



Burundian Culture

BACKGROUND INFORMATION

The **Great Lakes Region** is beset with endemic conflict and struggle. Hutu and Tutsi ethnic groups, armed rebels, and various governments seek control over the populated and resource areas of the region. Rwanda, Uganda, Tanzania, Democratic Republic of Congo as well as Burundi form part of the territory. Whilst Burundian culture is the focus of this chapter, some aspects of culture, beliefs and traditions may be shared by the neighbouring countries. **Health practitioners may assume some similarities between the cultures, but particularly between Rwandans and Burundians.**

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Burundi, officially known as the **Republic of Burundi** gained independence from Belgium in 1962. Since then it has experienced decades of extreme ethnic tensions, including the Burundian genocide against Hutu in 1972. The ongoing unrest and violence has been fuelled by the struggle for power between the majority Hutu and the ruling Tutsi ethnic groups. Various military dictators from the Tutsi minority held power, with violence escalating during 1988 between the Tutsi army and Hutu opposition. About 150 000 people were killed during this time alone and hundreds of thousands fled to neighbouring countries.

In 1991 a multi-ethnic government was constituted under international pressure, with the first Hutu president, Melchior Ndadaye elected in 1993. After his assassination in the same year and 2 more the following year (including the President of Rwanda, triggering the Rwandan genocide of 1994) Burundi was plunged into a vicious civil war. Extremists from both the Hutu and Tutsi groups massacred thousands of people from the opposing ethnicities. In 1996, the third-time president Pierre Buyoya, took power and later handed over to his Hutu Vice President Domitien Ndayizeye, after which a post-transitional government was established with approval from most Burundians in 2005. In spite of this achievement instability has continued with extreme human rights abuses and politicized violence in preparation for the 2015 elections.

The humanitarian disaster of Burundi resulted in over 300,000 deaths and over 700,000 Burundians fleeing to western Tanzania, Rwanda, the Democratic Republic of Congo and others, or being displaced within their own country. Gross human rights violations including murder, rape, torture and 'disappearances' have been rife during the struggle. These continue, noticeably along the Burundian Tanzanian border. Many of the women and girls have suffered sexual assault and domestic violence in the camps. Poverty is rife with over half the population living below the breadline. Burundi is one of the poorest countries in the world.

Many Burundians have been, and continue to be repatriated by the UNHCR although tens of thousands still reside in refugee camps in neighbouring countries. New Zealand has resettled about 170 people since 1996 most of whom live in Auckland. Burundians continue to arrive as refugees or through family re-unification programmes.

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Page	CONTENTS
2	Communications
3	Traditional Family Values
3	Health Care Beliefs and Practices
6	Health Risks
7	Women's Health
9	Youth Health
10	Special Events
11	Spiritual Practices
12	References and Resources

COMMUNICATION

Greetings

Hello greeting	(Burundi and Rwanda)	<i>Mwaramutse (you are alive!)</i>
Goodbye greeting	(Burundi)	<i>Nagasaga (stay alive)</i>
	(Rwanda)	Murabeho

Main languages

The official languages of Burundi are **Kirundi** and **French**. Some speak Swahili. Ethnic groups are Hutu (85%), Tutsi (14%) and Twa (pygmies) (1%).

Whilst French interpreters will be able to interpret for many Burundians (those with formal education have learned French), a Burundian interpreter is recommended whenever possible as there are some significant cultural issues that are likely to need clarification during clinical interviews and interventions. Kirundi and Kinyarwanda, the language of Rwanda are similar enough that both groups will understand one another.

