CHAPTER V

DISCUSSION

In the discussion chapter, the project facilitator compared and triangulated the survey findings, focus group discussion results, in-depth interview comments and other refugee health-related research findings as evidence for the current Myanmar refugees' health status and the factors that determine Myanmar refugees' health status. The project facilitator also discussed the lessons learned from the process of this project. Lastly, he put recommendations and suggested possible solutions to improve the health status of Myanmar refugees. He also offered suggestions for further research projects.

5.1 Glen Innes Myanmar refugees' health status

5.1.1 Perception of own health status

From the survey, 20.5% of 156 respondents answered that their health and their children's health status was excellent, 50% answered good, 23.1% answered fair and 6.4% answered poor. In summary, 70.5% of respondents were happy with their health status. None of New Zealand born children's mothers perceived that their children had poor health status. This would indicate that the health status of the resettled refugee population (131 people) was not much different from the health status of other refugees as identified by other researchers. The mean resettlement time for Myanmar refugees in Glen Innes is 4.8 years. When comparing the survey results with "Refugee Voices"(NZIS, 2004), (settled refugees were defined as more than five

years in New Zealand), Myanmar refugees' health status was similar to all refugees' health statuses in the excellent to good categories. However, only 8% of Myanmar refugees answered that their health status was poor and "Refugee Voices" research respondents answered poor health status as 12%. In this survey result, there was no statistically significant relationship between resettlement time and perception on health status.

Consequently, the health status of Myanmar refugees could be seen to be better than that of the overall refugee population. The possible explanations might be that there was no Myanmar refugee sample in the "Refugee Voices" settled refugee sample pool, and the percentages of different age groups in the samples were different.

5.1.2 Chronic diseases in the Myanmar refugee community

The participants responded according to their medical doctors' diagnosis, 36.5% answered they have one or more chronic diseases. There were a significant number of people who had chronic diseases. However, allergies were the most common disease (22.8%) among chronic diseases, asthma was the second most common disease (17.5%), and these were not life-threatening or infectious diseases.

Hepatitis B was the third most common disease (14%) among chronic diseases. It is an infectious disease and it might lead to deterioration of health. When refugees were at the Thai-Myanmar border, facilities for sanitation and sterilization methods for medical instruments were not standard and they might have contracted Hepatitis B when they were at the Thai-Myanmar border.

However, only nine people from 57 people (16%), who had chronic disease/s perceived their health statuses were "poor". Four people (7%) still perceived their health statuses were "excellent"; 21 people (37%) perceived their health statuses were "good", and 23 people (40%) perceived their health statuses were "fair". These perceptions were paralleled with the social benefit status as seven people responded that they received the sickness benefit. There was no identifiable statistical relationship between health status perception and chronic diseases.

The survey findings are similar to the health needs of Cambodian and Vietnamese refugees in Porirua, New Zealand (Blakely, 1996). Blakely surveyed these refugee communities and 38% were suffering from poor health, with asthma, hepatitis B and treated tuberculosis being the three most common conditions. Blakely's findings are very similar to Myanmar refugee's health status and chronic diseases. In this survey we did not ask about treated infectious diseases. However, the Myanmar community's chronic diseases were different from those studied by Cheung and Spears (1995) among adult Cambodians who lived in Dunedin, New Zealand. In terms of specific diseases for them, malaria, intestinal parasitic infestations and heart conditions were the three most frequently reported physical problems.

Myanmar refugees (3.2%) also complained of lethargy/fatigue as a fourth common disease by Myanmar refugees. As one of the practice nurse's concerns, "anaemia" might be a cause for these complaints. However, the majority of Burmese people did not usually complain about their emotions or feelings and they might present with somatic symptoms such as lethargy/fatigue. Blakely (1996) also

found that many vague somatic complaints may overlay psychiatric morbidity or stress.

Hypercholesterolemia was another fourth ranking disease for the Burmese refugees with 3.2%. Changing diet, lifestyle and lack of physical exercise in their recreational activities might be the explanations for hypercholesterolemia.

