

The People Centre Trust Manurewa Service Development Report, 2010

Acknowledgements

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Summary of findings and recommendations

- The project aimed to assess the accessibility, appropriateness and responsiveness of services of The Peoples Centre Trust (TPCT) Manurewa, towards its refugee clients in the Manurewa region of Auckland. Secondly, the project aimed to improve healthcare services through intersectoral and community development strategies to reduce health inequalities and increase community wellbeing.
- Although most participants reported that they were satisfied with their current housing conditions, 10 people (20.83%) reported problems with their current housing situation. Problems included expensive rents, over crowding, safety and security concerns.
 - To improve housing conditions of refugee clients (and reduce associated health risks) it is recommended that TPCT networks with Housing New Zealand, Work and Income Support, social workers and Middle Eastern communities. Engaging a community advocate would help promote this networking.
- Generally participants did not have a good understanding of public services and 25% of survey respondents reported that they had no understanding of any of the services listed on the survey. Participants' understanding and knowledge of the services were limited to health services (general practices and hospitals), Work and Income New Zealand, Housing New Zealand and community organisations such as prayer centres. Understanding of these services was greatly hindered by language barriers. Participants expressed a need for more knowledge of services to aid their understanding and help with finances, finding employment and immigration issues such as family reunification.
- Knowledge of public services was most commonly gained through word of mouth from family and friends, advice and guidance from refugee resettlement volunteers and from information provided from the Mangere Refugee Centre.
 - To increase knowledge and understanding of public services, information could be disseminated in Middle Eastern languages through community networks and refugee services as well as working closely with community advocates and social workers.
 - Help with finances, finding employment and accessing and understanding immigration services could be improved by TPCT networking with these services and the use of a community advocate/s to network between these services and their communities.
- Low service utilisation was reported for most public services, almost 17% of survey respondents reported not using any of the services listed on the survey. Public hospitals were the exception to this pattern, over 70% of respondents reported using this service. Results from focus group interviews also revealed similar low levels of utilisation. Health services, Work and Income New Zealand

- and Housing New Zealand were the most utilised services. Low utilisation was influenced by language barriers and lack of awareness of services.
- These barriers could be reduced through recommendations cited above.
- Public hospitals (72.22%) and Housing New Zealand (63.89%) were reported to have been (or would be) the most helpful services of those listed in the survey. For focus group participants, the most useful services reported were: Medical, financial, immigration, housing, those that provided knowledge about New Zealand and those that could provide recreational activities.
 - Interventions for refugee clients should concentrate on increasing refugees' knowledge and access to these services.
 - The majority of survey respondents (72.22%) stated they would find a service that helped them access public services useful. This finding was supported by focus group participants.
 - To facilitate service access, networks need to be established between refugee communities and services through consultation and advocacy.
 - Participants' understandings of TPCTs services were varied, over 20% of clients reported that they did not have a good understanding of the services. Services least understood included: New Zealand's health care system in general, interpreting services, referral processes, public and private divisions of health care, relationships of Māori in the health sector and using emergency services.
 - Focus group participants gained most knowledge of TPCT through word of mouth (from friends and family), the Mangere Refugee Centre and refugee resettlement volunteers. Participants suggested that advertisement in their own languages or through community networks would increase their understanding of TPCT (and the health care system in general). TPCT staff felt that having an Arabic speaking staff member could also improve refugees' understanding.
 - Producing a simple flyer or pamphlet explaining New Zealand's health care system in Middle Eastern languages could improve refugees' understanding of TPCT (and health care system in general). Such a resource could also be used as an educational tool to be disseminated to services such as the Mangere Refugee Centre as well as local Middle Eastern communities and support networks. The approach would be best achieved through a partnership approach with Middle Eastern community advocates.
 - English language, long waiting times for appointments, not receiving preferred medical treatment and costs of services were reported as the biggest problems experienced by participants when seeing a doctor at TPCT. Transport and not having a Middle Eastern doctor at TPCT were also problems experienced by refugee clients. In addition to these barriers, staff also felt that limited social networks and issues around privacy/disclosure were key barriers to treatment for refugee clients.

- To implement effective interventions to reduce these access difficulties, consultations will have to be undertaken with stakeholders from TPCT and refugee communities.
- Focus group participants suggested that the following factors would facilitate their access to TPCT: Employing an interpreter or improving interpreting services, employing a Middle Eastern speaking staff member/s, reducing appointment waiting times, having more walk-in-appointment times, offering more medical phone services and providing more biomedical treatment options.
- TPCT staff suggested that the following interventions would reduce refugee clients' barriers to treatment and help support their roles as health practitioners: Improved interpreting services, employing a social worker (ideally Middle Eastern), employing a Middle Eastern staff member, employing a community advocate, creating greater community networks with Middle Eastern communities and employing a Middle Eastern counsellor.
 - To reduce language barriers experienced by refugee clients, TPCT could improve awareness of, and use of, their phone interpreter system by advertising the service through community organisations. This could be done in partnership with community advocates and producing flyers/pamphlets written in Middle Eastern languages.
- The majority of participants were satisfied with the treatment of their physical, mental and spiritual health care at TPCT. Key aspects of treatment that were identified as being helpful included: Good doctors, nurses and reception staff, kind, friendly staff that smile, medical staff that listen to their patients, having questions answered in a prompt manner and good follow up to treatment.
 - These aspects of care should be acknowledged by TPCT staff and management and maintained in service practice.
- The only aspect of physical treatment that participants were dissatisfied with was not receiving their preferred type of bio medical treatment for ill health. Client's preference for medical treatment was influenced by their experience of health systems of their countries of origin and lack of understanding of New Zealand's health system.
 - This aspect of treatment can be reduced by improving refugees' understandings of New Zealand's health care system through recommendations previously outlined. In addition, New Zealand health care professionals should also be provided with education and resources to help them cope with divergent understandings of health care among their migrant and refugee patients.
- Most participants were satisfied with the availability of services at TPCT. Participants found having doctors, nurses and dentists available to them were the most helpful aspects of the services provided. Aspects of service availability that participants were not satisfied with included: Not being able to see a Middle

- Eastern doctor, not being able to see the GP they referred, not being able to access an interpreter and having limited medical phone services.
- Increasing awareness of the phone interpreting service could address problems encountered with English speaking doctors. Increasing medical services available through telephone services could also be explored by TPCT management and staff.
- Refugee clients reported low levels of satisfaction with TPCTs opening hours. During weekends and statutory holidays when TPCT was closed participants had to find alternative health care providers which often entailed long waiting times, increased costs of services and difficulties with transport.
 - A review of the opening hours of TPCT should be undertaken as opening the clinic over weekends could reduce barriers experienced by refugee clients. TPCT could also provide posters or flyers in Middle Eastern languages giving information about alternative after hour medical services (including costs, directions and transport options).
 - Satisfaction with TPCTs appointment system was divided among participants. While some participants found the walk-in appointment system to be one of the most helpful aspects of TPCTs services, it was also reported to be one of the greatest barriers to health care experienced by refugee clients. Long waiting times were the most problematic aspect reported for TPCTs appointment system.
 - TPCT should undertake an assessment of appointment waiting times to gauge the extent of this problem. Once average waiting times have been calculated the system can then be reviewed.
 - Satisfaction with referral processes varied between survey respondents, the majority of whom were happy with the process, and focus group participants who expressed dissatisfaction. Client's dissatisfaction was influenced by long waiting times to see a specialist, English language barriers they encountered and their lack of understanding of the referral system.
 - The aforementioned recommendations to improve refugees' knowledge of New Zealand's health care system could facilitate their experiences with referral processes.
 - The project included 53 participants (36 refugee survey respondents, 12 refugee focus group participants and 5 staff interview participants). All 48 survey and focus group respondents were of Middle Eastern ethnicity and ranged in age from 17 to over 65 years, including 30 women and 18 men.

Background: The People Centre Trust Manurewa Service Development Project

The project aimed to firstly assess the accessibility, appropriateness and responsiveness of services of The Peoples Centre Trust (TPCT) Manurewa, towards its refugee clients in the Manurewa region of Auckland. Refugee people were selected as the target population of this project as they currently suffer from health inequalities and face significant health needs (Hobbs *et al.* 2002, McLeod and Reeve 2005). Therefore, undertaking a health needs assessment for these marginalised populations will reveal broader health inequalities in the larger population and serve as a valid proxy to evaluate health service provision and service development. Secondly, the project aimed to improve healthcare services through intersectoral and community development strategies to reduce health inequalities and increase community wellbeing.

Ethics advice and approval was sought from Northern X Regional Ethics Committee on the 2nd of March, 2009. The project was deemed as an audit (for service development) and met the criteria outlined for 'potential to cause harm' thus did not need formal approval from the committee. In agreement with the committee, the project followed and abided by the Ministry of Health's 2006 'Ethical Guidelines for Observational Studies'.

Data collection methods for the project included questionnaires, focus group interviews with refugee clients and semi-structured interviews with TPCT staff. These methods were employed to identify barriers refugee clients experienced in assessing TPCT services and their satisfaction with TPCT and other public services in the Manurewa region. The project included a total of 53 participants including 48 refugee clients and 5 staff members of TPCT.

Participants and Methods

Questionnaires

The survey questionnaires were designed to gauge service satisfaction of TPCT services and knowledge and use of public and community services. A previous literature review was undertaken to identify barriers to health care services experienced by refugee people in New Zealand, which informed the survey's questions. The survey included 19 questions and provided a comment box for participant's to ask questions, and/or provide comments and feedback (Appendix 1).

