

3.04 Refugee People's Health

A refugee is “Any 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/her nationality and is unable, or owing to such fear, is unwilling to avail himself/herself of the protection of that country.” (United Nations Convention Relating to the Status of Refugees, 1951).

New Zealand is one of nine countries that offer a regular quota of places for United Nations High Commissioner for Refugees (UNHCR) mandated refugees for resettlement. The other countries besides New Zealand are Australia, Canada, Denmark, Finland, Netherlands, Norway, Sweden and the USA.

Refugee Resettlement and Immigration Policy

New Zealand is one of the few countries that do not require pre-settlement health screening for quota refugees. Unlike many other resettlement countries, New Zealand has not based its acceptance of refugees on their ‘resettlement potential’. Rather, the Government ensures that many of its quota placements are reserved for the most needy cases as identified by UNCHR, such as Women at Risk, Medically Disabled, and Protection cases (ICRR, 2000; NGO Group, 2000). Most of the cases accepted in New Zealand will become the responsibility of the Auckland District Health Board.

In 1987 the Government established a formal annual quota of up to 800 refugees, which was divided into specific categories. These categories originally reflected national, ethnic and religious groups, as well as refugees with special needs, such as the disabled and long stayers in refugee camps. Since 1992 the categories have been revised to reflect worldwide refugee concerns in an effort to provide the Government with greater flexibility to respond to resettlement needs. The quota programme year runs from 1 July to 30 June concurrent with the fiscal year. Consultations are held with the United Nations High Commissioner for Refugees (UNHCR) and with other relevant agencies in New Zealand to discuss resettlement priorities before the planned composition of the quota is set annually by the Minister of Immigration. The composition of the quota 750 places is as follows:

| | |
|--------------------------|-----|
| Women-at-Risk | 75 |
| Medical/Disabled | 75 |
| UNHCR Priority Referrals | 600 |
| Total | 750 |

Medical Cases

The medical/disabled category provides for the entry of refugees with medical, physical or social disabilities that place them outside the normal criteria for acceptance by resettlement countries. Medical screening prior to acceptance for resettlement is not

required prior to arrival as it is in other resettlement countries. No one is denied entry to New Zealand on the grounds of a medical or psychological condition or a disability. The Ministry of Health must give prior confirmation that suitable treatment is available before a case can be accepted.

Women- (and children) At-Risk

Annually ten percent of quota refugees are women and children who have been at risk in their country of origin and first asylum. The women-at-risk category and their children would usually be outside the normal criteria for acceptance by other resettlement countries. The majority of refugee women-at-risk in need of resettlement have gone through particularly harsh experiences, not only of rape, but torture and multiple losses, which have contributed to their psycho-social destabilization, or impose on them additional risks in the country of first asylum, which endanger their own and their dependants' future (UNHCR, 1994). Eventual return to their country of origin is often, impossible to envisage. The changes in their own society, added to the multiple personal losses deprive them of any family, social and economic protection and support (UNHCR, 1995). The stigma attached to rape constitutes another major obstacle for a dignified life (UNHCR, 1991). The trauma sustained often requires long term specialised care and strong psychosocial support in New Zealand. In camps, refugee children may have experienced prolonged exposure to infection and disease, malnutrition, lack of personal protection, and deprivation of education deprivation of the opportunity to play normally.

Priority Cases

These are all other cases submitted under the usual mandate some of whom will be identified as urgent cases.

Asylum Seekers

Up to forty people a week claim refugee status in Auckland, annually up to 2000. Under the guidelines set down by the UNHCR, New Zealand has a general obligation to admit asylum seekers who arrive at a port of entry and seek to have their claim for refugee status recognised (Immigration Act, 1987). Asylum seekers make application for refugee status with the Refugee Status branch of the New Zealand Immigration service (NZIS). Applications that are declined have the right of appeal to an independent appeal authority. These asylum-seekers are considered quite separately from, and in addition to, the UNHCR mandated refugees accepted for resettlement in New Zealand.

Almost all new arrivals that seek spontaneous refugee status will be given a work permit and will be entitled to publicly funded health, welfare and education. Very few claimants are detained and no person who is a refugee status claimant may be removed or deported from New Zealand until their refugee status has been finally determined, a period of between months and years. Fifteen percent of claimants, approximately 800 people will gain residence in New Zealand as refugees mostly from Sri Lanka, Afghanistan, Iraq and Iran. Claimants are usually men under 40 who have left families in their countries of origin. Most asylum seekers arrive at Auckland Airport and live in the central Auckland area.

Asylum seekers are eligible for free health public health screening in Auckland provided by Public Health Protection service. In Auckland there is insufficient funding to provide timely screening to all asylum seekers. Often there is a waiting list for screening. In addition, many asylum seekers do not access the free screening.

Family Reunification Category

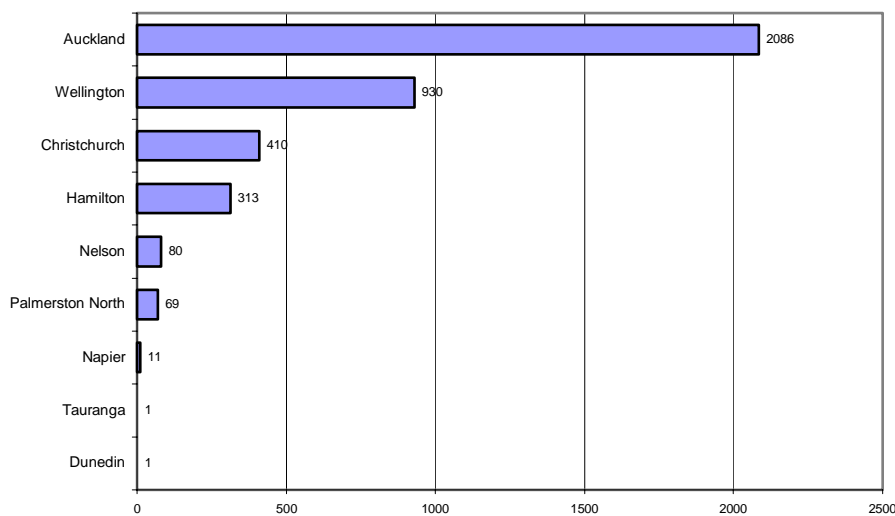
The New Zealand Immigration Service (NZIS) provides a humanitarian migrant category. Families entering New Zealand under this category are relatives of refugees who have residence. Entry is under the general immigration provisions that take into account humanitarian issues such as family reunification (Immigration Act, 1987). In some years, the number of family reunification refugees is roughly equivalent to the size of the refugee quota. On average two to three hundred people will be reunified with family in New Zealand under the migrant humanitarian category. Most families will arrive and remain in central Auckland.

Family reunification refugees are required to undergo health screening prior to leaving their homeland for New Zealand. This screening is often not reliable. This group is also eligible for free health screening from regional public health services on arrival in New Zealand but many do not access the service.

Demographic Profile of Refugee Peoples

The highest numbers of refugees in New Zealand live in the Auckland District Health Board area, approximately 40,000 and increasing by 2,000 annually (Solomon, 1999; 1997). Refugees and asylum seekers probably represent the most vulnerable health population in New Zealand society (Community Child, Adolescent and Family Service (CCAFS), 1999).

Figure 86: Quota Refugee Arrivals in Resettlement Regions from June 1994 to May 2001



Data Source: New Zealand Immigration Service, 2001.

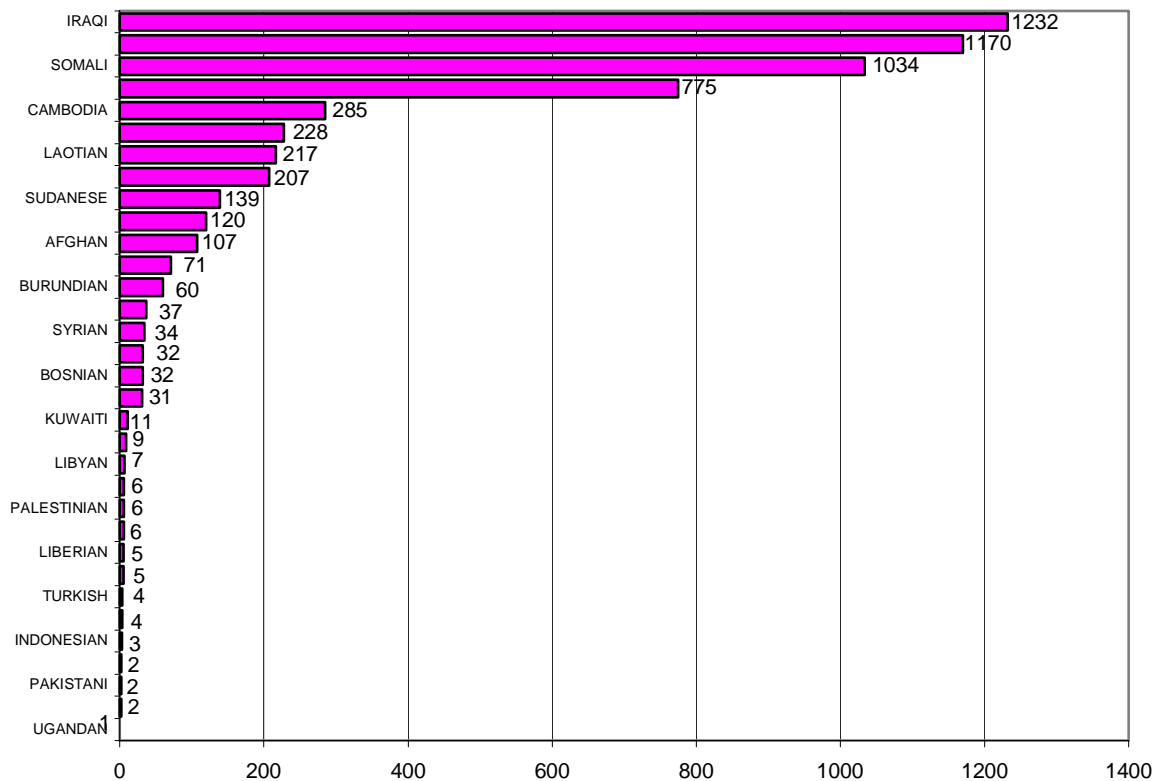
Accurate demographic data on either the existing refugee population or new arrivals is not available which makes the assessment of needs and planning for health services difficult. In 1997, it was estimated that the total refugee and asylum seeker population in New Zealand was around 36,000 and over two thirds of this group resided in central Auckland (CCAFS, 2001).

The data in Figure 86 refers only to those refugees arriving under the quota category. The number of refugees in Auckland is much higher when combined with pre-settled refugees and refugees arriving under other categories.

Ethnicity

In recent years, the Government’s allocations have focused on the Middle East, East Africa and Southeast Asia. The main nationalities accepted for resettlement to New Zealand included: Iraqi, Somali, Ethiopian and Vietnamese (Figure 87). In addition to those refugees accepted for resettlement, the Government granted entry to persons in refugee-like situations under its humanitarian and family reunion categories. In response to the humanitarian crisis in Kosovo in 1999, the Government granted resettlement to over 400 Kosovars who had family in New Zealand, under a special category in addition to the annual resettlement quota (ICRR, 2000).

Figure 87: Intake by ethnicity under refugee quota – June 1994 to May 2001

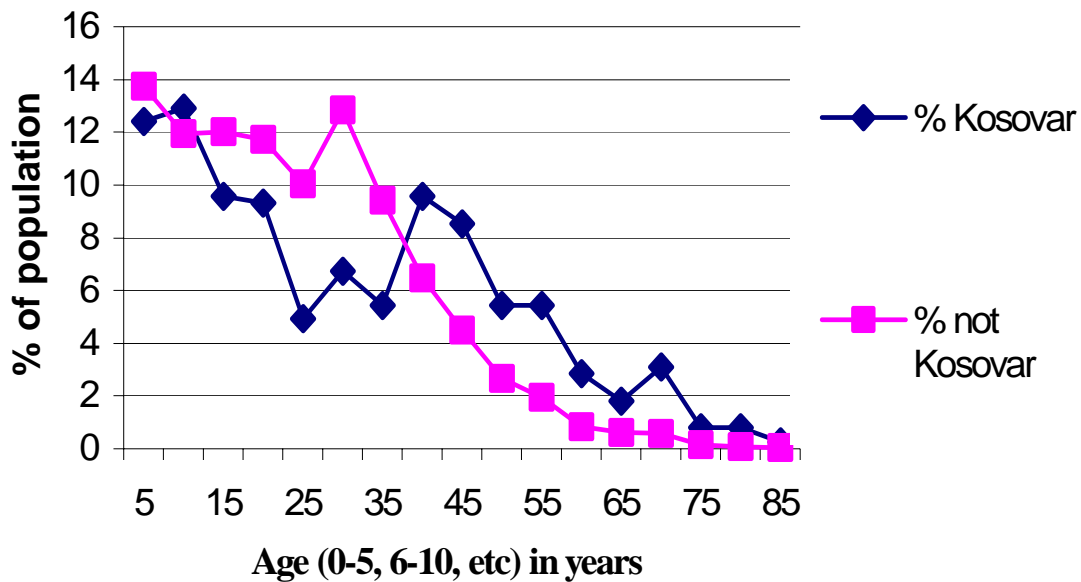


Data Source: New Zealand Immigration Service, 2001.

Age

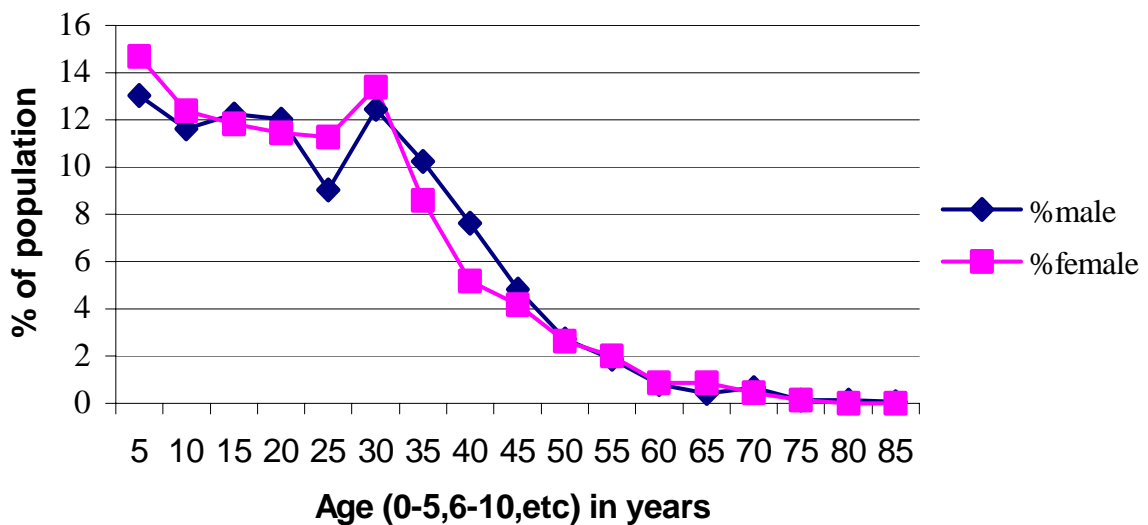
Figures 88 and 89 show the ethnicity, age and gender of families that arrived at the Mangere Refugee Resettlement Centre between July 1995 and July 2000. Approximately 3,000 people arrived during this period and approximately 12 percent were under the age of 25 years, compared with eight percent in the New Zealand population (Figure 90). The Kosovar group with an older age group were the exception to this pattern (Reeve, 2001).

