



Review of Migrant and Refugee Regional and National Health Needs Assessments

May 2007

Prepared for the Auckland Metropolitan District Health Board's Auckland Regional Settlement Strategy (ARSS) Health Workstrand Steering Group by Annette Mortensen

Contents

Executive Summary	4
Auckland Metropolitan District Health Boards	
Auckland District Health Board	
Auckland Regional Health Needs Assessments	6
Auckland District Health Board: Health Needs Assessment 2001, Refugee Peoples Health	6
Counties Manukau District Health Board	
Counties Manukau Public Health Information	11
Meeting Refugee Needs: A study of the needs of people with quota refugee backgrounds and how those needs are met in Manukau City	13
Waitemata District Health Board	
Improving WDHB services responsiveness for Asian, Migrant and Refugee communities	14
Health Needs Assessment Update 2005	16
Healthcare Needs of Asian People and Health Professionals in the North and West Auckland	19
Asian Smokefree Promotion and Smoking Cessation	22
Auckland Region	
Auckland Regional Settlement Strategy: Goal Four, Physical and Mental Health	23
<i>Primary Health Care Services</i>	
Survey of Primary Health Care Services in Auckland and Wellington on the impact of immigrant Patients	27
<i>Utilisation of Emergency Care Services</i>	
Refugees and asylum seekers: Implications for ED care in Auckland, New Zealand	28
<i>Antenatal, Perinatal and Post Natal Care</i>	
Motherhood and Migration	29
<i>Asian Mental Health</i>	
Northern Regional Mental Health and Addiction Strategy for Asian Service Users	30
Northern Region Mental Health and Addictions Services Strategic Direction 2005-2010	33
Improving mental health services responsiveness to Asian communities	33
Auckland Regional Asian Mental Health and Addictions Implementation Plan 2006 to 2010	33
<i>Refugee Mental Health</i>	

Identification of mental health needs and service gaps for small refugee groups in Auckland	39
Refugee Mental Health (Children and young people): Evaluation of ON TRACC	40
<i>Disability Services</i>	
Report to the Auckland Regional Settlement Strategy Working Group on Settlement Issues for Migrants and Refugees with Disabilities	44
Study for a Disability Empowerment, Advocacy and Support Service (DEAS) for Refugees and New Settlers	46
<i>Family Violence</i>	
Improving particular communities responsiveness to family violence: combining research, programme development and evaluation	47
<i>HIV Services</i>	
HIV Futures New Zealand: Refugees section	49
Waikato Regional Studies	
Hamilton: Mental Health Issues for Asians in New Zealand: A Literature Review	52
Wellington Regional Studies	
Wellington and Napier: Understanding the Health Needs of Refugees	54
National Studies	
Asian Public Health Project Report	57
Asian Health Chart Book	60
<i>Asian, Refugee and Migrant Mental Health</i>	
Mental Health Issues for Asians in New Zealand: A Literature Review	67
Research Agenda: Mental Health and Addiction Research Priorities for Asian, Refugee and Migrant Populations in New Zealand 2008-2012	67
<i>Asian Health</i>	
Asian Health in Aotearoa: An analysis of the 2002/03 New Zealand Health Survey	68
<i>Asian Youth Health</i>	
A health profile of young Asian New Zealanders who attend secondary school: findings from Youth2000	71
<i>Refugee Health</i>	
The health status of quota refugees screened by New Zealand's Auckland Public Health Service between 1995 and 2000	73

Executive summary

This report reviews the key migrant and refugee regional and national health needs assessments, studies and evaluations conducted since 2000. The review includes the health needs assessments conducted by the Auckland Metropolitan District Health Boards: Auckland, Counties Manukau and Waitemata. Additionally, studies and evaluations conducted in the area of refugee and migrant health in the Auckland region include the areas of mental health, smokefree promotion and smoking cessation, primary health care services, the utilisation of emergency care services, antenatal, perinatal and post natal care services, disability services, family violence and HIV services. The health needs assessments conducted by regional Public Health Units in Waikato and Wellington regions in 2005 are included. National refugee and migrant health studies include the Asian Public Health project and the Asian Health Chart Book, a literature review of mental health issues in New Zealand, a health profile of young Asian New Zealanders and a study of the health status of quota refugees screened by the Auckland Regional Public Health Service. The review includes both qualitative and quantitative studies and the findings of stakeholder, provider and community consultations with refugee and migrant communities.

Key findings in regard to the health of Asian populations in the Auckland region are that:

- The six top potentially avoidable deaths for Asian people in the Auckland region are:
- Ischaemic cardiovascular disease, motor vehicle crashes, stroke, lung cancer, diabetes and suicide.
- There is a relatively high rate of obesity, type 2 diabetes and cardiovascular disease among South Asian groups.
- The six leading causes of preventable hospitalisations for Asian people in the Auckland region are angina, respiratory infections, cellulitis, gastroenteritis, road traffic injury and asthma.
- There is evidence that the mental health of Asian migrants may decrease after arrival in New Zealand.
- The Asian student group are experiencing problems. Issues include car crashes, sexual health problems including higher presentation for abortions and sexually transmitted diseases.

The key recommendations from the regional and national health needs assessments and studies that have been conducted are to:

1. Address access barriers

- The need for interpreter services in primary health
- Information about the New Zealand health system available in ethnic minority languages
- Cultural competency training for the primary and secondary health care workforce
- Health information needs to be available in ethnic minority languages
- Successful pilots such as the 'Asian Smokefree Communities pilot', the 'Muslim Women's Swimming Programme' and the *Northern Regional Mental Health and Addiction Strategy for Asian Service Users* are good models for the development of other ethnic specific strategic approaches and services.
- Capacity building in mainstream services is needed rather than establishing separate ethnic specific services

2. Include migrant and refugee groups in national and regional health policy and strategy

- Migrant and refugee groups need to be recognised in national and regional health policy and strategy
- Standardisation of ethnic data collection systems to recognise the ethnic minority groupings in New Zealand

3. Improve Migrant and Refugee Research and health monitoring

There are extensive gaps in research and information about refugee and migrant population health including:

- A need for longitudinal data on the health of migrant and refugee populations in New Zealand
- Little is known about the health status refugee populations in New Zealand beyond infection rates for communicable diseases such as Tuberculosis and HIV/AIDS (Harrison et al., 1999; Hobbs et al., 2002; McLeod & Reeve, 2005; Mills et al., 2002).
- Much of the migrant and refugee health research conducted in New Zealand has been small-scale, locally based and ethnic group specific, and as such the findings are not generalisable to all migrant and refugee populations and all health issues.

Auckland Regional Health Needs Assessments

Auckland District Health Board: Health Needs Assessment 2001, Refugee Peoples Health

Name of study/health needs assessment/ evaluation	Auckland District Health Board, (2001). <i>Health Needs Assessment 2001, Refugee Peoples Health</i> pp 230-238: Auckland: Auckland District Health Board.
Conducted by	Annette Mortensen
Key Issues	<ul style="list-style-type: none"> • Refugees and asylum seekers are now a significantly large cohort within the Auckland region. Most communities are located in the Central Auckland area. The numbers are estimated to be approximately 40,000 and rising by up to 2000 annually; • Refugees and asylum seekers as a health care population have high health status problems when compared to the NZ population overall; • Refugee and Immigrants' health care needs are often more complex for health care providers to deal with than the corresponding needs in NZ-born people. They are also more costly to deal with; • Interpreter services are needed to facilitate the delivery of health care services to an ever-increasing proportion of ADHB's population for whom English is a second language. Trained health interpreters need to be available without cost to primary health care providers to improve access and acceptability and safety for clients and practitioners. The extension of interpreting services to general practitioners would reduce costs in the secondary and tertiary health sectors due to delays in seeking care, inappropriate use of emergency services and the use of secondary services for primary health purposes; • There is concern regarding the spread of communicable diseases in Auckland populations due to the levels of infections of HIV, Tuberculosis and other infectious diseases. The true incidence of disease in refugee populations is not known; • Medical screening for quota refugees and asylum seekers indicates that up to forty percent of those screened are referred on to specialist services, most requiring an interpreter; • ADHB has no systematic collection of ethnicity or accessible and useful information on the health status of refugees and immigrants by immigration category, either on entry or longitudinally. This impedes policy development, planning and service provision in the Auckland

	<p>region;</p> <ul style="list-style-type: none"> • Regional inequities exist in levels of health services available for refugee populations; • Children and young people from refugee backgrounds require in the Auckland region collaborative joint intervention including health, mental health, education, justice and children and young people's services; • There is inadequate provision in <i>The New Zealand Health Strategy</i> (Ministry of Health, 2000) and other health strategies, in legislation and in health infrastructure to address inequalities in health care to refugee populations in New Zealand and in particular Auckland; • Need to consider employing people from targeted language groups to co-work with health care professionals to provide health education, information and support to refugee communities; • Need to consider introducing cross cultural training for ADHB health care workers on the 'the refugee experience', epidemiology in countries of origin, health care issues and cultural beliefs and practices; • Need to provide health promotion resources appropriate for refugee populations; • Need to include refugee populations in all community consultation processes; • Need specialized mental health services for refugees within mainstream adult, child and adolescent mental health services;
Recommendations	<p>Auckland District Health Board (February, 2006). <i>The Health of Migrants and Refugees: Auckland District Health Board Health Improvement Plan 2006-2010</i> pp 24-26. Available from: http://www.adhb.govt.nz/downloads/publications/strategic_plan/060701-ADHB-HIP-2010.pdf</p> <p>Auckland District Health Board (February, 2006). <i>The Health of Asian People: Auckland District Health Board Health Improvement Plan 2006-2010</i> pp 26-27. Available from: http://www.adhb.govt.nz/downloads/publications/strategic_plan/060701-ADHB-HIP-2010.pdf</p> <p>The health of migrants and refugees</p> <ul style="list-style-type: none"> • Migrants are people who chose to leave their country. Refugees do not choose to leave their homelands but flee in response to crisis. People from refugee-like backgrounds have come from refugee producing countries. • There is little data on migrants and refugees, a lack of data to show where these communities live, and limited knowledge of health

	<p>status and current and future needs. There is also little research available about the barriers to good health or protective and resiliency factors.</p> <ul style="list-style-type: none"> • The health needs of migrants and refugees are not recognised in national policy and health strategies. The lack of long-term planning between Ministries at the policy level has led to fragmented approaches. • There are very few dedicated resources to meet projected increases in the migrant and refugee populations. Services are not well linked across Auckland between the DHBs, PHOs, public health efforts, other government agencies and non-government organisations. • Many refugees and migrants have major and multiple health issues and very high health needs. There is limited planning for long-term management of migrants with disabilities, chronic conditions and high and complex health needs. These issues particularly affect people who have had a refugee experience. • There are significant mental health issues within the refugee and migrant communities. For refugees post-traumatic stress disorder arising from pre-migration experiences is common. Both migrants and refugees have a high prevalence of depression and anxiety arising from post migration stressors including unemployment or underemployment. <ul style="list-style-type: none"> • Auckland DHB provides interpreters for over 155 different languages; however there is limited access to interpreter services within primary health care and the health and support services provided outside the hospital setting. • Non-English speaking migrants and refugees have limited access to, and knowledge of, primary health care services, including disability and community mental health services. • There is little information about services and how to access them written in people's own languages. There is limited access to written health promotion and prevention materials. • Health professionals have limited knowledge and skills to provide culturally relevant care for some migrant and refugee groups. The workforce doesn't reflect the diverse population groups in Auckland. • Refugees and some migrant groups have a low uptake of physical activity and may be at increasing risk of obesity, diabetes and cardiovascular disease due to changes in lifestyle. Women are especially at risk. <p>Actions for future health gain</p> <p>1 Expand health promotion, prevention and early intervention work</p> <p>1.1 Target health promotion activities to areas of priority for migrant and refugee populations: child health, sexual health, mental health and disease.</p> <p>1.2 Work with primary health care organisations to expand health promotion work. Help providers develop a wider range of health promotion and problem prevention activities that are culturally acceptable, accessible and appropriate.</p> <p>1.3 Prevent diabetes and other lifestyle related diseases affecting refugees and migrants by implementing the Smokefree initiative and the Healthy Eating, Healthy Action strategy.</p> <p>2 Improvements in service delivery</p>
--	--

	<p>2.1 Work with mainstream health providers to improve the transition between secondary, tertiary services and primary services. Integrate activities with other DHBs, primary, community, secondary and tertiary health services.</p> <p>2.2 Work with primary care providers to identify and reduce barriers to access with a special focus on the provision of interpreter services.</p> <p>2.3 Improve the ability of NGOs, community organisations and Auckland DHB services to link to refugee and migrant communities and to engage with them.</p> <p>2.4 Encourage all DHB services to respond to the diversity of cultures. Train more ethnic community workers in health, especially mental health and health promotion.</p> <p>2.5 Develop primary mental health services that respond to the background and resettlement issues specific to new migrants from refugee backgrounds.</p> <p>2.6 Expand culturally appropriate specialist mental health services (adult, child and adolescent) for refugees and migrants.</p> <p>2.7 Ensure all refugee and migrant children access Well Child Care.</p> <p>2.8 Improve sexual health and abuse services; developing sexual health initiatives and education for new migrants, African migrants in particular.</p> <p>2.9 Make sure disability and support services meet the needs of new migrants and their families, and that disabled people can participate within the community.</p> <p>3 Future priority actions for the refugee community</p> <p>3.1 Develop a refugee health strategy for health improvement; working with other sectors to co-ordinate responses to physical health, mental health, and social needs.</p> <p>3.2 Investigate all options for continued interagency services for children and young people from new migrant backgrounds with high and complex needs, especially On TRACC the Transcultural Care Centre.</p> <p>3.3 Improve research into refugee and migrant health (e.g. demographic profile of migrants, measure trends and health needs). Assist health services to analyse data and plan the service improvements required.</p> <p>The health of Asian people</p> <ul style="list-style-type: none"> • The Asian population is expected to increase by 18.7 percent by the year 2016, primarily through immigration. Less than 5 percent of the Asian population is older than 65 years. However older people are especially vulnerable to the effects of loneliness, isolation and alienation. These factors contribute to a higher rate of depression than the general population. • Over half of Asian people in the Auckland region are between the ages of 25 and 65 years. Working age migrant and refugees are disadvantaged through under employment. Women in this age group and the Indian community are especially at risk for diseases related to changing diets and a lack of exercise. There is still a relative lack of research evidence about the health status of the various Asian communities. • The six top potentially avoidable deaths for Asian people in the Auckland region are: • ischaemic cardiovascular disease, motor vehicle crashes, stroke, lung cancer, diabetes and suicide. • The six leading causes of preventable hospitalisations for Asian people in the Auckland region are angina, respiratory infections,
--	--

	<p>cellulitis, gastroenteritis, road traffic injury and asthma.</p> <ul style="list-style-type: none"> • The Asian population is diverse and differs according to ethnicity, settlement history, English language proficiency and socioeconomic status. • Overall Asian communities face poorer socioeconomic status, low participation in employment, poor access to health services and poorer levels of physical activity with higher levels of diabetes than Pakeha/Europeans. • As large sections of the Asian population are recent migrants, the international experience of migrants' health decreasing with acculturation (the 'healthy migrant' effect) needs to be taken into account. This results in significantly worsened health outcomes. • There is evidence that the mental health of Asian migrants may decrease after arrival in New Zealand. Dedicated actions are required to ensure the health status of the Asian population does not worsen and that risk factors are better understood and are mitigated. • The Asian population also reports mental health problems including problems arising from isolation and racism. • The Asian student group are experiencing problems. Issues include car crashes, sexual health problems including higher presentation for abortions and sexually transmitted diseases. <p>1. Priority actions for the Asian community</p> <p>1.1 Advocate for a national policy and strategy for Asian people that acknowledges and prepares for the increasing size and diversity of the Asian population.</p> <p>1.2 Involve community and Asian community organisations in the health sector, and especially in PHOs. Assist with cultural input into all stages of health service programme design and delivery.</p> <p>1.3 Active participation in appropriate joint sector initiatives which focus on key health determinants.</p> <p>1.4 Improve the links between Auckland DHB, PHOs, Auckland regional public health service, government, NGOs and community in health promotion programmes.</p> <p>1.5 Improve the collection of ethnicity data for research and evaluation, especially a consistent definition of Asian ethnicity. Disaggregate data into ethnic minority groupings to acknowledge the diversity within the Asian community.</p> <p>1.6 Establish a research programme on Asian health status and gaps in services; including research on Asian complementary and traditional medicine, and inequalities in health and socioeconomic status in Asian populations.</p> <p>1.7 Train health providers to show a high level of cultural sensitivity and awareness around Asian issues and deliver services that are responsive, accessible and culturally appropriate for Asian people.</p>
--	---

Counties Manukau District Health Board: Counties Manukau Public Health Information

<p>Name of study/health needs assessment/evaluation</p>	<p>Counties Manukau District Health Board (May, 2005). <i>Counties Manukau Public Health Information, 1st Edition</i> pp10-12. Available from: www.cmdhb.org.nz</p>
<p>Conducted by</p>	<p>Auckland Regional Public Health Service for Counties Manukau District Health Board</p>
<p>Key Issues</p>	<p>Immigrant and Refugee Health</p> <p>Key Trends</p> <ul style="list-style-type: none"> • Auckland continues to experience the largest population growth of any region in New Zealand and 52% of the growth between 2003 and 2004 was due to internal and external migration. • Manukau City had the greatest population growth absolute terms between 2003 and 2004. • By 2016 ethnic make up of Auckland region expected to change. Within the Auckland region Manukau city is expected to experience the second greatest absolute growth during this period. • The exact proportion of growth that arises from migration of refugees is unknown. • A conservative estimate of refugee numbers resettled annually in NZ is 1250 (Refugee Voices: A journey towards Resettlement, Department of Labour, June 2004). • 60% of quota refugees and 90% of asylum seekers remain in the Auckland region. <p>Health status of refugees and asylum seekers</p> <ul style="list-style-type: none"> • Review of quota refugees (Public Health Advice December 1996) showed: <ul style="list-style-type: none"> ○ 70% required referral to one or more secondary care service ○ Up to 46% infected with TB with 4% showing signs of active disease and 12% remaining under investigation after one year ○ 1.7% infected with HIV (2.6% among adults) ○ Other problems included: intestinal parasites (42%), schistosomiasis (21%), iron deficiency (54%), psychological disorders requiring referral (7%), disability requiring orthotics (8%), gynaecological problems associated with female genital mutilation (% not reported). • Other problems identified elsewhere include:

	<ul style="list-style-type: none"> ○ tobacco use among refugee men ○ (30%), physical inactivity among Muslim refugee females, undiagnosed diabetes and vitamin D deficiency (98%). ● Review by Solomon (1997) concluded that the health status of asylum seekers and family reunification refugees likely to be similar to quota refugees. ● Anecdotal evidence that follow-up in primary care is limited by <ul style="list-style-type: none"> ○ Lack of interpreter services ○ Financial barriers for asylum seekers awaiting refugee status hearing ○ Complex problems requiring lengthy consultations ○ Limited trans-cultural mental health community service ○ Culturally appropriate women’s health and tobacco cessation services.
<p>Recommendations</p>	<p>Priorities</p> <ul style="list-style-type: none"> ● Maintain screening services. ● Enhance primary care follow-up by supporting PHO’s to use Services to ● Improve Access (SIA) funding to subsidise consultations, prescription charges ● and interpreter services for primary care practices that are prepared to commit to this work. ● DHB diabetes control programmes need to incorporate refugee specific services.

