



Refugees with special health needs

Women:

Antenatal

Breast and cervical screening

Childbirth beliefs and practices

Family planning

Family violence

Female genital mutilation (FGM)

Asylum seekers

Muslims



Refugees with Special Health Needs

WOMEN

“Whatever a refugee woman experiences will be passed on to her family. She is the link between life in the country of origin and life in exile. She determines to a large extent the ability of the family to adjust to their present circumstances...”

*Women’s Committee, National Council of Churches NZ*⁶⁷

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

Most women from refugee backgrounds:⁶⁸

- 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 (FGM) 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 health problems due to untreated gynaecological and obstetric conditions after years in refugee camps or homelands where there is a lack of medical facilities
- may be unexpectedly ‘matter of fact’ in a female, sympathetic clinical setting.



TIPS ON CARING FOR WOMEN CLIENTS

- women may feel more comfortable with a female doctor
- a woman interpreter may be necessary
- many women will have been sexually abused or raped
- most will be experiencing financial hardship.

Key health issues for refugee women are listed in **alphabetical order** below.

Antenatal

It is important that refugee women, like other women in New Zealand, are offered the Lead Maternity Carer (LMC) service for continuity of care through pregnancy, childbirth and postnatally. GPs and midwives need to establish, in some detail, a pregnant woman's past obstetric history and assess her for general and specific risk factors. Refugee women may have higher-risk pregnancies for some of the following reasons:

- previous multiple, spontaneous or elective abortions
- previous still birth
- neonatal death
- multigravida
- short spacing between pregnancies
- recurrent urinary tract infections, possibly associated with FGM
- aged 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.

Women with FGM may require special care before, during and after delivery. Although this care requires a practitioner experienced in managing women with FGM, the continuity of care offered by LMC services is just as important for women with FGM.

Also note that among 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. Specialised management together with appropriate education can significantly



reduce the risk of mother-to-child transmission of HIV (see page 45).

Breast and cervical screening

Women from refugee backgrounds are unlikely to have had breast and cervical screening. Encouraging a woman to undergo breast and cervical screening requires:

- a trusting relationship between health professional and client
- a culturally safe approach by the health professional which recognises a woman's sensitivities, including cultural and religious values
- if appropriate, referring the woman to a female practitioner, a family planning clinic, the free national programme BreastScreen Aotearoa (for women aged 50 to 64 years), or a women's health clinic. If referring, make sure the service is aware of the special needs of the woman.

Doctors or nurses, in deciding whether or not to offer clinical breast examination, breast x-ray screening or a cervical smear, should consider the possibility that such procedures may be traumatic. At the same time they also need to be aware that many women very much want all health care measures.

A number of factors may determine the appropriate time to offer screening procedures:

- level of risk in the client; for example, women over 50 years of age are at higher risk of breast cancer; women who have ever been sexually active are at higher risk of cervical cancer
- whether or not the client is symptomatic
- the presence of a more urgent issue, such as pregnancy or suspected TB
- a client's sense of choice and control.

Childbirth beliefs and practices

Cultural beliefs and practices surrounding childbirth are many and varied. Some common beliefs state that:

- special food is necessary for lactation and future health
- certain types of food must not be eaten
- all food must be warm
- colostrum is not good for the baby
- plenty of rest is essential
- all domestic work must be done by female members of the extended family for up to four weeks after childbirth

- mother and baby must be warmly clothed
- it is unlucky to praise the baby
- the placenta must be disposed of in a special way
- males are not to be present at the birth
- the time of the birth must be recorded exactly for astrological purposes.

Where these practices clash with your own beliefs, remember that childbirth is a traumatic time and unless the practice is actually harming the health of the mother or baby, it should be respected.⁶⁹

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, lack of education and erroneous beliefs surrounding the use of contraception. Others may follow cultural contraceptive practices; for example, withdrawal, 'safe' period, breastfeeding, etc. While it is important that women are aware that contraception is a safe and effective way of spacing children and avoiding unwanted pregnancies, it is also important to respect people's attitudes and practices to family planning.

