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Refugees as ‘Others’

Social and Cultural Citizenship Rights for Refugees in New Zealand Health Services

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ABSTRACT

Citizenship, as effective social, cultural and economic participation for refugee groups, depends on appropriate institutional structures and processes in resettlement societies. This thesis using critical social theoretical perspectives addresses the paradox of being legally a citizen, but substantively excluded from the very rights that constitute such citizenship. The thesis draws on theoretical models of newcomer integration in order to promote the development of a more inclusive society for refugees in New Zealand. The issues to be considered include responses from central government and from public institutions—particularly health, education, employment and welfare—in addressing social exclusion and promoting integration. The questions of refugee integration to be addressed conceptually must take into consideration cultural and religious diversity, on the one hand, and socio-economic inequality on the other.

In New Zealand, the 1987 review of refugee resettlement policy, which established an annual quota of 750 places, has given priority to those with the highest health and social needs and removed preferences for specific national, ethnic and religious groups. Significantly, in the 1990s radical neo-liberal economic reforms were introduced and publicly provided health, education and welfare systems were restructured. This posed serious challenges to the core idea of social citizenship in general in New Zealand society. Noticeable ethnic diversification has been just one element of the resettlement policy changes; the other has been long-term social and economic exclusion in the refugee groups settled since this time. This study indicates that New Zealand's notably humanitarian refugee resettlement policy is not matched by adequate central government and public institutional responses and resources with which to integrate refugee groups.

This qualitative study examines the role of one institution in particular, health care. The study takes a multi-method approach, using historical and social policy analysis to set the structural context for the interpretation of data from participant interviews. During fieldwork, twenty-eight semi-structured interviews were conducted with health care providers in community, primary and secondary care sectors in the

Auckland region, in both governmental and non-governmental agencies. This research demonstrates at a service level, the consequences of overlooking refugee peoples in New Zealand social policy, data collection systems, research and health strategies. Importantly though, the research discovers a number of ‘activation points’—or approaches that have been developed by health care practitioners—that highlight future opportunities for the inclusion of refugee groups. One finding is that the New Zealand health system must address the question of how to effect a shift from universalist conceptions of generalised eligibility for health services to targeted interventions for refugees.

The conclusions drawn from the study are: firstly, that an overarching integration policy for refugees, led by central government, is required. Secondly, institutional responses that accommodate the special psychosocial, socio-economic and cultural/religious requirements of refugee groups are needed. This would include the development of a locally relevant multiculturalism to guide social policy in New Zealand. In the long-term, for peoples from refugee backgrounds to become full political, social, economic and cultural members of New Zealand society, there needs to be a rethinking of the contemporary models of citizenship offered.

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Key to Interview Terms

The following conventions used are presented here to assist the reader in their interpretation.

Name	The personal names of research participants have been changed where necessary and pseudonyms used for identification.
Number	The number of the interview and line of the transcript.
(...)	Material which has been edited.
...	Incomplete sentences without editing.
“ ”	Single words, or short phrases/ sentences used by the interviewee.
‘ ’	Words developed by the researcher or other authors.
[]	Insertion of additional material to make context and/or meaning clear.

Abbreviations

ADHB	Auckland District Health Board. Auckland DHB zone Refers to the Auckland District Health Board geographical area. Note that this is equivalent to the Auckland City geographical zone.
AEG	AIDS Epidemiology Group
AIDS	Acquired Immune Deficiency Syndrome
ALMPs	Active Labour Market Policies
ANZUS	Australia, New Zealand and the United States treaty of defensive alliance (signed in 1951)
ARC	Auckland Refugee Council
ARPHS	Auckland Regional Public Health Services
ASCP	Auckland Sustainable Cities Programme

Auckland/Auckland Region

Refers to the greater Auckland region, which includes the Central Auckland (Auckland DHB), West/North Auckland (Waitemata DHB) and South Auckland (Counties-Manukau DHB) District Health Board (DHB) geographical zones.

AUTREF	Auckland University of Technology Refugee Education
B & I	Border and Investigations
CBF	Capitation Based Funding
CCR	Canadian Council for Refugees
CCH&D	Community Child Health and Disability Service
CEDAW	United Nations Convention on the Elimination of all Forms of Discrimination against Women
CERD	Covenant on the Elimination on All Forms of Racial Discrimination
CESCR	Committee on Economic, Social and Cultural Rights
CHE	Crown Health Enterprise
CORSO	Council of Organisations for Relief Service Overseas
COMPAS	Centre on Migration, Policy and Society
CRC	Canadian Refugee Council
CRC	Community Relations Commission For a multicultural NSW
CSC	Community Services Card
CYF	Child Youth and Family

DHB	District Health Board
DIMIA	Department of Immigration and Multicultural and Indigenous Affairs
ECRE	European Council on Refugees and Exiles
EU	European Union
ESOL	English for speakers of other languages
EU	European Union
EUMS	European Union Member States
FGM	Female genital mutilation
GCIM	Global Commission on International Migration
GDP	Gross domestic product
GIS	Geographic Information System
HCA	Healthcare Aotearoa
HFA	Health Funding Authority
HHS	Hospital and Health Services
HIV	Human Immune-deficiency Virus
HoP	Hauora o Puketapapa/Roskill Union and Community Health Centre
HUHC	High User Health Card
IALS	International Adult Literacy Strategy
ICCI	Inter-Church Commission on Immigration and Refugee Resettlement
ICCPR	Covenant on Civil and Political Rights
ICM	Interpreter Cultural Mediator
ICRR	Inter-Departmental Committee on Refugee Resettlement
IELTS	International English Language Test Score
ILO	International Labour Organisation
IMES	Institute for Migration and Ethnic Studies
IMISCOE	International Migration, Integration and Social Cohesion
IOM	International Organization for Migration
IRO	International Refugee Organisation
IDP	Internally displaced person
IMES	Institute for Migration and Ethnic Studies
IOM	International Organisation for Migration
LMC	Labour Market Citizenship

LisNZ	The Longitudinal Immigration Survey: New Zealand
MOSD	Ministry of Social Development
MPI	Migration Policy Institute
MRRC	Mangere Refugee Reception Centre
NASS	National Asylum Support Services
NDSA	Northern District Health Boards Support Agency
NESB	Non-English speaking background
NGO	Non Government Organisation
NHI	National Health Index
NPA	National Plan of Action for Human Rights in New Zealand
NCNZ	Nursing Council of New Zealand
NZAF	New Zealand AIDS Foundation
NZNO	New Zealand Nurses Organisation
NZSCE	New Zealand Standard Classification of Ethnicity
NZIS	New Zealand Immigration Service
OEA	Office of Ethnic Affairs
OECD	Organisation for European Co-operation & Development
ON TRACC	Transcultural care service for children and young people from refugee backgrounds, who have high and complex needs.
OSH	Occupational Health and Safety
PAFT	Parents as First Teachers
PBF	Population Based Funding
PBFF	Population Based Funding Formula
PERPBFF	Population-based personal health care funding formula
PES	Public Employment Service
PISA	Programme for International Student Assessment
PHO	Primary Health Organisation
Plunket	The Royal New Zealand Plunket Society
PTSD	Posttraumatic Stress Disorder
RAS	Refugees as Survivors
RCOA	Refugee Council of Australia
RMS	Refugee and Migrant Service
RHA	Regional Health Authority

RHEP	Refugee Health Education Programme
RMS	Refugee and Migrant Service
RSB	Refugee Status Branch
SEU	Social Exclusion Unit (UK)
SBS	Special Broadcasting Service
SDPOA	Government's Sustainable Development Programme of Action for New Zealand
SIA	Services to improve access
SIS	Security Intelligence Service
SNZ	Statistics New Zealand
TCRR	Tripartite Consultations on Refugee Resettlement
UDHR	Universal Declaration of Human Rights
UN	United Nations
MPMC	UNESCO-MOST Multicultural Policies and Modes of Citizenship in European Cities project.
UNHCR	United Nations High Commission for Refugees
USCR	United States Committee for Refugees
WINZ	Work and Income
WHO	World Health Organisation

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CHAPTER ONE

INTRODUCTION

Introduction

This study is limited to refugee resettlement from 1987 to the present. The year 1987 is significant in terms of the integration of refugees for a number of reasons. Firstly, from 1987 until 1999, with the election of the Labour-led coalition, major changes in New Zealand social policies reduced state provision of health care, education, housing and income maintenance (Boston, Martin, Pallot & Walsh, 1996; Cheyne, O'Brien & Belgrave, 2000). Neo-liberal reforms led to economic upheaval and radical public sector restructuring which reduced universal health and social services. Refugees were not included as a priority group in social policies and strategies targeted at reducing health and social inequalities (Ministry of Health, 2001b, 2002d, 2005; Ministry of Health and University of Otago, 2006).

Secondly, from 1987 onwards, the New Zealand Government has systematically offered resettlement places to the most vulnerable refugees. The Labour Government undertook a comprehensive review of the Refugee Quota Programme in that year and increased the number of refugees arriving to an annual quota of 800—‘one of the highest refugee intakes per capita in the world’ (Department of Labour, 1994, p.25). This was later reduced to 750 places. The review authorised the Minister of Immigration to set numbers for specific high health and social needs categories within the quota (Department of Labour, 1994)—the three categories are ‘Women-at-risk’ 75 places, ‘Medical/Disabled’ cases 75 places and protection cases 600 places (UNHCR, 2002b).

Thirdly, as a result of the 1987 review, from 1992 the categories of the New Zealand Refugee Quota Programme changed from the selection of ‘specific national, ethnic and religious groups’ to ‘worldwide categories’ as this was considered ‘a fairer and more flexible means of enabling the Government to respond to the world’s refugee crises’ (Department of Labour, 1994, p.25). The profile of refugees in need of

resettlement from this time onwards has been increasingly characterised by new and diverse nationalities and by more complex health and social issues requiring specialised attention and treatment. Refugees resettled from this time have come mainly from: the countries of the Horn of Africa, Somalia, Eritrea, Ethiopia and the Sudan; the Middle East and West Asia, Afghanistan and Iran; as well as Burma and Sri Lanka (New Zealand Immigration Service (NZIS), 2004b).

This dramatic policy shift has significantly increased the numbers, dependency and diversity of refugees resettled since 1992. Refugees to New Zealand are not selected for their potential to integrate into the social and economic environment; rather those with high health and social needs are given priority (NZIS, 2004b; Worth, 2006). The New Zealand Government's stance is unusual because other resettlement countries give priority to those refugees with 'integration potential'. Most other resettlement countries provide medical screening to exclude those with high health needs prior to entry, but refugees to New Zealand are not required to undergo medical screening to exclude them from entry (UNHCR, 1998, 1999a, 1999b, 1999c, 1999d, 1999e, 1999f). Consequently, the role of the New Zealand health system in the integration of refugee groups is highlighted in this thesis.

Refugee studies is a new field of sociology which is attracting increasing international attention from theorists and researchers. This thesis focuses on two areas of interest within the field of refugee studies. The first area is the social exclusion of refugee groups and subsequent concerns about social cohesion in receiving societies. The second major interest addressed by the thesis, which has emerged during the research process, is the role of the state in the long-term integration of diverse refugee groups and their ethnic communities in second and subsequent generations.

New Zealand's Role in Refugee Resettlement

New Zealand's refugee resettlement programme fulfils the Government's commitment to the international humanitarian obligations and responsibilities of signatories to the United Nations 1951 *Convention Relating to the Status of Refugees* and to the 1967 *Protocol Relating to the Status of Refugees* (UN, 1951; UNHCR, 1967). New Zealand is one of nine countries that formally provide for the resettlement

of quota refugees. The other countries are Australia, Canada, the United States of America (USA), the Netherlands, Sweden, Denmark, Norway and Finland (UNHCR, 2002b, 2002c). In terms of the number of refugees accepted for resettlement, New Zealand now ranks fifth equal per capita per annum with Canada (New Zealand Parliamentary Library, 2001).

In addition to the United Nations mandated quota refugees, New Zealand has a general obligation to admit asylum seekers who arrive at a port of entry and who seek to have their claim for refugee status recognised (Immigration Act, 1987 & Amendments, 1999). Most asylum seekers are entitled to publicly funded health, welfare and education services (NZIS, 2004b, p. 52). Refugee status claimants cannot be removed or deported from New Zealand until their refugee status has been finally determined. Up to fifty per cent of asylum seekers will eventually gain residence in New Zealand as convention refugees (UNHCR, 2005). In this thesis, the complexities of the legal status of irregular migrants and of asylum seekers who have yet to receive refugee status will not be addressed, as these subjects are beyond the scope of the present study.

From World War II until 1987, New Zealand immigration policy effectively excluded all but a few carefully selected refugees (Ongley & Pearson, 1995). Prior to 1987, the small groups of refugees who were resettled proved to be the rare exceptions to an otherwise rigidly pro-British society and they were subject to assimilation (Belich, 2001; Ongley & Pearson, 1995). In spite of the humanitarianism for which New Zealand has long-held international repute, historically, proportionately far fewer refugees have been accepted compared to Canada, Australia and the United States (Ongley & Pearson, 1995). In terms of settlement support, New Zealand compares unfavourably with Canada and Australia, where the government sector plays a significant role in resourcing settlement needs in the initial and medium term phases (Ongley & Pearson, 1995). New Zealand is notable for 'a heavy reliance on a small and underfunded voluntary sector' to manage refugee settlement (Ongley & Pearson, 1995, p. 776).

New Zealand, while specifically targeting those refugees with high health and social needs has not developed a systematic means of integrating the newcomers. The adjustment difficulties that refugees face in integrating into New Zealand society have been documented since the arrival of Jewish refugees in the 1940s and 1950s (Beaglehole, 1988, 1989, 1990; Beaglehole & Levine, 1990). Since the early 1990s refugee communities have become increasingly problematised and racialised in New Zealand society, an issue to which I will return later in the thesis.

Refugees: A Special Case for Integration

Approximately 1,550 refugees are resettled in New Zealand every year (NZIS, 2004b, p. 44). While these represent small numbers, refugee groups represent cumulatively significant high health and social needs populations, particularly in the Auckland region. The Auckland District Health Board (ADHB, 2002a) estimates that a population of over 40,000 peoples from refugee backgrounds are resident in the greater Auckland region. Compared to other new migrants, refugee groups demonstrate a unique set of health and psychosocial needs as a result of both pre-and post-migration experiences. New Zealand studies indicate that refugees experience a relatively high rate of both physical and mental health problems on arrival (McLeod & Reeve, 2005; Mills, Yardley, Thomas, Blackmore, Pithie, Schroeder & Dickson, 2002). The poor physical and mental health in refugee groups reflects the population health patterns of countries of origin, the refugee experience of trauma, flight and deprivation, the conditions in refugee camps and little or no previous access to health care (Hargreaves, Holmes & Friedland, 2001). The psychological impacts of pre-migration experiences and post-migration, of unemployment, discrimination and a lack of family and social support act as significant long-term barriers to social and economic integration (Beiser, Johnson & Turner, 1993; Wilkinson & Marmot, 1998).

The state in New Zealand adopts a minimalist approach to integrating refugee groups. There is no overarching policy of institutional accommodation for refugee populations. Beyond the provision of initial settlement services there is little provision for the integration of refugee groups in social policy or public services. The targeted services that do exist are generally ad hoc responses to specific local contexts and are poorly resourced. In New Zealand, the questions that need to be addressed in

formulating state sponsored integration policies for refugees involve the development of an appropriate local multiculturalism and, critically, systemic inclusion in the public institutions. The indications are that long-term settlement outcomes for refugee groups are following the same patterns of poor health and social status that are occurring in other low socio-economic groups, particularly those of Pacific peoples (Fisk, 2003, Solomon, 1997, 1999).

Defining Refugees

The legal definition of a refugee is that of the United Nations 1951 *Convention Relating to the Status of Refugees*. Article 1 of the convention defines a refugee as:

... 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.

In 1967, the *Protocol Relating to the Status of Refugees* extended this definition to include displaced people who are seeking temporary refuge to escape political and social disruption. The New Zealand Government acceded to the 1951 Convention in 1960 and the 1967 Protocol in 1973 (Haines, 1999).

The New Zealand Immigration Service (2004b, p. 17) defines three groups of refugees:

...Quota refugees are people whom the United Nations High Commissioner for Refugees (UNHCR) has mandated as refugees offshore ... Convention refugees are former asylum seekers whose refugee status has been recognised in New Zealand by domestic authorities. Family reunion refugees have been

sponsored by refugee family members already residing in New Zealand.

Considerable literature has been devoted to questioning and challenging categories in the field of refugee and migration studies (Castles, 2003; 2004; Loughna, 2002; Russell, 2002; Turton, 2003a, 2003b). In Gibney's (2001) view, drawing clear distinctions between refugees and migrants has become ambiguous and controversial. From the legal category of 'refugee', the term 'forced migrant' has evolved as the name for a wider class of people (Turton, 2003b, p. 13). Commonly, in the academic literature, little distinction is made between categories of different kinds of forced migrants including refugees, asylum seekers, humanitarian migrants, migrants from refugee-producing countries and economic migrants (Richmond, 1994, 2001; Van Hear, 1998; Crisp, 1999).

Refugee studies has been established as a distinct field within the broader arena of migration studies because refugees have exceptional circumstances and needs compared to other newcomers. By comparison with migrants, refugees are 'fleeing from much *more* [italics in text] compelling, immediate and life-threatening circumstances, such as a civil war, an imminent political threat involving torture, imprisonment or other forms of persecution' and will therefore face the greatest challenges to integrating into receiving societies (Cohen, 1994, p.73). There are significant differences socially, psychologically and economically between the groups refugees and migrants, although there are theoretical and methodological difficulties in trying to separate the two groups. Most academics use the generic term 'immigrants' in theories of immigrant incorporation to include refugees (Banting & Kymlicka, 2003; Bauböck, 2001; Kymlicka, 2001a; Samers, 1998; Sassen, 1998a, 1998b; Soysal, 1994). For example, Samers (1998, p. 124) uses the terms 'immigrants and ethnic minorities' broadly in the context of the European Union to include refugees and asylum seekers and their settled ethnic communities.

There is no adequate term, Samers (1998, p. 125) argues, to adequately describe 'the vastly complex interweaving of legislation, social networks, and psychological spaces

which [refugees], immigrants/‘ethnic minorities’ inhabit and produce’. However, it is vital that the comparative disadvantage of refugees is recognised in the social policies of the receiving society. Although it is argued that the use of the generic term ‘immigrants’ does not adequately reflect or represent the social and economic issues of refugees, in places the terms ‘immigrants’ or ‘migrants’ will appear in reference to theoretical perspectives, such as Kymlicka’s (1995a, 2001a) ‘immigrant multiculturalism’, that include peoples from both refugee and immigrant backgrounds.

The implications of this discussion for the study are that it is important to distinguish legally between an immigrant and a refugee, or between those who leave their countries voluntarily and those who are forced to leave because of human rights violations. This distinction is important in terms of the significantly poorer settlement opportunities and outcomes for refugees in receiving societies. However, for the purposes of this study, which is concerned with refugees as a health care population, it is necessary to include not only those who meet the legal definition but, also, others who have been exposed to the refugee experience—that is, migrants from refugee producing countries. In this sense, some groups of migrants are ‘*refugee-like*’ in that they have come from the same regions of the world as refugees do, and have often moved because of the same fear of persecution (Potocky-Tripodi, 2002, p. 7). Further, there is overlap between some groups of refugees and migrants when referring to the recognition of cultural and religious diversity in receiving societies.

Towards a Sociology of Refugee Integration

Refugee resettlement is the most challenging component of migration faced by receiving societies. A number of studies indicate that economic poverty is an endemic and growing problem for refugees in western receiving states (DeVoretz, Pivnenko & Beiser 2004; Hiebert, Collins & Spoonley, 2003; Jenson & Papillon, 2001; Papillon, 2002; Schierup, Hansen & Castles, 2006; Shields, 2003). Papillon (2002) relates this trend largely to neo-liberal welfare and social reforms which have weakened the social safety net and to marked discrimination in the labour market against ‘visible minorities’. Studying the integration of refugees in the health system raises broader theoretical questions about New Zealand society, chiefly, the social, cultural and

economic frameworks with which to incorporate newcomers. In this context, Penninx (2000) usefully proposes an analytical tool based on the concept of 'citizenship', that is useful to theorising integration in this study. In Penninx's (2000) conceptualisation citizenship is divided into juridical/political, socio-economic and cultural/religious dimensions.

For many receiving societies, migration has been the key component of citizenship changes in the last three decades (Bauböck, 2004; Castles, 2003; Kymlicka, 2001a; Turner, 1993). Australia, Canada and the United States liberalised their immigration policies in the late 1960s. The expansion of citizenship rights in Canada and Australia in the 1970s took the form of an official multiculturalism, which was embedded within the policies and practices of all public service institutions. In the 1970s, New Zealand's move from a colonial to a post-colonial society took the form of a bicultural partnership between Maori and the Crown (Fleras & Spoonley, 1999). Unlike Australia and Canada, New Zealand has 'no multicultural policy framework to guide public policy development and political debate for both host and [refugee] ... communities' (Spoonley, 2004). In this sense, it is acknowledged that New Zealand lags thirty years behind both Canada and Australia in providing an inclusive model of membership for any newcomers (Spoonley, 2004).

The chief sociological concern of this thesis is a conceptual and theoretical understanding of integration for refugees and what this means in the context of citizenship. The meaning of the term 'integration' will be discussed later in the chapter. Of particular concern in the New Zealand setting is that refugees, although entitled to formal citizenship rights, remain substantively—socially, economically and culturally—excluded from participation. On the one hand, refugees are in a formal sense members of New Zealand society but on the other, they are rarely discussed in social policy. The New Zealand Government offers places for those who are not accepted by other resettlement countries—because of their poor integration potential or medical conditions and disabilities—but provides comparatively lower levels of support in terms of health, welfare and employment assistance (Hamilton, Anderson, Frater-Mathieson, Loewen & Moore, 2001; Humpage, 2002; Hunt, 2003; Nash et al., 2006; Zwart, 2001). On arrival, refugees are given minimal settlement assistance with limited language services, education and employment opportunities. Therefore, poor

social outcomes for refugee communities are becoming a characteristic of New Zealand society (Department of Labour, 2002; Fisk, 2003).

Refugee studies, as a subset of the larger field of migration studies is a relatively new area of sociological interest—especially in New Zealand. The phenomenon of refugee resettlement and the consequent issues related to the integration of refugees are of increasing sociological interest internationally (Castles, 2003; Papillon, 2002; Schierup, Hansen & Castles, 2006; Zetter, Griffiths, Sigona & Hauser, 2002). In this context a growing number of studies are concerned with the social exclusion of refugees in receiving societies (Castles, Korac, Vasta & Vertovec, 2002; Papillon, 2002; Samers, 1998; Schierup et al., 2006). Papillon (2002) has noted growing poverty in refugees resettled in Canada between 1991 and 2001, with serious disadvantage in particular in ‘visible minority’ groups. British studies of refugee integration find that refugees encounter racism and negative stereotyping—which is more difficult to overcome than language barriers (Castles et al., 2002). Zetter et al., (2002, p.136) are critical of an emphasis in the European Union Member States (EUMS) on settlement outcomes rather than on the inputs and processes of policies and instruments to promote integration in areas such as labour market participation. The most complex challenge is to tackle systemic inputs, that is, integrating refugees into the policies, structures, instruments and organisational frameworks of receiving societies. Few studies have focused on modes of integration for refugees that promote full membership in receiving societies.

In the context of the systemic integration of refugee groups in New Zealand society, there are three main issues. The first is that the Government specifically selects refugees with high health and social needs but there is no alignment between the refugee policy (Department of Labour, 1994) and New Zealand reducing inequalities strategies (Ministry of Health, 2002d; Ministry of Social Development, 2005a, 2005b). The second is that strategies aimed at reducing inequalities are based on ethnic group needs which do not acknowledge the presence of refugee peoples and overlook refugees as a high priority group. Thirdly, the inclusion of refugee groups in New Zealand social policy as a priority population is integral to improving health, social and employment outcomes in the long-term.

Refugees are numbered among the poorest groups in New Zealand society according to the Ministry of Social Development (MSD, 2002a). As a means of critically analysing refugee integration in the study, Samers' (1998) dialectical framework for understanding the concept of social exclusion is used. That is, the processes 'associated with real (material) exclusion, and those associated with discursive exclusion which may have real (material) effects' (Samers, 1998, p. 126). The distinction between material and discursive exclusion is an important one, both for the discussion of citizenship and for the thesis. As a template for analysis, Samers (1998) draws up lists of both material and discursive exclusions. Material exclusions include: employment and employment training; access to health and social services; adequate housing and education; civic and community participation; and exclusion from recreational and leisure activities and spaces. Among the types of discursive exclusions are those by: academics '(the question of representation; social 'invisibility' in reports and surveys)'; government and policy-makers '(social 'invisibility' in reports and surveys; inability of 'detection')'; and racism and xenophobia by housing, health and social services (Samers, 1998, p. 126). While cultural exclusion is missing from Samer's (1998) extensive list, it can be gathered that there are multiple social exclusions for refugees.

The discursive exclusion of refugees in New Zealand social surveys is two-fold. Studies of poverty and deprivation have not explicitly included peoples from refugee backgrounds (Cheyne, O'Brien & Belgrave 2000; Child Poverty Action Group, 2003; Howden-Chapman, 1999; Salmond, Crampton & Sutton, 1998). Secondly, from the late 1990s, social scientists and health researchers in New Zealand have focused greater attention on the role that access to public services plays in the social exclusion of particular populations but not of refugee peoples (Howden-Chapman, 1999; Ministry of Health, 2001b, 2002b, 2002c, 2002d). I will argue that refugees are a socially excluded group within the wider group migrants in that they face 'multidimensional disadvantage' in receiving societies (Samers, 1998, p. 126). Key sites for the social exclusion of refugees in New Zealand are in employment and equitable participation in universal public services.

Defining Integration and Social Exclusion

Integration is a key concept in this thesis. This section indicates how the terms

integration and social exclusion will be used. The concepts ‘integration’ and ‘social exclusion’, used in the context of this study, are ‘mirrored concepts’ in that ‘social exclusion’ arises from a lack of integration and a failure to provide real opportunities for ‘integration’ (ECRE, 2001a; Penninx, 2003b; Samers, 1998). It should be noted here that the term integration is contested in the literature. For example, the European Council on Refugees and Exiles highlights the way that the term ‘integration’ has often been used to mean assimilation (ECRE, 2001a, p.36). As Bauböck (2005) explains, the term ‘integration’ is preferable to alternative terms such as inclusion (Young, 2002a) or incorporation (Soysal, 1994). Bauböck’s (2005) rationale for this is that the terms inclusion and incorporation are generally only used transitively and not in the sense of the long-term societal accommodation of newcomers. That is, ‘societies include or incorporate migrants, but these do not include or incorporate themselves’ (Bauböck, 2005, p.2).

Furthermore, there is a question in the literature about how we explain the difference between refugees not being ‘integrated’ and being ‘socially excluded’ (Castles, Korac, Vasta & Vertovec, 2002). How these terms are defined is critical to responding to this question. Penninx (2005, p.1) importantly, defines integration as:

... the process of becoming an accepted part of society. There are two parties involved in integration processes: the immigrants, with their particular characteristics, efforts and adaptation and the receiving society with its reactions to newcomers. The interaction between the two determines the direction and the ultimate outcome of the integration process. They are, however, unequal partners. The receiving society, its institutions, structures and the ways it reacts to newcomers is much more decisive for the outcome of the process.

In Bauböck’s (2005, p2) view:

Integration in a broad sense refers to a condition of societal cohesion as well as to a process of inclusion of

outsiders or newcomers. In contrast with ‘assimilation’, integration in the latter sense is generally defined as a two-way process of interaction between given institutions of a society and those who gain access that will result in changing the institutional framework and the modes of societal cohesion...

There are few definitions that address integration from a refugee perspective though and even fewer that specifically address social exclusion in refugee groups in receiving societies. A useful definition of refugee integration is the process which ECRE (2001a, p.36) describes in its lengthy definition, as a:

- a) dynamic and two-way: it places demands on both receiving societies and the individuals and/or the communities concerned. From a refugee perspective, integration requires preparedness to adapt to the lifestyle of the host society without having to lose one’s own cultural identity. From the point of view of the receiving society, it requires a willingness to adapt public institutions to changes in the population profile, accept refugees as part of the national community, and take action to facilitate access to resources and decision making processes.
- b) Long-term: from a psychological perspective, it often starts at the time of arrival in the country of final destination and is concluded when a refugee becomes an active member of that society from a legal, social, economic, educational and cultural perspective.

Multi-dimensional: it relates both to the conditions for and actual participation in all aspects of economic, social, cultural, civil and political life of the country of durable

asylum as well as to refugees' own perception of acceptance by and membership in the host society.

Both integration and social exclusion are multi-dimensional concepts that should be understood dialectically (Samers, 1998). The usefulness of Samers (1998) concept of social exclusion to this study is that it can be shown that for groups such as refugees the specific dimensions of social exclusion will determine particular social outcomes. In the New Zealand context, rather than providing a new framework, social exclusion could be used in social policy as a further conceptual tool that could sit alongside the more familiar concept of 'poverty' (Peace, 2001, p.25). In this sense, the concepts of integration and social exclusion, which have been identified in this section, could become further ways of describing the collective processes that work to deprive refugees of access to opportunities to participate fully in New Zealand society.

Thesis Structure

This thesis is organised into fourteen chapters. The first half of the thesis, chapters one to nine, comprises the historical, political, theoretical and methodological underpinning of the thesis. Following the introductory chapter, chapter two outlines the history of refugee resettlement in New Zealand. To give a context to contemporary questions of refugee integration, an outline of the key shifts in refugee policies that have occurred in New Zealand in the recent past is given. New Zealand, until 1987 when the Immigration Act was introduced, practiced discriminatory immigration policies based on limiting the numbers of non-British migrants. Prior to 1987, the few exceptions to New Zealand's whites/British only immigration policy, were: small groups of refugees from Eastern Europe; Chinese refugees from Hong Kong and Indonesia; Ugandan Asians; Chileans; South East Asians from Vietnam; Cambodia and Laos; Iranian Baha'is and Iraqi Assyrian Christians. Many refugee families were dispersed around New Zealand with the intention of achieving rapid assimilation.

Chapter three explains the qualitative research methodology used in the study. A critical social theoretical approach is taken to the subject of integrating refugees into New Zealand health services. The method of analysis used is critical hermeneutics. The study has a multi-method focus using a variety of empirical materials, including

the findings of quantitative and qualitative research studies, historical material, social policy, interviews, media analysis and personal observations. In depth, semi-structured interviews were conducted with twenty-eight participants, working in a range of Auckland health care services. The services included: Public Health; the Plunket Society; Primary Health Organisations; Community Child and Family Health Services; Disability Support Services; mental health services; women's health services; HIV/AIDS services; drug and alcohol services; hearing and vision services; health promotion programmes; and community care agencies. Additionally, three focus groups were held, two for those working in Child health services and one for a health promotion service.

In chapter four, refugees will be used as a special case to test liberal democratic conceptions of citizenship in receiving societies. The concept of citizenship provides a useful analytical framework with which to make comparisons between the integration regimes of various receiving states. Understood in the broadest sense, the terms of citizenship determine the conditions of integration, or social exclusion, for refugee groups. Refugees offer some unique theoretical challenges to conceptions of immigrant integration. As groups admitted on humanitarian grounds, they offer neither economic advantage nor do they have, in most cases, cultural or historic similarities to the receiving society. The approach to restructuring citizenship regimes to enhance refugee integration that is suggested uses Penninx's (2004) economic, social, cultural and political dimensions. Samers (1998) social exclusion framework is a key conceptual paradigm for a critical analysis of refugee integration regimes. The concept of social exclusion defines the problem of refugee integration as the failure to achieve equality in the civil, political, social and cultural rights of citizenship.

Defenders of immigrant multiculturalism claim that immigrant groups have a valid claim not only to non-discrimination—contained in the human rights legislation of most liberal democratic societies—but also to explicit 'accommodation, recognition, and representation within the institutions of the larger society' (Kymlicka, 2001a, p.41). Within liberal democratic conceptions of minority rights, the special accommodations that refugees require are under theorised. These include: Bauböck's (1996a, 1996b) 'cultural minority rights for immigrants'; Kymlicka's (2001a)

'immigrant multiculturalism'; Young's (2002a) 'differentiated citizenship'; and Soysal's (1994) 'corporatist membership models'. There has been insufficient recognition within these theoretical perspectives that within the broad category 'immigrants', refugees are a significantly different and disadvantaged group. Concerns about declining refugee settlement outcomes have given rise to a revisioning of social and cultural citizenship in receiving societies (Castles et al., 2002; Papillon, 2002; Schierup et al., 2006; Zetter et al., 2002).

Chapters five to nine address the social, economic, cultural and religious dimensions of citizenship for refugees in New Zealand. In the chapters, the responsiveness of central government and its institutions to refugee integration are critiqued. For this purpose, Samer's (1998) social exclusion perspective and Penninx's (2000, 2003a, 2004) model of social, economic and cultural integration are used. The dialectical relationship between material and discursive exclusions and the relationship of social exclusion to social outcomes for refugees in New Zealand is demonstrated. Chapters five and six focus on social and economic dimensions because concerns about poor settlement outcomes in refugee groups have been highlighted in a number of Department of Labour and Ministry of Social Development reports (Fisk, 2003; Lockhart, 2001; Ministry of Social Development, 2002; NZIS, 2001d, 2001e, 2001f). These reports have raised governmental concerns about the management of refugee settlement (Fisk, 2003; Minister of Immigration, 2002; Ministry of Social Development, 2002). In 2003, a paper titled *The Immigration Settlement Strategy: A Programme of Action for Settlement Outcomes that Promote Social Cohesion*, was written jointly by the Department of Labour (DoL) and the Ministry of Social Development (MSD). The Cabinet paper, which is largely procedural, describes a general approach for central government to improve settlement outcomes for refugees in New Zealand. The 'whole of government' approach used focuses primarily on improved coordination and information sharing between government and non-government agencies (Department of Labour & Ministry of Social Development, 2003). Labour market participation, as an instrumental means of integrating refugee groups is prioritised in the strategy (Department of Labour, 2004a). However, broader structural support for integration through cultural and social policies and institutional accommodations has received little attention.

Chapter seven considers social and cultural citizenship for refugees in the context of access to health rights in New Zealand. It is argued that although refugees have the same entitlements as all New Zealanders to free, publicly provided health care and to subsidised primary health care, the health system is exclusionary for refugees as social and cultural citizens. In Chapter eight, the cultural and religious dimensions of citizenship for refugees are considered in the context of the responsiveness of the health system to accommodating cultural diversity. New Zealand society faces some unique political and cultural tensions upon which the integration of refugees in health and social service provision is contingent. Namely, that in the context of the bicultural partnership between Maori and the Crown, the multicultural/transcultural paradigms for health care that have been adopted by other receiving societies, are problematised (Bartley & Spoonley, 2006; Fleras & Spoonley, 1999).

The second half of the thesis (Chapters nine to fourteen) provides an analysis of the data collected from interviews with health care providers. The data analysis chapters enable a critical examination of the relationship between refugee and social policy in New Zealand in the context of the liberal democratic citizenship framework used in the thesis. The social processes uncovered during the data analysis provide the logic for applying Penninx's (2000, 2004) model of integration and Samers (1998) theoretical critique of social exclusion. The data analysis chapters are organised around the five interlinking processes that relate to the integration/social exclusion of refugees in health care that emerge from participant interviews. These processes are mapped diagrammatically in Figure 9.1: 'Social and Cultural Citizenship Rights for Refugees in New Zealand Health Services'.

The final chapter combines intersecting theoretical strands with the research findings in concluding that there is a need for the development of a substantive citizenship for refugees that takes account not only of cultural differences but also of the considerable inequities that exist between refugees and other New Zealand populations. Poor refugee settlement outcomes in the last two decades indicate that there is a need for more inclusive forms of social, cultural and economic membership than are currently offered.

CHAPTER TWO

THE HISTORY OF REFUGEE RESETTLEMENT IN NEW ZEALAND

Introduction

In response to changing global circumstances and needs, New Zealand's refugee policy has evolved over time. New Zealand's resettlement programme was significantly reviewed in 1987 under the Fourth Labour Government with the adoption, for the first time, of a quota of 750 places and the prioritisation of refugees with the highest health and social needs. The refugee resettlement programme is now targeted to those in greatest need of resettlement, with particular attention to emergency cases, medical/disabled cases, and women-at-risk. No refugee is excluded from entry to New Zealand on the basis of medical conditions or disabilities. This blanket humanitarian policy is in marked contrast to the policies of other refugee resettlement countries. In New Zealand, little theoretical attention has been given to the impact that changes in the political, cultural and economic climate, over the 50 years since formal refugee resettlement began, have had on the quality of settlement offered. The aim of this chapter is to outline the historic background to the refugee integration issues that challenge postcolonial New Zealand society today. The chapter is largely descriptive, with a focus on the refugee policies, past and present, which have led to the questioning of the role of the state regarding the management of refugee integration.

Refugees: A Challenge to Pro-British Immigration Policy

From the formal inception of the refugee resettlement programme in 1944, New Zealand has resettled over 26,000 refugees and displaced persons (NZIS, 2004b). The major groups of refugees resettled in New Zealand from 1944 to 2006 are shown in Appendix One. Historically, the question of which refugee groups were accepted for resettlement, and how New Zealanders were prepared to help is revealing. Prior to, and during, World War II potential refugees faced official attitudes towards non-British peoples that reflected the racist pro-British immigration policies of the time (Beaglehole, 1988). By comparison with Australia and Canada, the New Zealand Government imposed more severe restrictions on the entrance of refugees (Ongley &

Pearson, 1995). After World War II New Zealand maintained a cautious approach to refugee resettlement, accepting in total fewer than 5,000 European refugees; proportionately two-thirds less than Australia (Ongley & Pearson, 1995). New Zealand foreign policy, which was shaped by anti-communism, was the major influence on the groups resettled in New Zealand in the Post World War II Cold War environment (McKinnon, 1993). Those refugees who were resettled in New Zealand society were subject to assimilation (Beaglehole, 1988; Belich, 2001). Until 1992, the New Zealand Refugee Quota Programme was narrowly selective in terms of the national, ethnic and religious groups that were accepted for resettlement (Department of Labour, 1994).

Immigration Restrictions 1933-1939

Pro-British ethnocentrism has been a central feature of New Zealand's immigration policies from the 1880s operating as an early deterrent to the entrance of European refugees (Beaglehole, 1988; Belich, 2001; Spoonley, 2003b). As Belich (2001, p. 223) states, 'New Zealand immigration policy discriminated positively in favour of Britons; it discriminated negatively against most other groups'. Refugee immigration policy before World War II was determined by the Immigration Restriction Amendment Act 1931, which aimed at preventing the entry of non-Britons. The effect of the Act was to block European 'aliens', including Jewish refugees, from entering New Zealand unless they had guaranteed employment, considerable capital, or work skills that New Zealanders could not provide (Beaglehole, 1988 p. 14). Thirty-eight German Jews met these criteria and migrated to New Zealand between 1931 and 1935. The Immigration Restriction Amendment Act 1931 allowed free entry to immigrants of British birth and descent, whereas entry for those of any other descent required an entry permit.

From 1936 to 1940 the New Zealand Government declined numerous applications from Jews trying to escape Nazi persecution in Europe (Beaglehole, 1988). New Zealand, unlike Australia or the United States, did not have a quota for refugees and the interpretation of the guidelines adopted for processing migrant applications ensured that most refugees were prevented from entering the country. According to one estimate 50,000 refugees applied for permits to enter New Zealand prior to World War II—of whom approximately a thousand were admitted (Beaglehole, 1988, p. 15).

Refugee acceptance was supposedly based on whether ‘Jewish refugees from Europe were of a suitable type’ (Beaglehole, 1988, p. 21). Beaglehole (1988 p. 21) cites Polson, a Member of Parliament in 1939, who argued, based on an ‘excellent authority’, that ‘the number of people of Jewish extraction from the ghettos of Europe who are coming here are not of the type that will make good citizens of this country’. Nash, Minister of Customs during the pre-war period, held the view that Jewish refugees were not assimilable and would provoke anti-Semitism in New Zealand (Sinclair, 1976).

Arguably, until the review in 1987, New Zealand’s policy on the refugees selected for resettlement was that (Walter Nash cited in Beaglehole, 1988, p. 16):

... the refugees coming to this country should be of a type easily assimilable. For the sake of the refugees themselves this must be a prior consideration. This question of adjustment is possibly the most difficult. We must never create a situation where there is any antagonism whatsoever in our country to refugees who have come to our shores.

The refugee policy reflected the local racism that prevailed towards non-British immigrants. Jewish refugees were viewed as both a commercial threat to New Zealand’s professional and business associations and, at other times, as having skills unsuited to the New Zealand workforce. When skills were suitable, the trade union movement was opposed to Jewish refugees whom they considered would take work from New Zealanders (Beaglehole, 1988, p. 22). Beaglehole (1988 p. 22) concludes that in the circumstances prevailing in the 1930s it was difficult for the New Zealand Government to adopt a more generous policy because of:

... long-standing opposition to non-British immigration, the Depression, the enormous fear of unemployment, support for restriction from professional and working class groups, and the resistance to importing to New

Zealand problems of the Old World, such as anti-semitism ...

In the years before the Second World War, the New Zealand Government did not want Jewish refugees and did as little as possible to help, including declining the applications for the entry of relatives of Jewish families resident in New Zealand (Beaglehole, 1988, p. 23).

Refugee resettlement was of minor interest to the First Labour Government elected in 1935. During this period, Social Credit, an anti-Semitic political party, acted as a pressure group (Spoonley, 1987). The Labour Government was exclusively preoccupied with the welfare of New Zealanders. Many positive changes were brought about in the universal welfare state that was introduced. But few changes were wrought in the cultural climate which remained largely 'suspicious of foreigners and of diversity' (Beaglehole, 1988, p.14). Immigration policies continued to be criticised by those favouring on the one hand, more restrictions and on the other, advocating greater humanitarianism towards European refugees. Groups such as the League of Nations Union and refugee committees that had formed in the main centres lobbied Government to do more to assist refugees (Beaglehole, 1988). However, these groups had few members, were easy to disregard and elicited little sympathy from the general public. The situation of refugees prior to World War II did not alter the Government view that Jews and Eastern Europeans were undesirable settlers.

World War II: Finding Suitable Refugees

In June 1940, with the declaration of war, the New Zealand Government blocked the entrance of refugees by prohibiting entry permits to 'aliens'—those from enemy countries (Beaglehole, 1988, p. 89). With the passing of the Aliens Emergency Regulations in October 1940 the Government could deport, intern, and set up tribunals to investigate and classify aliens. 'Aliens', among them Jewish refugees, had to register with the police and, in a restricted category, needed permits if moving more than 24 miles from their usual residence. Thus:

... refugees' hopes for a classification system which would distinguish between refugees from Hitler and

other aliens, and which would clear them from suspicion of disloyalty to New Zealand, were not realised. The system which was set up was based predominantly on national origin and classified both refugees and Nazi sympathisers as enemy aliens ... (Beaglehole, 1988, p. 89).

After 1943, the New Zealand Government was unwilling to accept refugees from displaced person's camps in Europe, but agreed to accept a limited number of displaced persons on the sole condition that it could select the categories regarded as least unsuitable. Ministerial correspondence stressed that Jews and Slavs should be excluded and only orphaned children and young single people (who could work in a narrow band of non professional occupations) should be given priority (Beaglehole, 1988, p.6). The most desirable refugees (Beaglehole, 1988, p.6):

... were unskilled young people willing to work on farms, on hydroschemes and on logging operations, as domestic workers, and in hospitals. Nurses were welcomed, but not doctors or dentists... Orphans between the ages of five and twelve years were greatly desired, because 'from the point of view of assimilation, children present the least problems'.

Further, refugees should be of a racial type considered to be readily assimilable, namely those from the Baltic States of Estonia, Lithuania and Latvia (Beaglehole, 1988, p.6). However, there were too few 'suitable types' 'to fill the quota. From 1948 to 1952, 4,500 displaced peoples including Russians, Poles, Yugoslavs, Hungarians, Czechoslovaks, Bulgarians, Greeks, Ukrainian and some Jewish refugees were resettled in New Zealand (Department of Labour, 1994, p. 16).

The Beginning of Formal Refugee Resettlement

The Arrival of Polish Children 1944

New Zealand's refugee resettlement programme began in 1944 with the arrival of 733 Polish children—many of whom were orphans—and 105 accompanying adults. In

contrast to later refugee resettlement programmes, the offer of refuge for this first group was a temporary measure only. The initiative resulted from the work of Countess Maria Wodzicka who was the Polish Red Cross delegate in New Zealand and wife of the Polish Consul-General (Department of Labour, 1994). Countess Wodzicka and her friend Janet Fraser, the wife of the Labour Prime Minister Peter Fraser, succeeded in convincing Fraser to offer to receive up to 700 Polish refugees so that they could recuperate. Fraser did so as a matter of 'christian philanthropy and kindness' (Department of Labour, 1994 p. 16). The intake of Polish refugees was intended only as a temporary refuge for the duration of the war and, for five years, they stayed in an immigration camp in Pahiatua (Department of Labour, 1994, p. 16). At the end of World War II, when Poland became a satellite of the Soviet Union, Kristine Tomasyk recounts, 'we were not to return to our homeland. We felt betrayed and angry. It was specially difficult because we never chose to leave Poland—we were forcibly deported' (Department of Labour, 1994, p. 40). The Polish children were dispersed throughout New Zealand; this was the beginning of New Zealand's ongoing resettlement programme.

Post World War II and the Cold War Era

The Second World War, and the immediate post war period, produced the largest displacement of peoples in modern history with more than 70 million refugees and displaced people (UNHCR, 2000a, p.13). In addition to the widespread displacement in Europe, millions of Chinese people had been displaced in Japanese occupied territories in China. In 1947, a new body, the International Refugee Organisation (IRO), was established when the United Nations replaced the League of Nations. The International Refugee Organisation's work was limited to assisting European refugees. The IRO's mandate was to protect existing refugee groups and a new category, displaced persons—the approximately 21 million refugees dispersed throughout Europe in the wake of World War II. The initial objective of the IRO was to repatriate refugees but with the political tensions that preceded the Cold War the organisation accepted that many had 'valid objections' to returning home (UNHCR, 2000a). Efforts to resettle displaced persons therefore, 'matched the desire of Governments to facilitate the movement of certain people for foreign and domestic policy reasons' (UNHCR, 1998, p. 6). Over a period of five years, from 1947 to 1951,

the IRO resettled well over a million people—four-fifths of them outside Europe. The Office of the United Nations High Commissioner for Refugees (UNHCR) replaced the IRO in 1951, who by this time, had established their principal mandate as being the international protection of, and the seeking of permanent solutions for, the problems of refugees. The establishment of the UNHCR and formal refugee resettlement programmes coincided with the onset of the Cold War and a tense East-West environment (UNHCR, 1998). As Gibney (2001b, p. 6) states:

During the cold war refugee admission was primarily a foreign policy matter for Western states. The widespread view that accepting refugees took the glitter off communist regimes made their entrance central to the goals of controlling Soviet expansion and avoiding nuclear annihilation. By portraying refugee admission as an issue of *raison d'etat*, Western elites were able to carve out a significant degree of autonomy from the domestic politics of their states. Such autonomy was necessary because post War public opinion in Western states was generally xenophobic and favourable to tight entrance restrictions on both refugees and immigrants.

The focus at this time was Eurocentric. The new organisation was clearly intended by western governments to provide a means of resettling refugees escaping the communist regimes of Eastern bloc countries (UNHCR, 2000a, p. 5). The UNHCR, during its early years, made extensive use of resettlement as a means of clearing the European refugee camps after World War II (UNHCR, 1998, p. 6). In the Cold War atmosphere, there were political motivations in the resettlement of refugees who were 'firmly anti-Soviet', as were many of the displaced persons remaining in refugee camps in Europe (Cohen, 1994, p. 70).

For New Zealand's two main parties—Labour prior to 1949 and National after—foreign policy was shaped by anti-communism and traditional connections with the United Kingdom. Both parties placed relations with Britain, the Commonwealth, and

beyond that, the United Nations, at the centre of foreign policy and saw this as a model of international relations generally (McKinnon, 1993, p. 112). The difference between the two parties in terms of foreign policy was that while Fraser (the former Labour Prime Minister) and Nash (the Minister of Finance) had had an intense interest in international affairs, Holland (the new National Prime Minister), and most of his colleagues, did not. McKinnon (1993, p. 112) characterises the National Government's attitude to foreign policy in stating that:

...necessity sometimes dictated that the [National] government reach out beyond the familiar world of the Commonwealth...But not always. Parsimony remained a more powerful imperative than participation.

Most New Zealanders had little interest in external issues such as refugee resettlement. The prevailing philosophy on matters of foreign relations and participation in international affairs was that:

...if New Zealand interests were not directly engaged, why waste resources? The cost of foreign missions, of the contribution to the United Nations,...were all bugbears at different times (McKinnon, 1993, p. 116).

The Department of External Affairs (established by the Labour Government in 1943) and New Zealand representation at the United Nations continued under National. However, while the National Party had an 'interest based notion of foreign policy', it did not embrace the Department's commitment to internationalism and participation (McKinnon, 1993, p. 148). For this reason New Zealand played a minor role in refugee resettlement until the late 1980s.

Displaced Persons 1949-1952

Two years after the war was over, there were still 1,100,000 refugees and displaced persons in Europe; many were living in camps supervised by the allied forces in

Germany, Austria and Italy (Department of Labour, 1994, p. 16). These were the victims of forced deportations, survivors of concentration camps and those who had fled from advancing enemy armies. The United States took over 30 per cent of the total; Australia, Israel, Canada and a number of Latin American countries, took the rest. The economic gains to be made from increasing the labour force were a major motivation in the acceptance of refugees in these countries (UNHCR, 2000a). New Zealand accepted 4,582 European refugees in four intakes between 1949 and 1952 (Department of Labour, 1994 p.16). This was two-thirds less than Australia, proportionate to population and was in Belich's (2001, p. 532) view, 'mean-minded' and indicative of the continued privileging of British immigrants over all others.

By comparison with New Zealand, other western nations responded swiftly to the plight of refugees fleeing the Soviet suppression of the uprising against Hungary's Communist Government in 1956. The National Government agreed to accept 1,117 Hungarian refugees (Department of Labour, 1994). These refugees, though carefully selected to give the appearance of fulfilling international and humanitarian obligations, were mainly young single people chosen to fill non-professional occupations (Beaglehole, 1988 p. 6).

'Handicapped' Refugees 1959

Resettling 'handicapped' refugees from World War II was to become a lengthy and prolonged process in which the New Zealand Government was to play a significant role (UNHCR, 1959). In 1959, around 32,000 refugees remained displaced in Europe. Many had been living in refugee camps since the Second World War. One third of this group were families who had at least one member who was placed in the 'handicapped' category and considered 'unsuitable' for selection by resettlement countries as they were classified as 'uneconomic' and therefore, a potential burden on the state (Department of Labour, 1994, p. 17). The term 'handicapped' was used to categorise refugees who were medically, physically or 'socially handicapped'—that is, refugees who were elderly, unskilled or who had large numbers of dependent children (Department of Labour, 1994, p. 17).

The United Nations intensified its efforts to resettle this remaining group, and the new Labour Government—elected in 1957 and led by Prime Minister Walter Nash—was to become the first country to accept disabled refugees and their families. Felix Schnyder, the United Nations Secretary-General, was to note that ‘the international significance ... of New Zealand’s humanitarian action ... [went] far beyond that of this particular scheme. In fact it set off a whole chain reaction which saw a succession of overseas countries follow suit with similar programmes’ (Department of Labour, 1994, p. 18). At the time, New Zealand had one of the most developed social security systems in the world and undertook to provide for the welfare of families (Sinclair, 1976). The New Zealand Government did not ask, as did other resettlement countries, that private individuals sponsor disabled refugees in order to guarantee that they would not become a burden on the state. While the New Zealand Government received international recognition for this humanitarian gesture, it must also be remembered that the same Government had, during the 1930s, refused entry to all but a few Jewish refugees.

The precedent that New Zealand set was recognised by Dag Hammarskjöld, the Secretary-General of the United Nations (cited in the Department of Labour, 1994, p. 18) who stated that:

... [t]his evolution in thinking has helped to remove the dilemma that has confronted many refugee families in the past, ie, either to emigrate leaving one member of the family behind or to reject a resettlement opportunity and to remain together in the camp. It has also furthered the reunion of families already separated for such reasons, by allowing aged or sick refugees to rejoin relatives and friends already established abroad.

In 1980, Binzegger writing on *New Zealand’s Policy on Refugees* for the New Zealand Institute of International Affairs, noted that leading the world in resettling disabled refugees was an example of New Zealand’s influence on international action in certain circumstances. He stated that ‘while New Zealand has little impact on wars

and military dispositions, its potential in the humanitarian field is considerably greater' (Binzegger cited in Department of Labour, 1994, p. 18).

By 1963, two hundred refugee families in the disabled category had been resettled in New Zealand and had found work. The reportedly positive resettlement outcomes for these families and the international acclaim from the UNHCR ensured that New Zealand has continued to commit to resettling 10 per cent of the annual refugee quota, that is, 75 people in the medical/disabled refugee category (Department of Labour 1994, p.18).

Resettlement from 1960 to 1989

Refugee resettlement between 1960 and 1972 reflected anti-communist interests and, with minor exceptions, a continuing Eurocentric preference in the refugee groups resettled. After 1972, the focus shifted to refugees from postcolonial movements in the developing world, although the numbers resettled remained minimal and a policy of dispersal ensured assimilation.

