NEW ZEALAND **RED CROSS**
Refugee Services

The Refugee Health and Wellbeing Project

Changes in knowledge, attitude and practice of participants in the health and wellbeing programme

November 2013

"Visiting the house, speaking our own language, and giving awareness on health issues is really helpful to me and others in the society"

– Chhana, from the Bhutanese community, Manawatu

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Executive summary

THIS REPORT IS FOR ALL AGENCIES PROVIDING HEALTH AND WELLBEING SERVICES. IT AIMS TO ENSURE THAT THE NEEDS OF FORMER REFUGEES RESETTLING IN NEW ZEALAND ARE INCLUDED IN ALL ASPECTS OF THE DEVELOPMENT AND PROVISION OF THOSE AGENCIES' HEALTH AND WELLBEING SERVICES.

Key changes

The report presents the changes in findings, in 5 key areas, between the baseline knowledge, attitude and practice survey and a follow-up survey, after implementation of a 10-month long health education programme. See Table 1 for a summary of those changes.

TABLE 1: SUMMARY OF CHANGES, IN 5 KEY AREAS, BETWEEN THE FOLLOW-UP SURVEY AND THE BASELINE SURVEY

Key changes reported by respondents	Baseline survey (n=358)	Follow-up survey (n=113)
1. Increased awareness of 15 major public health programmes or services	Ranged from 15% to 42% awareness	Ranged from 86% to 100% awareness
2. Decrease in number of people who said they smoked	17%	8%
3. Increased awareness and use of cancer screening services including:		
a. awareness that breast cancer can be treated	46%	95%
b. that cervical cancer can be treated	42%	98%
c. enrolments with cervical cancer screening programmes	56%	86%
4. Increased awareness of the symptoms of meningitis	16%	93%
5. Increased awareness of availability of immunisation for communicable diseases, including tuberculosis, meningitis, whooping cough and measles	Ranged from 39% to 60% awareness	Ranged from 86% to 98% awareness

Factors contributing to key changes

- Health information delivered in the participant's own language, in their own homes or in refugee-community workshops
- Trained community health workers from the same ethnic backgrounds as the project participants
- Professional nurse supervision and involvement of the Regional Public Health services and the local District Health Boards
- Liaison and advocacy with Public Health Organisations and other health providers at local and regional level
- Participants' increasing integration into New Zealand society (including improved English)
- Support for the programme from the existing ethnic communities.

Recommendations

That agencies working with people from refugee-background communities:

- Provide intensive education about the New Zealand health system, as part of an integrated package of resettlement support.
- Ensure language support (e.g. interpreters, translated health information) is available for former refugees who do not speak English.
- Use dedicated health workers to help newly-resettling or former refugee families with health issues.
- Develop and implement health education programmes to meet the needs of former refugees, e.g. immunisation, smoking cessation, health screening services, and women's health.
- Advocate for the health needs of former refugees to be identified, planned for and addressed.

Background

Former refugees face unique health challenges

On arrival in New Zealand people from refugee background communities find the health system here very different from their previous experiences. While former refugees have access to the usual New Zealand health services, they face language, cultural, transport and financial barriers when using these services.

A Ministry of Business, Innovation and Employment Report in 2012* concluded that former refugees face unique challenges because of their backgrounds, and have higher levels of disadvantage than the population in general. The study of 512 former refugees found:

- high levels of psychological disorder or direct physical consequences of torture, chronic conditions and infectious diseases
- experience of long periods in camps with minimal medical services
- approximately 40% had a physical or emotional health problem or disability that caused difficulty or stopped them working.

*New Land, New Life: Long-term settlement of refugees in New Zealand (Preliminary Report): Quota Refugees Ten Years On Series

Red Cross Refugee Services Health and Wellbeing Project 2012/2013

The Red Cross Refugee Services Health and Wellbeing Project was a pilot, household-based, health education programme, to address some of the health challenges and disadvantages experienced by former refugees resettling in New Zealand.

The project worked with 167 families (358 individuals) from the Colombian, Myanmar and Bhutanese former refugee communities in Greater Wellington and Manawatu. Families were recruited from those who had arrived in New Zealand under the New Zealand Government quota programme during 2009 and up to January 2012.