Meeting Refugee Needs: A study of the needs of people with quota refugee backgrounds and how those needs are met in Manukau City

Name of study/health needs assessment/ evaluation	Sim, J. P. (2001). <i>Meeting Refugee Needs: A study of the needs of people with quota refugee backgrounds and how those needs are met in Manukau City, New Zealand</i> . Auckland: University of Auckland
Conducted by	Unpublished thesis: Master of Planning Practice: University of Auckland
Key Issues	<ul style="list-style-type: none"> • Deficit in information about refugee population health needs to inform planning and service provision • Poor knowledge of prevention programmes in refugee populations • Lack of culturally appropriate and accessible health information for refugee families • No interpreting services in primary health care
Recommendations	<ol style="list-style-type: none"> 1. Primary Health services need to be within walking distance or one stage on public transport as many refugee families do not have transport 2. Refugee families need information about primary and community health services e.g. Plunket 3. Interpreters are needed in primary health services 4. Services need to be free from racism and xenophobia 5. Primary and secondary health services need workforce development in relation to cultural competencies and the specific needs of refugees and asylum seekers

Waitemata District Health Board: Improving WDHB services responsiveness for Asian, Migrant and Refugee communities.

<p>Name of study/health needs assessment/evaluation</p>	<p>Waitemata District Health Board (November, 2006). <i>Improving WDHB services responsiveness for Asian, Migrant and Refugee communities</i>. WDHB Board Strategic Workshop: Background paper</p>
<p>Conducted by</p>	<p>Waitemata District Health Board: Compiled by Sue Lim, Dr Ratana Walker, Sandy Latimer and Kate Healey</p>
<p>Key Issues</p>	<p>Migrants Some issues are similar for migrants and refugees, particularly those around resettlement. Consultation with migrant and refugee communities on the development of the Auckland Regional Settlement Strategy found that their experience with health services was generally satisfactory, but that the health sector needs to address the following: Information about migrant/refugee rights to access health services, and how to access health services. Language support in accessing services. Awareness raising, and where necessary de-stigmatising, mental well-being issues within new settler communities. Mental health services being delivered in culturally appropriate ways.</p> <p>Refugees and Asylum Seekers Reports commissioned in 1997 by the Transitional Health Authority (Solomon, 1997) and the HealthWEST Primary Health Organisation (Assured Directions, 2003) summarised the health needs of refugees as relating to their pre and post settlement experiences and falling broadly into the following areas:</p> <ul style="list-style-type: none"> • Infectious diseases e.g. tuberculosis, HIV infection, hepatitis B. • Mental health conditions e.g. post traumatic stress disorder, depression. • Women's health needs e.g. antenatal health, contraception, screening and management of conditions such as female genital mutilation (FGM). • Chronic diseases e.g. diabetes. • Smoking.

	<p>Many of these health problems could be alleviated by improved access for all refugees to public health, primary health care and primary mental health care services, including access to interpreter services.</p>
<p>Recommendations</p>	<p>Suggestions for strategic priorities for Asian, migrant and refugee health strategy next 3-5 years</p> <p>The development of a strategy needs to consider the enhancement of mainstream services and where necessary to complement with the development of Asian/ migrant/ refugee-specific service components, with particular focus on needs and health disparities: The following are suggestions taken from consultation feedback, research reports and publications:</p> <p>7.1 Asian Health Strategy Development</p> <ul style="list-style-type: none"> • Addressing access barriers <ul style="list-style-type: none"> o improving initial access to information and advice o improving access to the use of interpreters for non-English speaking clients, especially at primary health and NGO levels o development of information resources (eg translated information) • Identifying and addressing priority health issues: <ul style="list-style-type: none"> • Cancer control: smoking, cervical and breast screening • Cardiovascular disease • Diabetes. • Sexual health • Workforce development (secondary, primary and NGO levels) – to enhance mainstream services <ul style="list-style-type: none"> o Developing Asian workforce:: recruitment, training, retention and supervision o Developing cultural competence within mainstream DHB and NGO workforce: cultural awareness and how to work effectively with interpreters <ul style="list-style-type: none"> o Addressing workforce development of primary health and NGO sectors, with specific focus on improving services for Asian mental health clients from different cultural and language backgrounds • Improving the collection of ethnicity data <ul style="list-style-type: none"> o Current service utilisation data most likely not matching with actual service utilisation data; impact on service design and delivery <p>For Mental Health Services Responsiveness to Asian communities in secondary mental health services</p> <p>A regional strategy and a local strategy for improving mental health services responsiveness to Asian communities have been approved and in progress:</p> <ul style="list-style-type: none"> • Asian Mental Health and Addictions Implementation Plan 2006-2010: Improving mental health services Responsiveness to Asian Communities: Auckland Regional

	<ul style="list-style-type: none"> • Improving mental health services responsiveness to Asian Communities in Waitemata District: Implementation Plan 2006-2010 <p>Work is underway for some of the recommendations listed below:</p> <ul style="list-style-type: none"> o Development of cultural competence within mainstream DHB and NGO workforce: cultural awareness and how to work effectively with interpreters o Development of Asian interpreter workforce o Development of Asian workforce:: recruitment, training, retention and supervision o Development of “clinical cultural advice” model o Development of information resources (eg translated information) o Developing community support worker services o Developing peer support/family networks o Developing prevention and early intervention initiatives to support better relationships with primary health care, migrant services, helpline o Exploring the feasibility of resourcing interpreters across to primary health
--	---

Waitemata District Health Board: Health Needs Assessment Update 2005

Name of study/health needs assessment/ evaluation	Waitemata District Health Board (April, 2005). <i>Health Needs Assessment Update 2005</i> pp 29-33. Waitemata: Waitemata District Health Board. Available from: http://www.waitematadhb.govt.nz/wdwb/
Conducted by	Waitemata District Health Board Health Gain Team
Key Issues	<p>Asian people’s health inequalities</p> <p>The Asian population is now the second largest ethnic group within the Waitemata district, making up 9 percent of the overall population in 2001. The Asian population is diverse in language, ethnicity and culture. It comprises people from Asia and South-East Asia. It includes every category of immigrant, including refugees with high and complex health needs (notably post-traumatic stress disorder), wealthy business people, highly qualified professionals and a significant number of students on fixed term visas as well as third and fourth generation New Zealanders. As immigration is the main reason for the Asian population increase and the young age structure of the Asian population explains the apparent</p>

	<p>good health status of the population group. However, it is noted that the top three leading causes of death for Asian people in Waitemata district are similar to those of the overall population.</p> <p>Leading health issues and concerns of Asian people include:</p> <ul style="list-style-type: none"> · Poor access and under-utilisation of health care services: <ul style="list-style-type: none"> • Difficulties in accessing primary health services (language barriers, lack of interpreting services, lack of understanding of health system, lack of appropriate health information resources, lack of cultural responsiveness of primary care programmes/services). • Difficulties accessing some secondary health services (lack of understanding of host country's health system, lack of appropriate health information resources, lack of cultural responsiveness to ethnic minorities). · Mental health issues: <ul style="list-style-type: none"> • Difficulties accessing mental health services (primary care providers do not commonly understand immigrant and refugee mental health issues, which affects access to appropriate services). • Language barriers, resettlement and acculturation issues, social isolation, discrimination, stigmatisation, lack of service providers' awareness of Asian cultural issues (cultural beliefs, interpretation of mental illness and mental well being, help seeking patterns, choice of traditional alternative health practices), lack of community support programmes. • Stress of migration and adaptation. · High prevalence of cardiovascular disease and diabetes. · Poor sexual health (including high abortion rates). <p>Migrants and refugees</p> <p>Migrants</p> <p>The majority of migrants settling within Waitemata district in recent years are from Asian countries, and their health needs have been described in the section above. However, there are many other ethnic groups represented among immigrants and refugees including, for example, Arabian, Russian, Croatian, Kurdish, Czechoslovakian, Ethiopian, Macedonian, Spanish, Polish, Somali and Turkish. Some issues are similar for migrants and refugees, particularly those around resettlement. Consultation with migrant and refugee communities on the development of the Auckland Regional Settlement Strategy found that their experience with health services was generally satisfactory, but that the health sector needs to address the following:</p> <ul style="list-style-type: none"> · Information about migrant/refugee rights to access health services, and how to access health services. · Language support in accessing services. · Awareness raising, and where necessary de-stigmatising, mental well-being issues within new settler communities. · Mental health services being delivered in culturally appropriate ways. <p>Health status of refugees and asylum seekers</p>
--	---

	<p>Whilst numerous reports have been written detailing specific aspects of refugee and asylum seeker health, little current comprehensive information exists regarding the demographic distribution of refugees in this region or their health status. Solomon (1997) undertook a comparative assessment of the health status of quota refugees and concluded that their overall health status was comparable to that of Pacific people. He found no evidence to suggest that the health status of asylum seekers was quantitatively different from that of quota refugees. However, it can be expected that they will have a high immediate and on-going level of health needs for the following reasons:</p> <ul style="list-style-type: none"> · In its annual quota of Mandated refugees, New Zealand gives priority to women at risk and medical/disabled refugees. · Refugees are frequently from countries (e.g. sub-Saharan Africa) where there are high levels of poverty, under-resourced health services, high levels of maternal and infant mortality and low life expectancy. · Refugees may well have been exposed to torture, violence and other trauma. · Refugees may have spent many years fleeing their country of origin and in that time have had little or no access to health services. · They are now needing to settle in an unfamiliar country and culture where, despite the assistance available to them, there will be numerous issues that they will need to confront and overcome e.g. language and cultural barriers, employment and educational barriers. <p>Reports commissioned in 1997 by the Transitional Health Authority (Solomon, 1997) and the HealthWEST Primary Health Organisation¹⁵ in 2003 summarised the health needs of refugees as relating to their pre and post settlement experiences and falling broadly into the following areas:</p> <ul style="list-style-type: none"> · Infectious diseases e.g. tuberculosis, HIV infection, hepatitis B. · Mental health conditions e.g. post traumatic stress disorder, depression. · Women's health needs e.g. antenatal health, contraception, screening and management of conditions such as female genital mutilation (FGM). · Chronic diseases e.g. diabetes. · Smoking.
Recommendations	

Waitemata District Health Board: Healthcare Needs of Asian People and Health Professionals in the North and West Auckland.

<p>Name of study/health needs assessment/evaluation</p>	<p>Ngai, M. M. Y., Latimer, S. & Cheung, V. Y. M. (2001). <i>Final Report on Healthcare Needs of Asian People and Health Professionals in the North and West Auckland</i>. Auckland: Asian Health Support Service, Waitemata District Health Board.</p>
<p>Conducted by</p>	<p>Asian Health Support Service: Waitemata District Health Board</p>
<p>Key Issues</p>	<p>The following is a summary of the findings of the surveys.</p> <p>Asian Survey:</p> <ul style="list-style-type: none"> • The project surveyed 4771 individuals, the majority of them resided in the Waitemata DHB (North and West Auckland) area. • 65% of the respondents arrived in New Zealand between 1995 and 1999. • The majority of the respondents were Chinese, followed by Korean. • Their social support system relies heavily on family relationship and friends from their own culture. • Their main negative experience is with employment. • When encountering health problems, the majority of respondents indicated that they would visit their GP, a pattern similar to that reported in the National Health Survey. • Generally, the pattern of illnesses was similar to that identified in the National Health Survey. • Respondents were dissatisfied with the cost of GP and private medical services, and with waiting times and the health information available in publicly provided services. • They requested support services to meet their language and cultural needs. The most frequent suggestions on how this could be done were: <ul style="list-style-type: none"> ○ Helpline ○ Information in their own language ○ Availability of interpreters ○ Asian health support workers ○ Asian health professionals ○ Majority of the respondents indicated that pamphlets printed in their own languages would be helpful and the most useful information would be on NZ healthcare system, followed by the Accident & Emergency service. <p>Health Professional Survey:</p>

	<ul style="list-style-type: none"> • 87% of the 300 health professionals who responded to the survey work within Waitemata DHB's catchment area. • Approximately half of the respondents were nurses, midwife and therapists. • The language barrier and cultural differences in assessment and treatment were the major difficulties experienced by the health professionals; mental health workers identified cultural perspectives differences as their most difficult area. • The availability of interpreters at health services is regarded as most useful for improving services to Asian patients, followed by pamphlets printed in Asian languages, an Asian helpline service, Asian health support workers, more Asian health professionals and healthcare services with cultural sensitivity. • The health professionals requested information and training on Asian customs and cultural perspectives. They also felt that support from Asian health professionals and Asian health support workers would facilitate their care to Asian patients/clients.
Recommendations	<p>Services to reimburse volunteers for travel expenses for home visits and meetings in their communities.</p> <p>The presence of cultural and linguistic barriers to health care should be identified and addressed. There is a pressing need for policymakers, healthcare providers, researchers and community leaders to work together to effect the needed change. At the national level, the Ministry of Health must take a leading role in formulating policies and take the initiative to promote the healthcare needs of Asians. At the district and local level, the planning and implementation of policies and strategies to meet the health care needs of ethnic minorities should be a joint effort between District Health Boards, health providers, and communities that they serve. Only then might the aim of providing an equitable health service for all groups in New Zealand be achieved.</p> <p>Recommendations to the Ministry of Health</p> <p>Health Policy</p> <ol style="list-style-type: none"> 1. National Health policies and strategies recognise and address the unique healthcare needs of Asian/ ethnic minority groups; 2. Ethnic-specific demographic profiles be provided in the national data collected by the Ministry of Health; 3. Data collection on health status be categorized according to different ethnic groups; <p>Funding initiatives & implementation</p> <ol style="list-style-type: none"> 4. The Asian health support service model be expanded to different regions of New Zealand; 5. Funding be made available to improve the accessibility of health service information in different languages (for example: helpline, pamphlets in Asian languages, interpretation services); 6. Policy guidelines be developed to encourage mainstream services such as elderly services, mental health services, social work services, child, youth and family services to provide Asian staff so as to benefit Asian clientele; 7. Community-based projects/ services for specific ethnic groups be developed and adequately funded so as to overcome linguistic and cultural barriers, e.g. diabetes programmes for Asian patients, respite service for Asian disabled children, school health promotion; <p>Research/ Training/ Quality Service</p>

