Refugee Health Care: A Handbook for Health and Social Care Providers

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Tangata ako ana i te kāenga, te tūranga ki te marae, tau ana

A person nurtured in the community contributes strongly to society[1]

Foreword

In July 2020, Aotearoa New Zealand's annual refugee quota was increased from 1,000 to 1,500 per annum and five new resettlement locations (Levin, Masterton, Blenheim, Ashburton and Timaru) were established to accommodate the increase. The continuum of services was extended to support quota refugees from screening offshore, to reception at Māngere Refugee Resettlement Centre | Te Āhuru Mōwai o Aotearoa and through to resettlement into one of 13 resettlement locations across the country.

The 2024 Refugee Health Care: A handbook for health professionals (the Handbook) has since been updated to reflect the current environment. The Handbook provides guidance on the delivery of culturally appropriate and safe healthcare for refugees and their families.

Originally published in 2002 and last revised in 2012, the Handbook aligns with advances in refugee health care in New Zealand. It reflects the All-of-Government approach that has been taken to improve refugee resettlement outcomes. It incorporates developments that were co-designed by former refugees working in the health and disability sector to ensure that health services meet the unique needs of former refugee families.

The New Zealand Refugee Resettlement Strategy (the Strategy) that was first established in 2012 has also been updated and expanded to cover refugee categories, in addition to those arriving under the National Quota Programme. The vision of the Strategy is to see former refugees and their families settle successfully into New Zealand and thrive in their new home.

Health issues can arise from offshore and lifestyle changes with the resettlement of refugees. The Handbook emphasises the importance of including former refugees and their ethnic communities in ensuring health services and programmes enable good health outcomes for resettled communities.

The Handbook explores emerging trends in the health of former refugee groups, outlines current therapies, and introduces new service providers. It has been written in consultation with health providers, experts in the field and refugees with lived experience. It is designed to support health workers in all health care settings to deliver culturally appropriate and safe health care and to achieve equitable health outcomes for former refugees.

We are confident that this refreshed edition will become a trusted and valuable online resource for health professionals and the community.

Fepulea'i Margie Apa

Chief Executive

Health New Zealand | Te Whatu Ora

The complexities of migration are especially poignant in Aotearoa New Zealand, where our geographical isolation meets a strong commitment to cultural diversity and humanitarian principles. As healthcare providers our responsibility extends beyond treating diseases; it involves understanding and responding effectively to the unique needs and barriers that refugees and refugee-like populations face in accessing healthcare.

In Aotearoa New Zealand, the integration of refugees into society is underpinned by the need to provide not only immediate health services but also long-term health monitoring and support. This approach helps us understand and effectively address the broader determinants of health that affect these populations, including language barriers, cultural differences, the social loss, and disruption inherent in the refugee journey, and the long-lasting impacts of trauma.

Our healthcare system must evolve to meet these needs with sensitivity and inclusivity. We must ensure that every interaction respects the dignity and rights of refugees, treating them not as passive recipients of care but as active participants in their health journey. This includes offering services in refugees' languages, providing culturally safe care, acknowledging, and respecting the beliefs and experiences each refugee client brings to their health care journey.

This handbook aims to be a comprehensive resource for health and social care providers, offering practical guidance on navigating the complexities of refugee health and well-being. It stresses the importance of an integrated approach that combines medical treatment with psychological support and social integration. By fostering an understanding of the full spectrum of challenges faced by refugees, we empower healthcare providers to make a significant difference in their lives and, by extension, in the broader health outcomes of our communities, and our country.

I encourage every healthcare provider to use this handbook as a critical reference text, to not only better understand the specific needs of refugees and refugee-like populations but also to advocate for and implement practices that enhance their well-being and wider health outcomes in Aotearoa New Zealand.

Ayan Said

Ayan Said *is the regional refugee health promoter at Te Whatu Ora, Te Toka Tumai Auckland and a member of the New Zealand Refugee Advisory Panel. She is of Somali descent and originally from Mogadishu, Somalia. Ayan has a strong commitment to improving healthcare outcomes for refugee communities and brings an African perspective to public health concerns affecting Aotearoa New Zealand. Ayan has been a public health professional, educator, and advisor for the past ten years, and holds qualifications in psychology, health promotion, and a master's public health. She is undertaking a PhD in public health at Auckland University of Technology.*

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About the lead authors

Serena Moran is a Nurse Practitioner in Primary Care. She completed her Bachelor of Nursing in 2007 and her Master of Nursing Science in 2019. Serena has worked in not-for-profit primary healthcare for many years specialising in refugee health. Up until recently, Serena was a Senior Professional Practice Fellow at the University of Otago, Wellington as a postgraduate convener and published researcher in refugee health. Serena has provided advice and professional development in refugee health for governmental and non-governmental organisations. Serena is interested in the intersections of health, culture, and social justice to improve health outcomes for all.

Marcia Gawith is a Registered Nurse, specialising in primary and community care. Marcia has experience in refugee health care which began prior to her nursing training when she volunteered with the Red Cross pathways to settlement support programme. More recently, Marcia was the clinical case manager for refugee resettlement for Masterton in the Wairarapa region of Aotearoa New Zealand when Masterton was established as a new settlement location.

Dr Jonathan Kennedy is a specialist general practitioner at Newtown Union Health Service in Wellington, and a senior lecturer in the Department of Primary Health Care and General Practice, University of Otago, Wellington. He has a special interest in the primary health care needs of refugees and migrant arrivals to Aotearoa New Zealand. This interest dates back to field experience with the medical charity Médecins Sans Frontières in South Sudan and Sri Lanka, and experience as a student in the Pacific islands. He graduated with an MBChB (Otago) in 1997 and subsequently completed postgraduate diplomas in obstetrics, paediatrics and public health. He has been a Fellow of the Royal New Zealand College of General Practitioners since 2007. He teaches medical students across their undergraduate curriculum and postgraduate primary care students in refugee and migrant health. He has authored peer-reviewed publications on refugee and migrant health in primary care, and his current research focuses on the interface between primary care and public health.

A note on the writing within this handbook: As demonstrated by the multitude of names listed above, many voices have shaped this resource. As such, different sections have different tones. Rather than homogenise the writing style of the following pages, we have opted to retain the diversity of voices out of respect and gratitude to our contributors.

1 Introduction

This handbook is intended for health and social care professionals, as an introduction and reference for those working with, or intending to work with, former refugees in health and social care services. Refugee health is a broad and rich area, and this handbook is not exhaustive. Health and social care professionals will find many additional resources, some of which are referenced throughout this handbook, to strengthen our ability to provide culturally safe and responsive support in this area of health.

This handbook can be used in conjunction with the online resource, *Community HealthPathways – Refugee Health*, an invaluable tool for day-to-day questions and decision-making arising in clinical settings. This handbook complements Community HealthPathways by building on concepts for working in refugee health care, utilising the experience and voice of health professionals and former refugees. All health professionals can access Community HealthPathways on request at communityhealthpathways.org.

Writing this handbook has been a collaborative process. It has been a privilege and pleasure to engage with former refugees and professionals across Aotearoa New Zealand working in this field. We are grateful to all those who have provided their expertise and shared insights from their lived experience.

2 The journey

2.1 Life before refuge

The following testimonials and stories speak to the rich and colourful lives people led before forced displacement and resettlement in Aotearoa New Zealand.

> *"People think of refugees often as being defined by our displacement, but there's a whole life before that. I was just a very normal nine-year-old. You know, I had my school friends and my cousins and my room that I was so proud of. There is this other life that isn't about war and oppression and the flight to safety."*
>
> Golriz Ghahraman, Aotearoa New Zealand's first ever Member of Parliament from a refugee background[2]

> *"I used to play in the Afghanistan national football team."*
>
> Former refugee, ChangeMakers Resettlement Forum[3]

> *"Mine was a happy and typical Eritrean upbringing. I grew up in a tolerant society where people from different cultures and religious backgrounds embraced each other. My extended family were Muslims, but our neighbours were Christians, and we shared our lives together. We celebrated Christian holidays with them, and they celebrated the Muslim holidays with us...I attended public schools, including an Islamic primary school, and then my local junior and high school. It was a loving and tolerant environment, culturally conservative, but there was a strong sense of social justice and standing up for people who didn't have enough."*
>
> Ibrahim Omer, Aotearoa New Zealand's first African Member of Parliament and former refugee[4]

> *"I was a fashion model and studied fashion design in Ethiopia."*
>
> Former refugee, ChangeMakers Resettlement Forum[5]

> *"All I remember from my childhood is an ongoing war. Flashing images of soldiers departing for the war front, jet fighters roaring in the sky and people fleeing villages. I know myself as a son of war and that is why I devoted myself to peace. Fighting for peace is my endless ongoing war."*
>
> Former refugee, ChangeMakers Resettlement Forum[6]

"Working as a midwife is part of me, anytime – midwifery is my passion. It means humanity, resilience, being kind. It means a lot to me… In Syria, I studied, graduated, had my own house and my own clinic, but now I have to start from scratch"

Alia Al Mohamad, Former refugee from Syria now living in Aotearoa New Zealand[7]

2.2 Displacement and seeking refuge

"I left the village with my two children and headed to the road that would lead us to the Kenyan border town of Nadapal. I walked for four days, with my two children. By the time I reached the border I had given birth to my third child. I had no papers with me at that time, but the border guard looked at me, a woman alone with two small children and a newborn, no food, ragged clothes and they let me through the border. One guard took us to the UNHCR office in Loko Cheko [sic] for processing and we were then transferred to the Kakuma refugee camp. It was 2005 and another new life had begun. I breathed peacefully and with freedom. My children would grow up without war, without fear."

Hellen John Lakang, Former refugee and author of *The blooming lotus*[8]

"I left behind everything I loved: my country, my family, my friends, and my dreams, including the long list of things I wanted to be and do."

Ibrahim Omer, First African Member of Parliament and former refugee[4]

"I escaped Kabul after the Taliban terrorist group took over. Kabul's dramatic fall was a disaster for all Afghanistan's people who were trying to establish democracy, freedom, and justice in their war-torn state."

Former refugee, ChangeMakers Resettlement Forum[9]

"I came over with my husband, my sister and two toddlers in 1985. We fled Laos on a boat away from the eyes of the guard soldiers. I am proud of working for the world's finest chocolate manufacturer; A made-in-Aotearoa industry here in Porirua. I have worked there for more than 30 years, and I don't see moving to a new job anytime soon."

Former refugee, ChangeMakers Resettlement Forum[10]

Conflict and persecution are the main drivers for displacement alongside increasing environmental pressures. People who are no longer safe in their homes, the places they usually reside are forced to move, often first seeking safety within their country.

An ‘internally displaced person’ (IDP) is a person who has experienced forced displacement within their country of origin.

Many people will remain internally displaced for years. Others will find a way out of their country of origin and cross over a national border into another country. Depending on the rules in the country in which they find themselves, they may have the option to seek asylum, which requires explicitly declaring that they are not safe to return. These people are considered ‘asylum seekers’ with accompanying international rules, legal precedents, and guidelines. Those unable to seek asylum may have the option of seeking refugee status under the 1951 Refugee Convention.

The 1951 United Nations Convention relating to the status of refugees[11]

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.

Most people who cross into another country seeking safety will spend years, if not the remainder of their lives, in exile, often in refugee camps or other precarious circumstances with limited rights and without secure access to the necessities of life. Many will never obtain refugee status.

For those who are successful in obtaining refugee status, international protection is codified by the United Nations High Commissioner for Refugees (UNHCR).

3 Refugee settlement in Aotearoa New Zealand: A brief historical overview

Once refugee status has been granted, some refugees may have the opportunity to apply to be resettled in countries like Aotearoa New Zealand, which have a formal quota refugee resettlement programme.

Aotearoa New Zealand's unique approach to refugee settlement in the past and today shows the partnership of the state and ordinary people in helping the survivors of wars and conflicts by offering them a chance to start a new life. The Aotearoa New Zealand refugee quota programme was developed and shaped in response to the movements and needs of displaced global populations over time.

Historian Ann Beaglehole *provides the following short history of refugee resettlement in Aotearoa New Zealand:*

Since 1840, Aotearoa New Zealand has given refuge to thousands of people from Europe, South America, Asia, the Middle East, and Africa. More than 40,000 refugees have settled in Aotearoa New Zealand since World War Two when refugees were first distinguished from other migrants in official statistics[12].

Small numbers of people, who were in effect refugees, though they did not meet the legal definition, arrived in Aotearoa New Zealand in the nineteenth and early twentieth centuries. They included Danes fleeing suppression of their language and culture under Prussian occupation in the 1870s[13].

The first sizable groups of people to be granted refuge in Aotearoa New Zealand arrived in the years before, during, and immediately after World War Two. They included Jews escaping Nazi Europe, Chinese women and children fleeing the advance of the Japanese, Polish children brought to Aotearoa New Zealand from Persia (Iran) in 1944 and European Displaced People (DPs) who settled between 1949 and 1952[13].

The establishment of new regimes after 1945 in Europe and Asia created waves of refugees fleeing oppression and lack of economic opportunities in their countries. Several groups of these refugees settled in Aotearoa New Zealand between the mid-1950s and the end of the 1980s[13].

Refugees from diverse places in Africa, Asia, South America, and the Middle East arrived in the 1970s and greater numbers in the 1980s and early 1990s. In the aftermath of the Vietnam War, the government accepted Vietnamese, Cambodian and Laotian refugees in significant numbers. In the 2000s, refugees came from Iran, Iraq, and Burma/Myanmar[13].

Recent groups welcomed have included refugees from Syria in 2015; refugees from Afghanistan in 2021 and from Ukraine in 2022. Other refugees settled in 2021-22 were from Pakistan, Myanmar, Colombia, Afghanistan and Syria[12]. In 2023 refugees settling in Aotearoa New Zealand were mostly Syrian, including Kurdish minorities located in Iraq, Jordan, and Lebanon[14].

Aotearoa New Zealand's refugee settlement policy has developed in an ad hoc manner, responding to specific circumstances and needs. The careful selection of

refugee settlers to ensure they would ‘fit in’ has been an important theme in twentieth-century refugee policy. Until the mid-1970s, Aotearoa New Zealand’s refugees were predominantly from Europe. Policy discriminated against others, based on their nationality, ethnicity, and religion. Major changes in refugee policy took place from the late 1980s, particularly in attitudes towards welcoming cultural diversity[13].

The government formalized Aotearoa New Zealand’s present refugee resettlement programme, known as the refugee quota programme, in 1987. Since 2020, the government has set the annual refugee quota at 1500[12]. The number of refugee and protection claims (i.e., from people seeking asylum) varies; during the 2022-2023 financial year, there were 780 refugee and protection claims, of which 104 were accepted (i.e., 21.6% approval rate). During the 2023-2024 financial year, 2009 refugee and protection claims were made, of which 105 were accepted (i.e., 23.3% approval rate) [15].

Border closures due to COVID-19 reduced the number of refugee arrivals in 2020[12], but since 2022, a three-year refugee quota has been in place[14], with 1507 refugees welcomed under the quota[16].

Aotearoa New Zealand’s refugee quota is not large relative to the many millions of refugees and displaced people in the world. United Nations High Commissioner for Refugees (UNHCR) estimated that the number of displaced people passed 100 million in 2022. However, Aotearoa New Zealand’s contribution is outstanding in at least two ways. Aotearoa New Zealand gives protection to quota refugees by granting permanent residency to them on arrival[12] and, since 1960, the country has been one of only a small number of nations to accept refugees considered hard to settle, such as women at risk, medical/disabled and emergency protection cases[17].

Some recent policy changes have contributed to positive settlement outcomes. In 2019, the government ended the ‘family links’ policy, which discriminated against refugees from the Middle East and Africa[18]. Refugee family reunification changes since 2022 have enabled more refugees to be reunited with their families, a crucial factor in helping refugees to settle well[12]. Also in 2022, Aotearoa New Zealand announced that an earlier offer to transfer 450 (150 per year) asylum seekers and refugees, held in Australia, or Australian offshore detention centres, would go ahead[12].

Aotearoa New Zealand’s model of resettlement has involved the use of volunteers to help refugees, particularly with their initial housing and employment needs. Until the 1990s, mainstream services were responsible for providing services for refugees on the same basis as any other New Zealand resident and citizen. The availability of specialist services, such as Refugees as Survivors (RAS) for refugees who had survived traumatic situations, began in 1995[13].

A sponsorship system under the wing of churches and other faith and community groups operated in the 1970s and 1980s. The National Council of Churches and the Inter-Church Commission on Immigration and Refugee Resettlement (ICCI) made significant contributions to refugee settlement. The ICCI underwent several name changes before becoming Refugee Services in Aotearoa. In 2012, Aotearoa New Zealand’s then main refugee resettlement agency RMS Refugee Resettlement

combined with the New Zealand Red Cross. The New Zealand Red Cross has been the main provider of refugee settlement services since that time[13]. In 2022, changes introduced by the government saw the New Zealand Red Cross overseeing eight regions and five other providers overseeing five other regions[12].

Several other organisations have also been involved in refugee settlement, such as the Islamic Association, the Polish Association, and various other ethnic groups. From the late 1980s, the government gradually recognized the essential role in the settlement of a critical mass of refugees in their communities, supporting each other and helping newcomers[13]. In 2018 the New Zealand Government established the Community Organisation Refugee Sponsorship programme (CORS) with churches, iwi, and community groups to enable further numbers of refugees to settle in Aotearoa New Zealand[12].

Compared with the diverse services available for quota refugees, such as access to orientation programmes, the government has provided limited settlement help to asylum seekers and convention refugees[12].

About the Author

Ann Beaglehole *is a historian, born in Szegö Aniko, Hungary, she came to Aotearoa New Zealand in 1957 after the Hungarian uprising against the Soviet Union. Much of her writing has focused on refugee immigration and settlement issues. Ann's book Refuge New Zealand (Otago University Press) is a history of New Zealand's response to refugees and asylum seekers from the 19th century until today. She is also the author of several other works of history about refugees, including A Small Price to Pay and Facing the Past (both published by Allen and Unwin). Ann has had a varied career in social work and public service (including at Te Puni Kōkiri and Ethnic Affairs), most recently doing research for Waitangi Tribunal district inquiries.*

3.1 Migration categories in Aotearoa New Zealand

In addition to the quota refugee resettlement programme, there are a few other migration categories in Aotearoa New Zealand available for a limited number of people from refugee backgrounds, including those not necessarily with formal refugee status. These categories are described below.

3.1.1 Quota refugee

As mentioned earlier, 'quota refugees' refers to the approximately 1500 people per year who are recognised as refugees by both the Office of the United Nations High Commissioner for Refugees (UNHCR) and the New Zealand Government and enter Aotearoa New Zealand as part of the New Zealand Refugee Quota Programme[19].

The Quota Programme accepts people from priority categories determined by the New Zealand Government and referred by UNHCR for resettlement consideration[20]. These categories include 'general and legal protection needs', 'women at risk', 'medical/disabled' and 'family reunification of immediate family members'.

Decisions about quota refugees are coordinated by the Refugee and Migrant Services Branch at Immigration New Zealand, whereas community and government

support for quota refugees is coordinated by the Refugee & Protection Unit at Immigration New Zealand. Immigration New Zealand is part of the Ministry of Business, Innovation & Employment (MBIE).

Quota refugees receive New Zealand residency before they arrive in Aotearoa New Zealand and are publicly funded for health care on arrival. For the first five weeks, these now-former refugees participate in an orientation programme at Te Āhuru Mōwai o Aotearoa – Māngere Refugee Resettlement Centre, involving onsite English language classes, information about living in Aotearoa New Zealand communities, health care and mental health support. Health care is provided by the Māngere Refugee Health Service, which integrates primary health care and health screening services and coordinates links and transfers medical records to health care services in resettlement locations. Quota refugees are settled in Auckland, Hamilton, Palmerston North, Wellington, Nelson, Christchurch, Dunedin, Invercargill, Levin, Masterton, Blenheim, Timaru, and Ashburton. *For more information about Te Āhuru Mōwai o Aotearoa – Māngere Refugee Resettlement Centre see Section 4.4.*

3.1.2 Asylum seekers, protected persons & convention refugees

Asylum seekers in Aotearoa New Zealand are people who make an application for 'refugee' or 'protected person' status to stay in the country. Refugee or protected person status is a legal status.

Table 1: Key definitions

Asylum-seeker	An asylum-seeker is someone seeking international protection. Their request for refugee status, or complementary protection status, has yet to be processed, or they may not yet have requested asylum, but they intend to do so. When someone crosses an international border seeking safety, they often need to apply to be legally recognized as a refugee. While they seek asylum and await the outcome of their application, they are referred to as asylum-seekers and should be protected. Not all asylum-seekers will be found to be refugees, but all refugees were once asylum-seekers[21].
Protected person	A protected person is someone whose deportation from New Zealand would violate the CAT [1984 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment] or Articles 6 and 7 of the ICCPR [1966 International Covenant on Civil and Political Rights [22].
Convention refugee	A refugee is a person who meets the definition of a refugee provided in Article 1A of the Refugee Convention [1951 Convention Relating to the Status of Refugees], as amended by the 1967 Protocol[22].

Asylum seekers are a diverse group and their pathways to Aotearoa New Zealand are varied. They may arrive in Aotearoa New Zealand without documentation, or they may already be in Aotearoa New Zealand under another immigration category

with a valid temporary visa before making the decision that they are not able to leave Aotearoa New Zealand and return to their country of origin because it would not be safe to do so.

Once a person has decided to apply for asylum, there is a specific process[22]. A person applies to the Refugee Status Unit of Immigration New Zealand and subsequently receives formal confirmation that they are being considered for refugee or protected person status.

Once asylum seekers have received the above confirmation, they are eligible for fully funded public healthcare until the outcome of their application is resolved[23]. However, despite holding a 'confirmation of claim' letter from Immigration New Zealand which can be presented at health services to receive funded treatment, some asylum seekers encounter barriers to health services due to repeated requests for updated proof of eligibility[24].

Asylum seekers are not usually in a position to provide such updates, and the initial 'confirmation of claim' letter is expected to be sufficient for the duration of their claim process which may take several years.

> *"We only ask for the letter to prove that their asylum application has been acknowledged. After that, we don't ask anything anymore. We know the process is long and complex."*
>
> Primary Health Organisation health manager[25]

Asylum seekers whose application for 'refugee or protected person' status is approved are known in Aotearoa New Zealand as 'Convention refugees'. This is because the relevant international law is determined by international conventions, in particular the United Nations 1951 Refugee Convention and its 1967 Protocol. Convention refugees can apply for New Zealand residency through standard Immigration New Zealand procedures after a specified period of residence. They need to obtain all the usual immigration medical checks and investigations. Asylum seekers whose applications are denied, revert to their prior immigration status.

Neither asylum seekers nor convention refugees are routinely offered an orientation to Aotearoa New Zealand at Te Āhuru Mōwai o Aotearoa, and resettlement support depends on their circumstances. As such, support is often limited and inconsistent, and entitlements can be difficult to access, resulting in the potential for asylum seekers to become subject to exploitation or extreme poverty[26].

3.1.3 Refugee Family Support Category

The Immigration New Zealand Refugee Family Support Category (RFSC) allows a person who has been granted residence as a refugee or protected person, as an Afghan interpreter, or under the Afghan Emergency resettlement category, to potentially sponsor family members to obtain New Zealand residence[27].

This category is in addition to some family reunification applications which occur within the New Zealand Refugee Quota Programme. RFSC family members are not officially designated refugees for resettlement services and entitlements, though some may have been designated refugee status prior to coming to Aotearoa New Zealand.

Responsibility for financial support and housing lies with the sponsors who have made the application. Like quota refugees and asylum seekers, RFSC people are granted New Zealand residency before arriving in Aotearoa New Zealand and are fully funded for healthcare.

3.1.4 Community Organisation Refugee Sponsorship

In 2018, Immigration New Zealand and HOST Aotearoa New Zealand partnered on a pilot programme for a range of community organisations and groups to sponsor 24 refugees for resettlement in Aotearoa New Zealand.

Under the Community Organisation Refugee Sponsorship (CORS) programme, refugees must come from a priority area and one of the Aotearoa New Zealand priority international regions, and not be eligible for other Immigration New Zealand family categories including the Refugee Family Support Category. They must have basic English language proficiency, have significant work experience or qualifications, and must be between the ages of 18 and 45 years.

Refugees under this category are granted New Zealand residency and are therefore fully funded for public health care and social services on arrival. Community organisations provide direct settlement support for two years and are responsible for finding suitable private accommodation. The programme was extended in July 2021 for three further years and up to 150 sponsored refugees.

3.1.5 Refugee-like migrants & family reunification refugees

‘Refugee-like migrant’, ‘family reunification refugees’, and similar terms are used in health and other settings to encompass other migrants with backgrounds like those who are officially designated refugees. These people are diverse and very hard to define and count. However, they may come from similar health and social backgrounds to quota refugees, Refugee Family Support Category migrants and asylum seekers[28]. Refugee-like migrants may arrive via visitor visa, work visa, or other immigration categories, usually to join family members already in Aotearoa New Zealand. What they have in common with officially designated refugees is the displacement from their homes for the same kinds of reasons that force refugee migration. Some may have the United Nations High Commissioner for Refugees (UNHCR) designated refugee status, others may not. Health funding eligibility varies depending on their status in Aotearoa New Zealand. In health and social care settings, we are interested in objective health and social care needs, so it is important to be aware of this group, especially as former refugee communities.

As populations and communities of former refugees become more established, so does the ‘refugee-like migrant’ population, as people innovate to bring their loved ones to reunite with them in their new home[28]. This can be relevant to general practices and other primary care services over time, as some higher-needs arrivals can bypass other support systems and present with complex care needs. Using knowledge and resources targeted at refugee people for refugee-like migrants can help health professionals navigate those needs[28].