5.1.3 Acute illnesses

In the three months prior to the survey 53.7 % of 156 respondents fell sick and the common cold was the highest cause (44.2%) of their sicknesses. Headaches were the second most common reason for them to feel sick. It was difficult to differentiate if the reason for headaches was a symptom of the common cold or a somatic pain conversion of their emotional stresses. The survey was conducted in September and October. The three months prior to the survey during which sickness was noted fell in wintertime, July, August and September.

5.1.4 Emotional Health

In respondents aged fourteen years and above, a total 90 people, 76.7% of respondents had felt one or more emotional stress in three months prior to the survey. However, only one respondent from 14 to 18 years age group answered that he had experienced emotional stresses.

"Language problem" was the highest concern by 53.6%. The majority of Myanmar refugees did not have a high level education and 46.8% from the adult population were also studying full-time in New Zealand at the time of the survey. Financial concerns and concern about children were both second level concerns.

Financial concerns are not uncommon for refugees, because most of the people were on social benefits and they always sent money back to their families. A different education system, belief in different disciplining concepts and role reversal (children can speak better English than their parents and the parents have to rely on the children) might be some of the causes for the second highest concern, "concern about children who live together with their parents in New Zealand". Being "unable to plan for life" was the third highest concern and it was a complicated issue. After only five years of resettlement, refugees still struggle with financial problems; are not able speak English at a sufficiently high level to get a secure job and the rapid adoption of the new culture by the children threatens parental authority and traditional cultural family structures which causes young adults and adults to feel that they cannot exercise control over their lives.

"Refugee Voices" research found that 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). Compared with "Refugee Voices" findings, the Myanmar community's emotional problems were greater; however, the survey results were in line with Pernice's (1989) observation, that there were fairly static levels of anxiety and depression among Indochinese refugees arriving in New Zealand.

In western culture, counselling is one of the solutions used to deal with emotional stress. In the Burmese culture there was no concept of counselling. Elder family members and extended family members helped with physical, financial and emotional support for people who faced difficult situations. However, Myanmar

refugees were living in their nuclear families without extended family members. It was helpful that Myanmar refugee community houses were close to each other, so that community members took extended family members' roles. The majority were coping well by talking to friends (20%), talking to their partners (16.7%), meditation (10%), talking to senior community members (7.8%) and watching and listening to TV/music (7.8%). However, a small number of cases were using smoking, drinking, playing cards/gambling and yelling at their children. These coping mechanisms were dangerous for health and needed to be addressed.

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. Again, Clinton- Davis and Fassil (1992) stated that 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. These concepts might be true for the Myanmar refugee community, as nobody answered that using counselling was their way to resolve their emotional problems and nobody consulted primary health care doctors about their emotional stresses. One practical level solution for the refugees might be to empower several key people in the community to be community counsellors and social workers in their grassroots level community organisations.

5.1.5 Age and gender composition and health perception

In the Myanmar refugee community, children aged six to thirteen years were the largest group. The thirty-one to forty age group was the second largest and the population aged sixty and above was the smallest group. This reflected on the overall health status perception.

As mentioned in the literature review, Myanmar refugees left their home after the 1988 pro-democracy uprising. At that time they were in their intermediate or high school years. They spent a decade at the Thai-Burma border or in the refugee camps. They married at that time and they came to New Zealand with their young children and most of them are now middle-aged. They were in the active reproductive age group and in the survey sample there were 25 New Zealand born (16%) children. Age composition shows that for the Myanmar community, child health, reproductive health and family planning are more important than geriatric health.

Gender composition was very similar to the "Refugee Voices" research (NZIS, 2004), being male 53% and female 47%. In this survey, the percentage of total male respondents was 52.26% and the total female respondent was 47.26%. Health status self-determination was not much different by gender difference, except for poor health status: 4.5% of males stated that their health status was poor, compared with 1.9% of female respondents. The forty to fifty years age group male composition was double that of females. Men were more in the late middle-aged group and they had experienced more exposure to accident, trauma and infectious diseases than females at the time they were in the jungle. All health professionals commented that lifestyle

changes in New Zealand and role changes for men and women had affected the men's self-esteem levels, so these emotional health issues might contribute to their health status. However, there was no statistically significant relationship between age and perception of health status as well as gender and perception of health status.