	<p>8. Research be funded to identify pathways to health for Asian people such as examining specific disease;</p> <p>9. Requirements for training and guidelines on culturally appropriate practice for the health professionals be established:</p> <ul style="list-style-type: none"> _ Training in academic institutions, professional institutions, and health services on a regular basis; _ “ Guidelines to Practice: Cultural Diversity” be developed and monitored so as to provide quality care to patients from culturally and linguistically diverse backgrounds. <p>Recommendation to the Waitemata District Health Board</p> <p>Support to Asian patients/ clients</p> <ol style="list-style-type: none"> 1. The data collection system standardized so that demographic data on Asian patients/ clients can be identified in every service; 2. More funding be made available for ongoing production of pamphlets on healthcare service information in Asian languages in collaboration with other district health boards if possible; 3. A mechanism be established to regulate the availability and quality of interpretation service to ensure that the language needs of patients are catered for; 4. Community development projects be initiated in collaboration with local Asian communities and different departments to cater for the increasing needs of Asian communities, such as Asian diabetes support group; 5. A standardized communication package in different languages to be produced to benefit both patients and staff; 6. Adequate information in appropriate languages be available at the reception of the hospitals; 7. An Asian social worker be sought to benefit Asian clients seen by the social work team; 8. An Asian clinical educator be appointed to provide both clinical and cultural support to Asian patients/ clients in two hospitals and to supervise and develop the helpline service; 9. Exploring the options of extending the support services suggested in these two surveys to better serve Asian patients/ clients, such as Asian Mental Health teams; <p>Support to health professionals</p> <ol style="list-style-type: none"> 10. Guidance and training on culturally appropriate practice be developed and monitored: <ol style="list-style-type: none"> (i) Regular in-service training programmes at both service and corporate levels; (ii) Detailed materials on cultural sensitivity to be developed in the service/location manuals of different departments; (iii) In partnership with institutions, social services or communities, promote training, teaching, and research on cultural perspective in clinical practice and patients care; <p>Support to volunteers</p> <ol style="list-style-type: none"> 11. Each service to support the training of volunteers by providing information on services and issues to equip the volunteers to meet the needs of patients/ clients.
--	--

Waitemata District Health Board: Asian Smokefree Promotion and Smoking Cessation

<p>Name of study/health needs assessment/evaluation</p>	<p>Auckland Regional Public Health Service, Harbour PHO and Waitemata DHB's Asian Health Support Services (2007). <i>Asian Smokefree Communities Pilot : A culture specific and appropriate approach that combines both smokefree promotion and smoking cessation in a family-oriented setting.</i> Auckland: Waitemata DHB Asian Health Support Services</p>
<p>Conducted by</p>	<p>Auckland Regional Public Health Service, Harbour PHO and Waitemata DHB's Asian Health Support Services</p>
<p>Key Issues</p>	<ul style="list-style-type: none"> • A stocktake of available cessation services and a gap analysis for the district conducted by the Waitemata District Health Board's Health Gain Team identified subgroups within the Asian population with particularly high smoking prevalence rates, and a lack of specific cessation or smokefree promotion services. The research involved consultation with ARPHS Asian Public Health and WDHB Asian Health Support Service, and confirmed that language difficulties and cultural differences are known barriers to accessing existing smoking cessation and other services for many Asian people in the district (Whittaker R, Thompson C, 2005). • The growing Waitemata District Health Board's Asian population - Asian peoples are the fastest growing ethnic community in New Zealand, particularly in the Auckland region. According to the 2001 Census, Asian people in WDHB make up 9.4% of the total population. This figure has since increased to 14.8% (Census2006). • Based on 1996 Census smoking rate and the 2001 census figures, it was estimated that there were 3,500-4000 Asian smokers out of 65,000-90,000 smokers in the Waitemata District • Specific cessation or smokefree promotion services for Asian people were not available even though cardiovascular disease and smoking are major health issues • Language difficulties and cultural differences are known barriers to accessing mainstream smoking cessation services
<p>Recommendations</p>	<ul style="list-style-type: none"> • Reducing language and cultural barriers through the provision of interpreters, recruitment of more Asian health professionals, development of more culturally-sensitive services, enhancing mainstream services, targeting of resources and ensuring that service development involves Asian communities through partnerships and other mechanisms • Improving access to smoking cessation services for Asian peoples

Auckland Regional Settlement Strategy: Goal Four, Physical and Mental Health

Name of study/health needs assessment/evaluation	Department of Labour (2006). <i>Auckland Regional Settlement Strategy: Goal Four, Physical and Mental Health</i>
Conducted by	Department of Labour and the Auckland District Health Boards ARSS Steering Group
Key Issues	<p>Common barriers and challenges for migrants and refugees</p> <ul style="list-style-type: none"> • having little knowledge of New Zealand’s healthcare system, services and entitlements, especially those from diverse cultural and language groups; • insufficient interpreting services to support those facing language and/or literacy barriers, which discourages use of the primary healthcare system; • some healthcare providers having little exposure to cultural differences, or not being aware of the impact of their services and practice on the health of migrants and refugees. In addition, some migrant and refugee communities have expectations and patterns of seeking healthcare that differ from common norms in New Zealand. • in some migrant and refugee communities, the stigma associated with mental health which prevents individuals and family members from accessing appropriate assessment and treatment services; • financial barriers, such as the cost of consultation fees, medicine and travel (particularly in the Auckland region which is renowned for its poor public transport systems) which can provide a significant barrier for migrants and refugees on low incomes. This is especially so for refugees who arrive with minimal assets, and have more complex health needs requiring them to have access to a wider range of health providers/services. <p>Mental health</p> <p>In addition to any mental health consequences of pre-migration experiences, it may take refugees three to five years to regain a sense of confidence and control over their new lives¹³. Experience indicates that mental health problems arising from differences in expectations and experience, the effects of discrimination, problems in adapting, and failure to achieve settlement goals may appear two or three years after the ‘honeymoon period’ is over. For some, serious mental health problems may be delayed through the deferred effects of pre-migration trauma while the immediate issues of resettlement are dealt with.</p>

	<p>Problems that particularly hinder access to appropriate mental health services are:</p> <ul style="list-style-type: none"> • stigma associated with mental illness, arising from cultural beliefs; • different interpretations of the nature of mental illness and well-being and different patterns of seeking help; • mental health services that are not responsive to the special needs of refugees. <p><i>Barriers and challenges identified by primary health practitioners delivering health services to refugees</i></p> <p>A recent study (Lawrence & Kearns, 2005) of a general practice clinic in Auckland that provides affordable and accessible primary healthcare services to locally based, low-income communities, where there are a high number of refugees, identified five key challenges clinic staff faced in delivering healthcare services to refugees. Similar challenges are likely to be faced when dealing with migrants with vastly differing pre-migration experiences and environments, as discussed in the Summary Report. The challenges for primary healthcare practitioners include:</p> <p><i>Medical challenges</i></p> <p>Refugee health needs tend to be complex, longstanding and may not have been encountered before by the local general practitioner.</p> <p><i>Cultural challenges</i></p> <p>Many healthcare workers may have limited knowledge, skill and awareness about working with refugees from different cultures, and of refugee-specific health issues arising from pre-migration and re-settlement experiences.</p> <p><i>Communication challenges</i></p> <p>Communication with migrant and refugee patients is a major barrier for general practitioners. For example, when families interpret and/or the interpreter has limited English, it can be difficult for general practitioners to determine the exact nature of the complaint.</p> <p><i>Operational costs</i></p> <p>These include challenges from:</p> <ul style="list-style-type: none"> • the funding model, which does not adequately provide for the extended consultation time required to address complex need and language difficulties, nor the high utilisation rates common for refugee patients; • the cost of interpreters that must be met by either the patient or the practice; • clinic staff experiencing considerable stress associated with providing healthcare in the absence of appropriate interpreting services. The cost of this can sometimes be seen in terms of reduced efficiency and productivity and increased sick leave. • the cost of providing professional supervision (where it exists) to health professionals dealing with torture and trauma patients, which must be met by the practice. <p><i>High need for mental health services</i></p> <p>There is a shortage of refugee-specific providers of mental health services. Refugee mental health needs are complex and varied and may</p>
--	---

	<p>present at later stages of settlement, often once more immediate concerns such as housing have been met. For example, there are insufficient services for children who have had traumatic refugee experiences and require mental health treatment. The discontinuation of funding for the On TRACC pilot will exacerbate this capacity issue, and there is concern that the proposed replacement services will not have the specialist mental health competencies needed for this target group.</p>
<p>Recommendations</p>	<p>It is recommended that the Ministry of Health and District Health Boards ensure that their work programmes for improving physical and mental health outcomes for migrants and refugees from diverse cultural and language backgrounds are aligned to the longer-term work programmes for the <i>New Zealand Settlement Strategy</i> and the <i>Auckland Regional Settlement Strategy</i>. It is recommended that the following opportunities are considered for this purpose.</p> <p><i>Policy, funding and planning</i></p> <ul style="list-style-type: none"> • Given the costs of providing healthcare services to refugees and the affordability issues for refugees with complex health needs, consideration should be given to reviewing current healthcare funding to ensure it adequately addresses these issues. This would include: <ul style="list-style-type: none"> o reviewing population based funding formulae; o reviewing and refining mechanisms for targeting funding to primary health services working with refugee populations; o developing accessible and cost-effective interpreter services for primary care providers with patients from diverse cultural and language backgrounds • Improve healthcare planning and service delivery, so that it is accessible, appropriate and available to migrants and refugees, by ensuring DHBs and other health service providers have robust information about these populations. Statistics New Zealand Level 2 ethnicity classification is too aggregated to assist identify health service provision needs, assessment or planning for migrant and refugees from a range of ethnic populations. This requires more accurate information on their health needs, where they are living and their countries of origin. For example, information on intakes of quota refugees including numbers being accepted, countries of origin, people accepted for family reunification, and where these people are being settled. • Use the existing whole-of-government <i>New Zealand Settlement Strategy's</i> Senior Officials Group, to improve forward planning, information sharing and collaboration, including the collection and sharing of ethnicity data in a consistent manner. This will improve policy and service development in healthcare and other settlement related areas for migrant and refugee communities. <p><i>Service Delivery</i></p> <p>Initiatives are needed to address the most common barriers of language, cultural differences and costs faced by migrants and refugees. These include:</p> <p><u>Communication</u></p> <ul style="list-style-type: none"> • Ensure an adequately funded <i>interpreting service</i> is available to primary care providers. This includes having trained interpreters present at

	<p>initial visits for refugees to obtain a comprehensive medical history and phone-interpreting services available at follow-up visits.</p> <ul style="list-style-type: none"> • Develop a centralised healthcare, phone-interpreting service and consider existing options such as the AHSS interpreting service (Waitemata Asian Translation and Interpreting Service – WATIS) and Language Line. <p><u>Workforce development</u></p> <ul style="list-style-type: none"> • Develop a workforce development strategy that enhances the cultural competencies of healthcare workers providing primary and secondary healthcare services to migrant and refugee communities, and encourages the employment of healthcare workers from these communities. This could include: <ul style="list-style-type: none"> o training programmes for existing mainstream healthcare workers; o professional supervision as part of occupational safety and health practices (as with counselling and social work roles) for those working with refugee communities, particularly in primary care; o the health sector, in conjunction with health professional bodies and communities, encouraging employment of migrant and refugee health workers by providing community-based healthcare information, training programmes and scholarships. <p><u>Mental healthcare</u></p> <ul style="list-style-type: none"> • Extend current work targeted at Asian populations to address the needs of wider migrant and refugee populations. This includes work underway on developing professionally trained and qualified interpreting services and providing equal opportunity of access to quality services delivered in a culturally appropriate manner. • Develop specialist mental health services to meet the needs of refugees, including those presenting mental health problems at later stages of settlement, and for specific age groups such as adolescents (previously services by ON TRACC) • Develop a mental health promotion strategy for migrants from refugee-producing countries with similar high and complex settlement support and mental health needs to quota refugees. • Promote research on mental health needs of migrants and refugees in the areas identified in the Mental Health Commission’s literature review (Ho et al., 2003) , and other needs identified in DHB needs assessments <p><u>Collaborative approach across the region</u></p> <ul style="list-style-type: none"> • Ensure healthcare providers across the Auckland region are building upon existing models of good practice and, where appropriate, working together on a more ‘regional’ (as opposed to local) level to develop more consistent and efficient services.
--	---

Primary Health Care Services: Survey of Primary Health Care Services in Auckland and Wellington on the Impact of immigrant Patients

<p>Name of study/health needs assessment/evaluation</p>	<p>North, N. & Lovell, S. (2002). <i>Survey of Primary Health Care Services in Auckland and Wellington on the Impact of immigrant Patients</i> Faculty of Medical and Health Sciences, The University of Auckland. Presentation at New Directions: New Settlers Conference, Wellington, 12-13 April, 2003.</p> <p>The study included Plunket services, Urgent Medical and Emergency Services, General Practices,</p>
<p>Conducted by</p>	<p>Faculty of Medical and Health Sciences, University of Auckland</p>
<p>Key Issues</p>	<ul style="list-style-type: none"> • Communicating with non-English speaking clients was identified by respondents as the most significant impediment to working with immigrant patients • A failure to communicate with patients can have serious outcomes for patient care including interfering with the ability to diagnose problems • Overwhelmingly it was the extra time involved in trying to communicate with immigrant patients that caused health professionals problems due to the lack of funding available to provide for the additional workloads • It was also recognised by practitioners that culture was a very important aspect to understanding illness and presenting concerns, symptoms and pain • Health professionals raised the issue of their cultural competency in working with culturally and linguistically diverse populations • Health service use in country of origin can have a significant impact on health care use in New Zealand and on perceptions and expectations of the New Zealand health system.
<p>Recommendations</p>	<ul style="list-style-type: none"> • Interpreter services are needed in primary health care • More education about preventative services (breast /cervical screening etc) • Further research is needed into specific ethnic communities e.g why emergency department use is higher in some ethnic groups • Research into contractual agreements with primary health care services is needed in the context of the time and complexity of working with culturally and linguistically diverse populations • Related to the above patient information for More pamphlets in other languages, particularly on the New Zealand health system needs to be factored into contractual arrangements • More qualitative research into the methods by which health professionals cope with immigrant patient load is necessary.

Utilisation of Emergency Care Services: Refugees and asylum seekers: Implications for ED care in Auckland, New Zealand

Name of study/health needs assessment/evaluation	Young, N. & Mortensen, A. (August, 2003). Refugees and asylum seekers: Implications for ED care in Auckland, New Zealand. <i>Journal of Emergency Nursing</i> , 29, (4), 337-341.
Conducted by	Auckland Regional Public Health Service
Key Issues	<ol style="list-style-type: none"> 1. There is increasing use of Auckland Adult and Children's emergency departments by refugee and migrant groups reflecting the shifting ethnic composition of central Auckland and health care utilisation in countries of origin. 2. Refugees are different from other immigrants and from low-income families in New Zealand in that they often have a history of trauma. In addition, they live with greater adversity—that is, more illness, unemployment, and isolation from support networks. 3. These factors may account for the proportionately higher rate of presentation in the emergency department by refugees with urgent and non urgent complaints. The health care needs of refugees are complex and place demands on both adult and children's emergency services. 4. In refugee families the normal patterns of family care and coping are disrupted. 5. For refugees, "illness behaviour" in seeking ED care is influenced by health care experiences prior to arrival and to barriers in accessing primary health services in New Zealand. Most refugee families are unused to the system of general practice and need instruction about how and when to use primary health and emergency services. However, significant barriers exist to accessing primary health care, particularly affordability and the inability to communicate.
Recommendations	<ul style="list-style-type: none"> • Refugees often present late in the course of an illness because of a range of factors, including difficulty in understanding how the New Zealand health system works, in particular the role of primary health care. • Poverty, the lack of interpreters in general practice, difficulties with transportation, and a preference for hospital-based care result in a disproportionate number of refugee families presenting to emergency departments. • Whereas many families may present "inappropriately," in addition, they often delay in seeking care when illness is acute. • To decrease this "inappropriate" or delayed ED presentation of refugee populations, many systemic issues need to be resolved, such as interpreting services in primary health care.

Motherhood and Migration

Name of study/health needs assessment/evaluation	Desouza, R. (November, 2006). <i>New spaces and possibilities: The adjustment to parenthood for new migrant mothers</i> . Auckland: Centre for Asian and Migrant Health Research, Auckland University of Technology
Conducted by	Auckland: Centre for Asian and Migrant Health Research, Auckland University of Technology for Blue Skies Research: Families Commission
Key Issues	<p>The key findings of the research were that:</p> <ul style="list-style-type: none"> • migrant women lose access to information resources, such as family and friends, in the process of migrating and come to depend on their husbands, health professionals and other authoritative sources. Importantly, the expectations from their country of origin come to inform their experiences of pregnancy, labour and delivery in a new country • migration has an impact on women's and their partners' roles in relation to childbirth and parenting. The loss of supportive networks incurred in migration results in husbands and partners taking more active roles in the perinatal period • coming to a new country can result in the loss of knowledge resources, peer and family support and protective rituals. These losses can lead to isolation for many women.
Recommendations	<p>The findings of the research suggest that:</p> <ul style="list-style-type: none"> • support services for women who have a baby in a new country need to be developed and services also need to be 'father-friendly' • the information needs of migrant women from all backgrounds need to be considered in planning service delivery (including European migrant women) • services need to develop linguistic competence to better support migrant mothers, for example by providing written information in their own language • those developing antenatal resources must consider the needs of migrant mothers; for example, by having antenatal classes available in a number of common languages, eg Korean • workforce development occurs among health professionals to expand existing cultural safety training to incorporate cultural competence • health and social services staff must become better informed as to the resources that are available if they are to provide effective support for migrant mothers. <p>Further research is required to:</p> <ul style="list-style-type: none"> • explore the information needs of migrant parents through the family life-cycle • identify the factors that support breastfeeding in the absence of social support • understand the experiences of migrant father • understand the needs of additional migrant groups, including African, Middle-Eastern and Latin American communities

Asian Mental Health: Northern Regional Mental Health and Addiction Strategy for Asian Service Users

Name of study/health needs assessment/evaluation	Northern DHB Support Agency (March, 2006). <i>Northern Regional Mental Health and Addiction Strategy for Asian Service Users</i> . Auckland: NDSA
Conducted by	Northern DHB Support Agency
Key Issues	<p>Sector consultation</p> <p>Five key issues.</p> <ol style="list-style-type: none"> 1. The Northern Regional Asian Mental Health and Addiction services are currently inadequate to meet demand. 2. More resources are required to offset the current constraints. 3. The few attempts at providing Asian Mental Health and Addiction services are at best fragmented in the Northern Region, and this limits the wider and effective use of already scarce resources. 4. For Asian Mental health and Addiction services to be more effective, central coordination is essential. 5. Communication problems, inadequate knowledge of existing services, cultural differences in assessment and treatment, and shame and stigma of mental illness are major barriers to accessing mental health services. <p>The review of best practice literature for culturally responsive mental health services found that cultural competence, capability and capacity are the key considerations in planning to meet the needs of Asian Mental Health and Addiction users. A number of key developmental themes emerge from effective culturally responsive service literature.</p> <ol style="list-style-type: none"> 1. Asian Mental Health and Addiction users and their families should be part of a comprehensive service programme that ultimately attempts to reduce the barriers to service use. 2. The literature suggests this effort should be conducted as a partnership with Asian communities, with jointly determined goals and objectives, roles and responsibilities. 3. Local and regional health leaders will play a pivotal part in developing services. 4. Planners and providers must work with Asian communities to find a common route to help develop the workforce and transform and implement a strategic plan.

