Chapter 7: Healthcare Needs of Ethnic Minorities

Overview

The right to public healthcare is implied in Articles 144 and 145 of the Basic Law of Hong Kong ("HKBL")[1] and all Hong Kong residents (persons with a Hong Kong identity card) are entitled to equal access to it, regardless of their socioeconomic status, race or religion. Hong Kong's international legal obligations also require that public services be made available to all as a matter of equal right and opportunity, regardless of language, race or other unreasonable distinctions or limitations.[2]

The Race Discrimination Ordinance ("RDO") prohibits discriminatory treatment or inequality in access to healthcare. However, as discussed in the Chapter on the Rights of Ethnic Minorities Under the Law: Equality and Non-Discrimination in this Report, the lack of reference in the RDO to government powers and functions raises a question as to whether government healthcare provisions and services are covered within its purview.[3] This makes it unclear whether ethnic minorities could use the RDO as a basis for legal action against discrimination in the provision of healthcare.

As noted in the Key Demographic Data chapter, ethnic minorities constitute 6.4% of the population of Hong Kong. This number is on the rise with a 31.2% increase between 2001 and 2011.[4] The population of elderly ethnic minorities (aged 65 and above) has grown from about 3,700 in 2001 to almost 10,000 in 2011, amounting to an increase of 170%.

Between 2001 and 2011:

Ethnic Minority Population ↑ 31.2%
Elderly Ethnic Minorities ↑ 170%

Although Hong Kong is regarded as having a world-class public health care system, ethnic minorities in Hong Kong struggle to have equal access to healthcare services due to language, cultural and religious barriers in such settings. Ethnic minorities also experience discrimination on the grounds of race, immigration status, and nationality. For instance, the lack of access to materials in a language they can understand deprives ethnic minorities of access to essential information on public healthcare services in Hong Kong and more importantly, their right to receive such services.

Ethnic minorities often rely on advice from friends and relatives about available services or what to do in certain health-related circumstances. However, individuals in their network may not be able to offer accurate information. This therefore impacts the appropriateness of the treatment received, the timeliness of the treatment and the outcome of the treatment. Without proper access to information, the right to autonomy in making decisions in relation to one's health is undermined. Whilst it would be serious enough if one were to experience any one of these barriers, many ethnic minorities experiences are compounded by multiple forms of discrimination, for example both racial and language discrimination.

Part A of this Chapter discusses common health issues affecting ethnic minorities as a group. For example, obesity is a serious problem among ethnic minority women of particular backgrounds. In addition, women from certain ethnic groups are prone to a higher incidence of cervical cancer and yet, while screening tests for early diagnosis are

available, ethnic minority women are largely unaware of them and the importance of taking such tests regularly as a preventive or early detection measure.

Part B addresses health needs of specific communities of ethnic minorities and raises issues requiring urgent attention, including the health needs of the elderly, female sex workers, female circumcision, female infanticide, and domestic violence victims. Indeed, gender has emerged as a crucial marker for targeted service provision in the healthcare setting for particular groups of ethnic minorities.

Part C explores ethnic minority's access to healthcare services in Hong Kong. It highlights the major difficulties that result from language barriers, hampering access to quality healthcare services and in some instances, has been shown to have detrimental and sometimes, even life and death, consequences for patients. The case of *Martin Jacques and others v Hospital Authority*[5] illustrates the seriousness of this issue and extent to which pervasive and systemic discriminatory attitudes in the healthcare context can undermine the equal right to life and dignity of all persons.

Part D of this chapter focuses on substance abuse, a serious problem among ethnic minorities, especially among the youth. Experiences of social exclusion and life at the margins of society have exacerbated the drug problem. Ethnic minority substance abusers lack access to rehabilitation services that are appropriate and suited to their needs, thereby further worsening their addiction. Families often find it difficult to deal with the consequences and effects of substance abuse, which entail serious disruptions to family life and harmony that result from domestic violence, unemployment and financial burdens, often caused by substance abuse, depression and various family crises. Conflict with and exclusion from both, Hong Kong society and their ethnic communities due to their 'modern' views is causing an identity crisis among ethnic minority youth, which peaks in the teenage years. Torn between lives in two different 'worlds' and a lack of belonging to either, are often primary markers of at-risk youth who turn to drugs in their desire to 'fit in somewhere.'

Part E of the Chapter considers the occupational health risks of ethnic minorities. This area warrants special attention given the significant risks of work injury and occupational diseases due to occupational hazards and the failure of employers to ensure their safety at work.

A. Common Health Issues

A1. Chronic Diseases

The South Asian Health Support Programme Annual Report 2010/2011, which presented the results of screening South Asians for diabetes, hypertension and obesity[6] revealed the extent to which South Asians are prone to these high-risk factors for cardiovascular diseases and other illnesses. As *Table 7.1* below shows, 6% had high blood sugar levels, over 30% had high blood pressure, and an overwhelming 80% were obese, 72% of whom were female. Nepali respondents were most at risk of high blood pressure and body fat whilst the Indian sample was most likely to have high blood sugar levels.

Sharmila Gurung, Project Manager of the South Asian Health Support Programme at the United Christian Nethersole Community Health Service Centre, said that South Asians were at a higher risk of diabetes since their diets contain large amounts of oil, fried food and sweets.[7]

Table 7.1 Screening Results of South Asians for Diabetes, hypertension and obesity

Screening item	Total cases	Positive cases	%
Diabetes	2400	142 *	6
Hypertension	2764	844 **	30.5
Obesity	2235	1783 ***	80 (72% female; 8% male)

* Random Blood Sugar was => 11.1mmol/L *Source: South Asian Health Support Programme Annual Report 2010/2011*
** Blood pressure measure >=140/90 mmHg
*** For female body fat % >27% and male >23%

Type 2 diabetes mellitus (T2DM) is one of the most common chronic conditions encountered in primary care, affecting up to 10% of Hong Kong population. Due to a combination of genetic and environmental factors, South Asians are at between 4 to 6 times higher risk of developing T2DM, compared to other ethnic groups. Recent research also shows that ethnic minority diabetes patients are much younger and more obese compared to ethnic Chinese patients.[8] Since certain South Asian groups tend to have poorer glycaemic control, culturally tailored health care interventions are required for chronic disease management.

> *"Though it is not possible to alter an individual's genetic composition, risk of developing chronic disease can be reduced by having a healthy lifestyle. Modifying traditional cooking methods, picking the right food and maintaining a regular exercise pattern are crucial. With the differences in religion, health beliefs and dietary practice, translating the existing health educational material for South Asians is inappropriate. There is an urgent need to develop new, culturally appropriate health educational material and use a culturally sensitive approach to promote the health of South Asians."*[9]

Despite their higher propensity for developing these chronic diseases, ethnic minorities do not appear to be exercising extra caution in their daily routines to prevent or minimize these risks. Medical experts advise the need for a culturally mindful approach to enhance the reach of programs to address the risk-factors in the South Asian population group effectively through tailored advice on dietary and exercise regimens.[10]

A.2 Cervical Cancer

Cervical cancer has been singled out as a major public health problem around the world. According to the World Health Organization, cervical cancer is the fourth most frequent cancer in women with an estimated 530,000 new cases in 2012, representing 7.5% of all female cancer deaths. Symptoms of cervical cancer tend to appear only after the cancer has reached an advanced stage,[11] delaying possibilities for early treatment and survival. In March 2004, the Hong Kong Department of Health launched a Cervical Screening Programme to encourage sexually active women aged 25-64 to have regular cervical smear tests. As of 2014, only 19% of all Hong Kong women aged 25-64 had registered with the Cervical Screening Programme.[12]

Despite the fact that South Asian women are prone to a higher incidence of cervical cancer, South Asian women appear to be unaware of the Cervical Screening Programme and the rate of uptake for regular cervical cancer screening among them is lower than that of Chinese women.[13]. However, since local NGOs, including the United Christian Nethersole Community Health Service and the Community Chest stepped up intensive promotion drives to raise awareness about the importance of screening for cervical cancer regularly as a preventive strategy, more South Asian women have become aware of the Pap smear, the test administered to screen women for cervical cancer.[14]

There is however, a lack of research on awareness levels, knowledge of, attitudes towards and behaviour in relation to preventive healthcare strategies for cervical cancer among ethnic minorities as compared to that of the Chinese population of women.[15]

Cultural taboos surrounding the discussion of sex and sexual activity and particularly around premarital sex makes it challenging to reach at-risk sexually active women in the South Asian community. This is, especially true for teenagers and unmarried women. Furthermore, conducting the Pap smear requires women to be naked from the waist down, and is in conflict with cultural or religious notions of bodily privacy, integrity and prohibitions against exposure, even in the medical context. These concerns highlight that even with awareness of the health related risks associated with cervical cancer South Asian women may be reluctant to undertake regular Pap smears. A decade of promotion of the need for women to have Pap smears has resulted in a mere 19% uptake among the general population. It is likely that there will be unique challenges in getting South Asian women to recognise the risks entailed and the need for action.

B. Specific Health Concerns

B1. Elderly People

Due to differences in culture and lifestyle, ethnic minority elderly may find it particularly difficult to seek assistance when they face physical and psychological health problems.

In response to the special needs of this vulnerable group, the Government reported to the Legislative Council that the Department of Health had sent letters to invite relevant NGOs to promote the Government Vaccination Programme and the Vaccination Subsidy Schemes and disseminate information of the Elderly Health Care Voucher Scheme to ethnic minorities.[16] However, it is unclear whether the NGOs concerned have the capacity to reach the ethnic minority population as a whole and in particular, those directly impacted, such as ethnic minority elderly and their carers. Not all ethnic minorities are aware of NGOs, their service provision and the facilities made available to them.

Some NGOs in Hong Kong provide healthcare services to the ethnic minority elderly. For example, the Senior Citizen Home Safety Association is a self-financing social enterprise and charitable organization with the mission to enhance the living quality of the elderly in the community.[17] As part of their services, they provide 24-hour personal emergency link service to ethnic minority seniors for emergency support, as well as consultation, counselling and referral services. They also arrange home visits to seniors by ethnic minority staff.[18]

The provision of additional services to be provided to ethnic minority elderly is highly dependent on the operation of these NGOs and the resources that are made available to them. This makes the sustainability of such initiatives precarious and leaves the elderly vulnerable to a potential shortage or gap if or when these groups are unable to continue their services.[19] Government-backed measures that are designed and dedicated to address this group's specific needs are not only its obligation under the law but are indispensable to ensure equal protection of the ethnic minority elderly population's right to health.[20] More ethnic minority healthcare personnel and services are needed to cater to the unique health needs of this group of elderly.

As the Government considers how to tackle Hong Kong's ageing population, it is important to bring into the discussion the needs of this group of elderly as well to see what measures are needed to effectively provide for the needs of all Hong Kong elderly, including ethnic minorities. There is to date, however, no data available on the status of Hong Kong's ethnic minority elderlies, their healthcare needs, the numbers in old age homes or in the longer-term care of non-family members and the level and types of support they require.

B2. Sex Workers

There is a visible presence of sex workers in Hong Kong. This group includes those from ethnic minority communities, including Indian, Nepali, Bangladeshi, Filipino and Indonesian. Many women and a minority of men and transgender women in Hong Kong, enter into sex work for different reasons, including debt, family burdens, unemployment, materialism or manipulation.[21] It is however, crucial to recognise the ways in which culture, stigma, shame, fear of law enforcement officers, financial destitution or indebtedness[22], trafficking and conditions of slavery, typically combine to heighten the risks of such work for this group of workers.

Some women have reported having been brought to Hong Kong by their spouses under a legitimate marriage but forced into sex work once they arrived.[23] They see no escape mainly due to shame, fear of imprisonment, and ending up even worse off due to threats by their husbands.