Figure 88: Age distribution, both sexes of quota refugees July 1995-July 2000



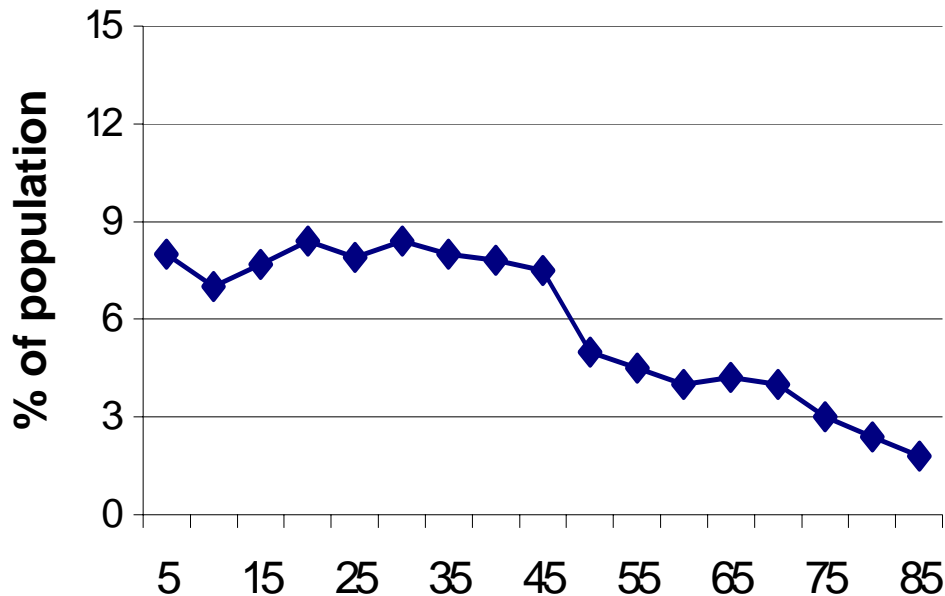
Data Source: Mangere Refugee Resettlement Centre, Auckland (Reeve, 2001).

Figure 89: Age by sex (not Kosovar) of quota refugees July 1995-July 2000 at



Data Source: Mangere Refugee Resettlement Centre, Auckland (Reeve, 2001).

Figure 90: Age distribution of New Zealand population, 1999



Data Source: NZ Stats.

Children and Young People

A considerable proportion of quota refugees are children. Statistics kept by the New Zealand Immigration Service do not however, distinguish children from adults in quota refugee intakes. The numbers of children and young people among the 300 people who arrive annually under the family reunification scheme are not identified. The only record kept of children who are quota refugees is for those under four years of age arriving by air. Staff at the Mangere Refugee Resettlement Centre estimate that one third of new arrivals to the centre are children (Reeve, 1997).

Currently there is no data collected by any government department identifying the exact numbers of children that have come from refugee and asylum seeking backgrounds. However, data from the Census indicates that there were 8,573 children under 19 years of age, who had arrived in the country from areas where there has been war or widespread political violence, between 1991 and 1996. (CCAFS, 1999). The majority of these children lived in the Central Auckland area.

Health Status & the Health Needs of Refugee Peoples

Solomon (1997) evaluated a number of high profile, high cost health status indicators in a comparative assessment across three refugee ethnic groups. The referent group for the assessment included the three ethnic groups that receive separate recognition with New Zealand's population-based personal health care funding formula (PERPBFF) –Maori, Pacific peoples and 'Other' peoples.

The PERPBFF formula is based on the established fact that Maori have the greatest health care need, with Pacific peoples with the second highest healthcare need. Refugee peoples and asylum seekers are treated under the formula in the same way as ‘Other’ peoples.

Primary care cost weightings are based on eligibility to hold the Community Services Card. Theoretically, there is a strong relationship between health need and socio-economic status. In this instance, the funding formula treats all ethnic groups equally. This is not the case with secondary care funding, where special provision is made for additional health care need for all Maori and all Pacific peoples, irrespective of socio-economic status. ‘Other’ peoples are also treated as a composite group, so that identifiable cohorts such as refugees and asylum seekers do not gain recognition for additional funding on the basis of health need (Solomon, 1997). Solomon demonstrates in the 1997 paper *The Cost of Health Services for Refugees and Asylum seekers* that refugees and asylum seekers have poor health status and high health need, and for the purposes of the PERPBFF, are best equated with Pacific peoples and not ‘Other’ peoples.

Tables 111 and 112 present key health indicators for the homeland countries of many of New Zealand’s refugee peoples. As can be seen, the health indicators for the countries presented are very poor in comparison to the health indicators for the New Zealand population.

Table 111: Key Health Indicators – Horn of Africa

| Country | Life expectancy at birth, years (a) | Under 5 mortality rate (b) | Maternal mortality rate, pregnancy-related © | Total fertility rate (d) |
|--------------|-------------------------------------|----------------------------|--|--------------------------|
| Eritrea | 50.8 | 112 | 1400 | 5.6 |
| Ethiopia | 43.3 | 173 | 1400 | 6.2 |
| Somalia | 47 | 211 | 1600 | 7.2 |
| Sudan | 55 | 115 | 660 | 4.5 |
| *New Zealand | 77.8 | 8.56 | 5.2 | 2 |

Data Source: Kizito, 2001.

Note:

Years a newborn expected to live based on prevailing patterns of mortality. Data refers to 1998 figures.

United Nations Development Program (UNDP) *Human Development Report 2000* Oxford University Press. <http://www.undp.org/hdro/>

Children under 5 years per 1000 live births. Data refers to 1998 figures. United Nations Development Program (UNDP) *Human Development Report 2000* Oxford University Press. <http://www.undp.org/hdro/> per 100 000 live births; Data refers to 1990 figures. World Health Organisation, *The World Health Report 1999 Making A Difference* World Health Organisation, Geneva.

Average number of live children born to a woman during her lifetime. Data refers to 1999 figures. World Health Organisation (2000) *The World Health Report 2000 Health Systems : Improving Performance* World Health Organisation, Geneva

*Data for New Zealand presented as a basis for comparison. New Zealand data source: a) and d) Statistics New Zealand (1997-99); b) and c) New Zealand Health Information Service (1997)

Table 112: Key Health Indicators – Iran, Iraq and Afghanistan

| Country | Life expectancy at birth, years (a) | Under 5 mortality rate (b) | Maternal mortality rate © | Total fertility rate (d) |
|--------------|-------------------------------------|----------------------------|---------------------------|--------------------------|
| Iran | 69.2 | 33 | 120 | 2.7 |
| Iraq | 62.4 | 125 | 310 | 5.1 |
| Afghanistan | 45.5 | 257 | 1700 | 6.7 |
| *New Zealand | 77.8 | 8.56 | 5.2 | 2 |

Data Source: Kizito, 2001.

Note:

(a) Years a newborn expected to live based on prevailing patterns of mortality. Data refers to 1998 figures. United Nations Development Program (UNDP) Human Development Report 2000. Oxford University Press. <http://www.undp.org/hdro/>

(b) Children under 5 years per 1000 live births; Data refers to 1998 figures. United Nations Development Program (UNDP) Human Development Report 2000 Oxford University Press. <http://www.undp.org/hdro/>

© per 100 000 live births. Data refers to 1990 figures. World Health Organisation, The World Health Report 1999: Making A Difference. World Health Organisation, Geneva.

(d): Average number of live children born to a woman during her lifetime. Data refers to 1999 figures. World Health Organisation (2000) The World Health Report 2000 - Health Systems: Improving Performance World Health Organisation, Geneva

*Data for New Zealand presented as basis for comparison. New Zealand data source: a) and d) Statistics New Zealand (1997-99); b) and c) New Zealand Health Information Service (1997)

There have been a number of studies of the health of refugees upon arrival in New Zealand. The following is a summary of some of the main points arising from the major studies that have been conducted to date:

- ❑ A study of health screening at MRRC indicates high rates of health problems among quota refugees arriving in New Zealand (Reeve, 1997).
- ❑ Specialist referrals: Approximately seventy percent of the 687 refugees screened in the year to June 1996 required referral to one or more secondary health care services for further assessment or treatment.
- ❑ Intestinal parasites: Screening detected infection with one or more intestinal parasites in 42 percent of refugees. These infections include Trichuris (whipworm), Taeniasis (tapeworm) and Ancylostomiasis (hookworm). Serological testing suggested 21 percent of all refugees were infected with schistosoma. The infection rate varied by region of origin with over half those refugees from some African countries likely to be infected
- ❑ Malnourishment: Fifty four per cent of refugees had some degree of iron deficiency. This deficiency was severe enough in 19 percent to require iron supplementation.
- ❑ Disabilities: Many refugees have escaped from regions undergoing military conflict. Frequently such conflict results in the civilian injury. Land mines in particular have lead to a number of injuries resulting in permanent disability. Disability among refugees may also be due to previous polio infection. About eight percent of refugees screened in the year to June 1996 required referral to orthopaedic or orthotic services

- ❑ HIV infection: Of the 687 refugees screened in the year to June 1996, twelve were confirmed to be infected with HIV (1.7%). There were no HIV infections detected among children under 16 years and the overall adult infection rate was 2.6 percent. Infection rates tend to mirror rates reported in the country of origin with low rates among refugees from the Middle East compared to those from Africa or South East Asia.
- ❑ Mental Health: Thirteen percent of refugees screened in the year to June 1996 reported suffering imprisonment, physical beating or torture prior to arrival in New Zealand. Such ordeals frequently result in ongoing mental health problems and in particular posttraumatic stress disorder. Forty-eight (7%) of the annual refugee quota were referred for ongoing management either to a specialised refugee counselling service in Auckland (“Refugees As Survivors”) or the local psychological medicine service if the refugee settled in another centre.
- ❑ Women’s Health: One of the main gynaecological problems encountered among refugees is female genital mutilation (FGM). Screening identifies FGM in 98 percent of females six years and over from Northeast Africa. FGM is associated with menstrual, urinary, obstetric, sexual and mental health problems.
- ❑ Dental Health: Many refugees and asylum seekers arrive in New Zealand with advanced or untreated dental disease, most having received little or no dental care for years. Disease levels vary on arrival, with many of those from poorer countries showing lower levels of decay. Basic dental care, for example, fillings and extractions, is offered to adult refugees. This does not usually include dentures or treatment for advanced periodontal conditions. Children receive treatment only for acute conditions since they will access free dental services in the community.

Tuberculosis

Recent research in Auckland has demonstrated that refugees and asylum seekers are a significant factor in the epidemiology of tuberculosis (TB) in New Zealand (Harrison, Calder, Karalus, Martin, Kennedy & Wong, 1999). Screening for infectious diseases has suggested that up to 46 percent of all refugees may be infected with TB. The rate of disease in this population (4000 per 100,000) is over 400 times higher than the rate of disease in the general New Zealand population (8.5/100,000).

The *World Development Report* (1993 cited in Solomon, 1997), provides a list of countries where annual tuberculosis notification rates are known to exceed one person per one thousand population, which is an unacceptably high rate. The list includes most Asian countries, all sub-Saharan Africa, some Middle Eastern countries and some Latin American countries and the Caribbean. In recent years, the Government’s allocations have focused on the Middle East, East Africa and Southeast Asia. The main nationalities accepted for resettlement to New Zealand included: Iraqi, Somali, Ethiopian and Vietnamese. In addition to those refugees accepted for resettlement, the Government granted entry to persons in refugee-like situations under its humanitarian and family reunion categories (ICRR, 2000).

TB notifications in New Zealand which had been declining since the beginning of the century, increased during the 1980's, and have remained high. In the first quarter of 1999, notifications were 11.1/100 000 (Martin, 2000). There are big differences between districts, with rates in March 1999 varying between 23.7 in Central Auckland and 17.3 in Wellington and 0 in the Manawatu. Rates are low in the South Island. Australia recently reported rates of 5.47 for the whole population and 1.7 in Australian-born people (Martin, 2000). Evidence from other countries has shown increased rates of TB to be influenced by immigration from high incidence countries and by low socio-economic conditions.

In New Zealand data from ESR Information Services show that between 1985 and 1998, annual notifications of TB in those of Other ethnicity rose from 49 to 144. In 1998, there were 340 people notified with TB, of whom 186 were foreign born. Of those born abroad the greater number were from Africa (48), SouthEast Asia (35), or the Pacific Islands (35). Eleven were notified within a month of arrival, twenty between one and three months, thirty between three months and a year, whilst 91 were notified more than a year after arrival. National surveillance shows that 46 percent of the foreign- born cases develop within five years of arrival; Mantoux screening of immigrants from high incidence countries reveals high rates of TB infection; The highest risk time for immigrant developing TB is soon after arrival (Harrison et al., 1999).

Table 113: Number of Arrivals in New Zealand under the Refugee Resettlement Programme, by Nationality and Fiscal Year, 1994/95 – 1999/00

| Nationality | 1994-1995 | 1995-1996 | 1996-1997 | 1997-1998 | 1998-1999 | 1999-2000 |
|-------------|-----------|-----------|-----------|-----------|-----------|-----------|
| Afghan | - | - | - | - | 41 | 26 |
| Bosnian | 21 | 4 | 4 | 3 | - | - |
| Burundian | - | 13 | - | 17 | - | 20 |
| Congolese | - | - | - | - | 3 | 26 |
| Eritrean | - | 21 | - | 10 | 47 | 26 |
| Ethiopian | 50 | 130 | 72 | 151 | 199 | 131 |
| Iranian | 6 | - | 24 | 70 | 39 | 2 |
| Iraqi | 318 | 136 | 266 | 241 | 130 | 52 |
| Laotian | - | 5 | 62 | - | - | 36 |
| Somali | 39 | 299 | 21 | 137 | 212 | 207 |
| Sri Lankan | 21 | 25 | 12 | 3 | - | 7 |
| Sudanese | 8 | - | 14 | 10 | 33 | 70 |
| Vietnamese | 341 | 116 | 23 | 8 | - | 60 |
| Yugoslav | - | - | 3 | - | - | 27 |
| Other | 18 | 31 | 26 | 27 | 22 | 26 |
| Total | 822 | 780 | 527 | 677 | 726 | 716 |

Data Source: ICRR, 2000.

The large number of cases being diagnosed in immigrants within one year of arrival has led to concerns about the adequacy of the screening procedures for immigrants and visitors to New Zealand. In 1999, in addition to increases among foreign- born people, there are increases amongst those born in New Zealand. Martin (1999) draws the conclusion that new immigrants are developing active disease within a year of arrival,

most notably in refugee and asylum seeking communities where risk is compounded by poor socioeconomic circumstances.

At present screening of immigrants from countries with a high incidence of TB is inadequate. There are deficiencies in procedures, inadequate screening coverage, ineffectual coordination between the Ministry of Health and New Zealand Immigration Service, incomplete follow up on those at risk of TB, confusion over financial responsibility, inadequate data to describe the problems and monitor interventions.

Abnormal Haemoglobin Diseases

An analysis of North Health hospital discharge data for 1996 and 1997 showed a 50% increased through put in discharges following treatment for sickle-cell anaemia (Solomon, 1997). During this period discharges following treatment for Thalassaemia have increased 30%. Review of ethnicity identifiers links these increases to immigrant people. In the case of sickle-cell anaemia refugees from sub-Saharan Africa are the single most likely cause for the inordinate increase. Of a total expenditure, in excess in 1997 of \$60,000 per annum, it was estimated that at least \$200,000 per annum is spent on inpatient hospital treatment for refugees with abnormal Haemoglobin diseases. It is clear that such inordinate costs will be ongoing and are highly likely to increase still further with the continuing arrival of refugees, and family reunification people from current quota refugee countries.

