CHAPTER II

LITERATURE REVIEW

Resettlement is one of the solutions for the world refugee population. New Zealand is one of the 18 countries in the world to accept refugees from different parts of the world. Resettlement is a long term process and refugees have to face different challenges in different phases of their resettlement. The health and social service organisations help the refugees with limited resources, so a lot of unmet needs are still barriers to successful resettlement. In terms of the health status of refugees, Refugee Voices research found that two in ten established refugees (more than five years in New Zealand) said their health was worse than during their early arrival (NZIS, 2004).

2.1 Who are refugees?

According to the United Nations High Commissioner for Refugees (UNHCR), there are over 20 million people 'of concern' around the world. This means that there are more people who are refugees, asylum seekers, returned refugees, internally displaced or stateless than the entire population of Australia (UNHCR, 2003).

The United Nations 1951 Convention (UNHCR, 1996) relating to the status of refugees defines a "refugee" as a person who:

> "Owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country"

History shows that in 1951 there were roughly one million refugees, mainly from countries in Europe. In 2003 there were over 10 million refugees, most of them having fled from one poor country to another; 5.7 million internally displaced people and over one million asylum seekers, mostly living in industrialised countries (UNHCR, 2003).

2.2 Refugees' journeys

Before resettlement in third countries like New Zealand, refugees have passed two stages in their pre-resettlement phase. The first phase was being *"forced to flee"*, when refugees fled from their home countries and the second phase was *"living in limbo"*, when refugees were in refugee camps (Hunt, 1999; World Vision, 2003). Possible solutions for refugees are repatriation to their own country, integration in the second countries or resettlement in the third countries (UNHCR, 2004).

2.3 Refugee resettlement in New Zealand

New Zealand has been accepting refugees for resettlement since the end of the Second World War. In 1987, the Government established a formal annual quota for the resettlement of refugees. Over time, New Zealand's refugee policy has evolved in response to changing global circumstances and needs (UNHCR, 2001).

New Zealand is one of a small number of countries that formally provide for the third country resettlement of a quota of refugees. Other countries include

Australia, Canada, the United States of America, the Netherlands, Sweden, Denmark, Norway and Finland. Nine other countries have recently introduced resettlement programmes, namely Argentina, Benin, Brazil, Burkina Faso, Chile, Iceland, Ireland, Spain and the United Kingdom (UNHCR, 2004).

In recent years, the New Zealand focus on refugees in need of protection - identified by the UNHCR - has resulted in the resettlement of a diverse range of nationalities, for example, from East Africa, the Middle East and Southeast Asia. New Zealand accepted for resettlement 4,219 quota refugees through UNHCR between 1997/98 and 2002/03 (NZIS, 2004) (Appendix 1). In this study all participants are Myanmar refugees who came to New Zealand as quota refugees and live in Glen Innes, Auckland.

New Zealand's refugee policy reflects the Government's commitment to fulfilling its international humanitarian obligations and responsibilities. Through refugee policy, New Zealand contributes to the global community's efforts to assist refugees in need of resettlement. Refugees can come to New Zealand through the quota programme, as asylum-seekers, or through family reunification. The size and composition of the refugee resettlement quota is set annually by the Minister of Immigration after consultation with the Minister of Foreign Affairs and Trade, relevant Government departments, the UNHCR and other stakeholders. In recent years, New Zealand's annual resettlement quota has been maintained at 750 places with a focus on the needs and priorities identified by the UNHCR (UNHCR, 2004).

2.3.1 Composition of New Zealand Refugee Resettlement Quota

The Refugee Quota of 750 places is comprised of the following subcategories:

- Women-at-Risk 75
- Medical/Disabled 75
- UNHCR Priority Protection 600 (including up to 300 places for family reunification)

All subcategories within the refugee quota generally include the principal applicant and dependent family members (i.e. spouse and dependent children) of the principal applicant. Up to 300 places, within the UNHCR Priority Protection subcategory may be used for the reunification of dependent family members as well as others submitted for resettlement by the UNHCR (UNHCR, 2004).

2.3.2 Permanent Resident status for refugees in New Zealand

The UNHCR is the sole referral source of applications for resettlement in New Zealand under the Refugee Quota Programme. Refugees accepted for resettlement in New Zealand under the Refugee Quota Programme are granted residence status on arrival. As New Zealand residents, they are entitled to live in New Zealand permanently and enjoy similar rights to New Zealand citizens in terms of access to education, health care, employment and social welfare. After a qualifying period of three years' residence, resettled refugees are eligible to apply for New Zealand citizenship (UNHCR, 2001).