> One man reported being brought to Hong Kong from India by a prospective bride whose family then started using him as a household maid. He escaped but had to turn to sex work due to his dependent visa which had expired. He lamented that he could not go back home due to the shame and stigma of having been duped into a life of slavery by a woman.[24]

Sex workers have long been considered a high-risk group both, for the contraction and transmission of sexually transmitted diseases (STDs) and AIDS. They are also at a serious risk of physical violence and harassment by customers and the police.[25] Living under the radar and fearful that they may be caught and booked for the offence of soliciting for immoral purposes because they are seen as 'having asked for it'. In addition they live an oppressed existence because they hesitate to call the police when in need. Numerous gaps in the law, for example, whether a consensual act of sexual intercourse becomes non-consensual and results in rape if a customer refuses to wear a condom or removes it mid-way during intercourse, leave sex workers vulnerable to and at a heightened risk for a number of health issues.

However, despite these relatively well-known risks associated with sex work, there is no data on the numbers of ethnic minorities involved in the industry, the numbers affected by STDs, AIDs, physical or sexual assault injuries sustained in the course of sex work or circumstances of death.[26] It is critical to recognise the serious health risks faced by sex workers and the barriers that social stigma and discrimination pose for sex workers when they seek assistance, whether for healthcare or other service interventions, including police protection.[27] The perceived undesirable nature of their work serves to detract from people's sense of responsibility towards this group. Most importantly, it undermines their right to equal protection under the law and right of equal access to healthcare.

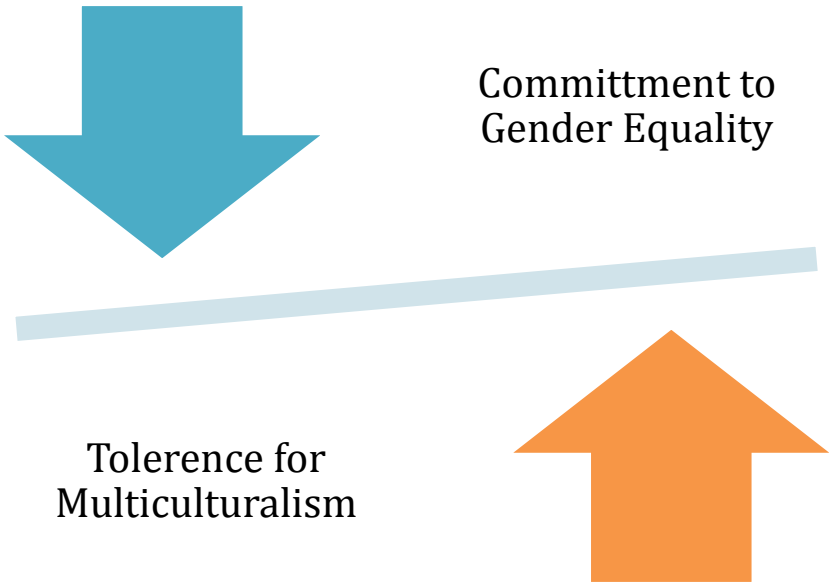
Adding to these sociocultural barriers, language further impedes ethnic minority sex workers ability to access information in relation to safe sex practices, the health risks associated with sex work as well as avenues for regular screening and tests and resources for protection, prevention and treatment. It is vital that ethnic minorities engaged in sex work be made aware of this information.

B3. Female Circumcision and Female Infanticide

There is a lack of research on the practice of female circumcision and infanticide in Hong Kong. These are serious global issues and we remain unaware of their prevalence in Hong Kong. Both these issues have significant health implications for ethnic minority girls in particular, not only in early life due to aborted female foetuses but also raise health and hygiene issues surrounding female circumcision, impacting the general and maternal health of ethnic minority women in later years.

Female circumcision is the removal of some or all of the external female genitalia for non-medical reasons. It is practiced in some communities as a cultural rite of passage for teenage girls or as a matter of religious edict. It is predominantly practiced in certain African and Islamic communities, and a small group of sects in South Asia. According to the World Health Organization, the procedure can cause severe bleeding and problems when urinating, and later, cysts, infections, infertility as well as complications in childbirth and increased risk of new born deaths.[28]

Although the practice has been internationally condemned and is outlawed in many parts of the world, it continues to be practiced widely and forcibly in hazardous conditions since health professionals are unwilling to perform the surgery. Despite the prevalence of the practice worldwide, there is limited literature in Hong Kong regarding the prevalence of the practice[29], the communities that continue to practice it, where and how the surgery occurs. One place to start gathering such data and information may be public hospitals where patients may come to have their wounds or injuries attended to.



Due to its high health risks, its gendered nature and most importantly, implications for the girl child, female circumcision has always tested the boundaries of a country's commitment to gender equality on the one hand and multiculturalism on the other to determine what is permissible in the name of culture and religion.

Another critical issue of global concern is female infanticide, the deliberate killing of new-born female children.

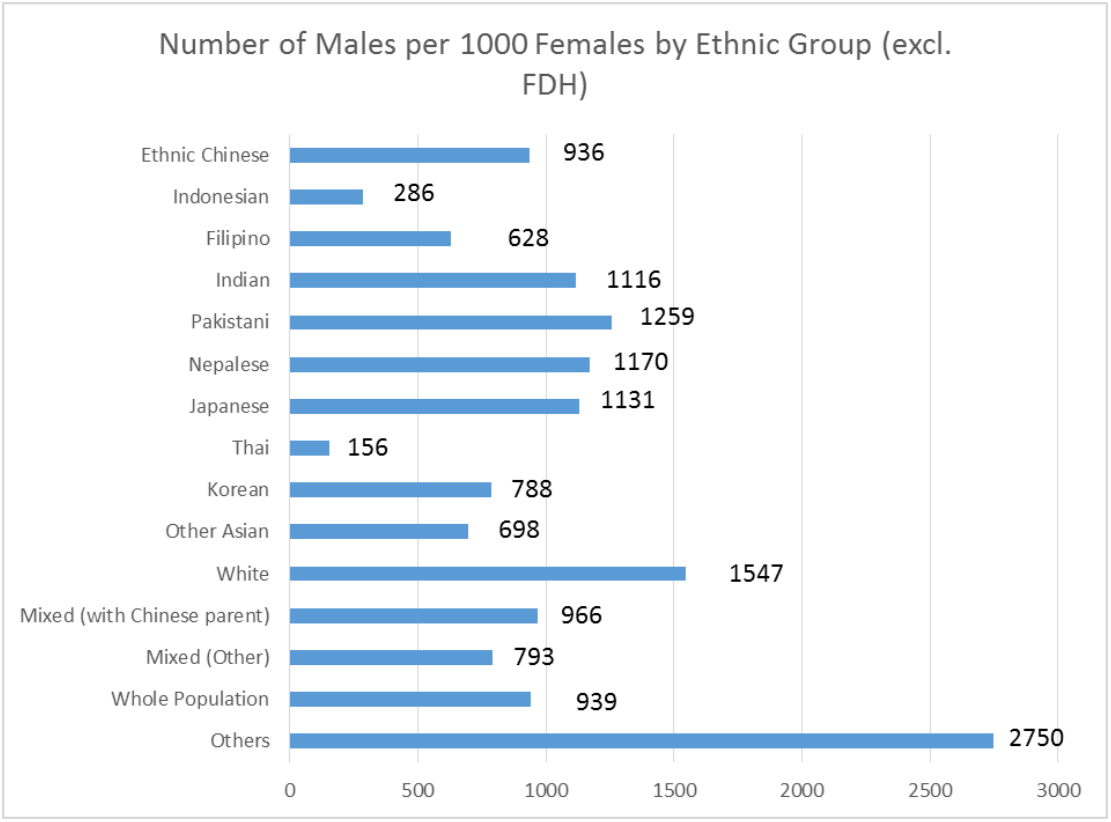
Article 6(1) of the International Covenant on Civil and Political Rights provides that every human being has the inherent right to life, which shall be protected by law. Infanticide is unlawful in Hong Kong,[30] as in many other parts of the world.

The availability of advanced technology in a place like Hong Kong makes sex selective abortions a possibility without due attention being paid to the grave gender implications underlying the availability of this facility to expecting parents. A lawful abortion in Hong Kong requires the clearance of two medical practitioners. However, the considerations involved are medical in nature and do not pay any regard to the cultural and gendered motivations that may underlie the request for an abortion. Abortion, in some cases, has replaced the practice of foeticide. Such practices undermine not only the right to life but also the women's right to decide on their own important life issues. Even in Hong Kong, which has one of the lowest birth rates in the world, when people do have children, there continues to be a preference for male children.[31] Therefore, practitioners may easily overlook such implicit preferences being expressed without attracting undue attention.

Global and individualized campaigns in India and China, countries with the highest rates of female infanticide and the largest gender imbalance ratio, have highlighted the challenges inherent in reconciling cultural values and preferences with human rights standards. The Hong Kong community needs to be made aware of the possibility that these attitudes are prevalent here and sex-selective preferences may be exercised in the healthcare context among certain population groups.

Graph 7.1 below highlights the male to female ratio by ethnic group (excluding foreign domestic helpers). Some groups have an alarmingly high male to female ratio. This warrants attention given the implications for health care planning, preventive strategies and proper resourcing to address the needs of specific target groups. The general sex ratio for the ethnic minority population is 1039 compared with 939 of the whole population of Hong Kong (excluding FDHs). The ratio of 1547 for Whites was also well above parity, as it was for Pakistanis and Nepalese at 1259 and 1170 respectively.

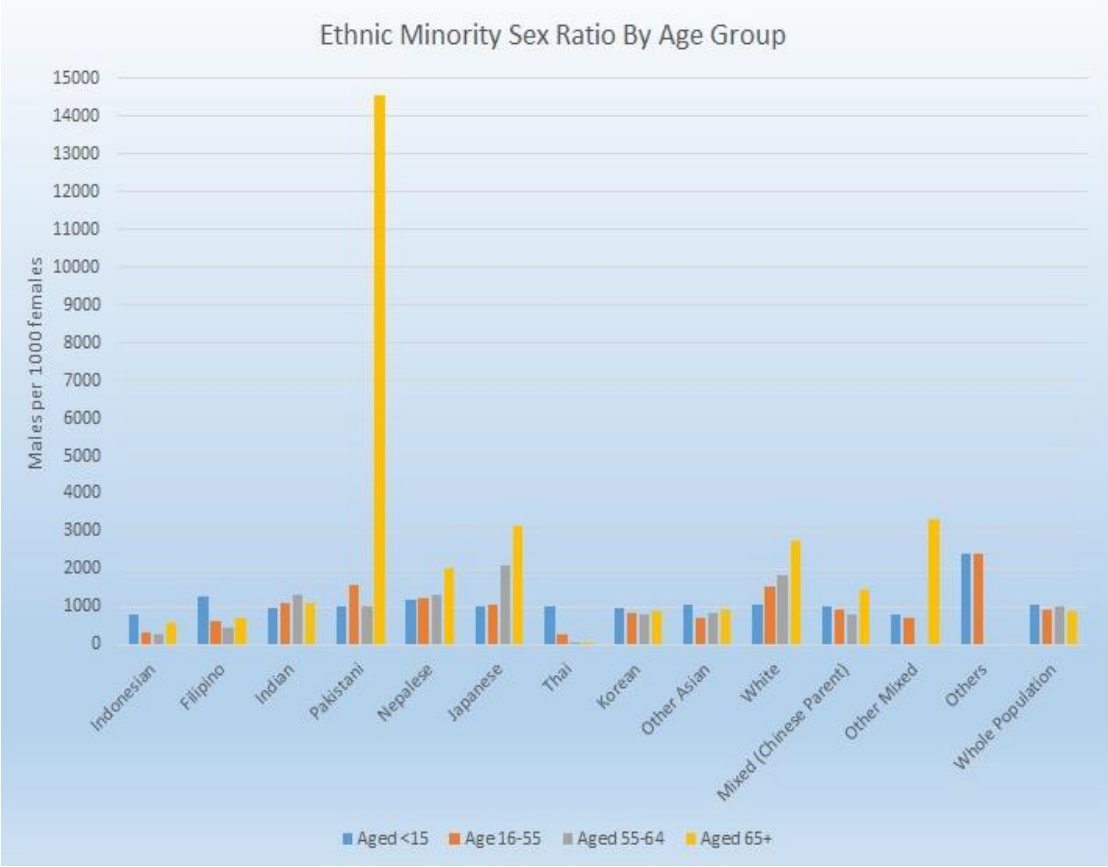
Graph 7.1 Graph Showing Number of Males per 1000 Females by Ethnic Group (Excluding FDHs)