In many cultures it is unacceptable for women to discuss family planning when men are present. In this case it is wise to consider:

- if you are male, referring the client to a female practitioner
- ensuring that any male present at the consultation is given the opportunity to leave
- using the services of a female interpreter only; if this is impossible, it may be helpful to place the male interpreter behind the client, out of sight.

Discussions on family planning could start with such questions as:

- *Have you any children? How old is the youngest child?*
- *Are you hoping to become pregnant in the near future?*
- *What age space would you like between pregnancies?*

If the client seems comfortable and positive, it may be appropriate to continue with:

- *In your culture, do you have ways in which you can achieve the spacing you want between children?*
- *Would you like to know other ways of planning your family?*



Family planning education can be a less threatening, more effective option for women if it is done in small groups of four to five women, facilitated by a trained educator. Visual resources are very effective for delivering family planning education.

Family Planning Association (FPA) services in New Zealand have some funding for the provision of professional interpreters for non-English speakers. Their services are free to those under 22 years, and to those with a Community Services Card.

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 woman to remain with her violent partner
- they may be wary about involving police and other authorities in family matters.



How should I manage a situation where family violence is suspected?

In a consultation, even if the woman has come about another matter but you suspect violence, provide an opportunity to speak to the woman on her own. Then:

- tell her you are concerned about her, and ask if there is violence in her relationship
- provide information on support options and legal rights, including the fact that violence between intimates is illegal

- expect excuses or rationalisations about her partner's behaviour; for example, that his mood swings are associated with his experience of torture; this does not justify his behaviour nor minimise the danger to his partner and children
- take steps to ensure the woman's safety; if she wishes to leave, give her the telephone numbers of services that can assist her to do so
- if she chooses to remain in the home, respect her decision; give her telephone numbers she can contact in the event of a crisis
- liaise with a local family violence organisation on how you might best assist your client
- involve someone trusted in the woman's community who can act as a support person/cultural broker.

Female genital mutilation (FGM)

The World Health Organization (WHO) defines FGM as comprising 'all procedures which involve partial or total removal of the external genitalia or other injury to the female genital organs whether for cultural or other non therapeutic reasons' (1995).

Under the New Zealand Crimes Act Amendment 1996, Sections 204A and 204B, it is a crime to carry out FGM on a child in this country or to send a child overseas for FGM.

FGM is widely practised in the Horn of Africa. The main types of FGM are:

- Type I:** excision of the prepuce with or without excision of part or all of the clitoris
- Type II:** excision of the prepuce and clitoris together with partial or total excision of the labia minora
- Type III:** excision of part or all of the external genitalia and the stitching/narrowing of the vaginal opening (infibulation)
- Type IV:** unclassified, includes piercing, pricking or cauterisation (this is rare).

Table 15 sets out the estimated prevalence and type of FGM in Horn of Africa countries.

Table 15

FEMALE GENITAL MUTILATION IN THE HORN OF AFRICA

| Country | Estimated prevalence (%) | Type |
|----------|--------------------------|-------------------|
| Eritrea | 90 | I and II |
| Ethiopia | 85 | I, II and III |
| Somalia | 98 | Predominantly III |
| Sudan | 89 | Predominantly III |

Source: World Health Organization, Female genital mutilation fact sheets. In: *Female Genital Mutilation Information Pack*, Geneva: World Health Organization, 1996.

Information on FGM type in Eritrea taken from: World Health Organization, Female genital mutilation: prevalence and distribution. In: *Female Genital Mutilation Information Kit*, Family and Reproductive Health, Geneva: World Health Organization, 1996.

What are the complications associated with FGM?

There are numerous physical, sexual and psychological complications associated with FGM, and they usually relate to the type of FGM undertaken. While not all women experience complications, most women with Type III experience some. Complications most commonly seen within practices in New Zealand include:

- difficulties with micturition
- recurrent urinary tract infections
- difficulties with menstruation
- complications in childbirth
- inability to achieve penetration during sexual intercourse
- sexual dysfunction.⁷⁰

Some women may not associate these conditions with FGM, but rather see them as a normal part of being a woman.