As over 95% of TPCTs refugee clients (from the Maurewa region) are of Middle Eastern ethnicity, the questionnaires were translated into both Arabic and English. The questionnaires were mailed out to 217 refugee clients (over the age of sixteen) to ensure a reasonable response rate. The questionnaires did not include any identifying information about individual participants. Participant information sheets were included in the questionnaires which ensured patient confidentiality, these were also translated into Arabic (Appendix 2).

Of the 217 clients, 215 (99.1%) were of Middle Eastern ethnicity and 2 were Asian. Questionnaires that were translated into Arabic were sent to all Middle Eastern clients and questionnaires written in English were mailed to the 2 Asian clients as their language was not known. By late March, 36 completed questionnaires had been received by TPCT giving a response rate of 16.59%.

Focus group interviews

Focus group interviews were employed to gain the refugee community's perspectives on barriers to primary health care, gauge their satisfaction with TPCT services, and to ensure a robust working partnership approach in the planning and implementation of interventions. Focus group interviews were informed by the results from questionnaire surveys. Unlike the surveys, interview questions were open ended to gain a greater depth of responses from clients (Appendix 3). Three focus group interviews were held with a total of 12 refugee clients (Table 2). To ensure a broad demographic representation of refugee clients, separate focus groups were held for women (n=5), men (n=3), and youth between the ages of 16 and 24 years of age (n=4).

Focus group participants were phoned and invited to participate in interviews by an Arabic speaking employee of the TPCT. Consenting participants were provided with participant information sheets and consent forms (Appendix 4 and 5). All participants were given the option of using interpreters for the interviews. All but three participants chose to use interpreters for the interviews. Interpreters from Auckland District Health Board Interpreting Services were used for the interviews. Participants were also provided with taxis if they were unable to travel to and from the venue, and each participant was given a \$50 grocery voucher as koha for their participation. The focus group interviews were between half an hour to an hour in duration and all were held at TPCT Manurewa.

Semi-structured interviews

Semi-structured interviews with TPCT staff members were undertaken to enable an in-depth understanding of factors that facilitated and/or created barriers to health care access and service provision from perspectives of health care providers (Appendix 6). Five staff members occupying various health care positions within TPCT were interviewed (Table 3). Staff members were contacted and invited to participate in interviews via email and telephone by the primary researcher. Consenting participants were provided with participant information sheets and consent forms (Appendix 7 and 8). Semi-structured interviews were held at TPCT and were between half an hour and an hour in duration.

Data Analysis

All questionnaire responses were coded and entered onto an Excel spread sheet. As most open ended questions were responded to in Arabic, these were translated into English and then qualitatively analysed into thematic categories.

With participants' consent, focus group and semi-structured interviews were audio recorded and transcribed. Interview transcripts were then qualitatively analysed and coded into thematic categories.

Participants

The project included a total of 53 participants, including 36 survey respondents (Table 1), 12 focus group participants (Table 2) and 5 semi-structured interview participants (Table 3).

Survey respondents

All 36 survey respondents were of Middle Eastern ethnicity. The 2 questionnaires mailed to Asian clients were not returned which may have been due to English language difficulties. Respondents ranged in age from 18 to over 65 years of age (Table 1), although most (n= 14, 38.89%) were between 45 to 64 years of age. No participants under the age of 18 returned surveys. Slightly more women (n= 21, 58.33%) responded than men (n= 15, 41.67%). The length of time respondents had lived in New Zealand ranged from less than 1 year to over 10 years. The majority (n = 23, 63.89%) had lived in New Zealand between 6 and 10 years.

Table 1 Survey respondents

Age groups in years	Women	Men	Total
10-17	0	0	0
18-24	5	2	7
25-44	5	2	7
45-64	7	7	14
65 and over	4	4	8
Total	21	15	36

Focus group participants

Three focus group interviews were held. The first 'Group 1' with women (n=5), the second 'Group 2' with men (n=3) and the third, 'group 3' with youth (n=4). All 12 focus group participants were from Iraq, Arabic was the most commonly spoken language of participants (n=6), followed by Kurdish (n=5) and Syrian (n=1). Respondents ranged in age from 17 to 59 years of age and only 3 men participated in the focus group interviews. The length of time participants had lived in New Zealand ranged from 1 year to 13 years.

Table 2 Focus group participants

Focus group	Sex	Age	Country of origin	First language	Time spent living in NZ
Group 1	Female	26	Iraq	Arabic	2 years
Group 1	Female	35	Iraq	Arabic	6 years
Group 1	Female	46	Iraq	Arabic	9 years
Group 1	Female	52	Iraq	Kurdish	7 years
Group 1	Female	54	Iraq	Arabic	2 years
Group 2	Male	34	Iraq	Syrian	9 years
Group 2	Male	54	Iraq	Kurdish	9 years
Group 2	Male	59	Iraq	Arabic	9 years
Group 3	Female	17	Iraq	Kurdish	13 years
Group 3	Female	18	Iraq	Kurdish	1 year
Group 3	Female	18	Iraq	Kurdish	13 years
Group 3	Female	23	Iraq	Arabic	11 years

Semi-structured interview participants

Semi-structured interview participants included 5 staff members of TPCT Manurewa. The staff members interviewed occupied a variety of health provision roles (Table 3) and all but one staff member were of New Zealand ethnicity.

Table 3 Semi-structured interview participants

Health care occupation	Sex	Ethnicity
Chronic care management nurse	Female	New Zealander
Dentist	Female	Iraqi
General Practitioner	Female	New Zealander
General Practitioner	Male	New Zealander
Mental Health Coordinator	Male	New Zealander

Results Section 1- Housing and Public Services

Housing conditions

Only one focus group participant lived in a home that was owned by her family and the rest lived in rented accommodation. All focus group participants lived with family members and the number of people per household ranged from 2 to 12 people.

Most survey respondents (n =31, 86.11%) reported to be happy or very happy with their current housing conditions, yet 4 people (11.11%) were not happy with their housing conditions. In contrast to the survey results, more focus group participants (n=6) reported to be unhappy with their housing situation than those who reported to be happy (n=3).

Key reasons cited for housing dissatisfaction among focus group participants included expensive rental payments, homes that were too small for the families occupying them

and a lack of security and sense of safety in their homes. Associations between poor housing conditions and health outcomes were also commented on by both focus group participants and survey respondents as illustrated by the following quote:

The situation is we've been living in this house for 9 years and we're a big family actually. We are looking for help for us to get a better house in New Zealand. We are sick of this house it is a big problem for me. Actually we are a bit sick. I am a diabetic and got high blood pressure. My home is not secure, not [a] secure place. We've been attacked four times, we've been broken into three times, our cars have been stolen, so not secure at all. All our children are facing the same problem they are not happy there (Iraqi Male, 54 years old).

Refugee clients' housing problems were also noted by TPCT staff members, who reported often writing referrals to Housing New Zealand on behalf of their clients in attempts to improve their patients' living conditions, such as those described by a GP:

Often the housing New Zealand houses are rubbish and they're usually old, they're draughty they're not well insulated.

Understanding of community and public services

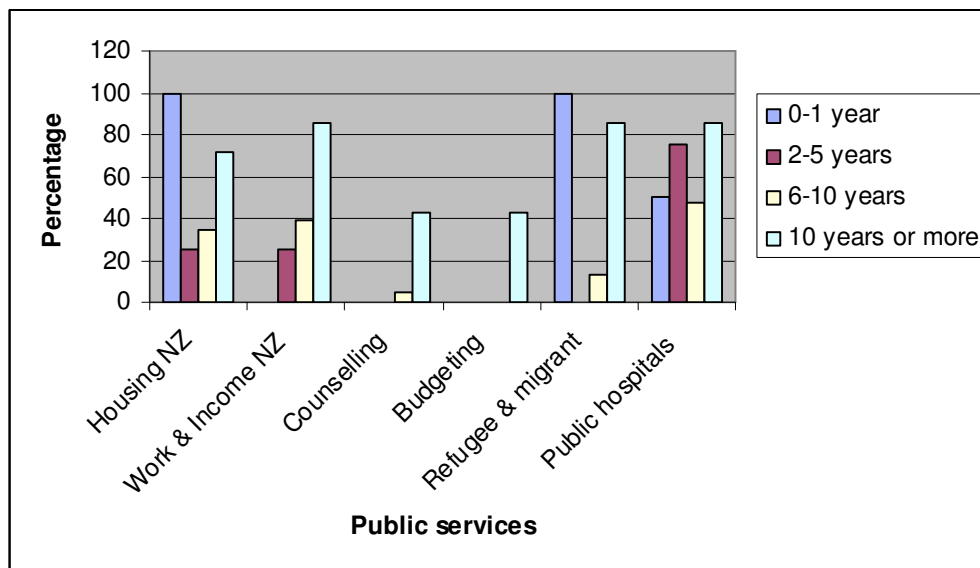
Generally participants did not have a good understanding of public services. A quarter of survey respondents (n =9) reported that they had no understanding of any of the services listed on the survey (Table 4). However, understandings were variable. The most well understood service of those listed in the survey were public hospitals (n = 21, 58.33%) followed by Housing New Zealand (n =16, 44.44%) and Work and Income New Zealand (n = 16, 44.44%). Budgeting (n=3, 8.33%) and counselling services (n=4, 11.11%) were the least understood services. Survey results were supported by focus group interviews where participants' understandings of services were limited to health care (including general practices and hospitals), Work and Income New Zealand, Housing New Zealand and community organisations such as prayer centres.

