

Elderly refugees and migrants: Health needs and recommendations

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Preface

There is a lot known about the health needs of elderly refugee and migrant populations in New Zealand, but little formal research done on the subject. Refugee and migrant communities are not a homogenous group and with many different needs it is easy to lose the needs of a specific cohort within the population. It also remains difficult to communicate the needs of a cohort to a host population that is still largely ignorant of the generic needs of the whole 'migrant' population.

This research is important both for the Waikato and also for New Zealand. It comprises of a demographic report, a literature review and results compiled from interviews and focus groups. This three pronged approach allowed for research that is well informed and robust. Unsurprisingly, the interviews and focus group discussions that formed the third part of this research corresponded closely to the results reported in the literature review.

Prior to continuing any further with this report it is important to have an understanding of the key concepts behind the terms 'refugee' and 'migrant'.

Refugee: The UNHCR definition of a refugee is a person who is outside their country of origin and who, for reasons of race, religion, political affiliation or persecution are not able to avail themselves of the protection of that country. New Zealand accepts a quota of 750 men, women and children a year as 'quota refugees'. In addition to this, refugees who have been settled in New Zealand for some time are eligible to bring family members through normal immigration channels. These people are referred to as 'family reunification' and also come from refugee backgrounds. Strictly speaking, a person is no longer a refugee once they have arrived in New Zealand. Therefore, this research discusses 'refugee populations' which are ethnically defined populations whose members have predominately come from a country from which New Zealand has also received refugees, without regard to which immigration channel they have come through. The advantage of this is that these populations present with similar health concerns and are captured statistically.

Refugee populations have always fled their countries of origin because of persecution. Often their journeys have included deprivation and physical hardship, including torture and rape. In the article 'Forced migration, Globalization and Public Health; Getting the big picture into focus', Zwi et al (2003) noted that people forced to move from their countries are at increased risk of disease due to poor access to food, shelter, water, sanitation and medical facilities prior to migration. Almost all refugees arrive in New Zealand with no financial resources and very little preparation, including not speaking English. On arrival they become permanent citizens and are entitled to access the public health care system. New Zealand takes a quota of approximately 750 refugee people a year.

Migrants are people who have chosen to live in New Zealand. There may be many reasons for this choice. This group of people is very diverse and their experiences can not, at any time, be captured through general comments. There are similarities in the experiences of those populations who do not speak much English and similarities in the

experiences of those who share cultural or religious backgrounds. The research shows differences between the experiences of those who are visible migrants and those who are invisible. Visible migrants are those that 'stand out on the street' and look different to the traditional population groups in New Zealand. Invisible migrants are not obvious at a glance but often still speak with an accent.

The research refers to people who are permanent residents in New Zealand. Other categories include international students (who do not apply because of age), people on work permits (these are also usually younger people) and visitors. 'Visitors' are not directly considered in this report but may constitute a hidden population of elderly who are in New Zealand doing domestic work for their children.

Through most of this report they are separated into newcomers (those who have been here less than 3 years) and long term migrants. These statistics are available through the Settlement Support division of the Department of Labour but have not been analysed for age demographics.

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Executive summary

This report contains three parts.

The **demographic study** captures the range of elderly refugees and migrants living in Hamilton and the wider Waikato region so as to identify which populations might face increased requirements from the health care system. Recent changes in the way statistics can be reported through the Census means that some of the data about small population groups that is no longer available has been extrapolated from earlier demographic reports.

Significant findings:

- On the whole, demographics show a fairly youthful age structure in migrant/ethnic communities. Statistics are no longer available for our region because of changes in privacy laws, but the large populations in the 45-65 age range shown in the 2001 demographics are now aged, at minimum, 53 and aging.
- More females than males are seen in all ethnic groups apart from South African. This should be considered in light of studies that show that migrant females tend to learn English at a slower rate and participate less in the economy.

The **literature review** is intended to survey existing research about the health needs of elderly refugee and migrant populations in New Zealand, and particularly those in Hamilton. The review begins with a comment on the general health differences between refugee and migrant populations and continues with a discussion of the research about health in elderly populations that pertains to communities that may be either refugee or migrant, or of a particular ethnicity, religious or cultural affiliation.

An extensive search was conducted for internet resources related to new migrants and refugee health services. This focused on scientific and grey-research literature, with an emphasis on literature that was evidence-based. Both qualitative and quantitative studies were sought. Refugee and Migrant Health related plans, reports and policy documents were also collected. The search focused on New Zealand, but included key analyses from the international arena, with an emphasis on source countries for refugees and migrants settling in New Zealand.

Significant findings:

- Limited body of research about elderly refugees/migrants once they are settled in new country
- Cultural competence of health professionals cited by most researchers as important for health delivery
- Language ability of refugees/migrants important factor in utilization of health services

Following this, the **final report** was written following a period of interviewing, during which 27 face to face interviews were conducted with key informants involved in health and social services intervention programmes related directly or indirectly to migrant and refugee health. These included general practitioners, Waikato District Health Board officials, Local Authority representatives, Community leaders, organisations assisting refugees and new migrants at Waikato Migrant Resource Centre as well as other non governmental and community based organisations in Hamilton (Appendix 1). A questionnaire was used to capture information (Appendix 2)

Organizations were purposefully selected to ensure a representative sample including looking at a range of sectors and different types of organization.

Following this, four focus group discussions were held with elderly refugees and migrants from the Somali, Chinese, Cambodian and South African communities. The researcher used an interview guide with open-ended questions based on focus areas, including perceived health needs, barriers to access to health services, communication and language, social interaction and recommendations.

Interpreters were used where the participants spoke a language other than English and the reports were then translated into English.

The fieldwork provided opportunities to gather programme reports, operational assessments, evaluations and relevant communication products, all providing insight into elderly new migrant and refugee health in the Waikato.

Significant findings:

- Actual health problems not as great an issue as factors limiting participation in health
- These factors included barriers of language, access to information, transport and finance
- Similar barriers reported by health professionals in providing services, including culture, language and funding
- These barriers result in late medical intervention, high incidences of self treatment and also social problems, including significant isolation, poor mental health and gambling.

Demographic report

Nature of material

The populations referred to in this report have, for the most part, arrived in New Zealand as migrants or refugees. Data collected about these populations sometimes includes people who are associated with the group through ethnicity rather than immigration status. However, due to New Zealand's history in immigration policy it is safe to assume that many of these demographics relate to migrants. The main diversion from this policy is for statistics relating to the Chinese population and for this it is important to recognize the difference in statistics relating to ethnicity and those relating to migration. Both are present and identifiable in this report.

The material that this report is composed of has been sourced from 2001 and 2006 census reports, records of the Department of Labour through the Settlement Support project and data reported in other demographic reports. Due to small population sizes, statistics relating to some of the refugee populations living in the area are unavailable from census records.

Statistics describing population groups as a whole have been included in this report as data about education, religion, language and gender have significant implications for the provision of health and social services.

1.3 Other important reports

A report was completed in 2005 by the Migration Research Group at the University of Waikato that looked at the public health issues facing migrants and refugees in the Waikato region and included some extensive demographic reporting. This report identified numbers of people by ethnicity living in the Waikato and identified age and sex data as well. The census could not provide data about refugee populations although it is common knowledge that particular ethnic groups come into New Zealand almost exclusively as refugees. The report also did not break down refugee related demographic information into regional areas.

Some demographics from 'The Public Health Needs of Refugees and Migrants' have been used in this report because some of this demographic data is no longer available from the Census statistics. It has been supplemented with more recent ethnicity data.

2.1 Populations

An analysis of the 2006 New Zealand population census data was carried out by the Department of Labour on behalf of Settlement Support New Zealand. This focused specifically on newcomers to Hamilton City. While not saying much about age demographics, the analysis revealed the following key points.

Hamilton City ethnicities

Hamilton City has a population of 129 249 people. Of these about 74% are New Zealand born while 16% are longer term migrants who have resided in New Zealand for three years or more and 4% are newcomers who have been here less than three years.

Newcomers living in Hamilton come from 100 different countries with 80 ethnicities of which the majority are from China (18%) and England (11%). Chinese as a broad category comprise the largest ethnic group of newcomers to Hamilton City (21%) while the Indians are at 14%. New Zealand Europeans follow at 8% and Koreans at 6%.

As regards longer term migrants in Hamilton City, 28% are New Zealand European and the second largest group is Chinese at 15%.

Waikato District

The 2001 Census identified 8460 migrants living in the Waikato District representing about 2.7% of the Waikato population. In 2006 the equivalent migrant population was 5865 an increase of 2595 or 44%. Over half of these people arrived in the last five years.

A large proportion of Somali, Cambodian and African populations in New Zealand reside in the Waikato. The 2001 census showed 15% of the national Cambodian population (of 762 people) live in the Waikato and one quarter of Somalis in New Zealand are in the Waikato. (Migration Research Group, 2005)

Educational Background

Educational backgrounds of newcomers vary across ethnicities. 27% have a bachelors degree, 18% a vocational qualification, 40% a school qualification while 7% have no qualification.

