

Refugee Health Care:

A handbook for health professionals

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MANATŪ HAUORA

Foreword

In the 10 years since the publication of the first refugee health handbook there have been considerable steps taken towards improving long-term settlement outcomes for refugees settled in New Zealand. This has been as a result of cross-sector collaboration between the Department of Labour, Immigration New Zealand and settlement service branches, the Ministry of Health and District Health Boards, and the wider governmental sector, including Housing New Zealand and the Ministry of Education.

In the health sector, partnerships between District Health Boards, non-governmental organisations, settlement services and refugee communities has led to the delivery of services which are culturally, linguistically and religiously appropriate to refugee communities. The participation of people from refugee backgrounds in the health and disability sector workforce is increasing, and contributes significantly to the capacity of services to meet the specific needs of refugee families.

In addition, health services have made considerable efforts to meet the high and complex health needs of refugee groups. Initiatives such as the provision of interpreting services and culturally and linguistically diverse group (CALD) cultural competency training, along with tailored and targeted health programmes, have made a difference to improving access and equity for refugee groups.

Health issues related to changes in lifestyle are emerging with the long-term settlement of refugee communities. Reduced physical activity, diets high in fats and sugars, and smoking place refugee groups, particularly those from South Asian, Middle Eastern and African groups, at risk of cardiovascular disease, obesity and diabetes. Including refugee groups and their ethnic communities in mainstream prevention, screening and intervention services and

programmes is of importance in maintaining good health outcomes for settled communities.

The 2012 update of *Refugee Health Care: A handbook for health professionals* discusses new refugee communities settled in New Zealand, emerging trends in the health of refugee groups and current therapies, and adds new service providers. Written in consultation with health providers, experts in the field and people from refugee backgrounds, it is designed to support health workers in primary, community and secondary health care settings in the delivery of safe, effective and culturally appropriate care for their refugee clients.

We are confident this update will be as valuable as the original handbook.

Hon Tony Ryall
Minister of Health

Hon Nathan Guy
Minister of Immigration

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Refugees – Who They Are and Where They Come From

Who is a refugee?

A refugee is: any person who, owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable, or owing to such fear, is unwilling to avail himself/herself of the protection of that country.

United Nations Convention Relating to the Status of Refugees¹

Refugees are the human casualties that stream from the world's trouble spots. They are driven from their homelands by major crises such as war, religious and political persecution, brutal regimes, ethnic cleansing, military uprisings and anarchy.

Very few refugees emerge from their experiences without having endured or witnessed some form of physical or psychological trauma. The long-term physical² and psychological³ sequelae resulting from this exposure are common features of the 'refugee experience'.⁴



Mikhail Esteves

What is the 'refugee experience'?

The term 'refugee experience' refers to the physical, psychological and social experiences of refugees as they flee conflict and persecution and seek safety.

Refugee experiences are diverse. Some refugees, such as those from Southern Sudan, have endured years of warfare. Others, such as the Hazara from Afghanistan, have suffered internal displacement or repression within their own countries for long periods. Still others

have been subjected to siege conditions in their home towns and cities, as in Burma, or have lived through the terror of total anarchy, as in Somalia.

It is estimated that 40 percent of refugees have experienced severe trauma, such as witnessing killings – often of their own family members.⁵ Many have survived detention, physical violence, rape and perilous journeys to countries of asylum, only to endure a hand-to-mouth existence in dangerous overcrowded camps or urban refugee environments.



Nikki Denholm

There are over 42 million refugees and displaced people worldwide.⁶ Less than 2 percent of refugees in need of resettlement are resettled every year. In resettlement countries, the refugee experience continues, as communities struggle to adapt to a new environment and to rebuild their shattered lives.⁷

How do refugees enter New Zealand?

There are three ways in which refugees arrive in New Zealand.

1. The refugee quota programme (quota refugees)

The Refugee Quota Branch of Immigration New Zealand within the Department of Labour is responsible for managing New Zealand's annual refugee quota programme. Through the refugee quota, New Zealand contributes to the global community's efforts to assist refugees in need of resettlement. The size and composition of the refugee resettlement quota is set by the Minister of Immigration and the Minister of Foreign Affairs and Trade, after consultation with the United Nations High Commissioner for Refugees (UNHCR), relevant government departments, non-government organisations (NGOs) and refugee communities.

All refugees considered for resettlement under New Zealand's annual refugee quota programme (except certain applicants who are nuclear or dependent family members of the principle applicant) must be recognised as a refugee under the UNHCR's mandate and have been referred to the UNHCR according to prescribed settlement guidelines.

In recent years, New Zealand's annual resettlement quota has been maintained at 750 places, with a focus on the needs and priorities identified by the UNHCR. The Government targets the quota towards refugees in greatest need of resettlement, balancing this with New Zealand's capacity to adequately provide for those accepted.

Quota refugees are considered under the following categories:

- women at risk
- protection
- medical/disability.

On arrival, quota refugees spend a six-week orientation period in the Mangere Refugee Resettlement Centre (MRRC).

2. Refugee family sponsored migrants under the refugee family support category (family reunification members)

Those entering the country under Immigration New Zealand's refugee family support category (RFSC) are relatives of refugees already living in New Zealand. The RFSC replaced the former refugee family quota policy. Its objective is to help refugees living in New Zealand to settle by allowing them to sponsor the emigration of family members who do not qualify for residence under any other immigration policy. The sponsored relatives may be refugees, but this is not a requirement of the policy. Application and travel costs are generally met by relatives, who are themselves often struggling with their own resettlement costs and challenges. There are 300 residence places available under the RFSC annually.

3. Spontaneous refugees (asylum seekers)

Asylum seekers usually seek protection on arrival at New Zealand's borders, or when their temporary visa expires. Immigration New Zealand confirms or rejects claims for refugee or protection status depending on whether claimants' circumstances meet criteria set out in the United Nations Convention relating to the Status of Refugees, the Convention against Torture (and Other Cruel, Inhuman or Degrading Treatment or Punishment) and Articles 6 and 7 of the International Covenant on Civil and Political Rights. Claimants have a right of appeal to the Immigration and Protection Tribunal. Those who are successful in either the first instance or on appeal are eligible to apply for permanent residence and, later, New Zealand citizenship.

What is the difference between a migrant and a refugee?

Table 1 gives a general outline of the typical differences between migrants and refugees. (However, it is important to note that some migrants can experience similar resettlement issues to refugees.)



Table 1: The difference between a migrant and a refugee

Refugees	Migrants
Refugees do not choose to leave their homeland. They flee in response to a crisis. They have little choice about where they go and by what means they will travel. They have no time to pack or to distribute possessions. Almost everything is left behind.	Migrants choose to leave their homeland and settle in a country of their choice. They arrange the most suitable method of travel and pack the possessions they wish to take. They can sell or dispose of possessions they do not wish to take.
Refugees, due to their hurried, often secret departure, are unprepared emotionally for leaving, and may not have time to farewell loved ones.	Migrants have time to prepare emotionally for their departure and to farewell friends and family appropriately.
Refugees often flee without any documentation whatsoever.	Migrants take with them their travel documents, passports and other documentation, including educational qualifications.
Refugees must often leave family members behind.	Migrants usually emigrate with their families.
Refugees, although they dream of returning home, know that this is unlikely to happen. ⁸	Migrants depart for their new country knowing that they can return to their homeland for visits, or return permanently if they cannot settle in the new place.
Refugees arrive in their new country ill-prepared and often traumatised. They have little in the way of possessions and financial resources. They are often debilitated by a pervading sense of loss, grief, worry and guilt about the family left behind.	Migrants are usually well prepared and well motivated to settle in a new country. Many will have found out about schools, employment and local conditions before they left their homeland.

The experience of refugee women

A mother of four children looks after her 10-year-old son who is chronically sick and unable to walk because of severe pain in his joints including knees, elbows, hip and back. She has to carry him everywhere, including to the toilet at night and to the health centre for treatment. She suffers pain in her shoulders and back and constantly worries about him when she is away from him such as when collecting rations, water, attending bail conditions etc.

No effective treatment has been provided for her son through the camp health centre so she sells rations to procure treatment and medications outside the camp. She has no male support in camp and shoulders the responsibility for her children, her elderly and sick mother, her siblings and nieces and nephews. She describes symptoms such as headaches, shoulder pains, dizziness when standing, poor sleep, loss of appetite, many fears and worries and ‘always thinking.’⁹
Burmese refugee woman¹⁰

The experiences of women and girls during flight, in exile and post-conflict are significantly different from those of men. Displaced women and girls hold their families together under the most difficult and inhumane circumstances, and do so while at increased risk to their safety and wellbeing – risks that include rape, beatings, torture, hunger and abandonment.

Approximately 50 percent of any refugee population are women and girls.¹¹ Stripped of the protection of their homes, their government and often their family structure, women are often particularly vulnerable.¹² They face the rigours of long journeys into exile, official harassment or indifference and frequent sexual abuse – even after reaching an apparent place of safety.¹³

The danger is the same, near or far, but there's no wood nearby. When we are there getting the wood, local people sometimes take the girls' clothes off and do bad things. The people wear green uniforms. Some have camels, some have horses. At the place where we get the firewood they tell us, 'Line up one by one'. They say, 'Stand two by two', and they take us off like that and then they rape us . . . Sometimes this happens until evening. We have told the police, but the police say, 'stay in your tent and nothing will happen'.

African refugee woman¹⁴

The numbers of single woman-and child-headed households increase during conflict. Female adolescent heads of households are particularly at risk of rights violations and marginalisation.¹⁵

The position of women and girls in society, their lack of means to travel and the particular risks they face during flight mean that it is generally more difficult for women than men to reach a country where they can safely seek asylum.¹⁶ Women are much more likely to make perilous journeys on foot over borders into the nearest safe country, together with their children and other family members, and to seek refuge in a refugee camp.¹⁷

Sexual and gender-based violence – including rape, forced impregnation, forced abortion, trafficking, sexual slavery and the intentional spread of sexually transmitted infections (STIs), including HIV/AIDS – is one of the defining characteristics of contemporary armed conflict.¹⁸ Its primary targets are women and girls.

Women and girls, like men and boys, also risk abduction and forced recruitment by armed groups, whether as fighters, for sexual exploitation or for other tasks.

The situation of displaced women and girls living in camps, often for years on end, leads to a host of protection risks.¹⁹ Refugee



Nikki Denholm

camps are often located in insecure areas, and may be subject to cross-border attacks. After many years, there may be declining international attention and resources for refugees in camps including: restricted access to health care, educational and skill-training assistance; and income-generating activities. Sexual and gender-based violence, including domestic violence and alcohol abuse, increases in such circumstances.

Women and girls' position in society often leaves them with fewer opportunities to get information, because they lack education and basic literacy skills and also because they are less likely to be invited to meetings or attend them due to other responsibilities such as child care. They are also less likely to be members of decision-making bodies in their community, which are often the main target of aid agency information-sharing activities. In the words of one woman in a refugee camp:

We are kicked like a ball from one service to the next and we don't get the help we need ... The implementing partner's offices are all in fenced compounds. When we go there for help, we have to take a token and wait outside in line. There is no shelter from the sun and no drinking water. We often have to wait most of the day and those who are sick and old can't do it.

Refugee woman²⁰

Refugee country of origin information

Groups from the Horn of Africa

During the 1990s, the largest proportion of New Zealand's refugee intake was from Horn of Africa countries such as Eritrea, Ethiopia, Somalia and Sudan.

Eritrea

The country of Eritrea was established in 1993. The country has a population of 3.6 million, comprising nine major tribes or clans, each with its own language. The population is roughly half Muslim, half Christian (see Table 2).

Eritrea was administered by the British until 1952, when the United Nations granted Eritrea self-government within a federal union of Ethiopia. Ten years later and after a number of incidents, Eritrea sought to shake off Ethiopian control. The war for independence from Ethiopia lasted 30 years.

From 1988, the Eritrean force began to gain the upper hand. Three years later, the Eritreans won Asmara, the capital, and a provisional government for Eritrea was established under Isaias Afewerki. In 1993, the country won independence under the People's Front for Democracy and Justice. Hostilities between Eritrea and Ethiopia broke out in May 1998. Despite various attempts at mediation between the two countries, fighting continued until 18 June 2000, when the Algiers agreement was signed and both sides agreed to an immediate ceasefire and the deployment of a United Nations peace-keeping force. However, the border demarcation is an ongoing obstacle to peace between Eritrea and Ethiopia – a circumstance the Government uses to justify repressive policies.²¹

Since 2001 the Government of President Isaias Afewerki has carried out unremitting attacks on democratic institutions and civil society in Eritrea by arresting political opponents, destroying the private

press and incarcerating anyone thought to be challenging the Government's policies. Almost no civil society institutions survive, and repression of religious practitioners, military service evaders and staff of international agencies continues.²²

Scores of Eritrean asylum seekers cross into Sudan every week; Sudan currently hosts in excess of 89,000 Eritrean refugees. The majority of Eritrean refugees fled to Sudan in the early 1970s and 1980s during the war of independence between Eritrea and Ethiopia as well as in the late 1990s during the border conflict between the two countries. A large number of refugees are second-generation, having been born and raised in Sudan and having limited ties to, or knowledge of, their country of origin. Internal strife within Sudan continues to impact negatively on refugee protection inside the country. Eritrean refugees began arriving in New Zealand in 1994.

Ethiopia

Ethiopia is a landlocked country bordered by Eritrea, Sudan, Kenya, Djibouti and Somalia. It has a population of around 55 million, comprising more than 80 ethnic groups. The largest of these groups is the Oromo, followed by the Amhara and Tigrayan groups. Roughly 40 percent of the population is Christian, 40 percent is Muslim and the rest follow traditional faiths (see Table 2). There are conflicts between ethnic groups and factions within political parties.

Ethiopia is unique among African countries for having never been colonised, although it was occupied by the Italians for five years before and during part of World War 2, after which the Italians surrendered to Allied forces and Ethiopia resumed its independence.

Ethiopia's neighbour, Eritrea, remained under British administration until 1952, when the United Nations granted it self-government within a federal union of Ethiopia. In 1962 Emperor Haile Selassie unilaterally annexed Eritrea as a province of Ethiopia. This led to an

outbreak of guerrilla warfare, because the Eritreans regarded the annexation as colonisation by another African nation. A border war with Eritrea late in the 1990s ended with a peace treaty in December 2000, but there have been continued border clashes with Eritrea since Ethiopia's attempt to annex the territory in 1962.

In 1974, a coup led by Lieutenant Colonel Mengistu Haile Mariam ousted the Emperor. From 1977 to 1991 wars and major famines ravaged the country, killing over half a million people. These catastrophes, and the withdrawal of Soviet support, forced Mengistu to flee, and the Government was taken over by a coalition of rebel groups led by Meles Zenawi. In May 1995 Ethiopia held its first ever parliamentary elections, and Zenawi was confirmed as prime minister.

The human rights situation in Ethiopia remains poor. There have been reports of political disappearances; the mistreatment of detainees and opposition supporters by security forces; poor prison conditions; restrictions on press freedom and harassment of journalists for publishing articles critical of the Government; restrictions on freedom of assembly and freedom of association; and the discrimination and abuse of women and children.²³

During the decades of warfare and famine, over one million Ethiopians fled to become refugees in neighbouring, or in a third country. Ethiopian refugees have been arriving in New Zealand since 1993.

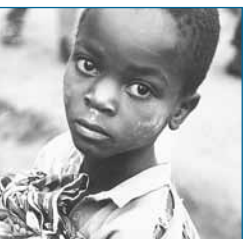
Somalia

The Somali are traditionally nomadic people; they have occupied the Horn of Africa for over 1000 years. Somalis are divided into six major clan-families (see Table 2), within which are many subclan-families. The clan-family system forms the basis of Somali society. Features of this system, such as shifting allegiances, have made the country vulnerable to political manipulation and corruption.



During the colonial era, the country was divided into British, French and Italian colonial territories. In 1960 these territories merged to become Somalia, an independent state. After a peaceful start, tensions between clans arose. In 1969, General Said Barre staged a coup and installed a military government. There followed clan persecutions, territorial conflicts with Ethiopia, famine and civil war. Throughout Barre's rule civilians suffered large-scale human rights abuses, including assaults, killings, torture and deliberate policies of genocide.

In 1991 General Barre was overthrown. Warring clans threw the country into a state of chaos and confusion. The power vacuum was filled in many areas by murderous warlords. More than 1.5 million people, representing more than a quarter of Somalia's population, fled to neighbouring countries. Most of New Zealand's intake of Somalis is drawn from refugee camps in Kenya, Ethiopia and Sudan.



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The first Somali refugees arrived in New Zealand in 1993. Somali people usually retain their clan identity and affinity in this country. It is important to take this into consideration when arranging interpreters or health education sessions for Somali clients and groups.

Sudan

The Republic of Sudan was previously the largest country in Africa, with an estimated population of 40 million.²⁴ From the late 19th century Sudan was jointly governed by Britain and Egypt until it won independence in 1956. Two years later, the first of several military coups took place. These military regimes consistently dominated the poorer south, and as a result the southern Sudanese People's Liberation Army sprang up to fight the Government for complete autonomy for the south. Years of civil war have reduced the south to a level barely above subsistence.

Sudan's borders were drawn up by colonial powers with little regard to the substantial cultural, religious, economic and historical differences between the peoples of the north and south. Most northerners are Arab or mixed Arab peoples, who are mainly Muslim. The south is made up of numerous African groups: mainly Nilotics, who follow Christian or traditional religions. With the government based in the north, many southerners were discriminated against, and the north and south have fought each other for most of the country's history.

Southern Sudan has been an autonomous region of the Republic of Sudan since 9 January 2005 when the Comprehensive Peace Agreement between the Government of Sudan and the rebel Sudan People's Liberation Army was signed.²⁵ The authoritarian President Omar Hassan al-Bashir, who chairs the ruling National Congress Party, repressed political opposition and escalated the war against the south.

The civil war killed an estimated 1.3 million people. Hundreds of thousands of southerners fled to bordering countries, or to safer areas in Sudan. The country has the largest internally displaced population in the world, estimated at 4 million people. Sudan's human rights environment deteriorated in 2010 during the April elections and in the months leading up to the historic referendum on southern self-determination.²⁶ In the election Omar Hassan al-Bashir, the subject of an arrest warrant from the International Criminal Court for crimes committed in Darfur, was re-elected president of the National Government, and Salva Kiir was elected as president of Southern Sudan and vice president of the National Government.²⁷

The referendum on independence took place in Southern Sudan from 9 to 15 January 2011. More than 98 percent of Southern Sudanese voted in favour of independence.²⁸ The Republic of Southern Sudan, Africa's newest country, came into being on 9 July 2011. Post-referendum negotiations toward a peaceful separation

and a constructive north-south relationship continue between the Sudan Peoples' Liberation Movement and the National Congress Party.²⁹ While these negotiations consume the attention of the Sudan Peoples' Liberation Movement leadership, the political landscape in South Sudan has begun to transform. Managing South Sudan's ethno-regional diversity will continue to be complex and challenging.³⁰

Refugees from Southern Sudan have been arriving in New Zealand since 1994.³¹



A comparison of the Horn of Africa refugees

Refugee intakes to New Zealand from the Horn of Africa region show a huge diversity of religion, language and clan groupings, as Table 2 indicates.

Table 2: Summary of religious, linguistic and ethnic/clan groups in the Horn of Africa

Country	Religion	Ethnic groups/clans	Languages
Eritrea	Coptic Christian; Islam; Catholic and Protestant minorities; some traditional religions	Include: Tigrinya, Tigre, Bilen, Afar, Saho, Kunama, Nara, Hidareb, Rashaida	Mainly Tigrinya or Tigray; also Arabic and local languages; some English and Italian
Ethiopia	Ethiopian Orthodox; Islam; some traditional African religions	Include: Amhara, Oromo, Tigre, Gurage, Niloti, Somali, Danakil	Amharic, Oromo, Tigrinya, and local languages; some English and Italian
Somalia	Predominantly Islam; some Christians	Include: Dir, Issaq, Hawiye, Digil, Rahawayn, Darood	Somali and Arabic; some English and Italian
Sudan: North and South	Predominantly Islam; minority Christian; some traditional religions	North: mainly Arabs, including Nubian, Jamla, Beja and other groups South: Nilotic Africans, including Dinka, Nuer and Shilluk and others	Arabic, including creole Arabic in the south, and many local languages; also some English

Source: Adapted from R Elissalde (ed). 2001. *The World Guide 2001/2002*. Uruguay: Instituto del Tercer Mundo. URL: www.itam.org.uy (accessed 20 July 2011).

The experience of conflict, flight and becoming a refugee

People from the Horn of Africa may have experienced:

- aerial bombardment and shelling
- torture, including torture of children
- arrest and killings of family members
- eviction and property destruction
- imprisonment or detention, often for prolonged periods
- separation from family members
- systematic and public rape.

Many refugees experience long and dangerous journeys to their countries of asylum. On arrival most are put into camps where conditions range from substandard to appalling. Some refugees have languished in camps for more than 10 years. Many Horn of Africa children currently in New Zealand were born in the refugee camps and have no other life experience.

Prior access to health care

The coverage of health care in the Horn of Africa countries is poor compared to New Zealand standards (see Table 3). While most major cities have hospitals with essential facilities (such as anaesthesia, theatres, pathology laboratories and X-ray machines) and programmes such as family planning and immunisation, rural areas are generally poorly serviced, and people have to travel very long distances, often on foot, to access care.

Health care is usually accessed through a community-based primary health care clinic. Much of the care routinely provided by general practitioners (GPs) in New Zealand is provided by health workers such as nurses or birthing attendants in Horn of Africa countries. Traditional healers are used extensively, particularly in rural areas. Many Horn of Africa refugees in New Zealand will be unfamiliar

with the concept of a family doctor and a formalised appointment system. These aspects will need to be explained carefully to them.

Table 3: Key health indicators – Horn of Africa

Country	Life expectancy at birth ^a	Under-five mortality rate ^b	Maternal mortality rate, pregnancy-related ^c	Total fertility rate ^d
Eritrea	60.4	58	450	4.2
Ethiopia	56.1	109	720	4.8
Somalia	50.4	200	1400	6.2
Sudan	58.9	109	450	3.7
New Zealand ^e	80.6	6	9	2

a Years a newborn is expected to live based on prevailing patterns of mortality.

b Children under five years per 1000 live births.

c Per 100,000 live births.

d Average number of live children born to a woman during her lifetime.

e Data for New Zealand presented as a basis for comparison.

Sources: United Nations Development Programme. 2010. *Human Development Report 2010 – 20th Anniversary Edition The Real Wealth of Nations: Pathways to Human Development*. New York: United Nations Development Programme.



Nikki Denholm

Groups from Central Africa

Refugees from the Central African region have formed part of New Zealand's refugee intake in the last two decades: Burundi and Rwanda since 1995; Democratic Republic of the Congo since 1999; and Republic of Congo (Congo-Brazzaville) since 2005.

Burundi

Burundi is a landlocked country in the Central African region bordered by Rwanda to the north, Tanzania to the east and south, and the Democratic Republic of the Congo (DRC) to the west. It is a constitutional republic with an elected government and a population of 8.6 million and comprising two main ethnic groups: the Tutsi and the Hutu. Sixty-two percent of Burundians are Roman Catholic, 8 to 10 percent are Muslim and the rest follow traditional beliefs and other Christian denominations.

Burundi's 16-year civil war ended in April 2009.³² In 2010, the country held its first direct presidential elections since 1993.³³ President Pierre Nkurunziza, of the ruling National Council for the Defense of Democracy-Forces for the Defense of Democracy (CNDD-FDD) party, ran unopposed in the June presidential election and was re-elected to a second term.³⁴ CNDD-FDD's election campaign relied in part on bribery and the use of state resources, along with intimidation.³⁵ In 2010, political repression reached a level not seen since 2006.³⁶

Burundi gained independence from Belgium on 1 July 1962. Much of the country's history since then has been characterised by tensions between Burundi's two main ethnic groups, the Tutsi (traditionally the dominant tribe, despite representing a minority of the overall population) and the Hutu,³⁷ resulting in violence and inter-ethnic massacres.³⁸ Since independence Burundi has also seen a number of coups and many more attempted coups.

The history of ethnic conflict goes back centuries. After World War 1 modern-day Rwanda and Burundi became part of the Belgian colonial empire known as Ruanda-Urundi. Belgium's influence as a colonial power did little to unite the two tribes. Neither tribe is contained within the borders of current-day Burundi. The Hutu-Tutsi conflict has also affected neighbouring DRC and Rwanda. Rwanda has been engaged in similar ethnic warfare. Whereas in Burundi much of the violence is perpetrated on the Hutu by the Tutsi, in Rwanda the situation is reversed. However, the two nations are closely linked, and events in one often influence and precipitate events in the other.