	<p>The delivery of culturally responsive Mental Health and Addiction services is a realistic medium-term goal for the Northern Region. Trans-cultural literature advocates for a culturally integrative approach as the ultimate long-term goal. A culturally integrative approach involves paradigm shifting – an attempt to see the world from another cultural viewpoint. Cultural responsiveness involves a degree of respect for cultural differences.</p>
<p>Recommendations</p>	<p>Short term recommendations</p> <ul style="list-style-type: none"> • Establish Asian Migrant and Refugee Mental Health Advisory Group <ul style="list-style-type: none"> ○ Initial composition of such a group should have representatives from District Health Boards (DHBs), Northern District Health Board Support Agency (NDSA), Non Government Organisations (NGOs), Primary Health, Auckland Regional Public Health, Asian consumers, communities and additional representation to be decided by the Advisory Group. The advisory group will develop close linkages and working relationship with the Network North Coalition and will lead the development of an implementation plan. • Establish regional project management role to support the advisory group <ul style="list-style-type: none"> ○ A Project Management role with responsibility for supporting and coordinating the function of the Advisory Group, scoping the implementation plan and project management as directed. • Scoping the development of a Web-based Regional Asian Mental Health Resource Management System <ul style="list-style-type: none"> ○ Scoping the development of an Asian Mental Health Resource Management System (Web based) containing information on the provision of primary and secondary Asian mental health and addiction services in the Northern Region, and compliance with the standards outlined by the New Zealand Health Information Service (NZHIS). <p>Medium term recommendations</p> <ul style="list-style-type: none"> • Stock take Asian mental health and addiction needs in the Northern Region <ul style="list-style-type: none"> ○ Research Asian mental health and addiction needs and demand in the Northern Region to support the development of culturally responsive services. • Build capacity and capability in the mental health sector to ensure services are responsive to the unique cultural needs of the Asian population <ul style="list-style-type: none"> ○ Development of an implementation plan that integrates the various strategies and recommendations pertaining to the Asian mental health workforce. Specific reference to:

	<ul style="list-style-type: none"> ▪ Asian Mental Health Workforce Development project. ▪ Asian Mental Health Interpreters project. <ul style="list-style-type: none"> • Improve mental health ethnicity data collection <ul style="list-style-type: none"> ○ Consistent with national efforts to improve ethnicity data reporting in health the DHBs will ensure that accurate information regarding the health status of ethnic groups is available for future policy development and health service planning purposes, monitoring health service utilisation and health outcomes, and to assist in measuring health inequalities and monitoring trends over time in health status and service utilisation. • Scope the development of a multi-lingual mental health resource information centre • Scope the development of an Asian mental health support/ language line • Support the development of an Asian mental health outreach/health promotion programme • Develop communication strategies on access and service availability • Strengthen NGO and primary health sectors in the development of services to Asian service users • Support the development of Primary mental health services to the Asian population • Establish an infrastructure to support Asian community input into service planning, funding and policy development <p><i>Long term recommendations</i></p> <ul style="list-style-type: none"> • Ongoing development of the capacity and capability of the mental health sector to respond to the mental health needs of the Asian population • Undertake review of the implementation plan and evaluate outcomes
--	---

Asian Mental Health: Northern Region Mental Health and Addictions Services Strategic Direction 2005-2010

Improving mental health services responsiveness to Asian communities: Auckland Regional Asian Mental Health and Addictions Implementation Plan 2006 to 2010

Name of study/health needs assessment/evaluation	Northern DHB Support Agency and Network North Coalition (October, 2004). <i>Northern Region Mental Health and Addictions Services Strategic Direction 2005-2010</i> . Auckland: Northern DHB Support Agency and Network North Coalition
Conducted by	Northern DHB Support Agency and Network North Coalition Recommendations by the Northern Region Asian Mental Health & Addiction Advisory Group.
Key Issues	<p>Northern DHB Support Agency and Network North Coalition (October, 2004). <i>Northern Region Mental Health and Addictions Services Strategic Direction 2005-2010</i>. Auckland: Northern DHB Support Agency and Network North Coalition</p> <p>Refugees and Recent Asian Migrants</p> <p>There is no agreed vision or direction for the development of Northern region mental health services to address the specific mental health needs of new migrant populations, notably of Asian origins, as well as refugees from a wide range of source countries.</p> <p>Development of detailed strategy work will be undertaken as a regional priority. A recent literature review on <i>Mental Health Issues for Asians in New Zealand</i> prepared for the Mental Health Commission¹ and the Ministry of Health's <i>Asian Public Health Report</i> provide useful starting points².</p> <p>Proposed Vision</p> <ul style="list-style-type: none"> • Equal opportunity to access quality services delivered in a culturally appropriate manner for refugee and recent Asian migrant clients and their families • Access to professionally trained and qualified interpreting services to meet the needs of migrants and refugees with experience of

¹ Mental health issues for Asians in New Zealand: a literature review. MHC 2002

² The Asian Public Health Project Report. Ministry of Health 2003

	<p>mental illness and their families.</p> <p>Key issues for Asian Mental Health</p> <p>The MHC review identifies a number of key adaptation problems:</p> <ul style="list-style-type: none"> • Language difficulties, especially for women, older migrants and refugees • Employment problems, even when the language barrier is overcome because qualifications may not be accepted, or prior local work experience is required • Disruption of family and social support networks • Acculturation attitudes. That is, the extent to which migrants have integrated into the local culture. <p>Research gaps are also identified:</p> <ul style="list-style-type: none"> • Prevalence studies. Because of the relatively small and rapidly changing population it is difficult to obtain representative samples. • Overseas studies as well as the limited New Zealand research indicates particular mental health problems associated with particular migration experiences. For example, high rates of depression among older Chinese migrants; post-traumatic stress disorder among Cambodian refugees; loneliness among students. • High risk groups requiring further research include women, students, older people, and refugees. <p>Other key issues identified in the consultation and submissions on this strategy include:</p> <ul style="list-style-type: none"> • Poor representation of Asian perspectives at different policy-making levels, and a sense that Asian voices and stories are rarely heard. • Responsiveness of mental health services is hampered by the fact that urban services have fallen behind population growth • There is a lack of understanding of the belief systems about mental health illness in Asian cultures. • Asian usage of mental health service is disproportionately low compared with the population in the region and reasons for this are not known <p>Key Issues for Refugee mental health</p> <p>In November 2003 the Mental Health Foundation consulted on what it is like to be a migrant or refugee living in New Zealand³. The purpose was to help identify initiatives that would support the mental wellbeing of migrants and refugees in the Auckland area. Some of the issues appear to</p>
--	---

³ Important factors in the experience of migrants and refugees. Summary of a consultation process, Mental Health Foundation, November 2003

	<p>be the same for both migrants and refugees, however there are some important differences. A more general report on refugee experiences of settlement in New Zealand was also published by the NZ Immigration Service in June 2004⁴.</p> <p>Refugees arrive with particular health problems, including post-traumatic stress syndrome and poor general health as a result of their refugee experience. While most report early improvement owing to a sense of safety and security, around one third continue to experience emotional problems, often associated with cultural adaptation. Women are more likely than men to continue to experience poor mental health.</p> <p>The experience of some mental health problems may be delayed by 'deferring' the effects of trauma (torture, witnessing or being subjected to violence, losing friends and family) while the immediate issues of resettlement are dealt with.</p> <p>Both migrants and refugees share the universal experience of acculturation. Acculturation was defined during the consultation as keeping your own culture alive, but assuming enough of NZ culture to operate effectively. Family members do it at different rates e.g. children acculturate quickly but men take the longest time. If their expectations are not met they may become withdrawn, depressed, and unable to learn the language or to find work. People may become partly acculturated, but not assimilated.</p> <p>It is thought to take 3-5 years for refugees to regain a sense of confidence and a sense of control of their new lives⁵:</p> <table style="margin-left: 40px;"> <tr> <td style="padding-right: 20px;">On arrival</td> <td>• They were happy and excited</td> </tr> <tr> <td>By 6 months</td> <td>• Morale sank while they dealt with the problems of finding accommodation, employment, learning the language etc</td> </tr> <tr> <td>Late in 1st year</td> <td>• Depression peaked</td> </tr> <tr> <td>Next 2-3 years</td> <td>• Morale rose gradually</td> </tr> <tr> <td>By 3rd year</td> <td>• Approaching normal</td> </tr> </table> <p>It is essential that primary care providers have some understanding of these concepts and processes if they are to respond adequately to the mental health needs of refugees and migrants.</p> <p>Goals and Objectives for Asian mental health</p>	On arrival	• They were happy and excited	By 6 months	• Morale sank while they dealt with the problems of finding accommodation, employment, learning the language etc	Late in 1 st year	• Depression peaked	Next 2-3 years	• Morale rose gradually	By 3 rd year	• Approaching normal
On arrival	• They were happy and excited										
By 6 months	• Morale sank while they dealt with the problems of finding accommodation, employment, learning the language etc										
Late in 1 st year	• Depression peaked										
Next 2-3 years	• Morale rose gradually										
By 3 rd year	• Approaching normal										

⁴ Refugee Voices: A Journey Towards Resettlement. Department of Labour 2004

⁵ Quoted in "Towards a successful resettlement of refugees" Dr San Duy Nguyen, 1989

	<p>The Mental Health Commission's literature review points out the limitations of current research on the mental health of Asian New Zealanders. Most has focused on recent immigrants and has involved Chinese, and to a lesser extent Koreans and Indians, while the research on refugees has focused on Cambodians. There are few studies of the prevalence of mental illness among Asian ethnic groups and none claims to be based on a representative sample. The focus has been on the adaptation problems, mental health status, utilisation of (and barriers to) mental health services and traditional healing practices.</p> <p>In spite of these limitations, the Review recommends the following strategies as a useful starting point for working with other organizations that impact on the mental health of Asian communities and for developing mental health services to better meet their mental health needs.</p> <p>Improve Cultural Responsiveness in Mental Health Services</p> <ol style="list-style-type: none"> Promote the development of educational materials and professional interpreter services <p>Information on mental illness needs to be developed and made available in Asian language and working with interpreters needs to be supported. Stigma is a major obstacle preventing Asians from using mainstream mental health services. Ethnic press, radio and television outlets, as well as the church, should be used to disseminate information promoting the use of services. There is also a need to improve professional interpreter services for each ethnic group.</p> <p>Northern DHB Support Agency and Network North Coalition (October, 2004). <i>Northern Region Mental Health and Addictions Services Strategic Direction 2005-2010</i>. Auckland: Northern DHB Support Agency and Network North Coalition</p>
Recommendations	<p>Northern District Health Board Support Agency (July, 2006). <i>Improving mental health services responsiveness to Asian communities: Auckland Regional Asian Mental Health and Addictions Implementation Plan 2006 to 2010</i>. Prepared Northern Region Asian Mental Health & Addiction Advisory Group. Auckland: NDSA</p> <p>Recommendations for 2006/07 (in no order of priority)</p> <ol style="list-style-type: none"> That the development of Asian-specific mental health specialist service components and enhancement of mainstream service to better service Asian communities is pursued. Note: These two approaches are complementary, but for clarity, this recommendation is <i>not</i> advocating the parallel development of an overall Asian-specific mental health service along the lines of current Maori and Pacific mental health services, but is suggesting the possible development of specialist components (e.g. a formalised Asian clinical cultural liaison service, the current interpreter service) to assist or enhance mainstream services. Therefore development of cultural responsive service delivery

	<p>within mainstream is given priority due to the need to retain service flexibility and best meet the needs of the diverse nature of Asian communities. The following recommendations reflect this emphasis.</p> <ol style="list-style-type: none"> 2. That dedicated resource is provided to facilitate regional coordination of Asian mental health services. Coordination activity would include (but is not limited to): <ul style="list-style-type: none"> • Providing support and access to expert advice to ensure effective functioning of the Regional Advisory Group. • Establishing and maintaining a database of mental health services, Asian migrant services, support and community groups, other networks and individuals relevant to Asian mental health. • Overseeing specific regional Asian mental health projects, initially commencing with a project to identify Asian mental health information needs (e.g. service information/accessing services, information on key mental health issues), developing translated resources and promoting/distributing information resources via websites and community networks. • Organising and facilitating an annual regional forum pertaining to Asian mental health. • Providing information and advice to mental health services, Asian migrant services, and service user, support and community groups. • Fostering Asian service users groups to actively participate in service planning and advocacy. • Assisting the Regional Advisory Group monitor and evaluate the regional strategy and implementation plan. 3. That Asian mental health information and communication mechanisms are established and overseen by the Regional Advisory Group with the following key outputs for 2006/07: <ul style="list-style-type: none"> • Regional Coordination to ensure provision of information and advice to mental health services, Asian migrant services, and service user, support and community groups is provided. • A regional (national) database of mental health services, Asian migrant services, support and community groups, other networks and individuals relevant to Asian mental health is established. • Asian mental health information resources (e.g. translated handouts pertaining to service information/accessing services, information on key mental health issues) are developed. • Information resources are promoted/distributed via websites and community networks (printed handouts). • Regional forums and workshops pertaining to Asian mental health occur. • Asian service users groups and support groups are well-supported. 4. That cultural competence within mainstream DHB and NGO mental health services is fostered and includes: <ul style="list-style-type: none"> • Recruitment, training, retention and supervision of Asian mental health practitioners; • Workforce development in use of interpreters and cultural awareness (already funded as part of current regional workforce
--	---

	<p>development project, move from one-off funding to sustainable funding), also including cultural assessment (each DHB to consider, possibly assisted by Regional Advisory Group);</p> <ul style="list-style-type: none"> • Access to competent and professional interpreter services (already funded by each DHB; clear referral protocols being developed as part of current regional workforce development project); • Establishment of clear protocols for utilising 'cultural clinical advice' (each DHB to develop as appropriate; regional consistency and alignment can be facilitated through the function of the Regional Advisory Group). <p>5. That the development of integrated and effective Asian specific mental health services across the Auckland region focuses on:</p> <ol style="list-style-type: none"> i. Professional interpreter services (see above) and investigate feasibility of resourcing interpreter access to primary health care; ii. Formalised cultural and clinical advice within mainstream DHB mental health services (each DHB to establish appropriate local models, but could include: appointment of local cultural/clinical coordinator – each DHB to determine best mix of cultural vs. clinical advice over and above cultural advice provided by interpreters; a database of clinicians from a range of ethnic backgrounds and establish a mandate for these clinicians to provide cultural input as required; structures and clear boundaries i.e. clear referral/involvement protocols to support these clinicians; build effective relationships with primary health care); iii. Community support worker services/ Asian home based support services (each DHB to determine configuration of DHB and NGO-based community support work-type services with the view to develop over time – current mainstream Community Support Worker services/roles may not be appropriate for Asian communities. Therefore, this type of service should be developed consultation with Asian communities and key informants); iv. Peer support, service user and family networks (consider regional/local funding of groups to establish a more comprehensive network of peer support groups); v. Prevention and early intervention initiatives (support initiatives to build better relationships with primary health care, helpline/s, migrant service agencies). <p>6. That at least annual monitoring and evaluation of the effectiveness of implementation of regional Asian responsiveness initiatives occurs.</p> <p>In conclusion, the implementation plan outlines a short and medium term approach to enhance mainstream mental health services and foster a coordinated regional approach to achieve more responsive services to Asian communities in the Auckland region.</p>
--	---

Refugee Mental Health: Identification of mental health needs and service gaps for small refugee groups in Auckland