Source: Census and Statistics Department, Thematic Report: Ethnic Minorities 2011, Table 3.4

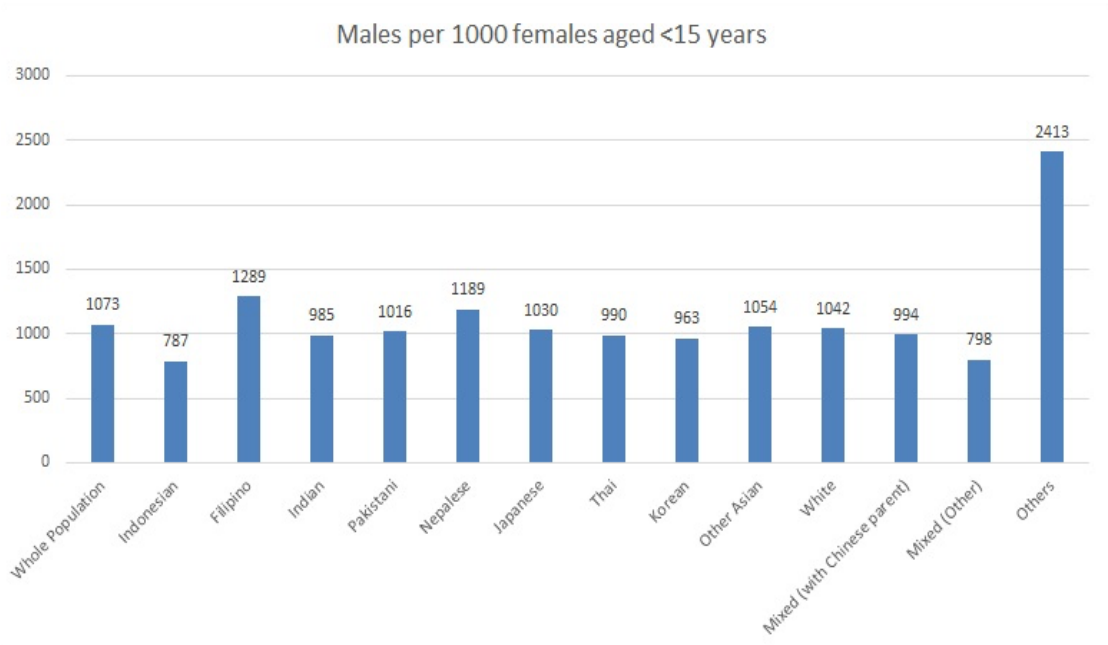
Whilst interesting patterns emerge across the different ethnic groups in *Graph 7.2*, the disparities in sex ratios for each of the age groups by ethnicity are pertinent. *Graph 7.3* below shows that there is a high male to female ratio among ethnic minorities for children under the age of 15, the highest representations being among the Filipinos at 1289 males for every 1000 females, followed by Nepalese with 1189 males for every 1000 females.[32]

Graph 7.2 Ethnic Minority Sex Ratio by Age Groups



Source: Thematic Report on Ethnic Minorities 2011

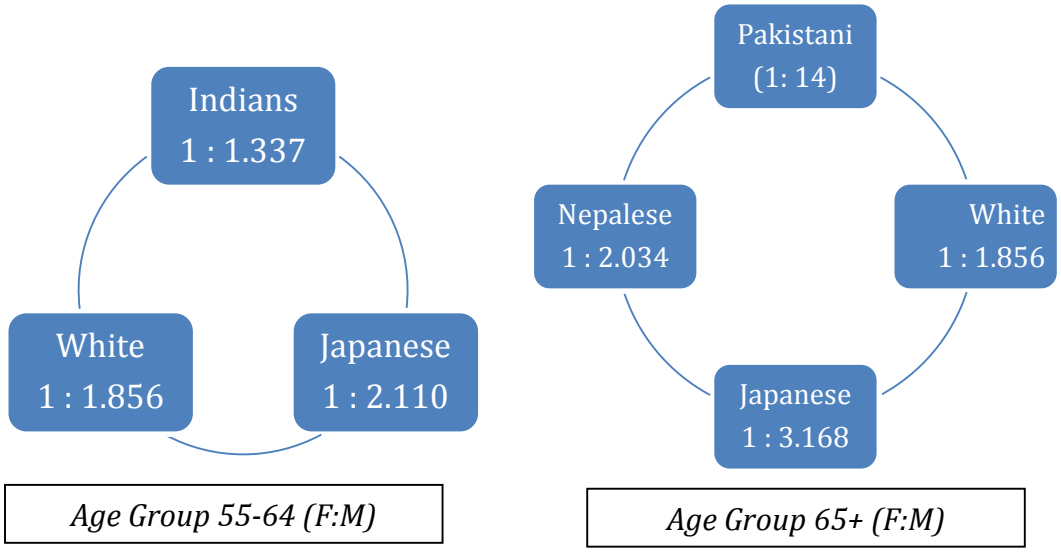
Graph 7.3 Graph Showing Number of Males per 1000 Females by Ethnic Group under the Age of 15 (Excluding FDHs)



Source: Census and Statistics Department, Thematic Report: Ethnic Minorities 2011

For the 16-54 years age group, Pakistani, Japanese and Nepalese have a significantly higher male: female ratio, with 1567, 1061 and 1222 males per 1000 females respectively. These numbers and the disproportionate number of White males (1525) compared to females can be attributed to the large number of men working in Hong Kong who have left their families in their home countries.

Among older groups too, there is a clear disproportionality, particularly within the Pakistani, Japanese, Nepalese and White ethnicities.



Source: Census and Statistics Department, Thematic Report: Ethnic Minorities 2011

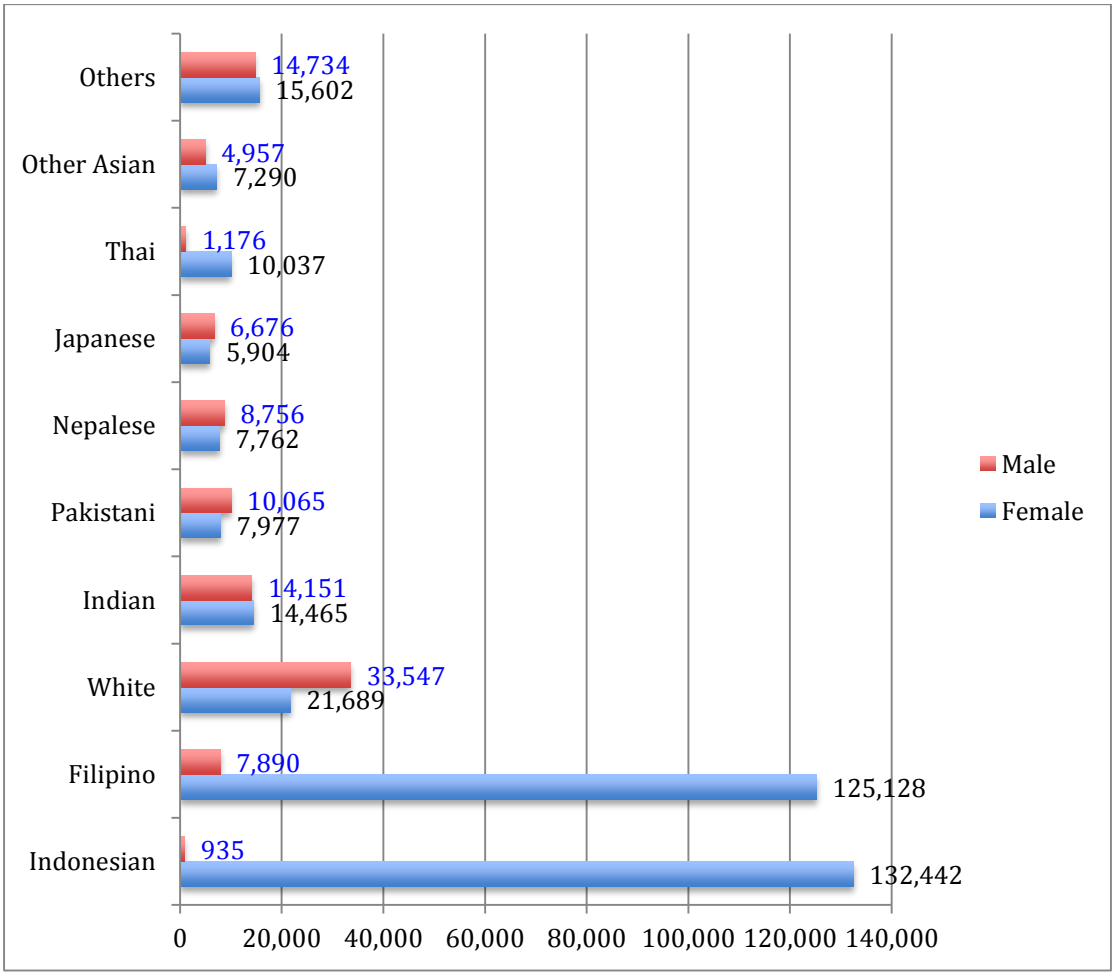
The skewed ratio for these older groups may have important policy and planning implications for the elderly, especially in the context of healthcare needs of men but also raise questions about the absence of elderly females from these population groups in Hong Kong.

The imbalance is decidedly more pronounced among the South Asian ethnic groups. There is, however, no research done on the prevalence of such attitudes and preferences for male children among Hong Kong's ethnic minorities and whether any of the abortions carried out within these communities are motivated by such considerations, thus this statistic alone, is inconclusive. In order to ensure that the rights of the girl child are equally protected, it is important to better understand this phenomenon and take an evidence-based approach to outlining the necessary educational, practical, medical and other initiatives.

Graph 7.4 presents the numbers of the whole population, inclusive of foreign domestic helpers, disaggregated by gender and ethnicity. This is a useful representation to bear in mind in the context of healthcare needs of ethnic minority women, since domestic workers as a group, have various health needs too and these need to be properly addressed. Given their significant presence in Hong Kong and the health issues that affect them given their proximity to various members of the family they are looking after who may be ill, or their own personal health issues, it is important to ensure that adequate resources are in

place to fully attend to their needs. An area warranting urgent attention are the maternal health needs of foreign domestic helpers and that of their offspring.

