'To be healthy is almost out of reach for refugee families because of the conditions we live in.'

Barriers to achieving good health outcomes in refugee-background communities

A report prepared for Regional Public Health and the Department of Labour

Contents

Executive summary

This report highlights the barriers facing people from refugee background communities in achieving and maintaining good health. Information in this report was gathered at four focus groups held in May 2011. Focus group participants came from 11 different refugee-background communities.

The main barriers identified by participants were limited English language skills and issues around the use of interpreters; living in damp, mouldy houses; being unemployed and having limited incomes; stress resulting from trauma and/or being separated from their families; a lack of awareness of how to keep healthy in New Zealand; discrimination and a lack of culturally sensitive health services.

Participants made a number of suggestions on how to reduce these barriers and improve their health. These included: more funding for English language classes, improved housing conditions, cultural awareness training for health practitioners, health promotion material for people who did not speak English, being re-united with family members in New Zealand and for health practitioners to take a more holistic approach when treating people from refugee backgrounds.

1.0 Introduction

The aim of this report is to increase understanding of the health requirements of refugee-background communities. Like many communities whose members are predominantly from low socio-economic backgrounds, former refugees face many cross-cutting health issues that are barriers to achieving and maintaining good health. This report highlights these barriers and documents research participants' suggestions on how these issues could be addressed.

2.0 Methodology

Information for this report was gathered from four focus groups held in May 2011. The research process was underpinned by ChangeMakers' Standards for Engagement (2008), which outlines the importance of working alongside communities and ensuring that participants are engaged in a meaningful way. As part of this process, and to ensure that participation was not limited to a select few, we assisted people to attend the focus groups by covering transport costs and by providing a koha. Where needed, interpreters were provided to ensure that the participants who had limited English language skills could express themselves freely.

A total of 24 people from 11 communities participated in the focus groups. Twelve participants were aged 30 years old and above and twelve participants were aged between 18-29 years. There were two male and two female focus groups in recognition that health issues can be sensitive and that we were likely to achieve more in-depth information if gender specific groups were run.

At the beginning of each focus group, we explained the format of the session, talked about confidentiality, and discussed speaking protocols (e.g. allowing equitable space for participant contribution and the right to 'pass' if participants do not wish to contribute). All participants signed an agreement form that gave their consent to participate, to be recorded and provided the option to withdraw from the process at any time (see Appendix A).

Each of the focus groups were recorded. ChangeMakers conducted a thematic analysis of the findings, identifying key issues and barriers to achieving and maintaining good health. Most of issues related to each theme were raised and discussed by all four focus groups. Where a specific group raised an issue that was not discussed at other focus groups, this has been noted within the report.

3.0 Research findings: factors influencing health

A range of interrelated issues were identified by participants as having a significant impact on their health.

3.1 Housing

Participants identified the link between living in unhealthy houses and their health. They stated that many of their houses were damp and mouldy, lacked proper ventilation and that these living conditions resulted in poor health for them and their families. Women felt that their health and the health of their children had deteriorated since arrival in New Zealand with increased rates of colds, allergies, hay fever, asthma and other respiratory diseases.

> *'Refugees who get a house in very bad places, that causes most of the sickness. The house is most important.'*

> *'Housing [New Zealand] never change anything. They just came a few months ago, they paint the whole wall but the mould is still coming... whenever we wake up in the morning we just cough, cough really hard.'*

Participants also observed that overcrowding was a problem among refugee-background families due to small houses being allocated to large families.

> *'Too many people live in one house, if one becomes sick, others become sick too'*

3.2 Income and employment

Participants spoke of the connection between income, employment and health. Being unemployed and having limited income was seen as a major barrier to attaining good health. Participants said that if they had a steady income they would be able to afford decent accommodation, buy healthy food, and have ready access to family doctors.

> *'If we can get a chance of employment, then that may change something'*

As many people from refugee backgrounds are beneficiaries, a key priority for participants was to ensure that they had enough money to feed their families.

Participants felt that the increasing cost of living in New Zealand made it difficult to live well and be healthy. Several stated that healthy food was expensive and for many refugee-background families on a limited budget they were unable to afford healthy food.

> *'All these good things are out of our reach, even though you know their importance.'*

> *'The cheapest things are those that can cause health problems. Because the refugees are not earning much, they have to go for the cheaper things.'*

> *'The organic food is so expensive. Nobody will go to buy them. If you go to buy them, then tomorrow you will not get anything to buy. So I think healthy food is a problem.'*

Participants also highlighted the link between unemployment and the deterioration of their health. They spoke of the stress, depression and other mental health issues they experienced due to the

financial pressures here and abroad. Several male participants spoke of expectations from family members back home that they would be supported by those who had been resettled here.