Diabetes

The prevalence of diabetes in quota refugees approaches that in Pacific Peoples (40.1/1000) (Solomon, 1997).

Coronary Heart Disease

The prevalence of coronary heart disease among quota refugees aged 35 to 64 years is likely to be similar to that of Pacific Peoples (Solomon, 1997).

Women's Health

The overall finding regarding Women's Health in the report of *The Cost of Health Services for Refugees and Asylum Seekers* (Solomon, 1997) was that refugee women have a health status disadvantage compared to NZ women. Furthermore socio-economic considerations are likely to compound 'hidden' health issues following resettlement.

Refugee women have a number of distinct health needs specifically related to their gender, their cultural and religious backgrounds, or their refugee experience (Mortensen, 2001).

Most women from refugee backgrounds:

- will have had little or no previous health screening, particularly cervical and breast screening;
- will have had little or no access to and knowledge of family planning services;

- ❑ may have psychosexual and mental health issues following trauma, rape and abuse during flight, and a lack of adequate follow up care and treatment in New Zealand;
- ❑ will have difficulty accessing health care services in New Zealand due to language barriers, cultural barriers, cost and difficulties with transport;
- ❑ may experience difficulties surrounding Female genital Mutilation and accessing services providing appropriate rehabilitative, gynaecological and obstetric care;
- ❑ may become increasingly socially isolated due to language barriers as their families become more proficient in English;
- ❑ may have other women's health problems due to untreated gynaecological and obstetric conditions after years in refugee camps or homelands where there is a lack of medical facilities.

Antenatal Care

Larger families are the norm for many refugee peoples. A study by Reeve (1997) of women screened at MRRC found that of 184 women aged from 14 years, 64 percent of women had had children, including 18 percent who had five, or more children. Refugee women may have higher risk pregnancies for some of the following reasons:

- ❑ multiple, spontaneous or elective abortions;
- ❑ previous still birth;
- ❑ neonatal death;
- ❑ multigravida;
- ❑ short spacing intervals between pregnancies;
- ❑ recurrent urinary tract infections, possibly associated with FGM ;
- ❑ age above 35 years or below 18 years;
- ❑ pregnancy weight less than 45 kg;
- ❑ short stature;
- ❑ cephalopelvic disproportion (a higher incidence among women from Africa);
- ❑ sickle cell disease, thalassaemia, anaemia below 10 g/dh;
- ❑ rheumatic heart disease.

Amongst African women the rate of HIV infection is higher, and screening may not have been done. Identifying and treating HIV in pregnant women is a priority issue. In addition, women with FGM may require special care before, during and after delivery.

Female Genital Mutilation (FGM)

FGM is widely practised in the Horn of Africa, a region from which New Zealand draws a large proportion of its refugees. There are numerous physical, sexual and psychological complications associated with FGM that include (Denholm, 1998; 1997):

- ❑ Difficulties with micturition;
- ❑ Recurrent urinary tract infections;

- ❑ Difficulties with menstruation;
- ❑ Complications in childbirth;
- ❑ Inability to achieve penetration during sexual intercourse;
- ❑ Sexual dysfunction.

Specialised obstetric management is required for women with FGM, including the need for de-infibulation prior to delivery, anterior episiotomy and re-suturing scar tissue.

De-infibulation (reversal of infibulation) may be requested by women with FGM, prior to marriage (in order to allow for penile penetration), or before and during pregnancy in preparation for childbirth. De-infibulation services are now accessible through gynaecology services at all main hospitals in New Zealand.

Most women affected by FGM have never accessed family planning services before and have little knowledge of the types of contraception available.

Women affected by FGM have had varying experiences with the New Zealand health system. A 1997 study conducted with Somali women in Auckland found that there was a lack of knowledge and/or training among health professionals about FGM (Denholm, 1998; 1997). This affected the care and sensitivity offered to women by doctors, nurses and midwives.

The women in the study were particularly concerned with childbirth care. They felt that most midwives and doctors did not know how to deliver circumcised women, as many women are given posterior episiotomies during delivery, resulting in the scar tissue tearing upwards. Most infibulated women require anterior incisions of their scar tissue. Women in the study were also concerned that re-stitching after delivery might not be done correctly by a New Zealand health professional.

Breast and Cervical Screening

Women from refugee backgrounds are unlikely to have had breast and cervical screening.

Family Planning

Many refugee women have never received family planning education. In New Zealand, refugee women may be reluctant to use family planning services due to religious beliefs, cultural attitudes and lack of education. Women from Middle Eastern and African backgrounds may follow unreliable cultural contraceptive practices, for example, withdrawal, 'safe' period and breastfeeding.

A study of Kosovar and non-Kosovar women at MRRC noted that in the case of Kosovar Albanian women contraception was poorly used and for family planning reliance was placed on termination of pregnancy. Non Kosovar women screened at MRRC had similarly low rates of contraceptive use and on higher rates of pregnancy on arrival in New Zealand (Reeve, Hay, Pearce, Sidwell & Pritchard, 2000).

Table 114: Medical Screening of 382 Kosovar Refugees at Mangere Refugee Resettlement Centre, May – December, 1999. Percentage of women more than 12 years taking hormonal contraception (oral or parenteral) and the number who were pregnant

| | Women on Contraception | No of Pregnancies |
|--------------------|-------------------------------|--------------------------|
| Kosovar | 1.2 | 1.2 |
| Non-Kosovar | 1.2 | 6.9 |

Family Violence

Refugee women subject to family violence are a vulnerable group because:

- ❑ they may lack family and community support;
- ❑ they usually have dependants;
- ❑ for some, an unsatisfactory relationship is better than no relationship;
- ❑ they may feel they should tolerate their partner’s violence because of trauma he has endured;
- ❑ they may be unaware of New Zealand laws prohibiting family violence;
- ❑ cultural differences, inability to speak English, and lack of knowledge on how to access alternative housing, income, legal and support services make it difficult for them to leave;
- ❑ feelings of shame, helplessness and resignation can prevent them from taking action;
- ❑ threats or intimidation by a partner may make it difficult for women to speak out or leave;
- ❑ cultural attitudes towards separation and divorce, and the desire to ‘keep the family together’ may pressure a women to remain with her violent partner;
- ❑ they may be wary about involving police and other authorities in family matters.

Mental Health

Refugees as with all population groups exhibit psychiatric symptoms and disease. Additionally, refugees have all experienced major disruption to their lives and the psychological effect of this. It is difficult to establish rates of non-psychotic illness in clients screened at the MRRC (Reeve,1997). A rate of 0.5 percent of psychotic illness is found at the MRRC health screening. This rate does not include the asylum seeker and family reunification groups. Medical interviews indicate that all refugees found to have serious psychological illness at MRRC have had previous episodes. The stress of relocation to a new country precipitates psychiatric crises requiring major psychiatric intervention. Less acute referrals are made to a community mental health service. Refugees who have been the victims of torture and are traumatised are referred to the Auckland Refugees as Survivors Centre.

A 1999 study by the Auckland Refugees as Survivors Centre at the Mangere Refugee Resettlement Centre found that twenty percent of refugees had suffered significant to severe physical abuse. About 14 percent reported significant psychological symptoms and about seven percent were diagnosed as having PostTraumatic Stress Syndrome (Refugees as Survivors (RAS), 1999).

In addition, many refugees suffer psychological sequelae following torture and trauma, as part of the refugee experience, including:

- ❑ Loss and grief;
- ❑ Guilt and shame;
- ❑ Distrust and anger;
- ❑ Anxiety;
- ❑ Depression;
- ❑ Psychogenic amnesia;
- ❑ Repressing/avoiding traumatic events;
- ❑ Isolation;
- ❑ Psychosomatic conditions;
- ❑ Post Traumatic Stress Disorder symptoms.

The clinical management of clients from refugee backgrounds is made complex by the presentation of symptoms of trauma including:

- ❑ Anxiety, distress, memory loss, confusion, inability to concentrate may interfere with a client's ability to 'hear' and understand questions and instructions;
- ❑ Brain damage as a result of past violence may interfere with memory and concentration;
- ❑ Confusion and major memory loss can lead to inconsistencies in information provided by the client;
- ❑ Hypervigilance, particularly in unfamiliar situations, is not uncommon. Startled reactions to sudden changes, such as noise can also occur;
- ❑ Feelings of shame may make being physically approached and touched a disturbing experience, particularly for survivors of rape and sexual torture;
- ❑ Anger, hostility and mistrust, particularly of authority figures, may interfere with obtaining information for diagnosis and treatment.

Mental health care for asylum seekers

Many asylum seekers are referred to Community Mental Health Services. Asylum seekers have the same psychological and physical health problems as quota and family reunification refugees, but on arrival in New Zealand they face considerably more stress (Kizito, 2001; Sinnerbrink et al., 1997). This arises from:

- the procedure required in making a claim for refugee status, including legal services which can be expensive;
- the uncertainty in relation to their claim;
- living "in limbo" whilst waiting for the outcome of their claim;
- the length of time they must wait to learn the outcome to the claim;
- their ignorance of and/or their limited access and eligibility to some government entitlements and support;
- the fear of deportation back to the country from which they are trying to escape.

The stress and worry caused by the above may not only exacerbate any pre-existing sequelae associated with psychological trauma, but may also lead to stress symptoms and

mental ill health, apparent long after arrival in New Zealand (Anstiss, 2001). Asylum seekers constitute forty percent of clients presenting with mental health problems at Auckland's Refugees As Survivors Centre (RAS, 1999).

Depression and anxiety

Depression and anxiety may exist co-morbidly. They are common psychological sequelae to trauma and torture. Other experiences that may not rate as trauma or torture, such as loss of loved ones, prolonged deprivation of human rights, dislocation from one's community, can also lead to depression and anxiety. Depression and anxiety can be triggered by or exacerbated by the additional stresses of resettlement.

Depression may be linked to a pervading sense of loss and hopelessness and may include such signs and symptoms as pessimism, loss of interest, sleep disturbance, appetite disturbance, poor concentration, self degradation, self blame, and suicidal thoughts.

Anxiety as a result of past traumatic events may include:

- ❑ physiological or somatic signs and symptoms, eg, panic attacks, hypervigilance, psychosomatic symptoms;
- ❑ cognitive signs and symptoms, eg, poor concentration, poor memory, worries, sleep disturbance, flashbacks, dissociation;
- ❑ Behavioural responses, eg, avoidance of potentially fear invoking situations, withdrawal, passivity, aggressive behaviour.

Mental health services for children and adolescents from refugee backgrounds

There is growing evidence that children and adolescents experience a psychological reaction to trauma not dissimilar to that found in adults (Rousseau & Drapeau, 1998; Rousseau, Drapeau & Corin, 1997). This may manifest itself in children in a number of ways including:

- ❑ withdrawal, lack of interest and lethargy;
- ❑ aggression, anger and poor temper control;
- ❑ tension and irritability;
- ❑ poor concentration;
- ❑ repetitive thoughts about traumatic events;
- ❑ physical symptoms such as poor appetite, over eating, breathing difficulties, pains and dizziness;
- ❑ regression, for example, return to bedwetting;
- ❑ nightmares and disturbed sleep;
- ❑ crying;
- ❑ nervousness, fearfulness and proneness to startling;
- ❑ poor relationships with other children and adults;
- ❑ lack of trust in adults;
- ❑ clinging, refusing to go to school;
- ❑ hyperactivity and hyperalertness;
- ❑ repetitive, stereotypical play;
- ❑ selective mutism.

The consequences of the refugee experience for children are multiple including in the country of origin the loss of homes, homeland, family members, economic wellbeing, and lost years of education. As well as increasing body of international literature indicates that the trauma of resettlement can be greater than previous traumas of war and refugee camps and requires if specialised mental health and educational intervention (Rousseau & Drapeau, 1998; Rousseau, Drapeau & Corin, 1997).

HIV in Refugee Populations in New Zealand

All adult quota refugees are screened for HIV infection as part of the health screening programme offered at Mangere. Asylum seekers and family reunification refugees however, may not have been screened. HIV infection amongst quota refugees is, confined to those from Sub-Saharan Africa, Southeast Asia, or those who have spent time in those places (Reeve, 1997). African refugees now consistently represent a significant number of the new HIV diagnoses each year. From January 1996 to June 2000, one hundred and four African people were diagnosed with HIV in New Zealand. This represents 27.2 percent of the total new diagnoses in New Zealand for this period over the last five years (AIDS Epidemiology Group, 2000). Approximately 120 HIV positive refugees in NZ represents 15 percent of total population of the HIV positive population. Most require health and social services in the Auckland District Health Board area.

The high HIV infection rate within the refugee communities and the lack of safer sex practices amongst community members has raised significant concerns surrounding HIV transmission. There is an urgent and ongoing need for HIV safer sex education and resources amongst refugees (Refugee Education Programme, 1998). Without HIV intervention strategies in Refugee and Immigrant populations it can be predicted that HIV will spread increasingly within refugee communities, and as refugees become integrated a growing epidemic among heterosexuals in NZ society.

The following findings from Refugee HIV screening Public Health Protection, Auckland District Health Board confirms that the rising rates of heterosexual transmission of HIV is of concern to immigrant and New Zealand populations.

Table 115: Public Health Protection Refugee HIV Screening 1996-2000: Auckland District Health Board. New HIV Diagnoses per year including breakdown of the diagnoses made at Mangere Refugee Clinic and Public Health Protection Asylum Seekers Clinic.

| Year | Total New HIV diagnoses | HIV diagnoses at MRRC/Asylum clinic | % of total HIV diagnoses made at MRRC/Asylum clinic |
|--------------|-------------------------|-------------------------------------|---|
| 1996 | 93 | 11 | 11% |
| 1997 | 63 | 3 | 4.5% |
| 1998 | 104 | 42 | 40% |
| 1999 | 71 | 15 | 21% |
| 2000 (<July) | 49 | 13 | 26% |

In addition to those diagnosed through Public Health screening on entry to New Zealand, there are potentially high numbers of undiagnosed HIV positive refugees among:

- Family reunion refugees who have not been tested for HIV;
- Asylum seekers who have not been tested for HIV;
- HIV positive people from refugee backgrounds who have been practicing unsafe sex in the community following arrival in New Zealand Communities and have not been re-tested for HIV since their initial test.

In addition to the burden of secrecy, fear and isolation, many refugees with HIV are also processing the pain and trauma of their experiences, the grief of all their losses and the day-to-day challenges of resettlement. This means that their coping capacity may be limited and their emotional resources for working through the issues of living with HIV may be severely compromised (Denholm, 2000).

Services Provided and Service Utilisation

Refugees accepted within the refugee quota have the status of New Zealand residents and are therefore eligible for publicly funded health and disability services in New Zealand under section 32 of the Health and Disability Services Act, 1993. Clause 5(4) of the Eligibility Direction issued by the Minister of Health refers to people who have refugee status or are in the process of applying for such status as being eligible. The New Zealand Immigration Service definition of an asylum-seeker is someone who has applied for refugee status. Asylum seekers are therefore eligible for all free publicly provided health services with an interpreter.

A person's asylum-seeking status can be confirmed by the Certificate of Identity issued to them by the Immigration Service, a letter from the Immigration Service confirming the date of that person's interview for consideration of their refugee application, or by seeking the authorisation of the person to request confirmation from the Immigration Service that they had lodged an application.

All refugees and asylum seekers who have made application for refugee status on benefits or in low income employment will receive a Community Service Card either for themselves if they are single or for their family if they have dependants.