The National Prime Minister Keith Holyoake, who held office from 1960 until 1972, had no particular interest in foreign affairs (Sinclair, 1976). It was well known to the UNHCR that New Zealand had white immigration policies and was therefore resistant to accepting refugees fleeing the Communist Government in China from the 1940s (Department of Labour, 1994). Holyoake's agreement in 1962 to accept 20 Chinese orphans from refugee camps in Hong Kong for adoption by New Zealand families was the bare minimum that New Zealand could provide; the number was later increased to 50 places. A total of 18 refugee families from China, who were in Hong Kong and Indonesia, were accepted between 1965 and 1970 and a further 42 Chinese refugees in 1970/71. In addition, a group of 80 White Russian fundamentalist Christians known as the 'Old Believers', who were living in China, were accepted for resettlement during this period, some arriving as late as 1978. The groups had fled Russia after the 1917 Bolshevik revolution and had been living since then in nomadic isolated communities in the Sinkiang province. The group was illiterate. They were forbidden by the Immigration Minister, Tom Shand from establishing an exclusive

religious community and sent to Southland and Christchurch (Department of Labour, 1994). New Zealand, under a National Government from 1968 to 1972 sought refugees with relevant occupational skills, rather than those with a need for humanitarian acceptance and resettled 125 Czechoslovaks, 244 Ugandan Asians, and 335 Soviet Jews. Additionally, 292 Polish refugees from martial law were accepted during the National led term from 1981 to 1983 on the basis of having contacts in New Zealand and work skills.

The election of the Third Labour Government in 1972 under Prime Minister Norman Kirk signalled a shift in the orientation of Labour internationalism, away from what was now seen as the conservative constructs of the Cold War towards 'Third World anti-colonial' interests (McKinnon, 1993, p. 240). When the democratically elected left-wing leader Salvador Allende was overthrown in Chile by a military coup, Kirk wrote a 'NO' in five-inch high letters, in response to the Ministry of Foreign Affairs proposal for recognition of the new Government (McKinnon, 1993, p. 241). Between 1974 and 1981, 354 Chilean refugees were resettled in New Zealand.

At the beginning of 1970, the Department of External Affairs changed its name to the Ministry of Foreign Affairs. The renaming importantly symbolised a shift in New Zealand's political positioning 'from a world of Commonwealth 'external' relations ... to a world of international 'foreign' relations' (McKinnon, 1993, p. 184). From the 1970s to the late 1980s, persecuted religious groups, from crises such as the Iran–Iraq war were accepted, with 142 Iranian Baha'is and a number of Assyrian Christians arriving between 1987 and 1989 (Department of Labour, 1994, p. 21). Ongley and Pearson (1995) report that, as a proportion of the population, New Zealand refugee intakes for this period were approximately half that of Canada and one third that of Australia. By 1985, Canada had admitted over 98,000 Indochinese refugees, Australia 96,000 and New Zealand just over 6,000 (Ongley & Pearson, 1995).

'Hard Core Cases'

Labour's new internationalism was short lived; the National Government was back in power in 1975 under Robert Muldoon. In response to the large scale Indochinese

refugee crisis beginning in 1975 and continuing through the 1980s, New Zealand's quota was almost entirely made up of Cambodian, Vietnamese and Laotian refugees. However, Indochinese resettlement did not constitute any significant shift in pro-white immigration policies. In 1984, the net gain of migrants from Asia was around 1,500, which was almost entirely accounted for by the Indochinese refugees (McKinnon, 1993). As McKinnon (1996, p. 44) states, 'with the numbers set so modestly, it was perhaps not surprising that the arrival of refugees did not provoke debate about the wisdom of bringing foreigners into the country'.

Half of the total number of Cambodian, Vietnamese and Laotian refugees accepted for resettlement in New Zealand departed. Between 1977 and 1993, New Zealand accepted close to 11,000 Indochinese refugees. Aussie Malcolm, the Minister of Immigration at the time, was to congratulate New Zealand on the speed of reuniting Cambodian families. Malcolm stated that the 'final seal of [approval] of a refugee programme is that nobody should hear of them again ... New Zealand becomes the present and the future' (Gallienne, 1991, p.200). Little may have been heard from this group again, as in the 1996 Census one-third of all Cambodian and Vietnamese refugees resettled in New Zealand were unable to speak English (Thomson, 1999). In 1996 approximately one-third were receiving income support and over half had moved to Australia (Thomson, 1999).

In June 1989, representatives of New Zealand and other resettlement countries attended the International Conference on Indo-Chinese refugees hosted by the UNHCR in Geneva. The conference requested that each resettlement country consider taking 'hard core cases' such as long-stayers in refugee camps, people with disabilities and medical conditions, and other groups at risk (Department of Labour, 1994, p. 22). New Zealand was committed to resettling 512, mainly Vietnamese, refugees from the camps in Hong Kong during the 1990 to 1993 resettlement programme (Department of Labour, 1994, p.23).

The 1987 Review of Refugee Resettlement Policy

The Fourth Labour Government, which took office in 1984, was committed to reviewing immigration and refugee policies and duly did so in the 1987 Immigration

Act. The review of refugee resettlement policy took place in the context of radical changes to the New Zealand immigration policy which removed the traditional country of origin preference. The Labour Government, in passing the new Immigration Act and in reviewing refugee policy sought a shift to a more internationalist, non-discriminatory immigration policy (McKinnon, 1996, p. 45):

... central to the new direction were policy advisors in the Immigration Division of the Labour Department and at the political level the Minister of Immigration, Kerry Burke, and members of the relevant caucus committee ... all of whom wanted to recast the long-standing British and white orientation of New Zealand immigration policy.

The 1987 review of the Refugee Quota Programme significantly altered the categories of refugees to be admitted to New Zealand. The Department of Labour (1994, p. 25), gave the following rationale for changes to refugee resettlement policies which were that:

... over the years the New Zealand Refugee Quota Programme has included a number of categories-for specific national, ethnic and religious groups, as well as special needs groups, such as “handicapped” refugees, longstayers in refugee camps, refugee boat people rescued at sea and victims of pirate attacks.

Since 1992 the categories of the New Zealand Refugee Quota Programme have changed from national to world wide categories based on current needs. This was considered a fairer and more flexible means of enabling the Government to respond to the world’s refugee crises.

The review set in place the prioritisation of the needs of refugees, rather than selecting people who have the greatest potential to most easily adapt to the New Zealand social and economic environment (NZIS, 2004b, p. 44):

For example, the annual Quota of 750 includes 75 places for women at risk, and 75 places for refugees with medical problems and disabilities. Places for emergency resettlement, for purposes of protection are prioritised over other settlement cases. This goes some way to explain why the resettlement of refugees provides challenges for both the individual refugees and the host community.

‘Women-at-Risk’

In 1989, New Zealand became the second country in the world to respond to a request by the UNHCR for governments to allocate places for women-at-risk within their refugee quota. The New Zealand Red Cross, as a special gesture during its 125th anniversary celebrations, sponsored the first intake of women and children (Department of Labour, 1994, p.25).

Women-at-risk are usually outside the normal criteria for acceptance by resettlement countries because women and children alone constitute a (UNHCR, 1998, p. 28):

... poor socio-economic profile, the lack of an adult male breadwinner, a high number of dependants, and/or a fragile physical or psychological condition. Admission obstacles may be magnified by perceived weak post-resettlement integration potential, and the perception that self-sufficiency cannot be obtained ...

Women-at-risk are particularly vulnerable to poor mental health pre-and post-resettlement and require ongoing specialised care and intensive support on arrival in the resettlement country as (UNHCR, 1998 p.27):

...they may suffer from a wide range of problems including ... sexual harassment, violence, abuse, torture

and different forms of exploitation. Additional problems such women face could derive from persecution as well as from particular hardships sustained either in their country of origin, during their flight or in their country of asylum. The trauma of having been uprooted, deprived of normal family and community support or cultural ties, the abrupt change in roles and status, in addition to the absence of an adult male head of family, renders some women, under certain circumstances, more vulnerable than others ...

Since 1989, the women-at-risk programme has resettled 123 Vietnamese women and children, over 200 Somali women and children, and smaller numbers of Cambodian, Ethiopian, Eritrean, Sudanese and Burmese women and children.

Resettlement in New Zealand from the End of the Cold War

The End of the Cold War

Conflicts beginning in the 1970s in the Horn of Africa and Afghanistan regions escalated in the 1980s when the political and military stalemate between the superpowers was diverted into immensely destructive proxy wars which created millions of refugees. In these regions the superpowers intervened in local conflicts that might have been minor and short-lived, 'but which instead escalated and resulted in large-scale displacement' (UNHCR, 2000a, p. 105). In late December 1979, the Soviet Union, with mounting armed opposition to the Communist Government, invaded Afghanistan, triggering a massive exodus of refugees to neighbouring Pakistan and Iran.

At the beginning of the 1990s, the proxy wars ended in these regions, taking on lives of their own without superpower patronage. What distinguished the 1990s from earlier decades was the weakening of central governments in countries that had been shored up by superpower support. In many cases, the ideological motivation for conflict diminished, but was often replaced by identity-based conflicts built around religion, ethnicity, nationality, race, clan, language or region. External intervention in

a conflict became less risky since it no longer threatened major retaliation from a superpower sponsor (UNHCR, 2000, p. 275).

In the post-Cold War period, civil wars and communal conflicts have involved wide-scale, deliberate targeting of civilian populations. The violence of these wars is often viciously gender-specific. Women are systematically raped and young men are the targets of mass murder or forcible conscription. Other states are often unwilling to intervene militarily, leaving humanitarian organisations to operate on their own in a desperate vacuum (UNHCR, 2000, p. 276). Since these internal conflicts were no longer connected to an 'epic geopolitical struggle', many of the people who were driven by violence and persecution to flee their homes were marginalised by powerful states which 'no longer found their vital national interests at stake' (UNHCR, 2000, p. 275).

In the 1970s, Ethiopia and Somalia made dramatic changes in their superpower allegiances. Ethiopia broke away from its allegiance to the United States and, with Soviet support; Mengistu became President in a Marxist regime, which took power in 1977. As a result, the United States increased its backing of the Governments in Sudan and Somalia (UNHCR, 2000a, p. 106). This had a significant impact on conflicts in the East African region. The Horn of Africa (UNHCR, 2000a, p. 106):

... was the scene of numerous large scale refugee movements. War, famine and mass displacement caught the world's attention, as the involvement of the superpowers fuelled the conflicts and magnified their consequences. Many Ethiopians, including people from Eritrea-then part of Ethiopia-sought refuge in Sudan, Somali and Djibouti, and large numbers of Sudanese and Somalis sought refuge in Ethiopia ...

In the 1990s, the largest proportion of New Zealand's refugee intake came from the Horn of Africa countries of Eritrea, Ethiopia, Somalia and the Sudan (Ministry of Health, 2001d). Don McKinnon, the Minister of External Relations and Trade issued

a statement expressing New Zealand's horror at the situation in Somalia and confirming that 'we are playing our part as an active international citizen' (Minister of External Relations and Trade, 1992, p.45). Between 1992 and 1994, at the request of the UNHCR, New Zealand accepted 94 Somali refugees in the women-at-risk and medical/disabled categories.

During the years 1992-1994, conflict in the former Yugoslavia, and most particularly in the republics of Bosnia-Herzegovina and Croatia, led to the biggest refugee crisis in Europe since the Second World War. In 1992, New Zealand resettled 29 men who were former detainees from Bosnia and two of their family members; then in the following year, 77 family members joined them. Five years later, in 1999, 405 Kosovar Albanians arrived in New Zealand when hundreds of thousands were forced to flee following the horrific Serbian-led ethnic cleansing programme in Kosovo. More than half of these refugees have since returned to Kosovo or have migrated to Australia (Ministry of Health, 2001d).

Table 2.1: Refugees approved for resettlement in New Zealand 1992-2003

Years approved	Refugee Type		
	Quota Refugees	Convention (former asylum seekers)	Total
	n	n	n
1992/93	412	128	540
1993/94	737	68	805
1994/95	822	134	956
1995/96	780	147	927
1996/97	527	180	707
1997/98	677	275	952
1998/99	726	538	1,264
1999/00	716	473	1,189
2000/01	746	312	1,058
2001/02	750	627	1,377
2002/03	604	247	851
Total	7,497	3,129	10,626

Source: NZIS, 2004b, p. 44

Table 2.1 indicates the number of refugees approved for resettlement between 1992/93 and 2002/03—including quota refugees and convention refugees (NZIS, 2004b). However, the numbers must be read with some caution, as they do not necessarily represent the total number of refugees living in New Zealand. The table does not show the number of family reunion members who have been resettled, or the numbers of refugees who may have gone on to settle in other countries as these figures are unavailable.

In New Zealand, responsibility for refugee resettlement and integration has largely been left to the voluntary sector (Department of Labour, 1994; Ongley & Pearson, 1995). From the beginning of refugee resettlement until 1989 the churches played a leading role in resettlement support. Until 1964, when it set up a formal Resettlement Office, the National Council of Churches provided support to refugees on an ad hoc basis. In 1976 the Inter-Church Commission on Immigration and Refugee Resettlement (ICCI) was formed from the National Council of Churches Resettlement Office and the Catholic Immigration Committee. The purpose of the ICCI was to 'handle all matters relating to the admission of refugees into New Zealand and their settlement in this country' (National Council of Churches as cited in Department of Labour, 1994, p.29). This was the first time that government funding was provided for resettlement work. In 1989, the ICCI became the Refugee and Migrant Service (RMS) and broadened its support base to include refugee communities. Refugee resettlement in New Zealand is primarily coordinated by the Refugee and Migrant Service, which is now called RMS Refugee Resettlement. The service is only available to quota refugees for the first six months after arrival.

New Zealand and the 'Pacific Solution'

The Department of Labour signalled a further refugee policy shift in the briefing to the incoming Minister of Immigration in 2002. The briefing instructed that the short to medium term priority for the New Zealand Immigration Service was to be regional refugee issues and provided the following explanation (Department of Labour, 2002, p. 48):

New Zealand is committed to ‘international responsibility sharing’ through support for the United Nations High Commissioner for Refugees and to resettling mandated refugees under annual Refugee Quota Programme. This needs to be balanced with New Zealand’s interest in assisting countries within our own region (such as Australia and Indonesia), which are facing intense pressure arising from refugee flows.

New Zealand is part of the ‘Pacific solution’, initiated by the Australian Government from 1999 onwards. This was a response to what the Australian Government termed an ‘influx’ of asylum seekers from the Middle East and Asia that began in late 1997 (United States Committee for Refugees (USCR), 2002a). At the end of the 1990s the Australian Government, led by John Howard, sought to establish a formal mechanism for the interception and processing of asylum seekers in Indonesia and other countries in the region. From early 2000, New Zealand became part of the ‘Regional Cooperation Arrangements’ that comprises Australia’s new approach to asylum seekers (USCR, 2002a, p. 44). The arrangements involve four key players: the Indonesian Government (both at the central and local levels—including police and immigration officials), their Australian and New Zealand counterparts, the UNHCR, and the International Organization for Migration (IOM).

In 2000, the New Zealand Immigration Service substantially increased the Refugee Status Branch from eight to 70 staff in order to enable speedier determination and removal processes for failed asylum seekers. These measures were intended to reduce the cost of providing for the health, education and welfare of asylum seekers who were awaiting determination of their refugee status—in many cases for up to four, or more, years. Additionally, the measures were designed to stop the abuse of the refugee determination system—a practice which flourished in the unregulated immigration consultancy environment introduced by National and National led Governments in the 1990s.

The Tampa Incident

In August 2001, the Australian Government, for the first time, refused entry to a ship carrying asylum seekers. The Australia immigration authorities had experienced a sudden upsurge of arrivals, with more than 1,500 persons landing on Australia's island territories within 11 days. The ship, the Norwegian freighter the *Tampa*, was carrying 430 asylum seekers, mostly Afghans (USCR, 2002a, p. 97). The *Tampa* was en route to Singapore, and had rescued the asylum seekers from a sinking Indonesian ferry the previous day. The New Zealand Government intervened saying that it would consider examining the passengers' asylum claims, as long as other countries would do the same (USCR, 2002a, p. 107). New Zealand took 150 of the asylum seekers from the *Tampa*, mainly women, children, and families. The remainder, who were mostly men, were destined to go to Nauru. The group were mainly Afghan Hazara—an ethnic minority who had fled the persecution of the Taliban regime. Additionally, the New Zealand Immigration Service agreed to assess the asylum claims of those taken to Nauru and to accept, as part of the annual quota, those found to be refugees (USCR, 2002a, p. 112). Between 2001 and 2004, New Zealand resettled over 500 Afghan, Iranian and Iraqi refugees from detention centres in the Asia-Pacific region. Throughout 2004/5 the family reunion members of the Afghan *Tampa* refugees were settled as quota refugees.

Conclusion

This chapter has focused on the historic context of New Zealand's refugee resettlement policy. Historically, refugees have been subjected to extreme assimilation in a largely homogenous British settler society. In spite of New Zealand's humanitarian reputation on the international scene, there are significant questions to be addressed about the management of refugee integration. Forthcoming chapters will evaluate and comment on the state's record in enabling the social, cultural and economic integration of refugee communities. Currently, New Zealand's acceptance of refugees, proportionate to population, is on a par with that of Canada. However, New Zealand differs substantially in the terms of membership offered to resident refugees in comparison to both Australia and Canada—notwithstanding the high level criticism that the Australian Government has attracted in its harsh and unjust treatment of asylum seekers.

CHAPTER THREE

RESEARCH METHODOLOGY

Introduction

This chapter which focuses on the methodological approaches used to analyse the data in the study completes the first half of the thesis. The methodology used in the study is informed by the sociological movements that started in the 1970s, led by neo-Marxist, feminist, anti-racist and post-colonial theorists. These theoretical positions called for a resounding rejection of the old ethical codes that failed to examine research as a morally engaged project. These perspectives overturned the social scientific codes that located the researcher as an outside onlooker. It was recognised that all researchers speak from within a distinct interpretive community which configures, in its special way, the multicultural, gendered components of the research act (Denzin & Lincoln, 2000a, p.1022). In my view, it is essential in a study that is concerned with social, economic and cultural citizenship for refugee groups that ‘given the new century’s serious challenges, sociologists need to rediscover their roots in a sociology committed to social justice’ (Feagin, 2001, p. 1). For this reason, the theoretical orientation of this thesis is influenced by critical social theory.

Critical social theorists seek to produce ‘practical, pragmatic knowledge that is cultural and structural, judged by its degree of historical situatedness and its ability to produce praxis, or action’ (Lincoln & Denzin, 2000, p.175). The study is grounded in critical hermeneutics, a method of analysis that attempts to connect the everyday troubles individuals face to public issues of power, justice and democracy. Critical hermeneutics put the politics of interpretation at centre stage because a central aspect of their sociocultural analysis ‘involves dissecting the ways people connect their everyday experiences to the cultural representations of such experiences. Such work involves the unravelling of the ideological codings embedded in these cultural representations’ (Kincheloe & McLaren, 2000, p. 291).

The study undertaken is a qualitative field study. In this chapter, the three interconnected generic activities that define the qualitative research process are

discussed. They go by a variety of different labels including theory, method and analysis, ontology, epistemology and methodology. The researcher approaches the world with ‘a set of ideas, a framework (theory, ontology) that specifies a set of questions (epistemology) that are then examined (methodology, analysis) in specific ways’ (Denzin & Lincoln, 1994, p.11). There are five phases that define the qualitative research process that will be discussed. These are: the researcher and the researched as multicultural subjects; theoretical paradigms and interpretive perspectives; research strategies; methods of data collection and analysis; and the evaluation criteria (Denzin & Lincoln, 1994, p.12).

The first section of this chapter identifies my own ‘extrasocial-scientific’ concerns, that is, the concerns that have brought me to the situation of doing this social analysis (Lofland & Lofland, 1995, p.11). The second section provides a background to the history of critical social theory and explores contemporary conceptions, in particular emancipatory inquiry (Henderson, 1995). The third section introduces the research strategy that has been used in this study. In the contemporary practice of qualitative inquiry the researcher turns into ‘a methodological (and epistemological) *bricoleur* (handy person)...The interpretive *bricoleur* can observe, study material culture, think within and beyond visual methods...do text-based inquiries...even engage...in policy formulation’ (Denzin & Lincoln, 2000b, p.1020). In the fourth section, the methods of data collection and analysis are discussed. Critical hermeneutics provides the methodology for developing a critical consciousness through the analysis of generative themes in the social world under study. Lastly, the evaluation criteria used in the study are explained.

The Researcher and the Researched as Multicultural Subjects

Critical researchers ‘begin their investigations with their assumptions on the table, so that no one is confused concerning the epistemological and political baggage they bring with them to the research site’ (Kincheloe & McLaren, 2000, p. 292). Behind this particular research stands the biographically situated researcher. Every researcher enters the research process from inside an interpretive community that incorporates its own historical research traditions into a distinct point of view. My concern with integrating refugees into health services first arose in the context of my own

professional experiences over six years as a refugee health coordinator for the Auckland Regional Public Health Service. These experiences revealed the limitations of health service engagement with refugee peoples. Lofland and Lofland (1995, p.176) refer to the matter of the researcher's voice, which should be very 'front and center' in research reports. It is especially so in revealing personal responses to the people studied that the researcher's role and the researcher's view of life and existence in general, is transparent (Lofland & Lofland, 1995). The fieldworker's task is to report what presumptively 'voiceless' populations believe and wish to communicate about their condition. In this respect, like Fine et al. (2000, p.108), I feel compelled to 'try to move public conversation about researchers and responsibilities toward a sense of research for social justice'. A review of New Zealand and international literature on refugee resettlement, New Zealand cultural safety concepts and multiculturalism led to the formulation of questions about refugee integration in New Zealand society which initiated the study. These questions needed the researcher to think 'historically and interactionally, always mindful of the structural processes that make race, gender, and class potentially repressive presences in daily life' (Denzin & Lincoln, 2000b, p.1019).

As Lincoln and Denzin (2000, p.182) say 'reflexivity forces us to come to terms not only with our choice of research problem and with those with whom we engage in the research process, but with ourselves'. There has for a long time been a tendency 'to view the self of the social science observer as a potential contaminant, something to be separated out, neutralized, minimized, standardized and controlled' (Fine, Weis, Weseen & Wong, 2000, p.108). In this context, the historically 'neutral' position of the social scientist is contested by Donna Harraway and others who rightly state that 'vision is always a question of the power to see—and perhaps of the violence implicit in our visualizing practices' (Harraway, 1991, p.192, cited in Fine et al., 2000, p.109). Denzin and Lincoln (2000, p.1022) correctly make the more critical observation that the previous stance of qualitative researchers was 'blatant voyeurism in the name of science or the state'. The responsibilities of social scientists are clarified by Fine et al. (2000, p.109) who state that:

... who is afforded—or appropriates—this power to see

and speak about what is seen as well as what is hidden from scrutiny is a question that is at the heart of our examinations of our social responsibilities to write and re-present in a time of ideological assault on the poor. Thus we seek to narrate a form of reflexivity and responsibilities in these very mean times.

The self-reflective points of critical consciousness in this study are gathered (Fine et al., 2000, p.108):

...around the question of how to represent responsibility, that is transform public consciousness and “common sense” about the poor and working classes, write in ways that attach lives to racial structures and economies, and construct stories and analyses that interrupt and reframe the victim-blaming mantras of the 1990s.

To reclaim the Chicago tradition of naturalist inquiry, we must first [*italics in text*], ‘*establish intimate familiarity with the setting(s) and the events occurring within it-as well as with the research participants*’ (Charmaz, 2005, p. 521). Lofland and Lofland (1995, p.11) tell the researcher to ‘start where you are’ which is what I have done in this study. While this study is not ethnographic, like critical ethnographers, my underlying motivation has been the need to work through how to represent the consequences of social exclusion on the lives of refugees—as a distinct group of disadvantaged newcomers—‘in times of punishing surveillance and scrutiny by the state’ (Fine et al., 2000, p.108).

Theoretical Paradigms and Interpretive Perspective

Guba and Lincoln (1994, p.105) define a paradigm as the basic belief system, or worldview that guides the investigator. Paradigms deal with first principles or ultimates. In contrast, perspectives are not as solidified, or as well unified, as paradigms, although a perspective may share many elements with a paradigm, such as a common set of methodological commitments. The critical paradigm, in its many

forms, articulates an ontology based on historical realism, an epistemology that is transactional and a methodology that is dialogic and dialectical (Denzin, 1994, p.100).

Critical social science, in Fay's (1986, p.4) view, is 'an attempt to understand in a rationally responsible manner the oppressive features of a society such that, this understanding stimulates its audience to transform their society and thereby liberate themselves'. This attempt has historically taken many forms, of which the most important is Marxism. Marx (cited in Fay, 1986, p.4) gave what is considered the most succinct statement of the aims of critical social science when he stated that [italics in text], 'heretofore the philosophers have only *interpreted* the world, in various ways; the point, however, is to *change* it'. In a post structural era a (Denzin & Lincoln, 2000b, p.1021):

... social science project seeks its external grounding not in science, but rather in a commitment to post-Marxism and an emancipatory feminism. A good text is one that invokes these commitments. A good text exposes how race, class, and gender work their ways into the concrete lives of interacting individuals.

Critical social theorists have always advocated varying degrees of social action, from the overturning of specific unjust practices to radical transformation of entire societies. The 'call to action' is the term that Lincoln and Denzin (2000, p.174) use to differentiate between positivist and postmodern criticalist theorists. I have taken an interpretivist perspective which, unlike positivist and postpositivist adherents, sees social action on research results as a meaningful and important outcome of inquiry processes. Whatever the source of the problem to which inquirers are responding, the shift toward connecting research, policy analysis and deconstruction (for example, deconstruction of the dominant hegemonic cultural assumptions embedded in social policies which is the project informing much postcolonial theorising), with action 'has come to characterise much new-paradigm inquiry work, both at the theoretical and *praxis*-oriented levels' (Lincoln & Denzin, 2000, p.175).

In praxis, thought and action (or theory and action) are dialectically related. The dialectic 'is often described as the opposition of a 'thesis' against its antithesis', with a new 'synthesis' being arrived at when thesis and antithesis are reconciled' (Carr & Kemmis, 1986, p.33). Dialectical thinking involves reflections back and forth between elements like (Carr & Kemmis, 1986, p.33):

... *part and whole, knowledge and action, process and product, subject and object, being and becoming, rhetoric and reality, or structure and function.* In the process, *contradictions* may be discovered...As contradictions are revealed, new constructive thinking and new constructive action are required to transcend the contradictory state of affairs.

For these reasons, researching health care for groups who have been under represented in health research, such as refugees, the very act of doing research can create change 'because the paucity of research about certain groups accentuates and perpetuates their powerlessness' (Reinharz, 1992, p.191).

There are wide ranging debates among the various criticalist schools, although central to the debates is the idea of social critique which, to be worthy of its name, must constitute a condemnation of an unjust social arrangement and a call for its replacement by better social arrangements. Postcolonial theories (Gilroy, 2000, 2004; Hall, 1995; Taylor, 1994, 1998; Young, 1998)—along with the ideologies of the German Frankfurt school of critical social theory, feminist theory and Marxist theory, fall under the broader heading of emancipatory inquiry (Fay, 1987). Emancipatory inquiry seeks to understand oppression in society and, through this understanding, transform it. These ideological movements, grounded in political resistance, each perceive society as consisting of groups that possess unequal levels of power and resources. For this study, which focuses on the integration of refugees, Hall's (1996) post-colonial critical approach is adopted because he retains a Marxist interest in the economic relations of capitalism, but argues that racial divisions are characteristic of the economic and ideological relations of capitalist societies in the late twentieth

century (McLennan, Ryan & Spoonley, 2000).

Kincheloe and McLaren (2005, p.304) broadly redefine the critical tradition and present an idiosyncratic version of a reconceptualised critical theory. This version will be utilised in the analysis in this study. While acknowledging that many critical schools of thought will contest Kincheloe and McLaren's (2005) definition, their focus on the underlying commonalities in critical social research is important. Because all forms of critical research have in common the aim of the empowerment of individuals (Kincheloe & McLaren, 2000, p. 291):

... inquiry that aspires to the name *critical* must be connected to an attempt to confront the injustice of a particular society or public sphere within the society. Research thus becomes a transformative endeavour unembarrassed by the label *political* and unafraid to consummate a relationship with emancipatory consciousness. Whereas traditional researchers cling to the guard rail of neutrality, critical researchers frequently announce their partnership in the struggle for a better world.

In this sense, Kymlicka's (2001a, p.9) liberal multiculturalism theory, for instance, is a highly significant critical social theory in the context of this thesis. Kymlicka's (2001a) research methodology, which is to identify biases, double standards, conceptual distortions and confusions in everyday discourse on the issues of accommodating ethnocultural diversity in western democracies, is a useful approach, which is used in this study.

Antonio Gramsci's notion of hegemony, in particular his notion of institutional power, is also informative for this study (Hall, 1996). The work of Gramscian sociologists, such as Stuart Hall (1996, 1995a, 1995b, 1992) and John Fiske (1994a, 1994b) provide a valuable interpretive perspective for the study in regard to the role of the state and its institutions in integrating refugee groups. Gramsci's complex

conception of hegemony provided the impetus for theorists of British cultural studies to review the more restrictive and totalising aspects of structural Marxism (Hall, 1992, 1996). The term ‘hegemony’, used in the Gramscian sense, means the success of the dominant classes in presenting their definition of reality and their view of the world in such a way that it is accepted by subordinate classes as ‘common sense’. Groups, such as cultural minorities who present an alternative view, are, therefore marginalised. Theorists such as Hall and Fiske have used Gramsci’s model of power to demonstrate the notion that hegemony belongs to an historic bloc, representing an alliance between a range of social groups.

Kincheloe and McLaren (2005, p.309) argue that the hegemonic field elicits consent to an ‘inequitable power matrix, a set of social relations that are legitimated by their depiction as natural and inevitable’. The important point is that hegemony is never complete because, in Fiske’s (1987, p.41) words there is:

... a constant struggle against a multitude of resistances to ideological domination, and any balance of forces that it achieves is always precarious, always in need of re-achievement. Hegemonies ‘victories’ are never final, and any society will evidence numerous points where subordinate groups have resisted total domination that is hegemony’s aim and have withheld their consent to the system.

This approach allows theories of integration which are useful to the nation-state because they are ‘self-consciously local, particular, situated, experimental, and physical’ (Fay, 1986, p.214).

Research Strategies

Lofland and Lofland (1995), acknowledging the terminological jungle in social science, make the strongest case historically for the use of the term ‘qualitative field study’ to describe studies of this nature. Field studies differ from other methods of research in that the researcher performs the tasks of selecting topics, decides what

questions to ask, and ‘forges interest *in the course of the research itself*’ (Lofland & Lofland, 1995, p.5). The fieldwork approach to social research is to bring the concerns of the researcher to the situation of doing social analysis. We ‘make problematic’ in our research matters that are problematic in our lives and ideally the concerns of the researcher overlap with the codified concerns of social science (Lofland & Lofland, 1995, p.13). Previously, I have discussed my professional concerns in regard to the social exclusion of refugees in New Zealand society and my position as an informed participant. This section is concerned with outlining the research strategies that have been employed in the study.

Firstly, the methodology of critical hermeneutics is explained. The interpretive or hermeneutic aspect of research informed by critical social theory comes under the category of philosophical hermeneutics. The purpose of hermeneutical analysis in a critical social theory driven context is to develop a form of cultural criticism revealing power dynamics within social and cultural texts. The central hermeneutic involves the interactions between the researcher, the research subjects and the situating of socio-historical structures that are relevant to the study. Hermeneutical analysis facilitates an understanding of the hidden structures and tacit cultural dynamics that inscribe social meanings and attitudes towards refugee groups in New Zealand society. In this study, the macro-dynamics of structural forces that are identified in the first section of the thesis (chapters one to nine) are connected to the micro-dynamics of the everyday interactions between health care workers and refugees which are analysed textually in the second section of the thesis (chapters nine to thirteen).

Secondly, the study is multimethod in focus. A variety of empirical materials that describe routine and problematic moments and meanings in individuals’ lives are used, including: case studies, personal experience, introspection, life stories, interviews, observation, historical material, and visual texts. Thirdly, bricolage is a concept and a strategy that was well suited to this study because confrontation with difference and diversity is basic to the concept and its critical concern is just social change. Bricoleurs, as they discern new topics to be researched, reshape research methods and interpretive strategies, informed by insights from the margins of western societies and the knowledge and ways of knowing non-western peoples. As Kincheloe

and McLaren (2005, p.319) say, in the criticality of the bricolage ‘the focus on power and difference always leads us to an awareness of the multiple dimensions of the social. Paulo Friere (1970) referred to this as the need for perceiving [the] social structures and systems that undermine equal access to resources and power’. In this research studying institutional responses in New Zealand society enables us to gain insights into the social structures and systems that impede equal access for refugee groups. Working directly alongside refugee communities and others who work with them, enables us to produce new, emancipatory forms of knowledge that can inform policy decisions and political action in general.

Methods of Data Collection and Analysis

In the following sections, the methods of data collection and analysis used in this study are detailed. The design of the study, setting, entry into the field, procedures for the recruitment of participants and methods of data analysis are indicated, along with other concerns related to this study. The ethical considerations in relation to this study are listed in appendix nine. The details of the specific data collection strategies, including interview guides, are found in appendices eight, ten and eleven.

In this study, the set of ‘tactics’ used for data analysis are those described by Huberman and Miles (1994) as moving from the descriptive to the explanatory and the concrete to the abstract. They list thirteen tactics which include: noting patterns and themes, clustering by conceptual grouping, making metaphors, counting, making contrasts and comparisons, and partitioning variables. More abstract tactics include: subsuming particulars into the general, shuttling back and forth between first level data and more categories; factoring; noting relations between variables, and finding intervening variables (Huberman & Miles, 1994, p.432). Lastly, a coherent understanding of the data set is demonstrated in building a logical chain of evidence, which is presented in diagrammatic form in Figure 9.1 in chapter nine. Conceptual coherence is made through comparison with referent constructs in the literature that apply to the phenomenon under study. Before discussing these stages of analysis a brief overview of the design and method of the study are given in the next sections.

Design and Method of the Study

The Study Setting

Over 65 per cent of refugees settled in New Zealand are resident in the Auckland region (NZIS, 2004b). It was decided to focus this study on health services in the Auckland region for reasons of demography, time and the cost of travel. In total, twenty-one health services were approached through professional nurse leaders and health service managers. These services were either known to have significant numbers of clients from refugee backgrounds, or to be located in areas where refugee communities were settled. It was important to involve as wide a range of services as was practicable in a study of this size, in order to gain a range of experiences. The services approached included community based health organisations, primary health services, mental health services, hospital services, non-governmental health organisations, public health services and social service agencies.

Entry into the Field

In the literature on qualitative methodology, access is one of the most written about and problematic topics. In order to collect rich data, one needs to 'come close' (Lofland & Lofland, 1995, p.17). A key consideration as a prospective investigator assessing sites for access was that to make sense of the social life occurring in a setting requires closeness. Starting from 'where I was'—that is, working in health services—the choice of data site was obvious. If you are already a member in the setting, you have access to easy understanding. However, this raises another issue which is that to ask questions of, to 'make problematic', to 'bracket' social life requires distance and analytical mechanisms for distancing in the research were needed (Lofland & Lofland, 1995, p.23). The issue for the researcher, as an insider, was to maintain enough analytical distance, while being actively involved in problem solving as a practitioner. In the study, Huberman and Miles' (1994) set of 'tactics' for data analysis were applied to achieve 'distance'. These are described in the data analysis section which is to follow.

To enter the field under study, an initial approach was made to the managers of Auckland health services in December 2002, in a formal letter requesting permission to approach staff (appendix two). Those services chosen were considered to represent

a wide range of services and were spread regionally. Included with the letter were: an outline of the proposed study, letters of introduction and information for potential participants (appendices three and four). When the service managers had granted approval, members of staff were then invited to participate. Of the twenty-one agencies that were approached, nineteen chose to participate. The initial intention was to interview up to eighteen participants but as the study got under way, there was a 'snowball' effect and, through word of mouth, others who had heard of the study contacted me and offered to be participants.

Participant Selection

When health workers responded to the invitation to participate that was sent to their managers, they were sent an information sheet entitled 'Research into refugee health care' (appendix four). The following statements were included in the initial information provided to potential participants:

- (a) That the intention of the researcher was to study the management of refugee health care.
- (b) That any staff including managers, doctors, nurses, social workers, health promotion and community workers who had current or recent experience working in the area of health care for people from refugee backgrounds were invited to volunteer.
- (c) That agreement by volunteers to the research would involve one or more interviews and that cumulatively there may be up to four hours time involved.
- (d) That interviews would take place at a time and place convenient to the participant
- (e) That typical questions asked would be the following:

"Tell me about your experiences of working with the people from refugee backgrounds?"

"Tell me about the particular needs of refugee families and how your service meets those needs?"

"Tell me about health promotion and community participation for families from refugee backgrounds in our health services?"

“Tell me about providing culturally appropriate care for clients and families from refugee backgrounds?”

“Tell me about any problems which you may have had in communicating with non-English speaking clients?”

“Tell me about the perceptions that others in health care and in society in general have towards your work?”

Volunteers were initially asked to make telephone contact with the researcher. Each volunteer was then contacted and sent the information letter (appendix two). The researcher then made arrangements to meet with the volunteer for further clarification and explanation (appendix seven). If the volunteer wished to participate in the study, written consent was gained (appendix five).

Procedures for Participant Involvement

In this study the method of direct apprehension used was intensive interviewing in the field of health care. Intensive, or unstructured interviewing, is a guided conversation with the goal of eliciting from the interviewee or ‘informant’ rich, detailed materials that can be used in qualitative analysis.

Participants who agreed to take part in the study were asked for an interview, a process involving one or more hours of audiotaping. Arrangements were made at times and places that were convenient to the participant. The interviews were conducted between December 2002 and May 2003. During the interviews, a series of open-ended questions were asked. In addition to the audiotaping of responses, the researcher made written observations and reflections in the form of field notes and memos that could be accepted as data.

Procedures for Handling Information

The researcher held the written consent forms of participants in a locked filing cabinet. All data collected, including audiotapes, written material, and field notes, were stored in a locked filing cabinet, separate from the consent forms, for the duration of the study. All research data was kept in strict confidence by the researcher,

her supervisor and the transcriber of the audiotapes. The transcriber was required to sign a confidentiality agreement stating that transcription would occur in privacy, that the confidentiality of tapes was assured and that tapes would be stored securely (appendix six). Audiotapes were available to be returned to participants, should they request this, following the study.

The Participants

There were twenty-eight participants in the study. The services that participated represented a geographical spread across the Auckland region. The participants worked in a range of Auckland health services including: the Auckland Regional Public Health Service, Refugee Health Service and Communicable Disease Control Teams, the Plunket Society, Primary Health Organisations, Community Child and Family Health Services, disability support services, mental health services, women's health services, HIV/AIDS services, drug and alcohol services, hearing and vision services, health promotion teams and community care agencies. Those interviewed included: nurses, doctors, midwives, health educators, health promoters, nutritionists, social workers, community health workers, hearing/vision testers, reception staff and managers. There were three focus groups, two for those working in child health services and one for a health promotion service, organised at their request, as this was a practical means of interviewing a number of staff in the same work site.

Ethical Considerations

The process and procedures for gaining informed consent, maintaining anonymity and confidentiality and preventing the potential for harm to participants and clients of health services are outlined in appendix nine.

Ethical Committees

Ethics Committee approval was gained from: the Massey University, Human Ethics Committee on the 1st of November, 2002; the Auckland Ethics Committees on the 17th of December, 2002; and the Royal New Zealand Plunket Society on the 17th of February, 2003.

Researcher Involvement

In this study, I did as Lofland and Lofland (1995) advise, to 'start where I was'. At

the commencement of the study, I had worked as a refugee health co-ordinator for a publicly provided health service for 2 years. I was immersed in the area of study and the relevant literature prior to beginning the study and have remained so throughout. In the majority of cases of those interviewed, participants knew me as a colleague who was working in the area of refugee health. However, not all participants knew me. The mechanisms employed for maintaining analytical distance in the study are outlined in the next section.

Data Analysis

Concept Formation

In qualitative field studies, analysis is either the product of 'loose' inductively oriented designs or 'tight', more deductively approached ones (Huberman & Miles, 1994, p.431). Tighter designs are indicated when the researcher has good prior acquaintance with the setting, has a good bank of applicable, well-delineated concepts and takes a more explanatory and/or confirmatory stance involving multiple, comparable cases (Huberman & Miles, 1994, p.431). This was the case in the study as the area was well known to the researcher, underpinned by the concepts of citizenship and of social exclusion and employed a critical stance by way of explanation.

The critical hermeneutic tradition holds that in qualitative research there is only interpretation. The hermeneutic act of interpretation involves making sense of what has been observed in a way that communicates understanding. The process of analysis used to interpret the data in the study is called the 'hermeneutical circle' (Kincheloe & McLaren, 2000). In this, researchers seek the historical and social dynamics that shape textual interpretation and 'engage in the back and forth of studying parts in relation to the whole and the whole in relation to parts' (Kincheloe & McLaren, 2000, p. 286). Hermeneutical analysis brings the parts into focus in a manner that grounds them contextually in 'the whole, the abstract (the general)', that is a larger understanding of the social forces that shape them (Kincheloe & McLaren, 2000, p. 287).

To begin analysing data, the researcher started with a process of immersion in the interview data collected. Each audiotape was repeatedly listened to; transcriptions were read and reread. Transcripts were analysed line by line for thematic content that

indicated the integrative or exclusionary processes occurring. In the first three interviews the researcher began to look for meaning, patterns and uniformity within descriptive incidents and experiences. Simultaneously, field notes and memos were made and became part of the constant comparative analysis. From the beginning to the final draft of the study every piece of data was compared with every other for commonalities and differences, underlying meaning and concept formation. The process of substantive coding produced initial tentative codes (Huberman & Miles, 1994).

Coding

The focus of early data analysis was to manage the volume of data by substantive coding. Pseudonyms were used, except in the case of those who wished to be named, to ensure participant anonymity in all quotations. Data was reduced into concepts and categories that reflected the processes of exclusion or integration that were occurring. The purpose of this process was to discover recurring integrative or exclusionary themes in the data. Initially, the participants' language was used to ensure that the concepts that were emerging remained factually grounded in the data. For instance, the words of a Plunket clinical service manager that refugees were 'the forgotten people' became an initial substantive code. In her words the Plunket society had:

... no strategic plans [in relation to refugee populations].
I have been harping at this for years, saying that we need
within Plunket our own policy to meet the needs of these
people...no money goes towards...not the really
forgotten people but in some respects they are...(Sue, 1:
234).

The Plunket Service had made repeated unsuccessful approaches to health funders to have refugee groups, who were a significant proportion of their client base, recognised as a high health needs population. Many of the other services interviewed said that national and organisational health policies and strategies did not reflect the refugee or migrant populations that they were serving. I concluded that there was a

process of discursive exclusion occurring. Refugee populations were ‘invisible’ in the strategic plans that were supposed to guide the interventions for ‘hard to reach’ populations because they were absent in data collection systems and in health studies. The code ‘forgotten people’ was recategorised into the selective code ‘the invisible people’.

Another example supported this conclusion of the ‘invisibility’ of refugee groups in population health studies. For instance, a primary health care service manager stated that in the service that she managed:

... in terms of specific population targeting, no funding has been available and even currently within the PHO formula, there is no acknowledgment of the high needs of migrant, refugee populations, other than on a deprivation basis, so if they happened to live in the right street, they get the money, if they happened to live in the next street across, which is not decile five or quintile five, they miss out on any specific funding load, based on deprivation. It is a huge issue... (Kate, 1: 18).

Other participants from the primary health care sector further reinforced the conclusion that reducing inequalities strategies overlooked refugee groups. For instance, a practice nurse who worked in a new general practice that had been set up in Mt Roskill in 2002 stated that they:

... weren’t prepared for that [refugee] population. We were expecting completely different demographics and it wasn’t ‘til a few months later that we realised and probably didn’t have the resources and the knowledge in all aspects, cultural, the whole thing (Jane 1: 07).

The site of the new practice, called Hauora o Puketapapa/Roskill Union and Community Health Centre (HoP), was chosen through a process of identifying population groups in central Auckland who were medically under-served (Lawrence

& Kearns, 2005). When HoP was established, analysis of the most recent data indicated that the Mt Roskill area was significantly underserved in terms of the availability of general practices and that the population comprised: Europeans/Pakeha (38.2%), Pacific Islanders (25.9%), Asians (18.6%), Maori (11.2%) and Others (6.1%) (Exeter, Collins & Kearns, 1999). The 'Others' were the refugee families from Afghanistan, Ethiopia, Iran, Iraq and Somalia who had been settled in the area since 1992, and were recorded in health or demographic studies only as 'Other'. In 2003, 46 per cent of HoP's enrolled population were from refugee backgrounds (Lawrence & Kearns, 2005).

There were multiple exclusionary patterns occurring in the data; some of these issues related to inequitable access to health care. For example, in the following interview a child health nurse found that during home visits to her non-English speaking client, in order to communicate:

... the older children from one family would come to this one mother because she had no one at home and she would interpret for me. It is the only way that I can do it ... (Lisa-May, 1: 223).

The substantive code from this statement was 'hearing refugees' which was recoded into the selective code 'having a voice' and was later categorised as 'problems with language'. I concluded that communication barriers prevented equitable access to health care for Non-English speakers and recoded the selective code to a broader theoretical category, 'Barriers to health care'.

The process of data analysis of participant interviews occurred simultaneously with policy analysis. Chapter seven describes the exclusionary statistical data collection systems that categorise refugees as 'Other' and which are used as the basis of health policies and of population funding formula in New Zealand. The 'Other' group is not a priority population in the reducing inequalities strategies for health and social policy. Subsequently, the initial tentative substantive codes of refugees as 'the invisible people' and the 'forgotten people' were recoded into an overall category of

‘Refugees as ‘Others’’, which best described the discursive and material exclusionary processes that were occurring.

There are tensions and contradictions in the data; while there are multiple instances of exclusionary processes, there were examples in the participant interviews of ‘activation’, demonstrating opportunities for institutional integration (Penninx, 2004, p.4). For example, Rose was a nutritionist who had started a healthy eating programme for the Somali community by spending time getting to know community members and:

... making contact. ...it was really interesting meeting the women and...it’s the same feeling I have whenever I have gone and done nutrition work with groups that aren’t from my own ethnicity. You have the same approach and it takes time to get comfortable (Rose, 1: 12).

Rose had successfully used a ‘train the trainers’ model of health promotion utilising:

... known and trusted people to become the nutrition experts for the community. Provide training for those people to get out there... (Rose, 1:167).

The initial substantive code in this case was ‘creating cultural exchanges’, which was recategorised as the selective code, ‘achieving cultural safety’, and later became part of the inclusionary theoretical code, ‘Promoting health’, in refugee communities.

The circular method of data analysis which continued until the completion of the study included simultaneously collecting data, coding and analysing interviews, policies and other supplementary data (Huberman & Miles, 1994). Through this process of hermeneutical analysis the researcher continued to categorise data, building up a descriptive conceptual framework of the interaction between the recurring

incidents, social interactions, and processes of integration and of social exclusion for refugee groups that were occurring in the health system.

Concept Development

Reduction of Categories

The development of concepts occurred through the process of reduction of categories. For each of the interviews the participant pseudonym (or first name), the interview number and line number were used to identify the substantive codes that were derived from the analysis of the transcripts. The substantive codes were printed and manually cut up and grouped, according to similarity and difference, under initial headings. When substantive codes had been refined into a selected code, they were entered into the computer using Microsoft Word. These codes were then further revised to determine theoretical coding categories. Using this system, a comparison of categories for each subsequent interview was made to identify variations, overlap and lack of clarity in the data. Concepts were connected together by this process of reducing categories. The original categories could then be clustered together into a more abstract category thus providing a context for analysing all incoming data. For example, the initial selected codes 'brokering between cultures', 'promoting western health', 'creating cultural exchanges', 'developing programmes specifically for refugees', 'linking with diverse communities', and 'refugees in New Zealand health systems' were finally abstracted as the theoretical code 'Promoting health' in refugee communities. As each theoretical code emerged, all new data was compared with it for commonalities and variances. Previous tentative codes were recategorised and reorganised. Line-by-line data analysis amounted to 88,522 words. This was eventually refined into sixty-two pages of selectively coded text.

Social Policy Analysis

The purpose of social policy analysis in the study is to examine the alignment of refugee resettlement, integration and social policies in New Zealand. As stated in chapter four if refugee integration policies are to be effective they should define clear priorities for action in social policy (Penninx, 2004). Inclusive social policies and practices for the long-term social, economic and cultural integration of refugee groups are of the greatest significance to reducing inequalities for refugee populations.

The social policy areas of welfare, education, labour market integration and health are of the most critical interest to the theorising of refugee social, economic and cultural citizenship in the New Zealand context. Social policy analysis provides a means of understanding the processes of social and cultural integration or exclusion for refugee groups that are occurring in New Zealand institutional settings.

Complementary and Background Data

Throughout the study, data was amassed from a range of complementary sources for the purposes of conducting social policy analyses that were relevant to the area of refugee integration. This data is significant as it applies and links the concept of critical social theory used in the study to New Zealand social policy and to social policy in other receiving societies. It provides evidence of the engagement of the researcher with the research. The documents used in the research, in addition to a literature search, included: newspaper, journal and magazine articles; media interviews; government and departmental policy papers; New Zealand, and relevant international, health and social strategies; annual budget statements; local studies and surveys; census data; and websites such as the United Nations High Commissioner for Refugees, Metropolis, Refugee Studies Centre, University of Oxford, Migration Policy Institute and the European Council on Refugees and Exiles. As Lofland and Lofland (1995, p.71) say, there is a considerable ‘mucking about’ quality to data collection where the researcher becomes a kind of human vacuum cleaner, sucking up anything and everything she comes upon that might be even remotely useful. This ‘mucking about’, combined with the interviews, added to the richness of the data collected.

The reduction of categories into a conceptual framework, reinforced by relevant literature, led to selective sampling of the data, from which gaps and problems were identified. Thirty-one Ministry of Health policies and strategies were analysed and were compared with the findings of the interview data (appendix twelve). The policies of the Ministry of Education, Department of Internal Affairs, Department of Labour, Ministry of Social Development and the Minister for the Environment were also analysed. In total more than 50 government policies and strategies were analysed. Comparisons were made between the strategic directions for the institutional integration of refugees of the Ministries of Health, Education, Immigration and

Internal Affairs on the one hand and on the other, the Department of Labour (2004a, 2004b) *New Zealand Settlement Strategy* and the *Auckland Regional Settlement Strategy* (Department of Labour & Auckland Sustainable Cities Programme, 2007a).

The policies analysed included those of: the Department of Internal Affairs (1999); the Office of Ethnic Affairs, (2001, 2002, 2003); the Ministry of Social Development (2002, 2003a; 2003b); Office of the Minister for Social Development and Employment, Office of the Minister of Immigration (2003); that of its predecessor, the Ministry of Social Policy (2001); the Department of Labour (2002, 2003, 2004a, 2004b); the New Zealand Immigration Service (1994, 2000a, 2000b, 2000c, 2000d, 2001a, 2001b, 2001c, 2001d, 2002a, 2002b, 2002c, 2002d, 2002e, 2002f, 2004a, 2004b, 2004c, 2004d); the Ministry of Women's Affairs (1996; 2000, 2001); the Ministry of Youth Affairs (2000); the Ministry of Education (1997a, 1997b, 2001, 2002a, 2002b, 2003a, 2003b, 2003c, 2003d, 2004); the Ministry of Economic Development (2003); and the Minister for the Environment (2003).

Comparisons were also made with relevant governmental policies in other resettlement countries. These included: the European Union (European Council on Refugees and Exiles (ECRE) 2001, 2001a, 2001b, 2001c, 2001d, 2001e, 2001f, 2001g, 2002, 2005); the Council of Europe (2004); the Organisation for European Co-operation & Development (OECD) (2004a, 2004b); the United Kingdom (Department of Work and Pensions, 2004; Social Exclusion Unit, 2004; 2006); Australia (Department of Human Services, 2000, 2001a, 2001b, 2002; Department of Immigration and Multicultural Affairs (DIMA), 1998, 2000a, 2001; Department of Immigration and Multicultural and Indigenous Affairs (DIMIA), 2004a, 2004b; Victorian Department of Human Services, 2004); Canada (Canadian Council for Refugees, 1998, 2004); and the United States (Office of Minority Health, 2002; United States Committee for Refugees, 1997, 1999, 2000, 2002a). The selection of data was directed by what was being indicated about the study problem during the process of data analysis.

Concept Integration

The dimension of concept integration, or elaboration as Lofland and Lofland (1995, p.164) call it, refers operationally to the number of major conceptual or analytic divisions and subdivisions that form the main body of the report. Strauss and Corbin (1990, p109, 121, 253-254) refer to this dimension as *density*, *specificity* or *integration*. Prime evidence is needed that the researcher has given detailed thought to one or more propositions used to structure and analyse the data. As a rule of thumb, Lofland and Lofland (1995, p.164) suggest a conceptual scheme that represents in the order of three to five major elements elaborating a proposition and a similar number of subdivisions within each element. Conceptual elaboration needs to demonstrate a balance between a conceptual scheme and the presentation of data, as well as interpenetration, that is, ‘the continuing and intimate *alternation* of data and analysis as text’ (Lofland & Lofland, 1995, p.165).

As descriptive categories were identified, it became necessary to explain the processes which were occurring when refugees entered health services. For example, the category ‘Refugees as ‘Others’’, describes the process of discursive exclusion that impacts in a material sense. Because the ethnic groups whose members come from refugee backgrounds are not included in studies such as *Degrees of Deprivation in New Zealand—An Atlas of Socioeconomic Difference* (Crampton, Salmond, Kirkpatrick, Scarborough & Skelly, 2000), except as the group ‘Other’, refugees are not prioritised as a ‘deprived’ group. Therefore they do not qualify for specific population targeting to reduce inequalities in health strategies (Ministry of Health, 2001a).

The themes that emerged were grouped as the dialectical processes of exclusion on the one hand and of opportunities for integration on the other, starting with ‘Refugees as ‘Others’’, ‘Barriers to health care’, ‘Providing primary health care’, ‘Promoting health’ and lastly, ‘Signs of activation’. These processes synthesised a number of related themes connected to the social interactions in the data and applied to a range of integration/exclusion concepts and conditions in the setting under study. Underpinning the data analysis are the theoretical frameworks for examining the exclusionary and integrative processes that emerge in the historic and contemporary

analysis of New Zealand immigration, health and social policies. The significance of the emergent thematic codes is that they systematically confirm the links between the researcher's critical analysis and data gathered in the field. Conceptual integration is represented when the abstract statements of the individual health workers who were interviewed and the social structures in the health services that they worked in, come together in emergent action.