Table 2: Aotearoa New Zealand refugee-like categories and health care entitlements

Terms	Visa Categories	Health Care Entitlement	Notes and Estimated Annual Intake
Quota refugee	Granted Permanent Residence status in New Zealand.	Publicly funded for health services.	Up to 1500[29] per year.
Asylum seeker	May apply for New Zealand Permanent Residence status if granted 'refugee' or 'protected person' status after the application process.	Publicly funded for health services while an application for 'refugee and protected person' status is under consideration	During the 2022-2023 financial year, there were 780 refugee and protection claims, of which 104 were accepted (i.e., 21.6% approval rate) [15].
Convention refugee (Asylum seeker whose application for 'refugee' or 'protected person' status is approved)	May apply for New Zealand Permanent Residence status	Publicly funded for health services once Permanent Residency status approved	During the 2023-2024 financial year, 2009 refugee and protection claims were made, of which 105 were accepted (i.e., 23.3% approval rate) [15].
Refugee Family Support Category (RFSC)	Granted Permanent Residence status in New Zealand.	Publicly funded for health services.	Up to 600 per year
Community organisation refugee sponsorship	Granted Permanent Residence status in New Zealand.	Publicly funded for health services.	Up to 50 sponsored refugees per year up to 2024 (extended pilot)
Refugee-like migrant	The heterogenous group with a variety of New Zealand visa categories, e.g., visitor, work, or critical purpose visa categories.	Variable, some are granted Permanent Residence status and have access to publicly funded health services. Others on visitor or work visas for less than 2 years may have no funded health or social care support.	Limited information.

(Modified from Kennedy et al. [28])

The table below provides generalisations about some of the typical differences between migrants and refugees. However, as noted earlier, some migrants have similar backgrounds, journeys and resettlement experiences to refugees.

Table 3: What is 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 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 may dream of returning home, know that this is unlikely to happen.	Migrants depart for their new country knowing that they can return to their homeland for visits or return permanently if they cannot settle in their 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 leave their homeland.

(From Ministry of Health, 2012[30])

3.2 Preparing for resettlement

3.2.1 International resettlement coordination

People displaced from their homes have huge challenges getting meaningful help from the international community. This is reflected in resettlement statistics. In 2022, of the 110 million displaced people worldwide, 36 million were designated refugee status, and of those a tiny 58,457 departed for resettlement to countries like Aotearoa New Zealand[31].

The unmet resettlement need is vast, with a range of health, legal rights and human rights international organisations supporting displaced people at different points of their journeys. Some have statutory roles in international treaties such as the Office of the United Nations High Commissioner for Refugees (UNHCR) and the International Committee of the Red Cross (ICRC). Others provide international governmental support such as the International Organisation for Migration (IOM).

3.2.2 Departing for resettlement

The reality for many people waiting for an opportunity to be resettled in Aotearoa New Zealand or other resettlement countries is that there are limited options for choice or preparation, and a considerable amount of determination and persistence is required as well as assistance and good luck. The small number of countries accepting refugees for permanent resettlement does not meet the international need. Refugees wait for long periods and have little say in which country they are resettled, sometimes resulting in refugee families being separated and dispersed around the world.

> *"I didn't know anything about New Zealand actually, we thought it was part of the European Union... The place that we came from, it's totally different [from Wellington]… Like, with the children, we had to teach the children how to go toilet. Even that was different... and the signs are all in English, so imagine someone can't speak English. Like you can't even find the toilets.... It's just totally different. I felt like an alien person from another planet."*
>
> Former refugee[32]

3.2.3 Offshore health screening

Former refugees have diverse health and social care backgrounds. Some will have received excellent health and social care prior to being displaced, while some will have received only basic or no health care. Many will have spent long periods in refugee camps or intermediate countries with limited access to health care. For this reason, standard offshore screening and healthcare provision processes are designed to accommodate any health background.

The Refugee Health Liaison Team within Immigration New Zealand is responsible for coordinating refugee health services offshore and connecting to health services onshore as required. They also provide facilitation of knowledge sharing in refugee health matters in Aotearoa New Zealand[33].

Offshore health screening for the New Zealand Quota Refugee programme is undertaken by the IOM on behalf of Immigration New Zealand. Quota refugees receive health screening as part of the application process. Since 2020, the quota refugee pathway has included the delivery of immunisations and initiation of offshore health care for some long-term conditions such as diabetes and hypertension. This is intended to give quota refugees a healthy start to life in Aotearoa New Zealand by ensuring healthcare is commenced as early as possible and already underway on arrival to Aotearoa New Zealand.

Quota refugees scheduled for resettlement in Aotearoa New Zealand have a more comprehensive process, including a visa medical, settlement health assessment and vaccinations, and then a final pre-departure health check just prior to coming to Aotearoa New Zealand. On arrival, Immigration New Zealand approved panel doctors provide medical checks for some groups. Asylum seeker health checks depend on their arrival pathway and their exposure to health services in Aotearoa New Zealand before applying for asylum[34]. RFSC, CORS and refugee-like migrant groups may receive only basic immigration medical checks before arrival via the standard visa medical process. Primary care services in Aotearoa New Zealand are tasked with consolidating a range of health information for each arrival, filling in the gaps with health assessments and health care initiation on a case-by-case basis.

4 Arrival in Aotearoa New Zealand

'Those words of welcome
Welcoming us all, summoning us to the hall.

So many years we spent in the cold
For so many years we were not told,
Not told where we belonged.

This pōwhiri has welcomed us all,
And welcomed us home!
Now I know where I belong,
Now I know New Zealand is our home!'

Poem by Parbati from Bhutan, 2016[35]

4.1 Resettlement support in Aotearoa New Zealand

Resettlement support varies depending on the arrival category. In addition to the categories listed below, the New Zealand Government on a case-by-case basis has opened new visa pathways in response to specific humanitarian circumstances. Support available to these arrivals depends on those specific circumstances and needs.

The New Zealand Refugee Resettlement Strategy

Immigration New Zealand is the lead government agency for refugee resettlement in Aotearoa New Zealand, setting the direction for all other agencies involved in resettlement support through the New Zealand Refugee Resettlement Strategy[36].

The New Zealand Refugee Resettlement Strategy includes provisions for the following groups:

- Quota refugees
- Convention refugees and protected persons
- Community Organisation Refugee Sponsorship visa holders
- Refugee Family Support Category visa holders
- Afghan interpreters and evacuees resident visa holders
- Any other one-off humanitarian residence categories that may emerge in the future

The goals of the strategy are that: "former refugees and their families settle successfully, achieve their goals, and thrive". This includes: "feeling safe and well, having a sense of belonging and being able to participate in and contribute to all aspects of life (social, economic, cultural, and civic)." [36]

There are five settlement outcomes measured within this strategy: participation and inclusion; health and wellbeing; housing; education, training and English language; employment and self-sufficiency.

4.1.1 Quota refugee resettlement support

Quota refugees are initially supported on their arrival at Aotearoa New Zealand at Te Āhuru Mōwai o Aotearoa, a bespoke refugee resettlement reception centre based in Māngere, Auckland, with its programme to welcome 1500 former refugees annually. Support and resourcing are extended beyond the initial five-week welcome and orientation period for a further 12-24 months when former refugees move to their designated refugee resettlement regions and participate in programmes in these locations.

Table 4: Regional resettlement services

Region/s	Provider
Auckland	Kāhui Tū Kaha https://kahuitukaha.co.nz/
Hamilton	Hamilton Multicultural Trust https://www.hmstrust.org.nz/
Palmerston North, Levin, Masterton, Wellington, Nelson, Blenheim, Dunedin, Invercargill	NZ Red Cross https://www.redcross.org.nz/
Christchurch	Purapura Whetu Trust https://www.pw.maori.nz/
Ashburton	Safer Mid Canterbury https://www.safermidcanterbury.org.nz/
Timaru	Presbyterian Support South Canterbury https://pssc.org.nz/

4.1.2 Support for asylum seekers and convention refugees

"Importantly, the lack of clarity between rights and entitlements between Quota and Convention Refugees also confuses the communities with forced migration experience. With different treatment for Quota Refugees, Convention Refugees, Community Sponsored refugees and the Refugee Family Support Category, confusion is bound to arise. Where entitlements and services differ, this can undermine community cohesion and also mean that people miss out on settlement support that they are eligible." [36]

Historically, support for asylum seekers and convention refugees in Aotearoa New Zealand has largely been provided through non-governmental organisations (NGOs) [26]. An example of this is the Auckland based Asylum Seekers Support Trust (ASST), who provide information, services, advocacy and resources to assist individuals to access services while making an asylum claim[37].

With these historical differences, an established community navigator role at Asylum Seekers Support Trust is contracted to support asylum seekers to understand and receive eligible services across the country[26].

A large majority of asylum seekers who enter Aotearoa New Zealand and make a claim for refugee status are not detained or imprisoned. Legislation and practice allow for an individual to be detained solely based on immigration grounds however, if they are considered at risk of absconding within Aotearoa New Zealand while their claim is being processed[38]. There are currently no asylum seekers in detention, nor for the preceding two years, at the time of writing this handbook[39].

All asylum seekers have the right to access publicly funded health services**,** including enrolling in general practice and referrals to secondary care, once they have a letter from Immigration New Zealand confirming their confirmation of claim form (INZ 1071) has been received. This eligibility is also clearly stated on the National Enrolment Service (NES) form. Yet many asylum seekers and Convention refugees on temporary visas have been denied publicly funded healthcare. Sometimes this is because administrators are only familiar with the experiences of quota refugees and assume services are restricted to residents.

Action or practice points

- Check that asylum seekers and convention refugees on temporary visas know they are eligible for all publicly funded healthcare and ask if they have ever been denied this care.
- Include reception and support team staff in training, including to ensure asylum seekers and refugees on temporary visas are coded as eligible for public healthcare, and addressed by their chosen name and pronoun rather than based on their appearance or voice.
- Asylum seekers' and refugees' eligibility for public health services should be coded in patient management systems.
- Explain other rights, including eligibility for ACC-funded services.

Table 5: Health and social service provision comparison between quota refugees and asylum seekers

Health and social service provisions	**Quota Refugees**	**Asylum Seekers**
Residency	New Zealand resident on arrival	Must make a claim for refugee status. If granted, can then apply for permanent residence.
Introduction to living in Aotearoa New Zealand	An orientation to the Aotearoa New Zealand programme, provided at Te Āhuru Mōwai o Aotearoa includes cultural issues, support services, and education	No orientation programme to Aotearoa New Zealand is offered, so may be unaware of support services and benefit entitlements.

Accommodation for new arrivals	Initially accommodated at Te Āhuru Mōwai o Aotearoa, and thereafter in housing arranged for them prior to resettlement.	Must find their own accommodation, often without any financial support. Some emergency accommodation may be available through the Asylum Seekers Support Trust
Access to health screening/ health care on arrival	Receive free comprehensive health screening/health care, offshore, on arrival, and follow-up treatment and management as required.	Free health screening is available through some regional public health services. Eligible for publicly funded health care, however individual(s) may not be aware or be turned away from health services due to visa status.
English language instruction	Receive free language instruction at Te Āhuru Mōwai o Aotearoa, which continues to be available when they move into the community. Eligible for study grants to learn English.	Asylum seekers to contact Work and Income regarding eligibility for funded English for speakers of other languages (ESOL) support.
Resettlement in Aotearoa New Zealand	Provided with sponsors to assist with their resettlement.	No formal assistance is offered to support day-to-day living. Limited support is offered through the Asylum Seekers Support Trust[37].
Financial assistance	*Eligible for:* emergency benefits, including hardship provisions, such as an accommodation supplement, disability allowance or special needs grants. They can access establishment grants to help meet initial costs.	Asylum seekers are to contact Work and Income regarding eligibility for financial assistance.

(Modified from Ministry of Health, 2012[30])

4.1.3 Refugee Family Support Category resettlement support

People arriving under the Refugee Family Support Category (RFSC) arrive directly at the location of their sponsor. The New Zealand government covers the costs of offshore health screening and travel to Aotearoa New Zealand. It is then the responsibility of the sponsor to ensure adequate housing and access to services when their family members arrive. There is usually no systematic prior notification to settlement providers or health providers of an upcoming arrival under this category.

Families who arrive through this process can access some government-funded support, as well as receive navigation and community orientation support from the regional settlement provider. The support agency is expected to carry out home

visits for new arrivals. Some support may be accessed prior to the sponsored person arriving in Aotearoa New Zealand.

4.1.4 Community Refugee Sponsorship Category Resettlement support

Sponsored refugees arriving in Aotearoa New Zealand under the Community Refugee Sponsorship (CORS) programme are resettled directly into the community and supported by the sponsoring community organisation for up to two years.

4.1.5 Refugee-like migrant resettlement support

Refugee-like migrants (RLM) may be supported by family members who have already settled in Aotearoa New Zealand. There is no routinely formalised additional refugee-specific support and resources available to this group beyond what is included in their visa entitlements.

4.2 Language Assistance Services

The Language Assistance Services Programme (https://www.mbie.govt.nz/cross-government-functions/language-assistance-services/) is a cross-government, multi-year work programme intended to improve access, quality, consistency and coordination of language assistance services in the public sector. It was established in 2017 to implement the recommendations of a comprehensive review of the provision of interpreting and other language assistance services across government agencies. It seeks to provide equitable access to public services and information for non-English speaking clients such as refugees and migrants.

Currently, 63 government agencies have access to language support through the Language Assistance Services Programme (LAS) which is needed to ensure communication with their clients from diverse cultural and linguistic backgrounds. Government users include the Ministry of Business, Innovation and Employment including Immigration New Zealand, Ministry of Social Development, Inland Revenue, Te Whatu Ora, New Zealand Police, Kainga Ora – Housing New Zealand, Accident Compensation Corporation, Ministry of Justice, and others, including NGOs such as Citizen Advice Bureaus (CABs), Shakti Community Council and Community Law. For a full list of participating agencies, go to: https://www.mbie.govt.nz/cross-government-functions/language-assistance-services/participating-agencies/.

The Language Assistance Services Programme has multiple facets:

- Language assistance services (https://www.mbie.govt.nz/cross-government-functions/language-assistance-services) – remote interpreting support that helps government agencies communicate with clients with limited to no English proficiency. Interpreters are available on demand in less than 60 seconds through telephone and video platforms. The service is available 24 hours a day, seven days a week, in over 120 languages. Rare languages and video interpreting may need pre-booking. For more information, see How to use the Telephone/Video Interpreting Service at: https://www.mbie.govt.nz/cross-government-functions/language-assistance-services/telephone-video-interpreting-service/how-to-use/.

- Face-to-face interpreting panel (https://www.mbie.govt.nz/cross-government-functions/language-assistance-services/face-to-face-interpreting-service/) – professional language service providers who have been appointed to offer face-to-face interpreting services in a range of languages throughout the country. These include over 200 community languages (https://www.mbie.govt.nz/cross-government-functions/language-assistance-services/face-to-face-interpreting-service/community-languages-providers-by-location/), Te Reo Māori (https://www.mbie.govt.nz/cross-government-functions/language-assistance-services/face-to-face-interpreting-service/te-reo), and New Zealand Sign Language (https://www.mbie.govt.nz/cross-government-functions/language-assistance-services/face-to-face-interpreting-service/nz-sign-language-by-location/).
- National Accreditation Authority for Translator and Interpreters (NAATI) system of interpreter standards and certification requirements (https://www.mbie.govt.nz/cross-government-functions/language-assistance-services/new-standards-and-certification-requirements/) – minimum standards for interpreters working across government, including accreditation and interim modalities, and guidelines which will set out agency best practice in the planning, funding, and delivery of public services to clients from non-English speaking backgrounds. From 1 July 2024, all interpreters for government agencies will require NAATI certification.

Table 6: Telephone/video interpreting: Top 10 participating government agencies December 2022 – November 2023

	Agency	**Calls/year**
1.	Ministry of Business, Innovation & Employment | Hīkina Whakatutuki	19333
2.	Ministry of Social Development | Te Manatū Whakahiato Ora	10695
3.	Inland Revenue Department | Te Tari Taake	9314
4.	Te Whatu Ora | Health New Zealand	6384
5.	New Zealand Police | Ngā Pirihimana o Aotearoa	3671
6.	Kainga Ora | Housing New Zealand	3629
7.	Accident Compensation Corporation | Te Kaporeihana Āwhina Hunga Whara	3439
8.	Ministry of Justice | Te Tāhū o te Ture	1105
9.	Department of Corrections | Ara Poutama Aotearoa	501
10.	Auckland Council | Te Kaunihera o Tāmaki Makaurau	412

(Ministry of Business Innovation & Employment[40])

Table 7: Telephone/video interpreting: Top 10 requested languages December 2022 – November 2023

	Language	Requests/year
1.	Mandarin	21234
2.	Spanish	4967
3.	Samoan	4367
4.	Arabic	4211
5.	Hindi	3485
6.	Korean	2406
7.	Persian (Farsi)	2150
8.	Cantonese	2122
9.	Dari	1484
10.	Tongan	1418

(Ministry of Business Innovation & Employment[40])

Focus area: Rainbow refugees

Rainbow Path

(Rainbow path will use the term refugees in this chapter because many Rainbow refugees living in Aotearoa do not have residency and their only immigration status for many years is as a refugee. Therefore, former refugee do not describe their experiences.)

Every person has a sexual orientation, gender identity and expression, and sex characteristics (SOGIESC). In this handbook, we use the umbrella terms LGBTIQ+ and Rainbow to describe the vast and intersectional range of people whose sexual orientation, gender identity, gender expression, or sex characteristics differ from majority norms. Rainbow people span all regions of Aotearoa New Zealand, are of all ages, abilities and faiths, and represent all ethnic and cultural backgrounds[41].

Language is shifting and evolving all the time, and Rainbow people use a range of words and names to talk about their identities and experiences. Asylum seekers and others from refugee or refugee-like backgrounds may not be known or identify with these terms. Some may have terms in their languages but often these are derogatory, signalling that Rainbow people are not accepted[41]. You may not always be aware when someone accessing your service, or their family member, is lesbian, gay, bisexual, transgender, intersex, queer or has another Rainbow identity (LGBTIQ+).

Rainbow asylum seekers and refugees have often been rejected because they do not fit very narrow, fixed life pathways prescribed for them, based on the sex they were assigned at birth.

Table 8: Examples of Rainbow identities

Characteristics	Definition of Rainbow Identities	Some Examples
Gender identity	Those who do not identify as the girl or boy that people assumed they were when they were born	Trans girls and women, hijra, fa'afafine, trans boys and men, or non-binary people
Gender expression	Those whose mannerisms, clothes, hairstyles, ways of talking or walking are different from what's expected of a female or male	People who are androgynous, femboys, tomboys, and those who perform drag
Sexual orientation	Those who are attracted to someone of the same sex, or who do not identify as being heterosexual	Lesbian, gay, bisexual, pansexual, asexual or queer people
Variations in sex characteristics	Those whose natural chromosomes, hormones, or internal or external	Intersex people or those born with specific intersex variations

	anatomy differ from the majority norms for females and males	

Action or practice points:

- Be aware that there will be refugees and asylum seekers who are LGBTQI+.
- Build trust and leave space for people to ask questions about sexuality, gender identity or having an intersex variation.
- To understand a person's identity, listen to them, connect, and ask respectful questions about the terms they use to describe their identity. This is more important than learning a list of English language Rainbow identity terms.
- Use inclusive language, such as partner, rather than boyfriend, girlfriend, wife, or husband.

In their countries of origin, many Rainbow asylum seekers and refugees face discrimination, violence, and persecution, for breaking any of these majority norms. This targeting may be codified in civil and religious laws and is routinely enforced by communities, including through conversion practices[42], with violence against lesbians and bisexual women often hidden within the home[43]. For some people, persecution based on their rainbow identities may have been the primary grounds for their designation as refugees.

As of May 2024, 62 United Nations Member States still criminalise consensual same-sex sexual acts, with six imposing the death penalty and in a further five countries the death penalty is possible[44]. In many countries, gender identity or expression is illegal under so-called "cross-dressing" or "public immorality" laws[45]. Many of the laws criminalising sexual orientation or gender identity came to countries through colonisation. In many countries, intersex people born with variations of sex characteristics are shunned, considered to be a curse, and may be forced to undergo medical treatments or have surgeries without their consent[46].

Often there are no laws protecting Rainbow people, with police, religious and other community leaders sanctioning this violence. This affects all parts of Rainbow people's lives. There may be pressure to suppress or hide their identities, as they may be excluded from accessing school, employment, housing, and general health services. In addition, there is limited or no support for Rainbow-specific health issues, including transgender people's access to medically necessary gender-affirming healthcare.

Action or practice points

- Reassure Rainbow people that they are safe and protected by laws in Aotearoa.
- Mention that there are Rainbow communities and support networks, and offer to connect the person if they want, when they are ready.

At each stage of their journey to safety, Rainbow people face extra challenges because of their sexual orientation, gender identity or expression or sex characteristics[47]. Often, they have no support, and may also be escaping from their

family and community. Fleeing on their own is especially unsafe for lesbian and bisexual women and for transgender and intersex people. Rainbow asylum seekers may not know when it is safe to disclose their identity or have words to describe who they are. Many hide their Rainbow identity, fearing exploitation or extortion if others find out.

Most countries Rainbow refugees and asylum seekers have fled from do not allow transgender and intersex people to change their name or gender marker on ID cards or passports[45]. But these documents must be shown to cross borders and to make refugee claims. If someone does not look like their ID documents, this exposes them to great risk.

For all these reasons, many Rainbow refugees and asylum seekers may still be on a journey to fully understand and accept their Rainbow identities when they arrive in Aotearoa New Zealand.

Action or practice points

- Take time, let the person develop trust in you and find out what they need.
- Give information about options that are accessible and offer space and time to ask questions and process this information. Then check back in the future to ask about their needs.
- Be aware that Rainbow people may not have had access to education and information about their bodies or healthcare including gender-affirming care. In many countries, this material may not be available.
- Provide a positive and welcoming environment for Rainbow people, including images of LGBTIQ+ people and having a gender-neutral bathroom. This means that people will be more likely to disclose their Rainbow identity, and you can provide tailored support to them.

Rainbow asylum seekers and refugees in Aotearoa New Zealand typically have not disclosed their Rainbow identity or Rainbow-specific health needs with a doctor in their country of origin. Some may have experienced conversion practices from health professionals or risked being criminalised if they were HIV+. So they may be less likely to disclose these personal parts of who they are until health and other service providers demonstrate that it is safe to do so.

Action or practice points

- Ensure confidentiality, as there are very real fears and risks for many Rainbow asylum seekers or refugees if their Rainbow identity or refugee status is disclosed.
- Do not discuss someone’s Rainbow identity or immigration status in a public reception area, to protect their safety and privacy.
- Collect any sensitive information in a private room or on forms or devices.

- Check whether phone interpreting may offer someone more confidentiality. However, some transgender people may be less comfortable using the phone if people misgender them based on their voice.

In Aotearoa New Zealand, Rainbow asylum seekers and refugees face the same structural and interpersonal barriers of racism, xenophobia, and Islamophobia as other asylum seekers, refugees, and migrants of colour[26]. In addition, Rainbow asylum seekers and refugees often don't have access to their cultural communities here for help with language, jobs, housing, and social support, and do not trust they will be accepted and safe in those communities[48].

For those with partners left behind and little public evidence of a relationship that had to be hidden because it was taboo or illegal, reunification can be a struggle. Those who do manage to bring a partner are then excluded from Aotearoa New Zealand's main family reunification pathway, as policy settings are based around bringing family members first. Often Rainbow refugees face severe isolation, miss their families and communities despite their rejection, and feel guilty about those left behind.

> *"I was told by a mental health professional (in New Zealand) that my family persecuted me for being Rainbow because they loved me and they did it for my own good. That put me off seeking mental health support for years."* [49]

> *"People often either pressure me to reconcile with my family or encourage me to cut them off. But it's often unsafe for me, and I often get hurt again when I reach out to them. At the same time, as someone from a collective culture, it is impossible to just walk away from your family. I'm often torn apart by the guilt that I couldn't be there for them."* [49]

Action or practice points

- Assess the safety of the person regularly, especially in terms of housing, and what interactions they have had accessing support from service providers and government departments.
- Offer trauma-informed care and ensure that any referrals are made to clinicians who can provide both culturally safe and rainbow-affirming healthcare.
- Address isolation by connecting people to support services you know are competent in supporting Rainbow asylum seekers and refugees.
- Ask whether a Rainbow asylum seeker or refugee has or wants family support.
- Ask whether a Rainbow person is comfortable being referred to support groups or agencies run by others from their country or cultural community, or who speak their first language.
- If interpreters are needed, also offer interpreters who are from outside the Rainbow person's cultural community or country of origin.

Most transgender and/or intersex asylum seekers and convention refugees do not initially have usable identification document ID in Aotearoa, so struggle to open a bank account, get an emergency benefit, or work or a place to stay[50]. Only permanent residents can change their name here, and that process can take asylum seekers many years. It can be difficult for asylum seekers to find a low-cost general practitioner, including if practices only register someone once they have a community services card. That process can be delayed for months for Rainbow asylum seekers, especially those without a usable identification document or card who struggle to meet all the steps needed to get an emergency benefit and therefore a community services card.

> *"When the only form of identification you have is not recognised or accepted, it's not just a document being turned down but your personhood being rejected like you're not recognised as the human you are. It's deeply humiliating and damaging."* [49]

Despite these significant barriers, patients can choose the name and gender on their health clinic enrolment forms, the National Enrolment Service, and their National Health Index number[51]. **These details are not required to match the outdated names and gender markers on an overseas passport.**

Action or practice points

- Ask people to check that any previous details you have been given about them are the ones they would like you to use, and then respect the person's chosen name and pronouns.
- Reassure people that name and gender details do not need to match what is on their passport or other legal documents.
- It can be useful if clinic forms give people the option to state if there are different details they want to be used in specific circumstances (e.g., the name on letters to their home address, or when being called in the waiting room)

In addition to general health needs, Rainbow people may have some specific health needs related to being lesbian, gay, bisexual, queer, transgender, and/or intersex. Examples include sexual healthcare, such as sexually transmitted infection (STI) screening and access to PrEP, gender-affirming care such as hormones and surgeries, and health issues linked to past treatments for an intersex variation. The availability of gender-affirming services varies between regions. Pathways through secondary health services may result in delays of months or more than a year before a patient is able to obtain hormone therapy[52].