Groups with the most likelihood of having vocational qualifications are from South Africa, UK and Ireland, Fiji and Australia while school only or no formal qualifications are highest among Somalis and Cambodians. (Settlement Support, 2007)

Language ability

Almost half (48%) of new migrants to Hamilton speak English and another language while 36% speak English only and 11% do not speak English at all. Communities with fewer English speakers are Somali (39% speak no English), Korean (31%) Taiwanese (21%) and Chinese, Tongan and Samoan (each at 17%). (Settlement Support, 2007)

Religion

The most common religion for newcomers to New Zealand is Christianity (43%) while 28% have no religion. 9% are Hindu, 7% Islam /Muslim, 5% Buddhist and less than 1% Jewish.

99% of Somali residents in New Zealand in 2001 were Muslims while among Africans Christianity was more predominant with only one in ten people being Muslim. About 45% of Middle Eastern people were Muslim. Among Indians, Hinduism is the major religion (56%) and 74% of Koreans were Christian. Within Vietnamese and Cambodian populations, Buddhism was the common religion at 50% and 70% respectively. Census figures show that 50% of Chinese and 60% of Japanese had no religion. (New Zealand Police, 2006)

Gender

Males comprise 51% while females are 49% of newcomers to New Zealand. The majority of older people in the Asian community are made up of women who are as high as 54 % of all Asians aged 65 years and over. In other ethnic groups women are also in the majority: Vietnamese 49%, Chinese 52%, Indians 53%, Korean 57% and 62 percent for Cambodian. (Migration Research Group, 2007)

3.1 Ages

In 2006 there were 495,600 New Zealand residents aged 65 years and over. This was a significant increase noted from 45,200 in the 2001 Census. It represented the greatest growth rate between census' in New Zealand demographic history. The 65+ group has increased faster than any other age group and now comprise 12% of all New Zealanders compared to 8.5% in the early 1970s.

The 65+ population is projected to more than double between 1 to 1.7 million by 2051. The baby boom experienced soon after World War 2, between 1946 -1965, has influenced this upward trend as baby boomers age. Other developed nations such as Japan, Italy and Greece also experienced this phenomenon. (Statistics New Zealand, 2007)

Currently most ethnic groups in New Zealand are reported as having a youthful age structure. In 2001 90% of the Somali population in New Zealand was under 45 years and children under 15 years comprised 43% of the population over all ethnic groups. (New Zealand Police, 2006) In 2001, there were about 5800 Chinese people in New Zealand aged 65 years and over. Indians were 2,232 (23%), Korean 333 (3%) Cambodian 195 (2%), and Vietnamese 117 (1%) Older people made up only a small percentage of all new migrant groups because older people can usually only gain entry to New Zealand under a family reunion scheme or on compassionate grounds. This doesn't mean that there are not significant populations of elderly migrants both in the Waikato and New Zealand wide, and these will continue to grow as populations age.

The Waikato region has a total population of 47,628 aged 65 years and above. This population includes refugees and new migrants and longer term migrants who have lived in New Zealand for ten years and over. Over half of the total migrants in the Waikato DHB area in 2001 were over the age of 45, and will now comprise a population of over 50 year olds (MRG, 2005). Hamilton City, on the other hand, showed 40% of total migrants over the age of 45 in 2001.

The 2005 report from the Migration Research Group detailed age structures for different migrant and refugee groups. The data is sorted by ethnicity and includes in the ethnic group quota and reunification refugees as well as migrants.

This report takes the recent statistics from the Department of Labour and discusses the demographics from the 2001 statistics. The demographics of populations are unlikely to have changed radically over the last 5 years as there has not been a radical change in immigration policy. The greatest change (in terms of this report) will be the aging of the 45-64 age demographic.

Chinese ethnic group: Total 5646

This population has grown since 2001. Their age demographics show slightly more women than men in the over 45 age group with just over 20% of the population moving into that demographic.

Indian ethnic group: Total 3699

The Indian ethnic group showed a less even spread through the younger ages than the Chinese ethnic group and a slightly higher proportion of those over the age of 45. Gender is balanced and just over 22% in this age range.

Korean ethnic group: Total 1089

Korean showed a smaller proportion of elderly women to elderly men but a significantly higher number of women in the 25-44 age demographic. About 15% of the population were in the 45+ age group in 2001.

Somalian ethnic group: Total 675

Of new migrants born in Somalia but now living in New Zealand the majority were male and they show a particularly high proportion in the 15-24 age demographic. Looking at the Somali ethnic group as a whole there is a far greater proportion of younger children. The population shows approximately 10% in the 45+ age demographic with almost double the amount of women to men.

Other African: Total 1089

Other African includes all those identifying as African, excluding Somali and South African, who have been identified separately. In the elderly ranges a similar structure is seen to Somali but gender is more balanced. Approximately 10% of the population are in this age demographic.

Cambodian ethnic group

The age structure of the Cambodian ethnic group showed slightly more females than males and a fairly even distribution through the 0-14, 15-24 and 25-44 age demographics, with a smaller proportion of over 45 yr olds.

Middle Eastern ethnic group

This data showed a greater proportion of male to female and the greatest proportion of these in the 25-44 demographic. There were also significant numbers in the 0-14 age demographic for both sexes.

South African

The South African population shows the highest proportion of elderly population compared to any of the other ethnic groups.

Asian ethnic group

The data showed slightly more females than males, fairly evenly spread through the 0-44 age range, with a smaller proportion of over 45 year olds (about 18%). The Chinese ethnic group was similar, as were the Korean and Japanese ethnic groups, although Korean showed a smaller proportion of elderly women to elderly men. The Indian Ethnic group showed a less even spread through the younger ages and a slightly higher proportion of those over the age of 45.

Hamilton City, broad ethnic groups					
Ethnic Group	Male	Female	Total		
Chinese	2,739	2,904	5,646		
Indian	1,863	1,836	3,699		
Korean	528	564	1,089		
Total Asian	6,315	6,729	13,047		
Somali	315	363	675		
Total African	531	555	1,089		
Middle Eastern/Latin American/African	948	900	1,848		
Maori	11,838	12,738	24,579		
Australian	363	405	771		
South African not elsewhere classified	492	510	1,002		
Total European	37,863	42,756	80,619		
Pacific Peoples	2,574	2,565	5,139		
Other Ethnicity	6,642	6,447	13,086		
Total people specifying one or more ethnic groups	59,160	64,221	123,381		
Not elsewhere included (3)	2,922	2,946	5,868		
Total	62,082	67,167	129,249		

Literature Review

Methodology

The literature reviewed in this document was gathered from databases searched with the keywords 'elderly, aging, old, migrant and refugee' with the keywords 'health, sickness, illness and wellbeing'. Specific population groups were searched for, including Chinese, Indian, Korean, Somali, African, Australian, English and European.

Research pertaining to both migrant and refugee elderly populations

In 2003, Biggs and Skull completed an analysis of the utilization of health facilities by new migrants in Australia. This research showed that within the first few months of arrival migrants did not use health services to the expected level due to factors which included literacy problems. Literacy problems are also cited in research by Minas 1990, Ho et al, Trang and Guerin.

Biggs and Skull also refer to cultural differences between countries of origin and the new country and inadequate health services or linkages that facilitate the migrant's access to services and information. According to this research, some health providers did not have appropriate culture, language capacity and 'know how' to deal with the new migrants.

In addition to this, other factors in this research that were cited as reducing the quality of care were that some health providers were faced with unfamiliar diseases, endemic in developing countries but for which there was limited experience in the local medical personnel. These included tuberculosis, HIV and Aids and parasitic infections.

This research echoed findings from Minas (1990) who identified factors exposing elderly migrants to mental illness. These included poor physical health, low incomes, social isolation, and trauma due to war (in the case of refugees), poor English skills, and cultural differences with host community and lack of opportunities for social interaction. Minas also noted the generation gap between elderly and their children who quickly adapted to new cultures which the elderly at times do not approve of, leading to loss of authority.

In 2006, Martindale also identified mental health, loneliness and isolation as one of the major challenges faced by older people of Asian ethnicity. Like other researchers (Fraser, 2007; Guerin et al, 2005) transport was noted to be a major barrier to accessing services by older people. She noted that they tend to rely on public transport, family and friends to facilitate their visits to hospitals. Martindale identified that health services for the elderly need to be culturally sensitive and delivery should be culturally accepted in that society.

This research echoed Wiek (2000) who found that cultural competence was also extremely important for engaging people of different cultures.

Rao et al (2006) reviewed various literature focusing on the health and social needs of older Australians from culturally and linguistically diverse backgrounds (CALD backgrounds). The findings revealed that while older Australians in general need support for health and wellbeing as well as social services the needs of older migrants may require special attention as the way their health problems present is influenced by cultural and language differences, migration experiences and socio economic status.

Language ability strongly affected their understanding of health messages pertaining to the services available to them, in particular where and how to access them. This was especially true of older migrants from non English speaking countries. The review showed that older Australians from CALD backgrounds faced serious difficulties in utilizing services the Government put in place for older people (Rao, 2006, 175).

Rao et al also found that even those elderly migrants who have acquired English language skills tend to lose the language as they grow older and they revert back to their first language particularly those patients who develop dementia.

Furthermore they reported that mental health services utilization by elderly migrants from CALD backgrounds were much lower than their Australian born counterparts. They hypothesized that one probable reason for this is that in some cultures mental illness is stigmatized or viewed as a spiritual issue and resulted in late reporting to medical facilities after the development of advanced dementia. Another reason could be poor collaboration between communities and mental health services providers. As reported elsewhere (Fraser 2007), little mental health education in countries of origin may result in elderly people not seeing mental health as a priority issue.

