zealand, there could be greater emphasis on how the existing system may evolve to meet the needs of culturally diverse peoples.

A study by Tony O'Connor (2007) that investigates the politics of the inclusion of Māori medicine into New Zealand’s national health care system indicates that even under the rubric of biculturalism, the process has been one of assimilation rather than dialogical.
O’Connor (2007) asserts that only Māori practices that align with a western understanding of health are legitimised.

A similar assimilationist pattern can be found within the Australian health care system where the *National Agenda for a Multicultural Australia* unambiguously supports policy that respects the needs and aspirations of different cultural groups (Fuller 1997). The Australian primary health care system, much like New Zealand (discussed in Chapter 1: section 2), endorses a universalist approach, which is effectively dominated by western biomedicine. Jeff Fuller argues that ‘[w]hile the appeal of universal healthcare services is that they appear to deliver equal health care to all, they in fact systematically advantaging those whose values most closely fit with the dominant social norms’ (1997, 153). Fuller advocates that—in order to align with the spirit of multicultural policy—Australian national health services undergo modification and attempt to ‘meet the interests of different groups in the community’ (1997, 154).

Todd Nachowitz (2015, iii) offers Charles Taylor’s (1994) conceptual framework of deep diversity as an alternative to approaches to multiculturalism ‘that position minorities as beneficiaries of policies designed for their social uplift and integration into majority society.’ Nachowitz claims that deep diversity—which instead ‘places the onus of social integration on both minorities and majorities’ (ibid)—is ‘more aligned with the pluralism found in liberal western democracies’ (2015, 90).

Multiculturalism is currently the site of much negotiation in New Zealand among academics, politicians, and non-governmental organisations alike. The local Dunedin Multi-Ethnic Council in conjunction with the Dunedin Council of Social Services recently hosted a seminar on multiculturalism. The discussion revolved around what a successful
multicultural society might look like, and the barriers to this. There was a call for greater understanding and accommodation of different cultural practices within public institutions because petitioners perceived local systems to be predominantly mono-cultural and lacking reflection on diversity (de Bres, 2015).

During my preliminary fieldwork in Dunedin, when I was making the rounds to doctors’ offices, circulating posters that call for interviews with participants of South Asian descent, I encountered a receptionist in one clinic that unequivocally refused to take a poster. I had told her that the focus of my research was the health practices of South Asian migrants. She retorted that the doctors at this clinic are not interested in alternative medicine. Admittedly, the receptionists at all of the other clinics I had approached graciously accepted the poster—some pinning them up in front of me and others assuring me they would be pinned up once granted permission from the doctors. Interestingly, not one of my interviewees came solicited from a poster in the waiting room of their doctor’s clinic.

4.5 Conclusion
If the ideals of multiculturalism—specifically ‘the need to give political recognition to ethnic diversity’ (Mulgan 1993, 77)—are to be upheld in New Zealand, there could be greater emphasis on how the medical system may evolve to meet the needs of culturally diverse peoples. In this chapter, I have traced the history of South Asian migration to New Zealand and highlighted that South Asians are currently among the fastest growing migrant populations, contributing significantly not only to a multicultural New Zealand but also as valuable and educated citizens.
My research is based in Dunedin, where the South Asian population may be small in numbers compared with other New Zealand cities but where the presence of two prominent Indian figures have had considerable influence, both politically and economically. 'Black Peter' went unacknowledged and only scantily rewarded for being among the first to discover gold in Otago (Leckie 2007, 21), yet the city of Dunedin was built from the proceeds of the Otago gold rush. Sukhi Turner was on the other hand an environmentalist who, although she had served her time as Dunedin mayor with some resistance from the conservative establishment, was popular enough among voters to be re-elected twice and had managed to implement some positive environmental policy.

As Dunedin becomes more culturally diverse, there is greater opportunity for an exchange of knowledge than ever before. This exchange may be facilitated through the unique contributions of individuals—as exemplified above—or through an overt and intentional sharing of cultural wisdom on a wider scale.

An assimilationist approach is inherent to the New Zealand health sector, which had early roots in the conservative medical training programs at Otago University.30 Much of the New Zealand literature focusing on migrant health reflects this approach.31 My argument here is anti-assimilationist. Globalisation offers the ‘opportunity to acquire knowledge about other cultures and their medical arts’ (Chopra 2008, 252). Taking such an opportunity may not only benefit those whom already ascribe to this cultural knowledge but may in turn prove a valuable contribution to the medical establishment itself.

30 See Chapter 1: section 2.

Chapter 5: Theory & Methods

5.1 Introduction

I begin this chapter with a discussion of the main theoretical paradigms that have inspired my research and contribute significantly to the way in which I approach and analyse my findings. These paradigms share in common a critical approach to dominant institutions; post-colonial theory turns its attention to the lasting and often harmful impact of colonial rule (see for example Blaut 1993; Ashcroft, Griffiths, & Tiffin 2013; Wininger 2011); critical medical anthropology aims to expose taken-for-granted assumptions behind a so-called objective biomedical science (see Scheper-Hughes & Lock 1996; Hahn & Kleinman 1983; Martin 2007; Rapp 2007); and critical ethnography—which has its roots in the traditionally non-partisan field of ethnographic research—makes no apology for voicing value-laden messages which aim to inspire social change (see Thomas 1993).

In this chapter, I explain the relevance of critical theory to my topic and go on to discuss the interpretive methods I apply to my research. Although the data is derived mainly from the narratives of instrumental case-study interviews, I make sense of the nuanced understandings and practices revealed within the interviews through drawing from field notes, observations, cultural and interpretive texts, and the academic theories described above. Post-colonial theory and critical medical anthropology inform my own critique of the power dynamics surrounding modern medicine. Although my informants do not necessarily share this perspective, an interpretive approach to some of their narratives helps to anchor critical theory to ‘the world of lived experience’ (Denzin & Lincoln 2008, 11).
My sampling method was purposeful; I recruited my participants through posters and word of mouth, with the exception of Sukhi Turner whom I selectively invited into the research because of her significant community involvement, serving three terms as Dunedin mayor from 1995 to 2004. The interviews were semi-structured with open-ended questions that allowed me to explore unanticipated paths of conversation. For interpreting the rich, qualitative data that emerged through the interviews, I used both grounded theory and narrative analysis methodologies. This doubling-up enabled me the rigour of thematic analysis and the freedom to explore unique, personal anecdotes that reach beyond the neat thematic categories I had anticipated.

Finally, I discuss in the ensuing pages the importance of a reflexive approach. Acknowledging my own position as an active agent within the research, I point out some of the ethical considerations that arise from this and how I have endeavoured to minimise the damage. Foremost of these considerations is that the researcher, who inevitably enters the field with subjective biases, ultimately wields the power of representation. There inherently exists an asymmetrical relationship between researcher and subject because it is the researcher who defines the parameters of the research, choosing what to include and what to leave out. Although I am myself a migrant to New Zealand, my positionality as a member of the white majority conducting research within an ethnic minority group further enhances the asymmetrical relationship between researcher and subject. While a reflexive approach does not necessarily balance this power dynamic, it indicates that the researcher takes accountability for their position. This may help to facilitate an informed evaluation of the research project.
5.2 Theoretical Paradigms

This research is informed by three main theoretical paradigms: post-colonialism, critical medical anthropology, and critical ethnography. In this section I explore how these theoretical paradigms share in common a critique of the institutions of power, and together contribute to a research approach that promotes the interests of minority groups.

5.2.1 Post-Colonialism

Post-colonial theory, which crosscuts many disciplines, is broadly concerned with examining ‘the processes and effects of, and reactions to, European colonialism’ (Ashcroft, Griffiths & Tiffin 2013, 205). Anthropologists agree that culture is not static but constantly changing with influences from both internal and external forces. Post-colonial theory is often used to shine light on such areas of change in societies that have endured colonial domination. Many who take a post-colonial perspective assert that the legacy of colonialism lives on in the institutions and the minds of the colonised even after liberation from foreign control (Wininger 2011). They critique, for example, how missionaries had taught ‘local people to devalue their culture, its spiritual practices, its medicine, its aesthetics, its languages, its education, and its social structure’ (Wininger 2011, np). These scholars do not only offer critical reflection on the lasting harmful impact of colonial rule, but some go as far as to suggest ‘strategies to be employed in rebuilding post-colonial cultures’ (ibid).

At face value, a post-colonial framework may appear to rob colonial subjects of any notion of self-determination; yet a nuanced post-colonial analysis will consider the elements of human agency that mediate processes of cultural change. Bill Ashcroft,
Gareth Griffiths and Helen Tiffin (2013, 10) assert that ‘although it may be difficult for subjects to escape the effect of those forces that “construct” them, it is not impossible’; and many scholars draw attention to the ways in which people ‘initiate action in engaging or resisting imperial power’ (ibid). Ashcroft (1994) argues that meaningful action often involves somehow engaging the colonial discourse, whether that is through subtle or straightforward modes of appropriation or resistance. It is this engagement that enables people whose culture has been oppressed by colonial domination to ‘generate transformative cultural production’ (1994, 177).

In Chapter 3, I discuss the widespread appropriation of western biomedicine in India during British colonial rule. Although biomedicine is now the dominant paradigm of medicine throughout the Indian subcontinent, it did not simply replace indigenous systems of medicine but was rather integrated into a previously existing ideology of pluralism. In agreement with my own findings, the international literature indicates that a similar pluralist approach to medicine—with biomedicine at its centre—also exists among many South Asians in diaspora.

New Zealand and India had both been part of the British Empire under colonial rule. Ruth DeSouza (2005) takes a post-colonial perspective in her research investigating the loss of indigenous knowledge among Goan (Indian) mothers living in New Zealand. She claims that ‘such a perspective seems apt in the context of New Zealand as a former colony and Goan women as former colonial subjects’ (DeSouza 2005, 87). I reiterate this point in reference to my own research. British colonialism has left its legacy in the medical policies and practices both in the Indian subcontinent and in New Zealand. I discuss material evidence of this in Chapters 1 and 3; and throughout the thesis I invoke a nuanced post-colonial analysis, which suggests that hegemonic discourses of
colonialism—that devalue indigenous knowledge—live on to some extent in the minds of colonial subjects even through subsequent generations.

I began my research with a theoretical stringency that envisioned colonial subjects as necessarily victims of domination, but the narratives of my Dunedin participants give me cause to acknowledge a tension between the hegemonic colonial structures that I critique and expressions of human agency that rise up in response to these structures. In Chapter 6, where I explore some of these narratives, I find evidence of a sort of resistance—expressed through the use of traditional remedies—to the modern, fast pace lifestyle that is symbolically linked to a dominant western approach to medicine.

Pervasive discourses that devalue indigenous knowledge are, however, reinforced and normalised by an institutionalised medical conservatism present in New Zealand.\textsuperscript{32} Although the use of traditional home remedies is common among participants in my research, and can be contextualised as a sort of resistance to these discourses, their bottom line tends to be a reliance on the dominant biomedical system. I do not propose this to be an outcome of migration itself but rooted in the complex and syncretic approach to medicine that exists throughout post-colonial South Asia (as discussed in Chapter 3). Hence the inquiry—central to my thesis—into whether the perceived needs of South Asian migrants are being met by the New Zealand health care system is complex and deeply nuanced when considered through a post-colonial lens.

\textsuperscript{32} For more on this see Chapter 1: section 2.
5.2.2 Critical Medical Anthropology

Like post-colonial scholars, many critical medical anthropologists are concerned with the hegemony of western ideology. The sub-field of critical medical anthropology (CMA) grew out of the realisation that there is a fundamental flaw in how medical anthropologists had been using the western medical model as a benchmark for evaluating other ethnomedical systems (see Rhodes 1996). Acknowledging biomedicine as itself a cultural system, with epistemological idiosyncrasies that conflict with other cultural understandings of health and the body, many proponents of critical medical anthropology turn their analysis toward the assumptions made within the field of western medicine (see Scheper-Hughes & Lock 1996; Hahn & Kleinman 1983; Martin 2007; Rapp 2007).

We believe that insofar as medical anthropology fails to consider the way in which the human body itself is culturally constructed, it is destined to fall prey to certain assumptions characteristic of biomedicine. Foremost among these assumptions is the much-noted Cartesian dualism that separates mind from body, spirit from matter, and real (that is, measurable) from unreal... this epistemological tradition is a cultural and historical construction and not one that is universally shared. (Scheper-Hughes & Lock 1996, 45)

The idea permeating western thought—that mind and body are separate—is integral to the mechanistic approach of modern medical science. Michel Foucault (1973), whose discourses of power are instrumental to many critical medical anthropologists, discusses at length how the authority of modern medicine relies predominantly on the so-called objectivity of its methods and representations.

Drawing from Foucault (1973), Jean Langford (2004, 158) un_masks a ‘potential crisis at the heart of medical scientific authority.’ She explains how the diagnostic images
rendered through medical technologies are not self-evident but coded with cultural messages. As with any visual representation, these images are framed by what is included, what is excluded and where attention is drawn (see Barthes 1977). These images require methods of decoding that rely on understanding them in terms of ‘the anatomical drawing, which reproduces only what is considered significant in the body’ (Langford 2004, 157). Students of anatomy are trained to see mechanically produced images of internal bodily organs—as they are trained to see actual live organs—as uniform shapes depicted in two dimensions through ‘various techniques of visual clarification’ against a ‘neutral, nonsituational space’ (2004, 159).

Critical medical anthropologists who approach biomedicine ‘as an object of study’ (Rhodes 1996, 165) are concerned not only with its cultural construction and the political hegemony that has for so long made biomedicine immune to critique, but some also turn their analysis towards encounters within the clinic. Foucault (1973) frames the clinical encounter in terms of power, where the authoritative gaze of the medical expert renders the body of the patient docile. While this archetype is often depicted in CMA literature (see for example Atkinson 1995; Hahn 1982; Langford 2004; Rapp 2007), many writers acknowledge patient agency and autonomy that emerges through varying forms of negotiation or resistance to authoritative knowledge.

Rayna Rapp (2007), for example, examines the setting of an ultrasound clinic where pregnant women negotiate their response to the medical technology. Rapp (2007) acknowledges that even while the images produced by the sonogram tend to eclipse her subjects’ experiences of pregnancy, ‘many women are delighted to claim this new knowledge for their own, using it for old purposes’ (2007, 618) such as feeling more connected to the baby or getting their husbands involved in the pregnancy.
Arthur Kleinman and Joan Kleinman (2007) discuss how autonomy from authoritative western medical knowledge can also be negotiated through resistance. They describe how Chinese neurasthenia patients resist defining their condition as depression because this label negates socially or morally appropriate views of their relationship to society. Although neurasthenia patients exhibit the same symptoms as those suffering depression in the western world, treatment for depression fails to relieve these symptoms.

Kleinman and Kleinman’s (2007) analysis leads to a final consideration of CMA that is relevant to my thesis; the efficacy of health care can have more to do with belief in the treatment and understanding between doctor, patient, family and community than the treatment alone (see Kleinman, Eisenberg & Good 1978; Hahn & Kleinman 1983; Waldram 2000; Kirmayer 2004). This understanding is not only based on language and communication, but explanatory models of health and the body, which are culturally mediated (see Kleinman 1978).