Transgender asylum seekers and refugees may have purchased hormones for many years overseas, with or without medical support. Some arrive in Aotearoa New Zealand with no relevant medical records or documentation about the type and dosage of hormones they have been using or may request hormones that are not subsidised here. Primary Care Guidelines released in 2023 give general practitioners and nurse practitioners tools and information to safely initiate or maintain gender-affirming hormone therapy for transgender patients[53].

Some regions have up-to-date advice on transgender health available on Community HealthPathways, or via access to a speciality service like Hauora Tāhine (https://www.countiesmanukau.health.nz/our-services/a-z/hauora-tahine-pathways-to-transgender-healthcare-services/) where general practitioners and nurse practitioners can request specialist advice about prescribing hormones. Such requests should contain all the information the health professional has about their patient's previous hormone use, including how long they have taken hormones and the effects the patient has already experienced. Longer than usual appointments with a transgender patient may be needed to collect all this information.

Action or practice points

- Seek further information about health issues for LGBTIQ+ people on Community HealthPathways.
- For further advice about prescribing gender-affirming hormones, connect to primary

Artwork by Huriana Kopeke-Te Aho

About the Author

Rainbow Path Aotearoa *is a refugee-led advocacy network and peer support community for Rainbow refugees and asylum seekers living in Aotearoa New Zealand. For more information, go to https://rainbowpathnz.com/*

4.3 Te Āhuru Mōwai o Aotearoa - Māngere Refugee Resettlement Centre

Those who arrive in Aotearoa New Zealand as part of the Refugee Quota Programme are welcomed to Te Āhuru Mōwai o Aotearoa, where they participate in a five-week programme delivered in partnership with government agencies and non-government organisations to facilitate successful resettlement and transition to life in Aotearoa New Zealand.

Key focus areas for the reception programme are:

- **Health** assessment, screening, treatment, education, and health promotion.
- **Social** support, settlement planning, including orientation to working and living in Aotearoa New Zealand and an employment assessment for those of working age.
- **Education** including English language. Children in the Early Childhood Education (ECE), Primary and Secondary sections are prepared for their introduction into the Aotearoa New Zealand classroom and national curriculum. Adults receive English language courses, at distinct learning levels.

4.3.1 Health

Before arriving in Aotearoa New Zealand, the Refugee Health Liaison Team at Immigration New Zealand work with the Refugee Quota Programme to ensure that the known health needs of individuals can be met in their resettlement regions.

Health screening is about providing a person arriving in Aotearoa New Zealand with the best possible start to their new life and is only rarely about identifying population health infection risks. Most health conditions affecting people arriving in Aotearoa New Zealand are long-term conditions similar to those in the overall population, with changes to risk because of a person's prior health background and refugee journey[54].

The Māngere Refugee Health Service has an onsite primary healthcare service at Te Āhuru Mōwai o Aotearoa where health screening and any health management started offshore is continued.

Every individual is allocated a scheduled appointment with the primary care team, allowing completion of general health screening, and including if required, sexual health assessment, gynaecological assessment, sensitive exams, cervical screening, and family violence screening. At this point, initiation of medical management, continuation of catch-up immunisations, and referrals to specialist care are organised as required. Pregnant women/people are seen by the Counties Manukau midwifery team. Alongside planned care, individuals also can attend to acute care needs.

Onshore health screening after arrival is carried out in accordance with current best practice guidelines, available on the Community HealthPathways platform.

- **Community HealthPathways – Refugee Health Screening covers** recommendations for initial health assessment, laboratory testing and management of common presenting situations in people with a refugee background.
- **Community HealthPathways – Refugee Health** separately covers long-term health concerns for adults with a refugee background and children with a refugee background.

Table 9: Health screening guidance for people with a refugee background

Take a comprehensive health history	**General medical history:** Consideration should be given to social history (birth date discrepancies, migration history, language preferences and social supports). **Immunisation history:** Where documentation is not available a full catch-up immunisation schedule should be offered. **Lifestyle history:** Consider any risk factors for vitamin and micronutrient deficiencies. Drugs or other substance misuse may include less familiar substances such as betel nut or leaf, sheesha or khat. **Family violence history:** People with a refugee background may have additional vulnerabilities such as language barriers, isolation, migration factors, gender norms and tension related to changed family roles. **Mental health history:** Rapport and trust are critical, and this history may need substantial time to elicit. **Additional history taking may be needed for specific population groups:** *See focus area chapters*
Examine the patient	Clinical examination requirements will depend on the patient's presentation. Quota refugees may have had a more extensive onshore physical assessment at Te Āhuru Mōwai o Aotearoa. People in good health may require very little clinical examination.
Invite the person to participate in health screening if indicated	• Cardiovascular Risk Assessment • Cervical screening • Breast screening • Bowel screening
Arrange investigations	**Tuberculosis screening:** If the person has not been tested within the last six months arrange an age-appropriate test with local public health unit guidance. **Parasite screening:** Not required if a person has received albendazole and ivermectin, is immunocompetent and asymptomatic, and is not from a schistosomiasis-endemic country.

	It is important to advise the laboratory regarding refugee background and travel history to ensure appropriate testing. **Blood tests:** If the patient has abnormal offshore results these can be acted on. If they have not been tested or have had normal results but are considered at-risk then further testing may be indicated. Tests may include HIV, syphilis, hepatitis B, hepatitis C, FBC, ferritin, renal function tests, liver function tests, calcium, vitamin D, HbA1c, lipids, thalassaemia screening, and B12 / folate. **H. pylori stool antigen:** If the person is aged 18 years or older and symptomatic. **Sexual health:** Consider sexually transmitted infection testing if indicated. See *Aotearoa New Zealand STI Management Guidelines for use in primary care – Refugees and asylum seekers*[55].

(Table adapted from Community HealthPathways - Refugee Health Screening[56])

Health screening is an important starting point for former refugees but is a relatively small part of high-quality health care. In the long term, health professionals need to pick up and help manage health and social conditions as they arise. Only some will have a particular relationship with refugee background experiences. Health professionals can easily develop a biased view that refugee patients all have many health problems, which may in part be due to their experience with a smaller number of former refugees with very high and complex needs.

It is worth considering that some people may have had excellent determinants of health and health care prior to becoming displaced, and others may have had very poor determinants of health and health care. Many former refugees arrive healthy, remain healthy, and only rarely see a health professional.

A specialist mental health and wellbeing support service for refugees and asylum seekers, Refugees As Survivors New Zealand (RASNZ) is based at Te Āhuru Mōwai o Aotearoa. RASNZ integrates clinical and community services for whānau. Services include specialist mental health assessment, treatment, and liaison on arrival at Te Āhuru Mōwai o Aotearoa, a community-based clinical mental health team servicing the wider Auckland region, a community team which runs psychoeducation programmes, and a youth team for young people from refugee backgrounds aged 13-22 years. Services vary in other regions.

If any new or not previously known health needs arise while residing at Te Āhuru Mōwai o Aotearoa that cannot be met in the allocated resettlement region, the Māngere Refugee Health Service advise the Refugee Quota Programme about these needs to facilitate suitable settlement options.

Social support

Prior to departing Te Āhuru Mōwai o Aotearoa for the resettlement region, individuals and families are introduced to their respective local settlement support providers. Where possible this is usually via an in-person introduction, with a representative from the local settlement team travelling to Te Āhuru Mōwai o Aotearoa towards the end of the orientation. Increased support and resourcing are extended beyond this

initial welcome period for 12-24 months through refugee resettlement programmes in each location. Some individuals may require community law support or referrals to immigration assistance for family reunification.

Table 10: Regional refugee resettlement programmes

Region	Provider
Auckland	Kāhui Tū Kaha https://kahuitukaha.co.nz/
Hamilton	Hamilton Multicultural Trust https://www.hmstrust.org.nz/
Palmerston North, Levin, Masterton, Wellington, Nelson, Blenheim, Dunedin, Invercargill	NZ Red Cross https://www.redcross.org.nz/
Christchurch	Purapura Whetu Trust https://www.pw.maori.nz/
Ashburton	Safer Mid Canterbury https://www.safermidcanterbury.org.nz/
Timaru	Presbyterian Support South Canterbury https://pssc.org.nz/

4.3.2 Education

The Auckland University of Technology (AUT) Refugee Education Centre provides an on-arrival education programme at Te Āhuru Mōwai o Aotearoa. This programme is expected to be a new physical and cultural learning environment for former refugees, so arrivals are introduced to the structure and format for classroom education in Aotearoa New Zealand. Students are given the opportunity to develop English language, literacy, and other skills as well as the chance to reflect on the challenges of entering a new society. Programmes for the Early Childhood Education (ECE), Primary, Secondary, and Adult Sections, focus on the strengths and resilience, languages, cultures, and aspirations of the learners.

4.4 After Te Āhuru Mōwai o Aotearoa: Leaving for resettlement

After completing the reception programme, former refugees are settled throughout Aotearoa New Zealand in one of thirteen locations. These locations are Auckland, Hamilton, Palmerston North, Wellington, Nelson, Christchurch, Dunedin, Invercargill, Blenheim, Timaru, Ashburton, Levin, and Masterton. Immigration New Zealand provides an indication of the annual composition of each of these settlement locations to allow resources and planning to be undertaken.

It should be noted that former refugees do not choose the resettlement location. Immigration New Zealand determines the regions where the former refugee will settle prior to their arrival in Aotearoa New Zealand. Should they choose to move away from the allocated region during the initial period of resettlement, formal support services are no longer provided to them.

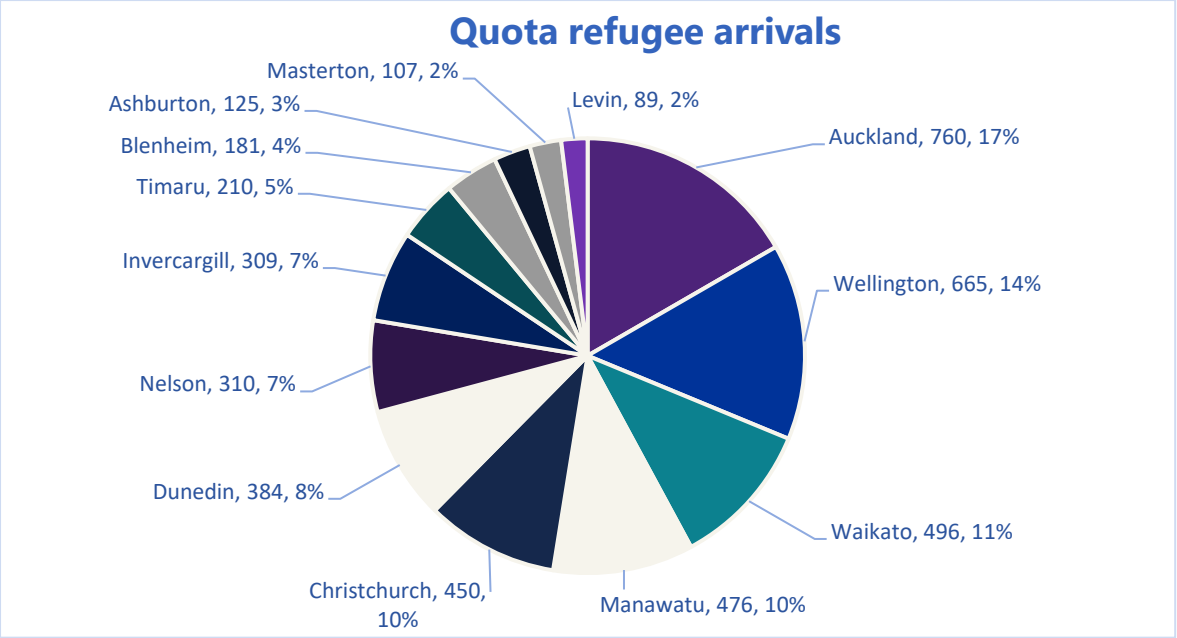

Figure 1: Quota refugee arrivals by settlement locations 1 January 2019-31 January 2024. (Immigration New Zealand[57])

Immigration New Zealand arranges regional housing alongside the local settlement support provider, which provides on-the-ground house checks and support. This is generally agreed upon prior to onward regional resettlement and can be in the form of either public housing or private rentals.

The Māngere Refugee Health Service team at Te Āhuru Mōwai o Aotearoa provides a written handover of health care provided to each person's nominated clinical lead or primary practice in each of the settlement locations. In some settlement locations, this process is fast-tracked and enrolment with local general practices can occur prior to the person departing from Te Āhuru Mōwai o Aotearoa. In these regions, the electronic transfer can be initiated when the patient leaves the centre and should be with the general practitioner within five working days.

When patients are enrolled with a local general practice, the general practice should email Māngere Refugee Health Service to request an electronic (e.g., GP2GP) transfer of notes. Include the standard information required for electronic notes transfer such as the clinic name and EDI address, the name of the receiving clinician and medical council number and the patient enrolment forms.

Referrals to hospital and specialist services are sent via the local e-referral platform to every settlement region except for Masterton, Levin, and Palmerston North. In these three locations, referrals are sent by e-mail. Accepted referrals which originate at Te Āhuru Mōwai o Aotearoa are expected to be followed up by the new general practitioner. Māngere Refugee Health Service will follow up on declined referrals and may reach out to the new general practitioner to make appropriate further plans.

Focus area: Sexual and Reproductive Health

Former refugees will have differing experiences of access to and understanding of sexual and reproductive care. This area of health is likely to be influenced by cultural and social norms that may differ from those of practitioners within the Aotearoa New Zealand healthcare system. The assistance of a trained interpreter and, where available, multilingual written and pictorial information will help to bridge communication and ensure understanding.

Assessing previous access to population-based screening such as breast and cervical, sexually transmitted infection (STI) screening and another relevant testing, e.g., prostate-related tests, is important for assessing knowledge, health literacy and needs in these areas. For those who have resettled via Te Āhuru Mōwai o Aotearoa, some screening may have already been undertaken onshore and may require follow-up. For others, health screening may begin on arrival to primary care.

Confidentiality

Ensure confidentiality is explained and emphasised and limitations to confidentiality are understood where there is a risk to self, others or dependents identified. Where language assistance is required ensure the use of a NAATI accredited interpreter. Explaining the interpreter training and adherence to a code of ethics will help to allay patient concerns around the disclosure of sensitive information. Requesting an interpreter not linked to the patient's community may also be useful.

> *"Confidentiality within the consultation should be emphasised as well as the fact that resources and support are available if violence is disclosed. Re-establishing trust is essential to emotional recovery for women who have experienced pre and/or post-migration trauma. Development of a quality therapeutic relationship with a primary care provider can be an important part of this recovery process"* [58]

Sexual Health Screening

Asylum seekers and those entering Aotearoa New Zealand through other refugee categories such as the Refugee Family Support Category are not provided with routine sexual health screening as part of their application process. Aotearoa New Zealand STI Management Guidelines for refugees and asylum seekers are particularly helpful for those who have not come via Te Āhuri Mōwai o Aotearoa and who require screening in primary care [Link Refugees and asylum seekers | NZ STI Guidelines].

It is important to ensure that sexual orientation, sexual preferences, and gender identity are discussed as appropriate so screening can be arranged and options such as PreP, PeP and support services can be offered where appropriate. More information can be found in the *Focus area: Rainbow refugees*.

Family planning considerations and sexual health screening for women who have experienced female genital mutilation (FGM) can be found in the *Focus area: Female genital mutilation (FGM)*.

Contraception

Understanding prior experience of contraception will provide insights into the risk of unplanned pregnancy and a contraceptive and obstetric history will be needed. Choices around contraception may be a shared decision between partners and may be influenced by religion, culture, and gender roles. Rather than make assumptions, use the approaches discussed in the 'Ways of Working' section to explore beliefs and goals. Provide information on emergency, reversible and irreversible forms of contraception[58].

Unplanned Pregnancy

Unplanned pregnancy will require information on options available, including abortion. There will be a variety of experiences and beliefs around termination of pregnancy. Again, not making assumptions and providing a non-judgemental approach with help to ensure information on all options and a safe space for discussion are provided.

Family Violence

Risk factors for family violence are layered and can include isolation, employment conditions, financial and emotional dependence, migration factors, gender norms and values, employment conditions and racism [59]. The risk of family violence is increased for women forced from their homelands and can occur at any stage of the refugee journey[60].

As rapport is established and confidentiality is understood, former refugees who have experienced family violence may feel safe to disclose. Underreporting of family violence in ethnic and migrant communities is common [59] due to the above risk factors as well as the risk of social stigma and/or community ostracization [58]. Discrimination, institutional racism and a lack of culturally appropriate services also present barriers to seeking support. Those with uncertain migration status may be particularly reluctant to disclose family violence, fearing negative impacts on migration status or asylum claims.

Sexual Violence

A history of sexual violence may be disclosed at any stage of the resettlement journey and offering support along with the appropriate physical health screening is critical. Support may be to a specialist sexual abuse support service or specialist refugee mental health service such as Refugees as Survivors or Refugee Trauma Recovery. Ensuring the support provider has the resources available to offer a trained interpreter is essential for those requiring language assistance. An introduction, referral, or handover to the support provider with the appropriate consent may provide a more supported and easier entry into another service[58].

Family Violence Screening Questions:

"We ask everybody over the age of 16 years about safety in the home. Have you ever been hurt or frightened by someone close to you in the past? Have you felt controlled or always criticised in your relationship? Have you been made to do anything sexual that you did not want to do?

Because family violence affects health, we are asking all our patients about it. Any information you wish to tell me will be kept secure and not disclosed to anyone without your permission unless I feel that somebody's life or safety might be in danger.

- Is there anyone in your life whom you are afraid of, who hurts you in any way, or prevents you from doing what you want?
- Is there anyone at home who makes you feel you are no good or worthless?
- Have you ever had a relationship with someone who made you feel afraid, hurt you, or made you have sex when you didn't want to or in a way you didn't want?
- Are you afraid of your partner or ex-partner?
- Have you been hit, kicked, punched, or hurt by someone in the last year?

Community HealthPathways[61]

5 Living in Aotearoa New Zealand

"Despite having fled Syria ten years ago, I still wake up in the middle of the night to operate in that time zone. Living as far as it can get from my first home does not mean I cannot try to improve the lives of people still living there. That doesn't make me less of a Kiwi, either. I'm lucky to have two countries I can wholeheartedly call home— one in the Middle East and the other in Middle Earth"

Former refugee, ChangeMakers Resettlement Forum[62]

"I had always dreamed of becoming a nurse. Aotearoa made my dream come true. My family and I were well looked after by the people of Aotearoa with their kindness and hospitality. Now it is my turn to give back that kindness"

Former refugee, ChangeMakers Resettlement Forum[63]

5.1 Social determinants of health

Once in their resettlement locations, former refugees embark on making a new life. There are several factors which are key to determining positive health and wellbeing. These factors are known as the social determinants of health and, while they contribute to successful resettlement experiences, they are often significantly disrupted for former refugees. Disruption is experienced prior to leaving a country of origin and during the period before arriving in resettlement countries such as Aotearoa New Zealand. The stressors of becoming a refugee and the refugee journey are diverse and of varying severity, but many people will experience poor living, working and housing conditions, inadequate health services, a lack of social cohesion, and limited safety and security[64]. They may also be exposed to discrimination, xenophobia and violence[65].

On resettlement in Aotearoa New Zealand, social determinants of health have a profound effect on the health and wellbeing and overall resettlement and integration of former refugees. Ager and Strang[66] identified determinants key to successful integration and positive health and wellbeing. These included *facilitators* - language, safety, and stability; *social connections* - social bridges, bonds, and links; *markers and means* - employment, housing, education, and health.

Unfortunately, there is growing evidence to suggest that the resettlement experiences of former refugees in countries like Aotearoa New Zealand are plagued by inequitable access to these social determinants due to systemic issues of racism, discrimination, and poverty.

Health and social care providers play an important role in helping to improve equity in the wider social determinants that affect health and wellbeing. One way this can be achieved is by ensuring former refugees experience respectful, culturally safe, dignified and empathetic care, with information, options, referrals and advocacy when needed[67]. How we work with refugee-background people matters.

6 Ways of Working

6.1 Enhancing refugee health care

Figure 2: Underlying principles for enhancing health care of former refugees

The above model developed by Nurse Practitioner Serena Moran depicts the underlying principles for enhancing the health care of former refugees. While its origins are in primary health care, the principles are applicable across all health and social care settings. The underlying principles of the model include human and strengths-based approaches, inter-collaboration, cultural safety and the five domains of health and wellbeing as depicted in Te Whare Tapa Whā, a Māori model of health, developed in 1994 by Sir Mason Durie[68].

The model also outlines eight components required to provide effective healthcare to former refugee populations:

- Access
- Engagement
- Health Screening and Management
- Long Term Condition Management

- Support
- Health Education and Promotion
- Training and Research
- Advocacy and Social Change

The eight domains highlight the importance of a whole-of-system approach to providing care to former refugees. From ensuring access and engagement to ongoing training and research to enhance care, and advocacy and social change to influence policy and improve the social determinants of health.

6.2 Māori models of health

Māori are the tangata whenua, the indigenous people of Aotearoa New Zealand. While Māori are diverse, there are shared cultural concepts which are used in Māori models of health such as Te Whare Tapa Whā as pictured below[68]. Unlike Western biomedical models of health that traditionally separate the physical from the mental and the environmental from the clinical, Te Whare Tapa Whā seeks to connect these domains believing that wellbeing is achieved when the physical, mental, spiritual, social and connection with land and community is in harmony.

Applying Te Whare Taha Whā proves useful when working with former refugees who require a connected and integrated approach to support them in building and strengthening their physical, mental, spiritual, and social wellbeing and finding a sense of belonging and connection to the new land they find themselves upon.

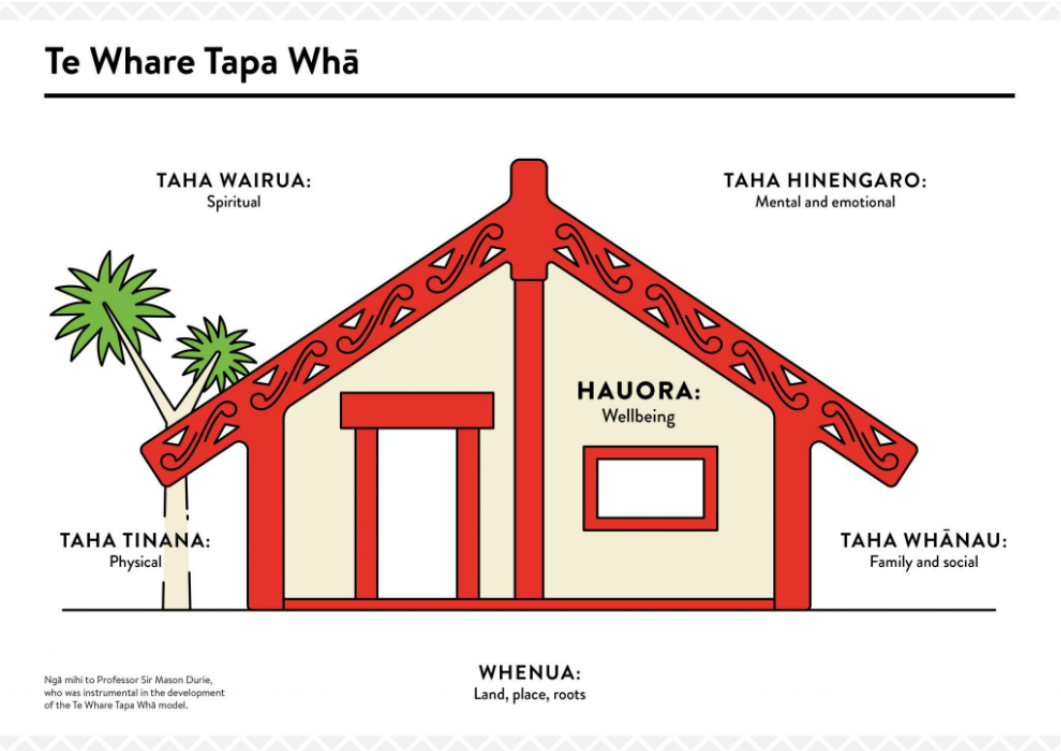

Figure 3: Te Whare Tapa Whā, Sir Mason Durie (1984)

6.3 Rights-based approaches to health

"*A human rights-based approach incorporates concepts that support people to realise their human rights. This includes non-discrimination, social justice, participation, and accountability.*" [69]

"*Health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right*." [70]

Human rights violations are at the centre of the refugee experience. Upholding human rights is therefore central to ensuring former refugees can settle, participate and thrive in a new society. This handbook goes beyond a sole focus on the resettlement *needs* of former refugees and prioritises a focus on *rights,* shifting the health services paradigm to one of understanding, equality, inclusion, participation and partnership[71].

The World Health Organization recognises health as a fundamental right of every human being[70]. The International Covenant on Economic, Social and Cultural Rights recognise the right of "everyone to the enjoyment of the highest attainable standard of physical and mental health" [72]. Ensuring access to timely, high-quality, acceptable health services which meet and are informed by the needs and aspirations of former refugees is paramount in ensuring this right is upheld.

The Code of Health and Disability Services Consumers' Rights[73] provides health practitioners with a rights-based framework within which to practice, contributing to a rights-based approach to health service provision in Aotearoa New Zealand.

At a systems level, a rights-based approach is informed by several international covenants, conventions, treaties and declarations[74] and requires governments, policymakers and organisations to provide affordable, accessible, acceptable, equitable and quality health services. The inclusion of former refugee communities in the identification of service gaps and requirements and design, delivery and evaluation of health care services cements a rights-based approach[69]. As practitioners, a rights-based approach requires our commitment to uphold the dignity, respect, and autonomy of former refugees without discrimination, and to provide flexible and responsive services. This approach engenders mutual understanding and trust.