The three key components of the health education programme are described in the following section.

Household-and-community-based health and wellbeing education programme

Refugee-background community health workers delivered the programme

Six former refugees, from the same ethnic backgrounds as the project participants, were recruited as community health workers to implement the health and wellbeing education programme.

The community health workers completed a tailored 2-week public health training programme before undertaking the following key activities:

- Conducting a baseline survey to establish the participants' current knowledge, attitude and practice in relation to the New Zealand health care system, living a healthy life, and preventative health care.
- Delivering a public health education programme, over 10 months, to the participating families in their own homes, primarily. Community education workshops were also held.
- Referring participants to the project's community health supervisors to address participants' immediate health issues.
- Conducting a follow-up survey to assess the changes achieved by the health education programme.

Supervision and support from public health nurses

Two public health nurses, recruited for the project, provided clinical supervision and guidance to the community health workers. The nurses also helped source or develop health education materials, and liaised with general practitioners and other public health service providers to address families' immediate health needs.

Advocacy with providers of public health services

Red Cross Refugee Services project members and area managers promoted the health education programme to regional and local public health organisations, District Health Boards and social service providers.

For more information about the wider project, see the following appendices:

- Appendix 1: Refugee Health and Wellbeing Project: Strategic framework
- Appendix 2: Refugee Health and Wellbeing Project: Outline
- Appendix 3: Refugee Health and Wellbeing Project: Team

Follow-up survey method

THE FOLLOW-UP SURVEY WAS CARRIED OUT BY THE HEALTH AND WELLBEING PROJECT TEAM OVER A 4 MONTH PERIOD FROM JUNE-SEPTEMBER 2013.

Survey sample

113 people were selected for the follow-up survey from the 358 participants in the project. Criteria for selection were used to proportionately represent the gender, age and country of origin of the participants in the baseline survey (see Table 2).

Table 2: Gender, age and country of origin of participants in follow-up survey, compared with baseline survey

Characteristic	Baseline survey (n=358)	Follow-up survey (n=113)
Gender		
Male	45%	44%
Female	55%	56%
Age		
Under 45 years	80%	75%
45 years and over	20%	25%
Country of Origin		
Bhutan	49%	50%
Myanmar	33%	28%
Colombia	18%	22%

Data collection and analysis

The baseline knowledge, attitude and practice survey was adapted for the follow-up survey, with open-ended and ambiguous questions being removed. Data was collected over 6 weeks in May and June 2013. The community health workers carried out face-to-face interviews with the 113 participants, interpreting the survey questionnaire in the participant's own language (Spanish, Myanmar or Nepali). The community health supervisors oversaw the process. Data from the completed questionnaires was entered into Microsoft Excel, which was also used to analyse the results.

Ethics

The Ministry of Health Ethics Committee granted ethical approval and clearance for the project and the surveys. All participants provided written consent in their own language.

A copy of the questionnaire may be obtained by contacting the Red Cross Refugee Services Contract and Stakeholder Manager.

Limitations

Different sized groups were used for the baseline study and follow-up survey. While age and gender characteristics of each community were taken into consideration when choosing the sample for the follow-up survey, the baseline and follow-up group were not exactly the same. There are limitations involved with using these comparisons to 'prove' the programme had an impact, and potential issues with the 'before and after' groups not being comparable.

The data was hand-tallied and entered into Microsoft Excel without unique identifiers and was therefore unable to be cleaned. Only single variable analysis was able to be undertaken on this data.

Self-reported data is limited by the fact that it rarely can be independently verified.

The survey was carried out by bi-lingual community health workers and not by academic researchers. This process built the relationship between the health workers and the families and facilitated the health education section of the project. The survey findings, while not being academically rigorous, have, however, provided a useful measure of the refugee community's response to the health education programme.

The community health workers had limited training to carry out in-depth survey interviews in a cross-cultural setting. Their limited interviewing experience and the methodological and ethical challenges in cross-cultural research are likely to have influenced some of the responses.