5.1.6 Socioeconomic status and health issues

5.1.6.1 Social structure and community support

Myanmar people are in a collectivist culture who subscribe to the social control of shame and blame of the family as a whole. It was not uncommon to have two to three generations living in the same house in Myanmar. In the Glen Innes Myanmar refugee community, 7.7% of respondents were living with their extended family members and 92.3% were living with their nuclear families. When New Zealand accepted the refugees they defined the family as only nuclear family and that was the reason why most families lived only as nuclear families. However, all houses were very close together and community members could take the role of surrogate extended family member. The community was very close and helpful towards each other. The Myanmar refugee community social health status was strong and supportive. The midwife also commented that there was no clinically identifiable post natal depression in any of the twenty-five mothers of New Zealand born children.

5.1.6.2 Accommodation

All respondents have been living in Housing New Zealand houses, except one family of four respondents. The project facilitator observed at the time of the survey that all houses were well-maintained and in good condition, as

required to meet health and safety standards. Refugees had not moved houses during their resettlement time, with the exception of two families. The majority of houses were around fifty years old and they had no insulation system and 12.2% of respondents stated that cold houses affected their health. Traditionally, New Zealanders have only a small number of children and only the nuclear family lives in the same house. There were very few four or five bedroom houses in the Housing New Zealand housing pool. Myanmar refugees who had five to seven family members, and who were living in two or three bedroom houses, complained of overcrowding, especially during the flu season, when infection could spread to all family members. Apart from a few families who complained about small houses, there were no problems related to accommodation.

5.1.6.3 Education

In terms of education, adult refugees left their home country when they were intermediate or high school students. There were only 10.1% who had studied tertiary level education and 2.5% had not been in the formal school system. The level of education initially affected the access to the health care system and health information, because of language barriers. However, after four to five years of resettlement time, all refugees' communication skills were better and the midwife and the practice nurse also commented positively on the improvement of language skills. At the time of the survey, 46.8% of the adult population (nineteen years and above) were studying full-time. The improvement in education levels was well-reflected in the survey comments, as only 16% asked for interpreter services at primary health care clinics and only 2.5% stated that they could not see the primary health care doctor at some times because of a language barrier. In order to transfer

health information, translating important health information related to the Myanmar refugee community and/or conducting health information sessions with a bilingual tutor at the English language classes could be possible solutions.

5.1.6.4 Financial health and employment

Many refugees still relied on the social welfare system for financial assistance. However, at the time of the survey, 31.6% of the nineteen years and older population did not receive the benefit. Within five years (means resettlement time - 4.78 years) one third of the adult population were working and did not rely on a social welfare benefit. Despite low education and the language barrier, this was a very positive sign of integrative resettlement and economic health. However, "financial concern" was still the highest number of first level concern for 20% for emotional stress and the second highest concern for all reasons related to emotional stresses. Another significant pressure around financial concern was that all refugees sent money back to their relatives and friends who were still in their home country, refugee camps or second countries of asylum. Ten respondents (6.4%) answered that they could not see the primary health care doctor when they wanted to because of financial constraints. The practice nurse stated that the clinic did not charge the children up to eighteen years of age and only $10 for adults with Community Services Cards. Some patients with chronic diseases who require regular follow-up visits are only charged five dollars. Despite this subsidy of consultation fees through the social security system, financial barriers were identified by 6.4% of respondents. As suggested by a general practitioner and the practice nurse, employment might be the possible solution to address the financial barrier to accessing health services.