<p>Name of study/health needs assessment/evaluation</p>	<p>Aye, A.Z.N. (2002). <i>Identification of mental health needs and service gaps for small refugee groups in Auckland</i> Unpublished Masters thesis. Auckland: University of Auckland</p>
<p>Conducted by</p>	<p>Amanda Aye: School of Population Health, University of Auckland</p>
<p>Key Issues</p>	<p>There are major mental health problems among refugee populations in Auckland</p> <ul style="list-style-type: none"> • Adjustment disorders and post-traumatic stress disorders are highly prevalent in refugee populations • While being unfamiliar with the health system in New Zealand and transport difficulties contribute to poor utilisation of mental health services, the major factor is cultural presentation of symptoms <p>Mental health is connected to resettlement issues</p> <ul style="list-style-type: none"> • On arrival at MRRC mental health is assessed however, as the early period of settlement is a “honeymoon” period, many symptoms of previous trauma are not picked up. Refugees at this stage are most concerned with “practical” issues- e.g. family reunification, communication issues and finding employment. • Cultural norms stigmatise mental illness in many refugee communities and seeking formal help is the last resort and often late • When refugees do utilise services, they are often faced with alien concepts of treatment such as counselling. Language and cultural barriers may become obstacles to effective therapy. • Mental health staff often have not had training in cultural competency related to ethnic minority groups • There is very little support for refugees with mental illness in the community (access to community based mental health services is impeded by cultural and language barriers) • There is no mental health promotion targeted at refugee communities

Recommendations	
------------------------	--

Refugee Mental Health (Children and young people): Evaluation of ON TRACC

Name of study/health needs assessment/evaluation	<p>Evaluation of ON TRACC (May, 2005) On TRACC: Transcultural Care Centre An intersectoral service for children and young people from refugee backgrounds and their families On TRACC was a pilot intersectoral service for children and young people from refugee backgrounds and their families with severe behaviour and / or mental health needs living in Central Auckland.</p>
Conducted by	<p>The service operated as a demonstration pilot from October 2003 to October 2005. The service was provided as a joint sector service by the:</p> <ul style="list-style-type: none"> • Kari Centre of the Auckland District Health Board ('ADHB') • ESOL, Refugee and Migrant Team in the Ministry of Education • Auckland City Group Special Education in the Ministry of Education • Royal Oak and Grey Lynn offices in the Department Of Child Youth And Family Services ('CYF')
Key Issues	<p>Identification of Outcomes</p> <p>There were indications that On TRACC achieved positive outcomes for clients and their families including:</p> <ul style="list-style-type: none"> • Reduction in the severity of symptoms of trauma; • Identification/ management of mental health needs; • Participation and achievement in education;

	<ul style="list-style-type: none"> • Identification and management of care and protection needs; and • Identification and management of youth offending. <p>1. Reduction in the severity of symptoms of trauma</p> <p>On TRACC staff were able to use interventions which resulted in the reduction of the severity of symptoms of trauma. Changes for clients and their families in this area included the following outcomes:</p> <ul style="list-style-type: none"> • Improved strategies for dealing with bed wetting with positive results; • Improved sleep patterns (fewer nightmares, less waking of parents at night); • Increased self esteem/ confidence (for clients and parents); • Families being more settled in New Zealand – not only focussed on ‘country of origin’ issues; • Improved strategies for dealing with ‘acting out’ behaviour; • Less separation anxiety; and • Improved strategies for dealing with stressful behaviour. <p>2. Identification/ Management of Mental Health Needs</p> <p>On TRACC staff were able to identify a number of mental health needs and carry out appropriate interventions. There were indications that the interventions used resulted in the following outcomes in this area:</p> <ul style="list-style-type: none"> • Reduction in stress for clients and their families; • Reduction in negative emotions; • Reduction in levels of depression; • Clients and their families more able to access and express their feelings in positive ways; and • Reduction in the level of self harm. <p>3. Participation and Achievement in Education</p> <p>There were indications that participation in education improved as a result of On TRACC interventions. Clients were attending school more often. Other educational outcomes reported included:</p>
--	--

	<ul style="list-style-type: none"> • Clients paying more attention at school; • Clients learned about and developed classroom and homework routines; • Social skills were improved reducing social isolation of clients; and • Academic performance improved. <p>4. Other Outcomes for Families</p> <p>There were a number of other positive outcomes indicated for families that resulted from On TRACC interventions. These cannot be categorised under the main headings suggested in the questions for this evaluation but are nonetheless noteworthy.</p> <p>There were indications that families of On TRACC clients improved their parenting skills as a result of On TRACC interventions. Outcomes included:</p> <ul style="list-style-type: none"> • Reduction of physical punishment and an increase in positive reinforcement techniques to improve behaviour; • Parents learning to set boundaries and doing so; • Parents presenting a united front to their children and no longer arguing in front of them; • The establishment of routines around bedtime and homework; • Improvements in nutrition; and • The use of more effective coping strategies for On TRACC clients and their parents. <p>There were also outcomes indicated in terms of strengthening of family units. These included:</p> <ul style="list-style-type: none"> • Improved family relationships; • Improved communication and being able to discuss issues more openly; • Less stress for families as a whole; • Less parental fatigue; and • Parents were better able to understand their children from their children's point of view.
Recommendations	<p>On TRACC staff used a range of interventions to assist families referred to them. Due to the challenges in establishing trust and developing strong relationships, strategies included setting up interventions that were likely to lead to early successes. In some cases, a targeted behaviour modification intervention was implemented to successfully change some of the more immediate negative behaviours. Early success with initial</p>

	<p>behaviour modification opened the door to deeper work (causal factors) with the family. This work built up the realisation that On TRACC might be able to help in other areas.</p> <p>Often the work that On TRACC staff carried out with families began in the resettlement area because families were so distressed about their housing, for example, that they were unable to begin to deal with other issues like behavioural issues. The On TRACC workers took families to WINZ or to Housing New Zealand to get these things sorted out before any clinical work could commence.</p> <p>The range of interventions used by On TRACC staff with clients included:</p> <ul style="list-style-type: none"> • Establishing structured behavioural modification programmes based on clients' needs and interests; • Getting clients and families to try new patterns of behaviours in order to change unhelpful habits; • Establishing client involvement in social programmes like joining sporting teams or walking buses or going to a holiday camp; • Teaching coping strategies like counting, seeing a counsellor or principal, using positive visualisation, or delaying phone calls to family members until school break times to clients to be used when they were feeling stressed at school; • Teaching clients memory exercises or other brain gym exercises; • Referring clients to other agencies that might be able to assist. <p>Interventions were also used with the families of clients. These included:</p> <ul style="list-style-type: none"> • Carrying out social work activities like advocating to WINZ or Housing New Zealand, making funding applications to community agencies for clients, and obtaining suitable bedding and clothing for families; • Coaching families to improve parenting skills; • Enlisting families in a collaborative way to be involved with the On TRACC interventions; • Talking to family members about their own issues; and • Referring families to other agencies that might be able to assist. <p>On TRACC staff also intervened with schools in the following ways:</p> <ul style="list-style-type: none"> • Working with the school staff to increase their understanding of refugee issues; • Working with school staff to develop programmes for clients; • Assisting in the transition of clients to new schools; and
--	---

	<ul style="list-style-type: none"> • Providing interpreter and cultural advice at school. <p>On TRACC staff also worked with staff from Child, Youth and Family around care and protection issues, and with mental health agencies around the mental health of the family members where required. As well On TRACC staff provided case management advice and cultural competency training for staff in mental health, education and Child, Youth and Family issues.</p>
--	--

Disability Services: Report to the Auckland Regional Settlement Strategy Working Group on Settlement Issues for Migrants and Refugees with Disabilities.

Name of study/health needs assessment/evaluation	Jorgensen, P. (January, 2005). <i>Report to the Auckland Regional Settlement Strategy Working Group on Settlement Issues for Migrants and Refugees with Disabilities</i> . Manukau City Council: Auckland Regional Settlement Strategy
Conducted by	Manukau City Council: Auckland Regional Settlement Strategy Working Group
Key Issues	<ol style="list-style-type: none"> 1. The prevalence of disabilities in the migrant and refugee population resident in the Auckland Region is unclear. 2. The NZ refugee quota makes provision for 10% (i.e. 75 places) per annum to be allocated to refugees with special needs. A significant number of quota refugees with disabilities and their families have therefore been settled in New Zealand under this quota, although it is unclear how many. 3. It is likely that there are significantly more new migrants (including Pacific and refugee) with disabilities living in the Auckland Region than previously indicated, and they may form a much higher proportion of people with disabilities than currently understood. This is because: New migrant' respondents to the 2001 Census may not have understood the questions (language barriers) and/or have a different perspective of disability; and/or may have been fearful of disclosing disability. <ul style="list-style-type: none"> • There has been a significant growth in the 'Asian/other' population in the Auckland region, mainly due to migration. In addition, the percentage of Asian and Other ethnic groups is much higher in the Auckland Region than for the rest of New Zealand. • At least some migrants have specifically chosen to immigrate to NZ in order to access services for their disabled family members. • Stress during the settlement phase is known to contribute to mental illness including depression. At least some cases will meet the criteria for disability. • There are indications that new migrants experience a higher rate of injury through accidents (e.g traffic, near drowning) than for the 'normally resident' population. • New migrants, including Pacific and refugee, with disabilities and their families, are likely to face a double disadvantage in overcoming barriers to full participation in NZ society. This will be compounded by: Lack of knowledge of the disability sector

	<p>and how to access services</p> <ul style="list-style-type: none"> • Disability support services being difficult to access because of <ol style="list-style-type: none"> 1. inadequate referral processes for new migrants (note that disability services across sectors in NZ are based on early intervention and tend to be targeted at the early childhood sector); 2. lack of culturally and language-appropriate services including diagnostic and assessment; and 3. the complexity of eligibility criteria across sectors. • Lengthy waiting times for services, often due to lack of resources within the service sector particularly where budgets are capped. This is compounded where population-based funding does not take account of the increasing Asian/other population in Auckland, and their 'double disadvantage'. • Delays in accessing appropriate support services for their disabled family members significantly increases the economic difficulties and isolation experienced by new migrants, and for disabled migrants themselves. • Language and cultural barriers as well as discrimination. <p>4. New migrants and refugees come from cultural and social backgrounds which have a very different perspective on disability, particularly mental health. This is likely to present challenges for new migrants and for people with disabilities, as well as the host community, in achieving a non-disabling society in NZ. On the other hand, disability support services, particularly home-based support and rest homes, increasingly rely on new migrants (including Pacific and refugees) to fill gaps in the workforce. While this provides employment opportunities for new migrants, it presents challenges for disability service providers and clients, particularly in cultural understanding and communication between helper and client.</p>
<p>Recommendations</p>	<p>The development and implementation of the New Zealand Disability Strategy provides a model for a whole of government approach that may be worth looking at in providing a framework, strategic approach etc for the national and regional settlement strategies:</p> <ul style="list-style-type: none"> • The Disability Strategy was strongly advocated for by the disability sector, through the 1990s, particularly in Auckland, out of concern that while disability affected all aspects of life including employment, housing and social participation, the only government policy and service provision was through the Ministry of Health, with no reference to other sectors. • The NZ Disability Strategy is a 'whole of government' approach, overseen by a Minister for Disability Issues – not by the Minister of Health. This enables the Minister for Disability Issues to require some accountability from all government departments. It is backed up by an Office for the Disability Sector, within the Ministry of Social Development. • The NZDS requires all government departments to develop annual work plans that specify steps that each agency will take to implement the NZDS. Other agencies are also invited to submit annual work plans. At the end of each year, agencies are required to report on how well they have achieved their goals. The monitoring and reporting on the strategy is supported by the Office for Disability

	<p>Issues (www.odi.govt.nz). The Minister for Disability Issues reports to Parliament annually on progress as a legal requirement under the NZ Public Health and Disability Act 2000.</p> <ul style="list-style-type: none"> • Local Territorial Authorities are all being asked to look at how they can contribute to the NZDS. Both Auckland City and Manukau City Councils have policy and action plans. • A number of issues are similar to those identified in the consultation phase of the ARSS.
--	--

Disability Services: Study for a Disability Empowerment, Advocacy and Support Service (DEAS) for Refugees and New Settlers.

Name of study/health needs assessment/evaluation	Assured Directions (2003). <i>Feasibility Study for a Disability Empowerment, Advocacy and Support Service (DEAS) for Refugees and New Settlers</i> . Project Report to Ripple Trust: Auckland: Ripple Trust.
Conducted by	Assured Directions for Ripple Trust
Key Issues	<p>Results of focus group interviews</p> <ul style="list-style-type: none"> • Migrants with a disability have a double disability • Migrant women with a disability are particularly disadvantaged • There are no consequences for not complying with the New Zealand Health and Disability Strategy • Transport issues are a major problem • Although subsidies are available, taxis are not always a safe form of transport for disabled people • Advocacy is needed • Information is an essential need • Knowledge on legal matters is poor • Education options are poor for non-English speakers • Access to support within the tertiary education system is poor • “We need to know what’s there” (eg. Caregiver support, temporary respite, , medical support) • Poor knowledge of the needs assessment process within the group • Appropriate training of support staff is essential

	<ul style="list-style-type: none"> • Ideally services would be delivered by “disabled for disabled in government departments • A simple directory for disability support services would be helpful • Help is needed to make safe disclosure to employers regarding disability support needs • Access to special clubs for disabled • It is very difficult to relocate to more suitable accommodation when you want to. <p>Barriers to full community participation</p> <ul style="list-style-type: none"> • Discrimination and abuse towards disabled peoples from within communities originating from stigma, prejudice and ignorance • Information about disability services not easily available and able to be understood • Seriously restricted access to the labour market • Limited choice of services offering suitable support • The avoidance of mainstream services as a result of fear of various forms of institutional control • The avoidance of complex systems that are heavily bureaucratic • Inadequate public transportation
Recommendations	<ol style="list-style-type: none"> 1. There is a need for a regional coordinator/liaison positions in regard to refugee and migrant disability service provision, policy development , workforce development, and capacity building in disability NASCs and services 2. That culturally appropriate needs assessments tools and processes need to be developed for culturally and linguistically diverse peoples 3. Disability services workforce development is needed in relation to culturally competent care for families from refugee and migrant backgrounds

Family Violence: Improving particular communities responsiveness to family violence: combining research, programme development and evaluation.

Name of study/health needs assessment/ evaluation	Tse, S. (2005). <i>Improving particular communities responsiveness to family violence: combining research, programme development and evaluation</i> . Prepared for The Social Policy Evaluation and Research committee, Auckland UniServices Limited, University of Auckland.
Conducted by	Prepared for The Social Policy Evaluation and Research committee, Auckland UniServices Limited, University of Auckland.

<p>Key Issues</p>	<p>The study identified a range of factors, causes and triggers for family violence within New Zealand Asian communities. The key important issues are related to difficulties in adjusting to living in a new country, in particular, finding suitable employment and financial hardship. Men's dominance in some Asian families remains a concern, especially when men see control or abuse over their wives as a last resort to protect their cultural values and traditions. The power men hold over their immigrant wife's residency status, coupled with the racism and discrimination some women experienced in this study when they attempted to find paid jobs or solve their financial dependency issues, put women at extreme risk of abuse and violence.</p> <p>The effects of family violence on individuals are far reaching. In the case of the Asian immigrant communities, family violence impacts not only on immediate family members, relatives and parents in New Zealand, but also extended family members in their country of origin. The barriers in preventing or dealing with family violence in Asian communities are related to the perception that family violence is a private matter among Asian peoples, the women's desire to keep the marriage/relationship intact, absence of witnesses, and limited responsiveness and capacity within the Asian communities. On the other hand, the strengths and capacities in preventing and reducing family violence are found within individual women, the immediate neighbourhood, existing organisations and family violence services as a collective.</p> <p>The gaps and needs analysis focused on what is needed to prevent family violence, to provide effective crisis interventions and finally to help women or families return to communities. All these require concerted efforts across various government agencies and community organisations, for example, involving immigration services, police, legal services, social welfare services, employment agencies, education to improve immigrants' language skills, counselling and clinical services.</p>
<p>Recommendations</p>	<ol style="list-style-type: none"> 1. Cultural value can be used as the source of strength to empower victims to reduce/prevent family violence (Home Office Policing & Reducing Crime Unit, 2004). <ul style="list-style-type: none"> • For example, Indians and Chinese have strong family ties and individuals may have immediate and extended family and social support to help them through the crisis. • Family violence or its devastating impacts can be reduced, by dealing with the situation with the perpetrator through existing family ties. • Certain cultural and religious practices such as prayer can build strong spiritual relationships. Some South Asian peoples have strong cultural beliefs that emphasis faith and prayer. • The Asian community should stop "scapegoating" a sub-group of people (e.g. the lower socio-economic classes, the recent arrivals, individuals with less education) for the community's problems, be it family violence or poverty, for fear of eroding a community image that is perceived as good and desirable (Abraham, 2000). 2. Consider family violence in Asian communities as the product of multiple levels of influence on behaviours. <ul style="list-style-type: none"> • That is, at the level of the individual, family/relationships (e.g. strained by role reversal for men and women at home), institutional (e.g. traditional values & images about Asian women), community (the ethnic and host community) and the societal level (e.g. racism, employment difficulties among recent Asian immigrants) (Krug et al., 2002 cited in Fanslow,

	<p>2005).</p> <p>3. Violence towards Asian immigrant women and children has to be viewed in the context of post-immigration adjustment (Astbury et al., 2003).</p> <ul style="list-style-type: none"> The fundamental principle is one of resource development and community-grounded action that links the macro and micro levels in addressing issues of central importance to Asian immigrant women and families (Abraham, 2000). <p>4. Various cultural and religious sanctions for family violence among Asian peoples should be considered or challenged.</p> <ul style="list-style-type: none"> Traditional Asian cultural customs and practices have to be observed, but the perpetrators of violence still have to be held accountable. <p>5. Collaborative efforts should cover social services, health, justice, education, faith/religion, media, immigration, employment and government sectors, cutting across the individual, family/relationship, institutional, community and societal levels</p> <p>6. Mobilise effort within migrant communities themselves to fight against family violence.</p> <ul style="list-style-type: none"> Provide Asian women with information about their basic human rights, legal rights and access to support services so that they can develop the necessary skills to take preventive care or to escape violent situations
--	---