Conceptual Categories

An initial concept map was developed to depict the processes occurring in this study. The researcher identified a focus for the study and developed a hypothetical title—'The process of integrating refugee peoples into New Zealand health services'. After months of intensive and repetitive analysis of data and personal reflections on professional experiences, the researcher recognised that what the data was conveying was simultaneously the processes of social exclusion and of integration. The original tentative category was changed to reflect the relationship between the discursive exclusion of refugee groups and the recognition of their membership rights. The title was changed to 'Refugees as 'Others': Social and cultural citizenship rights for refugees in New Zealand health services' (Figure 9.1). Conceptual maps were continuously tried and tested against the data for best 'fit' (Guba & Lincoln, 1981).

Data Map

The data map displayed in Figure 9.1 was systematically arranged to answer the question: 'how are health services responding to peoples from refugee backgrounds?' and to identify the exclusive and potentially integrative processes that are occurring. As Charmaz (2005, p. 508) says not only are justice and injustice abstract concepts, moreover they are '*enacted processes*, made real through actions performed again and again'. The map allowed me to conduct policy analysis in close conjunction with the displayed data and to see what further analyses of New Zealand social policy were called for. The map helped in seeing the particular processes of integration/social exclusion that were occurring in the New Zealand health system. The interactions between these processes are reflected in the organisation of the data analysis chapters.

Establishing Evaluation Criteria

Denzin and Lincoln (2000a; 2000b) have called the present post-structural moment in science a crisis of validity in scientific inquiry. Bricolage undermines traditional notions of triangulation and ‘because of its in-process (processual) nature, interresearcher reliability becomes far more difficult to achieve. No description is fixed and final and all features of the bricolage ‘come with an elastic clause’ (Kincheloe & McLaren 2000, p. 321). The collapse of foundational epistemologies has led to emerging innovations in methodology that have reframed what is meant by *validity*. Now the mission of social science research is in Christian’s (2005, p.152) view, to achieve ‘interpretive sufficiency’. This means taking seriously, lives that are loaded with multiple interpretations and grounded in social and cultural complexity. However, validity cannot be dismissed simply because it points to a question that has to be answered in one way or another.

The criteria for judging the adequacy of the study will be discussed in this section. Charmaz’s (2005) criteria for evaluating qualitative research will be utilised. These criteria are credibility, originality, resonance and usefulness (Charmaz, 2005, p.528). The criterion of credibility requires the researcher to provide evidence of intimate familiarity with the setting or topic that is being researched. As well, Charmaz (2005, p.528) asks the following questions:

- Are the data sufficient to merit the researcher’s claims? Consider the range, number, and depth of observations contained in the data.
- Has the researcher made systematic comparisons between observations and between categories?
- Do the categories cover a wide range of empirical observations?
- Are there strong logical links between the gathered data and the researcher’s argument and analysis?
- Has the researcher provided enough evidence for his or her claims to allow the reader to form an

independent assessment—and *agree* with the researcher's claims?

As described in the earlier section on the researcher, I have been deeply immersed in the area under study at a professional level for over six years. The question of whether the data provided in the study had enough integrity to merit the researcher's claims needed to be addressed.

To ensure the *credibility* of the study an audit trail was established which would determine if the conclusions and interpretations reached could be sourced to the data and could be accessed by other researchers to test validity. The analysis of data resulting from interviews as they are conducted is a subjective process. No two researchers can assimilate and react to the incoming information in the same way (Parahoo, 1997). To reduce the subjective effect in this research, an audit trail was left for others to follow the thinking processes and the actions of the researcher (Lincoln & Guba, 1985). The audit trail is useful for understanding the researcher's decisions, choices and insights, especially when the focus of interview questions changes as themes begin to emerge from the data (Morse & Field, 1996). According to Morse and Field (1996), it is important to be able to report when and for what reason thematic changes occurred. To show the links between the gathered data and the researcher's argument and analysis, the data available for review includes raw data, data reduction and analysis products, conceptual developments, process notes, material relating to hunches, questions, recurring themes and instrument development information. This includes the New Zealand social policy analysis data that is presented in chapters five to nine. A list of the policies and strategies analysed is set out in appendix twelve. Other raw data sources are the audiotapes and transcripts of participant interviews, both original and corrected, as well as all memos and written field notes. All interviews were verified by returning them to participants to crosscheck for accuracy and transcription errors. A trail of reduced and analysed data was recorded in write-ups of the levels of coding and abstraction of transcripts, memos and field notes. Conceptual developments were mapped in notes of tentative conceptual frameworks, diagrammatic models and summaries.

Within the criteria *originality*, Charmaz (2005) asks the following questions: Do the categories offer fresh insights? Does the analysis provide a new conceptual rendering of the data? What is the social and theoretical significance of the work? How does the work challenge, extend, or refine current ideas, concepts and practices? The study meets the criteria in these four domains. A strong combination of both credibility and originality increases resonance and usefulness. *Resonance* as a criterion is about whether the categories portray fully the studied experience. In the view of Lofland and Lofland (1995), the first and most important factor ought to be [italics in text] ‘*Is the content resonant with you?*’ [the researcher]. Charmaz (2005, p.528) also asks ‘whether the researcher has drawn links between larger collectivities and individual lives, when the data so indicates?’, and additionally whether analytic interpretations make sense to members and offer deeper insights about the participants in the study. When those involved in refugee resettlement and health care are able to recognise the phenomenon described in the study and their theoretical significance, *resonance* has been achieved (Charmaz, 2005).

Feedback on data analysis and on my critical reflections was sought from workers broadly in the fields of refugee health, social services and resettlement. The feedback indicated that the description and analysis in the study was meaningful and consistent with their experiences in a wide range of settings. Further, they observed that the findings of the study would be informative in improving institutional responsiveness. Finally, whether or not the study has *usefulness* will depend on whether the analysis offers interpretations that people can use in their everyday worlds, whether the analytic categories speak to generic processes, whether the generic processes have been examined for hidden social justice implications, whether the analysis can spark further research in other substantive areas and finally, how does the work contribute to making a better society? (Charmaz, 2005, p.528). In Kincheloe and McLaren’s (2000, p.287) view, in the hermeneutical process ‘the author’s answer is valuable only if it catalyzes the production of a new question for our consideration in the effort to make sense of a particular textual phenomenon’.

Conclusion

In conclusion, in this study critical hermeneutics was determined to be a good method for studying the social justice issues inherent in institutional responses to refugees

because of its ability to provide tools for analysing social processes within settings such as health care. Critical hermeneutics, in its ability to render the personal political, provides a methodology for arousing a critical consciousness through analysis of the generative themes of the present era. These generative themes are used in the study to examine the meaning-making power of the social and cultural sphere in contemporary New Zealand society in relation to the integration of refugees.

Chapter four focuses on the conceptual debates in the field of citizenship in relation to the integration of newcomers. Since the 1990s, political theorists have contributed significantly to our thinking on citizenship, particularly when focusing on newcomers. They have tried to answer the question of how basic democratic values can and should be combined with cultural and religious diversity on the one hand, and socio-economic equality on the other (Bauböck, 1994, 1996a, 1996b; Brubaker 1992; Kymlicka, 1995a, 2001a, 2001b; Penninx, 1996, 2000, 2003a, 2003b; Schierup, Hansen & Castles, 2006; Soysal 1994; Young 1990). However, few theorists have anything specific to say about the integration of refugees. The next chapter offers a full discussion of the dimensions of membership that are critical to refugee integration.

CHAPTER FOUR

THEORISING THE INTEGRATION OF REFUGEES

Introduction

To be a citizen means to be part of a specific political community, to participate in its economic, social and cultural life and to enjoy its support in case of need. To Jenson and Papillon (2000, p.6) citizenship, understood as a relationship between the individual and the state as well as among individuals ‘is the concrete expression of the fundamental principle of equality among members of the political community’. In this context, formal equality, in terms of universal rights to social citizenship, has been shown to be insufficient to integrate refugee groups (Schierup et al., 2006; Spencer, 2006). Refugee groups require special accommodations in receiving societies. The conceptual basis for organising the discussion in this chapter is that refugee integration in the long-term is vitally dependent on opportunities for socio-economic participation, alongside the accommodation of cultural and religious diversity in the receiving society.

A number of studies indicate that patterns of social and economic inequalities are solidifying in refugee groups in resettlement countries (Castles et al., 2002; Jenson & Papillon, 2000; Spencer, 2006; Zetter et al., 2002). The last two decades of refugee resettlement have coincided with neo-liberal economic restructuring in western receiving societies, giving rise to new modalities of social exclusion, posing threats to social cohesion and challenging the core idea of citizenship. The need to rethink the relationships between refugees and receiving societies, new diversities and exclusions, and the concept of citizenship, gives rise to the need for a theory of refugee integration. Many culturally inclusive concepts of social citizenship have been proposed within liberal democratic theoretical perspectives, including: ‘multicultural citizenship’ (Kymlicka, 1995a; 2001a), ‘differentiated citizenship’ (Young, 1990, 2002a), ‘cultural citizenship’ (Turner, 2001b), ‘postnational membership’ (Soysal, 1994) and ‘transnational citizenship’ (Bauböck, 1994). Most of these seek, in one way or another, to extend T.H Marshall’s (1950) classic notions surrounding ‘social citizenship’ and to explore new meanings of ‘membership’ and

especially, 'participation'. However, the position of refugees is under theorised in most conceptual frameworks of immigrant integration (Bauböck, 1996b, 2001; Brubaker, 2004; Kymlicka, 2001a; Penninx, 2000, 2003a, 2003b, 2004, Soysal, 1994; Young, 2002a).

In keeping with a growing rejection, since the 1960s, of policies of minority assimilation, the concept of minority rights has increasingly exercised both social and political scientists (Bauböck, 1996b, 2001; Kymlicka, 1995a, 1995b, 2002; Soysal, 1994; Young, 1995, 1998, 2002a). Will Kymlicka (1995a, p. 6 - 7) outlines a typology of three different sorts of minority rights demanded by specific kinds of groups, that is: immigrants, national minorities and indigenous peoples in western societies today. All three groups have histories, current conditions, claims and demands that need to be addressed specifically rather than through a generalised legal accommodation. Kymlicka (1995a, p. 6-7) identifies these as 'self-government rights (the delegation of powers to national minorities, often through some form of federalism)'; 'polyethnic rights (financial support and legal protection for certain practices associated with particular ethnic or religious groups)'; and 'special representation rights (guaranteed seats for ethnic or national groups within the central institutions of the larger state)'. Polyethnic rights, which Kymlicka (2001a, p.51) has termed 'accommodation rights', are associated with immigrant groups. Refugees as a disadvantaged sub-set of the wider group of immigrants, require as well as polyethnic rights, specific accommodations to address their particular psycho-social disadvantages.

The question of membership for refugees in this study is concerned with '*substantial citizenship*', the meaning of which is that citizenship for vulnerable groups in society is (Schierup et al., 2006, p.16):

... contingent on the existence or establishment of overall institutional and social conditions that would facilitate the actual exercise of rights by exposed individuals and social groups, and thus their actual participation as full and equal members of society.

Conversely, social exclusion in this study of integration signifies exclusion from citizenship in the broad sense of blocking opportunities for refugees to exercise full and fundamental social, economic, cultural and political rights in liberal-democratic welfare societies (Penninx, 2004; Samers, 1998; Schierup et al., 2006). The three key themes, which comprise the particular challenges of refugee integration, are: firstly, patterns of second-generation social and economic exclusion; secondly, conceptions that recognise cultural diversity cannot be isolated from frameworks to remove social and economic inequalities. Thirdly, there are growing concerns that ‘visible minorities’, who now constitute the majority of refugees being resettled, face greater systemic barriers to integration than did earlier groups (Brubaker, 2004; Papillon, 2002; Shields, 2003).

The chapter is organised into six sections. The first considers T.H. Marshall’s (1950, 1965) traditional notions of social citizenship. Marshall (1965) was first to argue that social citizenship plays a crucial role in the attainment of equality. The second section asks what the limitations of traditional conceptions of citizenship are in the context of multiculturalism models. The third considers the social/economic and cultural dimensions of membership for refugees that must be addressed in theories of integration. In the fourth section there are some models and typologies for critiquing citizenship that suggest differing approaches to the integration of newcomers. Fifthly, the theoretical shortcomings in contemporary models of membership for the integration of refugees are outlined. The last section offers a theoretical framework for the long-term integration of refugees in receiving societies.

Marshallian Notions of Citizenship

This section will explore the theoretical inadequacies of traditional Marshallian perspectives in the context of immigrant multiculturalism conceptualisations of citizenship. The central focus of the section is the operation of multiculturalism models in relation to the integration of refugees. To begin with, a brief background and critique is given of the classical analysis of citizenship suggested by sociologist T.H. Marshall (1950; 1965) in postwar Britain. Marshall (1965) described three categories of citizenship rights, civil, political and social. Civil rights guarantee fundamental freedoms, such as freedom of expression and religion. Political rights include the right to vote and to stand as a candidate. Social rights include the right to

education, access to housing, health services and income support. The claim that citizenship mitigates the negative effects of economic class within capitalist society by a redistribution of resources on the basis of rights, is an important foundation established by the Marshallian paradigm (Turner, 2001a, p.190). The recognition of social rights in the 20th Century was associated with a fundamental transformation of thinking on equality. The concept of equality became ‘more than a formal principle (equality in status), involving some measure of socio-economic reality (equality in practice)’ (Jenson & Papillon, 2000, p.10).

There are two key issues that challenge the Marshallian paradigm in the 21st Century. Firstly, reflecting his own historic location in the 1950s in the United Kingdom, Marshall ‘assumed a heterogenous society in which regional, cultural and ethnic divisions were not important when compared to social class divisions’ (Turner, 2001a, p.191). Marshall (1950, p. 69, cited in Turner, 2001a, p.190) defined social citizenship as the right to an acceptable level of ‘economic welfare and security, to the right to share the full social heritage and to live the life of a civilised being’. Marshall (1965) also assumed that there would be a progressive extension of social rights. From the 1980s, multiculturalism theorists called for a new component of citizenship, namely cultural rights, as an integral part of any citizenship politics (Kymlicka, 1995a; Taylor, 1994; Tully, 1995). In the 1990s, citizenship debates in political theory strongly focused on the cultural dimension that had been neglected in Marshall’s (1950; 1965) approach.

Secondly, the role of the state in administering the welfare associated with citizenship has been reduced in neo-liberally reformed societies (Schierup et al., 2006). In the words of Schierup et al. (2006, p.248):

... the neoliberal endeavour to roll back the welfare state has amply demonstrated the fragility of rights of citizenship. It has exposed the fallacy of any developmental optimism based on evolutionary presumptions like, for example, those of T.H. Marshall (1950) in *Citizenship and Social Class* (Bottomore, 1996; Giddens, 1982; Turner, 1990). But as we have

demonstrated, it has also brought out the particular vulnerability of migrants and ethnic minorities to the decline of social solidarity.

A central issue to raise in regard to models of refugee integration is (Schierup, Hansen & Castles, 2006, p.18-19):

...whether a sustainable policy targeted at equal opportunities can actually succeed without the precondition that some form of a broad social compact on citizenship and social welfare is still valid in terms of normative political consensus and strong institutions beyond and complementary to the market.

Elaborating a theoretical framework for refugee integration is a formidable challenge. The integration of refugees tests liberal democratic notions of citizenship in receiving societies. The challenges that must be addressed conceptually are not only those of culture, language and religion but also the sharp disparities between refugee groups and receiving societies in levels of education, dominant language and literacy proficiency and employment. Refugee groups challenge contemporary notions of community, identity, belonging and rights. The conceptual models of refugee integration that are needed must reflect national histories of immigration and the marked distinctions in the ways in which nation-states integrate newcomers (Bauböck, 2005; Penninx, 2003a; Soysal, 1994).

Immigrant Multiculturalism

The multiculturalism policies under discussion in this thesis are those of immigrant multiculturalism. Multiculturalism is one democratic policy response to cultural and social diversity in society. It embodies the ideal of reconciling respect for diversity with concerns for societal cohesion and the promotion of universally shared values and norms. Multiculturalism represents a systematic and comprehensive response to cultural diversity, with educational, linguistic, economic and social components and specific institutional mechanisms for integration. It will be argued in this chapter that

‘multiculturalism is not, of course, an *all-encompassing* [italics in text] policy for addressing diversity’ (Jenson & Papillon 2001, p.34). The different dimensions of social and economic inequality in society also need to be addressed. Banting and Kymlicka argue (2003, p.11):

...that the theory and practice of multiculturalism is intended precisely to supplement and enrich our conceptual tools and political spaces for arriving at a more adequate diagnosis of the full range of injustices faced by different groups in our society.

Importantly, Banting and Kymlicka (2003, p.10) contend that multiculturalism emerged as part of the New Left’s rejection of the Marxist dogmatic assertion of the primacy of class:

Multiculturalists were not suggesting that we should replace class inequality with cultural inequality as the mono-causal motor of history. [They were] contesting the idea that all inequalities can be reduced to one “real” inequality, and insisting instead that culture, race, class, and sex are all real loci of inequality, of varying salience, not reducible to each other.

The central question in this section is how well the theoretical literature on immigrant multiculturalism connects to integrating refugees in receiving societies. The key arguments to be made are: firstly that immigrant multiculturalism as a framework for refugee integration under-theorises the disadvantaged position of refugees within the broader group immigrants. Secondly, that the interesting questions theoretically in regard to immigrant multiculturalism, concern the particular ways that nation-states integrate or exclude refugees—socially, economically and culturally. Thirdly, immigrant multiculturalism concepts frequently under-theorise the importance of social policies in addressing the social exclusion of refugee groups.

Kymlicka’s (2001a, p. 54) multiculturalism model is a two-way integration process:

... first it involves promoting linguistic and institutional integration, so that immigrant groups have equal opportunity in the basic educational, political and economic institutions of society; and second, it involves reforming those common institutions so as to accommodate the distinctive ethnocultural practices of immigrants, so that linguistic and institutional integration does not require denial of their ethnocultural identities.

There are important differences in how official, or formal, shifts to multiculturalism have been in receiving societies. The Governments of Canada, in 1971, and Australia, in 1978, are the only two to have officially adopted multiculturalism. Canadian multiculturalism, which has gone further than that of Australia, (Hiebert, Collins & Spoonley, 2003, p. 7):

... has three defining elements: the right of individuals to retain their cultures (in contrast to the expectation of assimilation); the provision of services to enable both integration and cultural retention (e.g. language programs for immigrants to learn English and French, but also for their children to learn heritage languages); and anti-discrimination ...

In other cases, Banting and Kymlicka (2003, p. 25) characterise the United States as 'modestly' multicultural at the level of the state and the city, while not officially so at the federal level. However, Giroux (1996, p. 67) contests this claim, citing 'the intensity of the attack that is currently being waged against multiculturalism, cultural differences, and the politics of identity by conservative and right wing groups' in the United States. Countries such as Sweden and the Netherlands have adopted aspects of a 'multicultural' approach but not explicit 'multiculturalism' policies (Inglis, 1996).

Many authors have argued that immigrant minority rights are best represented within specific multiculturalism policies (MCPs) (Jenson & Papillon, 2001; Kymlicka, 2001a, 2001b; Modood, 2000a, 2000b, Papillon, 2002). Kymlicka (2001a, p.163), defines the twelve multiculturalism policies that are most commonly associated with immigrant groups as:

1. Adopting affirmative action programmes ...
2. Reserving a certain number of seats in the legislature, or government advisory bodies, for immigrant groups ...
3. Revising the history and literature curriculum within public schools to give greater recognition to the historical and cultural contributions of immigrant groups.
4. Revising work schedules so as to accommodate the religious holidays of immigrant groups ...
5. Revising dress-codes so as to accommodate the religious beliefs of immigrant groups ...
6. Adopting anti-racism educational programmes.
7. Adopting workplace or school harassment codes which seek to prevent colleagues/students from making racial ... statements.
8. Mandating cultural diversity training for the police or health care professionals ...
9. Adopting government regulatory guidelines about ethnic stereotypes in the media.
10. Providing government funding of ethnic cultural festivals and ethnic studies programmes.
11. Providing certain services to adult immigrants in their mother-tongue, rather than requiring them to learn English as a precondition for accessing public services.
12. Providing bi-lingual education programmes for the children of immigrants, so that their earliest years of

education are conducted partly in their mother-tongue, as a transitional phase to secondary and post-secondary education in English.

The emphasis in liberal multiculturalism is on the adoption of the group-specific rights and policies that are 'intended to recognise the distinctive identities and needs of ethno cultural groups' (Kymlicka, 2001a, p. 47). This focus has been the subject of criticism from theorists concerned with the political, social and economic integration of new comers (Brubaker, 2004; Fraser, 1995). Brubaker (2004, p. 121), for instance, notes the dramatic increase in inequality in American society in recent decades which 'has occurred during a period in which the left has been preoccupied with issues of identity and culture, and in which a general 'culturalization' of political rhetoric has made it more difficult to focus on underlying economic issues'. Fraser's (1995, p. 68) critique is that in the late twentieth century the 'struggle for recognition' became the paradigmatic form of political conflict in which demands for 'recognition of difference' fuelled:

... struggles of groups mobilized under the banners of nationality, ethnicity, 'race', gender, and sexuality. In these 'post-socialist' conflicts, group identity supplants class interest as the chief medium of political mobilization. Cultural domination supplants exploitation as the fundamental injustice. And cultural recognition displaces socioeconomic redistribution as the remedy for injustice and the goal of political struggle.

Kymlicka's (2001a) multiculturalism model undertheorises the social and economic integration of refugee groups. Economic mobility is crucial for refugees and is recognised as the key variable in their integration (Jean, 2006; Lemaitre, 2006; Wayland, 2006a, 2006b; Zetter et al., 2002). In this context, Shields (2003, p. xxxvi) and others (Papillon, 2002; Wayland, 2006a, 2006b) note the deteriorating position of identifiable minorities who have arrived in Canada since the 1980s. The overlaying of poverty with minority ethno-racial status has grown significantly in Canada's largest cities, indicating that there is a real danger that a process of racialisation of poverty is

underway (Shields, 2003). A number of Canadian studies indicate that since the early 1990s cohorts of refugees have been experiencing significant difficulties in achieving successful social and economic integration (Kunz, Milan & Schetagne, 2000; Papillon, 2002; Shields, 2003). Studies comparing the integration processes of different immigrant groups in Canada show that refugee groups are failing to integrate socially and economically (DeVoretz, Pivnenko & Beiser 2004; Hiebert, Collins & Spoonley, 2003; Jenson & Papillon, 2001; Papillon, 2002; Shields, 2003). Papillon (2002) relates this trend largely to neo-liberal welfare and social reforms and to marked discrimination in the labour market against 'visible minorities'. In Shield's view (2003, p.xxxii), 'dramatically weakened safety nets and [the reduction of] publicly supported settlement services have served to deepen the tensions within [recent refugee and] immigrant populations'.

Key Dimensions of Citizenship for Refugees

There is only limited consensus in the literature over the meaning of refugee integration in receiving societies. For some, integration is about promoting social and economic cohesion (Bauböck, 2005); for others it is overcoming the barriers of social exclusion which are endemic experiences amongst refugee groups (Samers, 1998). That it might be a two way process, involving key variables in the social and economic life of hosts and refugees, points to the core of the political and cultural factors and tensions on which integration is contingent (Zetter et al., 2002, p. 121). A key question is, 'what are newcomers integrating into?' (Samers, 1998, p. 129). That refugee groups are integrating 'into something' 'implies some stable form of society where hegemonic [groups] are not contested by the political, economic, social, and cultural participation of 'ethnic minorities' themselves' (Samers, 1998, p. 129). Whilst there is some measure of convergence surrounding the social and economic means of integration, there is rather less agreement on the end state.

Refugees are one of the most vulnerable groups in receiving societies. Among the many barriers to integration identified in the literature are poverty, unresponsive administrative structures, unemployment, housing shortages, political shifts to the right and the perceived threats to social cohesion posed by anti-immigration politicians and the media. On an individual level, trauma, social isolation, lack of skills and education, and poor physical and mental health among refugees impede

participation in the new society, as do hostility and rejection from the community. Refugee status implies the right to '*special protection*' in the country of resettlement (Castles, et al., 2002, p. 24). The dimensions of social and economic rights that are essential to newly resettled refugees are the provision of social protection and access to social services to facilitate settlement (Castles et al., 2002; Zetter, et al., 2002). The emphasis in the refugee studies literature, in the initial phase of settlement, is on what Korac (2001, p.2) terms '*functional integration*'. This includes assistance with housing, language training, education and re-training and access to the labour market. The evidence suggests that the integration process should start as soon as possible after arrival and must be supported by coherent settlement packages at different administrative levels (Zetter et al., 2002, p. 121). The indications are that short-term transitional settlement services are an insufficient means of achieving long-term integration (Papillon, 2002; Schierup et al., 2006; Zetter et al., 2002).

Bauböck (2005, p. 5), in response to the rise of anti-immigrant sentiment in Western Europe, highlights the need for integration which appeals to the universalistic norms of liberal democracies 'but pays equal attention to the historic particularities' of receiving societies. As a consequence, the scope of integration models, the agents involved and the instruments of policy action will differ between nation-states. In Kymlicka's words (1995a, p. 13), we cannot be 'locked into preconceived beliefs about how states must be structured, or into over-simplified dichotomies of assimilation or separation' in terms of integrating newcomers. Refugee integration models need to acknowledge a range of diverse social cultural and economic policies in receiving societies. For example (Penninx, 2003b, p. 3):

...in the socio-economic sphere...integration mechanisms in societies with a strong liberal market orientation (and limited welfare and social facilities) differ from those in welfare states where [in some cases] a greater part of the national income is redistributed. In addition, in the cultural and religious domain, historical peculiarities of institutional arrangements create significant differences in the feasibility of policies.

There are core political and cultural tensions in nation-states upon which integration is contingent (Bartley & Spoonley, 2005; Schierup et al., 2006). Refugees are the most challenging groups to societal notions of belonging in that they are often the most culturally different groups from those in the receiving society and the most socially and economically excluded (Papillon, 2002; Zetter et al., 2002). In Bauböck's (1996a, p.21) view, how societies accommodate their newcomers 'does not depend so much on the immigrants' characteristics as on these societies' own interests, identities and norms'. In a European Union study, Zetter et al. (2002) conclude that states' contrasting histories of immigration have been highly influential in shaping the processes and practices of refugee integration, and that beyond mechanistic and procedural harmonisation, elaborating a conceptual and operational framework for refugee integration remains a formidable challenge.

Typologies of Membership Models for Newcomers with a Special Focus on Refugees

This section assesses two conceptual typologies of membership models for newcomers, and their relevance for the integration of refugee groups. It is argued that the central issues to be resolved in models of refugee integration are 'how basic democratic values can and should be combined with cultural and religious diversity on the one hand and socio-economic equality on the other' (Penninx, 2000, p.4).

Soysal (1994), Young (1998; 2002a), and others (Bauböck, 1996a; 2001; Brubaker, 1989; 2001; Castles & Miller, 1993; Kymlicka, 2001a) have suggested various typologies of what may be called 'immigrant integration regimes'. Often these are idealtypic in that they collapse observed differences between countries into classification systems that exhaust logical or conceptual possibilities. The attempts to classify states according to a particular model give only a partial indication of their actual policy initiatives and programmes. More importantly, translating conceptual citizenship frameworks into action means that 'the ideological-normative models acquire their programmatic-political reality' (Inglis, 1996, p.40). The conceptual interest in this thesis is to focus on the structure and ideology of the political community in the receiving society, in order to understand the different kinds of immigration and integration regimes that have developed (Bauböck, 2001). Taking this perspective, the integration of refugee groups is contingent on the wider

normative and institutional frameworks in the nation-state. As Schierup et al. (2006, p.248) argue:

Democracy and the welfare states are the historical products of social and political struggles, and are based on particular political, institutional and structural assumptions and preconditions (Giddens, 1982; Bottomore, 1996). Like any achievement in citizenship, attempts to develop an inclusive multi-ethnic welfare society is vulnerable to radical social and economic change and in the last instance, contingent on the sustainability of established, or the renewed formation of, political compromises, coalitions, and ideological hegemonies.

Conceptual models are needed in which refugee integration is understood as pre-conditioned by civil, political and in particular, the social and cultural rights of citizenship which are sanctioned by the political compact of the welfare state. Critically, the reality of a '*substantial citizenship*' for refugee groups is contingent on the existence or establishment of overall institutional and social/cultural conditions that would facilitate the actual exercise of social rights, and their actual participation as full and equal members of society (Schierup, Hansen & Castles, 2006, p.16).

Soysal's Regimes of Incorporation

The chief concern of Soysal's (1994) model of immigrant incorporation is with the structures and agency of membership in the receiving society. In Soysal's view the *modes of inclusion* exercised by nation states in relation to newcomers holds the key to understanding the processes of citizenship and integration. A key criticism in this section is that conceptual critiques such as Soysal's (1994) and Young's (2000), in the following section, can divert attention away from the normative question of what states have to do to integrate refugees. The chief argument is that Soysal's (1994) *regimes of incorporation* and Young's (2000) model of deliberative democracy do not satisfactorily allow for the particular needs and socio/cultural-economic position of refugees to be reflected.

The argument that Soysal (1994) makes is that the way states incorporate newcomers (for example through participation in social institutions in the host country) reveal the structure and function of membership systems or *incorporation regimes*. These regimes comprise legal rules, policy frameworks and administrative and organisational structures. Incorporation regimes are the outcomes of the divergent histories and contrasting ways in which nation-states have come to define their understanding of membership and belonging. These regimes, amongst other impacts, define the relationship between the receiving state and newcomers and thus the modes of inclusion.

Operationalising this concept, Soysal (1994) develops a fourfold typology of membership models that elaborates the ways in which newcomers are incorporated. These are corporate, liberal, statist and fragmental membership models. There are two key parameters in the construction of the typology: first, the locus of governance and action in relation to membership—for example, the state, civil society or social groups which organise membership. Second, the degree to which the administrative organisation of membership is centralised or decentralised. The usefulness of the model for refugee integration is limited.

Soysal (1994) endorses corporatist polities, such as Sweden, where the state and its institutions take responsibility for the organisation of the integration of refugees. However, there are a number of difficulties with the corporatist model. First, in the context of ‘fortress Europe’ and of growing anti-immigrant sentiment, it needs to be recognised that ‘the prospects for the communitarianisation of integration policies with respect to refugees are challenging’ (Zetter et al., 2002, p. 13). Second, Bauböck (1996b) and others (Kymlicka, 1995a) are sceptical about the value of the special representation of immigrant associations, because those who are elected or appointed to represent them may not adequately represent the political goals and preferences of group members (Bauböck, 1996b). Third, Samers (1998, p.137) states that in spite of Soysal’s (1994) careful analysis of the various *modes of inclusion*:

... such as Sweden’s pro-active efforts to foster corporate ethnic identities and groups, many of the

consultative committees set up for the participation of ethnic communities are increasingly being abandoned by immigrants because they have neither real electoral power, nor are they state financed in many European countries.

Last, in terms of economic integration, Soysal's corporatist models have had little impact on 'the political decision-making surrounding wages and benefits, and redressing unemployment and social deprivation' in refugee groups (Samers, 1998, p. 128). The conclusion that Schierup et al. (2006) reach is that, although Sweden early on institutionalised far-reaching political measures to include refugees in a wide array of citizenship rights, 'formal incorporation as citizens or denizens had the ambiguous character of 'subordinated inclusion'' (Mulinari & Neergaard, 2004 in Schierup et al., 2006, p.228). Refugees were included in the least attractive parts of the labour market. Ethnic organisations received state support in the name of cultural diversity but at the price of depoliticisation. Until the 1990s, a high degree of social security and relative material welfare mitigated the effect of the ethnic division of labour on income differentials but since this time the economic position of refugee groups has declined. The new Swedish integration policy—introduced since 1997 as a 'policy for the *integration of society and all of its institutions* [italics in text] and through the agency of its multi-ethnic population'—appears to have had some success (Schierup et al., 2006, p. 230). Revealingly though the (Schierup et al., 2006, p. 230):

... striking disjunction between ideology and everyday institutional practice continues to augment rather than diminish threats to the legitimacy of a regime for which broad public support legitimacy and consensus across the social spectrum are a sine qua non.

The everyday reality in Sweden is a covertly discriminatory local government bureaucracy and labour market.

Young's Model of Deliberative Democracy

This section assesses the usefulness of Young's (2000) model of deliberative democracy which emphasises the political participation of oppressed minorities in liberal democratic states. In this view, formally democratic politics reinforce structural social inequality through the exclusion of non-dominant groups in decision-making processes. This perspective examines the processes of civic participation that could deliver a more inclusive citizenship for oppressed groups. Young (2000) proposes a theory of communicative democracy that would politically mobilise the subordinated groups in society. She advocates a 'decentred' model which 'gives more prominence to processes of discussion and citizen involvement in the associations of civil society' (Young, 2000, p. 46). However, the view that this process would allow oppressed minorities equal participation with dominant groups in all levels of public consultation and decision-making is unrealistic.

Young's (2000, p.8) argument is that most western societies are only 'thinly democratic' and practise democracy minimally with respect to their diverse ethnic communities. In particular, 'minority cultural groups and those positioned in devalued racial positions usually lack effective political voice' (Young, 2000, p. 141). For these groups, structural, social and economic inequality produces political inequality and 'relative exclusion from influential political discussion' (Young, 2000, p. 141). In this view, Kymlicka's (1995a) theory of minority rights is considered to be too tied to universal liberal values and insufficiently sensitive to contextual factors and to cultural differences. The model of deliberative democracy is proposed as a more inclusive way for ethnically diverse groups to participate in receiving societies in the sense that a group-differentiated politics is necessary in 'mobilisations and programmes to undermine oppression and promote social justice' (Young, 1995, p. 156).

There are three main criticisms of Young's (2000) model. The first is that arguments about political participation mean little, if oppressed groups are excluded from basic social and economic rights such as income support, employment, health and housing. The second criticism is that Young conflates three different kinds of rights, rights which Kymlicka (1995a) identifies as special representation rights for disadvantaged

groups, multicultural rights for immigrant groups and self-government rights for national minorities. Each of these groups requires sets of rights that pose different challenges to models of citizenship. The third criticism therefore is that without clarification of these different sets of rights, the model of differentiated representation proposed would be organisationally unworkable. This is because such a unitary conception of citizenship cannot deal sufficiently with issues of language, culture and identity (Kymlicka, 2001a). In this respect, Young's argument for differentiated group representation is unhelpful.

To use Brubaker's (2001, p.532) words: 'the differentialist turn in social thought, public discourse, and public policy shows signs of having exhausted itself'. There is more potential for 'thick' democratic processes—than that offered in Young's proposal—in conceptions such as Kymlicka's (2001a) and Penninx's (2000) which highlight the integrative role of the state and its institutions. Alternatively, the key to creating political opportunity structures for refugee groups in receiving societies is a public administration system in which communities are represented, as well as social policies that address refugee group claims, concerns and interests, and a public culture that is inclusive and accepts diversity (Bauböck, 2005).

Theoretical Flaws in Models/Typologies of the Integration of Refugees

Globally, models of refugee integration have been subsumed within wider frameworks for immigrant integration. While there are many points of contact between the experiences of refugees and the wider processes of migrant membership and integration in receiving societies 'a number of critical factors distinguish the experience of forced migration for refugees compared to other forms of voluntary migration' and these have implications for long-term integration that need to be addressed conceptually. (Zetter et al., 2002, p. 128). What is distinctive about models of refugee integration is the need to explore new conceptual approaches which combine cultural and religious diversity; social and political cohesion; and social and economic equality for refugee groups in the long-term. An important critique of models such as Soysal's (1994) (*italics in text*) *regimes of incorporation* and Young's (2000), 'deliberative democracy' is that they tend to focus on the abstract discussions of the merits and drawbacks of legal-political ideal types and pay less attention to the

questions of social inequality and political and economic power within various nation-states. What is needed is not 'reductive or simplifying models but, on the contrary, a debate and institutional practices that allow space for the complexity of diverse national situations' (Schierup et al., 2006, p.13).

In this sense, there are critical limitations, in terms of refugee membership, in the models of immigrant integration which have been discussed in this chapter. Kymlicka (2001a, 2001b) and others (Jenson & Papillon, 2001; Modood, 2000a, 2000b; Papillon, 2002) have argued that immigrant minority rights are best represented within specific multiculturalism policies. These policies are essential to accommodating the cultural, religious and linguistic diversity of newcomers in the institutions of the receiving society. However, to ensure the political, social and economic integration of refugee groups in the first, second and subsequent generations, receiving societies need specific strategies and social policy that is responsive to refugee groups.

There are four overarching theoretical considerations that need to be addressed in models of refugee integration. The first is that citizenship models conceptualised in terms of social exclusion, used in the broad sense of blocking opportunities for refugees to exercise full and fundamental social, economic, cultural and political rights, are useful (Penninx, 2004; Samers, 1998; Schierup et al., 2006). The critical perspectives that explore a dialectical relationship between social exclusion and integration are particularly helpful in explaining the ambiguities between being legally a citizen, but substantively excluded from the political, social, economic and cultural rights of citizenship (Samers, 1998). In this respect, one of the key theoretical questions to be addressed is how much inequality in the socioeconomic conditions of refugee groups are societies prepared to tolerate. In responding to this question, the differences in social protection provided by societies with strong liberal market orientations will differ from those in, for example, social democratic European Union states. The liberal 'culturalist' framework of integration offered by Kymlicka (2001a; 2001b) provides insufficient analysis in this respect.

The second point is that the nature, history and structure of the receiving society will determine refugee integration. In each receiving society (Castles et al., 2002, p. 26)

‘integration is relative and culturally determined’ and therefore integration policies will be, of necessity, context-bound. The differences in the immigration histories and membership models of the different resettlement countries have not always been adequately factored into models of integration. The historical peculiarities of institutional arrangements may determine the feasibility of policies—in particular, in cultural and religious domains. The introduction of institutional facilities for immigrant religions or languages, for example, may be relatively easy in countries with a tradition of diversity, while these same facilities may meet much more resistance in more homogeneous societies.

The third point is that, conceptually, it is important to make clear in integration frameworks the relationship between the various domains of citizenship. The next section shows the advantages in using Penninx’s (2000) typology of integration policies. By describing the practice of juridical/political, socio-economic and cultural and religious rights in separate spheres, as Penninx does, it is possible to explain how exclusion in one domain impacts on participation in other domains.

The fourth consideration is that the state and its institutions mediate the process of long-term integration or exclusion in significant ways. The role of the state and its public institutions are the key to ensuring that processes and structures are in place to enable refugees to access their social, economic and cultural rights through inclusive social policies, structures and services. Characteristically, there are two kinds of institutions that play a role in integration. The first is the state and its public institutions and the second the various institutions of civil society. This twofold model of institutional integration is important and conceptions that focus primarily on civil society are less helpful for the long-term integration of refugee groups (Soysal, 1994; Young, 2000).

Penninx’s (2000) typology of integration policies, which is discussed in the next section, resolves some of these theoretical flaws. The advantage of this typology is that it offers a more comprehensive framework for resolving the questions of cultural and religious diversity, social and political cohesion and social and economic equality, in the context of national histories and membership models.

Penninx's Typology of Integration Policies

The previous section outlined four essential conceptual components to be considered in models of refugee integration. In summary, these were that there is a dialectical relationship between the social exclusion and integration of refugee groups; that nation-state's integration policies are bound by their historic and socio-political contexts; that the impacts of participating or not participating in one sphere of citizenship will have proportional impacts on other spheres; and that the roles of the state and of civil society are critical to the integration of refugee groups. Penninx's (2000) typology of integration policies deals with these conceptual categories systematically and comprehensively. A chief contribution is reformulating the normative/idealtypic concepts of multicultural citizenship into a descriptive-analytical conceptual framework that can be used operationally (Penninx, 2000, p.6). Penninx (2004, p.4) views the institutional 'opportunity structure' as a key conceptual framework for critically analysing the participation of refugees. The important question posed theoretically, and in practice, is to what extent systems are open to integrate refugees socially and culturally, or can be opened or activated in the future?

Usefully, Penninx (2000, p.5) has reformulated citizenship into three key dimensions in order to analyse the policies of receiving societies as 'spheres of integration'. Penninx (2004) defines citizenship in three distinct domains of rights, which make clear the modalities by which citizenship and integration are enacted. The first domain, juridical/political, refers to the basic question of whether—and in how far—immigrants have differential formal rights and duties in relation to formal political participation opportunities. It includes not only access to national citizenship and thus the formal political system but also the granting of political rights to non-nationals and the juridical status as aliens, as far as this has consequences for political participation (Penninx, 2000, p.5). The second domain is the socio-economic aspect of citizenship which Penninx (2000, p.5) explains as 'the social and economic rights of residents, irrespective of national citizenship. These include industrial rights and rights related to institutionalized facilities in the socio-economic sphere'. These rights include: equal rights to accept work and to use the state's institutional facilities for finding work; access to work related benefits such as unemployment and sickness benefits; and access to state provided social security facilities, such as state housing, social assistance, welfare and care facilities. The third domain pertains to cultural and

religious rights and the right to organise as ethnic groups. The threefold concept of citizenship is used to typologise the orientations of various integration policies in receiving societies. Penninx's (2000) model envisages that culturally diverse individuals and groups can be fully integrated into society without either losing their distinctiveness or being denied full participation. The basic premise proposed by Penninx (2000, p. 8-9) is that:

...immigrants cannot become equal citizens unless state and society accept that both individuals and groups have the right to cultural difference. The prevailing institutions and rules in society are historical and cultural products that are not neutral for newcomers and thus may need revision in order to accommodate newcomers according to the multicultural vision.

The three spheres of integration are mutually reinforcing. They indicate the policy environments within which rights for refugee groups should be developed and protected. Integration policies should define clear priorities for action in all three domains. The role of the state is to activate the domains in which they have (Penninx, 2003b, p. 2):

...effective and generally accepted instruments to promote integration and prevent exclusion: the economic domain of work and the social domain, particularly of education and housing. Policies in the political and cultural domain (including religion) are indispensable over the long term to integrate [refugees].

National social policies should set general frameworks, rules and instruments to facilitate local actors. These integration policies (Penninx, 2003b, p.3):

...should combine 'top down' activation with 'bottom up' mobilization. It should define the process of integration as 'open' within the rules of liberal

democratic societies, leaving room for an outcome of a more diverse but cohesive society. The diversity reached in this way is neither predetermined nor static, but negotiated, shared and ever changing.

The advantage of Penninx's (2000, 2003b) model is that it allows the process of settlement and integration for refugees and their ethnic communities to be studied, including the consequences that this has for the receiving society. The model allows separate study of the two sets of actors in the integration process: the individuals, organisations and institutions in the refugee group themselves; and the actors in the political, socioeconomic, ethnocultural and religious domains of the receiving society. Ultimately, the interaction between the refugee groups and the receiving society determines the direction of the process, and the ultimate outcomes of settlement in the long-term.

The institutions of civil society influence the processes of integration, in particular, in the early stages of settlement. These institutional actors include: religious organisations; non-governmental organisations; political parties; the media; and other civil society organisations at national, regional and local levels as well as refugee communities. State settlement and integration policies should actively involve refugees in partnership with key players in civil society. These actors can function as direct partners in the implementation of resettlement policies. They provide an important role in advocating for social and economic rights and are influential in combating exclusion, discrimination, and xenophobia towards refugees and asylum seekers (Penninx, 2003a). However, while analytical attention must be paid to the role that civil society plays in refugee settlement, in the long-term central governments and their institutions are the primary engines of systemic integration.

The processes of integration that take place at the level of public institutions are of critical interest in this thesis. The sociological concept of institutions is 'a standardized, structured and common way of acting in a socio-cultural setting' (Penninx, 2004, p. 13). The functioning of the public institutions of receiving societies such as the education system, institutional arrangements in the labour market, or for public health, are supposed to serve all citizens equally. However, these public

institutions may hinder access or equal outcomes for refugee groups and their descendants in two ways. First, they may partially exclude them, for example, their health and welfare systems may offer unequal or restricted access to services to refugee groups (Penninx, 2004). Second, if access for all residents is in principle guaranteed, such institutions may hinder access and/or equal outcomes for refugee groups. This may occur because of the institution's historically and culturally determined ways of operating, or, by not taking into account the specific characteristics of refugees' situations which are related to their forced migration experiences, their cultural and religious backgrounds or their linguistic differences. The functioning of these public institutions and their ability to make cultural accommodations is, in Penninx's (2004, p.13) view, of paramount importance. Public institutions are also instrumental for refugee integration at another level. Institutional arrangements will determine, to a great extent, the opportunities and scope for action for non-governmental organisations, including refugee organisations. Institutions and organisations together create the structure of opportunities and limitations for individual refugees.

The key to integrating refugees is the harmonisation of immigration, integration and social policies. Comparisons between countries with an explicit formulation of immigration policies linked to integration and those that lack a coherent policy and institutional framework of integration show that the latter strongly disadvantage refugees (Banting & Kymlicka, 2003; Penninx, 2000; Spencer, 2006; Zetter et al., 2002). States that have linked these three policy areas are more likely to have positive settlement outcomes for newcomers and subsequent generations (Penninx, 2000). In the next section, Penninx's model (2000) provides the conceptual and theoretical rationale for establishing an integration model for refugees.

An Integration Model for Refugees

The first part of this section discusses the key conceptual approaches that are specifically required to achieve full membership for refugee groups in receiving societies. The second half of the section highlights the institutions that are essential to the long-term social, economic and cultural integration of refugees. Kymlicka's (2001a) multiculturalism model described previously, outlines the types of cultural

policies and institutional accommodations that are essential for the recognition of the cultural, religious and linguistic diversity of refugee groups. These accommodations will not be repeated in this section. There are two key approaches to refugee integration that are the focus in this section. The first is ensuring that the state takes responsibility for the alignment of refugee, integration and social policies. Whether or not refugees are able to participate in the key institutions of integration, that is, employment, education, welfare, health, housing and justice, will depend on the state's institutional arrangements for managing diversity and on whether or not their social policies are inclusive. The second is that refugee integration policies should define clear priorities for action in social policy. In this respect, it is important to distinguish between the forms of integration policy required for refugee groups as new arrivals and the forms of policy required for second and third generation communities.

The first conceptual approach is that states manage integration processes for refugee groups in the short-term and the long-term. In this view, central government leadership is instrumental to achieving long-term integration. The greatest influence on the long-term outcome of integration processes is the alignment of refugee resettlement and integration policies with the institutional arrangements and social policies of the state. The converse of managing integration in this way is governments who take a 'hands off' approach which, in the view, of this thesis, creates conditions for the long-term marginalisation of refugee groups. Further, integration policies and strategies need to be framed with as much detail as refugee selection policies. For example, the New Zealand Government selects refugees with high health needs and these policies need to be reflected in the responsiveness of the health sector to refugee groups.

Critically, social policies have to be organised to manage effectively both initial refugee resettlement and long-term integration. Different measures are required at different stages of integration. Settlement, using a Canadian definition, can be broken down into three phases (Mwaringha, 2002, p. 9-10):

- (1) *Immediate*: Persons require shelter, food, clothing,

information and orientation, basic language instruction, and other essential “reception” or early settlement services.

- (2) *Intermediate*: Persons require advanced or employment-specific language instructions, training and education to acquire or upgrade skills, usually with the goal of securing employment. Other needs at this stage include accessing health services, housing, and the legal assistance system.
- (3) *Long-term*: Persons work to overcome systemic barriers and to participate in Canadian society as equals to the [local]-born population. Long-term settlement includes civic participation and issues related to [social] citizenship. This phase may not be achieved until the “second generation”.

The second conceptual approach is that refugee integration policies should define clear priorities for action. Newly settled refugees face specific problems such as language difficulties, lack of familiarity with the receiving society’s institutions, the need to find housing and to access social services such as healthcare, welfare support and education. In the second and third generations, issues of political participation, cultural identity and long-term social exclusion are paramount issues for social policy.

Integration models in different receiving states will need to take a nuanced approach with social policies tailored to specifically address the types of refugee resettlement policies that they have in place (Collett, 2006). Attention to issues such as the need for gender inclusive planning are important, in particular, for family economic self-sufficiency (Ministry of Women’s Affairs, 1996; UNHCR, 2002a). Penninx (2004) and Schierup et al. (2006) find markedly different outcomes among refugee groups as a consequence of institutional arrangements (for example, the attitudes and actions of trade unions and traditions of public acceptance of religions) in European receiving societies. Differences in national institutional systems and historical experience with earlier immigration, refugee resettlement and diversity, determine the concrete

instruments and resources available to policy makers. These will direct processes in the vital domains of the labour market, housing, education and health. Because integration processes for refugee groups are long-term in nature, the test for integration and for the success or failure of social policies is the position of the second generation (Penninx, 2003).

The second half of the section highlights the institutions that are critical to the long-term social, cultural and economic integration of refugees. Refugee groups need to be specifically included in welfare, education, the labour market, housing and health institutions and social policies. In the first instance, economic integration is central, as it 'prestructures the possibilities in all kinds of other realms of life. Economic integration can be regarded as a decisive integrational step in the long process of integration' (Bommes & Kolb, 2004, p.7). However, the use of the term 'economic integration' in theoretical models is variable. It can mean active participation in the labour market or 'passive' integration by state welfare systems (Bommes & Kolb, 2004, p.7). In the view of this study, the state's role is to provide targeted labour market integration policies to assist refugees to move from a situation of receipt of welfare benefits to participation in the economy in the medium and long-term settlement phases (Lemaitre, 2006).

Applying Penninx's (2003b) model, integration frameworks should define clear priorities decided by governments for action in certain policy domains. Priority should be given to the domains in which central government has effective and generally accepted instruments to promote integration and prevent exclusion. These are the economic domain of work and the social domain, particularly education, health, housing, welfare and justice. Bassanini and Duval's (2006) OECD study comparing economic integration in receiving societies is important in this respect. They conclude that the type of economic integration policy and institutional framework employed, affects most particularly, labour market participation for those groups 'at the margin' (Bassanini & Duval, 2006, p.4). In particular, (Bassanini & Duval, 2006, p.4):

... more specific interactions across policies and institutions are found to be particularly robust, notably

between unemployment benefits and public spending on active labour market programmes as well as between statutory minimum wages and the tax wedge.

Active labour market integration policies are an essential component of refugee social and economic integration. Denmark is a successful example of the integration of active labour market policy programmes into income support (Bassanini & Duval, 2006). Danish reforms to the unemployment benefit system have, during the 1990s, undergone major reforms, away from 'passive' income maintenance, to an 'active' regime based on intensive labour market integration programmes (Kvist & Jaeger, 2004, p.9). The programmes include education, vocational training and apprenticeships, which are organised by the Public Employment Service. Importantly, there has not been a reduction of benefit generosity, and while access to unemployment benefits has been reduced, the system of active labour market policies has expanded opportunities to gain work experience and to upgrade skills and education for refugee groups (Kvist & Jaeger, 2004).

The Danish active labour market policies have been relatively successful for the long-term economic integration of some refugee groups, but not all. Husted, Nielsen, Rosholm and Smith (2000), demonstrate that there are short-term differences between migrants and refugees in a study of Danish labour market participation. Refugees have very low initial employment probabilities; very few refugees succeed in gaining full-time employment in their first ten years in Denmark. However, when employed, their wage rates converge towards the wage level of Danes within a ten-year period. After five to ten years in Denmark, the employment probability for refugees seems to approach the level of non-refugee immigrants and Danish-born individuals. But there are differences between rates of employment between different national groups from refugee backgrounds; refugees from Africa and Palestine have very low initial employment chances compared to refugees from Europe, Vietnam and Latin America (Husted et al. 2000).

Language policy and the quality of the language support programmes available from early childhood centres to the workplace are a highly significant dimension of refugee integration (Wayland, 2006b). Knowledge of the language of the receiving society is

the most important precondition for successful participation in education and economic systems (Bommes & Kolb, 2004). Language ability determines success in the education system, which in turn will determine access to employment opportunities and income levels. Resettlement countries where the performance gaps for second-generation refugee students are significantly reduced, compared to those observed for first-generation students, tend to have language policies and well-established language support programmes with clearly defined goals, standards and evaluation systems (Schleicher, 2006, p.5). Importantly, OECD studies show that the availability of language support programmes from early childhood education centres onwards has a significant impact on later educational achievement (Schleicher, 2006). In six, in the New Zealand context, English language and literacy skills are shown to be the most significant predictor of differential labour market outcomes for refugee groups (NZIS, 2004b; White, Watts & Trlin, 2002).

Health, along with employment and education, is one of the key markers of integration in receiving societies (Johnson, 2006). Good health enables better participation in society and the supply of appropriate health care shows the responsiveness of the resettlement country to refugee groups. The restoration of physical and mental health for refugee groups is vital to integration, with continuing poor health being a significant barrier to social and economic inclusion. To ensure long-term integration outcomes and to combat social exclusion, refugee groups will need to be incorporated into the reducing inequalities health and social policies of the receiving society.

As a final note of caution, theories of integration need not only a thorough analysis of the logic of integration processes in order to formulate and implement effective policies, they also need to be politically approved and accepted. Different rules apply to the logic of politics and policy making. The political process in democratic societies requires policies to succeed in shorter time cycles than the long-term character of processes of integration. An important consideration is that the viability of integration policies in the long-term will depend heavily on 'realistic targets to be attained and an adequate analysis of the institutional setting and its possibilities to build such policies' (Penninx, 2004, p.26). This pragmatic approach is most likely to engage the participation of refugee groups and less likely to cause a political backlash.

To summarise, there are three main points to be made in regard to models/typologies of immigrant integration that have been discussed in this chapter. First, the models presented highlight the ways in which contrasting national histories and traditions strongly determine the integration regimes and social policies of receiving societies. Second, models of immigrant multiculturalism have undertheorised the considerable adversity that refugees face in new societies, compared to migrants. Third, refugee integration in the second and third generation is vitally dependent on the socio-economic processes of integration, hand in hand with policies of the type described in Kymlicka's (2001a) immigrant multiculturalism model—in order to accommodate cultural and religious diversity. Governments play a critical role in fostering the integration of refugees through inclusive social and cultural policies that ensure access to publicly provided services such as health care, education, language training, housing and job training. Existing theoretical models have failed to pay sufficient attention to the long-term significance of the social exclusion of refugees in receiving societies.