Much of the literature suggests that the use of traditional remedies that are passed down through generations is common among South Asians in diaspora. My own findings agree with this. Among the people I interviewed, even those who do not have explicit knowledge of medicinal properties report the efficacy of the remedies they use. Ray, who is from Malaysia where multiple forms of traditional and western medicine is widely available, explains that ‘trust’ plays a large role in the medical choices people make:

I would say maybe around sixty percent of the community still remains taking the traditional medicine in the first place. … currently the available of scientific medicines throughout Malaysia, it’s easily available. So, because even small villages you have a
dispensary with doctor and everything. So accessibility is not a reason, but I think it’s exposure, whether you trust on herbal medicines or you trust on the home remedial medicines.

A CMA perspective that recognises the cultural contingency of biomedical knowledge (and efficacy) is central to my research; this is the lens through which my topic and questions are inspired. My South Asian participants report that they use home remedies as a first choice for many common ailments. In the following chapter, I explore how their reliance on traditional remedies that are passed down through the generations can be viewed as a form of resistance to a hegemonic biomedical authority.

5.2.3 Critical Ethnography

The final theoretical paradigm that informs my research can also be contextualised as a methodological approach. Critical ethnography is a radical approach to the ethnographic method of research because it explicitly endorses the role of researcher as advocate for their subjects. Critical ethnography does not diverge methodologically from conventional ethnography; it is rather ‘a style of analysis and discourse embedded within [but not always deployed by] conventional ethnography’ (Thomas 1993, 3). While ethnography is ideally characterised by objective, non-partisan description of the subject under investigation, those who take a critical approach go out of their way to acknowledge that their own view of the topic is not value-free.

Many critical ethnographers take a social justice perspective and attempt to promote the political or social interests of their subjects. Thus they are often concerned with areas of social life that involve structural disadvantage or subjects that are being silenced by institutions of power. The aim of the critical ethnographer is in fact to disrupt the status quo and inspire social change (Thomas 1993). Jim Thomas (1993, 21) asserts that ‘social
constraints exist and ... research should be emancipatory and directed at those constraints.’ So while it is the interest of conventional ethnographers to ‘describe what is; critical ethnography ask what could be’ (1993, 4).

As advocate for the interests and concerns around health that are raised by my research subjects, I support an approach to cultural competency in the New Zealand health sector that aligns with what Nachowitz (2015) refers to as deep diversity. This is an approach to diversity and multiculturalism that views social integration as a mutual responsibility between minority and majority society alike. While the intention of a universal approach to health care is to ensure that treatment is available for everyone, the prioritisation of biomedical treatment ‘systematically advantage[s] those whose values most closely fit with the dominant social norms’ (see Fuller 1997, 153). In this research I take a critical ethnographic approach and ask whether this universal approach to medicine meets the needs of my research subjects or whether there may be need for greater medical pluralism in the New Zealand health care sector.

The South Asian research participants in my project demonstrate a pluralist approach to health; each uses traditional recipes in the home and many visit traditional healers when visiting India. One of my respondents told me she felt a lack of empathy from the medical doctors she visited in Dunedin and another told me that he encounters derogatory attitudes toward traditional medicine among ‘westerners’. Yet the general tone of my informants is not one of feeling disadvantaged by the marginal status of unorthodox healing modalities. When asked, most of them told me that they would however appreciate access to affordable traditional health care if it were available in Dunedin. With this research, I hope to contribute to a body of literature that may help to inform health policy seeking to meet the interests of diverse groups in the community.
5.2.3.1 Theory vs. Methodology

I invoke the theoretical paradigm of critical ethnography to acknowledge that my voice is not passive and that my values are not dormant in this research, yet I do not frame the methodology of my research as full-fledged ethnography. According to Michael Angrosino (2007, 3), '[i]nterviewing and observing are the fundamental ethnographic data-collection techniques.' My research relies mainly on interviews for data collection, with some 'situational conversation' (Lindlof & Taylor 2002, 176) where I have met and spoke with people in the field who were not officially research participants. But I cannot claim to have immersed myself in what Clifford Geertz (2000, 110) refers to as 'deep hanging out'—or participant observation, which is the quintessential technique for ethnographic research.

Although much social research is also conducted through interviews, a rigorous anthropological project will gather data through ethnographic fieldwork, which relies on participation and involvement within the daily activities of those being studied. Bronislaw Malinowski (1961) emphasised the importance of total immersion in the field in order to gain privileged access into the cultural world of his informants. He outlined the difference between visiting a site for a brief time each day, participating only selectively in order to gather relevant data, and immersion in the daily life of those under observation.

Malinowski (1961) conducted his research in a rural setting among the relatively isolated peoples of the Trobriand Islands. In this context, traditional methods of fieldwork are both preferable and practicable. 'In making the transition to urban research,' according to Peter Jackson (1985, 157), 'anthropologists have discovered that
their traditional methods of year-round isolation from their own ordinary lives and round-the-clock participation in the ordinary lives of other people are no longer possible.’

My own research takes place in a multi-cultural urban setting where daily interactions necessarily involve negotiation and exchange with people of diverse cultural backgrounds. Although the context of my research complicates the imperative to rely on traditional ethnographic fieldwork methods, I acknowledge that my results are limited by the extent to which I have been allowed inside the lived worlds of my informants. A deficiency of the interview method is that as researcher I must rely only on what I am being told, not what I observe over time.

5.3 Qualitative Research Methods

Thomas Lindlof and Bryan Taylor (2002, 15) make a point of distinguishing between ethnography and qualitative research, which they claim are terms ‘often used interchangeably.’ Although both involve methods of interpretive research, qualitative research can be seen as an umbrella term that encompasses multiple forms of data collection and analysis; and ethnography falls under this umbrella—not as a distinct method itself but as a paradigm usually involving fieldwork and participant observation. According to Norman Denzin and Yvonna Lincoln (2008, 4) the aim of all qualitative research is to ‘make sense of, or interpret, phenomena in terms of the meanings people bring to them.’ This approach maintains that social reality is better represented through interpretive methods than a traditional positivist framework that presumes a stable and unchanging social reality can be measured by objective science.
As early as the 1920s, the ‘Chicago school’ of sociology established that qualitative modes of research have greater relevance ‘for the study of human group life’ than positivist quantitative research methods (Denzin & Lincoln 2008, 2). Although still criticised for its subjectivity by those who advocate scientific objectivity, qualitative research has largely established itself as a valid form of social research and is currently deployed within multiple disciplines (Denzin & Lincoln 2008; Lindlof & Taylor 2002).

There are a variety of methods to choose from when conducting qualitative research. To name a few, these range from classical observation and interview-based methods, to a researcher centred auto-ethnographic reflection, to performance ethnography or to writing as itself a method of inquiry (see Denzin & Lincoln 2008). Although the range is diverse and far-reaching, what remains stable throughout qualitative methodologies is the interpretative nature of inquiry. Unlike the positivist models of research, the qualitative paradigms acknowledge, to greater or lesser extents, the position of the researcher as an active agent within the research.

Ethnographic fieldwork, which involves ‘localized, long term, close-in vernacular field research’ (see Geertz 2000, 107), is the most common method among anthropologists. But as I mentioned above, this ‘deep hanging out’ (ibid) is not always practicable and some qualitative studies rely primarily on the interview method for collecting data. The use of interviews alone may be considered reductionist due to an inevitable ‘focus only on a partial set of relationships in a scene’ (Lindlof and Taylor 2002, 18). But interview methods on the other hand are appropriate when looking for ‘common patterns or themes between particular types of respondents’ (Warren 2002, 85).
To safeguard against potentially oversimplifying complex social phenomena, Denzin and Lincoln (2008) advocate a multi-method approach to qualitative research. They concede that the use of multiple methods, or ‘triangulation’, does not validate the research (in the terms of capturing an objective reality) but helps to provide ‘an in-depth understanding of the phenomenon in question’ (2008, 7). They use the metaphor of researcher as maker-of-quilts, piecing together a ‘set of representations that is fitted to the specifics of a complex situation’ (2008, 5).

The research I have conducted for this thesis has taken place over a period of two years. My data is derived mainly from the narratives of case-study interviews. I used grounded theory and narrative analysis both to organise the data and allow myself to be surprised by the unique experiences of my informants.33 In order to piece together and contextualise the nuanced understandings and health practices revealed through the narratives, I draw from field notes and observations, cultural and interpretive texts, artefacts supplied by my informants34, comparative medical epistemology35 and the theoretical paradigms discussed in the previous section of this chapter.

5.3.1.1 Representation: A Reflection on the Field

While the intention of my research is to promote the interests of my respondents, who represent a minority group in Dunedin, it is germane to consider that interpretive research methodologies have been intricately linked to the colonial project. Early ethnographic fieldwork was complicit in the power imbalance between coloniser and

33 See the interview section later in this chapter.

34 See appendices 2, 3 & 4.

35 See Chapter 3.
subject through mediating Eurocentric representations of the cultural ‘other’. The ‘object of the ethnographer’s gaze’ was the ‘primitive, non-white person from a foreign culture judged to be less civilized than ours’ (Denzin and Lincoln 2008, 2). The ethnographer would then capture an unavoidably biased version of the subject and represent this as some form of truth or authoritative knowledge.

While recruiting my participants and conducting interviews, I was often self-conscious of the racial politics behind interpretive research and of my own positionality as both white and an outsider to the ethnic group I had categorically defined and targeted for my research. I felt uncomfortably aware of the colonial legacy entwined in cultural comparison and the power imbalance inherent between researcher and subject. I was also aware that my own research involved a sort of ethnic profiling where I began with the assumption that people of South Asian descent would necessarily have an affinity with traditional medicine. When I approached an Indo-Fijian woman in my yoga class and asked if I could interview her about traditional health practices, her response gave me pause to reconsider this assumption. She said ‘I wouldn’t be of any help to you, I am a scientist.’ Her response contained layers of meaning for me, but of relevance here is how it confronted the bounded notions of culture I had held. Although unspoken, I felt her implore me not to make an ethnic ‘other’ out of her. I was embarrassed and ashamed.

The colonial legacy can still be found alive in certain aspects of the research process but qualitative research has taken many historic and ideological turns since its early alliance with colonialism. One important movement in social research that eventuated in the 1980s was the ‘crisis of representation’ (see Denzin and Lincoln 2008, 24-26). Aligning with an emerging feminist and post-colonial critique of the Eurocentric authority over
knowledge in academia, this movement brought to light the controversy around researchers’ authority to speak for their subjects.

Malinowski’s (1961, 25) famous claim that it was the ethnographer’s duty to ‘grasp the native’s point of view’ was ground breaking for the field of anthropology during his time, for it contradicted the imperialist model of anthropology that relied on cataloguing cultural practices and artefacts while maintaining a distant, objective and superior position. Yet Malinowski’s ambition was eventually criticised as both unattainable and presumptuous; Geertz (1983, 56-58) questioned the extent to which it is plausible for anyone to claim authoritative knowledge of the world-view of another. Indeed a dilemma I have faced throughout this research is that while I aspire to accurately represent the interests of my informants, my analysis is invariably influenced by my own values and convictions.

5.3.1.2 Reflexivity: A Reflection on the Researcher

As a response to the challenge—prompted by the crisis of representation—to the anthropologists’ authority over their subjects, some researchers deliberately began to include self-reflexivity into their text: revealing their own gender, race, age, experience, emotions, interests, and other personal factors that may influence their cultural analysis. Although naming one’s subjective position does not necessarily eliminate bias, self-reflection may weaken the impact of otherwise unconscious impulses. Kleinman & Copp (1993, cited in Hoffman 2007, 322) assert that ‘[w]hen researchers act without awareness of their own emotions and the emotional labor they perform in the field, they will be more influenced by their emotions rather than less.’ I would argue that this is not only true for emotions; subjective influences such as assumptions, prejudices or
engrained ways of viewing the world are likely to have less a hold once acknowledged. A reflexive approach can offer some accountability for these subjective influences, and transparency of the author's point of view may help to facilitate for the reader an informed evaluation of the research (see Richardson & St. Pierre 2008).

My own personal interest in herbal medicine has inspired me to choose my research topic. I grew up in the 1970s in California during a social revolution that, among other things, questioned conventional medical authority. As a child, my mother gave me homeopathic remedies, took me to an acupuncturist, taught me yoga, and considered my constitution and nutritional needs in terms of Ayurvedic principals. I am now mother to a teenage boy, and I carry on the tradition of treating his (and my own) ailments with herbal remedies.

Because of my upbringing, I possess some experiential knowledge of traditional South Asian medicine and home remedies. This both fuels my interest in the topic and potentially bridges a gap between my own world-view and the world-view of some of my participants, at least where health is concerned. But my tacit knowledge is limited and, although myself a migrant to New Zealand, I remain an outsider to the ethnic demographic I am researching. My outsider's perspective is reinforced by an academic interest in the health practices that are largely inherent to the life-worlds of many of my informants and the generations that taught them. It is these tacit, deeply rooted cultural understandings I am trying to reach through my research. My honours research, in which I explored some of the transcendental qualities and health benefits experienced by yoga practitioners in Dunedin (see Bailly 2014), has in some ways prepared me for research focusing more broadly on health practices of South Asians in Dunedin.
5.3.2 Participants

For this research, I interviewed nine participants (three male and six female) of diverse ages (the youngest was nineteen and the eldest sixty-three), all whom identify as being of South Asian descent. I recruited participants through distributing posters\(^\text{36}\) around the University of Otago campus, other public notice boards and the waiting rooms of private doctors’ clinics in Dunedin. I also approached the proprietors of local Indian grocers and restaurants, and I contacted the Sri Lankan Student Association and the Pacific Island Centre where notices were posted on their Facebook page and mailing lists respectively. The Star newspaper published an article\(^\text{37}\) about my research, from which one of my participants was recruited. I also networked via personal contact and word-of-mouth through university staff, the Dunedin Multi-Ethnic Council and Woman Across Cultures (the latter of which I am a member).

Several of the participants who responded to the recruitment posters had also heard of the project from another source, and disclosed that it was only on the second prompting that they decided to contact me for an interview. Although only one of my interviews came directly by referral from another participant, my recruitment appeared to achieve a snowball effect from the multiple levels of networking I had begun.

5.3.2.1 Sampling

I chose the purposeful sampling method, which is frequently used in qualitative studies where ‘field research is carried out according to criteria of selection that flow logically from the objectives of the project’ (Lindlof & Taylor 2002, 122-123). My research aims

\(^{36}\) See appendix 1.

\(^{37}\) See appendix 5.
to investigate cultural practices around health, specifically among people who live in Dunedin, New Zealand and identify as being from a South Asian background. I hope to gain insight into the extent to which biomedical practices and treatment meet the perceived healthcare needs of my respondents. My research does not aim to collect data that can be generalised to all New Zealanders of South Asian descent but rather aims to give voice to those who agreed to speak with me. It is thus apparent (and appropriate) that those who did respond to my posters or word-of-mouth recruitment have some vested interest in the topic.

While purposeful sampling by definition refers to a ‘nonprobability approach’ (see Lindlof & Taylor 2002, 122), I have stretched this method to its literal extreme in one instance; I had—with purpose—selectively invited a participant into the research. The contributions of this participant have great significance to my research not only due, incidentally, to her interest in the topic but because Sukhi Turner, who was born in the Indian Punjab, had served as Mayor to Dunedin for three consecutive terms until 2004.