5.1.6.5 New Zealand socio-environmental conditions

The Myanmar refugee community identified seven conditions which affect their health. "Good health care" was an important factor for them and the majority identified this in their first priority line. This point also matched the satisfaction levels for health care services mentioned above. In total "good food" gained the highest response as a health-supporting factor. All parents answered that food, especially diary products, were very good for their children's growth and health. They also recognised that "fresh air" and "better sanitation" positively influenced their health. When they lived in the second country their status was illegal. They were always worried and afraid of government officials, especially police and immigration officers. They pointed out that "safety and freedom" was important for their health, especially for their emotional health. Getting separate houses and flats for their family was also important for them and they stated this in both focus group discussion and questionnaires.

When they stated negative factors in New Zealand which affect their health 41% identified "cold weather" and 16.7% identified "language problems" as negative factors. Surprisingly, nobody stated the financial costs of health care. The language problem kept resurfacing in both accessibility issues and negative factors about New Zealand.

5.1.7 Lifestyle and recreational activities

In terms of the refugee resettlement journey, five years of resettlement is still considered fairly early. At the time of the survey, 46.8% of the adult population were still studying full-time and 68.9% of the adult population were

financially reliant on the social benefit system. Twenty recreational activities were identified in the survey. Among the eighteen years and under age group, watching TV/videos, TV games and reading were the top three recreational activities. For the nineteen years and older age group, watching TV/Videos, playing with children and visiting friends' houses were the top three recreational activities. Thirty-six point seven percent of the adult population answered gardening as their recreational activity and this was very promising for both physical and emotional health. Only 13% of young people and only 3.8% of adults went to gyms as exercise-related recreational activity. Scragg and Maitra (2005) also commented that Asian people are less likely to be physically active than other New Zealanders. In summary, the Myanmar refugee community's recreational activities were more physically inactive activities.

Some adults answered that smoking (12.7%), drinking (8.8%) and playing cards or gambling (12.7%) were their recreating activities. Fifty percent of hepatitis B patients were consuming alcohol regularly and this was a big concern for the community leaders and the health professionals. In "Asian Health in Aotearoa" research, Scragg and Maitra (2005) concluded that Southeast Asians are more likely to binge drink than other Asian men and they are more likely to allow smoking inside their homes than other Asian people. In the Myanmar refugees' health status survey, we did not ask specific behaviours around drinking and smoking habits, and these areas are very interesting areas for future research.

5.2 Health services and health services providers' concerns

Generally, all three health care providers agreed that the Myanmar refugee community's health status was good. Women's health status was better than men's,

because hepatitis B carrier patients and men's lowered self-esteem levels affected the men's health status in general. That comment was different from the "Refugee Voices" research, which stated that women were more likely to respond that their health had worsened since their arrival in New Zealand. They all felt that unemployment and role changes between husband and wife were the factors which affected the men's health status. However, in terms of the respondents' self-determination about their health status, there was no significant difference between the genders. Hepatitis B was the highest physical health concern from the health providers' point of view. They also believed that emotional and social health areas needed to be addressed, but the practice nurse stated that Myanmar refugees were keen to move on rather than addressing their past trauma issues. They expressed concern about drinking behaviours and violence issues in the family and community.

Primary health care clinics provided all preventive and curative treatments for the health needs and proper referral to specialist treatment whenever necessary. They all felt that Myanmar refugees seek help in the early stages of their illnesses and they followed the health care providers' instructions. Both nurses advocated for more work on family relationship issues and violence. Their comments supported the participants' "concern about children who live together with their parents in New Zealand". They all pointed out that learning employment skills and getting employment might be one of the best solutions to address all physical, mental and social health areas.

5.3 The existing health services in Glen Innes area for Myanmar refugees

According to the community mapping, all health resources were in walking distance of five to thirty minutes, depending on the location of the families' houses.

There were a total of 312 visits to 10 health professionals by the Myanmar refugee community, an average of twice per person in the three months prior to the survey. Various reasons for visiting to the ten different health professionals and different health care facilities showed that in Glen Innes there were excellent health care facilities and Myanmar refugees used them all.