Conclusion

The nature of citizenship in all receiving societies is shifting and changing. Penninx's (2000) typology of integration policies provides a good framework for the exploration of a theoretical model for refugee integration. The typology recognises, importantly, that political-judicial inclusion is a necessary aspect of civil and political membership but not alone a sufficient condition for refugee groups to attain equality with other populations in the long-term. The elements of socio/economic and cultural/religious membership available to refugees are instrumental in achieving second and third generation integration, and in maintaining social cohesion (Penninx, 2000). Kymlicka's (2001a) multiculturalism model outlines the types of cultural policies and institutional accommodations that are important in the recognition of the cultural, religious and linguistic diversity of refugee groups. Keeping in mind these key dimensions of citizenship, a theoretical analysis of refugee integration/exclusion will be applied to the New Zealand context in the following chapters.

Chiefly, it is argued that the state's management of integration processes is critical to achieving positive settlement outcomes for refugee groups as newcomers and also in subsequent generations. In this view, central government leadership is instrumental. The processes of integration that take place at the level of institutions are of critical theoretical interest to this thesis. In New Zealand, institutional frameworks that will facilitate, encourage and promote diversity, alongside fostering political, social and economic rights, are essential to a substantive citizenship for refugees. The public institutions that are highlighted in the study are the Ministries of Education, Health, Social Development and the Department of Work and Income, Immigration and the Department of Labour. Chapters five to nine undertake an analysis of the interaction of refugee policy, integration policy and social policy in New Zealand in the context of refugee resettlement outcomes. The focus is on the responsiveness of central government and of its public institutions. Chapters five and six will focus on the social and economic integration of refugees, and chapters seven and eight will focus on health policy and systems and the accommodation of cultural diversity in the health sector.

CHAPTER FIVE

REFUGEE INTEGRATION IN THE NEW ZEALAND CONTEXT: THE RESPONSE OF CENTRAL GOVERNMENT

Introduction

The New Zealand Government—in the context of economic transformation, national identity and secure families—is paying increased attention to social cohesion and settlement issues. This is in part triggered by poor settlement outcomes in the refugee groups settled in New Zealand in the last decade (NZIS, 2004b). In the last chapter the three essential dimensions of membership which can be applied to the policies of national and local governments as the yardsticks of integration for refugee groups were described. These are the legal/political, socio-economic, cultural and religious rights of citizenship (Penninx, 2004). This chapter and the next will review the integration frameworks for refugees in New Zealand in these domains, specifically by central government and its institutions.

This chapter identifies central governmental responses to refugee groups in New Zealand society. Foremost is the development of a national *Immigration Settlement Strategy: A Programme of Action for Settlement Outcomes that Promote Social Cohesion* and the pilot *Auckland Regional Settlement Strategy*, which are part of the Government's sustainable development goals (Department of Labour (DoL) & Auckland Sustainable Cities Programme (ASCP), 2007a; Department of Labour (DoL) & Ministry of Social Development (MSD), 2003). Another high level strategy that has been developed is an *Ethnic Perspectives in Policy* framework which aims to systematically recognise ethnic communities in the social policy and services of public institutions (Office of Ethnic Affairs (OEA), 2002). In order to demonstrate the complexity of the social policy environment for integrating refugee groups, there is ample descriptive material presented on New Zealand social policy, strategy and institutional settings (DoL, 2002; DoL & ASCP, 2007a; DoL & MSD, 2003; Lockhart, 2001; Minister of Immigration, 2001, 2000a, 2000b, 2004; NZIS, 2004b, 2004c; 2004e; OEA, 2002).

The chapter is in three parts. The first explores the meaning of social cohesion as a social policy goal in the New Zealand context. The second describes the

developments in the last five years in advancing the Government's settlement and social cohesion policy framework and evaluates their respective contributions to this agenda. The third explores the development of an overarching *Ethnic Perspectives in Policy* framework for New Zealand (OEA, 2002).

The Social Cohesion Agenda for New Zealand

The policy goal for the national *Immigration Settlement Strategy* is social cohesion (DoL & MSD, 2003). Jenson's definition of social cohesion is a useful introduction to this section as it considers notions of 'who is "in" and who is not, to whom members of society owe solidarity and those to whom they do not' (Jenson, 2002, p. 143). The borders of social inclusion and exclusion are therefore often analysed within the framework of social cohesion'. Jenson's (1998, p.15) five dimensions of a socially cohesive society which have been adopted by the national '*Immigration Settlement Strategy*' (DoL & MSD, 2003, p.5) are:

- *Belonging*, which involves a sense of being part of a wider community, trust in other people, and common respect for the rule of law and for civil and human rights; New Zealand is home to many peoples, is built on a bi-cultural foundation, and values the acceptance and celebration of our ethnic and cultural diversity.
- *Inclusion*, which involves equity of opportunities and of outcomes, with regards to labour market participation, income, education, health and housing; Good settlement outcomes will contribute to social cohesion.
- *Participation*, including involvement in social activities, in community groups and organisations, and in political and civic life such as voting or standing for election on a school board of trustees; All people should be able to participate in all aspects of New Zealand life.

- *Recognition*, all groups, including the host country, valuing diversity and respecting differences, protection from discrimination and harassment, and a sense of safety; there may be a diversity of opinions and values amongst the many cultures that make up New Zealand today.
- *Legitimacy*, including confidence in public institutions that act to protect rights and interests and to mediate conflicts, and institutional responsiveness; public institutions must foster social cohesion, engender trust, and be responsive to the needs of all communities.

Much of the work in social policy in relation to immigration and social cohesion in New Zealand derives from international analyses and concepts from Canada, the European Union, the OECD and the United Kingdom (Council of Europe, 2004; Jenson, 1998; OECD, 2001; Social Exclusion Unit, 2006) but the conceptual framework that has had most impact is that of the OECD (2001). In Jeanotte's (2000, p.2) view, the OECD (2001) framework offers 'the narrowest implicit definition of social cohesion, focusing almost exclusively on the economic and material aspects of the concept'. In the context of integrating refugee groups it is argued that social policy that focuses primarily on labour market inclusion is inadequate as the broader issues of institutional accommodations for newcomers, the main driver of integration, are not addressed. Confirming the importance of the role of central government and its institutions in integration, Jenson's view is that (2002, p. 149):

...institutions—public as well as private—are crucial for limiting threats to social cohesion. The findings about causation are clear. A cohesive society is one in which accommodation of socioeconomic conflicts is well-managed. Social cohesion will be at risk only if differences are mobilized as grounds for conflicting claims and then management of such claims is fumbled.

Thus, social cohesion is fostered by careful and sensitive management of mobilized differences or (cleavages) of all sorts-cultural, linguistic, and economic.

Studies of social cohesion in the international literature conclude that much more attention needs to be paid to social and economic, and cultural and religious rights for newcomers in receiving societies (Jeanotte, 2000; Jenson, 1998, 2002; Kymlicka, 2001a; Papillon, 2002; Penninx, 2000). In this perspective, institutional practices and processes are central to long-term integration for groups such as refugees 'because they are the locale for managing diversity and because their actual design will affect their capacity to contribute to cohesion' (Jenson, 1998, p. 31).

Immigration Settlement Strategies

There are six parts to this section: *The National Immigration Settlement Strategy* (DoL & MSD, 2003); the New Zealand Immigration Service 'Refugee Voices' study to improve understandings of the factors leading to successful refugee resettlement (NZIS, 2004b); the 'whole of government' strategy—a cross departmental approach to improving settlement outcomes (DoL & MSD, 2003) and Immigration Budget 2000; *The Auckland Regional Settlement Strategy*, a regional settlement policy initiative; and the impact of the Immigration Budgets for 2004 and 2005 on refugee settlement.

The National Immigration Settlement Strategy

In 2003, a report entitled '*The Immigration Settlement Strategy: A Programme of Action for Settlement Outcomes that Promote Social Cohesion*' was written jointly for Cabinet by the Department of Labour (DoL) and the Ministry of Social Development (MSD). The strategy has defined an inclusive New Zealand as 'one where all people are able to participate in the social and economic lives of their communities' (DoL & MSD, 2003, p.4). The *Immigration Settlement Strategy*, although an important new initiative, has some critical deficits. The key focus in the settlement strategy is to ensure that immigration policies deliver economic benefits for New Zealand society. Clearly though, refugees selected for their 'poor integration potential' are problematic for policies designed to deliver economic growth (NZIS, 2004b). The priority given to accepting refugees who have poor integration potential and high health needs means

that long-term settlement support is required. However, the settlement support offered is short-term and inadequate to address refugees' adverse circumstances on and post-arrival. The main arguments in this section are: first, that the emphasis in the *Immigration Settlement Strategy* on overcoming individual barriers to employment as the main means of integration is too narrowly focused; second, systemic frameworks to incorporate refugee groups as social, economic and cultural members of New Zealand society are not addressed adequately; third, New Zealand social policies need to be informed by the systematic monitoring and measurement of settlement indicators for refugee groups in the long-term.

The goals of the *Immigration Settlement Strategy* for refugee and migrant groups are to (NZIS, 2004e, p.4):

- obtain employment appropriate to their qualifications and skills.
- become confident using English in a New Zealand setting or able to access appropriate language support.
- access appropriate information and responsive services that are available to the wider community (for example housing, education and services for families).
- form supportive social networks and establish a sustainable community identity.
- feel safe expressing their ethnic identity and be accepted by and become part of the wider host community.
- participate in civic, community and social activities.

The main focus in the strategy is on the immediate settlement phase and a (Lockhart, 2001, p. 14):

...concerted effort is now going into this area, as witnessed by the development of integrated settlement and resettlement policies, a comprehensive research

programme and an enhanced settlement programme. These settlement and resettlement policies will articulate the Government's vision for migrant and refugee (re) settlement in New Zealand and, over time, help ensure migrants and refugees have access to services that meet their needs.

However, the *Immigration Settlement Strategy* (DoL & MSD, 2003) shows refugees to be problematic to integrate, because [emphasis in text]:

- refugees, including unaccompanied minors, who are likely to have experienced trauma, often protracted, before coming to New Zealand;
- migrants and refugees who do not speak English. Proficiency in the host country language has a positive effect on labour market opportunities. Migrants from non-English speaking backgrounds face the most difficulty in everyday living, including accessing information and social participation;
- those migrants and refugees who are particularly subject to discrimination, because they look and/or sound different to the dominant culture of the host country or community;
- migrants and refugees who are unemployed or underemployed. Their wellbeing and that of their families will be compromised where this leads to economic disadvantage; and
- non-principal applicants (spouses and partners of migrants and refugees, and their children) from all streams. Women are a high risk group for social isolation and mental illness, especially those from traditional cultures and religious backgrounds, and those who do not speak English. Children may

experience conflict between the values of home, school and friends.

Three levels of action to improve settlement and social cohesion are suggested. The first level of action is the ‘whole of government’ approach directed at improving coordination between: the central government agencies, local governments, NGOs and the community groups involved in settlement. (MSD, 2003b). The second level of action is identifying the gaps in survey and administrative data that is held by government departments. The strategy acknowledges that the quality and detail of the information that is collected by various departments needs to reflect the situation of groups such as refugees. As the strategy states (DoL & MSD, 2003, p.16):

... refugees and migrants are often recorded as “other” instead of recorded by their respective ethnic group and their country of origin. While information systems continue not to record data by their respective ethnic group and country of origin, the ability of Government to target and evaluate effective settlement strategies will be limited.

To monitor the impact of the strategy on refugee groups and the wider community, including the impact on social cohesion would require the development of a comprehensive set of impact indicators focusing on monitoring the effectiveness of the strategy (Peace, Spoonley, Butcher & O’Neill, 2005). The complexities of ‘ethnic’ data collection systems in New Zealand will be discussed more fully in chapter six.

The third level of action is the Government’s strategy for improving the responsiveness of public institutions to ‘ethnic peoples’ which is the Department of Internal Affairs’ *‘Ethnic Perspectives in Policy Framework’* (OEA, 2002). The policy, which will be discussed in more detail in the last section in the chapter, directs government departments to (DoL & MSD, 2003, p. 11):

- Identify existing or planned mechanisms to “mainstream” obligations with regards to migrants

and refugees, particularly those from Pacific and ethnic communities.

- Accelerate the development of their ethnic responsiveness strategies.
- Explicitly consider implications for social cohesion.

As a response from central government the *Immigration Settlement Strategy* is an important first attempt to address refugee settlement outcomes but it fails to provide an overarching integration policy. New Zealand settlement strategies need to begin with a redefinition of the basic notion of settlement, along the lines used in the Canadian definition outlined in chapter four, in which settlement can be broken down into three phases, immediate, intermediate and long-term, with each phase requiring different measures at different stages of integration (Mwaringha, 2002). Poor settlement outcomes for refugees in New Zealand society are directly related to a lack of long-term, multi-dimensional and societal vision of the settlement process for all immigrants. The settlement process is long-term and persists into the second generation, which needs to be reflected in New Zealand social policies.

Refugee Voices

This section addresses the key findings of the Department of Labour ‘*Refugee Voices*’ refugee resettlement research project undertaken between 2002 and 2004 (NZIS, 2004b). It considers the implications for settlement policies, in particular and social policy, broadly. There are three main points to be made about the significance of the study: first, the research undertaken is small-scale and one off; second, the findings are not generalisable to all refugees in New Zealand; and third, to effectively monitor the outcomes of refugee settlement policies in the long-term, consistent empirical data collection is needed, as is the development of a comprehensive set of impact indicators and a process to undertake this work (Spoonley, 2004). The ‘*Refugee Voices*’ project was a first attempt to develop an evidence base for settlement outcomes for refugees. Prior to this study, there had been no major government sponsored research on the settlement experiences of refugees. The purpose of the research was to identify areas where refugee well-being could be improved through changes to settlement support systems (NZIS, 2004b). The findings of the study were

intended to indicate barriers to settlement and to inform settlement policy and the development of services. However, the research undertaken did not provide a systematic, ongoing means of measuring refugee settlement outcomes.

The '*Refugee Voices*' study sample size was small, with 398 participants (NZIS, 2004b, p. 68). The project focused on three categories of refugees: mandated refugees; convention refugees (those who were granted refugee status in New Zealand); and people who come from refugee-like circumstances through the family reunification or humanitarian immigration categories. The research involved interviews over the first two to five years in New Zealand. It included two groups: newly arrived refugees and those resident for approximately five years. The latter group included only quota refugees, as, after five years in New Zealand, these were the easiest group of refugees to locate.

The findings of the research indicate poor settlement outcomes in terms of social and economic integration. Established refugees—those who had been in New Zealand five years and over—still needed assistance with English language training, financial support and finding work. There was notable variation in the need for ongoing settlement support by region of origin. Of the recently arrived refugees, a large proportion said that they still needed settlement support after two years in New Zealand. After five years only 50 per cent of established refugees reported that they could speak English well, although how this was defined in the study was not indicated. Twenty-seven per cent of participants indicated that they still could not speak English well. At five years, only four out of ten could write English well (NZIS, 2004c. p.9). The report stated that, 'as could be expected, employment rates were low for all participants—16 per cent of *recently arrived* [italics in the original] refugees aged between 15 and 65 years, were working at six months, as were 26 per cent at two years' (NZIS, 2004c. p.9). The main problem with finding work related to a lack of English language ability. Nearly all participants were earning a salary or wage of less than \$30,000 and many were earning less than \$10,000 (NZIS, 2004c. p. 12).

Other important findings in the study relate to the influence of age, ethnicity, gender and religion on settlement outcomes. Refugee women, in particular, reported the greatest barriers to settlement. For instance, childcare obligations, limited

opportunities to participate in English language classes and other training opportunities. The Muslim women in the study experienced the greatest discrimination related to their appearance and dress. For example, 'for girls, wearing traditional dress at school, such as a head scarf, was an issue, and attracted unwanted attention' (NZIS, 2004b. p. 361). Older refugees had the poorest English language and literacy ability. More than half of the established refugees aged 40 years and over said that they still needed settlement assistance after five years in New Zealand (NZIS, 2004b. p. 361). Refugees from the Middle East, Afghanistan and the Horn of Africa reported more discrimination than did refugees from other countries. This was attributed to negative media attention and to the more visible differences in dress and culture.

The main issue arising from the research was the 'importance of acknowledging and responding to refugee diversity (one size, or type, of service delivery will not meet all needs)' (NZIS, 2004b. p.360). The study recognised that characteristics such as ethnic and cultural background, English language ability, employment history, health status and the amount of time spent in refugee camps had a significant impact on the levels and length of time that settlement support was required. Further, refugee service providers' noted that (NZIS, 2004b. p. 363):

... New Zealanders were largely ignorant of refugees' cultures and position in the community, and lacked patience in dealing with difference. Measures to increase the public's understanding of other cultures would be useful.

The 'Whole of Government' Approach and Immigration Budget 2000

The *Immigration Settlement Strategy* outlines a 'whole of government' approach for improving settlement outcomes through better coordination between the central and local government agencies, NGOs and community groups. The term 'whole of government' means government agencies 'working across portfolio boundaries to achieve a shared goal and an integrated government policy, programme or service response to particular issues' (Humpage, 2005, p. 48). The strategy is underpinned by the view that the chief impediment to an integrated settlement programme for

newcomers to New Zealand is a lack of coordination and information sharing across the governmental and non-governmental sectors (MSD & DoL, 2003, p. 4). However, there is little evidence in the literature that intergovernmental collaboration in itself improves social and economic outcomes for low income groups (MSD, 2003b). In New Zealand, there are clear indications that structural change within central government is indicated in order to address the exclusionary effects of existing institutional arrangements for refugee groups. By comparison with the more explicit and proactive policies of Canada and Australia, the approach taken in New Zealand is reactive and consists of a range of ad hoc projects (These projects will be detailed in the data analysis chapters nine to fourteen).

It will be argued in this section that the strategy represents a 'one-way' framework for managing settlement rather than a 'two-way' long-term integration framework (Penninx, 2005). Integration programmes of this type require newcomers to adapt to the public institutions of society. By contrast societies such as Canada have developed elaborate institutional settings to manage immigration, diversity and social inclusion. Importantly, the international literature suggests that strong leadership from central government is instrumental in achieving a coordinated framework for the institutional management of settlement and of the long-term integration of newcomers (Jenson, 2001b, Kymlicka, 2001b; Kymlicka & Norman, 2000). In this context, Penninx's (2004) study of policies related to the process of settlement and integration in European societies is instructive. Penninx (2004, p.3) states that:

... any integration policy should be based on a thorough, science-based knowledge of processes of integration and exclusion: if a policy wants to steer such a process, it should have a clear idea with which instruments it can possibly intervene, in which part of the process, at what particular moment.

The programme of settlement initiatives in New Zealand are described in the following sections. In November 2000, Cabinet agreed to a strategy for refugee and migrant settlement and further agreed that the New Zealand Immigration Service coordinate the development of a work programme. The Minister of Immigration

(2000a) announced the establishment of four settlement service pilots (shown in Tables 5.1 and 5.2) to improve migrant and refugee settlement outcomes.

Table 5.1: Budget 2000 Pilot One: (Support for Groups Working with Refugee Claimants). Table 5.2: Budget 2000 Pilot Two: (Resident Refugee Family Orientation Courses)

Budget 2000	
Pilot One: (Support for Groups Working with Refugee Claimants)	
<i>Funds:</i> \$180,000 in 2000/2001 and a further \$200,000 in 2001/2002	
<i>Purpose:</i> One off grants to provide support for community groups working with refugee status claimants, and/or their families. This pilot targets refugee status claimants and their families, and also people whose status is not yet clarified.	
Groups and services funded:	
Auckland Refugee Council	Provide emergency accommodation, at West Auckland; provide other on-arrival emergency services and assistance
Shatki Asian Women's Safe House, Auckland	Accommodation, advocacy and assistance with victims of domestic violence: applied for part salary for social worker
Auckland Latin American Community (ALAC), Onehunga, Auckland	Social worker (part-time) for emergency services advice, referrals and assistance
Refugee and Migrant Centre	Provide emergency services – advice, referrals, assistance; some ESOL classes
Pilot Two: (Resident Refugee Family Orientation Courses)	
<i>Funds:</i> \$127,000 in both 2000/2001 and 2001/2002	
<i>Purpose:</i> To provide support for community groups working largely with family members of refugees who are in refugee-like situations have gained New Zealand residence, and are in need of orientation assistance. This pilot targets refugees' families who have entered New Zealand under the humanitarian or family categories.	
Groups and services funded:	
Enterprise Waitakere	Orientation for whole families; survival English, introduction to NZ systems and local services
MCLaSS Wellington	Group orientation on NZ systems and local services, needs assessment, support, referral, resettlement assistance
RMS, National Office	Assistance with info, housing, furniture, ESOL, support and referrals in Greater Wellington & Hamilton respectively.
Refugee Migrant Centre, Christchurch	General resettlement support and referrals. Group orientation, survival English, trainers trained Trainers to deliver home-based small group orientation information.

Source: Minister of Immigration, 2000b

The stated aim of the pilots was to enhance the capability of government and community networks to develop and sustain settlement services, with an emphasis on cooperation and coordination (Minister of Immigration, 2000b). The pilots were to evaluate the gaps in services currently provided and to help identify what new services needed to be provided in the future. Two of the four two-year pilots focused on refugees and asylum seekers and were contracted to third parties. In total, in 2000/01 nineteen NGOs nationally were funded—in partnership with the New Zealand Immigration Service (Minister of Immigration, 2000b). The pilots represent a patchwork of small, short-term contracts. The budgeted amount drastically under represents the feasibility of providing these services.

In 2001, a new Settlement Branch within the New Zealand Immigration Service was established to provide settlement advice, support and resources to refugee and migrant service providers. The Minister of Immigration (2001) announced in the 2001 budget, that for the first time in a decade extra funding was being provided to help refugees settle. The amount of funding allocated for refugee resettlement services amounted to an increase of \$350,000 a year, beginning in 2001/2002. This sum was promoted as a doubling of funding allocated for refugee resettlement and support services prior to 2000. The funding was intended to cover the costs for non-government organisations to provide for the support needs of quota refugees and their families including:

- volunteer training and support;
- housing assistance and interpreter services;
- information and advice to people in their first year of resettlement;
- ongoing support to refugees past their first year of settlement; and
- assistance with refugee family reunification applications.

In sum, the ‘integration’ across ministerial portfolios consists of the New Zealand Immigration Service ‘working well with other agencies of central government, local government, the private sector, and voluntary and community agencies’ (DoL, 2002, p. 49). Essentially, refugee settlement support remains the responsibility of family sponsors, volunteers, refugee communities and non-governmental organisations. The ‘whole of government’ approach has the potential to enhance the quality of services

for refugees. However, without an overarching framework for improving cultural and linguistic responsiveness in the key public institutions of health, education, welfare and employment, the impact of the strategy on long-term social and economic settlement outcomes will be limited.

Regional Responses: The Auckland Regional Settlement Strategy

In this section, the *Auckland Regional Settlement Strategy* is subject to the same critique as the national *Immigration Settlement Strategy*: both strategies are too narrowly focused on labour market participation as the main means of integration. What is missing is a framework for institutional responsiveness to the social, cultural and linguistic diversity of refugee groups. This spatially targeted strategy does not represent ‘a coherent set of initiatives based on a thorough understanding of the nature of evolution and change within areas. Also it is not as influential in affecting those changes as some national policy and wider economic trends’ (Hutchinson, 2000, p. 169).

The context for the *Auckland Regional Settlement Strategy* is the increasing cultural diversity in the Auckland region. Since 1996, there have been large increases in the number of New Zealand residents born in Asia, Africa and the Middle East, a significant number from refugee and refugee-like backgrounds. In the 2006 Census, there were 36,000 Muslims in New Zealand, most were living in the Auckland region and many were from refugee backgrounds (Statistics New Zealand, 2006). Social surveys have focused attention on the disproportionate impact of refugee settlement on the Auckland region where around 60 per cent of the refugee populations in New Zealand live (Fisk, 2003; McCormack, Davies, Nakhid & Shirley, 2003; Ministry of Social Development, 2002; Statistics New Zealand, 2003).

The *Auckland Regional Settlement Strategy* is a long-term plan to achieve sustainable settlement outcomes which contribute to social cohesion in the Auckland region. The strategy is about ‘providing the support so that migrants and refugees can find appropriate permanent employment, stable living environments and good health, and are integrated into NZ society to feel at home in the Auckland region’ (Hudgell, 2004). The stated aims are providing support for refugees and migrants to settle in the

Auckland region and aligning national and regional strategies effectively. The overall objective is to develop an agreed long-term plan to achieve sustainable settlement outcomes which contribute to social cohesion. The strategy is part of the Auckland Sustainable Cities Programme. This programme is a joint local and central government collaboration initiated by the Auckland City Councils' Mayoral Forum in response to the Government's *Sustainable Development Programme of Action for New Zealand* (Minister for the Environment, 2003; Stone, 2005). The initiative is aligned with the Government's Urban Affairs portfolio, which is the responsibility of the Minister for the Environment. Schierup et al. (2006, p.58) are critical of the sort of 'bottom-up' mobilisation of networks in civil society into composite 'development partnerships' of 'stakeholders' that this type of local government strategy represents. The weakness of this type of regional settlement strategy is that the networked governance structure model consisting of local and regional government; labour market organisations and institutions; educational bodies; and a proliferation of NGOs, is an inadequate solution to the need for 'new sustainable policies for social inclusion to repair the proliferation of socially exposed spaces left behind by increasingly deregulated national welfare regimes' (Schierup et al., 2006, p.58).

Immigration Budget 2004

The 2004 immigration budget has particular importance because for the first time there was recognition on the part of the New Zealand Government of the need to more significantly resource refugee settlement. The budget identified some key areas of practical support, such as English language acquisition, which are fundamental to settlement and integration. Prompted in part by increasing concerns about poor labour market participation among refugees, the budget was promoted as a 'package [which] will contribute to economic growth and social cohesion' (Minister of Immigration, 2004b). Mainly though, '*Budget 2004 Support for Migrants and Business*' focused on migrant employment and the interests of New Zealand business and not on refugee employment.

The Minister of Immigration's (2004b) announcement stated that the budget allocated 'more than \$62 million over the next four years for practical measures to help migrants, refugees and their families make a greater contribution to the economy and society'. However, the assistance specifically targeted to refugee groups, asylum

seekers and family reunion members, which is shown in Table 5.3 was minimal. More than half the budget, \$37.9 million, was allocated to the Ministry of Education from 2004 to 2008 for ESOL provision which includes all non-English speaking background children in New Zealand, only a small proportion of whom would be from refugee backgrounds (Ministry of Education, 2006). A small, but important, addition to this was funding assistance for the New Zealand Qualifications Authority of \$68,000 per year to enable 150 refugees to have their overseas qualifications assessed. The Refugee and Migrant Service, the government contracted refugee resettlement agency, received increased funding of \$6 million over four years: although, in reality, this agency has been chronically under funded for more than a decade and the increase barely meets baseline operational costs. One million dollars was allocated to establish a national secretariat, based in the Department of Labour, to support communication on migrant and refugee settlement issues between community groups, other organisations and central and local government.

Table 5.3 summarises the funding approved by Cabinet from the 2004 Immigration Budget (Minister of Immigration, 2004).

	Vote	2004/05	2005/06	2006/07	2007/08	Total (in millions)
Careers advice & information	Education	1.000	1.000	1.000	1.000	4.000
Adult ESOL	Education	0.226	0.450	0.450	0.450	1.576
ESOL in schools	Education	4.256	8.499	12.475	12.630	37.860
NZQA qualifications assessment	Education	0.068	0.068	0.068	0.068	0.272
Migrant resource services	Immigration	1.675	3.137	3.476	3.386	11.674
Refugee & Migrant Service	Immigration	1.500	1.500	1.500	1.500	6.000
National settlement secretariat	Immigration	0.252	0.252	0.252	0.252	1.008
Total package is		8.977	14.906	19.221	19.286	62.39
Total Vote Education		5.550	10.017	13.993	14.148	43.708
Total Vote Immigration		3.427	4.889	5.228	5.138	18.682

Source: Minister of Immigration, 2004

Ongoing initiatives outside the budget package that form part of the Government's broader *Immigration Settlement Strategy* included ongoing funding (\$1.3 million in 2005) for 'Language Line', a telephone interpreting service. As well, ongoing employment services for refugees and migrants were announced in 2003 and have been delivered through Work and Income, at a cost of \$21 million over four years. However, the Work and Income programme has had limited success in placing refugees in employment (Fisk, 2003).

Immigration Budget 2005

The budget in 2005 was less significant for refugees, with minor increases to the Office of Ethnic Affairs as the main budgetary focus. The May 2005 Budget announced a \$4.1 million dollar package of new funding over four years for the Office of Ethnic Affairs to provide support and advocacy work with New Zealand's ethnic communities (Minister for Ethnic Affairs, 2005). The extra resources were intended to allow the office to expand its policy, liaison and advisory work with ethnic communities to new areas of the country. In the final section of this chapter the New Zealand *Ethnic Perspectives in Policy* (OEA, 2002), which is a framework to integrate refugees and migrants into New Zealand society, is discussed.

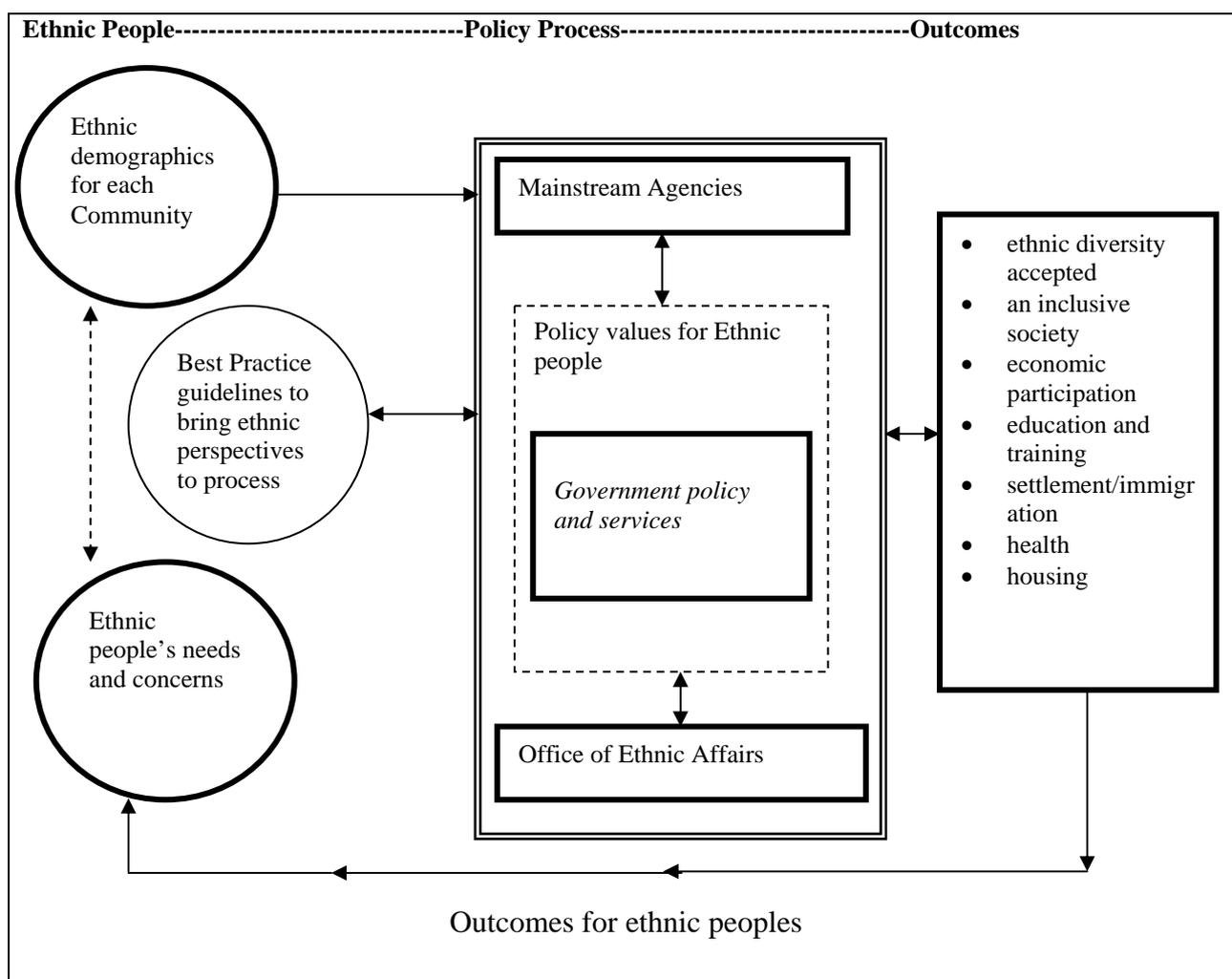
Ethnic Perspectives in Policy in New Zealand

The third part of the chapter discusses the *Ethnic Perspectives in Policy* in New Zealand (OEA, 2002). In this section, it will be argued that the New Zealand ethnic policy is flawed for a number of reasons. First, the underpinning concept of 'ethnic' policy is conceptually problematic and contests the historic Treaty partnership between Maori and the Crown. Second, the policy is not integrated into New Zealand social policy. Third, the framework adopted has a narrow view of integration (OEA, 2002, p. 46). The section begins with a brief background to the establishment of an Ethnic Affairs Service in New Zealand in 1999 within the Department of Internal Affairs (1999, p.1). The rationale that the Government gave for the new service was the recognition that there had not previously been a clearly articulated set of desired outcomes or a policy framework across government as a whole as the basis for assessing the potential impacts of policy and practices on ethnic communities in New Zealand. The operational budget allocated to the Ethnic Affairs Service nationally in 2000 was \$254,800. The Office of Ethnic Affairs (OEA) replaced the Ethnic Affairs

Service in May 2001. The role defined for the OEA was a ‘population-based’ one, similar to that played by the Ministry of Pacific Island Affairs (Department of Internal Affairs, 1999, p.1).

The Office of Ethnic Affairs (2002b) introduced an *Ethnic Perspectives in Policy* framework in 2002. The strategic overview of ethnic perspectives is presented in an operational model in Figure 5.1 (OEA, 2002, p. 11).

Figure 5.1: A strategic overview of the *Ethnic Perspectives Policy*



Source: Office of Ethnic Affairs, 2002, p. 11

The objective of the ethnic policy is ‘helping ethnic people be seen, heard, included and accepted’ through asking that ‘policy-makers at all levels take into consideration the distinctiveness and special needs of ethnic peoples’ (OEA, 2002, p. 4). The Office of Ethnic Affairs and publications such as *Ethnic Perspectives in Policy* seek to influence the policy process with a primary focus on government policy and services. However, the level of engagement with, and resourcing for, ethnic minorities in New

Zealand is minimal. Further, there is a significant tension in terms of the official recognition of integration frameworks ‘between biculturalism (hard regime of incorporation) and multiculturalism (soft regime of incorporation)’, which has not been addressed systemically (Bartley & Spoonley, 2005, p. 141). For this reason the policy framework leaves significant gaps in the structural means of incorporation for groups such as refugees as ‘there is no systematic policy that would provide a holistic policy framework and little by way of major policy and public statements to guide ethnic community development in the state system’ (Bartley & Spoonley, 2005, p.141).

The first problem with the *Ethnic Perspectives in Policy* is terminological. The terms ‘ethnic’ and ‘ethnic minority’ have conceptual difficulties in general. This is particularly so in the New Zealand context. The terms are problematic because they obscure the multiple identities shaped by age, gender, sexuality, class, and divisions of labour (Samers, 1998). Further, the use of the terms ‘ethnic’, and ‘ethnic minority’ can be viewed as colonialist and patronising. Ethnic peoples are defined in New Zealand as comprising people of non-Anglo Celtic and non-Polynesian ethnicity (OEA, 2002). Ethnicity ‘is seen as self defining—if people regard themselves as members of a particular ethnic group they are’ (Department of Internal Affairs, 1999, p. 1). The conception of New Zealand is of a nation of immigrants, ‘whether from the Pacific in the earliest times, or from Europe, or, more recently, from Asia, Africa, the Middle East, and Latin America’ (OEA, 2002, p. 4). Such a perspective contests the historic Treaty of Waitangi partnership between Maori and the Crown in which the Treaty partnership supersedes the multicultural rights of immigrants. Bartley and Spoonley (2005, p.145) summarise this binary tension between the state’s accommodation of indigenous concerns alongside those of newcomers, as a balance between a:

... meaningful Treaty partnership on the one hand, with the impact of increasingly diverse immigration flows on the other. Either of these divergent propositions would, in itself, problematise the nature of the New Zealand state in the twenty-first century; however, the challenge to reconcile the two carries pressing implications for

social cohesion that extend beyond the next generation of New Zealanders.

The second problem is that the *Ethnic Perspectives in Policy* is not integrated into New Zealand social policy. The policy values for the ‘ethnic sector’ in New Zealand are (OEA, 2002, p. 15):

- **Acceptance of ethnic diversity.** Each ethnic community is celebrated as part of New Zealand society, and diversity in culture, language and religion is valued
- **Participation by the ethnic sector.** Each ethnic community is supported, and enabled to contribute to all aspects of New Zealand life
- **Accessibility.** Ethnicity, including language, should not be a barrier to obtaining information and services
- **Responsiveness.** Ethnic groups are identified, and their needs recognised and provided for, in policy, programmes and services
- **Equity.** Ethnic groups are treated fairly and the outcomes for ethnic groups should be no less favourable than the New Zealand norm, e.g. in education, employment, health, housing, justice and welfare.

These policy values reveal the conceptual and operational difficulties that are inherent in the *Ethnic Perspectives in Policy* framework. For example, although it is intended as an addition to requirements to consider Treaty of Waitangi implications in the preparation of policy advice, the policy which is intended to ‘sit comfortably beside’ bicultural policies does not do so (OEA, 2002, p.10). Operationally, policy analysts should, according to the Department of Internal Affairs, be consulting with ethnic communities ‘when defining desired outcomes, identifying problems and issues, developing and analysing options leading to recommendations, implementing decisions; and monitoring and evaluating results’ (OEA, 2002, p.48). However, there

is no agreed process by which government departments should meet this requirement. Further, this requirement understates the tensions between the proposed multicultural and bicultural frameworks in government policies and institutional practices in New Zealand. Additionally, it is not clear whether Maori were consulted in the preparation of the ethnic perspectives policy.

The last problem is that the *Ethnic Perspectives in Policy* framework has adopted a narrow view of newcomer integration (OEA, 2002, p. 46). The purpose of the policy is poorly defined from an integration and social policy perspective. The focus is 'dealing with those issues which are of concern to ethnic communities at any point in time, rather than focusing on a fixed set of issues, or a single specific area of government activity' (Department of Internal Affairs, 1999, p.1). However, the Government's key goal for the policy framework is enabling migrants to achieve their economic potential to contribute to New Zealand society.

The *Ethnic Perspectives in Policy* includes the statutory obligations and key United Nations Conventions related to the human rights of ethnic communities. The most important of these is the Universal Declaration of Human Rights 1948 which proclaims that 'everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status' (Office of Ethnic Affairs, 2002, p. 36). However, the Human Rights Commission is not included among the agencies responsible for the implementation of the policy process in the operational model.

As a framework for integrating refugee groups, the *Ethnic Perspectives in Policy* framework makes little differentiation between refugee and migrant groups in terms of the intensive and long-term settlement support required by refugee groups. As well, the model shown in Figure 5.1 does not deal adequately with discrimination towards refugee groups. Earlier sections in the chapter indicated that refugee groups and in particular those which are visible minorities, face discrimination in the workplace (NZIS, 2004b). This points, not only to the need for a policy aimed at educating employers but to the need for an ethnic relations policy to 'change some of the

sentiments and attitudinal factors that prohibit a more inclusive understanding of the nature of New Zealand society' (White, Watts & Trlin, 2002, p.160).

Conclusion

In conclusion, this chapter has identified a number of governmental responses to refugees in New Zealand. Foremost is the development of the national and regional *Immigration Settlement Strategies* and the *Ethnic Perspectives in Policy* framework. These policies constitute an effort to create a more socially, economically and culturally inclusive society for migrants and refugees. However, neither of these policies represents overarching strategic frameworks for the institutional accommodation of the diverse cultural and linguistic groups in New Zealand. Central government has yet to address the lack of overall policy for integration and the confusion about the nature of an appropriate multiculturalism for New Zealand society. The initiatives presented in this chapter represent only minor tinkering, with some adjustments to small-scale resettlement assistance, occurring largely through non-governmental organisations. Collectively, these measures are insufficient to reverse the long-term pattern of poor social and economic outcomes for refugee communities. Overall, it can be concluded that in terms of refugee integration the state has adopted a minimalist approach whereby there are few 'state-sponsored formal structures through which new populations and their interests can be incorporated' (Soysal, 1994, p.38).

The next chapter highlights, both for refugees and for New Zealand society, poor settlement outcomes in the last two decades, with low refugee participation not only in the labour market, but also effectively in the services of public institutions. The role of key public institutions in New Zealand in the integration of refugee groups is discussed. These are the Ministry of Social Development, Departments of Work and Income and Child, Youth and Family Services, and the Ministry of Education. These public institutions will play significant roles with respect to how successful refugee integration will be in the long-term in New Zealand. Critically, the development of social and cultural processes and practices in public institutions that recognise diverse cultural groups are required. Such accommodations depend on the inclusiveness of social policies and progress towards new concepts and deeper notions of the value of diversity and the potential for new forms of citizen participation in New Zealand.

CHAPTER SIX

INSTITUTIONAL RESPONSES TO BECOMING SETTLED IN NEW ZEALAND SOCIETY

Introduction

In the early settlement phase, social and economic dislocation for refugee groups is to be anticipated and, therefore, the availability of well functioning unemployment benefit systems are critical in assisting families to establish themselves in the country of resettlement. In the intermediate and long-term stages of settlement, labour markets are the prime mechanisms through which refugees bind themselves to their new society and by which they are able to build standing within the new social structure. Penninx (2004) and others (Kymlicka, 2001a; Zetter et al., 2002) have highlighted the instrumentality of public institutions for the long-term social and economic integration of refugee groups. This chapter questions the state's management in New Zealand of the integration of refugees at an institutional level. In this context, the Ministry of Social Development, Ministry of Health, Department of Work and Income, the Ministry of Education and the labour market are instrumental institutions. The chapter raises the question of how far these institutions are open to the participation of refugee groups. The second question raised is: do these institutions take measures to stimulate refugee participation, that is, how far are they, in Penninx's (2004) terms, 'activated'?

Integration policies are part of the institutional arrangements in the receiving society. Using Penninx's (2004, p.12) integration model described in four such policy frameworks should broadly include the state's social policies and their effect on refugees, as well as 'policies that carry the explicit flag of integration'. The priority in framing integration policies should be given to the domains in which key institutions have effective and generally accepted instruments to promote long-term integration and to prevent social exclusion. These are: the economic domain of work and the social domains, particularly of welfare, education, health and housing. The policies and practices of public institutions, both formal and informal, will help or hinder integration. This chapter links institutional responses in the sectors of welfare, work and education in New Zealand to poor social and economic outcomes for refugees. It will be shown that New Zealand compares poorly to Australia, the United Kingdom

and Scandinavian countries in respect to inclusive social policies and institutional responsiveness.

There are four sections in this chapter. The first shows that integration efforts in New Zealand are minimal and focused largely on the initial settlement services delivered by non-governmental organisations. These are provided in the main by the voluntary sector. The second section focuses on the labour market exclusion of refugee groups and institutional responses from the Ministry of Social Development, Work and Income and the Ministry of Education. The third section focuses on English language and literacy provisions and the fourth on the broader context of the need for an overarching language policy in New Zealand.

Settlement Support in New Zealand

This section provides a context for refugee settlement support in New Zealand. Settlement support for refugee groups is mainly reliant on the voluntary sector, non-governmental organisations and refugee communities. A key point is that the concept of settlement in New Zealand is too narrowly conceived and the period of settlement support is too short. Refugees receive minimal short-term settlement services compared to the provisions for quota refugee groups in Canada and Australia (Department of Labour, 2004b). The Department of Labour (2004a) has the responsibility for providing on arrival settlement support services for refugees. These services are contracted through a number of non-governmental organisations.

In New Zealand, quota refugees spend their first six weeks in a refugee reception centre where they are provided with comprehensive medical care and psychological support (McLeod & Reeve, 2005). The Refugee Education Centre provides introductory adult English language training and an orientation to New Zealand society, a pre-school and a special programme for children and young people to prepare them for entry into mainstream schooling. The Refugees as Survivors Centre provides a trauma counselling service as well as therapeutic activities for children and adults. The Refugee and Migrant Service, Refugee Resettlement (RMS), offers immediate social support and links families with trained volunteers who will provide support for the first six months (UNHCR, 2002a). This settlement assistance is

available only to quota refugees. Asylum seekers and refugee family reunion members must resource their own settlement needs. Asylum seekers are largely reliant on the goodwill of a range of NGOs including Union Health Centres, City Missions and other charitable trusts that provide for those who exist below the poverty line. These services provide health care, food banks, clothing, household items, benefit advocacy and temporary shelter.

The Voluntary Sector

The role of civil society in refugee resettlement is important. However, long-term integration processes cannot be left to the non-governmental sector (Omidvar, 2001; Wayland, 2006b). It is argued in this section that governmental leadership enables the most efficient and effective planning of long-term integration for refugee groups in the receiving society. Importantly, the UNHCR (2002a, p.43) perspective on integration is that governments can provide a framework for ensuring that there is a coherent and predictable approach to settlement, whereas:

... NGOs are not governed by the same procedural and accountability requirements as their counterparts in the government sector, with the result that resettled refugees may lack access to a uniform range of integration supports and to the right to effective recourse in the event of poor quality or unfair treatment ...Government support also communicates to resettled refugees that they are an important constituency, and provides reassurance that they are welcome and valued.

The New Zealand Government has historically had limited involvement in the settlement of refugee groups. Settlement support continues to be highly dependent on the voluntary sector (Zwart, 2000). However, over the years, the number of people available in the community to provide volunteer support has dwindled and organisations encounter ongoing difficulties recruiting enough support workers for each new intake (Johns & Ainsworth, 2001; Lockhart, 2001).

Chapter one explained that at the end of the 1980s, the review of the Refugee Quota Programme established an annual refugee quota of 750 places and prioritised the most

vulnerable refugee groups. It was also explained that neo-liberal economic reforms taking place at this time extensively reduced publicly provided health, welfare and income support services. These welfare reforms from the late 1980s to the late 1990s were designed to reduce (Burden, Cooper & Petrie, 2000, p.77):

... state interference in the private domain, to give individuals greater 'choice' in running their own lives, to limit the power of state-employed professionals to control the lives of 'ordinary people', and to promote voluntarism. In this ideology, collective state provision is replaced by 'the community' in which caring is undertaken, generally by women, within the family, and unpaid.

The reforms exacerbated the social and economic position of new refugee groups which already had limited access to welfare and income support services due to language and cultural barriers. The reliance on voluntary organisations for settlement support for refugee groups increased significantly and they were unable to meet this demand.

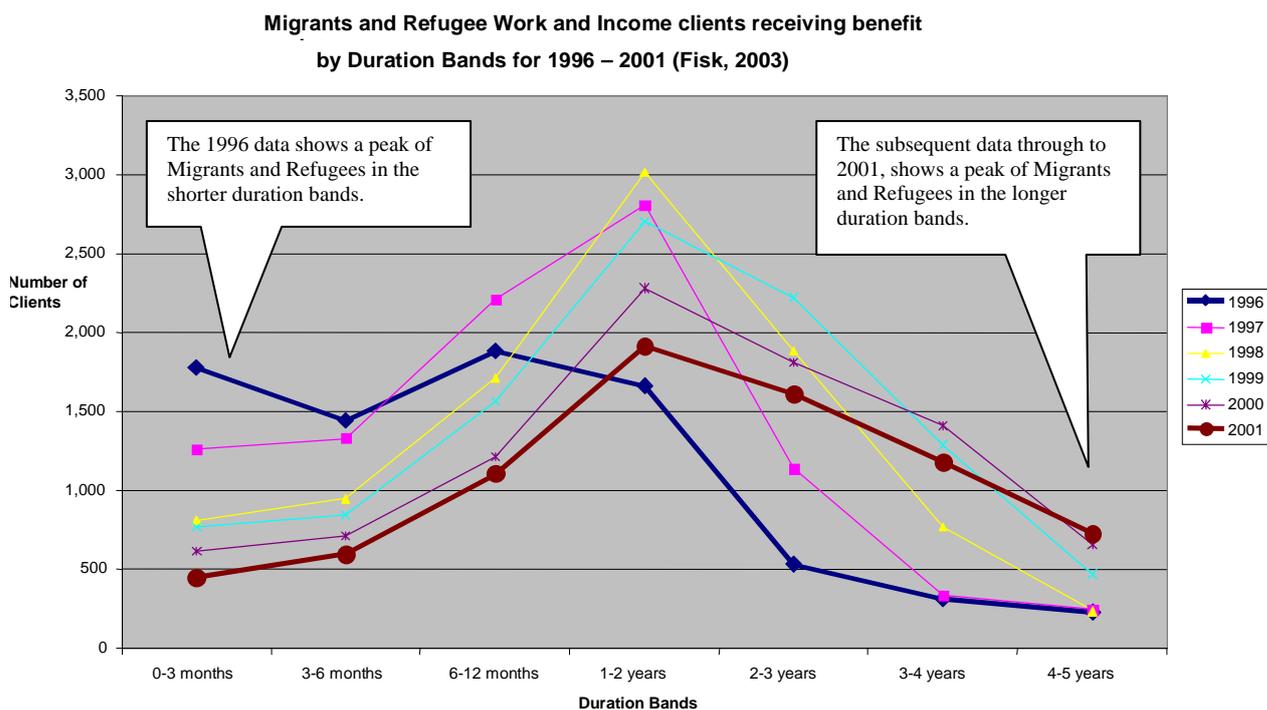
The consensus in the international literature is that governments have a pivotal role in integration and have the primary responsibility for funding, co-ordinating and monitoring settlement outcomes for refugee groups (ECRE, 2005; Penninx, 2000; Schierup et al., 2006; UNHCR, 2002a). This role, in the view of the UNHCR, is beyond the modest resource base of non-governmental organisations and volunteers (UNHCR, 2002a). In New Zealand, the voluntary sector and refugee community networks have proven to be inadequate to fill the gaps in welfare provision created by the neo-liberal reforms of the 1990s. These have had far-reaching social and economic effects on the refugee communities settled during that time.

Labour Market Exclusion

At the time of writing in 2004, New Zealand has one of the strongest labour markets it has had in two decades, with unemployment at around 5 per cent (OECD, 2004b). This represents one of the lowest unemployment rates in the Organisation for European Co-operation & Development (OECD, 2004b). This section outlines the nature and extent of long-term unemployment among refugee groups in New Zealand. Fisk (2003) demonstrates the decline in social and economic prospects for refugee

families since the 1990s, citing a disproportionate number of beneficiaries from refugee backgrounds in Auckland regional Work and Income benefit statistics. An analysis of migrant and refugee Work and Income clients (shown in Figure 6.1), between 1996 and 2001 demonstrates that a substantial number of refugees are now entering the two-years-plus duration bands for the unemployment benefit.

Figure 6.1: Migrants and refugee work and income clients receiving benefit by duration bands for 1996-2001



Source: Fisk, 2003

The Auckland regional Work and Income report, which included data relating to migrants and refugees, showed that a typical refugee client in receipt of income support was male and between 18 and 39 years old. Beneficiaries from refugee backgrounds had generally lived in New Zealand for up to three years and had been classified as long-term unemployed (Fisk, 2003). Fisk (2003) reports that refugees had significantly greater dependency on welfare, and reduced social and financial independence, than did migrants and other New Zealand nationals. Eighty five per cent of refugees on the Work and Income unemployment register were between three and four years duration. By comparison, 73 per cent of New Zealand nationals and 81 per cent of migrants were on the register for less than two years.

According to the *Longitudinal Immigration Survey: New Zealand (LisNZ)*, the rates of unemployment in the migrant group are declining due to the significant changes to immigration policy, to settlement initiatives to place migrants in employment and in the refining of the New Zealand Immigration Service entry criteria (NZIS, 2004a). However, refugees are excluded from the *LisNZ* study. Other studies indicate that refugees, 'particularly those from visible ethnic minority groups and/or the most different cultural backgrounds, face formidable barriers in gaining employment in New Zealand' (Butcher, Spoonley & Trlin, 2006, p.vi).

The *Refugee Voices* study conducted by the New Zealand Immigration Service (2004b) notes a lack of any overall approach to refugee education and employment policy in New Zealand. The study found that recently arrived refugees had a labour force activity rate of 26 per cent at six months, increasing to 33 per cent at two years (NZIS, 2004b, p.225). Two-thirds of quota refugees surveyed at two years after arrival did not speak English and had no educational qualifications (NZIS, 2004c). The study attributed long-term unemployment to multiple causes (NZIS, 2004c, p. 365):

...including language, adapting to different work cultures, and employers' reluctance to either employ someone from a different cultural background or to take a 'risk' with someone they know little about... Subsequently few were in employment even at five years. Those employed were often in part-time and/or low paid work.

Work experience is a critical factor in labour market success. Many employers see long-term unemployment as indicative of low motivation and poor work attitudes.

Another report, funded by the J.R. McKenzie Trust (2004), found that refugees seeking work faced significant discrimination from employers. Refugee women were found to be the most marginalised in employment as a consequence partly of the reality that in developing countries many women have little education. Some

employers rejected Muslim women who wore a headscarf on the grounds that this presented a risk to safety. However, the study noted that sometimes Occupational Safety and Health (OSH) requirements were used by employers to mask discriminatory practices against refugees entering the workforce (J.R. McKenzie Trust, 2004). Muslim women in employment were, therefore, said to face double discrimination 'because of their label as refugees and because of their dress' (J.R. McKenzie Trust, 2004, p.7). A compounding factor was stated to be the ongoing untreated mental health problems related to trauma and depression among refugees. This contributed to a lack of confidence and poor motivation in regard to finding and remaining in work. In the study, many young people were found to have left school early and without qualifications, in particular those who had arrived as teenagers with little or no previous education. Frequently, it was found that parents had unrealistically high expectations of what their children could achieve academically and were unable to advise on the career opportunities available in the New Zealand work place.