HIV services: HIV Futures New Zealand: Refugees section

Name of study/health needs assessment/evaluation	Grierson, J., Pitts, M., Whyte, M., Misson, S., Hughes, T., Saxton, P. & Thomas, M. (2002). <i>HIV Futures New Zealand: Refugees section</i> (pp. 97-105): Monograph Series Number 32. Melbourne, Australia: The Australian Research Centre in Sex, Health and Society, La Trobe University.
Conducted by	The Australian Research Centre in Sex, Health and Society, La Trobe University. In collaboration with the New Zealand AIDS Foundation, Body Positive, Positive Women and Refugee Health Education Programme
Key Issues	<p>SECTION 2: Refugees</p> <p><i>Pre- and Post- Test counselling</i></p> <p>We asked respondents if they had received pre- and/or post-test counselling at the time they tested positive, who provided this counselling and how satisfied they were with the information and support they received at the time.</p> <p>6.1% of refugees PLWHA indicated that they had received pre-test counselling.</p> <p>69.7% of respondents indicated that they had received post-test counselling.</p> <p><i>Experience of Health and General Well Being</i></p>

	<p>Around half the refugees (54.5%) rated their physical health as <i>good</i>. A further 21.2% rated their health as <i>fair</i>, and 24.2% as <i>excellent</i>. None of the refugees rated their health as being poor. Around half the refugees (51.5%) rated their well being as <i>good</i>. A further 27.3% rated their health as <i>fair</i> or <i>poor</i>, and 21.2% as <i>excellent</i>.</p> <p>Use of Antiretroviral Therapy When asked about their use of antiretrovirals, 60.6% of refugee PLWHA reported current use, 3.0% had used them in the past and 36.4% never having used them. Side effects were only reported by one refugee respondent currently using antiretrovirals.</p> <p>Treatment Most refugee respondents (84.8%) used an HIV specialist at an outpatient clinic for their main general medical treatment, while 9.1% used a GP with a high HIV caseload and 6.1% used a GP without a high HIV caseload. When asked about their main HIV-related treatment 90.6% said they saw an HIV specialist at an outpatient clinic, 6.3% saw a GP with a high HIV caseload and 3.1% saw a GP without a high HIV caseload. 87.5% of respondents said that the doctor they see for general medical services is the same doctor they see for HIV-related treatment. Of the four refugee respondents who see a different doctor, all said that that doctor knows their HIV status.</p> <p>Services Used in the Last Six Months We presented respondents with a list of services, both clinical and ancillary and asked which they had used in the last six months. Clinical services were the most utilised in the list with 90.6% using an HIV outpatient specialist and 28.1% using a GP with a high HIV caseload.</p> <p>Information about HIV management A similar pattern was reported for information on HIV management with the most common source again being an HIV specialist at an outpatient clinic (90.9%), followed by the Community AIDS Resource Team (48.5%) and a GP with a high HIV case load (39.4%).</p> <p>Information on living with HIV A somewhat different pattern emerged when respondents were asked about sources of information on living with HIV/AIDS. No single source of information was used by more than two of the refugee respondents.</p> <p>Publications Survey participants were asked which publications containing HIV information they read. Only 20.0% of refugee respondents read any HIV-related publications.</p> <p>WELL-BEING</p> <p>Contact With Other PLWHA Most of HIV positive refugees (60.6%) do not personally know anyone else with HIV, although 24.2% have either a positive partner or ex-partner and 18.2% of the refugees have a HIV positive friend. 15.2% of the refugees have been involved in the nursing or care of another positive person at some time in the last two years, and 18.8% have had someone close to them die from HIV/AIDS. Almost all the respondents (97.0%) spent no time with other HIV positive people.</p> <p>Relationships</p>
--	---

	<p>The refugee respondents were predominately (93.8%) heterosexual, but there was a small number of gay and bisexual men (6.2%). Most respondents (68.8%) had not had sex over the past 6 months, but 3.1% had had sex with casual partners only and 28.1% had been in a monogamous relationship. All but one of the respondents in relationships (88.9%) had told their partner of their HIV status, and all of those with negative partners always used condoms during anal and vaginal sex.</p> <p>Disclosure Respondents were asked to whom they had disclosed their HIV status. Respondents had most commonly told their partners or spouses of their HIV status (55%, 77.8% of those in relationships). Relatively few of the refugees had told other people of their status.</p> <p>Social Support We asked participants about the amount of social support they received from a range of sources including household members, social contacts and service providers. The source that participants were most likely to rate as one that they receive <i>a lot</i> of support from was the participant's doctor (93.9%). This was followed by partners, where 37% of those with partners rated them highly, and religious or spiritual advisers, where 36% of those with these rated them highly. 39.4% of respondents had access to a car. When asked how easy it was to access public transportation, 15.6% said it was very difficult, 9.4%, difficult, 59.4% easy and 15.6% very easy. Less than half (46.9%) of the refugees stated that their accommodation was suitable for their current needs. Of those who said their accommodation was unsuitable (N=17), the main reasons given were that it lacked privacy (47.1%), was too expensive (29.4%), in poor condition (29.4%) and was too small (29.4%).</p> <p>Employment Employment Status When asked about their employment situation refugees most commonly reported that they were unemployed (42.4%), followed by having part-time work (21.2%), being a student (21.2%), being in full time work (12.1%) and being retired or not working (3.0%).</p> <p>Finances Income Refugees most commonly reported having benefits or pensions as their main source of income (75.8%), followed by salary (21.2%) and other sources of income (3.0%).</p> <p>Poverty 62.5% of refugees were living below the poverty line.</p>
Recommendations	

Regional Studies: Waikato: Mental Health Issues for Asians in New Zealand: A Literature Review

Name of study/health needs assessment/evaluation	Ho, E.S. Guerin, P.B. Cooper, J. & Guerin, B. (2005). <i>The Public Health Needs of Waikato Migrants and Refugees</i> . Hamilton: University of Waikato
Conducted by	Migration Research Group, University of Waikato
Key Issues	<p>Priority areas For migrant and refugee primary health care</p> <ul style="list-style-type: none"> • Mental health • Women's health <ul style="list-style-type: none"> - Maternity - Reproductive / sexual health • Youth and children • Oral health <p>Health System</p> <ul style="list-style-type: none"> • Access to the health system <ul style="list-style-type: none"> -Culturally appropriate services -Relationship building between cultures -Education of health professionals -Multi-language interpretation -Health promotion in communities -Information resource centre • Holistic approach to health and well being: include determinants of health which underpin health issues, for example, transport, employment, education, income, housing

	<p>Service Gaps For migrant and refugee primary health care</p> <ul style="list-style-type: none"> • Interpreting • Mental health • Specific services for migrants and refugees • Traditional medicine • Oral health care <p>Health System</p> <ul style="list-style-type: none"> • Collaboration, co-ordination and relationship building <ul style="list-style-type: none"> -between health providers, funders, key stakeholders and communities-migrant and refugee community input into development of health programmes -between key stakeholders, funders and health providers Regular forums, knowledge sharing • Professional development for health professionals <ul style="list-style-type: none"> -information and knowledge sharing about backgrounds of migrants and refugees -continuing education -Train hospital staff how to use interpreters Consideration of the role of interpreters, i.e. professional level, advocacy -Protocols for accessing communities • Health services <ul style="list-style-type: none"> -culturally appropriate -counteract stereotyping, both in the local community and health services -health promotion in communities -advocacy • Dedicated portfolio for migrant and refugee health and well being
	<ul style="list-style-type: none"> • Collaboration between agencies and communities <ul style="list-style-type: none"> -develop service initiatives –evaluation of service-ask the clients as well as the providers -support migrant communities to develop their own services -improve communication between health providers and resettlement agency • Funding for interpreting <ul style="list-style-type: none"> -career path for interpreters

	<ul style="list-style-type: none"> -more training for interpreters <ul style="list-style-type: none"> • Ongoing information and support for health professionals -Professional development and training <ul style="list-style-type: none"> • Dedicated health coordinator • Improve data collection
--	--

Regional Studies: Wellington and Napier: Understanding the Health Needs of Refugees

Name of study/health needs assessment/ evaluation	Wellington Regional Public Health (October, 2005). <i>Understanding the Health Needs of Refugees</i> . Wellington: Wellington Regional Public Health
Conducted by	Wellington Regional Public Health
Key Issues	<p>Key Findings</p> <ul style="list-style-type: none"> • The most common health issues raised were physical (dental and women's health) and mental health • Other issues were isolation, discrimination, cost of health services, transport and low use or lack of interpreters • Suggested solutions included improved linking between providers and refugees to increase understanding of each other and how the health system works • Lack of funding for primary health care services that have refugee clients • Increased cultural awareness among all the agencies <p><u>Napier Findings</u></p> <ul style="list-style-type: none"> • No specialised mental health service e.g. Refugees As Survivors • The only English language centre has closed – this impacts on prospects for future employment • Recommended inclusion of driving lessons at MRRC so refugees are more independent on settling in Napier as they can already drive

	<p>Public Health Nurses – School Based Programme</p> <p>Key Findings</p> <ul style="list-style-type: none"> • 80% of respondents reported an average to high degree of contact with refugees • Reasons for contact were for physical health, psychological reasons, hearing and vision screening and immunisation • Barriers to working with refugee communities were cultural understanding and language • Support and information is needed in different languages and access to interpreters for staff <p>Regional Public Health – Health Promotion and Health Protection Co-ordinators</p> <p>Key Findings</p> <ul style="list-style-type: none"> • 75% of respondents reported not having worked with refugees in the last twelve months • 25% had assisted with the development of health education resources e.g. oral health and nutrition • 33% have planned activities with refugees included in their operational plans in the next twelve months while 67% have none • The barriers identified when working with refugee communities are resources, appropriate staff and limited funding (contracts) • Communication difficulties with and understanding of the refugee communities <p>Primary Health Care Providers</p> <p>Key Findings</p> <ul style="list-style-type: none"> • The provision of and a commitment to provide health services for refugee communities was seen as a positive initiative • Cost of services including dental care was a barrier • Cultural knowledge of communities, language and interpreter availability was limited • Lack of appropriate speciality services e.g. women’s health, mental health • Over stretched health services and a lack of awareness by providers of funding that may be available • Wider use of community workers would be beneficial • Networking and sharing of information between providers and refugee communities is important
--	--

<p>Recommendations</p>	<p>Goal 1 To facilitate a review of refugee demographic and health data used by DHB's for health planning and analysis</p> <ul style="list-style-type: none"> • Work with the DHB's funding and planning units and key stakeholders to investigate the review of this <p>Goal 2 To work closely with the PHO's on advocating for appropriate services for refugee clients</p> <ul style="list-style-type: none"> • Work with practice managers in primary care addressing identified health needs • Work with identified PHO's on interpreter policy development • Advocate for refugee representation on PHO's <p>Goal 3 To improve interagency and community collaboration on refugee health and wellbeing</p> <p>Approach the MOH for funding support to establish a full time position for a refugee project worker to:</p> <ul style="list-style-type: none"> • Assist with the implementation of the recommendations made in this report • Facilitate the formation of the regional intersectoral refugee health and wellbeing action plan and assist with the implementation of the recommendations of this plan as it relates to the health sector • Maintain and enhance the network between providers and community representatives and ensure information is shared amongst them • Where funding becomes available, work with key stakeholders to allocate it to suitable projects and initiatives • Contribute to the strategic planning activities of DHBs as they relate to refugee health. <p>Goal 4 To work with Regional Public Health teams to improve responsiveness to refugee health needs</p> <p>Recommendation</p> <ul style="list-style-type: none"> • Work with team leaders and co-ordinators to develop appropriate strategies in key areas • Have refugee health needs recognised in operational plans • Set priorities for nutrition and physical activity, mental health promotion, smokefree and infectious disease prevention • Advocate on housing, employment and education issues • Work with RPH staff to up-skill on the health and well being needs of refugees and cultural issues • Work with school PHN's and hearing and vision technicians on refugee personal health needs and cultural issues <p>Goal 5</p>
-------------------------------	---

	<p>To work with women's health services to improve responsiveness to the health needs of refugee women</p> <ul style="list-style-type: none"> • Meet with screening services (breast and cervical) to discuss screening and refugee women • Facilitate meeting with senior managers/clinicians and refugee women to identify and discuss issues • Provide training for staff on refugee resettlement and refugee women's health issues
--	--

National Studies: Asian Public Health Project Report

<p>Name of study/health needs assessment/evaluation</p>	<p>Asian Public Health Project Team (February, 2003). <i>Asian Public Health Project Report</i>. Auckland: Asian Public Health Project Team</p>
<p>Conducted by</p>	<p>Compiled by the Asian Public Health Project Team to assess Asian public health needs for the Auckland region.</p>
<p>Key Issues</p>	<p>Recommendations The Asian Public Health Project team recommends:</p> <p>1. Funding recommendations</p> <p><i>i. Public health</i></p> <p>1.1 That the Ministry of Health, District Health Boards and providers ensure that core public health services address the needs of Asian populations, including cultural training for staff, and development of appropriate resources in consultation with Asian communities.</p> <p>1.2 That the Ministry of Health amongst others, funds the ongoing development of Asian community organisation/s that can provide mainstream organisations with assistance on cultural input into programme design and delivery around public health issues.</p> <p>1.3 That the Ministry of Health funds advocacy around Asian public health issues.</p> <p>1.4 That the Ministry of Health maintains the Asian Public Health Project Team (or similar community partnership) for at least one year to assist with planning, implementation and monitoring the recommendations outlined in this report.</p> <p><i>ii. Personal health services</i></p> <p>1.5 That health funders and other government agencies ensure there is adequate funding of interpreters, appropriate health education resources (including translations) and culturally appropriate services for Asian populations.</p>

	<p>1.6 That health funders fund initiatives and programmes that add value to the information already provided by the Department of Internal Affairs (for new migrants) to ensure that Asian populations are fully aware of and understand the New Zealand health system, their health entitlements, and their health rights.</p> <p>2. Policy recommendations</p> <p>That the Asian Public Health Project Team and the Asian Network advocate for:</p> <p>2.1 central government agencies, local government authorities and District Health Boards to include the Asian population in policy development, include Asian communities in appropriate consultation processes and ensure Asian community representation in decision-making processes</p> <p>2.2 central government agencies and other national organisations to acknowledge New Zealand’s regional differences (eg, high percentage of Asian peoples in Auckland) within national planning</p> <p>2.3 immigration policy to include well resourced and supported settlement policies that are integrated with other policies (eg, education, employment, housing and Asian health professional recruitment and registration)</p> <p>2.4 social policy (eg, housing, employment, education, immigration, child, youth and family, local government) to be inclusive of Asian populations and to align with immigration policy</p> <p>2.5 government strategies to include targeted interventions for Asian populations (eg, the New Zealand Injury Prevention Strategy, the Responsible Gambling Bill)</p> <p>2.6 the category .Other. used in data collection and reporting by agencies to be disaggregated into identifiable ethnic minority groupings (eg, an overall Asian category based on the census definition)</p> <p>2.7 relevant government organisations (eg, the Office of Ethnic Affairs) to be mandated to carry out regular monitoring, evaluation and auditing of policies to determine appropriate reference to the Asian communities within New Zealand (Note: This role is in line with similar roles carried out by Te Puni Kokiri and the Ministry of Pacific Island Affairs).</p> <p>3. Health services recommendations</p> <p>That the Asian Public Health Project Team and the Asian Network advocate for:</p> <p>3.1 District Health Boards and other health service providers to deliver services that are more responsive, accessible and culturally-appropriate for Asian populations</p> <p>3.2 health service staff to have access to resources and interpreters in key Asian languages</p> <p>3.3 health service providers to develop outreach programmes to improve access to diverse communities</p> <p>3.4 the Ministry of Health, District Health Boards and health services to commence service planning to address the future needs of an increasing Asian population that could reach 20 percent of the overall Auckland population by 2021</p> <p>3.5 mainstream health services to develop services that are inclusive of Asian populations</p> <p>3.6 government agencies and non-government organisations to work to raise the awareness of providers around priorities and service delivery issues relating to Asian populations</p> <p>3.7 health services to utilise the expertise of community leaders to access Asian communities and to deliver health promotion programmes.</p> <p>4. Community development and community action recommendations</p>
--	--