In Burundi, the Tutsi are still disproportionately represented in government and among the wealthy. The Hutu remain largely illiterate and poor.

Refugees from Burundi have been arriving in New Zealand since 2000.

Rwanda

Rwanda is a unitary republic of central and eastern Africa with a population of approximately 11.1 million. It is bordered by Uganda to the north, Tanzania to the east, Burundi to the south and the DRC to the west. The capital is Kigali, which is near the centre of the country. Rwandans form three groups: the Hutu, Tutsi and Twa. These groups share a common culture and language, and are classified as social groups rather than tribes. Christianity is the largest religion in the country, and the principal language is Kinyarwanda. The Tutsi Kingdom of Rwanda dominated the country from the mid-eighteenth century; the Tutsi kings conquered others militarily, centralised power and later enacted anti-Hutu policies.

Germany colonised Rwanda in 1884, followed by Belgium, which invaded in 1916 during World War I. Both European nations ruled through the Tutsi kings, and perpetuated pro-Tutsi policy. The Hutu population revolted in 1959, establishing an independent Hutu state in 1962. The Tutsi-led Rwandan Patriotic Front (RPF) launched

a civil war in 1990, which was followed by the 1994 genocide in which Hutu extremists killed an estimated million Tutsi and moderate Hutu. The RPF ended the genocide with a military victory.



Rwanda's economy suffered heavily during the 1994 genocide, but has since strengthened. Rwanda follows a presidential system of government. The president has broad powers, while the parliament makes legislation and has limited oversight. The incumbent President is Paul Kagame of the RPF party. Kagame and the RPF receive electoral support

from across the community, although human rights organisations allege suppression of the opposition.³⁹

Refugees from Rwanda have been arriving in New Zealand since 2000.

Democratic Republic of the Congo (DRC)

The DRC (formerly Zaire) is a Central African state with a population of nearly 71 million. It is bordered by the Republic of the Congo, the Central African Republic, South Sudan, Uganda, Rwanda, Burundi, Zambia and Angola. It gained independence from Belgium in June 1960. Following a military coup in 1965, General Mobutu gained power, remaining largely unchallenged until the late 1980s. Moves towards democratisation in the early 1990s did not succeed in removing Mobutu from power. The already fragile state was further weakened by the aftermath of the Rwandan genocide of 1994. In October 1996 dissident groups, led by Laurent Kabila and supported by Rwandan Tutsi rebels and military from Uganda, took power by force. Since 1998, widespread conflict has devastated the country. The conflict in DRC is considered the world's deadliest conflict since World War II; 5.4 million people have been killed since 1998. Its causes are numerous and complex, including conflict over basic resources such as water, access to and control over rich minerals, and various political agendas.

In 2001, fighting intensified between various rebel factions, including the Congolese Rally for Democracy, the RCD Mouvement de Liberation and the Movement of Liberation of Congo, and forces from the governments of Burundi, Rwanda and Uganda.⁴⁰ By the end of 2001, as many as 2 million people had been displaced. Despite the signing of peace accords in 2003, fighting continues in the east of the country, where the prevalence and intensity of rape and other sexual violence is described as the worst in the world.⁴¹

In general, refugees from the DRC have been subjected to human rights violations and persecution on the basis of their ethnicity and gender. In 2004, violence against civilians broke out in Bukavu province, and many were killed. The minority Banyamulenge ethnic group were targeted. Other ethnic minority groups report ongoing persecution in inter-ethnic-tribal fighting. All ethnic groups are at risk of persecution and human rights abuses at the hands of the different militia and government forces involved in the conflict.⁴² Civilians have been subjected to rape, abduction, violence, alleged cannibalism and the destruction and pillaging of property at the hands of rebel groups.⁴³

Refugees from DRC have been arriving in New Zealand since 2000.

Republic of Congo (Congo-Brazzaville)

The Republic of Congo, sometimes referred to as Congo-Brazzaville, is located in the central-western part of sub-Saharan Africa. To the south and east is the DRC. The capital, Brazzaville, is located on the Congo River, in the south of the country, immediately across from Kinshasa, the capital of the DRC. The Republic of Congo is one of sub-Saharan Africa's main oil producers, although 70 percent of the population lives in poverty. Its recent history has been marked by civil wars and militia conflicts.⁴⁴

Upon independence in 1960, the former French region of Middle Congo became the Republic of the Congo. The People's Republic of the Congo was a Marxist-Leninist single-party state from 1970 to

1991. Multiparty elections have been held since 1992, although a democratically elected government was ousted in the 1997 Republic of the Congo Civil War.

Three coup-ridden but relatively peaceful decades followed independence then In 1993 disputed parliamentary elections led to bloody, ethnically based fighting between pro-government forces and the opposition. A ceasefire and the inclusion of some opposition members in the government helped to restore peace.⁴⁵ A second bout of violence erupted in 1997, when ethnic and political tensions escalated into a full-scale civil war, fuelled in part by the prize of control of the country's offshore oil wealth, which motivated many of the warlords.⁴⁶ The army split along ethnic lines, most northern officers joining President Denis Sassou Nguesso's side and most southerners backing the rebels. These were supporters of the former president, Pascal Lissouba, and his prime minister, Bernard Kolelas, who had been deposed by President Sassou Nguesso in 1997.⁴⁷ By 1999 violence had claimed an estimated 20,000 lives and displaced as many as 800,000 people – nearly one-third of the country's 2.7 million population. The capital, Brazzaville was in ruins. However, warring factions signed cease-fire agreements in late 1999, and the peace accord held during 2000–2001, despite the slow pace of disarmament and an isolated eruption of violence in mid-2001.⁴⁸

The Republic of Congo adopted a new constitution in late 2001, reportedly the 14th constitution or fundamental legal act in the country's short history. Sassou won controversial elections in 2002 with almost 90 percent of the vote. A new constitution extended his term to seven years. Following the elections, fighting restarted in the Pool region between government forces and rebel troops. A peace treaty to end the conflict was signed in April 2003. Human rights abuses have since resulted in hundreds of deaths and 'disappearances' among vulnerable civilian and refugee populations.⁴⁹

Sassou was re-elected in July 2009, in an election marked by very low voter turnout, fraud and electoral irregularities. Remnants of the civil war militias, known as ninjas, are still active in the southern Pool region. Most have yet to disarm, and many have turned to banditry. Despite relative peace, the political situation in the Republic of Congo remains fragile.

Refugees from the Republic of Congo have been arriving in New Zealand since 2006.

Groups from Iran, Iraq and Afghanistan

Since 1979, refugees from Iran, Iraq and Afghanistan have arrived as quota refugees and asylum seekers.

Iran

Constitutional monarchy was established in Iran around the beginning of the 20th century. In practice, the constitutional component was nominal, the country being ruled largely by shahs, who maintained a strict, authoritarian system. In the rule of the last shah (1925–1979) Iran, an oil-rich nation, experienced rapid economic growth and urbanisation. While this period was characterised by economic inequality and political repression, there was also a gradual liberalisation of Iranian society. Women were no longer required by law to wear the veil, were granted the vote in the 1960s and were gradually incorporated into public life.

In 1979, Iran underwent an Islamic revolution marked by the return of the Islamic leader, the Ayatollah Khomeini, from Paris, where he had been in exile. An Islamic government was popularly elected in 1981, and Iranian society was returned to a more traditional and religious lifestyle. Between 1980 and 1988 Iran was at war with Iraq over border territories.

Since the Islamic revolution, Iranian politics have been characterised by struggles between moderate and radical forces. This has resulted in a climate of marked political repression, including the banning

of political parties and the systematic persecution of some ethnic and religious minorities, most notably the Kurds (who were also persecuted under the Shah's rule) and those of the minority Bahá'í faith.⁵⁰

Documented human rights abuses in Iran have included:

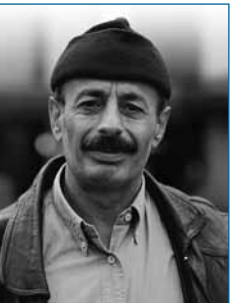
- summary execution
- amputation of limbs
- imprisonment and torture
- public flogging of women who break the Islamic dress code.

Many women report imprisonment, rape and sexually degrading treatment.

Refugees from Iran have been arriving in New Zealand since 1979.

Iraq

Following a coup d'état in 1968, Iraq was ruled by the Sunni-led Ba'ath party until 2003.⁵¹ In 1979, Saddam Hussein took control. The Ba'ath party crushed any alternative political organisation, with extrajudicial executions, detentions, torture and large-scale disappearances.⁵² Assyrian Christians and Kurds were systematically repressed.⁵³ Kurdish and Shiite Muslims who opposed the regime were subjected to particularly harsh oppression.⁵⁴



In 1990, Iraq invaded oil-rich Kuwait, in response to which the United Nations launched a military campaign resulting in the Gulf War.⁵⁵ In the same year, the UN also imposed a military, financial and trading boycott on Iraq. The 1991 uprising against Saddam Hussein by the Kurds and the Shiite Muslims in the south was brutally crushed by the Republican Guard, which arrested 150,000 people.⁵⁶ Two million people were forced to flee.

In 2003, after an invasion led by American and British forces, the Ba'ath Party was removed from power and Iraq came under a military occupation by a multinational coalition. Sovereignty was transferred to the Iraqi Interim Government in June 2004. A new constitution was then approved by referendum, and a new government was elected. However, sectarian violence between Sunnis and Shi'ites has continued to escalate.⁵⁷

Sunni-led insurgencies have staged ongoing attacks on United States-led troops, Iraq's Shi'ite-dominated government, its security forces, oil installations and civilians.⁵⁸ The insurgents include nationalists, former members of the Iraqi military and supporters of Saddam. Tens of thousands of Iraqis have died since the invasion, and the ongoing violence continues to drive many more to flee their homes. The United Nations estimates that over 4 million Iraqis have been displaced by violence in their country; the vast majority of these have fled since 2003.⁵⁹

Afghanistan

Afghanistan was a monarchy until 1973, when the reigning king was overthrown by a military coup and Muhammad Daoud became president of the new republic. Daoud's government came under increasing pressure from traditionalist rebels, who objected to the rapid social change he sought to implement.⁶⁰ By 1979 the rebels controlled much of Afghanistan, Daoud had been killed and the government's position had deteriorated. The Soviet Union invaded late that year, plunging the country into a full-scale war that lasted for the next 10 years.⁶¹ Rebel groups fighting the Soviets were sustained by weapons and money from the United States, Saudi Arabia, Iran and China.

During the Soviet occupation half the population were displaced internally, forced to flee to neighbouring countries, wounded or killed. One-third of the population was estimated to have fled the country, Pakistan and Iran sheltering a



combined peak of 6 million refugees.⁶² In 1989, after massive losses and under the relentless pressure of internationally supported anti-Communist mujahedin rebels, the Soviet Union was forced to withdraw from Afghanistan. For the next few years there was a power struggle between the new government and different factions within the country.

A series of subsequent civil wars saw Kabul finally fall in 1996 to the Taliban, a hard-line Pakistani-sponsored movement that had emerged in 1994 with the aim of ending the country's civil war and anarchy.⁶³ Harsh policies based on Sharia law were imposed. The extremist policies of the Taliban regime, deepening poverty, famine and a crippling three-year drought generated a major internal displacement problem and drove new population flows across Afghanistan's borders.⁶⁴ The new exodus added to the 6 million Afghans that had fled to neighbouring countries since 1980. Moreover, disillusioned by the state of their homeland, increasing numbers of Afghans had left the region and sought asylum throughout the world.



The Taliban controlled most of Afghanistan, with opposing factions holding the northern regions, until the United States-led invasion in October 2001. Following the 11 September 2001 terrorist attacks in New York and Washington DC, a United States, allied and anti-Taliban Northern Alliance military action deposed the Taliban government. The United Nations-sponsored Bonn Conference in 2001 established a process

for political reconstruction that included the adoption of a new constitution, a presidential election in 2004, and national assembly elections in 2005.⁶⁵ In December 2004, Hamid Karzai became the first democratically elected president of Afghanistan; the national assembly was inaugurated the following December. Karzai was re-elected in August 2009 for a second term.

Despite gains toward building a stable central government, a resurgent Taliban and continuing provincial instability – particularly in the south and the east – remain serious challenges for the Afghan Government.⁶⁶ Thousands have been killed in the violence of recent years, including many militants and foreign and Afghan troops, as well as large numbers of civilians.⁶⁷ Afghanistan is currently struggling to rebuild itself. It remains one of the poorest countries in the world, due to 30 years of war, corruption among high-level politicians and the ongoing Taliban insurgency.

Refugees from Afghanistan have been arriving in New Zealand over the last three decades.

A comparison of refugees from Iran, Iraq and Afghanistan

People forced to flee Iran, Iraq and Afghanistan come from a number of ethnic and religious groups and have different political sympathies (see Table 4).

Table 4: Summary of religious, linguistic and ethnic groups – Iran, Iraq and Afghanistan

Country	Religious and ethnic groups	Languages
Iran	Mainly Islamic (Shias predominating), other Muslim groups including Kurdish groups, Bahá'í, Catholics, Jews, Zoroastrians	Farsi (Persian), ethnic minority languages including Kurdish
Iraq	Arab and Kurdish groups, mainly Islamic (Sunnis in north and Shias in south), also Christian Assyrians	Arabic, Kurdish, Assyrian
Afghanistan	Mainly Sunni Muslims, with Shiite minority, also some Hindus, Sikhs and Jews; ethnic groups include Pashtun, Tajik, Hazaras, Uzbek and others	Pashtu, Dari, Turkic, and other minority languages

Source: Adapted from R Elissalde (ed). 2001. *The World Guide 2001/2002*. Uruguay: Instituto del Tercer Mundo. URL: www.item.org.uy (accessed 20 July 2011).

Table 5 sets out key health indicators for Iran, Iraq and Afghanistan.

Table 5: Key health indicators – Iran, Iraq and Afghanistan

Country	Life expectancy at birth ^a	Under-five mortality rate ^b	Maternal mortality rate, pregnancy related ^c	Total fertility rate ^d
Iran	71.9	32	140	1.7
Iraq	68.5	44	300	3.7
Afghanistan	44.6	257	1800	6.3
New Zealand ^e	80.6	6	9	2

a Years a newborn is expected to live based on prevailing patterns of mortality.

b Children under five years per 1000 live births.

c Per 100,000 live births.

d Average number of live children born to a woman during her lifetime.

e Data for New Zealand presented as a basis for comparison.

Sources: United Nations Development Programme. 2010. *Human Development Report 2010 – 20th Anniversary Edition The Real Wealth of Nations: Pathways to Human Development*. New York: United Nations Development Programme.

Refugees from Burma



Burma is under the control of one of the most repressive regimes in the world today. The authoritarian military government, the State Peace and Development Council (SPDC), restricts the basic rights and freedoms of all Burmese citizens.⁶⁸ Burma is one of the most ethnically diverse nations in the world. Out of Burma's population of approximately 45 million, around one-third come from ethnic minority groups, principally the Mon, Kachins, Chins, Shans, and Karen, each of whom

which have traditionally dominated a particular area of the country.⁶⁹ When Burma regained independence from Britain in 1947, the Burmese Government ignored many of the promises made by the British to ethnic minority groups. As a consequence, many ethnic groups formed armed resistance movements in opposition to the Burman dominated-government. The SPDC continues to use internationally outlawed tactics in ongoing conflicts with ethnic minority rebel groups.⁷⁰



Since a military coup in 1962, a repressive military regime has resisted a return to democracy, resulting in years of armed opposition to the Government and a dismal record of human rights violations.⁷¹ In 1988, a student uprising ended in a massacre, with thousands of mainly Karen people fleeing to the Thai border. In 1990, a national election resulted in a democratic victory, but the military regime refused to cede power.⁷² Since then fighting has intensified, as have human rights violations and the flow of refugees to Thai border camps.

Since the SPDC began forcibly relocating minority ethnic groups, they have destroyed nearly 3000 villages, particularly in areas of active ethnic insurgency and areas targeted for economic development. Abuses by the Burmese military against civilians include the widespread use of anti-personnel landmines, sexual violence against women and girls, extrajudicial killings, forced labour, torture, beatings, targeting of food production and means of civilian livelihood, and confiscation of land and property.⁷³

There is no indication that the human rights violation situation in Burma, especially towards ethnic minorities, will improve in the near future.⁷⁴ There are an estimated one million internally displaced people in Burma, and several hundred thousand Burmese refugees in Bangladesh, India, Malaysia and especially neighbouring Thailand.⁷⁵

In recent years there has been a significant rise in the number of Burmese refugees arriving in New Zealand.

Refugees from Bhutan

The Nepali-speaking Bhutanese citizens, also called *Lhotsampas* (people of the south), are Bhutanese citizens of Nepali origin, who are refugees from Bhutan.⁷⁶

People from Nepal were invited to populate the lowlands of southern Bhutan in the mid-to-late 19th and early 20th centuries. Contact between the Druk (Bhutanese) in the north and the Nepali-speaking Bhutanese (Lhotsampa) in the south was limited.⁷⁷



Despite living in Bhutan for up to five generations, the Lhotsampa retained their highly distinctive Nepali language, culture and mainly Hindu religion. However, they did participate in public life and politics, even attaining positions of significant leadership. The Lhotsampa coexisted peacefully with other ethnic groups in Bhutan until the mid-

1980s, when Bhutan's king and the ruling Druk majority became worried that the growing Lhotsampa population could threaten the majority position and the traditional Buddhist culture of the Druk Bhutanese. The Government therefore initiated a campaign known as 'One country, one people' or 'Bhutanisation', ostensibly to cement Bhutanese national identity.⁷⁸

By the late 1980s and early 1990s, a crisis had developed. Human rights violations, including detention, imprisonment without trial, and torture were not infrequent. The Nepali-speaking Bhutanese were denied basic services, including access to education, jobs and health care. The use of the Nepali language was prohibited in schools.⁷⁹ In addition, stringent and unrealistic requirements for proving citizenship were imposed on the Lhotsampa people, most of whom were denied recognition of their citizenship even when they were able to provide documentation. By the end of 1992, more than 100,000 Lhotsampa had fled or been forced out of the country,

mostly into refugee camps in Eastern Nepal.⁸⁰ Over 40,000 of the refugees are children who have lived in refugee camps all their lives.⁸¹ Following the instability in Nepal, one of the world's largest resettlement operations started in March 2008.⁸²

Bhutanese refugees in New Zealand have been arriving since 2008.

Refugees from Colombia

Colombia's 50-year internal conflict between paramilitaries, guerrilla groups and the Colombian army has created a massive number of internally displaced people; almost 5 million have been forced from their homes since 1985.⁸³ The protracted armed conflict and associated political violence involving the state and armed left-wing guerrilla groups, as well as a range of highly regionalised right-wing 'paramilitary' groups and armed drug-trafficking networks, means that Colombia has one of the largest displaced populations in the world.⁸⁴



The current violence in Colombia can be traced back to the 1960s, with the founding of the Marxist rebel groups: the Revolutionary Armed Forces of Colombia (FARC); and the National Liberation Army, which operated in rural regions in efforts to destabilise the central government.⁸⁵ In the 1980s, these groups began to finance themselves through the drug trade, while anti-communist paramilitary squads competed for the control of drug routes. The armed groups, particularly the vigilantes, began to forcibly displace civilian farmers as a tactic to gain control of these illicit trade routes.⁸⁶ They also became involved in frequent assassinations and kidnappings of civilians.⁸⁷

The displacement crisis worsened with the inception in 1999 of 'Plan Colombia'. This United States plan was aimed at curbing drug smuggling and combating left-wing insurgency by supporting different activities in Colombia. However, elements within the

Colombian security forces made use of United States aid and training in their involvement in supporting abuses by right-wing paramilitary forces against left-wing guerrilla organisations and their sympathisers. Moreover, the aggressive aerial fumigation programme in coca-producing regions that is part of an anti-narcotic strategy has destroyed the livelihoods of legitimate farmers as well as desperate coca growers for whom there was no legitimate profitable option with which to make a living.⁸⁸

Beyond battles between the Government and leftist guerrillas, since 2008 there has been a new dimension to the conflict. The Colombian military has pushed the violence out of the cities and escalated the conflict in rural border provinces such as Putumayo and Nariño, where civilians find themselves trapped between battling guerrilla groups.⁸⁹ In an effort to maintain control over their territory, armed groups funded by the drug trade have increased the level of threat and coercion against civilian populations – often forcibly recruiting civilians in rural areas.⁹⁰

Colombian civilians bear the brunt of the conflict. Every year thousands become displaced by the violence, losing their homes and livelihoods.⁹¹ Forced disappearances, extrajudicial executions, targeted assassinations, threats and kidnappings remain commonplace.⁹² The vast majority of abuses remain unaddressed. Paramilitary groups and guerrillas continue to be well financed through the drug business. Paramilitaries have also become increasingly involved in large-scale corruption schemes, infiltrating national governmental institutions, controlling local politicians and diverting funds from state agencies.⁹³ Violence against women is used as a means of intimidating and spreading terror among communities, thereby provoking the displacement of hundreds of families.⁹⁴ Both men and women are the victims of crimes perpetrated by all the actors in the armed conflict in Colombia, but in the case of women acts of physical and psychological violence are joined by acts of sexual violence.⁹⁵

These factors have led to a dramatic expansion of the displaced population in Colombia, as civilians have sought to escape the internal upheavals. While the majority of displaced Colombians seek to resettle elsewhere in the country, many seek refuge across the border in Ecuador. Ecuador now hosts the largest refugee population in Latin America. As of January 2009, the UNHCR estimates that Ecuador is home to more than 140,000 Colombians in need of international protection.

Refugees from Colombia have been arriving in New Zealand since 2008.

Prior access to health care

The overwhelming majority of the world's refugees originate from countries where the most basic resources required for health, such as safe drinking-water, housing, adequate food supply and education, are scarce.⁹⁶ In many refugee-producing countries diseases and conditions long controlled in western societies through public health measures, appropriate physical planning and social support measures are commonplace. This is also true of many of the countries in which refugees have spent a period of asylum before being resettled in New Zealand.

Many refugees have had poor access to health care prior to arriving in New Zealand. This may be due variously to the breakdown of health services in situations of war and conflict and limited access to health care in countries of first asylum. Refugee-producing countries often have poorly developed health care infrastructure, compounded by the effects of war and natural disasters.⁹⁷ As a result people from refugee backgrounds may have diseases and conditions, some sustained or acquired as a consequence of deprivation and trauma, which have been poorly managed. They are also likely to have had limited access to mental health support and to prevention or screening programmes such as immunisation.

Significant resettlement issues in New Zealand

- Many refugees are single women who face the burden of caring for a large family without the support of the traditional extended family.
- Some families may face adjustment issues associated with the changing role of women in the family, from home-maker to breadwinner.
- Many refugees send money back to family members, compromising their own capacity to meet the financial demands of resettlement.
- Some refugees may face difficulties in adjusting to their change in social status in New Zealand, particularly if they formerly held positions of power and prestige. Others may find that suddenly gaining rights and status (as in women who formerly held no status) is just as difficult.
- There are a significant number of young adults who arrive without adult support, or whose relationships with parents or guardians have broken down since arriving in New Zealand.
- Children, particularly those who have spent a prolonged period in a refugee camp, may have limited school experience and may have learning difficulties and problems adjusting to school life in New Zealand.
- Despite living in close proximity to other people from the same region, many people may feel socially isolated, or even experience hostility, because they belong to a different clan system or family grouping from those around them.

For information on other countries from which refugees come to New Zealand, see UNHCR's website:

www.unhcr.org/cgi-bin/texis/vtx/refworld/rwmain

Refugee Resettlement in New Zealand

Refugee resettlement and support

I have been in a lot of troubles. I was persecuted because it was a war, I have been in jail, I survived many years in a refugee camp where I saw a lot of people dying because they were too weak, children were very sick. I have learned how to be strong and how to survive and manage with life. I have experienced the worst and I have learnt how to hope.

Male refugee⁹⁸

It is estimated that more than 50,000 refugees and displaced people have settled in New Zealand since World War II.⁹⁹

Refugee resettlement in New Zealand began in 1944 with the acceptance of nearly 900 Polish refugee children and their guardians. Shortly after, the InterChurch Commission on Immigration and Refugee Resettlement (ICCI) – later to become the Refugee and Migrant Commission – was convened at the request of the Government. The Commission’s role was to promote and support refugee resettlement among churches and community groups, and to provide advocacy and policy advice on refugee issues. Over the next two decades the Commission’s work expanded, as New Zealand accepted specific refugee groups in response to requests from UNHCR and other NGOs.