Social support mechanisms in the communities elderly migrants settle in can facilitate their social interaction and integration into the new society. These help them link up with new friends and learn new culture, language and norms of the host country. Weak social support systems lead to isolation, loneliness and slow integration into the community.

These studies resonate with studies in Sweden which also found that in general migrants have greater health problems compared to the rest of the Swedish population. In particular migrants in Sweden who originated from Nordic countries show a much higher mortality rate. The lower uptake of health and social services has been attributed to cultural perceptions, language difficulties and socio-economic status adaptation to new society and experiences with social services in country of origin (Pudaric, 2000, p39).

Runci et al (2005) researched language needs and service provision for older people from CALD backgrounds in South-East Melbourne residential care facilities. The research looked at the language preferences for older people in residential care facilities.

The results showed that about 19% of residents preferred to speak one of 40 different non-English languages. More than 50% of the facilities surveyed had at least one staff member who could speak to residents in their first language. Some residents from nine non-English languages indicated that their language was never spoken in the residential facilities they were accommodated. Another interesting finding was that almost one quarter of residential homes for the elderly had no language-relevant facilities at all.

These findings further reinforce the role played by language in facilitating access to high quality services for the elderly people from non-English speaking background.

According to Runci “English language proficiency is pivotal to the experience of persons from CALD backgrounds, as it has a marked impact on social and cultural integration, employment prospects, remuneration and access to services” (2005,158)

The use of interpreters in the Australian case studies helped in bridging the communication gap. However health professionals and patients acknowledge that things like idioms and proverbs which sometimes have double meanings are not fully covered by interpreting as they vary according to cultures.

Geographical location has a huge impact on the health status of elderly migrants. In South Australia the elderly migrants resident in urban areas had better access to services as transport systems are efficient and the medical centres had appropriate personnel with cultural competence skills to deal with specific needs of migrants which are not the case in rural areas.

Pudaric et al (2000) looked at exposure to the risk factors for cardiovascular disease (CVD) for elderly male Swedish nationals born in that country and compared it to the risk exposure for elderly migrants born overseas. They analysed data pertaining to the risk factors for CVD i.e. Physical inactivity, smoking, increased Body Mass index (BMI). They also considered the presence of diseases such as diabetes mellitus and hypertension. Age, sex, income and country of birth were taken into account. The results showed that elderly foreign born Swedish residents were involved in little or no physical activity and had High Body Mass Index. The risk of an unhealthy lifestyle for elderly migrants in the study was between 50% and 80% compared to natural born Swedes. Smoking, low incomes, having hypertension and diabetes mellitus all further compounded the risk.

In conclusion Pudaric stated that “migrants who are retired or in transition to retirement have a disadvantaged risk profile for cardiovascular disease. It might be possible to improve this situation by intervention as for example by increasing person’s interest in walking (pp137)”

These findings are similar to other studies made among Mediterraneans in Sweden which showed increased risk among that ethnic group compared to Swedes. Country of origin is therefore an important factor in accessing exposure to risk factors for cardiovascular diseases in migrant populations. Low socio- economic status (SES) is also associated with smoking and lack of physical activity during leisure time. Level of education also influences levels of physical activity. Even where high incomes are earned physical activity and healthy eating was found to be low in some studies done in the USA comparing elderly people from different ethnic backgrounds.

Pudaric identified four factors that contribute to poor health among elderly migrants. These are:

- a) Circumstances surrounding migration
- b) The difficulties of living in a foreign and unfamiliar country
- c) Poor socio-economic conditions and

d) The changed role in the family which relocation can bring (pp146).

These studies and results resonate with information and reports recorded in Hamilton. Every year, the Hamilton City Council holds a 'Listening Forum', in which members of ethnic communities are invited to attend focus groups and share knowledge and examples about how communities are faring in the city. These discussions are written and published into a report. Participants to the Hamilton City Council Ethnic Communities listening forum in 2005 listed major concerns including the need for free interpreting services, transport to and from the Migrant Resource Centre, domestic violence, community safety, low awareness of other cultures and conflict between new and old generations.

The Forum report states that “Transport is especially an issue for older people who no longer drive but still need this interaction – older people have less of an opportunity to get out and interact” (2005, 9) Participants were also asked at the forum to suggest what they feel would make Hamilton better for the whole community and among other suggestions were affordable housing for old people as well as locating social facilities at places accessible to older people and sharing information on rights for older people who have less access to this information.

The report of the Hamilton City Council Ethnic Listening forum of 2006 indicated an increase in the number of older people with ethnic background allocated housing by Hamilton City Council (HCC). This forum again identified older people’s health and wellbeing as a major issue of concern in the community. Older people were reported as experiencing language barriers and in need of physical activities and information sharing. They also suggested optimum use of the Celebrating Age Centre to respond to isolation of older people from ethnic communities in Hamilton (Page 10)

Also arising in the Forum was the need to do programs for senior women – possible menopause education seminars (Ages 40+). There was a stated need for guidance for families about social structures in Hamilton which are very different to those of migrant’s country of origin.

Interestingly, the reported health needs of elderly non-migrant populations are similar to those reported in literature for both refugee and migrant populations. Martindale conducted focus group discussions with elderly people that revealed the health needs of older people as transport to get to GPs and hospitals, information on services available and how to access them, regular medical check ups and funding of costs involved nutrition and lack of cooking skills by older men (widows) and need for physical activity.

Echoing this, the Oranga Kaumatua study (Waldon and Hauora 2004) which looked at perceptions of Health and wellbeing among older Maori established a link between communication with other community members and wellbeing. The study found that those older Maori in poor health were not participating in Marae activities compared to their peers who had good health status.

In summary, the literature that relates to the health needs of elderly people of migrant or refugee status, without being specific about ethnicity, has particular trends in it. Firstly,

more research is focused on those population groups that are visible as migrant within the host community. Secondly, with the exception of the study about cardiovascular disease, much of the research focuses on the barriers to accessing health services rather than particular health problems for any of these community groups. The second part of this literature review looks at literature that is specific to particular populations. The survey of this literature was restricted to those populations currently found in Hamilton.

Refugee

As Zwi et al (2003) noted, “forced migrants (refugees) are not a homogeneous group, even when fleeing the same conflict zone or economic hardships. Populations are differentiated by their class, religion, socio-economic status, political affiliation and even state of health” The elderly, people with disabilities and women are some of the vulnerable communities he identified. While it is impossible to generalize in many ways between the diverse populations that are given refugee status, the following studies have found similarities.

Toole (1997) identified six major causes of death among refugees in low income countries. These are diarrheal diseases, measles, acute respiratory infections and malaria whose severity is made worse by high rates of malnutrition. These account for between 65-95% of all reported deaths. While these are deaths that took place outside of the country of resettlement, it is highly likely that many refugees arriving in New Zealand will have been exposed. Interestingly, Toole also noted that the treatment of chronic conditions such as cardio vascular diseases, cancer and renal conditions were overshadowed by the treatment of wounds due to war injuries (1997, 39). Part of the process of gaining resettlement to New Zealand includes rigorous medical testing and health checks so while it is unlikely that any of these conditions will be overlooked, it is important to note that they may have been overlooked for many years due to other, more obvious, injuries.

Ho et al, 2005, found that factors such as transport, employment, education and income and housing need to be addressed to promote access to services in a holistic manner. Furthermore the study found gaps in health services which included inadequate interpreting facilities, mental health services, traditional medicine and oral health care. In 2005, the research reported insufficient networking and collaboration among the various service providers who deal with migrant and refugee health care as well as limited professional development in for example cultural sensitivity.

There has been a lot of research regarding health services not accessed by women of refugee populations. Barnes et al completed research in the United States (2004) to determine the rates of breast and cervical cancer screening among refugee women. The results showed that “a significant percentage older than 40 (86%) had never had a mammogram when compared to American women of the same age (33%) only 24% reported having had a PAP smear test within the previous 3years.”

The study concluded that the refugee women newly arrived in the USA had lower access to reproductive services compared to other women. Therefore health services need to deliver programs specific to refugee women particularly the older age group.

Pieterse (2003) et al analysed the nutritional risk factors for older people among Rwandan refugees. Findings from the studies show several nutritional risk factors. These include limited physical activity and mobility as people get confined to refugee camp perimeter due to security concerns. Inadequate income, access to food and limited access to other basic needs such as shelter, water and sanitation, health care and psycho social support.

Concluding the study Pieterse noted that elderly people in refugee camps are at higher nutritional risk than the younger refugees and higher nutritional risk than their counterparts in stable situations. They have to compete with all other refugees to access social services despite their physical limitations.

This study recommends that reducing nutritional risk factors for elderly refugees should involve raising awareness among service providers who provide food to refugees on the vulnerability of the elderly and promoting physical activities for this group. Strong social support networks for older refugees in emergency situations can help in reducing social isolation and increase participation in community activities which promote health and wellbeing. Furthermore, on resettlement, services need to be aware of the effects of deprivation on these individuals.