It is also important to consider people's ability to assert or maintain their rights and this may be something former refugees, especially early on in their settlement, find challenging. Reduced autonomy and agency due to language, poverty, isolation, loss of social status and discrimination may result in rights being breached without redress.

The Code of Rights means that you should have:

Mā tēnei Ture Tiaki i ōu Tika, ka ahei kia u nga tikanga:

1. Respect
   Mana
2. Fair treatment
   Manaakitanga
3. Dignity and independence
   Tū rangatira motuhake
4. Appropriate standards
   Tautikanga
5. Effective communication
   Whakawhitiwhitinga whakaaro
6. Information
   Whakamōhio
7. Choice and consent
   Whakaritenga mōu ake
8. Support
   Tautoko
9. Rights during teaching and research
   Ako me te rangahau
10. Your complaints taken seriously
    Amuamu

Figure 4: The code of rights, Health & Disability Commissioner

Photo and artwork by Joel Bergner.

6.4 Strengths-based approaches to health

> *"Respect them as people … respect what they have been and what they can be … They were lawyers, policemen, doctors, teachers, and they come here and all of a sudden they have nothing… That's something to just always keep in mind."*
>
> Primary Care Nurse[75]

The refugee experience requires immeasurable perseverance, and resilience to overcome enormous challenges. Former refugees bring these qualities with them to

Aotearoa New Zealand, yet in amongst the challenges of resettlement, former refugees may also struggle to identify their strengths.

Health practitioners play a crucial role in assisting former refugees to identify their enablers by adopting a strength-based approach, rather than a deficit or problem-based approach. This approach requires health practitioners and service providers to identify strengths, knowledge, skills, resources, support systems and motivations[76]. Recognising the benefit that culture and language bring to individuals and communities is inherent in this approach and aids confidence, self-esteem, and wellbeing[77].

"Strengths-based case management allows service providers and participants to identify and highlight the strengths and assets participants possess, strengths that will help them succeed in their new communities. Taking time to examine strengths and resources is an ongoing process, as they can change and develop over time." [78]

Supporting former refugees to identify their strengths and to grow and utilise them can help to overcome the challenges of resettlement and improve long-term integration. A strengths-based approach fosters resilience and hope, is empowering, helps to grow trust and improves the therapeutic relationship[79].

6.5 Interprofessional collaboration

What is interprofessional collaboration?

An active and ongoing partnership often between people from diverse backgrounds with distinctive professional cultures and possibly representing different organisations or sectors, who work together to solve problems or provide services." [80]

"Collaborative care involves diverse service providers, aiming to build trusting working relationships between partners whose roles and contributions are recognized and adapted to the local context and culture of care and are flexible enough to follow the patient's changing needs." [81] (p. 204).

It is well known that interprofessional collaboration enhances care provided to people with complex health and social care needs[82]. Interprofessional collaboration puts the patient and whānau at the centre and a participant in their own care. It provides flexibility to meet changing needs, priorities, and expectations[81]. Working inter-collaboratively with other professional groups and agencies is important in ensuring the needs and aspirations of former refugees are met. It also provides support and mutual benefit for the health and social care providers involved in the care.

Former refugees are likely to have complex health and/or social needs, especially during the first years of their resettlement in Aotearoa New Zealand[75]. Needs are likely to be greater for those coming under the 'women at risk', and/or 'medical and disabled' quota categories, as well as asylum seekers and those entering under non-quota categories who miss out on tailored health and resettlement support.

Health and social care providers working in resettlement locations with refugee programmes and clinical leads in place can utilise their roles to help facilitate,

coordinate, and drive the collaboration between professionals and agencies, ensuring the right people and agencies are involved and roles are clear.

> *"I couldn't do this if I wasn't working in a team. Teamwork both within the service and also expectations of maintaining networks has been very important."*
>
> General Practitioner[83].

Regular interprofessional scheduled meetings in the resettlement locations with health and social care providers can be an efficient and practical way of keeping up to date with what's happening nationally and within the region and sector, and provide an opportunity for case collaboration around individuals, whānau, and communities, keeping in mind the importance of confidentiality.

It is essential to have social worker input for those former refugees identified as needing it, especially in the first years of resettlement. For quota refugees, this is provided through resettlement support, however, for asylum seekers, convention refugees and those coming under the Refugee Family Support Category, a community-based social worker will be able to assist with issues such as housing, income, employment, education, and family reunification[83].

New and emerging roles in primary health care and the community such as navigators, health coaches, and health improvement practitioners may be complementary with more time and flexibility than the traditional doctor, nurse, and social worker roles. They may also accommodate more practical support that other roles are unable to provide. Allied health practitioners are particularly important for older people, neurodiverse people, and those with disabilities.

> *"[The role] is wider than just your standard general practice role because refugees have a lot of other needs outside of health… it is like being a "communal garden GP"… the role is community focused and more social."*
>
> General Practitioner[75].

6.6 Cultural Safety

> *"The effective nursing practice of a person or family from another culture is determined by that person or family. Culture includes, but is not restricted to, age, or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual."* [84]

Former refugees come from diverse social, economic, and cultural backgrounds. Like the general population, former refugees have differing life experiences, health and social histories, educational backgrounds, and cultural understandings. The cultural identities, languages spoken and expectations of care among former refugees are likely to differ from what the majority of Aotearoa New Zealand's health and social care providers can or do offer.

The concept of kawa whakaruruhau, or cultural safety, provides a framework to ensure services are considered culturally safe by those receiving them[84,85, 86.] It is required at all – both individual and organisational – levels[87], and asks providers to understand themselves as culture bearers and question how power structures and assumptions inform processes within health and social care partnerships and organisations.

Culturally safe practice requires practitioners to consider how power structures and processes can enhance healthcare outcomes or contribute to further inequity[87-89]. Alongside clinical competence and ethical conduct, cultural competence is mandated for all health practitioners under The Health Practitioners Competence Assurance Act 2023 as defined by the relevant registration authority.

> *"It's no good saying: " I'll just treat them like anybody else"… That's not what equity and justice are all about. You've got to recognise that refugees need to be treated differently because otherwise, you will not meet their needs, and that's part of cultural competency."*
>
> General Practitioner[75]

The kawa whakaruruhau approach is about working in partnership with the patient or client while also recognising one's own culture, values, power, and advantage. It requires a collective examination of the political and cultural forces that shape healthcare and create inequities. It is about learning what is important to the former refugee, what they value and how their lived experience may influence their decisions. It is essential to recognise any assumptions or stereotypes we might make as practitioners based on the patient or client's ethnicity, culture, gender, or religion. This critical reflection will help to limit the impact of these assumptions and/or stereotypes on health management decisions[90].

Action or practice points

Seek to understand the following when working with former refugees:

- Views about causes of illness and disability.
- Expectations about ways in which illness and disability should be managed.
- Understanding and prior experience of 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.

6.7 Trauma-informed care

> *"Trauma is the lasting adverse effects on a person's or collective's functioning and mental, physical, social, emotional, or spiritual wellbeing, caused by events, circumstances or intergenerational historical traumatic experiences."* [91]

Trauma is experienced by many people with a prevalence across the general population[92]. Trauma can be a one-off event or ongoing with cumulative effects[91] and is associated with negative health outcomes. More is coming to light about the impact of adverse childhood experiences (ACEs) and negative health outcomes across the lifespan[92].

Former refugees are likely to have experienced trauma relating to the refugee journey. Trauma experienced by former refugees is diverse and will have differing impacts on individuals. Multiple traumatic events have been shown to have a cumulative effect on individuals, with the potential for a negative impact on mental health and overall wellbeing.

The impact of trauma varies from person to person and effects can be very different depending on past experiences and culture. Culture mediates how people understand, process, and respond to trauma. Culture also influences how trauma may be expressed, how different modalities of support are understood and how effective these modalities may be. Awareness of how our respective cultures impact and influence us all is essential for practitioners who are working with people with different cultural worldviews[91].

Working in a trauma-informed way requires a shift in thinking from "what is wrong with you?" to "what happened to you?" It prioritises the former refugee's capacity for making choices and having control and identifies and builds on strengths.

Trauma-informed care involves trauma screening, building safe working relationships and managing patient disclosure and distress. Looking after oneself as a practitioner through peer support, clinical supervision and advocating for an effective system for health and social care providers to work in is also crucial to a trauma-informed response[91, 93]. Marieke Jasperse & Jawahir Ahmed explore trauma-informed care further in the *Focus area: Trauma-informed approaches to refugee resettlement in Aotearoa New Zealand*.

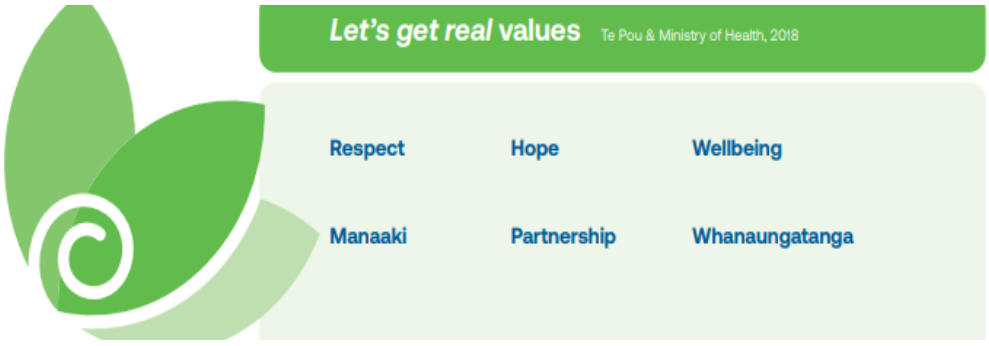

Figure 5: Let's get real: A framework for working effectively with people and whānau experiencing mental health and addiction needs. (Te Pou and Ministry of Health[94])

Focus area: Disability Support for Former Refugees

Disabled people are not a homogenous group. Disability needs are affected by many factors such as age, the nature of a disability (intellectual, neurological, sensory, physical), concurrent diagnoses including long-term health conditions, intersection with mental health, and the origin of the disability (accident, genetic, age).

Culture may inform a family or individual's response to disability. This can have important implications for the acceptance of disability support services that are offered. Some of the ways this might be apparent are:

- Cultural stigma associated with disability.
- Reluctance to involve anyone beyond the family to support the individual with disability.
- Cultural beliefs about the cause of disability.
- Exclusion of people with disabilities at community events.

Therapeutic interventions that are available in Aotearoa New Zealand, such as physiotherapy, occupational therapy and speech-language therapy, may not be familiar and therefore poorly understood by former refugees.

Action or practice points:

A framework for supporting a former refugee who has a disability should include:

- A trained interpreter when language is a barrier.
- All family members if desired – intensive engagement with the whole family may be required initially to ascertain the needs of the disabled person and the support people.
- Awareness and respect for the family's need to take time to adjust and cope with the loss of traditional family and community support and the multiple stressors of resettlement.
- Integrated social and medical models of intervention, underpinned by the enabling good lives principles; self-determination, early investment, person-centred, ordinary life outcomes, mainstream first, mana enhancing, easy to use, and built on relationships[95].
- Culturally appropriate care and support networks – consultation with a cross-cultural worker may be required.
- Acknowledgement of community stigma and discrimination.

Services available vary by region across Aotearoa New Zealand, and therefore it is better to refer to a regional Needs Assessment Service Co-ordination Centre (NASC) and Disability Information Specialists for guidance because circumstances may require bespoke services.

Meeting disability needs prior to arrival in Aotearoa New Zealand

Barriers to fulfilling basic needs experienced by disabled people amplify the challenges created by forced displacement. Transit countries will have varying levels of health infrastructure to support individuals with disabilities prior to resettlement. Disabilities may not always be identified or prioritised during offshore health screening.

Care coordination at te Āhuru Mōwai o Aotearoa

All former refugees arriving in Aotearoa New Zealand through the annual quota programme are allocated a case officer. This case officer will liaise with the housing team at the Ministry of Business, Innovation and Employment to ensure any housing needs are communicated prior to resettlement. The education team from Auckland University of Technology will communicate directly with the Ministry of Education so that children with disabilities are highlighted to the regional education provider.

Care provision for former refugees with disability needs on resettlement

Each resettlement location in Aotearoa New Zealand has a Needs Assessment Service Co-ordination (NASC) Centre to assess and allocate funding. Disability Information Centres are also available in some regions of Aotearoa New Zealand to assist community development and social workers supporting former refugees and their families to navigate the disability system. Any health and social practitioner can refer former refugees eligible for publicly funded healthcare for a NASC assessment.

Accident and injury support

The Accident Compensation Corporation (ACC) provides a no-fault accidental injury scheme for financial compensation and support to citizens, residents, and temporary visitors who have suffered personal injuries (this includes New Zealand residents, normally resident in Aotearoa New Zealand, injured overseas while travelling) [96]. On arrival in Aotearoa New Zealand, former refugees are permanent residents and are therefore entitled to ACC cover. However, former refugees may have no prior knowledge of ACC and their support entitlements, and it is important to provide information and assistance to access these entitlements.

Former refugees who sustained injuries before coming to Aotearoa New Zealand are not likely to be entitled to ACC cover for those injuries, even if those injuries were sustained while awaiting resettlement in Aotearoa New Zealand [96]. This can be particularly challenging for former refugees who have sustained long-term physical injuries, as rehabilitation and care for such injuries in Aotearoa New Zealand are usually provided in the private health system with ACC support. Timely and adequate services in the public health system for such long-term injuries may be difficult to obtain, resulting in a need for special advocacy from primary health and social care providers.

6.8 The consultation

> *"We do a lot of extra work with [refugees] in the consultations, and then there's quite a lot of behind-the-scenes work that we do as well … it's like volunteer work, we were aware that we weren't going to get paid for it."*
>
> General Practitioner[75]

Consultations are a meeting, a coming together of the health or social care provider and the former refugee. This may be an individual former refugee or a family, nuclear or extended. During the first phase of resettlement, there are likely to be several consultations to address immediate health and social issues. This consultation process provides the space to build rapport, explore understanding and negotiate priorities and plans for immediate and ongoing care. The ways of working previously outlined lay the ground for approaching a consultation to ensure respectful and effective communication and help create a trusting culturally safe partnership for ongoing care.

Previous experiences in healthcare will inform former refugees' expectations of the consultation. Some may not have had any organised healthcare, or their healthcare is likely to have been interrupted by the refugee journey. Initial contact with health providers in Aotearoa New Zealand may be the first opportunity some have had in their lives to receive client-focused, high-quality health care. Others may have come from sophisticated high-quality health care systems, others from health care systems where the first point of contact is with a specialist, or in a hospital, so primary health care provision and generalist and social providers may be a new concept.

Former refugees may have experienced a breach of rights or trust or outright abuse from social and political institutions and may therefore be untrusting of health and social services. Building trust and rapport may take some time and utilising the previously discussed ways of working will help the process. In addition, a prominent feature of trauma survivors is lower levels of trust overall and with authorities[97].

Building a trusting personalised relationship to provide optimal care to refugees can be a challenge for health professionals. Consider that former refugee clients:

- May be mistrustful of the health system or feel isolated and misunderstood because of English language proficiency
- May be experiencing impacts of trauma 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 HIV
- May be stigmatised by their community for a variety of reasons, e.g., sexual orientation, gender identity, or mental health diagnosis

6.9 Culture

Culture plays an important role in how we understand and explain health, disability, and wellness.

Culture will influence the consultation. A person may identify as belonging to many cultures. Ethnic, national, language, professional or sporting as some examples. As practitioners, it is unlikely we can become experts in any culture other than our own.

Matsumoto explains culture as flexible, everchanging and practised differently across people and communities from a particular culture[98]:

> *"a dynamic system of rules—explicit and implicit—established by groups to ensure survival, involving attitudes, values, beliefs, norms, behaviours, shared by a group, but harboured differently by each [individual] within the group communicated across generations, relatively stable but with the potential to change across time"* [98]

- The best way to understand someone's culture or culture is to ask about their culture and how it influences their understanding, explanations, or decisions. Consider finding out your client's/patient's views on[30]:
- Causes of illness and disability.
- Ways in which illness and disability are best managed.
- The relationship between clients and service providers.
- The role of western-style medicine in the management and prevention of illness.
- The individual versus collective approach to illness and health.
- The relevance of gender roles.

6.10 Communication, literacy and health literacy

Establishing rapport and trust with your client and communicating clearly throughout the consultation are crucial factors in providing safe, effective, and appropriate care. Literacy and health literacy have impacts on how practitioners communicate with clients during consultation and assessing for literacy, health literacy, and whether a trained interpreter is required are the first steps in ensuring optimal communication. *See Chapter 7: Working with interpreters and language assistance.*

There is wide variation in literacy, and health literacy across former refugees, and it should not be assumed that all former refugees are literate in their mother tongue. It is essential that health education and information are clear, concise, and visual in cases of pre-literacy. Utilising visual aids and ensuring written information is fully discussed are essential for effective care and informed consent[99].

Action or practice points

The following suggestions may be helpful[30]:

- 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 be negotiated.
- Respect your client's knowledge, and experience.
- Identify your client's strengths.
- Avoid making assumptions and generalisations about your client based on ethnicity, culture, religion, or attire.
- Knowing education and literacy levels
- Provide visual information and multi-lingual written information, as required.

The LEARN model[100] can help with finding out more about a person's understanding and explanation of their presenting issue, problem or symptom and coming to an agreed treatment or management plan.

Listen with sympathy and understanding to the patient's perception of the problem

Explain your perceptions of the problem

Acknowledge and discuss the differences and similarities

Recommend treatment

Negotiate agreement

A mural depicting home and belonging in Wellington[101].

6.11 Preparing for the consultation

> *"It is useful to consider all consultations as cross-cultural consultations with varying degrees of cultural distance. Navigating a cross-cultural consultation effectively entails having a good understanding of the concept of culture. It also requires an understanding of your own culture and your explicit and implicit biases."* [102]

For those who have arrived as quota refugees and attended the orientation programme at Te Ahuriri Mōwai o Aotearoa, medical records will be available for review prior to the first primary health care consultation via electronic record transfer. This will help with preparation and starting to prioritise care.

For those coming via other migration pathways, such as the Refugee Family Support Category or as asylum seekers, it is important to ask if they have medical records which they can bring with them to the consultation. Where prior communication is required and there is a language barrier a three-way phone call with a professional interpreter can be utilised. Alternatively, if there is a social service or family member assisting the family, then prior communication may be via them if appropriate.

Action or practice points

- Acquaint yourself with the background of the client and the community in which they live.
- If necessary, arrange for a trained interpreter, with the consent of the client.
- Check whether other family members need to be involved before fixing a consultation date.
- Schedule the appointment at a time convenient for the client/patient. Using a translated appointment booking tool may be useful Appointment Translation — MHCS (nsw.gov.au)
- Allow extra time for the appointment, to accommodate interpreting, establish rapport, establish priorities and plan ongoing care.
- Acknowledge that the client may be late due to a lack of experience with appointment systems, unfamiliarity with the transport system, or unfamiliarity with the location of the clinic.
- Some women may prefer a female practitioner.
- Tailored explanations and information may be needed to ensure clients understand our health system and how to access services and get prescriptions.
- Access multilingual information or pictorial resources which may aid communication and informed consent.

Focus Area: Medicines and Therapies

Quality use of medicines is one of the goals of providing safe and effective healthcare to former refugees[103]. It is influenced by numerous factors some of which have been identified as barriers for former refugees. Language, communication and health literacy, culture, health literacy, cost, coordination between health care providers, healthcare provider training, and the health system are critical factors that, if not considered fully, can present barriers to getting the right healthcare[103,104].

Key Considerations

Communication

Assessing language, literacy, education level, prior experience of medicine uses and obtainment, and health beliefs around medicine use will assist in tailoring a successful medication plan. Communication is facilitated by trained interpreters and language assistance where there is a language barrier. Trained interpreters may be available in one setting but not another, which can cause communication barriers and increase medicines-related risks.

> *"When a person from refugee background goes to get their medication after their prescription, they don't have an interpreter with them because the interpreters are always booked for the medical appointments but not for the pharmacy's access … there is no means of communication between them and the patient because there's no interpreter."* [103]

Pictorial resources and other available multilingual tools can be very useful in providing medical information. 'Easidose', a free web-based pictorial medicines instructions tool can provide an effective pictorial medication plan (See link: Picture-based)

Culture

Cultural or religious practices such as fasting during religious occasions such as Ramadan or Easter may impact medicine adherence. This may be particularly important for patients with long-term conditions such as diabetes. Accessing a patient's intention to fast and planning the management over the fasting period is important[105]. Knowing where to access resources to assist will be helpful.

Cost

Cost is a known access barrier to medical therapy. While subsidised medicines are currently free on prescription as of 2024, there are other associated costs with medicines such as the consultation with a prescriber, repeat prescriptions, over-the-counter medications and medications that are not subsidised.

Navigating the health system

Former refugees arriving in Aotearoa New Zealand will need to understand and navigate a new health system. Prior experiences of health systems will be diverse with some familiar with highly sophisticated, and others basic and under-resourced.

Experiences of medicine acquisition, accessibility and administration will vary. Former refugees may be accustomed to being dispensed medication as part of a consultation or going to a pharmacy and buying medicine without a prescription or prior consultation. Administration routes may differ. Oral forms of medication given in Aotearoa New Zealand may be more frequently given intramuscularly or intrarectally and the efficacy of the oral route needs to be reinforced[30].

Assessing former refugees' past experiences and current expectations of medical therapy helps to understand the proximity of their experience to the new system. This guides the education and support needed. Proving education about subsidized medicines, over-the-counter medicines, prescriptions, repeat prescription processes, the role of pharmacies and pharmacists and related costs to medicines will assist medicine adherence. Having pharmacists as part of the inter-professional team helps in delivering medicines education and support and is more likely to aid a seamless transition between services.

Traditional medicine and therapy

Former refugees may come from countries, communities or families where traditional medicine or therapy is widely practised. This may take the form of herbal medicine, relaxation techniques, body therapies such as massage, cupping, coin rubbing, henna tattooing, or acupuncture. Traditional medicines or therapies may have been utilised before engaging with a formal health system. With the move to Aotearoa New Zealand, there can be a loss of access to such medicines and therapies and the intergenerational support networks which hold such knowledge. This can impact the ability to manage common health conditions independently before seeking medical input and can be a disempowering experience for former refugees.

The use of more traditional therapies such as herbal medicine, relaxation, and body therapies like massage may be helpful for those concerned about the side effects associated with conventional medicines. Body therapies can also assist in re-establishing the mind-body connection commonly blocked in survivors of trauma and torture[30].

Pharmacogenomics

Pharmacogenomics affect the metabolism of medicines due to genetic variations in drug-metabolizing enzymes. Such variations may be present in ethnic groups affecting the likely response of an individual to a particular medicine. Examples include the Cytochrome P450 system and the 2D6 enzyme, known as CYP2D6. Some ethnic groups may express a genetic variation in this enzyme which can result in slow or ultra-fast metabolism of certain medicines. This can either reduce or increase the therapeutic effect[106]. Medications that may be affected include tramadol, codeine, and antidepressant selective serotonin reuptake inhibitors (SSRIs). This variance may impact on dose and titration. Pharmacogenomics is a complex and emerging field, and it is mentioned here briefly as a reminder to healthcare providers to consider ethical variations in drug metabolism where appropriate.

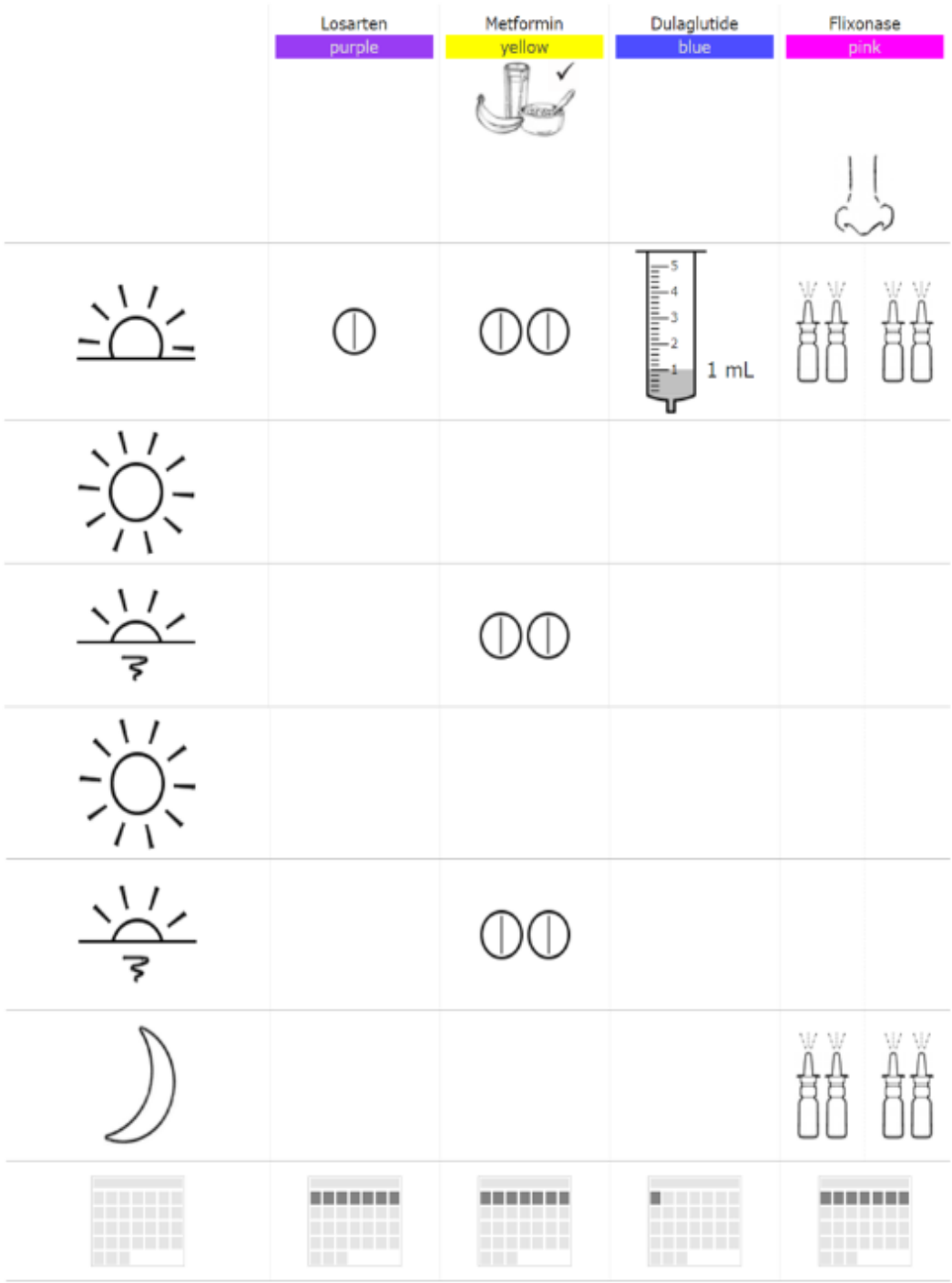

Figure 6: Picture-based prescribing (Easidose[107])

7 Working with interpreters and language assistance

"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[73]

Key considerations for practitioners:

- To enable access to health and social where there is a language barrier, language assistance is required
- NAATI-certified interpreters are the gold standard for use in Aotearoa New Zealand
- Assessing and documenting language requirements at the first point of contact or enrolment with a service is necessary.
- An interpreted consult will require additional time.
- A short pre-session brief and debrief between the client, practitioner and interpreter is recommended.
- Understand the reason why a client may decline a certified interpreter.
- Health and social care providers are recommended to undertake training in working with certified interpreters.