Gestures and interaction

- It is expected that **First names** will be used by practitioners in greeting (otherwise *aunt* and *uncle* are used as a term of respect for elders)
- **Hand** shaking is acceptable across genders. The **right hand** is used for shaking, the left hand used to support the lower right arm when respect is being shown
- It is common for Burundians to hug, kiss cheeks and touch heads with people they are familiar with
- Showing **respect**, especially for elders, is appreciated (e.g. greeting the elders first, the practitioner being on time for appointment, greeting them in their traditional way)
- Traditionally, **direct eye contact** is considered rude. Lowering or averting the gaze is a sign of respect. Most Burundians and Rwandans in New Zealand accept direct eye contact from the host culture, but may decline to return this out of respect
- The Western custom of **asking direct questions** can result in reticence to engage. Asking general questions about the wellbeing of the client (and importantly, family) will assist with establishing rapport and for the client to volunteer information for further questioning
- **Answering directly** is not customary in Burundian culture so an affirmative response from a client may not necessarily mean agreement or acceptance. 'Yes' may sometimes mean 'no' and vice versa. Further investigations may be necessary to gather relevant information. Burundians regard their privacy highly
- Health practitioners are usually highly regarded and clients are very unlikely to **ask questions** as it is considered disrespectful, even if invited to do so. It would be helpful for practitioners to offer any information they might think the client would need or want
- **Proverbs** are an important part of Burundi expression and will likely not be explained. They are intended to make the listener think

Special concepts

Belief in, and the practice of **witchcraft** is a common heritage in Burundian culture. Many people who have had formal education and who have migrated no longer subscribe to the beliefs or practices. However the caution and mistrust which arises from the legacy underlie many customary attitudes and traditions.

TRADITIONAL FAMILY VALUES

- In Burundi families are extended and live rurally in a compound called a 'urugo'. In New Zealand the nuclear family is the norm due to the benefit system and to housing limitations
- In the homeland extended family members maintain close ties (influenced by geographical factors), and this tradition continues in New Zealand as far as is possible
- Children are important to Burundian families and seen as security for the parents' old age. They are brought up to expect to take responsibility for the elderly relatives (a common Kirundi saying is 'Nta ndagukunda nka kwankira umwana' – 'You cannot say you like me, if you do not like my children').
- Fathers are heads of the family
- Traditionally women take care of household duties and the children. However there is increasing equality in responsibilities amongst younger resettled couples
- Young boys and girls are trained to follow the example of the same sex parent
- Children live at home and are supported financially until they are married
- After they leave home, filial duties are expected to continue
- Intermarriage between Hutus and Tutsis is common, despite the political inter-ethnic hostilities

HEALTH CARE BELIEFS AND PRACTICES

Most of the information in this section is taken from Jackson, K. (2006) *Fate, spirits and curses* book. Refer for more detail to chapter 9. Local community members have also provided additional material.

Consultation with community members reveal that whilst the practices outlined below are true for many (not all) people living in Burundi, there are no known Burundian traditional healers in New Zealand, and that no equivalent or substitute herbs have been found. Resettled Burundians accept and utilize Western medical care. There may, however, be some exceptions in the community.

Factors seen to influence health

- **Physiological Factors**
 - The concepts of blockage and flow are believed to be important in maintaining health. Fluids in the body should flow without excess or blockages from the top of the body down
 - Illness can be attributed to poison, imbibed through food or drink that has been contaminated intentionally by a malevolent person (known as a witch or poisoner, an 'umurozi')

- **Western** biomedical concept of disease causation is accepted in Burundi and in New Zealand
- **Spiritual/supernatural** (as per practice in Burundi)
 - Objects which have been symbolically poisoned can be used to create harm and ill health (also prepared by an 'umurozi')
 - Spirits (which vary from one region to another, and have their own specific effects) can cause harm through spells and poisoning. Ancestors are believed to provide protection, however if they have been neglected or offended they may abandon the individual. It is believed by many that the aforementioned spirits or poisons 'do not cross the waters' and so are unlikely to occur in New Zealand. However, current medical conditions may be perceived to be the result of spirit or 'umurozi' influence that occurred prior to re-settlement
 - A small number of people believe that illness can be caused by punishment from God as a result of sin