Graph 7.4 Absolute Numbers of the Whole Population by Gender and Ethnicity (including FDHs)



Source: Census and Statistics Department, Thematic Report: Ethnic Minorities 2011

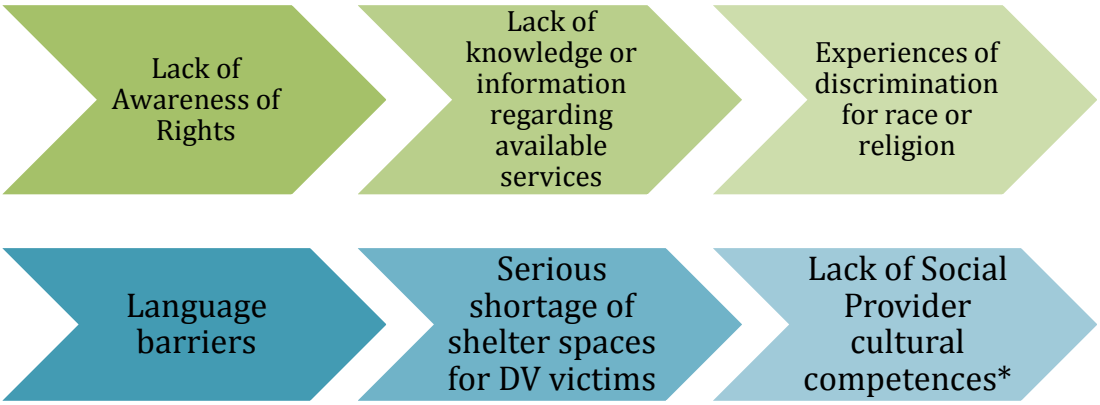
B4. Domestic Violence Victims

Domestic violence is a major women's health issue globally. Victims of domestic violence, whether physical or psychological, typically suffer from severe emotional and psychological consequences, including chronic fatigue, muscle tension, sexual dysfunction[33], increased anxiety, post-traumatic stress disorder and depression.[34] Around one in seven people who have experienced domestic violence sustain a physical injury.[35] Professional services of experts, including empathetic care, are fundamental to assisting victims in primary care and emergency care settings to ensure effective treatment and recovery.[36] Treatment is equally important for both, the victim and the perpetrator. Timely and appropriate interventions can have a significant impact on recovery and reducing the incidence of repeat domestic violence and the seriousness of violent episodes.

The early identification of domestic violence is critical to effective treatment and the proper handling of such cases. Research in Hong Kong has identified certain risk factors that act as predictors of violence. For example, pregnant women are more likely to be at risk of domestic violence.[37] Identifying relevant predictors of violence or perpetrator

traits, which signal a predisposition to violence, open up important spaces for intervention and strategies to ward off violence.

However, ethnic minorities' access to healthcare services has generally been impeded in numerous ways (See Part C below), including by reason of the following factors:



Including shelter staff, police, social workers and healthcare providers.[38]

In 2013, 4.7% (180) of the total domestic violence complaints recorded by the Social Welfare Department ("SWD") related to ethnic minority victims. Between April and December 2013, 3.4% (125) of the total cases recorded by the Family and Child Protection Services Unit ("FCPSU") of SWD related to ethnic minority victims.[39]

Many more incidents of violence are routinely underreported due to the shame, stigma and considerations attaching to cultural and religious value systems which would lead to undesirable consequences, including social exclusion, estrangement from family members, victim-blaming and shaming and isolation. This is particularly true for women who are subjected to sexual assault or rape and are often blamed for attracting the perpetrator's attention. The fear of such consequences, and other barriers such as dependence on perpetrator financially or for a valid visa, language barriers, fear of law enforcement authorities and past experiences of or fear of discrimination further undermine victims' willingness to expose the wrongdoings of family members or those in their extended, but tight-knit social circle. [40]

Of the ethnic minority women who have sought assistance under the available mechanisms, they share stories of mal- or under-nourishment due to a lack of suitable food for them at shelters since many ethnic minority women do not eat meat or beef or pork in some instances, whilst others have lamented the loss of their children and ostracisation and rebuke from their families and communities as a result of turning to outsiders for assistance.[41]

Chapter 6 of this report on Marriage, Family and Domestic Violence provides a detailed discussion of all these issues in relation to the help-seeking behaviour of ethnic minority victims of domestic violence and the many barriers they face in equal access to protection, health and other services.

In terms of healthcare and related interventions, the majority of ethnic minority women who experience domestic violence seldom reportedly seek medical attention.[42] The lack of tact is shown in the approach of services across various fronts and suggests that training in relation to identifying silent victims of domestic violence and how to obtain further information about their situation without alerting the abuser among healthcare professionals is imperative.

1. General Lack of Training on Handling Victims of Domestic Violence

Hospital nurses overlook the needs of a domestic violence victim who may prefer to sit in the internal waiting area beyond the triage point so that she can rest assured that the perpetrator will not spot her there.

Lack of sensitivity displayed when there is a suspicion that the patient may be a victim of domestic violence. For example, one woman reported that the doctor had asked whether her husband had abused her in the presence of her husband.[43]

The lack of expediency shown for processing these cases. A long absence from home arouses suspicion of an abuser, putting the victim in further danger of retaliation.

2. Poor Quality and Lack of Professional Ethics of Interpreters

Professional quality, **a lack of professional ethics** and integrity endangers victims

Reports of **refusal to interpret, abandoning interpretation midway** during a consultation, **inaccurate or even deliberate misleading by interpreter**s to jeopardise the consultation so that the victim would return to the abuser have created **fear and scepticism in the minds of victims.**

3. Lack of Cultural Sensitivity

The **reluctance or refusal to arrange for a female doctor** or nurse to handle any physical examinations or treatment pertaining to injuries

Male doctors asking women victims to remove item of clothing, such as scarf or veil or roll up their sleeves, trousers, shirts or blouses, and skirts in their presence.

4. Lack of Availability of Onsite Interpreter

Lack of availability of an onsite interpreter, and the publicised **four hour lead time** to request an interpreter in a particular language puts **victims at grave risk** of further violence as their long absence would arouse suspicion.

These impediments greatly compromise the quality of the medical attention the victim is able to receive at the time and highlights the challenges of finding interpreters from within a small community, members of which typically know each other and their families back home, which sometimes results in fear of retaliation or rebuke. This also underscores the patriarchal and judgmental attitudes that may be pervasive in a community and may impact treatment that the victims are receptive to.

> *"return to [your husband] like a good, dutiful wife, otherwise, [I will] reveal your location to [him]."*

Failure to Self-Identify as a Victim of Domestic Violence

Since understandings of what is unacceptable behaviour in a domestic relationship differ across cultural communities, there are lower rates of self-identification as victims of violence among the ethnic minority community.[44] For example, some ethnic minority women forced into sexual intercourse within marriage would not consider it as rape due to a cultural understanding that the husband can demand sex at any time and it is the wife's duty to oblige.

Interventions are Ineffective Because they Overlook Cultural Factors Impacting Victims and Perpetrators

- Counselling is also perceived to be **stigmatising in some cultures** as indicating a 'disease of the mind' and is **typically avoided** by ethnic minorities.
- Counselling services are predominantly tended to be **available in Chinese**.[45] The **language barrier** makes this **intervention ineffective** for ethnic minority victims and perpetrators of violence.
- The use of an interpreter **undermines the therapeutic quality and impact** of the counselling due to the loss of authenticity of the message and the inability to develop a relationship of trust between the counsellor and patient.[46]
- The **lack of culturally sensitive material** to work with also **compromises quality** or impact of therapeutic effects of the treatment.

Apart from the specific examples identified above, there are general barriers impacting the accessibility of ethnic minority women to healthcare services in Hong Kong. These have grave implications for the enjoyment of an equal right to quality healthcare for all people regardless of their status and background. Understanding the barriers, it is still vital to ensure the resources provided to ethnic minorities meet the best global standards. The government and NGOs could offer more accessible interpretation services when support services are provided. Given the small size of ethnic minority population, the use of technology, for example, to employ experts abroad to operate a 24/7 dial-in interpretation services may be an option.

C. Access to Healthcare Services

C1. Language and Cultural Barriers

In a 2009 survey conducted by the Hong Kong Polytechnic University and the Hong Kong Christian Service, around 80% of the respondents cited difficulties in communicating with doctors or other medical staff as the main obstacles when accessing health services. Some expressed that the fees charged by doctors were high whilst others remarked that most informative leaflets available in the hospitals were available only in Chinese, making it difficult for them to access health-related information. The lack of translated leaflets on critical health information and services highlights the primary impediment to catering effectively for healthcare needs of ethnic minorities.

Whilst the population of ethnic minorities continues to grow in Hong Kong, the Government has paid insufficient attention to the problems faced by ethnic minorities in terms of equal accessibility to healthcare services. Many ethnic minorities, especially the elderly, are unable to access appropriate and comprehensive healthcare information primarily due to language barriers.[47]

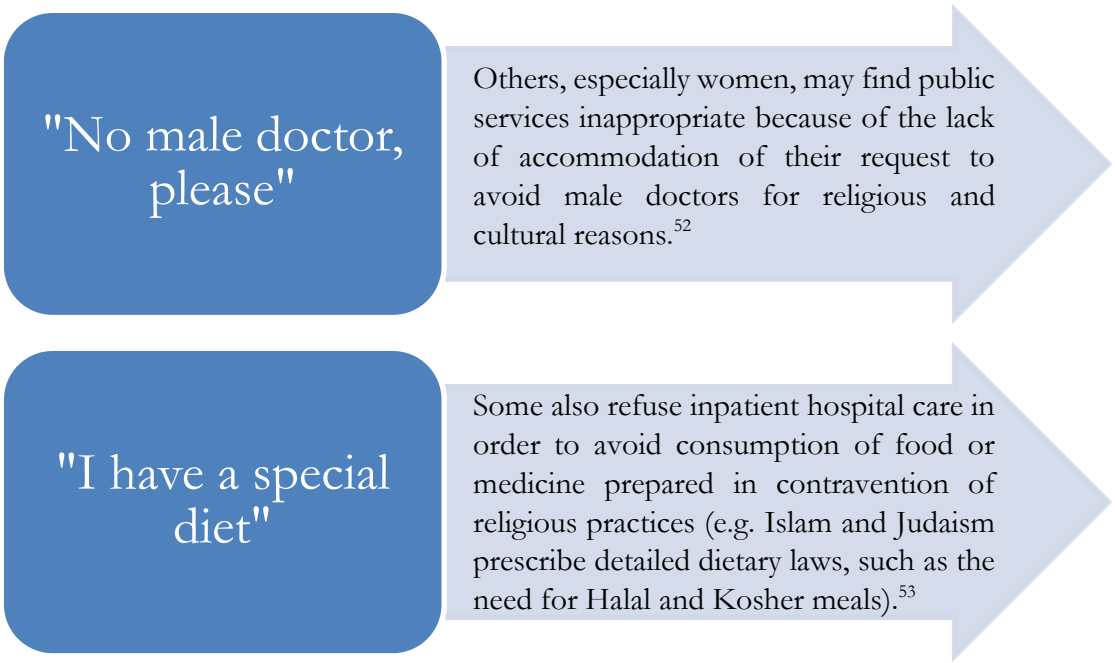
The lack of interpreters available, the long wait before an interpreter can attend the hospital and the poor professional quality of interpreters available make it challenging for ethnic minorities to communicate their needs effectively to the doctors, who may otherwise misunderstand their symptoms and concerns.[48]

Ethnic minorities, including children and refugee groups, have complained that they are being subjected to what has come to be known as 'Panadol therapy' in common parlance in NGO circles, whereby Panadol is prescribed by doctors without diagnosis, ignoring their specific health needs.[49]

Shana Devi, a 50-year-old native Indian, shared that when consulting local doctors, she could only show them her problems by pointing to the relevant part of her body. Most of the time, she would be prescribed painkillers.

This has serious ramifications where the patients concerned are children, as the excessive use of Panadol can cause liver damage.[50]

In another case dealt with by Hong Kong Unison, a client with a long-term headache was prescribed Panadol after each consultation. She was diagnosed of depression only at a later stage.[51]



To facilitate integration of ethnic minorities into the community and enhance their access to public services (including healthcare services), the Government introduced a policy to fund non-profit-making organisations to operate 6 designated support service centres and 2 sub-centres for ethnic minorities.[54] However, the quality control and scope of these designated service providers remain a matter of concern. For example, healthcare information on the websites of these service providers is not available in ethnic minority languages.[55] Although healthcare might not be the main service provided by these centres, as one of the most fundamental needs in society and when healthcare information is often urgently required, the designated support centres should ensure health-related information is readily accessible in terms of language and media, to the ethnic minority stakeholders, their primary clients.