2.3.3 Mangere Refugee Resettlement Centre (MRRC)

The "Mangere Refugee Reception Centre" (MRRC) is located in Auckland. The Centre can accommodate approximately 150 refugees. The facilities at the Centre include accommodation blocks, a nursery, classrooms, medical and dental clinics and general living and recreation areas. It is the starting place for all quota refugees in New Zealand (UNHCR, 2001).

All quota refugees have to stay at the MRRC for six weeks. There are five organisations working at the MRRC; 1) New Zealand Immigration Service (NZIS), 2) Auckland University of Technology (AUT), 3) Refugees and Migrant Services (RMS), 4) Refugees as Survivors (RAS), and 5) a clinic from the regional public health. These five organisations work together very closely to help refugees. The MRRC provides hostel type services; cooked food and individual rooms. The buildings are barrack style and rooms can accommodate two people and common toilet and showers are at the ends of the buildings.

There are three main reasons to stay in MRRC for six weeks. These are: medical screening, attending orientation programmes and preparation work to live in the community such as opening bank accounts, processing social benefits, finding accommodation by Housing New Zealand. All refugee families have to pass through these processes to get the basic necessary facilities and connections for settling in the communities (Thein, 2005).

2.3.4 Community supports for refugees

RMS continues to help refugees to resettle in the community after leaving from the MRRC. RMS helps quota refugees to set up a house and with the initial establishment of daily life through the volunteers' support programme. RMS volunteers commit to help refugees for up to six months after their arrival in New Zealand. The existing ethnic community, churches, schools and community health services are also in key positions to help the new refugees to resettle in the communities. There was no specific refugee health care organisation in the community in an ongoing basis.

2.4 Resettlement needs

2.4.1 What is resettlement?

When individual refugees are at risk, or when there are other reasons that require them to leave the region, UNHCR attempts to resettle them in safe third countries. Through resettlement, refugees gain legal protection – residency and often (eventually) citizenship – from governments who agree, on a case-by-case basis, to open up their communities to new members. It is often through the efforts of NGOs that the public in resettlement countries is made aware of the plight of needy refugees (UNHCR, 2004).

2.4.2 Challenges in the resettlement journey

Silove (1994) describes refugees' sufferings as a "continuum of trauma", beginning with experiences of social upheaval, danger, deprivation and multiple losses in the home country. This may be followed by a period as an internal

fugitive, before escaping to a country of first asylum, often without other family members.

Whether they are quota refugees, family reunification cases or asylum seekers, refugees arrive in the third countries (receiving countries like New Zealand) with a variety of needs, ranging from the intensely practical to intensely personal. Gary and Elliott (2001) summarised that practical needs include accommodation and household effects, employment, financial support, language classes, access to health care and educational opportunities, information and tuition in the laws, customs and practices of the receiving country and access to interpreters. Personal needs include; reunification of families, recognition and understanding of the trauma they have been through, access to appropriate health services, friendship, support and acceptance, the ability to retain their own culture, and the opportunity to make a contribution to their new society (Leisure & Community Services Unit, 1997; Robinson, 1999).

2.5 Refugee health

2.5.1 Health Care Services in New Zealand

The resettled refugees obtain New Zealand Permanent Resident status on arrival. They, like other New Zealand citizens on low incomes, are eligible for a Community Services Card, which entitles them to free outpatient treatment at hospitals and a maximum subsidy for general practitioner (GP) visits and prescriptions. In New Zealand everybody should register with a general practitioner (GP). They are gatekeepers of the health care system. Patients have to pay part of the expenses to access the GPs, however, secondary and tertiary care are totally subsidised by the Government. Community nurses or Plunket nurses take care of

under five-year-old children and provide regular assessment of their growth until the age of five for free. The dental services for children under 18 years of age are also free.

2.5.2 Primary Health Care Organisations (PHO)

The Primary Health Care Strategy was launched in February 2001 by the Minister of Health, Annette King. The Primary Health Care Strategy provides a clear direction for ensuring that primary health care services play a central role in improving the health of New Zealanders. Primary Health care will improve the health of all New Zealanders through:

- a greater emphasis on population health, health promotion and preventive care
- community involvement
- involving a range of professionals and encouraging a multidisciplinary approach to decision making
- improving accessibility, affordability and appropriateness of services
- improving co-ordination and continuity of care
- providing and funding services according to the population's needs as opposed to fees for services when people are unwell.

