CHAPTER IV

RESULT

The Myanmar refugee community health status survey was conducted in the Glen Innes area, Auckland, during September and October 2005. Three health care providers were interviewed about their experiences and concerns about the Myanmar refugee community's health status. The interviews were recorded and used for questionnaire preparation. One community focus group discussion was conducted in the last week of August, 2005 and their comments were used for preparing the questionnaire to identify the Myanmar refugees' health status.

According to the Myanmar community leaders there was a total population of 205 Myanmar refugees, making up 56 households in Glen Innes, Auckland. 156 people (76 % of community) from 39 households answered the survey questionnaires. 82 adults (52.6%) answered themselves and 74 questionnaires (47.4%) were answered by their family members. Mothers answered for their children who were under 13 years old.

4.1 Demographic Data and Life style

4.1.1 Age and gender composition

Among the 156 survey participants, 82 people (52.6%) were male and 74 (47.4%) were female. The three years and under (play centre) age group numbered 15 people (9.6%); the four to five years (kindergarten) age group numbered 12 people

(7.7%); the fourteen to eighteen years (secondary school) age group numbered 11 people (7.1%); the nineteen to twenty-five years (colleague/university) age group numbered nine people (5.8%) and the twenty-six years to sixty-five years (working) age group numbered 70 people (44.9%).

Table 4.1 Age distribution by genders (Total 156 respondents)

Age in years	Age Group	Male	%	Female	%	Total	%
<3	Play Center age group	6	3.8	9	5.8	15	9.6
4-5	Kindergarten	7	4.5	5	3.2	12	7.7
6-13	Primary School	25	16.0	14	9.0	39	25.0
14-18	Secondary School	6	3.8	5	3.2	11	7.1
19-25	Colleague/University	2	1.3	7	4.5	9	5.8
26-65	Working age group	36	23.1	34	21.8	70	44.9
Total		82	52.6	74	47.4	156	100

In line with the New Zealand benefit system, in this survey adult means eighteen years and over respondents. There were 79 adults (nineteen years and above) and 77 children and adolescents (eighteen years and under).

4.1.2 Marital status

In the adult population, twelve people (15%) were single, 60 people (75.4%) were married, five people (6%) were separated, one person (1.2%) was a widow and two people (2.4%) were living together in a de facto relationship.

4.1.3 Birth places

83 people (53.2%) were born in Myanmar, 12 people (7.7%) were born at Thai – Myanmar border, 36 people (23.1%) were born in Thailand and 25 people (16%) were born in New Zealand.

4.1.4 Resettlement time in New Zealand

The majority of Myanmar refugees have been resettled in Glen Innes, Auckland for more than five years. The longest resettlement time is five years three months and the shortest resettlement time is one year six months. Twenty five people were New Zealand born children and 131 people are resettled refugees. Mean resettlement time for resettled refugees is 4.8 years. The Refugee Voices research (NZIS, 2004) defined refugees who resettled five years and more as "resettled refugees" and in this survey 56 people (43% of 131) had a resettlement time of less than five years and 75 people (57% of 131) had a resettlement time of more than five years.

4.1.5 Level of education

The majority of people did not attain a high level of formal education in their home country, Myanmar. Among the adult population, (19 years and above - total 79 people), 27 people (34.2%) had experienced primary level education, 20 people (25.3%) had experienced intermediate level education, and 22 people (27.8%) had experienced secondary level education. Eight people (10.1%) had studied at tertiary level and two people (2.5%) had not been in the formal school system. Thirty-seven (46.8%) from 79 people of the adult population were also studying full-time in New Zealand at the time of the survey. All 18 years and under children were attending appropriate age-related classes in New Zealand.

4.1.6 Family structure and living conditions

All people, except one family, live in Housing New Zealand (HNZ) houses. Eighteen people (7.7%) are living with their extended family members and 144 people (92.3%) are living with their nuclear families. All families came to New Zealand with their nuclear family members, except two families who came to New Zealand with three generations of family members. All Housing New Zealand houses are provided by the government. All houses should meet health and safety conditions at all times. The HNZ tenancy managers visit all houses for regular inspections at six-monthly intervals.

4.1.7 Income – employment and social benefit

At the time of the survey 25 people (31.6%) of adult population did not receive the benefit and they were working. The rest of the Myanmar refugees were on social benefit.