Since 1987, a global refugee quota has been set annually by Cabinet on advice from government agencies and NGOs. Currently the quota is set at 750 refugees per year. Unlike many other resettlement countries, New Zealand has not based its acceptance of refugees on their ‘resettlement potential’.¹⁰⁰

Rather, the Government ensures that many of its quota placements



are reserved for the most needy cases as identified by UNCHR, such as women at risk, the medically disabled and protection cases.

The geographic pattern of source countries for New Zealand's refugee intake has changed over the past 25 years in response to changing global circumstances and humanitarian needs. Whereas from the late 1970s through to the mid-1980s Indochinese refugees were the dominant group resettled in New Zealand, a broader global focus beginning at the end of the 1980s has led to a more diverse range of source countries.



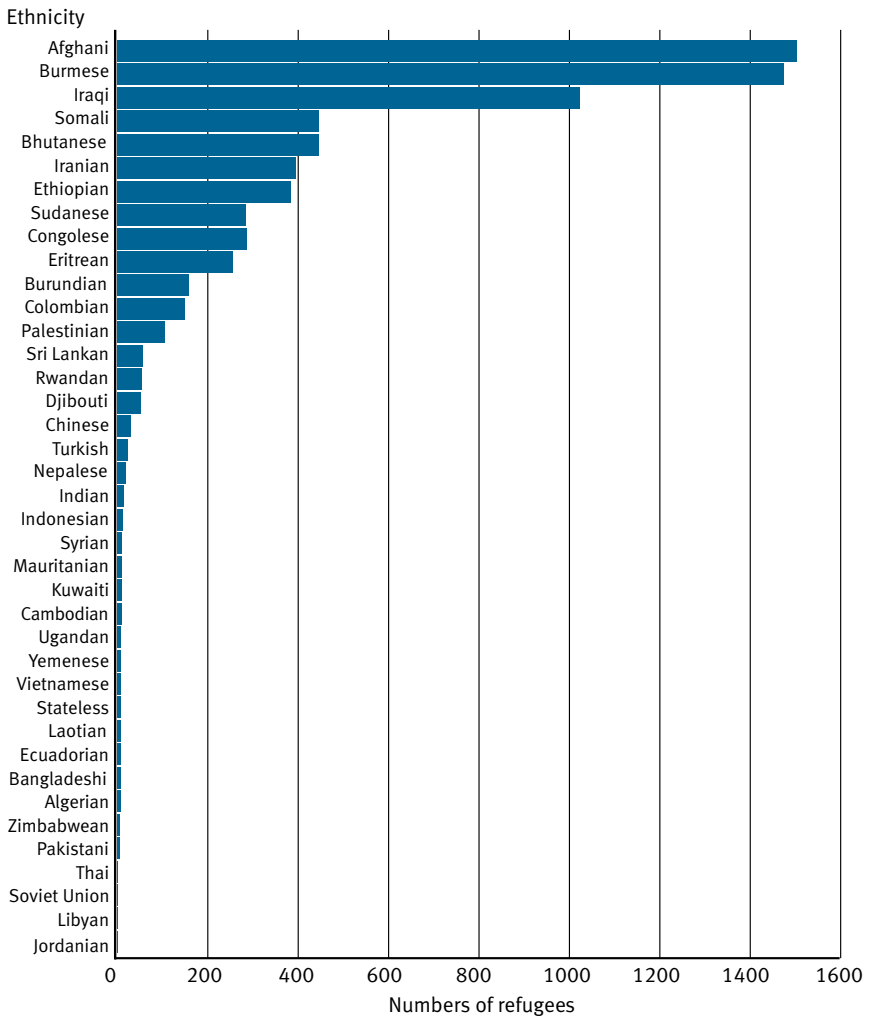
The top five source countries for quota refugees in New Zealand between 1997 and 2003 were Iraq, Somalia,

Ethiopia, Afghanistan and Burma, reflecting the global pattern of refugee crises over the same period. For convention refugees, the top source countries were Iran, Sri Lanka, Afghanistan, Somalia and Iraq.¹⁰¹ Since 2002, Iraq and Iran have been the main Middle Eastern countries represented in the quota, while Somalia, Ethiopia, Eritrea and Sudan have been the main Horn of Africa countries (see Figure 1).

The ethnic groups that make up the quota come from priority regions of concern identified by UNHCR. In the past 10 years, 7305 people from 55 different countries have been approved for residence through the refugee quota programme.¹⁰² The main source countries over that time were Afghanistan, Burma and Iraq. Between 2005/2006 and 2009/2010 Bhutan was the largest source country of quota refugees (177 people in 2009/2010), followed by Colombia (91 people) and Burma (83 people).¹⁰³

In 2009/2010, successful refugee status claimants approved for permanent residence came from 30 different countries. The main source countries were Iraq (73 people), Iran (40 people) and Sri Lanka (35 people).¹⁰⁴

Figure 1: Intake under refugee quota, by ethnicity, July 2000 to June 2010

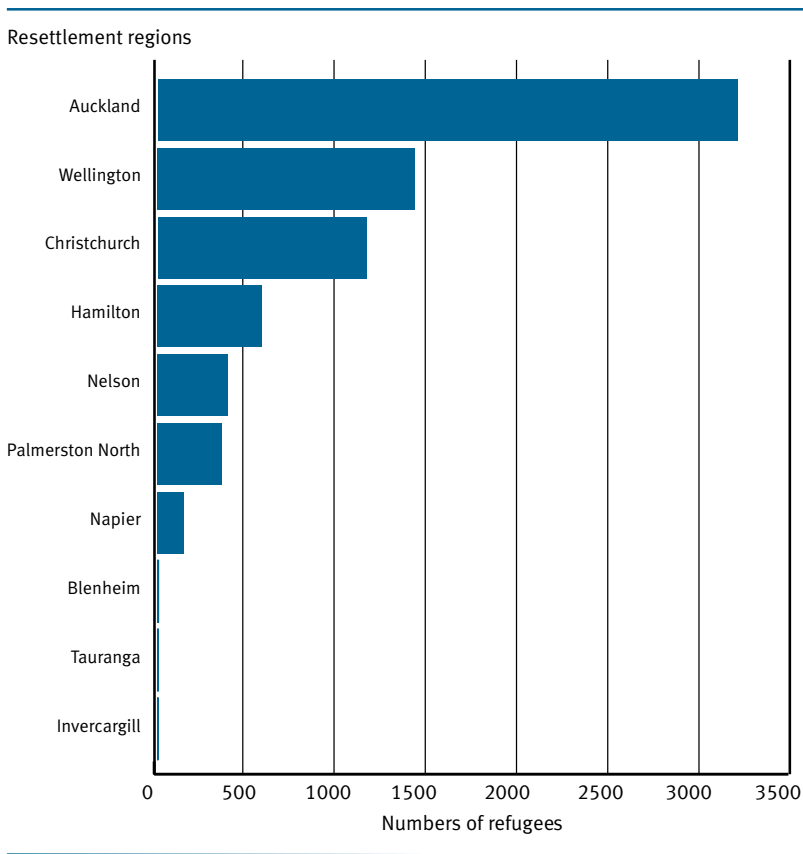


Source: Refugee Quota Branch, Immigration New Zealand, 2011.

Main regions of refugee settlement in New Zealand

Auckland is home to the highest number of refugees, followed by Wellington, Christchurch, Hamilton, Nelson and Palmerston North. The regional data in Figure 2 refers only to those refugees arriving under the quota category. The number of refugees in each region is, of course, much higher when pre-settled refugees and refugees arriving under other categories are included.

Figure 2: Quota refugee arrivals in resettlement regions, July 2000 to June 2010



Source: Refugee Services Aotearoa New Zealand, 2011.

The Mangere Refugee Resettlement Centre

Quota refugees arrive five times a year in groups of about 125 and spend six weeks at the Mangere Refugee Resettlement Centre (MRRRC), where they receive health screening, health care, English lessons and a basic orientation to New Zealand before starting their new lives in towns and cities throughout the country.

The MRRRC is located at 251 Massey Road, Mangere, Auckland. Its facilities include accommodation blocks, a nursery, classrooms, medical and dental clinics, a dining area, a lounge and meeting room, recreational and sporting facilities, a clothing store and administrative areas. Agencies represented at the Centre are:



- Immigration New Zealand, Refugee Quota Branch
- Refugee Services
- the Centre for Refugee Education (Auckland University of Technology)
- the Refugee Health Screening Service, Auckland Regional Public Health Service, Refugee Health Service, Auckland District Health Board
- the Auckland centre of Refugees as Survivors (RASNZ), an NGO providing mental health services.

Support on arrival

Quota refugees receive an organised programme of resettlement and support on arrival, including health, education, welfare and housing support. This is not the case with asylum seekers and family reunification members, although they are eligible for many of the same services and support.

Asylum seekers and family reunification members enter under general immigration provisions, so it is often not known when they

will arrive and where they will stay. It is therefore difficult for the available service providers to seek out these newcomers and offer health, education, welfare, employment, housing assistance and other support in an organised way. Family reunification members usually have the advantage of joining pre-settled families in New Zealand, and therefore tend to receive more support on arrival than asylum seekers.

Financial assistance

Quota refugees and family reunification members are generally eligible for the same benefits and entitlements as other New Zealanders; for example, emergency benefits, community wage benefits and community services cards. Re-establishment grants to help with resettlement and accommodation costs are also available, but usually only to quota refugees.

Asylum seekers are eligible for publicly available health, education and welfare services provided they have lodged a claim for refugee status and are awaiting a hearing. However, as there is no organised programme of support and orientation for asylum seekers, many are unaware of their eligibility, and may not access their entitlements. Unlike refugee family-sponsored migrants, asylum seekers do not usually have family in New Zealand to support them. They are not entitled to re-establishment grants unless or until their claim is approved by Immigration New Zealand. Claims may take a year or more before approval or otherwise is given. Table 6 sets out disparities in support available for quota refugees and asylum seekers.

Contacting Work and Income

Information about Work and Income financial assistance can be found on the website www.workandincome.govt.nz Applicants can call the Work and Income Contact Centre on 0800 559 009 or they can use the Language Line number (0800 000 196) to request language assistance.

The location of Work and Income service centres can be found at www.workandincome.govt.nz/about-work-and-income/contact-us/find-a-service-centre/index.html

Table 6: Disparities in health and social service provision between quota refugees and asylum seekers

Issue	Quota refugees	Asylum seekers
Residency	Become New Zealand residents on arrival	Must make a claim for refugee status. If granted, can apply for permanent residence
Introduction to living in New Zealand	An orientation to New Zealand programme, provided at MRRC including cultural issues, support services, etc	No orientation programme to New Zealand is offered, so may be unaware of support services and benefit entitlements
Accommodation for new arrivals	Initially accommodated at MRRC, and thereafter in housing provided for them	Must find their own accommodation (unless they are detained at the MRRC). Some initial accommodation may be available through the Auckland Refugee Council hostel
Access to health screening/ health care on arrival	Receive free comprehensive health screening/health care, including dental care, on arrival, and follow-up treatment and management as required	Free comprehensive health screening is available at the MRRC, and through some regional public health services. However, screening is voluntary and many do not access it

Issue	Quota refugees	Asylum seekers
English language instruction	Receive free language instruction at the MRRC, which continues to be available when they move into the community. They are eligible for refugee study grants to learn English	Asylum seekers should contact the Work and Income Contact Centre on 0800 559 009 in regard to eligibility for funded English for speakers of other languages (ESOL) support
Resettlement in New Zealand	Provided with sponsors to assist with their resettlement	No formal assistance offered to support day-to-day living. Limited support is offered through the Auckland Refugee Council
Financial assistance	<i>Eligible for:</i> the emergency benefit, including hardship provisions, such as an accommodation supplement, disability allowance or special needs grants. They can access re-establishment grants (\$1200 per family for re-establishment costs and up to \$800 (recoverable), for initial accommodation costs)	Asylum seekers should contact the Work and Income Contact Centre on 0800 559 009 in regard to eligibility for financial assistance

Issue	Quota refugees	Asylum seekers
Legal services	Do not require legal assistance	Require legal assistance for the preparation and presentation of their claims. This can be expensive. Citizen's Advice Bureaux and community law centres may provide some free legal advice. Legal aid can be applied for
Access to health services	Provided with a Community Services Card, and can therefore access subsidised health care	Eligible for a Community Services Card when they obtain refugee status, although may be unaware of this. They may be unwilling to access health care fearing an illness might affect their claim. As a result they often have unmet complex health needs, especially mental health needs. May be unable to afford prescription charges

Refugees and public health screening

The aim of health screening refugees is to:

- identify those who have health problems, and treat or refer to specialist agencies, as appropriate
- prevent the spread of infectious diseases such as tuberculosis (TB) and hepatitis B.



While quota refugees receive an organised, comprehensive screening programme on arrival, there is no organised on arrival screening programme for refugee family-sponsored migrants or asylum seekers. Asylum seekers are able to access health screening at the Refugee Health Screening Service at the MRRC, although many do not. For those who are unscreened, free screening services, although not nationally consistent, are available in some larger centres; for example, Auckland, Hamilton, Wellington and Christchurch. Screening in Auckland and Christchurch is carried out by public health services, while in Hamilton and Wellington screening services are contracted to private medical clinics (see pp 149–155).

Refugees who remain unscreened pose a risk to themselves and to public health. Every encouragement should be given to unscreened refugees to undergo screening.

Health screening and quota refugees

Physical health screening

All refugees arriving in New Zealand under the quota system receive screening tests at the MRRC. These tests are divided into three categories:

- core – universal
- conditional – depending on age and/or gender
- secondary – if clinically indicated.

The core tests are:

- full blood count, iron studies
- haemoglobinopathy screen,
- liver function tests,
- serology for HIV



- hepatitis B for immunity and carriage
- hepatitis C antibodies
- syphilis
- morbilli IGG
- rubella antibodies
- schistosomiasis (unless coming directly from Europe)
- three stools for parasites only
- physical medical examination.

The conditional tests are:

age-related:

- Mantoux tests for all under 16 years
- chest X-ray for all 12 years and over, unless pregnant
- creatinine and electrolytes for all 16 years and over

gender-related:

- urine test for chlamydia and gonorrhoea for all sexually active males
- STI check and cervical smear for eligible females, including enrolment on cervical screening programme register

age/gender-related:

- fasting glucose/lipid studies for all males 35 years and over, and for females 45 years and over.

Secondary tests are:

- any clinically indicated by clinical examination or laboratory testing, commonly including:
 - mid-stream urine
 - faeces for bacterial and other pathogens for those with diarrhoea
 - faeces for *Helicobacter pylori* antigens in those with dyspepsia
 - three midday urines for schistosomal parasites.

Note: ESR and faecal bacterial pathogens are not routinely tested for.

Dental care

At the MRRC basic dental care, such as fillings and extractions, is offered to adults and children. This does not usually include dentures or treatment for advanced periodontal conditions. Children under 18 years are screened by the dental therapist and receive treatment only for acute conditions, since they will shortly access free dental services in the community.

Mental health screening

The Auckland Refugees as Survivors Centre offers mental health assessment, initial treatment and referral to all newly arrived refugees, detained asylum seekers and community-based asylum seekers who have been exposed to torture and trauma. It provides support therapy groups, including womens' groups and asylum seekers groups. Any agency at the MRRC can refer clients to the RASNZ programme, or clients can self-refer.

Ongoing health care after leaving the MRRC

All refugees aged 17 years and over are given a copy of their medical records and an explanation of how the New Zealand health and

disability system works. Children's records are given to their care-givers. Adults are advised to give their records to their GP, with the help of their sponsor. Each record has a 'problem list' if needed, which lists ongoing problems and the person responsible for follow-up.

Another set of records is sent to the refugee health coordinator (Wellington and Christchurch) and/or to public health services in the area where the refugee is settling. This second set of records is mainly for following up TB investigations, if needed. Most districts also have a routine follow-up process in place, in addition to that required for TB.

Health screening and refugee family-sponsored migrants

Refugee family-sponsored migrants (or family reunification members) usually come straight from a refugee background – many directly from refugee camps – to join families in New Zealand.

Refugee family-sponsored migrants have the same health issues as quota refugees. The big difference is that refugee family sponsored migrants, before leaving for New Zealand, are required by Immigration New Zealand to have a medical check-up in their country of origin. Refugee family-sponsored migrants and the relatives of refugees applying for residence in New Zealand under any other Immigration policy are required to submit a full medical report along with their residence application. These medicals reports have been completed by a panel doctor approved by Immigration New Zealand.



While every encouragement should be given to refugee family-sponsored migrants to undergo screening on arrival the difficulties in tracing and locating them means that many remain unscreened in New Zealand.

Health screening and asylum seekers

Asylum seekers are those fleeing a crisis in their homeland who arrive at our borders and seek refugee status. Since 1997 border officials have been giving asylum seekers a form that offers free voluntary medical screening at public health services throughout New Zealand. The form identifies the appropriate contacts within public health services for the free screening. However, it is important to note that screening services are not offered by all public health services and that screening services, where they are available, do not operate consistently throughout the country.

Although asylum seekers have similar health problems to quota refugees, there is no formal requirement for them to undergo health screening until their permanent residence status has been granted. Since this process can take months or even years, many asylum seekers remain unscreened for long periods, which can have serious implications for personal and public health. Asylum seekers are particularly vulnerable to mental ill health (see p 145).

Asylum seekers in the community in the Auckland region are offered free medical screening at the health clinic at the MRRC. However, not all asylum seekers can be traced, and many do not use this service. All asylum seekers detained at the MRRC are offered medical screening, and any appropriate follow-up, while they are resident there. All asylum seekers screened at the MRRC are given their records and a letter with a 'problem list', to be passed on to their GP.



The Consultation – Communicating Effectively with Refugee Clients

Preparing for the consultation

Nursing in these areas . . . you don't enter into their minds, you have to enter into their hearts because it's chronic care and you are seeing them repeatedly for their chronic disease so gaining their trust is vital.

Diabetes nurse specialist¹⁰⁵

Many people from refugee backgrounds will not have had access to comprehensive health care for years. Their initial contact with New Zealand nurses and doctors may be the first opportunity they have had in their lives to receive client-focused, high quality health care.

Building a trusting personalised relationship with and providing optimal care to refugees can be a challenge for health professionals, because refugee clients:

- may be ignorant or mistrustful of the health system, or feel isolated and misunderstood because of their lack of English
- may be highly traumatised, or suffering from grief, depression or feelings of guilt for surviving when others did not
- may feel shame and rejection through having a communicable disease such as TB or HIV¹⁰⁶
- may be stigmatised by their community for having a mental illness.



Prior to the consultation, consider the following issues

Your client may:

- have physical and psychological sequelae associated with pre-migration trauma and torture
- require a professional interpreter
- need a thorough medical examination
- in the case of women, prefer a female practitioner
- not understand our health system and how to access services or get prescriptions etc, and will need careful explanations or diagrams



- be reminded of past trauma during the consultation; a common response to this is to dissociate or 'switch off', which may range from an extreme catatonic state to a momentary 'absence'.

Allow time to plan and prepare for the special needs of your client

For example:

- acquaint yourself with the background of the client and the community in which they live
- if necessary, arrange for the services of a professional interpreter, with the consent of the client (see p 52)
- check whether other family members need to be involved before fixing a consultation date
- avoid scheduling an early morning appointment, since sleeping problems are common among traumatised refugees
- allow extra time for the appointment, to accommodate interpreting, establishing rapport, careful explanations, etc

- acknowledge that the client may be late due to lack of experience with appointment systems, unfamiliarity with the transport system, memory problems, unfamiliarity with the location of the clinic, etc.

Check whether your client has had prior health screening

If your client has been screened, ask them to bring their records to the appointment.

Quota refugees will have been screened at the MRCC and will generally hold their own records. Asylum seekers and family reunification members may not have been screened. Those who have will usually have their records with them.

If screening records have been misplaced, or if there is doubt about whether screening has been done, contact your refugee health coordinator or public health nurse, your local public health service, the health clinic at the MRRC (in the case of quota refugees and asylum seekers screened at MRRC) (see pp 149–155) or the clinic where the screening initially took place. You can request a copy of the records if necessary.

Tip ⇨

Recognise that refugee families are under considerable financial constraints, and bear this in mind when considering follow-up appointments, ongoing management, prescriptions/medication, treatment and referrals.



Engaging a professional interpreter

Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.

Right 5:1 The Code of Health and Disability Services Consumers' Rights 1996

Why use a professional interpreter?

Professional interpreters are trained in the use of their language and English as a second language, and in the skills and role of an interpreter. They have a high level of competence in these languages, which is crucial when interpreting medical information. They are bound by a professional code of ethics, which places great emphasis on impartiality, accuracy and confidentiality.

Using family (especially children), friends or untrained people as interpreters runs the risk of exposing them to material of a highly sensitive nature and compromising confidentiality. These risks may influence a client to withhold information from a health professional. In addition, the potential for miscommunication between doctor, client and interpreter is heightened when using an untrained interpreter.

How do I access an interpreter?



Access to interpreters varies from region to region. Overall, the situation is far from satisfactory. District Health Boards provide interpreters for the community and secondary care services that they fund. In some regions primary health providers have access to DHB interpreting services or to the Office of Ethnic Affairs' Language Line. (See pp 149–155 for information on interpreting services.)

What if my client has some knowledge of English?

Consider offering an interpreter even to those clients who have some knowledge of English because:

- anxiety associated with the consultation may inhibit the client's ability to communicate effectively in English
- the client may lack a 'health' vocabulary, particularly one relating to bodily processes
- politeness may lead the client to indicate that they have understood when they have not.

What should I take into account before engaging a professional interpreter?

Always gain the consent of the client prior to booking an interpreter. In small communities the interpreter may be known to the client socially, in which case a different interpreter may be needed.

Confirm the client's preferred language. Place of birth and ethnicity are not always reliable indicators of language. Within some countries, several languages may be spoken. There may be tensions between language groups, so it is important to establish the preferred language of the client.

Check if your client is fluent in a second language. If an interpreter is not readily available in the

Tips for communicating through an interpreter

- ⇒ Speak slowly and clearly, using one or two sentences at a time. Pause to allow time for interpreting.
- ⇒ Make sure your client is the focus of attention, not the interpreter.
- ⇒ Use simple English. Try to avoid medical terms and colloquialisms.
- ⇒ Avoid conversation with the interpreter in front of the client. If this cannot be avoided, try to include the client or explain what is happening.

client's first language, another may be available in the second. Many refugees have acquired a second language; for example, a Somali client may also speak Arabic or Italian.

Establish whether the client prefers a male or a female interpreter. Always abide by the client's choice in this regard.

Remember that a longer consultation time will be needed to allow for the interpreting process. Also allow time (10–20 minutes) for a pre-briefing with the interpreter. The time taken will depend on whether the practitioner and interpreter have worked together previously, whether it is a first session with a client, and the de-briefing time will depend on the nature of the session and the challenges that may arise.

The pre-session briefing

The pre-session briefing is used to establish rapport between you and the interpreter, to prepare the interpreter for the session and to determine which mode of interpreting is needed. It is also an opportunity for you to ask questions about cultural issues before meeting the client. The briefing is invaluable in creating a working alliance within which a refugee client can feel safe and contained.

Consider the following.

- The interpreter needs to be briefed about the case, including the objectives/purpose of the session.
- As practitioner, you need to clarify the health related terminology that is likely to be used.
- You may need to obtain cultural background information from the interpreter.
- The interpreter needs to establish the mode of interpreting (that is, either consecutive versus simultaneous).
- The interpreter needs to confirm with you that the first person will be used throughout by both parties (that is, 'I' rather than 'he' or 'she').

- You and the interpreter need to ensure that seating is prepared appropriately (with the interpreter having equal access to you and the client).
- The interpreter needs to inform you of any relevant cultural etiquette and expectations.

During the session

Establish 'ground rules' in the first session, as follows.

- Explain your role carefully to the client.
- Introduce the interpreter to the client and explain their role.
- Give reassurances about client confidentiality, client consent, client choice and client control. It can be helpful to the client to know that both the practitioner and the interpreter are bound by a confidentiality clause under a code of ethics. Conditions under which confidentiality cannot be maintained (for clinical safety) can also be explained at this time.
- Make sure the client knows that everything that is said in the session will be interpreted. It is your responsibility to direct the interview. It is imperative that any side conversations must be interpreted.
- Familiarise the client with the mode of interpreting that will be used (that is, either consecutive or simultaneous).

Enhancing communication and rapport

Establishing rapport and trust with your client and communicating clearly throughout the consultation are crucial factors in providing safe, effective and appropriate care.

The following guidelines may be helpful.

- Encourage questions.
- Be aware of the differences between you and your client in terms of perceptions of health, treatment, values and belief systems, and recognise that adjustments need to go both ways.
- Respect your client's knowledge and experience.
- Avoid making generalisations about ethnic groups. People from one group may 'look' similar, but differences can be enormous – some may be pre-literate while others have tertiary qualifications; some may be from rural backgrounds, others from urban; some may be religious, others non-practising.
- Avoid making assumptions. For example, a Muslim client may not necessarily abstain from alcohol.
- Beware of attributing too much to culture and ethnicity. Other factors, such as torture and trauma, pervading grief and resettlement issues can influence a person's behaviour.