Key findings of the follow-up survey

THE REFUGEE HEALTH AND WELLBEING PROJECT TEAM CHOSE TO REPORT ON THE FINDINGS IN FIVE KEY HEALTH AREAS: AWARENESS OF PUBLIC HEALTH SERVICES; SMOKING; AWARENESS AND USE OF CANCER SCREENING SERVICES; KNOWLEDGE OF MENINGITIS SYMPTOMS, AND AWARENESS OF AVAILABILITY OF IMMUNISATION AGAINST COMMUNICABLE DISEASES.

We consider that these public health programmes and services have the most impact on the achievement of public health strategy priorities and resettlement health outcomes. See Appendix 1: Strategic framework

The key findings, as reported by the participants of the follow-up survey, are as follows:

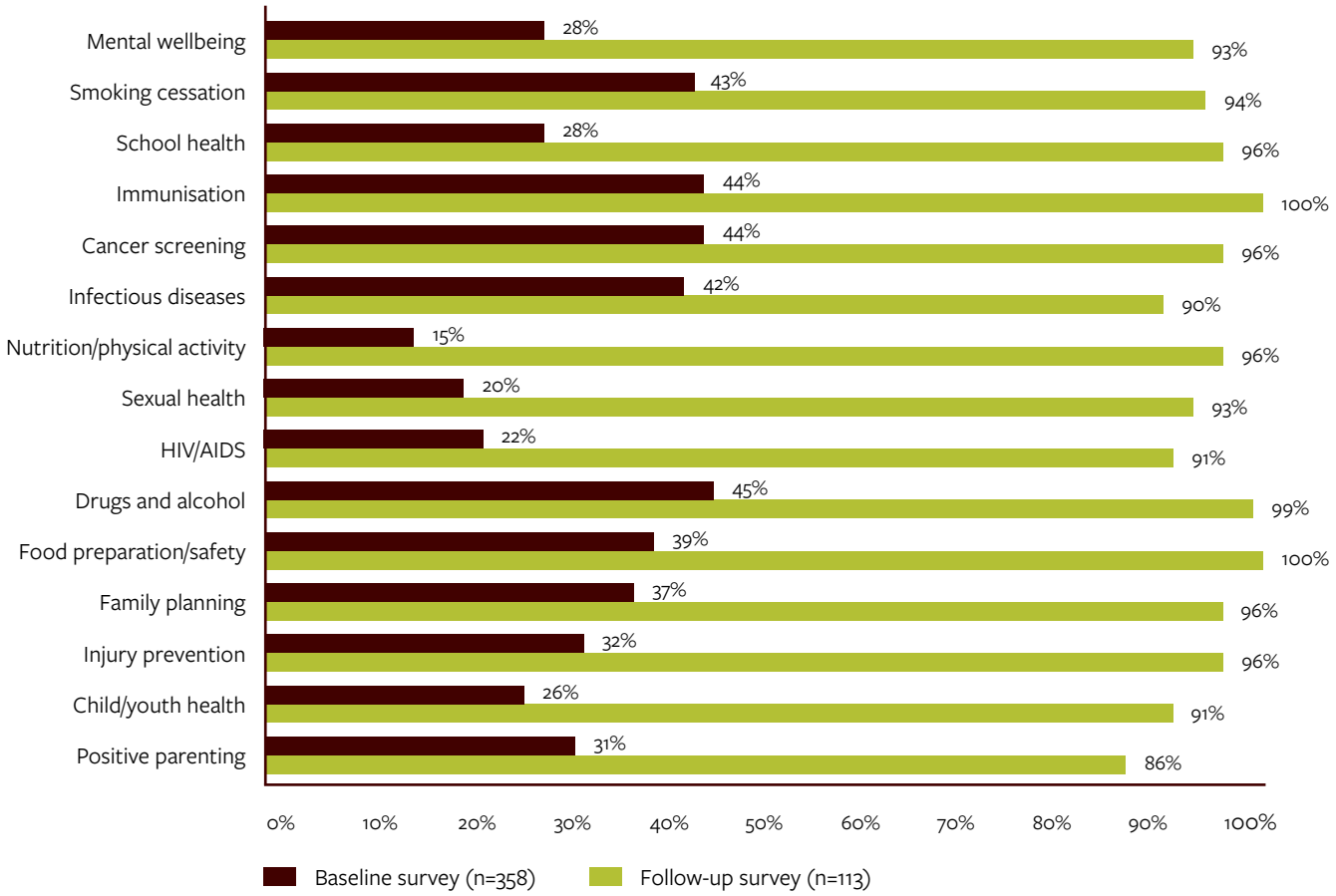
- Increased awareness of 15 major public health programmes or services.
- Decreased numbers of people who said they smoke cigarettes.
- Increased awareness and use of cancer screening services including:
  - awareness that breast cancer can be treated
  - awareness that cervical cancer can be treated
  - enrolment with cervical screening programmes.
- Increased awareness of the symptoms of meningitis.
- Increased awareness of the availability of immunisation against tuberculosis, meningitis, whooping cough and measles.