A lack of competency in English language and literacy was a major barrier to entering employment. There was a concern on the part of employers that those with limited English language skills would not understand OSH guidelines. When refugees did find employment, it was largely in low-skilled, poorly paid work. In some cases, the travel costs of getting to work made low-paid work a financially non-viable option. The *Refugee Voices* study found that the difficulties of making the transition from income support into employment were in part related to the punitive attitudes of some staff in Work and Income towards refugees (J.R. McKenzie Trust, 2004). This made it difficult for refugees entering the workforce to find out about ongoing benefit entitlements and to access them.

Institutional Responses to Labour Market Participation for Refugees

After briefly outlining income support policies in New Zealand, the main points addressed in this section are: first, that the active labour market policies (ALMPs) adopted by the Ministry of Social Development are insufficiently targeted to refugee groups to make a significant impact on long-term unemployment trends. Second, that the labour market policies implemented in the United Kingdom and Denmark are instructive for economic integration in New Zealand. Lastly, it is suggested that there

needs to be a consistent indicator framework for systematically assessing employment outcomes in refugee groups in the long-term.

Income Support Policies in New Zealand

It is first acknowledged that income support policy is part of a wider policy issue of income distribution within the nation-state. However, as this chapter focuses on institutional responsiveness, the primary focus in this section is on the state's actions in regard to income support. The distinctive characteristics of income support policy in New Zealand are 'a heavy use of means testing for benefits and a relatively ungenerous welfare state funded primarily through general taxation. This contrasts with the more universal and more generous provisions of many European welfare states, and Scandinavian welfare states in particular' (Cheyne, O'Brien & Belgrave, 2004, p.163). In 2006, it was noted that Denmark had the lowest proportion of the population with incomes below the low-income threshold (4.3 per cent) (MSD, 2006, p. 63). In 2004, the New Zealand rate was 10.8 per cent (MSD, 2006, p. 63).

As a context for the issues of social and economic integration for refugee groups in New Zealand, economic and social changes since 1984 have produced a significant widening of inequalities in income distribution, defined as the extent of disparity between high and low incomes (MSD, 2006). Inequality has widened more extensively in New Zealand than in any other OECD country (MSD, 2006). Refugee families and households (represented within the ethnic group 'Other') are over-represented among those in poverty and in the bottom income quintile (MSD, 2006, p. 49). The Ministry of Social Development in *The Social Report 2006* showed that the employment rate for the 'Other' ethnic category has fallen from being the highest in the late 1980s to the lowest since the mid 1990s (59% in 2005).

The neo-liberal economic reforms of the National Government of the 1990s reduced income support significantly. The cuts represented the first actual reductions in social-security benefits in New Zealand's history. Major benefit reforms in 1991 led to a tightening in eligibility criteria and a cut in benefit rates, targeted especially at couples with children. Using a Labour Market Attachment (LMA) logic, the National Government argued that the cuts would provide more incentives for the unemployed

to join the workforce and would increase self-reliance. There was a subsequent increase in poverty and a deterioration in living standards for beneficiaries. Poverty is defined in this context as deprivation and inadequacy of income, relative to the particular society in which it is occurring, for those reliant on state income support (Cheyne et al., 2004). The proportion of the population with low incomes increased sharply in the 1990s, reached a peak in the mid 1990s, and dropped over the latter half of the decade. However, in 2004 the proportion of the population living below these thresholds was still substantially higher than it had been in 1988. Refugee groups are one of the population groups more likely than others to experience low living standards.

Social development approaches to benefit dependency, introduced in 2001 by the Labour led coalition, have important implications in terms of the institutional opportunity structure to include refugee groups, although they are not specifically included. The model of social development employed by the Ministry of Social Development (2001) is based on social inclusion principles. The *Social Development Approach* is a strategy for social policy based on reducing social exclusion by focusing on both protection and prevention. In the strategy (MSD, 2001, p. 4):

... protective policies include strengthening the income protection for those who suffer unemployment and ill health. Important preventive interventions include early intervention amongst at risk children, improved education and a focus on literacy, the alleviation of child poverty, and policies to expand employment through economic development.

The concept of 'social exclusion' is used widely in international work on inequality, poverty and development, and in particular in regard to the integration of refugee populations (Penninx, 2004; Samers, 1998; Schierup et al., 2006). The New Zealand approach offers a framework for cross sectoral social policy which has important, but as yet underutilised, opportunities for refugee inclusion.

Importantly, the MSD (2001) model signals a shift away from historic social policy analysis organised around functional interventions, such as economic, education, housing and health policies, which tended to result in poorly coordinated and integrated policy (MSD, 2001). Social exclusion, according to the definition used by MSD (2001, p. 3) is said to occur ‘where people fall below some minimum threshold of well-being and are hindered from fully participating in society’. According to the Ministry of Social Development (2001, p.3), social exclusion occurs where people suffer separately or in combination from any of the following:

- poverty;
- illiteracy and low levels of educational qualifications;
- unemployment or poor quality employment;
- poor health and avoidable mortality;
- criminal victimisation;
- social isolation;
- discrimination; and
- alienation from political participation.

The *Social Development Approach* acknowledges that social exclusion is an important cause of poor outcomes in the future, citing, for example, evidence of the links between the experiences of poverty and future poor health and, as well, the links between educational failure and future unemployment and poverty (MSD, 2001, p.4).

There are nine elements that collectively form the social development model. These include (Cheyne et al., 2004, p. 181-182):

... using welfare programmes to improve beneficiary levels through active assistance aimed at moving beneficiaries into paid employment; and emphasis on economic and social development rather than distribution; emphasising individualised assessment of capacity and need rather than entitlement; and lifting

skills and abilities and factoring in dimensions of ‘social exclusion’ rather than a total focus on income support.

Since 2000, the Government’s income support policy has focused, based on the social development model, on individual opportunities and responsibilities, and on building individual capability, but poverty, particularly child poverty, remains a key issue. Policy debates in New Zealand have been heavily influenced by the concentration on benefit dependence as the major consideration in income support provision. The issues of benefit and income adequacy persist as strongly as ever, and particularly so for refugee families (Cheyne et al., 2004).

Active Labour Market Policies

The main points in this section are: first, that while the social development approach provides some opportunities for inclusion, overall social protection and labour market responses are poorly and unevenly targeted at refugee groups; second, the application of a strong social policy focus on exclusion and poverty in refugee groups could be utilised in the New Zealand context in the Ministry of Social Development’s (2001) *Social Development Approach*, which has been explained earlier in this section. In relation to the first point, since 2000, labour market policies have included a growing emphasis on employment assistance and employment transition schemes (Spoonley, Wright, Perry & Davidson, 2005). These schemes have been targeted in particular at Maori, Pacific Peoples and youth but few labour market programmes have been specifically targeted to refugee groups. Significantly, Work and Income predicts, that in the case of refugees, ‘without specifically tailored interventions, it is likely that this group will establish themselves as long-term beneficiaries, compounding the risk of cross-sectoral and intergenerational issues’ (Fisk, 2003, p.5). Work and Income acknowledges though, that there is tension between extending levels of interventions to refugees and migrants, due to ‘the impact it will have on other priority groups’ (Fisk, 2003).

The Ministry of Social Development *Auckland Metropolitan Region Migrant and Refugee Strategy* is an important initiative in respect to refugee labour market integration although it is poorly aligned to the overall labour market policies described earlier (Ministry of Social Development, 2003). The strategy was developed

as a response to the difficulties faced by refugee groups in finding employment. In the strategy the Work and Income Regional Commissioner's from the Auckland Metropolitan region have defined the five key employment issues for refugees and migrants as (Fisk, 2003, p.7):

1. Work Readiness

The low perceived levels of employability for Migrant and Refugee clients in the identified at-risk group are an issue. Often multiple facets need to be addressed in preparing the clients for the New Zealand work environment. These include re-education of clients and prospective employers, as well as the handling of issues faced by clients such as health issues that may face some refugees as the result of torture and trauma experiences from their country of origin. In addition, there are more general health issues...

2. Dependency

Over the past two years, the length of time (on average) that...refugees require benefit assistance has increased illustrating greater dependency on welfare and reduced social and financial independence...85% of refugees on the register are between 3 and 4 years duration.

3. Culture Shock

There are many geo-political differences faced by migrants and refugees when integrating with New Zealand society. If these differences are left and not addressed, they can have long-term social implications for the social services, health and justice sectors alike.

4. Access

Migrants and refugees face barriers that hinder access to conventional social services. This is in part linked to their expectations (or lack of understanding of the role of social and community services), part to linguistic

difficulties and part to the fragmented nature of support providers themselves.

5. Resources

Migrants and refugees require more intensive interventions and support than is currently provided. The ability within existing resources to extend the level of desired interventions to migrants and refugees must be balanced with the impact it will have on other priority groups.

The key components of the strategy are to place Work and Income services in Migrant Resource Centres, to establish specialist migrant and refugee Work Track and Work Action programmes, to provide specific client development programmes (such as driver education and adult literacy courses), to provide a multi-lingual call centre for Work and Income services, and to reduce the client case loads for specialist case managers in Work and Income services (MSD, 2003). But Work and Income acknowledges that while refugees require more intensive interventions and support than are currently offered by their services, it is a matter of which populations have priority access to resources and refugee groups are not considered a priority group (Fisk, 2003).

There are lessons to be learned from British and European labour market integration and social protection policies, in particular, the United Kingdom social exclusion and Danish 'flexicurity' models (Byrne, 2003; OECD, 2004a, 2004b). In Danish workfare programmes, social integration, rather than anti-welfare dependency ideology, is a central objective. Danish social policies and welfare reforms are most concerned with (Byrne, 2003, p.198):

...integrating people into a social order through participation in work, something which has particular significance in relation to the poorly qualified young at the time when changes in labour market structure have

massively reduced employment opportunities for citizens with low skill/qualification levels.

The important characteristics of Danish labour market policies for refugee integration are a substantial investment in training and education. However, there is a note of caution as Denmark has the highest expenditure on labour market policies in the OECD (Madsen, 2001, p.8). While the flexicurity model is an apparent success, there is some speculation as to its viability as a social policy in the event of an economic downturn, in which case revenues would drop at a time of a greater call on benefits (Spoonley et al., 2005).

A good example of central government leadership, and its significance for promoting inclusive welfare and labour market integration policy for refugees, is in the United Kingdom, where the Social Exclusion Unit was established within the Prime Minister's Department following the election of the Blair Government in 1997. The UK Social Exclusion Unit (SEU, 2006, p.1) defines social exclusion as what happens 'when people or places suffer from a series of problems such as unemployment, discrimination, poor skills, low incomes, poor housing, high crime, ill health and family breakdown. When such problems combine they can create a vicious cycle'.

The Home Office strategy for refugee integration (*Integration Matters*) and the Department for Work and Pensions' (2004) Refugee Employment Strategy (*Working to Rebuild Lives*) emphasise the importance of employment for refugee membership in British society. The Refugee Employment Strategy, launched in 2005, aims to: improve National Asylum Support Service support; ease the transition to work; increase the availability of 'adaptation' courses; outreach; and provide better translating and interpreting services (Somerville & Wintour, 2006). The Labour Government's welfare-to work interventions, which are largely focused around the Public Employment Service, Jobcentre Plus, have been largely successful in placing refugees in employment. An important research finding has been that better employment outcomes are achieved by dealing with refugee settlement issues

alongside benefit services and by having advisers in Jobcentre Plus offices and providers of employment training working closely together (Bloch, 2004).

Another social protection policy is the Department of Work and Pensions *Building on the New Deal* strategy which provides intensive case management for refugees and asylum seekers (DWP, 2003). The strategy recognises that a separate approach is needed for refugees, including increased flexibility for Jobcentre Plus staff to meet individual needs. The strategy emphasises moving groups towards 'work readiness' (rather than into the first available job) (DWP, 2004). Importantly, the New Deal includes arrangements for refugees to get work experience. The key lessons to be learned from the United Kingdom Labour Government social policy initiatives are to recognise that welfare-to-work measures are only part of the solution to increasing labour market participation. Social issues such as access to housing, health and mental health care are also considered crucial to participation.

To conclude this section, in terms of income support and labour market policies in New Zealand there are few strategies targeted to refugee groups. Although the agencies that have a brokering role, such as WINZ and Migrant Resource Centres, pay some attention to refugee groups; there is no overarching policy framework that addresses a programme for long-term labour market integration or that provides adequate resources for refugees. The ad hoc responses to refugee training and employment from the Ministry of Social Development in the *Auckland Metropolitan Region Migrant and Refugee Strategy* and the Department of Labour in the *Immigration Settlement Strategy* do not compensate for a systemic policy for integrating refugees into the labour market. In this respect, the Ministry of Social Development proposal for an indicator framework to assess the impact of settlement policies on long-term labour market outcomes for refugee groups is useful (Peace et al., 2005). The proposed framework captures not only the disparities between refugee groups and the general population but also institutional responses to refugee groups. The MSD indicator framework would include barriers to employment, such as, racism and discrimination, the responsiveness of MSD, WINZ and the Ministry of Education to refugee groups, and measures of refugee participation in education and the labour market (Peace et al., 2005, p.20). Systematically monitoring the impacts and

outcomes of employment programmes for refugee groups would provide an assessment of whether employment policy objectives were being achieved in the government sector.

English Language and Literacy Skills

Reaching proficiency in English is a crucial component of the settlement process in New Zealand. White, Watts and Trlin (2002, p.149) note that English-language proficiency is 'critical in facilitating social contacts, in enhancing employment and educational opportunities, and in providing the basis for productive involvement in the economic, social and cultural life of the receiving society'. This four-part section begins with a brief overview of the research findings on English language and literacy levels in refugee groups in New Zealand. In the 2001 Census, peoples from refugee backgrounds, specifically from Southeast Asia, East Africa and the Middle East had the highest proportion of non-English speaking adults, and many had been in New Zealand for ten years or more (Ministry of Education, 2002a, 2003a). Ministry of Education studies conducted in 2002, 2003 and 2006 indicated that refugees had the highest level of need for foundation education level ESOL and literacy courses. Eighty per cent of refugees who arrive as quota refugees have less than four years schooling, 40 per cent are not literate in any language, and a further 40 per cent have some literacy skills in their first language but no literacy skills in English (Ministry of Education, 2003a).

English language and literacy skills are the most significant predictors of differential labour market outcomes for refugee groups (NZIS, 2004b; Schleicher, 2006; Wayland, 2006b; White, Watts & Trlin, 2002). Adult non-English speakers earned on average \$11,000 in the twelve months prior to March 2001, which was 40 per cent of the average income for the general adult population (Ministry of Education, 2002a, p. 30). Similar results were found in the 2004 *Refugee Voices* study and this showed that many refugees who were settled more than five years and in employment, but who could not speak English well, were earning a salary or wage of less than \$10,000 (NZIS, 2004c. p. 12). The Ministry of Education (2003a) anticipates that refugees with the highest concentrations of low or no literacy skills populations will become increasingly vulnerable as the availability of low-skilled jobs within the economy diminishes.

The first part of this section addresses language training and education for adult refugees. The second part focuses on education for school-age children and youth; the third focuses on preschool education. Each section contains an overview of the language learning needs of refugees, the language programmes available and the policy barriers to more effective language learning for refugee groups.

ESOL (English for Speakers of Other Languages) for Adult Refugees

The main points in this section are that first, a higher level of government support is required to support ESOL provision for adult refugees from voluntary schemes such as the ESOL Home Tutors network and community education programmes to courses at the more advanced level in tertiary institutions (White, Watts & Trlin, 2002). Second, the provisions for adult refugees should be carefully coordinated and systematically planned from an evidence-base (Clark, Ramasamy & Pusch, 2006). Third, the New Zealand strategy for adult ESOL provision could look to Australian and Canadian models of English language instruction. Fourth, workplace English language opportunities for refugees are critical to improving labour market participation.

New Zealand is well behind other resettlement countries in terms of a strategic approach to adult English language and literacy instruction. It was not until 2001 that a New Zealand adult literacy strategy was developed, and then in 2003 an adult English for Speakers of Other Languages (ESOL) strategy (Ministry of Education, 2001, 2003a). The Adult ESOL strategy was prompted by the recognition that there were issues with the quality of ESOL tuition offered and poor progress in existing classes, a lack of trained ESOL teachers, long waiting lists for classes, particularly in central Auckland and impeded access for women due to childcare and transport difficulties (Ministry of Education, 2002a, 2003a).

As part of the implementation of the Adult ESOL strategy the provision of bilingual language and literacy tuition was successfully piloted in Somali, Ethiopian and Burmese refugee communities in 2003 (Ministry of Education, 2004). These groups had some of the highest educational needs, many being pre-literate or beginners in English. The key factors in the success of the trial programmes were that the classes were: free, community-based, ethno-specific, owned by ethnic communities, provided

transport and childcare when required, offered inter-generational learning opportunities, provided a curriculum that was learner-driven and responsive to student needs, addressed settlement issues and, importantly, prepared students for employment (Ministry of Education, 2004).

The Ministry of Education (2002a, p.25) estimated that in 2002, the total ESOL target population at approximately 250,000 and the scale of provision at 20,000 places per year. ESOL tuition provision has been largely undertaken through the informal programmes offered by the National Association of ESOL Home Tutors Schemes. The ESOL scheme is run by a non-governmental agency that provides English language tuition through a network of trained volunteers. The service struggles to meet the demands for English language instruction and there are continual difficulties in retaining experienced volunteers in the under resourced community sector. Additionally, there are recognised limitations in the ESOL Home Tutors model which provides English language but little literacy teaching.

For many refugees, needs for ESOL learning are closely connected with needs for literacy learning. The Ministry of Education (2001) recognises that raising the level of adult literacy requires a large increase in the number of specialist qualified adult literacy teachers and that the adult literacy provider sector is poorly developed. The gaps in adult ESOL provision that have been identified are that there are a limited number of providers, insufficient professionally qualified adult literacy teachers, few appropriate teaching resources, a lack of professional development opportunities and very few qualifications available for adult literacy teachers (Ministry of Education, 2002a).

In general, New Zealand compares poorly to other resettlement countries in the provision of ESOL courses (Ministry of Education, 2003a, 2006; White, Watts & Trlin, 2002). Whereas Canadian and Australian schemes offer refugees free ESOL classes for a set number of hours or until a certain level of proficiency is achieved, New Zealand providers lack quality-assured provision, coordination, and leadership from Government (Ministry of Education, 2003a). By comparison, the Australian Government provides up to 510 hours of basic English language and literacy tuition to migrants and refugees from non-English speaking backgrounds. Up to an additional

100 hours is also available to refugees and humanitarian entrants through the Special Preparatory Programme (DIMIA, 2004b). In particular, the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA, 2004b) *Australian Migrant English Program* (AMEP) model, and the *Language Instruction for Newcomers to Canada* (LINC) model (Citizenship and Immigration Canada, 2000) could usefully be applied in New Zealand adult English language instruction settings.

Workplace English language opportunities for refugees need to be available to improve labour market participation. There is a need in New Zealand to develop the range and quality of workplace ESOL classes. The advantages of work preparation training courses that include ESOL components are developing links with the workplace and assisting refugees to obtain jobs. New Zealand could gain from the adoption of Canadian work-based models of language instruction (White, Watts & Trlin, 2002). For example, the *Language Instruction for Newcomers to Canada* (LINC) programme, and an associated *Labour Market Language Training* (LMLT) programme which both provide funding to accredited public and private organisations for the provision of basic English-language instruction to adult refugees in the workplace (Citizenship and Immigration Canada, 2000).

ESOL in Schools

New Zealand compares poorly to Australia and Canada in English language and literacy instruction for school-age children and young people. There has been a programme for ESOL provision since 1998 which gives extra funding to schools for all school-aged refugees for up to five years (Ministry of Education, 1997a, 2001, 2003a, 2003b, 2006). In the 2004 budget, schools received an increase in funding of \$37.9 million for four years from 2004 to 2008 to provide more English language instruction (Minister of Immigration, 2004b). However, although there is now much greater support and structure than in the past, further systemic support would enhance ESOL provision and student learning (Ministry of Education, 2003b). Currently, ESOL providers are not skilled enough to design excellent ESOL language development and this should not be done on an individual school basis (Ministry of Education, 2003b).

In 2002, refugees accounted for 8.6 per cent of the population of funded NESB students (Ministry of Education, 2003b). Refugee students, many of whom have had little or no education and have not learned to read or write in their first language, were recorded as having the lowest levels of performance in literacy levels. This trend in poorer performance literacy levels also extended into first generation children. A Ministry of Education report recorded (2003b, p.16):

... statistically significant differences in reading literacy performance between “Non-native” (Migrant and Refugee) and “First Generation” students (New Zealand born of immigrant or refugee parents), and “Native” New Zealand born students with at least one New Zealand born parent...First Generation students, on average, in New Zealand perform at a similar level to Non-native students, whereas in Australia and Canada, First Generation students perform at a similar level to Native students.

Minority language students in New Zealand were more than twice as likely as majority language students to be in the bottom quarter of performance in reading literacy (Ministry of Education, 2003b). By comparison, in Canada and Australia, the difference between minority and majority language students was less than half a proficiency level. The report stated that while there had been no research to investigate the poorer performance of NESB students in New Zealand compared to counterparts in Australia and Canada (Ministry of Education, 2003b, p.16):

...a number of factors outside the school system are known to differ. For many years, both Australia and Canada have had extensive language policies, and support for language learning throughout schools and the community, including ongoing funded programmes for adults. In addition there has been a large amount of research into second language learning and bilingual

education, especially in Canada, and production of many teaching resources. All these activities, as well as community resources and support very likely contribute to the differing results in those countries.

The limited provision of bilingual minority language pre-school education is among the factors which may contribute to poorer results in English language acquisition in New Zealand NESB students.

ESOL in Pre-Schools

Over the years, a substantial body of evidence has accumulated that highlights the importance of programmes targeted to pre-school children from disadvantaged backgrounds (Machin, 2006). In Australia and Canada, pre-school and school environments serve as a primary source of contact between refugee families and the receiving society. Typically, in Australian and Canadian pre-school models, there is cross sector collaboration between pre-schools and schools, mental health, settlement support services, and refugee communities to assist the settlement of refugee families (UNHCR, 2002a).

In New Zealand, there is limited access to pre-school education for refugee families. Hunt (2003), in a study of Kurdish refugees, draws the conclusion that access to pre-school education is almost non-existent for refugee families. In her study less than a third of Kurdish children attended a pre-school, although all pre-schoolers arriving at the Mangere Refugee Reception Centre attended the kindergarten there. In the study, although the parents interviewed were enthusiastic about continuing to send their children to pre-school once resettled in the community, a number of factors worked to reduce refugee access to and participation in early childhood education. These factors included English as the language of communication and instruction, a knowledge of how to enrol children at a pre-school centre, the age of the child and the places available, the payment of a 'donation' at each centre, and the availability of transport and of supervised delivery and pick up of children (Hunt, 2003, p. 112). Separation anxiety was reported to be a factor in the withdrawal of some children, suggesting that specialised therapeutic intervention was needed for traumatised pre-schoolers (Hunt, 2003).

There is clear evidence that bilingual education beginning in early childhood leads to greater educational achievement for refugee communities (Marchin, 2006). In May's (1994, p.188) view, when children from minority ethnic groups, such as refugee groups, are equipped with both 'cultural recognition *and* academic skills' there is much greater opportunity for children to succeed than there might otherwise have been.

A Language Policy for New Zealand

The last section focuses on the need for a language policy in New Zealand. The purpose of a language policy is to guide policy development from early childhood to the tertiary education level, including employment, which is consistent with national economic, social and cultural development goals (Ministry of Education, 2003b). The type of language policy needed for New Zealand is one that balances an emphasis on acquiring English language and literacy skills and the maintenance of minority languages (Ministry of Education, 2006; Spoonley et al., 2005). In this section, the main points are: that language is of key importance in maintaining minority cultural identities, that it is not enough to promote the merits of cultural and linguistic diversity without pursuing minority language and education rights as a matter of social justice (Kymlicka, 2001a; May, 2001), that for the future development of a language policy in New Zealand the Canadian Government's language policy is instructive. Language policies in Canada are supported by the *Multiculturalism Act* 1988, which ensures the funding of bilingual education or mother tongue instruction (Banting & Kymlicka, 2003).

In New Zealand advocates of minority languages have called for the development of a state sponsored language maintenance policy (Bartley & Spoonley, 2005; Hunkin-Tuiletufuga, 2001; May, 2001). In this perspective, the absence of a policy that would encompass non-English and non-Maori languages is symptomatic of the gaps in systemic policies of integration for groups such as refugees. This is a significant gap because (Bartley & Spoonley, 2005, p.141):

...given that the major arena for the incorporation of adolescents is the education sector, the lack of systemic

policy concerning immigrant and ethnic children, and their engagement with educational processes, highlights the inadequacy of what passes for a multicultural framework.

Largely, language maintenance for Pacific and other minority languages has been left to the resources of respective communities and to schools and pre-schools. However, while educational responses have been in advance of public opinion, there are limitations on the extent to which education systems can go in responding to minority needs for language maintenance (Churchill, 1986). In this context the lack of attention to language issues in the national *Immigration Settlement Strategy* and *Ethnic Perspectives in Policy* is an important clue in understanding the restricted nature of what passes for an integration framework for culturally and linguistically diverse groups. Beyond the important bilingual initiatives in the education system, the absence of official minority language support is an indication that there is little willingness to accommodate minority groups in New Zealand (Bartley & Spoonley, 2005; Churchill, 1986; May, 2001).

Conclusion

In conclusion, New Zealand lags behind Canada, Australia and the Scandinavian countries in post-settlement assistance, institutional accommodations, integration and social policy that is inclusive of refugee groups. The markedly poorer settlement outcomes in New Zealand, compared to other countries, reflect inadequate measures to respond to the post-arrival adjustment and long-term integration needs of refugee groups. The social policy frameworks of the Ministries of Education, Social Development and the Department of Work and Income set the limits for social, economic and cultural participation for refugee groups in New Zealand society. These policy frameworks are themselves determined by, and a reflection of, the more profound social dynamics which prevail in New Zealand society which demarcate levels of social inclusion and connectivity for groups such as refugees. The extent to which refugee groups are able to participate in the education system, training opportunities and in the labour market is crucially dependent on key inputs such as the form and appropriateness of language and literacy training programmes and the institutional accommodation of cultural and linguistic diversity.

CHAPTER SEVEN

HEALTH POLICIES AND REFUGEES IN NEW ZEALAND

Introduction

Chapters seven and eight analyse the New Zealand health system from the perspective of the social and cultural rights for refugee groups. Chapter eight will focus specifically on the psycho-social and cultural accommodation of refugee groups in the New Zealand health system. This chapter focuses on the health policies developed after 1999, when the Labour-led coalition was elected. The socio-political context for this chapter is that although the New Zealand Government continues to select refugees with high health needs, there is no structural framework to guide the integration of culturally and linguistically diverse groups in the New Zealand health system. As four explained, how far groups such as refugees are able to participate in receiving societies is determined by the systemic channels available to them to access social and cultural rights. This chapter will explain descriptively, the limited opportunities for social and cultural inclusion for refugee groups in New Zealand.

The chapter is organised into two main parts: the first offers an overview of health rights for refugees in the context of the universalist health rights in New Zealand and notes in particular the impact of ethnic data collection systems on the allocation of population health funding; the second analyses the health policy environment as a context for the structural integration of refugee groups. The main points made in this chapter are that first, health status is a key marker in identifying social inequalities in New Zealand populations and second, universalist health policies overlook the population health issues of refugee groups; third, New Zealand systems of health monitoring and funding represent exclusionary regimes for refugee groups; and fourth, the overarching structural and societal strategies for improving the population health of New Zealanders could provide a systemic framework for integrating refugee groups.

Universal Health Rights in New Zealand

In part one of this chapter, the universalist notions that underpin health rights in New Zealand demonstrate the limitations of the Marshallian (1950, 1965) conceptions of social citizenship which were discussed in chapter four. The shortcomings of

providing social rights without cultural accommodations are that for groups such as refugees, these conceptions remain Anglocentric and reinforce notions of culturally diverse groups as 'Other' and as outsiders (Solomos, 1998).

In New Zealand, health rights for refugees are ambiguous and contradictory. In spite of the specific inclusion of refugees and asylum seekers in the *2003 Direction of the Minister of Health Relating to Eligibility for Publicly Funded Personal Health and Disability Services in New Zealand*, in practice there are differential terms and conditions being offered compared with other New Zealand populations. Section 4, Clause 3 of the Ministerial Direction states that 'a person who has refugee status in New Zealand or, is in the process of having an appeal against refusal of refugee status determined by the Refugee Status Appeal Authority' is eligible for publicly provided health services (Minister of Health, 2003a). While universal health rights accord refugees the same formal rights to health care as other New Zealanders, refugees have unequal access to services compared to other groups in New Zealand society.

Ethnic Data Collection Systems in Health Care

In this section the ethnic data collection systems used by the New Zealand health system are explored in relation to the inclusion of refugee groups. The main issues raised are that first, the minority ethnic groupings of the refugee communities in New Zealand do not meet the qualifying conditions for ethnic inclusion in the statistical data collection systems used by the Ministry of Health; second, refugee groups are recorded as 'Other' for the purposes of allocating the population-based funding formula (PBFF); third, refugee groups are not included in New Zealand health monitoring systems.

The qualifying conditions for ethnic inclusion in statistical data collection systems in health care do not include the ethnic groups of refugee peoples. The data collection categories provided by Statistics New Zealand (SNZ) at Level 2 of the coding system form the basis for the estimated health population projections in each District Health Board (DHB) region to which the population based funding formula will be applied (Ministry of Health, 2004e). The ethnic data reporting systems at Level 2 are limited to the broad groupings of: 'European'; 'New Zealand Maori'; 'Pacific Island'; and 'Other'. But in the 2006 Census, Statistics New Zealand recognised that the ethnicity

codes collected in official social statistics had become less relevant with the number of refugee and new migrant groups settling in New Zealand and adjusted Level Four codings to include these groups (Statistics New Zealand, 2001). The Level 4 codes which represent all the ethnic groups in New Zealand are not used by the Ministry of Health.

The significance for refugee groups of being recorded as 'Other' in health monitoring and funding formula systems is that the groups defined as 'Other' are not included in targeted reducing inequalities strategies or health monitoring systems. Although health strategies such as *Monitoring Ethnic Inequalities in Health* (Ministry of Health, 2001b), *Reducing Inequalities in Health* (Ministry of Health, 2002d) and *Decades of Disparity III: Ethnic and Socio-economic Inequalities in Mortality, New Zealand 1981-1999* (Ministry of Health & University of Otago, 2006) make strong links between ethnicity, health status and the broader patterns of inequalities in education, employment, income and housing, in New Zealand health populations there are no structural means by which refugee groupings can be included. To reduce inequalities for groups such as refugees, in Iris Marion Young's (1995, p.159) words:

...besides guaranteeing individual civil and political rights, and guaranteeing that the basic needs of individuals will be met..., a vision of social justice provides for some group related rights and policies. These group institutions will adhere to a principle that social policy should attend to, rather than be blind to, group difference in awarding benefits or burdens, in order to remedy group based inequality or meet group specific needs.

In Young's (1995) view defining groups as 'Other' actually denies or represses social difference.

The Ministry of Health (2001b, p.24) *Monitoring Ethnic Inequalities in Health* strategy forms the basis for monitoring the health of the ethnic groups in New Zealand. The strategy uses the rationale that to improve ethnic data collection and to

monitor the impact of ethnic inequalities in health in New Zealand (Ministry of Health, 2001b, p.34):

1. Appropriate statistical methods should be developed to better understand the interaction of age, gender, ethnicity, socioeconomic position and region in generating the observed health inequalities.
2. Research is needed to measure and monitor institutional racism, including its impact on access to and quality of primary and secondary health care services.
3. Consideration should be given to including questions on the experience of personal racism in future health and social surveys.

While in the following quotation, the strategy highlights clearly the relationship between: ethnicity, socioeconomic status and health, this analysis has not been applied to refugee groups (Ministry of Health, 2001b, p. 24):

...socioeconomic status (SES)—whether measured by education, occupation, income or deprivation—is not simply a confounder of the ‘ethnic effect’, like age or gender, but rather constitutes a pathway variable linking ethnicity to health: at least part of the effect of ethnicity on health is mediated through SES, to which ethnicity is logically prior.

The *Reducing Inequalities in Health* strategy (Ministry of Health, 2002d) acknowledges that differential access to health care and differences in the care received for different groups has a considerable impact on health status (Davey Smith, 2000; Howden-Chapman, 1999; Howden-Chapman, Blakely, Blaiklock & Kiro, 2000). The view taken is that to tackle the ‘root cause’ of inequalities in health, that is, ‘the social, cultural, economic and historical inequalities’, requires policies directly concerned with education, occupation, income and the economy (Ministry of Health,

2002d, p.20). This analytical framework has the potential to be applied to the social, cultural and economic circumstances of refugee groups.

The Allocation of Health Funding

As the last section explained, in New Zealand ethnic identity is an important dimension of the allocation of health funding. However, the allocation of population-based funding in health care overlooks refugees as a priority group. The population-based funding formula (PBFF) is based on the premise that Maori have the greatest health care need, with Pacific peoples second (Ministry of Health, 2001b). The grouping of refugees under the formula in the same way as ‘Other’ peoples, that is, all non-Maori/non-Pacific peoples, has considerable social and cultural impact. The category ‘Other’ peoples is a composite group of European, Asian, African and Middle Eastern groups who do not qualify for additional funding on the basis of health need (Solomon, 1997). There is a primary care cost weighting based on financial access barrier adjusters, and calculated on geo-coded areas of deprivation (Ministry of Health, 2002f). There should be, according to this formula, a strong relationship between health need and socio-economic status for all New Zealand population groups (Ministry of Health, 1999a). However, this relationship is not pursued in the case of refugee groups.

Population-Based Funding Formula

The population-based funding formula (PBFF) determines the share of funding to be allocated to different health districts based on the population living in each district (Ministry of Health, 2005c). After explaining the aims of the PBFF, this section undertakes the following: first, the assumptions on which the PBFF is based are challenged. Second, it is argued that because refugees have high health needs they warrant separate identification in population-based funding formula. The PBFF aims to distribute available funding fairly between DHBs according to their populations’ relative needs, and the cost of providing health services. The intent of the PBFF is to give each District Health Board the same opportunity, in terms of resources, to respond to its population’s needs. According to the PBFF each DHB’s share of health and disability funding is determined by (Ministry of Health, 2005c, p.67):

- its share of the projected New Zealand population, weighted according to the national average cost of

health services and disability support services for older people used by different demographic groups

- an additional policy-based weighting for unmet need that recognises the different challenges DHBs face in reducing disparities between population groups
- a rural adjustment and an overseas visitors adjustment, each of which redistributes a set amount of funding between DHBs to recognise unavoidable differences in the cost of providing certain health services and disability support services.

Comparative analyses of the cost of health services for refugees and asylum seekers show that refugees have similar health utilisation rates to those of Pacific peoples (Solomon, 1993, 1995, 1997, 1999). Solomon (1997), in a study commissioned by the then Health Funding Authority, compares the health status of refugee populations with the three ethnic groups that receive separate recognition with New Zealand's population-based personal health care funding formula: Maori, Pacific peoples and 'Other' peoples. The analysis concludes that refugees and asylum seekers in a number of high cost health status indicators have poor health status and high health needs, and for the purposes of the PBFF, are best equated with Pacific peoples, and not 'Other' peoples (Solomon, 1997). Based on Solomon's (1993, 1995, 1997, 1999) studies, there is an argument for a separate cost-weighting for refugee groups within the population-based funding formula.

Capitation-Based Funding

In 2002, the Labour-led Government introduced Primary Health Organisations (PHO), a population based approach to primary health care. A key objective for the PHOs is to 'better understand and meet the needs of [their] constituent populations' (Ministry of Health, 2002h, p.2). Capitation-based funding is the system for linking funding to the diverse population health needs in the respective Primary Health Organisations (Ministry of Health, 2002f). Primary Health Organisations gather patient information according to the CBF system and this data determines the level of funding that they will receive for high health needs populations. The issues of social equity and access for refugee groups are that the CBF system does not include

refugees as a high health needs populations. Although the CBF system is intended to link funding to population health needs, and a number of PHOs in the main centres in New Zealand have high numbers of refugees in their enrolled populations, there is no provision for gathering patient information on refugees under the CBF system. There is therefore, no funding mechanism for PHOs for the refugee populations that they have enrolled, or any means of understanding refugee health utilisation in primary health care, or of addressing their specific access needs.

New Zealand Health Policies

The second part of the chapter examines the health policy environment in New Zealand and the potential for the inclusion of refugee groups. The main points are that health policy in New Zealand is based on social democratic assumptions about inequality, and can be applied to refugee groups (Ministry of Health, 2001b, 2002d); and, in the context of the first point, the difficulties of monitoring population health in small groups in New Zealand, such as refugees, could be approached using ‘minority health’ statistical analysis models.

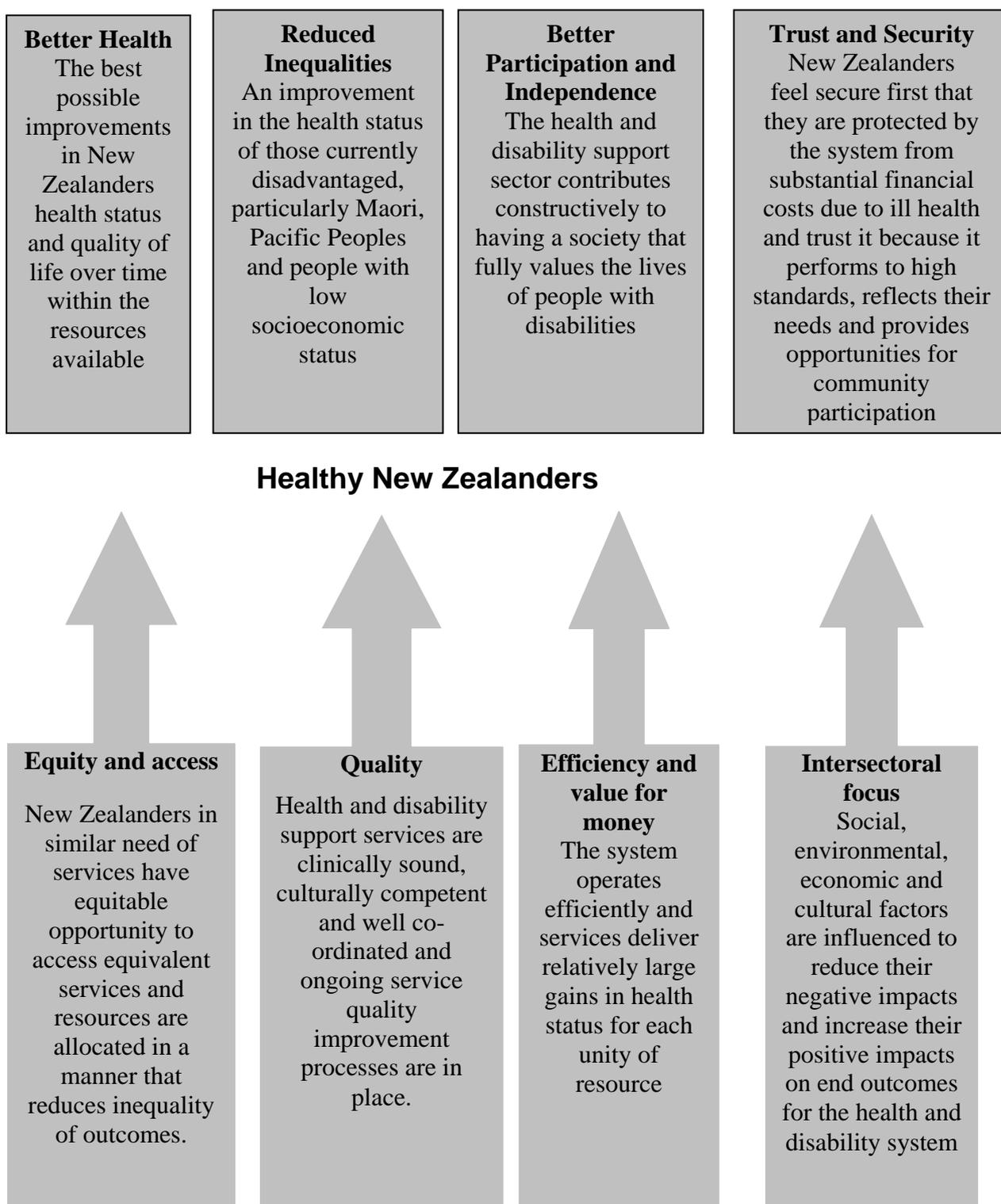
The Overarching Strategies for Improving the Health of New Zealanders

The overarching health strategies of concern to the study are: the *New Zealand Health Strategy* (Ministry of Health, 2000), the *Primary Health Strategy* (Ministry of Health, 2001a), *Monitoring Ethnic Inequalities in Health* (Ministry of Health, 2001b), *Reducing Inequalities in Health* (Ministry of Health, 2002d) and the associated *Primary Health Care Strategy Services to Improve Access (SIA) Funding* (Ministry of Health, 2002g). To understand the potential for the inclusion of refugee groups, the underpinning principles, goals and objectives of key New Zealand health strategies will be analysed in the following sections.

Objectives for Health Outcomes

The Ministry of Health Statement of Intent Outcomes Framework shown in Figure 7.1 summarises the high level objectives for health outcomes in the New Zealand health system and for health populations (Ministry of Health, 2005). The diagram shown in Figure 7.1 represents the ‘headline’ indicators, for assessing progress towards health system and societal outcomes in New Zealand (Ministry of Health, 2005, p.4). These indicators link back to the goals and objectives of key sector strategies, including the *New Zealand Health Strategy* and the *Primary Health Care Strategy*.

Figure 7.1: Ministry of Health Statement of Intent Outcomes Framework



A fair and functional health system

Source: Ministry of Health, 2005, p. 3

This section highlights the systemic possibilities in the New Zealand health system for including refugee groups. In the *Ministry of Health Statement of Intent Outcomes* (2005) there are two outcome levels that are of interest in regard to the inclusion of refugee groups: these are system outcomes and societal outcomes. The Ministry of Health system outcomes are that New Zealand has ‘a fair and functional health system’. This raises questions about equity and access to services, the quality and effectiveness of services, the extent to which the system uses public resources in the best way and how the system interacts with other sectors to enhance health and independence outcomes. The societal outcomes for ‘Healthy New Zealanders’ are in particular, better health, reduced inequalities, better participation and independence, and trust and security. These outcome levels suggest where the ‘activation points’ are for the institutional incorporation of refugee groups (Penninx, 2005).

The New Zealand Health Strategy

The main issue in regard to the New Zealand Health Strategy (2000) is that the universal approach to health care, while important, is not inclusive of culturally diverse groups, such as refugees. The New Zealand Health Strategy identifies seven fundamental principles (Ministry of Health, 2000, p. vii) which are:

- acknowledging the special relationship between Maori and the Crown under the Treaty of Waitangi
- good health and wellbeing for all New Zealanders throughout their lives
- an improvement in health status of those currently disadvantaged
- collaborative health promotion and disease and injury prevention by all sectors
- timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of the ability to pay
- a high performing system in which people have confidence
- active involvement of consumers and communities at all levels

The key population health objectives that are identified in the *New Zealand Health Strategy* are to (Ministry of Health, 2000, p. vii):

- reduce smoking
- improve nutrition
- increase the level of physical activity
- reduce the rate of suicides and suicide attempts
- minimise harm caused by alcohol, illicit and other drug use to both individuals and the community
- reduce the incidence and impact of cancer
- reduce the incidence and impact of cardiovascular disease
- reduce the incidence and impact of diabetes
- improve oral health
- reduce violence in interpersonal relationships, families, schools and communities
- improve the health status of people with severe mental illness
- ensure access to appropriate child health care services including well child and family health care, and immunisation

However, the targeted population health programmes that have been developed to support these key objectives do not include refugee populations.

The Primary Health Care Strategy

The Primary Health Care Strategy is the Ministry of Health's (2001a) key strategy for reducing health inequalities. There is good evidence that adopting a broader approach to primary health care can contribute to reducing health inequalities and to improving population health outcomes (Anderson & McFarlane, 2000; Baum & Kahssay, 1999; Gottschalk & Baker, 2000; Kemp, 2000; Pincus et al., 1998; Pincus, 2004). *The Primary Health Care Strategy* is the Government's key response to delivering overall improvements in New Zealand health populations and in health service delivery. The

strategy enables organisational structures, known as Primary Health Organisations (PHOs) to address problems of access to health services and to improve the coordination between providers. Primary health organisations are funded through capitation, with funding levels dependent on the level of deprivation in the local area.

The Primary Health Care Strategy aims to reform the entire provision of primary health care over a five to ten year period from 2001 to 2010. The definition of primary health care adopted by the Ministry of Health is that drawn up by the International Conference on Primary Health Care at Alma-Ata in the USSR, in September 1978 (Ministry of Health, 2001a, p.27):

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

The strategy outlines six key directions which are to do the following (Ministry of Health, 2001a, p.6):

- work with local communities and enrolled populations
- identify and remove health inequalities
- offer access to comprehensive services to improve, maintain and restore people's health
- co-ordinate care across service areas

- develop the primary health care workforce
- continuously improve quality using good information.

Table 7.1 shows some of the key differences in the 2001 primary health care strategy compared with previous arrangements.

Table 7.1. The Primary Health Care Strategy

Old	New
Focuses on individuals	Looks at health populations as well
Provider focused	Community and people-focused
Emphasis on treatment	Education and prevention important too
Doctors are principle providers	Teamwork—nursing and community outreach crucial
Fee-for-service	Needs-based funding for population care
Service delivery is monocultural	Attention paid to cultural competence
Providers tend to work alone	Connected to other health and non-health agencies

Source: Ministry of Health, 2001a, p.6

The *Primary Health Care Strategy* gives priority to reducing barriers for the groups with the greatest need through additional services to improve health care, and by improving access to existing first-contact services. The strategy also identifies the need to encourage developments that emphasise multi-disciplinary approaches to services and decision-making, including the coordination of services with secondary care, public health and other community-based services.

A study of refugee access to primary health care in Mt Roskill, Auckland demonstrates that the primary health strategy has had a limited effect in improving access for refugees (Lawrence & Kearns, 2005). In the study, Lawrence and Kearns (2005) profile Hauora o Puketapapa/Roskill Union and Community Health Centre (HOP), a non-profit, community owned and operated health clinic designed to deliver accessible, affordable and appropriate primary health care services to low-income groups. Mt Roskill has one of the highest refugee populations of any New Zealand suburb. In spite of the success of the HOP service as an acceptable service for refugee peoples, the research questioned the long-term sustainability of the service from a resourcing and staffing perspective. The key challenges were found to be medical, cultural, communication barriers, funding difficulties and adequate staffing levels. For

example, the general practitioners in the study were poorly prepared to meet the health needs of refugees. The staff at the service lacked the training to meet the social complexities and cultural challenges that they faced daily. As trained health interpreters were not available to the service there were communication barriers between staff and refugee clients. Although HOP provided services according to the new primary health capitation funding formula, the clinic had had to resort to an offshore charitable trust to maintain financial viability. Staff retention and high stress levels were an ongoing issue compounded by the lack of funding available to employ enough medical staff in proportion to patient ratios. This had resulted in medical and nursing resignations.

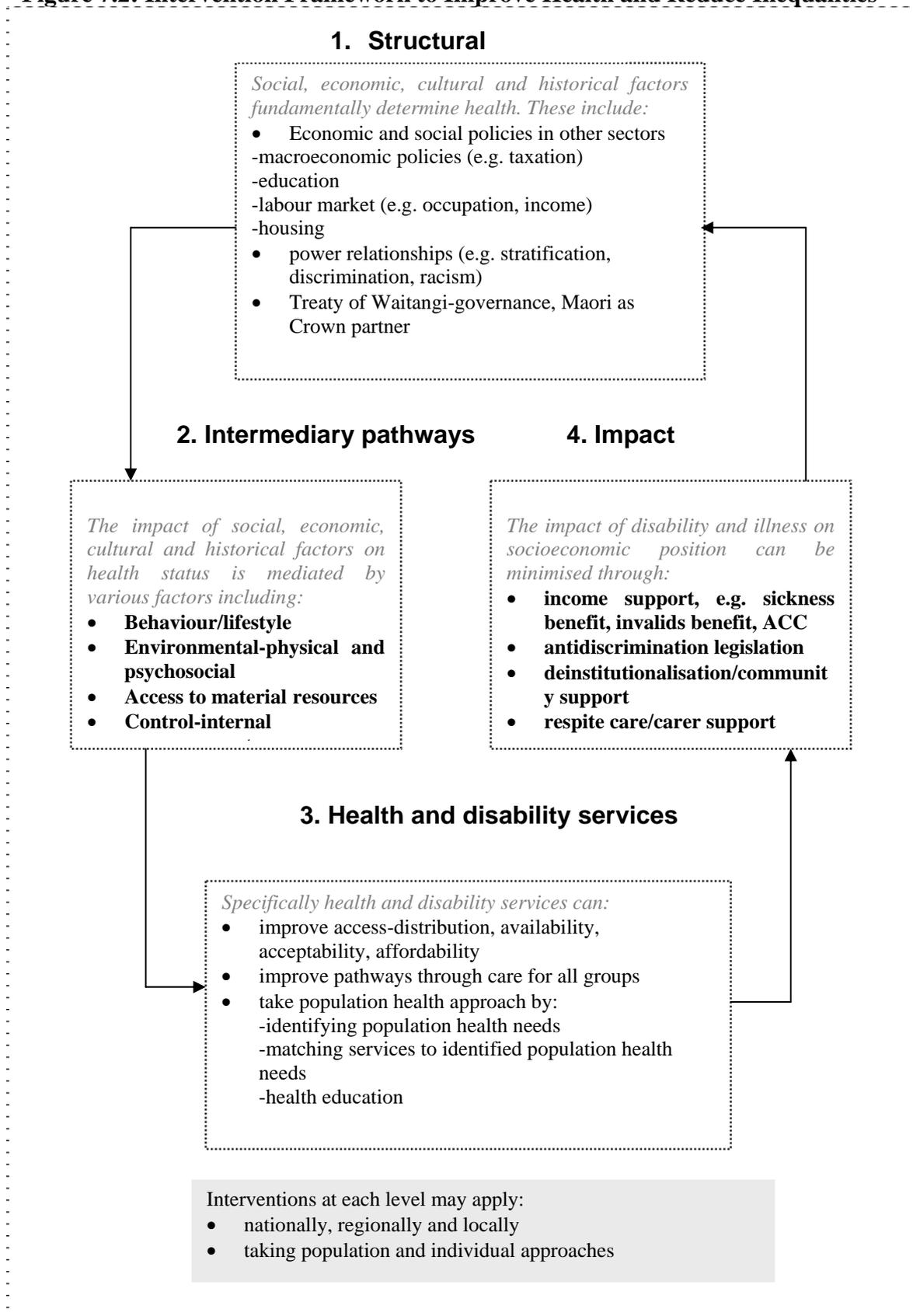
Services to Improve Access Funding

Services to Improve Access (SIA) Funding is available to all Primary Health Organisations to reduce inequalities among those populations that are known to have the worst health status: Maori, Pacific peoples and those living in the New Zealand Deprivation (NZDep) index 9-10 decile areas (Ministry of Health, 2002g). The funding is for new services, or improved access, and is additional to the main PHO capitation funding for general practice type care. The funds are allocated according to the number of people from these population groups who are enrolled in the Primary Health Organisations. Primary Health Organisations are directed to design services and activities to improve access to primary health care services for high need groups in the areas that they serve. Lawrence and Kearn's (2005) study demonstrates that difficulty of including refugee groups when they are not recognised as a high need group in reducing inequalities strategies.

The Reducing Inequalities in Health Strategy

The *Reducing Inequalities in Health* strategy aims to assist the health sector to implement a population health approach that will improve the overall health of the population and reduce health inequalities (Ministry of Health, 2002d). The *Reducing Inequalities in Health* model (shown in Figure 7.2) which identifies four points of intervention to reduce socioeconomic inequalities, could be applied to improving the social, economic and health outcomes for refugee groups.

Figure 7.2: Intervention Framework to Improve Health and Reduce Inequalities



Source: Ministry of Health, 2002d, p. 19

The main point in this section is that the methods used by the Ministry of Health for analysing inequalities in health, which are based on international models, could be applied to the refugee populations in New Zealand (Benzeval, Judge & Woodward, 1995; Dahlgren & Whitehead, 1991; Davey Smith, 2000; Jones, 2000; Karlson & Nazroo, 2002; Kirchheimer, 2003; Mackenbach & Bakker, 2002).

At Level One, the structural level, it is intended that Treasury, the Ministry of Social Development, Ministry of Health and other government departments, all work collaboratively to make a significant impact on inequalities in health. The Ministry of Health intervention model for reducing inequalities could provide a systemic framework at national, regional DHB and local service levels for including refugee groups in social policy. At Level Two, intermediary pathways, the health sector could provide effective intervention points to improve refugee health. For example, refugee groups could be assisted in areas such as collaborative housing policies, community development programmes, and access to the recreational facilities that councils provide.

Monitoring Ethnic Inequalities in Health

The New Zealand framework for *Monitoring Ethnic Inequalities* recognises that ‘all disadvantaged ethnic groups’ have ‘common issues of discrimination and racism, and common concerns regarding measurement and monitoring of ethnic inequalities in health’ (Ministry of Health, 2001b, p.32). The *Monitoring Ethnic Inequalities* strategy defends the use of ethnicity as (Ministry of Health, 2001b, p.1):

...both a marker of socioeconomic location (structural dimension) and an aspect of one’s identity (cultural dimension). The report proposes that underlying both structural and—to a lesser extent—cultural dimensions of ethnicity is discrimination (institutional and personal racism). Discrimination also has a direct impact on health, acting through psychological pathways. These three dimensions of ethnicity—structure, identity and the direct experience of discrimination—are thought to interact with each other and with age, gender and social class to generate the observed health inequalities.