The Ministry has been working with the health sector to progressively implement the strategy, building on already successful initiatives in primary health care. District Health Boards will work with local communities, existing organisations and new ones to find the best way locally to set up Primary Health Organisations (PHOs) (MOHNZ, 2001).

PHO is a team of doctors, nurses and other health professionals who work with a community to give community members and their families better health services. This team will work with community members to improve their health as well as treat them when they need care. Community members can tell their PHO about the services they want to improve their and their families' health (MOHNZ, 2004). Now nearly all GPs in New Zealand are member of the different PHOs.

2.5.3 Refugees' health problems

2.5.3.1 Health Care on Arrival

The regional public health service operates a medical clinic (including dentistry) at the MRRC, which medically screens all refugees during their stay and treats or refers them to health specialists, as appropriate. Access to specialised medical services outside the clinic is also facilitated (UNHCR, 2001).

The Refugees As Survivors Centre (RAS) implements an early intervention programme in the MRRC to assess refugees' emotional health and mental health. This programme links with other key agencies to identify and assist "at-risk" individuals (i.e. severely traumatised refugees). The assessment results are brought to the attention of relevant government and non-government agencies in a manner that allows for informed decisions with regard to service delivery (UNHCR, 2001).

2.5.3.2 Health related issues and health status

There are common and well-known health-related issues faced by refugees, these apply even when settling into a developed country such as

New Zealand. While there are physical and mental health issues resulting from their previous experiences in war and camps, other health determinants in New Zealand come up from unemployment and housing, separation from family, poor proficiency in English, changes in food and diet, and changes in daily exercise patterns. These reflected mental health issues, anemia, gastro-intestinal disorders, obesity, back problems, possible diabetes, respiratory problems, dental problems, eye conditions, and vitamin deficiency disorders as Gary and Elliott (2001) summarised.

Guerin, et al (2003) also summerise that health problems are relevant to psychology and the social sciences rather than medicine alone, since the difficulties stem from interconnected issues of language proficiency, transportation, different views of health, lack of childcare if the family is not reunited, and a lack of suitably written health information.

New Zealand Immigration Service (NZIS) also conducted a longitudinal research (Refugee Voices) on recently arrived refugees (within six months in New Zealand), and settled refugees (more than five years in New Zealand) in 2001-2004. The second follow up interview was conducted one and a half years after the first baseline interview. NZIS (2004) found that of the recently arrived refugees, 45 percent interviewed at six months and 50 percent at two years rated their health as very good or excellent. Thirty-three percent rated their health as good at both interviews. However, 22 percent at six months and 17 percent at two years rated their health as fair or poor. Established refugees were asked to rate their health at five years compared to when they arrived in New Zealand, four in ten said their health was better than when they arrived while another four in ten felt their health was about the

same as when they arrived. Two in ten established refugees said their health was worse. These research findings clearly stated that both recently arrived refugees and settled refugees' health statuses were needed to address even after their long-term resettlement period.

However, half of recently arrived refugees interviewed at six months said their children's health had improved since arriving in New Zealand. Two thirds of established refugees said their children's health had improved.

The Refugee Voices research also clarified that Women were more likely to respond that their health had worsened in New Zealand. At six months, 24 percent of women said their health was worse than when they arrived compared to 9 percent of men. Of the established refugees, 23 percent of women said their health was worse compared to 16 percent of men. Common reasons for health being worse were developing a medical condition (such as asthma) or concern about family overseas (NZIS, 2004).

2.5.3.3 Physical health

Blakely (1996) surveyed in health needs of Cambodian and Vietnamese refugees in Porirua, New Zealand, and results showed that 26 out of 68 individuals (38%) as suffering from poor health; asthma, hepatitis B and treated tuberculosis being the three most common conditions. Blakely (1996) also found that many vague somatic complaints that may overlay psychiatric morbidity or stress. This finding agrees with the Canadian Task Force (1988) finding of patients tend to concentrate on physical symptoms rather than mental health complaints.

Cheung and Spears (1995) studied among all adult Cambodians living in Dunedin, New Zealand and in term of specific diseases, malaria, intestinal parasitic infestations and heart conditions were the three most frequently reported physical problems in the study.

2.5.3.4 Mental health

Around one third of both recently arrived refugees interviewed at six months and established refugees said they had experienced emotional problems as a result of past experiences and moving to and settling in New Zealand (NZIS, 2004). According to Pernice (1989) observation, there were fairly static level of anxiety and depression among Indochinese refugees arriving in New Zealand. Pernice (1989) comment agrees with NZIS (2004) findings.