How can I minimise the risk of miscommunication?

You can minimise the risk of miscommunication with refugee clients in the following ways.

- Be specific about what you want to happen and why. For example, rather than saying 'Now I would like to check your chest,' consider saying 'Could you remove your shirt so that I can check your heart and lungs?'
- Avoid colloquialisms which may have little meaning for people from other cultures; for example, 'You seem a bit under the weather today'.
- Where appropriate, ask the client's perspective; for example, ask:
 - What do you call your sickness or illness?



- What do you think has caused it?
- What do you fear most about your sickness?
- What problems has your sickness caused you personally, your family, or at work?¹⁰⁷

De-briefing after the session

A de-briefing following the session will provide an opportunity for clarification between you and the interpreter, and for the interpreter to address any emotional distress that may have been triggered during the session.

During the de-brief:

- summarise the session, and whether objectives were met. If they were not, establish whether that might have been due to cultural barriers or misunderstandings
- clarify any cultural issues, interpretation of words or concepts that you were unsure about
- assess whether the interpreter was affected by the content of the session, and address this as necessary
- plan follow-up procedures/appointments as appropriate (it is preferable to work with the same interpreter with each client, wherever possible)

Respecting cultural and religious diversity

The information in this section is adapted from information first published by Foundation House-The Victorian Foundation for Survivors of Torture Inc 2007.¹⁰⁸

The impact of culture and religion on health care

Communication with a refugee client may be affected by cultural and religious differences in:

- patterns of communication
- views about causes of illness and disability
- views about ways in which illness and disability should be managed
- views about the relationship between clients and service providers
- views about the role of western-style medicine in the management and prevention of illness
- individual versus collective approaches to illness and health
- views about gender roles
- cultural and religious customs and practices.¹⁰⁹

Taking into account the clients' cultural and religious beliefs and practices

As a health practitioner, you need to make sure that you take into account the clients' cultural and religious beliefs and practices. Although documenting the specific cultural and religious beliefs and practices of New Zealand's diverse refugee communities is beyond the scope of this handbook, the following general guidelines for practitioners will help promote culturally and religiously responsive care for the client and their family.¹¹⁰

- Take opportunities to familiarise yourself with the cultural and religious beliefs and practices of the clients with whom you work.
- Acknowledge that you understand that clients may have different perspectives and experiences of illness, health and disability.
- Ask clients if there are any special requirements or information that they would like you to take into consideration when providing care.

- Avoid making generalisations about individual clients on the basis of your experience of other clients from that cultural, ethnic or religious group: there is significant diversity within groups.
- Avoid making assumptions based on a client's adherence to cultural or religious practices. For instance, a Muslim woman may wear the traditional veil, but may not be devout in other respects.
- When working with individual clients, check any impressions you have formed directly; for example, ask 'I understand that many Muslim women prefer to see a woman doctor . . . is that your preference?'
- Beware of attributing too much to culture and religion, particularly as: there are a range of factors affecting refugee clients (such as, trauma and torture, experiences in country of origin, level of education and settlement stressors).
- Be aware of the impact of your own culture and religion on the way you relate to clients. Consider your own values, expectations and attitudes and how they may affect the care that you give people from diverse cultural/religious backgrounds. For example, your confidence in a western biomedical approach may lead you to overlook or dismiss a client's traditional health beliefs.

Tips for understanding the client's view of their health problem ⇨

If it is your assessment that a client is unfamiliar with western approaches to health care, consider asking straightforward questions about their view of the causes of their health problem, how they feel at present, what their biggest worries are about their sickness and what they believe will help.

- In some cultures it is common for family members to be involved in decision-making in health care matters. Additional time may be required for explanation and discussion with family.

For more information, see the *Cross-cultural Resource for Health Practitioners working with Culturally and Linguistically Diverse Clients*,¹¹¹ which can be downloaded at www.caldresources.org.nz/info/Cross_Cultural_Resource_Kit-Printable.pdf

Physical Health Care

Medical history and examination

Medical interventions, and the way in which they are delivered, may need to change in order to accommodate the beliefs and practices that are important to the patient and their family. A family's faith and membership of a faith-based community may be central to their coping skills and resilience in managing illness, disability and end-of-life care. In collective cultures, decisions about the healthcare of an individual are often made by family members and will be influenced by the family's religious and cultural interpretations of health and illness.

Waitemata District Health Board – Asian Health Support Services¹¹²

This section provides a comprehensive and specific guide to health assessment for refugees. The section covers a complete history taking, examination, investigation, problem list and management plan for new arrivals. While medical information in this section relates primarily to the recently arrived refugee patient, it is also relevant to all patients from refugee backgrounds.

The information in Table 7 may be helpful in initial consultations, particularly when taking a medical history of a client or carrying out a medical examination.



When scheduling a first full consultation, be aware that an interpreter may be required and, if necessary, make arrangements in advance.

Table 7: Issues to consider in history taking and medical examination

Check for/consider	Notes
Addictions	Addictions may include: <ul style="list-style-type: none"> • alcohol and other drugs • tobacco, including chewing forms • gambling.
Anaemia	Iron deficiency anaemia is common, particularly in women and children. Sickle-cell anaemia may occur in those from Africa and occasionally the Middle East. Alpha and beta thalassaemia may occur in those from the Middle East.
Breast and cervical screening	This subject requires sensitivity. It may be desirable to refer a client to a female practitioner (see p 143).
Chronic medical conditions	Chronic conditions may be exacerbated by delayed diagnosis, poor management and periods without treatment or management in the country of origin. Chronic diseases are becoming more prevalent in some developing countries. Consider routine screening for cardiovascular disease risks.
Dental problems	Dental problems may be related to lack of dental care, poor diet and/or injuries caused by torture. Treatment of dental problems can contribute to psychological recovery. Dental decay may become worse after arrival in New Zealand due to dietary changes.
Developmental screening (children)	Developmental delay may result from chronic infections in childhood (for example cerebral malaria), from recurrent illness or from environmental deprivation due to war and famine.

Check for/consider	Notes
Family planning	Family planning needs to be discussed in a culturally sensitive manner (see pp 127–129).
Family violence	Refugees may have suffered abuse. It is important to discuss this matter with the potentially affected person in a safe and confidential environment – this will usually mean without other family members being present.
Female genital mutilation (FGM)	FGM is prevalent in women from the Horn of Africa, in particular. It has an impact on antenatal, obstetric and gynaecological management (see pp 134–142).
Hearing impairment (screening)	Hearing problems may be due to past or current infection, exposure to explosive noise in war zones, or blows to the head in conflict and torture. Hearing impairment in children may lead to developmental problems and learning difficulties.
Helicobacter pylori	<i>H. pylori</i> infection should be considered in refugees with persistent abdominal discomfort (see p 71 for further information).
HIV infection	Quota refugees are screened for HIV at MRRC. Screening should be considered for asylum seekers from high prevalence regions (see pp 71–73 for further information).
Infectious and parasitic diseases	Refugees may present with a wide range of infectious or parasitic diseases very rarely seen in New Zealand (see pp 77–97 for further information).
Mental health	Anxiety, depression, post-traumatic stress disorder (PTSD) symptoms and other mental health disorders are common psychological sequelae of trauma and torture. Regressive behaviour in children (such as thumb sucking and bed-wetting) may indicate anxiety.

Check for/consider	Notes
Nutrition	<p>The following should be considered:</p> <ul style="list-style-type: none"> • weight/height body mass index. For children, weight and height percentiles and a weight history • vitamin D deficiency • if the client has recently lost weight, food insecurity, illness, diabetes, and so on • if a client has recently gained excessive weight, primary factors (such as high fat/high sugar intake as a result of change to local diet) • iron deficiency anaemia, especially in women and children • malnutrition associated with intestinal parasites • micro-nutrient deficiency disorders • folate supplements for women of child-bearing age • iodine supplements for pregnant or breast-feeding women • new diet-related disorders (for example non-insulin-dependent diabetes mellitus) • eating disorders associated with torture and trauma experiences (for example poor appetite, anorexia, excessive consumption) • caffeine, alcohol or tobacco consumption exacerbating anxiety and PTSD symptoms • economic constraints/unfamiliarity with local foods.
Rheumatic heart disease	<p>Rheumatic heart disease is more common in developing countries. It may not have been diagnosed, or may have been poorly managed.</p>

Check for/consider	Notes
Sexual assault and STIs	Dealing with sexual issues requires extreme sensitivity. Consider offering routine sexual health checks to adolescents and adults, especially HIV testing for those from high-prevalence groups, with appropriate discussion. Although sexual screening may have been done at the MRRC, ongoing screening is advised. Note that sexual assault does not necessarily only affect females. For information on rape and sexual assault, (see information on p 100).
Skin disease	Check for ulcers, fungal skin disease, scabies, lice and secondary infection and, less commonly, parasitic-related skin disease and leprosy.
Smoking	Ask all adolescent and adult refugees whether they use tobacco, and how often.



Check for/consider	Notes
TB	<p>Maintain a low threshold of suspicion for TB (see p 102). Note the following:</p> <ul style="list-style-type: none"> • TB is very prevalent in developing countries; incidence is increasingly associated with the HIV pandemic and deteriorating health/social welfare. • Refugees from the Horn of Africa may have received partial treatment with one or more drugs. • Many refugees will have received a Bacillus Calmette-Guerin (BCG) immunisation in their own country. The degree of protection this confers is unclear, but it is thought to be around 50 percent effective in adults and up to 80 percent effective in children against the more serious forms of TB (such as meningitis, bone, kidney and joint). • If you strongly suspect TB, particularly if a patient has a productive cough and is acutely unwell, consider immediate referral to a hospital infectious diseases service.
Visual impairment	<p>Visual impairment may result from past or current infection (for example trachoma) or deficiency (for example of vitamin A).</p>
War and torture-related injuries	<p>Check for evidence of old fractures, tendon or nerve damage, mine injuries or other untreated or poorly managed trauma.</p>
Women's health	<p>Enrol women clients as appropriate in breast and cervical cancer screening. Offer human papillomavirus (HPV) immunisation, as per New Zealand's immunisation schedule.</p>

Common health issues in refugees

This section lists in alphabetical order some of the more common health issues among refugee groups. Specific information on women's issues can be found in Section 6: Refugees with Special Health and Disability Needs: Women (pp 127–145).



Body modification

Virtually all cultures engage in some sort of body modification, such as tattooing or piercing, for various reasons. Some such practices are temporary, such as henna paintings on the extremities, which is considered by some Middle Eastern groups to have healing properties. Others, such as scarification, are permanent and may involve procedures such as cutting, burning or piercing. While most such procedures are harmless, some are not, or may be mistaken for serious pathology.

Minor body modification procedures may include:

- amputation of the uvula in some African groups – a traditional healing practice
- ‘coin rubbing’ among South East Asian cultures – traditional healing whereby the edge of a coin is rubbed over the skin, producing a red stripe
- artificial penile nodules in South East Asian men – foreign bodies are implanted under the skin of the penis to enhance sexual performance
- scars or lesions, especially in African cultures – found on the trunk or face and other parts of the body; produced by cutting or burning, for ritual or cosmetic reasons, or for traditional healing
- male circumcision, particularly among Muslim males.

One example of a major body modification procedure is female genital mutilation (FGM) (see pp 134–142).

Lifestyle changes

New Zealand studies of the health of Asian,¹¹³ Middle Eastern, Latin American and African¹¹⁴ groups have investigated the impact of acculturation on health. The refugee experience often substitutes traditional dietary and physical activity patterns with sedentary lifestyles and diets high in sugars and fats. Studies indicate that refugee populations are at increased risk of:

- obesity (proportional to the length of their residence in New Zealand)
- low levels of physical activity
- low fruit and vegetable intake
- adverse patterns of alcohol drinking and tobacco smoking
- hypertension, high blood cholesterol and diabetes
- hospital admission for respiratory diseases such as pneumonia and bronchiolitis
- poor oral health.

Circumcision (male)

Male circumcision is widely practised in many of the countries from which New Zealand draws its refugees. For religious and cultural reasons many refugee parents in this country will require that their sons be circumcised. This service is not typically available through DHBs. Where it is, it is not free.

Complementary therapies and cultural practices

Many refugees come from countries where traditional medicine is widely practised. Care provided by the New Zealand health system can be complemented with the use of such therapies (for example herbal medicine, relaxation and tactile therapies such as massage). These therapies may be helpful for those clients concerned about the side-effects associated with conventional medications. Tactile therapies can also assist in re-establishing the mind-body connection commonly blocked in survivors of trauma and torture.

Dental disease

Many refugees and asylum seekers arrive in New Zealand with advanced or untreated dental disease, having received little or no dental care for years. Those from poorer countries tend to have lower levels of decay. However, many, particularly those who are marginalised because of language, social and economic factors, subsequently go on to develop high levels of dental disease, largely due to increased consumption of sweet foods and drinks. Infants and children are particularly at risk.



Dental health services

The following dental health services are available.

- **Children:** up to the end of school year 8, children are eligible for free dental care from DHBS' school dental services (SDS).
- **Adolescents:** from school year 9 until their 18th birthday, adolescents receive free dental care from general dental practitioners (GDPs) who participate in the adolescent dental scheme.
- **Adults:** only limited publicly funded dental care is available for adults, usually for urgent conditions such as toothache or facial swelling. Beneficiaries may be eligible for a special needs grant for dental care. Subsidised treatment for urgent conditions is also available from dental services at major hospitals, and from some GDPs. Available services vary considerably from region to region.

Dental tip ⇨

GPs and nurses can play an important part in identifying early tooth decay in children. The technique is simple – lift the child's lip and look at the top front teeth. Before a cavity forms, tooth decay presents as white chalky areas near the gum.

General dental practitioner

Accessing dental health services may be challenging for refugee clients. For example, parents may not be able to read a letter from school advising them to register their child with an SDS.

Parents need to contact an SDS to arrange dental care for their preschool-aged children, and a GDP for adolescents. GPs, nurses and other health care providers can assist refugee families to make contact with appropriate dental services.

Failure to thrive in children under two years

Refugee children may have undergone periods of acute or chronic poor growth due to inadequate energy intake, illness or both. This may affect both weight and height (resulting in stunting).



In taking the history of and examining refugee children, consider developmental problems (such as cerebral palsy), congenital disorders (such as heart disease), chronic infection (such as TB), nutritional deficiencies and intestinal parasitic infections. Rarely, HIV infection may be implicated.

Investigations to consider include full blood examination, urinalysis, urine microscopy, culture and sensitivity and blood chemistry.

Current failure to thrive may also be caused by nutritional, environmental, social and psychological factors as well as diseases. Psychosocial problems and organic problems may coexist. Consider referral to a paediatrician.

Haemoglobinopathies

Haemoglobinopathies are inherited disorders of haemoglobin synthesis (thalassaemias) or structure (sickle cell disorders) that are responsible for significant morbidity and mortality the world over. They are mainly seen in patients originating from Africa, the Middle East, the Mediterranean, Asia and the Far East.

Unexplained anaemia in patients from these regions may be the result of an undiagnosed haemoglobinopathy.

Helicobacter pylori

Refugee populations are likely to have a relatively high prevalence of *Helicobacter pylori* infection. Practitioners should therefore consider non-invasive diagnostic testing of clients with symptoms of dyspepsia. Patients with alarm signals¹¹⁵ such as severe or persistent dyspepsia, previous peptic ulcer disease, unexplained weight loss, anaemia or gastro-intestinal bleeding should be referred directly for oesophago-gastro-duodenoscopy.

Hepatitis B and C

All refugees should be screened for Hepatitis B and C. Those with these infections, and where indicated their close contacts, should be managed and referred according to current clinical and public health protocols. It is important that these clients receive good education about transmission and safe practices.

All children who are Hepatitis B carriers should be referred to a paediatrician.

HIV infection

Having AIDS in our culture from a social perspective is a complete catastrophe. AIDS is considered a terrible disease and is extremely shameful. If you have it, you will lose your friends and family, you might be cast out by society and left on your own. It is almost better to die than to tell people that you have AIDS.

Ethiopian woman¹¹⁶

All quota refugees are screened for HIV infection at the MRRC. Asylum seekers, however, may not have been screened.

Regions of Africa and South East Asia continue to have a relatively high HIV prevalence. Consideration should be given to testing all refugees from high prevalence areas. All HIV positive people should be referred to the appropriate specialist service for medical management.

Socio-cultural issues associated with HIV among refugees

HIV is generally regarded as a source of shame and fear among refugee groups in New Zealand.¹¹⁷ For this reason, many refugees choose not to tell anyone in their community (sometimes even



spouses) that they are HIV-positive, and live with an enormous burden of silence and a constant fear of exposure and ostracism. This presents a challenge to health providers. Secrecy increases the potential for spreading HIV infection. Women are particularly vulnerable if partners who are HIV-positive resist the use of condoms.

Fear of exposure may impact negatively on care and treatment.

For example:

- consultations with GPs may be missed because of a client's fear of the family finding out, or of meeting someone they know in the waiting room or hospital
- if an interpreter from the client's community is used during a consultation, the client may withhold information, or may miss the appointment
- clients may feel the need to hide medicine from others in the household
- health workers may not be able to visit the client at home
- clients may not be willing to access the usual support networks in their community
- clients may miss doctors' appointments because they do not want to ask friends or family for transport to the clinic

- a combination of the factors listed above may compromise treatment of HIV, which is typically complex.

In addition to the burden associated with their disease, many refugees with HIV are also processing the pain and trauma of the refugee experiences in general. This means that their coping capacity may be limited.¹¹⁸

How do I assist an HIV-positive refugee client in facing the many issues associated with HIV?

Memory and concentration problems are common features of the refugee experience, so clear, careful explanations are necessary. In particular, refugee clients should know that they will not be sent home because of their HIV status. For those who have some literacy, a comprehensive range of HIV education material for refugees is available in English and some African languages (see p 163). Note that HIV among African refugee women is a growing concern; the rate is nearly as high as it is among men.

Women and HIV

HIV among African refugee women is a growing concern, with the rate being nearly as high as for men. Issues for GPs to be aware of include:

- women wanting to have children
- issues around safer sex and contraception.

HIV testing during pregnancy is important. If a woman with HIV is pregnant or considering pregnancy it is vital to refer her to appropriate services. Early intervention and appropriate management can reduce the risk of mother-to-child transmission of HIV from around 30 percent to less than 2 percent.¹¹⁸

Breast feeding is contra-indicated in HIV positive mothers and support is available for women in this position.

GPs should ensure that all refugee clients from high-prevalence areas have been tested for HIV. Further HIV testing should be offered to clients from these areas on a regular basis.

Immunisation

Many refugees have incomplete immunisation by New Zealand standards, or unsatisfactory records of vaccination. Procedures for obtaining prior consent for vaccination are outlined in the Ministry of Health (2011) *Immunisation Handbook*¹⁹, and should be followed for both adult and child immunisations. This handbook is available from your local Public Health Service.

Quota refugees: immunisation screening at the MRRC

All quota refugees are tested at the MRRC for immunity to morbilli,



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rubella and Hepatitis B. Immunisation status is established through serological testing, discussion with the patient (or parents) and immunisation records, where available.

Where indicated, refugees are offered all the vaccines on the New Zealand vaccination schedule (including HPV and the influenza vaccine). Those over the age of 16 are offered Td when indicated, as well as other funded vaccines, such as rubella for non-immune women and hepatitis B for family contacts of hepatitis B carriers.

The MRRC provides every quota refugee with a summary of vaccinations given and suggested follow-up primary care.

Asylum seekers

Asylum seekers may not have been screened for immunisation status.

Tables 9 and 10 based on Ministry of Health recommendations may be useful in offering appropriate immunisations to adults and children.

Table 9: Immunisation in refugee children

Standard childhood immunisations	<p>Offer a primary course if there is no satisfactory history or documentation.</p> <p>Aim to bring up to date with New Zealand immunisation schedule.¹²⁰</p>
BCG	<p>Offer BCG to infants and children under five years old at increased risk of TB, defined as those who:</p> <ul style="list-style-type: none">• will be living in a house or with a family containing a person with either current TB or a past history of TB• live with someone who within the last five years lived for a period of six months or longer in countries with a rate of TB greater than or equal to 40 per 100,000, or• during their first five years will be living for three months or longer in a country with a rate of TB greater than or equal to 40 per 100,000 and are likely to be exposed to those with TB. <p>As a general indication, the following global areas have rates greater than or equal to 40 per 100,000:</p> <ul style="list-style-type: none">• most of Africa• much of South America• Russia and the former Soviet states• the Indian subcontinent• China, including Hong Kong• South East Asia (except Singapore)• the Pacific (except the Cook Islands, Fiji, Niue, Samoa, Tokelau and Tonga). <ul style="list-style-type: none">• Children at risk may be vaccinated at any time up to five years of age. If the child is six months or older they should have a pre-vaccination Mantoux test to detect if they have already been infected.• See <i>Guidelines for Tuberculosis Control in New Zealand 2010</i> (Ministry of Health) for further information on BCG or Mantoux testing, or consult your local public health service.

Table 10: Immunisation in refugee adults

Adult diphtheria tetanus	Check for previous history of diphtheria or tetanus immunisation. If a client has not received a primary course, they need two doses at a one-month interval, followed by a third dose to complete the primary course.
Hepatitis B vaccination	<p>Notify all acute cases of hepatitis B to the medical officer of health and discuss the need for vaccine and hepatitis B immune globulin. Note:</p> <ul style="list-style-type: none"> • serology (HBsAg, HBsAb) is recommended before vaccination • provide vaccine to: <ul style="list-style-type: none"> – susceptible household contacts of acute/chronic carriers – susceptible sexual partners of hepatitis B carriers.
BCG	BCG is not routinely recommended (see <i>Guidelines for Tuberculosis Control in New Zealand 2010</i> (Ministry of Health) or the <i>Immunisation Handbook</i> (Ministry of Health 2011)).
Rubella	<ul style="list-style-type: none"> • Offer the measles, mumps and rubella vaccine (MMR) to all seronegative women of child-bearing age. A rubella vaccine is available for women not wishing to have MMR. • Women must not be pregnant or planning pregnancy for the next three months at the time of immunisation.
Standard childhood immunisations	<ul style="list-style-type: none"> • Offer a primary course if there is no satisfactory history or documentation of immunisation.

Infectious and parasitic diseases

Infectious and parasitic diseases are common in many of the countries from which refugees originate. While quota refugees will have been screened for a number of these diseases, many asylum seekers and family reunification refugees will have received little or no screening. When examining those who have not been screened, consider the following:

- TB infection and disease should always be considered
- HIV is increasingly common, along with other STIs
- some helminths infections (strongyloides, opisthorchis, schistosomiasis) may be asymptomatic, and persist for many years before causing serious disease.

For those who have some literacy, resources in English on some infectious diseases (including TB, HIV and hepatitis B and C) are available free from public health services.

Table 11 below sets out the signs and symptoms of common infectious and parasitic diseases. Maintain a low threshold of suspicion for these conditions and refer appropriately. Common infections of childhood should always be considered and excluded in children.



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Table 11: Infectious and parasitic diseases

Symptoms and signs	Diseases to consider	
Fever/high fever	Malaria dengue* – rash, purpura, petechiae, hepatomaly filariasis leishmaniasis leptospirosis* – conjunctivitis, meningitis, jaundice, petechiae meliodosis* – acute septicaemia or more chronic	acute schistosomiasis rickettsial disease sickle cell crisis +/- sepsis strongyloides trypanosomiasis TB (pulmonary, extra-pulmonary) typhoid* typhus* viral haemorrhagic fevers* yellow fever – fever, jaundice, bleeding meningococcal meningitis*/septicaemia
General ill health, weight loss	leishmaniasis TB	worms/parasites, HIV/AIDS
Fever and jaundice	amoebic liver abscesses brucellosis haemolysis and sepsis (Sickle cell) hepatitis leptospirosis malaria	Q fever rickettsial disease septicaemia TB typhoid typhus viral haemorrhagic fevers

Symptoms and signs	Diseases to consider	
Fever and diarrhoea/colitis	amoebic dysentery (note: exclude before giving steroids for inflammatory bowel disease)	malaria shigella – <i>may be very resistant</i> typhoid
Diarrhoea/abdominal discomfort	<i>Helicobacter pylori</i> parasites such as strongyloides, giardia, salmonella, shigella, cholera, campylobacter, amoebiasis	schistosomiasis
Acute neurological symptoms (such as fitting, deterioration of conscious state)	cerebral cysticercosis malaria meningitis rabies – <i>can have a long incubation period</i>	sickle cell disease (infarction) trypanosomiasis
Muscle pain/limb pain	cysticercosis leptospirosis malaria	schistosomiasis septicaemia
Bone/joint pain	dengue lyme disease rheumatic fever	sickle cell disease typhus
Haematuria/haemolysis	malaria – <i>haemolysis</i> schistosomiasis	sickle cell disease – <i>haemolysis</i>

Symptoms and signs	Diseases to consider	
Eosinophilia	cysticercosis dracunculiasis filiariasis hydatid disease	onchocerciasis/loiasis parasites trichinella visceral larvae migrans (toxocara)
Urticaria	ascaris hookworm loiasis/onchocerciasis	schistosomiasis strongyloides
pyrexia of unknown origin	amoebiasis brucellosis filariasis HIV leishmaniasis leptospirosis loiasis/onchocerciasis malaria melioidosis other, non-infectious, causes, such as rheumatological or neoplastic disease	meningococcal disease (chronic) Q fever relapsing fever rheumatic fever TB toxocara trypanosomiasis typhoid typhus (some)
Altered pigmentation	leprosy	

* May affect the skin

What diseases should I be aware of in refugees from specific countries?