Sukhi currently lives in Wanaka, New Zealand, and is the only participant I have recruited from outside Dunedin. I maintain that her long-term residence in Dunedin from 1973 justifies including her voice in the research, and her significant contribution to what Freisen (2009, 13) refers to as the ‘ethnoscape’\(^{38}\) of Dunedin implores me to include her voice. Her contributions came not only during her time as Mayor, but Sukhi told me that after her children were born she taught evening classes in Indian cooking at the Otago Polytechnic. These classes ran for eight weeks and she repeated them four

\(^{38}\) Freisen uses the term ‘ethnoscape’ to describe the impact on the physical, cultural and political environment made by migrant populations. For more on this see Chapter 4, page 86.
times. She also started the ‘Garam Masala Club’, where she hosted Indian dinners fortnightly:

And people flocked to that. So there was a real demand. Because a lot of New Zealanders go to the UK, and there's so many Indian take-away places there. They come back over here and they sort of pine for the spicy food.

Sukhi’s brother later opened the Little India restaurant in Dunedin, which became a chain throughout New Zealand.

5.3.2.2 Instrumental Case Studies

My thesis is based on small-scale qualitative research that, through eliciting stories from only nine participants, aims to investigate some of the ways in which Dunedin residents of South Asian descent approach their own health issues. This is not a survey and I do not intend to generalise the data across or even within populations. I do however intend to generate theory based on an analysis of each case study and some collation of common themes that emerge. While I acknowledge that the stories and experiences of each of my nine participants are unique, each case is instrumental39 in providing insight into a broader understanding of the health practices of South Asian migrants in Dunedin.

5.3.3 The Interviews

Attempting to make the interviews as comfortable as possible, I had offered participants the option of being interviewed in a public setting such as a café, in the privacy of their own home or place of work, or in a quiet room at the university. Of my nine participants, two opted to meet for the interview at their place of work in Dunedin, five met with me at the university library, one in a private office of the anthropology department, and I

39 For an elaboration on instrumental case studies see Stake (2000, 437).
travelled to Wanaka to interview Sukhi Turner where we spoke at her home over green tea and homemade Anzac biscuits.

The interviews were conversational. Most of them lasted just under an hour, with two extending longer than two hours. We usually broke the ice talking about family or the journey either of us had taken to get to our meeting place; or I answered questions about my research, often explaining my own interest in the topic. I had drafted my ‘interview guide’40 (see Lindlof & Taylor 2002, 195) by grouping open-ended questions under broad topic areas that I was interested in exploring with my participants. I used this guide in a semi-structured manner that allowed me to follow their unique narratives and explore unanticipated paths of conversation. But the guide also gave me a reference point to draw back to if the conversation strayed too far off topic.

When wording the questions I wanted to ask, I was cautious that they were open-ended so I might elicit my respondents’ own unique stories and understandings. Elizabeth Hoffman (2007, 344) advocates open-ended interview questioning as ‘an excellent means for gathering deep, rich, qualitative data.’ The questions I asked were effective in guiding the general direction of conversation without limiting the data to fit neatly within preconceived themes.

5.3.3.1 Grounded Theory & Narrative Analysis

Having audio-recorded my conversations with participants, I transcribed each interview verbatim shortly after it had taken place. I found my own personal engagement in this process to be useful because it allowed me to relive the interviews while engaging more

40 See appendix 6.
objectively with the conversations. After I had completely transcribed all nine interviews and done several close readings of each script, I set about collating the narratives to find common emergent themes between them or to highlight unique stories and perspectives. I also searched the data for themes that matched previous New Zealand and overseas literature on the topic, aware that the absence of such matches may be just as, if not more, interesting than their presence.

Because my aim is to find common themes between the narratives and to explore unique, individual perspectives, it was appropriate for some of the data be coded and categorised for grounded theory analysis (see Strauss & Corbin 1994; Lindlof & Taylor 2002) and some narratives to stand alone as discrete personal anecdotes, remaining open for a more nuanced narrative analysis. Both of these techniques I approached with the ‘old-fashioned “ear and eyeball” method’ (see Redfern-Vance 2007, 61) rather than computer software technology.

The grounded theory methodology involves a rigorous process of thematic analysis, which involves breaking down excerpts from the interview narratives into specific categories that may be pre-set or emerge from the data itself. The interviews are cross-referenced, and relevant excerpts are coded into the assigned categories. Although I had not gone about setting thematic categories before my formal analysis of the material, some themes began to emerge through the interviews and more generally throughout the course of the research.

The broad themes that emerged from the interviews, which align with much of the international literature, indicate that a pluralist approach to medicine is common among my South Asian participants; all of my participants to some extent use home remedies
and many of them visit Homeopathic, Ayurvedic or Siddha clinics on visits to India. They also tend to prioritise treatment for specific conditions; home remedies or traditional medicine is commonly used for general health or chronic conditions while they claim to seek biomedical treatment for more serious or life threatening concerns. There is a general view among the participants that traditional remedies are natural and therefore safe in contrast to chemical based pharmaceuticals, which have unwanted side effects. These themes are discussed at length in the following chapter.

While these broad themes are relevant because they relate back to the literature—corroborating, contesting or offering further insight into previous findings on the health practices of South Asians in diaspora—a nuanced analysis of the participants’ narratives enables me to explore what I refer to in the following chapter as their unique ‘messages.’ I have highlighted four such messages that have emerged, each from a given narrative, and expanded upon these with supporting examples and anecdotes from the other interviews. These messages provide a means to illustrate some of the personal character that is unique to my participants. An exploration of these messages also enables me expand upon some of the unanticipated themes and revelations that emerged from my interview data; these were indeed inspired through a certain element of surprise.

It was not until my sixth interview that I became suddenly aware that for the first time I had fully lost control of the direction of conversation. I had planned the interview to last one hour and to follow more or less my guiding questions that I trusted would bring us back to the topic when the conversation strayed. The interview in fact lasted over two hours and moved into unchartered territory. After the interview I felt shattered. But when I came to transcribe the recording, I was pleasantly surprised at the richness and relevance of the stories that I had initially taken for digressions.
Reading Catherine Riessman’s (2002) account of a similar situation where a straightforward question led her participant to go “on and on” (2002, 695), I discovered—as she had—a useful approach to analysing this sort of unruly interview. Narrative analysis is a feminist approach that navigates a ‘less dominating and more relational mode of interviewing’ (2002, 695). The feelings of powerless I had experienced during the interview in question gave way to a sort of breakthrough whereby I understood the benefits of letting go of control to ‘follow participants down their diverse trails’ (2002, 692).

Narrative analysis is traditionally used when collecting data in the form of life histories where themes range more broadly than they do during interviews that focus on select topics (see Redfern-Vance 2007; Riessman 2002). But as I relay above, my open-ended questions often led to the unravelling of personal anecdotes that reached beyond the neat categories I had anticipated. These stories are important because they reveal to me some of the more difficult to access ontological or personal perceptions of health and illness that are too oblique for a direct line of questioning. For example Nidia, a PhD student in the school of medicine, did not overtly claim her loyalty to western medicine over traditional remedies (which, only through prodding did she acknowledge some use of). It was rather the life history events she shared, certain metaphors she used, and her tone of voice in certain interludes that revealed to me her preference for biomedical approaches to health.

My sixth interview—whose direction I had totally lost control over—was unique to the others in the depth of narrative that was performed. Most of my participants drew back and awaited my cue after speaking at any length on a topic. For this reason, I found it useful to incorporate both methods of grounded theory and narrative analysis to make
sense of the interview data. I am not however limited to use only one or the other approach for any one of the interviews. While grounded theory is my formal mode of analysis, I apply narrative analysis to the relevant anecdotal stories my participants tell me. The objective is ‘not simply to take the narrative at face value, but to search for the intersections between personal biographies and the collective culture’ (Redfern-Vance 2007, 50). Furthermore, I acknowledge that the interview conversations are ‘a joint production of narrator and listener’ (Chase 2008, 65), thus I apply narrative analysis to some of the dialogic exchanges between my participants and myself.

5.3.4 Ethical Considerations

This project has been granted approval from the ethics committee of the University of Otago (reference no.14/167) and has been acknowledge by the Ngāi Tahu Research Consultation Committee as to not directly affect the Māori community.41 The participant consent form42, the information sheet43 and the poster for recruiting interview participation44 are included in the appendices. Minors (under the age of eighteen), the elderly (age sixty-five or over) and those suffering serous illness were excluded from participating in the research to avoid issues of consent or undue distress. I compiled a list of support networks for those who might require debriefing if sensitive issues arose from the interviews.45 Participants had the option to be given a pseudonym to represent

41 See appendices 7 & 8.
42 See appendix 9.
43 See appendix 10.
44 See appendix 1.
45 See appendix 11.
their contribution to the research. Several took this option. Below I disclose some other ethical considerations that arose during the course of my research.

As discussed earlier in this chapter\(^{46}\), there is some controversy in the field around the researchers’ authority to speak for their subjects. I am cautious about categorically defining the participants as South Asian migrants, not only because this may not be accurate but also because they may not describe themselves in these terms. When I use the term ‘migrant’ in reference to participants in my research, it is mainly for heuristic purposes of relating back to the broader literature. I do not intend this as a narrow category representing a homogenous group but to broadly include those who are second generation to New Zealand, those who have lived outside South Asia prior to settling in New Zealand and those who could be described as ‘twice migrant’\(^{47}\) (Voigt-Graf 2003, 368): like for instance Ray who has come to Dunedin from Malaysia but is fourth generation from Andhra Pradesh.

Furthermore, identity is both personal and self-ascribed; therefore it is important that I do not identify the participants as South Asian without their consent. The interview recruitment posters and participant information sheets specify that eligibility to participate in the research extends to those who identify as being of South Asian descent. Thus, volunteering for the research implies that participants do self-identify as being South Asian.

\(^{46}\) See section 5.3.1.1.

\(^{47}\) For more detail on this term see Chapter 4: page 78.
5.4 Summary

In this chapter, I have discussed the theory and the methods that I have employed to bring together—as a comprehensive and multi-faceted study—an inquiry into the perspectives and health practices of the South Asian participants in the research. I used qualitative interviews as my main source for data collection. These have proven a rich source that—mediated through critical theory and interpretive methods of thematic and narrative analysis—have enabled me to ‘make sense of, or interpret, phenomena in terms of the meanings people bring to them’ (Denzin & Lincoln 2008, 4).

I have outlined the three main theoretical paradigms that inform my research, and discussed how they share in common a critical approach that evaluates taken-for-granted assumptions and challenges dominant socio-political structures. Post-colonial theory and critical medical anthropology inform my own critique of the power dynamics surrounding modern medicine while critical ethnography inspires me to take responsibility for my personal investment in the topic and use my voice, alongside the voices of my research participants, in an attempt to inspire social change.

Analysis of the participants’ narratives through a grounded theory approach gives voice to the multiple ways in which they negotiate and resist the hegemony of authoritative medical discourse that I critique. Although there are some contentious and ethical considerations around my authority as researcher to provide a true representation of the participants and their interests, I discuss how a transparent and reflexive acknowledgment of my own investment in the topic and positionality in the field helps to contextualise, if not validate, my findings.
My research is based in Dunedin where the South Asian population may be small in numbers compared with other New Zealand cities, but where the presence of two prominent Indian figures have had considerable influence, both politically and economically. ‘Black Peter’ went unacknowledged and only scantily rewarded for being among the first to discover gold in Otago (Leckie 2007, 21); yet the city of Dunedin was built from the proceeds of the Otago gold rush. Sukhi Turner was on the other hand an environmentalist who, although had served her time as Dunedin mayor with some resistance from the conservative establishment, was popular enough among voters to be re-elected twice and had managed to implement some positive environmental policy.

As Dunedin becomes more culturally diverse there is greater opportunity for an exchange of knowledge than ever before, whether this is through the unique contributions of individuals, or through an overt and intentional sharing of cultural wisdom on a wider scale.

An assimilationist approach is inherent to the New Zealand health sector, which had early roots in the conservative medical training programs at Otago University. Much of the New Zealand literature focusing on migrant health reflects this approach. My argument here is anti-assimilationist. Globalisation offers the ‘opportunity to acquire knowledge about other cultures and their medical arts’ (Chopra 2008, 252). Taking such an opportunity may not only benefit those whom already ascribe to this cultural knowledge, but may in turn prove a valuable contribution to the medical establishment itself.

48 See Chapter 1: section 2.

Chapter 6: Voices of Participants

6.1 Introduction

In this chapter, I focus on my conversations with research participants, highlighting the broad themes that arise through the interviews and tracing some of the more unique messages that are embedded in their narratives. Aligning with much of the previous literature that addresses South Asian migrant health, my findings indicate that a pluralist approach to medicine is common and that participants tend to prioritise treatment based on the nature of their health concern and the perceived safety of medication.

Each participant had shared with me at least one recipe for a traditional remedy they prepare at home using culinary herbs or spices. Yet this use of home remedies alone does not necessarily indicate a pluralist approach to medicine because some do not view their health tonics as medication per se. They each told me however that they themselves or family members visit homeopathic, Ayurvedic or Siddha clinics when in India or Malaysia; and most said that they would utilise traditional medicine were it more easily accessible locally.

While an analysis of the broad themes is important to set a general background, I go on in this chapter to explore some of the unique and unanticipated messages embedded within the participants’ narratives. I examine some of their concerns about the loss of traditional knowledge, discuss the connections they perceive between Indian food and traditional medicine, offer details of some of the specific health recipes that they share with me and look at how some might revive traditional health knowledge through the use of the internet.
I end this chapter with a brief discussion that centres on some of the ways in which the South Asian participants in my Dunedin study negotiate biomedical authority and express their agency through opting for ‘natural’ remedies they perceive to be safe and, as one of my informant claims, ‘really good for our health.’

6.2 Analysis

As discussed in Chapter 5, while analysing the interviews I used both grounded theory (see Strauss & Corbin 1994; Lindlof & Taylor 2002) and narrative analysis (see Redfern-Vance 2007; Riessman 2002) in order to find common themes that emerge through our conversations, and to explore in greater depth some of the unique perspectives that extend beyond these themes. In this section I first explore the broad themes that have also been found commonly throughout the New Zealand and overseas literature.

To discuss the nuances of my findings, I have broken down the main themes into four categories that I discuss at length below; these are a pluralist approach to medicine, prioritising treatment, notions of ‘safe’ & ‘natural’ and body & mind. Succinctly, these broad themes reveal that the research participants tend to express a pluralist approach to medicine, which includes some modalities of traditional or alternative medicine and the use of home remedies in conjunction with western medicine. While tending to prioritise treatment based on the nature of their health concern, many state a preference for ‘natural’ remedies that they perceive as ‘safe’ in comparison with pharmaceutical medication or prescription drugs, which often produce unwanted side effects. Although I do not go into great depth in this thesis discussing the specific area of mental health—which is currently the focus of some debate in literature on culture and
medicine—several participants mention the interconnection between body and mind, and how the latter may impact on physical health.

My findings within these broad themes relate back to the literature through corroborating or offering further insight into previous findings on the health practices of South Asians in diaspora. While my use of open-ended interview questions enabled a rich exploration of some of these themes, the relational style of interviewing I used also leads me to unravel some personal anecdotes that did not fit the neat categories I had anticipated. Through following unanticipated paths of conversation, I have the opportunity to recognise and voice some of the unique messages that were imbedded within the narratives. In the second half of my analysis entitled messages, I look closely at some of these unique narratives and draw from them several distinct messages that denote some of the particular views and concerns expressed by my research participants.