What are the specific health care needs of women affected by FGM?**Obstetric Care**

Obstetric care should always be provided by a practitioner experienced in the obstetric management of women with FGM, and the possible complications. Special attention should be given to education in the antenatal period and preparation for delivery, particularly that relating to de-infibulation, anterior episiotomy and re-suturing scar tissue.⁷¹ Doctors and midwives may suture disrupted scar tissue after delivery, but it is against the law to fully re-infibulate a woman.



De-infibulation

De-infibulation (reversal of infibulation) may be requested 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.

Note: women may present to health services only days before marriage requesting deinfibulation and it is *important that the request is treated as urgent*. Some women have been put on long waiting lists, with the result that de-infibulation is not carried out before the marriage and husbands have tried to penetrate their new wives themselves. This has caused trauma and distress. Booking clerks in hospitals must be alerted to the nature of the referral so that a prompt booking can be made.⁷²

It is essential that de-infibulation is accompanied by comprehensive health education.⁷³

Family planning

Most women affected by FGM have never accessed family planning services before and have little knowledge of their reproductive cycle and the types of contraception available. Diaphragms and IUDs may not be able to be used with infibulated women. Natural family planning can be difficult for infibulated women, who may have difficulty assessing the state of their mucus.⁷⁴

Sexual health screening

Performing vaginal examinations on infibulated women prior to childbirth is often difficult and requires sensitivity. Screening for some STIs and cervical smear taking may not be possible.

Sexuality

This is a very sensitive area requiring trust and sensitivity. Women with Type III may need to be de-infibulated to allow sexual intercourse to occur. This needs to be assessed on an individual basis. Areas that may need addressing include painful intercourse (particularly first intercourse), fear of intercourse, frigidity⁷⁵ and vaginismus.



HOW WELL DO OUR HEALTH SERVICES MEET THE NEEDS OF WOMEN AFFECTED BY FGM?

Women affected by FGM have had varying experiences with the New Zealand health system. A 1997 study⁷⁶ conducted with Somali women in Auckland found that there was a lack of knowledge and/or training among health professionals about FGM. This affected the care and sensitivity offered to women by doctors, nurses and midwives.

One of the concerns highlighted in the study was that health professionals did not seem to acknowledge that for Somali women FGM is a very normal practice. The shocked and horrified reactions of some health professionals – with some doctors calling in other staff to view the circumcision – often left women feeling shy and too embarrassed to return. The study also found that Somali women considered it inappropriate to be offered male doctors for obstetric and gynaecological examinations.

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. This is not the practice in Somalia and it often results 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.

What approach should I use in the care of a client affected by FGM?

Health professionals could start by examining their own personal attitudes towards the practice of FGM. For example, they may regard FGM as oppression of women, but this view is not shared by many circumcised women who see FGM as part of their 'honour' and self-identity.⁷⁷ Furthermore, health professionals need to be aware that:

- FGM is carried out with the best interest of young girls at heart, however harmful it may seem from a Western viewpoint
- it is sanctioned by the community and endorsed by loving parents in the belief that it will ensure their daughter's health, chastity, hygiene, fertility, honour and eligibility for marriage⁷⁸
- it is seen as 'normal' to the women who are affected by it.

An appropriate approach to FGM might include:

- using appropriate, non-judgemental terminology when referring to FGM (consider refraining from using the loaded Western term 'female genital mutilation'; ask for the client's own terminology for FGM or use such words as 'cutting,' 'female circumcision' 'sewn' or the Somali word 'gudniik')⁷⁹
- being sensitive to the possibility that the woman may wish to discuss issues associated with FGM; however, avoid raising the subject when there is no apparent reason to do so

- considering referral to a female doctor
- reassuring women that any questions relating to FGM are to do with health care, not the New Zealand law
- avoiding discussing FGM in a family consultation – it is not customary to discuss the topic around family members
- being aware that your client may never have had a gynaecological examination
- being aware that pelvic examination may be difficult, painful or impossible and not continuing if it is unduly uncomfortable or painful; careful angulation of instruments and one-finger examination may be necessary
- documenting findings in detail to minimise the need for repeat examinations, and so that future needs can be anticipated and arranged
- recognising that a woman may regard her genitalia as normal; she may be unaware that she has undergone FGM or may even deny that this is the case
- recognising that women may be unaware that there are medical complications associated with FGM.