4.1.8 Recreational activities

A total of 21 recreational activities were recorded from the survey. Different people prioritized the different recreational activities and they prioritized the most frequent activities (one) to least frequent activities (five).

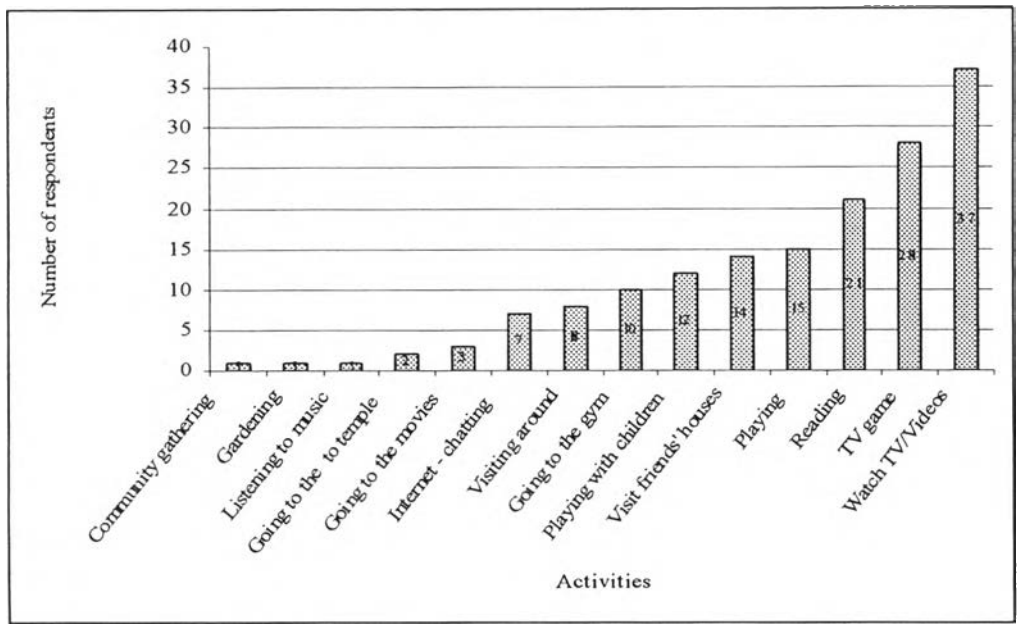

Figure 4.1 Recreational activities – 18 years and under (n = 77)

Among the eighteen years and under age group, 15 (19.5%) people stated their most frequent recreational activity was watching TV/videos and 13(16.8%) people also put watching TV/videos as a second priority. In total, watching TV/videos was the highest recreational activity (48.1%), TV games followed with (36.6%) and reading was in third position with (27.3%). Nobody responded to drinking alcohol, smoking, playing cards and going to the casino, fishing, walking and shopping as their recreational activities.

