

Refugees and asylum seekers: Implications for ED care in Auckland, New Zealand

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Abstract

Refugees and asylum seekers are a significant proportion of attendees in Auckland emergency departments. While culture and ethnicity are factors in addressing the healthcare needs of refugee families, other factors such as the physical and psychological sequelae of the refugee experience, health care prior to arrival in New Zealand, poverty, language, and the trauma of resettlement also have a major impact. This article discusses some of the special health needs of refugee populations and the contribution emergency nurses can make to improving health outcomes for these people.

Key Words: emergency department, refugees, migrant

Introduction

The increasing use of emergency departments by refugee and migrant groups reflects the shifting ethnic composition of central Auckland. Refugee families are different from both other immigrants and low-income families in New Zealand in that they often have a history of trauma. In addition, refugees live with greater adversity including more illness, unemployment, and isolation from support networks. These factors may account for the proportionately higher rate of presentation with urgent and non-urgent complaints. The health care needs of refugees are complex and place demands on both adult and children's emergency services. By working closely with referral agencies and being aware of the complexity of the refugee experience pre and post migration, emergency nurses can contribute to better health outcomes for families from refugee backgrounds.

People from refugee backgrounds in New Zealand

People from refugee backgrounds in New Zealand number over 30,000 and are increasing by up to 2000 per year. Most arrive from the Middle East, the Horn of Africa and from Southeast Asian countries and live in central Auckland. In addition to an annual quota of 750 refugees mandated by the United Nations, every week up to forty asylum seekers make application in Auckland for refugee status. All United Nations-mandated refugees and

asylum seekers applying for refugee status are entitled to publicly provided health services in New Zealand. ¹

Refugees in New Zealand are a legally and constitutionally well-defined group.² The United Nations Convention Relating to the Status of Refugees provides an internationally agreed definition:

"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." ²

New Zealand ranks first (equal per capita) in the world in the number of refugees accepted. However, of the ten countries regularly resettling refugees, New Zealand rates lowest in post-arrival support and services. New Zealand offers no barriers to resettlement for those with pre-existing medical conditions and disabilities. Refugees in New Zealand are a high risk healthcare population because they typically come from countries with high rates of communicable diseases, little or no functioning health care systems, and many arrive with physical and mental trauma and ill health. ³ Often secondary care has been interrupted and long-term illness untreated during civil war and refugee flight. ⁴ Refugees have some of the poorest health outcomes in New Zealand society.

The following case is an example of the complexity of care for refugee children in ED.

Case Review

Hashem arrives at the Children's Emergency Department with a history of three day history of fever and vomiting. He is 13 years of age, Afghani and is an unaccompanied minor. A uniformed guard accompanies him from the detention centre where he has been placed on arrival. Hashem was rescued in the Indian Ocean by a passing freighter ship and has been resettled in New Zealand. He is from an ethnic minority group from Afghanistan. He says that he had to flee as his community are Shi'a Muslims who were in conflict with Sunni Muslims who ruled the area in which he was living. Before leaving his village Hashem was badly beaten by the Taleban. Hashem is diagnosed with Plasmodium vivax malaria. He is hospitalised with secondary jaundice and anaemia.

Problem	Action
<p>Making an accurate diagnosis</p> <ul style="list-style-type: none"> • The client is unable to give a medical or family history. • The client is from an ethnic minority and is mistrustful of the 	<ul style="list-style-type: none"> • If possible provide an interpreter from the same ethnic minority group as the client. Explain that interpreters are bound by confidentiality. Reassure the

<p>Afghan interpreters supplied by hospital services.</p> <ul style="list-style-type: none"> • The accuracy of the birthdate given is doubtful. • The client is malnourished. • Are there symptoms of PTSD. • The client is awaiting determination of refugee status and has considerable anxiety about the impact of health testing on his refugee status claim. 	<p>client that medical information will not affect the outcome of his refugee status claim.</p> <ul style="list-style-type: none"> • Order a bone density in order to ascertain an accurate age. • Avoid asking direct questions about mental health as mental health disorders are culturally highly stigmatised.
<p>Examination procedures</p> <ul style="list-style-type: none"> • The culture and custom of the client forbid examination and care from female doctors and nurses. 	<ul style="list-style-type: none"> • Ensure that a male doctor is available. • Explain what is happening and why. • During examination bodily exposure should be minimal.
<p>Hospitalisation</p> <ul style="list-style-type: none"> • The client is not literate in any language. • The client cannot speak English. • The client has no family support. • It is the season of Ramadan and the client is fasting and does not wish to take any medication. • The client has not yet been screened for TB or any other communicable diseases • The client has spent considerable time in Indonesia where he may have been exposed to parasitic infections and tropical diseases • The patient has never had any health care or any experience of hospitals previously 	<ul style="list-style-type: none"> • Explain ward layout and systems carefully through the interpreter. • Explain to staff the circumstances of the client, along with any customs and beliefs that may impact on care. • Ask an appropriate Muslim religious leader to explain to the client that food and medication during Ramadan is acceptable when unwell. • Screening should include iron and vitamin deficiencies, common parasitic infections and tropical diseases as well as haemoglobinopathies. • Protect the client from vicarious interest from other staff members.