ASYLUM SEEKERS



Asylum seekers have particular health needs. Although they arrive with the same physical and psychological health problems as other refugees, the stresses they face after arrival have a profound effect on their health.

Many have fled situations of political unrest or terror and may have experienced intense and prolonged traumatic experiences such as war, rape, torture, starvation, and loss of families.⁸⁰ On arrival in New Zealand they become people in transition, often without family or friends, and often left to 'find their own way' with little or no English and no understanding of the prevailing system. This can result in a burden of unsupported needs and enormous worries. As a result, asylum seekers are particularly vulnerable to feelings of profound isolation, hopelessness, helplessness and depression. In addition, low income, non-recognition of qualifications, poor housing and lack of social support serve only to compound the day-to-day stress levels which have been identified as one of the more significant determinants of their ill health.⁸¹

Asylum seekers are subject to further stress and anxiety over the procedures required in making a claim for refugee status. These stresses are associated with:

- accessing legal services, which is mandatory and which can be expensive, confusing and intimidating
- the uncertainty in relation to their claim
- living 'in limbo' (for example, being unable to make plans) while waiting for the outcome of their claim
- the length of time they must wait to learn the outcome of their 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 have escaped.

The anxiety and worry caused by the above may, in some people, lead to re-traumatisation. In others it may not only exacerbate any pre-existing sequelae associated with psychological trauma, but may also lead to the surfacing of stress symptoms and mental health problems years after arrival in New Zealand. Asylum seekers constitute 40 percent of clients presenting with mental health problems at Auckland's Refugees as Survivors (RAS) centre.⁸²

Asylum seekers who have had no health screening will eventually need to be fully screened as part of their application for refugee status. This may cause further anxiety, as they may fear that any medical condition detected will jeopardise their chances of gaining permanent residence and lead to deportation. Health professionals may need to reassure clients that medical findings are not a deterrent to gaining residence in New Zealand.

Note: in Auckland, health screening for asylum seekers is carried out at the Asylum Seekers Clinic at Green Lane Hospital. In addition, the Auckland Refugee Council offers other services to asylum seekers, including accommodation, advocacy, and a half day a week free health clinic with a GP (see pages 96-97 for contact details).



TIP ON ISSUING MEDICAL REPORTS TO SUPPORT CLAIMS FOR REFUGEE STATUS

Sometimes GPs, psychiatrists, psychologists and counsellors are asked by the Refugee Status Branch of NZIS to issue a medical or psychological report in relation to a claim for refugee status by an asylum seeker. Where the report is to corroborate claims of torture, the practitioner is expected only to say whether or not an injury or condition is consistent or inconsistent with the claimant's story. The Refugee Status Branch advises that it is inappropriate for practitioners to express opinions on whether refugee status should be granted or whether a claimant's story is credible.

MUSLIMS

New Zealand's quota programme draws many refugees from Islamic countries. As in all religions, the level of commitment by Muslims to their faith varies from individual to individual. However, it is useful for the health professional to know some of the beliefs and practices of Islam and how these may impact on the provision of health care.

- During Ramadan (the Islamic month of fasting) adult Muslims are required to abstain from eating, drinking and smoking from dawn until sunset. Medication schedules need to be organised to accommodate this.
- Pregnant, lactating and menstruating women and the ill are exempt from fasting, although some still elect to do so.
- For some Muslim patients participation in invasive medical procedures may be prohibited during Ramadan.
- Ask clients who are fasting to identify the best time for a consultation since fasting can make them weaker or more tired at certain times of the day.
- Islam has strict rules regarding physical contact and modesty between the sexes. Accordingly, some Muslim patients may prefer a health care provider of the same sex.
- Medical examination techniques should be modified so that as little of the patient is exposed as possible.
- The mentally ill are absolved from the requirements of Islam.
- Chemical, barrier and irreversible methods of contraception are considered undesirable in some Muslim communities unless pregnancy is contraindicated on medical grounds. The same applies to abortion.
- Muslim males are required to be circumcised before puberty.
- Some medications contain alcohol, which is forbidden by Islam. Some clients may require alternative medication. If there is no alternative, explain this to the patient.