7.1 Accessing interpreting

"If there is no (trained) interpreter and you cannot explain the problem how you can clarify the problem, how can you get quality care from the GP?" [108]

Language interpreting is essential for the safe and effective provision of health and social services. However, there can be times when accessing a professional interpreter in person may be difficult or there is unease or unacceptability from the client or patient to use a particular interpreter.

Communication and language gaps are often cited as the main barriers to accessing and utilising health services for former refugees with limited English proficiency[64,108]. Gender compatibility, consistency of the interpreter used (where possible) and a trusting relationship have been identified to improve the acceptability of using professional interpreters[108]. To enable access to health and social services, it is necessary to provide language assistance if required.

A trained interpreter will ensure:

- Accuracy
- Impartiality
- Confidentiality
- Equitable access to services
- Effective communication
- Meaning, emotion, and context conveyed
- An explanation of any factors from either culture which could lead to misunderstanding or lack of desired response[109].

Assessing the need for an interpreter, choosing the right interpreter, choosing the right modality (face-to-face, phone or video) to suit the situation, and working effectively with an interpreter are all essential skills when providing health and social services to former refugees[110]. Health and social care providers are encouraged to undertake a training course on working with interpreters to ensure they feel prepared, skilled, and confident in working with professional interpreters via phone, video, and face-to-face. This aids in ensuring use of professional interpreters is appropriate, effective, and acceptable to clients and patients.

Access to, and funding for interpreters varies across the country and there is more than one national provider. The availability of interpreting has greatly improved over recent years with 24 hours a-day, seven days a week phone services available in up to 180 languages[111] across most of the country.

For primary health care services, the interpreting budget may be held by the Primary Health Organisation (PHO) and is variable in terms of the amount of funding and conditions of use. Community-based midwives, known as Lead Maternity Carers (LMC) who claim under section 88 can access interpreting services via Te Whatu Ora. NGOs have no clear access to interpreter funding nationally and it is dependent on the resettlement location and individual organisational budgets. This can present a barrier to those with limited English proficiency who require social services.

7.2 Language interpreter standards

New standards and certification requirements are part of the cross-government Language Assistance Services Programme (LAS) discussed earlier. The NAATI Certification System supports the growth of an interpreting profession and ensures consistent technical and ethical standards of language interpreting. Language interpreters are either NAATI certified, working towards NAATI certification or untrained.

Using NAATI-certified interpreters is the gold standard to ensure the right to effective communication is fulfilled. Such interpreters are skilled in the use of their language and English as another language and in the proficiencies of an interpreter which includes intercultural competency. They are bound by a code of ethics, which places

emphasis on impartiality, accuracy, and confidentiality. The high level of competence attained reflects the knowledge, skill and attributes required for language interpretation and provides health and social care providers with consistent, accurate and quality interpretation.

7.3 Modalities of language assistance

Language assistance in the health and social care setting is primarily via the use of language interpreters. Other modalities of language assistance can include bilingual staff members, trained or untrained, professional translation, untrained family members or friends, machine translation (e.g., Google translate) and no assistance, using gestures and whatever shared language is available. While the gold standard is a NAATI-certified interpreter, there may be times when this modality is not available. Utilising other modalities may be appropriate but care and consideration for any ethical or safety concerns must be considered and mitigated.

Using family (especially children), friends or untrained people as interpreters for important consultations is unacceptable because of the risk of inaccuracy, exposing family to material of a highly sensitive nature, compromising confidentiality, influencing a client to withhold information from the health or social practitioner, miscommunication between provider, client and interpreter or an unsafe outcome[112]. There may be times, such as in an emergency or for logistical arrangements that a family member or friend may be utilised.

7.4 Documenting language requirements

> *"I don't feel satisfied when I can't understand my doctor."* [108]

Systems are required to identify and document a person's requirement for language assistance and their preferred language. For quota refugees coming from Te Āhuru Mōwai o Aotearoa, interpreter needs and preferred language will have been identified. For those coming via other migration pathways, this is something that will be required at the first point of contact or enrolment with a service provider.

The following questions may be useful in this assessment:

- Does the person use a language other than English at home? If so, specify the language.
- If yes, how well does this person speak English? (Very well, well, not well, not at all) [113].

Additional indicators for language assistance may include:

- Has requested an interpreter or shown an 'I need an interpreter' card.
- Does not appear to understand information given in English.
- Is using family or friends to assist with communication.
- Shows hesitation in using English, or a preference to speak in another language.

- Cannot respond adequately to questions.
- Is unable to explain key information.
- Is newly arrived in Aotearoa New Zealand from countries where English is not the primary language.
- Appears to be emotional or showing signs of stress[114,115].

7.5 What if my client has some knowledge of English?

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

- Unfamiliarity, anxiety, or mistrust 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.
- The complexity or significance of the content in the session may require an interpreter to ensure full understanding by all parties involved.
- Politeness may lead the client to indicate that they have understood when they have not understood.

> *"The use of professional interpreters for newly arrived refugees from non-English speaking backgrounds is a cornerstone of good clinical practice."* [116]

Action or practice points

Before engaging an interpreter:

- Always gain the consent of the client prior to booking an interpreter and assess any preferences they have for gender, language, and modality of interpreting.
- In small communities or small language groups or when someone experiences social stigma from their community a phone interpreter may be more appropriate and/or an interpreter from another region or community.
- 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.
- Check if your client is fluent in a second language. If an interpreter is not readily available in the client's first language, another may be available in the second language.
- Establish whether the client prefers a particular gendered interpreter.

- Communication with former refugees may be affected by cultural differences and/or experiences of torture or trauma.
- Consider the complexity of the information you wish to convey to the patient and the appropriately credentialed interpreter.
- Remember that a longer consultation time will be needed to allow for the interpreting process.

7.6 Pre-session briefing & de-briefing

A well-briefed interpreter does a better job. A pre-session brief with the client and interpreter for this reason is recommended. The nature of the appointment, the time available, and whether the practitioner, client and interpreter have worked together previously will determine the extent of the information given. A short pre-session brief can include, an introduction, the role of the agency and practitioner and the purpose of the consultation or appointment.

The time required for a debrief will depend on the nature of the session and the challenges that may arise. A de-brief 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. Interpreters should have available to their professional development and supervision opportunities for any significant emotional distress they may experience.

Studies are beginning to recognise the importance of professional development for interpreters, working in health and social care services[108,117]. Exposure to distressing personal experiences of former refugee clients and patients can be a routine part of this work and González Campanella (2022) argues that a trauma-informed approach to interpreting practice is essential in keeping both client and interpreter safe[117].

Consider the following:

- The interpreter needs to be briefed about the case, including the objectives/purpose of the session.
- As a 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 confirm with you that the first person will be used throughout by both parties (that is, ‘I’ rather than ‘he’ or ‘she’).
- If in-person interpreting is used 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[118].

7.7 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 let them explain their role.
- Give assurance 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 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) [118].

7.8 Declining language assistance

There may be times when a patient or client declines an interpreter either during or before an appointment. It is important to understand the reasons why. They may not understand why an interpreter is required, they may prefer a family member rather than someone unknown, they may be worried about additional cost, and they may have concerns around accuracy and confidentiality[114].

Once the reasons for declining an interpreter have been discussed and the client or patient continues to decline an interpreter, the practitioner needs to determine if the appointment or consultation can safely go ahead. Documenting that an interpretation has been offered but declined is also important.

Photo and artwork by Joel Bergner

8 Management of Refugee Health in Children and Adolescents

8.1 Considerations for children and young people

Children and adolescents make up a high percentage of arrivals through all refugee migration categories into Aotearoa New Zealand. As with other age groups, children and adolescents with refugee-like experiences may:

- have experienced displacement and changes in country, language, culture, and education
- have had limited or interrupted access to health services and education
- have experienced trauma and human rights violations
- require time, trust, and rapport before disclosure of difficult experiences or trauma.

(Community HealthPathways) [119]

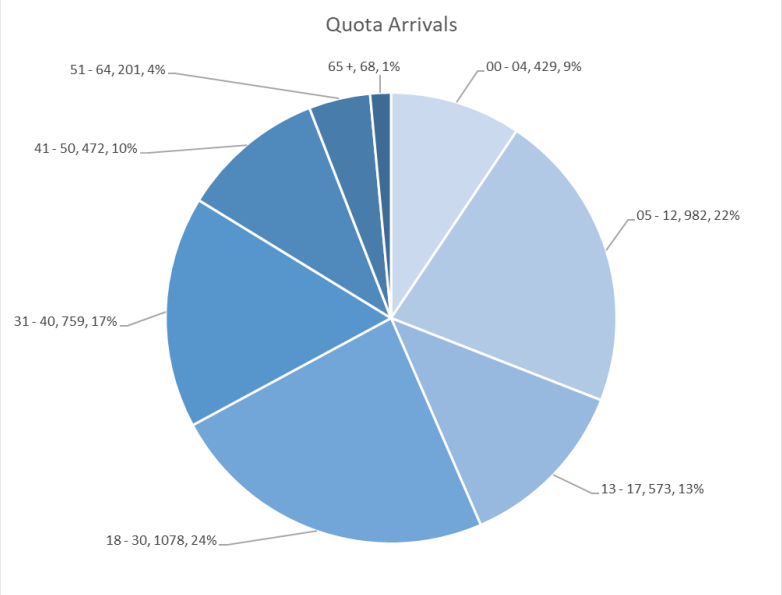

Figure 7: Quota refugee arrivals 2019-2024 (Immigration New Zealand[57])

The above table shows Quota refugee arrivals to Aotearoa New Zealand from 01/01/2019 to 31/01/2024. 44% of arrivals are under 18 years old.

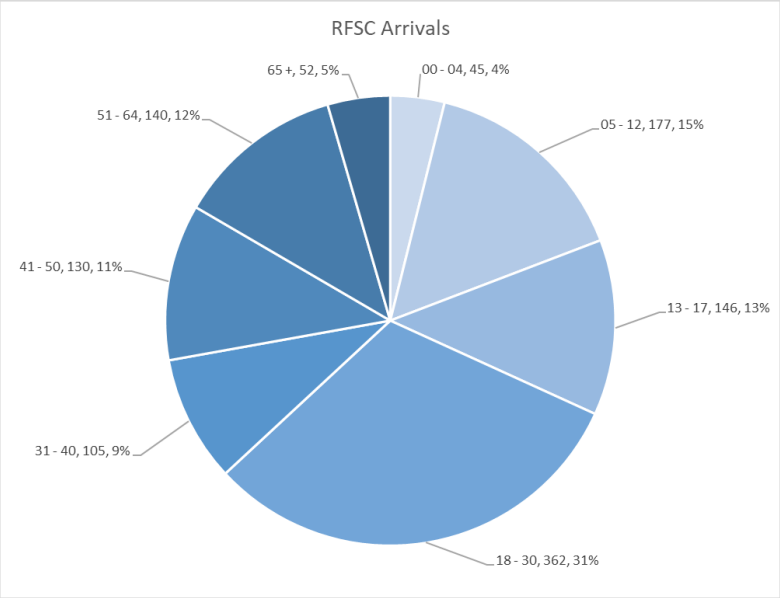

Figure 8: Refugee Family Support Category arrivals 2019-2024 (Immigration New Zealand[57])

The above table shows Refugee Family Support Category arrivals to Aotearoa New Zealand from 01/01/2019 to 31/01/2024. 32% of arrivals are under 18 years old.

> *"The word 'refugee' often comes with a stigma that youth don't want to carry"*
>
> Former refugee[120]

Children and adolescents from refugee backgrounds face many challenges on resettlement including increased familial responsibility, a disruption in education, family and social networks, separation from loved ones, adjusting to a new culture and at times bullying and discrimination[121-123]. Such challenges are balanced with significant resilience, a will to succeed and future aspirations[122,123].

Building rapport and trust with families and children also builds a bridge with adolescents for future individual health and social care provision when required. While approaches to adolescent health care, such as the Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide/Depression, and Safety (HEEADSSS) assessment tool to help assess youth wellbeing (see https://healthify.nz/healthcare-providers/y/youth-health-hcps/ and more generally, https://starship.org.nz/guidelines/adolescent-consultation/) are very useful, there are some additional considerations for working with adolescents from a refugee background.

8.2 Health assessment and management

It is important to remember that most clinical care for former refugee children and adolescents is similar to clinical care for those without a refugee background.

Management will be in accordance with usual paediatric best practices, and there may be additional considerations specific to cultural contexts and influence by

refugee experiences. For management of identified health conditions refer to the relevant Community HealthPathways

Table 11: Relevant health conditions for consideration in a syndrome-based approach.

Presentation	Common causes	Additional considerations in refugee-background children
Fever	• Viral infections • Bacterial infections	• Malaria • Measles • Typhoid fever • Dysentery • Dengue and arboviral infections • Hepatitis A • Hepatitis B
Respiratory symptoms	• Viral RTI, including COVID-19 and influenza • Pneumonia • Asthma • Bronchiolitis • Croup	• Pertussis – vaccination may not have been available in the country of origin • TB – consider in children with chronic cough or contact history • Parasite infections may (very rarely) cause wheezing and/or respiratory symptoms • Sickle cell disease may present with acute chest syndrome
Abdominal pain	• Acute infection • Constipation • Surgical or gynaecological causes	• Parasite infection • *Helicobacter pylori* gastritis epigastric pain, early satiety, nausea or vomiting, and family history • Hepatitis • Typhoid fever • Female genital mutilation
Diarrhoea	• Viral gastroenteritis • Bacterial gastroenteritis • Malabsorption	• Parasite infection • Lactose intolerance is more common in some racial groups. • Bacillary and amoebic dysentery

Hypocalcaemia **Tetany, muscle cramps, stridor, seizures**	• Vitamin D deficiency • Low calcium is more likely in children 12 months or younger.	• Rickets (bossing, swelling of wrists and ankles, or bony deformity)
Skin conditions and rashes	• Infective • Eczema • Dermatophyte (tinea) • Ulcers	• *Strongyloides* infection may cause an intermittent urticarial rash, lasting a few days (larva currens). This may be located anywhere, typically buttocks or perianal. Patients with untreated *Strongyloides* infections can develop hyperinfection syndrome (with high mortality) if given immunosuppressant therapy, including steroids. • Measles • Leprosy (Hansen's disease) • Cutaneous leishmaniasis • Haemophilus ducreyi
Continence and Urinary Symptoms	• Cystitis • Irritable bladder • Enuresis	• Chronic cystitis may not have been detected or treated. Consider mental health issues as a cause of secondary enuresis. • Consider female genital mutilation as a potential factor.
Eye conditions	• Dry eye • Conjunctivitis • Red eye	• Trachoma • Onchocerciasis / River blindness
Musculoskeletal pain	• Injury • Growing pains • Joint pathology or inflammation	• Low vitamin D is an extremely common cause in refugee children and adolescents with risk factors.
Nutrition concerns	• Poor intake	• Malnutrition – may need admission • Food insecurity (not being able to afford or access adequate food)

	• Increased losses (gut, urine) • Increased requirements • Behavioural issues • Excess milk intake • Enlarged tonsils	• Iron deficiency is common in refugee children. • Vitamin B12 deficiency. • Helicobacter pylori gastritis • Other gastrointestinal infections • Dental disease – pain with chewing may restrict food intake. • Rickets may restrict linear growth.
Disability (and developmental or learning concerns)	• Genetic • Environmental • Trauma – injury	• Maybe a multifactorial combination of antenatal, peri- and post-natal contributors. • Children with a complex disability may not have had any access to treatment. Check nutrition and clarify seizures. Seek urgent specialist review. • Be wary of attributing to English as an additional language – seek specialist review. • Check age. Consider birthdate issues and interrupted schooling. • Consider mental health.
Mental health	• Behaviour concerns • Sleep issues • Anxiety or separation issues • Mental health diagnosis	• PTSD • Experience of violence or conflict, including sexual violence • Clarify family background, separations, migration history, parent mental health, and detention experience for people arriving as asylum seekers. • A paediatric assessment can be a useful first step to provide comprehensive assessment and aid mental health referral.

(Table adapted from Community HealthPathways - Refugee Health in Children and Adolescents[119])

8.3 Immunisations

There is some evidence to suggest that children in Aotearoa New Zealand born overseas with a migrant or refugee background are less likely to be enrolled on the Aotearoa Immunisation Register (AIR). Those enrolled on the previous National Immunisation Register (NIR) and from a refugee background, were found to have a low age-appropriate vaccine coverage rate[124]. This exposes former refugee children to an increased risk of vaccine-preventable diseases. It is important that former refugee children receive timely age-appropriate vaccines. Where vaccination history is undocumented then a full catch-up course should be offered and recommended[125].

Immunisation for those who enter as quota refugees via Te Āhuri Mōwai o Aotearoa may have started offshore and continued at the reception centre. In the resettlement location immunisations need to be completed in a timely way in primary care.

The Ministry of Health 'Immunisation Handbook' – https://www.tewhatuora.govt.nz/assets/For-the-health-sector/Vaccine-Information-for-health-professionals/Immunisation-handbook/Immunisation-Handbook-2024-v1.pdf – provides references for vaccinators planning appropriate age-based catch-up schedules. *Appendix 2: Planning Immunisation Catch-ups* provides detailed plans that will assist in creating an individual's catch-up schedule[125].

Consider BCG vaccination for children aged under 5 years at high TB risk. Funded BCG may be offered to children aged under 5 years if they are tuberculin skin test- or interferon gamma-release assay negative and are at increased risk of TB because they:

- will be living in a house or family/whānau with a person with either current TB or a history of TB
- have one or both parents or household members or carers who within the last five years lived for six months or longer in countries with a TB rate ≥40 per 100,000*
- during their first five years will be living for three months or longer in a country with a TB rate ≥40 per 100,000[126]

8.4 Well Child and Tamariki Ora services

It is important for health and social providers working with former refugees to know and connect families with local child support services as part of fostering a wider social support network. It can be a challenging time for new parents/carers navigating unfamiliar systems without their own wider support network of family and friends. This can result in an increased level of anxiety and worry about the health of their child.

Providing ongoing information to parents/carers on where to find information and about publicly funded health services available to them and their children in different ways and at different time intervals is essential. Legal requirements of daily activities such as car safety, parenting and school attendance may be different to a family's

prior experience. It is not enough to provide the information once on arrival and assume that this will be retained during the initial resettlement period, often a very overwhelming and busy time.

Well, Child Tamariki Ora services are available in all resettlement locations. Discussing provider options and enrolling families with these services supports equitable access to their funded schedule of visits and promotes healthy child development. Communicate any language and transport needs families might have with the relevant providers to reduce barriers to access.

PlunketLine – Whānau Āwhina is a valuable resource to share with families. Most health and social providers are not accessible at all hours of the day, and parents/carers may not be aware that services like PlunketLine are available 24/7. Let parents/carers know that trained interpreters are available for callers. PlunketLine – Whānau Āwhina will ask parents/carers to advise their spoken language and access an on-the-spot interpreter for the call. Where an interpreter is not available PlunketLine – Whānau Āwhina will arrange for a call back once an interpreter has been accessed.

For those with school-aged children, parents/carers can be made aware of the school-based nurse service and any child identified with complex physical or mental health needs can be connected directly to the service through the relevant Primary Health Organisation or Public Health Unit for additional support and coordination of school-based services.

Support families to access free oral health care for their children up to 18 years of age. For pre-high school children, this means enrolment in the Bee Health Regional Dental Service. High school students receive publicly funded dental care through Te Whatu Ora.

Dentists who are culturally safe and use language assistance will promote positive experiences for former refugee children and young people. Health navigators in resettlement locations can be utilised to support enrolment with dental providers.

Prioritise adolescents that arrive in Aotearoa New Zealand at age 16 or 17 years of age for speedy enrolment while dental care is still publicly funded. Dr Zeina Al Nassan provides further information in *the Focus area: Oral health.*

8.5 Family structure and responsibility

Adolescents often have increased responsibility within the family unit during resettlement, including caring for siblings and assisting parents/carers in resettlement activities[122]. This can be due to English language proficiency being acquired by young people at a much faster rate than their parents/carers[127] as well as asymmetrical cultural adaptation enabling young people to navigate a new society and culture more easily than parents/carers. Such differences in the acquisition of language and culture can disrupt traditional family roles, cause parents/carers to feel disempowered, and create conflict. At the same time, overcoming family struggles experienced during the refugee journey in the safety of a new home can assist with family cohesion[127,128].

8.6 Education

Disruption to education is often experienced during the refugee journey and this may mean that some children and young people may need to catch up academically and/or be out of kilter with peers. Young people from a refugee background can achieve the same educational outcomes as the host population[128] but acquiring the level of English language proficiency required for school can take time and young people may be impatient to pursue their aspirations. A strengths-based approach that identifies risk and resilience factors will help ensure the right support is in place with appropriate programmes to support young people to achieve their goals in a timely way.

> *"Attending school and achieving an education is one of the most desired opportunities among resettled refugee young people."* [122]

8.7 Incorrect birth date records

Birth dates may be incorrect due to administrative inaccuracies resulting from forced migration experiences where people flee without identity documents or necessary paperwork or calendar discrepancies. For children and young people, this may impact developmental assessment and eligibility for health screening, dental treatment, housing or income support[129].

Age determines school year placement, and an inaccurate date of birth can negatively impact social integration into age-appropriate peer groups. Positive peer relationships are very important for the long-term wellbeing of former refugees, and disruption to this can be just as detrimental[127]. Age inaccuracy can also impact learning and sporting achievements. As outlined in the *'Enhancing refugee health care'* model (*Section 6.1*), advocacy may be needed to facilitate accurate age-appropriate integration. Encourage former refugees to seek legal advice from Community Law Centres, if they believe that their recorded birth date requires correction.

8.8 Sexual and reproductive health

Former refugee adolescents may arrive in Aotearoa New Zealand with low levels of sexual health knowledge, limited prior exposure to sexual health screening and services and limited opportunities to learn about sexual and reproductive health. Providing appropriate information and explanations about available screening and contraception is important to reduce the risk of unplanned pregnancy and STIs. Cultural stigmas and taboos, and our assumptions as practitioners, may create barriers to communication about sexual and reproductive health. Innovative ideas around health education, health promotion, and service design to overcome such barriers may be helpful[127] and encourage sensitive and culturally safe discussion and approaches.

8.9 Cultural identity

Adolescence is a time of identity formation and for former refugees, a strong ethnic and cultural identity is known to correlate with a sense of happiness[122]. The task of blending values and expectations of one's own culture with a new peer and social culture brings challenges and opportunities[128]. Parents/carers may themselves be struggling to culturally adjust and not be able to assist young people in navigating this process. Health and social care providers can play important roles in providing support for difficulties or stress arising from identity and referring appropriate support for young people.

> *"I had lots of difficulties keeping my kids' well-being and mental health because of different cultures and a new life in New Zealand"*
>
> Former refugee father[130]

8.10 Interprofessional collaboration

Where appropriate and with consent, additional and complementary support may be needed to help young people with refugee backgrounds achieve wellbeing and a sense of belonging in their schools and communities. Collaboration across professions and agencies when working with adolescents can be important in ensuring needs are met. These may include refugee-specific teams in government agencies like the Ministry of Education, settlement support providers, local councils, and health providers. Support roles like health navigators or health coaches can help young people access support and community or extra-curricular activities.

Focus area: Oral health

Dr Zeina Al-Nassan

FDI Word Dental Federation Definition of Oral Health[131]:

Oral health is multifaceted and includes the ability to speak, smile, smell, taste, touch, chew, swallow, and convey a range of emotions through facial expressions with confidence and without pain, discomfort, and disease of the craniofacial complex. Oral health:

- is a fundamental component of health and physical and mental wellbeing. It exists along a continuum influenced by the values and attitudes of people and communities.
- reflects the physiological, social, and psychological attributes that are essential to quality of life.
- Is influenced by the person's changing experiences, perceptions, expectations, and ability to adapt to circumstances.