As explained in chapter six, institutional racism and discrimination towards refugee groups impacts on the long-term integration of refugee groups in social and economic domains in New Zealand society. The *Monitoring Ethnic Inequalities* model is useful in explaining the process by which refugee groups are socially excluded at structural and societal levels.

In New Zealand, capturing data for small ethnic groups is considered to be too problematic. The reason given for not capturing data on small population groupings is that it leads to instability of rates for health analysis (Ministry of Health, 2001b). Other countries with small ethnic minority groups use 'minority health' statistical analysis models (Office of Minority Health, 2002; Department of Social Security/Centrelink & Department of Health and Family Services). For instance, the United States Office of Minority Health (2002) uses multi-year data averaged to give greater statistical accuracy and reliability in small populations. Peace et al. (2005) propose the development of an indicator framework for measuring the impact of settlement policies in New Zealand including health status and access to health services. However, they say little about how the framework could measure health outcomes for refugee groups. This could be achieved by routinely collecting data for refugee groups on key health and social indicators which would measure the effectiveness of health and social policy in the reduction of inequalities in the health status of refugee groups.

Conclusion

Poor health and poor access to health care services are key markers for social exclusion for refugee groups in receiving societies (Beiser & Hou, 2001; Beiser, Johnson & Turner, 1993). Penninx's model of institutional integration which has been adopted for this study highlights the importance for second generations of systemic integration for newcomers. The social and cultural responsiveness of the health care system in New Zealand is critical for refugees who are selected for their high health needs. Excluding refugee groups in targeted reducing inequalities strategies has potentially long-lasting and cumulative consequences for the integration of refugee groups in the first and second generations. Refugee groups are of considerable social policy interest in the areas of health, education, welfare, housing and employment. However, the statistical classification systems used in monitoring the health of New Zealanders continue to overlook refugee groups.

CHAPTER EIGHT

CULTURALLY DIVERSE POPULATIONS AND THE HEALTH NEEDS OF REFUGEES

Introduction

This chapter focuses on the psycho-social and cultural accommodation of refugee groups in the New Zealand health system. From the moment that refugees settle in a new society, they not only have to acquire a place both in the physical sense of a home, income and access to health care but also in the psychological, social and cultural sense. Refugees aspire to belong to New Zealand society and to become accepted as social, cultural and religious members (Joudi, 2006). This chapter is in two parts: first, the medicalised responses to refugee psycho-social adjustment to the receiving society; and, second, the cultural responsiveness of New Zealand health services to refugee groups. In the first part, medicalising perspectives which focus on refugees as primarily traumatised and psychologically destabilised groups are contested. In this context, the psychiatric approach to refugee mental health overlooks the profound distress with which many refugees live. The psychiatric model sanctions the continuing neglect of refugee suffering which is associated not only 'with the experience of persecution and trauma but with the stigma, isolation and rejection of being irretrievably out of phase with the host society and its values, and with one's parents generation and with the generation of one's children' (Ager, 1997, p. 420). The second part considers the model of cultural safety that has been developed in New Zealand. The ambivalent application of the cultural safety model to culturally diverse peoples is indicative of the restricted nature of social and cultural citizenship for refugee groups in New Zealand.

The Medicalisation of Refugee Populations

Part one challenges the dominance of medical and psychiatric perspectives on refugees as health populations. At the outset, it needs to be acknowledged that the refugees selected for resettlement in New Zealand have high and complex health and psycho-social needs. The main issue identified in this section is that an understanding of refugee health from a purely positivist medical paradigm has limitations (Jackson, 2007). What is contested here is the tendency to reductionist interpretations, in the sense that refugees are consistently presented primarily as 'sick' and traumatised

(Muecke, 1992). The concept of resilience, by contrast, has received less attention. This is discussed in the next section which focuses on the debates about the psychosocial management of refugee populations in receiving societies.

In New Zealand, the refugee groups settled in the past two decades have come from markedly diverse socio-cultural backgrounds including from the Horn of Africa, the Middle East, South Asia, and South East Asia. Many of these groups have a range of health issues that are relatively uncommon in New Zealand. The medical problems of refugees are typically severe and prevalent; they include infectious diseases, malnutrition, long-term untreated illnesses, sexual assault, trauma and war injuries (UNHCR, 1991, 1995, 1998). Health care providers have responded by doing what they do well, which is providing medical and psychological assessment, diagnosis and treatment and publishing medical findings.

Much of the literature on refugees as health and mental health populations in receiving societies is highly medicalised (Ackerman, 1997; Ager & Loughry, 2004; Hauff & Vaglum, 1997; Stockman, 2001). Medicine and psychiatry are the predominant influences in shaping refugee health research and service delivery in New Zealand. The international and New Zealand literature on refugee health is dominated by articles on infectious diseases of tropical origin (Ackerman, 1997; Gavagan & Brodyaga, 1998; Hayes, Talbot, Matheson, Pressler, Hanna & McCarthy, 1998; Jong, 1995; McLeod & Reeve, 2005; Mills et al., 2002). The main point in this section is that public health approaches to the screening and treatment of refugees on arrival in New Zealand has an essential role in the early intervention and treatment of health conditions. However, this approach as a singular health intervention is ineffective in promoting long-term population health in the refugee groups.

In the past twenty years the groups of refugees resettled, in general, bear a significantly greater burden of sickness and disease than do the national populations of the countries that they have settled in. Increasingly, the overriding concern of governments has been the protection of national populations from the diseases that refugees could import (Muecke, 1992; Worth, 2002a, 2002b). Cookson et al. (1998, p.427), for example, describe the significant public health risks presented by refugees and asylum seekers because:

...most of these displaced persons are from developing countries where infectious diseases (e.g. tuberculosis, hepatitis, malaria, various parasitic and emerging diseases) are prevalent...Identifying and addressing individual and public health risks necessitates international and quarantine health legislation, health policy and social economic evaluation, risk-benefit and utility analysis, and risk-predictive modelling...The consequences of these relationships, including the real and potential vulnerability of populations, are becoming increasingly important indicators of national security.

Studies of health status have been used by political lobby groups as a means of making racist and xenophobic attacks on refugees (Peters, 2003). In many countries, anti-immigration lobbyists, and in New Zealand's case Winston Peters, have been quick to exploit the health risks posed by refugees to pressure governments to implement increasingly restrictive immigration policies (Ackerman, 1997; Cookson et al., 1998). For these reasons the protection of national populations has 'permeated refugee-related policy, program development and research' in receiving societies (Muecke, 1992, p. 519).

Beyond infection rates for communicable diseases in refugees and asylum seekers, in New Zealand, very little is known or understood about the health status of populations from refugee backgrounds (Harrison et al., 1999; Hobbs et al., 2002; McLeod & Reeve, 2005; Mills et al., 2002). Much of the refugee health research conducted has tended to be small-scale, locally based and ethnic group specific and, as such, the findings are not generalisable to all refugee populations and all health issues (Denholm & Jama, 1997; 1998; Hobbs et al, 2002; Madjar, 1998; Mendelsohn, 2002; North, 1995; Reeve, Hay, Pearce, Sidwell, & Pritchard, 2000). However, there are some common findings in New Zealand health studies that indicate that in spite of the provision of universal health care, there are considerable barriers to access for refugee groups (Denholm & Jama, 1997; Lawrence & Kearns, 2005; Madjar & Humpage, 2000; Solomon, 1999). For example, a number of New Zealand primary and

secondary health utilisation studies indicate a pattern of under utilisation by refugee and migrant populations (Ngai, Latimer & Cheung, 2001; North & Lovell, 2002; Young & Mortensen, 2003). Madjar and Humpage (2000) summarise barriers to health care as issues of communication, transport, an inadequate understanding of the health care system, cost, cultural differences, the stigma associated with illness and a lack of confidence in the health care provider.

Psychosocial Debates

In resettlement countries, the focus in the 1980s on communicable disease control shifted in the 1990s to the psychological sequelae of trauma among refugee groups (Agger, 1992; Hauff & Vaglum, 1994, 1997; Pernice & Brook, 1994, 1996). This section discusses the psychological management of refugee populations from the perspective of long term social, cultural and economic integration. The unintended effect of defining refugees primarily as clinical populations has been, in Muecke's (1992, p.519) words, that 'medical problems became the primary route for refugee recourse when in any kind of pain, whether medical, social or emotional'. Medical opinion and diagnosis is the means of accessing specialised health services and of gaining eligibility for special economic benefits. The main points in this section are that psychological models, particularly the diagnostic category post traumatic stress disorder (PTSD), have important limitations in capturing the complex ways in which individuals and groups experience massive trauma, socialise their grief, and reconstitute a meaningful existence in a new country (Bracken, 1998; Bracken, Giller & Summerfield, 1995; Flett, et al., 2004). The medicalisation of social responses to the collective suffering of refugees, in the form of the routine provision of 'trauma counselling', reflects a poor understanding of the relationships between health and its social determinants in receiving societies. It is suggested that by offering a positive focus on good outcomes and possible interventions, the concept of resilience offers a better outlook for refugee integration than the negative outcomes of trauma on refugee populations (Nisbet et al., 2007).

This section begins with an overview of the developments in the psychological management of refugees and their impact on long-term integration. Psychiatry has been quick to apply diagnoses of PTSD and to endorse western therapeutic intervention for refugee populations through the provision of special refugee mental

health centres (Bracken, Giller & Summerfield, 1997). The notion of refugee victimhood that has resulted has led to a pre-occupation with psychological well-being and not with the social determinants of health such as adequate housing, language acquisition and employment opportunities. This pre-occupation demonstrates that pathologising conceptions can interrupt measures to incorporate refugee groups as social and economic members of society. In this context, Bracken et al. (1997, p.438) give the example of the impact on refugee groups, of changes to the Swedish policy of refugee assistance in the 1970s. The policy was focused on the material support and rapid labour market integration of refugees and there was little awareness of the psychological needs of settlement. In the late 1980s, the psychological needs of refugees were recognised and many Torture and Trauma Survivors Care Centres were established. At this time there was considerably less attention paid to integrating refugees into the labour market. Eastmond, Ralphsson and Alinder (cited in Bracken et al., 1997, p.438), in a study of Bosnian refugees in Sweden, question whether access to extensive psychological assistance may in fact have created and maintained a sick role for refugees. In the absence of work and the material means to reconstitute a meaningful life, an emphasis on refugees as traumatised victims has promoted helplessness.

It can be argued that 'the current discourse on trauma has systematically sidelined this social dimension of suffering' (Bracken, 1998, p.200). The way in which refugees as individuals and communities experience and cope with the suffering of war depends on the social, cultural, and political aspects of their situation (Bracken, 1998; Bracken, et al., 1997). Both the psychological impacts of specific social policies directed towards refugees and the ways in which refugees are pathologised in social policy will have a direct impact on their well being (Watters, 2001). The primary concern of the vast majority of refugees on resettlement is not finding psychological intervention but instead, the re-establishment of family and community, finding work, and the maintenance of cultural and religious practices and beliefs (ECRE, 2001a; UNHCR, 2002a). Bracken, Giller and Summerfield (1997) maintain that the focus in the last two decades on establishing psychological help for resettled refugees is a Eurocentric medical agenda based on the western psychological and psychiatric conceptual and theoretical frameworks for trauma and stress.

In the international literature, perspectives on mental health in refugee populations in receiving societies differ substantially. On the one hand, Bracken et al., (1997, p.434) question the medicalising agenda in which the refugee experience is considered to be 'amenable to standardized measurement, analysis and intervention'. In other perspectives, all refugees experience overwhelming trauma and an emphasis is placed on the description of the clinical effects of this trauma (Hauff & Vaglum, 1994, 1997; Mimica, 2001; Neugebauer, 1997; Pernice & Brook, 1996; Zwi & Ugalde, 1991). As an example, Neugebauer (1997, p.726) states that 'while the role of culture in the definition and expression of disturbed behaviour remains to be fully elucidated, instrumentation is now adequate for pursuing quantitative and clinical questions relevant to research and program planning' for refugee populations. Others cite epidemiological studies in the last twenty years, across diverse cultures and contexts, which document high levels of trauma exposure in displaced populations (Hauff & Vaglum, 1994; Mollica, McInnes, Sarajlic, Lavelle, Sarajlic, & Massagli, 1999; Mollica, Wyshak & Lavelle, 1987). They present strong evidence that this trauma exposure is a predictor of long-term poor mental health among refugees. Furthermore, they argue that longitudinal studies of refugee groups reveal the second and third intergenerational transmission of trauma (McDonald, 2002).

The diagnosis of PTSD is at the heart of what Bracken (1998) calls the trauma discourse. Post traumatic stress disorder was first given full recognition in the 1980s in *Version Three of the Diagnostic and Statistical Manual (DSM-III) of the American Psychiatric Association* (APA, 1980). A diagnosis of PTSD is made if the person exhibits a certain combination of symptoms. These symptoms fall into three groups: firstly, symptoms of intrusion, such as recurrent thoughts about the trauma, nightmares, flashbacks and exaggerated reactions upon exposure to reminders of the trauma; secondly, symptoms of constriction and avoidance, such as efforts to avoid thoughts about the trauma, efforts to avoid places or activities which remind of the trauma, and evidence of more general withdrawal from the world; and thirdly, symptoms of increased arousal, such as irritability, insomnia, poor concentration and hypervigilance (APA, 1980). These symptoms are now held by western psychiatry to be universal reactions to trauma, a position that Bracken (1998) terms psychiatric universalism.

Psychiatric universalising ignores the influence of other factors (such as gender, socio-economic status, cultural and religious differences, stigma and discrimination) that are significant in assessing the continuing mental health status of resettled refugees (Pedersen, 2002). Studies on narratives of distress have not contributed sufficiently to the understanding of interrelations between poverty and trauma as health determinants in refugee communities. The effects of the refugee experience go far beyond the impact of the loss of life, to the devastation of the social and cultural fabric of communities. In this context there are a number of questions in regard to social and economic integration that are unanswered. These questions are importantly about are the processes by which 'poverty and trauma connect to the soma (the body-mind) and to the expression of emotions?' (Pedersen, 2002, p.188). They are about 'what magnitude of the complaints reported by patients are due to social exclusion, social and economic inequalities, and severe trauma experiences?' (Pedersen, 2002, p.188).

The assumptions of psychiatric universalism that guide mainstream cross-cultural psychiatry are substantially challenged by views such as Kleinman's (1991) that the meaning of particular symptoms differs across cultures. Bracken (1998) argues that PTSD was created, rather than discovered, by psychiatry, at a particular historical and cultural moment when a set of ideas and practices known collectively as 'cognitivism', became increasingly dominant within psychology and psychiatry. Cognitivism is based on the following assumptions: a strongly individualistic approach, universality of the forms of mental disorder, and the relevance of western therapy in non-western societies (Bracken, 1998). Bracken's (1998) analysis is that western psychiatry is essentially an ethnopsychiatry, meaning that it is a particular, culturally based way of thinking about, and responding to, states of madness and distress. While not denying the reality of the suffering which the PTSD concept attempts to define, Bracken (1998) instead asserts that PTSD is only one particular way of approaching and understanding the sequelae of such events.

Both western medicine and psychiatry are 'grounded in the assumptions of the inviolate primacy of the individual and of the necessity of treating the patient instead of the environments that constrain patients' (Muecke, 1992, p.5). The psychiatric

model highlights the value of clinically based programmes, and the effectiveness of individual therapeutic intervention (Agger 2001). In many traditional societies there are very different notions of the self in relationship to others and to the outside world which invalidate western notions of the individual. As well, there is no firm evidence that trauma counselling works effectively, nor that clinical intervention provides something more valuable than what can be obtained from personal social support networks (Raphael, Meldrum & McFarlane, 1995). Some clinician-researchers claim that trauma counselling may actually be harmful. The therapeutic benefits of talking about traumatic experiences are questionable when there is a growing body of clinical evidence 'that the detailed retrospective inquiry characteristic of psychiatric therapy is associated with a disturbing intensification of symptoms' (Muecke, 1992, p.520).

A further implication of the development of trauma centres and programmes for refugees is that trauma and suffering are seen to be of a special nature requiring special expertise. Bracken, Giller and Summerfield (1997, p.436) argue that doctors and other professionals have become the prime authenticators of suffering, the legitimators of the sick-role and the 'gatekeepers' for a newly formed category of victim groups, refugees. In this view, being diagnosed with PTSD becomes advantageous: for instance, it is often applied as a mechanism for the allocation of resources in accordance with established norms of clinical need (Friedman, 2000). This special expertise is contested because it means (Bracken, Giller & Summerfield, 1997, p.436):

...that professionals who work with refugees are often moved away from the provision of care, into a role primarily involving the authentication of the effects of torture. In this role it serves the short-term interests of the professionals to further develop the 'special nature' message. This is because their testimony is powerful only to the extent that their expertise is real. If traumatized refugees are not understood to have any specific forms of suffering, then the testimony of

sympathetic professionals becomes simply that:
sympathetic.

It is not uncommon therefore, for general practitioners to want to avoid discussing mental or emotional issues with refugees because they perceive that they have little expertise to do so. As a result, clients from refugee backgrounds are viewed as being too complex, needy and overwhelming to manage. The subsequent emergence of a 'culture of victimhood', as evidenced in the growth of centres for Torture Trauma Survivors, conveys the notion of enduring individual mental injury. This notion of victimhood is discordant with the resilience demonstrated by individual refugees and communities (Bracken, Giller & Summerfield, 1997, p.436). Alternative perspectives instead promote the construction of 'refugees as prototypes of resilience despite major losses and stressors' (Muecke, 1992, p.515).

Opponents of psychiatric universalism challenge the category PTSD as the most appropriate psychiatric diagnostic tool for refugee populations. In this view, western psychiatric models are not attuned to the cultural nuances of symptoms in non-western populations (Friedman, 2000; Friedman & Jaranson, 1994; Hollifield, Warner, Lian, Krakow, Jenkins, Kesler, Stevenson & Westermeyer, 2002). The psychological disorders present in refugee populations are not necessarily psychopathological but rather illustrate the aspects of normal cognitive functioning, that fall within the range of normal responses to an adverse context (Summerfield, 1999). A study by Hollifield et al. (2002, p.611) questions the wide variation of the prevalence of the symptoms of PTSD in refugee populations. In Rogler's (1999) view, a wide-ranging examination of the procedural norms used in mental health diagnosis is needed. Rogler's (1999, p.424) opinion stems from examining cross-cultural studies in mental health and concluding that cultural insensitivity:

...stems from procedural norms in the development of
content validity based on experts' rational analysis of
concepts, in linguistic translations that try to conform to

the exact terms of standardized instruments, and in the uncritical transferring of concepts across cultures.

The resilience literature offers an alternative perspective to the negative outcomes of trauma on refugee populations by offering a positive focus on good outcomes and possible interventions (Hamilton et al., 2001; Mackay, 2003; Masten & Coatsworth, 1998; Rousseau, Said, Gagne & Bibeau, 1998). The definition of 'resilience' used by the 'stress and coping' literature which is 'sustained competence despite severely challenging circumstances', is helpful (Masten, Best & Garmezy, 1991, p.430). Used in this sense, resilience is effective coping. The refugee experience can play a critical role in mobilising social cohesion and demonstrate the capacity for resistance, as well as resilience, in individuals and communities (Zarowsky & Pedersen, 2000). In this perspective, resilient outcomes can be promoted and social environments created which support the coping mechanisms of communities (Luthar & Zigler, 1991; Masten & Coatsworth, 1998). A number of studies have researched resilience in the context of the refugee experience (Baruth & Carroll, 2002; Dumont & Provost, 1999; Wolkow & Ferguson, 2001). Well known are the kinds of specific 'risk' factors that refugees are likely to have experienced pre-migration, including war, famine, persecution, violence, flight, loss of home, family, friends, a way of life and involuntary migration. There are good indications that the post-migration factors which affect the ability to cope are connected with 'meaningful employment, secure housing, family and community support and a safe and welcoming environment' (UNHCR, 2002, p.191).

Furthermore, there is an emergence of perspectives that view the effects of trauma not only in psychopathological terms but in ways that may permit the development of new capacities or strengths and coping styles in war-affected populations (Agger, 1992; 2001; Anderson, 1999; Gilliland, Spoljar & Rudan, 1995). For example, Pedersen's (2002, p.184) understanding is that 'collective responses in confronting extreme violence and death represent a range of critical mechanisms for restoration and survival, which should not be underestimated'. Clearly researchers require a broadened awareness of a wide range of responses to trauma, including adaptive and

strategic coping mechanisms, at the individual and at the collective level (Pedersen, 2002). Despite claims to the contrary, there is insufficient evidence supporting the universal effectiveness of a range of psychosocial and pharmacological therapeutic approaches to addressing refugee mental health issues (Pedersen, 2002). The clinical discourse on trauma has systematically sidelined the social and cultural dimensions of suffering. There is on the other hand, considerable evidence to suggest that mental health and well being in resettlement countries is strongly related to social, economic and cultural conditions for refugees in new societies (Beiser & Hou, 2001).

Cultural Care for Refugees in New Zealand Health Services

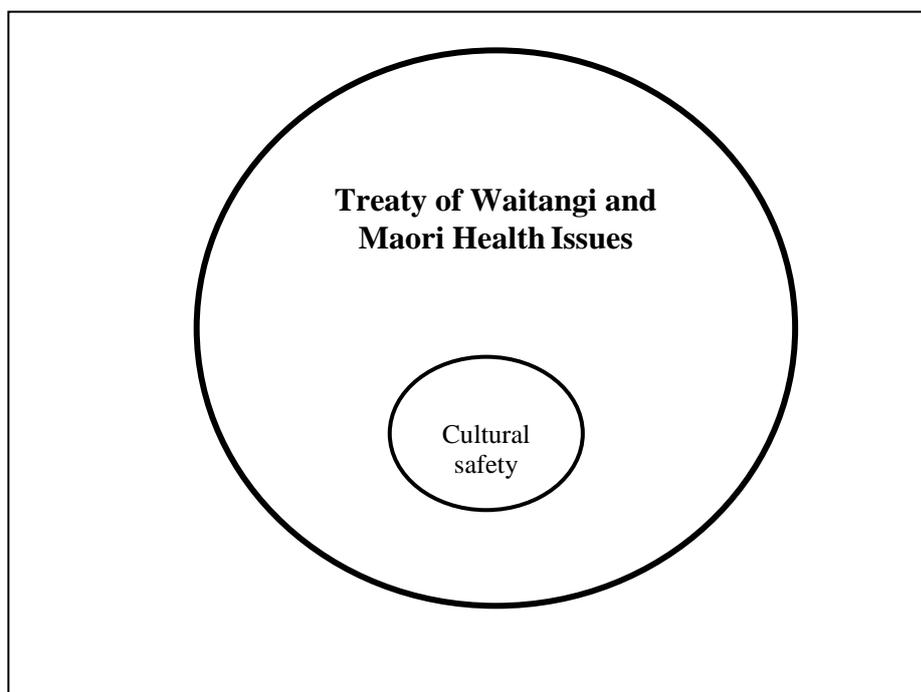
Part two of this chapter analyses the Nursing Council of New Zealand (NZNC) (and subsequently health service) concept of cultural safety in the context of the systemic integration of refugee groups in health care. The concept of cultural safety used in health care settings in New Zealand is highly significant as it identifies the limits of social and cultural recognition for the diverse cultural and religious groups. The main points in this section are that first, the cultural safety model has provided the standards for the cultural care for all peoples in New Zealand (Papps, 2005; Wepa, 2005; Wood & Schwass, 1993). Second, the model problematises the multiculturalism model of integration, outlined in four, that has been used to incorporate groups such as refugees into health services in other receiving societies.

Background to the New Zealand Model

This section gives a background to the development of the concept of cultural safety in New Zealand. In 1990, the Nursing Council amended the standards for nursing registration to incorporate cultural safety in curriculum assessment processes (NCNZ, 1990a, 1990b). Applicants for registration for nursing and midwifery were required to demonstrate 'culturally safe' practice (NCNZ, 1990a, 1990b). In 1991, the Nursing Council commissioned Irihapeti Ramsden to write the guidelines for cultural safety in nursing and midwifery education. The subsequent document was approved by the Nursing Council in 1992 and distributed to all polytechnic nursing courses (Ramsden, 1992).

Historically, the New Zealand cultural safety guidelines arose out of three nursing hui [meetings] in 1988, 1989 and 1990 (Ramsden, 2005). The hui addressed nursing education from the perspective of the principles of the Treaty of Waitangi which are partnership, participation, and protection. It also considered recruitment and retention issues for Maori women in nursing (Ramsden, 1993; Ramsden, 2005; Spence, 2001).

The cultural safety guidelines introduced in 1990 and approved in 1992, were subsequently reviewed and rewritten in 1996 (NCNZ, 1996; Ramsden, 1990a, 1990b, 1992). The 1996 *Guidelines for Cultural Safety in Nursing and Midwifery Education*, represented diagrammatically in Figure 8.1, placed cultural safety within the overall context of the Treaty of Waitangi. A further Nursing Council review in 2002 highlighted a number of important clarifications, namely, that equating the guidelines for cultural safety with the Treaty of Waitangi and Maori health had ‘contributed to the confusion surrounding cultural safety, which is a broader concept’ (NZNC, 2002, p.4). **Figure 8.1: The 1996 Interpretation of Cultural Safety**

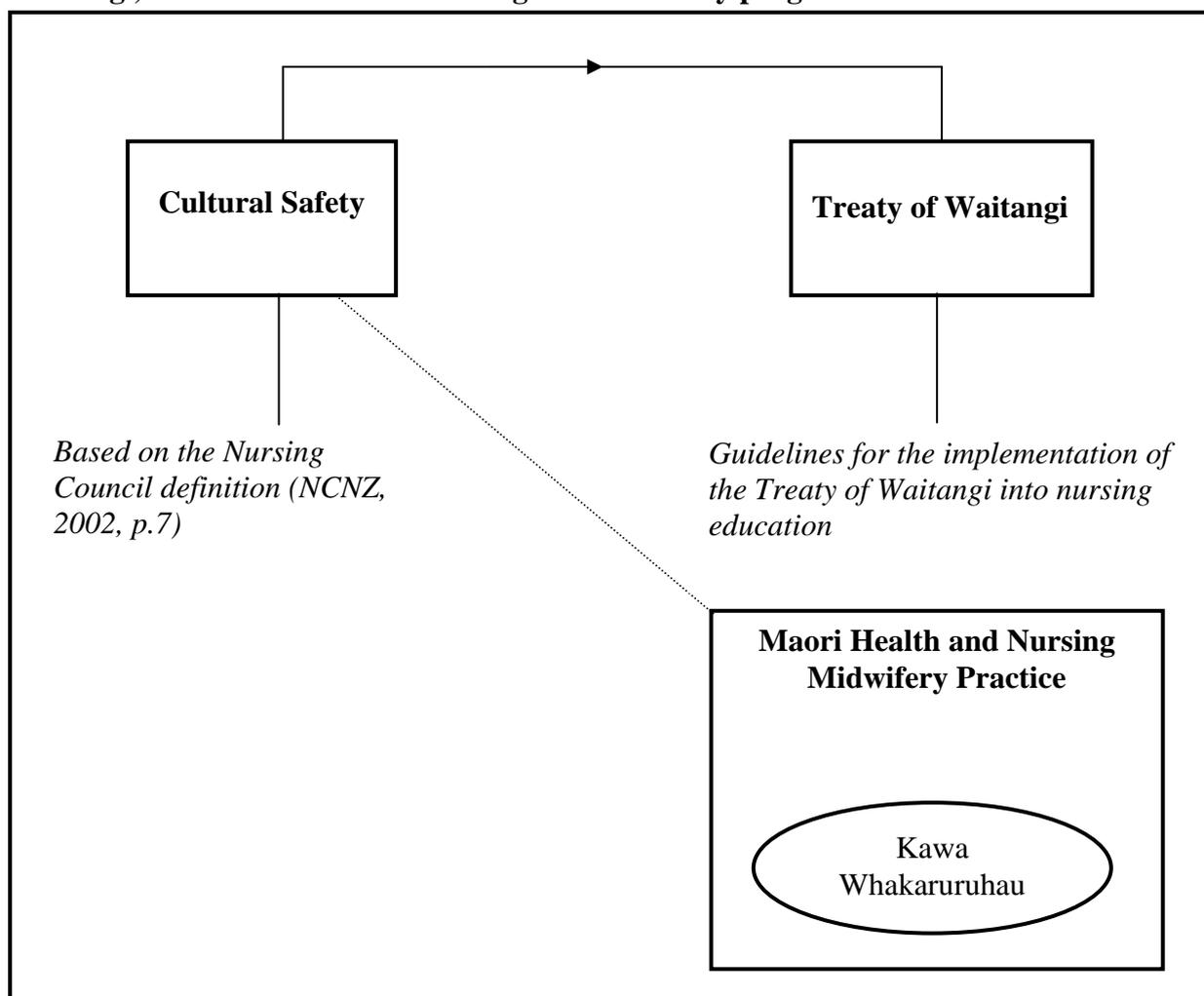


Source: Nursing Council of New Zealand, 2002, p.5

In 2002, the 1996 guidelines were replaced with the *Guidelines for Cultural Safety, the Treaty of Waitangi, and Maori Health in Nursing and Midwifery Education and Practice* (NCNZ, 2002). The 2002 model, represented in Figure 8.2, separates cultural safety conceptually from the Treaty of Waitangi and Maori health (NCNZ, 2002, p.5). With respect to the relationship between the Treaty of Waitangi and cultural safety, it is the specific concept of *kawa whakaruruhau*, or cultural safety within the Maori context, that informs Maori health and nursing practice (NCNZ, 2002, p.6). The basis of the practice of *kawa whakaruruhau* and the role of the health care provider in this, are clear and specific. The expectation in the Maori cultural safety paradigm is that health care providers are ‘active Treaty of Waitangi partners’ as Crown agents

(NCNZ, 2002, p.14). As such, health care providers undertake to critically analyse the Treaty of Waitangi and its relevance to the health of Maori and to demonstrate the application of the principles of the Treaty of Waitangi to nursing or midwifery practice. As well, there was a significant shift in the guidelines to widen the cultural safety concept to ‘incorporate a broad definition that expresses the diversity that exists within cultural groups’ which ‘in addition to ethnicity’ includes, ‘groups that are as diverse as social, religious and gender groups’ (NZNC, 2002, p.4). However, the cultural basis of cultural safety practice for ethnic peoples, separated as it is from the concept of kawa whakaruruhau, is far from clear. Indeed, as is shown in Figure 8.2, there is no identifiable paradigm underpinning cultural safety practices for ethnic minority groups in the cultural safety guidelines.

Figure 8.2: Revised model for the teaching of cultural safety, the Treaty of Waitangi, and Maori health in nursing and midwifery programmes



Source: Nursing Council of New Zealand, 2002, p.5

Culturalist Paradigms in Healthcare in New Zealand

In New Zealand, the Nursing Council view that multiculturalism is ‘simply a statement of who is present in the country’ has been strongly influential (NCNZ, 1996, p.34). New Zealand nurses have maintained the stance that ‘our country is unique in that we have two major groups of people, [with] a...collective history and a Treaty which binds the past and future’ (Ramsden, 2001, p. 26). The analytical perspective of the cultural safety framework is primarily, the recognition of the deleterious effects of colonialism on the health and well being of Maori and the need to rectify this (Kearns, 1997). Importantly though, it is recognised that the cultural safety model is dynamic and evolving and that with an increasingly culturally diverse society in New Zealand the (Wepa, 2005, p.38):

... implementation of multiculturalism need not be at odds with biculturalism as long as Maori are recognised as being equal partners with the Crown rather than having to compete for cultural space with other cultures. Once biculturalism becomes normalised within nursing and midwifery multiculturalism will unfold thereafter.

The main points in this section are that in the decade between 1992 and 2002, there has been a shift in the scope and interpretation of the New Zealand cultural safety model to include diverse populations. The shift, though significant, remains inadequate to address cultural safety in health care for the culturally and linguistically diverse groups (Guerin, Abdi & Guerin, 2003). The *Ethnic Perspectives in Policy* (OEA, 2002) (discussed in chapter five) appeared in 2002, the same year as the revised Nursing Council cultural safety guidelines. However, the revised NZNC guidelines have not incorporated the recommendations for including ‘ethnic’ peoples. Indeed, there are tensions between the bicultural policies that the Ministry of Health has adopted since 1986 and the wider ethnic perspectives of the Ethnic Affairs framework. It is apparent that the Nursing Council remains the major influence in the health sector in determining the perspective of cultural safety that is adopted within all New Zealand health services. In this context, a significant debate has taken place in nursing in New Zealand between the bicultural model of cultural safety that has

been adopted for the health sector and a rival theoretical perspective, *Transcultural Nursing Care*, which was developed by the North American nursing theorist, Madeleine Leininger, (1978). This debate has extensively informed nursing views on the inclusion of multiculturalism frameworks for ethnic peoples in the health sector.

(a) The Theory of Transcultural Care

In this section, the differences in the theoretical stances of respectively, North American models of transcultural care (Leininger, 1978, 1988) and of the New Zealand cultural safety model (Ramsden, 2001) are examined. The main point in this section is that the concepts of cultural safety and transcultural nursing in the New Zealand context are due for re-examination in the light of the increasing ethnic diversification of the population. In this context, the claim that the New Zealand model of cultural safety is substantively and significantly different to concepts of transcultural nursing care is contested and it is suggested that both paradigms are needed to deliver effective care to culturally and linguistically diverse groups. However, it is argued that both perspectives are only partial responses to refugee groups as social and cultural citizens in New Zealand. It is helpful first to give this important cultural debate an historic context because, in one sense, it may be viewed as reflecting the differing immigration policies adopted by New Zealand, the United States, Australia and Canada after World War II (These were outlined in chapter two).

It has been argued by some in New Zealand that transcultural models are problematic because they are applicable only to 'countries such as the United States of America with large immigrant populations' and that New Zealand's history 'its colonisation and its patterns of growth are unique as are its peoples' (Smith, 1997, p. 16-17). In this sense, it is true that New Zealand differs from other classical countries of immigration (Australia, Canada and the United States) in that pro-British immigration policies persisted until the late 1980s. The admission of small groups of refugees since the 1950s has represented one of the few exceptions to the otherwise restrictive immigration laws prior to 1987. Conversely, the United States maintained high levels of net migration from a wide range of source countries after World War II (Leininger, 2001). The development of transcultural care reflects the nursing environment for North Americans in the 1950s with the (Leininger, 2001, p. 16):

... increasing numbers of immigrants, native peoples, refugees and travellers from many places in the world... Nurses were functioning in a multicultural society and expected to care for people of diverse cultures. But the reality was that there was no body of knowledge (discipline knowledge) nor principles, concepts and guidelines to care for clients of different cultures.

Madeleine Leininger (1978) developed the theory of transcultural care from clinical experience in the United States in the 1950s which led to the recognition that culture was the missing link in nursing knowledge and practice. The theory challenged the existing 'traditional medical and unicultural practice' in health care in the United States (Leininger, 1996, p.1). The transcultural model of nursing knowledge was designed to meet the health needs of a multicultural world (Leininger, 1997a). Leininger's (1988, p.152) contention was that 'if one fully discovers care meanings, patterns, and processes, one can explain and predict health or well-being' in all diverse populations. The term transcultural nursing is a (Leininger, 1978, p.8) (*Italics in text*):

...substantive area of study and practice focused on comparative cultural care (caring) values, beliefs, and practices of individuals of similar or different cultures. Transcultural nursing's goal is to provide culture-specific and universal nursing care practices for the health and well-being of people or to help them face unfavourable human conditions, illness, or death in culturally meaningful ways

In New Zealand, opposition to the transcultural model has centred primarily on the anthropological base of the theory (Cooney, 1994; Ramsden, 1993; Smith, 1997). For example, Ramsden (1993, p. 3) was critical of the, 'external and observer position', that 'involve[d] researchers attempting to gain 'emic' or insider views of various cultures while apparently not involving those cultures beyond that point' (Smith, 1997, p. 13). Leininger (2001, p. 17) discounts this view as she has always maintained

that ‘transcultural nursing was not the same as anthropology, sociology or other fields. It was different—as professional nursing should be—focused on humanistic and scientific care to make a distinct contribution to society’.

(b) The Cultural Safety Model

In this section, the perception that cultural safety is substantively and significantly different to concepts of transcultural nursing care is challenged. The Nursing Council maintains that the New Zealand model is best able to ‘recognise inequalities within health care interactions that represent the microcosm of inequalities in health’ (NCNZ, 2002, p.10). Contrary to the ‘traditional American ideas of transcultural nursing’, in the cultural safety model, the role of the nurse is pivotal as the focus of social change (Ramsden, 2001, p.26). In Ramsden’s (2001, p.26) view, the transcultural model is based on western notions of anthropology and remains ‘focussed on the “cultural” activities of the patient’. However, Leininger (1997b) has always maintained that understanding the dynamics of power, race and social inequities is an integral part of the North American culture care theory.

The main points in this section are that claims that the cultural safety model works best for any marginalised group, whereas the transcultural model is a superficial response, are flawed. Srivastava and Leininger (2002, p.500) rightly state that in relation to the care of diverse ethnic groups ‘without a substantive knowledge base one cannot ensure safe, effective and quality transcultural nursing care outcomes’. The cultural safety model needs to be responsive to cultural diversity as New Zealand society becomes increasingly multi-ethnic. The broadening of the 2002 definition of cultural safety to include ‘*ethnic origin or migrant experience; religious or spiritual belief*’ (NZNC, 2002, p.7), could be developed to address the social and cultural dimensions of integrating refugee groups.

The Nursing Council maintains that Leininger’s (1988, 1993, 1996a) approach is reductionist in the sense that it is concerned with little more than providing ‘a checklist’ of ‘rituals, customs and practices’ (NCNZ, 2002, p.7). Cultural safety is defined by the Nursing Council of New Zealand (2002, p.7) as (Italics in text):

The effective nursing or midwifery practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.

The nurse or midwife delivering the nursing or midwifery service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.

The main basis for the criticisms of transcultural approaches in New Zealand are that they are limited to 'obtaining a cultural knowledge base and using it to develop a theory of care specific to that culture' (Ramsden, 2002, p.7). Cooney (1994, p.10), for instance, states that transcultural nursing theory, while identifying monoculturalism, offers few strategies for political challenge; rather, nurses learn to work 'at a practice level' to provide 'culture-specific care' to individuals and groups'. In Ramsden's (2002, p.7) terms 'a simple differentiation between the two models is that cultural safety is about life chances and transcultural nursing is about lifestyles'. Kearns (1997, p. 24) is critical of the transcultural care model because it requires no more than cultural sensitivity by health professionals and rarely involves 'any actual transfer of power'. Instead, 'conditions need to be created within health services in which consumer views occupy a place of legitimate, rather than alternative (often interpreted as lesser), knowledge' (Kearns, 1997, p.24). The concept of cultural safety claims to provide consumers with an active role in their health care by having 'the power to comment on practices and contribute to the achievement of positive health outcomes and experiences' (NCNZ, 2002, p.7). Proponents of the approach insist that

any analysis of power relations within health care in New Zealand must take account of the historical and social contexts of the persons involved.

Srivastava and Leininger (2002, p.500), in line with Kymlicka's (2001a) model for accommodating cultural diversity, state that 'explicit philosophical statements, policies, curricula and education practices need to be developed for health care practitioners'. They explain that this is, in their words, 'a basic human right and ethical obligation for consumers of all cultures' (Srivastava & Leininger, 2002, p.500). There is in the international literature a clear view that social, cultural and economic rights for groups such as refugees are (Kymlicka, 2001a, p.6):

... not just a matter of discretionary policies or pragmatic compromises, but rather a matter of fundamental justice. Minority rights are increasingly seen precisely as 'rights', the violation of which can be an assault on basic dignity and respect.

The Nursing Council (2002, p.7) definition of unsafe cultural practice, which is 'any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual', requires the nurse or midwife to have at least some specific cultural knowledge of the ethnic group being cared for. A reconsideration of the cultural safety/transcultural care debate may find that Leininger's perspectives offer a tangible set of competencies and skills that are missing from the cultural safety guidelines when applied to culturally and linguistically diverse groups. Furthermore, there is empirical evidence that developing an in-depth knowledge and direct experience with ethnic minority groups does produce culturally competent health and social services care (Al-Krenawi & Graham, 2000, 2001; Luna, 2002; Potocky-Tripodi, 2002). For instance Luna (1989, p. 22), a transculturally trained nurse practitioner, maintains that:

...the use of Leininger's theory and modes of nursing interventions can be most helpful as a basis for decision-making processes related to care of the Arab Muslim client ...The importance of culturological assessment for each client and family cannot be over emphasized, since cultural background, education and degree of acculturation will lead to variation in these patterns ...

Leininger (1997b, p.22) offers compelling evidence for the efficacy of transcultural nursing in that the approach offered can 'prevent nurses from placing clients in medical or nursing diagnosis categories or medical labels that fail to fit the cultural participants'. It is difficult to refute Leininger's (1997b, p.22) empirical evidence that the transcultural approach 'is powerful in providing culture specific care which includes cultural safety factors and in discovering some entirely new ways of working with clients that clients like'. There has been no proof, on the other hand, that the New Zealand nursing guidelines have provided cultural safety for ethnic groups such as African and Middle Eastern, or South East Asian communities.

Conclusion

The conclusion of this chapter is that medicalising approaches to refugee health, particularly the psychiatric model, may be unhelpful when refugees' immediate concerns relate to social and economic issues. It is unlikely that approaches that are based primarily on western techniques such as counselling and psychotherapy will be successful in treating trauma and loss unless some of the more fundamental issues that face refugees, such as housing, employment and language acquisition, are addressed first. In the long-term structural inequalities are the most important determinants of health in refugee populations.

Before moving on to the analysis of data and discussion of findings, which is to follow in chapters nine to fourteen, the theoretical perspectives on integration which this study has utilised need to be reiterated. According to Penninx's model, the two essentials for the integration of refugee groups are social and economic equality in the long-term and recognition of linguistic, cultural and religious diversity. The

interaction between refugee, integration and social policies in the receiving society are critical to long-term outcomes for refugee groups. In this context, the receiving societies' institutional structures and policies are decisive for the outcome of the integration process. Refugee groups not only require the social and economic, and cultural and religious membership that will in the long-term place communities on the same footing as other New Zealanders, they are a case for special accommodation related to their experiences of forced migration.

The second part of the thesis provides an analysis of the data collected from interviews with health care providers. The experiences, perceptions and reflections of health practitioners are critical in discovering the processes of the integration/exclusion that are occurring. The data analysis map in Figure 9.1 'Social and Cultural Citizenship Rights for Refugees in New Zealand Health Services' maps these processes diagrammatically. The data analysis is organised into five major thematic chapter headings which are: 'Refugees as 'Others''; 'Barriers to health care'; 'Providing primary health care'; 'Promoting health' in refugee communities, and 'Signs of activation'.

The data analysis chapters give empirical evidence of the exclusionary processes that are occurring in health care. These are related both to the discursive exclusions, in evidence in health policy in chapter seven and the problematising of multiculturalism approaches in the cultural safety model discussed in this chapter. Importantly, in applying Penninx's (2004) integration model, how far the institutional structures and processes of health care are activated or could be activated in future to accommodate the social and cultural needs of refugee groups will be assessed. Identifying the points of activation in the New Zealand health system and the actors involved are central to an understanding of the processes by which organisational and policy changes will occur.

CHAPTER NINE

THE FINDINGS

The findings of the analysis of data in the study are described in the data map ‘Social and Cultural Citizenship Rights for Refugees in New Zealand Health Services’ which is shown in Figure 9.1. The data map provides the organising structure for the discussion of data that is to follow in chapters nine to fourteen. The map presents diagrammatically the five thematic analysis chapters that describe and theorise an aspect of social exclusion and/or the opportunity to integrate refugee groups into the New Zealand health sector. The themes are: ‘Refugees as ‘Others’’, ‘Barriers to health care’, ‘Providing primary health care’, ‘Promoting health’ and ‘Signs of activation’.

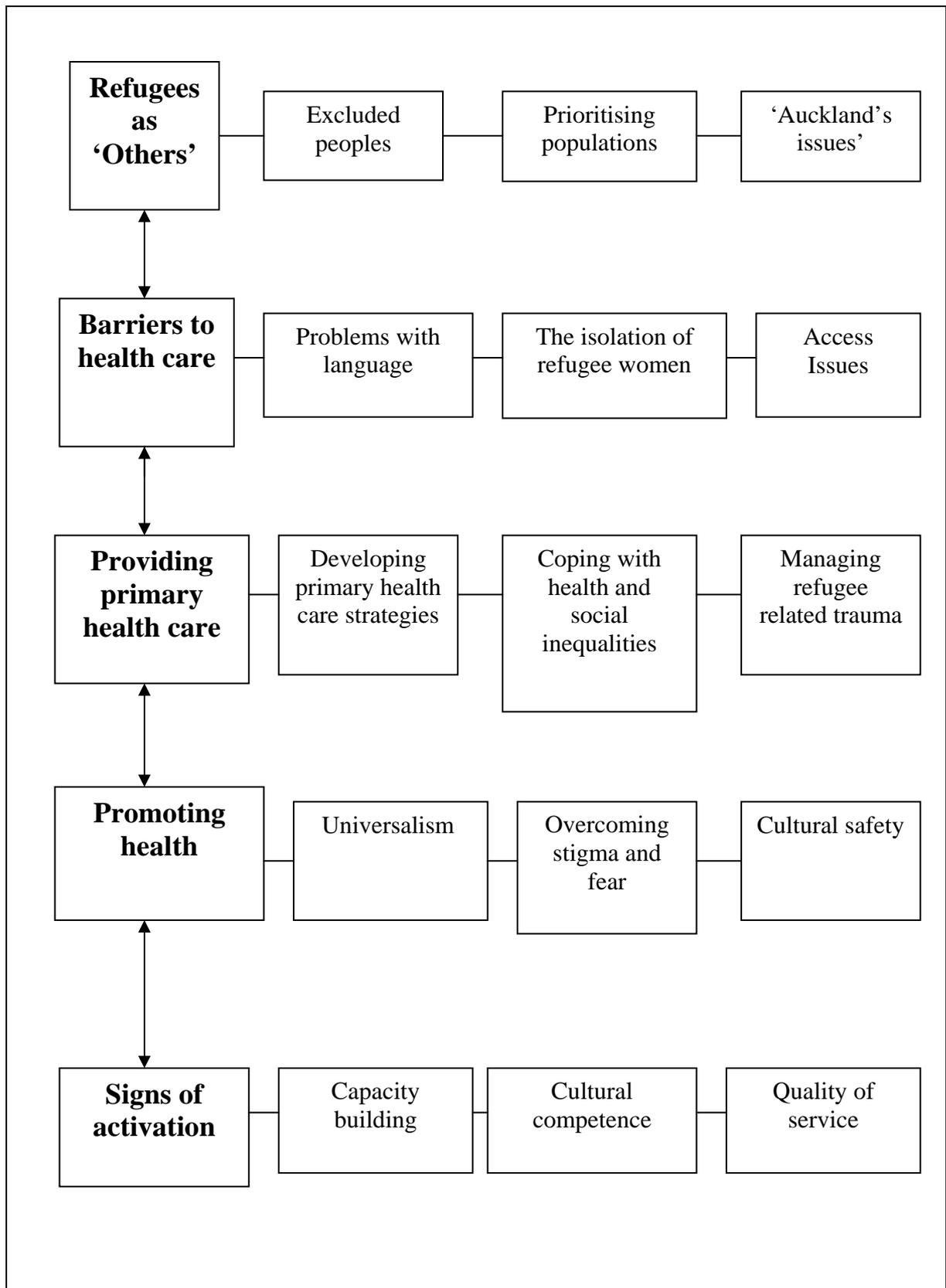
The data map categorises the processes that are dialectical and interactive, areas of discursive and material exclusion and signs of activation in the health sector. As a starting point the category ‘Refugees as ‘Others’—in the statistical sense discussed in chapter seven—means that refugee groups are overlooked in health policy as a priority health population and for targeted funding and resources. There are examples shown in the diagram of refugee group inclusion in health policy, strategy and service provision. These points indicate where future opportunities for systemic responsiveness could lie, in other words they constitute ‘signs of activation’ in the health sector. The integration processes that are occurring are interconnected and interdependent, for example, in chapter ten (‘Barriers to health care’) ‘problems with language’ between health practitioners and refugee clients, are connected to the inadequate structural framework for providing English language instruction to adult non-English speakers. In another example, in chapter twelve (‘Promoting health’), it is shown that in the long-term health outcomes for refugee groups will involve resolving the relationship between ‘universalism’, general eligibility to publicly provided health services and the recognition of refugee groups in targeted reducing inequalities strategies.

The data map enables the reader to view the conceptual categories of the full data set in one location. The key factors, constructs or variables, and the relationships that are

presumed between the processes of the social exclusion/or of integration in the health sector are laid out. Huberman and Miles (1994) argue that graphic displays of 'bins', that is core variables, connected by directional arrows which specify intervariable relationships are useful in making researchers' frameworks clear. The data display is systematically arranged to answer the core research question which is 'how is the New Zealand health system responding to the integration of refugee groups?' The 'full' data set can also be 'interrogated' for analytic validity (Huberman & Miles, 1994, p.432).

As a strategy to allow visual clarity, the relationships between conceptual categories appear more linear than they in fact are. The changes occurring in the health sector in response to refugee groups are non-sequential, partial and strategically disconnected. To provide an organising structure the themes are listed on the left hand side of the data map, and the lower order conceptual categories to the right. Each code or theme has been developed by clustering conceptual groupings together. When combined as an analytical framework the codes and their conceptual categories construct a picture of the dialectical relationship between the processes of integration and social exclusion that are occurring.

Figure 9.1: Social and Cultural Citizenship Rights for Refugees in New Zealand Health Services



REFUGEES AS 'OTHERS'

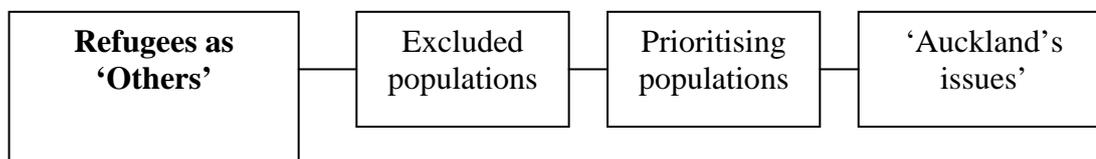


Figure 9.2: Refugees as 'Others'

Introduction

Chapter nine is the first of five data analysis chapters which will explore, in the context of the New Zealand health system, how refugee groups are overlooked as social, cultural and linguistic citizens and the opportunities that exist for inclusion. Although it is recognised that there are a number of difficulties with the concept of social exclusion, it is argued that Samer's (1998) concept-process (see chapter one) has utility in terms of unpacking what exactly refugees are excluded from in New Zealand health systems. Samers (1998, p.126) raises the question of the representation of minority groups as a matter of social visibility, or of 'invisibility' in government reports and surveys. Chapter nine shows that the matter of whether minority groups are discursively excluded or included has real effects on the affected populations, as well as upon the regions and organisations that serve them.

Participant Data - Refugees as 'Others'

In the conceptual category 'Refugees as 'Others'', shown in Figure 9.2, the ethnic data collection systems used in health care report refugee groups only as 'Other'. As a result refugee groups are not a priority population in national reducing inequalities strategies (Ministry of Health, 2002d). In the study, the health service providers who were interviewed found it difficult to plan for and to provide services for refugee groups within existing service specifications. In essence, what participants were reporting was the growing presence of refugees in health services in the Auckland region, but that they were omitted from any specifically targeted population health programmes. This phenomenon is categorised as 'excluded populations' in Figure 9.2.

Excluded Populations

In chapter seven it was explained that the term ‘Others’ is the category given by the Ministry of Health to populations who are not Maori, Pacific peoples, or New Zealand Europeans. This section explores the impact on service provision of being designated as the ethnic category ‘Other’. There are two main issues in this section: the first issue is the discursive exclusion of refugee groups in New Zealand studies of ethnic group disparities and inequalities; and the second is discriminatory practices towards refugees from health care workers. In the study, health professionals expressed the view that designating refugee groups as ‘Other’ meant that they missed out on targeted funding and interventions, when they had significant health inequalities. Service managers stated that often their efforts to highlight refugee health issues in national policies were perceived as merely ‘Auckland’s issues’. Health service requests to central funding agencies for additional funding or resources to address the unmet needs in refugee groups had therefore elicited no, or a negative response.

Discursive Exclusion

The first point—discursive exclusion—demonstrates how the absence of strategic direction from the Ministry of Health impacts on health care delivery to refugee groups. Mostly, health policies and contracting processes do not specify refugees as a target population. Therefore at an operational level there were no service plans or funding for refugee groups. The provision of appropriate services for refugees and the funding of these were left to individual health services to manage. For instance, in the primary health care sector, in a Union Health service, refugees and new migrants made up 47 per cent of the client caseload. A significant proportion of the clients did not speak English and there were no interpreters available to the service. The practice was funded on a fixed capitation rate based on standard consultation times of fifteen minutes. The manager of the service stated that the funding available did not meet the costs of providing care for refugees and asylum seekers. The service’s budget deficit had been only partially relieved by a one-off reducing inequalities contingency fund which provided free access to primary health care for under 18 year olds (Ministry of Health, 2002d). The service had met the criteria for funding from an American charitable trust, the Baxter Foundation, because the service could demonstrate, that their refugee health project did not have:

... a level of government support (Kate, 1: 133).