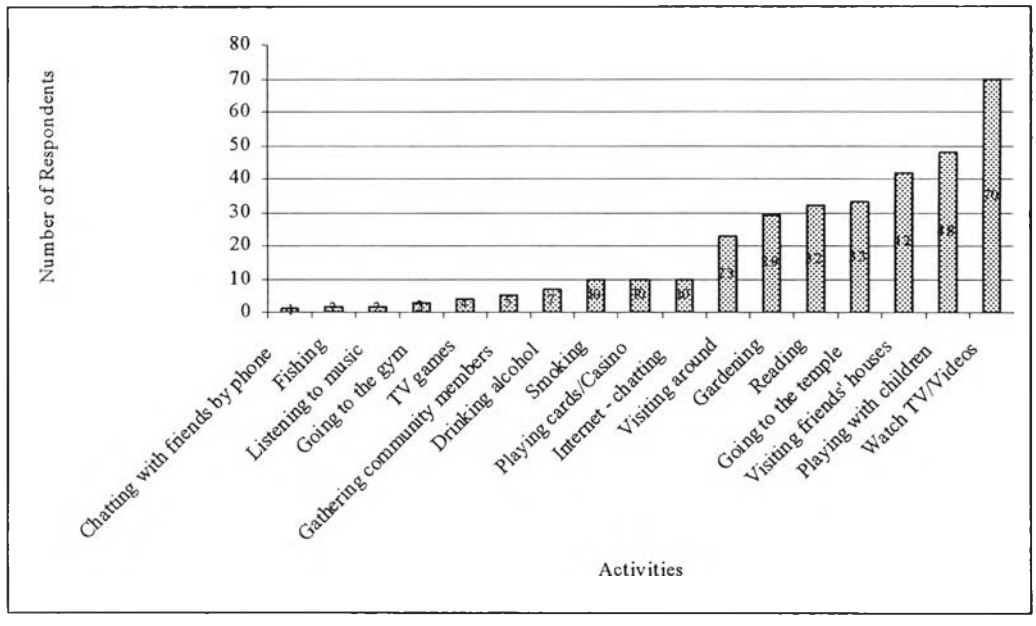

Figure 4.2 Recreation activities – 19 years old and above (n = 79)

The nineteen years and above population were similar to the eighteen years and under group. 33 people responded that watching TV/videos was their frequent recreational activity and 17 people also responded that this was their second priority recreational activity. In total, watching TV/videos was the first priority with 88.61% and playing with children was second priority (60.76%) and visiting friends' houses was the third priority recreational activity (53.16%). Seven people (8.8%) answered drinking alcohol, 10 (12.6%) people answered smoking and 10 (12.6%) people answered that playing cards or playing at casino were their recreational activities.

4.2 Health status of Myanmar refugees as perceived by members of the Myanmar community themselves

4.2.1 Self-perception of health status (All community members, n=156)

All respondents (156 people) determined their current health status as they perceived it. Parents stated their children's health status. Thirty-two people (male

19, female 13) (20.5%) answered that their health status was *excellent*; 78 people (male 36, female 42) (50%) answered *good;* 36 people (male 20, female 16) (23.1%) answered *fair* and 10 people (male 7, female 3) (6.4%) answered *poor*. Non of the New Zealand born children's mothers perceived that their children's health was *poor*.

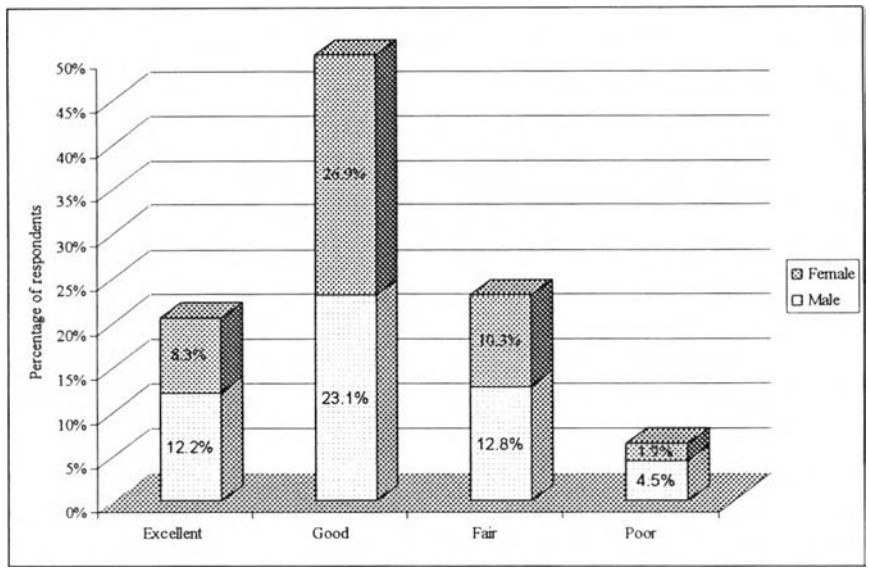

Figure 4.3 Myanmar refugees' perceptions of their health status (n=156)

4.2.2 Self-perception of health status (Only resettled refugees, n=131)

If the twenty-five New Zealand born children had not been included in the analysis, the self-perception of health status would not have been much different. Twenty-six resettled refugees (20%) answered that their health status was *excellent*; 64 people (49%) answered *good*; 31 people (24%) answered *fair* and 10 people (8%) answered *poor*.