Table 4. Number and proportion of survey respondents who reported a good understanding of services

Services	N	%
Public hospital services	21	58.3
Housing New Zealand	16	44.4
Work and Income New Zealand	16	44.4
Refugee & migrant services	11	30.6
Counselling services	4	11.1
Budgeting services	3	8.3
Did not have an understanding of any of the above services	9	25

Knowledge and understanding of services was influenced by the amount of time respondents spent living in New Zealand. Survey respondents who had lived in New Zealand for 6 years or longer had a broader understanding of more services than those who had lived in New Zealand for 5 years or less (Figure 1). Respondents who had lived in New Zealand for 6 years or longer also reported better understanding of many services (with the exception of Housing New Zealand and Refugee and migrant services) compared to those who had lived in New Zealand for 5 years or less.

Figure 1. Percentage of self reported understanding of public services, by time lived in New Zealand (measured in years)



Use of community and public services

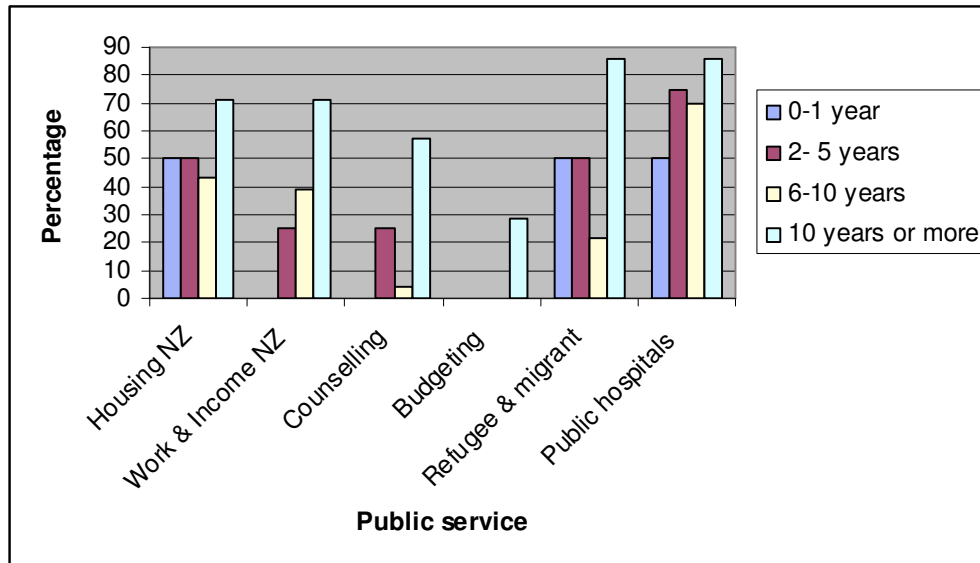
Low service utilisation was reported for most public services, almost 17% of survey respondents (n=6) reported not using any services listed on the survey (Table 5). Public hospitals were the exception to this pattern, over 70% of respondents (n=26) reported using these services. Budgeting services were the least used service (n=2, 5.56%) of those listed on the survey. Survey results were supported by focus group interviews where participants only discussed using the following public services: health care (including general practices and hospitals), Work and Income New Zealand, Housing New Zealand and community organisations.

Table 5. Number and proportion of survey respondents who reported using services

Services	N	%
Public hospital services	26	72.2
Housing New Zealand	18	50
Work and Income New Zealand	17	47.2
Refugee & migrant services	14	38.9
Counselling services	6	16.7
Budgeting services	2	5.6
Have not used any of the above services	6	16.7

Knowledge and utilisation of services was influenced by time spent living in New Zealand, social networks and language barriers. Survey respondents who had lived in New Zealand for longer time periods had broader knowledge of services, respondents who had lived for 10 years or longer in New Zealand utilised more services than those who had lived in the country for less than 10 years (Figure 2).

Figure 2. Percentage of self reported service utilisation, by time lived in New Zealand (measured in years).



From focus group interviews it was evident that refugees' social networks (including friends, family and organisations such as the Mangere Refugee Centre) facilitated their understanding and use of public services. In contrast, English language difficulties were the most commonly reported barriers for service utilisation.

The majority of survey respondents (n=26, 72.22%) reported that they would find a service that helped them to access public services useful. No respondents reported that that this would not be useful. When asked what would be the best way to inform refugees of public and community services in New Zealand, focus group participants reported that social networks (including local Middle Eastern community associations, friends and family) should be employed. They reported that this could be achieved through word of mouth, advocacy, and media advertisements in Middle Eastern languages:

Okay so educate the new comer (refugee), tell them, ah guide them to the special centre where they can get all the services through local communities. We have associations and through them we could advertise and assemble (Iraqi woman, 52 years old).

Perceived and/or experienced usefulness of public services

Most survey respondents thought all of the services listed in the survey have been or would be useful, only 2 people reported that none of the services listed had been or would

be useful (Table 6). Public hospitals (n =26, 72.22%) and Housing New Zealand (n =23, 63.89%) were reported to have been or would be the most helpful services of those listed in the survey.

Table 6. Number and proportion of survey respondents who reported that services have been or would be useful.

Services	N	%
Public hospital services	26	72.2
Housing New Zealand	23	63.9
Work and Income New Zealand	17	47.2
Refugee & migrant services	14	38.9
Counselling services	8	22.2
Budgeting services	4	11.1
None of the above services	2	5.6

Focus group participants identified a number of public and/or community services they thought would be useful for them. These included:

- Health services
- Financial and employment support services
- Housing support services
- Immigration advice (particularly in relation to family reunification)
- Services that could provide more information about New Zealand in general
- Recreational services

Financial, employment and immigration services were the most common themes reported in relation to services in focus group discussions. Many participants described that they felt frustrated because although they wanted employment, there are limited job opportunities in New Zealand, as described by an Iraqi man (54 years old):

We can't find a job, that's the biggest problem. Life is expensive, we're not coping coping with it. There are no jobs even for our children. Because of the language barrier I could not do any service and I am a sick man. Those are the main problems if there are jobs we can work and if we are fit we can work.

Results section 2- Knowledge and satisfaction of TPCT Manurewa's services

Understanding of TPCT Manurewa's services

Most survey respondents (n= 22, 61.11%) reported to have a good understanding of the services provided by TPCT, although 8 participants (22.22%) reported they did not. Focus group participants' understandings of TPCTs services were varied. In general terms, TPCT was described as a medical or "family doctor" service where patients could

see doctors, nurses and dentists. Five interview participants said they understood the services well, and in contrast, 2 participants stated that they did not know anything about the services. Specific aspects of TPCT services, and New Zealand's health care system in general, that were poorly understood by interview participants included:

- Interpreting services
- Referral/specialist systems
- Public and private divisions of health care
- Relationship and role of Māori in the health sector
- Accessing and using emergency health services

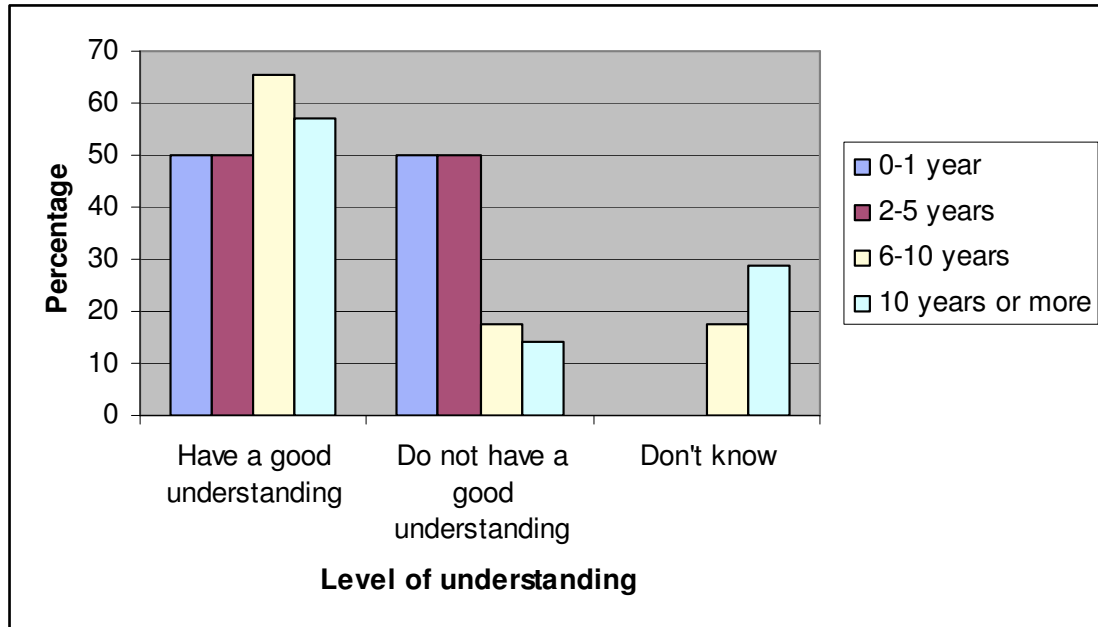
TPCT staff members were aware of their refugee clients' lack of understanding of New Zealand's health care system, particularly in regards to the role of GPs in New Zealand and the referral system. As a result, staff members would devote a lot of their consultation time in explaining these aspects of care to patients as described by a GP:

I'm there to educate, so I'm there to explain the role of a GP, so in a way I'm guiding them along our health system, I'm there to explain how the system works so that they can better utilise me

Understanding of TPCTs services also varied by time spent living in New Zealand. Survey respondents who had lived in New Zealand for 6 or more years had a better understanding of the services compared to those who had spent less time in the country (Figure 3). This finding was also supported by focus group interviews, where the 5 participants who reported having a good understanding the services had lived in New Zealand between 6 and 13 years. In contrast, the 2 participants who had no understanding of the services had been living in New Zealand for no longer than 2 years. The lack of understanding of New Zealand health care services is apparent in the following quote by a 54 year old Iraqi woman who has been living in New Zealand for 2 years and did not know where to seek emergency treatment:

In an emergency situation, for example like an appendicitis, if someone needs an appendicitis operation, is there like again a waiting list or an urgent referral or admission or anything?