Indian

Research by Nandan (2007) in the USA looked at the adoption of American culture by Asian Indians and its influence on access to social services. They found a strong correlation between adapting to new cultures and willingness to utilize social services by elderly migrants. The study covered Asian Indians who migrated to USA from India and other parts of the world between 1965 and 1999.

Indians who migrated without family and settled in mixed communities adapted faster to American lifestyles than those who come with families and settled predominately in Indian suburbs where they continued with customs and traditions from home and their social networks were limited to their own ethnic group. Those with no family ties learned English faster through constant interaction with host community. In addition, their knowledge of social services and how to access them was far better.

Younger Indians were found to adapt faster than older ones as the latter had life experiences in India which influenced their perceptions about American culture.

Other Indians who migrated to the USA from countries such as Guyana and South Africa adapted faster than those who went to USA straight from India. The experiences gained with other cultures outside India made them more receptive to American culture and style of social services delivery.

Marriage to Americans was found to have huge influence on the adaptation process. Nandan also found that those who got married to Americans adapted faster than those who travelled back to India to get a bride. The intermarriages helped in bridging the culture gaps between the two ethnic groups.

The use of social enclaves such as grocery stores, restaurants and social clubs to deal with loneliness and need for companionship was found to actually delay the adaptation process as social interaction is limited to ones' own ethnic group.

There are fundamental differences between the cultural beliefs of Asian Indians and American society about responsibility for caring for elderly people. In Indian culture older people are cared for within the extended family environment where they live with their grown up children, daughters in law and grandchildren. The family takes responsibility for caring for the elderly, a marked difference from American society where care is institutionalized in nursing and rest homes.

Studies in Australia by Rao (2006) found similar trends and perceptions of social service provision for older migrants. Family values and social services structures in the country of origin influenced access to residential care. Some ethnic groups believe in the family caring for their elderly rather than the government, which may have been the case in the host countries.

African

Toole et al (1997) analysed the Public Health impact of mass displacement of people from their countries due to war and armed conflict in the African region.

A major finding from the study showed that “refugees are usually at highest risk of mortality during the period immediately after their arrival in the country of asylum, reflecting long periods of inadequate food and medical care prior to or during their flight” (1997, 288). Examples include Mozambican refugees in the Chambuta refugee camp in Zimbabwe in July and August 1994 where the daily crude mortality rate (CMR) for refugees who had been in the camp for less than one month was 8 per 1000 population. This was four times the death rate for refugees who had been in the camp for one to three months and 16 times the normal death rate for non displaced population in Mozambique during that period. This trend also prevailed with Rwandan refugees in Goma, Cambodian refugees in Thailand and Somali refugees inside Somalia in 1992.

These results underscore the need to supply high quality effective health services to refugees as soon as they settle in the host country as this is the most critical intervention point which determines future health status.

Afghans/Muslims

Morioka – Douglas et al (2004) reviewed literature pertaining to care for elderly Afghan people in the USA. They also held focus group discussions to gain insight into perceptions of Afghan people to health delivery systems and determine factors that create barriers to accessing health care.

The major findings of the literature review and focus group discussion is that religion is seen as being part of health and wellbeing. This means that non compliance to strict

hygiene as stated in the Qu'ran (Koran) can lead to illness and that evil can cause disease. Prayer and use of verses in the Koran can cure disease.

Care-giving for ill people in Afghan communities is done strictly by a same sex health provider. These communities require a male doctor for male patients and female for female. A person of the opposite sex should never be involved, even for handling deceased. Once women were banned from working in Afghanistan, husbands became the ones who visited doctors and consulted on behalf of their wives left at home because the health providers were male.

Pork is seen as unclean according to religious beliefs and thus any product containing pork is prohibited. Hospitals should therefore avoid giving such food to Afghan patients. The set up of hospital beds for admitted patients even more importantly for elderly are required to face Mecca in accordance to Islamic teachings.

Morioka-Douglas further noted in the literature review that mental health is a major health problem among Afghan refugees in the USA. This includes depression and physical symptoms related to stress from refugee trauma and loss, occupational and economic problems, culture conflict and social isolation for the elderly (2004, 31).

Interpreting services in Pashto and Dari are critical as most elderly Afghans have limited or no English language competence.

The conclusion noted that the most effective way to reduce disparities in access to health care for migrant communities is for health providers to design programs that embrace the cultural backgrounds and beliefs of the communities.

Many of these findings are also relevant to other Muslim communities, in particular those issues relating to food and gender.

Asian

A study of depression in older Chinese migrants to Auckland by Abbott et al (2003) showed that 26% of participants in the study suffered from or were at great risk for depression. They attributed the depression to factors such as low emotional support, inadequate orientation to New Zealand culture and frustrations associated with difficulties in accessing health services. Surprisingly the study detected no signs of depression in recent migrants which seemed to indicate that people became depressed after staying in New Zealand for a period of time.

A study by The Migration Research Group of the University of Waikato in 2007 looked into safety awareness and service utilization of social services including health care among older Asians. They found that elderly Asians were aware of the possible hazards that expose them to accidents at home and on the roads. However differences in the traffic rules between New Zealand and their home countries and use of unfamiliar heating devices at home to keep warm in winter made them vulnerable to accidents.

The study also found that older Asians had limited information about ACC and how they could access services (Ho et al, 2007, 8-10).

Somali

Research by Guerin (2002) which looked at obesity and physical fitness among refugee Somali women in New Zealand found that overweight and low physical fitness was prevalent among Somali women aged 30 years and above. They concluded that the older Somali women “are at increased risk of developing lifestyle related diseases” (2002, 191)

Older women are particularly vulnerable as they have limited reading and writing skills even in their own first language. This means added difficulty even where materials are translated.

It has been noted that, due to the difficulties associated with life as a refugee, many people arrive in a new country having a level of health risk. This risk can be minimized by provision of health services in communities they settle especially where there are no adequate social support systems to cater for refugee health needs. Therefore providing high quality health services to refugees does not only benefit that group but the rest of the community as well (Zwi et al, 2003).

Literature review conclusion

The foregoing literature review uses a large cross section of the available literature about elderly refugee and migrant populations. Many grey areas exist in the available body of knowledge and the evaluation of the health needs of older refugees and migrants in the Waikato is important for health services design and delivery to this diverse population.

Through all this research, themes of cultural difference and language barriers are evident. These themes are also very evident in the next part of the research.

Data and analysis of interviews and focus groups

This section of the research relates to data captured in the interviews and analyzed using content analysis to provide an overview of major themes and topics within focus areas.

A major finding of this part of the research is that many of the problems faced by refugee and migrant elderly are also faced by non-migrants and are already addressed by the health system or through social services. However, the condition of being migrant or refugee in New Zealand results in a number of barriers for the elderly to accessing available health services. Focus groups were asked what these barriers might be and the results are grouped thematically here. In particular, issues of language and social isolation were significant.

Summary of Findings

Common findings from health screening of refugees.

The following conditions are commonly picked up during health screening of new refugees and their family members. They are not age specific and do not just relate to refugees that settle in Hamilton. However, they are commonly experienced by elderly as well as other family members.

- Vitamin D deficiency (mostly Muslim women whose dressing exposes the skin to little sunshine. Dietary habits contribute to this condition in other ethnic groups).
- Stomach parasites
- Iron deficiency
- Dental problems requiring fillings , extractions etc
- Positive mantoux results – but no active TB found.
- Fungal skin infections
- Hepatitis B+ carrier status

Apart from the above no other serious diseases are being identified and refugees are generally in sound health at the time of arrival in New Zealand.

Other conditions identified

Participants to focus group discussions and general practitioners interviewed by the researcher identified the following as some common diagnoses in elderly new migrants and refugees after settlement in New Zealand. Many of these are also present in elderly non-migrants.

- Weight gain (major problem)
- Increasing cholesterol in blood
- Increasing heart attacks in Indians, particularly from Bangladesh, and Sri Lanka
- Increasing 100% vitamin D deficiency
- Increasing 50% vitamin B12 deficiency.
- Knee and joint pain problems

- Bone pains
- Arthritis
- Eye sight
- Hearing
- High Blood Pressure (Hypertension)
- Diabetes
- Cancer (Breast and cervical)
- Obesity
- Heart disease
- Back pain
- Hip problems
- Lack of exercise
- Colds and flu in winter due to cold damp housing.
- Breathing problems (respiratory problems)
- Dental problems
- Allergies and very severe hay fever is common for elderly people coming from Africa who lack dehumidifiers to get rid of dust mites which thrive in damp conditions. Asthma cases can be reduced if housing is improved.

Other health system related needs

Interview and focus group participants also identified a number of needs related to the health system in a broader sense. These needs came from open discussion and were not ranked in order of need.

- A need for knowledge about medicines and their safe use
- Shorter waiting periods for operations
- Transport to and from hospital
- A need for caregivers at home when recovering after operations
- Need for economical home based support
- Need for regular social interaction with other community members
- Rest homes not fully equipped to deal with refugee and migrant residents
- A need for information about NZ Health Systems
- Lack of Doctors and Nurses from own ethnic background

All of these health conditions and needs are also experienced by other populations and health and social supports are in place to address them. The majority of the rest of this report, therefore, is concerned with what barriers are in place stopping refugee and migrant populations accessing the appropriate health care and/or services.