See Table 1 (in the executive summary) for a summary of the data for the findings.

Key finding 1: Public health programmes and services

After taking part in the health education programme, follow-up survey respondents reported a much greater awareness of 15 major public health programmes and services.

Chart 1: Participants' awareness of public health programmes and services at baseline survey and follow-up survey (before and after the health education programme)



Participants reported significant increases in awareness of:

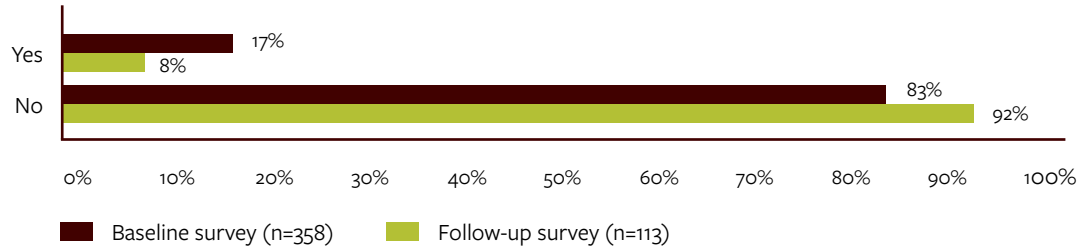
- mental wellbeing information and services (from 28% to 93%)
- smoking cessation information and programmes (from 43% to 94%)
- school health programmes (from 28% to 96%)
- immunisation programmes and services (from 44% to 100%)
- cancer screening services (from 44% to 96%)
- infectious disease control information and programmes (from 42% to 90%).

"It was very positive for our family to get to know about the services available for us in this new country."
– Jenny from the Colombian community, Wellington

Key finding 2: Smoking

In the follow-up survey, fewer respondents said 'yes', they smoked cigarettes (from 17% to 8%).

Chart 2: Respondents' answers at baseline survey and follow-up survey to the question 'Do you smoke?'



A report from one of the project's community health supervisors read:

"Family education sessions and five Quit Smoking workshops were held during the programme. A community health worker and a community member are now qualified to run Quit Smoking Coaching classes and to prescribe nicotine patches. This will allow more members of the community to use the service at a time to suit them, and in their own language."

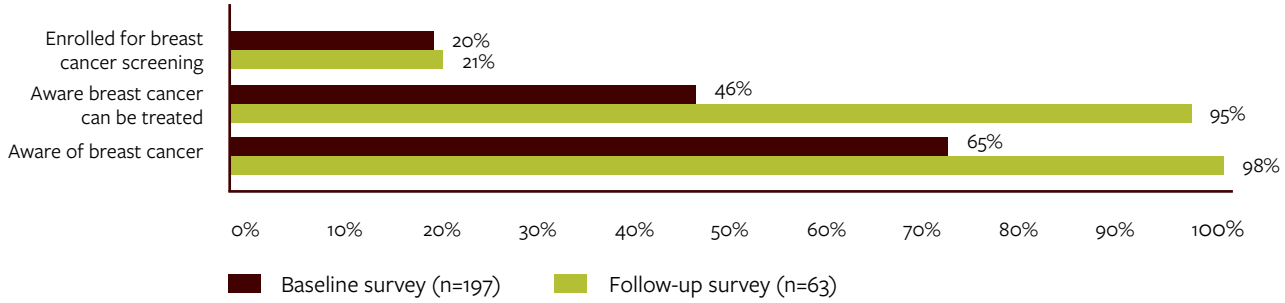
Key finding 3: Cancer screening services

This section was completed by the 63 women taking part in the follow-up survey.