Figure 3. Percentage of self reported understanding of TPCT Manurewa’s services, by time spent living in New Zealand (measured in years)



Social networks and refugee organisations were key facilitators of refugees’ awareness of TPCT. Seven people were informed of TPCT through family and friends and 2 through the Mangere Refugee Centre and/or refugee settlement volunteers. Participants reported that word of mouth and advertisement through local refugee networks would be the best mediums to inform and educate refugees about TPCT Manurewa. Staff members of TPCT also proposed that advertisement in Middle Eastern languages and working with refugee community organisations would be the best means of creating greater understandings of their services.

Problems experienced when seeing a doctor at TPCT Manurewa

Overall, English language was reported as the biggest problem always or sometimes experienced by survey respondents when seeing a doctor at TPCT Manurewa (n =21, 58.33%), followed by cost of services (Table 7).

Table 7. Number and proportion of survey respondents who reported problems with services provided by TPCT Manurewa

	English language		Cost		Transport		Type of doctor		Cultural understandings of doctor	
	N	%	N	%	N	%	N	%	N	%
Sometimes a problem	10	27.8	14	38.9	10	27.8	10	27.8	5	13.9
Always a problem	11	30.6	5	13.9	0	0	0	0	0	0
Never a problem	10	27.8	4	11.1	12	33.3	18	50	15	41.7
Did not respond	5	13.9	13	36.1	14	38.9	8	22.2	16	44.4

English language was also reported as the most common problem experienced by focus group participants (n=8), followed by long waiting times for appointment (n=5), not receiving preferred treatment (n=3) and cost of treatment (n=2). Other problems experienced by focus group participants when seeing a doctor at TPCT included:

- Not having a Middle Eastern GP at TPCT
- Transport
- Not being able to see the GP you want to see
- Referral processes
- Opening hours of TPCT

TPCT staff members also identified English language as the biggest problem experienced by their refugee clients, followed by cost of services and transport.

Language

Language difficulties reported by focus group participants related to not being able to understand or communicate with staff at TPCT Manurewa, and often not having access to professional interpreters or family members to act as informal interpreters. A participant's quote below illustrates these problems:

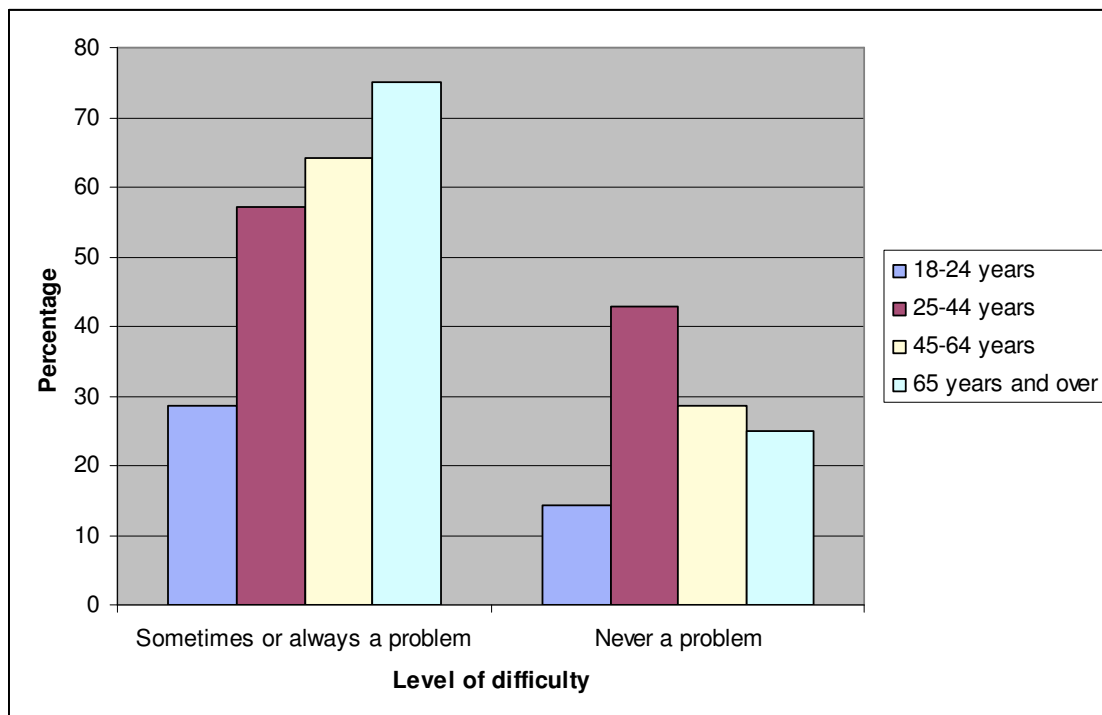
The problem we are facing or one of the main problems is when we book for an appointment, for all Iraqis actually, for people when we book here [TPCT Manurewa] we need an interpreter. Because sometimes when we come here we can't communicate with the doctor or we rely on family members for an interpreter who sometimes is [are] not available. That's why when they [refugees] come here, they face bigger problems and because of this misconduct maybe [get] in bigger trouble. Because we don't know how to communicate with the doctor, there are some ah language [words] we can't actually understand. (Iraqi man, 54 years old).

Language difficulties and use of family members as informal interpreters was also identified by staff members as a potential barrier to refugee health care provision. As evident from the following GPs statement:

I always try and get an interpreter because, particularly if it's something, you know if it's a cough and a cold and there's a 12 year old [family member] interpreting then that's fine. But I'd feel really uncomfortable if it was a 10 year old boy who was trying to explain his mother's menstruation. Because you can tell he's uncomfortable, I mean it doesn't bother me but you know he's uncomfortable and you just wonder how much information is being passed along?

There was a positive association with English language difficulties and age. Older survey respondents experienced more problems than younger respondents (Figure 4) and this was supported by data from focus group interviews. Only 3 focus group participants did not require an interpreter for their interviews and spoke English fluently, all 3 were under 25 years of age.

Figure 4. Proportion of survey respondents who sometimes or always experienced problems with English language when seeing a doctor at TPCT, by age group.



Although TPCT has a telephone interpreting service, only 2 focus group participants were aware of the service and only one participant had used the service and found it to be helpful- *“I used the phone interpreting service, it was very helpful actually”* (Iraqi male, 59 years old).

Generally TPCT staff found the telephone interpreting service to be a beneficial resource yet some experienced difficulties with it. Staff said that some patients were hesitant to disclose personal information to an interpreter if they personally knew the phone interpreter and others found it could not be utilised in certain health contexts as described by a Mental Health Coordinator:

Even though it's a great service [telephone interpreters] for a quick intervention, um I haven't been able to do things like put people through CBT [cognitive behavioural therapy] um because you can't use a telephone translator for it and they don't have the funds to pay for a translator um and we don't have it either. So I'm sitting in a very hard basket, I have a handful of people that I simply can't help.

Cost

There were conflicting results about how great a barrier the cost of services were for TPCTs clients. Although cost of treatment was identified as a barrier by survey respondents, focus group participants and TPCT staff members, it was also reported as a positive aspect of TPCT services in comparison to other primary care clinics- *"The fees here are very small compared to other services"* (Iraqi woman, 35 years old). Results from focus group discussions may indicate that concerns over cost are related more to dental services and external specialist services rather than applicable to TPCT itself, as shown by a participant's statement below:

Dental treatment actually is a bit expensive. Especially when you need to go to other places, when they send [you] to other places, very expensive. Yeah because there are some situations when they [TPCT] can't treat it, where they send you to other places, yeah some situations (Iraqi man, 59 years old).

Transport

Transport to TPCT was a barrier to treatment for survey respondents and focus group participants. Half of the focus group participants (n=6) did not own, could not drive or did not have access to a car and had to rely on public transport, walking or family and friends for transportation:

Transport for me is another problem actually because I don't have a car and I have to come by bus and sometimes there's a delay, the bus is delayed (Iraqi woman, 18 years old).

TPCT staff members were well aware of transportation problems for their patients and commented that many clients walked to their medical appointments or took public transport:

Transport is always an issue because the public service isn't always very good. Um I don't know, I don't really know if there is much we can do to be honest because it costs us. And also with the

transport, a lot of them [patients] do live nearby so they walk
(Chronic Care Management Nurse).