The U.S. Committee for Refugees (1999) believes that refugees and survivors of torture need early access to culturally appropriate mental health services to help them deal both with the trauma they fled and the challenges of resettlement. Post Traumatic Stress Disorders (PTSD) symptoms differ depending on culture and background, as well as on exposure to trauma. Once they reach their host country, refugees may be reluctant to seek help because of shame and the fear of being labelled 'crazy'. They fear that such a label would isolate them from their communities and affect their refugee status or employment (Clinton- Davis and Fassil 1992). There are also difficulties in measuring psychopathology in refugees.

Gray and Elliott (2001) note that it is not appropriate to assume that all refugees have been tortured or that torture is the root cause of

refugees' mental health status. From cultural point of view, in some cultures, especially in Asia, it is unacceptable to complain to a doctor about feeling despondent, lonely or suicidal. Patients tend to concentrate on physical symptoms, which can lead to misdiagnosis (The Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988; U.S. Committee for Refugees, 1999).

2.5.3.5 Barriers to access health services

According to the WHO (1989) definition of "Accessibility":

> "Accessibility is the number or proportion of giving population that can be expected to use a specified facility, service, etc given a certain barrier to access, which may be physical (distance, travel, time), economic (travel cost, service fee, time cost), or social and cultural (language) barriers."

Ratana Somrongthong (2004) summarised, four dimensions of accessibility to health care as Thinh mentioned (2001):

1) Geographical accessibility: this include transportation, travel time
2) Financial accessibility: the ability of people to pay for health services
3) Cultural accessibility: related to an appropriate approach used with the cultural patterns of the community
4) Functional accessibility: the process, method of managing of care to those who need it. The way that a service is delivered to clients affects accessibility.

Ratana Somrongthong (2004) also refers modified indicators of accessibility by Penchansky (2001) and Lee (2001), as follows:

1) Geographic accessibility means the location of populations and travel resources relative to the location of the health facility.
2) Availability means the quantity of need/demand relative to the quantity of health services.
3) Affordability means the resources to purchase or pay for health care relative to the price/cost of the care.
4) Acceptability means the characteristics of services vs. user attitude, perception or expectations of services, including social, cultural concerns, and the attitudes of refugees and health providers.

Related with accessing to the health services, the Refugee Voices research found that twelve percent of recently arrived refugees interviewed at six months and 16 percent of established refugees said they had needed to see a doctor at some stage but were not able to see one. From 12 percent (n=209) of recently arrived refugees (less than 6 months), the main reasons they gave were the cost involved (11 responses), not being able to get an appointment (8 responses) and communication problems (7 responses) (NZIS, 2004). Sixteen percent (n=187) of established refugees (more than 5 years) said they had not been able to see a GP when they needed to. A common reason was the cost of visiting a GP (11responses). Other reasons related to appointments not being available when needed (8 responses) and long waiting lists (5 responses).

Guerin, et al (2003) conducted a survey in Somali refugees in Hamilton, and that research summerised that the Somali community reported themselves as being in good health with not much concern and overall positive

towards medical services. However, the Somali refugees had many problems accessing the services required, the biggest problem being language, and to a lesser extent transportation and medical costs.

Refugee Voices research (NZIS, 2004) showed a high number of hospital visits compared to what would be expected of the general population. Some refugees may not be used to the concept of a GP, especially those who come from countries where health systems are not highly developed and where healthcare is sought directly from public hospitals where most doctors are located. Blakely (1996) also states that health service utilisation by Cambodian and Vietnamese refugees was as high, or higher, than a comparable needs assessment in the Porirua region of a population based random household sample in 1993/4.

2.6 Myanmar refugee in New Zealand

2.6.1 Background

Myanmar (Burma) is one of the South East Asia Countries and many ethnic groups are living in Myanmar. Main ethnic groups are; Karen (majority Buddhist, a number converted to Christianity during British rule) Shan, Mon, Chin (Tibeto-Burmese origin), Kachin, Arakanese Muslims, Karenni. Myanmar consists of 135 major ethnic groups and seven ethnic minority states. Since its independence in 1948 from British it has been torn by political strife and ethnic unrest (NZIS, 2004).