Public Health Services

Health Screening for Quota Refugees at Mangere Refugee Resettlement Centre

On arrival in Auckland, quota refugees spend a six-week orientation period in the Mangere Refugee Resettlement Centre (MRRC), where they receive comprehensive health screening provided by the regional Public Health Protection Service of the Auckland District Health Board. At the Reception Centre, refugees undergo medical, psychological and dental checks. Immunisation is also carried out and medical treatment is provided for any medical conditions identified. Access to specialised medical services outside the clinic is also facilitated. Referral is made to appropriate health services for ongoing medical needs.

The aim of health screening in refugees is to:

- ❑ Identify those who have health problems, including mental health and treat as necessary, or refer to specialist agencies where appropriate;
- ❑ Prevent the spread of Tuberculosis HIV and other communicable diseases.

All refugees arriving in New Zealand under the quota system receive the following screening tests at Mangere Refugee Resettlement Centre:

- ❑ Midstream urine;
- ❑ 3 faecal specimens – examined for all intestinal parasites. Bacterial examination is confined to Salmonella and Shigella;
- ❑ Mantoux test;
- ❑ Full blood count, ESR, hemoglobinopathy studies;
- ❑ Liver function tests;
- ❑ Iron studies;
- ❑ Serology for HBV, HCV, HIV, rubella antibodies, morbilli IGG, treponemal infection and schistosomiasis. (The latter is not undertaken with refugees coming directly from Europe);
- ❑ Chest X-rays for all aged 16 years and over, unless pregnant;
- ❑ Cervical smears and associated gynaecological bacteriological screening offered to all sexually active women – including enrolment on cervical screening register;
- ❑ Clinical physical examination;
- ❑ Other screening tests as necessary after examination, For example, lipid levels.

Health Screening For Asylum Seekers

Since 1997 border officials have been giving asylum seekers a form that offers a free voluntary medical screening at Public Health Services throughout New Zealand. This form identifies the appropriate contacts within Public Health Services for the free screening. Most screening is carried out by the Auckland regional Public Health Protection service. The service is based on the same screening procedures as that for quota refugees.

Although asylum seekers have similar health problems to quota refugees there is no formal requirement for them to undergo health screening until their permanent residence status has been granted. Some asylum seekers may avoid public Health screening fearing that any medical condition detected will jeopardise their chances of gaining permanent residence and lead to deportation. Since the process of claiming refugee status can take months or even years, many asylum seekers remain unscreened for long periods which has serious implications for personal and public health in the Auckland area. Asylum seekers whose claim for refugee status is successful and who have had no health screening will eventually be required to complete an immigration medical as part of their application for residence.

Health Screening For Family Reunification Refugees

Family reunification refugees usually come straight from a refugee background, many directly from refugee camps and therefore, they have many of the same health issues as quota refugees. Families are required by NZIS to have a medical check up in their

country of origin before leaving for New Zealand. They are not required to have screening when they enter New Zealand. The experience of health providers is that many medicals completed for refugees in their country of origin are unreliable and out of date. In some instances, medicals can be “bought” by desperate refugees, from complying doctors. This has potentially serious implications for personal and public health, since this group often do not access further screening on arrival in New Zealand. While every encouragement is given to family reunification refugees to undergo screening, the difficulties in tracing and locating them mean that many remain unscreened.

Primary Health Care

An important requirement for the delivery of health care to refugees is an introduction to the services of a general practitioner. The first appointment after arrival in New Zealand is seen as critical to follow-up on the public health screening received at the Mangere Resettlement Centre for Quota refugees, some of whom are family reunification members. The purpose of the visit is additionally to discuss health issues and problems in general and to provide information about how to access health care in the future.

For many refugees, a lack of interpreting services is a barrier to receiving adequate and confidential care at a General Practitioner. General Practitioners involved in the care of refugee patients are not funded in Auckland to provide trained health interpreters, and therefore use a family member, including children or someone from the community. Regional inequities exist in access to a General Practitioner and to interpreting services.

In Christchurch a ‘*Free Introductory Visit to a GP*’ scheme was developed and instituted in 1999 by Crown Public Health to facilitate an early entry for refugees into the health system. It provides an opportunity for refugees to meet their chosen doctor and address any personal health needs they may have. The scheme was also designed to:

- ❑ Ensure continuity of care from the Public Health Screening clinic at Mangere Refugee Resettlement Centre Protect to the General Practitioner;
- ❑ To provide trained interpreters and to eliminate problems with confidentiality within the community of the client through the use of family members or community members as interpreters;
- ❑ Introduce the patient to the NZ medical health care system.

The Newtown Union Health Centre in Wellington has a contract with the Wellington District Health Board to provide primary health care to refugee communities with interpreting service. The service includes a refugee health coordinator for the practice and social workers. Auckland Union and People’s Health Centres who provide the majority of primary health care for refugee communities are not funded to a similar level. Providing safe and ethical medical care for non-English speaking populations, who have high and complex health needs is a considerable challenge in terms of practice costs and workloads.

Personal Health Care Services

A report by Solomon (1997) on *The Cost of Health Services for Refugees and Asylum seekers* found that Population – based funding allocations in the Auckland District Health Board have not included refugee personal health and disability services needs (Solomon, 1999; 1997; 1993). Solomon concluded that:

- ❑ Health care need as evident in the two funded public health screening programmes for refugees and asylum seekers is largely personal health care need. Additional to public health ring-fenced funding of \$209,784 p.a., annually North Health commits and estimated \$716,000 of population-based personal health care funds to meet these needs. These hidden costs are unfunded.
- ❑ Interpreter services are needed to facilitate the delivery of health care services to an ever-increasing proportion of North Health's population for whom English is a second language. This is a *Code of Health and Disability Services Consumers' Rights* (1993) responsibility and annually around \$425, 000 of personal health care funding is committed to providing health care interpreters to assist refugees and asylum-seekers. North Health does not receive any additional funding allocation to meet these identified additional personal health care services needs.
- ❑ These specific personal health care costs total \$3.2m and are seen as additional to the ongoing deficit in funding.

The impact of refugee populations on Health and Disability services in Auckland is considerable and it is growing in magnitude.

A study on the health status of quota refugees upon arrival to the MRRC, conducted by Reeve (1997), indicates high rates of referral to secondary services including the following:

- ❑ 6% of quota refugees were referred to a chest clinic or Paediatric tuberculosis clinic following screening upon arrival;
- ❑ 4% of quota refugees were referred to a sexual health service;
- ❑ 6.4% of quota refugees were referred to an orthopaedic and/or orthotic service;
- ❑ 4.5% of quota refugees were referred to a ORL services, primarily for assessment of chronic ear diseases;
- ❑ 4.5% of quota refugees were referred to an eye clinic, many for previous eye injury;
- ❑ 2.6% of quota refugees were referred to a gastroenterologist;
- ❑ 6% of adult (41yrs+) quota refugees were referred to a diabetic service;

- 6% of quota refugees were referred to a urological service.

In total, Reeve found that there were over 500 referrals from 687 people screened at MRRC. A number of refugees required more than one referral.

Mental Health Services

Mental Health services available to refugees include:

- Crisis Teams - for intervention in major psychotic episodes;
- Community Mental Health Services - referrals to Community Mental Health Services indicate a significant degree of psychological stress and dysfunction during the first two years of resettlement. Serious and pervasive adjustment problems affect some sectors of the refugee population, such as high levels of somatisation, anxiety and depression, and Posttraumatic Stress Disorder. These symptoms persist many years after resettlement (Anstiss, 2001);
- Inpatient mental health facilities;
- Refugees as Survivors Centre at the Mangere Refugee Resettlement Centre - the Refugees as Survivors Centre is a specialist trauma centre providing short-term therapy to clients and families with interpreters. Clients requiring services for other mental health issues are referred to community mental health services and crisis teams (Jane, 1996);
- Community, Child, Adolescent and Family Service - a mental health service for children and young people in the central Auckland area reports however, in the last three years, up to 75 new cases annually from refugee backgrounds and a current caseload of 300 cases from refugee and migrant backgrounds. some of the most serious and complex issues that come to attention are in refugee populations (CCAFS, 1999);
- Maternal Mental Health - maternal mental health services are under utilized by women from refugee communities.

The utilisation of health services by children and adolescents from refugee backgrounds is not known. Currently there are no specific mental health services provided for the children of refugees or asylum seekers either in the non-governmental mental health agencies or in the publicly provided mental health services sector. New Zealand is alone among the twelve countries worldwide that accept refugees for resettlement in not providing any specific assistance for the mental health and welfare of refugee children (Mortensen, 2001). None of the agencies involved with the health, education or welfare of refugee children collects data on the numbers of refugee clients who are referred. The Community, Child, Adolescent and Family Service, a mental health service for children and young people in the central Auckland area reports however, in the last three years, up

to 75 new cases annually from refugee backgrounds and a current caseload of 300 cases from refugee and migrant backgrounds. Other agencies in a survey carried out by the (CCAFS) including the English as a Second Language (ESOL) service of the Ministry of Education, secondary schools, and the Child, Youth and Family service report some of the most serious and complex issues that come to attention are in refugee populations (CCAFS, 1999). The CCAFS proposal in Appendix 1 contains detailed information about the mental health of refugee children in New Zealand

A review of the literature indicates that in populations of refugee children there is a high prevalence of mental health diagnoses in the categories of posttraumatic stress disorder (PTSD) depressive and anxiety states (Tousignant et al., 1999).

Oral Health Services

- ❑ *Children* - up to the end of school year 8, children are eligible for free dental care from the School Dental Service (SDS);
- ❑ *Adolescents* - From school year 9 until their 18th birthday, adolescents can receive free dental care from general dental practitioners (GDPs) who participate in the Adolescent Dental Scheme;
- ❑ *Adults* Only limited publicly funded dental care is available for adults, usually for urgent conditions such as toothache or facial swelling. Clients receiving a benefit may be eligible for a Special Needs Grant. Subsidised treatment for urgent conditions is also available from Dental Services at major hospitals, and from some GDPs. Most refugees are unable to afford dental services.

Refugee Health Service Access Issues

Many people from refugee backgrounds will not have had access to comprehensive health care for years. Their initial contact with New Zealand nurses or doctors may be the first opportunity in their lives to receive client-focused high quality health care. Many will have pre-existing health conditions that are exacerbated by a lack of treatment or inadequate treatment in countries of origin and in refugee camps (Kizito, 2001).

Families from refugee backgrounds are over represented in requiring income support and in general have large families. Many have multiple health problems and costs for repeated GP visits, prescriptions from the pharmacy, dental and other health care, and associated transport costs can place enormous pressure on the family budget.

Additionally health care seeking behaviour in New Zealand is influenced by health services in the country of origin. Health care in the Horn of Africa countries is poor. While most of the major cities have hospitals with essential facilities (anaesthesia, theatres, pathology laboratories, X-ray machines) and programmes such as family planning and immunisation, the rural areas are generally poorly serviced with people having to travel very long distances, often on foot, to access care.

Many refugees in their countries of origin have been used to accessing health care through a community-based primary health care clinic. Much of the care routinely provided by GPs in New Zealand is provided by health workers such as nurses or birthing attendants in the Horn of Africa countries and in the rural areas of Iran, Iraq and Afghanistan. Traditional healers are used extensively, particularly in rural areas. Many refugees in New Zealand will be unfamiliar with the concept of a family doctor and a formalized appointment system. Many patients from refugee backgrounds arrive at Auckland Hospital and Starship emergency services as they are unused to a system of primary health care and as well may bypass the general practitioner due to inability to pay for services

Publicly provided health services are providing primary health care, as clients are unable to communicate their health needs to general practitioners, as trained interpreters are not available. Using family, especially children, friends or untrained personnel including tuberculosis, HIV and STDs and compromising confidentiality. The use of specialist services for primary health care is extremely costly.

Other health service access issues include:

- ❑ Difficulties in communication. In a study on the health needs of Cambodian and Vietnamese refugees in Wellington, only 22 percent of refugees aged 16 or over considered themselves competent enough in English to communicate independently with a general practitioner or other service provider, despite a mean length of residence of four years (Blakely, 1996);
- ❑ Differing cultural perceptions and descriptions of illness and the difficulty in identifying specific physical ailments from a background of vague somatic symptoms that may be related to stress and psychological issues can deter people from seeking health care;
- ❑ Asylum-seekers may be reluctant to engage with official organizations due to previous traumatic experiences or concerns regarding their refugee status application, or they may lack the knowledge of how to do so;
- ❑ In comparison to accepted quota refugees, asylum-seekers are provided with much fewer social supports and yet may be dealing with a greater degree of stress and number of untreated health problems due to an abrupt upheaval and migration, and uncertainty regarding their future. They are also likely to have greater difficulty accessing health services due to their poorer orientation into New Zealand society (Uprety et al., 1999);
- ❑ High fail to attend rates - onward referral agencies for specialist health and mental health management report high rates of failure to attend. Refugee families frequently have no transport, childcare and no money for public transport or taxis and will therefore have difficulty attending follow up appointments. Low literacy rates in some communities and additionally poor English language skills mean that people

may not respond to letters of appointment, as well the client may be late due lack of experience with appointment systems, unfamiliarity with the transport system and memory problems.

Refugee Health Service Gaps & Issues

Community Consultation with refugee primary health, mental health and dental health care users has revealed that sixty percent of clients seen at the Hauora O Puketapapa-Roskill Union and Community Health centre and forty percent at Auckland Community Medical Centre Trust/ The Peoples Centre are from refugee backgrounds (Sefuiva, 2001). Health consumers from refugee backgrounds were included in a needs assessment of mental health consumers completed by the Auckland Community Medical Centre Trust/ The Peoples Centre, Hauora O Puketapapa- Roskill Union and Community Health, Ngati Whatua O Orakei Health Clinic, Auckland DHB Community Mental Health Services (July, 2001).

The following gaps were identified in existing services available to mental health consumers:

- ❑ Affordable primary health care services;
- ❑ Affordable dentistry;
- ❑ Mental health services.

Consumers identified that they would prefer to use a mainstreamed 'One Stop Shop' to access mental health care, including General Practitioners, dental and benefit advocacy services. A shared-care service has been proposed by Auckland Community Medical Centre Trust/ The Peoples Centre, Hauora O Puketapapa- Roskill Union and Community Health, Ngati Whatua O Orakei Health Clinic and Auckland DHB Community Mental Health Services, who currently provide services for Maori, Pacific peoples, migrants, refugees and populations with mental ill health.

Mental Health Services for Children and Young People from Refugee Backgrounds
Need for specialised mental health service within mainstream acute and community mental health services for children and young people from refugee backgrounds. (See Appendix 5: CCAFS, 2001, Proposal for a specialised mental health service for the children of Refugees and Migrants). The proposal includes the cross-sectoral involvement of Children, Young People and Family services, Mental Health services, Police and Education services.

Children with Special Needs

The Auckland special education service states that a number of children who have come through the Mangere refugee resettlement centre (MRRS) with special needs do not fit the criteria for special needs funding. Currently there are no special education 2000 resources available to refugee children, who are identified as having special needs, after they have entered the school system. In particular this is a problem for 12 to 16 year olds. The New Zealand system is oriented towards the early identification of special needs in

the younger age group and not during adolescence. During the five to six weeks that families spend at MRRS, it is often difficult and sometimes inappropriate to uncover children's special needs unless it is very obvious, for example in the case of cerebral palsy. Malnourishment among children in refugee camps has a significant impact on the health and intellectual development.

There are also refugee children who arrive outside the quota system, through asylum seeking and family reunification who do not go through the Mangere reception centre. Often these children show up at schools with no prior assessment. The ESOL teacher does an assessment when they arrive at school. There are also bi-lingual tutors available to schools with migrant and refugee students, through "Team Solutions".