Table 12 below sets out by country common infections and parasitic diseases (indicative only).

Table 12: Infectious and parasitic diseases, by country

Country	Common	Possible	Rare
Afghanistan	giardia helminths intestinal parasites TB	amoebiasis cutaneous leishmaniasis hepatitis B	leprosy malaria
Bhutan	giardiasis gut parasites TB	dermatophytoses	hepatitis B carriage rabies
Burma	giardiasis gut parasites including strongyloides stercoralis TB	clonorchis sinensis hepatitis B carriage hepatitis C scabies schistosomiasis trichostrongylus species	malaria opisthorcis viverrini
Colombia	giardiasis gut parasites	<i>Helicobacter pylori</i> syphilis	American trypanosomiasis (Chagas disease) bartonellosis

Country	Common	Possible	Rare
Eritrea and Ethiopia	giardia/amoeba helminths hepatitis B intestinal parasites	dracunculiasis hepatitis (including E) leishmaniasis schistosomiasis malaria trachoma TB HIV	diphtheria filariasis leprosy measles meningococcal disease polio onchocerciasis rabies syphilis
Iran	giardia helminths hepatitis B intestinal parasites	amoebiasis brucellosis cutaneous leishmaniasis hydatids strongyloides trachoma TB	leprosy rabies schistosomiasis
Iraq	giardia helminths hepatitis B intestinal parasites	amoebiasis cutaneous leishmaniasis hydatids schistosomiasis trachoma TB	diphtheria leprosy rabies vivax malaria

Country	Common	Possible	Rare
Somalia	intestinal parasites giardia/amoeba helminths hepatitis B	hepatitis (including E) leishmaniasis malaria schistosomiasis trachoma TB syphilis tinea	diphtheria leprosy measles rabies strongyloides HIV
Sudan	intestinal parasites giardia / amoeba helminths hepatitis B	dracunculiasis filariasis hepatitis (including E) HIV leishmaniasis malaria schistosomiasis syphilis TB tinea trachoma	diphtheria leprosy measles meningococcal disease onchocerciasis polio rabies sleeping sickness typhoid

Notes on unfamiliar infectious and parasitic diseases

In New Zealand we do not see large numbers of the infectious and parasitic diseases listed in this section. However, it is important to be aware and remain vigilant. Where infection is suspected, consider immediate referral to an infectious disease specialist.



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Table 13 below offers brief notes on some of the less common infectious and parasitic diseases. The Australasian Society for Infectious Diseases document *Diagnosis, management and prevention of infections in recently arrived refugees*¹²¹ is also a very useful source of information.

Table 13: Notes on unfamiliar infectious and parasitic diseases

Disease	Clinical/management notes
Amoebiasis	
<p>Organism: <i>Entamoeba histolytica</i>. Amoebiasis occurs mainly in developing countries in the tropics and subtropics. There is increased incidence in refugee camps related to lack of water, poorer hygiene and sanitation.</p> <p>Transmission: The organism is transmitted through contaminated food and drinking water. After ingestion, the cyst breaks down and enters the colon, causing local invasive disease (amoebic colitis). It can also invade the liver, lungs and brain, resulting in abscesses.</p>	<p>Clinical features: Dysentery may be accompanied by weight loss, anaemia, dyspnoea, and blood/mucus in the stool. Chronic features may include meningoencephalitis and other organ involvement, for example liver abscess.</p> <p>Note: the pathogenic <i>Entamoeba histolytica</i> cannot be distinguished microscopically from the harmless <i>Entamoeba dispar</i>. Therefore asymptomatic individuals with either in their stools should not be routinely treated. Those with symptoms should be referred to an ID specialist.</p> <p>Diagnosis may require:</p> <ul style="list-style-type: none"> – a stool sample (looking for haemophagocytic trophozoites) – amoebic serology (useful in diagnosis of invasive disease) – ultrasound/CT scanning (helpful in liver disease). <p>Management: should be undertaken in consultation with an appropriate specialist.</p>

Disease	Clinical/management notes
Brucellosis	
<p>Organism: <i>Brucella</i> organisms: <i>Brucella melitensis</i>, <i>Brucella abortus</i>. Brucellosis usually occurs in those who have close contact with cows or goats, such as farmers, vets, abattoir workers (<i>Brucella abortus</i>) and those consuming unpasteurised dairy products (<i>Brucella melitensis</i>). The disease has been eradicated in much of the western world.</p> <p>Transmission: The <i>Brucella</i> organism is passed to humans through infected cow or goat milk.</p> <p>Incubation period: highly variable: 5–60 days for acute brucellosis.</p>	<p>Notifiable disease</p> <p>Clinical features: Brucellosis is a systematic bacterial disease with protean manifestations. Onset may be acute but relapsing and chronic forms are seen, particularly with <i>Brucella melitensis</i>. Features include non-specific symptoms such as fever, headache, weakness, chills and sweats. Musculoskeletal symptoms such as arthralgia, arthritis and myalgia are seen in acute brucellosis. Arthritis is a particular feature of relapsing disease, and chronic brucellosis may manifest with systemic symptoms and arthritis or consist of localised spondylitis or uveitis. Depression and chronic fatigue are significant in chronic brucellosis. Epididymitis and endocarditis may complicate brucellosis.</p> <p>Diagnosis: requires isolation of the agent from bone marrow or blood. Diagnosis is usually made on the basis of serology and clinical features. When diagnosis is confirmed, discussion with or review by an ID specialist is appropriate.</p>

Disease	Clinical/management notes
Clonorchiasis	
<p>Organism: <i>Clonorchis sinensis</i>. This is caused by the Chinese liver fluke endemic in south-east China, but also occurs in south-east Asia.</p> <p>Transmission: Clonorchiasis is acquired by consuming raw or under-cooked freshwater fish or crayfish. It is not transmissible human to human.</p>	<p>Clinical features: Chlonorchiasis is a trematode disease of the bile ducts – symptoms may be absent with light infestations; heavier infestations may present with loss of appetite, abdominal discomfort or diarrhoea. The disease is associated with increased risk of cholangiocarcinoma.</p> <p>Diagnosis: consists of visualisation of characteristic eggs in faeces or duodenal aspirate.</p> <p>Management: discussion with an ID specialist is recommended. Typical therapeutic agents include albendazole and praziquantel.</p>

Disease	Clinical/management notes
Filariasis	
<p>Organism: several different nematode filariae species, such as <i>Wuchereria bancrofti</i> and <i>Brugia malayi</i>. This infection is widely spread through subtropical and tropical countries.</p> <p>Transmission: The causative organism is transmitted to humans through the bite of an infected mosquito. The bite allows microfilariae to enter the blood and infect the human. In lymphatic filariasis, the microfilariae reside in the lymphatics, causing elephantitis (lymphoedema).</p> <p>Incubation period: 6–12 months (<i>bancrofti</i>); 3–6 months (<i>Brugia</i>).</p>	<p>Clinical features: Infections may be asymptomatic or cause acute fevers, lymphadenitis and retrograde lymphangitis. Chronic features may include hydrocoele, chyluria, elephantitis in limbs/breasts/genitalia, tropical eosinophilia.</p> <p>Diagnosis: can be made on the presence of the relevant filarial nematode either in a blood smear or in one of the body fluids. Filarial serology can be an indicator of previous exposure.</p> <p>Management: refer to ID specialist.</p> <p>Treatment: non-sedating long-acting antihistamines for allergic symptoms.</p>

Disease	Clinical/management notes
<p data-bbox="124 185 395 217">Hydatid (Echinococcus)</p> <p data-bbox="124 240 412 491">Organism: tapeworm <i>Echinococcus granulosus</i>. The disease is mainly found in countries where dogs are widely used or kept, since dogs are the host of the mature tapeworm.</p> <p data-bbox="124 515 421 858">Transmission: Worm embryos can be transmitted to humans by dogs. Once ingested, the organisms pass through the stomach wall into the blood, where they are carried around the body. They may encyst in the liver, lungs, kidney or brain.</p> <p data-bbox="124 882 384 938">Incubation period: 12 months to many years.</p>	<p data-bbox="440 240 654 264">Notifiable disease</p> <p data-bbox="440 288 947 539">Clinical features: Cysts form and enlarge slowly over years. Signs and symptoms depend mainly on the size of the cyst and consequent pressure. Very small cysts in the brain may produce serious results like those of a tumour, while in the liver a cyst might grow to the size of a human head before causing much trouble.</p> <p data-bbox="440 563 925 651">Diagnosis: usually made on the basis of imaging appearances (ultrasound, CT) and hydatid serology.</p> <p data-bbox="440 675 925 730">Management: Refer to hospital ID service/ specialist.</p> <p data-bbox="440 754 882 842">Treatment: cyclical albendazole with percutaneous cyst drainage or surgical excision depending on location.</p>

Disease	Clinical/management notes
Leishmania, cutaneous	
<p>Organism: protozoa Leishmania species, such as <i>Leishmania tropica</i>, <i>Leishmania major</i>, <i>Leishmania aethiopica</i>, <i>Leishmania brasiliensis</i>. This protozoan disease of the skin occurs in the Middle East, Asia, Africa, Central and South America and the former Soviet Union.</p> <p>Transmission: The protozoa is spread through the bite of an infective sandfly. While person-to-person spread may sometimes occur, sexual spread is rare.</p> <p>Incubation period: weeks to months</p>	<p>Clinical features: This infection is characterised by localised cutaneous ulcers.</p> <p>Diagnosis: requires demonstration of leishmania amastigotes within macrophages in biopsy specimens or culture of promastigotes from biopsied tissue. Species identification can be made by PCR.</p> <p>Management: Refer to ID specialist. Initiate antibiotic if secondary infection suspected.</p> <p>Treatment: a variety of agents, depending on the likely or confirmed strain of parasite.</p>

Disease	Clinical/management notes
Leishmania, visceral (kala azar)	
<p>Organism: protozoa <i>Leishmania donovani</i>. This organism is found in Africa, Asia, parts of the Mediterranean and tropical South America.</p> <p>Transmission: The parasite is spread through the bite of an infective sandfly. The organism invades mononuclear cells in organs such as the spleen, liver, lymph nodes, bone marrow and intestinal mucosa, causing hyperplasia and granulomatous reaction.</p> <p>Incubation period: 2–6 months to 1 year.</p>	<p>Clinical features: The disease is systemic and can be subacute, chronic or relapsing. In the acute stage there may be papule at bite site, fever, malaise, weight loss, cough or diarrhoea. Usual features include enlargement of spleen and liver, fever, anaemia and generalised lymphadenopathy. Consider co-existing disease (such as TB). HIV/AIDS patients may not have typical findings. Mortality is 75–95 percent within two years of infection, if untreated.</p> <p><i>Note:</i> consider differential, including malaria, schistosomiasis, typhoid, endocarditis, lymphoma, brucellosis, TB, histoplasmosis and chronic lymphocytic leukemia.</p> <p>Diagnosis: full blood examination. Diagnosis is usually made from a bone marrow specimen, splenic aspirate or liver-biopsy specimen; amastigotes of <i>Leishmania donovani</i> can be visualised.</p> <p>Management: Refer to ID physician for definitive diagnosis.</p>

Disease	Clinical/management notes
Malaria	
<p>Organism: Five species of plasmodium: <i>Plasmodium falciparum</i>, <i>Plasmodium vivax</i>, <i>Plasmodium ovale</i>, <i>Plasmodium malariae</i> <i>Plasmodium knowlesi</i> have been identified as causing disease in humans.</p> <p>Malaria is common in tropical and subtropical countries (for example in Africa, India, Asia, South America and parts of the Pacific). <i>Plasmodium falciparum</i> is the most dangerous type of malaria due to potential complications of cerebral malaria and renal impairment in acute severe infections. It progresses rapidly and may be fatal, particularly in non-immune travellers. Suspect it in any recent arrival from an endemic area with fever. Beware of unusual presentations (such as diarrhoea).</p>	<p>Notifiable disease</p> <p>Clinical features: usually include myalgia and general malaise and sometimes fever, chills, sweats, headaches, cough, diarrhoea and vomiting. Splenomegaly can occur, as can secondary jaundice and anaemia. With <i>Plasmodium vivax</i> relapses may occur months to years later.</p> <p><i>Note:</i> laboratory tests cannot be relied upon to exclude malaria. Where there is reasonable suspicion of malaria in an acutely ill person, urgent advice from an ID specialist should be sought.</p> <p>Diagnosis: is done by examining for parasites in smears of peripheral blood. A single negative smear does not exclude the diagnosis. Ideally three smears should be examined, and more on occasion if clinical suspicion is high. Semi-immune individuals from endemic areas may have low level parasitaemia, making detection in smears more difficult. Many laboratories now use antigen detection tests using monoclonal antibodies to plasmodium antigen as an adjunct to microscopy. Tests are now available for both <i>Plasmodium falciparum</i> and <i>Plasmodium vivax</i>.</p> <p>Management: <i>Plasmodium falciparum</i>: refer to hospital ID service. <i>Plasmodium vivax</i>: refer if unfamiliar with management or if there is difficulty in accessing primaquine for eradication.</p> <p>All cases of malaria in children should be discussed with a paediatric infectious disease specialist.</p>

Disease	Clinical/management notes
Malaria (continued)	
<p>Transmission: The causative organism (sporozoite) is transmitted to humans by a mosquito bite, and is carried in the blood to the liver cells. Here the sporozoite divides, releasing trophozoites into the blood stream, which then invade the erythrocytes. Trophozoites are periodically released into the blood, causing the fevers, rigors and malaise characteristic of malaria.</p>	<p>Treatment: <i>Plasmodium falciparum</i>: quinine, doxycycline, mefloquine and others on occasion. <i>Plasmodium vivax</i>: chloroquine followed by primaquine (hypnozoite eradication). <i>Plasmodium Knowlesi</i>: chloroquine and mefloquine.</p>

Disease	Clinical/management notes
Schistosomiasis	
<p>Organism: blood fluke/trematode <i>Schistosoma</i> species, including: <i>Schistosoma mansoni</i>, <i>Schistosoma haematobium</i> and <i>Schistosoma japonicum</i>. <i>Schistosoma</i> organisms are common in fresh-water lakes and rivers in Africa, parts of South America (Brazil, Surinam and Venezuela), the Middle East and parts of Asia (Laos, Cambodia, Philippines and China).</p> <p>Transmission: The intermediate host is a species of fresh-water snail. When humans come in contact with contaminated water, the cercarial stage of the fluke enters via intact skin. Adult worms live within the human host's mesenteric or vesical veins over many years.</p> <p>Incubation period: 2–6 weeks.</p>	<p>Clinical features: Acute schistosomiasis (Katayama fever) can result in fever, cough, an urticarial rash and enlargement of liver and spleen. Chronic infection with <i>Schistosoma mansoni</i> and <i>Schistosoma japonicum</i> can result in liver problems. Signs and symptoms include diarrhoea (sometimes bloody), abdominal pain, hepatosplenomegaly and colonic symptoms. <i>Schistosoma haematobium</i> leads to urinary manifestations (for example dysuria, frequency, terminal haematuria, bladder and renal complications). There is an increased risk of bladder cancer.</p> <p><i>Note:</i> schistosomiasis infection is frequently asymptomatic or presents with fatigue.</p> <p>Diagnosis: is done by blood test to detect anti-schistosomal antibodies. Definitive diagnosis requires demonstration of ova by microscopic examination of urine or faeces or biopsy material. All cases must be treated. Serology titre may not decline after treatment.</p> <p>Management: Consult or refer to ID unit/specialist.</p>

Disease	Clinical/management notes
<p>Strongyloidiasis</p> <p>Organism: nematode worms, <i>Strongyloides</i> species. The infection is common in many tropical and subtropical countries.</p> <p>Transmission: Larvae of the worms usually penetrate intact skin, especially on the feet, and enter the blood. Eggs hatch in the lower gastrointestinal tract, and larvae can re-enter the circulation, thus setting up an autoinfection cycle which can continue over a lifespan.</p> <p>Communicability: many years.</p>	<p>Clinical features: While an infected patient is frequently asymptomatic, heavy infection can cause jejunal mucosal abnormalities, and an absorptive defect, with weight loss. Acute symptoms include transient dermatitis and pneumonitis. Chronic symptoms may be mild to severe, and include:</p> <ul style="list-style-type: none"> • abdominal pain: usually epigastric, which can simulate peptic ulcer • diarrhoea • urticaria • eosinophilia • nausea and vomiting • weight loss • weakness • constipation • migrating serpiginous rash. <p>Autoinfection leads to increased parasitic load and can result in severe disease and even death, particularly in an immunocompromised host.</p> <p>Diagnosis: consists of visualisation of larvae in stool, duodenum aspirate or a jejunal biopsy-section. Serological testing can be done in Australia, but should only be ordered in consultation with an ID specialist.</p> <p>Management: Discussion with an ID specialist is recommended. All children younger than five years should be referred to a specialist.</p> <p>Treatment: treat all infections. Untreated infection may persist for years due to autoinfection. Subsequent immunosuppression (such as through steroids) may result in hyperinfection with colitis and polymicrobial sepsis, which is frequently fatal. Treatment options include albendazole and ivermectin.</p>

Disease	Clinical/management notes
Trachoma	
<p>Organism: Chlamydia trachomatis. Trachoma is common in developing countries, where it is the leading cause of preventable blindness.</p> <p>Transmission: The organism is transmitted by flies or contact with infected material (for example towels or clothing). Chlamydia trachomatis causes inflammation of the conjunctiva and cornea and consequent scarring. Infection may persist for years if untreated, and causes blindness. Active disease in hyper-endemic areas is the result of frequent reinfection.</p> <p>Communicability: long-term.</p>	<p>Clinical features: diffuse conjunctival inflammation, especially on tarsal conjunctiva lining upper eyelid. This can lead to:</p> <ul style="list-style-type: none"> • vascularisation of the cornea or pannus • scarring of the conjunctiva • in-turned lashes/lid deformities (trichiasis and entropion) • corneal abrasion leading to visual impairment and blindness. Early trachoma is endemic in children in many developing countries. <p>Diagnosis: either through a conjunctival swab for culture or through non-culture methods, such as antigen detection via direct fluorescent antibody.</p> <p>Management:</p> <ul style="list-style-type: none"> • Commence treatment in conjunction with an ID specialist or refer to ophthalmologist, particularly in the case of long-standing disease. • Advise patient to observe strict hygiene control. • Check other family members or intimate contacts. <p>Treatment: oral azithromycin (single dose)</p>

Disease	Clinical/management notes
Tuberculosis	
<p>Organism: Mycobacterium tuberculosis. Prevalent in developing countries (see p 66). In Asia an estimated 60–80 percent of children under 14 are infected.</p> <p>Transmission: Bacilli may be transmitted:</p> <ul style="list-style-type: none"> • in airborne droplets from those with lung or laryngeal TB • by ingestion of infected product (for example milk). Once inside the body, bacilli are carried in the lymphatics or blood vessels to organs such as lungs, joints and kidneys, where they form tubercles (fine granules) which multiply and change and lead to destruction of the organ. <p>Incubation period: exposure leading to primary lesion or a positive purified protein derivative test is about 4–12 weeks. Progressive pulmonary or extra-pulmonary TB is most likely to occur within two years, but latent infection carries a lifetime risk of reactivation.</p>	<p>Notifiable disease</p> <p>Clinical features: The severity of the disease varies according to the organs involved. Symptoms include chronic cough, fevers, night sweats, malaise, failure to thrive in children, anorexia and weight loss. In pulmonary TB there may be haemoptysis; in meningitis chronic headache; in laryngeal TB (highly infectious) hoarseness. Pain may be associated with infection in various sites.</p> <p>Note: Maintain a low threshold of suspicion for TB in refugees, especially if unscreened.</p> <p>Management: On suspicion of TB refer to an ID specialist or respiratory specialist with an interest in TB. If productive cough is present a chest X-ray should be obtained and sputum sent for acid-fast bacillus examination and culture for TB.</p> <p>Treatment: multi-drug therapy, dependent on sensitivities.</p>

Disease	Clinical/management notes
Tuberculosis (continued)	
<p>Communicability: depends on factors such as:</p> <ul style="list-style-type: none"> • numbers of bacilli in sputum • virulence of bacilli • adequacy of ventilation • degree of closeness of contact. <p>Prolonged contact carries a higher risk. Risk of developing TB is highest in:</p> <ul style="list-style-type: none"> • children under three • adolescents • young adults • the very old • immunosuppressed people. 	

Medication

Many refugees come from countries where medication is given out by health professionals during consultation. Ask patients to bring their medicines to first assessments, so that doses and formulations can be reviewed. Refugee clients may be unfamiliar with the New Zealand system of prescribing medication. Explain carefully how a prescription works, including the role of the pharmacist, the likely cost and waiting time, and how patients can get repeats.



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Be aware of the following.

- It has been reported that some refugees in this country leave consultations feeling angry, neglected and short-changed if they are not prescribed medications, or if they are ‘just told to take Panadol’ every four hours.¹²² If no medication is indicated during consultation, or if over-the-counter medication like Panadol is advised, it may be useful to explain this carefully.
- Many refugees will have been able to self-prescribe antibiotics and other medication in their countries of origin. They may not be aware of the consequences of incorrect, under- or over-dosing or not completing a course of medication. It is therefore particularly important to emphasise the correct dose and course.
- When working with an interpreter, ask them to write down the dose and course in the client’s own language. If the client is unable to read (which is often the case) good verbal instructions through the interpreter are crucial. Colour coding can also be useful.
- Prescribing may need to take into account a client’s cultural or religious practices; for example, Muslims may need an alternative to alcohol-based medication and may require exemption from fasting requirements during Ramadan.
- You may need to explain such safety measures as safe storage of medicines, expiry dates and the importance of not sharing medication.
- Costs are a significant barrier to many refugees. Consider the cost of medications, and wherever possible choose subsidised medications. If this is not possible, choose the best-priced drug with equal efficacy. Explain and encourage enrolment with a primary health organisation as a way of accessing lower-cost care.
- Some refugees may have an expectation that only drugs given intravenously will be effective: you may need to reinforce the efficacy of oral administration.

Nutrition and diet

Health problems among refugee groups may be related to diet and lifestyle. Such issues may include the following.

- **A nutritionally inadequate diet, sometimes related to unfamiliar foods:** vulnerable micronutrients include: iron, vitamin A, vitamin D and iodine. Anaemia is common among refugees, especially in women and children. As haemaglobinopathies are also common, investigate 'anaemia' further. If people, especially children from the Horn of Africa, present with lower joint pains, bleeding gums or rashes, suspect scurvy.
- **Failure to thrive in children** (see p 70): this can be of mixed aetiology, and may need investigation by a paediatrician. Nutritional factors could include insufficient breast milk or formula, inadequate introduction of solid foods, food allergies or food intolerance. Consider the accuracy of the birth date; if doubtful, X-ray for bone age.
- **Inadequate water intake:** refugees may have spent long periods without access to safe water, and may need encouragement to drink tap water.
- **Lack of education about potentially harmful effects of food:** for example, the relationship between dental caries and sugar consumption, or high-fat foods and obesity, or obesity and diabetes.
- **A reduction in breastfeeding:** refugees may wrongly see bottle feeding as a modern, better alternative. You may need to encourage breastfeeding from the day babies are born.



- **Lack of local knowledge about shopping and food preparation among new refugees, especially young people and single men:** dietitians, nurses, GPs and social workers can provide basic skills and information in this regard, including how to select healthy food on a limited budget, accessing food banks, and sourcing and using food from refugees' own culture. Pamphlets on healthy eating for different age groups are available free from regional public health services.

Rape and sexual assault

Rape or sexual assault is part of the refugee experience of men, women or children, but by far the most cases involve women. In dealing with a disclosure of rape or sexual assault, the same procedure applies as when dealing with disclosure of other forms of torture (see p 113).