Oral health and access to appropriate treatments is considered a health priority for refugees and asylum seekers by the United Nations High Commissioner for Refugees[132] and is seen as an integral part of health by the World Health Organization[133].

It's only teeth, why should I care?

Former refugees from Syria living in Aotearoa New Zealand reported pain and embarrassment due to dental problems[134]:

> *"When I eat, I chew half of the food and the other half gets swallowed."*
>
> *"I was supposed to get a lower denture and still waiting. you know that this affects appearance, speech and eating. When one goes out, they feel embarrassed that his teeth look like this."* [135,136]

Good oral health is important, in itself, and for our overall health and wellbeing. Poor oral health challenges a person's ability to chew, enjoy food, have adequate and appropriate nutrition and digestion, communicate and socialise, work or learn, and conduct other activities of daily living. It can have considerable adverse consequences for a person's self-esteem, and, ultimately, their quality of life137.

Many of these issues are particularly concerning for former refugees[138]. Poor oral health affects our ability to work, manage phonetics and correct pronunciation. These are especially important issues when trying to learn a new language and successfully resettle[139].

Refugee oral health: What would you expect to see?

> *"It might be late for me, but I want my children to have better health"*

Former refugee[135]

Refugees around the world often have limited access to oral health care services with unmet oral health needs that are greater than most immigrant populations and host communities [140]. A wealth of research shows poor oral health in refugee populations from different host countries and across all age groups. Evidence also indicates that, at the time of arrival, most refugees have retained most of their teeth and have tooth decay that is 'manageable'.

Early treatment to prevent further disease progression is essential, however oral health care services in host countries typically face challenges in providing care that meets the unique needs of refugee communities[141].

Former refugees may arrive in their host country with:

- Poor oral hygiene/homecare
- Unsatisfactory and expensive treatments completed overseas (based on common experiences of being given advice to get all their dental issues addressed before resettlement). These treatments can result in complex treatments that require considerable ongoing maintenance.
- Incomplete treatments, such as orthodontic (braces) treatment or implants.
- Abscesses, extensive dental decay, and other untreated oral diseases, across all ages.
- Torture-related dental and maxillofacial trauma.
- Low health literacy, low, pain relief , antibiotics.

Table 12: Common oral concerns and available health promotion activities and resources

Age group	Oral health concern	Health promotion activities and resources
Children up to 10 years old	• Nursing bottle caries • No/inadequate tooth brushing or not assisting/supervising children to brush • Multiple teeth with dental caries and dental pulp conditions with the need for general anaesthesia • Extractions (primary and permanent teeth) • Beliefs of caregivers e.g., that milk teeth are not important. • Consumption of high-sugar and processed foods	• Tooth brushing chart • Brushing advice storybook, video etc. • Fluoride • Healthy diet • Brushing apps
Adolescents up to 18 years old	• Might start risk behaviours such as smoking tobacco, vaping or sheesha.	• Get the most out of free dental care • Early intervention: this is a good time to improve your lifestyle and affirm good habits for homecare. • Brushing advice, storybooks, videos etc.
Adults	• Early tooth loss that needs replacement • Diet and smoking/vaping • Adjusting to settlement	• Improve access to care • Oral health promotion interventions that are culturally safe

	• Soft tissue lesions, including oral cancer • Trauma • Presence of other chronic conditions, such as diabetes or may be taking multiple medications that cause a dry mouth	
Older adults	• Surrendering lifestyle • May be carer for grandchildren • Uneasy to cope/acculturate • Diet needs and diet change • Might use home remedies • Beliefs e.g., could exhibit strong negative attitudes towards dentistry, tooth loss is a 'normal process' of getting old, artificial teeth are better than natural teeth, etc. • Poor knowledge and awareness of risk factors	• Need support • Peer support • Socialising • Improve their access to oral healthcare • Culturally and linguistically appropriate oral health promotion programmes

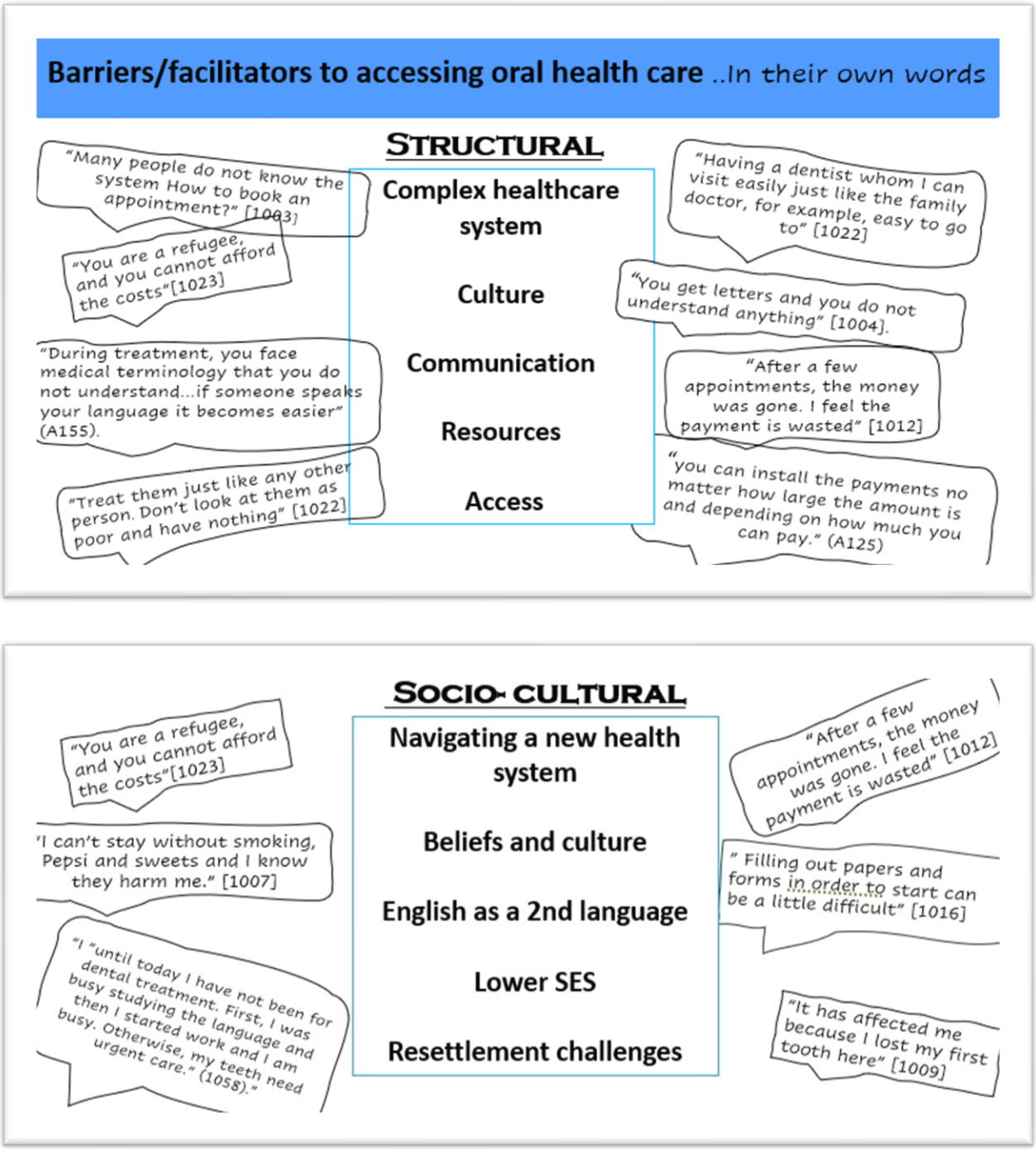

Figure 9: Barriers / facilitators to accessing oral health care ...in their own words (Modified from Al Naasan[135,136])

> *"…the paperwork ... in Syria, this was not present ... it was much easier… filling the papers [in New Zealand] and waiting ... The dental school is cheap, but of course, the private dentist is very expensive ... compared to the private clinics that we used to go to in Syria ... because in Syria is much better"*
>
> Former refugee[135,136]

Action or practice points

Former refugees will confidently access oral health services when the healthcare system is sensitive and safe[142].

8.10.1 Lanage

- Ensure interpreters who are accepted by clients are available, on time, competent, speak the same dialect, if possible, regularly see the same client and keep private information confidential.
- Reassure clients that interpreters are professionally trained and that they will keep all information confidential.
- Be trained in working with interpreters and provide health information in the appropriate language.
- Match clients with providers who speak the same language.

Accessibility and safety

- Provide culturally safe, patient-centred and assumption-free care that ensures clear communication of patients' treatment options and rapport building from first encounters.
- If possible/applicable, have a similar cultural background to the patient - this can help build rapport and trust in the system.
- Explain about the health care system and what is available, possibly more than once. An understanding of the healthcare system of the country of origin is important.
- Undergraduate and postgraduate healthcare training courses need to include modules on refugee health.

Cost

- Offer a flexible payment scheme, for example allowing payment in instalments.
- Provide a clear and prioritised treatment plan.
- Assist with access to community health providers and WINZ assistance.

Knowledge about oral conditions and health promotion

- Be informed on refugees' health needs and encourage health promotion efforts.
- Improve and advocate for health promotion activities that are tailored to the communities and delivered by capable providers.
- Include refugees in the planning and design of health promotion interventions.

“We came after siege for three and four years, we could not go to a dentist and use the toothbrush and there was no toothpaste! I wish they do not judge us in the wrong way that we are people who do not care about the cleanness of our teeth."

Former Refugee[136]

Case study: A co-designed oral health promotion initiative in Aotearoa New Zealand

A study with former refugees from Syria[136,143] identified potential oral health behaviours, requiring targeted health promotion interventions, including:

- excessive sugar consumption and/or improper replacement of sugar, despite knowing about its impact on teeth
- less frequent tooth brushing with inadequate duration and technique, despite knowing about brushing and dental checkups
- a focus on emergency treatment approaches rather than preventive treatment
- tobacco smoking and vaping, not wanting to quit despite knowing about smoking harms
- knowing about having dental checkups, but not put into practice, with the encouragement needed to access oral health services.

Study participants codesigned bilingual health promotion resources, which were used to improve knowledge about oral health and service access in Aotearoa New Zealand[143]. After 6 months of targeted oral health promotion (see *Figure 10*), clinical examinations of 20 participating former refugees showed a significant reduction in gum disease-related clinical indicators, that is, plaque scores, bleeding on probing and pocket depth, as a consequence of their improved tooth brushing[144].

Figure 10: Example of tailored health promotion materials (From Al Naasan[144])

About the Author

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9 Management of refugee health in adults

9.1 Health assessment and management

It is important to remember that most clinical care for former refugee adults is similar to clinical care for those without a refugee background. Up-to-date health management recommendations for former refugee adults can be found in Community HealthPathways.

Table 13: Relevant health conditions for consideration in a syndrome-based approach.

Presentation	Common causes	Additional considerations in people of refugee background
Fever	• Viral infections • Bacterial infections	• Malaria • Measles • Typhoid fever • Dysentery • Dengue and arboviral infections • Hepatitis A • Hepatitis B
Respiratory symptoms	• Viral RTI, including COVID-19 and influenza • Pneumonia • Asthma	• Pertussis – vaccination may not have been available in the country of origin • Tuberculosis • Parasite infections may (very rarely) cause wheezing and/or respiratory symptoms. • Sickle cell disease may present with acute chest syndrome.
Abdominal pain	• Acute infection • Constipation • Surgical or gynaecological causes	• Parasite infection such as Schistosomiasis or Strongyloides • Helicobacter pylori gastritis, epigastric pain, early satiety, nausea or vomiting, and family history • Hepatitis • Typhoid fever • Female Genital Mutilation

Diarrhoea	• Viral gastroenteritis • Bacterial gastroenteritis • Malabsorption	• Parasite infection • Lactose intolerance is more common in some ethnic groups. • Bacillary and amoebic dysentery
Skin Conditions and Rashes	• Infective • Eczema • Dermatophyte (tinea) • Ulcers	• Strongyloides infection may cause an intermittent urticarial rash, lasting a few days (larva currens). This may be located anywhere, typically buttocks or perianal. Patients with untreated Strongyloides infections can develop hyper-infection syndrome (with high mortality) if given immunosuppressant therapy, including steroids. • Measles • Leprosy • Cutaneous leishmaniasis • Haemophilus ducreyi
Eye conditions	• Dry eye • Conjunctivitis • Red eye	• Trachoma • Onchocerciasis/River blindness
Musculoskeletal pain	• Injury • Joint pathology or inflammation • Chronic pain	• Low vitamin D • Somatising presentations
Low Weight / Nutrition concerns	• Poor intake • Increased losses (gut, urine) • Increased requirements • Eating disorders	• Food insecurity (not being able to afford or access adequate food) • Deficiencies, including iron, vitamin B12, and thiamine • Helicobacter pylori gastritis or other gastrointestinal infections • Dental disease as pain with chewing may restrict food intake

Fatigue	• Viral or post-viral infections • Sleep issues • Psychological disorders (e.g., anxiety, depression) • Thyroid disorders	• Deficiencies, including iron and vitamin B12 • Blood disorders, including sickle anaemia
Disability	• Genetic • Environmental • Trauma – injury	• Maybe a multifactorial combination of contributors. • People with complex disability may not have had any access to treatment. Check nutrition and clarify seizures. • Be wary of attributing to English as an additional language – seek specialist review. • Check age. Consider birth date issues. • Consider mental health.
Mental Health Concerns	• Sleep issues • Anxiety • Mental health diagnosis	• PTSD • Experience of violence or conflict, including sexual violence • Clarify family background, separations, migration history, parent mental health, and detention experience for people arriving as asylum seekers.

(Table adapted from Community HealthPathways - Refugee Health in Adults[61])

9.2 Immunisations

Immunisation schedules vary internationally. Some countries offer different combinations or fewer immunisations in comparison to Aotearoa New Zealand. It is therefore important to check the immunisation history for each individual and offer immunisations in line with the appropriate catch-up schedule. Documentation of previous immunisations may not be available and in this case, a full catch-up schedule should be offered and recommended.

Immunisation for those who enter as quota refugees via Te Āhuri Mōwai o Aotearoa may have started offshore and continued at the reception centre. In the resettlement location immunisations need to be completed in a timely way in primary care.

For adults over 18 years old and not eligible for publicly funded healthcare, e.g., refugee-like migrants on a short-term visa, deferring catch-up immunisation may be required until eligible for publicly funded healthcare. These individuals should be put on a recall system as a prompt to check any change in visa status and offer again at regular intervals, e.g., every 6-12 months.

The Immunisation Handbook guides vaccinators in planning catch-up vaccination schedules for young people and adults[125].

Action or practice points

- Immunisation appointments early in the resettlement process are a good opportunity to check in with families, assess progress and provide support and referrals as needed.
- Interpreters should be used when providing immunisations to ensure informed consent is obtained. Use the appointment with the interpreter to schedule follow-up immunisation appointments.
- To ensure catch-up schedules are completed promptly it can be useful to bring the family group in together for an appointment, with enough time allocated for everyone.
- Take the time to understand an individual's hesitance about immunisations. This may be due to mistrust, resettlement stressors or components of vaccines incongruent with cultural or religious practices.
- Access written resources in a language that is appropriate for the individual.
- Consider running community events for additional immunisations, like seasonal influenza. These events can be delivered in accordance with a community's cultural and language needs.
- Regional health navigators or immunisation outreach teams are a great resource to link with to facilitate access to primary care for those who are difficult to engage.
- Check out these videos created by the Ministry for Ethnic Communities, available in several different languages https://www.ethniccommunities.govt.nz/resources/language-information/

Focus area: Maternity care provision for former refugees

Carol Bartle & Claire MacDonald

Main Considerations:

- Primary maternity care is provided by a midwife or midwives in a continuity of care relationship throughout pregnancy, labour, and birth, and postpartum to 4-6 weeks.
- Midwives work in collaboration with obstetric and other medical services when women and birthing people have complex care needs.
- Midwifery care is person and family-centred, enabling, and empowering.
- Midwifery continuity of care situates cultural safety at the heart of care and cultivates relationships of shared power and trust.
- Midwifery care incorporates trauma-informed care by being responsive to the social, psychological, physical, emotional, spiritual, and cultural needs of women and birthing people and by the prevention of new trauma and re-traumatisation during care.
- There is no homogenous 'refugee experience' or reality and experiences of pregnancy are also personal and diverse.
- Some health conditions are more commonly experienced by former refugee populations than the general population, but it is important to avoid assumptions. Taking a full health history elicits necessary information.
- Formal interpreting services are necessary for the safe provision of maternity care in situations where pregnant women and people are proficient in a language other than English, and where the midwife does not speak a woman's language.

Introduction

For a pregnant woman/person arriving in Aotearoa New Zealand following forced migration as a refugee or asylum seeker, maternity care may be the first systematic engagement with the health system in this country. Woman/person and family-centred midwifery care can make this experience enabling and empowering. Midwifery continuity of care within an integrated maternity service which situates cultural safety at the heart of all care provision has the potential to cultivate relationships of shared power and trust. From this foundation, effective maternity care can be achieved.

Meeting the information needs of women and birthing people from all refugee backgrounds is an essential part of midwifery care. Some former refugee women and birthing people may have lost access to their usual information sources, such as extended family and friends, and their husbands/partners may become their sole support. It is important to include the woman's/birthing person's partner and/or chosen support people during discussions about expectations of care.

A positive experience of maternity care can support pregnant women and people to engage with and demystify a new health system. It can also promote parent/caregiver confidence to access ongoing health care as they raise their children in their new home. Midwifery care responds to the social, psychological, physical, emotional, spiritual, and cultural needs of all women and birthing people seeking maternity care[145]. Labour and birth with a trusted midwife who has come to know the woman/person and whānau, their history and birth plan, and works collaboratively with secondary services as needed, represents optimal, culturally safe care for former refugees.

This section outlines the components of primary maternity care and specific considerations for former refugee women and gender-diverse people.

Continuity of care

Pregnancy involves significant changes in the lives of women, people and whānau. The arrival of a baby or the growth of a family can signal a new start in a new home but also may involve the expression of physical, emotional or mental health difficulties reflecting the circumstances that led to a former refugee woman/person arriving in Aotearoa New Zealand.

Continuity of midwifery care is when there is one lead maternity care professional (and their back-up/s) who plans, organises and provides care from confirmation of pregnancy through to the postnatal period.

Primary maternity care is provided by a midwife or midwives in a continuity of care relationship throughout pregnancy, labour, and birth, and postpartum to 4-6 weeks. Midwife-led continuity of care provides individualised and personalised care and support during pregnancy, childbirth, and the postnatal period. When women/birthing people have complex care needs, midwives work in collaboration with obstetric and other medical services.

Continuity of midwifery care provides an opportunity for the woman/person to gain confidence, trust, and self-efficacy through a positive experience of the health system in their new home country. Women and birthing people are entitled to receive the care they need for a healthy pregnancy, birth, and postpartum period as part of their wider, lifelong healthcare requirements. During maternity care, this may involve additional support alongside midwifery care such as medical services, social support services, peer-to-peer support, refugee support services and navigators, and interpreting services throughout.

Continuity has been identified as an important factor in improving the quality of care, trust, confidence, and overall satisfaction in refugee maternity care[146]. Using a continuity of care model in a clinic for refugee pregnant women reduces the need to revisit traumatic experiences, allowing more time to discuss current issues and facilitate a trusting relationship[147].

Communication between health care providers is paramount so that women and birthing people can experience the health system as being seamlessly integrated, to minimise barriers to access. Indeed, this level of care should be the expectation for all women and gender-diverse people accessing our maternity service.

Preparing for the provision of midwifery care

If the woman/ birthing person is pregnant on arrival to Aotearoa New Zealand, a maternity care record will have been commenced in the Maternity Clinical Information System used in Aotearoa New Zealand, Badgernet, by the Counties Manukau community midwifery team at Te Āhuru Mōwai o Aotearoa. LMC midwives who use Badgernet will be able to continue the same record. Secure electronic transfer of records from Badgernet to other practice management systems can be arranged through the Aotearoa New Zealand College of Midwives.

If the referral has been received from a third party, ask for any information they can share about the woman/birthing person's circumstances and needs to prepare for the registration visit. If the woman/person becomes pregnant after arrival in the resettlement area, request a health history document from the primary health care provider as background for the midwifery registration visit.

If they are not proficient in English, ask which language the woman/birthing person prefers to receive their midwifery care in and arrange an interpreter for that language. Maternity care providers are encouraged to undertake education on working with interpreters to optimise effectiveness and appropriateness.

Allow additional time

Appointment times may need to be flexible to support access to care – women/people and whānau may not drive and may rely on others for transport. Work conditions of the woman/birthing person or partner may be inflexible in terms of taking time away for an appointment.

Ask about the woman's/birthing person's understanding and expectations of antenatal care from their homeland or previous births. The use of professional interpreters (for more information, see Section 7) is essential where the woman/birthing person does not have proficient English. Some women/people may exercise collective decision-making together with their families, and it is important to use an interpreter even if someone in the family is able to translate.

Cultural considerations

The following information is provided as points to be aware of, but with the clear proviso that everyone defines their own culture and its relevance to childbirth. Midwives demonstrate culturally safe practice by always asking and not making assumptions about beliefs, practices, or world views.

In many cultures, pregnancy and childbirth are situated as women's processes, and male partners/husbands sometimes have limited involvement. It is important to ask pregnant women and people if they would like a partner and/or other support people to be involved in care, and to take time for discussions with the identified support people about what is important for them.

Former refugee women and birthing people bring with them the knowledge and practices from their home countries where pregnancy care will differ from the model of care in Aotearoa New Zealand. At the same time, former refugee and migrant women often wish to explore the choices and options open to them in their new country[148].

Pregnant women often look to their mothers, mothers-in-law, sisters, or other female relatives to support them and provide advice and cultural guidance about pregnancy and motherhood. Some women have reported dissonance when the advice they receive from their midwife differs from that of those in their family[148,149]. That said, traditional roles and expectations may also change over time with migration so, again, the most important thing to do is ask. Intergenerational practices should be discussed and respected. Meeting at the woman's/birthing person's home at least once or twice during the pregnancy can support the balancing of power and help to build trust and shared understanding.

Encouraging the partner or family support person to attend midwifery visits enables questions to be asked and answered. Discussion about the woman's/birthing person's experience of pregnancy, their expectations for birth and cultural considerations about how a new baby will be welcomed can be initiated for the partner/father or other carers to be involved and supportive of the woman/birthing person. Postnatal examinations and discussions about recovery from childbirth, family planning, and sexual and reproductive health are important for the woman's/birthing person's wellbeing but must be undertaken with sensitivity and in discussion about what is appropriate to share if others are present.

The first midwifery visit

The first visit, also known as the registration visit – is an opportunity to understand and explain how maternity care works in Aotearoa New Zealand and the midwife's role. Carefully exploring the woman's/ birthing person's expectations of care can support sensitive discussion about the maternity system.

Women, people and whānau from some countries may not have received any formal antenatal care and others may have only had hospital-based or medical-led care. In some parts of the world, midwives are considered low-status and have had minimal education or training. This can mean that some women, people and whānau may be focused on medical care, expecting to routinely see an obstetrician, because of this different understanding of the scope of midwifery care.

Consider undertaking the registration visit in the woman's/birthing person's home to build rapport and develop an understanding of their family and living circumstances. Advise the woman/birthing person that they are welcome to have a partner and/or other support people with them at the appointment.

To build trust from the outset, it can be valuable to explain that in Aotearoa New Zealand:

- antenatal care is provided by midwives who have a wide scope of practice, which includes providing information, making clinical assessments, ordering, and interpreting investigations and making clinical decisions including when to refer for medical involvement
- midwives are degree-educated and integrated into the wider health system, working closely with medical doctors when needed
- if any concerns arise during pregnancy a referral to an obstetrician will be arranged

- the midwife will always take the woman's/birthing person's concerns seriously and make a full assessment and plan should the need arise.

Clear explanations and cultural sensitivity can help create a safe and trusting environment. A study of asylum-seeking women in high-income countries identified a theme, "I was never sure if I had understood" which demonstrates how a lack of effective communication can exacerbate experiences of isolation and distress[150].

Advise the woman/birthing person that their privacy will be respected and that their information will be kept confidential and only shared with other health professionals directly involved in their care, which occurs in discussion with the woman/birthing person. In some situations, confidentiality may be an unfamiliar concept resulting in the woman/person people being reluctant to share their health information.

Respect women and birthing people's informed decisions, even when contrary to the care provider's own beliefs. The process of informed decision-making necessitates the midwife to have clear and detailed discussions, with the woman/person and, where appropriate, to make clinical recommendations.

Information about Ongoing Midwifery Care

- Explanation of the maternity system and the midwife's role, as well as the role of medical practitioners and social support services
- Backup arrangements and how to make contact for urgent and non-urgent issues
- Reasons to contact the midwife urgently
- Frequency and place of antenatal visits.

Midwifery Clinical Assessment

- Compile health history: previous pregnancy, birth and postnatal experiences, physical psychological, and emotional wellbeing. Review health assessment from Te Āhuru Mōwai o Aotearoa, Counties Manukau midwifery team or primary health care provider.
- Collect and compile relevant information such as country of origin, and personal and family details. Ask whether the couple is related to one another (prior to marriage) and if so, how. Marriage within wider family groups is not unusual in some cultures and the potential for genetic issues needs to be considered.
- Ask about FGM (female genital mutilation, also called female genital cutting) if the pregnant woman/person is from a country or culture where this is practised. See *Focus area: Female genital mutilation*.
- Ask about specific cultural and spiritual beliefs/needs.
- Discuss and refer for specialist consultation as required. Note the need for an interpreter and the language required on the referral. Assess the ability to access services and where barriers to access exist, refer to navigational support or other regional support services to facilitate attendance.

- Screen for family violence (when a partner is not present); offer support and referrals where necessary. See *Section 8.8* for family violence screening tool.
- Provide clear, understandable information about maternity-related screening, investigative and diagnostic tests and how these are accessed.