Traditional and current treatment practices

- **Western medicine**
This is commonly practiced in urban areas and accepted by most Burundians who have received formal education. **Traditional medicine** is used when biomedical interventions are not effective, when the illnesses/misfortunes are ongoing, or when the illness is sudden or unusual. However, Western health care and medicines are scarce (3 physicians per 100,000 people; *UNDP 2006*) or unaffordable for many, and so for some, 'traditional' or herbal remedies are relied on out of necessity rather than choice.
- **Traditional/complimentary practices**
 - **Herbs**, plants or animal and insect parts are used in all treatments, irrespective of their cause. These are ingested either through drinking potions, inhaling smoke or herbal powders. It is reported that to date (February 2007) no known substitutions are being used in New Zealand (although they may be being sought)
 - 'Abapfumu', or practitioners invested with special powers will pronounce incantations and give instructions to the sick person or family for the remedies to be effective (there are no known 'abapfumu' to date in the Burundian community in New Zealand)
 - **Moxibustion** ('indasago') (using a sharp instrument) or making incisions on breasts, hands, feet or back is practised, particularly for pain. Scarring may result, so abuse should not be assumed (it is reported that this is unlikely to be practised in New Zealand)
 - **Magico-religious articles** and **religious/supernatural rituals** may be used by some

Important factors for Health Practitioners to know when treating Burundian and Rwandan clients:

1. As many Burundians who enter New Zealand have arrived as refugees, extra sensitivity and care in treatment is necessary given the possibility of extremely difficult pre-settlement experiences (see 5. below).
2. Traditionally it is taboo to discuss any sexual matters. Practitioners will need to explain that in New Zealand it is acceptable and normal to give information about sexual matters for the purpose of treatment, and in fact **necessary in order for them to receive appropriate treatment**. Interpreters can assist in

informing the clients about protocol in this regard. However, it may still take a few sessions of rapport building before the client will disclose.

3. Burundians generally value their privacy highly and disclosure is often limited, particularly amongst people with little formal education. Practitioners may need to rely on their observation, investigations and examinations. Older people are often willing to disclose but may lack the vocabulary to do so. It is reported that Rwandans tend to be more disclosing than Burundians.
4. Pregnancy is customarily concealed for as long as possible (see 5. below) and is unlikely to be disclosed in a routine interview, or when a client is presenting with other issues (particularly amongst newly settled people). Practitioners will need to enquire as to whether a client is pregnant or not. **NB** Other family members, including children, should not be informed about pregnancies without the mother's permission.
5. In the case of terminal or serious illness (including HIV/AIDS), the practitioner should not disclose this fact to **any** other family member without the permission of the client first.
6. If treatments require the co-operation of a partner or family members, practitioners need to invite the parties to a consultation as clients (particularly husbands) often do not reveal the information to their spouses.
7. In Burundi, injections are a standard form of treatment for many ailments and are therefore expected. If other interventions are offered here in New Zealand, an explanation would be helpful.
8. Compliance with prescriptions can be affected by language difficulties. Interpreters can assist with providing written instructions in the client's own language.
9. Due to reticence to disclose, to the need for stoic attitude to hardship, and to unfamiliarity with counseling, it is reported by local community members that counseling services are very unlikely to be effective.
10. However, contrary to the privacy around emotional and relational issues, Burundians will speak out when they have health problems believing that discussing the problem will help alleviate it.
11. Violence towards women is common in the home country, particularly during the ongoing civil unrest, and women themselves have become resigned to this. As a result women may not feel supported by their community if they make use of the assault laws in New Zealand, and would be afraid of losing face. This issue may need particularly sensitive handling and support.
12. As blood is an important part of the culture, explanations will be needed for blood sampling, particularly if drug levels need monitoring on a regular basis, or if a number of samples need to be taken.
13. Some women may wear decorative beads around the waist. These may be removed for examination purposes.