In 1988 there was nation wide democracy up rising in Myanmar and thousands of democracy activists left their homes to the border areas to fight against the military government. They have spent their time at the Thai-Myanmar border

military camps or in refugee camps for more than 10 years. Most of them left their hometown when they were teenagers and did not finish their education. After a decade, the country is still under the military regime and some democracy activists registered at UNHCR, Bangkok to get refugee status. The most of political Myanmar refugees were camped in Maneeloy camp, Ratchaburi, Thailand. Since July 2000, numbers of Mynamar refugees from Maneeloy camp resettled in New Zealand (Thein, 2005). Maneeloy camp was closed in 2002 with many refugees being resettled to third countries including New Zealand, Finland, Australia, and the United States of America.

The National League for Democracy was voted into power in 1990, but military leaders prevented the opposition party from taking office. The Burmese Border Consortium reported that 2002 was "the worst year for human rights abuses and destruction by the Burmese army since 1997" (NZIS, 2004).

2.6.2 Myanmar refugees Intakes to New Zealand

During July 1997 to June 2003, New Zealand Immigration Service (NZIS) accepted 344 Myanmar refugees from Thailand through the UNHCR. Majority of Myanmar refugee arrived New Zealand in 2000 – 2002 and they have been resettled in New Zealand about three to five years. Among them, 160 people (45 households) were resettled in Glen Innes (GI), Auckland City. Other people are in North Shore City and Nelson City (Thein, 2005).

2.6.3 Myanmar Refugees in Glen Innes, Auckland

Only one population statistics was collected by Thein (2005) in early 2004 to implement youth programme in the community. In that time total 160 Myanmar refugees were in the Glen Innes. Among 160 Myanmar refugees, under five children were 30 (18.8%), age 5 to 13 (primary school age) was 23 (14.4%), age 13 to 22 (secondary school age) was 21 (13.1) and age 22 to 60 was 86 (53.8%). In 2002 New Zealand Immigration Service accepted more than 20 single refugee men, so male population is higher in the Myanmar refugee community. Only few families came along with their extended family members and majority of the family are their nuclear family members. Majority of refugees left from their home in their teenage, so only few refugees finished their secondary education.

All refugees are living in the houses owned by Housing New Zealand Cooperation. These are Government houses and rents are automatically deducted from the social benefit. The most of the people are still on social benefit. The families receive the social benefit according to their family size. Primary and secondary educations are free and all refugee children have to study according to the law. The kindergartens accept three years to five years old children. Age five to thirteen years old children go to primary school and age 14 to 21 years old young adult go to secondary school. However, all refugee adults who are older than 22 can go to the adult education classes and these classes are free for basic levels. The parents have to buy school uniforms, stationeries and text books.

Primary health care is paid service, however, the government subsidises the rest through PHO and $ 10 dollars for a GP visit for a person. For the

prescriptions the patients have to but at the pharmacies and essential drugs are subsidies by the government. The families with many children have to face financial difficulties

History of Myanmar citizens left the country as a refugee was a shorter period than other refugees. It was happened after 1990 in larger scale. The Myanmar community leaders could not trace the specific researches or surveys about Mynamar refugees' resettlement issues including health issues in the resettling countries. There was a case study, conducted in Australia for a Myanmar refugee. In this case study New South Wales (NSW) Refugee Health Service (2000) concluded; "limited trust of health service providers arising from experiences of human rights abuses at the hands of government authorities, psychological impact of torture and trauma, physical sequelae of torture including oral health needs, risk of re-traumatisation when health care treatments could be reminiscent of past abuse, unfamiliarity with Australian health care services and systems preventing self-referral to health care services".

As Refugee Voices research findings, majority of Myanmar refugees may cope well with their health issues, however, many commentators state that a numbers of health related issues are still concerns for refugees in long term resettlement period. So that Myanmar refugees may still face difficulties to access health services and struggling with their health needs as Dr Nagalingam Rasalingam's comment. There is no specific research for Myanmar refugee community about their health status and as a specific population, only a little is known about their health situation and with a few exceptions. They are an out of sight group in New Zealand health research.

The New Zealand Government introduced new public health strategy in 2003 to address the primary health care through Primary Health Care Organisations (PHO) as mentioned above. PHO is multidisciplinary team and it also would like to fill the gap of community health needs through community involvement. However, language barrier and unfamiliar with health system, refugee community's voices did not reach to the PHO personnel. On the other hand PHOs and existing health service providers could not implement appropriate health programmes, if they do not get right information about the refugees' health needs. This study finding will be hard evidences to implement the community health programmes for the Myanmar refugee community by the primary health care services and other community specialist health care services.