Nancy Redfern-Vance (2007, 50) suggests that the objective of narrative analysis is ‘not simply to take the narrative at face value, but to search for the intersections between personal biographies and the collective culture.’ Each message that I highlight in this chapter had emerged from a particular narrative; hence the sections are titled with a quotation that reveals the essence of each message. Ray, for instance, talked at some length about ‘losing our tradition’. Ray’s message about this has been endorsed or elaborated throughout the other interviews. For example, Sirisha and Rajesh offer some explanations as to why traditional medicine is ‘dying out’ amidst the high-pressure demands of a modern lifestyle. In the messages section of my analysis, I discuss at length four of the prominent and recurring messages voiced by participants.
6.2.1 Broad Themes

In the following sections, I explore some of the broad themes that have emerged from the interviews with my research participants and that have also been found commonly throughout the New Zealand and overseas literature.

6.2.1.1 A Pluralist Approach to Medicine

The participants report that they each, to varying degrees, make use of home remedies that have origins in traditional medicine and that have been passed down through the generations. This aligns with much of the overseas literature where researchers have found their South Asian respondents tend to use traditional remedies consisting mainly of culinary herbs and spices as a first choice for general or chronic health concerns (Ahmad et al. 2008; Bhopal 1986; Choudhry 1998; Dyck 2006; Hilton et al. 2010; Rao 2006).

Each of my nine participants has shared with me at least one simple restorative recipe (and some more complex recipes) that they prepare at home with culinary spices commonly used in Indian cooking.\(^5\) While claiming remedial effect, respondents do not necessarily view their home remedies as medication. For some this term appears to be reserved for treatment of more serious conditions than can be addressed by their remedies. For instance Nidia, a student of psychiatric medicine who had grown up in Kerala, talked about taking antibiotics for what she considered to be a serious cough:

Me: Did you try to subdue it with anything yourself first? Would you have taken something off the shelf from a pharmacy or would you have taken...

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\(^5\) See section 6.2.2.3: ‘Mum’s recipe for general good health.’
Nidia: Not really. ... I wouldn't go for over the counter medication or anything. I'd rather go get it prescribed.

Me: Um, do you have anything that your mum taught you to do when you have a cold?

Nidia: Black coffee with dry ginger and pepper for a cold. So it's just natural remedies. And steam inhalation. So, that's what she tells me the minute she hears my voice change on the phone. And I try to do that. ... Yeah, just this stuff. But otherwise, unless it's really serious, I wouldn't go take medication.

It is evident that for Nidia home remedies are separate from medication, which is a term reserved for prescription drugs or pharmaceuticals. Sirisha draws a similar distinction between traditional remedies and medicine. Having grown up in Hyderabad, Sirisha had been living in Dunedin just over three months at the time of our interview. Thus her narrative centres mainly on her family and experiences in India:

Most my family is very healthy. We don't use most medicines. Generally the common health problems are like cold, cough, flu, like that. We use only the home remedies, not medicines or anything.

While Nidia claims to avoid over-the-counter medication and Sirisha claims to avoid medication all together, several respondents concede that for the sake of convenience, or if the remedies do not provide effective relief, they will resort to using over the counter pharmaceuticals.

None of the participants expressed adversity to visiting a medical doctor when symptoms persist, and all but two are registered with a primary health care organisation. According to the latest report on Asian health in New Zealand, South Asians whom have been in New Zealand under five years are less likely to have access to a primary health care practice than those whom have been here longer (see Scragg 2016, 54). Sirisha and Ray are the only two of my respondents who have been in New
Zealand less than five years, and incidentally the only two who told me they are not registered with a general practitioner. Yet Ray had noticed the posters around the university campus, which had informed him of the student health services and, having come down with the flu, had been for a consultation only days after his arrival in Dunedin. He told me that he found the doctor’s approach quite different to his expectations:

[In Malaysia] we get a lot of medications. Antibiotics, flu medicines ... then I say okay I am not having enough sleeps. Can you give me some sleeping pills or something? So we get a lot of pills and everything. So usually we will get three to four medicines, packets. But when I came here, and I see the GP, I didn’t get any medicine. ... Of course she checked my pulse, my blood pressure and everything. She said you are perfectly all right. You don’t need medicine. ... Initially I was frustrated because my flu’s keep on flowing. So I say quickly give me the medicine or something. But when in the end she made a summary, so I understand okay this is the cultural practice that I have to adapt, which is good for me.

Ray appeared ambivalent about his experience; although he told me that the student health doctor was attentive to his needs and that her assessment seemed appropriate, leaving the clinic without medication was unfamiliar and somewhat frustrating. The doctor had explained to Ray that ‘in New Zealand the way that [we] prescribe medicine is different compared to Asian, because we don’t simply give medicines.’ Although this made sense to Ray, he told me with some exasperation:

Reality is when mom is around I just go and take the water steamed [steam inhalation].

While Ray accepts the doctor’s authority both in the case where medication is given and where it is not, his mother’s home remedy stands out as a simple solution to the whole question of prescription medicine.
The use of traditional folk remedies in conjunction with western medicine that is common among participants in this research corroborates findings from much of the international literature on South Asians in diaspora (Ahmad et al. 2008; Bhopal 1986; Choudhry 1998; Colley 1978; Dyck 2006; Heggenhougen 1980; Hilton et al. 2010; Lim et al. 2005; Rao 2006; Singh, Raidoo & Harries 2004). This pattern of pluralism can be traced back to South Asia, where both western and traditional medical treatment is widely available (see Chapter 3).

My respondents do not necessarily view the recipes passed down from their mothers or their grandmothers as medication, thus it may be a stretch to identify their approach to medicine as pluralist. Yet further inquiry reveals that some of my respondents also visit acupuncturists or naturopaths in Dunedin and, often at the prompting of friends or relatives, many will go for a course in homeopathy, Ayurvedic or Siddha medicine while in India or Malaysia.

Nidia stood out for her tendency to explain health matters predominantly in terms of a western model of medicine. Nonetheless she told me that when she last visited Kerala, she was quite run down and her mother convinced her to go for a course of Siddha medicine.

That's always our first line of treatment if you have a cold or a cough. There is a doctor near my house in India that we would all go to and take like a course of ten-day Siddha medicine from him. And it actually works. It takes about twenty-four hours for it to kick in and show relief. But it does work.

Reyna was born in Malaysia but had lived in many parts of the world before settling in Dunedin. She spoke openly about her use of home remedies and traditional medicine. Although Reyna told me that she and her children have been visiting the same family
doctor since the early nineties, she expresses some reservations about western medicine:

It’s just uh there are so many, you know, the worry about doctors just giving out drugs unnecessarily. I don’t feel that I need to be taking drugs or anything like that if I don’t have to and if there are other ways that I can help myself. I just feel that it’s better for my body because, I haven’t read enough or thought in great detail about this to be able to sort of really justify, make arguments. But it’s just an emotional thing I suppose. ... So, yes I’m just not happy taking drugs if I don’t have to. So if I feel like I’m coming down with a cold or anything like that I take, I find ginger for myself is really good. And of course lemon, ginger and I found cider vinegar... with a bit of honey. Things like that, I try.

She also told me that her family doctor is ‘open-minded’ about alternative medicine:

He knows how we feel about taking medication and, yeah. We've not necessarily discussed the use of ginger specifically. We may have discussed sort of natural remedies. And he’s quite supportive of us trying things if that's what we’re happy with.

Reyna speaks of her doctor’s open mindedness and acceptance of alternative practices, yet she concedes that she has not specifically disclosed what remedies she uses. While none claim to directly discuss their use of traditional medicine with their doctors, several participants voice a general assumption that their doctor would or should understand and accept alternative practices. Kirit’s doctor is from Sri Lanka and—although trained in New Zealand—Kirit suggests that his cultural background would impact how he views medicine. Sukhi takes another angle; she expects that, due to popular demand, biomedical doctors should take an interest in alternative medicine:

Really. Alternative medicine. I mean a lot of doctors now actually try to keep up with it because their patients are actually interested in it.
These attitudes diverge somewhat from findings in studies from Canada and the United Kingdom (Bhopal 1986; Bottorff et al. 2001; Hilton et al. 2010), which explore reports of South Asian respondents feeling patronised or ridiculed when they disclose their cultural practices with health professionals. Although New Zealand boasts a high rate of interest among biomedical doctors for alternative medicine (see Duke 2005), DeSouza’s (2005) interviews with Goan mothers in Auckland reveals that her respondents find little support from health care workers for their traditional maternity practices.

The normativity of a biomedical model of health in mainstream society has been noted in the Canadian literature to stigmatise divergent cultural understandings and ‘perpetuate an imbalance of power between dominant and minority groups’ (Hilton et al. 2010, 554). This biomedical normativity may prevent patients from discussing their traditional practices even with doctors they perceive to be open minded.

While Reyna is ‘not happy taking drugs’ and would prefer to use ‘natural remedies’, she told me of two situations where it was necessary for her to take prescription medicine. Fifteen years ago she took a course of antibiotics to treat bronchitis; and having been diagnosed with lymphatic tuberculosis in 1986, Reyna was on medication for about a year. But for more general health concerns she relies on home remedies; some of which are based in South Asian medicine and others—like cider vinegar—have a western origin.

Sukhi also demonstrates a pluralist approach to treating health concerns that includes a combination of South Asian and western remedies. She used cider vinegar in conjunction with a ‘health potion’ her mother had given her comprised mainly of turmeric to treat a small stomach ulcer. Sukhi had also shared with me a recipe for
‘general good health’ that her parents had emailed to her. She gave me a photocopy of this email\textsuperscript{51}; scribed upon it are hand written notes that outline other recipes for strengthening the prostate and preventing cold sores. These recipes include ingredients such as olive leaf, cannabis oil, and baking soda as well as cumin seed, ginger, and \textit{kalongi}\textsuperscript{52}. There is also reference to a pharmaceutical medication noted at the bottom of the page.

Sukhi told me that she had tried homeopathy to treat hay fever, but this without success. Homeopathy is common in India and Reyna told me that many of her family members ‘swear by it.’ Her mother’s aunt, who is a homeopathic doctor in Kerala, had treated Reyna during a visit to India when ‘the whole party came down with very bad diarrhoea.’ While this treatment appeared to help, Reyna told me that she has not had enough experience with homeopathic medicine herself to ‘have a lot of faith in it.’

But after her daughter’s birth Reyna had suffered a prolapsed uterus and, when visiting her parents in Brunei, she consulted a yoga healer whom her mother had been seeing:

\begin{quote}
Reyna: … and he devised a set of asanas for me that took about fifty minutes. And I would visit and just practise those asanas to make sure that I got them correct and got the…
\end{quote}

\begin{quote}
Me: The alignment?
\end{quote}

\begin{quote}
Reyna: Yes and also all of them in that order, the sequence. I just started doing that. Came back here and started doing that and things went back to normal. My son was conceived and I had a home birth. So.
\end{quote}

\textsuperscript{51} See appendix 2 for a copy of this.

\textsuperscript{52} \textit{Kalongi} (Nigella in English) is related to cumin and also commonly used in Indian cooking.
Reyna demonstrates a pluralist approach to health and medicine that includes not only western and South Asian modalities, but she has also taken her daughter, Lila, to an acupuncturist for treatment of bronchitis. I later spoke with Lila, who reflected on those visits:

... he was just at his house ... and I went a couple of times for my cough, and I don’t know, I was really excited because I just find Chinese traditional medicine really fascinating. I love how they examine your tongue and they can tell so much about that. And I really like the idea of flow and also balance again. But I think it did work. But maybe it was just me like wanting it so much to work. ... But it definitely worked as much as the antibiotics I was prescribed.

On a visit to India, Lila’s ‘amaji’ took her to visit a Vaidya, who prescribed Ayurvedic remedies that gave her relief from what she describes as severe menstrual discomfort.

Simran, who like Lila has grown up in Dunedin, told me that on visits to India with her parents, she goes to a homeopathic clinic when feeling unwell:

It’s just that people strongly believe in homeopathic medicine, Ayurvedic medicine. And for things like stomach pain, like I had really bad stomach pain once. I was vomiting as well. And sometimes like they believe in India like if you have harsh medication it can maybe make you feel worse, so they try to give you things that are softer. So I always go with my mum to the homeopathic doctor in the area.

One of Simran’s relatives has a homeopathic practice in Auckland where her father had been treated while suffering anxiety.

I would visit uncle in Auckland for sure. Just because we’ve seen a lot of people get better with homeopathic medicine.
Simran told me that most of her family in India rely on homeopathic medicine; but not solely—they have a pluralist approach. Her grandmother, for instance, uses homeopathy for arthritis but for 'back pain and a whole lot of things ... she uses western medicine.'

6.2.1.2 Prioritising Treatment

While participants in this research demonstrate a pluralist approach to medicine—which involves not only the use of folk remedies in conjunction with western medicine but also homeopathy and other modalities of traditional medicine—they also tend to prioritise treatment based on the nature of their health concern. Much of the international literature\(^{53}\) suggests that South Asians living both in the Indian subcontinent and abroad demonstrate a general pattern to their prioritisation of treatment; most rely on biomedical treatment for serious conditions—especially where surgery is required—and use home remedies or traditional medicine as a preventative measure or a first approach for general or chronic conditions.

My findings broadly fit this pattern. For instance, Nidia will use her mother’s recipe for treating a common cold, and when in India she will go for a course in Siddha medicine instead of antibiotics to treat a chest infection. She told me that her mother also uses traditional medicine to treat arthritis but her father's heart condition is a different matter:

We know you’re not going to cure heart failure with [Siddha]. If you need a medical or surgical procedure you need to go for allopathic medicine. And we have prioritised that with my dad. For his heart condition, we didn’t choose anything other than allopathy. And we went for the medical check ups and then for the surgical procedure,

\(^{53}\) See Ahmad and colleagues (2008); Bhardwaj (1975); Bhopal (1986); Choudhry (1998); Dyck (2006); Hilton et al. (2010); Izhar (1990); and Rao (2006).
and then surgery follow ups. But minor issues that, you know, you don't go, before you go for these high dose pharmaceutical drugs, you can actually go for something else.

Another example of this pattern of prioritisation can be found in Reyna’s life history narrative. When she suffered bronchitis and tuberculosis, she felt she had no option but to take prescription medication. But for a cold she will take ginger and lemon or use her mother’s recipe for *rasam*. She speaks of her use of home remedies as the ‘little things, which I suppose I just do without thinking so much’. One of these ‘little things’, she told me, was to sprinkle cinnamon in her cereal every morning because she has been told that cinnamon is a good preventative for diabetes, which runs in her family.

In consideration of traditional medicine as a preventative measure, Rajesh highlights the issue of timing:

> My wife has a problem. She’s got uterus fibroids, and somebody came to us and said Ayurveda’s got proper medicine for that. So we called our doctor Josh [a relative who is an Ayurvedic doctor]. He was in Germany again, so my mother called up. He wanted to see all the results, like radiology and all the bits and pieces. ... And he looked at it and said that if it was in the very beginning we could have treated it easily, but since it is all too big we can’t do anything, so it’s better to go down the allopathy, you know the western medicine way, you know surgery and things.

While these narratives suggest that participants generally follow the pattern of prioritising biomedical treatment for serous concerns and traditional remedies for general health problems, the interviews also reveal some interesting discrepancies in just where people draw the line between general or more serious concerns. Ray for example finds relief for insomnia through Indian head massage and uses steam inhalation for the flu. Yet he draws the line at having a fever:
In the case I got fever of course I cannot go to the traditional medicine. I will go for the scientific medicine.