	<p>That the Asian Public Health Project Team and the Asian Network support:</p> <p>4.1 the Asian community to develop appropriate community structures (eg, the development of the Asian Network in Auckland) to promote and advocate for Asian health and wellbeing (eg, encourage mainstream services to be more inclusive of Asian populations)</p> <p>4.2 the Ministry of Health, District Health Boards and other health services to provide opportunities and funding for Asian communities to mobilise themselves around health issues</p> <p>4.3 the Auckland Regional Public Health Service to develop and disseminate a directory of Asian health services, information on the health system and access to relevant health information and resources (eg, development of a central information mechanism including a website) to Asian communities in the Auckland region.</p> <p>5. Health workforce recommendations</p> <p>That the Asian Public Health Project Team and the Asian Network advocate for:</p> <p>5.1 the Ministry of Health and District Health Boards to encourage mainstream public health providers to recruit and support staff to fully reflect the ethnicity of the populations they serve</p> <p>5.2 all health providers to ensure management and staff have a high level of cultural sensitivity and awareness around Asian issues. This might include:</p> <ul style="list-style-type: none"> • on-the-job training • Asian cultural awareness training and workforce development programmes (including undergraduate health professional training) • access to appropriate cultural expertise • the development of multi-cultural teams <p>5.3 central government agencies and District Health Boards to develop policy and programmes to facilitate both recruitment of more Asian health professionals and assistance for health professionals from Asia to gain registration or re-training.</p> <p>6. Research recommendations</p> <p>That the Asian Public Health Project Team and the Asian Network advocate for:</p> <p>6.1 central government agencies to establish a consistent definition of the Asian ethnicity categories based on the census definition for use in data collection by various agencies</p> <p>6.2 central government agencies and District Health Boards to commence ongoing data collection (especially New Zealand Health Information Statistics, but also other data sets) and reporting using an Asian population category (as opposed to the currently often used .Other.category) at national, regional and district levels</p> <p>6.3 research funders and researchers to establish an ongoing research programme relating to Asian health status and gaps in services - the research should:</p> <ul style="list-style-type: none"> • focus on established priorities, such as mental health, lifestyle factors that lead to heart disease and diabetes, and sexual and reproductive health • establish a mechanism to co-ordinate Asian population research.
--	--

	<ul style="list-style-type: none"> • encourage the compilation and dissemination of available research • foster integration of evaluation, research and practice <p>6.4 central government agencies to establish reporting on inequalities in health and socioeconomic status (eg, NZDEP . scale of deprivation) in Asian populations</p> <p>6.5 research funders to consider research that investigates the role of traditional Asian medicines in New Zealand.</p>
Recommendations	<p><i>Conclusions from community consultation meetings and key informant interviews</i></p> <p>Both the community consultations and key informant interviews identified</p> <ul style="list-style-type: none"> • mental health as a leading public health issue. This was related to the migration process and the requirements to adapt to a new country. • heart disease, high blood pressure and diabetes. • Sexual health was identified as an area of concern, particularly the perceived increase in sexually transmitted diseases and unwanted pregnancies. • Many participants in the consultation meetings commented that language and cultural barriers are the biggest obstacles to better utilisation of health services. • The Asian community and the key informants are keen to effect changes to improve the health of their community. • Participants at the consultation meetings commented that education is the most essential component of the solution. Education needs to delivered in a culturally-appropriate manner, rather than in simple language translations. • <i>Workforce development:</i> Participants at the consultation workshops and key informants felt that there was a need to recruit and train more Asian health professionals. Participants at the consultation workshops also advocated that mainstream health professionals need to be trained on Asian cultural perspectives to improve communication with Asian patients.

National Studies: Asian Health Chart Book

Name of study/health needs assessment/ evaluation	Ministry of Health. 2006. <i>Asian Health Chart Book 2006</i> . Wellington: Ministry of Health.
--	---

Conducted by	Public Health Intelligence Monitoring Report No 4
Key Issues	<p>Infants and children 0-14 years</p> <p>Infant mortality is significantly lower in Chinese and Other Asian ethnic groups than in the total population.</p> <ul style="list-style-type: none"> • Chinese and Other Asian infants have a significantly lower neonatal mortality rate than the total population. • Chinese infants also have a significantly lower post-neonatal mortality rate than the New Zealand average. • Low birthweight is significantly less prevalent among Chinese newborns than the total population, while Indian newborns are at significantly higher risk of low birthweight than the total population (using the conventional cut-point of 2500 grams). • Chinese, Indian and Other Asian children are less likely to be hospitalised for an unintentional injury than the total population. • Indian boys are 1.5 times more likely to be hospitalised for asthma than the total population, while Chinese and Other Asian children are significantly less likely to be hospitalised for this condition. <p>Young people (15--24 years)</p> <p>The health indicators selected for young people include intentional self-harm and suicide, road traffic injury and fertility – the major health problems faced by young people.</p> <ul style="list-style-type: none"> • Chinese and Other Asian youth have significantly lower intentional injury hospitalisation rates than the total population, while Indian female youth have a higher rate than the total population. • Chinese and Other Asian male youth have significantly lower suicide mortality rates than the total population. • Youth road traffic injury hospitalisation rates for all Asian ethnic groups are significantly lower than the all New Zealand average. • In the 15 to 19 years age group, Asian females have significantly lower birth rates than the total population. <p>Adults (25+ years)</p> <p>The indicators selected for this section focus on the key health issues facing adults, including: cardiovascular diseases, diabetes, cancer and injuries from falls.</p> <ul style="list-style-type: none"> • Indian males and females have significantly higher cardiovascular disease hospitalisation and mortality rates than the total population. • There is a dose-response relationship between duration of residence in New Zealand and cardiovascular disease mortality for the Asian ethnicity groups. • Ischaemic heart disease hospitalisation is significantly higher for Indian males and females across all age groups than the total population. • Ischaemic heart disease mortality is significantly higher in Indian females than in their Chinese and Other Asian counterparts. • Overall, stroke hospitalisation and mortality are lower for Chinese than for the total population, while Indian and Other Asian have higher stroke hospitalisation than the total population.

	<ul style="list-style-type: none"> • The prevalence of self-reported diabetes is over three times higher for Indian people than for the total population. • Overall, cancer registrations and mortality rates are lower for all Asian ethnic groups than for the total population. This applies both to lung cancer (a proxy for tobacco attributable cancers) and non-lung cancer. • Female breast cancer registrations and mortality are lower for all Asian ethnic groups than for the total population. • Stomach cancer registrations are higher for Chinese females and Other Asian males than for the total population. <p>Health services utilisation</p> <p>The indicators in this section focus on utilisation of primary health care and clinical preventive services.</p> <ul style="list-style-type: none"> • Among the Asian ethnic groups, Chinese are less likely than New Zealand Europeans to have a usual carer (after controlling for age, sex, deprivation and duration of residence in New Zealand). • All Asian ethnic groups are significantly less likely to have been to a doctor or a dentist in the last 12 months than New Zealand Europeans (after controlling for age, sex and deprivation). • All Asian ethnic groups are less likely to have seen a complementary/alternative provider than the New Zealand Europeans (after controlling for age and deprivation). • Women of all Asian ethnic groups have lower mammography screening uptake than New Zealand European women, but the differences are not statistically significant (perhaps reflecting relatively small numbers). • All of the Asian ethnic groups have a lower rate of cervical screening than New Zealand European women. • Indians are more likely to have had a cholesterol test than New Zealand Europeans. • Indians are also more likely to report having been tested for diabetes than the total population. <p>Risk and protective factors</p> <p>The indicators selected in this section focus on key biological risk factors and key lifestyle behaviours, including: high blood cholesterol, high blood pressure, body weight, physical activity, dietary pattern and tobacco use.</p> <ul style="list-style-type: none"> • After controlling for age, sex, deprivation and Asian ethnicity, longer duration of residence of Asian New Zealanders is significantly related to the likelihood of self reporting high blood cholesterol and high blood pressure. • Indians appear to have a higher prevalence of obesity than New Zealand Europeans after controlling for age, sex and deprivation. • Chinese, followed by Other Asian and Indian ethnic groups, have a significantly lower prevalence of hazardous alcohol consumption than the total population. • All Asian females are significantly less likely to be current smokers than European females (controlling for age, deprivation and duration of residence in New Zealand). • Chinese and Other Asian females are significantly less likely to participate in at least 150 minutes of physical activity per week than their total population counterparts. • Indians and Other Asians appear less likely to consume the recommended intake of fruit and vegetables than Europeans (controlling for age, sex and deprivation).
--	---

	<p>Socioeconomic determinants</p> <ul style="list-style-type: none"> • Asian New Zealanders are more likely to have higher educational qualifications than the all New Zealand average. • Incomes of Asian New Zealanders are lower than those of the total population. • Overall, the unemployment rate of Asian New Zealanders is higher than the all New Zealand average. • Asian New Zealanders are less likely than average to own their own homes. • English-language competence is an issue for some Chinese and Other Asians, but generally not for Indians. • The deprivation distribution of Asian New Zealanders does not differ substantively from that of the population as a whole.
<p>Recommendations</p>	<p>Conclusion</p> <ul style="list-style-type: none"> • This report reveals major differences in health outcomes and exposure to health hazards between the Chinese and Indian ethnic groups, with 'Other Asians' generally intermediate. Positive health outcomes are shown in a range of health indicators for the Asian ethnic groups, especially the Chinese ethnic group, compared to the total New Zealand population. • On the other hand, the relatively high rate of obesity, type 2 diabetes and cardiovascular disease among the Indian ethnic group is concerning. • The report also reveals major differences in health and health service use between recent migrants and established communities, similar for all three Asian ethnic groups. For almost all health indicators, recent or first-generation migrants do better than long-standing migrants or the New Zealand born. This is believed to largely reflect a healthy migrant effect (ie, health selection). Over time, this health advantage is likely to dissipate, as the selection effect wears off and acculturation progresses. The relatively low utilisation of health services by Asian peoples, particularly recent migrants, will need to be carefully monitored.

Asian, Refugee and Migrant Mental Health

Mental Health: Mental Health Issues for Asians in New Zealand: A Literature Review

<p>Name of study/health needs assessment/evaluation</p>	<p>Ho, E., Au, S. Bedford, C. & Cooper, J. (May, 2003). <i>Mental Health Issues for Asians in New Zealand: A Literature Review</i>. Prepared for Mental Health Commission. Migration Research Group, Department of Geography, University of Waikato</p>
<p>Conducted by</p>	<p>Prepared for Mental Health Commission. Migration Research Group, Department of Geography, University of Waikato</p>

<p>Key Issues</p>	<p><i>Mental Health Commission's identification of research limitations on mental health of migrants from diverse cultural and language backgrounds</i></p> <p>The Mental Health Commission's literature review points out the limitations of current research on the mental health of migrants from diverse cultural and language backgrounds including:</p> <ul style="list-style-type: none"> • within New Zealand most research has focused on recent immigrants and has involved Chinese, and to a lesser extent Koreans and Indians, while the research on refugees has focused on Cambodians; • prevalence studies. Because of the relatively small and rapidly changing population it is difficult to obtain representative samples. • overseas studies (and the limited New Zealand research available) indicate particular mental health problems associated with particular migration experiences. For example, high rates of depression among older Chinese migrants; post-traumatic stress disorder among Cambodian refugees; loneliness among students. • High-risk groups requiring further research include women, students, older people and refugees. <p>In spite of these limitations, the review recommends the following strategies as a useful starting point for working with other organisations that impact on the mental health of Asian communities and for developing mental health services to better meet their mental health needs to:</p> <ul style="list-style-type: none"> • promote mental health in Asian Communities; • improve cultural responsiveness in Mental Health Services.
<p>Recommendations</p>	<p>Recommendations for Promoting Mental Health in Asian Communities</p> <ul style="list-style-type: none"> • <u>Increase public support for cultural diversity</u> <p>Among the many factors determining whether migration will be a negative or positive experience, host societies' receptivity towards newcomers and their tolerance for cultural diversity are among the most important. Public education is useful to improve receptivity by increasing awareness of the benefits of cultural diversity and the contributions of people from different ethnic and cultural backgrounds to New Zealand society. Public support for cultural diversity can be promoted in school and university curricula, in work settings as well as in the media.</p> <ul style="list-style-type: none"> • <u>Provide extensive information before and after migration</u> <p>Access to information and support networks is a vital part of the settlement process. Providing information to increase the newcomers' knowledge of the resources and opportunities in the host society before and after migration will help them have a more realistic outlook and expectation, which in turn will improve their participation in New Zealand society. Topics addressed should include employment, housing,</p>

	<p>schooling, language training, and social and cultural relations.</p> <ul style="list-style-type: none"> • <u>Improve access to English language education</u> <p>Inability to speak the language of the host country is a major factor affecting the mental health of newcomers. Besides the isolation and loneliness it imposes, a lack of proficiency in the English language is also a barrier to utilisation of mainstream services in various areas. Mastering a local language and understanding native ways of life through language courses translate into empowerment for the newcomers. They will be more confident and find life as more comprehensible, manageable and meaningful. It will also enhance their opportunities in employment and higher education, thereby facilitating their full and equal participation in the New Zealand society.</p> <ul style="list-style-type: none"> • <u>Encourage and support the development of community support programmes</u> <p>Social isolation is a taxing problem for newcomers. The provision of practical assistance in housing, transportation and employment at the time of arrival will have long lasting effects on their mental well-being. Community support programmes should also be developed to help those with less potential to participate in the host society (such as women, youth and older people) to have contacts with people from the same culture, thereby forming a supportive subculture for better social interaction and mutual support. In addition, ethnic communities are important sources of social support for newcomers. They help members maintain pride and cultural identity, which can also facilitate their integration with the dominant society.</p> <p>In view of the lack of local research regarding the particular needs of Asian ethnic groups, ethnic organisations and community services agencies that have daily contacts with Asian migrants should be encouraged to assist in research to provide relevant information to policy makers and service providers to improve understanding of the needs and problems of particular migrant/ethnic groups.</p> <p>Recommendations for Improving Cultural Responsiveness in Mental Health Services</p> <ul style="list-style-type: none"> • <u>Promote the development of educational materials and professional interpreter services</u> <p>Stigma is a major obstacle preventing Asians from using mainstream mental health services. Public education is one way to promote the appropriate use of mental health services by Asians. Because language is a major barrier confronting Asian people, translations of culturally appropriate materials are necessary to increase understanding of mental disorders and mental health problems, to help counter traditionally held feelings of shame and guilt about mental illness in the family, and to promote earlier help seeking. Ethnic press, radio and television outlets, as well as the church and other valued agencies in ethnic communities, should be used to disseminate information.</p> <p>There is also a need to improve professional interpreter services. It is necessary to train interpreters for each ethnic group. The interpreters should have an adequate awareness and understanding of the cultural backgrounds and mental health situation in their communities.</p> <ul style="list-style-type: none"> • <u>Increase service providers' awareness of Asian cultural issues</u> <p>It is essential that the formal mental health care system becomes more responsive to the needs of the Asian communities. Health care providers can deal with their clients more competently if they are knowledgeable of their clients' cultural beliefs, their interpretation of mental illness and mental well being, their help seeking patterns and choice of traditional alternative health practices.</p>
--	---

	<p>High-Risk Groups for Further Research</p> <ul style="list-style-type: none"> • <u>Women</u> Studies of Asian immigrant and refugee women in New Zealand are very limited. However, in the international literature, many immigrant and refugee women are found to be in high-risk situations. While learning the skills of housekeeping and child-rearing in a new cultural system is already a demanding task, many immigrant and refugee women are also forced to seek jobs in order to help support the family financially. For many, lack of English language proficiency creates problems when seeking employment. This often results in women accepting unskilled jobs at the lowest level of the labour market which, in turn, limits the development of their English skills. There is also a need to assess the mental health needs of women from smaller ethnic communities. Many are likely to suffer intense social isolation because migration has cut up their traditional sources of support and the lack of English language ability has deepened their dependence on children and relatives. In addition, lack of a local ethnic community delays opportunities for them to develop support networks. • <u>Students</u> Research to establish the extent of mental health needs among immigrant and fee-paying students from Asian countries is much needed. The various stressors faced by Asian students, such as language barriers, acculturative stress and the lack of social support networks, place them at risk for emotional and behavioural problems. There is a need for further research, in particular, into the social and cultural integration issues Asian students face outside the classroom. This kind of research will provide information that can assist with the development of programmes to promote better understanding, participation and cooperation of both newcomers and members of the dominant society. • <u>Older people</u> There has been very little local research conducted on older migrants and refugees, their mental health needs and utilisation of mental health services. There is however evidence in the international literature that depression is a major psychological problem that affects older people. Elderly Asians are particularly vulnerable because of their poor English language skills, small emotional support networks and limited involvement outside the home. Many have often experienced loneliness, isolation, anxiety, and a feeling of being marginalised by the host society. Some also feel distressed by their adult children's and grandchildren's rapid acculturation to the new society, and apparent lack of respect. With the growth of the aged population in Asian ethnic groups, there is a need to pay special attention to the problems and mental health needs of older people within the Asian population. Many elderly Asians encounter great difficulties gaining access to mental health services. Research which can provide information to remove barriers to access and make services more effective should receive priority attention. • <u>Refugees</u> Studies have consistently shown that refugees are at particular risk for depression and post-traumatic stress disorder, because of pre-migration traumas and the post-migration stressors of adapting and living in a new culture. Refugee youth is a special needs group within this high-risk group. In the international literature, it has been suggested that refugee youth experience elevated mental health risk because of language difficulties, identity conflict, racism, and rejection by the labour market. Recently, a report from the refugee NGO groups also drew special attention to the vulnerability of this group, and their special needs for services.
--	--

	Refugees from smaller ethnic groups are also vulnerable. To date, New Zealand research on Asian refugees has been focused on the Cambodians, and to a lesser extent, Vietnamese and Laotians. Those from smaller communities of Sri Lanka, Myanmar, and Indonesia are not represented in the literature. Refugees from smaller ethnic groups often experience added difficulties in the resettlement process, as they do not have as much access to their own community support networks and are therefore subject to higher degrees of isolation.
--	--

Research Agenda: Mental Health and Addiction Research Priorities for Asian, Refugee and Migrant Populations in New Zealand 2008-2012.