Refugee funding within education is only for ESOL teaching and there is no specific additional special needs funding. Refugee children attract funding of only \$1,100 for the first 2 years in primary school, \$1,700 for the first two years in secondary school and \$500 per year after that. Refugee children with little or no literacy in their first language are having major problems when mainstreamed. Currently a survey is being developed in Auckland that can go out to schools to identify the numbers of refugee pupil who have additional special needs for example, developmental delays, speech impairments and behavioural problems. The survey is to include questions regarding the unmet needs of refugee children and the current funding that is accessed. The purpose is to establish the numbers of refugee children with special needs, including trauma counselling, to ascertain where children fit into current SE2000 resourcing plan and to develop guidelines and requirements for targeting additional resources.

Oral Health

Many refugees, particularly those who are marginalised because of language, social and economic factors have untreated dental disease. The increased consumption of sweet foods and drinks in infants and children predisposes to dental decay.

Accessing dental health services may be challenging for refugee clients. School children may be given a letter to advise them to register with the their local SDS. However language or literacy problems may mean that the letter is not read and the child not registered with the local SDS.

Parents of preschool-aged children need to contact the SDS to arrange for their children to receive dental checks and treatment. Families will also need to choose and contact a GDP for adolescents to receive dental care. GPs, nurses and other health care providers are an important link in assisting refugee families make contact with the appropriate dental services.

Inadequate Health Service Planning Prior to Arrival for Quota Refugees

Auckland District Health service providers are hampered in their ability to respond to health needs by a lack of availability of information gathered prior to arrival Jorgensen, 2001). While New Zealand accepts people with disabilities and medical conditions and

mental ill health no additional health budget is made available to health service providers for example:

- ❑ People with disabilities require life-long support. Their support needs are being accessed from a budget that is capped and for which there are already long waiting lists even for NZ-born citizens;
- ❑ There are long-term health and development consequences of malnutrition, for example developmental delays including intellectual disabilities can take two to three years to recognize. Many children are outside the criteria for the paediatric needs assessment team and disability and special education needs services;
- ❑ Infectious diseases departments and the community AIDS Resource team do not receive additional funds to provide for the health needs of refugees with HIV;
- ❑ Many mental health problems do not surface for several years after settlement. Community mental health services and mental health crisis teams are under resourced to meet the needs of refugee clients.

Public Health Screening Services for Asylum Seekers and Family Reunification Members

Asylum seekers are eligible for free health public health screening in Auckland provided by Public Health Protection service. The Public Health Protection team is contracted for 500 screens, however up to 2000 people arrive in Auckland annually and make a claim for refugee status, additionally a further 300 people arrive as migrants under the family reunification category. The Auckland regional Public Health Protection service has insufficient funding to provide timely screening to all asylum seekers. Often there is a waiting list for screening. In addition, many asylum seekers do not access the free screening.

Appropriate Health Education, Information and Health Promotion

The Auckland University of Technology Refugee Education Centre (AUTREC) estimates that of all adults who arrive as refugees including those who arrive in the annual quota and in the humanitarian family reunification category, Twenty percent are illiterate in any language and eighty percent are beginners, or less, in English. An 'English as a Second Language' report on children from refugee backgrounds states that a total of 1737 young people in the year April 2000 to April 2001 needed ESOL classes in NZ schools (AUTREC, 2001). There is a need for health promotion and information that is audio visual and linguistically appropriate.

HIV in Refugee Populations in New Zealand

It is important to understand the cultural and social context of HIV within refugee communities, and the significant impact this has on HIV prevention and service delivery in this population:

- ❑ HIV is generally regarded as a source of shame and fear amongst most refugee groups in New Zealand. For this reason, many refugees choose not to tell anyone in their community that they are HIV positive. They therefore live with an enormous burden of silence and a constant fear of exposure and ostracism (Denholm, 2000);

- ❑ There is a lack of refugee community support for refugees with HIV;
- ❑ Communities lack HIV awareness and education. Existing health prevention and promotion campaigns do not target refugee populations culturally or linguistically;
- ❑ African men are reluctant to use condoms;
- ❑ Disclosure to husbands or wives can be difficult and presents a challenge to health providers;
- ❑ Failure to disclose HIV status increases the potential for spreading HIV infection;
- ❑ Women are particularly vulnerable if partners who are HIV positive resist the use of condoms;
- ❑ The fear of exposure may impact negatively on care and treatment. For example:
 - health care consultations with GPs may be missed for fear of the family finding out, or meeting someone they know in the waiting room or hospital;
 - using an interpreter from the client's community during a consultation may lead the client to withhold information for fear of the interpreter breaching confidentiality. It may also result in the client missing the appointment;
 - medicine must be hidden from others in the household;
 - health workers may not be able to visit the client at home;
 - clients with HIV often will not access the usual support networks in their community;
 - they may miss doctor's appointments as they cannot ask friends or family for transport to the clinic for fear of raising suspicion;
 - treatment may be compromised as HIV regimes are complex and the client may fear to seek advice and support from health workers for fear of attracting attention.

Training for Medical Practitioners

There is a lack of training available to medical practitioners in health care for refugees and migrant populations. The health care needs of refugee peoples differ from those of the average New Zealander, and are a challenge to the health-care practitioners who care for them. Diseases that are common in the home country of refugees and asylum-seekers are uncommon in NZ therefore health-care practitioners may have little experience in their diagnosis and treatment. For example, hookworm is one of the commonest causes of iron-deficiency anaemia worldwide, but is rare in New Zealand (Walker & Jaranson, 1999).

Key Issues

- ❑ Refugees and asylum seekers are now a significantly large cohort within the Auckland region. Most communities are located in the Central Auckland area. The numbers are estimated to be approximately 40,000 and rising by up to 2000 annually;
- ❑ The health needs of refugees appear to have been generally increasing since the advent in 1992/3 of refugees from Somalia and Ethiopia;
- ❑ Refugees and asylum seekers as a health care population have high health status problems when compared to the NZ population overall;
- ❑ Refugee and Immigrants' health care needs are usually far more complex for health care providers to deal with than the corresponding needs in NZ-born people. They are also more costly to deal with;
- ❑ Interpreter services are needed to facilitate the delivery of health care services to an ever-increasing proportion of ADHB's population for whom English is a second language. Trained health interpreters need to be available without cost to primary health care providers to improve access and acceptability and safety for clients and practitioners. The extension of interpreting services to general practitioners would reduce costs in the secondary and tertiary health sectors due to delays in seeking care, inappropriate use of emergency services and the use of secondary services for primary health purposes;
- ❑ All quota refugees are medically examined on arrival at Mangere Refugee Resettlement centre. All family reunion refugees are medically examined overseas, though there is some evidence that examinations are of a questionable quality. Asylum seekers are not medically examined before arrival in New Zealand. Some family reunion refugees and asylum seekers are medically screened following arrival in New Zealand. Need to improve the coverage of medical screening for asylum seekers and family reunion refugees;
- ❑ Up to forty asylum seekers in Auckland every week make application for refugee status. All are entitled to publicly provided health services during the period of application and appeal and if residence in New Zealand is gained;
- ❑ There is good evidence that the health status of quota refugees, family reunion refugees and asylum seekers is similarly poor. This is because all three groups come from the same regions. There is a serious concern regarding the spread of communicable diseases in Auckland populations due to the levels of infections of HIV, Tuberculosis and other infectious diseases. The true incidence of disease in refugee populations is not known;

- ❑ Medical screening for quota refugees and asylum seekers indicates that up to forty percent of those screened are referred on to specialist services, most requiring an interpreter;
- ❑ ADHB has no systematic collection of ethnicity or accessible and useful information on the health status of refugees and immigrants by immigration category, either on entry or longitudinally. This impedes weakens policy development, planning and service provision in the Auckland region;
- ❑ Regional inequities exist in levels of health services available for refugee populations;
- ❑ Children and young people from refugee backgrounds require in the Auckland region collaborative joint intervention including health, mental health, education, justice and children and young people's services;
- ❑ There is inadequate provision in *The New Zealand Health Strategy* Ministry of Health, 2000) and other health strategies, in legislation and in health infrastructure to address inequalities in health care to refugee populations in New Zealand and in particular Auckland;
- ❑ Need to consider promoting the use of the General Practitioner by introducing in Auckland 'the Paid First Visit to a GP with an interpreter scheme' which is available to refugees in Christchurch and Wellington;
- ❑ Need to consider employing people from targeted language groups to co-work with health care professionals to provide health education, information and support to refugee communities;
- ❑ Need to consider introducing cross cultural training for ADHB health care workers on the 'the refugee experience', epidemiology in countries of origin, health care issues and cultural beliefs and practices;
- ❑ Need to provide health promotion resources appropriate for refugee populations;
- ❑ Need to include refugee populations in all community consultation processes;
- ❑ Need specialized mental health services for refugees within mainstream adult, child and adolescent mental health services;
- ❑ Adequate communicable disease risk management systems need to be in place. These systems could include screening and follow up, signing of health declarations;
- ❑ Entitlement to free health care during the first two years in NZ is required,
- ❑ Information sharing between government departments is required;

- Coordinated and planned services for refugee communities are needed in Auckland:
 - Better coordinated and comprehensive disability, personal health and public health care services for refugees and immigrants during the vulnerable period after migration are required in the ADHB area. At present delays and duplication in services escalates the costs of providing health care to refugee populations. ADHB is currently under funded to provide the level of care required;
 - The stresses imposed by migration cause a wide range of illnesses. There is extensive epidemiological research showing that refugees and migrants suffer poorer health status than indigenous populations and that migrants' health is impaired after migration. Refugees (including quota refugees and asylum seekers) often have major pathologies as a result of torture, disadvantage and dislocation prior to migration;
 - The personal health problems of immigrants include all the diseases from which NZ-born people suffer but in addition a wide range of parasitic and infectious diseases (such as HIV, tuberculosis, hepatitis B, gut parasites and schistosomiasis), and mental health conditions (such as torture trauma and post-traumatic stress disorder). In addition immigrants often suffer isolation, racism, the stresses of adjustment with few English language skills, and material deprivation such as low income, restricted nutrition and inadequate housing. They have little, or no knowledge of local systems and how to access local health care.
 - There are inadequate services for asylum seekers and family reunification migrants who experience the same rates of health problems as quota refugees since they come from the same parts of the world;
 - Follow up of refugee and immigrants' health problems by public health authorities is difficult;
 - The NZ health care system is not well adapted to respond to refugees and immigrants' health care needs. The use of interpreters is not widespread. There is no key caseworker system (Jorgensen, 2001). The knowledge and skill level of the health care workforce with respect to the problems which refugees and immigrants suffer is under-developed. The sharing between government departments of information essential to good clinical management is not routine. There is virtually no systematic collection of accessible and useful information on the health status of immigrants by immigration category, either on entry or longitudinally. This impedes policy development, planning and service provision.

- Changes to Immigrant Health Policy needed:
 - New Zealand needs a clear policy with respect to health care of refugees and immigrants and this should be covered in the Bill. This should state that the poor health status of immigrants is one of the risks, which the government seeks to manage, for the welfare of the immigrant communities themselves and the protection of the wider NZ community and the NZ taxpayer. The obligations of the NZ government to refugees and immigrants should be stated and the obligations and entitlements of refugees and immigrants should also be made clear;
 - Bring immigrant health policy in line with other resettlement countries. People wishing to remain in Australia for longer than 12 months are required to have

medical screening. The same is true in Canada, except that certain visitors staying longer than six months are screened. In NZ a person can be in the country for up to two years without screening. This is too long in the case of people who have spent their lives in countries where communicable diseases such as tuberculosis are common;

- It should be mandatory that the NZIS consult with the Ministry of Health on policy matters and that the NZIS should periodically conduct assessment of the social (including health) impact of its policies.

3.05 Women's Health

This chapter focuses specifically on women's reproductive health and includes analysis of demographics, fertility, sexual health, obstetric procedures and gynaecological procedures. Gender analysis has been conducted throughout the report. For information related to women in other health areas please consult other sections of the report.

Services Available

Health services for women in the central Auckland DHB zone include hospital health services and primary care/community care services. Listed below are the names of key providers and a brief description of the service supplied.

Personal and Family Health Services

National Women's Hospital

National Women's Hospital is the third biggest obstetric and gynaecology hospital in New Zealand and is specifically focused on providing women's health services. It provides inpatient and outpatient services including fertility services [Fertility Plus], abortion services, and specialist outpatient clinics for PMS, HRT, pelvic pain, incontinence, and miscarriages. These services are not provided at other hospitals in the region.

Sexual Health Service

The Auckland DHB sexual health service provides reproductive and sexual health services, sexual abuse services for young women, prostitutes, street kids, and services to high schools within a peer education program.

Primary Care /Community Providers

New Zealand Family Planning Services

New Zealand Family Planning Services has a Regional Office in Newmarket, and another four sites in Central Auckland, providing reproductive and sexual health services for women.

BreastScreen Aotearoa

BreastScreen Aotearoa provides breast-screening services for the region.

St Marks Women's Health Services

St Marks is a private provider of women's health services. Services provided include cervical and breast screening, cancer treatment, cosmetic surgery etc.

Auckland Sexual Abuse Help Foundation Trust

Auckland Sexual Abuse Help Foundation Trust is a 24-hour post trauma care call out service for women who have suffered sexual abuse, which may include physical abuse.

Safer Auckland Families through Intervention Network (SAFTINET)

Safer Auckland Families through Intervention Network (SAFTINET) provides a 24-hour intervention call out service involving advocacy to meet the needs of individuals. A 24 hour telephone crisis line is available for monitoring and feedback of police actions in domestic violence cases; coordination of linked referral agencies (in particular the Auckland Help Foundation, the South Auckland Help Foundation and the Pacific Island Women's Health Project), and coordination and regular facilitation of meetings between providers in the district (see section on violence for further information).

Pacific Island Women's Health Project

Pacific Island Women's Health Project is a 24-hour post trauma care call out service for women who have suffered sexual abuse, but may include physical abuse.

Well Women's Nursing Service

Well Women's Nursing Service provides cervical screening services, and HRT for older women and those from different ethnic backgrounds eg, Chinese, Korean, Pakistani, Iranian etc.

Natural Family Planning Inc

Natural Family Planning Inc provides natural family planning advice, counselling on fertility services, HRT, PMS and other related reproductive and sexual health services to the public and young people at high school.

Birthcare Auckland

Birthcare Auckland provides primary maternity care services including LMCs, antenatal, perinatal and postnatal care.

Waiheke, Penrose, Onehunga, Tamaki and Western Springs High Schools

Waiheke, Penrose, Onehunga, Tamaki and Western Springs high schools provide community-based services around reproductive and sexual health, and other health related matters.

NZ AIDS Foundation

NZ AIDS Foundation provides counselling and support to women who are living with HIV or AIDS.

Ngati Whatua Ki Orakei Health Trust

Ngati Whatua Ki Orakei Health Trust has Maori midwives who work in conjunction with National Women's Hospital and Birthcare for primary birthing to provide whanau care and support.

General Practitioners

General Practitioners in the Auckland DHB zone provide women's health services either directly or indirectly. There are a number of all female practices in Central Auckland, catering to the primary health care needs of women in the DHB zone.

In addition, there are a number of support groups and non-health funded services providing care for women in the Auckland DHB zone.

Demographics

Table 116 compares the number of women living in the Auckland DHB with the total number of women living in New Zealand for 1999/2000. Approximately 11 percent of women in New Zealand live in the Auckland DHB zone.