Type of doctor

Ten survey respondents reported that they experienced problems with the type of doctors at TPCT. Focus group participants discussed not being able to see a Middle Eastern doctor at TPCT as a barrier to health care, as well as not being able to see their preferred GP. Qualitative analysis also found that ethnicity, continuity of care and gender were key themes associated with preference for particular doctors.

From focus group interviews it was evident that Middle Eastern clients prefer seeing doctors from their own ethnic group due to shared understandings of culture, health and ease of communication:

Ah I'd prefer to hire a doctor, an Arabic doctor who is bilingual. In the past there was an Egyptian doctor [at TPCT], not Iraqi, an Egyptian doctor who spoke Arabic, so any Arabic doctor yeah (Iraqi woman, 35 years old).

Clients also preferred continuity of care and were dissatisfied when they could not see their regular GP at TPCT. Clients spoke of building up a rapport and trust with particular GPs whom they felt understood them and their health needs and were often suspicious and wary of other GPs.

TPCT staff members also commented that clients often preferred to see a GP of their own sex depending on their medical problems:

Um I often get the young mothers with kids and um some of the young guys come and see me. But most of the time, if given the choice, the older ones prefer seeing XY (male GP). So it depends if the wife is coming in for breast related or a abdomen related or a shoulder[related medical condition] where she thinks she might have to take her top off, they'll always come and see me. Because they don't like Dr. XY (male GP) looking at them. But sometimes if they're just [coming in] for scripts or something like that you know, they'll go in and see Dr. XY (male GP). And I see all of the pregnant ones generally, Dr. XY (male GP) sees them sometimes but you know if they've got bleeding or discharge or anything they see me. I almost exclusively see all of the teenage girls. (Female GP)

Treatment

The majority of all participants (survey respondents and focus group participants) were satisfied with their treatment at TPCT (Table 8).

Table 8. Survey respondents' self reported responses on happiness with TPCT services (* Note one participant did not respond to opening hours question).

Responses	Physical Health		Mental Health		Spiritual Health	
	N	%	N	%	N	%
Very happy	5	13.9	3	8.3	3	8.3
Happy	29	80.6	26	72.2	25	69.4
Unhappy	1	2.8	0	0	1	2.8
Don't know	1	2.8	7	19.4	7	19.4
Total	36	100	36	100	36	100

Physical health

The majority of survey respondents (n = 34, 94.44%) were happy or very happy with the treatment of their physical health at TPCT (Table 8). Only one respondent reported they were unhappy. Focus group participants also reported that overall, they were satisfied with treatment of their physical health at TPCT providing comments such as- “*This is the best [health] service we have been to*” (Iraqi male, 34 years old). Key aspects of treatment that were identified as being most helpful for their treatment included:

- Good doctors, nurses and reception staff
- Kind, friendly staff that smile
- Medical staff that listen to their patients
- Having their questions answered in a prompt manner
- Good follow up to treatment

Female participants in particular discussed how they felt welcomed and appreciated at TPCT due to the patient and friendly manner of staff members, as described by a 35 year old Iraqi woman- “*When you smile at someone it is good, better for you than if they don't. I feel more relaxed when someone greets me [at TPCT] with a big smile*”.

Three young female participants also described the importance to them of being listened to by their doctors:

They're really friendly, kind, yeah. Um doctor XY, he's helpful, friendly, kind, and he you know, when he checks you he listens. Yeah like other doctors they can like type and fidget and they don't really listen to what you say but he really listens to what you say (Iraqi woman, 18 years old).

The only aspect of physical treatment that focus group participants were dissatisfied with was not receiving their preferred type of bio medical treatment for ill health. This theme was also identified as a key barrier to health services. Three participants stated that when they would go to their GP with a specific health problem they expected to be prescribed with a specific medication but their GPs prescribed an alternative medication. Such a scenario is described by a 54 year old Iraqi woman:

For my self, for here [TPCT], more like doctors only prescribe panadol, when I get the flu I like to get the voltaren injection. So for my flu symptoms I prefer the injection because I get relief from it.

Middle Eastern clients' preferences for biomedical treatment were also observed by staff members of TPCT. A Mental Health Coordinator felt that many of his patients did not understand that their physical symptoms were associated with psychosocial conditions such as anxiety and depression. This understanding was also expressed by a GP who attributed Middle Eastern clients' biomedical preferences to a lack of understanding of New Zealand's health care system and psychosocial dimensions of illness, as described below:

A lot of the people that I see are focused on the physical aspects [of health], it's very disease focused. And yet they're coming with a lot of psychological problems. And they keep coming to me complaining of pain. Which probably is a manifestation of their psychological problems. And they're wanting a cure, a painkiller but that actually, the pain will only, it won't go away, until you've dealt with the psychological aspects. So I guess that what I'm saying is that if they understand, because often they don't understand the system, it seems to be a foreign concept.

Another TPCT staff member, an Iraqi dentist, felt that these preferences were also due to the different medical systems between New Zealand and Iraq, with Iraq having a more biomedical and specialist focused system compared to New Zealand. This understanding was supported by focus group interviews, where medical treatment in Iraq was described as being "superior" to New Zealand in relation to medical technology, treatment and availability of medical specialists. Another participant felt that TPCT's medical services could be improved by employing medical technology used in Iraq such as telephone diagnostic services.

Treatment of mental & spiritual health

The majority of survey respondents (n=29, 80.56%) stated they were happy or very happy with their mental health treatment at TPCT and none reported to be unhappy, although 7 people (19.44%) reported 'don't know'.

Most survey respondents (n=28, 77.77%) also reported that they were happy or very happy with the treatment of their spiritual health at TPCT, only one person described being unhappy with their treatment and 7 others (19.44%) reported that they did not know.

Treatment of mental and spiritual health was not discussed by participants in focus group interviews.

Service availability and systems

Overall, most survey respondents (n=31, 86.11%) reported to be happy or very happy with the availability of services at TPCT (Table 9), three people (8.33%) were unhappy and 2 (5.56%) people did not know.

Table 9. Self reported responses on availability of TPCT services (* Note one participant did not respond to opening hours question).

Responses	Service Availability		Opening Hours		Appointment System	
	N	%	N	%	N	%
Very happy	5	13.9	6	16.7	1	2.8
Happy	26	72.2	17	47.2	15	41.7
Unhappy	3	8.3	3	8.3	14	38.9
Don't know	2	5.6	9	25	6	16.7
Total	36	100	35*	97.2*	36	100

As with survey respondents, most focus group participants were satisfied with service availability at TPCT. Participants found having doctors, nurses and dentists available to them were the most helpful aspects of the services provided.

Aspects of service availability that participants were not satisfied with included:

- Not being able to see a Middle Eastern doctor
- Not being able to see the GP you want to see
- Not being able to access an interpreter
- Limited medical phone services

Opening hours

Although more than half of the survey respondents (n=23, 63.88%) stated they were happy or very happy with the opening hours of TPCT, this was a relatively low level of service satisfaction when compared to the generally high response rates for happiness with other aspects of TPCT's services and care (Table 9). Three respondents (8.33%) reported that they were unhappy with TPCT's opening hours and a fairly large proportion of respondents (n=9, 25%) selected the 'do not know' option for this service response (one person also did answer this question). Concerns regarding TPCT's opening hours were also evident from open ended survey comments. The following respondent's quote illustrates client's concerns over limited access during weekends- *"I would like the Centre to be opened on stat [statutory] holidays as well as weekends at least for few hours a day for emergency cases"*.

Opening hours of TPCT was identified as a key barrier to health care by focus group participants. Participants explained that when TPCT is not open (on weekends and statutory holidays) they have to go to a more costly health care provider where they often encountered long waiting times. Transport to alternative health care providers was also a problem described by 2 participants. Most participants who experienced problems with

limited opening hours were those seeking treatment for their children, as described below:

The weekend is [was] a long weekend and the children they were sick. We go to Manukau [health care practice] and they charge us a lot. We are talking after hours, they will charge us if we go to another place. Sometimes [there is a] lack of staff, so sometimes only one doctor, so have a waiting list, long waiting list (Iraqi man, 34 years old).

Appointment system

There was only a small margin of difference between survey respondents who were and were not happy with TPCTs appointment system (Table 9). In contrast to other high levels of service satisfaction reported for TPCTs health services, (with the exception of opening hours), notably fewer respondents (n=16, 44.45%) reported that they were happy or very happy with the appointment system. These results were similar to findings from focus group participants. Long waiting times for appointments was as the second greatest barrier to health care experienced by participants. Yet one participant described the prompt waiting times as one of the best aspects of TPCT and another participant described the walk-in-appointment system to be helpful:

It's really, really good. Sometimes I bring my kids if they're really, really sick you know I come late, you know it's [TPCT] full and they [receptionists] say "Oh that's okay since they're little bring them in" and the nurse will see them or the doctor, so it's really, really good. What they [TPCT] do with the kids, if they're sick and there's no appointment you know, they say "that's okay". Because I can't drive all the way all the way to Takanini because I've got two [children] so, they're like "no, come in and we'll see them because they're little", so that's really, really helpful (Iraqi woman, 23 years old).

Concerns regarding TPCTs opening hours and appointment system were also apparent from respondent's open ended survey comments. Three participants provided feedback for this question in the survey and their narratives revealed problems relating to waiting times for appointments, efficiency (or inefficiency of this service), inconsistencies between international health care systems and a preference for a booking appointment system rather than a walk-in system.