Breast cancer

After the health education programme 95% of respondents reported being aware that breast cancer can be treated, compared with 46% in the baseline survey.

Chart 3: Women's knowledge, attitude and practices about breast cancer, at baseline survey and follow-up survey



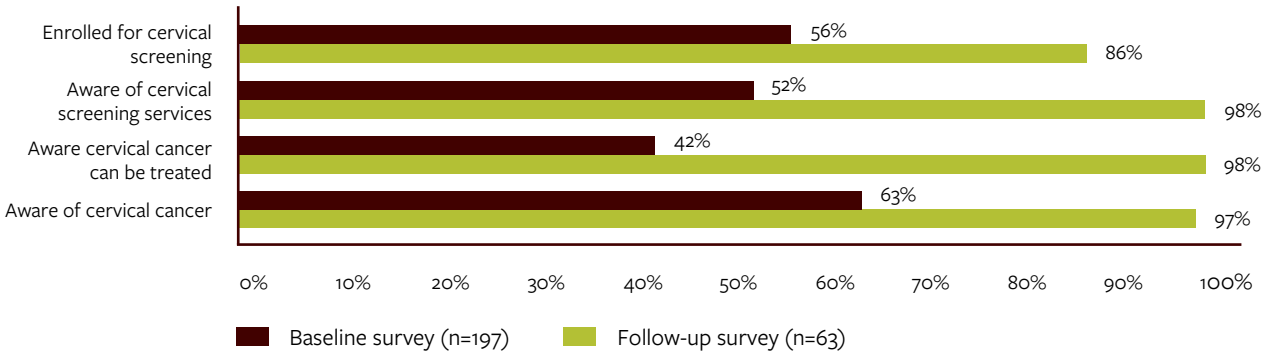
"We received valuable information regarding prevention of diseases here in New Zealand."
– Luz, from the Colombian community, Porirua

Cervical cancer

As shown in Chart 4, respondents also reported a much greater awareness of cervical cancer:

- 98% said they are aware that cervical cancer can be treated, compared with 42% in the baseline survey.
- 86% of respondents said they are enrolled for cervical cancer screening, compared with 56% at the baseline survey.

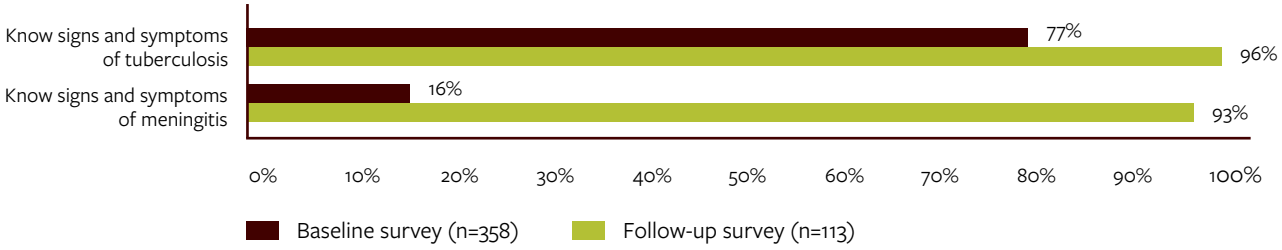
Chart 4: Women's knowledge, attitude and practices about cervical cancer, at baseline survey and follow-up survey



Key finding 4: Meningitis and tuberculosis

After the health education programme respondents reported a greater awareness of meningitis and tuberculosis. Chart 5 shows that the most significant increase was in reported knowledge of the signs and symptoms of meningitis (from 16% to 93%).