Table 116: Total Auckland District Health Board and New Zealand Female Populations by Age Group 1999/2000

| Age group | Auckland DHB | New Zealand |
|-----------|--------------|-------------|
| 10-14 | 11,500 | 137,090 |
| 15-19 | 12,350 | 132,400 |
| 20-24 | 15,300 | 124,710 |
| 25-29 | 17,450 | 141,180 |
| 30-34 | 18,400 | 147,460 |
| 35-39 | 17,200 | 158,630 |
| 40-44 | 14,900 | 143,000 |
| 45-49 | 12,850 | 127,350 |
| 50-54 | 10,750 | 113,720 |
| Total: | 130,660 | 1,225,549 |

Table 117 compares the number of women (aged 10-54 years) living in the Auckland DHB by ethnicity for 1999/2000. The majority of women living in the Auckland DHB were 'Other peoples' (101,710 of 130,660, 78%), followed by Pacific peoples (16,340 of 130,660, 12%) and Maori (12,610 of 130,660, 10%).

Table 117: Total Auckland District Health Board Female Population by Ethnicity 1999/2000

| Age Group | Other People | Maori | Pacific Island | Total |
|-----------|--------------|--------|----------------|---------|
| 10-14 | 7,780 | 1,570 | 2,170 | 11,520 |
| 15-19 | 8,810 | 1,530 | 2,010 | 12,350 |
| 20-24 | 11,050 | 2,040 | 2,200 | 15,290 |
| 25-29 | 13,560 | 1,780 | 2,090 | 17,430 |
| 30-34 | 14,530 | 1,500 | 2,380 | 18,410 |
| 35-39 | 13,800 | 1,440 | 1,930 | 17,170 |
| 40-44 | 12,270 | 1,140 | 1,500 | 14,910 |
| 45-49 | 10,700 | 920 | 1,230 | 12,850 |
| 50-54 | 9,210 | 690 | 830 | 10,730 |
| Total: | 101,710 | 12,610 | 16,340 | 130,660 |

Fertility

In New Zealand, 56,597 live births were registered for the year 2000, compared with 57,053 in 1999 (www.stats.govt.nz). This represents a difference of 456 fewer births (0.8%) in 2000 compared with 1999. The average fertility rate for 2000 was 2.01 births per woman and is below the birth rate required for the population to replace itself, in the absence of migration (approximately 4%). For 18 of the last twenty years, fertility has been below that required to replace the New Zealand population. Among developed countries, sub-replacement fertility is a common demographic occurrence, including Australia (1.7 births per woman), Canada (1.6), and England and Wales (1.7). Increased access to and use of contraception, participation of women in the work force and general economic conditions have been attributed to the decline in fertility (Ministry of Women's Affairs, 2001).

In the Auckland DHB zone there were 5,933 births between July 1999 and June 2000 (Table 118). The number of births per month fluctuated with the peak number in the month of November (n=544 births (approximately 9% of total births)) and the lowest number in the month of August (n=415 (approximately 7% of total births)). Compared with the rest of New Zealand, the 5,933 births in the Auckland DHB region represents around 11percent of the national total for births over the same period.

In general, New Zealand women are delaying motherhood. In the Auckland DHB zone for the 1999/2000 period, the highest fertility rate was in the age group 30 to 34 years (110.7 per 1,000) and this compares closely with the fertility rate of all New Zealand women aged 30 to 34 years (110.9 per 1,000), for the same period (Table 118). The fertility rate for the 25 to 29 years of age group in the Auckland DHB region was 81.3 per 1,000 and below the fertility rate for all New Zealand women for the same age group (106.6 per 1,000). There is some evidence of a trend for women in the Auckland DHB zone to have children at an older age compared with New Zealand, as the age-specific birth rate is higher for both the 35 to 39 and 40 to 44 age groups in the Auckland DHB zone compared with New Zealand.

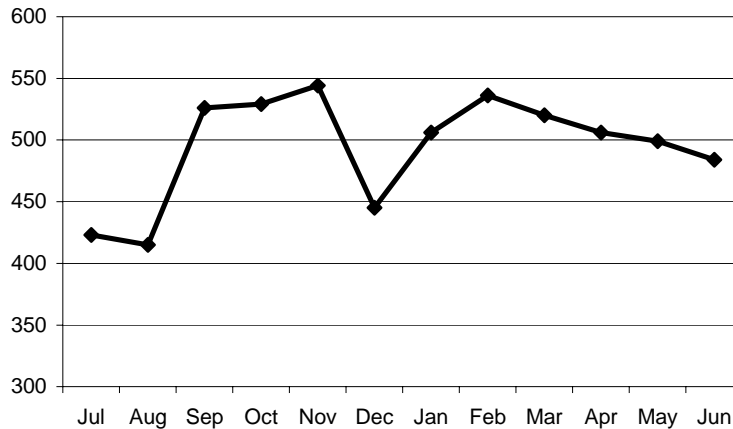
Table 118: Total Auckland DHB and New Zealand Public Hospital Births by Age Group 1999/2000

| Years | Auckland DHB | New Zealand |
|---------|--------------|-------------|
| Unknown | 1 | 6 |
| 10-14 | 7 | 26 |
| 15-19 | 272 | 3,787 |
| 20-24 | 821 | 9,655 |
| 25-29 | 1,418 | 15,048 |
| 30-34 | 2,037 | 16,350 |
| 35-39 | 1,157 | 8,071 |
| 40-44 | 209 | 1,345 |
| 45-49 | 10 | 38 |
| 50-54 | 1 | 3 |
| Total | 5,933 | 54,329 |

Data Source: NMDS

The fertility rate has changed dramatically from the early 1970s when New Zealand women of that time, aged 20 to 24 years, had the highest fertility rate (201 per 1,000) followed closely by women aged 25 to 29 (191 per 1,000). Among Maori women, however, the fertility rate is concentrated in the younger age groups (Ministry of Women's Affairs, 1998). For example, in 1995 the age specific fertility rate for Maori women was 150.4 per 1,000, compared with 83.6 per 1,000 for all New Zealand women.

Figure 91: Auckland DHB Public Hospital Births by Month, 1999/2000



Data Source: NMDS

Table 119: New Zealand and ADHB Age-Specific Birth Rates/1000 population by Age Group 1999/2000

| Years | Auckland DHB | New Zealand |
|------------------------------|--------------|-------------|
| 10-14 | 0.6 | 0.2 |
| 15-19 | 22.0 | 28.6 |
| 20-24 | 53.7 | 77.4 |
| 25-29 | 81.3 | 106.6 |
| 30-34 | 110.7 | 110.9 |
| 35-39 | 67.3 | 50.9 |
| 40-44 | 14.0 | 9.4 |
| 45-49 | 0.8 | 0.3 |
| 50-54 | 0.1 | 0.0 |
| Average over all age groups: | 45.4 | 44.3 |

Data Source: NMDS

Table 120 shows the number of Auckland DHB public hospital births from 1996/97 to 2000/01, by ethnic group. The number of Maori births in public hospitals increased during this period by approximately eight percent. In comparison the number of public hospital births for Other Peoples and Pacific peoples decreased by six and nine percent respectively, for the same period. Overall Auckland public hospital births have decreased by around three percent between 1996/97 and 2000/01.

Table 120: Auckland DHB Public Hospital Births by Ethnic Group, 1996/1997 - 2000/2001

| Year | Maori | Other Peoples | Pacific Peoples | All Ethnic Groups |
|-----------|-------|---------------|-----------------|-------------------|
| 1996/1997 | 560 | 4,151 | 1,408 | 6,119 |
| 1997/1998 | 595 | 4,085 | 1,413 | 6,093 |
| 1998/1999 | 596 | 4,021 | 1,318 | 5,935 |
| 1999/2000 | 593 | 3,998 | 1,342 | 5,933 |
| 2000/2001 | 611 | 3,933 | 1,297 | 5,841 |
| Total | 2,955 | 20,188 | 6,778 | 29,921 |

Data Source: NMDS

There is further fertility data and information in the section on demographics in Part I of the report.

Teenage Pregnancy

Compared with other OECD countries New Zealand has a high teenage birth rate, although this is largely accounted for by the high birth rate among Maori and Pacific teenagers (Dickson et al, 2000). The New Zealand European/Pakeha birth rate is lower than the UK or USA Caucasian teenage birth rate (50.9 per 1,000) and close to the overall rate in Australia and Canada.

In the Auckland DHB zone the Maori teenage birth rate is nearly seven times higher than that of Other Peoples (Table 121). The Pacific Island teenage birth rate is nearly six times higher when compared with the teenage birth rate of Other Peoples. If the proportion of Maori and Pacific young people increases as expected, the overall teenage birth rate is also anticipated to increase. The teenage pregnancy rate is thought to be affected by attitudes towards sexual activity and contraceptive use.

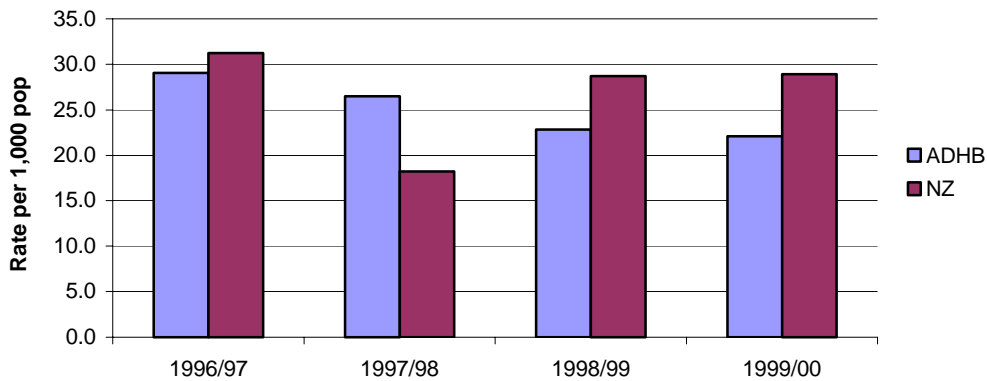
Table 121: Auckland DHB Teenage (<20yrs) Birth Rate/1000 Population, by ethnicity, 1999/2000

| | Maori | Other Peoples | Pacific Peoples | All Ethnic Groups |
|---------------------------|-------|---------------|-----------------|-------------------|
| Rate per 1,000 population | 60.8 | 8.9 | 50.5 | 22.1 |

Data Source: NMDS

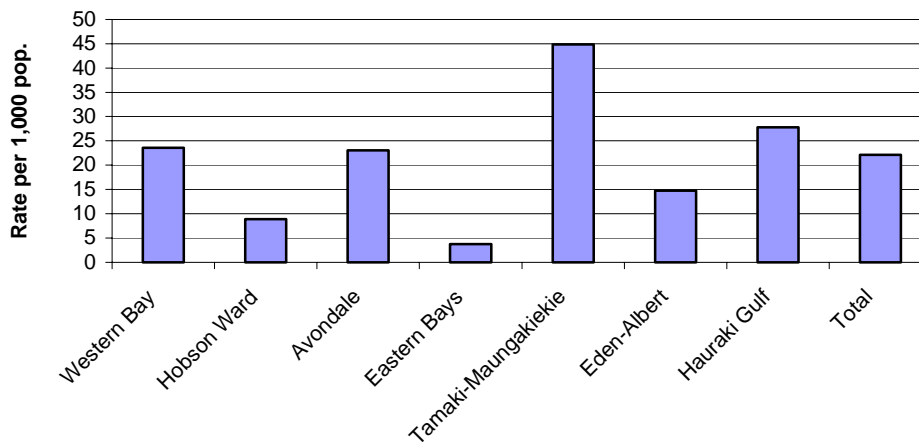
Figure 92 compares the rate of teenage (<20 years of age) births per 1,000 population in Auckland DHB with the remainder of New Zealand. The teenage birth rate was higher in the New Zealand population compared to the Auckland DHB zone every year with the exception of 1997/1998, where the teenage birth rate in the Auckland DHB region was 26.5 births per 1,000 compared with 18.2 per 1,000 in New Zealand.

Figure 92: Teenage <20yrs Birth Rate per 1,000 women aged 16-19 years for Auckland DHB and New Zealand, 1996/1997 - 1999/2000



Data Source: NMDS

Figure 93: Total Auckland DHB Teenage (<20yrs) Births by Ward, 1999/2000



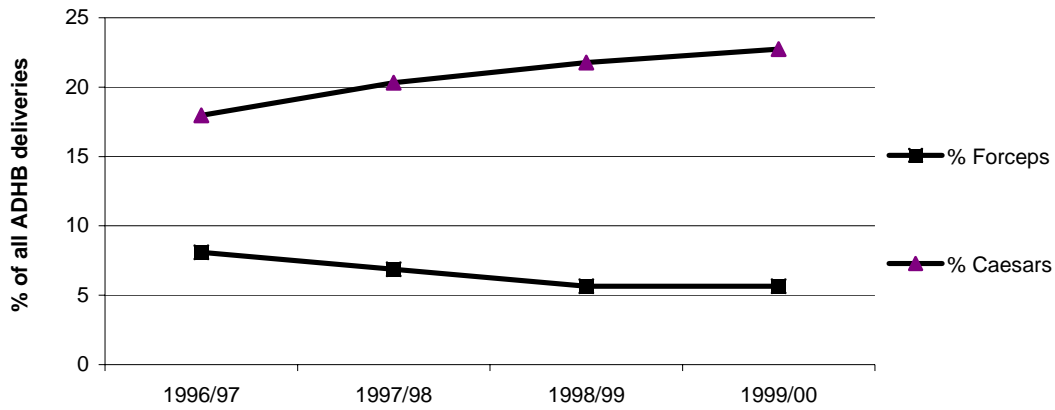
Data Source: NMDS

Figure 93 shows the Auckland DHB teenage (< 20 years of age) birth rate by Ward of residence. Eastern Bays had the lowest teenage birth rate (3.7 per 1,000) compared with Tamaki-Maungakiekie, which had the highest teenage birth rate (44.8 per 1,000 population) for the 1999/2000 period.

Surgical Interventions at Birth

Figure 94 shows the percentage of Auckland DHB resident's forceps and caesarian deliveries, for the 1996/1997 to 1999/2000 period. The percentage of forceps deliveries decreased over this period from 8.1 percent to 5.7 percent (difference -2.4%) and the percentage of caesarian deliveries increased from 18.0 percent to 22.7 percent (difference +4.7%).