Women who arrived in New Zealand on the refugee quota programme will probably have been screened for some STIs. Regardless, consider referring women to a service or doctor who has experience in the area of sexual abuse care, such as Doctors for Sexual Abuse Care. Reassure women clients that this may not necessarily involve a vaginal examination.

When deciding whether to encourage a woman to have STI screening, take into account the invasive nature of some of these tests. Anxiety associated with testing, particularly in women who have undergone FGM, is high. Chlamydia, often asymptomatic, can be detected by a urine test, which has the advantage of being non-invasive.

Syphilis

Review the cases of all patients with positive syphilis serology in respect to their past history of exposure and treatment, and manage according to local guidelines. A paediatrician should review all cases of children with positive syphilis serology.

Referrals

When assessing the need for further investigation and/or specialist referral, be aware that these services can involve a great deal of organisational effort on the part of refugee clients. Clients may require detailed information on and practical support in arranging referrals, including explanations about how a specialist appointment is made, why the referral/investigation is necessary, what procedures will be done, how to get to the specialist, where to go on arrival, how much it will cost, what the client will need to bring to the appointment, and so on.



Given the language difficulties and lack of familiarity refugee clients may have with referral services, consider making the first appointment for them. With the client's permission, brief the specialist on the need for an interpreter and other special needs, including financial constraints.

Note that female clients may prefer to be seen by female specialists.

Smoking

A third of all male and 6 percent of female refugees over the age of 17 years screened at the MRRC smoke.¹²³ Tobacco and cigarettes are cheap in the countries of origin of many refugees. Smoking cessation support and counselling should be offered to refugees who smoke, including the use of interpreters and translated information where required. Additional psychological support may be required for refugee clients, as their smoking may be linked to traumatic experiences. Emphasise the risks of smoking to health and the importance of smokefree homes and cars.

Tuberculosis

If someone has TB, everyone in the community will isolate them. They will often lose their friends because they have this terrible infectious disease.

Vietnamese man¹²⁴

Refugees have an increased risk of TB, which is typically found in deprived, overcrowded living conditions. All refugees arriving on the quota programme are screened and, if necessary, treated for active TB prior to entering the country. Once in the country, all quota refugees undergo a full medical examination and chest X-ray. Quota refugee children younger than 16 years are screened for latent TB infection at the MRRC.

Detection, treatment, prevention and follow-up in New Zealand is effective. Full medical reports for GPs are given to every refugee screened in the MRRC, including guidelines for follow-up for those who have a positive TB result. TB follow-up is the responsibility of regional public health services, not GPs. The *Guidelines for Tuberculosis Control in New Zealand 2010* (Ministry of Health) provide advice on the diagnosis, management and prevention of TB.

What about refugees who have not been screened for TB?

Currently, screening and treatment for latent TB infection (LTBI) in people from high-incidence countries is limited to quota refugee children aged under 16 years. Adult recent immigrants from high-incidence countries should be screened and considered for LTBI treatment if they have:

- a known history of exposure to an infectious case within the preceding two years
- immune-suppression or a predisposing medical condition
- a fibrotic lesion (discovered through chest X-ray), where disease requiring full multi-drug treatment has been excluded.

An appropriate medical or public health specialist should supervise the management and treatment of LTBI.

Although GPs are not usually responsible for initial health screening, they should maintain a high level of suspicion for TB. Active TB is most likely to occur within the first five years of a refugee moving to New Zealand.

Children can develop extensive disease with minimal symptoms, so a high index of suspicion should be maintained.

Socio-cultural issues associated with TB

As with HIV, there is deep shame associated with having TB.

Inadequate treatment of TB in the homelands of some refugees may have resulted in a high TB mortality rate, so that many are fearful of the disease.

TB Tip ⇨

After being caught out, my advice re back pain in a refugee client – ‘think TB until proved otherwise!’

GP working with refugees

Many refugee clients will keep a diagnosis of TB secret from their community. The burden of secrecy and sense of isolation place an enormous stress on a client, who may also be struggling with past trauma and trying to resettle in a new country. Secrecy also impacts on health care providers; for example, visits may need to be arranged at a time when extended family members are not in the home; directly observed therapy (DOT) may be difficult; compliance with medication may be low; and consultations at clinics or outpatient services may be missed due to fear of exposure.

Managing clients with TB

Careful explanations may be needed due to memory and concentration problems, which are common features of the refugee experience. This is particularly the case with instructions for medication. Check that clients understand:

- when to take the medication
- dosages
- the consequences of under- and over-dosing
- any side-effects
- safe storage of medication
- not to share medication
- the need to complete the course of medication.



TB management should always be supervised by a medical specialist and a public health office. DOT is often necessary. Education about TB is essential. Many refugees are unaware of the cause and effect of TB, and believe it ends in death. Education should cover:

- the cause of TB and how it may be spread
- types of TB (infection versus disease: infection is treated with chemoprophylaxis, disease with multi-drug therapy)
- the fact that TB is curable with medication
- the importance of adhering to a medication regime
- the importance of continuing medication even when patients are feeling well

- myths and the facts about TB; for example, well-meaning families may believe it is appropriate to isolate a family member on TB medication, or to require them to use separate cups and plates.

The use of visual resources in education is strongly recommended for those with low literacy. Illustrated booklets on TB disease are available in Amharic, Arabic, Cook Islands Maori, Fanti (Chinese spoken in Hong Kong and Taiwan), Farsi (Persian), Jan-ti (Chinese spoken in mainland China), Khmer, Somali, Samoan, Tongan, Vietnamese and English, from Public and Community Health Services, Auckland District Health Board.

See new migrant health website www.healthed.govt.nz/health-topic/new-migrant-health



Vitamin D deficiency

Vitamin D deficiency has been noted to be very common in refugee populations in New Zealand.¹²⁵ Women, particularly those of child-bearing age – are at greatest risk. Exclusively breast-fed infants whose mothers have low vitamin D are also at risk. Consider screening and ongoing surveillance for vitamin D deficiency for clients from refugee backgrounds.

Vitamin D deficiency has re-emerged as a significant paediatric health issue, with complications including hypocalcaemic seizures, rickets, limb pain and fractures.¹²⁶

Screening for vitamin D deficiency

- Screen all newly arrived refugees, especially those at risk (for example darker-skinned, veiled, housebound, women and children).
- In particular, screen refugee women who are pregnant, planning pregnancy or breast-feeding.
- Recheck vitamin D levels in those previously deficient during the winter months.

Referral and follow up

For severe vitamin D deficiency with significantly high ALP and PTH, and/or renal impairment, and in children with severe deficiency; or where levels are not increasing despite adequate supplementation, seek specialist advice.

Mental Health Issues

Torture and trauma experiences

Refugees are dominated by one feeling and that is a painful, traumatic and deep sense of loss. Loss of what is obvious and tangible and external such as possessions, a home, work, role, status, lifestyle, a language, loved members of a family or other close relationships – and the loss that is less obvious, ‘internal’ and ‘subjective’ such as loss of trust in the self and others, loss of self esteem, self respect and personal identity.

R Baker: *Torture and its Consequences*¹²⁷

Health assessments routinely conducted with refugee entrants to Victoria, Australia, by the Victorian Foundation for the Survivors of Torture indicate that 7 in 10 had experienced psychological or physical violence of some kind.¹²⁸ A New South Wales study of humanitarian entrants found that one in four had been subject to severe trauma and torture.¹²⁹ It is estimated that up to 35 percent of the world’s refugee population has had at least one experience of torture.¹³⁰ The high incidence of rape among Central and East African refugees is now well documented.¹³¹

In New Zealand, a 2005 study of the health status of quota refugees screened by the Auckland Regional Public Health Service between 1995 and 2000 at the MRRC found that 20 percent had suffered significant to severe physical abuse.¹³² About 14 percent reported significant psychological symptoms, and about 7 percent were diagnosed with post traumatic stress disorder (PTSD).¹³³ A greater proportion of females reported psychological symptoms, but a greater proportion of males reported mistreatment.¹³⁴

Most refugees arriving in this country will have been exposed to traumatic events. These may include:

- threats to their own lives or those of their family or friends

- witnessing death squad killings
- witnessing mass murder and other cruelties inflicted on family or friends
- disappearances of family members or friends
- perilous flight or escape with no personal protection
- separation from family members
- forced marches
- extreme deprivation – poverty, unsanitary conditions, hunger and lack of health care
- persistent and long-term political repression, deprivation of human rights and harassment
- removal of shelter or forced displacement from homes
- refugee camp experiences involving prolonged squalor; malnutrition; physical, psychological and sexual abuse; absence of personal space; and lack of safety.

Table 14 outlines common forms of torture, and typical physical and psychological sequelae resulting from torture.



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Table 14: Common forms of torture, and typical physical and psychological sequelae resulting from torture

Common forms of torture
<ul style="list-style-type: none">• severe beatings, including falanga (severe and prolonged beating of the soles of the feet)• deprivation of sleep and sensory stimulation• use of psychotropic drugs• electric shocks• burning with cigarettes, hot irons, corrosive liquids, etc• bodily mutilation• sexual violence and rape of men, women and children, including a variety of sexual abuses• starvation• sham executions• water or submarine torture• being forced into abnormal body positions for long periods, including suspension from arms or legs• forced witnessing of psychological abuse, torture or killings of others, including family members• brainwashing, mind control and psychological torture, including all forms of deceit, humiliation and the devaluation of all things that are sacred to human beings.
Common psychological sequelae of trauma and torture
<ul style="list-style-type: none">• grief• psychogenic amnesia• guilt and shame• sense of isolation• distrust and anger• psychosomatic conditions• anxiety• depression• repressing/avoiding/forgetting traumatic events• post traumatic stress (PTS) symptoms (see pp 122–124)

Common physical sequelae of trauma and torture

The physical sequelae of torture are as many and varied as the methods of torture. Many survivors do not have enduring physical sequelae, particularly as some forms of torture leave few visible signs.¹³⁵

Physical sequelae may include:

- brain damage
- chronic pain and poor mobility resulting from inadequate treatment of broken bones
- missing teeth
- impaired hearing (which may result from beating or electrical torture)
- difficulties in walking resulting from falanga
- bronchitis (from submarine torture)
- mutilation of body parts
- scars and disfigurement from burning
- damage to cervix and uterus, fissures, fistulas, pain from the testes, irregular periods, etc, resulting from sexual torture.

How trauma experiences may affect the consultation

Traumatic experiences may affect consultations with refugee clients in a variety of ways, including the following.

- Anxiety, distress, memory loss, confusion and an inability to concentrate may interfere with a client's ability to 'hear' and understand questions and instructions.
- Brain damage as a result of past violence may interfere with memory and concentration.
- Health clinics or surgeries, the instruments used in certain procedures and health professionals themselves may invoke memories of past torture perpetrated in medical settings. This can reinforce a sense of helplessness, and can induce anxiety, panic or avoidance of further consultations.

- Confusion and major memory loss can lead to inconsistencies in the information a client provides.
- Hypervigilance, particularly in unfamiliar situations, is not uncommon. Startled reactions to sudden changes such as noise can also occur.
- Feelings of shame may make being physically approached and touched a disturbing experience, particularly for survivors of rape and sexual torture.
- Anger, hostility and mistrust, particularly of authority figures, may interfere with obtaining information for diagnosis and treatment.

How best can I manage a client who may have a trauma and torture history?

- Use a professional interpreter if possible (see pp 52–57), and check that the client is comfortable with the interpreter. This can be achieved by having the interpreting service check the suitability of the interpreter with the client prior to the consultation.
- Explain that procedures can be rescheduled for another day if the client becomes overly anxious.
- Establish trust by emphasising confidentiality and obtaining consent for all procedures.
- Give the client as much choice and control as possible.
- Avoid a style of questioning that may be perceived as inquisitorial.
- Anticipate reactions of fear, anxiety and even hostility. These are predictable responses to trauma, and should not be taken personally.
- Minimise any resemblance to a torture situation in the surroundings; for example, remove medical instruments.

- Explain any procedures carefully, including their purpose, the time they will take and any likely reactions or side effects.
- Be prepared to repeat information, particularly if the client appears confused.
- Avoid sudden movements, particularly when performing an examination or procedure.
- Reduce anxiety by carefully planning the client’s management and sharing the details with the client.

How can I establish whether a client is a survivor of trauma and torture?

It is rare for a client to disclose traumatic material, *and it is not advised that health professionals probe for this*. Generally, an awareness that a person has come from a ‘refugee-like’ situation is sufficient reason to orient your care to meet their needs. Information on cultural backgrounds in Section 1 of this book gives some indication of the experiences that refugee clients from particular regions are likely to have endured.

Gentle enquiries/discussions, possibly over several consultations, can help to build up a picture of the refugee client’s past and help in establishing the likelihood and extent of exposure to trauma.

What management is indicated for a client presenting with persistent trauma-related symptoms?

Under GP management, medication may be required to manage symptoms that significantly interfere with a client’s functioning.

Anxiolytics and sedatives should be prescribed cautiously, owing to their potential for dependency. However, there is a consensus among practitioners experienced in caring for this client group that optimum treatment involves non-pharmacological approaches, either in addition to medication or as the primary treatment modality.¹³⁶



Disturbed sleep is common and can make clients very tired. A period of sleeping pills and anti-anxiety medication at night may be helpful.

Where a patient presents with persistent symptoms believed to be related to trauma, a referral to a psychiatrist, psychologist or specialised agency such as a RAS Centre or community mental health services should be considered.

If the patient presents with symptoms of violence or self-harm, urgent psychiatric management should be arranged in the usual way.

I watched a girl being raped and I couldn't do anything because I was too scared they might do something to me. I will never forget it.

Refugee youth¹³⁷

Managing a disclosure

How should I respond to a disclosure?

- Ask the client whether they wish to discuss the event further. Don't probe. Let the client direct the conversation. Offer another appointment or other resources, such as counselling services, if necessary.
- Validate the refugee's reaction by acknowledging their experience and its associated pain (for example, say '*That's a terrible thing you have been through. I've heard about other people who have been through similar experiences and who have had similar feelings/thoughts/worries*'). The aim is to normalise – not minimise – the client's reaction.
- Remind the client that their reaction is a characteristic response to their circumstances. This is important, because survivors often blame themselves, seeing their reactions as abnormal or weak.
- Expect that a client who has disclosed a painful event may be unwilling to talk about it in subsequent consultations. Rather

than pushing them, talk about other things that may be troubling them in the ‘here and now’.

- Expect inconsistencies in the retelling of their trauma history.
- In completing the interview, explain the areas in which you can help.

Tip ⇨

The depth of traumatic response and how it affects normal mental and somatic functioning should never be underestimated.

Psychiatrist working with survivors of torture and trauma

Counselling and the refugee client

Many people who have been psychologically affected by traumatic events can be cured or helped by therapy that asks them to recall their experiences and then reframe them and work through them.

On the other hand, there are many people who are not able to do this, and such therapy is not helpful at all. Certainly anyone who has psychotic symptoms or who is already overwhelmed with their emotions and/or is suicidal should not be expected to carry the additional burden of recovery type therapy. These people need to stay in the ‘here and now’ and be helped with problem solving and survival.

In short, there may be a time when therapy helps and there may not.

Psychiatrist working with refugees ¹³⁸

Professional counselling involves a long-term relationship between a client and a skilled person with whom the client can discuss and identify specific causes of stress, and ‘work through’ this material. After traumatic events, sensations and images can predominate. In counselling these are discussed with the aim of enabling better

understanding and integration. Since there is the potential for re-traumatisation in revisiting these experiences, the process should take place only within the professional counselling relationship.

Be aware of the following issues.

- Counselling is a western therapy. For many it is an unfamiliar process which may need to be fully explained.
- Counselling requires high levels of engagement and investment of time by the client, who may be preoccupied with the immediate challenges of resettlement. The client's priorities need to be respected.
- Some clients may not want counselling, fearing that talking about their experiences may make them worse.
- Counselling, with its focus on the individual, may be unacceptable in some cultures in which greater emphasis is placed on whole families or communities working through a problem together.
- Some clients may be wary about a referral to a counselling service, seeing it as the preserve of the mentally ill – a stigma in many groups.
- Some clients may fear that confidentiality will be breached by the counsellor.

How do I assess and manage my client's attitude to counselling?

If a patient presents with persistent symptoms that you suspect are related to trauma, first try to establish a trauma history and then assess the client's interest in a referral to counselling.

- Begin by saying what you have noticed as a problem. For example, *'I have noticed that you have been crying a lot'*.



- Ask if there is anything you can do to make things easier.
- Explore the possibility that the symptoms may be related to trauma.
- Affirm that it is not unusual for people to feel the way they do, particularly in light of the hardships and violence they experienced before coming to New Zealand.
- Advise them of specific services that help people deal with problems that have resulted from trauma. This will enable you to ascertain the client's interest in a referral.
- Be mindful that it may take time and a great deal of encouragement for a person to agree to counselling. If the client is unwilling to pursue counselling, accept their decision. It may be helpful to offer them information about self-referral at a later date.

Mental health issues in children and young people

Does the refugee experience affect children and adolescents?

My Kiwi friends were allowed to go out at night to the movies or to each other's house. I was not allowed because my parents are very strict. I used to argue a lot about this with my parents because they weren't treating me fairly. They were treating me like a little kid.

Refugee youth¹³⁹

It is often assumed that refugee children will settle down and adapt to life in their new country. However, refugee children and young people live in families where there are many stressors including: multiple traumas and losses; social and economic pressures; cultural transitions; and possible parental mental illness.¹⁴⁰

Adolescent children, in particular, may experience difficulties. Some may be caught uncomfortably between two cultures, with many coveting the lifestyle of their New Zealand peers. Mixing with the opposite sex may be unacceptable in their community's eyes.¹⁴¹

Multiple indicators suggest the need to broaden the concept of health prevention with refugee youth to include not only their mental health but also sexual health risk behaviours, the prevention of early pregnancy and of drug and alcohol abuse.¹⁴²

Some refugee children and young people in the first and second generation of refugee families are resilient. However, many experience mental health difficulties, including PTSD, depression, anxiety and grief.¹⁴³ Studies show the transgenerational effects of trauma on a sub-set of children of refugee parents. First- and second-generation children born to refugee parents with PTSD are more vulnerable themselves to PTSD and other psychiatric disorders.¹⁴⁴

Factors which have been found to be protective in minimising psychological distress in children and young people in refugee communities are social and peer support from their ethnic communities, and the well-being of their parents.¹⁴⁵



The effects of trauma on children and young people

There is growing evidence that children and adolescents experience a psychological reaction to trauma¹⁴⁶ not dissimilar to that found in adults. This may manifest itself in children in a number of ways including:

- withdrawal, lack of interest and lethargy
- aggression, anger and poor temper control
- tension and irritability
- poor concentration
- repetitive thoughts about traumatic events
- physical symptoms such as poor appetite, overeating, breathing difficulties, pains and dizziness
- regression (for example, return to bedwetting)
- nightmares and disturbed sleep
- crying
- nervousness, fearfulness and proneness to startling
- poor relationships with other children and adults
- lack of trust in adults
- clinging, refusing to go to school
- hyperactivity and hyper-alertness
- repetitive, stereotypical play
- selective mutism.

What sort of guidance can I offer to parents of children experiencing a trauma reaction?

Ensure parents have the ability and willingness to support and guide their children and young people.

Make use of appropriate services; for example, DHBs' Child, Adolescent and Family Mental Health Services and RAS Centres (Auckland and Wellington) (see pp 149–155 for contact details).

Consider advising parents to:

- encourage their children to express their emotions
- offer children support while they are upset
- ask their children questions to find out what they are thinking and imagining
- reassure their children about the future: the small details of their lives are important and need to be valued
- encourage their children to be children – to play, explore, laugh and do usual things for their age
- maintain routine and predictability, as this helps children to believe that life is secure and predictable
- set caring but definite limits: most children experiencing internal chaos will indicate their need to have clear boundaries set
- minimise change and, when it is necessary, take time to prepare children for it
- give children feedback about how they are going
- avoid making this the time to correct any bad habits
- avoid over-reacting to difficult behaviour as this may be the child's way of letting tension out
- give the child time to adjust to a new situation
- make time for just being together.¹⁴⁷



Common mental health conditions



This section of the handbook outlines, in alphabetical order, some of the more common mental health issues among refugee people.

Anxiety and depression

Anxiety and depression may exist co-morbidly. They are common psychological sequelae to trauma and torture. Other experiences that may not rate as trauma or torture, such as loss of loved ones, prolonged deprivation of human rights or dislocation from one's community, can also lead to depression and anxiety. Depression and anxiety can be triggered or exacerbated by the additional stresses of resettlement.

Signs of anxiety as a result of past traumatic events may include:

- physiological or somatic signs and symptoms (panic attacks, hypervigilance, psychosomatic symptoms)
- cognitive signs and symptoms (poor concentration, poor memory, worries, sleep disturbance, flashbacks, dissociation)
- behavioural responses (avoidance of potentially fear-invoking situations, withdrawal, passivity, aggressive behaviour).

Depression may be linked to a pervading sense of loss and hopelessness and may include such signs and symptoms as: pessimism, loss of interest, sleep disturbance, appetite

Tip⇒

A key cause of stress and anxiety in refugee people relates to family members left behind. The guilt this may cause and the constant worry and stress of trying to bring family members to New Zealand may interfere significantly with their ability to resettle.
Provider

disturbance, poor concentration, self-degradation, self-blame, and suicidal thoughts.

Eating disorders

The stress and disruption of the refugee experience may manifest itself in psychological barriers to eating well. The management of eating disorders may involve the care of one or several health professionals: for example, GPs, dietitians, community health nurses, counsellors, psychologists and natural therapists.

Eating disorders may arise as a consequence of trauma and torture. In some regimes food was used as an instrument of torture. Some survivors may restrict their food through guilt about relatives who may be hungry in their country of origin. Others may have conditioned themselves to an inadequate dietary intake as a response to prolonged periods of hunger.

Excessive food consumption (particularly foods high in sugar and fat) can be a response to prolonged periods of deprivation. In particular, parents may be unwilling to restrict their children's food intake, seeing it as both physical and emotional nourishment for their children.

Tobacco use and excessive consumption of coffee and other stimulants may affect eating habits, and exacerbate conditions such as sleeplessness and anxiety.

Refugee clients with persistent psychological barriers to eating well may require referral for counselling with the aim of addressing underlying issues.

Grief and loss



The process of becoming a refugee, by definition, involves tremendous grief and loss. Losses often include loss of one's family and friends, loss of one's culture, country, material goods, physical and mental health and socioeconomic status. Disappearances or violent deaths of family and friends are a common feature of the refugee experience, and can result in prolonged and unresolved grief. The destruction of

certain assumptions about human existence can result in a loss of trust, meaning, and a sense of one's future. This applies to refugees of *all* ages.

Refugee grief is often complex, unresolved and fuelled by survivor guilt and the re-traumatisation of the resettlement process. This tends to be exacerbated by the fact that family and community are often unavailable to provide the support that would normally assist with coping. Mourning rituals, for those killed or lost are rarely given the necessary time due to war and flight.

Depression, anxiety, psychosis, psychosomatic presentations and relationship/attachment changes need to be seen in the context of grief and loss. Where such conditions are severe, consider referring the client to a Community Mental Health Service or to a RAS Centre.

Post traumatic stress disorder

There is now a large body of evidence showing that people who have been exposed to horrific, life-threatening events may experience psychological symptoms soon after the event or many years later.¹⁴⁸ This constellation of symptoms known as PTSD, is commonly exhibited by survivors of trauma and torture.¹⁴⁹

The PTSD classification in the Diagnostic and Statistical Manual of Mental Disorders (DSM)¹⁵⁰ published by the American Psychiatric Association is based on the results of studies involving traumatised

United States soldiers returning from the war in Vietnam. Clinicians need to take into account the differences between the experience of refugees and of these US soldiers. When using this classification as a diagnostic tool and/or as a basis for treatment, care should be taken to account for cultural, spiritual and philosophical differences.

The fundamental impairment in PTSD is the failure to integrate traumatic experiences with other life events. PTSD symptoms can include:

- intrusive and recurrent memories
- flashbacks
- nightmares
- poor concentration
- poor memory
- avoidance of reminders of traumatic events
- detachment from others
- emotional numbing
- hypervigilance
- proneness to startle, hyper-arousal
- poor eating habits
- psychosomatic symptoms
- multiple ill-defined somatic symptoms.

Experiences of trauma and torture do not often occur in isolation – rather, they may overlay, or be overlaid by, other events such as the loss of loved ones, prolonged undermining of religious beliefs, and deprivation of human rights or dislocation from one’s community. As a



consequence, the psychological sequelae of torture and trauma can be far more pervasive than PTSD. Many of these sequelae may be compounded by the added stresses of resettlement.