> *'You are expected to support families back home, you cannot find a job here, so you get stressed.'*

> *'If people see one of their people is outside [the country], they hope that they have got money, they will be asking for help. And if you cannot be able to help them... because of your conditions here then it can really create a big problem.'*

> *'You look at yourself, I'm eating here but my brothers and sisters are not eating there... You cannot feel happy because you cannot support anyone who is there in need of help.'*

Many participants spoke about long hospital waiting lists. Some commented that the lack of income in refugee-background communities meant that most could not afford health insurance and were therefore forced to wait which created additional stress.

3.3 Language

Participants stated that having limited English language skills was a major barrier to achieving good health. They identified several language-related issues that are covered in the following sub sections.

3.3.1 Access to services

Participants felt that the best way to facilitate access to services was for people to learn English and that the New Zealand Government needed to put more resourcing into this area. Female participants highlighted that not knowing English impeded not only their access to health services but also to other services, including those provided by Work and Income and Housing New Zealand. Participants stated that limited English language skills made it very difficult to communicate effectively or even explain their sickness.

> *'It cripples us...we can't say what we want.'*

> *'At the end of it language plays a very big role. ' [in keeping healthy]*

> *'If you can't express yourself, everything is difficult for you.'*

Participants felt limited English language skills resulted in limited health service provision. They felt they were dismissed by health professionals who didn't have time to work out what they were trying to communicate.

3.3.2 The use of interpreters

Participants recognised the need for and the importance of interpreters when people could not speak English. However, some were unaware of their right to an interpreter and either went alone or brought their children with them to appointments. Others experienced situations where there was no interpreter provided, or when an attempt was made to get one, a suitable interpreter was not available. This experience applied outside the health system as well (e.g. Work and Income and Housing New Zealand).

Participants felt that informal interpreters (i.e. family or community members) needed to be trained so that they were aware of issues such as confidentiality. Male participants stated that if the community was aware that the person had received training, then the community would have confidence that their health issues would remain confidential. They also stressed that the community would need to know the person who was interpreting.

> *'Trust plays a big role here.'*
>
> *'If you don't know someone then you can't trust them.'*
>
> *'Health issues are sensitive. You need to be able to trust the person who is interpreting and that they will keep the information confidential. If this was done through training then people would have confidence that the interpreter would be educated about ethics and confidentiality.'*
>
> *'... if the person is more connected to the people and then the moment the people start to know that person...this person seems to be a very good person within the community. They can see him, they can talk to him.'*

In reality, many people were faced with using someone to interpret who was not trained and they worried that the community would hear about their health issues.

> *'They still take someone [to interpret] and that's the problem, some people are not training, there is some news that happen that come out of the room.'*

Participants agreed that interpreters needed an understanding of the health system and medical terminology so that interpreters could explain clearly to patients what the health practitioners were saying.

Some participants suggested that the health system provide interpreters but others, mainly the female participants, felt that they didn't want outsiders knowing about their personal issues and so preferred to have family members interpret. However, they also acknowledged that some children did not want to act as an interpreter.

Female participants were also very uncomfortable with having male interpreters and wanted more women interpreters to choose from.

> *'I cannot say all my problems to male interpreter because of our culture... I'd rather lose the therapy/treatment than losing my privacy.'*

3.3.3 Participation in society

A language-related issue that impacted on participants' health was the extent to which they were integrated into the wider community.

People who had limited English language were in danger of isolating themselves, which had a negative impact on their physical and mental health.

> *'...because of language barrier we stay at home, we isolate ourselves, we stay at home, don't want to go out.'*

'When people isolate themselves, they sit there, they think about what happens in your own country, they have friends, they have uncles, they have sisters...'

Participants from the younger women's group highlighted that it was difficult for them to socialise with 'Kiwis' and that they were often excluded because of their limited English language skills.

'It's hard to find some other Kiwi friends...to learn more about the culture.'

Participants also noted that many refugee-background communities do not participate in physical activities like swimming due to language and cultural barriers. They felt that service providers needed to develop better ways for refugee communities to be involved in physical activities.

3.4 Mental health

While participants spoke of specific health issues such as headaches, digestion, problems sleeping, arthritis, diabetes, and blood pressure problems, they acknowledged that many of these problems were stress related. Participants agreed that mental health issues were of great concern to them and their communities.

'The main problem that refugees face is related to trauma, is related to stress.'

'When a person is not in a good condition mentally, he cannot do anything.'

'Stress is most important because if you are stressed you don't eat food and if you don't eat food your body is getting weaker and weaker, you don't sleep properly...'

Participants felt that mental health issues were not given enough consideration when they went to the doctor and that health issues were not considered from a holistic perspective; there was tendency to treat the symptoms.

'It shouldn't all stop at the lab. That's what happens; you get these three or four tests that are negative and that is the end of the story, they don't want to know anymore about you.'

Participants suggested that doctors work closely with psychologists to ensure that mental health issues were being treated.