5.4 Accessibility of health services

In response to questions about accessibility to health services, 91.7% answered that they were able to see their family doctors, if they needed to. The remaining respondents stated that sometimes they were not able to see the doctor because of financial reasons (first barrier) language reason (second barrier). They had no problems around cultural issues, service availability and transportation issues. All respondents had registered at the family general practitioners. According to Guerin, et al., (2003) findings, accesibility to health services by the Somali refugees, showed language to be the biggest problem, and, to a lesser extent transportation and medical costs. However, Refugee Voices research findings were in line with Myanmar refugees' barriers to access health services, with financial problems identified as the first level barrier.

Myanmar refugees received health information from a number of different sources. The majority of the participants received information from the clinics, television and teachers at the schools. Because of the limitation of their language skills, audiovisual information was more suitable for them. Again, because most of them watched television for their recreational activity, they have received a lot of health information from the television. The majority of the adult population was also

studying, so that they had received a lot of health information from the teachers, too. However, 95.5 % of fourteen years and above respondents did not know the meaning of PHO (Primary Health Care Organisation). It might be effective if health care providers and teachers work together for refugee health education sessions.

There was overall satisfaction with the New Zealand health care system. Only one respondent chose "poor"; 32.2% chose "excellent" and 48.3% chose "good". More than seventy percent of the people were satisfied with their primary health care clinics, and they were happy that they had received appropriate treatment and thorough examinations. However, 6.4% of respondents were not satisfied with the primary health care clinics. 14.7% of respondents still felt that they hadn't received appropriate treatment, 20.5% of respondents felt that they hadn't received thorough examinations and 5.8% felt that there was a long waiting time at the clinic, despite arriving at the appointed time. Scragg and Maitra (2005) also stated in "Asian Health in Aotearoa" that most Asian people (92%) were very satisfied with their primary health care doctors at their last visit, which is similar to the proportion for all New Zealanders.

Most of the primary health care clinics worked on fifteen minutes slots for each patient. Some patients take more than fifteen minutes and sometimes waiting time at the clinics could be long. Myanmar refugees were very familiar with symptomatic treatments and getting injections at the clinics in Myanmar and at the Thai-Myanmar border areas. In New Zealand, doctors usually treated the root problems and they did not prescribe a lot of medications. Most of the Myanmar refugees received only paracetamol for minor illnesses and they felt that they had not

received appropriate treatment. Because of time limits for individual consultations, Myanmar refugees also felt that they had not been examined thoroughly by the doctors. Language might be the reason for these issues, because they could only communicate with the doctors and nurses in limited English and they might not understand thoroughly about their diseases and confusion lead to low satisfaction levels. For other health care providers, nobody stated "poor" for their satisfaction level.

5.5 Health seeking behaviour of Myanmar refugees for their health

Most of the Myanmar refugees used over-the-counter analgesic medications when they felt sick and if that medication did not help them they went to see the doctor. However, they went to see the doctor straight away when children fell sick. They were still using traditional Myanmar indigenous medicine for minor illnesses like dyspepsia, indigestion and dizziness. Scragg and Maitra (2005) also stated in "Asian Health in Aotearoa" that Asian people (81%) were less likely to have visited a health practitioner when they were first unwell than were all New Zealanders (93%). That finding was validated in this survey, 17.9% went to see the doctor as their first priority. They also commented that Asian people most commonly visited their primary health care clinic because of a short-term illness or for a routine check-up compared with other New Zealanders who visited for injury, poisoning or for mental health or emotional health reasons.

Myanmar refugees, 69.2% had met with a health professional at least one time in the three months prior to the survey. They used a variety of health services; doctor-clinic, doctor-hospital, practice nurse, community child nurse, midwife, school nurse,

dentist, dental nurse, diagnostic-lab technicians and health staff from the diabetic clinic. It also showed that Myanmar refugees knew about available health services and they could access required health services easily. The majority of people (67.7%) visited their primary health care clinic; 51.3% visited their family doctors, and 14.1% visited the practice nurse. "Refugee Voice" research (NZIS, 2004) showed a high number of hospital visits compared to what would be expected of the general population. However, Myanmar refugees visited their primary health care clinics more than hospital.