4.2.3 Health status on early resettlement period and the present time

Twenty-five New Zealand born children did not need to answer this question. When Myanmar refugees (131people) compared their health status during the early resettlement period with their current situation, eight people (6.1%) felt that they were much better than during the early resettlement period; 61 people (46.6%) felt that they were better than during the early resettlement period; 38 people (29%) felt that their health status was the same and 24 people (18.3%) stated that their health status was worse compared with the early resettlement period.

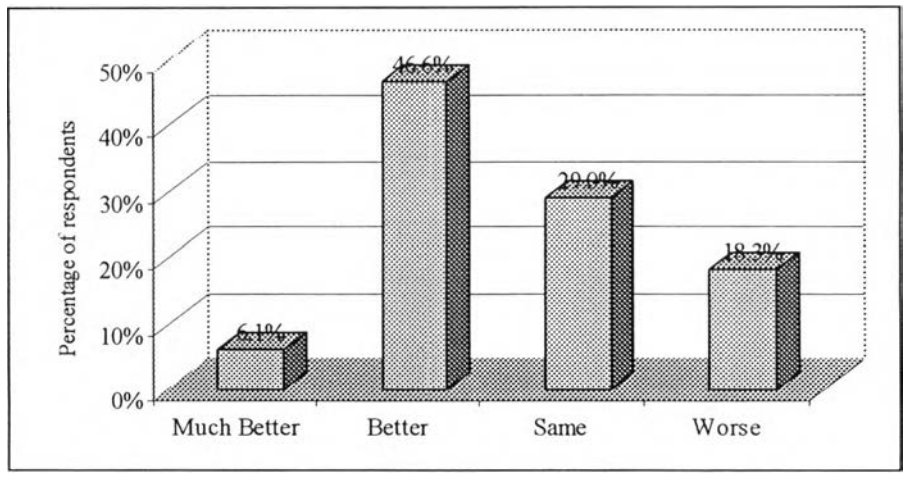

Figure 4.4 Myanmar refugees' perceptions of the comparison between their health status during the early resettlement period with the present time (n=131)

4.2.4 Refugees' perceptions on factors in New Zealand that contribute to health (n=156)

- **Positive factors**

The majority of people, 44 people (28.2%) perceived 'good health care' was important for them to categorise as the first priority. The 'good health care' factor gained the highest points in the first priority line. In the first priority line 'good food' followed with the second highest points and 'fresh air' with the third highest points. In

total 'good food' was rated highest by 97 people (62.2%), with 'fresh air' and 'good health care' rated in the same position by 85 people (54.5%).

- **Negative Factors**

Participants also prioritised the negative factors that impact on their health. In the first priority line (59 people) 37.8% felt that 'cold weather' affected their health. 'Cold weather' gained the highest number of points and was perceived to be the factor most detrimental to good health. 'Language problems followed 'cold weather' with the second highest points in the first priority line. In total, 'cold weather' was still the first concern (64 people) 41% for the Myanmar refugees and language problems (26 people) 16.7% was second concern.

4.2.5 Chronic diseases

Ninety-nine from 156 people (63.5%) answered that they have no disease. Fifty-seven people (36.5%) answered they have one or more chronic diseases, according to their doctors. Two people suffered from three diseases and two people suffered from two diseases.

Among the Myanmar refugee community allergies are the most common chronic disease (13 people, 22.8%); asthma is the second most common chronic disease (10 people, 17.5%) and hepatitis is the third most common chronic disease (8 people, 14%).

4.2.6 Acute Illness (Frequency of sickness in the three months prior to the survey)

Table 4.2 Frequency of sickness in the three months prior to the survey

Number of times fell sick	Number of people	Percent
1	43	47.7
2	18	20
3 times and > 3 times	29	32.3
Total	90	100

Signs and symptoms of illness were not more than two weeks defined as acute illness in this survey. Ninety people, 57.6 % of respondents, fell sick in the past three months prior to the survey. The following table shows the type of sickness that respondents suffered from during that time. 10 people suffered more than one disease. Common cold was the most common illness.