- It is not required that a Muslim client adhere to the tenets of Islam where to do so would present a threat to life. A devout Muslim may wish to consult with a Muslim doctor to determine whether this is the case.⁸³
- Some medical treatments may involve pig products, such as heart valves. It is essential to consult with the client and the family if any type of pig product is being considered in treatment.
- If requesting a urine sample from a Muslim client, provide the client with a bowl of water for ablutions after urinating.

In hospital settings

- Be mindful of Islamic dress codes and the need for privacy, particularly in Muslim women. For example, during bodily examinations make sure:
 - curtains are completely pulled around the bed
 - a blanket is offered to the client to cover the body.
- Advise the Muslim client in advance if visitors are coming, to allow time to dress appropriately.
- Prayer requirements (five times a day) may involve the need for some ablutions and a prayer space. A clean prayer mat should always be available in a quiet room within the hospital.
- In the event of death, Muslims require prompt access to and prompt release of the body.
- Be aware of dietary codes within Islam; for example, abstinence from pork or pork products, availability of halal meats.
- In acute situations utilise key Islamic leaders as cultural brokers or advisers.⁸⁴





Contact List

For all public health queries relating to refugees and asylum seekers in the first instance contact the Public Health Service at your local District Health Board.



RESOURCE PEOPLE

For queries relating to national health screening:

For quota refugees:

Health Clinic, Mangere Refugee Resettlement Centre, Auckland (09) 276-6719

For asylum seekers:

Asylum Seeker Screening Clinic, Auckland (09) 262-1855

For queries relating to mental health issues:

Consultant Psychiatrist for refugee clients, Mental Health Services, Auckland District Health Board (09) 845-0940

For all other enquiries relating to refugee health:

Auckland:

Refugee Health Co-ordinator, Auckland District Health Board (09) 262-1855 x 5821

Hamilton:

Public Health Nurse, Waikato District Health Board (07) 838-3565 x 7216

Wellington / Hutt Valley:

Refugee Health Advisor, Hutt Valley District Health Board (04) 570-9310

Christchurch:

Communicable Diseases Nurse, Crown Public Health Ltd (03) 379-9480 x 807

Some primary health care providers experienced in refugee health:

Auckland:

In the first instance contact:
Mangere Refugee Resettlement Centre Health Clinic (09) 276-6719

Hamilton:

Dr. Mike Harris, Fairfield Family Health Centre Ltd
(includes some screening services) (07) 855-2079

Dr. Michael Kahan, Hamilton East Medical Centre
(includes some screening services) (07) 839-1232

Wellington:

Newtown Union Health Service (04) 389-2070
(includes some screening services)

Christchurch:

Union and Community Health Centre (03) 366-8076

REFUGEE HEALTH CARE PROVIDERS IN MAIN CENTRES

Auckland

Auckland District Health Board

Medical Officers of Health (09) 262-1855

Refugee Health Co-ordinator (09) 262-1855

Refugee Community Health Worker (09) 262-1855

Mangere Refugee Resettlement Centre
Medical/Screening Clinic (09) 276-6719

Asylum Seeker Screening Clinic (09) 262-1855
Green Lane Hospital – all bookings

Community Child Health and Disability Service (09) 639-0200

Mental health services for refugees

Consultant Psychiatrist (09) 845-0940

St Lukes Community Mental Health (09) 376-1054

Community Child Adolescent and Family Service (CCAFS)
(mental health services for refugee children) (09) 307-4949

Maternal Mental Health (09) 630-9943
(Green Lane Hospital)

Refugees As Survivors (RAS) Centre (09) 270-0870

Community support services

Community AIDS Resource Team (CART) (09) 309-2693

Doctors For Sexual Abuse Care (09) 376-1422

NZ AIDS Foundation – Burnett Centre (09) 309-5560

Refugee Health Education Programme (09) 524-0695
(HIV and FGM)

Auckland Refugee Council (ARC) (09) 378-7434
ARC accommodation for asylum seekers (09) 835-1570