Rajesh on the other hand speaks of the efficacy of Ayurvedic and homeopathic medicine specifically for the treatment of fevers:

... That's basically because what they do is they actually treat the cause ... In Ayurveda they figure out what's wrong, and then they treat that. So it takes some time. Because obviously fever is a reaction to infection, so they find out where the infection is or where the problem is, and treat it. But that thing will take a bit of time to heal. So the temperature will not go down. Same in homeopathy. Homeopathy does this other thing, you know, they only increase your resistance capacity or your thing to fight. So it gives the immune system a boost. That's what they do.

Here Ray prioritises treatment based on tacit and experiential knowledge while Rajesh prioritises treatment based on his learned knowledge of the various medical systems. The reasons for seeking one modality of treatment over another are complex and varied. Minocha (1980, 218) wrote:

It is often assumed that when making a choice, people are fully aware of the underlying ideologies of these systems. I.e. that they make a conscious choice based on substantial knowledge about the distinguishing and distinctive characteristics of the various systems. However, a closer view reveals different levels of information ranging from full knowledge about one or more systems to very superficial if not distorted notions about all or most medical systems. People’s knowledge about medicine and health is actually a total of fragments of beliefs and practices found in diverse systems.

The costs involved in treatment may be another factor upon which people base their choice in medicine. Home remedies can be cost effective for treating or preventing general health concerns. But in New Zealand there is limited availability and limited
subsidy for non-biomedical modalities of treatment.\textsuperscript{54} Thus the costs of visiting a traditional medical practitioner may be restrictive for some people, further complicating notions of choice.

6.2.1.3 Notions of ‘Safe’ & ‘Natural’

Another factor that appears to motivate choice in medicine is the perceived risks involved in treatment. Participants in this research speak of traditional medicine as natural, safe and having fewer side effects than western pharmaceuticals. Similar findings have been cited in the international literature (see Bhopal 1986; Dyck 2006; Hilton et al. 2010; Rao 2006).

The term ‘natural’ is a slippery one in the social sciences, because it indicates something that is unaltered by human interference. Several of the people I spoke with use the term ‘natural’ to describe traditional or homeopathic remedies. For example, Nidia told me it is ‘just natural remedies’ that her mother recommends she take for a cold; Simran refers to homeopathy as ‘the softer, natural medicine’; and Reyna told me that she may have discussed her use of ‘natural remedies’ with her doctor, but nothing specific.

Sirisha contributes to this discourse not by naming home remedies as natural but identifying them as non-chemical. When I asked her why she prefers to use home remedies to pharmaceuticals, she answered me thus:

\begin{quote}
Um. Maybe because the home remedies is not the chemical ones. And it's good for health. We prepare all with spices. Those are really good for our health. So instead of the medicines which are prepared with chemicals and everything.
\end{quote}

\textsuperscript{54} See Chapter 1: section 2.
Food and medicine are intricately linked for many of the participants due to the medicinal qualities of culinary spices used in Indian cooking. Sukhi told me that she has developed an interest in learning about the specific properties of culinary spices, and that she views good health largely in terms of the dietary choices people make. Indicating what could be defined as natural, but again without using the word itself, she speaks of organic, non-processed and whole grain foods as preferable to off-the-shelf packaged foods from the supermarket.

... We are actually very conscious of the fact that the nutrition that is taken out of processed foods. You know my mother's always actually said whole grain bread is better, chapattis, you know they tried to actually make sure that they have the whole grain in there. And they won't actually take out the nutrients. And everything that you actually eat these days, if it's processed, you just don't know the additives.

While the idea of optimal health seems to be at the centre of Sukhi's narrative on whole foods, she also expresses some concern about the ill affects of ‘additives’ in processed foods. This mirrors Sirisha’s concerns about the chemicals in pharmaceutical medicines. Kirit, who manages an Indian restaurant in Dunedin, expands on this discourse; his main concern is whether the medicine he uses will be harmful or safe. When I asked him if he would use traditional medicine were it easily available here, he responded thus:

Of course. Yeah. Because most of them are harmless. When there's like side effects wise, it's not that harmful as say in allopathic medicine some of the antibiotics. Like penicillin, you are allergic to penicillin, or you are allergic to say sulphurs, if you happen to take that you end up in big trouble. You know. That way Ayurvedic medicines are mostly safe. Unless you took in very large quantity without like considering, that's the only problem. If you take in the right dose there is not a side effect. If it does not, does not work, but it wont give you a side effect. But with allopathic medicines you end up in big trouble if you end up with the wrong ones. Sometimes those toxins they give you trouble for months.
Sukhi visited her doctor complaining of pain in her fingers. She was prescribed painkillers that her husband, Glen, identified as a medication commonly taken by athletes. He told her this medication is very bad for the stomach. Sukhi was stumped:

I said why would she give me a whole thing of these?

Reyna told me that when her children were young she was wary of giving them medication because they had experienced negative side effects with antibiotics:

It definitely affected their gastro, their stomach … and so I try and give them yoghurt and things like that to put the good bugs back into their stomach. … It strips the good bugs. Also, I don’t know, and again I cannot justify this with studies or anything, but I’m under the impression that… well I feel that I’d rather allow my body to fight, uh learn to deal naturally with illness. And I believe that if it gets used to antibiotics, medication, then that ability is weakened. … I’d like my immune system to have all the advantages it can. And by limiting my use of medication, I believe that that’s good for it.

The side effects of western pharmaceuticals are also a great concern for Lila, who responded in no uncertain terms when I asked how she feels now about taking medication:

I don’t. Just basically I don’t. Even when I have my period and when it’s really terrible, I’m extremely reluctant to even use painkillers. And I haven’t been to the doctor in about four years. Last time I went I had a urinary tract infection. There [were] a couple of things. I had a urinary tract infection and they prescribed the wrong antibiotics twice. And I also had to take the ECP, … which is the morning after pill. And I gained a lot of weight, and I knew it was from that. Because I can tell, it’s my body. … And then they said ‘you don’t gain weight from this.’ And I said ‘no I’m sorry I did gain a lot of weight.’ And they said ‘no, that’s not one of the side effects.’ I’m like ‘I’m sorry but no.’ … Why won’t they just trust that you can know your own body?

Her exasperation with the medical establishment is apparent throughout my interview with Lila, and her interest in traditional and alternative medicine is a clear example of
resistance to the biomedical authority that she rails against. While this is not expressed so clearly among other participants, traces of such resistance can be found in the way that they tend to contrast the safety of natural remedies with the dangers of biomedical side effects.

6.2.1.4 Body & Mind

Ruth DeSouza (2015, 33) qualifies mental health as ‘a specialty in health where culture comes to the fore as it so strongly shapes how mental illness is understood and treated.’ Thus a universal approach to mental health that neglects to consider cultural difference has become a serious topic of debate in recent literature on medicine and multiculturalism. Although the issue of mental health is not central to my research, it is of notable interest that participants tend to discuss their view of optimal health in terms of a balance—both physically and mentally. For instance, when I asked Lila to broadly describe what being healthy means to her, she told me:

For me, it's a balance between body and mind, and also, yeah, just your situation; like where you are in life. I would say it's all of those things. I wouldn't locate it just to the body.

Me: And so … what about being ill? How would you define that?

Lila: I would also say it's not just located in the body. But that's probably where the symptoms [are]. For me personally, if something is going on for me emotionally or I feel like imbalanced, it will express itself through my body, definitely.

Simran and Nidia also expressed their understandings of health in terms of an interconnection between body and mind. Simran talked at length about how mental

55 See for example the multiple articles in ‘Pathways to Better Mental Health: Overcoming Barriers, Exploring Reform, Creating Constructive Solutions.’ Australian Mosaic: The Magazine of the Federation of Ethnic Communities’ Councils of Australia, PP229219/00162(1447-8765), Spring 2015.
stress can impact on physical health; and for Nidia to be healthy is to be both physically fit and 'mentally or emotionally stable':

You should have a sense of calm or peace of mind and be able to relate psychologically to day-to-day things [without] being stressed and upset. And numbers don’t mean anything like in terms of height, weight, your body measurements, as long as you’re fit, mentally and physically. ... I think all aspects counts: mental, physical and your social well being as well. In terms of whether you are isolating yourself or you can actually interact with others. So, when there’s a balance of all those aspects you’re well. But if there’s some imbalance there, then I count it as you aren’t well. Or ill.

These attitudes towards health and illness somewhat align with Khare’s (1996) holistic depiction of eastern medical traditions, where diagnosis and treatment tend to acknowledge an interrelationship between the physical body and ‘environmental and climate factors, psychological dispositions, and moral and spiritual states’ (Khare 1996, 838). Participants in my research do not discuss a connection between health and spirituality or morality but do emphasise that their states of mind may influence their physical health:

So how do you actually ... balance wellness of mind of body and spirit? That’s very important, I think. I think a sunny nature usually is a good indication of keeping you pretty healthy. Being more positive about things. I think you can get negative. And negativity I think can sort of, you know … (Sukhi)

In a study that interviewed psychiatric out patients in Bangalore (Raguram et al. 1996) the authors surmised that because mental illness carries social stigma in South Asia, there is a tendency for people to express their distress in somatic terms, or physical pain. Nidia works in the mental health sector and spoke with me about cultural stigma within the Indian community surrounding issues of mental health. She considers herself
fortunate to be from a liberal family and views her occupation as unorthodox for someone from her cultural background:

‘In more orthodox countries like India and parts of Southeast Asia, they are very reserved. They are very high tech in all the general medical surgical aspects. But nobody wants to seek mental help for their mental issues. ... Coming from a country that sort of is in denial of mental health, I think ... to work in mental health is considered, I don’t know if you call it a taboo, but it’s a very challenging decision to make ...’

Literature that investigates South Asian mental health in New Zealand (see Ho et al. 2003) and abroad (see Raguram et al. 1996; Giebel 2014) agrees that there is an under representation of help seeking among South Asian migrants. Corroborating Nidia’s narrative, these studies have commonly found that social stigma surrounding mental health issues can be a significant barrier to help seeking. However, Penny Antonopoulos (2015, 28) reminds us that ‘all communities experience stigma, whether we look at the dominant culture ... or people from CALD [culturally and linguistically diverse] background.’ Of issue is whether culturally sensitive resources are available to those who do seek help.

Although I did not encounter reluctance from participants to speak of their own experiences of depression or anxiety, none discussed remedies used specifically to treat these conditions. Simran told me that she had always been quite anxious. When her uncle was diagnosed with cancer it came as a huge shock and her anxiety increased ‘beyond [her] control’. She told me that she had been to see a councillor who assisted her through this difficult time. When I apologised for raising a topic that may bring her discomfort, Simran responded with candour:
No. I’m proud of the fact that I got over it. So I don’t mind talking about it. If somebody asks me you know if you went through that, I go yeah I did. But I’m proud that I got out of it.

6.2.2 Messages

In the following sections, I explore some of the more unique narratives that diverge from the broad themes I had anticipated; and I draw from these narratives several distinct messages that denote some of the particular views and concerns expressed by my research participants.

6.2.2.1 ‘Losing our tradition’ (Ray)

Ray is a post-graduate student currently living in Dunedin. He grew up in a Malaysian village and moved to the city of Serdang for his undergraduate studies at age nineteen. Reflecting on his own experience, Ray highlights a marked distinction between urban and village life in Malaysia. He tells me that western medical clinics are easily accessible throughout Malaysia. But in contrast to Colley’s (1978) observations56, Ray’s stories indicate that traditional medicine—which is popular among villagers—is rarely utilised by people of his own generation in the cities.

Because I lived in village, so I know some of the old ladies. You know what they will do; they will have all kind of plants. So like avocado, and I don’t know what they call it because we know it in our own language. So they have so many plants. So they use their plants to make medicines with. ... They live their life with herbal medicines, traditional medicines. ... Now my generation, because once we move to the city and everything, I think we don’t really bother about it. When we see the plant we think oh yeah last time we used it but I don’t remember what for I used that plant.

56 Colley (1978) observed that traditional medicine had, at the time of writing, been gaining popularity in urban Malaysia.
Ray considers the fast pace of city living to be one of the reasons traditional medicine is losing popularity with the younger generations:

I think the lifestyle of the current generation [is] changing the perception. Example like if you move to the town, and if you’re living in urban city, first we don’t have that much facility to access the traditional medicine. Second thing is traditional medicine sometimes is costly compared to the scientific medicine. Scientific medicine you can get cheaper. And third thing is I think the current generation is not, uh, they want actually everything to be fast.

Sirisha, who is from Hyderabad, also considers that in India there seems to be a generational shift away from the use of traditional remedies and towards a greater reliance on western pharmaceuticals. This, she thinks, is a result of the stress levels inherent to what she refers to as ‘the work culture’:

Maybe because of the stress we need very fast relief. And we can't spend at least maybe one day at home, without going to work or without doing anything. So we have to find the western medicines that will give immediate relief.

Rajesh, whose great uncle was the principal of the Ayurvedic College in Trivandrum, demonstrates in-depth knowledge of both Ayurveda and homeopathy. He concedes that neither give instant results and he describes lengthy processes of healing which involve, according to Rajesh, a ‘very strict regime of doing things’ that does not fit the pace of modern living:

... the way you eat, what you eat and the way you do your day-to-day stuff. Right from going to the toilet, sleeping, all these things. And you have to rub in a lot of things on your body. ... And then some of them has a very bad smell, stench, as well. Some of the oils you rub on.

These narratives contribute to the argument that traditional medicine does not suit the high-pressure demands of a modern lifestyle. Yet Ray makes the point that retaining
some cultural knowledge of traditional remedies would enable him to be more self-reliant, which is important to him whether living in urban Malaysia or here in Dunedin. He expresses regret that he did not pay closer attention to the recipes his elders used to prepare for him:

I always depend on my parents or my mother in law. I mean the elders in the family. ... I didn’t learn how to cook the way my mother or my mother in law used to do, because we always pampered at home. But when I came here I realise I think that are the things actually to keep you live your life even in New Zealand. If you’ve flu, then you can make the simple remedial medicine by yourself. Just drink, and you will get a good sleep and all that. But we used to do rely on people and we rely on scientific medicines. So we came here we always choose the fastest option, which is scientific medicine. Go and see the GP to get medicines.

One of the remedies that Ray’s mother had used to pamper him when suffering from the flu is called rasam. Several participants spoke of this concoction, which is comprised of numerous culinary herbs and spices boiled up in varying combinations often with curry leaves and a tomato base.

And you have to take two or three cups, small cups. So after that you can see your head is feel light and your, all what do you call the flu, the flows, it runs faster. Then you will get more fluids is coming out.

Ray told me that rasam also acts as a digestive agent and is commonly served along side the meal in restaurants throughout Malaysia.

It’s a very simple, one of the simple meals. But they supposed to give you, example when you are ordering a lunch, of course they give all set of meals with vegetables, curry, you know all that. But this is one of the items supposed to be there. Once you finish your meal, if you take the rasam it will actually to make you digest faster. It’s some kind of like cleansing water for your tummy.
Ray also told me that in New Zealand you would not find rasam on the menus of the Indian restaurants; and he views its exclusion from the standard lunch platter as another example of how traditional medicine is dying out:

... It’s very sad to say but we Indians, we forgetting thing which is how our ancestors designed. Even the meal is designed for your health purpose. So you hand up a meal with this [rasam]. But we are not doing that. Yeah, that’s a problem. That is one of the major things why we are losing our tradition.