Table 4.3 Type of illness suffered by the respondents in the past three months prior to the survey (n=90)

Type of sickness	Number of people	Percent
Common cold	69	76.7
Headache	11	12.2
Skin Infection	7	7.8
Arthritis	3	3.3
ENT problems	2	2.2
Peptic ulcer	2	2.2
Diarrhoea	1	1.1
Dental problems	1	1.1
Urinary tract infection	1	1.1
Back pain	1	1.1
Myoma	1	1.1
Pneumonia	1	1.1

4.2.7 Emotional Health

Respondents aged thirteen years and above (90 people) were asked *"Did you experience any emotional stress in last 3 months?"* Twenty-one respondents (23.3%) answered that they had experienced no emotional stress in last three months. The remaining respondents (69 people, 76.7%) had experienced emotional stresses in last three months. Among 69 people, there was only one respondent (1.4%) from 14 - 18 years age group. Sixty eight people (98.6%) came from above 19 years age group.

Reasons for the emotional stresses were identified as "language problem", which was the highest concern by 37 people (53.6%), "financial problems" and "concern about children who live together with their parents in New Zealand" were the same frequencies for 32 people (46.3%) as the second highest concern. "Unable to plan for life" was the third highest concern for 29 people (42%).

The following table shows the different coping mechanisms used to deal with their emotional stresses. People responded with more than one coping mechanisms.

Table 4.4 Different coping mechanisms to deal with the emotional stresses (n=69)

Coping mechanisms	Number of respondents	Percent
Talking to friends	18	26.1
Talking to partner	15	21.7
Prayer/Meditation	9	13
Talk to senior community member/s	7	10.1
TV/Music	7	10.1
Smoking	6	8.7
Drink beer or alcohol	6	8.7
Stay alone/ keep to self	5	7.2
Shopping	5	7.2
Talk to a monk	4	5.8
Exercise	4	5.8
Chores/gardening	4	5.8
Talk to your teachers	3	4.3
Playing cards/Gambling	3	4.3
Play with children	3	4.3
Sleep	3	4.3
Yell at children	2	2.9
Visiting around	1	1.4

Talking to friends was the highest coping mechanism by 18 people (26.1%), talking to partner was the second highest coping mechanism by 15 people (21.7%) and prayer/meditation was the third highest coping mechanism by 9 people (13%) in the. Six people (8.7%) answered smoking, six people (8.7%) answered drink alcohol/beer and three people (4.3%) answered gambling was negative coping mechanisms for emotional stresses.

4.2.8 Observation by the project facilitator at the time of delivering the questionnaires and facilitating the survey

The project facilitator visited all respondents' houses. He physically delivered the questionnaires after making appointments. All houses were neat and tidy. They were all well-dressed and showed no signs of malnutrition or sever illness.

4.3 The health service providers' concerns about Myanmar refugees in Glen Innes

The project facilitator interviewed three health providers based in Glen Innes. They all are New Zealanders and main-stream health providers.

4.3.1 A General Practitioner

The project facilitator interviewed a local doctor from the Line Road Surgery. He stated that social problems were underpinned by the unemployment and language problems. He said that domestic violence was a very typical indicator of social health issues. Using alcohol was a kind of coping mechanism that people, who could not access or did not know other coping mechanisms, used to deal with resettlement challenges. He commented that because of other resettlement issues like employment and language problems, refugees' health was left behind. With regard to the Myanmar refugee community, he was concerned mostly about hepatitis patients and he mentioned that one client had already passed away with liver cancer.

4.3.2 A Practice Nurse

She felt that the health status of the Myanmar refugee community in Glen Innes was good. She also raised concerns that if children fall sick, most of the time the mothers bring the children, and she met with more women than men in the

clinic. She would like to encourage fathers to take more responsibility for family health. She thought that role reversal might be an issue and the community needed to look at the bonding issues within families. She stated that the women's lives in New Zealand were different and they were stronger now, so men might be experiencing low self-esteem. She was concerned about the drinking habit and violence. In terms of chronic disease, hepatitis carriers and thyroid problems were her concerns. She was not much concerned about the physical health status of the children.

She answered that Burmese refugees did not mention their traumatic experiences and she felt that they were all keen to move on. Finally, she expressed concern about anaemia, because a lot of people eat chicken, because it is cheap and she advised that they should eat red meat, too. In summary, she confirmed again that women's health appeared excellent; however, men's health was not good in general because of hepatitis and the drinking habit.

She also stated that their attitude to health was also good, because they came to get treatment in the early stages of disease; women come on the exact day for their birth control injections, and parents brought their children regularly for vaccinations. She also said that Myanmar people were very co-operative, compared with other people, that they were not demanding and very humble.