Chart 5: Respondents' knowledge of signs and symptoms of meningitis and tuberculosis, at baseline survey and follow-up survey



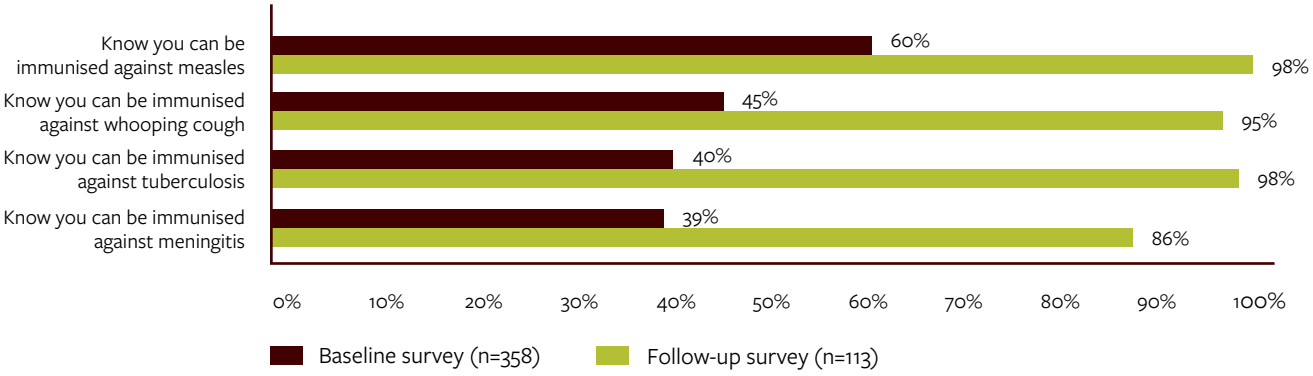
"I have learned about communicable diseases and how to prevent them. I hope they can give me continuous support with my health." – KK, from the Myanmar community in Wellington

Key finding 5: Immunisation

After the health education programme there was a marked increase in the number of respondents who reported knowing that immunisations are available against communicable diseases, including (as shown in Chart 6):

- tuberculosis (from 40% to 98%)
- meningitis (from 39% to 86%)
- whooping cough (from 45% to 95%)
- measles (from 60% to 98%).

Chart 6: Respondents' reported knowledge of immunisation availability, at baseline survey and follow-up survey



"We are from an under-developed country and didn't have any idea about communicable diseases."
– Chhana, from the Bhutanese community in Manawatu

Influences and factors contributing to changes

As reported earlier, the key changes found in the follow-up survey were:

- marked increases in respondents' awareness of public health programmes and services, cancer screening services and communicable diseases, and
- positive changes in respondents' practices, including fewer people smoking and more women being enrolled in cervical screening programmes.

The project team considers several factors have combined to contribute to these changes, including:

- the refugee household-based health and wellbeing programme itself
- participants being more settled in New Zealand, and
- support from the existing ethnic communities.

Refugee-household-based health and wellbeing programme

The refugee-household-based health and wellbeing programme was an integral part of the package of resettlement services provided by Red Cross Refugee Services. The programme took an holistic approach, comprising three components: health promotion and education (through home visits and community education workshops), community networking and referrals, and liaison and advocacy with health and social service providers.

Health promotion and health education

The project community health workers visited families at home to deliver health information directly to each household, in their own language. Information about disease prevention, early detection programmes and health and lifestyle risks was provided. Literacy skills, education levels, language skills, and disabilities were considered when planning sessions for each household group.

"I saw that lots of our community people got help from the project." – Saraswoti, from the Bhutanese community, Manawatu

The community health workers and supervisors also arranged a number of well-received workshops in collaboration with health providers and non-government organisations.

See Appendix 2: Project outline – Health education data and topics.

Community referrals, advocacy and networking

The project community health workers and supervisors liaised with health and social service agencies to address any immediate health concerns or issues, such as access to interpreters, enrolment with dentists, GPs, and screening and immunisation programmes.

"The community health worker helped me to make appointment with my GP through the telephone. The programme was really good for the people who don't have English." – Keshav, from the Bhutanese community, Manawatu

A report from one of the project's community health supervisors included the following comments:

"During the programme, it was found that families were not making separate appointments for each family member to see the GP. They were also taking a large number of people for support, filling up the waiting areas. Families were educated on the usual practice for GP visits and are now believed to be following usual practice when visiting the doctor."