Screening Tests

Women and birthing people from some countries may be unfamiliar with routine screening tests such as cervical screening and screening for chromosomal anomalies during pregnancy.

Former refugee women made a key point in relation to screening tests:

> *It is important that no assumptions are made, and that care is provided in a way that does not signal racial or ethnic profiling.*
>
> Focus group, New Zealand College of Midwives[149]

Careful discussion and explanation are necessary to avoid misunderstanding and to ensure full comprehension of why screening tests are offered. Make sure to explain that certain tests – the first antenatal screen, which includes HIV, hepatitis B and syphilis, and other tests offered routinely for certain clinical presentations such as STI swabs – are offered routinely to all pregnant women and birthing people and not solely targeted at former refugees. Full and culturally appropriate information is provided about risk factors, and the implications of being HIV positive in pregnancy, in a safe environment for all women.

Key practice considerations

First trimester

- Develop a plan for midwifery care together with the pregnant woman/person and whānau.
- Folic acid.

Full first antenatal screen blood tests:

- Consider adding ferritin, given the higher rates of anaemia in refugee populations.
- Seek advice and follow up on any unusual haematology results which may flag haemoglobinopathies, parasitic infections or other health issues not commonly seen in Aotearoa New Zealand. [Consult Community HealthPathways – Refugee health in adults]

Combined screening for chromosomal anomalies:

- NT scan and MSS1. https://www.nsu.govt.nz/pregnancy-newborn-screening/antenatal-screening-down-syndrome-and-other-conditions/about-test

- Place of birth options: Some women and birthing people from refugee backgrounds may have complex maternity care needs and require birth in a secondary or tertiary maternity hospital. Discuss this possibility, as well as explain that women and birthing people with straightforward pregnancies also have the option of birth at home or a primary birthing unit.

Second trimester

- MSS2 (if MSS1 is not undertaken and the woman wants to screen for chromosomal anomalies).
- Gestational diabetes screening according to the Aotearoa New Zealand national guidelines.

Third trimester

- Foetal growth assessment: fundal height, referral for ultrasound if concerns about foetal growth or clinical indication for serial growth scans.
- Foetal movements: information provided to women and birthing people, and assessment of concerns about decreased foetal movements.

Birth Interventions

- Induction of labour (IOL): Discuss guidelines for prolonged pregnancy as IOL may not be customary in a woman's/person's former homeland.
- Caesarean section: Discuss indications for both pre-labour and acute in-labour caesarean birth, along with any concerns a woman/person and whānau may have regarding the need for an emergency caesarean.
- Previous caesarean section in another country: an obstetric consultation is necessary due to differing surgical birth practices globally and the difficulty in obtaining clinical records from overseas hospitals. Caesarean sections may have been performed in settings where minimum standards of safety and quality have not been achieved which increases the potential for complications[151]. Decisions about the mode of birth warrant careful consideration.

Additional health promotion and education

- Discuss and provide routinely recommended prescriptions. Recommend iodine.
- It is important to explain the importance of vitamin D supplementation for women and birthing people and babies with darker skin pigment and/or who completely avoid sun exposure for religious, personal or medical reasons e.g., women and birthing people who are covered by veils and clothing over their whole body. Prescribe according to Ministry of Health recommendations[152].
- Influenza and pertussis vaccinations: Recommend and ensure the woman/birthing person understands how they can access these in a timely way,

i.e., pertussis from 16 weeks of pregnancy and influenza during flu season in any trimester.

- Breastfeeding and infant feeding: Discuss during antenatal care in preparation for birth. Commercial promotion of formula feeding has resulted in some people holding perceptions that bottle feeding is modern or superior. Antenatal discussion and education about the recommendation for breastfeeding are important.
- Nutrition: ask about which foods are important during pregnancy in the woman's/birthing person's culture or country of origin. Consider how this can be integrated with nutrition recommendations for pregnancy or specific clinical situations, such as gestational diabetes. Consider how recently the refugee journey occurred and whether there is a potential for undernutrition. Ask about access to nutritious food for pregnancy wellbeing (food security) and refer to a refugee navigator or social support agency if needed.

Postnatal Care

Along with the comprehensive routine postnatal care that midwives provide, there are some relevant points to consider in the care of former refugee women, birthing people, and their babies:

1. Postnatal Cultural Practices

Culture plays a role in how a woman/person and family prepare for having their baby. Cultural postpartum practices can include specified rest periods, some restricted activities, prescribed diets, hygiene practices, diverse beliefs and practices around breastfeeding and infant feeding, and practical and emotional support and assistance from family members over designated periods of time[153,154]. These practices are in response to the recognition of women and birthing people's specific needs to aid their recovery from childbirth.

Women and birthing people may or may not intend to observe the cultural practices of their home country, ethnic or religious group. It is important to ask questions about what cultural practices they would like the midwife to be aware of during pregnancy, birth and the postnatal period.

There may be an elevated risk of perinatal mental illness due to the psychosocial stressors associated with forced migration and resettlement adjustment[155] although it cannot be assumed that complex life factors will affect all women in the same way[156]. A factor to be considered in terms of postnatal depression is the possibility that women and birthing people may feel isolated and have limited family support systems resulting in the absence of expected care and practical assistance after birth.

2. Postnatal Recovery

A key point made during a focus group held with former refugee women was that with the woman's permission, sensitively discussing postpartum recovery with both

partners present in relation to the resumption of sexual activity can be of benefit to women[149].

3. Infant feeding

While providing information about breastfeeding, be aware of the importance of recognising the knowledge, traditions, and practices of other cultures. This may include discussing infant feeding together with the woman/person and family/support people and ensuring that the knowledge of other experienced mothers in the woman's/person's life is valued.

4. Transfer from midwifery to Well Child Tamariki Ora (WCTO) and primary health care provider.

Sharing information with the woman/person and whānau about ongoing care provision is necessary and important. It can be helpful to provide an in-person introduction when referring clients to the primary health care and/or WCTO provider to outline any specific care needs including interpreting services.

Clinical considerations relating to former refugees during maternity

Vitamin D Deficiency

- Vitamin D deficiency is associated with an increased rate of adverse pregnancy outcomes[157] and is a risk factor for the development of hypocalcaemia and rickets in the baby/child[152]. Vitamin D deficiency is common in Aotearoa New Zealand and more common in former refugee populations[158], but is not routinely screened for as part of the offshore or arrival refugee health assessments.

Anaemia: Iron deficiency and other causes of anaemia

- Anaemia is common among former refugee and migrant women and birthing people, and iron deficiency is the most common cause of anaemia.
- Haemoglobin is routinely assessed at the first antenatal screen and subsequent antenatal screen/s. It can be of value to add ferritin to assess iron stores.
- Iron deficiency anaemia (IDA) affects wellbeing and energy levels and is associated with several adverse pregnancy outcomes, so treatment is important. Consider alternate-day oral iron supplementation if not well tolerated to decrease gastrointestinal side effects.
- Delayed cord clamping after birth is recommended to ensure that newborn babies have optimal blood volumes. This practice supports improved infant iron levels which are detectable for several months after birth.

Haemoglobinopathies

- Haemoglobinopathies cause other types of anaemia. Midwives providing care for women and birthing people from regions where haemoglobinopathies are more common are recommended to seek early medical advice in relation to screening, ideally during the first trimester. These regions include Southern Europe, the

Middle East, Africa, Southeast Asia, India, and the Pacific Islands. If test results are positive, partner testing may be recommended.

- If there are other unusual haematological results (MCH/MCV/HCT out of normal range) or comments (microcytosis, macrocytosis, increased reticulocytes etc) or IDA is not resolved with oral iron, be aware of the potential for undiagnosed haemoglobinopathies. Seek advice for any unusual results and refer for obstetric consultation as required.

Sickle cell disease in pregnancy

- Sickle cell disease (SCD) is a transfer-level condition in the Aotearoa New Zealand Referral Guidelines[118]. Women and birthing people with SCD should be referred as early as possible in pregnancy for obstetric consultation and multidisciplinary pregnancy care.

  During pregnancy, SCD can become more severe and pain episodes can occur more frequently, and it is associated with a higher chance of maternal and foetal complications. Aotearoa New Zealand clinicians may refer to the UK RCOG guidance on the Management of Sickle Cell Disease in Pregnancy. For general information about SCD, see the main section of this handbook.

Thalassaemia in pregnancy

- For general information about thalassemia, see the main section of this Handbook.
- Pregnant women and people with thalassaemia require referral for obstetric consultation and management according to the particular trait and status of their partner. Pregnant women and people with β thalassaemia have an increased risk of cardiomyopathy due to iron overload and an increased chance of foetal growth restriction.

Aotearoa New Zealand clinicians may refer to the UK RCOG guidance on the Management of Beta Thalassaemia in Pregnancy.

Artwork by Huriana Kopeke -Te Aho

About the authors

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Claire and Carol led the development of this chapter in collaboration with their advisor and stakeholders. Focus group participants referenced throughout this section include Naema Nur Warsame, Shamsia Zahedi, Shaqaiak Masomi and Sahra Ahmed.

Focus area: Female genital mutilation (FGM)

Nikki Denholm & Ayan Said

The World Health Organization defines female genital mutilation (FGM) as 'all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons[159].

FGM is recognised as a global human rights issue, with 200 million girls, and women affected by the practice and 4 million at risk each year. It constitutes a form of discrimination against women, is a violation of the rights of children, a woman's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman, or degrading treatment, and the right to life when the procedure results in death[159].

FGM is a complex multifaceted practice, deeply embedded in a range of cultural, social, and religious beliefs - and can only be understood within this context. It is important that health practitioners treat FGM with sensitivity, understand the cultural context of the practice, and are mindful of other refugee issues clients may be experiencing.

It is also helpful for practitioners to reflect on their attitudes towards FGM. While FGM may be regarded as oppressive, women affected by the practice may view FGM as part of their 'honour' and self-identity[160]. However harmful FGM may seem from a Western viewpoint, it is often endorsed by loving parents in the belief that it will ensure their child's health, chastity, hygiene, fertility, honour and eligibility for marriage[161].

Types of FGM

The World Health Organisation provides technical descriptions of the different types of female genital mutilation known to be practised:

Type I: Clitoridectomy: partial or total removal of the clitoris and/or the prepuce. Variations/subdivisions include:

- Type Ia. removal of the clitoral hood or prepuce only.
- Type Ib. removal of the clitoris with the prepuce.

Type II: Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora. Variations/subdivisions include:

- Type IIa. removal of the labia minora only
- Type IIb. partial or total removal of the clitoris and the labia minora
- Type IIc. partial or total removal of the clitoris, the labia minora and the labia major

Type III: Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without the removal of the clitoris. Variations/subdivisions include:

- Type IIIa. removal and apposition of the labia minora
- Type IIIb. removal and apposition of the labia majora

Type IV: All other harmful procedures to the female genitalia for non-medical purposes 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 tissues; scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts) or introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it[162].

Estimated prevalence of FGM

Over 200 million women and girls have undergone FGM globally. The table below shows the countries with the highest concentration of FGM; not all are represented in Aotearoa New Zealand's former refugee population.

Table 14: Countries with the highest prevalence of FGM

Countries	Prevalence in population (%)
Benin	9
Burkina Faso	68
Cameroon	1
Central African Republic	22
Chad	34
Cote d'Ivoire	37
Djibouti	90
Egypt	87
Eritrea	83
Ethiopia	65
Gambia	73
Ghana	2
Guinea	95
Guinea-Bissau	52
Indonesia	49
Iraq	7
Kenya	21
Kurdistan	42.8
Liberia	32

Maldives	13
Mali	89
Mauritania	64
Niger	2
Nigeria	15
Senegal	25
Sierra Leone	83
Somalia	99
Sudan	87
Togo	3
Uganda	0.3
United Republic of Tanzania	10
Yemen	19

(Source: UNICEF[163])

FGM health care needs and working with individuals with FGM in Aotearoa New Zealand

FGM has become an important reproductive health issue in Aotearoa New Zealand following the increase of refugee and migrant women settling here from countries that practice FGM. Many women with FGM have unique reproductive and sexual health needs and these needs can be poorly understood.

> *"The women are reluctant to talk to their doctors or midwives about Gudniinka (FGM) because they think they don't know anything about it and so they don't feel comfortable to bring it up."*
>
> *Former refugee, Aotearoa New Zealand*[164]

> *"We are afraid to share about FGM Type 3 – but we face a lot of difficulties with it"*
>
> *Former refugee, Aotearoa New Zealand*[165]

A 2018 FGM Health Care Survey with Somali women affected by FGM in Aotearoa New Zealand indicated that few Somali women living in Aotearoa New Zealand receive antenatal FGM examinations and/or discussions surrounding birth and re-suturing[165].

> *"The midwife should talk to the woman about Gudniinka [FGM] before the birth. I'm currently pregnant but my midwife hasn't mentioned circumcision."*

Former refugee, Aotearoa New Zealand[164]

The survey findings also indicated that women affected by FGM have unique sexual and reproductive health care needs. These include a self-reported high rate of painful initial intercourse, regular painful sex, urinary difficulties, and urinary tract infections (UTIs).

Communicating FGM-related needs to health practitioners can be difficult, particularly for newer refugee arrivals. The survey indicated women are often reticent to raise sexual and reproductive health care issues with their primary care provider due to cultural, religious and gender taboos and barriers.

Longitudinal data collected in Auckland shows there has been a persistent lack of communication between health providers and women with FGM[165]. This includes a lack of discussion surrounding sexual and reproductive health needs, birth planning, and post-partum care. Effective and sensitive communication with women affected by FGM is therefore vital and may need to be practitioner-led.

> *"My midwife never talked about FGM Type 3. It is possible she doesn't know about the anxiety, sleeplessness and stress that can be related to FGM Type 3 during pregnancy"*
>
> *Former refugee, Aotearoa New Zealand*[165]

> *"In New Zealand, they are silent about it. I need someone to give me more information about childbirth and FGM and someone who knows about our culture"*
>
> *Former refugee, Aotearoa New Zealand*[165]

What are the complications of FGM?

There are a range of potential short- and long-term complications associated with FGM. These vary depending on factors such as the type of FGM, the extent of cutting, parity, and the skill of the operator.

Complications can include the following:
• haemorrhage, shock, and pain[159,166,167]. • infection and injury to adjacent tissue and/or the urethra[159,166,167]. • vulval abscesses, keloid scars, dermoid cysts, neurinoma[166,168]. • difficulties with micturition and recurrent urinary tract infections[166,168]. • difficulties with menstruation. • chronic pelvic infections[166]. • difficulty, fear, anxiety, or pain associated with sexual intercourse[166,168]. • difficulties in pregnancy[167]. • difficulty monitoring the progress of labour and/or performing induction[167].

- complications during delivery such as obstructed labour and tearing to the perineum[167].

"It was very difficult. My husband and I suffer during our marriage to have sex due to FGM. They (doctors and midwives) need to learn and have knowledge about FGM"

Former refugee, Aotearoa New Zealand[165]

"There can be so many health problems for us with FGM … period, sex and childbirth problems"

Former refugee, Aotearoa New Zealand Refugee woman[164]

Of note, women affected by FGM may not associate these health complications with FGM, but rather see them as 'normal'.

Pregnancy, labour, birth, and postnatal care for women with FGM

Care for women with FGM during pregnancy, labour and birth, and postnatal care should, where possible be provided by a health care provider who is familiar with FGM and with the New Zealand FGM Clinical Care Antenatal, Labour & Birth and Postnatal Guidelines*[169]*. At a minimum, it is crucial that maternity care providers ask about FGM and refer for relevant specialist assessment, birth care planning and follow-up. Women with FGM Type 3 may require de-infibulation before or during labour as detailed in the New Zealand clinical care de-infibulation guidelines[170].

Wider areas that may need discussion during the antenatal period include:

- The anatomy and physiology of unaltered genitalia compared with FGM
- Physiological changes in menstruation, urination and sexual intercourse following deinfibulation.
- The need for referral to a registrar/obstetrician during labour or birth, and deinfibulation during delivery.
- Gender preference of medical staff - some women and birthing people may request a female registrar/obstetrician, so availability needs to be discussed in advance.
- Preference for re-suturing the scar site after birth - as restoring the scar site to a state of infibulation is illegal in Aotearoa New Zealand.
- Some women may experience psychological trauma or flashbacks during childbirth related to FGM and require support.

Source: New Zealand FGM Education Programme[169]

An FGM genital assessment is recommended during the early antenatal period once a trusting relationship has been established with a provider. Identifying the type of FGM and the degree of impact will help inform birth plans and minimise the risk of complications. Midwives are encouraged to seek support from colleagues in Te

Whatu Ora – Health New Zealand or the New Zealand College of Midwives if they are not confident in providing FGM clinical care.

> *"We need someone who knows about FGM Type 3 and how to cut us open during labour"*
>
> *Former refugee, Aotearoa New Zealand*[165]

For many women affected by FGM, childbirth is a collective experience, with family members involved in all aspects and stages of care. Decisions surrounding childbirth such as induction of labour or caesarean section may therefore need to be made in consultation with family members.

> *"They really need support at this time because they often don't have family here"*
>
> *Former refugee woman, Aotearoa New Zealand*[164]

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 birth (at around 24 weeks gestation); or during teenage years if menstruation and urination are difficult [170]. For more information, see Deinfibulation Guidelines: https://fgm.co.nz/wp-content/uploads/2021/04/fgm-deinfibulation-guidelines-2009.pdf

Some women may present to health services days before marriage requesting deinfibulation. It is important that the request is treated as urgent where possible as prolonged unsuccessful attempts to penetrate the scar tissue can cause physical and psychological pain and distress to both partners.

It is essential that deinfibulation is accompanied by education on the physiological changes to urination, menstruation and sexual intercourse following the procedure to help minimise 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"*
>
> *Former refugee woman*[171]

Family planning considerations for women with FGM

Women with FGM Type 3 may have slightly fewer effective contraception options as the narrowed introitus and lack of vaginal access can prevent natural family planning and diaphragms and intrauterine contraceptive devices (IUCD) including Mirena may be difficult to insert. Depo Provera or Jadelle may be a preferred contraception option for women affected by FGM. Some women may also hold views that are opposed to the use of family planning due to cultural and religious beliefs [165].

Sexual health screening for women with FGM

Performing vaginal examinations and cervical smears and screening for STIs on women with Type 3 FGM (prior to giving birth and/or sexual intercourse) can be

difficult due to the narrowed introitus. In the homelands of women affected by FGM, routine screening may also not be customary so they may not be familiar, or comfortable with sexual screening procedures, particularly in the absence of any symptoms of disease or illness. In these instances, pre-screening education should be provided.

Action or practice points

When caring for an individual with FGM, consider the following:

- Use appropriate, non-judgemental terminology when referring to FGM. Avoid 'female genital mutilation' and ask for the client's own terminology (such as the Somali word 'Gudniinka'), or use terms such as 'cutting,' or 'female circumcision'.
- Upskill on FGM, to increase your understanding and clinical skills.
- Let the client know of your understanding of FGM - this may make them feel more comfortable raising concerns.
- Consider referral to a female doctor.
- Document findings in detail, to minimise the need for repeated questions and/or examinations.
- Use discretion in discussing FGM in a wider family consultation.
- Be aware that your client may never have had a gynaecological examination before.
- Pelvic examinations may be difficult, painful, or impossible; so careful angulation of instruments and one-finger examination may be necessary.
- Many women with FGM regard their altered genitalia as normal and some could be unaware if they have undergone FGM if the procedure was performed in infancy.
- Illustrations can be helpful (see www.fgm.co.nz) to help clients self-identify FGM without requiring an examination.
- Some clients may be unaware of the medical complications associated with FGM, regardless of their own experiences.
- Some women may wish to discuss FGM-related concerns but be reticent to raise them due to traditional cultural taboos around discussing sexual health issues. Raising the issue may need to be practitioner-led.

> *"It's very hard for the young girls – especially if they have pharaonic (Type 3). The doctors need to communicate well with the women. With me, I was cut open during birth, and no one told me what happened afterwards. No one told me"*
>
> Former refugee, Aotearoa New Zealand[164]

FGM and New Zealand law

FGM is illegal in Aotearoa New Zealand under the Crimes Act Amendments 1996 and 2020[172].

It is illegal to perform FGM on a child in Aotearoa New Zealand or to send a child overseas to have FGM performed[173]. It is also illegal in Aotearoa New Zealand for medical professionals to re-infibulate (re-stitch the remaining labia) a woman or gender-diverse person's genital scar tissue following de-infibulation either in pregnancy or labour[169].

Male baby circumcision

Male circumcision is not a routine procedure in Aotearoa New Zealand and is only recommended and funded for a very small number of medical conditions such as phimosis and recurrent balanitis. Most circumcisions are done for religious and cultural reasons and health care providers are likely to encounter situations where families plan to have their male babies circumcised.

The Royal Australasian College of Physicians (2012) has developed a position statement on circumcision that states parents need to weigh the benefits and risks when deciding whether or not to circumcise their sons, and parental choice should be respected. The provision of accurate unbiased and up-to-date information on the risks and benefits of the procedure should be provided by the health practitioner, who is also responsible for postoperative instructions and care. Health practitioners can support families by providing information about services in their localities when necessary.

Circumcision operations are unavailable in the public health system, and a fee is charged for services provided by health practitioners whether in a primary or private clinic[99].

About the authors

N*ikki Denholm* *MNZM, has a nursing and midwifery background and founded the National NZ FGM Education Programme in 1998. She has worked on FGM issues across Africa, as an FGM technical advisor for WHO, and alongside communities affected by the practice for 30 years.*

Ayan Said *is an FGM educator and researcher. She is of Somali descent and originally from Mogadishu, Somalia. Ayan has been a public health professional, educator, and advisor for the past ten years. Ayan holds a bachelor's double major in psychology and health promotion, a Master's in public health, and is undertaking a PhD in public health at Auckland University of Technology*

Focus area: Trauma-informed approaches to refugee resettlement in Aotearoa New Zealand

Marieke Jasperse & Jawahir Ahmed

> *"We have only certain images about refugees. When you hear 'refugee' it looks like somebody is scared, it means somebody escaped and they have no options. We need to change that idea about refugees. We need to focus on the positive side of their lives. How they managed to survive. How they were able to succeed here in New Zealand"*
>
> Former refugee interpreter assisting resettling communities and clinicians across Aotearoa New Zealand[174]

While it is crucial to acknowledge the devastation and distress associated with displacement, we start this chapter by acknowledging the dignity and determination of resettling clients, communities, and colleagues across Aotearoa New Zealand[1]. Inspired by international and indigenous insights, we provide our interpretation of Te Whare Tapa Whā, trauma, and trauma-informed care. We aim to assist you in cultivating an awareness of the resettlement context in Aotearoa New Zealand so that you can provide trauma-informed care to resettling clients. Specific considerations for clients across the life span (childhood, adolescence, adulthood, and older adulthood) are provided towards the end of the chapter.

Te Whare Tapa Whā

The World Health Organization describes wellbeing as a fundamental human right. Our wellbeing is reflected in our overall physical, psychological, and social state, and is the result of a complex interplay of individual, collective and contextual factors[175].

A complimentary conceptualisation of wellbeing in Aotearoa New Zealand[2] is Te Whare Tapa Whā, developed by Sir Mason Durie, an indigenous psychiatrist and scholar[176,177]. This model describes wellbeing as a wharenui/meeting house with four walls (*see Figure 3*). These walls represent taha wairua/spiritual wellbeing, taha hinengaro/mental and emotional wellbeing, taha tinana/physical wellbeing and taha whānau/family and social wellbeing. One's connection with the whenua/land forms the foundation and when all these things are in balance, people thrive. When one or more of these is out of balance one's wellbeing is impacted[178].

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[1] Throughout this chapter we refer to "resettling individuals", "resettling communities" and/or "resettling clients". This is an attempt to acknowledge that resettlement in New Zealand is an ongoing, often protracted process and that individuals are granted residence on arrival in New Zealand and thus are technically no longer refugees.

[2] Any discussion of health in Aotearoa New Zealand requires acknowledgement of Tangata Whenua and Te Tiriti. We acknowledge that Tangata Whenua have their own experiences of displacement and distress and are disproportionately represented in our healthcare system. Honouring the principles of Te Tiriti, protection, partnership, and participation, and decolonising healthcare is not only required to address this issue but has significant implications for wellbeing of resettling communities.

Trauma

One thing that can throw these things out of balance is trauma. In this chapter, we acknowledge an international definition of trauma [179] that has been revised by indigenous scholars in Aotearoa New Zealand[180].

> *"Trauma is the lasting adverse effect on a person's or collective's functioning and mental, physical, social, emotional or spiritual wellbeing, caused by events, circumstances or intergenerational historical traumatic experiences."* [181]

The effects of trauma vary significantly from person to person.

- Adverse mental symptoms can include difficulty concentrating and recalling information, distortion of time and space, intrusive memories or flashbacks, self-blame and/or suicidal ideation.
- Adverse physical symptoms can include nausea and/or gastrointestinal distress, sweating or shivering, elevated heartbeat, respiration and blood pressure, preoccupation with body aches and pain, exhaustion and trouble sleeping.
- Adverse social symptoms can include difficulty expressing oneself, isolating and avoiding social situations, aggression, increased use of alcohol, drugs, and tobacco and/or other high-risk behaviours.
- Adverse emotional symptoms can include a sense of numbness, overwhelm, anxiety, anger, guilt, grief, depression, and/or shame.
- Adverse spiritual symptoms can include despair and disillusionment, loss of perceived self-efficacy, cynicism, or loss of faith.

Many of these adverse symptoms are associated with mental disorders such as post-traumatic stress disorder, depression, and anxiety[182] (see *Table 15).* If these symptoms persist, then a range of interventions may be required, including a referral to a primary health care provider and/or mental health practitioner. An awareness of the resettlement context and principles of trauma-informed care can assist you in working with resettling clients to identify the most appropriate intervention.