6.2.2.2 ‘Indian cooking is the best Ayurvedic medicine’

(Rajesh)

If somebody’s gonna come and ask me, do you follow Ayurveda? Uh, no—but yes. Do you know how? Because no: in the sense like I don’t have Ayurvedic medicine stacked in my house. All right? But the Indian cooking is the best Ayurvedic medicine. (Rajesh)

A common misunderstanding I encountered when seeking participants for this research was that, because I wished to talk about health and traditional medicine, prospective participants expressed concern that they did not have a medical background. I had to explain that it was their own day-to-day experience of health and their use of herbal remedies that I was interested in talking about.

I do not expect my informants to necessarily share my academic interest in the health practices that are largely inherent to their life-worlds. My textbook research has offered me some insight into the interconnection between Indian folk practices and the scholarly systems of Ayurveda, Siddha and Unani medicine.57 I learned that botanical herbs and spices—many of which are used in Indian cooking—are essential ingredients found in folk medicine and Ayurvedic pharmacopeia. I have entered the field with some

57 See Chapter 3.
presumptions based on the research I had done. Through my fieldwork, however, I am trying to reach the tacit, deeply rooted cultural understandings of my participants; and what better doorway can there be into the realm of tacit knowledge than the subject of food?

Lila and Simran are both second-generation to New Zealand and they both express a similar sentiment; food is important to their cultural identity. Lila is the daughter of Reyna who was born in Malaysia and had migrated to New Zealand in 1989 with her Kiwi husband. Lila told me that although she does not have a tangible connection with a South Asian community in Dunedin, she always feels like smiling at Indian people in the street.

I feel growing up, I’ve had more of an influence, even though I’ve been based here; my family influence has been the Southeast Asian influence, rather than the western influence.

Lila’s grandmother had taught her to cook.

... For me, cooking and food ... we all come together as a family around food, and for me it just is equated so much with my Indianness.

Simran, a nineteen-year-old student who has lived in Dunedin since a small child, told me that unlike her sister (who had always been concerned with fitting in to New Zealand culture), learning to speak her parent’s native tongue was important to her. But despite the fact that Simran’s parents continued to speak Punjabi at home in New Zealand, she

58 I use the term second-generation to indicate those who have grown up from childhood in New Zealand. While Lila was born in Dunedin, Simran was born in the United States, and came to Dunedin at eighteen months with her parents who had both grown up near Calcutta. Each of my other participants were born either in India or Malaysia, and migrated to New Zealand as an adult.
had found it difficult to retain the language herself. Simran had managed, on the other hand, to retain the tradition of her mother’s south Indian cooking.

I think food is just a little bit easier to hold onto, ‘caus you don’t have to put a lot of effort into it. Whereas language, you definitely have to put a lot of effort into retaining and, you know, learning and speaking and understanding.

While both language and food are important to her cultural identity, Simran makes an important distinction between ‘holding onto’ the ability to cook traditional meals and the ability to speak Punjabi. The knowledge of food is intricately connected with the visceral senses of taste, texture and smell. Thus it is no wonder that retaining knowledge around cooking, for Simran, involved less effort than language.

While the subject of food may be a splendid entry point for accessing tacit cultural knowledge during the interviews, the expectation that each participant would divulge explicit knowledge of the medicinal properties of the herbs and spices that go into Indian cooking is another story. When Gill (2010) had interviewed Indo-Fijians about their use of household remedies, many of her informants at first denied their use or appeared ‘not even conscious of them’ (2010, 77). She notes that what appeared to be incognisance arose from a tendency not to compartmentalise health-seeking practices. This phenomena is consistent with findings from studies of South Asian migrants in the United Kingdom and Canada, where the use of herbal remedies is so integrated into daily life that it is not considered a ‘health practice’ per se (see Bhopal 1986; Choudhry 1998; Hilton et al. 2010). Indian cooking is one of those areas of daily life where the tacit knowledge of health is lived.
All of the participants in my research claim to cook mostly Indian food at home. I discovered that, with the exception of only one, they also to a greater or lesser extent do consider the health properties of the spices used in their cooking. Nidia stands out because where the others appear somewhat sentimental in their attitude towards traditional Indian food, Nidia is matter-of-fact about the unhealthy aspects of an Indian diet:

... every type of cuisine, you have your good choices and your bad choices. Like in India probably the excess ghee, yes it’s a pure form of oils and fatty acids, but you can abuse it as well. ... Too much of spice is also not good for your gut.

She had visited a naturopath in Dunedin who gave her some dietary recommendations, which included cutting down on carbohydrates:

Because you know Indian cuisine is actually carbohydrate loaded. It's very high. From breakfast to dinner, the carbs are really really high. So I’ve just gone for alternate choices. And fortunately I can survive not having traditional meals for all my three meals. I just like to go for alternate high protein sources and cut out the carbs. And I've survived one month without rice, without any Indian breads. So, yeah, I haven’t eaten any for four months. So I think I’ve done pretty well.

Nidia went to a British boarding school in Tamil Nadu where, she tells me, she grew accustomed to European food. Much of Nidia’s narrative suggests that she adheres predominantly to a western approach to health and diet. Her attitudes towards nutrition are unique among the people I spoke with. She does not express awareness of the medicinal qualities of the culinary spices used in Indian cooking but focuses rather on the fatty and high carbohydrate elements of Indian cuisine. She speaks of a traditional Indian diet as a risk to her health. This prioritisation of what is typically a western construction of nutrition over indigenous knowledge leads me to reflect on the recent
study by Hannah Jennings and colleagues (2014)\textsuperscript{59} who highlight the way authoritative health messages tend to eclipse traditional knowledge in migrant communities.

Nidia told me that although she is not ‘die hard’ about needing to eat Indian meals three times a day, she does cook Indian food at home, mixing fresh spices from scratch as her mother had taught her. But even while she claims not to think about the medicinal qualities of the spices she adds to her meals, she will add dry ginger and pepper to her black coffee when she has a cold, as her mother had also instructed.

The way in which Nidia separates the nutrition in her daily meals from the remedial qualities of her mother’s home remedies also stands out among my informants. The conversations I had with most of the others about food tended to centre on the medicinal properties of the spices used in cooking, with the narrative crisscrossing back and forth between traditional dishes and traditional remedies. Spices such as turmeric, black pepper, ginger or cardamom were central to the discussion. To exemplify this, here is an excerpt of my conversation with Sirisha:

Sirisha: Do you know that Indian curries, they will put so many spices in Indian Curries. Like eh, mustard seeds. Do you know the mustard seeds?

Me: Uh huh.

Sirisha: Cumin seeds. Turmeric powder. And spices like chilli (pause) and so many other seeds. Cardamom seeds. Do you know the cardamom seed?

Me: Mmm. Cardamom seed is beautiful. I put it in my coffee.

Sirisha: Oh. And fenugreek. That’s very good for health, the fenugreek. It’s a bitter taste. And do you know the fennel seeds? And yeah we use all those. Poppy seeds?

\textsuperscript{59} For more on this study see Chapter 2, pages 26-27.
Me: Yes.

Sirisha: Coriander seeds?

Me: Yes coriander. And lots of ginger as well?

Sirisha: Yeah and garlic. And all these are good for health. We'll put all these in our regular daily curries so those really get really good health for us. So maybe because of that reason we don't get unwell frequently.

Me: That makes sense to me. A lot of them are good for digestion I think.

Sirisha: Yeah digestion.

Me: And then turmeric is...

Sirisha: Antibiotic.

6.2.2.3 ‘Mum’s recipe for general good health’ (Sukhi)

Although explicit knowledge of the remedial effects of ingredients used in home remedies varies greatly between the people I spoke with, each participant has shared with me at least one recipe that was passed down from their mother or grandmother, and of which they have experienced remedial efficacy.

When I first discussed my research project with Sukhi on the telephone, she told me she would be interested in participating because she has recently been taking a tonic that her mother had recommended, and she was having success with it. During our interview at her home in Wanaka, I asked her about this tonic:

Well, yes you know because I said I have this sort of stomach thing. So dad sent an email and said ‘this is mum’s recipe for general good health.’ And so it’s a mixture of ginger, garlic—juice basically.
Sukhi produced a large bottle of a milky-yellow liquid and offered me to try a tablespoon of the tonic. It was a potent blend of sweet, sour, bitter and spicy. The taste was strong, but I found it delicious! She later photocopied the recipe for me, which I have included in the appendices.\textsuperscript{60} The recipe consists of copious amounts of ginger and garlic that have been juiced to produce a cup each. The juice of limes and vinegar are added and this is boiled down for half an hour before honey is mixed in. Sukhi regards this as a general tonic but has been using it specifically for a stomach condition.

As I mentioned earlier, a popular remedy among participants is called \textit{rasam}. Rajesh suggests that it is a mainstay of Ayurvedic medicine:

\begin{quote}
Rajesh: So, am I using Ayurveda, yes I am. Because you know like every time, whenever I’m not feeling a hundred per cent, I’ll get this dish called rasam. Have you heard of rasam?

Me: I have. It’s a drink after a meal?

Rajesh: You can if you want to, or you can actually pour it along with your rice, like sambar and rasam. You pour it along, eat it and…
\end{quote}

Ray had told me that I would be hard pressed to find \textit{rasam} in Dunedin but if I asked the cook at K. L. Aroma on George Street, he might make it for me. When I went for a meal at the restaurant I did ask but the cook told me that, although they do make \textit{rasam} on occasion, it takes too long to prepare on demand.

The precise ingredients for making \textit{rasam} vary, but my informants all describe it as a broth or gravy into which a number of culinary herbs and spices have been boiled. Ray tells me it is a very simple recipe:

\begin{footnotesize}
\footnote{See appendix 2.}
\end{footnotesize}
They will use water, two spices with curry leaves and they can use some tomato.

Rajesh expands on this, considering the medicinal properties of the spices and the recipe’s link to Ayurvedic medicine:

Black pepper, garlic, tomatoes and coriander. See the combination. So that’s black pepper, garlic, are two basic things of Ayurveda, you know like things that are used a lot in Ayurveda. Along with tomato and coriander. Coriander’s also got a lot of medicinal values to it.

Reyna told me that her mother gave her the recipe for rasam and she has in turn passed it on to her daughter. This was her mother’s recipe:

So she’s got a version of rasam that uses cumin seeds, black pepper, lemon zest. Not lemon zest but lemon juice. Asafetida. And it’s a very potent mix. You boil it together and drink that. And that really helps. ... If you have curry leaves you can throw those in too.

Reyna also adds ginger to her rasam. Her daughter, Lila, is partial to her grandmother’s rasam but recalls a different set of ingredients from what her mother had told me:

My amama has this rasam recipe for colds, and I drink that all the time. And I also drink a lot of ginger. Ginger tea. But the rasam recipe also has curry leaves and fresh turmeric, and ghee, and chili, and pepper. It’s really good. I definitely feel like that makes a difference.

Turmeric and black pepper are also popular among my informants for their remedial qualities. Reyna told me that she buys fresh turmeric from the Indian grocers and uses this along with ginger to make a tea:

... Turmeric is very good. ... I know it’s antiseptic, it has strong antiseptic properties. And I do know that in India it’s used for all sorts of things. Also for young women, if you use turmeric, it stops hair growing I believe. So if from the time you’re quite
young, you apply turmeric paste to your under-arms and upper lips and so on, I'm told. ...

Ray also identifies turmeric as an antiseptic. He told me his mother uses it to wash the vegetables:

... So because she will always say like in case the, because we go to the market, there's so many hands touched the vegetables. And of course there's any bacterias or whatever. So if you clean with turmeric water, so turmeric water's of course the antiseptic, you carry the antiseptic things. And even if you get injured, a little small injuries in your body, so we use turmeric to just wrap it ...

Sukhi recalls her mother rubbing turmeric into her open wound after an accident involving a bicycle when she was a young girl of eight or nine:

So this was quite an open wound. So my mother actually said 'I haven't got any savlon' or whatever. So she put turmeric in it. ... So turmeric is, you know, an antiseptic.

Kirit also talks about the efficacy of turmeric. He speaks of combining it with ajwain\textsuperscript{61} to make a paste for applying to the chest and back for treating a cough or common cold; and Sirisha told me her grandmother used to boil milk with turmeric and pepper:

 Uh, generally if we are suffering with cough, my grandmother used to prepare some milk. Just you add some turmeric, and pepper, and you boil the milk with those two. And you filter those and you drink warm milk. So it will clear your throat and it will give relief from cough and cold.

The recipe Nidia's mother gave her for the common cold was another simple combination of pepper and ginger; only Nidia took that in her coffee. Simran told me that she also uses pepper for a sore throat or a cold, and that she shares this remedy with her friends in Dunedin:

\textsuperscript{61} Ajwain is of the same family as caraway.
... I mean, my friend fell sick she had a cold, a sore throat, and my mum will always give me whole pepper, like six or seven, and really hot tea. So I bite the pepper then I'll have the hot tea. And that kind of does something in here [pointing to her throat] that makes me feel better. So that's the remedy I give my friends.

Rajesh also stresses the remedial efficacy of the peppercorn, and shared with me this anecdote:

... My sister's father in law is a big fan of these peppercorns. So, you wouldn't believe like in the evenings when he having a cup of coffee, he'll have a coffee and take a slice of bread and pour some fine-grounded pepper on that and then eat it. I say why you want to do that? He said like somehow I want to make sure that I'm having a certain amount of pepper going into my body system every day. It kind of gives me the whole you know thing to fight. And I've noticed that the entire family will be down with viral fever, he doesn't get it. Viral fever is extremely contagious you know? He doesn't get it. So all those type of contagious things, do you know those contagious things you can get in the eyes? There was like one time everybody had it in the house. He didn't get it.

6.2.2.4 ‘But without education, they know so many things’

(Sirisha)

In a Canadian study, Hilton and colleagues (2010, 564) found that passing down traditional health knowledge to younger generations provides, for their South Asian informants, a way ‘to preserve health and culture within the family context.’ The researchers also observe that the more integrated into western culture, the less likely were their respondents to rely on traditions from their homeland. While elders traditionally pass down health knowledge to the younger generations, schooling and other modes of enculturation facilitate a shift in traditional roles whereby the younger generations tend to educate their elders in western ways (see Dyck 2006).

I found however that several of the participants in my research—especially those who are second generation to New Zealand—expressed a wish to retain their cultural
knowledge in regards to health. The majority of these participants have lived in New Zealand for many years and, although they rely on traditional medicine to varying degrees, together they demonstrate a plethora of knowledge about the preparation of traditional remedies and the health benefits of the ingredients that go into these preparations.

Sirisha, who is a thirty-year-old computer software technician, migrated to Dunedin with her husband only a few months before I met with her. During our interview she handed me a list of twenty-six medicinal culinary herbs and spices. She had translated these from her native tongue to English as to make easier reference to them when speaking with me. She also handed me a list of recipes passed on to her by her grandmother; and she proceeded to demonstrate a wealth of knowledge about the remedial qualities of the culinary spices she uses in these remedies. When I noted that Sirisha’s seemed to have a lot of knowledge and asked if she had done some research, she responded thus:

No actually, uh, it’s not the research ... after my schooling I started my computer science education and ... I can say I’m almost addicted to computer. ... So, whenever, if someone says like this bla bla bla, I will go and search. What is this? Is it true or is it false? Is there any specific reason behind that? So I started like searching more for everything. So the same way, when I discussed with my mother or with my grandmother about something, then I will start searching. And if I find any specific reasons for that, I will discuss with them and say oh there is this reason for this, there is reason behind this. So that’s why you are doing. Then my grandmother says ‘we don’t know all those things. We are doing because my grandmother said to me that you had to do like this. So that’s why I’m doing. I don’t know all this.’ So, but my mother is too very eager; ‘oh is there, is there reason behind this?’ Oh then for everything, if my grandparents are doing something that means there is some

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62 See appendix 3.