Refugee and Migrant Service (RMS)
RMS central office (09) 638-9077
RMS Mangere Refugee Resettlement Centre (09) 276-6423

Domestic Violence Centre (09) 303-3939
(24-hour crisis line)

Shakti Women's Support Group (09) 625-6714
(refuge and support)

Interpreting services

Interpreting and Translation Service (ITS) (09) 276-0014
Public Health Interpreter Service (09) 262-1855
(at present only available in DHB settings)

Hamilton

Waikato District Health Board

Medical Officer of Health (07) 838-2569

Public Health Nurse (07) 838-3565

Community Mental Health (07) 834-6902

Community support services

Doctors For Sexual Abuse Care (DSAC) (09) 376-1422
(ask for name of a DSAC doctor in your area)

NZ AIDS Foundation (07) 838-3557

Refugee and Migrant Service (07) 834-2052 or
(07) 855-6339

Waikato Refugee Resettlement Society Inc (07) 839-3492

Interpreting services

Hamilton Multicultural Interpreting
Services Trust (07) 839-3902

Palmerston North

MidCentral Health District Health Board

Medical Officer of Health (06) 350-9110

Communicable Disease Co-ordinator (06) 350-9110

Community support

Refugee support contact (06) 358-9152

Wellington, Porirua and Hutt Valley

Capital and Coast District Health Board; Hutt Valley District Health Board

| | |
|-----------------------------------|---------------|
| Medical Officers of Health | (04) 570-9002 |
| Refugee Health Advisor | (04) 570-9310 |
| Public Health Service, Lower Hutt | |

Mental health

Wellington

| | |
|---|---------------|
| Community Assessment and Treatment Team | (04) 494-9169 |
| Child Adolescent and Family Services | (04) 801-2960 |
| Wellington RAS Centre | (04) 384-7279 |

Porirua

| | |
|---|---------------|
| Porirua Community Mental Health | (04) 237-1301 |
| Puketiro Centre, Child and Family Service | (04) 237-5222 |

Lower Hutt

| | |
|---|---------------|
| Hutt Valley Health Community Mental Health Services | (04) 570-9801 |
| Crisis and Assessment Team | (04) 566-6999 |
| Child and Family Service | (04) 587-0900 |

Community support services

| | |
|--|---------------|
| Doctors For Sexual Abuse Care (DSAC) (ask for name of a DSAC doctor in your area) | (09) 376-1422 |
| NZ AIDS Foundation, Awhina Centre | (04) 381-6640 |
| Wellington Refugee and Migrant Service | (04) 384-6295 |
| Lower Hutt Refugee and Migrant Service | (04) 566-9353 |
| Porirua New Settlers Centre | (04) 237-7315 |

Interpreting Services

| | |
|---|---------------|
| Wellington Interpreting Services (nationwide) | (04) 384-2265 |
| Telis, or telephone interpreting (nationwide) | (04) 384-2849 |

Nelson

Nelson Marlborough District Health Board

| | |
|---------------------------|---------------|
| Medical Officer of Health | (03) 546-1800 |
| Public Health Nurse | (03) 546-1537 |

Community Support Services

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|----------------------|---------------|
| Refugee Co-ordinator | (03) 548-9638 |
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Christchurch

Canterbury District Health Board

| | |
|---|---------------------|
| Medical Officer of Health | (03) 379-9480 |
| Communicable Diseases Nurse, Crown Public Health Ltd | (03) 379-9480 x 807 |
| Psychiatric Emergency Service | (03) 364-0482 |

Community support services

| | |
|--|---------------|
| Doctors For Sexual Abuse Care (DSAC) (ask for name of a DSAC doctor in your area) | (09) 376-1422 |
| NZ AIDS Foundation, Ettie Rout Centre | (03) 379-1953 |
| Refugee and Migrant Service | (03) 366-0497 |
| Refugee Resettlement Service | (03) 377-0292 |

Interpreting services

| | |
|------------------------------|---------------|
| Refugee Resettlement Support | (03) 377-0292 |
| Refugee and Migrant Centre | (03) 372-9310 |
| Christchurch Public Hospital | (03) 364-0648 |

Dunedin

Otago District Health Board

| | |
|----------------------------|---------------|
| Medical Officers of Health | (03) 474-1700 |
|----------------------------|---------------|

Community support services

| | |
|-----------------------|---------------|
| Refugee Support Group | (03) 474-0127 |
|-----------------------|---------------|





Additional Information

FURTHER READING

Section 1: Refugees – Who They Are and Where They Come From

Carbello M, Simic S, Zenc D. Health in countries torn by conflict: Lessons from Sarajevo. *Lancet* 1996, 348 (September): 872-74.