Long waiting times were problematic for 3 respondents, and 4 interview participants. Clients reported having to wait between half an hour and two hours to see health care professionals. The following quote from a survey respondent demonstrates how long waiting times can have broad impacts on client's lives where tradeoffs and negotiations around time management affect both their employment and health needs:

[I] Would like to have extended hours of working in the People Centre to be able to accommodate people's work schedule. Also the walking-in system is useless considering the waiting time required. [I] Would prefer the appointment system, it was working better in previous years.

Qualitative analysis indicates that many refugee clients associate waiting time with service efficiency as seen in the survey respondent's quote below, which describes the walk-in system as less "civilised" than booking systems. As with understandings of medical treatment, many refugee clients also appear to judge booking systems on the basis of experience of international health care systems:

I am not satisfied with the walk-in system, the bookings are more efficient we wait sometimes for two hours in the morning to see the doctor. The booking system is more civilized and accurate and it's used every where in the world.

Experience and satisfaction with referral systems and medical specialists

Almost 70 percent of survey respondents (n= 25, 69.44%) had been referred to a medical specialist by TPCT. This was reasonably consistent for all participants, except those between 25 and 44 years of age who proportionally, had less experience (57.14%) with referral systems than those of different ages. All participants who had been referred to medical specialists reported that they were very happy or happy with the process. All but one respondent also stated that they were happy or very happy with the medical specialist they were referred to.

In contrast to results from questionnaires, many focus group participants reported to be dissatisfied with referral processes. Client's dissatisfaction stemmed from long waiting times to see a specialist, English language barriers they encountered with medical specialists, and hospitals, and a lack of understanding of the referral system. Participants described waiting for up to 11 months to see a medical specialist:

To see a specialist takes a long, very long time. Like my husband had an eye problem, like his vision for some reason, I had to take his hand to guide him around the house and for some reason it took a very long time to see a specialist. So it took 11 months waiting just to see the specialist in the hospital (Iraqi woman, 54 years old).

GPs at TPCT were also aware that some of their refugee clients were experiencing long waiting times to see specialists. Although the GPs said they were vigilant in following up on referrals, they described the process as often being hindered by lack of communication with patients (due to their lack of understanding of the referral process and language barriers) and their busy working environment:

And [referral] waiting lists they [refugee patients] have a hard time comprehending...I had a wee lady that I referred to an ultrasound scan, she waited 6 months without telling us that she was waiting for

an ultrasound scan, you know, and its like you know, we see 30, 40 sometimes patients a day, you know what I mean? And she'd seen other doctors before me, other doctors after me. You know when we're moving around like this [between Manurewa and City clinics] it's hard to keep track. Because you know when I always see a patient I like to go back and see if there's anything outstanding that they're waiting on or stuff like that and I'll follow that up.

Preventing barriers to health care

Focus group participants proposed a number of strategies they felt could prevent barriers to health care and improve TPCTs services. These included:

- Employing an interpreter or improved interpreting services
- Employing more Middle Eastern staff such as doctors, nurses and receptionists
- Having more walk in appointments times
- Having a more prompt appointment system with reduced waiting times
- Extending medical telephone services
- Creating a play space for children in the reception area
- Offering more biomedical treatment options

TPCT staff members also felt that employing more Middle Eastern staff members and improving interpreting services would improve health care for their refugee clients. In addition, three staff members felt that employing a social worker would also improve services. Focus group participants and staff members also suggested that interventions should be undertaken through consultation with Middle Eastern communities.

Discussion and recommendations

Given the small sample size of the project some of the results should be treated with caution as they may not be representative of all Middle Eastern refugee clients. For example, Middle Eastern refugee men were underrepresented in the study.

In accordance with New Zealand's Health Care Strategy (Ministry of Health 2001) and New Zealand's Primary Health Care Strategy (Ministry of Health 2001), all interventions undertaken in response to the report should adopt a community participatory approach based on The World Health Organisation's Alma Ata Declaration. Employing a community participatory approach can enable interventions to be undertaken in socially and culturally appropriate contexts and promote community development, advocacy and empowerment (Baum 2002).

Although most participants reported that they were satisfied with their current housing conditions, 10 people (20.83%) reported problems with their current housing situation. Problems included expensive rents, over crowding, safety and security concerns. Substandard housing conditions are a significant risk factor for poor health outcomes in New Zealand. Cold, mouldy and damp housing has been shown to increase the risk of colds, asthma and other respiratory symptoms (Buttler *et al.* 2003) and overcrowding creates risks for transmission of infectious diseases such as tuberculosis (Das *et al.* 2006,

De Zoysa *et al.* 2001). Lawrence and Kearns (2005) also identified housing as a key determinant for refugee health needs in their Auckland based study.

To help improve the housing conditions of refugee clients, consultation should be undertaken with key stakeholders including Housing New Zealand, Work and Income Support, social workers and Middle Eastern communities. Engaging a community advocate would help promote this networking.

Refugee clients did not have a good understanding of public services, and a generally low service utilisation. Health, financial (particularly in relation finding employment) and immigration services were reported to be the most useful services for participants. Not surprisingly, there was a strong association between knowledge and utilisation of community and public services, where participants were more likely to use services they knew and understood. Low service utilisation due to poor understanding of services has also been found in other migrant and refugee groups in New Zealand (Anderson 2008, Lawrence and Kearns 2005). Service utilisation was also influenced by time spent living in New Zealand, social networks (friends, family, community groups and refugee services) and language barriers.

Knowledge and utilisation of public services could be improved by disseminating information in Middle Eastern languages through community networks and refugee services, as well as working closely with community advocates and social workers. Help with finances, finding employment and accessing and understanding immigration services could be improved through TPCT networking with these services as well as Middle Eastern community advocates.

Participants' understandings of TPCTs services were varied, over 20% of clients reported that they did not have a good understanding of the services. Services least understood included: New Zealand's health care system in general, interpreting services, referral processes, public and private divisions of health care, relationships of Māori in the health sector and using emergency services. Lack of understanding of New Zealand's health care services has also been identified as a key barrier to accessing health care for other refugee and migrant groups in Auckland (Anderson 2008, Lawrence and Kearns 2005). Barriers to accessing health care in New Zealand, and internationally, have been cited to contribute to many health inequalities such as accidents and disability (Bollini and Siem 1995), mental illness (Abbott *et al.* 2000), cardiovascular disease and type 2 diabetes (Ministry of Health 2006). Understandings of health care services are often influenced by time spent living in New Zealand, differing cultural understandings and experiences with international health care systems, limited social networks and language difficulties (Anderson 2009, Lawrence and Kearns 2005).

Middle Eastern refugee clients gained most knowledge of TPCT through word of mouth (from friends and family), the Mangere Refugee Centre and refugee resettlement volunteers. Participants suggested that providing information about health care services in Middle Eastern languages and dissemination information through community networks would increase their understanding of TPCT (and the health care system in general).

Producing a simple flyer or pamphlet explaining New Zealand's health care system in Middle Eastern languages could improve refugees' understanding of TPCT (and health care system in general). Such a resource could also be used as an educational tool to be disseminated to services such as the Mangere Refugee Centre as well as local Middle Eastern communities and support networks. The approach would be best achieved through a partnership approach with Middle Eastern community advocates.

English language, long waiting times for appointments, not receiving preferred medical treatment and costs of services were reported as the biggest problems experienced by participants when seeing a doctor at TPCT. Transport and not having a Middle Eastern doctor at TPCT were also problems experienced by refugee clients. These results are consistent with other research findings focused on barriers that migrant and refugee people face when accessing health care in New Zealand (Anderson 2009, Anderson 2008, Lawrence and Kearns 2005, Wean *et al.* 2007). To implement effective interventions to reduce these access difficulties, consultations will have to be undertaken with stakeholders from TPCT and refugee communities.

Focus group participants suggested that the following factors would facilitate their access to TPCT: Employing an interpreter or improving interpreting services, employing a Middle Eastern speaking staff member, reducing appointment waiting times, having more walk-in-appointment times, offering more medical phone services and providing more biomedical treatment options.

Employing an interpreter or Middle Eastern staff member may not be a feasible option for TPCT. To reduce language barriers experienced by refugee clients, TPCT could improve awareness of, and use of, their phone interpreter system by advertising the service through community organisations. This could be done in partnership with community advocates and producing flyers/pamphlets written in Middle Eastern languages.

The majority of participants were satisfied with the treatment of their physical, mental and spiritual health care at TPCT. Key aspects of treatment that were identified as being helpful included: Good doctors, nurses and reception staff, kind, friendly staff that smile, medical staff that listen to their patients, having questions answered in a prompt manner and good follow up to treatment. These aspects of care should be acknowledged by TPCT staff and management and maintained in service practice.

The only aspect of physical treatment that participants were dissatisfied with was not receiving their preferred type of bio medical treatment for ill health. Clients' preference for medical treatment was influenced by their experience of health systems of countries of origin and lack of understanding of New Zealand's health system. Similar findings for treatment preferences have been found for migrant groups in New Zealand (Anderson 2008, 2009). These difficulties can be reduced by improving refugees' understandings of New Zealand's health care system through recommendations previously outlined. In addition, New Zealand health care professionals should also be provided with education

and resources to help them cope with divergent understandings of health care among their migrant and refugee patients.