63 See appendix 4.
goodness, there is some good thing is there. So, she realised. And maybe because of that reason I'll follow the same things for my daughter also.

Sirisha’s narrative brings to light an interesting angle on Dyck’s observation that traditional roles reverse when younger generations educate their elders in western ways, becoming ‘conveyors of “new” food [and health] knowledge’ (2006, 9). Sirisha uses the Internet as a tool to confirm or verify the efficacy of the tacit knowledge passed on by her elders, and then offers her discoveries back to them in the form of ‘new’ knowledge:

... whatever they are doing, I started searching why is it useful or not. Is there a scientific reason behind that. So once I started searching I feel very impressed, oh my god, there is a lot of scientific reason. But they don't know the scientific reasons. But they are doing without knowing.

While (inadvertently) borrowing from a biomedical discourse that suggests efficacy should be measured by scientific standards alone64, Sirisha’s narrative simultaneously tends to subvert biomedical authority through reaffirming indigenous knowledge. She also distinguishes tacit from explicit knowledge, telling me that the reasons many people use traditional remedies are rooted in sentiment rather than education:

But with out education, they know so many things ... So if they say it's sentimental how to do, everyone will do. In India, especially like Asian countries, people believe the sentiments. Yeah so the grandparents and the older generations will tell it's sentimental for us. You have to do this.

Reyna, who works at the university, draws a similar distinction between emotion and reason in relation to health knowledge, and expressed some uncertainty when she

64 See Chapter 1, especially section 2.3: status, stigma and subsidies.
described her proclivity to use natural remedies and to shy away from prescription medication:

I just feel that it’s better for my body because, I haven’t read enough or thought in great detail about this to be able to sort of really justify, make arguments. But it’s just an emotional thing I suppose.

6.3 Discussion

Biomedical discourses are authoritative. This is a topic of concern for many critical medical anthropologists. Some address how this authority can eclipse patients’ experiential knowledge of their own bodies and how patients negotiate their autonomy through appropriating biomedical practices and categories that fit their cultural world view and resisting those that do not (see for example Rapp 2007; Kleinman & Kleinman 2007).

The South Asian participants in my Dunedin study negotiate biomedical authority and express their agency in various ways. Ray, for example had expressed a subtle form of resistance when his expectations were not met by the student health services. He had expected the doctor to give him medication for the flu because—in his experience—that is what an allopathic doctor in Malaysia would have done. Although he understood the reasons the student health doctor gave him for withholding prescription medication, his unmet expectation was punctuated with this exclamation:

... when mom is around I just go and take the water steamed.

This vignette captures a complex state of affairs; although Ray does not resist the authority of the doctor, he proclaims his mother’s remedy as a sort of resistance to the
confusion that arises because the doctor's advice does not meet his expectations of biomedical treatment.

Participants who conscientiously discuss their health care choices—and perceive western pharmaceuticals to produce unwanted side effects—express their agency through opting for ‘natural’ remedies they believe to be safe and, as Sirisha claims, ‘really good for our health.’ To a large extent they associate the ingredients used in home remedies with food rather than medication. Sukhi’s narrative on healthy food choices highlights this understanding; she views good health in terms of the dietary choices people make; and she told me that her ideal is to ‘live off the land’—keep chickens, have a garden and eat organic, slow cooked foods:

We try and grow as much of our vegetables as we can. ... and I think that having a balanced life, I think that these things come to people when you have time to reflect. And in the sort of hurly burly of modern life, sometimes it's not possible. Especially when you've got kids and you're sending them to school. And you've got so many things to tend to that you don't have time for your backyard garden.

Like food choices, health treatment choices can also be influenced by this 'hurly burly of modern life.' There is consensus among my participants that traditional remedies do not offer the fast relief of western pharmaceuticals; still they appear to be a popular first choice for treating general health concerns. The reasons for choosing a given paradigm of treatment are complex and varied. While many participants claim to use ‘natural’ remedies because they are safe and do not produce unwanted side effects, some of the narratives outlined in this chapter give cause for me to consider the use of traditional remedies, for some, as a sort of resistance to the modern, fast pace lifestyle that is symbolically linked to a western approach to medicine.
This is most evident throughout the narratives that reflect on the loss of traditional knowledge. Rajesh had told me that he has lost confidence in modern Ayurveda because its medicine is no longer prepared in the traditional ways, which involved lengthy and elaborate processes. Ayurvedic preparations are now mass-produced and the modern modes of production are modelled after biomedical pharmacopeia (see Bode 2002). Yet Rajesh finds that the efficacy of traditional medicine lives on in some of the more simple preparation of the foods he eats and the remedies prepared at home from the spices used in Indian cooking.

While there is some consensus among the participants that traditional medicine does not suit the high-pressure demands of a modern lifestyle, the use of home remedies offers a way to be self-reliant and attend to general health concerns without necessarily interfering with the day-to-day flow of life by making visits to the doctor. Ray expresses regret that he did not pay closer attention to the recipes his elders used to prepare for him, and he perceives a loss of this traditional knowledge among the younger generations.

In Chapter 3, I discuss how traditional medicine in South Asia has come to stand as a symbol for cultural or national identity. Manasi Tirodkar (2008) attributes the popularity of Ayurvedic medicine in contemporary India to a need for culture remembrance after colonisation—and later globalisation—has threatened the loss of traditions. Lila and Simran—who are both second generation to New Zealand—express some nostalgia for traditional medicine that echoes this; they articulate a certain imperative to hold onto their cultural heritage for the very reason that if they do not, it may be lost.
Hilton and colleagues (2010) assert that the more integrated into mainstream society, the less likely South Asian migrants are to rely on traditions from their homeland. Although my research is too small-scale to either support or dispute this finding, Simran’s narrative complicates the assumption that second generation migrants are necessarily more integrated than those born overseas. Speaking for herself and her second-generation South Asian peers, Simran tells me:

... we're very Indian compared to what people think, you know, how we would be. I mean when they hear our accents and stuff, and they see the way that we dress, they think that we're very westernised and stuff. And then they'll see us like the types of things that we're interested in, you know, our medicines and the food that we eat; it’s all very much like our parents. So we're very much like our parents in that sense.

Simran’s narrative highlights a loyalty to some of the traditions embedded in her cultural heritage, and exposes resistance to being categorised as ‘very westernised’. It is evident from our conversation that her use of homeopathy, traditional remedies and her knowledge of the medicinal properties of the spices she uses in Indian cooking all contribute to Simran’s cultural identity.

Kirmayer (2004, 44) asserts that ‘healing practices address core values and concerns in which individuals and communities have a profound stake.’ The universal approach to health in New Zealand—that prioritises biomedical treatment through government subsidies—is premised on assimilationist discourses that do not address many of the core values and concerns present within a rapidly growing diversified community. The narratives of my South Asian participants demonstrate how traditional health practices that are used in the home are not only effective for treating some general health concerns, but may also offer some autonomy from the hegemony of biomedical authority.
Chapter 7: Conclusion

Many critical medical anthropologists argue that explanatory models of health and the body are culturally mediated and that—despite the preeminent position western biomedicine holds on a global scale—the biomedical ‘epistemological tradition is a cultural and historical construction and not one that is universally shared’ (Kleinman 1978; Hahn & Kleinman 1983; Scheper-Hughes & Lock 1996, 45). Among differing cultures are diverse ways in which health and the body are understood. The central questions that have inspired this research attend to whether a universal approach to health care dominated by western biomedicine meets the perceived needs of South Asian migrants in an increasingly multicultural society, or whether there is call for greater medical pluralism in Dunedin than currently exists.

These questions are more complex than they imply because South Asian migrants do not necessarily move from one distinct medical paradigm to another when coming to live in New Zealand. Practised medicine in South Asia is plural and syncretic. Western biomedicine has been widely appropriated since British colonial rule and remains the official state sponsored system of medicine throughout the Indian subcontinent. Biomedicine did not however simply replace indigenous systems of medicine but rather integrated into a previously existing ideology of pluralism. Ethnomedical traditions of Ayurveda, Siddha, Unani and homeopathy remain popular, widely practised and to some extent also funded by state and national government (see Sujatha & Abraham 2009).

I began my research project with a pragmatic interest in contributing to the growing call for cultural competence in the New Zealand health sector, and was driven by questions as to whether a rapid increase in migration and multiculturalism necessitates some re-
evaluation of the assimilationist ideology inherent in health policy. Conventional research is ideally characterised by objective, non-partisan description of the subject under investigation. Yet the critical ethnographic approach I take in this project urges me to acknowledge my own investment in the topic, while endorsing my role as an advocate for the concerns and values of my research subjects.

The priority of much of the New Zealand literature on migrant health lies in locating potential causes for a perceived disparity in health seeking among Asian migrants. This indicates an implicit assumption that migrants should assimilate into the existing mainstream health system. Although there is a growing voice in the literature that calls for greater cultural awareness and inclusion of culturally diverse practices in the health sector, there is yet a paucity of ethnographic research from New Zealand that investigates people’s lived experience of traditional health practices and strategies used to attend to their own and their families’ distress.

The area of mental health is of central concern in discussions on culture and medicine. Both the international and the New Zealand literature indicate that mental health services are especially under utilised by South Asians in Diaspora. DeSouza (2015, 33) asserts that culture ‘strongly shapes how mental illness is understood and treated’; and much of the recent literature critiques a universal approach to mental health treatment in multicultural societies. This thesis does not however look in detail at issues specifically surrounding mental illness, which is an important area of health that deserves further attention.

Although the qualitative interview methods I use cannot be described as full-fledged ethnography, my research does contribute some ethnographic reflection to the growing
voice that challenges assimilationist attitudes towards health care. Over a two-year period of research I relied mainly on case-study interviews and informal conversations in order to find out the values and concerns of the people I was interested in. It was not possible for me to live with families or participate in the day-to-day lives of the research subjects. For a more robust ethnographic study, I might have extended to a wider sample of people and spent time at religious and cultural gatherings. One of my barriers to using more vigorous ethnographic methods is the relatively small numbers—and lack of a cohesive community—of South Asians in Dunedin.

In order to achieve more in-depth observation, a study might take place in a clinical setting with patients and doctors or with traditional healers. A barrier to accomplishing the latter was that in my South Island wide search for Ayurvedic practitioners, I found only three listings for clinics in Christchurch. Of these, one had officially closed down, another did not answer my emails or telephone calls and the third operates as a resort style bed and breakfast that specialises in relaxing massage treatments. There are however traditional Ayurvedic clinics in the North Island, especially Auckland, which could be approached for further research.

My research thus relies on what people tell me, not what I observe, about their health related experience. Although participants in my research have indicated that they would patronise traditional medical clinics were these affordable and accessible locally, the nature of my small-scale, qualitative and interpretive research differs from a survey type study from which definitive answers to straightforward questions may be deduced. Nor does my research aim to collect data that can be generalised to all New Zealanders of South Asian descent. Rather, through an in-depth exploration of some of the perceptions, experiences and health practices of nine self-selected interview
participants, this research gives voice to some of their concerns and offers local insight into some of the complex issues surrounding multiculturalism and medicine.

The broad findings I have discussed in the previous chapter align with much of the international literature that offers ethnographic insight into health practices of South Asians in diaspora and at home. The decisions my informants make about their health care reflect a pluralist and often syncretic approach where learned and imbedded traditional knowledge appears to play as great a part as relying on conventional medicine. Their practised pluralism challenges the archetypal divide between traditional and modern medicine that is reinforced by theorists, colonialists and policy makers alike. This divide is typified within New Zealand health policy by a scientific legitimisation of modern biomedicine and an implicit marginalisation of healing modalities that do not pass the gold standard for scientific testing.

Although complementary and alternative medicine is popular in New Zealand, there appears to have been some past and present legislative attempts to thwart unorthodox medical practices. The marginal status of non-scientific healing modalities—which had early roots in a conservative medical training at Otago University (see Dew 2003)—limits access to subsidised health care for patients who prefer non-biomedical treatment for chronic conditions.

In the analysis section of this thesis I considered how participants negotiate biomedical authority and express their agency through opting for traditional remedies they perceive to be ‘natural’ and safe in comparison with pharmaceutical medication or prescription drugs, which often produce unwanted side effects. Some of the participants express concerns about a loss of traditional knowledge around health, which they
attribute to the high-pressure demands of a fast-pace lifestyle and the convenience of modern medicine. Traditional remedies often take time to prepare and do not always offer the fast relief promised by western pharmaceuticals. Yet each participant continues to prepare at home at least one of the simple remedies that had been passed down to through the generations.

Furthermore, Indian cooking, which Simran and Lila consider to be important to their cultural identity, remains a strong tradition in each of the participants’ households. According to Rajesh ‘Indian cooking is the best Ayurvedic medicine’ and he claims that although he does not ‘have Ayurvedic medicine stacked in [his] house,’ the meals his wife prepares are themselves medicinal. Culinary herbs and spices that are crucial to the preparation of Indian meals are also essential ingredients found in traditional folk medicine and Ayurvedic pharmacopeia. While most of the people I interviewed express explicit knowledge of the medicinal properties of these ingredients, others indicate vaguely that they know some of these spices are good for their health.

Sirisha points out that tacit traditional knowledge is rooted in sentiment rather than education and she sets out to find the scientific explanations for the medicinal properties of culinary spices and the efficacy of her grandmother’s remedies. The knowledge she gains—from researching online the traditions of her elders—serves not only to validate the efficacy of these traditions but to keep indigenous knowledge alive.

Although my data is derived from a small sample of people who may not be representative of all South Asians in Dunedin, their voices are nonetheless important. It is evident from these participants’ narratives that using traditional remedies, which have been passed down through generations, provide them with self-empowering and
effective strategies for attending some of their general health concerns. I propose that health practices that are culturally learned may be an integral part of the diaspora experience and—in the interests of an approach to diversity and multiculturalism that views social integration as a mutual responsibility between minority and majority society alike—such concerns should be reflected in the New Zealand health sector.
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Appendix 1: Recruitment Poster

Perceptions of Health and the Body Amongst South Asian Migrants to New Zealand’s South Island

Are you of South Asian descent and interested in being a part of an exciting research study investigating personal and cultural understandings of health and the body?

I am looking for participants between the ages of 18-65, who reside in the South Island & identify as being of South Asian decent (but need not be first generation to NZ), and who are not suffering serious illness.

This project aims to consider the healthcare needs of diverse peoples living in New Zealand’s increasing multicultural South Island.

Interviews will last up to one hour (Refreshments will be available!)