Another example of discursive exclusion is provided by the Royal New Zealand Plunket Society (Plunket), a national provider of child and family health services. The Plunket Society clinical and support programmes include: home visits and child health clinics; parent education; car seat rental schemes; child safety programmes; ante-natal education classes; and community support initiatives, based on local needs (The Royal New Zealand Plunket Society, 2005). The service is a not for profit organisation and relies on an extensive volunteer support network. In a further example of the 'one-off' funding rounds introduced to reduce inequalities, Plunket were given additional funding to improve child health in high needs areas of the Auckland region. However, in analyses of areas of deprivation in the Auckland region there:

... was nothing specifically said about new immigrants... just...how many people living in deprivation areas...The idea behind it was...home visiting for high need families and high needs families translated at the beginning as having been Pacific Island, Maori, but then of course gradually there has been an increase of new immigrants into Mt Roskill...(Jo, 1: 18).

Many of these immigrant families were refugees from Somalia, Ethiopia, Eritrea, Iraq, Iran and Afghanistan (Lawrence & Kearns, 2005).

Refugee groups have not been included in any New Zealand deprivation studies and have been 'invisible' in Samer's (1998) discursive sense in government reports such as the Ministry of Social Development *Social Report*. The annual report gives an indication of social well-being in New Zealand population groups in areas that include health, education, employment and income (MSD, 2006). The *Social Report* could potentially be used to monitor the disparities between refugee and other New Zealand populations and provide a basis for improving their social conditions.

Discrimination

The social construction of the 'Other' in society can shape discriminatory attitudes towards those groups. Penninx (2004, p.11) contends that it is this kind of construction which 'play[s] out at the collective level, defining in-groups and out-groups', resulting in discriminatory practices against groups perceived to be 'different'. Some participants reported a hardening of attitudes towards refugees from health practitioners:

... in terms of providing support for these people, it has probably become slightly harder because of the political environment and because of the backlash against refugees in our social environment ... (Christine, 1: 13).

A general practitioner cited instances where families encountered:

... receptionists that think that they are a nuisance ...
(Rob, 1: 130).

Other participants noted the tendency in some hospital outpatients departments to:

... leave refugees sitting in the waiting room...
(Christine 1: 105).

It was noted by some participants that health professionals could be poorly informed about refugees when:

... it is very widely [known]...what these people have left behind, what they have gone through to get here, what they have risked and whether they are legitimate or not, what they have done to get here...There is this

horrendous prejudice, which is really quite alarming
(Robyn, 1:77).

In general, New Zealand health services have not been supported to accommodate the growing number of refugees who are entering their services. Subsequently, health care has not developed services that are trained or resourced to meet the needs of these culturally and linguistically diverse groups. Mostly, as a result of systemic exclusion but in some cases the discriminatory attitudes of health service staff, access to health services and the quality of care delivered to refugee groups is inequitable compared to other New Zealanders.

Prioritising Populations

Refugees are not a priority population in New Zealand health policy as identified 'ethnic' groups, or as targeted 'deprivation' groups. This means that they are overlooked in targeted population health strategies, such as *Primary Health Care* and *Reducing Inequalities in Health*, which have led to new health initiatives and community based programmes in low decile areas (Ministry of Health, 2001a, 2002d). The main issues that are raised in this section are: first, in some areas of the Auckland region, prioritised health populations do not reflect the demography of the communities identified in health strategies as 'deprived'; second, there is no additional funding available to health services to compensate services for the additional cost and complexity of managing high health needs non-English speaking populations; third, there is little information available to inform health planners about refugee health priorities because of the ethnic data collection systems for health care (which were discussed in seven); fourth, where refugees were included in consultation processes, there was no obligation for health planners to respond, as refugees were not a priority health group; last, the *Reducing Inequalities in Health* model could accommodate refugee groups through targeted activities, community interventions and resources.

Deprived Groups

Reducing Inequalities in Health targets are based on the analysis of deprivation in New Zealand populations (Crampton, et al.,2000) but the ethnic data collection

systems used in health care leave obvious gaps in population health information when:

... there is no break down of 'Others', just 'Other'.
Maori, Pacific, European and 'Other'... (Ruth, 1: 243).

In the Auckland region, refugee and refugee-like families represented half or more of the enrolled populations of some general practices, such as the following example in central Auckland where:

...in terms of specific population targeting, no funding has been available and even currently within the PHO formula, there is no acknowledgment of the high needs of migrant, refugee populations, other than on a deprivation basis, so if they happened to live in the right street, they get the money, if they happened to live in the next street across, which is not decile five or quintile five, they miss out on any specific funding load, based on deprivation. It is a huge issue... (Kate, 1: 18).

Even where services, such as Plunket, had specific funding for high needs families, the contracts did not recognise the complexity of need in refugee families so that nurses stated that they could not:

...make a difference popping in and popping out for eight contacts. I can make it a high needs and go back in, but then someone else has to suffer...We have got this target each day of seeing six or seven core contacts a day. In my area I only have 20% European, so it takes me an hour at most people's houses if I am going to make a difference. I can't maintain that rate (Lisa-May, 1: 26).

In this case, the nurses' workloads were calculated on the average time needed for appointments with English-speaking mothers. Many non-governmental health

organisations, such as Plunket, do not have funded health interpreting services available to them. This meant unmanageable caseloads for nurses working in areas where a high proportion of women are non-English speaking. Service managers repeatedly stated that when negotiating contracts with funders, attempts to gain recognition for the additional costs of service for refugee groups were rejected. So that refugee groups could attract the funding allocated for low decile groups they suggested that there would have to be changes to:

...the access formula to acknowledge those refugees...if we can have some way of capturing them, rather than the ad hoc way of doing it through the geo coding, then that additional funding will go, partly to cover the costs of providing the essential services, the other part of it goes to health promotion and special initiatives to improve access ...it would be up to us to argue and push for specific money from...health promotion and the access money to come to refugee patients...(Kate,1: 206).

Participants commented that the patient management systems that they were required to use were unable to report on the ethnic composition of the groups seen by their services, or their refugee status, as in the following example:

...We record country of origin or the ethnicity that the patient declares, which is often around country of origin anyway, but that fits into a different ethnicity coding for the Ministry and for our requirements in terms of reporting and funding, so that even if we want to break it down to all the different groups, it is still recorded as African, Asian, Middle Eastern. There is also nothing on our practice management software that actually allows you to record refugee as any form of status or asylum seeker, it is either resident or non-resident and that is all that is available to us, so how we record and collect that data is a problem... (Kate, 1: 255).

Funding for Refugee Groups

Health services were expected to provide care to refugee groups out of baseline funding allocations. Organisations described being caught in a double bind of having to either ignore the additional needs of refugee groups, or to do so over and above prescribed population targets. This was succinctly summarised by a Plunket nurse manager in the following quotation:

...I have some very good staff who are very committed and would like to be giving extra time [to refugee families], but you are caught in this Catch-22 situation really. The Ministry of Health who fund us and also people wanting us to meet targets and do [other] stuff and so it is trying to marry up all these needs... (Sue, 1: 65).

Service Planning for Refugee Groups

In the study, health services had little information about the refugee groups in their area or their health needs with which to plan care. There was no specific directive to address the health issues of refugee groups in health services. As participants noted refugees were consistently absent as a priority group:

...The health policy has become very focused on Maori and Pacific people, well particularly Maori of course, which is...no complaints about that...and obviously poor people, so my impression is that smaller groups like refugees who have particular needs don't fit into those categories and so their needs aren't high priority...(Rob, 1: 91).

Consultation with Refugee Groups

Where refugees were included in District Health Board's consultation processes, there was no obligation to act on the recommendations made. While the District Health Boards are legally bound to consult with their communities every three years according to the *New Zealand Public Health and Disability Act 2000*, with regard to

refugees, they were unable to respond to the findings of the needs analyses conducted for this group. The following quotation is a typical description of the outcome, in regard to refugee groups, of the health consultation processes that had occurred. In this case a doctor working for the planning team of the *West Auckland Child Youth Strategy* had found that the feedback given about the needs of refugee youth during the consultation stage were ignored. The doctor commented on how easily refugee communities were excluded from the planning process:

...My experience of that was that when we did [the] consultation, there was a lot of interesting information that came in on refugees and a lot of discussion about refugees, but then when we went to the next stage which was prioritising the issues, they got squeezed out because you needed to focus on fewer issues and again they just weren't big enough...The whole way that that community prioritisation went was really interesting. They came up with very broad issues that to me...things that you could focus on, [refugees] just disappeared... (Rob, 1: 183).

As the participant said, excluding communities as too small:

...doesn't reflect the potential to do something either. There are a number of things [that could have been done] ...there were obviously high needs areas [for refugee youth]... (Rob, 1: 194).

Accommodating Refugee Groups in Reducing Inequalities in Health Strategies

Participants considered that the health system was too slow in making efforts to accommodate refugee groups. One health educator commented that in comparison to New Zealand, multicultural health programmes were the norm in most resettlement countries:

...We would be one of the only countries in the world that hasn't adopted that a long time ago. Everywhere has cultural brokers, community workers, community aides that interface between the community and health providers ...we are quite behind ... (Nikki, 1: 44).

In summary, universal programmes to improve the health status of all New Zealanders and to reduce inequalities in health populations overlook refugee groups. Further, ethnic data is poorly collected in the health sector and there is little information available to inform the Ministry of Health and District Health Boards about the health status of the refugee groups within their regions. It is argued that the Ministry of Health system of prioritising populations, based on Maori, Pacific and 'Other' groupings, marginalises refugee communities.

Auckland's Issues

Refugee resettlement has made the greatest impact on the Auckland region where more than 60 per cent of refugees settle (NZIS, 2004b, p.64). Central government health funders, in the view of the participants, took the view that the pressure on the region's health services was one of 'Auckland's issues' that needed to be managed locally. There are four main issues that the health services in the Auckland region face in regard to refugee groups. These are: first, settlement support services are short-term and under resourced; second, there has been no overall integration plan to prepare health agencies for managing the psycho-social complexity and the cultural and linguistic diversity of refugee populations; third, refugee groups have become problematised—because they have high rates of health utilisation—in the context of regional District Health Board's budgets which are based on population based funding formula which overlook refugee groups; fourth, Auckland health services have been comparatively less well funded than their counterpart boards in other parts of the country.

Settlement Support Services are Short-Term

Many of the health workers interviewed in the study compared New Zealand poorly in terms of settlement support with other refugee resettlement countries where they had worked. They stressed that the levels of support available were:

...very low, it is an inadequate level of support for people in a city like Auckland...I think particularly around healthcare support, I think there could be more mental health support for people at a critical phase of that transition for them...the main things, health, social and financial, practical support, housing, mental health support, English language stuff, like a package of genuine resettlement [services]...(Jennifer, 1: 247).

Integrating Refugees into Auckland Health Services

There was a notable lack of health planning for refugee groups in areas of the Auckland region where many refugee communities had become established. For example, in 2000, a new general practice had been established in Mt. Roskill, an area with the highest number of refugee families of any suburb in New Zealand (NZIS, 2004b, p.115). However, when interviewed, a staff member in the newly set up service stated that, we:

...weren't prepared for that population. We were expecting completely different demographics and it wasn't 'til a few months later that we realised and probably didn't have the resources and the knowledge in all aspects, cultural, the whole thing. I think the other shock was the numbers and also the size of the families, bigger than Pacific Island families or Maori families and extended families as well, not just Mum and Dad and the kids, brothers, sisters, uncles...(Jane, 1: 07).

District Health Board Funding

Participants reported that the responses that they met with from other health professionals in regard to refugee groups were often that they were an additional and unwanted burden in the health sector:

... the concept is, there are too many. When you actually say how many are arriving here, we can't keep bringing these hoards of people in and using up the health dollar. That is a classic and that is from health professionals... (Jane, 1: 180).

In the Auckland region, refugees 'compete' for services with other high health needs populations. In general, as noted by one participant, services did their best to accommodate refugee groups but in the Auckland region there are:

... massive waiting lists, massive demand, not just for the refugees. You are trying to slot the refugees into a system that is already fairly heavily taxed...(Lynette, 1: 197).

Regional Pressures on Auckland District Health Boards

The regional inequities in the allocation of health funding to Auckland District Health Boards were commented upon. Service managers had found that there was a lack of responsiveness at a national funding level to the pressures on health services in the Auckland region from increasing refugee populations. The following example which is given by Plunket services in central Auckland was typical. The service had made an unsuccessful proposal to their national contract body for additional funding for the refugee and migrant families in their region:

...being funded nationally...there are no considerations given to the fact of where the nurses work, what they have to deal with here, so it does make it difficult. It puts extra stress on staff...(Sue, 1: 30).

Plunket services, which were reliant on voluntary committees for fundraising, were placed in financial jeopardy when attempting to meet the needs of growing refugee communities. Some Plunket committees in areas with increasingly diverse communities had been overwhelmed and had withdrawn their voluntary support:

...they don't want to be associated with that centre any more so all the resources go out of it, people take all their knowledge, all their money, to what they perceive to be better areas which then leaves the migrants and the

refugees on their own and with no resources, and no one to show them, and so the Government needs either to fund that or to do something about that...(Catherine, 1: 29).

The underlying issue was that there had been no additional funding available to community health services, to deliver care to refugee families.

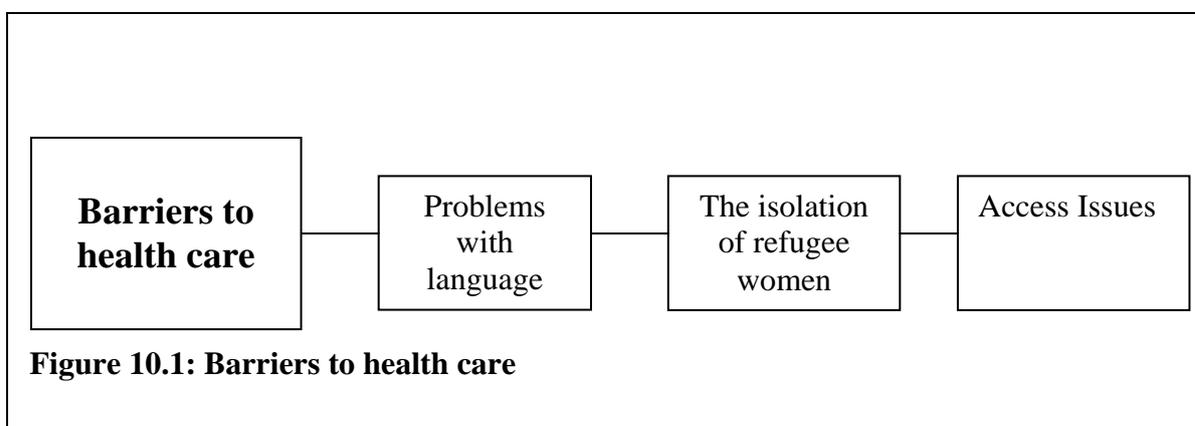
Refugees, while eligible for publicly provided services, face multiple barriers to accessing equitable health care in New Zealand. At a national level, policies for *Reducing Inequalities in Health* impact locally when ethnic groups do not match national priority populations. In this context there are significant regional pressures for the Auckland District Health Boards resulting from their rapidly increasing ethnically diverse populations. At both national and regional levels, health services' requests for support to manage growing refugee communities had been largely ignored. Further, the attitudes of health care workers towards refugees were in some cases unreceptive, or discriminatory. In summary, there were multiple impacts resulting from the discursive exclusion of refugee groups including: inadequate funding arrangements for the health sector; an unwillingness to accept referrals for refugees in some services; and an inability to accommodate the cultural and religious diversity of refugee groups in services.

Conclusion

Public institutions, such as health care, are explicitly oriented towards the social, economic and cultural interests of the majority group. The examples given in this chapter demonstrate the institutional bias in ethnic data collection systems towards some ethnic groups and not 'Others'. In this context, the official statistics released by public institutions reflect the limitations of addressing the health and social disparities for ethnic groups in New Zealand. Governments determine decisions about the ethnic data that is collected and from whom, the questions asked on surveys and censuses, and how and what data is analysed and disseminated, and for what purposes. Importantly, for refugee groups the quality of societal membership depends not only on acceptance from other New Zealanders but also on an equitable distribution of publicly provided resources. The policy of defining refugee groups as 'Other' results in an inequitable distribution of benefits for these high needs populations.

CHAPTER TEN

BARRIERS TO HEALTH CARE



Introduction

In this chapter, I examine the ways that inequitable access to health services challenges the ideal of health care provision as a right of citizenship for all groups in New Zealand society. The differences in access to health care demonstrate the limits of the social citizenship available to refugee groups. In this context, refugees have many prior needs which are to be addressed before they can access health services fully and equitably. For refugee groups claiming the right to health care is linked to their access to income support, employment, housing and language instruction. In particular, refugee women's access to health care is restricted by the limited opportunities available for them to learn English language and literacy.

Participant Data - Barriers to Health Care

This chapter highlights the particular accommodations that refugee groups require from the health sector to enable them to participate not only in the health system but also to participate in the social and economic life of New Zealand society. The importance of providing health care that is culturally responsive has already been highlighted in chapter eight. Socially responsive health care services are affordable, provide trained health interpreters, take a managed approach to trauma and the refugee experience and provide practical support, such as childcare and transport to health care services (Nash, Wong & Trlin, 2006). Figure 10.1, 'Barriers to health care' outlines the difficulties that refugees have accessing health services including,

‘problems with language’, ‘the isolation of refugee women’ and other physical, social and cultural ‘access issues’.

Problems with Language

Most refugees who come to New Zealand do not speak English fluently and a significant proportion are not literate in their own language(s) (Ministry of Education, 2003, p.13). The New Zealand Immigration Service argues that the ability to speak and write in English impacts on all areas of integration (2004b, p. 366):

... it can be a major factor in unemployment, and makes it difficult to make full use of the services that W&I provide. Without a reasonable level of English, social integration becomes a greater challenge...In essence, refugees are unlikely to fully access their entitlements or participate in society to the extent desired while they have poor English.

In New Zealand, there has been insufficient attention on linguistic accommodations for non-English speaking groups in health and social services. The main issues in this chapter are the following: first, access to health services for refugee groups is inequitable because of the language barrier and this is particularly so for women; second, there are legal and safety issues for refugee groups arising from the inability to communicate with health service providers; third, refugee groups have often missed out on the follow-up to routine screening and health prevention programmes.

Equitable Access to Health Services

New Zealand health services have been slow to respond to the needs of refugee groups for equitable access to services. The *Code of Health and Disability Services Consumers' Rights* which cites failure to provide an interpreter as a breach of the *Health and Disability Commissioner Act (1996)* was passed a decade ago. However, many primary and non-governmental community health services do not have funding for interpreting services. As succinctly noted by one doctor:

... the fact that they are refugees is not the issue so much, it is...how are we going to communicate?
(Dennis, 1: 56).

Communication barriers between health practitioners and clients make providing care complex and practically difficult. For example, a general practitioner stated that:

...looking after refugees and migrants from those countries was certainly very time consuming for a number of reasons...language difficulties, and there were certainly cultural difficulties. And because of that the consultation tends to take much longer...(Rob, 1:5).

Client Safety Issues

Working in health care without interpreters is unsafe. For this reason the Auckland District Health Board company policy is that an interpreter is to be provided when the patient has a limited command of English (ADHB, 1999). Within this policy interpreters are required for the purposes of attaining informed consent, communication, confidentiality and ensuring best patient outcomes (ADHB, 1999). District Health Board company policies specify that health care services are to use professional interpreters and not family members for interpreting. Any 'untrained' interpreters who accompany clients are only to be used to interpret information that is not clinical, technical, confidential, sensitive or of a critical nature (ADHB, 1999). However, in the non-governmental sector, many primary and community health services do not have trained interpreters available. The following case is typical of the difficulties that practitioners face in trying to ensure that their non-English speaking clients are receiving the right treatment and medications:

... you talk to the child, who translates to the mother, who then talks to the child, who then translates it again to tell you. What has been missed in that chain? Tell your mother that tomorrow she has to take a pink pill in

the morning. Now how do you know that this five or six year old? ... scary ... (Jane, 1: 237).

Poor compliance with medications and treatments among refugee clients was reported by a number of health practitioners. Without an interpreter there was a significant risk that important health information would be misunderstood, for instance in the following example when a diabetes nurse visited a client who could speak very little English, the:

... information was not given properly... the [diabetes] nurse had said ... that she was leaving that Community Service and she wouldn't be seeing her [the client] any more. What she then failed to say ... [was that] there will be another nurse carrying on. This lady was like, this is it, I have finished, I don't need it [diabetes treatment] any more. You really have to be careful and she had to continue doing the diabetes stuff...Although they say, yes, yes, it is not always that they do understand...(El, 1: 49).

Health Screening and Prevention Programmes

Refugee families were less likely to participate in routine health screening or to act on medical advice when health issues were detected, because they were unable to read the follow-up letters or to understand the health care workers instructions. Community health services stressed the difficulties that they experienced in explaining children's health screening processes to parents who did not speak English. For instance, when vision defects were found in a refugee child during routine vision/hearing screening at school, the parents could not understand what was required of them:

... [it's] in the too hard basket. You are in a new country, you are having to grapple with everything that is different and then you have got this piece of paper and it is not that important at the moment, particularly with vision, eyes don't normally hurt ... (Rachel, 1:64).

Without interpreters or translated information hearing/vision testers had considerable difficulty explaining to parents the results of the tests:

... we sent a rip-off slip when we see a child we put their name on it, we tick the boxes, what we tested them for and what the result is...it was hard work for him... (Rachel, 1:76).

Sometimes communication with refugee families failed completely as demonstrated by the experiences relayed by this worker:

...you are just banging your head against a...you make a phone call, I make several phone calls, 'hello is Mr So and So there?' and you just get someone who doesn't even know a thing that you are saying and they end up just hanging up in your ear. It is just so frustrating and you don't really know where to go from there really...(Di, 1: 82).

Representatives of women's health services found the same difficulties with communicating routine women's health screening programmes, such as cervical screening. They found that refugee women in general had little understanding of the purpose of preventative screening programmes:

...because of the language problem, even after lots of diagrams and discussion... I still don't really know if they had a good grip about what we were actually doing. Some other ethnic groups, we did have some translated material that we organised with one of our patients who is a woman Iranian gynaecologist, and we had that translated into Farsi, which was helpful, but no way did we have it in Somali or the seven languages that they need in Ethiopia ... (Jane, 1: 194).

The purpose of drug and alcohol harm reduction programmes was also poorly understood. In the following example, programmes such as needle exchanges were only accessible to English speakers:

...for those Vietnamese and other non-English speaking people...there is no intervention whatsoever, whether it's mental health needs or even getting information to go to RADS [Regional Drug and Alcohol services] if they want to do that (Karen, 1: 211).

Health care workers had found that when families were able to communicate in English they were very keen to engage in decisions about their health care:

...the actual health seeking behaviour is extremely high, they're often an extremely rewarding population to work with, because I have found that if they speak the language, they have got active health seeking behaviour, they have got low social determinants of health but that is overridden by the desire to know...(Catherine, 1: 29).

English language competence is a basic requirement for negotiating the health system in New Zealand. Due to the lack of linguistic accommodation in health services many refugees are unable to understand basic instructions, such as directions for taking medicines and how to contact emergency services which leaves them at risk and vulnerable. One way to enhance refugees' ability to participate in health care is to facilitate English language acquisition. Another is providing health care in refugees' own languages rather than requiring them to learn English as a precondition for access. In the study, refugee women faced the greatest barriers to English language acquisition and to accessing services (Ministry of Education, 2002a, p.12). This will be explored in the next section.

The Isolation of Refugee Women

There are gender related differences in refugee and settlement experiences that need to be considered when planning integration programmes and responding institutionally in receiving societies (UNHCR, 2002a). Many refugee women in New Zealand do not have English language skills and a significant proportion are pre-literate in their own language(s) (Ministry of Education, 2002a; NZIS, 2004b). Refugee women are not only vulnerable to personal and psychological problems such as social isolation, depression and anxiety but are less able to ensure that their

children and other family members receive adequate health care. A number of countries put in place specific programmes for refugee women including providing child care to promote participation in language training and in health care, support for women to access hospital based obstetric care (UNHCR, 2002a, p.246). There are three main issues discussed in this section in relation to the isolation of women: first, refugee women have considerable difficulty accessing health care; second, many are socially isolated not only in relation to language and cultural barriers but because of the stigma and discrimination that they face in the community as ‘visibly different’ cultures; third, due to these and other factors, refugee women are at risk of mental health problems.

Refugee Womens’ Access to Health Care

A number of New Zealand studies have shown refugee women to have the greatest difficulties in accessing health care (Clendon & White, 2001; Denholm & Jama, 1997, 2002; Mendelsohn, 2002; NZIS, 2004b; Ministry of Health, 2001d). There are multiple contributing factors to these difficulties including women’s level of education, access to transport, English language and literacy ability, cultural issues, poverty and social isolation. Women from developing countries are less likely to have received a formal education than their male counterparts (NZIS, 2004b). In the following quotation a child and family health service emphasised the difficulties that women had in accessing English language classes and how this impacted on their self-esteem:

... English is a big one and [they have] no confidence ...
The waiting lists [for ESOL home tutors] are forever. I
hardly refer them any more for that very reason ...
(Lisa-May, 1: 58).

As one practice nurse stated:

... the men seemed to have better command of the
English language than the women so they would be very
keen about the vaccination programme and want to
know the whys and wherefores...more than the women
(Jane, 1: 121).

Refugee women often depended on their children to interpret for them during health visits. In the following case, a Plunket nurse who was working with Afghan families had to rely on the children of other Afghan families during child health check ups:

...the older children from one family would come to this one mother because she had no one at home and she would interpret for me. It is the only way that I can do it ... (Lisa-May, 1: 223).

In the study, transport to health services was often a problem. In the following example a client had difficulties accessing ante-natal care because:

...they haven't got enough cars and people around, that particular family. I asked her to go to the doctor because her BP (blood pressure) is very low, she feels like she is going to faint all the time...(Lisa-May, 1: 46).

Discrimination and Social Isolation

Refugee women are socially isolated not only in relation to language and cultural barriers but also because they face harassment in the community. In this context health care workers were an important link with mainstream society and in connecting women with others in their community:

...[many refugee women] hungry for contact with the outside world...women who are of course more kept at home and don't have any outside contact. Another woman to come in and understand a little bit of what they are going through, I think is a bonus ... (Sue, 1: 89).

A community health nurse commented that an Afghan women's health group had been successful because it had created social opportunities for women who were otherwise quite isolated from New Zealand society. In the following case, Plunket nurses who set up a Somali women's group to improve infant nutrition found that they wanted to know about what other women cooked for their families:

...banana cake and cheesecake. They asked for cheesecake and chocolate cake. They said, do you know how to cook those and I said yes but we were promoting

healthy baby food...but we did show how to do potatoes and carrots, how to strain them... and it came about because I noticed that all their little two year olds were constantly at the doctors with lactulitis because they had not enough vegetables. The vegetables were all foreign to them. I presumed that they knew how to cook potatoes but they didn't and we carried the Watties chart and as soon as you got that out of the bag they asked could you leave it (Catherine, 1: 67).

Plunket nurses also played an important role in ensuring that refugee children had access to pre-school education. They had started an early childhood group which was combined with health education sessions in a suburb where many refugee families lived:

...there is a high percentage of Somali women...and once one or two come, then the others feel confident in coming [to a play group]...so now we have our Somalian group that meets three times a week and we have...our Egyptian lady, who goes in and does these key health messages to these women. We are using our funding...to do this work ...(Sue, 1: 41).

Women valued highly the recognition that they were given for participating in programmes, such as women's health education:

... they appreciated that certificate (Ruth, 1: 98).

They were committed to:

...their self-development, as well as the community's self-development...(Ruth, 1: 58).

Refugee Women and Mental Health

Refugee women and children are particularly vulnerable in New Zealand society. Plunket nurses encountered some complex child protection issues in refugee families. One Plunket coordinator described the work of a nurse in her team who was involved

with responding to family violence:

... She has been trying to get extra resources for this poor woman who is an overstayer and she has to deal with that on top of her normal work, working in with the social worker in CYFS [Child, Youth, and Family Services], family violence agencies ... (Sue, 1: 21).

In many cases, refugee women were cut off from social support agencies because they were unable to communicate in English. The words of this community worker describe the importance of this:

Research done on a group of Somali women showed ... that all...agreed that having limited or virtually no knowledge of the English language was crucial to the way they felt about their country of settlement. Despite their language difficulties, lack of knowledge of their rights and sense of inadequacy, they have to deal with complex problems as they arise. They are not aware of special services, which could help them... (Sarah, 2: 99).

In addition, women often lacked the skills and self-efficacy to start community development projects. In a Burmese women's project a community worker found that the women were reluctant to ask for funding from community agencies:

The general consensus was...to keep a low profile. This is understandable considering the background of these women who became refugees because they demanded that the political situation be changed. They would not want to disrupt anything they have now. For them to feel more of a sense of belonging and more in control of their lives, it will...take a long time, until they feel immersed in the community...(Sarah, 2: 311).

Some community health workers cited cases of active discrimination and hostility towards refugee women which undermined their already fragile sense of belonging and physical security. For example, health workers noted among Afghan families the profound impact of:

... the shock of September 11th ... I felt their health was most at risk of all the families in my area. They are the most depressed...(Lisa-May, 1: 59).

Community nurses described the neighbourhood harassment of refugee families, particularly women alone with children. Some nurses had had to intervene to protect families from the verbal and physical abuse of neighbours. A child and family service gave the example of:

...one of the Ethiopian families...[who] was being abused ...and nurses were working to try and get her shifted... abuse, it was really very nasty...(Sue, 1: 190).

Refugee women faced the greatest settlement difficulties in New Zealand society. In some cases this was related to hostile community attitudes towards Muslim peoples and other 'visible minority' groups. Community health nurses provided a vital link between refugee women and mainstream society, services and supports. However, much of this work was reliant on children communicating between their mothers and the nurses.

Access Issues

The extent to which health rights are achieved for refugee groups is crucially connected to key accommodations such as language and literacy training opportunities, the availability of income support and the recognition of cultural and linguistic diversity in the health sector. In this section, 'access issues' are concerned not only with the issues previously discussed but also to the social and cultural acceptability of health services to refugee families. In this context the health services that visited homes and schools were essential to access for refugee women and children. In addition access to services improved markedly when health services employed refugee community health workers to work with refugee families (Jackson-Carroll, Graham & Jackson, 1998). In the study, health services provided a vital link between refugee families and income support, housing, ESOL and immigration services.

Community Based Health Services

Community based health services have a key role in reaching refugee families who would otherwise have limited access to health care. Refugee women readily accepted:

...a service that meets them in their own home...and listens to them...we don't have any trouble being accepted, being European or whatever...(Sue 1, 75).

Many women for a number of reasons were unwilling or unable to visit community based clinics. The way to ensure that these families were linked to child health services was to visit them in their homes, as explained by this worker:

... I never ever get them to [come to the] clinic because I know that they are never going to come...there are some out there that will, but the majority of my Afghani and Pakistani, I home visit permanently because I have to see them, so I might as well see them in their own home where they are comfortable. I have just been to a Pakistani family now and [the mother] is pregnant as well, and she needed me to take her blood pressure, so I was able to do that for her (Lisa-May, 1: 39).

Plunket nurses in mobile caravans in the Auckland region had successfully used a 'door-to-door' approach to access refugee families. In some areas where there were large numbers of new arrivals, nurses and community health workers would target a whole street:

What she would do is go out first and do a leaflet drop into absolutely every house in that street, saying exactly when she was going to come back and then she would go back in and then working with the health workers they go and knock on the doors. Once things become established they start becoming like a little clinic...people will come in for all sorts of problems and queries and...sick children and everything, they just present. Very, very labour intensive and hard to get the 'numbers', but often the cases are quite complex, we have a range of scenarios from housing to abuse to poor

nutrition and unimmunised children, so that would be across the spectrum of cultures (Sue, 1: 144).

Without this community based approach maternal and child health problems would have been missed as evidenced by the story of this Plunket nurse:

...[I] managed to be lucky enough to pick up something with an Afghan family that I was visiting, it was nutrition, they were putting the child on the floor and they were bottle feeding it and they started it on formula too early and all sorts of things, eventually I managed to get her [the mother] to go to the doctor because this child was becoming very developmentally delayed and was grossly anaemic...(Sue, 1: 285).

In the above case, there had been numerous visits to the family and months of relationship building with the head of the household before the Plunket nurse was able to intervene. In traditional societies new mothers rely on the child rearing support and expertise of older women in the community. These systems of knowledge and support are disrupted in refugee families. The New Zealand system of having nurses who visit the family routinely after a baby is born is unfamiliar to many newcomer families. Gaining access to families, unused to the intervention of 'outsiders' required considerable time and persistence from health care workers:

...I absolutely got in there and talked to the guy, got them to go [to the doctor], so whenever I went in the door...it was quite remarkable from being really guarded to, come in, come in. It took ages to make that breakthrough, it took months and months and months of painstakingly home visiting, coming back when they weren't there and it was only because I was working in that group at that time and I had that extra time that I could give. But if that family had been in another area with another Plunket system, that family probably wouldn't have made it through the system and that child would not have been picked up. So it is only through

time, effort and persistence that these families get the care that they need really... (Sue, 1: 288).

The school based community health services were also an important means of connecting newcomers to health care services for children. Families who were newly arrived, particularly family reunion members:

...don't know where to go and...fortunately the links within school will pick things up and know to refer to us ...so we can help enable them to get those services... children needed glasses so I was able to access some glasses from the system, because they don't know...(Sue, 1:32).

Refugee Community Health Workers

Access to health care improved markedly when services employed refugee community health workers. In one example, the Plunket society in central Auckland had employed Farsi and Arabic speaking community health workers. Families from Arabic and Farsi speaking communities could speak to:

...people that speak their language [and]...have knowledge of their religion and culture, that is an added bonus...the Health Worker...can help you do those initial visits and overcome those language barriers (Sue, 1: 80).

The refugee community health workers were often asked by families to assist with housing and benefit issues as well as health care. This raised concerns from employers about the levels of stress on the:

...health workers who would physically take them [families] to Housing New Zealand...I am just hoping that the two [refugee community workers] that I do have won't burn out with the demands made on them...(Sue, 1: 210).

Advocacy

Refugee families had multiple unmet social needs related to income support, employment, English language instruction, housing and immigration issues. Health

services provided advocacy for families who were unable to communicate with local welfare services. The manager of a primary health service summarised the difficulties that families had accessing social support:

...there are language difficulties...[but also] in terms of how do we make sure that people understand what we are saying in the broader context. There is the specific health issue but then there is the other broader context about how do they access the benefits that they are entitled to. What sort of response do they get from other agencies? (Kate, 1: 49).

The ability of refugee families to participate in social services was restricted by cultural and linguistic barriers and in some cases the discriminatory attitudes of the staff in the services:

...transport...language, cultural difficulties and the time that we spend on it depends on the urgency. It is done pretty much on a case-by-case basis, whether or not a particular family can be linked in with others who can support them to get that degree of support that they need... (Kate, 1: 49).

Many health practitioners commented that the quality of care that refugee families received was inadequate compared to that received by other service user groups:

... families don't get the best of services... But on the other hand, if they make a personal connection to someone in the practice, they might get more than what others might get...(Mary, 1: 196).

Many health agencies who had raised concerns about the lack of settlement support for refugee families commented on a lack of response from local and central government bodies:

...people further up the chain...don't have the same level of understanding, because we are in the midst of it all and my thoughts and feelings are, that if we don't look after these people now, we are going to be reaping further down the track...(Sue, 1: 55).

How far health organisations would go in offering additional assistance to refugees:

...depends on the whole philosophy of the organisation... (Rob, 1: 130).

It was acknowledged that the community based Primary Health Organisations had the potential to create models of care for refugee families that addressed health and social needs in local areas:

...at PHO level about different service delivery models so that it is not just about the patient coming and seeing the GP, it is about looking at a whole range of the social determinants, which is what we are on about in terms of the community links, what are the housing situations like in the area and do people access benefits. All that sort of stuff. So that is very clearly part of the service delivery model that this PHO is pushing...(Kate, 1: 239).

Health services were endeavouring to be as responsive as they were able to be to refugee groups within a health system that was largely unable to accommodate all cultural and linguistic diversity. The health workers in the study had had to advocate on behalf of their refugee clients with services such as housing, income support and immigration, in order to gain an adequate response from those service providers. Employing refugee community workers was a highly successful strategy for improving access for refugee families both to healthcare and to social services but few services could fund these roles. Most health agencies in the study had been unsuccessful in gaining additional funding or resources for refugee groups either at a local or a national level.

Conclusion

The extent to which refugee groups can access health care, housing, income support and language instruction determines the limits of their social and economic rights in the receiving society in the short and the long-term. Refugees in New Zealand, in the early and intermediate phases of settlement, and women in particular, have restricted access to the social rights to which they are entitled. While health, housing and income support services are publicly available, without cultural and linguistic accommodations there is inequitable access to these services for refugee groups. The operation of social rights in the various spheres of social protection are mutually reinforcing in their impact, in that barriers in one area will create difficulties in accessing rights in another. How far refugees are able to claim health rights is dependent on the role that the state has played in ensuring that all areas of social protection are responsive to the social, cultural and linguistic needs of refugee groups. In this context, inclusive social policy is instrumental in addressing the disparities in the health status, education and income levels of refugee groups.

CHAPTER ELEVEN

PROVIDING PRIMARY HEALTH CARE

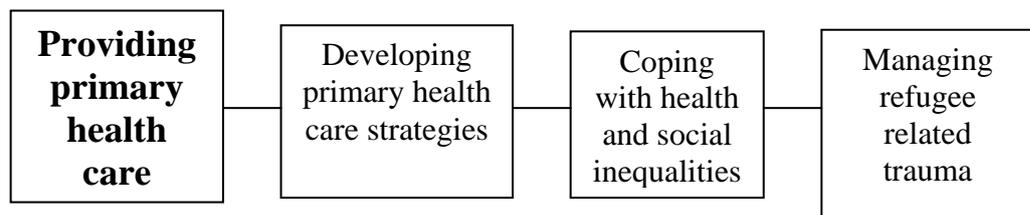


Figure 11.1: Providing primary health care

Introduction

Chapter eleven analyses the responsiveness of primary health care services in the Auckland region to refugee groups. In this chapter, the policies, organisational practices and special accommodations required by refugee groups in primary care settings are considered. Figure 11.1 presents the three themes that will be addressed which are, ‘developing primary health strategies’, ‘coping with health and social inequalities’ and ‘managing refugee related trauma’.

The Health of Refugees in New Zealand

There are some key points to be considered before making an assessment of the responsiveness of *The Primary Health Care Strategy* and primary health services to refugee groups. Refugees selected for resettlement in New Zealand have high and complex health needs and require intensive psycho-social support in the early and intermediate stages of settlement. Chapter one has explained New Zealand’s refugee policy. As a reminder, the refugee policy does not require pre-settlement health screening for quota refugees. Further, it does not exclude family reunion members, or

asylum seekers for medical reasons. The New Zealand Government ensures that many of its quota placements are reserved for the most needy cases as identified by the UNCHR. These are Women-at-Risk, Medical/Disabled, and Protection cases (UNHCR, 2002b). These groups are so categorised because they have the highest physical and mental health needs and are considered by other resettlement countries, to have 'poor integration potential'.

The findings of New Zealand studies of refugee health provide information about the level of complexity of providing health care for refugees in general and primary health care in particular (Guerin et al., 2004; Hobbs et al., 2002; McLeod, & Reeve, 2005; Ministry of Health, 2001d; Solomon, 1997; Wishart, Reeve & Grant, 2007; Zwi et al., 2007). McLeod and Reeve (2005) report high rates of health problems among quota refugees screened at the Auckland Regional Public Health Service (ARPHS), Refugee Health Service (RHS) at the Mangere Refugee Resettlement Centre (MRRC). Reflecting countries of origin, there are higher rates of disease detected in refugee populations, compared to New Zealand populations, particularly tuberculosis, HIV infection, malaria and schistosomiasis. Non-communicable diseases are also prevalent including abnormal haemoglobin diseases, such as sickle-cell anaemia and thalassaemia (Ministry of Health, 2001d). Nutritional deficiencies in refugee groups are common. Fifty four per cent of refugees on arrival have some degree of iron deficiency (McLeod, & Reeve, 2005; Reeve, 1997). Vitamin D deficiency is reported in 98 per cent of women and children on arrival (Wishart, Reeve & Grant, 2007). Many refugees have advanced or untreated dental disease, most having received little or no dental care for years (Ministry of Health, 2001d).

Mental health issues are also common among refugees and asylum seekers (Ahearn, Loughry & Ager, 1999; Hobbs et al., 2002; Mollica et al., 1987; Silove et al., 1999). The study by McLeod and Reeve (2005) notes that 20 per cent of the refugees screened by the Refugee Health Centre had been subjected to some form of significant mistreatment in the form of detention and/or physical mistreatment and 14 per cent had significant psychological symptoms. Research by Hobbs et al. (2002) on the health status of 900 asylum seekers in New Zealand, screened between 1999 and 2000, found that 38.4 per cent had symptoms or a history of psychological illness. Such ordeals

frequently result in ongoing mental health problems and, in particular, post traumatic stress disorder (Pernice & Brook, 1994, 1996).

The Ministry of Health (2001d) publication—*Refugee Health Care: A Handbook for Health Professionals*—documents the following health problems in refugee women. Most women will have had little or no previous health screening, particularly cervical and breast screening. They will have had little or no access to and knowledge of family planning services. Many have psychosexual and mental health issues following trauma, rape and abuse during refugee flight. Some groups may experience difficulties surrounding Female Genital Mutilation (FGM) and in the accessing of services for appropriate rehabilitative, gynaecological and obstetric care. Refugee women have high birth rates and many have untreated gynaecological and obstetric conditions after years in refugee camps or homelands where there is a lack of medical facilities. Larger families are the norm for many refugee communities. A study by Reeve (1997) of refugee women screened at MRRC found that of 184 women aged from 14 years, 18 per cent had five or more children. Refugee women may have higher risk pregnancies than other groups in New Zealand (Ministry of Health, 2001d).

Solomon (1997) has evaluated a number of high profile, high cost, health status indicators in refugee ethnic groups in New Zealand and has demonstrated that settled refugee communities have poor health status and high health need. For example, the prevalence of diabetes in quota refugees approaches that of Pacific populations (Solomon, 1997). Similarly, the prevalence of coronary heart disease among quota refugees aged 35 to 64 years is likely to be similar to that of Pacific populations (Solomon, 1997).

Participant Data - Providing Primary Health Care

The Primary Health Care Strategy aims to make services more accessible and affordable to disadvantaged communities and to reduce inequalities in population health (Ministry of Health, 2001a). Primary health care is the first and main link to health care in New Zealand (Ministry of Health, 2001a, p.29):

It forms an integral part both of the country's health system, of which it is the central function and main focus,

and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

The vision of the Minister of Health was that from 2001 communities would be part of local primary health care services that improve their health, keep them well, are easy to access and coordinate their ongoing care. The primary health vision involves a greater emphasis on population health and the role of the community (Minister of Health, 2003b; Ministry of Health, 2001a; Neuwelt, 2007). Population health is defined in *The Primary Health Care Strategy* as (Bennett, 2003, p.12):

... an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that determine health...a population health approach is likely to emphasise that action across many sectors such as education and social support are necessary if health inequalities are to be reduced.

Two questions that Primary Health Organisations (PHOs) are expected to be responsive to are (Ministry of Health, 2002c, p.23):

Are there any subgroups with unequal health status with whom the PHO should be consulting when considering its development and service planning?

and

Are there groups that are not currently represented and how can the needs of these groups be identified and heard within the new environment?

Primary Health Organisations are required to involve their communities because (Ministry of Health, 2001a, p.7):

Services will then be more likely to reflect needs and priorities that are set by the people, not just by providers.

Primary Health Organisations will be required to include some members of the community on their governing bodies. They must also be able to demonstrate that they have processes for identifying need and allowing community members and those who use services to influence the organisation's decisions.

The Ministry of Health (2001a) estimates that health services contribute to only a fifth of health improvements and that health gain occurs mainly through changes to the social, economic and cultural circumstances of communities. In this context primary health services are expected to take a broad intersectoral approach, working with other sectors to effect change for specific population groups (Ministry of Health, 2001a). In terms of opportunities to expand social and economic citizenship for refugee groups, the conception and role of primary health care raises two questions which will be answered in this chapter:

- Are PHOs addressing the needs of refugee groups?
- and
- Are PHOs consulting with refugee communities?

Developing Primary Health Care Strategies

The Primary Health Care Strategy (Ministry of Health, 2001a, p.6) directs the primary health sector to 'identify and remove health inequalities' but the strategy overlooks refugee groups. The main point in this section is that the model has the potential for the inclusion of refugee groups as all PHOs are required to understand the nature of their populations and to identify disadvantaged groups, in order to address their needs. The strategy states that 'hard-to-reach' groups will require 'different strategies' and that

PHOs must ‘identify different ethnic communities within their populations, and... provide for their different needs and priorities’ (Ministry of Health, 2001a, p.10). Primary Health Organisations are encouraged to take a community development approach to find appropriate solutions for disadvantaged groups (Neuwelt, 2007). There is particular emphasis given to improving services to people who would otherwise have difficulty accessing primary health care.

However, the strategy does not specifically target refugees as a high needs group. Participants in the study indicated that despite the provision of targeted funding according to income and high need, there was unequal access to primary health care for refugee groups. The outcome of the strategy is disappointing, so far, in regard to refugee populations. Since the development of PHOs, studies that assess the impact of primary care on vulnerable populations have not included refugee populations (Barnett & Barnett, 2004; Crampton, Dowell & Woodward, 2001; Minister of Health, 2003b). The one study that has been directed at refugee populations is of the Roskill Union and Community Health Service, Hauora o Puketapapa (HoP) where there are significant refugee populations (Lawrence & Kearns, 2005). The study finds that there are continued problems with accessing primary care, and that the new funding environment has not led to greater equity for these groups. Hauora o Puketapapa was developed in 2000 as part of a New Centres programme which was initiated by Health Care Aotearoa, a body established to provide affordable primary health care to low income families and their dependants through capitated arrangements with the Ministry of Health (Crampton et al., 2000; Exeter, Collins & Kearns, 1999; Health Care Aotearoa, 2003). The conclusions drawn in the Mt Roskill study support the findings in this study that refugees continue to face considerable barriers in accessing and utilising health services within the new PHO structure. Some of these barriers are outlined in the following sections which detail how primary health services are ‘coping with health and social inequalities’ and ‘managing refugee related trauma’.

Coping with Health and Social Inequalities

In this section, the systemic factors that prevent refugee families gaining improved access to primary health care are discussed. These are: first, that refugee groups are not specified as a target population in *The Primary Health Strategy*; second, the level of

unmet social need in refugee groups makes health care provision complex and staff quickly burn out; third, the cost structures for primary health care do not compensate service providers for the time it takes to ensure that refugee families have their basic living needs met; fourth, the community health services provided by District Health Boards were also limited in the level of support that they were able to offer refugee families.

Target Populations in the Primary Health Strategy

It is expected that primary health services will provide equitably for all the health needs of refugee families and asylum seekers but the contractual arrangements for primary health services do not prioritise services for refugee groups. The primary health services in the study were unable to make any specific service plans for refugee groups, although in some cases they represented a significant proportion of their enrolled clients. This was because PHO contracts did not:

...take account of particular populations, other than Maori and Pacific... (Kate, 1: 9).

Compared with other communities with high health and social needs, such as those of Pacific peoples, refugee groups were perceived by providers to be more isolated and marginalised:

Pacific groups usually are much better established within the community, they have been here a long time, they have bigger family networks and they usually have access to people who speak English. There is a whole range of other supports available to Pacific networks and groups, than there are to refugee groups...and also there is...the community perception and understanding of the issues, so it is not only around language and the difficulty in finding their way around, it is a totally different cultural experience for them and there are cultural issues about women travelling alone or coming to appointments alone and that sort of thing... (Kate, 1:40).

Unmet Social Needs in Refugee Groups

The unmet social needs of refugees are overwhelming for primary health care providers. Refugee families presented to health services in significant states of ill health and deprivation. They were often sick and exhausted on arrival. Refugee households were often overcrowded, had few financial resources and the arrival of more family members meant further financial hardship, such as:

...one family...there was grandma, children, grandchildren and a young woman who was waiting for her husband, an Afghani man who had been in a camp in Pakistan. He arrived on a Sunday evening at the airport and she brought him to us on the Monday morning because he was itching. We sorted that out but I noticed he had a nasty cough and was very emaciated, pressure sores, because he was so thin, lying virtually on the ground, on rock, two days before [arrival]...within two days we had a positive TB. He is living in the community with his family of eight... (Jane, 1: 37).

Many community health workers found refugee households in situations of considerable financial hardship, for example:

...there was a 20 year old boy working supporting his father, his wife, younger brother at school...and another one, on his meagre wage, five adults in the house that he was trying to support...(Sue, 1: 103).

Poverty in refugee families meant that public health nurses would:

... often have to get food parcels for these families... (Di, :104).

Some families were unable to afford glasses for their children, such as the case of this Burmese child who:

...was very worried about it [her family affording glasses] and

they were very hard up and Dad was saying, just look harder and between me and the school we convinced him and we managed to get some frames and we took them along and got the lenses put in and you have never seen such a change in a child or the parent... (Rachel 1:117).

The issues for primary health providers were even more challenging when the clients were asylum seekers:

...in the same family, an extra family member would arrive from a refugee camp, especially the Afghans... and then they would wait [for health screening]...they [had] not necessarily joined the family as a refugee, but quite often as an asylum seeker, which brought a whole new complex of health problems...(Jane, 1: 28).

Asylum seekers were a particularly complex group to care for in terms of social needs:

...a family that were using our service, they would bring them along because usually they were straight off the plane, undernourished, very sick... (Jane, 1: 33).

The process of seeking refugee status as an asylum seeker is extremely stressful and the level of income support available to this group is minimal. Health care workers quickly 'burn-out' when faced with high workloads and social needs that they could never fully address. Practice nurses often had to provide a level of 'social work' for refugee families:

...that was the other kind of work that we were doing too. We were actually intervening for patients with WINZ and Housing New Zealand, which we tried not to do, but to separate it, was really difficult. So we became actually social workers and...writing letters 'cause someone had

asthma and the room was damp... (Jane, 1: 257).

Some participants in the study had left jobs in primary health services because they had been overwhelmed by the demands of families for social assistance which they were unable to meet. Typically, on an average day in a practice:

...in an area where refugees...live and most of your day, families, five and six with no appointment and the children are all so sick, that you can't turn them away and there are another four people waiting, it becomes a huge, huge day and you don't go home until you have finished and it goes on through the day, and I think that is different [from any other practice] (Jane, 1: 222).

Workers in the primary health services interviewed in the study did not have the resources or the capacity to meet the needs of refugee families:

...trying to deliver health needs, it is just basic, not enough resources to start...and the people who are keen to do that kind of work, they can't keep [up]. It is not about money, it is not about recompense, it's about time management and trying to do a job that is an enormous amount of time and never ever getting it done... (Jane, 1: 315).

The Primary Health Cost Structure

In general practices, appointments for refugee clients are often lengthy and complicated for a number of reasons and interpreting services are not routinely available. Many refugees had had little access to health care prior to arrival:

...so they had a number of problems that they needed to sort out and that could often take quite a lot of time. You needed to see them repeatedly until...you had sorted out their problems to a degree that you were comfortable with

... (Rob, 1:14).

District Health Board Community Health Services

There were few agencies that health services could refer refugee families to for the social assistance that they needed. In the study, community health services could provide only short-term interventions. They had limited capacity to provide the specialised support needed by refugee families. As one community child and family health provider stated:

...everybody wants to be a referral agency and nobody wants to do it... Absolutely nobody...oh, we don't do that. I do keep these people on by various means but I am not meant to carry long term caseloads or...if they need that kind of support I should be referring them on but there is nobody to refer them on to... (Lynette, 1: 205).

The community nurses in the study recognised that unless they intervened, refugee families would not have access to the services that they needed to survive and to which they were entitled. Often community nurses had encountered mixed reactions from other health, housing and social service agencies in response to referrals, which ranged from extremely helpful to hostile. In many cases the referral agencies available were equally limited in the level of assistance that they could offer refugee families.

The Primary Health Care Strategy is intended to expand social and cultural citizenship rights for all high health needs populations but in the context of refugee groups there are breaches in terms of equity and inclusion. The research data in this chapter indicates that access to social and economic participation for refugee groups is highly restricted. Refugee groups have limited access to the health rights to which they are entitled because of the systemic social and cultural barriers that they face in the New Zealand health system.

Managing Refugee Related Trauma

Refugees are a case for special psycho-social accommodations in primary health care. There are four main issues raised in this section: first, refugees present with significantly higher levels of mental health issues compared to other groups in primary health care; second, social isolation, unresolved family reunion matters and unemployment compound these issues (Chapter eight contested medicalised responses to refugee psycho-social adjustment in receiving societies); third, many refugees have post traumatic stress disorder which is often beyond the scope of general practice to manage; fourth, managing highly traumatised people is complex and psychologically demanding work and this is particularly so in the case of asylum seekers.

Refugees and Mental Health Care

Primary Health Organisations are key providers of mental health services in the primary mental health care plan released by the Ministry of Health in 2003 (Ministry of Health, 2003d). The *Primary Healthcare Organisation Service Development Toolkit for Mental Health Services in Primary Care* acknowledges that many refugees in New Zealand (Ministry of Health, 2004a, p.12):

...experience significant ongoing psychological and cultural adjustment difficulties. Tremendous grief and loss can accompany resettlement. Losses include loss of family and friends, culture, country, material goods, physical health, mental health and socioeconomic status. Refugee grief is often complex, unresolved and fuelled by survivor guilt and the retraumatisation of the resettlement process ...Depression, anxiety, psychosis, psychosomatic presentations and relationship/attachment changes frequently occur after settlement...PHOs need to be aware of these factors.

As well as the assessment and treatment of those with a mild to moderate mental illness, PHOs are expected to work with specialist mental health services to address the physical health needs of people with severe mental illness and to support their recovery and management in the community.

Managing refugee related trauma is highly challenging for primary health services for a number of reasons. Refugees present with significantly higher levels of complex mental health issues compared to other groups. General practices with high numbers of refugees have higher than average caseloads of mental health issues to address. General practitioners when asked what differences there were if any, between refugee and other migrant populations responded that:

... the outstanding difference with refugees would be the higher mental health needs...recent migrants all tend to have mental health needs and certainly refugees would be higher again (Rob, 1: 57).