The concept of ‘barriers’ has been separated into barriers to accessing health services (predominantly identified by communities) and barriers to providing health services (predominantly identified by practitioners). In this, however, there is some crossover.

Barriers to accessing health services

The first section looks at the language barrier, including interpreting, translation, learning English and lack of information, the transport barrier and financial barriers.

Language

Individuals, focus groups and organizations providing social services and health care all identified language as a major barrier for elderly migrants and refugees who have no/or limited English language proficiency. Migrants of Asian background, including Chinese, were described as the group experiencing the most difficulties with communicating in English. Elderly Cambodians, Afghans and Iraqis also experience difficulties accessing GPs and hospitals because of an inability to speak English.

Issues around interpreting, translation, English language learning and lack of information are all part of the language barrier.

Interpreting

To facilitate communication with non English speaking elderly clients, the Waikato District Health Board makes use of interpreters to convey messages into the languages understood by clients. However, most General Practitioners do not use interpreters at all and those that provide a level of 'interpreting' do not use trained professional interpreters through the Interpreting Service and therefore have no quality control of the accuracy of interpreting. A focus group discussion with Chinese elderly people revealed that some of the patients only go to seek medical help when there is an emergency because of difficulty explaining themselves to GPs.

Discussions revealed that three types of interpreting are used by GPs and some clinics: family members, trained interpreters provided by the service provider and volunteer interpreters from the local communities sourced by the GPs.

Family members used as interpreters are mostly children or grandchildren of the elderly migrants and refugees. One elderly migrant from the Chinese focus group said

“Using our children to interpret at the hospitals is not good because they get to know our secret matters”.

Participants also identified discontent with family members interpreting because the children are usually busy at work or at school and are not always available to take them to the hospital which causes delays in seeking treatment when needed. Another participant added

“If the children are not home we don't go to the GP until the time that they are free which can take many days”.

The concern was felt through all the ethnic groups who participated in focus groups. An elderly participant in the Somali focus group said

“Sometimes when you have an illness and you are not able to communicate it to the doctor we are forced to use our children as interpreters. This creates problems for us because it stresses the children to know that their mother is having a health problem. Also when you have a women specific illness and you only have sons it is hard to ask them to interpret. We need to have an access to professional interpreters that we can trust.”

Although no formal evaluation has been carried out to assess the impact of interpreters in improving access to services, feedback by both individuals and health workers who have access to interpreters interviewed during the survey indicated that this has been a useful tool. It has improved communication between elderly migrants and refugees and the health service providers.

Interviewees expressed more confidence in trained interpreters than in family members as trained interpreters are bound by professional codes of conduct. One GP mentioned using a volunteer interpreter from the local community for the Somali language but struggled because the interpreter was not always available and the clinic cannot hire a paid interpreter because of budgetary constraints.

An elderly Afrikaans speaker from South Africa described his way of getting around the problem of GP appointments conducted in English, saying

“Expressing ourselves in English is difficult. The GP has only seven minutes for the patient. It’s hard for us who are both old and are migrants. The GP has to get to the next patient in the next 15 minutes. That is why I go to Cambridge (30km away) to see a GP because there is an Afrikaans speaking GP there”.

The traveling to another town for services due to language barriers is an added financial burden to the elderly migrants from the South African community.

Interviewees and focus groups showed that language was a problem for elderly even in communities where many were expected to speak English, such as the South African and Indian communities.

In contrast to the widespread expressions of need for interpreters, one organization dealing with elderly migrant mental health clients reported that they experienced situations where the clients preferred to use family members to interpret rather than a trained interpreter. They suggested that this was because mental illness in some migrant communities is viewed with stigma and the clients fear that confidentiality can be compromised if the hired interpreter discloses information to third parties which the family member is not likely to do.

Experiences shared by an organization supporting the resettlement of refugees in the Waikato indicated that sometimes refugee clients are not prepared to use a professional interpreter out of mistrust about whether the interpreter will keep their health matters confidential. In such instances they opt to use family members.

Discussions with the Hamilton Interpreting Service revealed that this is a common fear especially of communities who have previously lived under conditions in which information could be collected and used against them. This fear could extend to allowing any professional access to personal information and community education was needed to ensure people understood the professional role of interpreters as well as that of doctors, nurses, teachers and other professionals they might come across.

The language barrier in a mental health setting is more severe for the elderly migrants as the interpreters often find it difficult to understand “the muddled up speech” for them to interpret accurately. The patient themselves cannot express the symptoms which makes the task of the interpreter very difficult.

Experiences from one organization dealing with elderly migrants showed that,

“Some of the elderly migrants do understand English to a certain extent but have more difficulty expressing themselves. Sometimes you can assume that they are shy and don’t want to talk until another person from their ethnic group comes through then they start to chat and laugh”.

This sentiment was echoed by another social worker from a mental health organization who when asked to identify challenges for the elderly in accessing health services described the language barrier but said it was important to recognize that people’s understanding of English is often greater than one would assume.

Indications suggest that this ‘understanding gap’ cuts both ways as it is impossible to assess a person’s real comprehension through a casual conversation. Most migrants and all refugees have had a free English assessment through the Waikato Migrant Resource Centre and this can be provided as an accurate language level indicator, although in most cases it is wise to assume a lower level if the practitioner is uncertain.

The language barrier for some ethnic groups is compounded by clan and tribal differences in the community dating back to times prior to migration to New Zealand. In one mental illness case handled by one of the organizations interviewed in this survey it is reported that the family turned down the services of an interpreter after realizing that the interpreter belonged to a different tribe in Southern Somalia.

The social worker recommended that because of these tribal differences clients need to be given a choice even when the interpreter belongs to the same ethnic group and is from the same country of origin. Somali clan problems also affect other services. A community nurse dealing with many schools in Hamilton observed that, “At schools, children find it difficult to mix and mingle with tribes/clans they were not friendly to in their home country yet they are supposed to now learn in harmony with them - this is stressful for the children”.

Translation

Another factor cited as creating a communication barrier is the lack of translated resources.

“Most health information pertaining to diseases of the elderly people is written in English and we cannot understand it”.

This was mentioned in several focus groups, and discussed at length in the South African one. Information for new migrants concerning health and other social services distributed to newcomers to New Zealand is in English and not in Afrikaans which creates an information gap as to how and where the elderly migrants can seek medical and other help. While some health information is translated, not all of it is. The Waikato Migrant Resource Centre ensures these resources are on hand but they are frequently not given out by health professionals.

One Somali community leader described to the researcher instances where elderly refugee patients received letters from the hospital/GP about their appointments which they could not read. He said,

“With such cases we have to help them read the letters, some take the letters to the mosque where somebody can read and explain to them.”

The process of finding someone to read the letters at times caused delays in reporting for the appointments even though the elderly would be keen to seek treatment.

Learning English

Waikato ESOL Home Tutors describe the process of learning English as different for every learner and depending on such things as the age, background and ‘preparedness’ of the individual. Generally, the older the learner is the longer it can take for them to grasp another language.

A GP interviewed suggested that

“A lot of refugees in the 40 and over age group find it very stressful to go to English classes”.

He has treated many clients with migraine headaches which he believed was caused by stress from the English lessons. The GP suggested that some other method of teaching English other than classroom based would be preferred. Some of the elderly refugees feel the classroom is intimidating and embarrassing. One to one tutorials at home such as those provided by the ESOL Home Tutors would be preferable for the elderly refugees and migrants.

A community health worker recommended that there is a “Need to develop English language teaching for elderly people in appropriate ways less stressful to the elderly”.

While Home Tutors are usually available for people from refugee backgrounds they are often less so for people from migrant backgrounds.

In African culture wisdom is associated with age and elderly people who are taught language by tutors and family members much younger than them feel disempowered and feel loss of a place of authority in the family power structures. This sudden change of power relationships in the family and society was cited as slowing down learning especially where teaching methods are not culturally sensitive.

Lack of information about what is available

The difficulties with interpreters and translators mean that elderly migrants are often not able to access language appropriate information.

Access to information about health services and where to get help is one of the major needs identified by almost all ethnic groups and service providers interviewed. According to a manager of an organization providing leisure and entertainment to elderly people in Hamilton, people lacked information about their entitlements as older persons in society, who provides what services at what cost, housing health, health, transport and work income benefit schemes for elderly migrants and refugees.

Lack of information about how to access New Zealand health services was discussed at length in the Chinese focus group, who reported

“We know very little about New Zealand health system so we use experiences from China and sometimes we don’t know what to do, the hospitals are different”.

The participants indicated that in China this information was readily available.

A local authority official identified the information gap as a serious problem in refugee and new migrant communities because while it was needed it was not easy to get to the elderly directly due to language and transport. To address this situation the official recommended that

“information needs to go via their connection through family members, neighbors, their own community by word of mouth”

New migrants may be aware of the existence of some services but lack information as to how they can access them.

“We see St Johns vans going around picking patients but we don’t know how we can also benefit”

A community based health professional attributed a perceived low uptake of physical exercise among elderly migrants/refugees to a lack of information and awareness on the benefits of physical activity and their link to preventing obesity and heart disease.

The effect of the lack of information was summed up by a psychiatrist interviewed who mentioned that *“people cannot access services they know nothing about”*.