14. Informed Consent may be a new process and will need explaining.

15. When doing HOME VISITS:

- Give a clear introduction of nature of service, of roles and purpose of visit
- It is customary to address the male adult or elders of the household first
- Food or drink may be offered. It is acceptable to decline politely, although accepting would be appreciated, particularly on a first visit, as some clients may feel disrespected if their hospitality is rejected

Stigmas

Mental illness is not stigmatized in the same way as in most other non-African cultures. Spirit possession can be seen as responsible for strange behaviour.

Diet and Nutrition

Beans, particularly red kidney beans and rice are staples, and also sorghum. Plantains, sweet potatoes, cassava and peas are common foods. A 'wine' made from bananas called, 'urwarwa' is drunk quite often. Meat and butter are highly valued. Meat is eaten when available although cattle are seen as a status symbol so the slaying of own animals, other than poultry, is limited in Burundi.

Death and dying

Death is marked by prayers, speeches and rituals. Close family members do not take part in all the activities. Traditionally they do not work in the fields or have sexual relations, or eat meat during the mourning period. Resettled people may take time off work during mourning. When the period is over, the family will hold a special ceremony.

HEALTH RISKS AND CONCERNS

According to the Perumal (2010) report on MELAA people living in the Auckland Region, key health concerns for African people include:

- Diabetes (significantly higher prevalence than Europeans, including associated hospitalizations)
- Respiratory diseases (asthma for females, and pneumonia)
- High HIV (23% of all the people diagnosed as HIV positive in the Northern region from 1996-2009 were African)
- Asthma, especially women
- TB (highest rate of hospitalization within MELAA group)
- Cellulitis (highest rate of PAH amongst females from all ethnicities)
- Kidney and urinary infections (highest amongst all Other females)
- Low vitamin D deficiency (particularly women and girls which may be due to avoidance of sun and because of dress code to cover up)
- Malnutrition (due to prolonged periods of war)
- Obesity after suffering malnutrition
- Lack of sufficient physical exercise (may be prohibitive for some women with conservative dress and behavioural expectations)

Indexamundi (2014) lists the following as major diseases for people living in Burundi:

- Hepatitis A and E
- Typhoid fever
- Malaria
- Dengue Fever
- Yellow Fever
- Japanese Encephalitis
- African Trypanosomiasis
- Cutaneous Leishmaniasis
- Plague
- Crimean-Congo hemorrhagic fever
- Rift Valley fever
- Chikungunya
- Leptospirosis
- Schistosomiasis
- Lassa fever
- Meningococcal meningitis
- Rabies

Social issues affecting health

- Isolation (including older people who spend a lot of time alone at home)
- Unemployment and poverty (many have significant financial issues and difficulties finding work)
- Loss of standing in society
- Being marginalized (race, cultural difference, clothes, education and refugee experiences)
- Cultural adjustments impacted further by the lack of support from usual networks of family and community
- Experiencing racial discrimination based on ethnicity (within own cultures)
- Stigma of mental health, HIV and disability often means no societal support, and no disclosure of issues

Mental Health issues (particularly PTSD and depression):

- African communities experience a disproportionately higher rate of mental health illness compared with the rest of New Zealand, largely due to their earlier life experiences and potential exposure to torture, violence, rape and harassment
- There may be strong emotions of grief and loss for family, culture, and country especially following refugee experiences
- Experiencing discrimination is strongly linked to high levels of anxiety and depression which negatively affects Post Traumatic Stress Disorders (PTSD)
- Mental illness is stigmatised which results in limited use of appropriate assessment and treatment services, especially in smaller communities

WOMEN'S HEALTH

According to the Perumal (2010) report on MELAA people living in the Auckland Region, issues for African women include:

- Within the MELAA group, African women had the second highest number of live births followed by Latin American women.
- Low levels of health screening, particularly in cervical and breast cancer screening
- Female Genital Mutilation (FGM/FGC) and its associated complications (See Introduction, Chapter 3 for more details)
- The need for more education around pregnancy and child birth in New Zealand
- Health issues related to refugee backgrounds, and sexual violence in particular
- A preference for women to use interpreters and health care practitioners of the same gender. For issues of trust, appropriateness and awareness, it is important to engage professional interpreters whenever possible

For Burundian and Rwandan women who have resettled as refugees a careful history taking will be needed to ascertain whether sexual abuse or rape has occurred. This is a frequent experience amongst refugee women in general, but it has been particularly widespread in Burundi during the civil war and in the refugee camps. Disclosure may take some time and will depend on rapport and trust. In general, refugee women (and men) need to be treated with extra sensitivity and care since they are very likely to have suffered the conditions related to the atrocities and trauma of war, of trauma during flight, and re-location stress. In addition they are often responsible for the emotional wellbeing of the family who too may be weighted by similar psychological and physical loads. Some Burundi women re-locate alone as a result of family losses, separations and displacements.

Various sources report that Female Genital Cutting (FGC) is not practised in Burundi. It is reported however, that Rwandans practice what may be classified as a Type IV procedure where the labia minora is stretched to increase size (by the individual themselves, under instruction from an elder) over a few months from around the age of seven. The effect is believed to heighten sexual pleasure for both men and women.

Traditional fertility practices

- Breast feeding (up to three years) was the natural birth control. However, the use of contraception is a growing practice in Burundi, due particularly to efforts at population control and to the spread of HIV and AIDs.
- Pregnancy is usually concealed for as long as possible to avoid poisoning by an *abarozi*, or intervention by malevolent spirits (see **Health care beliefs and practices** above). Although it is reported that fears from the dangers of spirits and *umurozis* are minimal in New Zealand, the belief is deeply ingrained and so concealment takes place irrespective. Pregnant Burundian women are reluctant to disclose the stage of pregnancy or the date of the last menstruation. Rapport and trust is crucial. The pregnant state is not revealed to friends or other family members, **including children**.
- Traditionally, enemas are used weekly by some Burundian women, from 5 months onwards during pregnancy for the relief of indigestion, discomfort and heartburn
- **Labour**
 - Traditional birth attendants were customarily chosen for the birth, particularly by older mothers with previous delivery experience
 - Younger people will elect hospital births when this service is accessible

- Traditionally men are not present at the delivery, but this is changing with resettled people due mainly to the lack of extended family
- Caesarians are only expected in emergencies
- **Postnatal period**
 - Breast feeding is the norm and continues for two to three years (is also used as a natural form of contraception)
 - Mothers and infants are massaged after the birth with a substance much like *ghee* (a clarified butter) and warm water. Massage of the lower back and stomach continue after the birth
 - In addition, fabric is tightly tied around the mother's abdomen to encourage flattening of the stomach, for up to 6 months
 - It is important that the baby is not touched by strangers (apart from health professionals) after the birth. Visitors to the home will not be invited to see that baby for the first month and no-one should expect to touch or pick up the infant (to avoid any possible malevolent action)
 - Mothers do not leave the home for the first three to four weeks
 - Mothers do not share the same bed with their husband during the first three to four weeks, their food is prepared and served by relatives/friends and they eat alone during this period. Some re-settled people may not have family and will need to manage alone
- **Religious Ceremonies Related to Birth**
 - After the first three to four weeks a naming ceremony takes place after which the mother is allowed to leave the home
 - Family are invited to the ceremony, the baby is displayed to the gathering on a traditional 'tray' and rotated around to face each of the cardinal points. Sometimes a corn or bean seeds are planted in commemoration of the birth
 - At this ceremony the mother is given assistance with learning how to tie the baby on her back

YOUTH AND CHILD HEALTH

According to the Perumal (2010) report on MELAA people living in the Auckland Region, key health concerns for African children include:

- A possible higher standardized mortality ratio (SMR) as compared to Others
- The PAH rates in children from all causes was higher in African children compared with Others
- Asthma was the main cause of PAH, followed by dental conditions
- African children had the highest rate of hospitalisation for asthma, pneumonia and bronchiolitis
- They had higher hospitalisation rates than Others for dental conditions and gastroenteritis
- At the 6 month mark only 23% of African babies were exclusively or fully breastfed, (below the recommended 2007/08 national health target of 27%)
- In children <5 years of age and in Year 8, there were more African children with caries than in Others
- Chlamydia infections are prevalent in all teenagers in the MELAA group

Malnourishment is extremely high with 35% of children malnourished (UNICEF 2012)

Adolescent Health

- Most resettled adolescents will be faced with:
 - role changes at home
 - pressures from peers to integrate more quickly than they or their families may be comfortable with
 - the stigma of 'difference'. Assistance and sensitivity from authority figures will be helpful in the schools
- Many young refugee children and adolescents have been subjected to violence or have been witness to the atrocities leveled at their families and communities during war, and in refugee camps. They may bear their experiences unnoticed. Parents managing the challenges of resettlement as well as their own pre- and post-relocation traumas are often unable to attend to, or to manage the distress of their children adequately. Sometimes children do not tell their parents in order to avoid added stress on the family, out of respect, or because they believe they are in some way to blame. Symptoms of trauma may present as behaviour problems, withdrawal, learning difficulties, poor concentration and motivation as well as with various somatic complaints. These presentations may mask post-traumatic stress, depression, anxiety and other mental health conditions. Practitioners and teachers need to be alert to the possibilities of pre-relocation trauma.
- Young girls are equally as exposed to rape and sexual abuse in their home country as the adult women
- No sex education is given to adolescents and the subject is not discussed at home. Of concern are illegal abortions, pregnancy-related dropouts from school, and potential risk of HIV infection

SPECIAL EVENTS

- **1 July Independence day** (for Burundians and Rwandans) is celebrated on the 1st Saturday in July in New Zealand
- **6 April Ntaryamira Day** for Burundians (Presidents of Burundi and Rwanda were shot down in an airplane creating the catalyst for the start of the Genocide)
- **7 April** is Genocide Memorial Day for Rwandans
- **21st October** is a day of remembrance for all those who died during the struggle for democracy, and also for the first elected Burundian president, Melchior Ndadaye who was assassinated

Noteworthy is the importance of drumming to Burundians who have practised the art for centuries. The drums are considered sacred and represent power and a means of communication. 'The Drummers of Burundi' are a 14-member troupe, who tour major cities of the world. They dance as well as perform on the drums. Each member takes a turn beating a large drum called an *inkiranya*, which sets the rhythm for the other drummers. In New Zealand the resettled Burundians continue this tradition with their own troupe. They have become well-known, hold status and play an important role in creating identity for the community.

SPIRITUAL PRACTICES

Burundians and Rwandans are predominately Christian. A smaller minority practice indigenous religion and some combine Christianity and indigenous beliefs. Spirits of dead relatives, called *abazimu* are messengers for God to the human world. The *abazimu* can dispense good or bad luck.

DISCLAIMER

Every effort has been made to ensure that the information in this resource is correct at the time of publication. The WDH and the author do not accept any responsibility for information which is incorrect and where action has been taken as a result of the information in this resource.

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Useful Resources

1. RAS NZ (Refugees As Survivors New Zealand) can provide assistance to mental health practitioners on clinical issues related to refugee and cultural needs, and contacts for community leaders/facilitators. They can be contacted at +64 9 270 0870.
2. ARCC can provide information on resettlement issues and contacts for community leaders. Contact +64 9 629 3505.
3. Refugee Services can be contacted on +64 9 621 0013 for assistance with refugee issues.
4. The <http://www.ecald.com> website has patient information by language and information about migrant and refugee health and social services.