C2. Translation Services and Government Measures

Although the Government has introduced various measures to address the language barriers in this context (as outlined in this section), the reported effectiveness of these measures remain in doubt due to the conflicting information from the Government departments or NGOs concerned and the user groups and their representatives.

In 2009, the Government first launched a telephone interpretation service to help ethnic minorities gain access to public services. The services are run by the Centre for Harmony and Enhancement of Ethnic Minority Residents (CHEER) of the Hong Kong

Christian Service and sponsored by the Home Affairs Department. Around 20 full-time interpreters are hired to provide translation between Chinese or English and seven ethnic minority languages, namely Urdu, Hindi, Punjabi, Nepalese, Tagalog, Bahasa Indonesian and Thai.[56] Although interpreters are predominantly university graduates and have a strict code of ethics to follow, they receive only on-the-job training as opposed to pre-service training.[57] Until recently, CHEER was the only NGO providing free translation services to ethnic minorities. There is now a new NGO called 'THEM' which provides similar services.

On the other hand, Hong Kong TransLingual Services (HKTS) is a social enterprise that provides paid interpretation and translation services in 20 languages, including Asian and European languages[58] and sign language. They serve both public institutions and private companies. Their interpreters are selected based on their educational qualifications, written and oral tests, and interviews. HKTS cooperates with Centre for Translation, Hong Kong Baptist University for the training of interpreters, service supervision and assessment. [59]

In addition, the Government has taken various measures to minimise language barriers to ethnic minorities in accessing the healthcare system. These include the following:

(1) The Hospital Authority (HA) has arranged for **on-site, free-of-charge interpretation services** in a number of ethnic minority languages by appointment in all public hospitals, health centres, clinics and Maternal and Child Health Centres. They are provided under the management of HA mainly through a service contractor, part-time court interpreters, volunteers and consular offices**. The services cover 18 ethnic minority languages**[60] but these services are **available by advance booking** only.

(2) The Department of Health (DH) also offers **interpretation services** through the Support Service Centres for Ethnic Minorities and part-time court interpreters.[61] Such services can be arranged for non-urgent care subject to availability in most instances. However, the **unavailability of such services with respect to emergency cases poses a significant danger** to the health of ethnic minorities, especially where the patient and the doctor are unable to communicate effectively.

(3) Public hospitals and clinics have displayed in conspicuous **locations posters showing information, printed in various ethnic minority languages**, about the arrangement for **applying for interpretation services**.[62] Despite this, however, there are still many who remain unaware of the availability of such services. Ironically, it requires one to visit the clinic or hospital in order to learn about such services. If one does not feel able to communicate effectively with public healthcare practitioners or their staff, it is unlikely that they would go to the public clinics or hospitals in the first place unless there is no other option. A prime example is ethnic minority victims of domestic violence. In the study conducted by the author, none of the women sought medical attention.[63]

(4) For non-scheduled cases, hospital staff will make appropriate arrangements as soon as possible. Past data shows that in such cases **interpreters were able to arrive at sites to provide services within an hour on average**.[64] This is at odds with what has been reported by some users who said that without advance booking, they were advised that such requests may take up to 4 hours to process and arrange. This typically **discourages ethnic minorities from seeking healthcare at the hospital**, as they may be unable to wait for 4 hours. If the waiting time is shorter, this should be communicated so that they will at least book an interpreter in advance. Needless to say, if the waiting time is indeed 3-4 hours, for an emergency case, the consequences could be fatal. **Greater transparency is required on actual waiting times**, the experiences of the service users and the overall effectiveness of the interpreter in bridging the communication gap.

(5) The utilisation rate of the interpretation services was quite high. During the period from April 2013 to March 2014, public hospitals and clinics under the HA provided related **interpretation services about 6,000 times**; whilst in the two-year period since April 2012, interpretation services were provided in DH's health centres and **clinics a total of 863 times and 50 cases were handled by CHEER and part-time interpreters respectively**.[65] Interpretation services requested were **mostly for Urdu (57%), Punjabi (16%) and Nepali (9%)**.[66]

(6) Training on medical knowledge and terms has been provided to all interpreters working under the Department of Health and Hospital Authority. Such training includes those **conducted by university lecturers** and **covers basic knowledge** about the operation of hospitals, medical terminology and infection control. As of October 2014, **over 80 interpreters** have received such training. In collaboration with representatives of the Centre for Translation of the Hong Kong Baptist University, the service contractor commissioned by the Hospital Authority conducts **annual inspection in hospitals to monitor the service quality of interpreters**.[67] There appears to be a gap however, as to whether the training covers culturally sensitive issues, particular health risks ethnic minorities are exposed to and identifying whether domestic violence may be a possible health issue.

(7) Service users were in general very satisfied with the interpretation services. In the 2012-13 financial year, **out of the 4,900 sessions of interpretation services, only 12 complaints were received**. Those complaints mainly related to the failure of interpreters to arrive on time.[68] In the 2013-14 financial year, **out of the 6,000 sessions of interpretation services, only 3 complaints were received**. The complaints were mainly about the skills of interpreters and none of them was about the punctuality of interpreters.[69] As noted above, this needs to be reconciled with the different user experiences reported by ethnic minority women victims of domestic violence.

(8) Seminars and online trainings have been organised **targeting front-line workers**, including those manning enquiry counters, nurses and clerks, to **enhance their communication skills with ethnic minority patients** and to educate them on cultural needs of ethnic minorities and anti-discrimination legislation. Between April 2011 and March 2014, **over 5,000 of the Hospital Authority staff** at various levels received the relevant training.[70] The training appears to be provided by the Hospital Authority and hospitals internally.

(9) The Department of Health and Hospital Authority have **translated salient points of some healthcare information into different languages** and they are available on the Internet as well as in public hospitals and clinics. For example, the Hospital Authority prepared **pamphlets in 18 ethnic minority languages on some common diseases** (e.g. headache, chest pain and fever), **treatment procedures** (e.g. blood transfusion and radiation safety issues) and **information about the services of the Hospital Authority** (e.g. fees and charges and the triage system of the Accident and Emergency Departments).[71] However, this healthcare **information is very general** and **does not aim to cater specific health needs of the ethnic minorities**, which is a critical gap because, as noted above, ethnic minorities are prone to certain high-risk factors for cardiovascular diseases and cervical cancer among women.

(10) The Hospital Authority has **set up a website for ethnic minorities**, providing basic information of clusters, hospitals and institutions that provide public healthcare services, list of Accident & Emergencies (A&Es) and General Out-patient Clinics (GOPCs) services. However, the **information is only available in 5 ethnic minority languages,** namely Urdu, Punjabi (Pakistani), Punjabi (Indian), Hindi and Nepali.[72]

Also, the hospitals of the Hospital Authority have put in place measures to cater for the needs of patients of different religious backgrounds. For instance, public hospitals have special meal arrangements for patients of different religious backgrounds, such as halal food for Muslims; and some hospitals have set up small chapels and prayer rooms as well as bereavement rooms in the mortuary for use by people of different religions.[73]

There is currently little or no information about policies and guidelines in relation to dealing with near-death or the death of persons of ethnic minority background who may have particular cultural or religious preferences for how the body is handled and any rites or rituals that need to be complied with. Health circumstances and impending death have very significant connotations for cultural and religious communities, particularly surrounding dealings with the body pre- and post-mortem. There is a need for active consultation on these issues so that appropriate policies and guidelines and any necessary accommodations can be facilitated.

It is encouraging to see that the Government is paying more attention to the impediments to healthcare services faced by ethnic minorities. However, some of the comments in the Government's report are general and lack supporting statistical data. The impact of these measures for health outcomes in relation to ethnic minorities and their effectiveness must be examined in greater detail to assess whether these measures are

implemented fully and assist the target group in accessing healthcare effectively and on an equal basis.

C3. Racial Discrimination: A Matter of Life and Death?

Racial discrimination is another significant barrier that impedes ethnic minorities' access to healthcare services, as can be seen from the *Martin Jacques and others v Hospital Authority* case.

In *Martin Jacques and others v Hospital Authority*, Harinder Veriah, a solicitor qualified in the United Kingdom was seconded to a Hong Kong law firm and arrived here with her husband Martin and their infant son. On the first day of the millennium, Harinder suffered from a seizure from epilepsy and was sent to Ruttonjee Hospital. According to Jacques, Harinder, being a Malaysian of Indian descent, told him that she was treated as the "bottom of the pile." The next morning, Harinder had another episode of epileptic seizure and died shortly after. The coroner's court returned a verdict of natural death due to sudden unexplained death in epilepsy. Having shared the coroner's report and Harinder's medical records with his medical professional friends, Jacques was unconvinced of the verdict reached and filed a civil lawsuit against the Hospital Authority, alleging racial discrimination and medical negligence. The evidence showed that someone had administered a fatal dose of a medication to Harinder as a result of which her body was steadily being deprived of oxygen. This catalysed the next epileptic seizure. Jacques also complained that he got to the hospital before any doctors had managed to attend to Harinder – a time lapse of around 10 minutes between the phone call he received from the hospital and his arrival. Harinder had gone into cardiac arrest and was unable to be revived in time as a result of the delay.
Initially dismissive of any misconduct on the part of their staff and all denying responsibility on its part in contributing to the death, after a pre-trial hearing that went against the Hospital Authority, Jacques was finally offered a substantial settlement.[74]

"The settlement demonstrated that the Hospital Authority was neither willing nor able to defend their treatment of my wife. Hari's death was entirely unnecessary and utterly avoidable. The hospital succeeded in turning what is a relatively commonplace event in the lives of many into a human catastrophe."

- Martin Jacques[83]

The outcry sparked by the case propelled the call for the implementation of an anti-racial discrimination law, which was achieved in the form of the Race Discrimination Ordinance in 2009. Although the legislation has been in force for more than 6 years, to date, there remain questions about whether, in practice, ethnic minority patients in critical medical conditions are treated equally and attended to with the same kind of urgency as other patients in Hong Kong and if not, whether there is any scope to bring a claim against such discrimination under the RDO.

D. Drug Abuse

D1. Vulnerability of Ethnic Minority Youths

Drug abuse can lead to serious health problems, both physical and psychological. Research has shown that among different ethnic groups in Hong Kong, ethnic minority youths were most vulnerable to drugs.[76] Furthermore, the lack of access to rehabilitation services makes it hard for ethnic minority drug abusers to seek help in the long run.

According to a survey conducted by the KELY Support Group and the Hong Kong Polytechnic University in 2012:

- 60% of ethnic minority youth respondents displayed **a critical lack of knowledge about drugs and their effects**.
- Compared to Chinese-speaking and English-speaking students, ethnic minority youth had the highest response rates to the statements "I don't mind trying drugs" and "I don't know where to get help if I have a drug problem."
- 26% of them stated it was hard to turn down their friends' requests to try drugs, **twice as high as** the rate reported in the other two groups.

The KELY Support Group cited that the government is to blame as most of their anti-drug campaigns appeared to be directed only at the Chinese population.[77]

Fermi Wong, Executive Director of Hong Kong Unison said the survey results aligned with her social work experiences. According to Wong, there are three major factors that are likely to lead ethnic minority youth to experimenting with drugs. First, ethnic minority youth are likely to yield to peer pressure, which is prevalent amongst ethnic minorities because of the tight knit community and the sense of brotherhood that prevails. Second, ethnic minority youth are likely to turn to drugs for relief after feeling defeated and excluded from the Hong Kong education system and society at large. Third, discrimination from "mainstream groups" makes it hard for ethnic minority youth to get an early head start in life, increasing the chances they would take drugs out of loneliness fuelled by social isolation and marginalisation in education, employment and other settings.[78]

"Although all youths could be attracted to drugs out of curiosity, minority youths are especially vulnerable. They tend to use drugs to escape reality and to feel the happiness that they find it difficult to feel in real society." ~ Fermi Wong Wai fun

D2. Basic Statistics of Drug Abusers

The use of hard drugs has become a growing problem among ethnic minority youth in Hong Kong. [79]

In 2006, the Chinese University of Hong Kong and Hong Kong Unison conducted a survey to analyse the drug abuse situation among ethnic minorities in Hong Kong ("Drug Abuse Among Ethnic Minorities").[80] One hundred ethnic

minorities were surveyed. The sample included 68 Nepalese, 17 Vietnamese and 15 members of other ethnic groups (Indian, Pakistani, Filipino and Thai). The average age of the respondents was 28.2, with 63% over 25 or above. 98% of them were male and 46% were born in Hong Kong. Half of them attained primary or junior secondary education as the highest level of education; while 49% attained senior secondary education level or above.