Transport barrier

Many elderly migrants rely on family members for transport to hospitals and clinics. An elderly South African stated in a focus group discussion that

“I rely on my children who are teachers to take me to hospital but it is difficult for them to get time off from work”

The issue about transport was often also linked to that of English. One elderly Chinese lady received a letter offering her free breast screening in the hospital, but she did not go because she said,

“My children were busy and there was no-one to take me there, I cannot speak English so I did not go”.

Employed refugees who live with their elderly parents have limited time to take them to clinics when need arises. They work long hours or have several jobs to compensate for low salaries. Elderly cited this reason as one of the factors contributing to delayed reporting to clinics or missing appointments.

Elderly Somali women identified lack of driving skills as a major contributing factor to transport problems. They are keen to learn driving if facilities are made available with financial support. There are two organizations in Hamilton who offer limited drivers education to refugee and migrant participants at low cost and closer links are currently being made to enable the Somali community to access this.

A mental health social worker based in Hamilton reported that some of the elderly refugees and migrants they deal with miss appointments and do not participate much in social activities citing transport problems. The worker suggested putting in place a van that goes round to various suburbs picking up elderly to the Migrant Centre and other venues for health and social activities.

Another organization assisting elderly woman pointed out that they have a number of free activities for elderly women at their Centre in Hamilton but attendance is low as transport to get the women to the Centre is a problem due to financial limitations. They have done some activities where transport was provided and the participation has been high but they could not continue as they do not have the resources to continue offering transport.

The Somali community facilitated participation of elderly from that community in key events such as Waitangi Day by organizing a van that ferried them to the function.

There is currently a van, owned by the Hamilton Multicultural Services Trust, that is available for this purpose and is used on a regular basis but must be paid for on a per km basis by whatever organization is in charge of the activity. If transport costs are not

written into a budget for working with elderly migrants then it is difficult to meet the need.

Financial Barriers

Some elderly migrants reported having financial problems due to having no retirement savings and having to balance rising cost of living with health demands. Examples given were whether one buys healthy food or pay heating bills in winter. South African, Indian and Somali community leaders all identified lack of financial resources as a major problem delaying elderly people from migrant communities seeking health services when needed.

Elderly Chinese find New Zealand dental charges to be expensive and unaffordable. An example given by a member of the focus group discussion to illustrate this point was that four elderly Chinese had to travel back to China (including a 76 year old) for dental treatment as it was cheaper even after considering the flight fare.

The South African focus group discussion revealed that even though there are free services for older people not all new migrants can access them as one has to go to the GP first which costs money. There seems to be considerable confusion (expressed both in focus groups and from providers) about which migrants and categories are eligible for free services through the GPs. One participant had this to say

“Older people from South Africa depend on savings from home country retirement which is divided by six as the currency is weaker than New Zealand dollar”

Inadequate finances for personal preventive measures expose refugees to illnesses that are otherwise preventable. For example some participants from the Somali elderly women focus group said they have not enough money to pay for heating in winter,

“The cold weather affects us badly, especially winter a lot of elderly people get sick and electricity is very expensive and we are forced to use less often as we would have liked. Most of us have back pains and joint pains”

Barriers to providing health care services

General practitioners and other health practitioners indicated facing the following challenges when delivering services to the elderly refugees and new migrants:

Health care challenges

There was reported difficulty in getting elderly refugees to take any long term preventive medication for example hypertensive medicines. Some clients from migrant communities do not go back to the doctors once they finish the prescribed medicines. Some do not understand that some medicines are for life eg high blood pressure. They stop taking the medicines as soon as they feel better. This could be related to cultural perceptions of what is important in health care, or misunderstandings due to language.

Providers also perceived the transport barrier reported by communities and remarked on the difficulties of getting refugees to attend to their hospital appointments and follow on appointments with their GPs.

Older people suffering loneliness and grief mean that providers have to offer psycho-emotional support over and above their services.

A further challenge is faced when many people from non Western cultures don't want to be considered begging so they are reluctant to seek social welfare support as in their countries it is seen as a service for the poor and desperate. Seeking such services is perceived as reducing self respect and dignity.

Funding challenges

Financial problems faced by GPs affect services delivered to elderly refugees, particularly women. A GP told the author that,

“I did have a female locum doctor for looking after female refugees but I couldn't afford to keep her and had to terminate employment. It is difficult for a male GP to provide the services that some female refugees need e.g. with regard to gynecological problems”.

A Hamilton based GP identified financial allocation imbalances across regions in New Zealand as a major challenge affecting service delivery. He gave the following narration to support his assertion: “The Waikato area receive the same amount of funding for refugees for General Practitioner services as other parts of the country e.g. Canterbury refugees/ migrants have received \$208 plus GST for each refugee for 2005, 2006, 2007 and 2008 whereas Waikato refugees have received \$46 plus GST for 2008 and nothing at all for 2005- 2007. In my own case I have received \$30 000 but should have received over \$400 000. If the money was being distributed fairly with more money I could expand the services I provide, enlarge the rooms, employ a social worker and a female Doctor etc. Waikato has received by far the lowest amount of funding and is grossly inequitable”.

Lack of knowledge about cultural beliefs of different ethnic groups.

This problem does not just affect GPs but also medical centre staff and other health practitioners. Often these people are not aware of the extent of their lack of cultural sensitivity.

There are countless examples of this in practice. An incident encountered by one of the nurses interviewed who dealt with an Arabic client is described as follows.

“The client had a string tied around her waist which was expected to be removed for bathing. The patient voiced her concern and refused to take it off on religious grounds”.

Often the reasons for refusal to do things are not well understood and refusal is unexpected, leading to communication breakdown and, in most cases, frustration on behalf of the practitioner.

As an interviewee from the local authority said

“Cultural beliefs about health illness and caring do not suddenly disappear when migrants arrive in a new country. Understanding cultural beliefs is really important when trying to deliver services to migrant and refugee communities”.

Another nurse working with older migrants and refugees interviewed as part of this study said in her experience

“Cultural backgrounds affect openness to express health problems. You need a lot of probing when history taking to get information. Involving family is necessary for older patients yet at times family is busy and not available at appointments”.

On participant suggested that what is needed is a social interpreter who can advise on cultural aspects not just language. Hamilton Interpreting Service Interpreters are trained and required to explain cultural and social issues that may be affecting consultations. However, the sharing of this information is usually limited by the time allocated for consultations. There is also intercultural training available in Hamilton through the Department of Internal Affairs and the Waikato Migrant Resource Centre.

Awareness of cultural difference but difficulty engaging because of it

Practitioners perceived a lack of knowledge and distrust in the refugee and migrant communities about mental illness and treatment approaches in New Zealand which are different from those of home countries. Practitioners report that clients and their families have quite a different concept of mental illness.

There have also been reported difficulties in using the Western medical model which is not always compatible with migrants’ model of health and illness which can be based more on family, community and spiritual and traditional beliefs.

Gaining the faith of migrant and refugee communities for local New Zealand health services has been difficult. New elderly migrants take time to build trust in local services and the turnover of ‘new’ migrants is constant. It is not a matter of approaching communities once, or a hundred times. There needs to be constant and appropriate engagement.

A number of service providers who participated in this evaluation identified low utilization of their services by elderly migrants and refugees as a major challenge. A community worker from one such organization said

“Sometimes we advertise for senior group but there is low response. We don’t know where they are or how to find them”.

Because of their isolation and limited interaction with other people in the community, elderly refugees miss out on information about events and programmes designed and

offered to assist them. Different organizations around Hamilton City confirmed this experience.

Another community worker suggested that many elderly are hard to access because there are no networks that reach them other than their children – if their children do not relay information about events or services available then the elderly miss out.

Some practitioners understood differences between cultures and understanding of diseases, but there remains tension between understandings of causes and how to deal with medical problems. For example Chinese prefer traditional treatment such as acupuncture.

Language

Practitioners identified this as a barrier to provision. Communication with elderly migrants without English speaking skills is difficult. However, it costs money to use interpreters and the elderly cannot afford them.

A growing and specific problem is that of elderly reverting to first language as they age. This is a growing problem in the Dutch community as Dutch migrants are losing English as they grow older in New Zealand. They learnt English when they came to New Zealand during World War Two. This problem was reported about the Dutch community but anecdotal evidence suggests it is much more widespread through all communities who learn English as a second language.

Practitioners reported refugees and new migrants often relying on their family members for interpretation. Appointments are missed when the family members are not available to escort the elderly. People are also afraid to talk to Pharmacy assistants to seek more information about prescriptions and how to take medicines due to language problems.

Low level of participation in social events organized for older migrants and refugees.

There are a few reasons contributing to this low level of participation, including language, transport, a buddy to go with and understanding of the activities and lack of interest. Understanding of the activities is important in that posters and leaflets calling people to such events give little information assuming that all people in the community understand the event and what is involved. A local authority official involved in organizing events for migrant communities indicated that elderly migrants take many things into consideration before deciding to attend or not.

“The elderly are nervous/scared about what is happening, do I fit to be there? How will people look at me? Will I be alone? Will I find someone to talk to and am I safe there?”

To address those questions and concerns organizers of events for older refugees need to give a lot of details to reassure them and show the benefits of attending.