Psychosomatic disorders

It is common for refugee people to somatise their psychological stress. Consider the following approaches.

- Take complaints seriously, and conduct appropriate examinations. Thorough investigation can reassure the client that nothing is physically wrong.
- Help the patient to make connections between the body and mind. Explaining the body's physiological response to extreme danger can be helpful in making this link.
- Avoid dismissing somatic complaints, or giving reassurances that they 'will go away with time'. The client may interpret this as trivialising their concerns.
- If somatic symptoms persist, consider a referral for counselling and support. This may involve establishing a patient's trauma history if they have not already disclosed this to you.

Substance abuse

Stresses such as trauma, loss, cultural adjustment and social and economic pressures place refugees at an increased risk for substance abuse. Alcohol and other drugs may be used for symptomatic relief when the effects of war, terror, torture, rape, imprisonment and physical injury become overwhelming. Alcohol, cannabis and other drugs may be used to calm the symptoms of PTSD. The use of mild sedative drugs such as khat occurs among (mainly) men from Horn of Africa regions.

The stresses associated with resettlement and limited access to support services can lead to feelings of depression and anxiety and therefore increase susceptibility to substance misuse. Substances may be used to cope with the distress, and a lack of family

cohesiveness and social support. Many refugee groups show high tobacco and caffeine use. These and other stimulants are often used as a means of coping with anxiety and meeting social needs, although usage may exacerbate some symptoms such as anxiety and sleeplessness.

When providing advice on the use of stimulants, consider setting achievable goals that accommodate the client's coping style, for example, moderating caffeine consumption may be more achievable than cessation. It may be helpful to explain the effects that stimulants such as tobacco and caffeine have on anxiety and sleeplessness, and to suggest how these effects can be minimised; for example, by avoiding coffee after 3 pm.

Where a client has problems with substance abuse, referral to mainstream alcohol and drug services should be considered. This may require considerable preparation and reassurance. If necessary, seek advice from a RAS centre.

Refugees with Special Health and Disability Needs

Women from refugee backgrounds

Women and girls displaced by conflict or natural disasters are vulnerable to rape and sexual violence and have limited access to quality reproductive health care and education. This contributes to high mortality rates for mothers and children. These women may not have had access to comprehensive reproductive health care or education due to lack of funding for non-HIV/AIDS related services in countries affected by conflict.

Women's Refugee Commission¹⁵¹

Sexual and reproductive health in refugee women

Women from refugee backgrounds have a number of distinct health needs specifically related to their gender, ethnic, cultural and religious backgrounds and refugee experiences. On arrival studies of refugee women's health show that 50 percent do not use contraception.¹⁵² Seventy-eight percent of refugee women of reproductive age screened by the Refugee Health Service at the MRRC had vitamin D deficiency or insufficiency.¹⁵³ Some communities of origin have a very high prevalence of harmful traditional practices such as female genital mutilation (FGM).¹⁵⁴ On arrival, the prevalence of HIV in refugee women reflects rates in sub-Saharan African and some areas of South East Asia.¹⁵⁵ Post arrival, women from refugee backgrounds have lower cervical screening coverage, higher rates of pregnancies complicated by diabetes, and lower rates of breastfeeding compared to other New Zealand groups.¹⁵⁶



Nikki Denholm

Many women from refugee backgrounds:¹⁵⁷

- will have had little or no previous health screening, particularly cervical and breast screening
- will have had limited access to and knowledge of family planning services
- will have had limited access to sexual or reproductive health screening services
- will have had minimal exposure to formal hospital-based antenatal care
- may have psychosexual and psychological health issues following trauma, rape and abuse during refugee flight, and subsequently a lack of adequate follow-up care and treatment in New Zealand
- may have difficulty accessing health care services in New Zealand due to language barriers, cultural barriers, cost and difficulties with transport
- may experience difficulties associated with FGM and in accessing services providing appropriate rehabilitative, gynaecological and obstetric care
- may become increasingly socially isolated due to language barriers as their families become more proficient in English
- may have health problems due to untreated gynaecological and obstetric conditions after years in refugee camps or homelands where medical facilities were lacking.

Tips on caring for women clients:

- ⇒ women may feel more comfortable with a female doctor
- ⇒ a woman interpreter may be necessary
- ⇒ many women will have been sexually abused or raped
- ⇒ most will be experiencing financial hardship.

Key health issues and concerns for refugee women are listed in the following sections.

Prenatal screening

Women from refugee backgrounds may have many potentially complex medical needs. It is therefore important to actively inquire about the possibility that a client is pregnant or planning pregnancy (or at least, not actively preventing pregnancy), in which case a comprehensive health assessment should be offered. For women of child-bearing age a routine antenatal screen should be included (FBC, blood group and antibodies, vitamin D, ferritin, hepatitis B, TPHA, rubella, and HIV with pre-test discussion, MSU and a cervical smear). Offer maternal screening for chromosomal abnormalities at the correct stages of pregnancy. Note that cervical screening may be difficult for women affected by FGM Type 3 (see pp 139–140).

Family planning

Refugee women practice a diverse range of culturally and religiously prescribed family planning practices in countries of origin, and most commonly will be unused to using western family planning services. Traditional contraceptive practices may include, for example, using withdrawal, a ‘safe’ period, and exclusive breastfeeding. While it is important that women are aware that contraception is a safe and effective way of spacing children and avoiding unwanted pregnancies, it is also important to respect the client’s cultural attitudes and beliefs surrounding family planning.

In many cultures it is unacceptable for women to discuss family planning when men are present. In this case, consider the following:

- if you are male, refer the client to a female practitioner
- ensure the confidentiality and privacy of the female client



- use the services of a female interpreter. If this is impossible, it may be helpful to place the male interpreter behind the client, out of sight
- use a telephone interpreting service
- Some women may be unfamiliar with the term ‘family planning’ and may feel more comfortable using the term ‘family spacing’.

Discussions on family planning could start with such questions as:

- ‘Do you have children?’ ‘How old is the youngest child?’
- ‘Are you hoping to become pregnant in the near future?’
- ‘What age gap would you like between your children?’ ‘In your culture, do you have ways in which you can achieve the spacing you want between children?’
- ‘Would you like more information about spacing your children?’

Family planning services in New Zealand use professional interpreters for clients who are non-English speaking.

Antenatal care

Many refugee women will have had minimal exposure to formal hospital-based antenatal care. Previous deliveries may have taken place at home, often with the assistance of a traditional birthing assistant.¹⁵⁸ Members of the extended family may have played a pivotal role in the post-natal care of mother and baby.



Many refugee women will not be familiar with the options for antenatal care and delivery available in New Zealand. It is important that women are offered the lead maternity carer (LMC) service for continuity of care throughout pregnancy, birth and the post-natal period. It is important for general practitioners and midwives to establish, in some detail, a pregnant woman’s past obstetric history and to assess her for general and specific risk factors. Women from refugee

backgrounds may have higher-risk pregnancies for some of the following reasons:

- previous multiple, spontaneous or elective abortions
- previous stillbirth
- previous neonatal death
- multigravida
- Rhesus disease
- Pre eclampsia (higher prevalence of risk factors)
- short spacing between pregnancies
- recurrent urinary tract infections, possibly associated with FGM
- pelvic infections (endemic, seldom treated or resulting from sexual assaults or complications of FGM)
- aged above 35 years or below 18 years
- pregnancy weight less than 45 kg
- short stature
- cephalopelvic disproportion (a higher incidence among women from Africa)
- sickle cell disease, thalassaemia, anaemia below 10 g/dh
- vitamin D deficiency
- exposure to STIs or HIV
- rheumatic heart disease
- higher risk of TB causing ‘common’ problems of pregnancy, eg, back pain and headaches
- FGM.

In regions such as Sub-Saharan Africa and South East Asia refugee women are vulnerable to HIV infection.¹⁵⁹ Offer all pregnant women antenatal HIV screening, along with screening for rubella, hepatitis B, and syphilis, as a routine part of antenatal care.¹⁶⁰ Specialised management, together with appropriate education, can significantly reduce the risk of mother-to-child transmission of HIV (See p 73).

Antenatal care for women with FGM

Women with FGM may require special care before, during and after delivery: see the *Female Genital Mutilation Clinical Care Antenatal, Labour & Birth and Postnatal Guidelines* for information.¹⁶¹ The New Zealand FGM Education Programme publishes information relating to the possible health complications of the practice of FGM, including legal information (available at www.fgm.co.nz).^{162 163}

Childbirth beliefs and practices

Many women from refugee backgrounds have traditional cultural and religious beliefs and practices around childbirth. They may have very different views from those of their LMCs about how pregnancy should be managed, the causes of pregnancy complications, the need for medical interventions such as caesarean sections, and of the midwife-client relationship.

Some women affected by FGM may continue to follow the practices of traditional medicine in New Zealand. This may include: consulting traditional healers; using homeopathic treatments; herbal teas and washes; scarification; bloodletting; or using herbs to prepare the birth canal. Some pregnant women wear anklets or belts made of beads to ward off the ‘evil eye’.

It is important that LMCs, although they may disagree with traditional practices, acknowledge and show respect for women’s health beliefs. It is best to work alongside women to discourage

the use of potentially harmful traditional remedies while endorsing those which may be of physical or psychological benefit.¹⁶⁴ This approach is most likely to build trust between the LMC and the client.

Some common traditional beliefs about pregnancy among refugee groups may include the belief that:

- special food is necessary for lactation and the future health of the child
- reducing calorie intake in the third trimester will result in a smaller baby and therefore an easier delivery
- pregnant women must not eat certain types of food
- all food eaten by pregnant women must be warm
- colostrum is not good for babies
- pregnant women must have plenty of rest
- all of a pregnant woman's usual domestic work must be done by female members of the extended family for up to four weeks after childbirth
- mother and baby must be warmly clothed
- it is unlucky to praise a baby
- placentas must be disposed of in a special way
- males are not to be present at births
- time of birth must be recorded exactly for astrological purposes.

Where these practices may clash with the LMC's beliefs, remember that childbirth is a challenging time, and unless a practice is actually harming the health of the mother or baby, it should be respected.

Female genital mutilation



UNHCR

The World Health Organization (WHO) defines FGM as: ‘all procedures which involve partial or total removal of the external genitalia or other injury to the female genital organs whether for cultural or other non therapeutic reasons’.¹⁶⁵

The main types of FGM are:

- Type 1: Clitorodectomy – partial or total removal of the clitoris
- Type 2: Excision – removal of the clitoris together with partial or total removal of the labia minora
- Type 3: Removal of the clitoris, labia minora and part of the labia majora, and narrowing of the opening
- Type 4: Includes pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterisation by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding, or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of FGM in the WHO definition.¹⁶⁶

Effective communication

Most studies on the maternity experiences of women affected by FGM in western countries indicate that their needs are poorly understood and frequently not met. Most women report very negative experiences, particularly in regards to the attitudes of health professionals, care in labour and delivery, and postnatal care. Many women affected by FGM have reported experiencing offensive and condescending reactions from health professionals regarding their circumcisions. Effective communication requires sensitive and non-judgemental attitudes from health professionals who are caring, supportive and knowledgeable about FGM.

Table 15: Origins of women affected by FGM living in New Zealand¹⁶⁷

Country	Percentage of women affected in country of origin	Type of FGM	Terminology
Somalia	97.9	Type 2 and 3	Gudniinka
Ethiopia	74.3	Type 1 and 2	Gerezat
Eritrea	88.7	Type 1 and 2	Mkinshab
Djibouti	93.1	Type 2 and 3	Excision
Sudan, northern	90.0	Type 2 and 3	Tahoor
Egypt	95.8	Type 1	Khitan
Kurdistan	77.9	Type 1 and 2	Khatana
Indonesia	No documented prevalence	Type 1 or 2	Sunat
Malaysia	No documented prevalence	Type 1 or 2	
India	No documented prevalence	Type 1 or 2	

Note: Of the small number of women from Sudan residing in New Zealand, most come from South Sudan, where the prevalence of FGM is extremely low.

What are the complications of FGM?

There are numerous physical, sexual and psychological complications associated with FGM, which vary depending on the extent of the tissue removed. The most severe complications occur with FGM Type 3, and can include:

- difficulties with micturition
- recurrent urinary tract infections
- difficulties with menstruation

- inability to achieve penetration during sexual intercourse
- anxiety and fear of sexual intercourse
- complications in pregnancy
- complications in labour and delivery
- sexual dysfunction¹⁶⁸
- physiological distress related to the initial procedure which could possibly continue throughout the woman's life.¹⁶⁹

Where FGM has been practiced for many generations, women may not associate these health complications with FGM, but rather see them as a normal part of being a woman.

Managing pregnancy, labour and birth, and postnatal care for women with FGM

Care for women with FGM during pregnancy, labour and birth, and postnatal care should always be provided by a LMC who is familiar with the *FGM Clinical Care Antenatal, Labour & Birth and Postnatal Guidelines*¹⁷⁰ and experienced in the management of women with FGM. Women affected by FGM Type 3 will require specialised pregnancy care which may include deinfibulation before or during labour.¹⁷¹

In addition to routine antenatal education, LMCs should discuss the following areas to prepare the woman for pregnancy, labour and birth and what to expect in the postnatal period:

- the anatomy and physiology of unaltered genitalia compared with FGM
- the physiological changes that follow deinfibulation during labour, including changes in menstruation, urination and sexual intercourse
- the potential for referral to a registrar/obstetrician during labour

or birth, and the possible need for deinfibulation during delivery

- the fact that gender preference of a registrar/obstetrician is dependent on availability. Women may request a female registrar/obstetrician. Where possible, this should be arranged
- the process of suturing the scar site after deinfibulation (restoring the scar site to a state of infibulation is illegal in New Zealand)
- culturally appropriate dietary advice (also refer to information on childbirth beliefs and practices on pp 132–133)
- gender preferences for interpreters
- cultural resistance to induction of labour, and relevant DHB induction of labour practices for post term pregnancies (Note: Where there is opposition to induction of labour or other interventions this should be clearly documented in the clients' notes)
- cultural resistance to caesarean section, and relevant DHB indications for performing caesareans
- postnatal support – note that some women may experience psychological trauma or flashbacks during childbirth related to FGM and/or the refugee experience. If necessary refer for psychological support.
- Genital assessment is recommended during the antenatal period, once a trusting relationship has been established between a client and her LMC. It is important to determine early in the pregnancy the degree to which a client's FGM is likely to impact on her labour and birth. The New Zealand *Female Genital Mutilation 2008 Health Care Survey* showed that only 20 percent of women affected by FGM had undergone a genital assessment prior to labour.¹⁷² Lack of assessment places a woman and her baby at unnecessary risk of complications during labour and birth.

It is important to note that health literacy varies greatly across the

range of women affected by FGM. Women who have come from urban areas commonly have higher levels of health knowledge than those from rural backgrounds. It should not be assumed that all women are literate, even in their mother tongue.¹⁷³ Provide antenatal health education that is clear, concise and highly visual.

Additionally, be aware that for most women affected by FGM, pregnancy and childbirth are considered normal events in their homelands. In many traditional societies the childbirth process is viewed as a collective experience, largely involving closely related women. Family members are intimately involved in supporting the pregnant mother, helping with childbirth, caring for the newborn and influencing any health decisions. Lead Maternity Carers therefore need to be aware that decisions about issues such as induction of labour, caesarean section and choices for labour may need to be made in consultation with a number of family members.

The *Female Genital Mutilation Resource Kit* contains a number of tools and resources to assist service providers to communicate effectively with women affected by FGM: see www.fgm.co.nz

Deinfibulation

Deinfibulation (reversal of FGM Type 3) may be requested by women prior to marriage (in order to allow for penile penetration), during pregnancy in preparation for delivery (at around 24 weeks' gestation) or during teenage years (or beyond) if menstruation and urination is difficult. The *Female Genital Mutilation Clinical Care Deinfibulation Guidelines*¹⁷⁴ includes information on undertaking a deinfibulation assessment, the deinfibulation procedure, post procedure care and referral contacts for gynaecological outpatients services throughout New Zealand: see www.fgm.co.nz

Couples or women on their own may present to health services days

before marriage requesting deinfibulation. **It is important that the request is treated as urgent.** Some women have been put on waiting lists while husbands have repetitively tried to penetrate through the scar tissue during sexual intercourse. This has caused unnecessary physical and psychological trauma and distress to both partners.

It is essential that deinfibulation is accompanied by comprehensive health education,¹⁷⁵ including discussion on physiological changes following the procedure. The woman will experience significant changes in urination, menstruation and sexual intercourse; being prepared for these changes will help prevent confusion and anxiety following the procedure.

My doctor never talked about re-stitching the circumcision, or what it would be like afterwards. I was left wide open and I thought that I was incontinent for many months.

Female refugee¹⁷⁶

Family planning considerations for women with FGM

Many women affected by FGM have not accessed family planning services, and may have limited knowledge of their reproductive cycle and the types of contraception available. *The Female Genital Mutilation 2008 Health Care Survey* indicated that only 20 percent of Somali women were using any form of contraception, while 82 percent stated they would like more information about sexual and reproductive health issues.¹⁷⁷

Women with FGM Type 3 have fewer effective contraception options. Natural family planning can be restrictive for infibulated women, who may have difficulty assessing the state of their mucus. Diaphragms and IUDs including Mirena may be difficult to insert due to a narrowed introitus. Depo Provera may be a preferred contraception option for women affected by FGM.¹⁷⁸

Sexual health screening for women with FGM

Performing vaginal examinations on infibulated women (prior to giving birth and/or sexual intercourse) is often difficult due to the narrowed introitus and requires sensitivity. Screening for some STIs and cervical smear taking may not be possible.

Discussing sexuality

Sexual and reproductive health issues are very sensitive topics among women affected by FGM; discussing these requires a trusting relationship between the client and practitioner. Women with FGM Type 3 may require deinfibulation prior to marriage. However, a woman may feel reticent about discussing deinfibulation with her doctor. General practitioners are encouraged to raise the issue with clients affected by FGM. Other areas that may need to be addressed include painful intercourse (particularly initial intercourse), fear of intercourse, decreased sexual fulfilment and vaginismus.¹⁷⁹

What approach should I use in the care of a client affected by FGM?

It is important that health practitioners examine their attitudes towards the practice of FGM. While health practitioners may regard FGM as an oppressive act against women, women affected by the practice view FGM as part of their ‘honour’ and self-identity.¹⁸⁰

The practice is carried out with the best interest of young girls at heart. However harmful it may seem from a western viewpoint, FGM is commonly sanctioned by the community and endorsed by loving parents in the belief that it will ensure their daughter’s health, chastity, hygiene, fertility, honour and eligibility for marriage.¹⁸¹



When caring for a woman with FGM, consider the following issues.

- Use appropriate, non-judgemental terminology when referring to FGM. Consider refraining from using the loaded western term ‘female genital mutilation’; ask for the client’s own terminology for FGM, or use such words as ‘cutting,’ ‘female circumcision,’ ‘sewn’ or the word used in the client’s own language, (such as the Somali word ‘gudniika’).¹⁸²
- Use FGM resources to increase your knowledge about FGM, including the beliefs which sustain the practice.
- Let the client know of your understanding of FGM: this may make her feel comfortable raising concerns.
- Consider referral to a female doctor.
- Document findings in detail, to minimise the need for repeat examinations.
- Avoiding discussing FGM in a family consultation.
- Be aware that your client may never have had a gynaecological examination.
- Be aware that pelvic examination may be difficult, painful or impossible and not continuing if it is unduly uncomfortable or painful; careful angulation of instruments and one-finger examination may be necessary.
- Recognise that a woman may regard her genitalia as normal; she may be unaware that she has undergone FGM, or deny that this is the case.
- Recognise that women may be unaware that there are medical complications associated with FGM.

FGM and New Zealand law

Female genital mutilation is illegal in New Zealand under the New Zealand Crimes Act Amendment 1996, ss 204A and 204B. It is illegal to perform FGM on a child in New Zealand or to send a child overseas to have FGM performed. For more details see the *Female Genital Mutilation Child Protection Recommended Guiding Principles*.¹⁸³

It is also illegal in New Zealand for medical professionals to reinfibulate (re-stitch the remaining labia) a woman's genital scar tissue following deinfibulation either in pregnancy or labour. For more details see the *FGM Clinical Care Antenatal, Labour & Birth and Postnatal Guidelines*,¹⁸⁴ accessible at www.fgm.co.nz

Post-natal care for women from refugee backgrounds

In New Zealand, the experience of post-natal care for many women from refugee backgrounds is very different to that in their countries of origin. In many traditional societies women and their babies have a period of confinement at home after the birth (commonly 40 days) in which they are cared for by their families.¹⁸⁵ Many women from refugee backgrounds do not have family members in New Zealand to provide this level of support. Consequently, they are at high risk of post-natal depression. Be alert to your clients' expressions of isolation and depression.

At home (in Somalia) all our relatives and neighbours care for us after the baby is born, they cook us porridge and help with all the household chores. Here we are expected to get up and do everything as soon as the baby is born and then when we go home we are very alone.

Survey participant¹⁸⁶

Breast and cervical screening

Women from refugee backgrounds are unlikely to have had breast and cervical screening before arriving in New Zealand. In addition, they may be unfamiliar with the concept of screening, and uncomfortable with undertaking invasive procedures in the absence of sickness. Encouraging a woman to undergo breast and cervical screening requires:

- a trusting relationship between health professional and client and a clear explanation of the purpose and advantages of screening
- a culturally safe approach by the health professional which recognises a woman's sensitivities, including cultural and religious values
- if appropriate, referring the woman to a female practitioner, a family planning clinic, the free national programme BreastScreen Aotearoa (for women aged 45–69 years) or a women's health clinic. If referring, make sure that the service is aware of the special needs of the woman
- a female interpreter, if the woman requests one
- clear information about breast and cervical screening prior to proceeding, including written information in the client's own language if available.

A number of factors may determine the appropriate time to offer screening procedures, including:

- the level of risk for the client (for example, women over 50 years of age are at higher risk of breast cancer; women who have ever been sexually active are at higher risk of cervical cancer)
- whether or not the client is symptomatic
- previous exposure to HPV

- the presence of a more urgent issue, such as pregnancy or suspected TB
- a client's sense of choice and control.

When assessing the need for a clinical breast examination, breast screening or a cervical smear, acknowledge that these procedures may be traumatic.

Family violence

Women from refugee backgrounds may be particularly vulnerable to family violence for many reasons including the following.

- They may lack family and community support.
- They usually have dependants.
- For some, an unsatisfactory relationship is better than no relationship.
- They may feel that they should tolerate their partner's violence because of the trauma that he has endured.
- They may be unaware of New Zealand laws prohibiting family violence.
- Cultural differences, inability to speak English and a lack of knowledge as to how to access alternative housing, income, legal and support services make it difficult for them to leave their partners.
- Feelings of shame, helplessness and resignation can prevent them from taking action.
- Threats or intimidation by a partner may make it difficult for women to speak out or leave.
- Cultural attitudes towards violence, and towards separation and divorce, and the desire to 'keep the family together' may pressure a woman to remain with her violent partner.
- They may be wary about involving police and other authorities in family matters.

How should I manage a situation where I suspect family violence?

- If you suspect family violence, ask the woman if this is the case (when her husband or partner is not present).
- Use a professional interpreter, preferably female, if required. However, use discretion with your choice of interpreter. If the interpreter is known to the family the woman may not feel comfortable disclosing information.
- Tell the client you are concerned about her, and ask if there is violence in her relationship.
- Provide information on support options and legal rights, including the fact that violence between partners is illegal in New Zealand.
- Expect excuses or rationalisations about her partner's behaviour (for example, that his mood swings are associated with his experience of torture). Remember that this does not justify his behaviour, nor minimise the danger to his partner and children.
- Take steps to ensure the woman's safety; if she wishes to leave, give her the telephone numbers of services that can assist her to do so.
- If the client chooses to remain in the home, respect her decision; give her telephone numbers she can contact in the event of a crisis.
- Liaise with a local family violence organisation on how you might best assist your client.
- Involve someone trusted in the woman's community who can act as a support person/cultural broker.

Asylum seekers



Asylum seekers have particular health needs. Although they arrive with the same physical and psychological health problems as other refugees, the particular stresses they face after arrival can have a profound effect on their health.