The average history of drug abuse was 12.7 years. For those below 25 years of age, the average history of drug abuse was 8.9 years. This indicates that most respondents started taking drugs at around the age of 14, very early on. This has significant implications for future prospects and stability in light of addiction, the economic, social and personal costs of drug abuse and its disruptive impact in various aspects of life.

D3. Drug-related Services

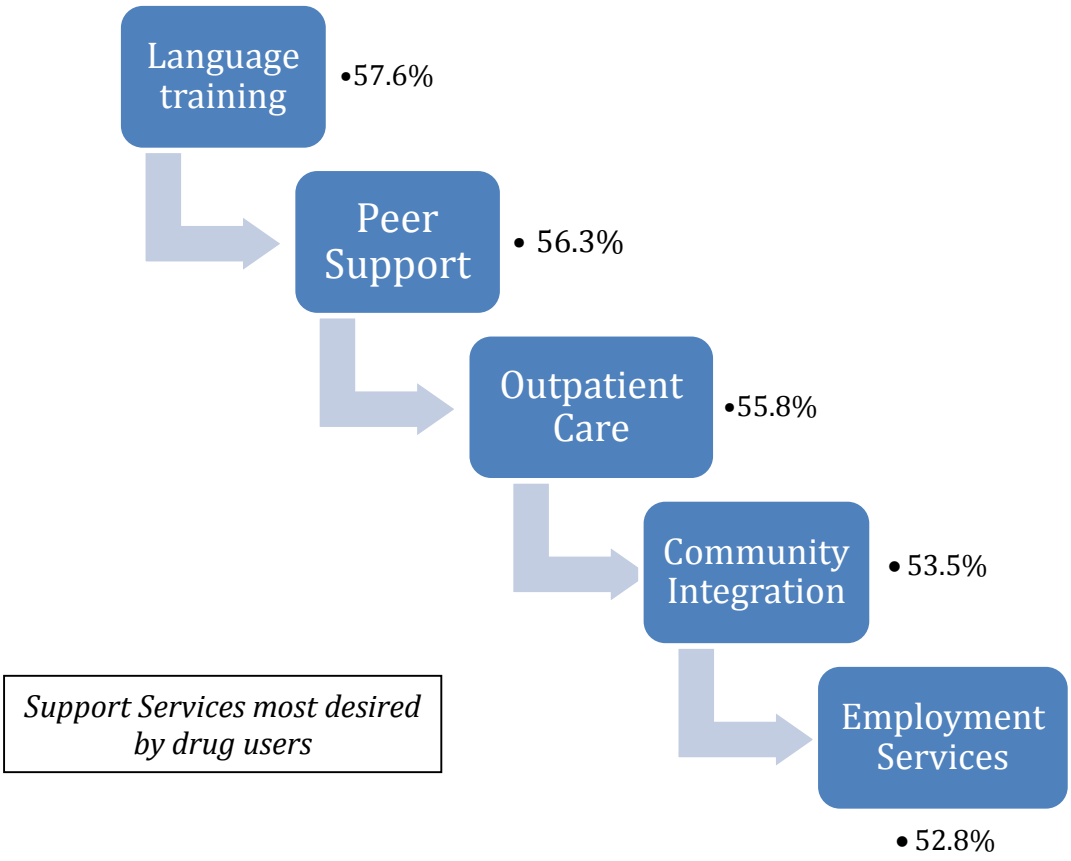
88% of the respondents were aware of the services of the methadone clinic. 57% of them also knew about the services of the Correctional Services Department. However, non-South Asians were much more likely (roughly twice as likely) to be aware of most of the drug rehabilitation services.[81]

The methadone clinic service was utilised the most among the respondents (72%). One in five would also turn to NGO rehabilitation services. However, South Asians were only willing or able to persist for an average of 1.8 years, whereas non-South Asians were using the services for an average of 3.5 years.[82]

The respondents highlighted that the difficulties they faced in integrating into the service user support groups made the services less desirable. Other barriers include racial discrimination and language.[83] One past abuser, Ganesh Milan explained that it was crucial for a drug abuser to understand the spoken language of the rehabilitation programme. Milan first started on drugs when he was 16 years old but decided to quit one year later. Yet, he found it difficult to understand the rehabilitation programmes in Hong Kong, mostly due to the language barrier. It took him 10 years to successfully quit the addiction but only when he returned to Nepal for rehabilitation.[84]

Insensitivity to cultural and religious differences in terms of the content of the rehabilitation program, which may conflict with basic tenets of ethnic minorities' personal value systems pose a further difficulty for ethnic minorities in seeking drug-related services. For example, some Pakistani drug abusers reported that they were not willing to attend rehabilitation services because the service providers had an affiliation with Christianity.[85] It is therefore important to ensure an option of religion-neutral service providers is available to them.

Regarding the help offered by NGOs, Yuen How-sin, coordinator at the Society of Rehabilitation and Crime Prevention comments that not enough NGOs are carrying out community outreach work to help ethnic minority youths, who often do not know where to look for information or to seek help. She urges the Government to provide more active and culturally sensitive support to ethnic minority drug abusers, for example, supporting social organizations to recruit ethnic minority social workers so that the special needs of ethnic minorities can be attended to more effectively.[86]



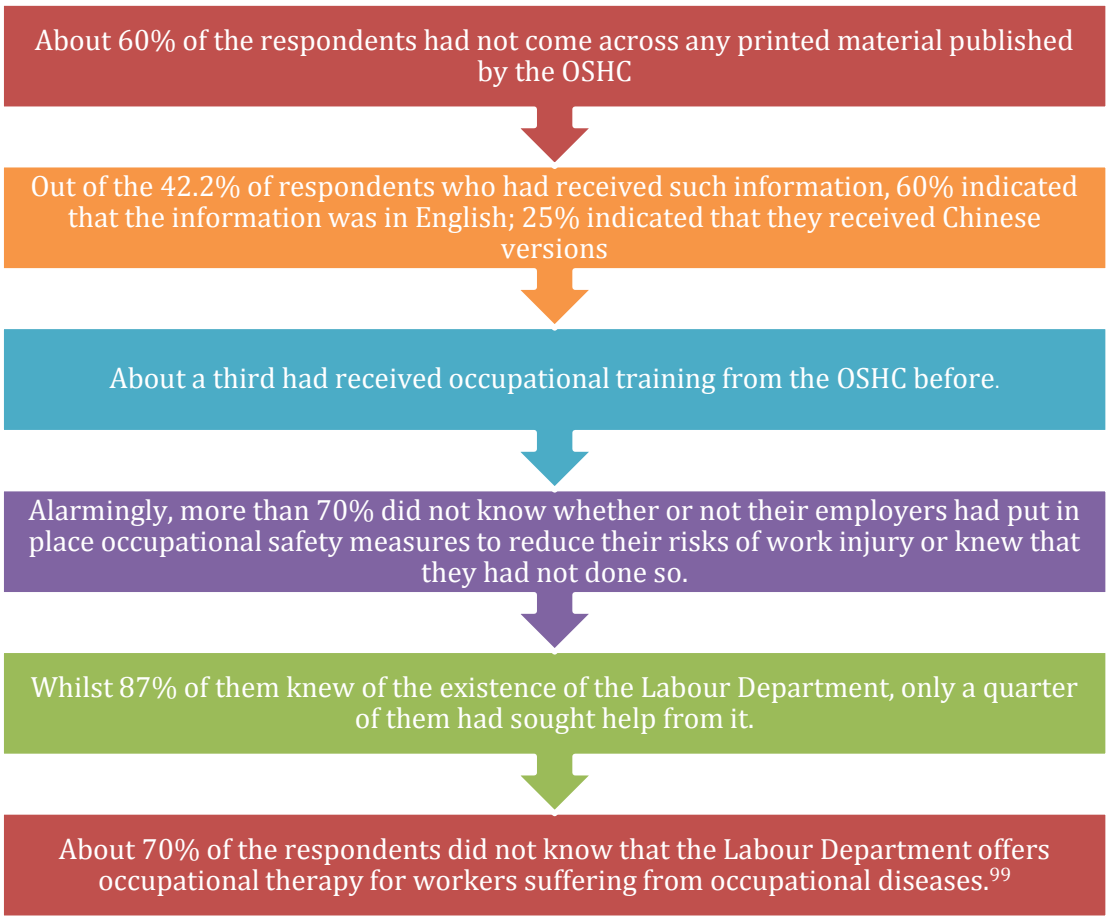
This shows that, apart from language support, **what ethnic minorities desperately need is an inclusive society** where they are accepted and supported.[87] As discussed above, **one of the reasons ethnic minorities turn to drugs is racial discrimination, exclusion and isolation** from the broader Hong Kong society. This is **a systemic problem** stemming from the lack of effective measures for inclusion through policies to facilitate social integration from an early age and in a variety of contexts.

Public education also plays an important role because many ethnic minority parents are ignorant about drug abuse and its harmful effects. The patriarchal value system often condones male abuse of alcohol and drugs because it may be viewed as an acceptable means to socialise or a necessity of maintaining a high-end social circle. Sometimes, this thinking has translated into permissive attitudes towards their children's drug abuse.

E. Health Issues in the Employment Context

As discussed in Chapter 5 of this report on Poverty and Social Welfare, many ethnic minorities are engaged in elementary occupations, which are mostly low paying, physically demanding and at times dangerous. Coupled with the fear of job security, some ethnic minorities will tolerate dangerous workplaces despite low paying jobs, even if they are over-worked and assigned dangerous tasks. Their vulnerability puts them at increasing and significant risks of work injury and occupational disease.[88]

Although the Occupational Safety and Healthy Council ("OSHC") has published guides on occupational health issues in ethnic minority languages in the form of books, leaflets and posters, a study from 2011 reveals that the majority of ethnic minority workers do not know how and where to obtain this information. Moreover, since some of them do not have Internet facilities at home, the information available on the Internet is inaccessible to them.[89]



The study also found that ethnic minority workers are often deprived of their employees' rights when they are injured at work. About half of them did not know about the Employees Compensation Ordinance (Cap. 282) which entitles employees to seek statutory compensation from employers when they are injured in the course of employment.[91] On top of that, some did not know about their contractual entitlements because their employment contract was in Chinese.[92] One respondent even reported that his employer forbade him from telling the doctors about where and how the incident took place so that no compensation had to be paid to him.[93] For fear of losing their jobs, some ethnic minority workers do not complain or seek help.

Some ethnic minority workers reported that they were often asked to take up manual and physically demanding tasks because of their apparent strong and more muscular build but they were not provided with appropriate tools to lift and transport heavy objects, rendering them extremely prone to injury.

One respondent, Ali, was asked by his supervisor to carry some steel bars which were extremely heavy. He told his supervisor that the weight of the bars was beyond what he could manage but the supervisor simply demanded him to carry on the task with whatever means he could. In the end, one steel bar fell and broke his knee. He was immediately dismissed after his injury on the basis that there was not enough work so they did not require him. However, Ali later found out from his ex-colleagues that what he was told was not true and suspected that he was sacked only because the employer wanted to avoid future troubles which might arise due to his injury.[94]

Moreover, many respondents did not understand the classes on occupational training as they were often conducted in Cantonese. On the other hand, supervisors failed to provide adequate instructions and training to ethnic minority workers because of the supervisors' poor proficiency in English. Coupled with the lack of safety measures and equipment provided at work, ethnic minority workers are prone to serious risks of injury at work.