Summary of barriers to accessing and providing health care

There are strong links between the barriers that community leaders and members see as affecting their access to health services and those that practitioners see as limiting their provision to access. However, it is an important finding that while practitioners spent a significant amount of time discussing the difficulties associated with cultural difference, community members did not perceive cultural difference to be a big issue and focused more on language.

One potential reason for this may be that if community members were able to express themselves and overcome the language barrier they could do a lot more explaining of factors that practitioners describe as cultural barriers.

Barriers result in not seeking appropriate health care at the appropriate time. They also result in the following social and health problems.

Social Isolation

Community leaders interviewed from the Somali, South African, Indian and Chinese all identified social isolation as a major problem affecting elderly people from migrant and refugee communities in Hamilton. This was also confirmed by participants in focus group discussions. The following are the factors mentioned as contributing to this situation.

Lack of family

Some elderly people are living alone without family. For refugees and migrants this has happened for a number of reasons, including because they lost family members during war and conflict or because they have failed to secure family reunification visas from immigration. One community leader summed up the situation for elderly as

“They may have good houses and food yet they are very sad and frustrated”

Elderly people living alone is a common feature across ethnic groups in Hamilton as revealed by interviews.

Young people who move out of New Zealand to overseas such as Australia for greener pastures at times leave behind their elderly parents and grandparents because they could not secure visas for them to move with to the new country. They remain behind alone and if their English language is not good they get cut off from the community as the people who used to help them around would have left. This problem is particularly obvious in cultures with a highly skilled younger population such as the Chinese.

Language

As discussed earlier, this factor is not just a barrier to accessing health services but is also a factor in increasing social isolation. Not speaking English was cited as a major handicap contributing to social isolation for elderly refugees. The opportunities for communication with English speakers are very limited. Because of the lack of English language experience, people stay at home most of the time and only go out when their

adult children and grandchildren are at home as they need someone to interpret whenever they communicate with English speakers.

Even where public transport is available people have resisted going out as they have difficulties reading bus timetables, maps and asking for directions in public places. A focus group with the Chinese elderly reiterated this finding.

A community worker whose organization assists new migrants with settlement support in Hamilton revealed that the negative impact of elderly sticking to their group is that English language learning remains low as there is no constant practice. Learning about other cultures and New Zealand way of life is limited when the elderly are not outgoing.

Fear and security concerns

Safety is a major concern among older people from ethnic communities. Older people feel safe in the company of their own ethnic group. The discussions revealed that there is low interaction with local population and with migrants and refugees from other countries. Elderly participation in public events, particularly those held at night, is low and security fears are cited as the main reason. Those interviewed said they fear being robbed, harassed or verbally, racially abused by host community. They are however willing to attend events in safe secure places especially during day time. While lack of security is a common fear expressed by elderly people, it has a valid basis particularly for those elderly people who are 'visibly' migrant or refugee and may become targets as such.

Child care-giving duties

A number of elderly people reported that they came to New Zealand to help their adult children look after their newly born babies. The arrangement is meant to reduce the financial burden of paying child care facilities for working mothers. This trend is common across all migrant and refugee communities.

Some participants revealed that they liked the child caring role even though it tied them indoors most of the time. They felt they had a useful role in the family appreciated by their family members. However, others felt that the child care duties denied them their own lives as they stayed home all the time especially when the young mothers are doing shift work.

According to a Mental Health social worker

“They can be ghettoized and fail to meet their own age group in society. Old people should not be ghettoized so that they get a sense of new life, they come for a new life and if they are always staying indoors it is frustrating for them”.

Missing Home

An organization helping elderly women in Hamilton from different cultures reported that their clients often complain about missing their home country lifestyle. A staff member from this organization summed it up as

“they miss family, food, culture and celebrations back home”.

The feeling of loneliness and isolation is worse for elderly women who have no family in New Zealand. To assist those women the organization has come up with cooking lessons, driving, English, knitting classes, shared lunches and outings to encourage women to come out of homes and integrate with Kiwi people and form new friendships.

They highlighted one success story of an elderly woman who started learning English from scratch until she passed her learner’s driver’s license. However they had to stop or scale down some of the activities due to financial limitations. They needed money to pay for transport to pick them up to and from the Waikato Migrant Resource Centre which was something that the organization could not sustain.

Lack of friends

One elderly Chinese man who has been in New Zealand for eleven years told a focus group discussion that he still has no friends and has little interaction with the local community. English classes were identified as one place where elderly Chinese have made friends with local New Zealanders and other Chinese people.

The South African community in Hamilton reported overcoming this isolation by using church groups and meetings to mix older people with other people. The church community is very influential, supporting in immigration matters and counseling as part of the church programmes. Trips and outings are held regularly for elderly people to places such as Auckland aquarium, Waipa Delta, Hamilton Zoo, the natural bridge at Waitomo caves and Raglan.

Another initiative to deal with isolation arose in the Chinese community where a group called Chinese Golden Age Society meets every week at Celebrating Age Centre for presentations on various topics and physical exercises such as Tai Chi. They also undertake trips to various places to enable older people to learn important things about New Zealand culture and way of life.

The Somali organize transport for elderly people to attend national and other important events such as Waitangi day to make it easier for older people to participate in such events. They would like to assist more elderly people but are constrained by limited financial resources.

However, it is obvious that even where there are initiatives to support the elderly it is impossible to reach many.

Culture Shock

There are elderly migrants who avoid finding work because they cannot cope with the new culture in New Zealand. They are not sure how to relate to other citizens and hence prefer to stay at home and keep to themselves. An experience by one GP is that “some people come to me and say that they are sick and are unable to go to work, but to me it is culture shock.” In the GP’s opinion this situation can be improved if workplaces and public institutions encourage staff to do things in a culturally sensitive way to accommodate the diversity in the community.

Generation gap

There is a reported disparity between generations where the beliefs of elderly about their culture and the need to preserve it differs from those of the younger family members who are more liberal and willing to embrace new cultures. The elderly feel a loss of control over the family as their authority and role in the family is eroded by the new culture.

Mental Health

A psychiatrist attributed the mental illness cases he has seen from elderly refugees to be resulting from traumas of separation from family, challenges and stresses of coping with a new culture. He also noted that treatment procedures in New Zealand may be different from home country for mental illness cases.

He also indicated a general trend of late reporting for mental illness “People with mental illnesses are kept at home until too late, some people think mental illness is a normal part of getting old when its not”.

A church pastor who is also involved in counseling families and individuals with mental illness in the South African community in Hamilton revealed that depression is a major problem in that community. He said

“depression in our community is due to migration trauma where we have been uprooted from our social support systems, inability to find suitable employment and sudden change of gender roles. In South Africa the man is the head of the family and is expected to provide for his family financially irrespective of the profession of the wife. It has been hard for some new migrants to adjust to the new reality whereby the man stays at home and looks after the kids while the wife go to work.”

The pastor also described a situation where highly qualified professionals have accepted job positions far below their former status because of desperation after their qualifications could not be recognized in New Zealand. Such people live in constant frustration and often turn to the pastor for help.

Some interviewees speculated that the low referrals of mental illness cases from GPs for new migrants and refugee clients could be because some GPs are from other cultures and may not be fully aware of what is available at mental health services and the mental health approaches in their countries of origin may be different to New Zealand

approaches. Alternatively, it could be because 'kiwi' GPs do not have a good understanding of how mental health issues can present in non-western cultures.

English language ability has been seen to affect the assessments of the elderly mental illness patients. A psychiatrist informed the author that "The test used to determine the initial screening gives better results for those who can read and write in English than those who will have to deal with interpreters." Understanding of the test and responses are compromised by poor English.

Gambling

Boredom associated with staying at home with few activities to occupy the elderly in the Chinese community has resulted in gambling habits at casinos in Hamilton. They are attracted to such venues because they provide them with a place to meet many people and enjoy company.

Some elderly migrants come to NZ with a lot of money after having retired as business people from their countries. They find themselves with few activities to spend the money on and end up turning to the pokies and casino for entertainment.

Casino venues are perceived to be safe and secure by the elderly and their opening till late hours is particularly attractive. Lack of awareness of the harm caused by pokies machines is also a contributing factor. For instance pokies machines cause problems much faster than casino type gambling.

Past trauma and grief of leaving family behind and migrating to New Zealand as an individual lead some elderly migrants to unconsciously turn to gambling to deal with loneliness and stress.

Elderly migrants facing financial difficulties in New Zealand turn to gambling as a way to increase their income and in the process they lose the little money they had and end up worse off. As they lose money gambling, the desire to recover the lost money drives them further into betting more money. Some then turn to loan sharks to refinance their gambling while others steal money or goods that they can sell to get cash for the casino and pokies machines. One of the service providers interviewed referred to a case where an elderly refugee was in prison for fraud committed to finance a gambling habit.

Asian communities, Cambodians, Chinese and Korean are more attracted to casino type gambling. The Indian community has smaller numbers of people involved in gambling at casinos.

Limited opportunities for entertainment for migrant communities in Hamilton City specific to the interests of their ethnic groups led some elderly migrants to go to casinos. One elderly Chinese lady told a social worker that she goes to the casino "to enjoy the noodles and to meet with many people".