Contact Hannah Bailly: Otago University, Richardson Building, Rm.1C12a

Email: hannah.bailly@otago.ac.nz

[This project has been reviewed and approved by the University of Otago Human Ethics Committee. Reference: 14/167]
Appendix 2: Sukhi’s email

Dear Dolly
SSA
This is the recipe of desi medicine your mumis taking for general good health. It may help for prostate also for Glenn. Even you should take it.
Recipe
1 cup ginger juice
1 cup garlic juice
1 cup lime juice
1 cup vineger

Mix all the juices and boil for about half hour on medium heat. Mix 2 cups of honey in it. After it has cooled down bottle it.
Take one tablespoon first thing in the morning.

As claimed by one Dr. Chopra of PGI cooked tomatoes can kill prostate cancer cells.

Love

Dad and Mum

- Coconut water - cannot everything
- Olive leaf 100c.c. (use once a day in a breakfast smoothie)
- (the above ginger drink) 100
- Apple cider vinegar before breakfast - daily

Pharmaceuticals: 100mg (200mg) tablets 2 - 3x daily for first 2
Appendix 3: Sirisha’s List

1. Hibiscus — Mandaram
2. Turmeric — Pasupu
3. Giradpa — Gateway
4. Soap nuts — Kunkudukai
5. Cumin seeds — Jeera
6. Fennel seeds — Soomip
7. Fenugreek — Methulu
8. Curry leaves — Korvepakku
9. Cardamom seeds — Yolatulu
10. Asafoetida — Inguva
11. Poppy seeds — Qasugasulu
12. Coriander seeds — Dhanguulu
13. Cloves — Lavangulu
14. Bay leaves
15. Neem flower — Vepa pumusu

→ Twigs of the neem tree — to brush the teeth.
16. Betel leaves — Thamalapakku
17. Betel nuts — Vakkapodi
18. Dry ginger — Sunli
19. Nutmeg — Javikaya
20. Fynd seeds — Vaaunu
21. Mustard seeds — Navolu
22. Sesame seeds — Muvvulu
23. Anuta — Vanius
Appendix 4: Sirisha’s Recipes

→ cold and cough - Turmeric & pepper to milk
→ Ginger & lemon juice - to clear stomach.
→ cold & cough - pinch of salt, two pinches of turmeric powder to warm water - gargle
→ Toothache - clove oil
→ Bad breath - lime juice mixed with water - wash, chew comander seeds
→ Sore throat - betel leaves
→ Digestion - betel leaves & betel nuts
→ Swelling - drink barley water
→ Lack of sleep - drink warm milk with honey.
Appendix 5: ODT Article

student focusing on health practices

Hannah Bailly

health and the body are understood differently between Eastern and Western medical traditions. Raised on an Ashram in California in the 1970s, Ms Bailly was exposed to a variety of alternative and traditional medicines, including homeopathy, Chinese medicine and the Indian herbal practice of Ayurveda.

“The whole understanding of Ayurveda is quite different from the biomedical system, which is an important cultural difference,” she said.

As part of her research into cross-cultural health practices, Ms Bailly is keen to discuss whether migrants from India practise Ayurveda, Unani, acupuncture, Siddha medicine, herbal remedies or homeopathy in the home, or whether they seek them elsewhere.

The experience of migrants in accessing their traditional forms of medicine in a new country could be an important settlement issue, she said.

“Having difficulty accessing the forms of medicine they are used to could contribute to culture shock.”

The research could help to explore whether there might be a greater need for alternative medicine, or a greater understanding of diversity, in New Zealand, she said.

Ms Bailly plans to conduct her research through interviews, with an emphasis on people’s own perceptions of health and wellbeing.

She is seeking people aged from 18 to 65, who are not suffering serious illness, and who identify as descendent from the Indian subcontinent. Anyone who wishes to be part of the research is invited to email hannah.bailly@otago.ac.nz.
Appendix 6: Interview Guide

Interview Guide

General Background Questions
Age?
Religion?
Where did you grow up?
How long have you lived here?
Do you have family here?
When did your parents/grandparents come to NZ?
Do you feel a part of a community here?
How do you come together with others in the community?

Guiding Questions

Health:
How would you define being healthy?
How would you define being ill?

Do you think of health or illness in terms of solely the physical body, or is there more involved? Like what?

What kinds of things might influence your health? Or illness?

How does stress seem to affect your health?

What do you do to maintain your own health, or the health of your family members?

What do you do when you have a cough, a cold, fever, flu or a headache?
What do you do for more serious health problems?

In what ways do your family influence what course of action you might take where you are feeling unwell?

How do you feel about using medications or herbal medicines?
What sort of medications or herbs would you use?

How do you think about what these medications are doing?
(eg. Treating the symptoms not the cause?
...Are you concerned about side effects?)
GP:
Do you have a GP in Dunedin?
For what reasons would you visit your GP?

When you visit the GP, does the advice or treatment make sense to you?
Can you describe how well the communication goes with your GP?
In what ways does your GP understand or misunderstand your needs?
How does your GP support or discourage the use of traditional remedies?

What made you chose your GP?
Did you intentionally find an (Indian) GP? Why?

Do you visit a doctor or Vaidya upon visits to your country of origin? If so, can you describe your experience? In what ways does this experience differ from your visits to a GP in New Zealand?

In what way could your experience at the GP be better for you?

Do you visit a homeopath or naturopath? If so, what made you decide to do this?
Do you find the cost prohibitive?

Traditional Medicine:
How do you feel about fasting?

How important is food to your health?

What is your understanding of healing properties of spices and herbs used in cooking?

What do you know about traditional (Indian/ Sri Lankan/ or other) medicine?
What ways have you learned about traditional medicine?

What sort of barriers (if any) do you experience to using traditional medicine or remedies in NZ? (GP? Availability? Cost?)
Do you think you would make use of wider access to Ayurveda (Siddha, Unani, Homeopathic) treatment or herbal remedies if it were more readily available?

Under what circumstances would you choose to use traditional medicine over Western medicine? (Eg. Chronic conditions or long-term discomfort? Preventative medicine?)
Appendix 7: Ethics Approval Letter

30 September 2014

Assoc. Prof. J Leckie
Department of Anthropology and Archaeology
Division of Humanities

Dear Assoc. Prof. Leckie,

I am again writing to you concerning your proposal entitled “Perceptions of Health and the Body Amongst Migrants of South Asian Descent to New Zealand’s South Island”. Ethics Committee reference number 14/167.

Thank you for your letter of response dated 30 September 2014 and for providing your revised documentation.

Thank you for advising that you withdraw the intention to hold focus groups. You will now conduct formal interviews instead. Thank you for correcting the spelling of “descent” throughout, for removing to term “mentally ill”, and for developing a separate information sheet with contact details of support networks. We note that you will provide this to participants if additional support is required.

On the basis of this response, I am pleased to confirm that the proposal now has full ethical approval to proceed.

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

Yours sincerely,

[Signature]

Mr Gary Witte
Manager, Academic Committees
Tel: 479 8256
Email: gary.witte@otago.ac.nz

c.c. Assoc. Prof. J V Leckie  Head  Department of Anthropology and Archaeology
Appendix 8: Maori Consultation Approval Letter

NGAI TUHU RESEARCH CONSULTATION COMMITTEE
TE KOMITI RAKAHAU KI KAI TUHU

Tuesday, 19 August 2014.

Associate Professor Jacqueline Leckie,
Department of Anthropology and Archaeology,
DUNEDIN.

Tēnā Koe Associate Professor Jacqueline Leckie,

Perceptions of Health and the Body Amongst Migrants of South Asian Decent to New Zealand's South Island.

The Ngāi Tahu Research Consultation Committee (the committee) met on Tuesday, 19 August 2014 to discuss your research proposition.

By way of introduction, this response from The Committee is provided as part of the Memorandum of Understanding between Te Rūnanga o Ngāi Tahu and the University. In the statement of principles of the memorandum it states "Ngāi Tahu acknowledges that the consultation process outlined in this policy provides no power of veto by Ngāi Tahu to research undertaken at the University of Otago". As such, this response is not "approval" or "mandate" for the research, rather it is a mandated response from a Ngāi Tahu appointed committee. This process is part of a number of requirements for researchers to undertake and does not cover other issues relating to ethics, including methodology they are separate requirements with other committees, for example the Human Ethics Committee, etc.

Within the context of the Policy for Research Consultation with Māori, the Committee base consultation on that defined by Justice McGeachan:

"Consultation does not mean negotiation or agreement. It means: setting out a proposal not fully decided upon; adequately informing a party about relevant information upon which the proposal is based; listening to what the others have to say with an open mind (in that there is room to be persuaded against the proposal); undertaking that task in a genuine and not cosmetic manner. Reaching a decision that may or may not alter the original proposal."

The Committee acknowledges that this research project is based on migrants of South East Asian descent therefore further consultation is not required in this instance. However the Committee notes the researchers have identified that this may provoke further research into Māori traditional medicine and should the project develop further research the Committee would request that you come back for further consultation.

We wish you every success in your research.

This letter of suggestion, recommendation and advice is current for an 18 month period from Tuesday, 19 August 2014 to 19 February 2016.
Nāhaku noa, nā

Mark Brunton
Kaiwhakahaere Rangahau Māori
Research Manager Māori
Research Division
Te Whare Wānanga o Otago
Ph: +64 3 479 8738
Email: mark.brunton@otago.ac.nz
Web: www.otago.ac.nz
Appendix 9: Consent Form

Perceptions of Health and the Body Amongst South Asian Migrants to New Zealand’s South Island

CONSENT FORM FOR PARTICIPANTS

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:

1. My participation in the project is entirely voluntary;

2. I am free to withdraw from the project at any time without any disadvantage;

3. Personal identifying information [specifically contact details and audio recordings] will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for at least five years;

4. This project involves an open-questioning technique. The general line of questioning will inquire into how you think about health and the body, the extent of knowledge and investment in traditional forms of medicine or healing you may possess, and the extent to which you are satisfied with Western medical treatment. The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. In the event that the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the project without any disadvantage of any kind.

5. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve my anonymity, should I choose to remain anonymous.

6. I, as the participant: a) agree to being named in the research, OR; b) would rather remain anonymous (a or b)

I agree to take part in this project.

.............................................................................                     ...........................
(Signature of participant) (Date)

.............................................................................
(Printed Name)
This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph +643 479 8256 or email gary.witte@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
Perceptions of Health and the Body Amongst South Asian Migrants to New Zealand’s South Island

INFORMATION SHEET FOR PARTICIPANTS

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

What is the Aim of the Project?

Although New Zealand is increasingly becoming a multicultural nation, Western biomedicine remains the dominant form of healthcare available. Amongst differing cultures, there are diverse ways in which health and the body are understood. The aim of this project is to consider the extent to which biomedical practices and treatment meet the healthcare needs of people of South Asian descent living in New Zealand’s South Island. This research will also look cross culturally at the philosophical underpinnings of how health and the body are understood differentially between Eastern and Western medical traditions. Through my interviews with local migrants of South Asian descent, I wish to find out whether healing traditions such as Ayurveda, Unani, Acupuncture, Siddha medicine, herbal remedies or homeopathy are practiced in the home or clinically sought out. Ultimately, I hope to find out whether there might be a greater need for medical pluralism in New Zealand than currently exists. This research is being undertaken to fulfil the requirements for Hannah Bailly's Masters thesis in Social Anthropology.

What Type of Participants are being sought?

I am seeking both male and female participants between the age of 18 and 65, who identify as being of South Asian descent and are living in the South Island. Participants need not be first generation migrants to New Zealand, but may be children and grandchildren of migrants from any part of South Asia, Fiji or elsewhere. Anyone suffering serious illness will be excluded from this study for ethical reasons.
This is a small scale, qualitative study where the stories and perspective of individual people are important, thus I will seek to interview as few as seven people (with a maximum of eleven). Participants will be recruited mostly through word of mouth and personal contact.

**What will Participants be Asked to Do?**

Should you agree to take part in this project, you will be asked to be available for an interview (the duration of approximately one hour) in your home or a venue such as a café or room at the University of Otago campus: whichever is most comfortable to you. During the interviews, we will discuss topics related to health, healing and medicine (or remedies). If you become uncomfortable with a topic, you will not be pressed to continue. You may elect to change the subject, or terminate your participation at any time.

Please be aware that you may decide not to take part in the project without any disadvantage to yourself of any kind.

**What Data or Information will be Collected and What Use will be Made of it?**

The interviews will be audio recorded and transcribed by the researcher. The personal statements, ideas and understandings that emerge through conversation will be used as qualitative data and may be included in the final thesis draft. This data will however remain anonymous unless you have instructed me to disclose your identity in the research. I will seek your permission to include such details as age, gender, and profession, or other information that does not personally identify you. You may decline to have any of these details included in the thesis. You are also at liberty to correct or withdraw any contributions (statements) or personal information at any time during the project. Should you wish to view chapters in the thesis that include your contributions, this opportunity will be open prior to final printing.

The final thesis draft will be publicly available through the University of Otago, however the raw data (recorded and transcribed conversation) will only be accessible to the student researcher and her supervisor at the University of Otago.

The data collected will be securely stored in such a way that only those mentioned above will be able to gain access to it. Data obtained as a result of the research will be retained for at least 5 years in secure storage. Any personal information held on the participants [such as contact details and audio recordings] may be destroyed at the completion of the research even though the data derived from the research will, in most cases, be kept for much longer or possibly indefinitely.

The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve your anonymity if so requested.

On the Consent Form you will be given options regarding your anonymity. Please be aware that should you wish we will make every attempt to preserve your anonymity. However, with your consent, there are some cases where it would be preferable to
attribute contributions made to individual participants. It is absolutely up to you which of these options you prefer.

This project involves an open-questioning technique. The general line of questioning will inquire into how you think about health and the body, the extent of knowledge and investment in traditional forms of medicine or healing you may possess, and the extent to which you are satisfied with Western medical treatment. The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. Consequently, although the University of Otago Human Ethics Committee is aware of the general areas to be explored in the interview, the Committee has not been able to review the precise questions to be used.

In the event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and also that you may withdraw from the project at any stage without any disadvantage to yourself of any kind.

**Can Participants Change their Mind and Withdraw from the Project?**

You may withdraw from participation in the project at any time, before the thesis is completed and goes to print, and without any disadvantage to yourself of any kind.

**What if Participants have any Questions?**

If you have any questions about our project, either now or in the future, please feel free to contact either:

*Hannah Bailly* and *Jacqui Leckie*

Department of Anthropology & Archaeology  
Department of Anthropology & Archaeology  
Tel 64 3 479 9272  
Tel 64 3 479 8760  
*hannah.bailly@otago.ac.nz*  
*jacqui.leckie@otago.ac.nz*

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph +643 479 8256 or email gary.witte@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
Appendix 11: List of Support for Debriefing

In the event that any of the topics discussed in the interviews have left participant unsettled, below is a list of support networks that may be contacted.

The Dunedin Multi-Ethnic Council
226 High St. Dunedin
Phone: (03) 4777915
http://www.dmec.org.nz/

Nelson Multicultural Council
4 Bridge Street, Nelson
Phone: (03) 539 0030
http://www.nelsonmulticultural.co.nz/

Counselling at Space2Be
Ika Peuckert: Social Worker (MANZASW)
Church of Christ Community
Corner Filleul St & St. Andrew St, Dunedin
Mobile: 027 203 4153
ikap662@gmail.com

Shakti Asian Women’s Centre
Shakti Ethnic Women’s Support Group (Central region & Christchurch)
Phone: 0 800 742 584
http://shakti-international.org/shakti-nz/

Citizens Advice Bureau
http://www.cab.org.nz

The Human Rights Commission
http://www.hrc.co.nz/