'The doctor needs to give some space for psychological problems. He must understand that we are a community of refugees and that we have gone through a lot of problems.'

'A lot of the problems are actually psychological and obviously influence what happens on your body.'

'So it would be good for doctors to have a bit more information about us and for them to have the ability to move us to a psychologist or whatever for them to get a proper assessment of what is happening.'

3.5 Separation from family

Participants spoke about the stress of having left friends and family overseas, and about the negative impact that worrying about them had on their health.

> *'We worry every time, every day.'*
>
> *'It is worse when you are the only one in New Zealand, when you've got your wife and kids back home, you don't sleep, you don't eat, you don't do anything, you don't integrate...it's like you are living in a prison.'*
>
> *'Having your whole family here will make you smile, seeing your kids.'*
>
> *'When we are eating here we are thinking about our families back in Africa. ...what is happening with them? Are they having food?'*
>
> *'We worry every day, every time, your mind is always divided, you don't know where to concentrate.'*

3.6 Access to information

Participants felt that the dissemination of health messages to refugee-background communities was sometimes poor, and this was accentuated by people in communities not having adequate English language skills. They felt that service providers needed to give more consideration to how to communicate health messages to people who did not speak English.

Participants wanted more awareness among refugee-background communities about how to attain and maintain good health, what foods were good for you, and where you could go to get good advice.

Being aware of who to talk to when there was a health problem or being able to advocate on behalf of yourself or someone else was also seen as important. As one participant stated:

> *'...my mother has an eye problem where the eye was weeping and they said it will be six months before she can have an operation to fix this. Because I complained it is now 1 month.*

While the participant was grateful that his mother would receive the operation sooner than expected, he observed that many refugee-background people would not know who to complain to or have the language skills to do so.

> *'There is no one to tell you about these things and if you don't know the language you cannot solve these problems.'*

Several participants spoke about differences between their home country and New Zealand and how these impacted on their health.

> *'Our country is a warm country and this is a very cold country.'*

Another participant stated that people needed to be well briefed before arriving in New Zealand so that they had realistic expectations about life here.

> *'You were expecting you know, milk and honey as you have been told and when you come you see things differently here...some people even ask themselves, why am I here? I am not getting what I expected.'*

Participants also noted that the differences between their culture and life in New Zealand presented many problems that could impact on their health. They noted that greater awareness of these differences would help them manage expectations and to address issues when they arose.

3.7 The cost of services

Many participants spoke of the cost of going to the doctor and felt that this was a barrier to achieving good health.

> *'.... is the price of those visits. The price is $17. If you have two family members then that is going to be $34 and if you have more than one thing that is wrong with you then that is going to be more.'*

> *' I went to the doctor once about my head, it was hurting and the doctor asked me if there was something else. So I told him about my stomach and he said those are two visits, you have to pay for two visits.'*

> *'Lowering the price would make things much easier.'*

Participants stated that access to free blood tests and ambulances was beneficial.

3.8 Culturally sensitive health services

Participants recommended that doctors should have not only medical information about patients but also information on where the patient comes from, what was happening in that country (as this could result in stress and related health problems) and the sort of diet that patients were used to. Doctors should be trained to work with culturally diverse patients and to be culturally responsive.

> *'Health professionals...cultural awareness training so they don't have preconceived ideas about you. They should be welcoming and not try and see you as quick they can.'*

Women in particular felt that health practitioners were not culturally sensitive. They identified the need for better communication between health practitioners and communities, and in particular better cultural understanding from health practitioners. Women expressed concern about what they believed was an increase in caesarean rates among women in their communities and felt they were rushed into agreeing to have caesareans, which they considered to be unnecessary and culturally inappropriate.

> *'We are hurried to have caesarean section... sometimes we feel like objects.'*

Another participant stated that she felt that health practitioners did not engage with female patients or allow the patient to give input.

> *'I know what happens to my body.'*

Female participants also spoke of the need for the gender of the health practitioner to be matched to that of the patient. Women participants preferred to be treated by female doctors; a point that was reinforced by one male participant.

> '*She would rather lose that treatment than lose her privacy' [in terms of having a male doctor]*

Participants stressed the need to provide social support to individuals who are sick and that this cultural practice should be accepted by hospital staff. Two female participants described the Somali tradition of how unwell people were accompanied from 'a to b', explaining that sick people in their communities are never left alone. They talked about the effect of Somali 'traffic increases' at hospitals; when a member of their community was in hospital, community members are expected to visit and provide comfort. These participants noted that doctors appeared to find this practice frustrating and would ask community members to provide space for the patient.

Participants noted a difference in beliefs between New Zealand healthcare and communities' cultural beliefs about what was important for a patient (Somali: touch, community support, comfort). Participants agreed that community support was an enormously important aspect of care.