Wealthy retired businessmen from China find casinos attractive because they are very respected and given very special treatment (VIP) at casinos unlike ordinary restaurants. In China a businessman gets a lot of respect in the community and when they visit restaurants their presence is acknowledged whereas in New Zealand the staff at the restaurants treats them like ordinary customers. When they visit casinos in Hamilton they get the same level of respect and comfort as in China and because of this they visit casinos more often than other forms of entertainment.

The free entry to casinos and Pokies bars make elderly migrants and refugees more vulnerable to gambling as they look out for free entry venues due to limited financial resources. Their inability to identify the consequences or hidden catch in terms of temptation to spend money on gambling in such venues is a major problem.

Some of the challenges faced by counselors working with elderly migrants is that there is a sense of shyness and embarrassment to seek help and counseling by affected individuals from ethnic communities. They also find it hard to convince migrants that, although gambling is legal it can be harmful and that they should “gamble with caution”.

Language is also a problem as counselors do not speak the same language with the gambling victims especially from the South Asian countries.

Gambling victim counselors interviewed identified training programs that could improve the coping capacity of affected individuals i.e budgeting courses and spending techniques, self esteem training for victims of gambling and psychotherapy training for volunteers involved in assisting communities.

Self Treatment

Chinese elderly indicated that because of barriers such as language, financial costs and transport they rarely go to GPs for minor illnesses and only go when it is an emergency. For minor illnesses some participants said that they treat themselves using medicines they brought with them from China. Such medicines can last them for several years after arrival and they can replenish them whenever they visit China. They also get some from other community members.

One elderly migrant reported that they had been in New Zealand for two years and only went to the GP for serious conditions. The rest use medicines they brought from their home country. Some of them said that they don't go to GPs because they don't like the appointment system which may entail a day or two of waiting. Instead they visit the emergency facility in the city centre where you just walk in and get treatment without an appointment. This is preferred as it is similar to China where you can see a Doctor anytime you require one without an appointment. They feel New Zealand has few clinics compared to China.

Another reason given by a participant for not seeking the services of a GP is that, “Some of the prescriptions given are conservative because you only get panadol and nothing else”. In such circumstances they resort to taking the medicines at home from China.

Low levels of medical check ups in the elderly Chinese community: One elderly participant in a focus group discussion described how they had no medical check up for 8 years after arriving in New Zealand. The next check up was when they visited family back in China. They cited language and cost as the main reasons they did not have check ups.

The Chinese practice traditional medicine including massage, acupuncture use of caps and animal bones to diagnose and treat diseases.

Recommendations

Language

Of obvious, instant and primary importance is the need to bridge the communication gap between communities and health providers.

Main recommendation:

That interpreting services are funded to be readily available in a broad range of health situations. It is important that they can be accessed by the individual prior to attending the health provider so as to ensure that appointments are made correctly and information about when and where to attend is correctly transmitted. This will ensure that clients are not shy about making initial appointments.

Indicators: Language factor mentioned in majority of research literature and every focus group and interview. Interpreting remains the only instant solution to overcoming the communication barrier in a way that maintains confidentiality and personal security. There are no indications as to the type of interpreting (face-to-face or telephone) although other research suggests the two are complementary forms of interpreting and suit different situations.

Supplementary recommendations

- Attract ethnic youth to health profession to increase diversity in the health workforce, open up opportunities for understanding of client needs and cultures and provide language appropriate consultation.
- Train and employ ethnic community members in health promotion and health services to facilitate access to migrant and refugee communities to provide information and culturally appropriate support.
- Support a range of English language learning options for elderly refugees and migrants including transport options.
- Give more time for elderly migrant's consultations at clinics than other clients as it takes longer to take clear history of illness due to language and culture.
- Increase the range of translated resources and include Afrikaans translations.
- Have different language website pages on the Waikato District Health Board website where people can get information in their own language.

Provision of health services

Main recommendation

That an ethnic health clinic is established where people can feel comfortable that their health needs will be met in a culturally appropriate manner. That the clinic contains material in a wide variety of languages and that the doctors and nurses that staff it are from ethnic backgrounds.

Indicators: One of the greatest barriers to service provision was that of providers offering services but not being able to access the community. Research discussed in the literature review indicated a high need for professionals to be culturally competent prior to communities engaging closely with health services.

Secondary recommendations:

- Continue cultural perspectives seminars at the Migrant Resource Centre as previous participants from service providers found them to be useful.
- Timely distribution of information about the New Zealand health delivery system to elderly migrants and refugees. This should be at the time of arrival through community networks and agencies assisting with settlement issues such as migrant resource centers, Local Authorities and community associations.
- Establish Clinics for elderly people once a month at Waikato Migrant Resource Centre or Celebrating Age Centre for treatment of minor conditions to reduce need to go to GPs
- A single point of contact for promoting physical exercises for elderly migrants and refugees in the areas they reside. (Walking groups, swimming, Bowling, Tai chi etc) The single point of contact would allow for trust and understanding to be built up.
- Provision of cultural advisers from ethnic communities who can provide cultural advice and information to health professionals whenever problems arise while dealing with a particular cultural group.
- Prioritize insulation of houses of the elderly and refugees to reduce respiratory infections and improve general quality of life for this group.
- Equip elderly migrant/refugees with knowledge and skills to deal with medical emergencies at home.
- More general education about available health services – linked into ESOL provision.
- Educate families to seek treatment early rather than wait for later when the illness gets complicated and severe.

Provision of information

Main recommendation

That information is made available in different languages and is accessible online to be printed and given to clients at medical centres and from various other locations. A database of translated resources is already available. If health practitioners were able to request the translation of any further material needed it could then be placed online for multiple use. Over time a fully comprehensive database could be produced. The management of this requires a single point of contact and coordination.

Indicators: Focus groups and interviewees all indicated that the lack of language relevant resources meant that many elderly relied on family and friends for information. Online publishing of the information would reduce the cost associated with printing resources and would make it accessible to all service providers to disseminate.

Secondary recommendations

- That Medical Centre staff and other health providers are made aware of where resources can be located for dissemination

Provision of social support

Main recommendation

To support providers who currently have networks within communities to run social activities for the elderly.

Indicators: Trust, information and awareness and cultural understanding are all indicated barriers to elderly participation in social activities that would provide some support. Some providers indicated that they found it hard to access the communities and other providers had the trust of the communities but funding was too limited to sustain much activity.

Secondary recommendations

- Transport must always be considered a budgetary factor when working with these communities.
- Incorporate health messages into ESOL provision, for example teaching vegetable growing for better nutrition, reduction of food expenses and physical exercise.
- Organizers of social events to design activities mixed with other ethnic backgrounds so that the elderly can learn from each other.
- Organize Tai Chi classes for elderly refugees and migrants. They could be encouraged to attend with two or three friends to meet other ordinary New Zealanders.
- Work closely with Mosque to host programs for Muslim elderly refugees.
- Motivate and support ethnic elderly women to participate in women only swimming sessions at Gallagher's pools particularly Muslim women held every Sunday.
- Fund assistance for elderly migrants living alone with shopping services and visiting them at home to break isolation.

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APPENDIX1: ORGANISATIONS INTERVIEWED

Name	Organization	Position
Teresia Kanyi	Refugee Services Aotearoa New Zealand	Social worker
Ismail Gamadid	Waikato Refugee Forum.	President
Katherine O’Kelly	Problem gambling foundation	Psychotherapist
Gail Gilbert	Age Concern	Manager
Dr Alison Stearn	Mental Health Services for Older People- Waikato DHB	Psychiatrist
Dr Colin Patrick	Mental Health Services for Older People- Waikato DHB	Psychiatrist
Ngaire Sargeant	Mental Health Services for Older People- Waikato DHB	Community Mental Health Nurse
Mary Hayes	Waikato DHB community Health	Public Health Nurse
Lindsay Lowe	Waikato DHB Population Health	Refugee Health coordinator
Dr Tom Watson	Waikato District Health Board	Chief Medical Advisor (WDHB)
Barbara Redfern	Waikato Refugee Resettlement Society Inc	Trustee
Emelda Corby	Citizens Advise Bureau	Volunteer
Dr Suresh Vatsyayann	The Family Clinic	General Practitioner
Dr Paul Spry	Dr GP Spry Surgery	General Practitioner
Zinai Siviter	Hamilton Ethnic Womens Centre Trust (SHAMA)	Social Worker
Suman Kapoor	Global Organisation of People of Indian Origin Waikato (IndiaNZ Global Association)	President
Jenny Nand	Hamilton City Council	Neighbourhood Advisor
Soujan Mitra	Hamilton City Council	Co-ordinator
Philip Yeung JP	Hamilton City Council	Ethnic Development Advisor
Bridget Richards	Older People’s Assessment Unit	Clinical Nurse Manager
Maureen Mildon	SF Waikato, Supporting families in mental illness	Field worker
Jo de Lisle	Hamilton Multicultural Services Trust(HMST)	Chairperson
Mohamed Khalif Abdi	New Zealand AIDS Foundation.	Health Promoter,African Communities
Wendy Wen Li	Chinese Golden Age Society	President
Guillaume Muzombo	Refugees Reorientation Centre	Chairperson
Lucia Reijgersberg	Settlement Support New Zealand	Settlement support Coordinator
Madan s. Bange	Indian Central Association	President
FOCUS GROUPS	Chinese Migrants Somali Refugees South African Migrants Cambodia Refugees	