Name of study/health needs assessment/evaluation	Chen J & Long J, 2008. Research Agenda: Mental Health and Addiction Research Priorities for Asian, Refugee and Migrant Populations in New Zealand 2008-2012. Te Pou, The National Centre of Mental Health Research, Information and Workforce Development. Available from: www.tepou.co.nz
Conducted by	Chen J & Long J. Te Pou, The National Centre of Mental Health Research, Information and Workforce Development. www.tepou.co.nz
Key issues	Asian, refugee and migrant communities and the mental health and addiction sector were engaged in the development of a national research agenda. Research involving intersectoral and community collaboration can work to enhance service responsiveness, achieve positive health outcomes, and contribute to mental health and wellbeing. The objective of the study was to encourage and facilitate research with ethnic and migrant communities and to coordinate research publication and information-sharing.
Recommendations	It is recommended that in the next 3-5 years: <ul style="list-style-type: none"> • The Ministry of Health allocate research funding for the implementation of top research priorities identified for Asian, refugee and migrant populations • academic, government (including DHBs and PHOs) and NGO agencies explore strategic alliances and funding partnerships to implement top research priorities identified for Asian, refugee and migrant populations • Te Pou work with overseas and New Zealand academic/research centres to: <ul style="list-style-type: none"> ▪ encourage and facilitate research with ethnic and migrant communities ▪ undertake collaborative research locally and internationally ▪ build national research capacity ▪ coordinate research publication and information-sharing • A national policy and strategy for Asian, refugee and migrant populations be developed and implemented in New Zealand

--	--

Asian Health: Asian Health in Aotearoa: An analysis of the 2002/03 New Zealand Health Survey

Name of study/health needs assessment/evaluation	Scragg, R. & Maitra, A. (September, 2005). <i>Asian Health in Aotearoa: An analysis of the 2002/03 New Zealand Health Survey</i> . Study commissioned by The Asian Network Inc (TANI). Available from: www.asianhealth.govt.nz
Conducted by	Scragg, R. & Maitra, A. Epidemiology and Biostatistics School of Population Health University of Auckland
Key issues	<p>Socio-demographic variables</p> <p>1. <i>Age</i></p> <ul style="list-style-type: none"> • Asian people have a similar age-distribution to Maori and Pacific, but are younger (on average) than Europeans. • South Asians are older (on average) than Chinese, South-East Asians and Koreans <p>2. <i>New Zealand Born</i></p> <ul style="list-style-type: none"> • Asian people are less likely to have been born in New Zealand compared with other New Zealanders, with nearly half arriving in New Zealand within the last 5 years. <p>3. <i>Housing</i></p> <ul style="list-style-type: none"> • Nearly all Asian people (99%) live in urban areas. • Asian people (31%) are more likely to live in most deprived (lowest NZDep2001 quintile) areas than Europeans (13%), although less likely than Maori (43%) and Pacific (66%). • South Asians (38%) were more likely to live in the lowest NZDep01 quintile areas than other Asian people. <p>4. <i>Education, Occupation & Income</i></p> <ul style="list-style-type: none"> • Asian people (35%) are more likely to have a university degree than all New Zealanders (15%). • Asian people (47%) are less likely to have a paid job than all New Zealanders (65%). • Asian people (25%) are less likely to receive government income support than all New Zealanders (38%). • Asian people (20%) are more likely to live in a low income household (<\$15,000 annually) than other New Zealanders (12%). <p>Lifestyle</p>

	<p>1. <i>Physical activity</i></p> <ul style="list-style-type: none"> • Asian people are less likely to be physically active than other New Zealanders. • South Asian women are less likely to be physically active than other Asian women. <p>2. <i>Fruit and Vegetables</i></p> <ul style="list-style-type: none"> • Asian people have a similar fruit and vegetable intake to Maori and Pacific, but lower than Europeans. <p>3. <i>Alcohol</i></p> <ul style="list-style-type: none"> • Asian people are less likely to drink alcohol, and less likely to binge drink, than other New Zealanders. • South-East Asian men are more likely to binge drink than other Asian men. <p>4. <i>Tobacco</i></p> <ul style="list-style-type: none"> • Asian people are less likely to smoke tobacco than other New Zealanders. • South-East Asians were more likely to allow smoking inside their homes than other Asian people. <p>5. <i>Cannabis</i></p> <ul style="list-style-type: none"> • Asians people are less likely to use cannabis than other New Zealanders. • South-East Asian men were more likely to use cannabis than other Asian men. <p>6. <i>Gambling</i></p> <ul style="list-style-type: none"> • Asian people were less likely to gamble than other New Zealanders. • Chinese were more likely to gamble at a casino than other Asian people. <p>7. <i>Obesity</i></p> <ul style="list-style-type: none"> • Asian people are less likely to be overweight and obese than other New Zealanders • South-Asians are more likely to be overweight and obese than other Asian people. <p>8. <i>Lifestyle & Years in New Zealand</i></p> <ul style="list-style-type: none"> • Increasing time living in New Zealand was associated with increased consumption of alcohol and cannabis among Asian people. <p>Chronic Disease</p> <p>1. <i>Cardiovascular Disease & Diabetes</i></p> <ul style="list-style-type: none"> • Asian people have a similar prevalence of treated high cholesterol compared to other New Zealanders, but reported a significantly lower prevalence of heart disease than other New Zealanders (5% v. 8%). • The prevalence of diabetes was higher among Asians than Europeans (8% vs.3%). • South Asians have a higher prevalence of treated high cholesterol (12%) and diabetes (14%) compared with other Asian people. <p>2 <i>Other Chronic diseases</i></p> <ul style="list-style-type: none"> • The prevalences of asthma (5% vs.14%), neck and back disorder (14% v. 24%), cancer (3% v. 6%) and other long term illness (17% v. 23%) were significantly lower among Asian people in comparison with the national prevalence. • South Asians have a higher prevalence of asthma (16%) than other Asian people.
--	--

	<ul style="list-style-type: none"> • Koreans have a lower prevalence of arthritis than other Asian people. <p>Access to Health Care</p> <p><i>1. Type of practitioner consulted</i></p> <ul style="list-style-type: none"> • Asian people (81%) were less likely to have visited a health practitioner (or service) when they were first unwell than other New Zealanders (93%). • 12% of Asian people visited an alternative health care provider for their own health in the last 12 months. • Among people with chronic disease, Asian people were less likely than Europeans to visit a health practitioner in the last 12 months. • Asian women were less likely to have had a mammography or cervical screening test in the last three years than other New Zealand women. <p><i>2. Reasons for visiting General Practitioner (GP)</i></p> <ul style="list-style-type: none"> • Asian people most commonly visited their GP for a short term illness or a routine check up. • Asian people were less likely to visit a family doctor for injury or poisoning, or for mental or emotional health reasons, than other New Zealanders. <p><i>3. Level of satisfaction at last GP visit</i></p> <ul style="list-style-type: none"> • Most Asian people were very satisfied (92%) with their last GP visit, similar to the proportion for all new Zealanders (93%). <p><i>4. Use of Telephone Helplines</i></p> <ul style="list-style-type: none"> • Asian people were less likely to use any type of telephone helpline in the last 12 months than all New Zealanders (6% v. 16%). • Most common helpline used by Asian people was Plunketline (2%). <p><i>5. Mental Health</i></p> <ul style="list-style-type: none"> • 77% of Asian people felt happy all or most of the time in last 4 weeks, similar to the national figure of 78%. • Feelings reflecting mental health status did not vary between the four Asian communities.
Recommendations	<ol style="list-style-type: none"> 1. Asian people in New Zealand are more highly educated than other New Zealanders, but are less likely to have jobs and less likely to receive government income support. These are important socio-economic determinants of health. 2. Asian people in New Zealand currently have lower prevalences of most chronic diseases, aside from diabetes, compared with other New Zealanders. However, the health status of Asian people needs to be monitored as disease rates are likely to change over time with acculturation. Already, South Asians have an increased prevalence of diabetes compared with other New Zealanders. 3. Asian people with chronic disease are not accessing health services, and Asian women are not having mammography or cervical screening tests, to the same degree as Europeans. The reasons for this need to be identified. 4. Asian people in New Zealand are not a single cultural entity, but made up of distinct communities, each with its own unique health needs. Culturally aware health services should be developed to meet these unique needs.

--	--

Asian Youth Health: A health profile of young Asian New Zealanders who attend secondary school: findings from Youth2000.

Name of study/health needs assessment/evaluation	Rasanathan K, Ameratunga S, Chen J, Robinson E, Young W, Wong G, Garrett N, Watson PD (2006). <i>A health profile of young Asian New Zealanders who attend secondary school: findings from Youth2000</i> . Auckland: The University of Auckland. Available from: www.youth2000.ac.nz
Conducted by	Kumanan Rasanathan (Auckland Regional Public Health Service) Shanthi Ameratunga (The University of Auckland) Janet Chen (Auckland Regional Public Health Service) Elizabeth Robinson (The University of Auckland) Wilson Young (Auckland Regional Public Health Service) Grace Wong (Auckland University of Technology) Nick Garrett (Auckland University of Technology) Peter Watson (The University of Auckland) Study funded by Auckland Regional Public Health
Summary findings	<p>FINDINGS</p> <p>Overall</p> <ul style="list-style-type: none"> • Most young “Asian” New Zealanders are healthy, report positive family environments and do not engage in risky behaviours. Overall, young Chinese and Indian New Zealanders are less likely to engage in risky behaviours than their NZ European peers. <p>Demography</p> <ul style="list-style-type: none"> • Young “Asian” New Zealanders are an extremely diverse group, differing in ethnicity, mother tongue, socio-economic status, and duration of residence in New Zealand. These differences correspond to differences in health status amongst this group. • Many young “Asian” New Zealanders were born in New Zealand, and many others have been resident in New Zealand for over 5 years. Young “Asian” New Zealanders who are recent migrants represent a minority. • Most young “Asian” New Zealanders have a good command of English and feel comfortable in Pakeha/ NZ European cultural settings.

	<p>However, more than half of young Chinese New Zealanders and around 40% of young Indian New Zealanders have a language other than English as the major language at home.</p> <ul style="list-style-type: none"> • The largest groups of young “Asian” New Zealanders are Chinese and Indian. Many young “Asian” New Zealanders do not have a sole ethnic identity. Many also identify with a non-“Asian” ethnicity. <p>School Safety</p> <ul style="list-style-type: none"> • Many young “Asian” New Zealanders, in particular young Chinese New Zealanders, do not feel safe at school, and for some students this leads to absenteeism. • Young “Asian” New Zealanders are less likely to report bullying than their NZ European peers, but for those who do, they are more likely to report traumatic bullying. Few of these young people report their bullying experience to an adult. <p>Access to Healthcare</p> <ul style="list-style-type: none"> • Many young “Asian” New Zealanders do not access healthcare, especially young Chinese New Zealanders and those who have been in New Zealand less than five years. Young Chinese New Zealanders are much more likely to report lack of access to healthcare than their NZ European peers and are also more likely to report obstacles to accessing healthcare. <p>Mental Health</p> <ul style="list-style-type: none"> • Mental health is a major health issue for young “Asian” New Zealanders. Many report significant depressive symptoms and anxiety, with females and Indian young people particularly vulnerable. Young Indian New Zealanders report higher prevalence of depression than their NZ European peers. Some of these young “Asian” New Zealanders report suicidal thoughts. <p>Physical Activity</p> <ul style="list-style-type: none"> • Many young “Asian” New Zealanders, particularly female students, report low levels of physical activity. <p>Risky Behaviours</p> <ul style="list-style-type: none"> • While overall “Asian” New Zealanders are a healthy group with low levels of risky behaviours, a small group of young “Asian” New Zealanders do engage in risky behaviours such as binge drinking, smoking, unsafe sex, and marijuana use. • Young male Indian New Zealanders are more likely to engage in risky behaviours than female Indian New Zealanders. This gender difference is not seen amongst young Chinese New Zealanders. • Young “Asian” New Zealanders who are recent migrants are less likely to engage in risky behaviours than those born in New Zealand – a “healthy migrant effect”. This appears to be an effect of acculturation as young “Asian” New Zealanders who were born overseas but are not recent migrants fall between these two groups in terms of prevalence of risky behaviours.
Recommendations	<p>For Schools and Communities</p> <ul style="list-style-type: none"> • Provide safe environments for all students, particularly those from ethnic minorities, and provide safe means for students to report bullying. • Confront bullying in school curriculum and uphold a policy of intolerance of bullying in school environments. • Work with families to improve communication with students about risky behaviours and problems at school.

	<ul style="list-style-type: none"> • Identify young Indian female students as a group who are particularly at risk of poor mental health. • Encourage and enable young “Asian” students, especially female students, to undertake more physical activity and provide activities and means for participation that are culturally appropriate for all students. • Support, value and celebrate cultural practices and traditions of “Asian” students, which are diverse, in school and community settings. <p>For Service Providers</p> <ul style="list-style-type: none"> • Engage more specific “Asian” ethnic groups and avoid treating young “Asian” New Zealanders as a single group. • Provide access for young Chinese New Zealanders and young recent migrants to healthcare. <p>This is particularly important for primary health organisations in partnership with schools.</p> <ul style="list-style-type: none"> • Use new technologies such as mobile phones and the internet to provide healthcare services and reduce barriers to access. • Consider the protective effects of young recent migrants’ traditional family cultures, structures and practices and consider ways to preserve these healthy effects. • Promote collaboration across sectors for providers of services to young “Asian” New Zealanders. • Develop culturally specific tools and knowledgeable workforce to provide services for young “Asian” New Zealanders. <p>For Ministry of Health, funding agencies, researchers and policy-makers</p> <ul style="list-style-type: none"> • Undertake and fund further research into the health of young “Asian” New Zealanders. • Investigate factors which contribute to the comparatively low levels of risky behaviours in young “Asian” New Zealanders. • Identify and consider the diverse groups of young “Asian” New Zealanders when developing any national youth strategy.
--	--

Refugee Health: The health status of quota refugees screened by New Zealand’s Auckland Public Health Service between 1995 and 2000.

<p>Name of study/health needs assessment/evaluation</p>	<p>McLeod, A & Reeve, M. (2005). The health status of quota refugees screened by New Zealand’s Auckland Public Health Service between 1995 and 2000. <i>Journal of the New Zealand Medical Association</i>, 118, (1224). Available from http://www.nzma.org.nz/journal/118-1224/1702/</p>
<p>Conducted by</p>	<p>Dr Alison McLeod and Dr Martin Reeve: Auckland Regional Public Health Service, Mangere Refugee Resettlement Centre</p>

<p>Summary findings</p>	<ul style="list-style-type: none"> • The different pathway between quota refugees and asylum seekers also has an impact on the prevalence by nationality of disease, particularly for acquired diseases. By definition, a refugee does not come to New Zealand from his or her country of origin. Many have complex travel histories, and an attempt to relate prevalence to nationality is generally unrewarding or even misleading. • However there are some exceptions, particularly the prevalence of HIV infection in those from Sub-Saharan Africa, and also a few notable diseases, for example the prevalence of Clonorchis among the Lao, due to their habit of eating uncooked fish. • Even for non-acquired disease, for example haemoglobinopathies in relatively high prevalence among all nationalities of refugees, makes detailed listing by nationality a hardly worthwhile exercise. In the main, however, for screening refugees it is better to offer a comprehensive set of tests rather than attempt to modify the tests by ethnicity. • The data also shows that health concerns traditionally found in the population of resettlement countries also occur in refugees, for example diabetes and hypertension, hence the possible need to include appropriate screening among refugees, as well as screening for more unusual diseases. • The prevalence of excess weight among quota refugees was noted: <ul style="list-style-type: none"> ○ The lack of correlation between iron deficiency and low weight shows that quota refugees are generally malnourished rather than undernourished. • The high prevalence of smoking, particularly among males, offers an area where health education should offer significant benefits. • The data also draw attention to the health needs (reproductive and otherwise) of refugee women, although the rates of sexually transmitted infections and cervical smear abnormalities appear to be low compared with the host population. • In Auckland, at least, there are now specific services for those whose health is adversely affected by FGM. • Practitioners involved with services for refugees should make particular provision for the health needs of refugee women, bearing in mind the greater than usual need for these services to be gender sensitive. • Among the infectious diseases, there are no unexpected findings when comparing refugees resettled in other parts of the World and asylum seekers screened in Auckland. The cost-benefit utility of routine Mantoux testing has been questioned. • Overseas screening of refugees and screening on arrival, appear to have little impact on the subsequent incidence of TB among the resettled refugees. Hence the fact that although refugees and asylum seekers have been screened for TB it does not mean that practitioners should relax their vigilance for this disease. • At the time of writing, the only overseas screening carried out for quota refugees destined for New Zealand is for active tuberculosis and HIV infection. Tuberculosis must be treated before travel to New Zealand, and the number of quota refugees with HIV infection accepted for resettlement is limited to 20 per year. • Alleviation of psychological upset is an important health need among quota refugees, although it appears to be a greater concern in asylum seekers; this may be due to the uncertain state in which asylum seekers find themselves. Nevertheless, for quota refugees, it still represents one of the most common reasons for referral to secondary services.
--------------------------------	---

Recommendations	
------------------------	--