5.6 Recommendations

Primary Health Care Clinics

1. Develop a project for interpreter availability at the primary health care setting
2. Advocate for primary health care practitioners to allow for longer consultation time in the primary health care clinics
3. Request the primary health care clinic to send reminders about immunisation follow-ups
4. Encourage the community members, especially those with chronic diseases, to do physical activities with green prescriptions by primary health care providers (prescription to go to the gym)

Accessibility to health services and health information

5. Health information, especially about common chronic diseases in the Myanmar community and about PHO services, should be made available in the Burmese language

6. Establish regular information groups and discussions in the community about child health, reproductive health and family planning and/or conducting health information sessions with bilingual tutors at the English language classes
7. Information about after hour health care services should be made available
8. There could be more collaborative work among PHOs, schools, Housing New Zealand, Social Welfare offices and the Myanmar refugee community
9. Increase the use of audio visual aids for health information

Social health promotion and accessibility to social health programmes

10. Develop a basic counselling skills programme for the key community members and peer supervision facilities
11. Develop and deliver parenting, couple relationship and family resilience programmes
12. Develop life planning programmes and continue with job training programmes
13. Develop health education programmes and encourage health promotion activities related to smoke-free cars, smoke-free homes and develop culturally appropriate smoking cessation assistance
14. Develop health education programmes and encouragement for health promoting activities related to alcohol-free recreational activities
15. Offer gambling awareness information sessions and create culturally appropriate gambling counselling services

Further research

16. Conduct similar research in North Shore Karen refugee community as a comparative study
17. Undertake qualitative surveys related to chronic diseases and lifestyle influences on the particular disease

18. Conduct similar research in other ethnic refugee communities as a baseline study for the community and as a comparative study with others

5.7 Lessons learned

This survey concerned the health situation analysis of the Myanmar refugee community. The survey identified not only the individual level, but also analysed the whole community's strengths and weaknesses. The focus group discussion and in-depth interviews provided the project facilitator with a very good starting point for the questionnaire development. In-depth interviews also allowed for an analysis of available health services and an expression of health practioners' concerns. However, because of time constraints and availability of participants, the group was not homogeneous. The pre-test exercise was one of the key processes in this survey and the pre-test analysis made sure questionnaires were user-friendly and allowed for linkage among questions. In the questionnaire, important issues were asked from different point of view to make sure that the responses could be cross-checked, which increased the validity of the data. However, Conbrah α Analysis was not applied for content analysis of questionnaire development process, and the project facilitator strongly recommended for future surveys in order to validate findings.

The community was a small community. Explaining information about the survey and ensuring confidentiality was very important in the process of trust-building and getting the right information. Myanmar people do not usually criticise health care providers. However, in this survey we wanted to know their satisfaction levels in relation to health care providers. The project facilitator needed to make sure that the information was treated as confidential and would be presented collectively

and anonymously. People did not usually disclose their drinking and gambling behaviour, so we needed to frame these questions in non-judgemental and non-threatening ways. Trust was one of the important factors in this survey process to elicit correct information from the respondents. The project facilitator was one of the respected community members and this factor was a big bonus for the survey process.

Because their level of education was not very high, most of them did not understand the questions and needed a lot of facilitation and explanation in order to answer the questions. The project facilitator used survey questionnaire cards (multiple choice answers were printed in big fonts) to help respondents to see clearly and he explained the questions in casual language. It was a very effective process and respondents understood the questions well and they could give more accurate answers. When we used casual language to clarify the survey questions, questioning skills were very important and all questions needed to be culturally appropriate. If different ethnic researchers conduct a survey with refugees, these researchers need a high level of cultural sensitivity. However, in this survey, this might reflect bias on the part of the surveyor and respondents, because project facilitator used to work as a doctor with the respondents in the second country, Thailand.