The practice nurse thought the language barrier was the most important barrier to access and to get thorough explanation about the diseases. She thought that financial limitation might also be a barrier, because most of the refugees were on social benefits. However, the clinic did not charge for the children under eighteen and

for the adults they charged only ten dollars. All immunisations and regular check-ups like pap smears were free. Patients who are chronic cases and who require regular follow-up are only charged five dollars. They get subsidies from the government for medication and usually clients have to pay only three dollars, however, she was not sure about medical costs for big families with numbers of children who fall sick at the same time. The clinic is open up to 5: 30 pm and if people need to access an after hour clinic they could go to the White Cross at the shopping centre which is twenty minutes' drive from Glen Innes. Their clinic issued cards for the clients to show at the White Cross Clinic and they get ten percent discount.

4.3.3 A Midwife

A midwife stated in the in-depth interview that the Myanmar refugee community's health as a whole was reasonably good: physical health was good, for some, it could be better, however, some aspects of health, are very good. She said that socially (her personal opinion) some of them did not seem able to move on. When she attended the celebration of Myanmar democracy uprising day in Glen Innes in August 2005, she witnessed a Burmese lady weeping for her parents who were killed in the demonstration. She wondered how many others were like her and that they might need counselling. She felt that not all Myanmar refugees used all the social facilities from New Zealand like night schools to get formal qualifications. She saw a need for education, career and life planning exercises to increase motivation and self-esteem.

She felt that Burmese refugees' health status was higher than that of some New Zealanders, because Burmese people eat a balanced diet and do not eat a

lot of junk foods. However, she was concerned about drinking behaviour and she knew that violence occurred in some families.

She also mentioned that she dealt a lot with women, mothers and newborns and she was happy with the Burmese mothers' early health-seeking behaviour. She stated that all pregnant women followed instructions very well and they all appeared strong and very capable of taking care of their children. She also mentioned that the community was very strong and lived closely together, so post partum depression was not an important issue for the Burmese people.

In terms of accessibility, the midwife said that she provided home visits and the service was free. She and her team provided on-call service for emergencies and at the time of delivery. She was amazed at how they learned English and now she rarely had a problem around language. She could also access the interpreter service, if necessary. With regard to cultural appropriateness for service delivery, she always asked the clients about their beliefs and preferred ways of doing things. However, she hasn't had any experience of complaint around her service delivery.

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

4.4.1 Community mapping

Two community leaders and the project facilitator located the health care services and Myanmar refugees' households on the Glen Innes map that is shown in appendix 4. All Myanmar refugees' houses were within walking distance. Fifty-six households were located on the map. All social resources: shops, supermarket, library,

schools, community centre, six health care services are around the Glen Innes shopping centre and another three health clinics are located at different places in the community. All health services are in twenty to thirty minutes walking distance.

4.5 The health seeking behaviours of Myanmar refugees

All respondents were registered at the family general practitioners. When they felt sick 113 people (72.4%) of respondents used over-the-counter western medicines as the first response. However, 28 respondents (17.9%) went to a medical clinic as the first response. They also answered that if children fall sick, they took them to the doctor straight away. One-hundred-and-five respondents (67.3%) mentioned they would go to see doctor, if analgesic did not work for their sickness. Five people (3.2%) preferred to use Myanmar indigenous medicines as the first and second responses.

4.6 Identify the accessibility of health services for Myanmar refugees

4.6.1 Number of visits to the health care professionals

One-hundred-and-eight people (69.2%) met with a health professional at least one time in the three months prior to the survey. There was a total of 312 visits to health professionals by the Myanmar refugee community, an average of twice per person. Eighty people (74.1%) met with a General Practitioner, 22 people (20.4%) met with a practice nurse, and 18 people (16.7%) visited a diagnostic laboratory.

Table 4.5 Number of visits to health care professionals in the three months prior to the survey (n=156)

Number of visit to health care professionals	Number of people	Percent
No visit	48	30.8
1	31	19.9
2	38	24.4
3 visits and above	39	24.9
Total	156	100

During their visit to the health professionals, 70 people (64.8%) received treatment for their sickness, 27 people (25%) received a vaccination and 13 people (12%) received a follow-up check up for their chronic disease. The remaining people went to different health professionals to received antenatal care, dental care, family planning and pep smear tests.