3.9 Continuity and quality of care

Participants spoke of the difficulty interacting with different health professionals when they were at hospital or at medical centres instead of one person who knew the participant well.

> *'Continuous assessment over a long period, they would be able to know this person better and whether one sickness is creating all these others. They would know exactly what's wrong.'*

3.10 Discrimination

Part of this was simply feeling unwelcome when accessing health services. As one participant noted:

> *'[people should]...be appreciated because they are people who have a problem and they live in New Zealand. They should feel welcome.'*

Many women participants felt that doctors didn't take the time to ensure that the patient understood the problem and often they would be referred to the hospital without knowing why. Others felt alienated by doctors especially at hospitals.

Participants in the older women's focus groups agreed that the skills and knowledge they brought with them from their home country were not appreciated, because they could not speak English. One participant, a professional midwife back home, observed that women in her community trusted

and valued her expertise, but that her skills were not recognised by health practitioners in New Zealand. She noted that when she accompanied women to the delivery suite, ward staff were dismissive of her knowledge and the support she provided to patients. This participant described a range of experiences from supporting family members, to receiving treatment herself, to trying to ask for a drink of water, where staff were dismissive and impatient.

> *'It was like a slap in the face.'*

Other participants described doctors and staff as being rude, judgemental and automatically stereotyping patients.

In contrast, young male participants did not feel discriminated against.

> *'They are not racist, by racist I mean they don't care about your...who you are, they just help you.'*

4.0 Key barriers

This report has highlighted focus group participants' perceptions of the barriers to achieving and maintaining good health for people from refugee background communities. These include:

- Living in damp, mouldy overcrowded houses.
- Having limited income to buy healthy food, and to support family and friends who are in their home country.
- Having limited English language skills.
- Not having access to trained interpreters who are trusted by communities or being offered an interpreter who was not the same gender as the patient.
- Feeling isolated and not welcomed by 'Kiwis'.
- Being separated from family members who were not in New Zealand.
- Mental health issues not being considered when they presented at a doctor for a physical complaint.
- Having to deal with different health professionals rather than someone who knew them well.
- A lack of awareness of how to keep healthy, particularly for people who don't speak English.
- Unrealistic expectations about life in New Zealand.
- A lack of culturally sensitive health service provision.
- Discrimination.

5.0 Recommendations

Participants made a number of suggestions on how to improve health outcomes for people from refugee background communities. These were:

- Prior to their arrival, refugees receive information so that they have realistic expectations of life in New Zealand.
- Houses are upgraded and maintained so that they are warm and dry.
- Families are allocated houses that are appropriate for their family size.
- Greater employment options are made available to people from refugee backgrounds.
- More funding is allocated for English language tuition.
- Health promotion activities include resources targeted at those who do not speak English.
- Greater access to trained interpreters is made available.
- Community members can access trained interpreters whose gender matches that of the patient.
- Family members are supported to resettle in New Zealand.
- Health practitioners are trained to work with culturally diverse patients and to be culturally responsive.
- Health practitioners recognise the important role communities play in supporting people who are hospitalised.
- Health practitioners are educated about refugees, where they have come from and the situation in their home countries.
- Health practitioners take a more holistic approach when treating people from a refugee background that incorporates the patient's mental health, their history and where they have come from.
- Recognition, among health practitioners, of the skills and experience that people from a refugee background bring to New Zealand.
- More acceptance of diversity among the wider community with people welcoming refugees into their community.

- Better coordination and cooperation between refugee service providers including health and other social service agencies to enable interrelated health issues to be addressed.

Participants recognised that the health system alone could not address the issues that they had raised or their suggestions on how these issues could be resolved:

> *'They [the health system] have to get help from Housing, from MCLASS from ChangeMakers...anyone who is related to the communities. One hand can't make a sound, two hands makes a sound.'*

Appendix A

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Wellington refugee-background communities - Health needs assessment: Focus Group Agreement

You agree to be part of this focus group for the Wellington refugee-background communities health needs assessment.

This group is run by ChangeMakers Refugee Forum.

You understand and agree that:

- You may leave at any time you want.
- You can choose not to answer any questions.
- We will respect you and your opinions.
- We will not tell the government who you are or where you are from.
- We will take notes and record the focus group to make sure we don't miss anything.
- The recordings and notes will be kept safely stored at ChangeMakers Refugee Forum.
- We will cover your transport costs and you will receive gift vouchers worth $50 for being part of the focus group.

I have read these terms and agree to them.

Your name:_____

Signature:

_____

Tim O'Donovan, ChangeMakers Refugee Forum (signature):_____

Focus group date:_____ Location of focus group:_____

I have received a $50 voucher for participating in this focus group.

- ☐ **Supermarket Voucher**
- ☐ **Petrol voucher**

I have received a $10 / $20 petrol voucher (circle one) to cover my travel costs.