Trauma-informed care

Trauma-informed care is based on a set of principles, rather than a prescribed set of practices or procedures[179,181,183]. These principles are as follows:

- **Realise** the widespread impact of trauma and the range of potential pathways for recovery.
- **Recognise** the signs and symptoms of trauma in all individuals, including practitioners. **Respond** by fully integrating knowledge about trauma into policies, procedures, and practices.
- **Resist** re-traumatisation, restore a sense of safety, and reflect on any assumptions you may hold.

An overview of these specific considerations for resettling clients is provided in the following section.

Trauma-informed considerations for resettling clients

> *"I guess what I'd like people to know about refugees is that they're not helpless individuals who we should all pity and wrap in cotton wool. They're people. People who would like to have a life and be independent. Some of them do have textbook post-traumatic stress with the nightmares, flashbacks, and all the rest of it but the resilience is remarkable"*
>
> Psychiatrist supporting resettling clients across Aotearoa New Zealand[174]

Realise

In the context of refugee resettlement, trauma-informed approaches realise that resettling individuals have likely been exposed to a range of potentially traumatic experiences while becoming and being a refugee[184]. These potentially traumatic experiences tend to be characterised by profound loss: loss of loved ones, loss of land, loss of lifestyle and status, loss of safety and security, and ultimately a loss of control. No one chooses to be a refugee[185].

Once in their new society of settlement, resettling individuals are often subject to further traumatisation as they navigate the process of resettling in a foreign country and culture. This can include encountering restrictive resettlement policies, prejudice and discrimination, difficulty obtaining employment, and experiencing poverty, isolation, shame, and stigma[186-188]. These types of experiences can elicit significant adverse physical, psychological, social, and spiritual symptoms and will require a range of responses, referrals, and resources to recover and resettle successfully.

> *"War exposure, for all of its destructive power, should not be assumed to be the sole or even primary, source of distress among refugees"*
>
> Psychologist supporting resettling communities in the USA[186]

Recognise

Trauma-informed approaches recognise the resilience of resettling clients and acknowledge that adverse symptoms of trauma are not always an indication of mental illness[189]. While it is important to be cognisant of the symptoms associated with post-traumatic stress disorder, depression, and anxiety[3] (see *Table 15*), it is important to assess resettling individuals their interpretation of their distress, their perceived level of impairment, and their interest in intervention.

> *"Being a refugee is not a diagnosis. Refugees may present with any of the psychiatric disorders or none at all"*
>
> The British Psychological Society[190]

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[3] The most common psychological reactions associated with trauma are depression, anxiety and post-traumatic stress disorder.

Considering the attribution of their distress and available resources is crucial, as is the recognition that there is a range of responses to trauma that can co-occur. Resettling individuals often report simultaneously experiencing increased self-awareness, solidarity, spirituality, and strength alongside adverse symptoms and it's our responsibility to recognise and reinforce that resilience during resettlement and recovery[191,192].

In this context, trauma-informed approaches also recognise that practitioners assisting resettling individuals may start to experience symptoms of distress similar to those of their clients. The importance of self-care care, supervision, and support of staff is crucial to counteract the occurrence of burnout and vicarious traumatisation in this context[193.] Just as resettling clients experience a range of responses to trauma, practitioners can also experience a range of responses to trauma including an increased sense of perspective, strength of interpersonal relationships, spirituality, and professional satisfaction that sustain their practice. These perceptions are referred to as vicarious resilience[194] and vicarious post-traumatic growth[195].

> *"There is the reaction of "Oh, those poor people". "Oh, you're just amazing helping them". "Oh, how do you cope?". It's disempowering for everybody. It's disempowering for the refugee communities. It's disempowering for people working in the sector. It's disempowering for me. The people I work with have helped me observe my own life. It's made me a richer person and it keeps people here. I've got colleagues who have been here for 15, 20, 25 years"*
>
> Aotearoa New Zealand-born resettlement social worker[174]

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is used by mental health professionals to diagnose various psychological disorders[182]. DSM-5 criteria specify that symptoms must cause clinically significant distress or impairment of functioning and cannot be attributable to the physiological effects of a substance or another medical condition. With resettling clients, it is important to determine whether they have been relying on substances to manage their distress and/or whether they have other conditions such as a traumatic brain injury[196].

Table 15: DSM criteria for post-traumatic stress disorder, depression, and anxiety

DSM-5 criteria for post-traumatic stress disorder (PTSD) [189]	
These symptoms must persist for more than one month and cause significant distress or impairment in social, occupational, or other important areas of functioning. The severity and duration of symptoms can vary widely among individuals with PTSD.	
1.	Exposure to a traumatic event: Individuals must have experienced, witnessed, or been confronted with an event involving actual or threatened death, serious injury, or sexual violence.

2.	Intrusive symptoms: This involves recurrent, involuntary, and distressing memories, nightmares related to the traumatic event, flashbacks, or intense distress or physiological reactions when reminded of the event.
3.	Avoidance: Persistent efforts to avoid distressing memories, thoughts, feelings, or external reminders associated with the traumatic event.
4.	Negative alterations in cognition and mood: This might include memory problems related to the traumatic event, negative beliefs about oneself or the world, persistent negative emotions, feelings of detachment, and diminished interest in previously enjoyed activities.
5.	Alterations in arousal and reactivity: This involves symptoms like hypervigilance, irritability, angry outbursts, difficulty concentrating, sleep disturbances, and an exaggerated startle response.
DSM-5 criteria for depression	
An individual must exhibit five or more of the following symptoms during the same two-week period and represent a change from previous functioning.	
1.	Depressed mood most of the day, nearly every day, as observed by oneself or reported by others.
2.	Markedly diminished interest or pleasure in almost all activities most of the day, nearly every day.
3.	Significant weight loss or gain without intentionally dieting, or an increase or decrease in appetite nearly every day.
4.	Insomnia or hypersomnia nearly every day.
5.	Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6.	Fatigue or loss of energy nearly every day.
7.	Feelings of worthlessness or excessive or inappropriate guilt.
8.	Diminished ability to think or concentrate, or indecisiveness, nearly every day.
9.	Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, a suicide attempt, or a specific plan for committing suicide.
DSM-5 criteria for anxiety	
An individual must exhibit excessive anxiety and worry about various events or activities on more days than not for at least six months. This worry is difficult to control and is accompanied by three or more of the following symptoms.	
1.	Restlessness or feeling keyed up or on edge.
2.	Being easily fatigued.

3.	Difficulty concentrating or mind going blank.
4.	Irritability.
5.	Muscle tension.
6.	Sleep disturbances (difficulty falling or staying asleep, or restless, unsatisfying sleep).

Respond

Trauma-informed approaches respond by integrating knowledge about trauma into policies, procedures, and practices. To do this, the following phases of resettlement and subsequent settlement outcomes should be kept in mind[197]. The first phase is 'arrival', commonly referred to as 'the honeymoon phase'. This phase is characterised by a sense of safety, excitement, and relief. The second phase is 'reality' and is characterised by an increasing awareness of challenges associated with resettlement, a sense of overwhelm, disappointment, and/or frustration, and a preoccupation with loss. During this phase, an individual can go down one of two ways – negotiation and integration or alienation and marginalisation. This trajectory is influenced by a constellation of factors, including the stability of an individual's life before becoming a refugee, their personality, physical and psychological health, exposure to traumatic experiences during the process of becoming and being a refugee and resettling in their new society of settlement, in addition to the support and resources available after arrival.

The phase of 'negotiation' is characterised by initiative and a determination to succeed, the development of a support network, and a sense of accepting the losses associated with their life. This leads to 'integration' which is characterised by good psychological and social adjustment, self-confidence and a sense of control and contribution to their new society of settlement. In contrast, the phase of 'alienation' is characterised by withdrawal, despair, apathy, anger, and poor physical and psychological health. Resettling clients you encounter in your practice are most likely in this phase and it is crucial that they receive appropriate support to prevent them from entering the phase of 'marginalisation', a phase characterised by despair, dependence, and dysfunction. What constitutes appropriate support with vary according to the client's presentation and interpretation of their symptoms. Conducting such an assessment requires compassion and core competencies associated with working with culturally diverse clients. These will be addressed in the following section.

> *"Not all refugees are traumatised. They've had traumatic things happen in their lives but a lot of them are remarkably resilient. There is an assumption here that some people are badly traumatised and need specialist trauma treatment. That needs to be recognised but there isn't one approach that fits all people. Some of the traumatised people are not remotely interested in any trauma-type therapy. They present wanting help with practical stuff and if that's what they want, that's what they should get"*
>
> Psychologist supporting resettling clients across Aotearoa New Zealand[174]

Resist, Restore & Reflect

Trauma-informed approaches aim to resist re-traumatisation and restore an individual's sense of safety. Our ability to do so often requires us to reflect on the assumptions that inadvertently inform our practice. A common assumption amongst clinicians is that the source of resettling clients' distress stems from what happened to them before arriving in Aotearoa New Zealand[174]. This is not always the case.

Identifying a client's interpretation of their distress, their perceived level of impairment, and their interest in the intervention will require consistently considering the context, accounting for individual variation, providing clear information, seeking informed consent, and creating opportunities to provide the client with a choice [186]. Interpreters are often required to do this appropriately and it may take time to establish trust. Traumatic disclosure in initial consultations is also rare and to be respected[198].

The concept of Te Whare Tapa Whā can be a powerful way of communicating with resettling clients to identify which walls of wellbeing have been compromised and require reconstruction. For instance, what was their initial orientation and welcome to Aotearoa New Zealand like? Have they had the ability to develop new relationships whilst maintaining old ones? [taha whānau/social wellbeing]. Have they been able to remain connected to their homeland whilst developing a connection to Aotearoa New Zealand? [whenua/land]. What is the state of their sleep, nutrition, and exercise? Do they require medication for chronic or acute conditions? [taha tinana/physical wellbeing]. Are they able to access their spiritual community and conduct their spiritual practices? [taha wairua/spiritual wellbeing]. The integrity of these walls will influence perceptions of taha hinengaro/psychological wellbeing and interventions will likely require addressing these aspects. It is important to acknowledge that specialist psychological intervention alone will rarely resolve the issues causing resettling the client's distress.

Whilst we've tried to summarise considerations for providing trauma-informed care to resettling clients you encounter in your practice we want to acknowledge that there is no perfect approach and if in doubt 'just be human':

Considerations for clients across their lifespan

The following section provides specific considerations for resettling clients across their life span - childhood, adolescence, adulthood, and older adulthood.

Childhood

Despite being displaced at such a crucial phase of their physical, emotional, social, and cognitive development resettling children are resilient, and the majority resettle remarkably well[199,200]. An observation identified not only internationally but in research conducted in Aotearoa New Zealand also[201].

When it comes to indices of distress, data on infant and early childhood is limited and research conducted with older cohorts has identified a wide range of prevalence rates of PTSD, anxiety, and depression[202,203]. This is often a reflection of the variation within this cohort according to age, gender, country of origin and settlement, approach to psychological assessment, and the stage and certainty of

settlement (seeking asylum versus resettling). Additional signs of distress include somatic complaints such as headaches, stomach aches or dizziness. Sleep disturbance is also commonly reported, as are changes to behaviour such as regression, withdrawal, distractibility, disruptiveness and/or aggression.

Indices of distress are often a reflection of an interplay of past exposure to traumatic experiences, present perceptions of safety and stability, and personal factors such as age, time since displacement, self-efficacy, and self-esteem[200,204,205]. Contextual factors such as the wellbeing of their caregivers, access to supportive school environments, and a sense of belonging to their new society of settlement are also crucial. Promoting the wellbeing of this resettling cohort therefore requires a range of interventions that often prioritise resettlement support, the recovery of their caregivers, the wellbeing of their wider community, access to supportive school environments, and the ability to develop positive connections with their peers[206,207]. Cultivating a sense of acceptance is critical and often challenging during resettlement.

In addition to the experiences of rejection and racism, research has identified the following risk factors for this resettling children; death of family members, parent/s missing overseas, unaccompanied minor status, altered family composition, separation from parent/s overseas, history of long-term disruption to schooling, lack of completion of primary school, an abrupt transition to mainstream schooling, limited literacy in native language, limited English language skills, parental underemployment, economic difficulties, and unsuitable accommodation[204]. Unfortunately, exposure to these risks is common for resettling children, including those resettling in Aotearoa New Zealand[208].

In addition to investing in initiatives that improve the intercultural competence of those interacting with resettling children, healthcare practitioners are encouraged to conduct coordinated clinical assessments involving the client's caregiver/s. This increases the likelihood of identifying the most appropriate strategies to promote a sense of safety, strengthen positive parent-child interactions, and provide assistance and referrals to the resettling child and their caregiver. Individual therapeutic techniques utilised with this cohort include activities that encourage creative expression, relaxation, and self-regulation. Such an approach aims to assist resettling children adjust and develop a sense of connection, confidence, agency, and achievement in their new society of settlement[206,207].

Adolescence

Adolescents resettling in Aotearoa New Zealand face a constellation of challenges[209]. Despite this, research consistently identifies their determination and desire to succeed. For this desire to be realised, resettling youth requires culturally appropriate case management, mentoring, and cross-sector collaboration and advocacy in the community. There is no "one size fits all" solution and it is important to acknowledge that the support provided to youth who arrive in adolescence is often inadequate[210].

Consistent with the specific considerations provided above for resettling children, indices of distress and the interplay of past exposure to traumatic experiences, parental wellbeing, present perceptions of safety and stability, settlement support,

access to supportive school environments and a sense of belonging are important. Again, estimates of psychological distress in this cohort vary significantly[203]. PTSD, depression, and anxiety are commonly considered however the risks of adjustment disorder, substance abuse, and suicidality can also occur in this cohort. Additional signs of distress include somatic complaints, sleep disturbance, and behavioural changes varying from apathy to aggression.

Many of these characteristics are considered common in adolescence however there are specific considerations for those who are resettling in Aotearoa New Zealand. For instance, the concept of adolescence is a Western cultural construct and many resettling youth have had to assume significant responsibilities from a young age[211]. These responsibilities often include having to work to relieve financial pressure, interpreting and advocating to address settlement issues for family, and caring for younger siblings. Intergenerational conflict can also occur within families as resettling youth start to integrate into their new society of settlement and confront the competing priorities and preferences of their parents and peers.

One aspiration that is generally shared is getting a good education. While school has been identified as a significant source of potential support it can also cause distress[212]. Young people from refugee backgrounds have often had minimal and/or disrupted schooling and the transition into mainstream high school can be difficult. Many report struggling with their English and experiencing bullying, both of which diminish their self-esteem, sense of belonging, and safety. Such experiences can compound pre-existing distress, create additional distress and result in some youth disengaging from education entirely. This cohort is more likely to experience significant mental health issues, and substance abuse and be involved in the justice system[213].

Another specific consideration for this cohort is ensuring they have access to information, advice, and support for their sexual health. Sexuality plays a significant role in the formation of identity during adolescence and resettling youth must navigate this in a context of cultural and religious expectations promoted by their parents, multicultural peers, and wider Western society[214]. Practitioners are encouraged to provide safe supportive environments where sexuality and sexual health can be carefully discussed. School-based initiatives regarding sexual health and referrals can also be promoted, especially when caregivers are unable or unwilling to engage in this aspect of adolescent wellbeing. Social media has also been identified as a powerful resource for resettling youth to access information, experiment with self-presentation, expand their social networks, and seek support[215].

Adolescence is a turbulent time for most and while resettling youth navigate numerous unique challenges, the majority take on the trials of resettling during adolescence exceptionally well.

Adulthood

The process of resettling in a foreign country and culture is challenging and individuals resettling in adulthood often experience significant distress throughout this process. This distress is often a normal response to adversity and is influenced by an interaction of pre-displacement experiences, exposure to potentially traumatic experiences, personality characteristics, access to settlement support and a sense of

safety and solidarity[189]. Whilst many manage to settle, it is important to acknowledge that resettling individuals who arrive in adulthood may never achieve the aspirations with which they arrived in Aotearoa New Zealand.

A reflection acknowledged by the New Zealand government also[216].

> *"It is very evident that the process of resettlement is ongoing. On the evidence of this research, some may never get to the place where they can participate in this country's life to the same extent as other residents."*

While indices of distress vary, recent research indicates that approximately one in five resettling adults will experience PTSD, anxiety or depression[217]. As mentioned earlier in this chapter this distress can manifest emotionally, physically, socially, and spiritually and it is important to decipher the interpretation of the distress with each client. Unfortunately, many practitioners assume that the source of resettling clients' distress can be attributed to what happened to them before they arrived in Aotearoa New Zealand[174]. This assumption can silence an individual's priorities for resettlement and recovery and inhibit the application of appropriate interventions. The research indicates that more often than not, resettling adults request assistance with practical settlement support and share reflections on the detrimental impacts of discrimination, unemployment or underemployment, the inability to provide for their families and the associated shame, stigma and loss of status[187].

Reflections on one's 'refugee' and 'resettling' status can also be complicated. For some, it is a source of strength while for others it is a source of shame. Research has indicated that resettling individuals are acutely aware that their distress tends to be attributed to their refugee status and inability to process their pre-displacement trauma as opposed to reflecting on the shortcomings of the society of settlement and its responsibility to provide adequate resettlement support and safety[218]. As practitioners it is important to avoid assumptions, ask clients how they prefer that part of their history to be acknowledged in a consultation and remain cognisant that individual therapeutic interventions may not be a priority for this cohort, many of whom come from cultures who do not practice or prioritise such support. Regardless, practitioners should take care to acknowledge the resilience of resettling clients, recognise the personal resources that they already have, and offer a range of referrals to assist them in reclaiming their agency and ambition.

Older Adulthood

Older resettling adults play a crucial role in maintaining the cultural identities and practices of resettling communities[219]. Unfortunately, their needs are often overlooked[220]. Research conducted with older resettling individuals has identified that this cohort is particularly prone to depression, anxiety and PTSD[221]. This is due in part to the losses associated with becoming a refugee and being displaced from their ancestral land but also the associated stress of adapting to a foreign country and culture, an ability that tends to decrease with age[222].

Learning the language of their new society of settlement can be particularly difficult and opportunities to learn can be limited for older resettling adults also[223]. This can result in significant social isolation and perpetuate their loss of status, social

networks, and independence. The psychological distress associated with these losses can be compounded by chronic physical illnesses, disability or reduced mobility, nutritional deficiencies, and dementia. Such conditions require regular monitoring, medication, and resources which is not always possible for older resettling adults to access.

Older resettling adults often rely on their families. Families are often preoccupied with all the responsibilities associated with resettlement. This can result in a sense of being a burden and become a source of shame. It can also create conflict within the family[224].

When assisting older resettling adults, it is important to take the time to understand the source of their distress and discomfort. Ideally, you can work with an interpreter to consult not only the client but their whānau, so that the most accurate assessment can be made, and a suitable course of action identified. The involvement of the whānau is crucial as decisions are often made collectively. Furthermore, resettling communities often come from countries where there are no formal aged care services and/or such services may be considered culturally inappropriate. Older resettling adults may also be resistant to recommended interventions as their distress or discomfort may be an accepted part of their circumstances and ageing[224]. It is therefore important to incorporate where possible traditional interpretations of health and healing and tailor a treatment plan to align with their preferences.

Conclusion

In this chapter, we introduced you to Te Whare Tapa Whā, trauma and trauma-informed care. We shared insights to assist you in cultivating an awareness of the resettlement context in Aotearoa New Zealand and summarised specific considerations for resettling clients across their life span. We did this to support you in providing trauma-informed care to clients who have dared to seek refuge and resettle in Aotearoa New Zealand. We acknowledge that the trauma-informed approach outlined in this chapter can transcend traditional conceptions of clinical practice, but we believe it is our responsibility to assist resettling clients in reconstructing their world and wellbeing. You may find your own world and well-being transformed in the process.

About the authors

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10 Dying in Aotearoa New Zealand

Main Considerations:
• Understand and respect cultural beliefs, traditions, and rituals related to death, dying end-of-life care preferences and memorialisation. • Use a language interpreter to ensure access to services and accurate and effective communication. • Recognise the potential trauma and past experiences of loss and displacement that former refugees may have faced, which may influence their responses to illness, death, and grief. • Acknowledge that some cultures do not want to share diagnosis with the person who is dying and be prepared to explore these differences. • Encourage and facilitate discussions about end-of-life preferences, goals of care, and advance directives to ensure that patients' wishes are respected documented and shared with other health and social care providers with consent. • Advocate for access to palliative care and support the individual and family to understand what their options are for end-of-life care. Palliative care may be an unknown concept. Frame this as a tool to enhance rather than take away from the care the family wishes to provide. • Accommodate religious and spiritual beliefs and rituals of the individual and their family members regarding death, dying, and afterlife. • Provide compassionate support and resources for grieving individuals and families, including culturally safe bereavement counselling and referrals to community-based support services.

Death, dying and end-of-life care in former refugee communities in resettlement countries is an area of health with limited research globally[225]. This section provides a brief overview of themes identified in the literature, both in Aotearoa New Zealand and internationally

As former refugees come to the end of life, either due to ageing or life-limiting illness, there are a number of key factors which need to be considered to support quality of life and enable a ‘good death’[226]. The Western medical view of a ‘good death’ is likely to be different to that of patients from refugee backgrounds, their relatives or their community. Understanding the whole person and approaching their care holistically is vitally important at the end of life.

Death and dying pose both challenges and opportunities for former refugee communities[227] and experiences will naturally be diverse. Te Whare Tapa Whā[68] is once again useful in encompassing the human domains for consideration at the end of life. Taha tinana (physical), taha hinengaro (mental), taha wairua (spiritual), taha whānau (family/social) and whenua (land/belonging) are recognised in the end-of-life

care, and the vision of palliative care is to facilitate the resolution of issues within these domains to enable the person to die well[226]. Experiences of displacement, separation from country and loved ones, language, culture. spirituality and religion, health beliefs and social connectedness could impact to varying degrees during this time[228,229].

Language has been identified as one of the biggest barriers to access to end-of-life care for ethnic minority groups in Aotearoa New Zealand[230]. Cultural differences and complexity in understanding and approaching the end of life, accuracy and cultural nuance in communication are vitally important. Appropriate and acceptable language assistance is therefore paramount in bridging understanding and ensuring access to essential services[231].

Past experiences of loss, displacement and trauma may impact responses to illness, death, and grief for former refugees and the wider family and community. Each person's support needs will be multidimensional. Person-centred care involves practitioners working alongside their patients, and first undertaking a holistic assessment that is informed by the unique experience, priorities, beliefs values, and needs of the patient. A person-centred approach provides a practice framework that involves patients as active and equal decision-makers who are experts in their lives[232].

The theme of culture once again shines through as a defining factor in how death, dying and end-of-life care are discussed, understood, and experienced[228,229]. For some cultures, even conversations around life-limiting illness, death, dying, end-of-life care or advanced care planning may be seen as confronting, insensitive, accelerating death or bringing bad luck[230,233].

There may be taboos around sharing life-limiting diagnoses directly with a patient for fear of suppressing their will to live or believing this will protect the patient. This may mean diagnoses are not shared with the patient, which is not typical in a Western medical model, even if this runs counter to the patient's desire to know and understand their condition[229,234, 232].

There may also be a reluctance to accept assistance from services due to language or cultural appropriateness. Caring for loved ones may be considered the duty of family members and assistance from others may be seen as shameful or a relegation of duty[230,235].

Conflicting beliefs and culturally informed differences can pose challenges for health and social care providers who are likely to have differing cultural beliefs and ethical and professional obligations. A gentle, flexible, and person-centred approach will be required to consider the wishes of patients and families and understand individual and collective approaches to autonomy and decision-making. Seeking advice from religious or cultural organisations or community leaders may give insight on how to approach these aspects. The goal is to enhance the acceptability of, and options for, planning and receiving an acceptable form of end-of-life care which is known to improve life quality[230].

Eliciting traditions from country of origin, preferences for end-of-life care and the impact of dual identity have been identified as important tasks for health and social care providers[236]. Considering one's identity comes to the fore at the end of life and

for former refugees there is often a sense of dual identity and a complex examination of who one is in relation to country of origin and country of resettlement[236]. Varying degrees of harmony between these two identities were experienced by participants in one study which identified the importance of life review and making meaning from the lived experiences of resettlement at the end of life[226]. This was found to be helpful in finding a sense of belonging to the country of resettlement and in turn, helped with finding resolve about the end of life ahead.

The value of traditions both in connecting with those back home and passing on to future generations has also been identified as important at the end of life. Remembering, reminiscing, recording life stories, making connections with loved ones both close and far and exploring history and roots contribute to living and maintaining traditions at the end of life[226,236].

Articulating preferences for end-of-life and dying was another identified area of importance[226,227]. Taking ownership of death and dying can be valuable for former refugee communities to maintain traditions, provide spaces for mourning and remembrance and pass on traditions to future generations[227]. Preferences may include the place of dying, final resting place, spiritual or religious rituals during mourning, burial and remembrance by others after death[236].

Additionally, this process may include reconciling an inability to reunite with the country of origin at the end of life and those left behind or for their body to be returned to the country of origin. Religious or cultural organisations, individuals or community leaders may lend a hand in assisting with preparation for end-of-life preferences. Individual funeral homes may be more likely to appreciate cultural or religious rituals and country of origin beliefs.

Advanced care planning where the issues above are intentionally discussed and recorded may be useful for navigating the end-of-life challenges and opportunities with former refugees, especially as they age or confront long-term or life-limiting conditions. This can be done at any time in the primary care setting and can be an incremental process over the healthcare relationship for encouraging and facilitating discussions about end-of-life preferences, goals of care, and advance directives to ensure that patient's wishes are respected and documented. There are formats available for recording information which can be shared with other health care providers such as social workers, district nurses or palliative care services with the person’s consent.

To learn more about advance care planning, go to Advance care planning – Tō tātou reo, at https://www.myacp.org.nz/. Advance Care Planning is a programme by Te tāhū hauora – Health Quality & Safety Commission.

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