Most participants were satisfied with the availability of services at TPCT. Participants found having doctors, nurses and dentists available to them were the most helpful aspects of the services provided. Aspects of service availability that participants were not satisfied with included: Not being able to see a Middle Eastern doctor, not being able to see the GP they referred, not being able to access an interpreter and having limited medical phone services.

As aforementioned, it may not be feasible for TPCT to employ a middle Eastern doctor but increasing awareness of the phone interpreting service could address problems encountered with English speaking doctors. Increasing medical services available through telephone services could also be explored by TPCT management and staff.

Refugee clients' reported low levels of satisfaction with TPCTs opening hours. During weekends and statutory holidays when TPCT was closed, participants had to find alternative health care providers which often entailed long waiting times, increased costs of services and difficulties with transport. Difficulties associated with using after hours medical services for migrant groups in Auckland have also been discussed by Anderson (2008, 2009). She found that these services often created greater financial burdens for already economically marginalised groups.

A review of the opening hours of TPCT should be undertaken as opening the clinic over weekends could reduce barriers experienced by refugee clients. TPCT could also provide posters or flyers in Middle Eastern languages giving information about alternative after hour medical services (including costs, directions and transport options).

Satisfaction with TPCTs appointment system was divided among participants. While some participants found the walk-in appointment system to be one of the most helpful aspects of TPCTs services, it was also reported to be one of the greatest barriers to health care experienced by refugee clients. Long waiting times were the most problematic aspect reported for TPCTs appointment system. Participants reported waiting times of up to two hours for medical appointments with TPCT. Long waiting times for primary health care services and limited opening hours have been found to contribute to low utilisation of health care services and impact on health inequalities for migrants in New Zealand (Anderson 2008, 2009).

TPCT should undertake an assessment of appointment waiting times to gauge the extent of this problem. Once average waiting times have been calculated the system can then be reviewed.

Satisfaction with referral processes varied between survey respondents, the majority of whom were happy with the process, and focus group participants who expressed dissatisfaction. Client's dissatisfaction was influenced by long waiting times to see a specialist, English language barriers they encountered and their lack of understanding of

the referral system. These findings are consistent with previous research that reviewed migrants' experiences with New Zealand's referral system (Anderson 2008).

Reducing waiting times and language barriers encountered by patients in secondary and tertiary health care contexts are beyond the scope of this report. However, the aforementioned recommendations to improve refugees' knowledge of New Zealand's health care system could facilitate their experiences with referral processes.

On a final note, appreciation of refugee clients for the service development project was evident from a number of their comments on the surveys and expressed during interviews such as "*Thank you very much for the big effort and concern*". These acknowledgements highlight their support for the project and demonstrate its importance to them.

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Appendix One: Questionnaire

MANUREWA PEOPLES CENTRE SERVICE DEVELOPMENT SURVEY

Please indicate your answer to the following questions by ticking the boxes

1. What is your age? 0-17 18-24 25-44 45-64 65-90

2. What is your gender? Male Female

3. How many years have you lived in New Zealand? 0-1 2-5 6-10 10+

4. How happy are you with your current housing conditions? Unhappy Happy Very happy Don't know

5. Which of the following services do you have a good understanding of?

Housing New Zealand

Work and Income New Zealand

Counselling services

Budgeting services

Refugee and migrant services

Public hospital services

None of the above

6. Which of the following services have you used?

Housing New Zealand

Work and Income New Zealand

Counselling services

Budgeting services

Refugee and migrant services

Public hospital services

None of the above

7. Which of the following services has been or would be helpful?

Housing New Zealand

Work and Income New Zealand

Counselling services

Budgeting services

Refugee and migrant services

Public hospital services

None of the above

8. Would a service that helped you access the above services be useful?

Yes No Don't know

9. Do you have a good understanding of the services provided by the Manurewa Peoples Centre?

Yes No Don't know

10. Which of the following have been a problem when seeing a doctor at the Manurewa Peoples Centre on a scale from never to always?

	Never	Sometimes	Always
Transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
English language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cultural understanding of doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cost	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type of doctor (race, gender, age etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. How happy are you with the treatment of your physical health at the Manurewa Peoples Centre?

Unhappy Happy Very happy Don't know

12. How happy are you with the treatment of your mental health at the Manurewa Peoples Centre?

Unhappy Happy Very happy Don't know

13. How happy are you with the treatment of your spiritual health at the Manurewa Peoples Centre?

Unhappy Happy Very happy Don't know

14. How happy are you with the availability of services at the Manurewa Peoples Centre?

Unhappy Happy Very happy Don't know

15. How happy are you with the opening hours of the Manurewa Peoples Centre?

Unhappy Happy Very happy Don't know

16. How happy are you with the appointment system at the Manurewa Peoples Centre?

Unhappy Happy Very happy Don't know

17. Have you ever been referred to a medical specialist by the Manurewa Peoples Centre?

Yes No

If you answered yes to question 17 please answer the following two questions (18 & 19). If you answered no, please go straight to question 20.

18. Were you happy with your referral? Unhappy Happy Very happy Don't know

19. Were you happy with the medical specialist? Unhappy Happy Very happy Don't know

20. If you would like to provide any further comments about the questions in this survey please write them in the space provided below

Thank you for participating in this survey, your contribution is much appreciated

Appendix Two: Questionnaire Participant Information Sheet

Manurewa Peoples Centre Service Development Survey

You are invited to take part in a survey for the Manurewa Peoples Centre. All information from this questionnaire will be kept confidential and no questions will be used that could personally identify you. If you choose not to take part in the survey you will still continue to receive the usual medical treatment from the Manurewa Peoples Centre.

The aim of the survey is to gain a better understanding of patient's health needs so the services provided by the Manurewa Peoples Centre can be improved.

If you would like to help the Manurewa Peoples Centre improve its services, please complete all the questions in the questionnaire included and mail back the completed survey in the self addressed envelope. The survey will only take approximately five minutes to complete.

The survey has received ethical approval from Counties Manukau District Health Board (CMDHB).

Please feel free to contact the researcher if you have any questions about the survey

Dr Anneka Anderson
Ph 027 315 1154
Email a.anderson@auckland.ac.nz

Thank you for your time and consideration

Appendix Three: Focus Group Interview Questions

FOCUS GROUP INTERVIEW QUESTIONS FOR TPCT MANUREWA'S REFUGEE CLIENTS

- 1. Can you tell me a little bit about yourselves?**
 - Age
 - Country of origin
 - Time spent living in NZ
 - Family/home context

- 2. How would you describe your current housing situation?**

- 3. Could you please tell me about any public or community services you know about in New Zealand?**
 - Use services from survey as prompt if needed to clarify what is meant by public/community services!
 - How did you come to know of these services?
 - In your opinion, what would be the best way to inform people of these services?

- 4. What kind of public or community services do you think would be helpful to yourself or other people you know? (Why?)**
 - What would prevent you from using these services?
 - What would help you to be able to use these services?

- 5. Can you explain to me what you know about The People Centre Trust Manurewa's services?**
 - How did you come to know of The People Centre Trust Manurewa?
 - Is there anything about the services you have difficulty in understanding?
 - In your opinion, what would be the best way to increase people's understanding of The People Centre Trust Manurewa's services?

- 6. What kinds of things would prevent you, or people you know from seeing a doctor or nurse at The People Centre Trust Manurewa?**
 - In your opinion, what do you think could be done to prevent this/these problem/s?

- 7. Can you describe your experiences with health care at The People Centre Trust Manurewa?**
 - Have you ever encountered any difficulties with health care at The People Centre Trust Manurewa? (If yes, what do you think could be done to prevent these difficulties?)
 - What aspects of The People Centre Trust Manurewa have you found most helpful for your health care? (Why?)

- 8. Are there any questions or comments you would like to make?**

Appendix Four: Focus Group Interview Participant Information Sheets

Client's Participant Information Sheet (Version 17/11/09)

PROJECT TITLE: The Peoples Centre Trust Manurewa Service Development Project

RESEARCHER: Dr Anneka Anderson

You are invited to take part in a service development project for the Manurewa Peoples Centre Trust. Your participation is entirely voluntary. If you chose not to take part you will receive the usual medical treatment from the Manurewa Peoples Centre.

What is the project about?

The aim of this project is to gain a better understanding of refugee and migrant patient's health needs so the services provided by the Manurewa Peoples Centre Trust can be improved.

Who and what will the project involve?

The project will involve staff and Middle Eastern clients of The People Centre Trust Manurewa who are 16 years or older.

If you decide to take part in the project, we invite you to participate in a focus group interview with the primary researcher. The interview will be conducted privately and take place at The People Centre Trust Manurewa during weekdays from 10 to 11am. It will take approximately 60 minutes, and will be digitally recorded with your consent. At any time you can request the audio recorder to be switched off. During the interview you do not have to answer all the questions, and you may stop the interview at any time.

If you need an interpreter for the interview, which will be conducted in English, a telephone interpreter will be provided for you. You may have a friend, family or whanau support person with you at the interview to help you understand the risks and/or benefits of this study and any other explanation you require.

How will the findings of the project be used?

The findings of the project will be used to provide information that will help assess and improve the accessibility, appropriateness and responsiveness of services of the Peoples Centre Trust Manurewa, towards its Middle Eastern refugee and migrant clients. The results of the project will be written into a report for Counties Manukau District Health Board and may also be disseminated through community consultations and academic presentations and published in academic and health journals.