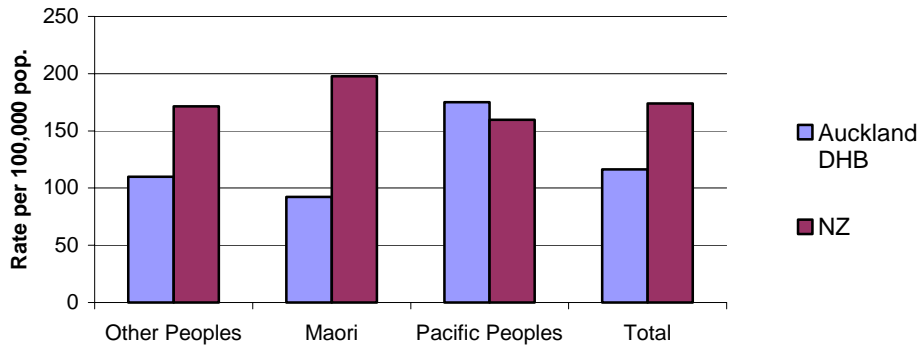
Figure 94: Forceps and Caesarian Deliveries as a % of All Auckland DHB Resident's Deliveries 1996/97 - 1999/2000



Note: Forceps delivery = ICD-9-CMA Procedure 720-724
 Caesarian delivery = ICD-9-CMA Procedure 740-749 excl. 7491

Data Source: NMDS

Figure 95: Age Standardized ADHB & NZ pop. Public Hospital Discharge Rates for Hysterectomies, 1999/2000



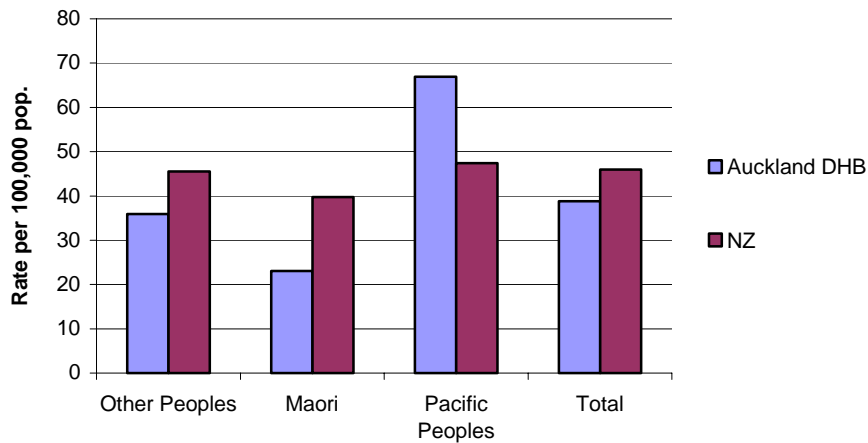
Data Source: NMDS

Figure 95 compares the age-standardized public hospital discharge rates for hysterectomies in the Auckland DHB and New Zealand populations, by ethnicity. In the Auckland DHB zone, the highest age-standardized discharge rate for hysterectomies was for Pacific peoples (175.0), followed by Other peoples (109.0). Maori had the lowest age-standardized discharge rate (92.2). Compared with the rest of New Zealand, the discharge rates were lower for both Other People and Maori, and higher for Pacific People.

Figure 96 compares the age-standardized public hospital discharge rates for oophorectomies in 1999/2000 in the Auckland DHB and New Zealand populations, by

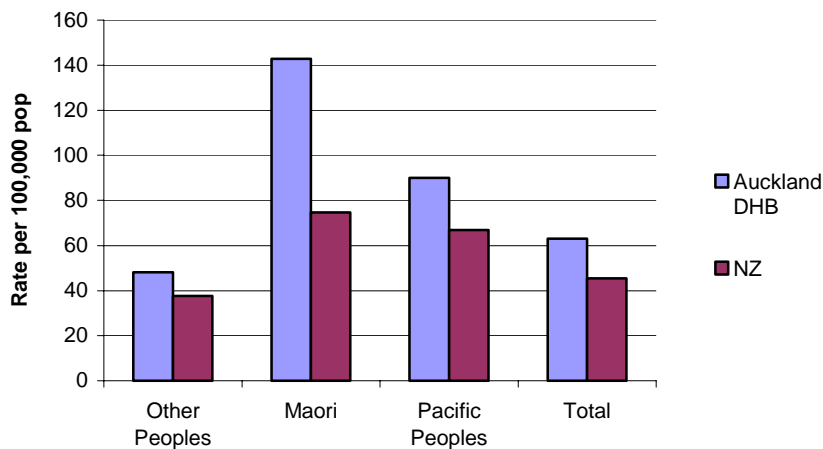
ethnicity. Compared with New Zealand, the rate was lower for both Other peoples and Maori, and higher for Pacific women in the Auckland DHB zone. Overall, the age-standardized discharge rate for oophorectomies was lower in the Auckland DHB zone compared with New Zealand.

Figure 96: Age Standardized Discharge Rate for Oophorectomies, 1999/2000



Note: Oophorectomy = ICD-9-CMA Procedure 653-656
 Using NZ population as a standard population
 Data Source: NMDS

Figure 97: Age-standardized ADHB & NZ pop. Public Hospital Discharge Rates for Reproductive Tract Infections, 1999/2000



Data Source: NMDS

Figure 97 compares the age-standardized public hospital discharge rates for reproductive tract infections in the Auckland DHB and New Zealand populations, by ethnicity, for the 1999/2000 period. In the Auckland DHB zone, the discharge rate for reproductive tract

infections was higher in each ethnic group compared with the rest of New Zealand. The difference in age standardized discharge rates between Auckland DHB and New Zealand was most marked in Maori. Maori had a reported standardized discharge rate for reproductive tract infections of 142.7 in Auckland DHB, compared with 74.6 in New Zealand for 1999/2000.

Key Issues:

- ❑ Approximately 11 percent of all NZ women live in the Auckland DHB zone;
- ❑ Approximately 11 percent of all NZ births occur among women in the Auckland DHB zone;
- ❑ More Auckland DHB women appear to be having children at an older age than in the NZ pop;
- ❑ The number of babies born to Maori mothers is increasing in the Auckland DHB pop, but the number of babies born to women of other ethnic groups is decreasing;
- ❑ Auckland DHB teenage birth rate is lower than the rate for the all NZ pop;
- ❑ Auckland DHB Maori and Pacific teenage birth rates are extremely high;
- ❑ Auckland DHB caesarian rates are increasing and forceps rates have decreased in recent years;
- ❑ Auckland DHB hospitalization rates for reproductive tract infections are higher than for the all NZ pop;
- ❑ Auckland DHB Maori hospitalization rates for reproductive tract infections are higher than for the all NZ Maori pop;
- ❑ Auckland DHB hysterectomy rates are lower than the rates for the all NZ pop;
- ❑ Auckland DHB oophorectomy rates are lower than the rates for the all NZ pop.

3.06 Hauraki Gulf Islands

There are more than ninety islands in the Hauraki Gulf, whose communities are included in the Auckland DHB catchment zone. This section reviews the health needs of communities on Waiheke and Great Barrier Island, the two largest islands in the Gulf with significant populations. The Gulf islands have been included in the needs assessment because they have a number of unique features, or characteristics, that impact on the health of their populations and the manner in which services are planned, funded and delivered. Although the Auckland DHB zone population is assumed to be an urban population, the island communities are rural, or semi-rural communities, physically isolated from the mainland. Thus, the problems faced by the health providers on the islands and the needs of island communities are very similar to those experienced by health providers and communities in other areas of rural New Zealand.

Waiheke Island

Waiheke Island is the second largest island in the Hauraki Gulf. Waiheke is the most populated of all the islands and the most accessible, with a regular, daily ferry service and air services connecting local communities with the mainland. Waiheke is approximately 17km East of Auckland (a 35 minute ferry ride from the Auckland CBD).

| | | |
|----------------------------|---------|-----------------|
| Ferry service to Auckland: | \$23.60 | return (Adult); |
| | \$9.00 | return (Child); |

The island has 96km of coastline and there are a number of small townships clustered along beachfronts and around sheltered bays. There is a public transport service on the island that allows local residents to travel between these coastal communities.

Services Available

There is no hospital on Waiheke, but primary and community services are supplied to local residents by a number of health and social service providers based on the island (Adams, 2000). Secondary and tertiary services are provided on the mainland. At present, there are two dental practices (both in Oneroa), a diagnostic lab service (Medlab), two pharmacies (one at Ostend and one at Oneroa) and there are two medical practices (Ostend Medical Centre and the Red Cross Medical Centre in Oneroa) with a total of five GPs that provide an oncall, after-hours service to residents. The pressure on the 5 GPs to provide 24 hour cover and act as an A&E service for the community makes working as a GP on the Island less attractive than it would be in an area well resourced by after-hours and tertiary medical centres.

St Johns operate an ambulance service and there is an x-ray service available part-time. Patients in need of emergency care are either treated on the island, or ferried or flown by helicopter to Auckland Hospital, depending upon the urgency of any given situation. There are three midwives, an optometrist, a podiatrist and a physiotherapist on the island.

There are a limited number of visiting specialist clinics provided on the island that require ongoing review as the population and the associated health profile changes.

There is a Marae-based Maori health service (Piritahi Marae) that delivers alcohol and drug counselling services, family therapy, advocacy and support, health checks, education, information, cervical screening services etc. Clinics are run on a part time basis and a doctor from one of the medical practices is present one day a week. The Maori population is growing steadily and this has implications for future demand for Maori services.

In addition, there is an Auckland DHB community mental health service, although there are no secure facilities available at present for mental health patients. Local health professionals report that mental health emergency service access is an issue on the island. There are counselling services available – including school counselling services. With a rise in school roles in recent years, there have been increases in demand for more school based health services.

The Waiheke Health Trust is a community owned Trust which provides district nursing, child health, social work, occupational therapy, family therapy, community workers, home support, meals on wheels, occupational therapy and a plunket car seat service are also available to residents.

There are two rest homes on the island and a hospice providing palliative care. There are a total of four respite beds available on the island. Local social workers report that there are not enough respite beds available at present to meet existing demand for respite care.

There are a number of community support groups on Waiheke including an arthritis support group, cancer support group, a stroke club and an ME support group.

Finally, alternative therapists on the island include a hypnotherapist, a chiropractor, an acupuncturist and an osteopath.

Drug and Alcohol related health problems are of particular concern to health care providers on the Island. Police also report high levels of domestic violence, with strong links to drug and alcohol abuse.

Demographics

The usually resident population at the time of the 1996 Census was 6,288. Projections to 2001 indicate the population has grown to a total of 7,286, an increase of approximately 12 percent. The rapid increase in population has implications for the level of service currently provided on the island. If the population continues to grow at this rate, existing services will require further expansion and further funding. Anecdotal evidence suggests that existing service levels do not meet current demand in many areas and will fail to meet demand in future if population growth continues at this rate (12%).

In addition, local residents report substantial undercounting of the usually resident population during Census. It is difficult to ascertain the exact number of people that permanently live on Waiheke, thus it is difficult to ascertain the exact level of service required on the island. This problem is compounded by the large, semi-resident, batch-owner, weekend-holiday population, the tourist population and the influx of boat owners and holidaymakers during summer and extended public holidays. Estimates suggest there are approximately 1,400 visitors to the island each day during January (Adams, 2000).

The influx of visitors to the island each day in summer provides a number of challenges to local health providers and their staff. Apart from the added demand for services and the strain this places upon existing staff, there are often difficulties in getting access to information from health records on the mainland for Auckland residents that access local island health services. Staff are also unable to take holidays during this period with other family members and children on school holidays. There are also problems in arranging relief for health staff on the island.

Table 122 presents a summary of major demographic statistics from the 1996 Census. As can be seen, there were slightly more females than males in the population in 1996. The proportion of the Waiheke usually resident population that were Maori (11.6%) was greater than the proportion of Maori in the total Auckland DHB population in 1996.

The table also shows that approximately twenty percent of the population were between 0-14yrs, which was similar to the proportion of children in the Auckland DHB population in 1996.

The 1996 Census data also shows that there were 939 older adults (65yrs+) on the island, representing approximately 14.9 percent of the usually resident population. The Waiheke population is aging rapidly. More older adults are choosing to retire to the island from the mainland and as time progresses, there will be implications in terms of changing population health need. A greater proportion of the population can be expected to present with conditions associated with the aging process such as arthritis, cancer, alzheimers etc. over time. The aging population on Waiheke has implications for the mix and level of services that will be required in the future. For instance, demand for rest home care and respite care will likely rise over time. There were no alzheimers representatives or support groups on the island at the time of writing.

There are a number of health determinant variables from the 1996 Census that are of particular concern. Smoking rates on Waiheke appear to be high in comparison to the rates for the total Auckland DHB population. The rate of smoking among local residents is likely to have an impact on future health status and the prevalence of smoking related disease (eg heart and lung disease) if smoking rates remain unchecked.

In addition, a lower percentage of households on Waiheke have phones, compared to the percentage for all Auckland DHB households, which is important, as having ready access to a phone is crucial in emergencies and when trying to access other services. It also has

an impact on the amount of time health providers spend organizing appointments and visits for people without telephones.

Table 122: Demographic profile of the Waiheke Island community (usually resident pop.), 1996.

| | | Waiheke Island | Auckland DHB |
|-------------------------------|--|-----------------------|---------------------|
| Gender | % Male | 48.8 | 48.5 |
| | % Female | 51.2 | 51.5 |
| Ethnicity | % Maori | 11.6 | 9.1 |
| | % Non-Maori | 88.4 | 90.9 |
| Age Group | % Child (0-14yrs) | 20.2 | 20.1 |
| | % Young people (15-24yrs) | 8.8 | 15.6 |
| | % Adult (25-64yrs) | 56.1 | 53.0 |
| | % Older adult (65yrs+) | 14.9 | 11.4 |
| Determinants of Health | % Regular smokers (15yrs+) | 26.6 | 18.2 |
| | % Households w no vehicle access | 9.38 | 14.0 |
| | % Households w no phone access | 14.0 | 10.4 |
| | % Households w no rent/mortgage | 39.6 | 56.2 |
| | % Unemployed | 10.5 | 4.8 |
| | % Personal income >\$30,000/year | 16.0 | 25.0 |
| | % On income support | 53.0 | 29.9 |

Data Source: Census 1996

Although there is a bus service and a taxi service on the island, transportation is an issue for older people, the disabled and the very young, especially those required to travel to the mainland for services. Community nursing staff complete a number of home visits on the island because of transport access issues for patients. Buses are only available on defined routes and many people do not live close to these bus routes.

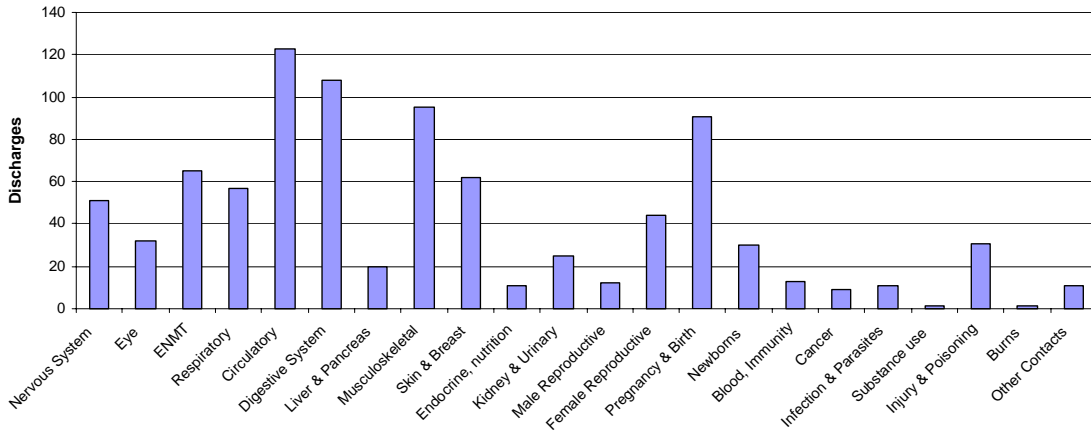
It can also be expensive for many residents to access health services on the mainland. As can be seen in Table 122, unemployment rates were high and a large proportion of residents were on income support in 1996, thus many people find the cost of travel to the mainland prohibitive. The Jassey Dean Trust, however, does assist residents with travel costs to access services on the mainland.

Table 122 also shows that a smaller percentage of households were owned, or rent-free on the island in 1996, compared to the percentage of homes that were owned, or rent-free in the total Auckland DHB zone.

Service Utilization

This section reviews public hospitalisation data obtained from the NMDS. Figure 98 presents the conditions that Waiheke residents were hospitalized for in 1999/00. The majority of hospitalizations appear to be for circulatory, digestive system, musculoskeletal and pregnancy and birth conditions.