KEY OBSERVATIONS

Ethnic minorities do not appear to be exercising sufficient caution in their daily routines to prevent or minimize health risks. Medical experts advise the need for a culturally mindful approach to enhance the reach of programs to address the risk-factors in the South Asian population group effectively through tailored advice on dietary and exercise regimens

Despite the fact that South Asian women are prone to a higher incidence of cervical cancer, they appear to be unaware of the Cervical Screening Programme. The rate of regular cervical cancer screenings among them is lower than that of Chinese women, which may owe to the cultural taboos surrounding the discussion of sex and sexual activity and particularly around premarital sex makes. This makes it challenging to reach at-risk sexually active women in the South Asian community.

The absence of permanent and sustainable government programs for elderly assistance is an issue. The elderly are vulnerable to a potential shortage or gap if or when government funded groups are unable to continue their services. The skewed ratio (particularly of men) in the older age groups within certain ethnic minorities may have important policy and planning implications for the elderly.

Language barriers to help for victims of Domestic Violence impede those needing help form both considering and accessing the necessary assistance. In terms of healthcare and related interventions, the majority of ethnic minority women who experience domestic violence seldom reportedly seek medical attention. Racial discrimination and a lack of cultural sensitivity are significant barriers that obstruct ethnic minorities' access to healthcare services.

Despite case law and government efforts, there remain questions about whether ethnic minority patients in critical medical conditions are treated equally and attended to with the same kind of urgency as other patients in Hong Kong. In cases where they are not, it is still unclear if there is any scope to bring a claim against such discrimination under the RDO.

Many ethnic minorities are ignorant about drug abuse and its harmful effects. Moreover, many drug users are in need of specialised treatments that are more accessible.

With respect to employment, many workers are ignorant of their rights to occupational safety due to a lack of information dissemination, which can lead to their abuse and unfair treatment.

RECOMMENDATIONS

1. In light of the emerging knowledge about particular health risks that ethnic minorities are prone to, a proactive action plan to promote and disseminate information about preventive measures to combat these health problems and in particular, to raise awareness about the need for regular testing to facilitate early identification and treatment, is urgently required.
2. The Government needs to collect data on the status of Hong Kong's ethnic minority elderlies, their healthcare needs based on the illness and recovery patterns among this group, the numbers in old age homes or in the longer-term care of non-family members and the level and types of support they require. Such data disaggregated by ethnicity, age and gender is indispensable for proper policy development, planning and implementation.
3. Given the number of ethnic minority elderlies, 24-hour personal emergency link for emergency support, consultation, counselling, home visits to seniors by ethnic minority staff and referral services for ethnic minority seniors should be implemented to enhance accessibility to healthcare for this group.
4. The lack of data on the demographics of sex workers highlights the need for Government to gather such data about sex workers, disaggregated by ethnicity, so that their relevant needs can be better understood and specifically addressed in light of their pattern of work, the risks they are exposed to and the barriers they face in seeking treatment in the health setting.
5. It is necessary to collect data pertaining to the practice of female genital mutilation, its prevalence in Hong Kong or whether the operations have been undergone elsewhere among returning girls during their time away. Mapping out the scale and extent of the practice would be very useful in designing appropriate health intervention and awareness raising measures that are targeted and specific to the population group concerned.
6. Gender imbalance in the South Asian population and particularly for certain ethnic groups: rights of the girl child are equally protected under the law. It is important to better understand this phenomenon and take an evidence-based approach to outlining the necessary educational, practical, medical and other initiatives.
7. Treatment approaches for health issues arising as a result of domestic violence require a holistic and regular treatment programme, coupled with culturally appropriate impact assessment tools to determine behavioural responses and triggers and design effective preventive, treatment and therapeutic strategies to deal with the high incidence of domestic violence.
8. Therefore, there needs to be a wider dissemination of information about the types of acts that constitute domestic violence in Hong Kong, and the help available whilst at the same time, data collection efforts need to be standardised across

service sectors to better understand patterns of domestic violence and help-seeking within the ethnic minority population. For example, the use of a standardised assessment tool and intake form for ethnic minority victims of domestic violence.

9. Accreditation of interpreters through a rigorous training program in professionalism and ethics is vital to guard against compromising the safety of the women and to minimise their exposure to risks to their health and life. More importantly, this would help secure their equal right to timely and quality healthcare.

10. These barriers highlight a distinct message for medical professionals: there is a need for a culturally appropriate treatment program for victims suffering from PTSD, perpetrators needing cognitive behavioural therapy and to address the physical and mental health needs of ethnic minorities.

11. Given the centrality of effective communication to an effective counselling relationship and experience, there is a need for culturally sensitive and culturally appropriate counselling [95] preferably without the intervention of an interpreter in order for it to be empowering and effective in achieving the desired treatment outcomes. This is unprecedented in Hong Kong.

12. Perpetrator intervention programs such as the batterer intervention programmes or cognitive behavioural therapy are predominantly available in Chinese. The few programmes that are available in English may or may not be of assistance to certain groups of ethnic minority perpetrators, who may only be able to benefit from a programme that resonates with their cultural and language needs. For reasons similar to the need for culturally sensitive counselling, culturally sensitive programmes designed to rehabilitate a perpetrator through cognitive behavioural therapy need to be developed and made readily accessible.

13. Hospitals should consider different cultural and religious needs of families whose relatives are nearing death or die in the course of treatment and make available a room for them to grieve or pray in accordance with their beliefs whilst staying close to their loved ones. There should also be greater sensitivity displayed in the handling of bodies post-mortem to ensure that the actions are not hurtful given certain cultural, religious or traditional beliefs. Efforts should be made to display understanding, empathy and respect in times like these.

14. The Government should consider using technology to provide interpretation services to patients in need, for example, through working with overseas interpretation service providers to operate a 24/7 dial in hotline to cover a wider range of languages, for example.

15. Civil society organisations should be clear in their mission to assist ethnic minorities without requiring them to abandon their own religious, cultural or traditional belief frameworks or insisting that they convert to another religious doctrine before offering assistance.

16. Mandatory and regular human rights and cultural sensitivity training for all those engaged as professionals in the healthcare sector. This should be formalised into the ongoing medical education programme and accreditation schemes for licensed medical practice.

[1] Kar Wai Tong, 'Good Death Through Control Over Place of Death: A Snapshot in Hong Kong' in Tong Kar-wai and Kenneth Fong Nai-kuen (eds), *Community Care in Hong Kong: Current Practices, Practice-research Studies and Future Directions*, (City University Press 2014) 170.
[2] International Covenant on Civil and Political Rights, art 25(c); International Covenant on Economic Social and Cultural Rights, art 12.
[3] Race Discrimination Ordinance (Cap 602).
[4] Census and Statistics Department, 'Population Census Thematic Report: Ethnic Minorities' (Hong Kong SAR Government 2012) para 2.2.
[5] [2009] HKCFI 245; HCPI 1162/2002.
[6] United Christian Nethersole Community Health Service, 'South Asian Health Support Programme Annual Report 2010/2011' (United Christian Nethersole Community Health Service 2012) <http://health-southasian.hk/sahp/document/SAHP_annual_report_2010-11-25_th_May__.pdf> accessed 7 August 2015.
[7] Albert Wong, 'Diabetes screening, tips offered' *South China Morning Post* (Hong Kong, 15 November 2008) <http://www.scmp.com/article/660289/diabetes-screening-tips-offered> accessed 7 August 2015.
[8] Catherine XR Chen and KH Chan, 'Type 2 Diabetes Management in Hong Kong Ethnic Minorities: What Primary Care Physicians Need to Know' (2014) *Hong Kong Medical Journal 222-228* <http://www.hkmj.org/system/files/hkm1406p222.pdf> accessed 7 August 2015.
[9] *South China Morning Post*, 'City should offer health education appropriate to different cultures' *South China Morning Post* (Hong Kong, 1 October 2012) <http://www.scmp.com/comment/letters/article/1051114/city-should-offer-health-education-appropriate-different-cultures> accessed 7 August 2015.
[10] *Ibid.*
[11] World Health Organization, 'Fact Sheet of HPV and cervical cancer' (World Health Organization 2015) <http://www.who.int/mediacentre/factsheets/fs380/en> accessed 7 August 2015.
[12] http://www.cervicalscreening.gov.hk/english/sr/files/2014_Eng.pdf, p. 2.
[13] United Christian Nethersole Community Health Service (n 6) 12.
[14] *ibid* 13.
[15] One study which examines cervical cancer screening related knowledge in 2004 has been conducted by Dr Gurung Sharmila, 'Cervical Cancer screening related knowledge, attitude and behaviour: a comparison between South Asian and Chinese women in Hong Kong' (MSc, University of Hong Kong 2014) <http://hub.hku.hk/bitstream/10722/26948/1/FullText.pdf> accessed 7 August 2015.
[16] Legislative Council, 'Progress Report on Motion on "Formulating a medical policy to support ethnic minority elderly people" at the Legislative council meeting on 27 November 2013' (Legislative Council of Hong Kong 2013) <http://www.legco.gov.hk/yr13-14/english/counmtg/motion/cm1127-m3-prpt-e.pdf> accessed 7 August 2015.
[17] Senior Citizen Home Safety Association, 'Services' (*Senior Citizen Home Safety Association* 2014) <https://www.schsa.org.hk/en/services/index.html> accessed 7 August 2015.
[18] Senior Citizen Home Safety Association, 'Ethnic Minority Service' (*Senior Citizen Home Safety Association* 2014) <http://www.schsa.org.hk/remc/#anch2> accessed 1 August 2015.
[19] This observation is based on anecdotal evidence gathered by the author as reflected to her by NGO staff and boards of management.
[20] The legal obligation to protect the healthcare needs of all people regardless of race, ethnicity, nationality, origin or other status stems from Hong Kong's obligations under the International Covenant on Economic, Social and Cultural Rights, which is constitutionally incorporated into the Hong Kong Basic Law through Article 39. For specific provisions of the Covenant, see (n 2).
[21] Ziteng, 'The Sex Industry in Hong Kong' (*Ziteng* 2014) <http://www.ziteng.org.hk/platform/pfc03_e.html> accessed 7 August 2015.
[22] For example, Eni Lestari, adviser to the Association of Indonesian Migrant Workers in Hong Kong, shares that Indonesians who first arrived in Hong Kong as domestic helpers ended up working as sex workers due to financial difficulties. See Yenni Kwok, 'Not Just Sex Workers: Here's What We Know

About the Hong Kong Murder Victims' (Time, 5 November 2014) <http://time.com/3557731/rurik-jutting-wanchai-murder-sumarti-ningsih-seneng-mujiasih-jesse-lorena-indonesia-migrant-worker-domestic-helper> accessed 7 August 2015.

[23] Puja Kapai, 'Understanding and integrating cultural frames of reference in the development of intervention strategies to address domestic violence among ethnic minority victims and perpetrators of domestic violence' (The University of Hong Kong's Centre for Comparative and Public Law 2015) <www.hku.hk/ccpl/publications> accessed 7 August 2015.

[24] *Ibid*.

[25] Ziteng (n 21).

[26] There was a string of sex worker murders in 2009 in which sex workers were robbed and murdered. These remain unresolved cases. The common pattern of the crimes against sex workers in these cases led to an outcry over their vulnerability as fuelled by the prohibition against vice establishments, which covered a case where more than sex workers were operating out of the same premises. This has led to a proliferation of one-woman brothels, leaving the women vulnerable without security or access to help if something goes wrong in the course of the trade. This is a general matter which warrants due attention. See: Deena Guzder, 'Hong Kong Alarmed Over Sex-Worker Murders' (*TIME Magazine*, 10 February 2009) <http://content.time.com/time/world/article/0,8599,1878395,00.html> accessed 15 September 2015.