"Children with skin conditions were not making progress despite many trips to the PHO and being provided with medication and creams. Ran advice clinics for parents, referred children to the Children's Eczema clinic and school public health nurse. Skin problems resolved with proper use of creams and better understanding of skin conditions."

"GPs and hospitals were not using interpreters for appointments. I liaised with PHO to remind GPs about using Language Line. I worked with Refugee Services and the PHO to get language assistants paid for by the PHO and DHB for the [refugee] community to use at all medical appointments. Use of Language Line has increased significantly and attendance for medical appointments has improved."

The project aligned itself with key national health strategies and was promoted to local PHOs and District Health Boards to raise awareness about refugee health and wellbeing.

Project participants settling into New Zealand

English language ability helps people find and use information more easily, communicate more confidently and build wider networks. Participants had spent a further 12 months in New Zealand compared with when the baseline survey was conducted. In the follow-up survey, a greater number of respondents reported:

- having a good command of English (from 3% to 16%)
- being employed (from 21% to 29%) or studying (from 11% to 14%).

Support of existing ethnic communities

The health education programme had the support of the existing Bhutanese, Myanmar and Colombian former refugee communities. This was valuable in raising awareness and reinforcing the value of the health education programme, which built on the strengths already in the communities.

Conclusions

THE FOLLOW-UP SURVEY HAS SHOWN THAT INTENSIVE SUPPORT AND EDUCATION ABOUT THE NEW ZEALAND HEALTH SYSTEM – AND HOW TO ACCESS SERVICES – IMPROVES NEWLY-SETTLING REFUGEES' KNOWLEDGE ABOUT PUBLIC HEALTH SERVICES.

Refugees arriving in New Zealand are doubly disadvantaged. They arrive with compromised health and then, while they do have access to New Zealand health services, they are again disadvantaged by cultural, financial and language barriers when they use these services. Without interventions, these factors can combine and contribute to some refugee households being excluded from New Zealand health services.

The value of using trained and skilled bi-lingual community health workers, with professional nurse supervision, was reinforced by the good outcomes achieved in a short period.

The involvement of the Regional Public Health services and the local DHBs was very productive in terms of health education materials, advice, advocacy for language support and support with data collection and analysis.

"This is a very useful programme for refugees. I learned how to prevent most diseases. Thank you for giving me a chance to be on this programme." – RJ, from the Myanmar Kachin community, Wellington

Recommendations

THE REFUGEE HEALTH AND WELLBEING PROJECT TEAM RECOMMENDS THAT ALL AGENCIES WORKING WITH PEOPLE FROM REFUGEE-BACKGROUND COMMUNITIES:

1. Provide intensive education about the New Zealand health system, as part of an integrated package of resettlement support

Early intervention after arrival in New Zealand promotes good health knowledge and behaviours. By using the appropriate health services, former refugees may limit their use of medical specialists and hospitals, and reduce health costs incurred.

2. Ensure language support (e.g. interpreters, translated health information) is available for former refugees who do not speak English.

All people have a right to be able to get information from, or give information to, their health provider. Providing language support (e.g. interpreters, translated health information materials) for former refugees helps both the individual (and/or family) and the health practitioner.

3. Develop and implement targeted health education programmes to meet the needs of former refugees

Former refugees need to be able to make informed choices about using local community health services at the right time. Health education programmes might include immunisation, smoking cessation and women's health and screening services, those being key health issues targeted under national health strategies.

4. Use dedicated refugee health workers to help bridge the gaps

One-to-one support with former refugees increases their knowledge and ability to use health services in the best way. Culture, literacy and language skills, education levels, and health issues all need to be considered when providing this support.

5. Advocate for the health needs of former refugees

Links need to be strengthened between all agencies providing health services to people from refugee-background communities, so that the health needs of former refugees are identified, planned for and addressed.