<p>Follow up</p> <ul style="list-style-type: none"> • The client is resident in a refugee reception centre. There is no residential medical care available at the centre after hours. • The client is under the guardianship of social services. • The client does not have a General Practitioner. • Ongoing psychological support and management of mental health. 	<ul style="list-style-type: none"> • Arrange for a social work referral and for the coordination of care between the hospital and community health, social and refugee resettlement agencies involved in the care of the client. • Ensure that the client is not discharged until proper arrangements have been made for the care of the client. • Refer to client to the Refugees as Survivors Centre for ongoing psychological support. • Relapses of <i>P. Vivax</i> can occur months or years later. Provide patient education in regard to further medical care if he has a recurrence of malaria. • Ensure that the client understands medication regimes.
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The impact of the refugee experience on the coping skills of refugee families

The impact of the refugee experience is essential to understanding refugee responses to illness and medical emergencies. For many ethnic minority communities care protection and responsibility for the sick person is approached collectively within the family. Normal patterns of family care and coping are disrupted through the dissolution of family and community that results from war and exile. The ability of families to cope with emergencies and crises are limited and numbed through trauma. The entire family system, or whoever is left can be propelled into disequilibrium.⁵ There are as well multiple stresses on arrival in New Zealand including financial problems, overcrowded housing, language barriers, culture shock, racism, unemployment and the ongoing anxiety related to family left behind. Working with refugee families can appear to be chaotic and feel overwhelming.

Seeking emergency care and illness behaviour

Little research exists on the utilisation of emergency services by refugee and migrants from refugee-like backgrounds. For refugees "illness behaviour" in seeking ED care is influenced by health care experiences prior to arrival and to barriers in accessing primary health services in New Zealand. Most refugee families are unused to the system of general practice

and will need explanation about how and when to use primary health and emergency services. However significant barriers exist to accessing primary health care most particularly affordability and the inability to communicate. ⁶

Specific considerations for the care of people from refugee backgrounds in emergency departments

Using Interpreters. It is best to confirm the client's preferred language, as the place of birth and ethnicity is not always reliable indicators for booking an interpreter. There may be tensions between language groups so it is important that the preferred language of the client is established. If possible gain the consent of the client prior to the booking. In small communities the client may know the interpreter socially and a different interpreter may be needed. Establish whether the client prefers a male or female interpreter. Always abide by the client's choice of gender of interpreter.

Decision making. It is best to check out with the client who to talk to within the family or community and what they can be told in relation to health, treatment and ongoing care. Interpreters can often advise regarding key decision makers within extended families.

Specifying symptoms. In some cultures the client's experience of symptoms, may emphasize and interpret the somatic over the psychological. History taking needs to include an awareness of culturally specific symptoms so that symptoms are not misdiagnosed or unrecognised.

Somatisation. An understanding of the relationship between somatic complaints and mental health issues is important in assessing client presentations. When clinical symptoms appear vague and indefinable depression may be indicated.

Communicable disease control. Not all asylum seekers and family reunification refugees receive public health screening. A high index of suspicion should be maintained in regard to undiagnosed communicable diseases including HIV and Tuberculosis.

Trauma. Minimising, denial or silencing regarding war-related traumas, rape and injuries are common coping strategies in refugee families. Sensitive questioning will be required in order not to overlook trauma-related injury and illness in refugee adults and children.

Sexual and reproductive health. Any discussion of sexual matters and of rape and sexual assault in front of male family members is deeply shameful. The use of female interpreters and the opportunity for male relatives to leave the room will be essential to gaining an accurate history regarding sexual and reproductive health.

Physical exposure. At all times minimal bodily exposure is essential for Muslim peoples and others of Middle Eastern, African and South Asian backgrounds.⁷

Family violence. A number of studies of refugee health have confirmed an increased rate of risk factors for family violence such as poor mental health, trauma, family losses, parental unemployment, cultural and social isolation.^{8 9 10.} Where family violence is suspected during history taking it is important to provide an opportunity to speak to the woman who is presenting on her own without other family members present. It is appropriate to tell the client that you are concerned about her, and ask if there is violence in her relationship and as well to provide information on support options and legal rights, including the fact that violence within marriage is illegal in New Zealand.

Prescribing medication. Refugee clients may be unfamiliar with the system of prescribing medication in Western countries. It is helpful to explain how a prescription works, including the role of the pharmacist, the likely costs and waiting times, and how to get repeat prescriptions. Many refugees come from countries where medication is given out by the health professional during the consultation and will expect to be prescribed medicines. To avoid poor compliance with medicine regimes it is important that detailed and clear explanations are given to patients when prescribing medicines. It is particularly important to emphasize the correct dose and course of the medication. Compliance is a problem in the general community and may be further exacerbated in refugee communities owing to communication difficulties. It is best to prescribe the simplest and shortest course of treatment and to use once daily or state regimes. It is important to explain such safety issues as safe storage of medicines, expiry dates, and not sharing medication.

Conclusion

Refugee communities in New Zealand have inequitable access to health services compared to other groups in New Zealand society.^{11.} Many families use emergency departments for primary care, however this should not be perceived as 'indigence' but the result of poverty, the lack of a safe alternative, and a poor understanding of the differences between primary and secondary care in New Zealand. In an emergency refugee families often present late to ED and communities need education about what to do in a medical emergency. Proportionately high numbers of people from refugee backgrounds attend ED and it is essential and professional education programmes for ED include an understanding of the refugee experience and of the cultures of refugee communities.

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