4.6.2 Accessibility to primary health care services

One-hundred-and-forty-three respondents (91.7%) answered that they were able to see their family doctor, if they need to see one. Only 13 respondents (8.3%) answered they were not able to see doctors, even if they needed to see their family doctor. Among 13 respondents, ten people (77%) stated financial reasons and three people (23%) stated language problems as barrier to access. They did not mention geographical distance, transportation problem or availability of services.

4.6.3 Accessibility for the Health Information

Ninety Myanmar refugees aged fourteen years old and above could access health information from different places. Forty-four people (28.2%) received

health information from the General practitioners' clinic, 31 people (19.9%) received information from television, and 22 people (14.1%) received information from their school teachers.

4.6.4 Satisfaction levels in relation to General Practitioners' clinic visited

All respondents were asked to select from four levels on a satisfaction scale with regard to the General Practitioners' clinics that they had visited.

4.6.4.1 Satisfaction level for the General Practitioners' clinics

Respondents used a four level satisfaction scale to rate the General Practitioners' clinics and nineteen people (12.2%) answered excellent, ninety-one people (58.3%) answered good, thirty-five people (22.4%) answered fair and 10 people (6.4%) answered poor and one (0.6%) answered don't know.

A total of ninety-six people (61.5%) answered that they received "appropriate treatment" from their General Practitioners' clinics and it was the highest response for the reason for satisfaction. Eighty-eight people (56.4%) also selected this as their second highest reason for satisfaction.

However, 71 people (45.4%) also selected negative responses. Thirty two people (20.5%) answered "not through clinical examination" as the highest response for a negative reason. "Inappropriate treatment" was selected by 23 people (14.7%) making this the second highest score for a negative reason. "Long waiting time" was the third highest score (5.8%) for a negative reason.

4.7 Possible solutions to address the health needs of Myanmar refugees

4.7.1 Suggestions from the health care practitioners

The General Practitioner felt that the community needed to address the domestic violence and drinking problem. He also felt that employment would help most of the social issues, would keep people busy and it would also help their socio-economic status. He suggested that helping the refugees to get employment might be one of the best solutions to deal with health problems.

The practice nurse commented in terms of solutions for the improvement of community health. She admitted that her point of view, sitting in the clinic, would be very limited, but she suggested that work for more couple and family bonding and employment opportunities for the men would be helpful in both the physical and emotional health areas.

4.7.2 Suggestions from the Myanmar refugees

A total of 40 respondents (25.6%) offered 53 suggestions for increased cultural accessibility to PHOs and acceptability. All suggestions are listed in Table 4.6. Twenty-five people (16%) commented on the inaccessibility of interpreter services at the primary health care clinic and this deficit elicited the highest number of comments. Seven respondents commented on the physical examination at the clinic and they preferred to get a more thorough examination. Another seven (4.4%) respondents commented about the long waiting time at the clinic, after they had made appointments and they were there at the right time. Five people (3.2%) preferred to get injections when they fell sick. Two (1.3%) respondents felt that the clinic had to do thorough hospital referral follow-up for hospital appointments. The clinics were

generally closed at 5:30 pm and two participants (1.3%) needed to get more information about after hour health services. One participant (0.6%) the general practitioners were not available at the clinics at all times. They have to go to another clinic or on other business (e.g. attend meetings). One participant (0.6%) commented that she preferred the doctor to be at the clinic all the time. One respondent (0.6%) preferred to get more assistance from the clinic to access the local gymnasium for physical exercise.

Table 4.6 Suggestions from the Myanmar refugees

Suggestions	Frequency	Percent
Interpreter service at the primary health care clinic	25	16
More thorough physical examination at the primary health care clinic	7	4.4
Long waiting time at the primary health care clinic regardless of making an appointment	7	4.4
Prefer to get stronger medication at the clinic	5	3.2
Get more information about after hours health services	2	1.3
Efficient follow-up for hospital appointments and contact back to the clients	2	1.3
Prefer to get Burmese doctor at the primary health care clinic	1	0.6
Doctor to stay at the clinic all the time	1	0.6
Give priority to children at the clinic	1	0.6
Reminders about immunisation dates	1	0.6
More support form primary health care clinic to access the gymnasium	1	0.6