Appendix 1: Refugee Health and Wellbeing Project Strategic Framework

New Zealand Government, Refugee Resettlement Strategy

- Self-sufficiency
- Participation
- Health and Wellbeing: Immunisation rates, GP use, mental health services
- Housing
- Education

New Zealand Red Cross, Towards 2020 Strategy

Strategic Aim 3: We will promote a culture of social inclusion... Understand and meet the needs of refugees by supporting their transition into New Zealand society

New Zealand Health Strategy, Ministry of Health and District Health Board, National Health Targets

- Emergency department stays
- Access to elective surgery
- Increased immunisation
- Quit smoking

New Zealand Government Quota Programme Refugee Resettlement Pathway to Settlement

ARRIVAL

Mangere Refugee Reception Centre

Settlement location

Auckland
Waikato
Manawatu
Wellington
Nelson

PATHWAY TO SETTLEMENT

- Social Work
- Casework
- Cross-cultural work
- Volunteer support
- Links with mainstream services
- Community connections
- Ethnic community connections

PATHWAY TO SETTLEMENT INDICATORS OF SUCCESS

- Self-sufficiency
- Participation
- Health and wellbeing
- Housing
- Education

HEALTH AND WELLBEING PILOT PROJECT MANAWATU AND WELLINGTON

Families and individuals are empowered to take control of their own health and wellbeing along their Pathway to Settlement

Appendix 2: Refugee Health and Wellbeing Project Outline

Long term goal

That participating families are taking responsibility for managing their own good health and maintaining a healthy lifestyle.

Objectives

That refugee households:

- have a good knowledge of New Zealand health care systems and how to use them
- know how to be healthy and stay healthy
- understand the value of preventative health services and how to use them.

Funding

J R McKenzie Trust for 2012-2013 and the Todd Foundation in 2012.

Participants

- 358 former refugees, representing 167 households.
- Recruited from Colombian and Myanmar, and Bhutanese refugee households who arrived in New Zealand under the New Zealand government Quota Refugee Programme between 2009 and January 2012.

Project location

- Greater Wellington (Colombian and Myanmar households)
- Manawatu (Bhutanese households).

Key activities

- Participating communities engaged
- Appointment and training of:
  - community health workers (former refugees from same ethnic background as participants)
  - community health supervisors (public health nurses)
- Baseline knowledge, attitude and practice survey conducted
- Health education programme implemented (10 months)
- Follow-up survey conducted.

Health education programme strategies

- Creating a supportive environment to improve understanding about health issues for newly resettling refugees
- Participatory capacity building and awareness raising, development of health enhancing personal skills
- Strengthening the links between refugee families and health and social service providers.

Health education data and topics

Table 3: Health education programme data

Refugee household health and wellbeing project data	Totals (n)
Households enrolled in the programme	167
Health education home visits	1192
Average visits per household	7
Community education workshops	20
Community education workshop attendees	400

Table 4: Health education programme topics

New Zealand Health care system	How to access health care	Healthy nutrition
Physical Activity	Safety at home	Food safety and storage
Preparing for emergencies	Injury management	Family planning
Plunket Services	Pregnancy and breast feeding	Family violence
Smoking cessation	Alcohol and drugs	Diabetes mellitus
Skin Infections	Personal/household hygiene	Oral health/dental services
Breast/cervical cancer	Immunisation	Eye care
Rheumatic fever	Tuberculosis	Hepatitis B

Table 5: Community health education workshop topics

Hepatitis B	Rheumatic fever	Quit smoking
Pregnancy and beyond	Meningitis	Gastroenteritis
Women's health	Men's health	

Appendix 3: Refugee Health and Wellbeing Project Team

Red Cross Refugee Services Health and Wellbeing Advisor: Dr. Demissie Diressie

Red Cross Refugee Services Contracts and Stakeholder Manager: Miranda Pittaway.

Manawatu

Bhutanese Community Health Workers:

- Kumari Bhattarai-Timsina
- Laxman Dangal

Community Health Supervisor: Margaret Sheridan

Red Cross Refugee Services Manager: Kevin Petersen

Greater Wellington

Myanmar Community Health Workers

- Annie Coates
- Titus Lian

Colombian Community Health Workers

- Maggie Rapson
- Gabriella Peralta Montane

Community Health Supervisor: Lynnette Singh

Red Cross Refugee Services Manager: Shane La'ulu

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