[27] This has been well documented by Ziteng in relation to sex-workers in Hong Kong. See *ibid* (n21).

[28] See Fact Sheet on Female genital mutilation, updated February 2014: World Health Organization, 'Female genital mutilation' (World Health Organization 2014) <http://www.who.int/mediacentre/factsheets/fs241/en/> accessed 7 August 2015.

[29] Paul O'Connor, *Islam in Hong Kong: Muslims and Everyday Life in China's World City* (Hong Kong University Press 2012) 192.

[30] Offences Against the Person Ordinance (Cap 212), s. 47C.

[31] Diana Martin, 'Motherhood in Hong Kong: the working mother and child-care in the parent-centred Hong Kong family' in *Hong Kong, the Anthropology of a Chinese Metropolis* (Curzon Press 1997).

[32] Census and Statistics Department, 'Thematic Report: Ethnic Minorities' (Census and Statistics Department of the Hong Kong Special Administrative Region 2011' <http://www.statistics.gov.hk/pub/B11200622012XXXXB0100.pdf> accessed 6 August 2015.

[33] *ibid*.

[34] *ibid*.

[35] Joyful Heart Foundation, 'Effects of Domestic Violence' (*Joyful Heart Foundation* 2015) <http://www.joyfulheartfoundation.org/learn/domestic-violence/effects-domestic-violence> accessed 7 August 2015.

[36] Women's Commission, 'Women's Safety in Hong Kong, Eliminating Domestic Violence' (Women's Commission in Hong Kong 2009) <http://www.women.gov.hk/download/library/report/Safety-Supp.pdf> accessed 7 August 2015, 26.

[37] Douglas Brownridge and others. 'Pregnancy and Intimate Partner Violence: Risk Factors, Severity, and Health Effects' (University of Nebraska 2011) <http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1158&context=sociologyfacpub> accessed 7 August 2015. The Government has launched Comprehensive Child Development Services in phases since July 2005 to identify at-risk pregnant women, families with psychological needs, and pre-primary children with physical, developmental and behavioural problems, 31.

[38] Association for Concern for Legal Rights of Victims of Domestic Violence, 'Re: Shelter service for Ethnic Minority Victims of Domestic Violence and Sexual Violence' (2015) LC Paper No. CB(2)824/14-15(11) <http://www.legco.gov.hk/yr14-15/english/panels/ws/ws_dv/papers/ws_dv20150209cb2-824-11-e.pdf> accessed 7 August 2015.

[39] *ibid*.

[40] Puja Kapai, 'Understanding and integrating cultural frames' (n 23).

[41] *Ibid*.

[42] *ibid*.

[43] *ibid*.

[44] Kumaralingam Amirthalingam, 'Women's Rights, International Norms, and Domestic Violence: Asian Perspectives' (2015) 27(2) *Human Rights Quarterly*; Puja Kapai, 'Minority Women: A Struggle for Equal Protection against Domestic Violence' in Beverley Baines, Daphne Barak-Erez and Tsvi Kahana (eds), *Female Constitutionalism: Global Perspectives* (Cambridge University Press 2012) 14.

[45] This is suggested, for example, by the fact that only a Chinese version of the pamphlet on Batterer Intervention Programme, is available by the Social Welfare Department, see Social Welfare Department – Support for Victims of Child Abuse, Spouse/Cohabitant Battering and Sexual Violence, 'Welfare

Services' (Social Welfare Department of Hong Kong 5 February 2015) <http://www.swd.gov.hk/vs/english/welfare.html> accessed 7 August 2015.

[46] Matthew A Pugh and Arlene Vetere, 'Lost in Translation: An Interpretative Phenomenological Analysis of Mental Health Professionals' Experiences of Empathy in Clinical Work with an Interpreter' (2010) 82(3) *Psychology and Psychotherapy: Theory, Research and Practice* 305.

[47] Numerous NGO submissions to various human rights treaty bodies of the United Nations have included these complaints.

[48] Hong Kong Unison Limited, 'Submission to the Panel on Home Affairs in response to the Outline of the Second Report of the HKSAR under the convention on the Elimination of all Forms of Racial Discrimination' (Hong Kong Unison Limited 2007) <http://www.unison.org.hk/DocumentDownload/R01-Position%20papers/2007/ha0112cb2-914-1-e.pdf> accessed 7 August 2015.

[49] *ibid* 7.

[50] Harvard Medical School, '12 things you should know about common pain relievers' (*Harvard Health Publications*, 26 January 2015) <http://www.health.harvard.edu/pain/12-things-you-should-know-about-pain-relievers> accessed 7 August 2015; Ray Sahelian, MD, 'Acetaminophen dosage and benefit, side effects, safety, danger, risks, known by brand name Tylenol' (*Dr. Ray Sahelian, MD.*, 4 February 2015) <http://www.raysahelian.com/acetaminophen.html> accessed 7 August 2015.

[51] http://www.com.cuhk.edu.hk/varsity/0901/periscope2.pdf, p. 1.

[52] Hong Kong Council of Social Service, '少數族裔在香港' (*Hong Kong Council of Social* Service, October 2013) <http://www.hkcss.org.hk/uploadFileMgnt/pb15.pdf> accessed 5 August 2015, 17.

[53] Ibid.

[54] Race Relations Unit, 'Support Service Centres for Ethnic Minorities' (*Home Affairs Department of Hong Kong*, 19 January 2014) <http://www.had.gov.hk/rru/english/programmes/programmes_comm_sscem.html> accessed 1 August 2015.

[55] For example, see Services for Harmonious Integration & Neighbourhood Empowerment, 'Health Care in Hong Kong' (Christian Action 2012) <http://www.christian-action.org.hk/shine/index.php?option=com_weblinks&view=category&id=44%3Ahealth-care-in-hong-kong&Itemid=102> accessed 7 August 2015.

[56] Hong Kong Christian Service, 'Centre for Harmony and Enhancement of Ethnic Minority Residents' (Hong Kong Christian Service 2015) <http://www.hkcs.org/gcb/cheer/cheer-e.html> accessed 7 August 2015.

[57] Information obtained through a conversation with a member of staff at the Centre for Harmony and Enhancement of Ethnic Minority Residents on 6 July 2015.

[58] Urdu, Hindi, Punjabi, Nepali, Thai, Bahasa Indonesia, Tagalog, Bengali, Vietnamese, Korean, Japanese, German, French, Sinhala, Arabic, Spanish, Portuguese, Malay, and Taiwanese.

[59] Hong Kong TransLingual Services, 'Ethnic Minority Interpretation and Translation Services' (*Hong Kong TransLingual* Services, 2014) <http://www.hk-translingual.com/new/en/index.php> accessed 7 August 2015.

[60] *Ibid*,Urdu, Hindi, Punjabi, Nepali, Bahasa Indonesia, Vietnamese, Thai, Korean, Bengali, Japanese, Tagalog, German, French, Sinhala, Spanish, Arabic, Malay and Portuguese.

[61] In November 2013, a member of the Legislative Council, Professor and the Honourable Mr. Joseph Lee, moved a motion on "Formulating a Medical Policy to Support Ethnic Minority Elderly People" to urge the Government to address issues of healthcare faced by ethnic minority elderly. In January 2014, the Government published a progress report (the Progress Report) setting out measures implemented and follow-up action taken by the Government in response to the motion: see Food and Health Bureau, 'Progress Report for Motion on "Formulating a medical policy to support ethnic minority elderly people" at the Legislative Council meeting on 27 November 2013' (Legislative Council 2014) <http://www.legco.gov.hk/yr13-14/english/counmtg/motion/cm1127-m3-prpt-e.pdf> accessed 7 August 2015, para 3.

[62] *ibid*, para 4.

[63] Puja Kapai, 'Understanding and integrating cultural frames' (n 23).

[64] Food and Health Bureau, Progress Report (n 61) para 4.

[65] Food and Health Bureau, 'Existing and planned measures on the promotion of equality for ethnic minorities' (Food and Health Bureau 2015) <http://www.cmab.gov.hk/doc/en/documents/policy_responsibilities/the_rights_of_the_individuals/aggpre/FHB-Medical_and_Health-e.pdf> accessed 7 August 2015.

[66] *ibid* para 5.

[67] On 15 October 2014, the Secretary for Food and Health, Dr. Ko Wing-man responded in a Legislative Council Meeting to a question regarding steps taken by the Hospital Authority to deal with language barriers facing ethnic minorities in seeking appropriate medical treatments: Government Information Centre, 'Steps Taken by HA Regarding Language Barriers Reply' (Hong Kong SAR Government 2014) <http://www.info.gov.hk/gia/general/201410/15/P201410150649.htm> accessed 7 August 2015.
[68] *ibid*, para 6.
[69] *ibid*.
[70] *ibid*.
[71] Food and Health Bureau, Progress Report (n 61) para 10.
[72] Hospital Authority, 'Hospital Authority Ethnic Minority Website' (*Hospital Authority of Hong* Kong, 2015) <http://www3.ha.org.hk/em/> accessed 7 August 2015.
[73] ibid para 11.
[74] Martin Jacques, 'It seemed impossible, but at last Martin Jacques got justice for the wife he loved' *The Guardian* (London, 4 April 2010) <http://www.martinjacques.com/articles/it-seemed-impossible-but-at-last-martin-jacques-got-justice-for-the-wife-he-loved/> accessed 7 August 2015.
[75] Settlement in Hong Kong Case, Leigh & Day, < http://www.leighday.co.uk/News/2010/March-2010/Settlement-in-Hong-Kong-case> accessed 28 August 2015.
[76] KELY Support Group and Department of Applied Social Sciences of the Hong Kong Polytechnic University, 'More than half of ethnic minority youths are at risk of drug abuse among other findings in ground-breaking research' (*KELY Support Group*, 27 May 2012) <http://www.kely.org/assets/files/PDF/Press%20Release/Press%20Release_Report%20Launch%20for%20Stand%20Up%20and%20Say%20Something_English_web.pdf> accessed 7 August 2015.
[77] Candy Chan, 'Minorities missing out in war on drugs' *The Standard* (Hong Kong, 28 May 2012) <http://www.thestandard.com.hk/news_detail.asp?we_cat=4&art_id=122826&con_type=1&d_str=20120528&fc=1> accessed 7 August 2015.
[78] Shirley Zhao, 'Drug use on the fringes', *TimeOut News* (Hong Kong, 2 July 2012) <http://www.timeout.com.hk/big-smog/features/51903/drug-use-on-the-fringes.html> accessed 7 August 2015.
[79] *ibid*.
[80] Kwok-leung Tang, Hung Wong and Chau-kiu Cheung, 'A Study on the Drug Abuse Situation among Ethnic Minorities in Hong Kong' (Department of Social Work at the Chinese University of Hong Kong and Unison Hong Kong 2006) <http://www.nd.gov.hk/pdf/executive_summary_eng.pdf> accessed 7 August 2015.
[81] *ibid* 27.
[82] *ibid* 28.
[83] *ibid* 3.
[84] 'Drug use on the fringes' (n 78).
[85] *ibid* 57.
[86] 'Drug use on the fringes' (n 78).
[87] *ibid* 29.
[88] 香港工人健康中心, 天主教香港教區教區勞工牧民中心(九龍), '香港少數族裔共融職業健康行動研究報告' (社福智匯平台 2011) <http://c4e.hkcss.org.hk/chi/research.php?n=5> accessed 7 August 2015.
[89] *ibid* at 3.
[90] *ibid* at 5.
[91] *ibid*.
[92] *ibid* at 8.
[93] *ibid* at 12.
[94] *ibid* at 7 - 8.
[95] Charles R Ridley, *Overcoming Unintentional Racism in Counselling and Therapy* (Sage Publications 2005).