Many asylum seekers have fled situations of political unrest or terror, and may have experienced intense and prolonged traumatic experiences such as war, rape, torture, starvation and loss of family.¹⁸⁷ On arrival in New Zealand they become people in transition, often without family or friends, and often left to ‘find their own way’ with little or no English and a limited understanding of the prevailing system. This can result in a burden of unsupported needs and enormous worries. As a result, asylum seekers are particularly vulnerable to feelings of profound isolation, hopelessness, helplessness and depression. In addition, low income, non- recognition of qualifications, poor housing and a lack of social support compound day-to-day stress levels and ill health.¹⁸⁸

Asylum seekers are subject to further stress and anxiety associated with the procedures required in making a claim for refugee status. These stresses are associated with:

- accessing legal services. Asylum seekers are assisted to find legal support through Immigration New Zealand’s Refugee Status Branch. If they are unable to pay for legal support, these services are provided free of charge
- uncertainty in relation to their claim
- living ‘in limbo’ (for example, being unable to make plans) while waiting for the outcome of their claim
- their ignorance of and/or limited access and eligibility to some government entitlements and support
- fear of deportation back to the country from which they have escaped.

Anxiety and worry can lead to re-traumatisation. It may not only exacerbate any pre-existing sequelae associated with psychological trauma, but may also lead to stress symptoms and mental health problems years after arrival in New Zealand.

Tips on issuing medical reports to support claims for refugee status

⇒ Sometimes GPs, psychiatrists, psychologists and counsellors are asked by the Refugee Status Branch of INZ to issue a medical or psychological report in relation to a claim for refugee status by an asylum seeker. Where the report is to corroborate claims of torture, the practitioner is expected only to say whether or not an injury or condition is consistent or inconsistent with the claimant's story. The Refugee Status Branch advises that it is inappropriate for practitioners to express opinions on whether refugee status should be granted or whether a claimant's story is credible.

Asylum seekers who have had no health screening will eventually need to be fully screened as part of their application for refugee and protection status. This may cause further anxiety, as they may fear that any medical condition detected will jeopardise their chances of gaining permanent residence. Health professionals may need to reassure asylum seeker clients that medical findings are not a deterrent to gaining residence in New Zealand.

Note: In Auckland, health screening for asylum seekers is carried out at the Refugee Health Screening Service, provided by the Auckland Regional Public Health Service, Refugee Health Service, Auckland District Health Board. In addition, the Auckland Refugee Council offers accommodation and advocacy services for asylum seekers (see www.aucklandrefugeecouncil.org.nz and p 150 for contact details).

For further information see the *Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (the ‘Istanbul Protocol’), paras 187 (medical) and 287 (psychological), accessible at www.ohchr.org/Documents/Publications/training8Rev1en.pdf¹⁸⁹

Refugees with disabilities

Working with refugees with disabilities

The ‘medical/disabled’ category for quota refugees allows entry to those who either have a medical condition that can be treated or helped in New Zealand or a disability that requires support.¹⁹⁰ For refugees, the New Zealand disability system is difficult to understand and hard to navigate.¹⁹¹ Disability services and disability support services are often non-existent in countries of origin. Therapeutic interventions offered in western countries, such as physiotherapy, occupational therapy and speech language therapy, may be unknown and therefore poorly understood.¹⁹² Where language is a barrier, the use of interpreters is essential.

When engaging with clients with a disability, incorporate families in decision-making.¹⁹³ Engagement with refugee families as to the support needs of their family member may be intensive in the initial stages.¹⁹⁴ Families’ coping ability may be compromised by the loss of traditional family and community support, and the multiple stressors of resettlement.

Refugee communities may have different understandings of disability and of caring for people with a disability than people in western countries.¹⁹⁵ Families may respond to disability from the perspective of the beliefs and values of traditional societies, which may involve:

- a cultural and family sense of stigma associated with disability
- an unwillingness to look outside the family for support

- cultural beliefs about the causes of disability
- the exclusion of individuals with disabilities at community events.

Cultural differences have important implications for the acceptance of disability services and family support. Frameworks of intervention need to:

- include all family members
- organise culturally appropriate care
- integrate social and medical models of intervention
- address community stigma and discrimination towards people with disabilities and their families
- focus on enhancing the capacity of families to cope effectively with settlement-related stressors, including finding culturally appropriate support networks.

Refugee clients with disabilities and their families will need assistance to claim their entitlements to the following benefits: the child disability allowance, the disability allowance, the invalid's benefit and the Community Services Card. Information about eligibility for benefits is available on the Work and Income website: www.workandincome.govt.nz

Clients can call 0800 559 009 to make an appointment to discuss their case with a Work and Income case manager. Work and Income have interpreters available on the phone and face to face.

Contact list

For all public health queries relating to refugees and asylum seekers in the first instance contact the public health service at your local DHB.

Resource people

For queries relating to national health screening

For quota refugees

Refugee Health and Screening Service,
Mangere Refugee Resettlement Centre,
Auckland (09) 276 6719

For queries relating to mental health issues

Consultant psychiatrist for refugee clients

Mental Health Services,
Auckland District Health Board (09) 845 0940

For all other enquiries relating to refugee health

Auckland

Health Promoter – Refugee and Vulnerable Communities
Auckland Regional Public Health Service (09) 633 4600 x 27271

Hamilton

Refugee Health Coordinator
Waikato District Health Board (07) 838 2569

Wellington/Hutt Valley

Refugee Health Advisor
Hutt Valley District Health Board (04) 570 9739

Christchurch

Communicable Diseases Nurse (03) 364 1777 or
Community and Public Health 027 2138009

(includes: screening for family reunification members;
linking families to a general practice for a free initial visit with
an interpreter)

Some primary health care providers experienced in refugee health

Auckland

In the first instance contact:

Mangere Refugee Resettlement Centre:
Refugee Health and Screening Service (09) 276 6719

Hamilton

Waikato District Health Board
Refugee and New Migrant Screening (07) 838 2569

Wellington

Newtown Union Health Service
(includes some screening services) (04) 380 2020

Christchurch

Partnership Health: Wayne Reid, Ethnic
Liaison Manager (03) 375 7136

Piki Te Ora Health Centre (03) 381 8048

(Services include refugee health care workers and nurses)

Refugee health care providers in main centres

Auckland

Auckland Regional Public Health Service

Medical Officers of Health (09) 623 4600

Health Promoter – Refugee and Vulnerable Communities

Mangere Refugee Resettlement Centre (09) 2766719

Medical/Screening Clinic

Community Child Health and Disability Service (09) 639 0200

Mental health services for refugees

Consultant Psychiatrist (09) 845 0940

St Lukes Community Mental Health (09) 845 0940

Community Child Adolescent and Family Service (CCAFS) (mental health services for refugee children) (09) 307 4949 x 28600

Refugees As Survivors New Zealand (RASNZ) 0800 472 769

Community support services

Community HIV Team (09) 375 7077

Doctors For Sexual Abuse Care (09) 376 1422

New Zealand AIDS Foundation – Burnett Centre (09) 309 5560

FGM Education Programme (HIV and FGM) (09) 302 4031

Auckland Refugee Council (ARC) (09) 378 7434

Auckland Refugee Council (accommodation for asylum seekers) (09) 828 6067

Refugee Service central office (09) 621 0013

Refugee Service, Mangere Refugee Resettlement Centre Office (09) 276 6423

SHINE* Safer Homes in New Zealand Everyday 0508 744 633

Family Violence Helpline

Shakti Women’s Support Group (refuge and support) (09) 634 5427

Interpreting services

Counties Manukau DHB Interpreting and Translation Service	(09) 276 0014
Auckland DHB Interpreting and Translation Service	(09) 630 9943
Waitemata DHB Interpreting and Translation Service	0800 887 765
Language Line (free to clients of participating agencies, listed on www.ethnicaffairs.govt.nz).	0800 656 656

Hamilton

Waikato District Health Board

Medical Officer of Health	(07) 839 8899
Public Health Nurse	(07) 838 3565
Community Mental Health	(07) 834 6902
Refugee Health Coordinator	(07) 838 2569

Community support services

Doctors For Sexual Abuse Care (ask for the name of a DSAC doctor in your area)	(09) 376 1422
Waikato Migrant Resource Centre	(07) 853 2195
Waikato Refugee Resettlement Society Inc	(07) 855 6339

Interpreting services

Interpreting Service	(07) 853 0480
Language Line (free to clients of participating agencies, listed on www.ethnicaffairs.govt.nz).	0800 656 656

Palmerston North

MidCentral District Health Board

Medical Officer of Health	(06) 350 9110
Communicable Disease Nurse	(06) 350 9110

Community support

Refugee Services (06) 355 1415

Interpreting services

Language Line 0800 656 656

(free to clients of participating agencies, listed on www.ethnicaffairs.govt.nz).

Wellington, Porirua and Hutt Valley

Capital & Coast DHB, Hutt Valley DHB

Medical Officers of Health (04) 806 2262

Refugee Health Advisor

Public Health Service, Lower Hutt (04) 570 9739

Mental health

Wellington

Community Assessment and Treatment Team (04) 494 9169

Child Adolescent and Family Services (04) 237 2860

Wellington Refugees as Survivors Trust (04) 805 0361

Porirua

Porirua Community Mental Health (04) 381 1600

Puketiro Centre, Child and Family Service (04) 237 5222

Wellington Refugees as Survivors Trust (04) 805 0361

Lower Hutt

Hutt Valley Health Community (04) 570 9801

Mental Health Services Crisis and Assessment Team (04) 566 6999

Child Adolescent and Family Service (04) 237 2860

Wellington Refugees as Survivors Trust (04) 805 0361

Community support services

Doctors For Sexual Abuse Care (DSAC)

(ask for the name of a DSAC doctor in your area) (09) 376 1422

New Zealand AIDS Foundation, Awhina Centre	(04) 381 6640
Wellington Refugee Services	(04) 805 0300
Hutt Valley Refugee Services	(04) 566 9353
Porirua Refugee Services	(04) 237 7946
Porirua Settlement Support Coordinator	(04) 237 3578

Interpreting services

Wellington Interpreting Services (nationwide)	(04) 384 2265
TELIS: telephone interpreting service (nationwide)	(04) 384 2849
Language Line	0800 656 656
(free to clients of participating agencies, listed on www.ethnicaffairs.govt.nz).	

Nelson

Nelson Marlborough District Health Board

Medical Officer of Health	(03) 546 1537
Public Health Nurse	(03) 543 9820

Community Support Services

Refugee Services	(03) 548 4978
Language Line	0800 656 656

(free to clients of participating agencies, listed on www.ethnicaffairs.govt.nz).

Christchurch

Canterbury District Health Board

Community and Public Health

Medical Officer of Health	(03) 364 1777
Communicable Disease Nurse	(03) 364 1777
Psychiatric Emergency Service	(03) 0800 920 092 (Option 3)

Community support services

Christchurch Resettlement Service (03) 335 0311
Refugee Services Aotearoa (03) 339 0721
or (03) 339 0483

Doctors For Sexual Abuse Care (DSAC)
(ask for the name of a DSAC doctor in your area) (09) 376 1422
New Zealand AIDS Foundation, South (03) 379 1953

Interpreting services

Christchurch Resettlement Service (03) 335 0311
Christchurch Migrants Centre (03) 366 1315 0311
Interpreting Canterbury (03) 372 9311
or 0508 468 377

Christchurch Public and
Burwood Hospital Interpreting Services (03) 364 0843
Citizens Advice Bureau Language Link 0800 788 877
Language Line
(All Canterbury general practices can access free
Language Line telephone interpreting, by phoning their PHO).

Dunedin

Southern District Health Board

Medical Officers of Health (03) 476 9800
Community support services Refugee Support Group (03) 474 0127

Interpreting services

Language Line 0800 656 656
(free to clients of participating agencies, listed on
www.ethnicaffairs.govt.nz).

Additional Information

Further reading

Section 1: Refugees – who they are and where they come from

Department of Labour, International Migration, Settlement and Employment Dynamics (IMSED). 2009. *Quota Refugees in New Zealand: Approvals and Movements (1999–2008)*. Wellington: Department of Labour, IMSED. URL: www.dol.govt.nz/publication-view.asp?ID=326 (accessed 19 July 2011).

Department of Labour, New Zealand Immigration Service. 2004. *Refugee Voices: A Journey Towards Resettlement*. Wellington: Department of Labour, New Zealand Immigration Service. URL: www.immigration.govt.nz/NR/rdonlyres/0470B22-71C0-4B76-A8F5-398A4503F05E/0/RefugeevoicesTitleContentsSummarypp136.pdf (accessed 22 July 2011).

United Nations High Commissioner for Refugees. 2006. *The State of the World's Refugees 2006: Human displacement in the new millennium*. New York: Oxford University Press. URL: www.unhcr.org/4a4dc1a89.html (accessed 19 July 2011).

United Nations High Commissioner for Refugees. 2000. *The State of the World's Refugees: Fifty years of humanitarian action*. Oxford: Oxford University Press.

Websites

United Nations High Commissioner for Refugees' 'Refworld' resource: www.unhcr.org/cgi-bin/texis/vtx/refworld/rwmain (accessed 19 July 2011).

The Refugee Studies Centre, University of Oxford: www.rsc.ox.ac.uk (accessed 19 July 2011).

CALD Resources: www.caldresources.org.nz/info/Home.php (accessed 19 July 2011).

Section 2: Refugee Resettlement in New Zealand

Department of Labour, IMSED. 2010. *Migration Trends and Outlook 2009/10*. Wellington: Department of Labour, IMSED. URL: www.dol.govt.nz/publications/general/migration-trends-outlook/2009-2010/mto-2009-2010.pdf (accessed 19 July 2011).

Pahud M, Kirk R, Gage JD, et al. 2009. The coping processes of adult refugees resettled in New Zealand. United Nations High Commissioner for Refugees Policy Development and Evaluation Service *New Issues in Refugee Research*, Research Paper No 179. URL: www.unhcr.org/cgi-bin/texis/vtx/home/opendocPDFViewer.html?docid=4b167d769&query=New%20Zealand (accessed 19 July 2011).

Perumal L. 2010. *Health needs assessment of Middle Eastern, Latin American and African people living in the Auckland region*. Auckland: Auckland District Health Board. URL: www.refugeehealth.govt.nz/resources/articles/MELAA%20Health%20Needs%20Assessment%202010.pdf (accessed 19 July 2011).

Website

Refugee information on the Ministry of Health website: www.moh.govt.nz/refugeehealth (accessed 19 July 2011).

Section 3: The Consultation – Communicating Effectively with Refugee Clients

Camplin-Welch V. 2007. *Cross-cultural Resource for Health Practitioners working with Culturally and Linguistically Diverse Clients*. Auckland: Waitemata District Health Board Asian Health Support Service and Refugees as Survivors.

Gray B. English Language Difficulties at General Practices in Auckland, New Zealand: A major limitation to good practice. *New Zealand Medical Journal* 120(1264). URL: www.nzma.org.nz/journal/120-1264/2777 (accessed 19 July 2011).

Medical Council of New Zealand. 2006. *Statement on Cultural Competence*. Wellington: Medical Council of New Zealand. URL: www.mcnz.org.nz/portals/0/guidance/cultural%20competence.pdf (accessed 19 July 2011).

Potocky-Tripodi M. 2002. *Best Practices for Social Work with Refugees and Migrants*. New York: Columbia University Press.

Waxler-Morrison N, Anderson JM, Richardson E. 1990. *Cross Cultural Caring: A handbook for health professionals in western Canada*. Vancouver: University of British Columbia Press.

Wearn A, Goodyear-Smith F, Everts H, et al. 2007. Frequency and effects of non-English consultations in New Zealand general practice. *New Zealand Medical Journal* 120(1264). URL: journal.nzma.org.nz/journal/120-1264/2771 (accessed 19 July 2011).

Website

CALD Resources: www.caldresources.org.nz/info/Home.php (accessed 19 July 2011).

Section 4: Physical Health Care

Allotey P (ed). 2003. *The Health of Refugees: Public health perspectives from crisis to settlement*. Melbourne: Oxford University Press.

Foundation House-The Victorian Foundation for Survivors of Torture Inc. 2007. *Promoting Refugee Health: A Guide for doctors and other health care providers caring for people from refugee backgrounds, 2nd edition*. Brunswick: Victorian Foundation for Survivors of Torture Inc. URL: www.foundationhouse.org.au/resources/publications_and_resources.htm (accessed 19 July 2011).

McLeod A, Reeve M. 2005. The health status of quota refugees screened by New Zealand's Auckland Public Health Service between 1995 and 2000. *Journal of the New Zealand Medical Association* 118(1224). URL: www.nzma.org.nz/journal/118-1224/1702 (accessed 19 July 2011).

Ministry of Health. 2010. *Guidelines for Tuberculosis Control in New Zealand*. Wellington: Ministry of Health.

Ministry of Health. 2008. *HIV and AIDS Information: Recommendations for HIV Testing of Adults in Healthcare Settings – 2008*. Wellington: Ministry of Health.

Ministry of Health. 2011. *Immunisation Handbook 2011*. Wellington: Ministry of Health.

Ministry of Health. 2011. *Targeting Diabetes and Cardiovascular Disease*. Wellington: Ministry of Health.

Ministry of Health. 2011. *Targeting Smokers: Better help for smokers to quit*. Wellington: Ministry of Health.

Section 5: Mental Health Issues

Jackson K. 2006. *Fates, Spirits and Curses: Mental health and traditional beliefs in some refugee communities*. Auckland: Auckland Refugees as Survivors Centre.

Miller KE, Rasco LM. 2004. An ecological framework for addressing the mental health needs of refugee communities. In Miller KE, Rasco ME (eds). *The Mental Health of Refugees: Ecological Approaches to Healing and Adaptation*. New Jersey: Lawrence Erlbaum Associates, Inc.

NCTSN. 2005. *Mental Health Interventions for Refugee Children in Resettlement: White Paper II*. Los Angeles: National Child Traumatic Stress Network.

National Collaborating Centre for Mental Health. 2005. *Post-traumatic stress disorder: the management of PTSD in Adults and Children in primary and secondary care*. London: Gaskell and the British Psychological Society. URL: www.nice.org.uk/nicemedia/live/10966/29772/29772.pdf (accessed 19 July 2011).

Sobrun-Maharaj A, Nayar S, Choummanivong C. 2011. *Developing Culturally Responsive Services for Working with Refugee Youth with Mental Health Concerns*. Auckland: Te Pou.

Te Pou. 2010. *Therapies for Refugees, Asylum Seekers and New Migrants: Best and promising practice guide for mental health and addiction services*. Auckland: Te Pou.

UNICEF. 2009. *Machel Study 10-year Strategic Review: Children and conflict in a changing world*. New York: United Nations Children's Fund.

Websites

'Asian, refugee and migrant research' on the website of Te Pou, New Zealand's National Centre of Mental Health Research, Information and Workforce Development: www.tepou.co.nz/page/427-our-projects+asian-refugee-and-migrant-research-agendas-and-tools (accessed 19 July 2011).

CALD Resources: www.caldresources.org.nz/info/Home.php (accessed 19 July 2011).

Section 6: Refugees With Special Health and Disability Needs

Denholm N. 1997. Female genital mutilation. *New Zealand College of Midwives Journal* 17.

Denholm N. 1998. *Manual One: Female Genital Mutilation in New Zealand: Understanding the health and protection issues*. Auckland: Refugee Health Education Programme.

Denholm N. 1998. *Manual Two: Female Genital Mutilation in New Zealand: Understanding and responding. A guide for health professionals*. Auckland: Refugee Health Education Programme.

Dorkenoo E. 1994. *Cutting the Rose: Female genital mutilation. The practice and its prevention*. London: Minority Rights Group.

Friedman AR. 1992. Rape and domestic violence: The experience of refugee women. *Women and Therapy* 13: 65–78.

Royal Australian College of Obstetricians and Gynaecologists. 1997. *Female Genital Mutilation: Information for Australian health professionals*. Melbourne: Royal Australian College of Obstetricians and Gynaecologists.

Websites

Auckland Regional Public Health Service's Refugee Health website: www.refugeehealth.govt.nz (accessed 19 July 2011).

CALD Resources: www.caldresources.org.nz/info/Home.php (accessed 19 July 2011).

EthnoMed: <http://ethnomed.org/> (accessed 19 July 2011).

Health education resources

Resources produced by the Ministry of Health

Immunisation: immigrants and refugees

Ministry of Health. 2011. *The Immunisation Handbook 2011*. Wellington: Ministry of Health. URL: [www.moh.govt.nz/moh.nsf/pagesmh/10711/\\$File/ImmunisationHandbook2011-v3.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/10711/$File/ImmunisationHandbook2011-v3.pdf)

This provides information for health practitioners on immunisation for adults and children who enter New Zealand as refugees or immigrants (see pp 23–24).

See also www.moh.govt.nz/moh.nsf/indexmh/immunisation-schedule-immigrants (accessed 21 September 2011).

New immigrants' health

Pamphlets: *Healthy Food Healthy Family; Take care of your teeth* in English, African and Middle Eastern languages.

See the new migrant health website: www.healthed.govt.nz/health-topic/new-migrant-health (accessed 21 September 2011).

Pamphlet: Information for patients about *latent tuberculosis* in English, Arabic, Farsi, Amharic and Somali.

See the new migrant health website: www.healthed.govt.nz/health-topic/new-migrant-health (accessed 21 September 2011).

Resources produced by Auckland Regional Public Health Service

Information for refugee patients on the New Zealand health system (2007) in English, Arabic, Tibetan, Burmese, Chin, Dari, French, Nepali Spanish and Tigrinya.

After a child's immunisation (2007)

Pamphlets on vaccines and common side-effects (2007) in English, Arabic, Tibetan, Burmese, Chin, Dari, French, Nepali and Spanish.

When your doctor refers you to a specialist at the hospital (2002)

Information for patients attending specialist appointments (2002) in English, Amharic, Farsi, Pashtu, Somali, Arabic, Burmese, Nepali and Spanish.

See also Auckland Regional Public Health Service's Refugee Health website: www.refugeehealth.govt.nz/ (accessed 22 July 2011).

For FGM and childbirth

Resources produced by the FGM Education programme

Denholm N. 2004. *Female Genital Mutilation in New Zealand: Understanding and Responding*. Auckland: Refugee Health Education Programme (a handbook for health and child protection professionals working with women affected by FGM).

2004. *FGM Information for Health Professionals*. pamphlet on FGM information for health professionals

2009. *FGM Clinical Care Antenatal, Labour & Birth and Postnatal Guidelines*. guidelines for antenatal, labour and birth and postnatal care

2009. *FGM Deinfibulation Guidelines*. guidelines for deinfibulation

2009. *FGM Teaching Module* (a 28-page teaching module on FGM background information for nursing, midwifery and medical students).

2004. *FGM and New Zealand* (a pamphlet on health and legal information in English and African languages).

2009. *FGM Child Protection Recommended Guiding Principles*.
child protection recommended guiding principles for suspected and
imminent FGM

Other resources

For more information on FGM resources, contact the FGM Education Programme: info@fgm.co.nz, or see www.fgm.co.nz (accessed 19 July 2011).

For HIV/AIDS

Health Information on HIV and AIDS (2000)

HIV education and awareness pamphlets for African communities are available on the New Zealand Aids Foundation website: www.nzaf.org.nz (accessed 19 July 2011).

Other resources

Print material, videos and other health education resources on a range of health topics are available, free, from the authorised health education resource provider in your local public health service.

Endnotes

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- 3 Somnier F, Vesti P, Kastrup M, et al. 1992. Psycho-social Consequences of Torture: Current knowledge and evidence. In: Basoglu M (ed). *Torture and its Consequences: Current treatment approaches*. Glasgow: Cambridge University Press.
- 4 Ibid.
- 5 Pahud M, Kirk R, Gage JD, et al. 2009. The Coping Processes of Adult Refugees Resettled in New Zealand. United Nations High Commissioner for Refugees, Policy Development and Evaluation Service *New Issues in Refugee Research, Research Paper No. 179*. URL: www.unhcr.org/cgi-bin/texis/vtx/home/opendocPDFViewer.html?docid=4b167d769&query=New%20Zealand (accessed 21 July 2011).
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- 11 UNHCR. 2008. *UNHCR Handbook for the Protection of Women and Girls*. Geneva: United Nations High Commissioner for Refugees.
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- 19 Crisp J. 2003. No Solutions in Sight: the Problem of Protracted Refugee Situations in Africa. *New Issues in Refugee Research, Research Paper no. 75*. Geneva: United Nations High Commissioner for Refugees Evaluation and Policy Analysis Unit.
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- 21 Human Rights Watch. 2011. *World Report 2011: Eritrea*. New York: Human Rights Watch. URL: www.hrw.org/en/world-report-2011/eritrea (accessed 21 July 2011).
- 22 Ibid.
- 23 United Kingdom Home Office. 2009. *Ethiopia Country of Origin Information Report 18*. London: United Kingdom Home Office RDS-IND COI Service, March 2009. URL: www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/countryspecificasylumpolicyogns/ethiopia.pdf?view=Binary (accessed 21 July 2011).
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- 26 Human Rights Watch. 2011. *World Report 2011: Sudan*. New York: Human Rights Watch. URL: www.hrw.org/en/world-report-2011 (accessed 21 July 2011).
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