Moussa H. *Storm and Sanctuary: The journey of Ethiopian and Eritrean women refugees*. Canada: Artemis Enterprises, 1993.

United Nations High Commissioner for Refugees. *The State of the World's Refugees: Fifty years of humanitarian action*. Oxford: Oxford University Press, 2000.

Wilkes S. Don't let the sun go down. *Refugees* (December, 1993).

Also visit websites:

<http://www.unchr.ch/refworld/welcome.htm>

<http://www.encarta.msn.com/maps>

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Section 3: The Consultation: Communicating Effectively with Refugee Clients

Ethnic Affairs Service. *Let's Talk: Guidelines for hiring interpreters*. Wellington: Ethnic Affairs Service, Department of Internal Affairs, 1995. Revised edition available on Ethnic Affairs website: <http://www.ethnicaffairs.govt.nz>

Metge J, Kinloch P. *Talking Past Each Other: Problems of cross cultural communication*. Wellington: Victoria University Press, 1979.

Waxler-Morrison N, Anderson JM, Richardson E. *Cross Cultural Caring: A handbook for health professionals in western Canada*. Vancouver: University of British Columbia Press, 1990.

Section 4: Physical Health Care

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American Family Physician, 1998, 57 (5): 1061-67.

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Also visit website:

<http://www.who.int/m/topics/fgm/en/index.html>

HEALTH EDUCATION RESOURCES

For FGM and childbirth

Resources produced by the FGM Education programme

Denholm N. *Manual One: Female Genital Mutilation in New Zealand: Understanding the Health and Protection Issues*. Auckland: The Refugee Health Education Programme, 1998.
- a 40-page manual for child protection professionals.

Denholm N. *Manual Two: Female Genital Mutilation in New Zealand: Understanding and Responding. A guide for health professionals*. Auckland: The Refugee Health Education Programme, 1998.
- a 45-page manual for health professionals.

FGM and New Zealand (2001)
- pamphlets in African languages outlining the New Zealand law on FGM.

FGM Training Kit (1998)
- a kit with overheads, slides, posters and pamphlets used for FGM training.

Guidelines for Obstetric/Gynaecology Care (2001)
- guidelines for de-infibulation, antenatal, delivery and postnatal care of women with FGM.

FGM: Information for Health Professionals (2001)
- pamphlet for health professionals.

Other resources

Childbirth Picture Books by WIN NEWS
- Somali childbirth picture books for use by health professionals.

For more information on FGM resources, contact the Refugee Health Education Programme: fgm@exposure.org

For HIV/AIDS

Resources produced by the HIV Education programme

Health Information on HIV and AIDS (2000)
- HIV education and awareness pamphlets in African languages.
Note : can be used for pre-test counselling.

HIV Community Education Poster Kits (2000)
- HIV poster sets for use in HIV education.

Taking your Medication (2000)
- anti-HIV medication information sheet available in African languages (Amharic, Somali, English).

Non Nucleosides (2000)
- anti-HIV medication information sheet available in African languages.

Nucleosides (2000)
- anti-HIV medication information sheet available in African languages.

Protease Inhibitors (2000)
- anti-HIV medication information sheet available in African languages.

HIV and Pregnancy: Considering having a child? (2000)
- pamphlet on considering becoming pregnant available in African languages.

Living with HIV Handbook (2000)

- a 20-page handbook for HIV-positive refugees, in African languages.

For more information on HIV resources, contact the Refugee Health Education Programme: hiv@exposure.org

Other resources

Print material, videos and other health education resources on a range of health topics are available, free, from the Authorised Health Education Resource Provider in your local Public Health Service.



Endnotes

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