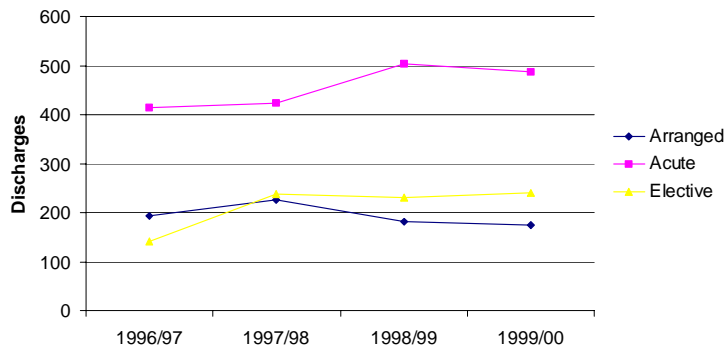
Figure 98: Waiheke Island resident’s public hospital discharges, by major diagnostic category, 1999/00.



Data Source: NMDS

Figure 99 presents Waiheke resident’s public hospitalizations by admission type for the period 1996/97 to 1999/00. As can be seen, there has been an increase in acute admissions in recent years, whilst elective admissions have remained relatively stable over time.

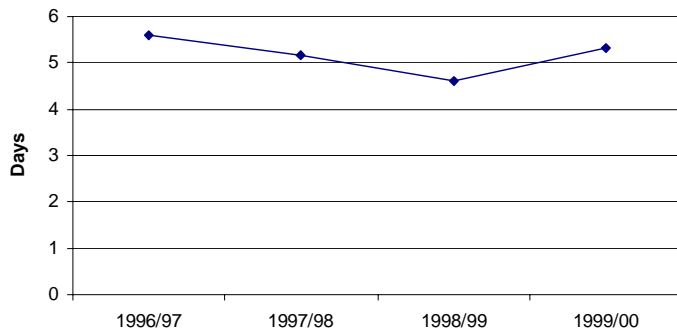
Figure 99: Waiheke Island resident’s public hospital discharges, by admission type, 1996/97 - 1999/00.



Data Source: NMDS

Figure 100 shows that the average length of stay in public hospitals, for Waiheke residents, has decreased slightly in recent years.

Figure 100: Waiheke Island resident's public hospitalisation aver length of stay (days), 1996/97 - 1999/00.



Data Source: NMDS
Data excludes daypatients.

Key Issues:

- ❑ Rapid population growth has not been accompanied by similar growth in service levels. Significant population undercounting reported at Census. Issues arising around service demand for Maori health services, school based services, services for older adults etc;
- ❑ Tourist population fluctuations etc put added pressure on existing health services during weekends and summer holidays;
- ❑ Mental health emergency service access is an issue. No secure facilities available on the island at present for mental health patients;
- ❑ More respite beds required;
- ❑ There is a need to address the issue of domestic violence on the island;
- ❑ Problems securing relief staff to cover employed staff on leave;
- ❑ Difficulties obtaining health information on visitors to the island from mainland sources;
- ❑ Smoking rates high – implications for future health and Wellbeing of population and future health need;
- ❑ Low proportion of households have access to phones – implications in emergencies;
- ❑ Transportation an issue, especially for the elderly, young and disabled. Getting to the mainland to access services can be expensive for many on the island.

Future Tasks:

- Review population health needs with providers on Waiheke Island.

Great Barrier Island

Great Barrier Island is an isolated island in the Hauraki Gulf with a rural, widely dispersed community of approximately 1,500 permanent residents. There are no reticulated services (power, water etc) on the island and there is no public transport available. Commercial transport both within and off the island is expensive and often beyond the financial means of local residents:

Airfares to Auckland: range between \$139-\$189 return;
Taxi from Claris to Port Fitzroy: average \$65 one-way.



Transport to and from Auckland and accommodation whilst in Auckland is expensive for people seeking healthcare. They must first outlay the cost of travel and accommodation and seek reimbursement at a later date. It is also expensive for people seeking healthcare on the mainland whose travel costs are not met by current subsidy schemes. At present, the local primary and community healthcare provider on the island has a limited budget to fund the cost of transportation for children and older people to the mainland for secondary and tertiary health services. The provider also seeks reimbursement for travel

expenses from other agencies such as ACC. It should be noted here that travel to Auckland via air, and sea in some circumstances, is limited during periods of bad weather and this is a risk for local residents.

Health services to the community are funded by the Auckland DHB. Basic primary and community services are provided by Aotea Health, from a base health centre at Claris on the Central Eastern side of the island and a small health clinic at Port Fitzroy on the North Western side of the island. There is no hospital on the island, no ambulance service, no lab, physio or undertaker.

Information about health need on the island was obtained via discussion with Aotea Health staff, review of available primary care information, Census data and routinely collected inpatient data.

Demographics

Local residents report significant undercounting of the usually resident population for the 2001 Census. It is therefore difficult to be certain of the exact number of people that currently live on the island. Local estimates, based upon the patient register kept and regularly updated by Aotea Health, suggest that the population may be as high as 1,500 people, although preliminary estimates from the 2001 Census suggest there are just over a thousand residents. The population fluctuates throughout the year, as it is a popular tourist destination. Anecdotal evidence suggests that there are as many as 12,000 people serviced by the island on any one day over the peak summer holiday period (late Dec – beginning of Jan) each year. DOC estimates suggest there are between 30-35,000 visitors to the island each year.

Table 123: Demographic profile of Great Barrier Island community, 1996.

| | | |
|-------------------------------|--|-----------|
| | | % of pop. |
| Gender | % Male | 53.6 |
| | % Female | 46.4 |
| Ethnicity | % Maori | 13.0 |
| | % Non-Maori | 87.0 |
| Age | % Child (0-14yrs) | 27.3 |
| | % Young people (15-24yrs) | 9.9 |
| | % Adult (25-64yrs) | 56.0 |
| | % Older adult (65yrs+) | 6.8 |
| Determinants of Health | % Regular smokers over 15 years of age | 24.2 |
| | % Households with no vehicle access | 22.4 |
| | % Households with no telephone access | 27.6 |
| | % Households with no rent/mortgage paid | 53.5 |

Data Source: 1996 Census

Table 123 presents a summary of major demographic statistics from the 1996 Census. As can be seen, there are slightly more males than females in the population. The proportion of the population that are Maori (13%) is similar to the proportion of Maori in the New Zealand population. Approximately half of the Maori population on the island are *Tangata Whenua*.

The table also shows that there are more than three hundred children on Great Barrier, aged between 0-14 years, representing a large proportion of the population. The 1996 Census data suggest there are fewer than one hundred older adults, aged 65 years or more on the island, representing only 6.8 percent of the resident population. However, Aotea Health report that the resident population appears to be aging and that there have been changes in the disease profile of patients seeking healthcare services as a result. There has been an increase in recent years in the incidence of diseases normally associated with mid-older aged adults eg cancer, cardiovascular disease etc. Aotea Health also report an unusually high number of breast cancers detected in the last 12 months in women aged less than fifty years, which is of particular concern.

The Census figures for health determinant variables are of particular concern. For instance, the proportion of the adult population (15yrs+) that smoke on the island (24.2%) is high in comparison to the smoking rate for the Auckland DHB (18.2%). The high rate of smoking among local residents will have an impact on future health status and the prevalence of smoking related disease if smoking remains unchecked.

A larger proportion of households on the island do not have access to either a vehicle (22.4%) or a phone (27.6%), compared to all households in the Auckland DHB zone with no access to vehicles (14%) and no access to a phone (10.4%). Both phones and vehicles assist individuals in accessing healthcare when it is required. Having direct access to these items is especially important in isolated rural areas where accidental injury is common and acquiring timely access to emergency services can be difficult.

Although the proportion of households that are rent or mortgage free on Great Barrier (53.5% is similar to the proportion for all of the Auckland DHB zone (56.2%), many of the houses that are owned by residents are not well insulated and they are lightly clad, sewerage and facilities are basic and many are 'unfinished'.

Services Available

Aotea Health provide all primary and community services to residents on the island. There are currently 1.6 GP FTEs providing primary and basic emergency services to the community. However, with a shortfall in funding predicted for the year, it is likely that the island will lose 0.6 GP FTE. Although Aotea Health receive a rural bonus supplement to their funding, a scheme run by the MOH that provided additional funding for extreme rural services, is about to cease and this is causing the crisis which may lead to the loss of 0.6 of a GP on the island.

Aotea Health have expressed concern about the prospect of losing their second GP and the extra demands this would place upon the remaining GP, especially during the busy summer tourist period when the local dependent population rises significantly (up to 12,000) and the nature of local health issues change – more accidents and injury-fractures, gastro, prescriptions for chronic conditions (difficult to obtain tourist's health information from the mainland) etc. Aotea Health have also raised concerns over the difficulty of attracting locums to provide cover, or relief and the difficulty of attracting another permanent GP to the island.

Local community nursing services are provided by two extended role rural nurses and two part-time nurses on the island. Between them, the nurses provide not only district nursing services, but public health nurse services, emergency services, palliative care, relief of pain services, homecare assessment services, practice nurse services, service co-ordination, administration and management.

One of the nurses also provides midwifery services. The island has a very high home birth rate. There are approximately 17-18 pregnancies a year and approximately five miscarriages a year. From the 12-13 deliveries per year, there are approximately 4-10 births on the island each year. A shared care arrangement currently exists between the island midwife and LMCs on the mainland, where some of the Great Barrier Island resident women deliver.

A mental health nurse is employed, counseling services are provided and the island's oral health services are provided from the Claris-based Community Health Trust clinic and a mobile school clinic provided by Waitemata DHB. This DHB funds the regional school dental service. Great Barrier Island is a non-fluoridated area so there is a real concern with children's oral health.

Aotea Health also employ a receptionist and a part-time community worker. The community worker also provides assistance with WINZ queries. Home help services are sub-contracted by Aotea Health to another social service organization.

There are no dietetic, occupational therapy or physiotherapy services available locally to residents.

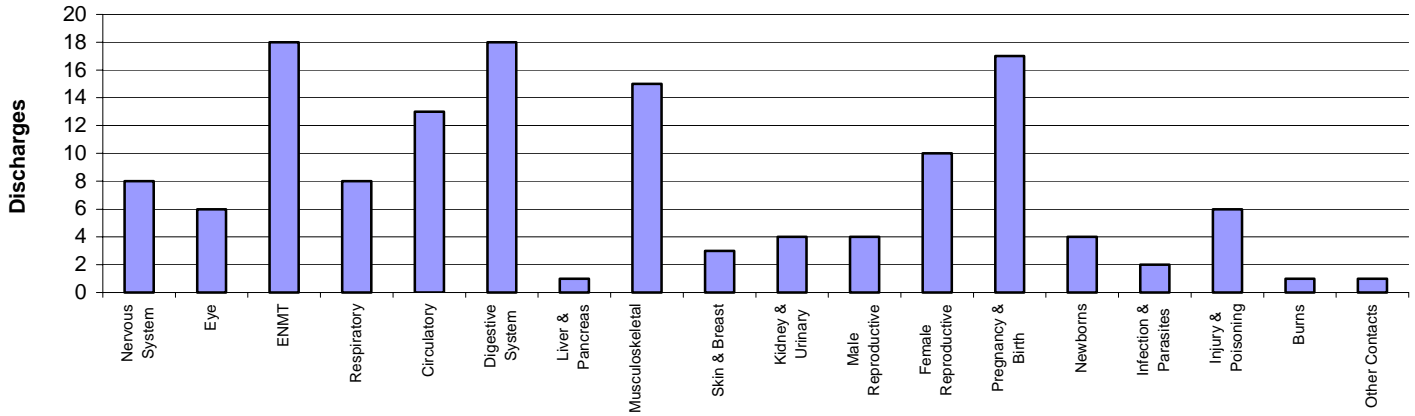
There are no DHB funded visiting specialist clinics provided and Aotea Health perceive a need for general surgery and obstetrics clinics. The hospitalization data provided in Figure F indicates that there is likely to be demand for these clinics. Although the need for clinic frequency would likely be low, it may be more cost-effective to transport clinicians to the island, than maintaining current practice whereby patients fly to the mainland to access these specialist services.

Service Utilization

The service utilization data presented in this section includes public hospitalization data. There was no primary healthcare data available at the time of writing. It should be noted that although reference is made to 'Great Barrier Island residents' in this section, residents of the neighbouring islands – the Aiguilles, Rakitu, Rangiahau, Motuheku etc.

Figure 101 presents the conditions that Great Barrier residents were hospitalized for in 1999/00. The majority of hospitalizations appear to be for ear, nose and throat conditions, digestive system conditions, pregnancy and birth, musculoskeletal and circulatory conditions.

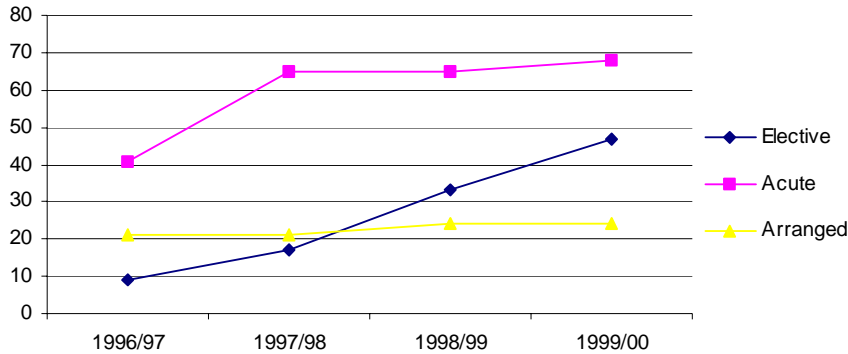
Figure 101: Great Barrier Island public hospitalizations by major diagnostic category, 1999/00.



Data Source: NMDS

Figure 102 presents Great Barrier resident’s public hospitalizations by admission type for the period 1996/97 to 1999/00. As can be seen, both arranged and acute admissions to hospital have increased marginally in recent years, whilst the number of elective admissions have increased markedly over time.

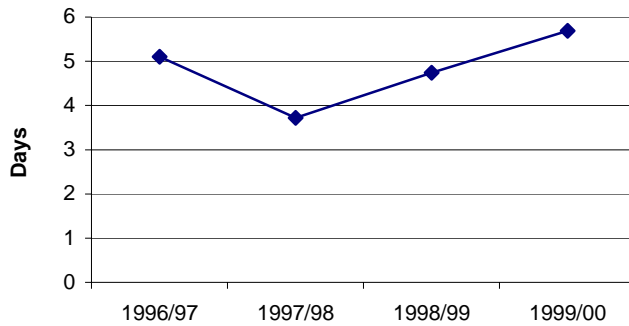
Figure 102: Great Barrier Island public hospitalizations by admission type, 1996/97 - 1999/00.



Data Source: NMDS

Figure 103 presents the average length of stay in hospital for Great Barrier residents over the period 1996/97 to 1999/00. As can be seen, with the exception of a ‘dip’ in 1997/98, the average length of stay has increased slightly in recent years.

Figure 103: Average length of stay (days) in public hospitals, for Great Barrier Island residents, 1996/97 - 1999/00.



Data Source: NMDS
NB: Excl. daypatients

Key Issues:

- ❑ Require secure funding for a second GP;
- ❑ Visiting specialist clinic– general surgery, obstetrics - required;
- ❑ Dietician, OT and physiotherapy service required;
- ❑ Difficulties obtaining relief staff when required;
- ❑ High incidence of breast cancer in women under fifty years;
- ❑ The cost of transport to and from Auckland and accommodation whilst in Auckland.

Future Tasks:

- ❑ Update demographic profile once 2001 Census data becomes available;
- ❑ Follow-up on investigating cost-effectiveness of providing limited visiting specialist clinics from Claris.