Benefits, risks and safety

The study aims to benefit patients of the People Centre Trust Manurewa and the greater Manurewa community through a better understanding of accessibility, appropriateness and responsiveness of health and public services.

The study proposes no risk and the only inconvenience is the time taken for an interview.

Participation

If you agree to take part in this project you are free to withdraw from the study at any time, without having to give a reason and this will in no way affect your health care or treatment with the People Centre Trust Manurewa.

Keeping information confidential

This project will ensure confidentiality. Your name will not be used in any reports or publications. Your identity will remain anonymous. The interview recording will be transcribed and the researchers will be the only people who have access to it. Transcripts will not identify you. The study data will be kept securely and destroyed after ten years, which is usual research practice.

Statement of approval

This project falls under the Northern X Regional Ethics Committee's audit (for service development) criteria. It has been approved as an audit for service development by Counties Manukau District Health Board (CMDHB) in March 2009.

Any questions?

If you have any queries or wish to know more information about the project, please contact the primary researcher, Dr Anneka Anderson:

Email: a.anderson@auckland.ac.nz

Phone: 0273151154

If you have any questions or concerns about your rights as a participant in this project you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.

Telephone (New Zealand wide): 0800 555 050

Free Fax (New Zealand wide): 0800 2787 7678 (0800 2 SUPPORT)

Email (New Zealand wide): advocacy@hdc.org.nz

Thank you very much for your time and help in making this project possible.

Appendix Five: Focus Group Interview Consent Forms

Consent Form (The People Centre Trust Manurewa's clients)

This consent form will be held for a period of ten years

**PROJECT TITLE: The Peoples Centre Trust Manurewa Service
Development Project**

RESEARCHER: Dr Anneka Anderson

REQUEST FOR INTERPRETER (to be included on all consent forms)

Arabic	I wish to have an interpreter.	Yes	No
Other	(please state which language)	Yes	No

I have read and I understand the Participant Information Sheet dated **17/11/09** for volunteers taking part in the project and have had the study explained to me.

I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.

I have had the opportunity to use whanau support or a friend to help me ask questions and understand the study.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the project at any time and this will in no way affect my health care with The People Centre Trust Manurewa.

I understand that my participation in this project is confidential and that no material which could identify me will be used in any reports or publications that may arise from this project.

I have had time to consider whether to take part.

I know who to contact if I have any questions about the study.

I understand that the interview will be held in private and will last approximately 30 to 60 minutes. I also understand that the audio recorder will be turned off at anytime during the interview if I feel uncomfortable. I understand that the audio files will be kept confidential. The data will be kept for up to ten years upon the completion of the project but it will be anonymous and stored securely.

I consent to my interview being audio-taped

YES/NO

I consent to a copy of the audiotape being stored securely under the conditions described in the Participant Information Sheet

YES/NO

I wish to receive a copy of my transcript (please provide a mail or email address below if you select yes).

YES/NO

Mail/email:

I _____ (full name) hereby consent to take part in this study.

Date

Signature

Name of Researcher:

Dr Anneka Anderson

Email: a.anderson@auckland.ac.nz

Phone: 027 315 1154

This project falls under the Northern X Regional Ethics Committee's audit (for service development) criteria. It has been approved as an audit for service development by Counties Manukau District Health Board (CMDHB) in March 2009.

Appendix Six: Semi-Structured Interview Questions (TPCT Staff)

SEMI-STRUCTURED INTERVIEW QUESTIONS FOR STAFF AT TPCT MANUREWA

- 9. Can you tell me a little bit about your role at The People Centre Trust Manurewa?**
- 10. Middle Eastern refugee clients**
- How many Middle Eastern refugee clients would you see in a week?
 - Have you noticed any commonalities with these clients in terms of age, gender, socioeconomic status, time spent living in New Zealand or occupation?
 - From your experiences with these clients, what aspects of the service do you think they DO NOT have a good understanding of (Why)?
 - What do you think could be done to improve refugee client's knowledge of services?
 - In your experience, what factors can facilitate or create barriers for refugee clients and their treatment?
 - What do you do when you see/treat clients with English as a second language?
- 11. From your experiences of working with Middle Eastern refugee clients, what factors prevent your clients from seeing you or another health professional at The People Centre Trust Manurewa (cost, transport...)?**
- In your opinion, what do you think could be done to prevent this/these problem/s?
- 12. Are there any questions or comments you would like to make?**

Appendix Seven: Semi-Structured Interview Participant Information Sheet (TPCT Staff)

TPCT Manurewa's Staff Participant Information Sheet (Version 27/09/09)

PROJECT TITLE: The Peoples Centre Trust Manurewa Service Development Project

RESEARCHER: Dr Anneka Anderson

You are invited to take part in a service development project for the Manurewa Peoples Centre Trust. Your participation is entirely voluntary. We will contact you in approximately one week if you are willing to take part in this research.

What is the project about?

The aim of this project is to gain a better understanding of refugee and migrant patient's health needs so the services provided by the Manurewa Peoples Centre Trust can be improved.

Who and what will the project involve?

The project will involve staff and Middle Eastern clients of The People Centre Trust Manurewa who are 16 years or older.

If you decide to take part in the project, we invite you to participate in an interview with the primary researcher. The interview will be conducted privately and take place at The People Centre Trust Manurewa, or by telephone during weekdays from 9am to 5pm at a day and time that suits you. It will take approximately 30 to 60 minutes, and will be digitally recorded with your consent. At any time you can request the audio recorder to be switched off. During the interview you do not have to answer all the questions, and you may stop the interview at any time.

If you need an interpreter for the interview, which will be conducted in English, a telephone interpreter will be provided for you. You may have a friend, family or whanau support person with you at the interview to help you understand the risks and/or benefits of this study and any other explanation you require.

If you are a health professional taking part in this project and you have any queries or concerns regarding your rights as a participant, you may wish to contact your professional organisation.

How will the findings of the project be used?

The findings of the project will be used to provide information that will help assess and improve the accessibility, appropriateness and responsiveness of services of the Peoples

Centre Trust Manurewa, towards its Middle Eastern refugee and migrant clients. The results of the project will be written into a report for Counties Manukau District Health Board and may also be disseminated through community consultations and academic presentations and published in academic and health journals.

Benefits, risks and safety

The study aims to benefit patients of the People Centre Trust Manurewa and the greater Manurewa community through a better understanding of accessibility, appropriateness and responsiveness of health and public services.

The study proposes no risk and the only inconvenience is the time taken for an interview.

Participation

If you agree to take part in this project you are free to withdraw from the study at any time, without having to give a reason and this will in no way affect your employment with the People Centre Trust Manurewa.

Keeping information confidential

This project will ensure confidentiality. Your name will not be used in any reports or publications. Your identity will remain anonymous. The interview recording will be transcribed and the researchers will be the only people who have access to it. Transcripts will not identify you. The study data will be kept securely and destroyed after ten years, which is usual research practice.

Statement of approval

This project falls under the Northern X Regional Ethics Committee's audit (for service development) criteria. It has been approved as an audit for service development by Counties Manukau District Health Board (CMDHB) in March 2009.

Any questions?

If you have any queries or wish to know more information about the project, please contact the primary researcher, Dr Anneka Anderson:

Email: a.anderson@auckland.ac.nz

Phone: 0273151154

If you have any questions or concerns about your rights as a participant in this project you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.

Telephone (New Zealand wide): 0800 555 050

Free Fax (New Zealand wide): 0800 2787 7678 (0800 2 SUPPORT)

Email (New Zealand wide): advocacy@hdc.org.nz

Thank you very much for your time and help in making this project possible.

Appendix Eight: Semi-Structured Interview Consent Form (TPCT Staff)

Consent Form (The People Centre Trust Manurewa's Staff)

This consent form will be held for a period of ten years

PROJECT TITLE: The Peoples Centre Trust Manurewa Service Development Project

RESEARCHER: Dr Anneka Anderson

REQUEST FOR INTERPRETER (to be included on all consent forms)

Arabic	I wish to have an interpreter.	Yes	No
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I have read and I understand the Participant Information Sheet dated **27/09/09** for volunteers taking part in the project and have had the study explained to me.

I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.

I have had the opportunity to use whanau support or a friend to help me ask questions and understand the study.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the project at any time and this will in no way affect my employment with The People Centre Trust Manurewa.

I understand that my participation in this project is confidential and that no material which could identify me will be used in any reports or publications that may arise from this project.

I have had time to consider whether to take part.

I know who to contact if I have any questions about the study.

I understand that the interview will be held in private and will last approximately 30 to 60 minutes. I also understand that the audio recorder will be turned off at anytime during the interview if I feel uncomfortable. I understand that the audio files will be kept confidential. The data will be kept for up to ten years upon the completion of the project but it will be anonymous and stored securely.

I consent to my interview being audio-taped

YES/NO

I consent to a copy of the audiotape being stored securely under the conditions described in the Participant Information Sheet

YES/NO

I wish to receive a copy of my transcript

YES/NO

I _____ (full name) hereby consent to take part in this study.

Date

Signature

Name of Researcher:

Dr Anneka Anderson

Email: a.anderson@auckland.ac.nz

Phone: 027 315 1154

This project falls under the Northern X Regional Ethics Committee's audit (for service development) criteria. It has been approved as an audit for service development by Counties Manukau District Health Board (CMDHB) in March 2009.