These issues are related to experiences pre-migration:

...those mental health issues may relate to their time in their country. The other thing would be if they had been tortured. Seeing loss of family and other things that have happened to them... (Rob, 1: 58).

Compounding Stressors

The effects of the traumatic experiences that refugees experience prior to arrival are compounded by post migration stressors once settled in New Zealand:

... other mental health issues would relate to their time in New Zealand...which would be obviously stress from being unemployed and being separated from families, dislocated from their culture and support... (Rob 1:29).

Beiser and Hou (2001), in a Canadian study of language acquisition, unemployment and depressive disorders among Southeast Asian refugees, examined the risk-inducing effects of unemployment and the protective effects of language facility on the mental health of refugees. They found that for men, in particular, unemployment was a potent risk factor for depression. By the end of the first decade after settlement, a lack of English language proficiency was a significant predictor of depression and unemployment (Beiser & Hou, 2001).

The Refugee Experience and Trauma

Refugees are traumatised and this is often difficult to treat. In refugee families in many cases children as well as adults experience poor mental health (Guerin & Abdi, 2004; Jackson, 2006). In primary health care providing therapeutic intervention is complicated by a lack of interpreting services and clients often need childcare, transport and access to mental health support workers as evidenced in this excerpt from an interview:

...the women with post traumatic stress ... really need that relationship building...that takes time...trying to find somebody to mind the children while you take a person for the English lesson. This mother with the child that is going off the planet, this...twelve year old boy... (Lynette, 1:213).

In some cases refugee families had been retraumatised by international events. This was the case with many Afghan families in the aftermath of the terrorist attacks on the World Trade Centre in New York on September 11th 2001. Many refugee families following these events had become:

... sick and depressed because of what is going on overseas, that they can't get out of their house....When September 11th happened, my Afghani families went down like a lead balloon. There were truckloads of illnesses ... (Lisa-May, 1: 24).

Usefully, in this context cross-cultural research demonstrates the overlap between depression, anxiety and somatic complaints (Buchwald et al., 1995; Kirmayer & Groleau, 2001). For example:

...an Afghani woman who looked about 68, she was in fact younger...and she came to me with awful chest pain and then she did have a heart problem and she did have some surgery and she was discharged and she is absolutely fine but the chest pain persists. We have done ECG's,

(electroencephalogram) we have sent her back to the specialist and still...twice a week we see her with these chest pains and that is really hard...(Jane, 1: 194).

Psychological distress in some cultural contexts may in some clients present as physical symptoms (Von Kaehne, 2001). Explaining that physical symptoms may be related to traumatic experiences, grief and loss, is hard to grasp in some cultural contexts and difficult for clinicians to treat (Howard & Hodes, 2001; Kleinman, 1988, 1991; Kleinman, Das & Lock, 1997). Doctors found that refugees presented to primary health services more frequently than other groups with unexplained pain:

...usually because of traumatisation, so that is what is different... (Jane, 1: 188).

In one general practice there was a significant improvement in the mental health care provided for refugees when as part of a primary mental health pilot, a consultant psychiatrist and a body therapist were added to the practice:

... we would check out what was happening but then if that was all normal, that there is a connection to what has happened to you and to your heart. Up here (the head) and up here (the heart) is actually connected and it is very real ...that was wonderful in our practice that we could actually then refer on...my arms not better, and it was unconnected pain, it was quite nice to say, well this [body therapy] might help, and quite often it did, to be nurtured ... (Jane, 1: 194).

However, funding for the pilot ran out after one year and the refugee mental health service was withdrawn.

Managing Post Traumatic Stress Disorder

Lastly, managing highly traumatised people is complex and psychologically demanding work in primary health care settings. The following example of asylum seekers, who had been tortured, represented the sorts of challenges that primary health services faced:

...the younger men that were so demanding in their needs, when we offered appointments with the counsellors, they weren't compliant. They would either not turn up and then demand to be seen because they hadn't slept for two nights —well you missed your appointment last week and they were quite angry, naturally...(Jane, 1: 57).

Making a claim for refugee status is uncertain, lengthy and extremely stressful. Many asylum seekers presented to their doctors with extreme anxiety and depressive disorders (Hobbs et al., 2002). Typically, asylum seekers required:

...a lot of paperwork...for Government, a lot of social work, desperate to get residency, desperate to get their wives here and most of...the asylum seekers have been tortured and so we need to link them up with psychologists...(Jane 1: 46).

In the study, general practices faced unmanageable workloads and found it difficult to maintain support for refugee families within their current levels of staffing and funding.

In answer to the questions asked in the beginning of the chapter:

- Are PHOs addressing the needs of refugee groups?
- and
- Are PHOs consulting with refugee communities?

The response to the first question is that while there is good evidence that adopting a broader intersectoral approach to primary health care can contribute to reducing health inequalities and to improving population health outcomes, refugee groups are not

included at present. Participants in the study highlighted the impact on the health of refugees of restricted access to social services [including housing, work and income and family support services]. In this context the strengthening of social protection for refugee families acquires significant importance. In answer to the second question there is very little evidence of PHOs consulting with refugee communities (The next chapter 'Promoting health in refugee communities' supports this finding). Overall, primary health strategies that specifically recognise refugee groups are needed before PHOs can facilitate the interventions that will improve the health of the refugee communities that they serve.

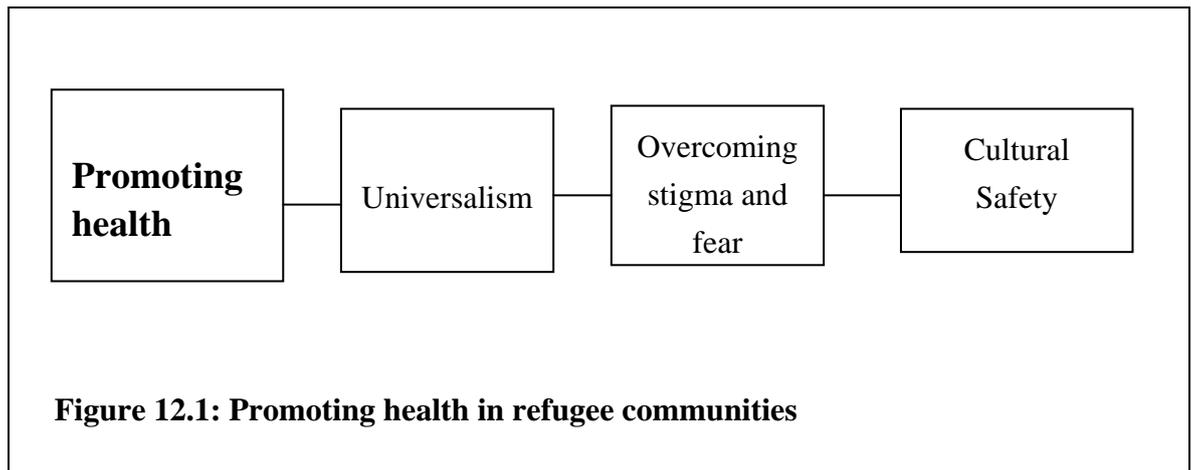
Conclusion

Recognising the socially and culturally relevant differences that disadvantage refugee groups compared to others is fundamental to any commitment to equitable access to health care in New Zealand. In the health sector structural approaches are needed that effectively address the systemic discrimination towards refugee groups that is in evidence in this study. The realisation of the social rights of refugee groups in health care necessitates responses that will compensate for their life circumstances and cultural, religious and linguistic differences. The inclusion of refugee groups as a priority health population has yet to be recognised in key population health policies and strategies such as *The Primary Health Care Strategy*.

Social citizenship for refugee groups requires the structural support of a strong relationship between the Ministry of Health, Ministry of Social Development, Ministry of Education, the Department of Work and Income and the Department of Labour. Inclusive social policy in these domains will need to be reframed with an awareness of the social, cultural and economic rights of refugee groups as full members of New Zealand society. This chapter demonstrates, using the example of *The Primary Health Care Strategy* and the development of primary health organisations, that there is as yet no overarching framework for a participatory social citizenship for refugees. Such a framework in health policy would allow an expanded commitment to reducing health inequalities and to improving health outcomes for refugee groups.

CHAPTER TWELVE

PROMOTING HEALTH IN REFUGEE COMMUNITIES



Introduction

The delivery of health promotion programmes in New Zealand highlight in practice the difficulties of including refugee groups. There are some important points that are relevant to this chapter that have been made earlier in this study. These concern the limited opportunities for social and cultural citizenship for refugee groups. While universal health rights accord refugees the same rights and entitlements as other New Zealanders, they are overlooked as a priority groups in the targeted health strategies that are designed to reduce inequality. Secondly, the health promotion programmes that are universally available are not culturally and linguistically appropriate for refugee groups. In this context, the cultural safety approach (discussed in chapter eight) challenges the multicultural frameworks of inclusion adopted by Australian and Canadian Governments. Kymlicka (2001a) and Penninx (2002, 2004) (as quoted in chapter four) have outlined social and cultural citizenship rights for immigrant groups based on the maintenance of universal rights for individuals accompanied by a set of cultural and linguistic rights and institutional accommodations for groups such as refugees. These multicultural models are helpful in the identification of the sorts of institutional

arrangements that are necessary for the equitable integration of refugee groups in the health sector.

Participant Data - Promoting Health

The following sections address three main issues that are problematic for the inclusion of refugees in health promotion campaigns aimed at reducing health inequalities in New Zealand populations. They are represented diagrammatically in Figure 12.1, 'Promoting health' in refugee communities as: 'universalism', 'overcoming stigma and fear' and 'cultural safety'. The first section is concerned with the impact of universal health promotion campaigns on refugee communities. The second section concerns the fear and stigma in refugee communities that surround sensitised health issues such as HIV and tuberculosis. The third section questions the responsiveness of the cultural safety paradigms underpinning health care in New Zealand (discussed in chapter eight) to refugee groups.

Universalism

Contemporary citizenship theories suggest that if there is to be equitable access to social goods and services, then there will need to be particularist patterns of resource distribution for those groups who are least able to access those resources (Bauböck, 1996a; Kymlicka, 2001a; Penninx, 2000; Young, 1990). In social policy terms, within prescribed universalist goals, the needs and interests of particular groups may be accommodated (Spicker, 1996). For instance, in terms of the right of all citizens to equal levels of health care, inequalities between groups can be addressed through attention to populations with particular high health needs. One way in which high needs groups may be accommodated is by the incorporation of elements of 'positive selectivism' so that health services in deprived areas may have a greater value of resource in order to meet proportionately greater needs to match the general goal of universal care (Ellison, 1999, p.64). Particularist needs may also be met by the matching of specific types of service to the particular needs of, for example, refugee groups.

In this section universal approaches to the reduction of health inequalities in New Zealand populations are shown to overlook refugee groups. The first issue discussed in this section is that health promotion in New Zealand is not informed by consultation

with refugee communities. The second issue is that there are language and literacy barriers to the accessing of health information. The third is that acculturation to New Zealand lifestyles and, in particular, a lack of physical activity and poor dietary habits, means that the patterns of poor health occurring in other low socio-economic groups are also emerging in refugee groups. The fourth issue is that, as the study shows, health promotion projects need to be community led in order to be successful. The fifth issue is that, although refugee communities have wanted to participate in health promotion activities there have been few opportunities for them to do so.

Health Promotion with Refugee Groups

Health promotion in New Zealand has not been informed in consultation with refugee communities. The health promoters in the study had little knowledge of the communities with whom they were working, their cultural and religious practices, or their health issues. For instance, when a nutritionist was asked to develop a healthy eating programme for the Somali community she had:

...no concept of what their food practices are like and what their living arrangements were like and so it is really hard to find this base to start with...(Rose, 1: 24).

In another example, Plunket nurses had found most New Zealand nutritional resources to be unsuited to the food preferences of the African families with whom they worked:

...We used pictures of the vegetables, to tell them what the celery was and what it looked like—to make fish pie. I had to show them a picture in a magazine about what celery looked like (Vivienne, 1: 88).

In other cases, mainstream prevention messages were inappropriate for some refugee groups. For example, the *SunSmart* campaign highlights the importance of promoting 'SunSafe practices and behaviours' as melanoma is the most common cancer in New Zealanders aged 20 to 39 years (Cancer Society New Zealand, 2005). The campaign advises that all ethnic groups must use prevention strategies since the risk of skin cancer

is 'not only associated with New Zealanders of European descent but also includes those who identify as Maori, Pacific Island or Asian' (ARPHS, 2004)'. The potentially harmful effects of the sun's rays are emphasised and the need to reduce exposure to sunshine advised. But, as a community nutritionist explained, keeping out of the sun:

...is the message you would give to the mainstream population. The message, if you look at all the risk factors [for African peoples], the dark skin, the anaemia, the iron deficiency, probably been breastfed by a mother who is vitamin D deficient, a much harder line needs to be taken in relation to the need instead, for exposure to sunshine (Rose, 1:152).

The campaign messages have contributed to problems with Vitamin D deficiency for African and Muslim peoples, particularly in women and children:

...They would be acting on the skin cancer messages... they obviously need sunlight for vitamin D...you actually absorb less vitamin D with dark skin, so they probably need a longer time in the sun...otherwise there is that big risk of rickets...children should be encouraged to play outside in the sunlight...(Rose, 1:128).

The Plunket nurses in the study were concerned about restricted exposure to sunlight for babies and infants in refugee families because:

...rickets comes into the equation as well... they like curtains on their windows because of privacy and a lot of them have been so fearful for their lives and so are security conscious that this adds to it as well. We have had to be very proactive about the need for some light... (Sue, 1: 116).

Language and Literacy Barriers

Language and literacy were major barriers to be addressed in providing health promotion for refugee groups. Health workers found that written materials were not useful in some communities as the women were often not literate in any language. The health promotion programmes for some refugee groups needed to be oral, visual and interactive. As one WellChild provider said:

...when I started, we had the ‘WellChild book’ and we had the ‘Thriving Under Fives’, and they were beautiful resources but for people—some of the people couldn’t read or write—even in their own language, so we realised that it was a waste of time. A lot of our work is demonstration and asking and speaking slowly. You have to touch, feel, and so it takes us longer to get the knowledge across... (Catherine, 1: 91).

The changing of health behaviours is particularly complex when one cannot communicate in the same language. For instance, explaining the need for more dietary fibre without an interpreter:

...has to be very visual...I had to buy bran from the supermarket... [constipation]...is a huge problem...It is no good saying, ‘look in the cereal section where there is flour, there is bran on the shelf’. You say it looks like this, it is in a packet like this, put some in your hand and this is what you can do with it. You have some water there with the bread mix and you put it in and...that is how I see that work...It is no good some nurse standing up there saying, now you need this in your breakfast...(Jane, 1: 150).

The same difficulties arose when trying to explain the causes of diabetes and the diagnostic tests for high blood sugars:

...by measuring with a glucose stick. What is in a glass of

milk and what is in a glass of Coke...? [It has to be] ...
practical, hands-on and fun ... (Jane, 1: 153).

Acculturation and Patterns of Poor Health

There are indications that poor health in refugee groups on arrival is compounded by lifestyle changes in New Zealand. Poor nutrition patterns are replacing traditional eating habits in refugee groups. For instance:

...\$1.29 for 1.5 litres of Coke is cheap compared to milk
...suddenly dietary problems are very common (Jane, 1: 173).

Often parents wanted to make up for the deprivation that their children had endured in refugee camps by giving them treat foods and drinks. A community health worker found for instance that:

[In one] Somalian family the [infant's] teeth were quite rotten and I asked the father what he was giving the child to drink and he was giving them all the sachets that you make up, loaded with sugar, because he thought we are in New Zealand now and these were treats for his children that had been deprived (Sue, 1: 118).

Community-Led Health Promotion

In the study, the most successful health promotion projects for refugee groups have been those which have been community-led. For instance, a mental health promotion programme for a Burmese group had been introduced to the community as a focus on young people and their issues of integration. However, after a community needs analysis, the health promoter discovered that Burmese women had the greatest adjustment difficulties and therefore she:

...shifted [her] initial objectives of working with teenagers
to working with...women instead (Sarah, 2: 133).

The Burmese women had rejected the idea of a proposed therapy group. They identified that:

...learning conversational English was their main concern to be able to live their lives in the community...another major observation I made was that they are not grieving about their losses...the general consensus was that they were happy to be here, with a lot more hope for their future and their children's future...

They expressed wanting to be involved in physical activity and since the YMCA aquatic centre was nearby, one woman brought up the idea of swimming and then everyone else said they would be keen to learn how to swim as this would keep them active...(Sarah, 2: 199).

The project leader was then:

...faced with finding ways to justify the approach to mental health organisations whose approach to refugee mental health is the mindset of a sickness approach to health [that is to] deal with the mental health issues of "patients" (Sarah, 2: 259).

The swimming class had the added benefit of establishing links with local community members and of improving the women's English language skills. There was so much enthusiasm for the programme that:

...on the day of the first lesson, there was a one hundred per cent turnout. Swimming coaches were also very eager to help these women learn not only to swim but also to learn English along the way. It was a great experience for them to be actively involved in the community doing something physically active... (Sarah, 2: 220).

Ensuring that the project was community focused had meant an intensive involvement with the Burmese women and their day-to-day lives and problems. The time taken by the health promoter had extended:

...very much beyond working hours. It is about having to spend weekend hours socialising with the community, explaining about the health promoter's position and purpose, not just for a project in development but also in life, and also wanting to find out about the individuals in the community and their wishes and needs ... (Sarah, 2: 438).

Similarly, Rose had started a healthy eating programme for refugee communities by spending time getting to know community members and:

...making contact. ... it was really interesting meeting the women and...it's the same feeling I have whenever I have gone and done nutrition work with groups that aren't from my own ethnicity. You have the same approach and it takes time to get comfortable (Rose, 1: 12).

Once trust had been established with community members, health promoters found that communities were:

...very keen to share their culture with you... (Jane, 1: 164).

Increasing the Opportunities for Participation

The health promoters in the study had found that refugee communities wanted to participate in health promotion activities but had had few opportunities to do so. Few health programmes involved refugee groups but when they did, budgets did not cover the costs of interpreting, or of developing culturally and linguistically appropriate health education materials. For this reason the Well Women's Nursing Service, which was

contracted to provide cervical screening for refugee women found that some programmes had failed because:

...we just didn't get anyone on board with that community who had the energy and was prepared to drive it themselves, but you also need to reward that person who has got the energy with money. You can't go in and expect communities to work for nothing (Ruth, 1: 111).

Many participants highlighted the need to employ people from refugee backgrounds in health promotion projects. As a community nutritionist stated there needs to be:

...funding to pay some known and trusted people to become the nutrition experts for the community. Provide training for those people to get out there... (Rose, 1:167).

Frequently, the health promotion programmes that had started up—such as this Afghan women's health group—although successful, were unable to continue as no sustainable funding was available. In the following case, the intention had been that, once established, the child health project would be handed over to an Afghan community health worker to:

...facilitate their own thing...They loved the food and the developmental ones that PAFT (Parents as First Teachers) were coming in and talking about, easy toys to make and that you don't have to have a toy box like that, in order to have a healthy well developed child...(Lisa-May, 1: 31).

To enable refugees to participate in health promotion projects every programme faced:

... issues of transport and costing, funding... (Ruth, 1: 57).

To summarise, universalism is a key aspect of the language of citizenship rights in liberal democratic states. However, despite the appearance of universalism, full social and cultural citizenship requires particularist interventions to facilitate the actual participation of refugee groups in mainstream health promotion programmes (Guerin et al., 2006). In the study, the health promotion programmes that were provided for refugee communities were largely a series of sporadic, short-term, one-off initiatives. Importantly, in this section, projects such as the Burmese women's swimming programme provide a model of health promotion for refugee groups. It is evident that refugee communities participated when health promotion campaigns were community-led, relevant and appropriate to their issues and cultural and religious values.

Overcoming Stigma and Fear

Some areas of health promotion and prevention are particularly sensitive in the context of traditional societies' beliefs regarding the causes of illness and their attitudes towards those with potentially fatal diseases (Nisbet et al., 2007). This section, which is in four parts, discusses culturally acceptable approaches to health promotion and prevention for refugee communities including: tuberculosis and HIV prevention campaigns, mental health promotion and harm reduction campaigns for injecting drug users. There are a number of issues to be considered in health promotion campaigns in the context of the stigma and fear that surrounds these health issues in refugee communities. For example, it was significant that participants commented that in order to engage refugee communities in prevention campaigns, health promoters had had to overcome deep-seated denial and avoidance of these topics. Fear and stigma are natural reactions to infections that can cause chronic debilitating illnesses and fatalities within communities (Alonzo & Reynolds, 1995; Gilmore & Somerville, 1994). In parts of the developing world where there is little treatment available, curable diseases such as tuberculosis are life threatening and the individuals affected are a danger to the community. Once resettled in a new country, stigmatised attitudes towards people with communicable diseases continue even although effective treatment or interventions are available.

Refugee Groups and HIV Prevention Campaigns

In refugee communities stigmatised health issues such as HIV/AIDS carry heavy social consequences for those affected (Lamb, 1999; Martin, Brookes, Cham, Sowe, Khan, Thomas & Hill, 2005; Ministry of Health, 2001d; Worth, Reid, Ackroyd & Tamirate-Bowden, 2001). The fear of life-threatening diseases may manifest themselves in communities as displacement behaviour towards people with HIV infections. This can take the form of scapegoating, shaming and social and physical isolation (Gilmore & Somerville, 1994). For example, the *HIV Futures New Zealand* study found that HIV positive refugees in New Zealand were extremely socially isolated (Grierson, Pitts, Whyte, Misson, Hughes, Saxton & Thomas, 2002). In the study, almost all of the respondents, who were from refugee backgrounds, reported that they spent no time with other HIV positive people and most (93.9%) reported that their doctor was their main source of support (Grierson et al., 2002).

New Zealand prevention campaigns that take a liberal 'safer sex' approach to preventing HIV are unacceptable to many refugee groups (Ministry of Health, 2003c). In the study, an example of a model programme which was culturally and religiously acceptable for refugee communities was the African Refugee Education Programme (AREP) which promoted HIV prevention (Worth, Denholm & Bannister, 2003). The programme was one of the few targeted Ministry of Health funded health promotion campaigns available for refugee communities. The African HIV/AIDS prevention programme was community based and provided an effective model of engagement with ethnic communities and religious leaders. The programme, which was established in 2001, arose out of the rising numbers of HIV positive African refugees in New Zealand and the need for HIV prevention programmes that were acceptable to diverse African peoples (Mills et al., 2002; Worth et al., 2001). The purpose of the programme was to promote safe sexual behaviour including, as appropriate, delaying the onset of sexual activity, practising abstinence, reducing the number of sexual partners and using condoms. The project worked collaboratively with African community leaders and elders to develop culturally appropriate health education resources (Denholm & Birukila, 2001; Worth, Denholm, & Bannister, 2003). In addition to the work of destigmatising attitudes towards people with HIV/AIDS, the project had established community support networks for African people with HIV (Denholm & Birukila, 2001).

The philosophy of the AREP programme director was that health promotion in refugee communities had to be based on:

...community training and interfacing, working closely with the community... There is no alternative other than to use...refugee community leaders and key people themselves to work within the community, otherwise it won't succeed... (Nikki, 1: 63).

It was noted by this participant that New Zealand, compared to other resettlement countries, had responded poorly to the need for culturally appropriate health promotion models for refugee groups:

...You take any country, like Australia, the people that head programmes like what I am doing in New Zealand are African people that have lived there, know the system and know the culture and they also know the African culture and system and so they work really well with interfacing between both, but we simply haven't had that ... (Nikki, 1: 59).

The African Refugee Education Programme had developed a training model called in Kiswahili *Tuelimishane* and in English *Lets Talk Together*. The resource *Tuelimishane* was used by health promoters to facilitate learning in traditional ways—such as the use of story telling, song and dance (Denholm & Birukila, 2001). In total, there were 140 African HIV/AIDS community educators in 40 African communities in New Zealand. In 2005, the project became part of the New Zealand AIDS Foundation which is now funded by the Ministry of Health to provide the African Refugee Education Programme (New Zealand Aids Foundation, 2006).

Refugee Groups and TB Prevention Campaigns

Tuberculosis is a highly stigmatised illness in refugee communities. In the study, a refugee community tuberculosis prevention project had been piloted by public health

nurses in the Communicable Control Disease (CDC) Team of the Auckland Regional Public Health Service. Prior to the TB health prevention programme, the public health nurses had encountered considerable resistance in refugee communities to compliance with TB treatments:

... [The refugees] felt that we were targeting them as having TB and...they didn't feel good about TB, they had a bad image of it (Jill, 1: 74).

The CDC team had decided to approach community leaders in order to resolve these difficulties and the misunderstandings in refugee communities about the purpose of tuberculosis treatment and of contact tracing:

... [The CDC team had decided] to do an education session about TB for the Somalians...because we had so much trouble getting them to consent to having contact tracing. The TB cases were always difficult and we often found that they would default on appointments, they were resentful towards the nurses, both in the hospital and in the community and we had a lot of lack of cooperation really. We had previously had awareness sessions with other ethnic groups which had been successful and we felt that if we heightened the awareness of TB to the Somalian people, that things might improve. That was why we decided to go to the Somalians about it... (Jill, 1: 4).

When a tuberculosis awareness programme was suggested to the Somali community there had been initial resistance to the idea. The CDC team had offered to fund community members to become health educators but:

...although they were all key people in the community, it was stuff that they didn't feel comfortable with and they didn't really want to go and talk to people about it because

of their own perception about TB ... (Jill, 1: 83).

There had been a turning point when an agreement was made between Somali community leaders and the CDC Team that the programme would be left:

...up to the Somalian community to decide how and where and when the funds were actually utilised... (Jill, 1: 31).

The community had decided which people would become trainers and the public health team provided:

...weekend sessions for a whole month. It was basically a whole day each weekend that we would train the trainers so that they could take the message back to the community ... (Jill, 1: 13).

At first, community members were:

...frightened about TB because they didn't know very much about it...I believe that they felt HIV and TB went hand in hand and that it was a death sentence and people didn't want to know about it. Once they actually felt comfortable that TB was okay, they were then ready to engage and to learn. It was probably one of the most successful programmes, even if just the trainers had that knowledge... (Jill, 1: 45).

The Somali community resistance to the acknowledgment of TB as a problem was overcome when public health nurses, in the words of this participant, 'owned' attitudes of denial to:

...TB in our own country, in the fact that people in New Zealand also think that everyone else has got it and we

said to them that that wasn't true and we put it back to them in the context of Somalia, then they actually did admit to us that there were huge signs in Somalia saying about TB and don't spit (Jill, 1: 41).

Through the TB awareness project there was a gradual process of the demystifying and 'normalising' of TB:

...the training was really actually the most amazing awareness that we have done. Basically the first session was turning things around because the participants were put into the context of their own country and we talked a lot in the beginning about TB and TB in Somalia. Originally they said, oh there is no TB, it is everywhere else, other people from other countries have it, but not in Somalia... (Jill, 1: 37).

The project had resulted in marked improvements in the understanding and perceptions of TB disease:

... [The CDC Team] haven't had any trouble from Somalian people since this session...People are very willing to stick out their arm and get pestered and they are very willing to go to the hospital and take their medication and...we still tend to put them on direct observed therapy if [we have]...a case...Their attitude seems to be really different... we don't really know, but even in the hospitals the attitudes are so different. It's great (Jill, 1: 53).

At the completion of the programme, relationships between the CDC Team and the Somali community had improved dramatically:

...[The public health nurses stated that] the nice part of it was that we have actually become known to the participants and they actually greet us like long lost friends and seem to really like us

and it is kind of like, she is okay, and they recognise us as being okay...(Jill, 1: 64).

Refugee Groups and Mental Health Promotion

In another example, New Zealand mental health promotion campaigns that focused on ‘normalising’ mental illness were unacceptable to many refugee groups because, in these cultural and religious contexts, the concept of mental illness carried significant social consequences for the families affected (Disley, 1997; Lamb, 1999; Public Health Group, 1997; Ministry of Health, 1997). Chapter eight discussed the inappropriateness of western constructs of mental health care in the context of refugee communities and the following example of a Burmese women’s mental health project demonstrates this. The mental health promotion project leader working with the Burmese community had realised that:

...Burmese refugees...have faced mental health problems but have not been able to talk about it due to cultural issues; it is not the ‘norm’ to talk about mental health, as mental health is synonymous with being crazy... (Sarah, 2: 20).

The project leader had decided instead to focus on extending her knowledge of:

... so-called mental health issues beyond the diagnosis of psychological symptoms. I wanted to know the types of issues and problems that are faced by refugees who are not mentally “ill” enough to be seeing a psychiatrist, or a psychologist...I have realised that most of the mental health problems faced by the minority refugee communities such as the Burmese community are stresses of assimilation into the community, not being able to speak English and wanting to work but not being able to due to language barriers and not being trained. I learnt this through my focus group interview but mostly I learnt it through chats with the women outside of that formal focus

group environment. I went along to gatherings and other community discussions and it was only through these informal but much more meaningful experiences that I realised what the “real” issues were... (Sarah, 2: 360).

It was only after identifying community attitudes to mental health and identifying the settlement stressors that the Burmese group faced, that a meaningful and acceptable community based intervention strategy was developed (This was the Burmese women’s swimming programme discussed in the previous section).

Refugee Groups and Harm Reduction Campaigns

Illegal behaviours such as injecting drug use are highly stigmatised in New Zealand society in general, in South East Asian communities this practice results in drug users becoming social outcasts (Higgs, Vu & Pham, 2002). A community worker in the study who provided a drug information outreach programme had encountered considerable suspicion and resistance from these communities.

...[I had to] reassure them that we were concerned for their health and wanted to help them but we had nothing to do with any kind of enforcement or police and they may have had that association from their cultural background from what happens in their country...to drug users (Karen, 1: 71).

In this context people working in health services for government agencies were regarded initially with fear and suspicion. The outreach worker had only been able to overcome the drug user’s mistrust by communicating through an interpreter:

... Just chatting amongst themselves in Vietnamese, it came out that they were sharing and so then I gave them the spiel about sharing and about single use and then I asked them if they wanted some syringes and ended up giving them over a period of three or four weeks, three or four hundred syringes (Karen, 1: 243).

The outreach worker had become accepted by providing practical assistance, by being able to identify with the injecting drug culture and by getting to know the community sub culture. She described the process of engagement with this group:

I gave them my card and told them where to come and reassured them that I was a peer as well, that I was part of the community and that I could understand some of their issues and that they could come to the needle exchange and there are no names taken and it is all very safe and friendly and other users worked there and they could get any information they needed, so even though we have reservations about that approach, it turned out to be the only thing that worked...(Karen, 1: 244).

The outreach worker highlighted the importance of finding out:

...more about the cultural side of things, like how do you talk to people that haven't got kiwi culture about drug use, about injecting and about safer injecting. I was aware that there probably were different ways of thinking about all those things, issues maybe of privacy, of shame. I just didn't know anything about that. I have learnt a little bit doing it. The first thing I did was contact Australia because I knew they had a huge influx of Vietnamese into Sydney and Melbourne into the using communities there and that had been for some time and they already had well established outreach projects because there is a lot of street use going on over there...(Karen, 1: 98).

The Drug Information Outreach Service which participated in the study reported that, in Sydney, delivering needle exchange services was by comparison with Auckland:

...easier...When there are people walking up and down the street with backpacks full of syringes on giving out syringes, that is a

kind of easy way to get into talking ... and they have got specific outreach workers, Vietnamese outreach workers... they're paid workers (Karen, 1: 106).

In this section the health promotion programmes that had been successful were those that had been planned with refugee groups.

Cultural Safety

As material in this thesis indicates, New Zealand health promotion approaches are largely culturally and religiously inappropriate for refugee groups. In this section the main issues concern first: as an example, religiously appropriate care for Muslim peoples, second; the development of practice guidelines for culturally competent care for refugee groups; third, the development of linguistically appropriate resources for refugee groups.

Health Promotion and Muslim Communities

According to the census data (Statistics New Zealand, 2002a), between the 1996 and 2001, the number of Muslim peoples living in New Zealand increased by 74 per cent. For many people who practice the Islamic faith, religion has a much more comprehensive role in life than is often typical in non-Muslim western families, and this needs to be addressed in the planning of health care and health promotion programmes (Haq, 2003). Although there are over 35,000 Muslims living in the Auckland region, there are few health promotion resources that are religiously appropriate for Muslim groups. For example, in the study nutritionists were unable to access any material in New Zealand that was appropriate to the dietary requirements of Muslim populations. This was important because there are religious proscriptions that govern the food eaten by Muslim families. Participants reported that including Muslim peoples in the national *Healthy Eating* campaign was challenging because (Ministry of Health, 2003a):

...so much of it isn't relevant...they would choose not to listen to any nutrition, partly because of the Halal diet, so that would be seen as...you wouldn't know if you could eat those foods or not, so it all becomes irrelevant...it needs to be tailored to the group to be even halfway

effective...(Rose, 1: 158).

The foods that are allowed are defined as *halal*. Halal foods include all foods of plant origin and some of animal origin only if they conform to the Muslim religious method of slaughtering (Islamic Council of Queensland, 1996). Lamb, goat, camel, cow and chicken are halal animals when slaughtered in the proper way. The Islamic mode of slaughtering involves two steps, firstly, the mentioning of the name of Allah before beginning the slaughter and secondly, the severing of the throat, the wind pipe and the jugular veins in the neck without cutting the spinal cord. *Haram* or forbidden food and drink include the following; pork, blood, animals not slaughtered in the proper way, alcohol, drugs and foods containing ingredients obtained from other haram foods (International Muslim Association of New Zealand (IMAN), 2001). Muslim families may avoid foods such as commercially prepared baby foods, yoghurt and cheese, as these foods may contain non-halal ingredients such as animal fat, rennet and gelatine. To provide information that was relevant to the dietary requirements of Muslim peoples there needed to be:

...guidelines for a halal diet, translated into the right language just to put nutrition on the agenda really...
(Rose, 1:86).

Guidelines for Health Practitioners for Cultural Care

In the study, health services reported that they had no practice guidelines for culturally competent care for the ethnic minority groups whom they served. Other countries, such as Australia, Canada, the United Kingdom and the United States were important sources of information about the specific cultural care requirements of refugee communities. The following list provides some key examples including, the American *Ethnomed* website; the Australian *Victorian Foundation for Survivors of Torture* website and guidelines (2000); and the *Canadian Cultural Profiles Project* (Citizenship & Immigration, 2006).

The health care workers in the study voiced apprehension about their cultural competence in refugee community settings. When a nutritionist started a programme

with the Somali community she:

...just approached it like I do with other nutrition promotion in other communities and doing sessions but then once you get there...it is just such a different culture, so I was out of my comfort zone ... (Rose, 1: 06).

The health promoters in the study in the case of the *Healthy Eating* programme had been largely reliant on:

...known and trusted people in those communities who have got good nutrition knowledge... (Rose, 1:101).

The development of health resources for refugee groups was generally left to the practitioners who had an interest in refugee groups. The health workers in the study who had undertaken health promotion with refugee communities had carried out needs analyses, literature reviews and community consultations on their own initiative before starting new projects. For instance, to develop a healthy eating programme for Muslim communities, nutritionists had had to:

...go into the internet to find out about food preservatives and things...but there almost needs to be a document for health and nutrition professionals about the halal diet so that if these people are seeing a dietician or a doctor...the health professional understands their diet...a resource would be able to actually educate health professionals and nutrition professionals...so that they understand the typical foods eaten and the requirements of a halal diet... (Rose, 1:117).

In another case, a Plunket nurse had developed a health education programme for Afghan women from research conducted as part of a postgraduate degree:

[She had] done all the research all about the Islamic women, so I called it Afghani Women's Spiritual and Cultural Needs and I started it off...I saw a website on Islam...one of my women found a fantastic article in a magazine and she got that for me, so I just found all this stuff...(Lisa-May, 1: 75).

The Burmese mental health project had been based on the '*people-centred*' health promotion model developed by Raeburn and Rootman (1998, p.1). In this view, health promotion is an intensely personal and human area and should begin from a perspective of people's experience in the context of their everyday community lives. PEOPLE is a mnemonic which stands for *People-centredness, Empowerment, Organisational and Community development, Participation, Life quality and Evaluation* (Raeburn & Rootman, 1998, p.1). Having a sound theoretical framework had been important for this community health worker and equally:

... building trust was the foundation to my project and my approach and this was the other main lesson from the experience. I could not have carried out any of the steps of the PEOPLE system if I had gone in there as someone who wanted to work on them not with them (Sarah, 2: 343).

Well Women's Health Services had found that each programme for refugee groups had needed to be specifically designed according to the group's health beliefs and values, their understanding of the health system and level of formal education:

...you are actually going right back to basics...we have found that we have to have different structured programmes...you might cover 'periods' in one evening and 'cystitis' in one evening and the contraception, child spacing—they don't call it contraception—and we have to make sure that the context is correct for them and that it is

not offensive and we have had to review our teaching tools, so it has been a really slow process... (Ruth, 1: 54).

In some refugee communities, western family planning concepts were unacceptable and needed to be addressed sensitively due to the groups' cultural and religious beliefs and their attitudes to family size (Ministry of Health, 2001d, p.84). In the following example health promoters had found that it was important that communities' taboos around discussing sex and sexuality were respected (Lewis, 1996; Muslim Women's League, 2001):

...the women who came to sessions weren't the younger women, they were adults in their mid twenties onwards, and [the community]...sheltered the younger women from the sessions. But that is fine because that is the way that they will probably teach them, themselves (Ruth, 1: 69).

Linguistically Appropriate Resources

Health educators in the study had found that the adaptation of health promotion resources had required more than simple translation in order to be meaningful to refugee groups. For instance, in some cases such as the following example, when the 'mainstream' messages, such as eat more fruit and vegetables were appropriate:

...There needs to be some sort of recognition of their [refugee groups] special attributes, whether we are talking about the halal issue, which again I don't fully understand but that might restrict their food intake. You need to talk about the sources of protein that they are comfortable with ...so they probably need to have food and nutrition guidelines for a Muslim person following a halal diet because otherwise it is just not going to seem relevant to them. And there is going to be suspicion that what they are saying, will that be okay for me. I only want to eat halal food, so unless they are written from that perspective...

probably the same inherent messages as...written to someone following a Muslim diet... (Rose, 1: 70).

In this example, the health promotion service had successfully employed a Somali woman to coordinate the community education sessions, interpret, develop and translate food messages that were appropriate to the dietary requirements of the Somali group (Auckland District Health Board, 2004b).

In other cases, the messages given—such as encouragement for women to attend regular cervical screening tests were new to refugee groups. In the following example, a women's health educator had found that for African women's groups learning about the importance of cervical smears had meant:

...a lot of work to get them to feel happy about even asking, because it is not in their vocabulary or history, to have smears (Ruth, 1: 65).

The findings of this section relate in practice the conceptual difficulties of applying New Zealand health promotion models to refugee groups. The universal approaches to reducing inequalities in health in New Zealand populations have been shown to overlook refugee groups. In the study, the health promotion campaigns developed for mainstream populations related poorly to the cultures and religions of refugee groups. In order to be effective, health promotion activities had needed to be specifically oriented to the issues and concerns of refugee communities. Health promotion campaigns had been highly successful when they worked as a partnership between health providers and refugee communities. The examples of successful health promotion programmes in the study provide important models for New Zealand health services of culturally responsive approaches to refugee groups.

Conclusion

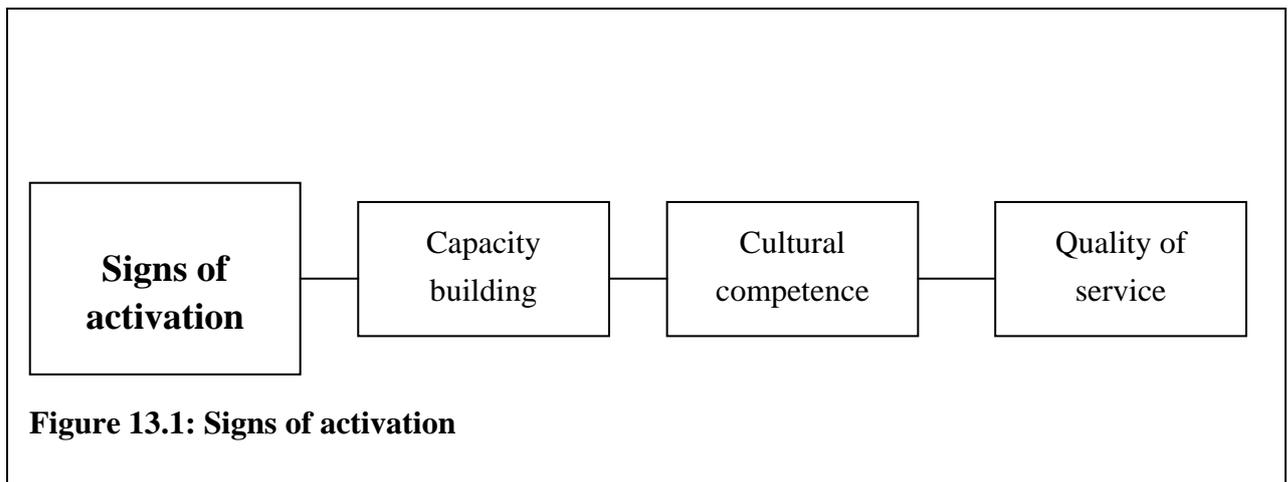
The question raised in this chapter is how to include refugee groups in campaigns to reduce health inequalities in New Zealand. It has been shown that the health sector hinders access to and equal participation in health promotion programmes for refugee

groups. As a result of the multiple informal systemic barriers in the New Zealand health system and of limiting access through culturally determined ways of operating, refugee groups receive only partial services compared to other groups. The examples shown in this chapter demonstrate in practice the systemic biases which, for refugee groups, create a range of burdens, barriers, stigmatisations and exclusions in health and in the other public institutions of the state. Importantly, in this context Kymlicka (1995) has argued for a model of cultural inclusion that involves public measures that are aimed at protecting or promoting ethnocultural recognition for groups such as refugees. The measures include linguistic accommodations, respect for cultural and religious practices and the provision of cultural diversity training in public institutions. Cultural membership for refugee groups in New Zealand society means the provision of the institutional means to recognise and accommodate their diverse cultural identities and practices. In Kymlicka's (2001a, p.32-33) words:

If these interests are ignored or trivialized by the state, then people will feel harmed—and indeed will be harmed—even if their civil, political and welfare rights are respected. If state institutions fail to recognize and respect people's culture and identity, the result could cause serious damage to people's self-respect and sense of agency.

CHAPTER THIRTEEN

SIGNS OF ACTIVATION



Introduction

The thirteenth chapter evaluates the findings of the study in the context of refugee integration in terms of the structures, processes, strategies and activities at ‘top-down’ and ‘bottom-up’ levels of the health sector (Penninx, 2005). The important question posed theoretically and in practice in this chapter is—how far the New Zealand health system is activated? The concept of activation is used in the sense that public institutions are important ‘actors’ in the integration of refugee groups. In this chapter, Penninx’s (2004, p.4) theoretical perspective on the role of institutional ‘*opportunity structures*’ provides a means of analysing refugee participation in the health sector. In this view, public institutions determine the nature and quality of refugee integration through social, cultural, religious and linguistic accommodations. In the study, there are some signs of ‘activation’ in the health sector but the broader question of how far the health system can institutionally accommodate refugee groups will be answered in response to the following series of questions:

- How accessible is the health system for refugees?
and/or

- How far it can be activated in the future?
- How far are refugee groups able to participate in mainstream health structures?
- What is the content of these participatory efforts in terms of the socio-economic/cultural/religious domains of citizenship?
and
- How equitable is participation in terms of the quality of services provided and the social and cultural capacity of services to respond?

Within the themes of ‘capacity building’, ‘cultural competence’ and ‘quality of service’, (shown diagrammatically in Figure 13.1) the ‘signs of activation’ that are present in the health system are demonstrated. There are two main points in this chapter: first, that there are efforts at a local level to meet the needs of refugee groups but this is largely the result of the ‘bottom-up’ efforts of practitioners in front line services. The second point is that the local developments in health care that are occurring have not been integrated at the regional level of District Health Boards and are almost entirely neglected at the central policy level.

Participant Data - Signs of Activation

The following sections combine the analysis of central government and institutional responsiveness to refugee groups in the first half of the thesis, with the data analysis of health service responsiveness in the second half of the thesis. The signs of activation in the New Zealand health system can be understood by studying the interactions between these ‘top-down’ and ‘bottom-up’ processes. The study shows that for refugee groups the health sector has developed responses to local needs and demands in highly specific health care settings which are, typically, poorly resourced. Of interest, are the ‘bottom-up’ led actions by health practitioners and provider organisations to advocate for refugees and to provide services and the ‘top-down’ institutional responses to the issues raised by health providers.

Capacity Building

The importance of state led measures to integrate refugee groups was highlighted in the thesis in chapters four, five and six. At the ‘top-down’ level the health system has been

largely unresponsive to refugee groups. This section demonstrates that without a strategic response at a national level there is little capacity for the health sector to respond regionally to the needs of refugee groups. The targeted service initiatives described in chapters nine to thirteen indicate where there are some opportunity structures for including refugee groups in the health sector. However, overarching state sector led cultural diversity and social policies are needed before there can be a consistent planned approach to health care for refugee groups at a regional level. In the study, there were few signs that health planners and strategists at national and local levels were attempting to grapple with the structurally unequal position of refugees. Problematically, this study shows that while the high health needs of refugee groups are acknowledged at the District Health Board level, the national policy environment gives inconsistent directions on the inclusion of refugees (Auckland District Health Board, 2002a). This section demonstrates that there is a tension between national and local strategic goals and that there is little capacity to respond regionally where needs have been identified.

National Responsiveness

The term ‘capacity building’ refers to the Government’s ‘whole of government’ approach to strengthening community participation in health and social services, particularly those that are hard-to-reach (MSD, 2005b, 2005c). The Labour-led coalition Government elected in 1999, introduced the concept of capacity building as part of the Ministry of Social Development (2001) ‘social development’ approach. The main point in this section in regard to the theme of ‘activation’ is that the New Zealand social development strategy does not focus on institutional responsiveness but rather on organisational capacity in the community and voluntary sector (MSD, 2005b). In other words, returning to the definition of integration given in chapter one, the operation of the social development strategy is a one-way process of integration. A two-way approach to integration would provide a state sector led overarching institutional framework to support responsiveness to cultural diversity and to refugee group inequalities in the public sector.

The ‘social development’ approach applies a conceptual framework for cross-sectoral social policy which aims to reduce social exclusion in New Zealand populations. Health

is nominated as the first of the suggested set of desirable social outcomes for New Zealanders, namely that (Ministry of Social Development, 2001, p.2):

...all people have the opportunity to enjoy long and healthy lives. Avoidable deaths, diseases and injuries are prevented. People have the ability to function, participate and live independently.

However, this outcome is related primarily to economic participation in New Zealand society. The purpose of the goal 'access to health services' is so that, 'people achieve economic independence throughout their working lives' (MSD, 2005b, p.11). The means to achieve this social outcome is to build organisational capacity in the community and voluntary sector by (MSD, 2005b, p.9):

- Supporting individuals, families and communities to develop and deliver their own solutions
- Focusing on the whole package of needs, strengths, and issues for individuals, families and communities
- Taking a whole-of-life perspective
- Government working in partnership with local authorities, with the community and voluntary sector, and with the private sector to develop 'joined-up' local services
- Developing solid evidence about what works and regularly monitoring New Zealander's well-being
- Ensuring there is flexibility to respond to regional and local needs

The Ministry of Social Development capacity building strategy focuses on 'any activity that strengthens the performance of community and voluntary groups' (MSD, 2005c, p.1). The social development approach underpins the *Auckland Regional Settlement Strategy* goals (discussed in chapter five) to improve health and social outcomes for refugee communities (Department of Labour & Auckland Sustainable Cities

Programme, 2007b).

Regional Responsiveness

In the study, there is some limited evidence for District Health Board's regional responsiveness to refugee groups at a strategic level. In 2000, the New Zealand Public Health and Disability Act required the establishment of District Health Boards (DHBs). Subsequently, most Ministry of Health funding has been devolved to the regional District Health Boards (New Zealand Public Health and Disability Act, 2000). The DHBs have the following statutory responsibilities which are to assess population health status, develop strategic and annual plans, consult with their communities and providers and manage resources and service delivery to best meet the needs of the communities in their local districts. However, the inclusion of refugee populations in health services has, in the words of this participant, become even more problematic within the new system of funding allocation because:

... splitting into 21 DHB's... makes it much more difficult for a group like refugees to have an effective voice, because a lot of those resourcing issues are decided at DHB level. And it is very hard to advocate at 21 different levels or even in the Auckland context at three different DHB's. Each one has a different agenda, different motivators. It is hard to know politically where they are at. I guess Auckland, the Auckland region has always been cash strapped in terms of health... (Rob, 1: 95).

Regional District Health Boards are required to conduct health needs assessments for their local populations. For example, the Auckland District Health Board identified the following issues for the refugee groups in their *Strategic Plan 2005-2010* (ADHB, 2005, p.35-36):

- There is a lack of comprehensive demographic data on migrants and refugees. There is limited knowledge of health status and current and future needs. There is a lack

of data to identify where these communities live

- The health needs of migrants and refugees are not recognised in national policy and health strategies. The absence of long-term planning between Ministries at the policy level fragments approaches
- There are few dedicated resources to meet projected increases in the migrant and refugee populations. Available services are not well linked across Auckland between DHBs, PHOs, public health efforts, other government agencies and non-government organisations
- Many refugees and migrants have major and multiple health issues and very high health needs. There is limited planning for long-term management of migrants with disabilities, chronic conditions and high and complex health needs. These issues particularly affect people who have had a refugee experience
- Although the Auckland DHB provider arm provides interpreters for over 155 different languages, there is little or no access to interpreter services within primary health care or other health and support services provided outside the Auckland DHB arm
- Non-English speaking migrants and refugees have limited access to, and knowledge of, primary health services, including disability and mental health services in the community
- There is little information about services and how to access them written in people's own languages. There is limited access to written health promotion and prevention materials
- Health professionals have limited knowledge and skills to provide culturally relevant care for some migrant and refugee groups. There are significant mental health issues within the refugee and migrant communities...

But the Auckland District Health Board has had little capacity to respond to these identified health needs because there were no national policy frameworks or funding available for refugee groups.

The following refugee-focussed service initiatives are important models but are characteristically short-term, small-scale pilots. These services have been developed from the 'bottom-up' that is agencies have identified gaps and advocated for the funding of projects to improve access for refugee groups. One example is 'On TRACC', a transcultural care service for children and young people from refugee backgrounds who have high and complex needs. On TRACC was an intersectoral mental health, education and social service which started in central Auckland in 2003. The development of the programme is significant because it demonstrates the activation points and exclusion zones in the public service sector for refugee groups. On TRACC was a collaborative pilot project funded by the national High and Complex Needs Unit (HCNU, 2005). The On TRACC service brought together relevant health, education and Child Youth and Family services to provide a coordinated and culturally appropriate service for refugee children with severe behaviours, mental health and/or care and protection needs (Manchester, 2004; Shaw et al., 2005). There had been significant barriers to refugee families accessing these services prior to the establishment of On TRACC because (Shaw et al., 2005, p.25):

...the challenge for workers in the various sectors is that the refugee population typically does not fit neatly into one category of referral and their needs spread across a number of services. This can be both challenging for the workers and confusing for the refugees, who have often come from cultures where there is no "service"....

The pilot scheme developed effective service delivery practices for working with refugee families and provided workforce development programmes in health, education and social service sectors in the Auckland region. The On TRACC pilot had been a finalist in the Ministry of Health sponsored New Zealand Health Innovation Awards

(2006), where it was reported that refugee children with problems were now benefiting from an integrated transcultural service in Auckland. An evaluation of the service showed that the benefits for children referred to the service included improved mental health, improved participation and achievement in education and more appropriate management of the care and protection issues for children in refugee families (New Zealand Health Innovation Awards, 2006). The pilot had improved the responsiveness of the participating government agencies to refugee groups. However, funding for the pilot was discontinued in September 2006 and the service was closed.

Another regional approach and an important strategic development was the launch in 2007 of the cabinet approved *Auckland Regional Settlement Strategy, Phase 2 Auckland Settlement Action Plan* led by the Department of Labour (Department of Labour & Auckland Sustainable Cities Programme, 2007a). The strategy is a pilot for the national *Immigration Settlement Strategy* ‘whole of government approach’ which was discussed in chapter five. The action plan sets out what will be done in the Auckland region in the priority areas identified in the strategy, including improvements to on-arrival settlement services, employment, ESOL, health, education, housing, local government responsiveness and ethnic policy development. However, the new policy framework is jeopardised by too narrow a focus on economic citizenship. The connotation of substantive citizenship in the *Auckland Regional Settlement Strategy’s* vision is of inclusion in employment, without equal emphasis on the exercise of social, cultural and political rights.

The policy framework for the Department of Labour led regional *Auckland Regional Settlement Strategy* is premised on a notion of social exclusion which stresses labour market integration as a precondition for ‘social cohesion’ (Department of Labour & Ministry of Social Development, 2003). In this context the social policy links between economic disadvantage and cultural exclusion for groups such as refugees are not recognised. Good health and access to health care are highlighted as important settlement outcomes but primarily in the context of refugee and migrant group’s ‘economic contributions to the wider community’ (Department of Labour & Auckland Sustainable Cities Programme, 2007b, p.2). This is demonstrated clearly in the vision of the *Auckland Regional Settlement Strategy* which follows (Department of Labour &

Auckland Sustainable Cities Programme, 2007, p.2):

Migrants, refugees and their families have a sense of belonging through opportunities to fully participate and contribute economically and socially in the Auckland Region; and by being recognised and respected as equal and valued New Zealanders.

Chapter five considered the whole of government strategy in the context of settlement outcomes for refugee groups in New Zealand. The conclusions drawn were that the approach is conceptually limited in the sense that it offers a one-way framework for managing settlement rather than a systemic approach to integrating refugee groups. Further, the *Auckland Regional Settlement Strategy* is an eighteen month pilot. Significantly, studies of whole-of-government approaches in Australia and New Zealand have demonstrated that the benefits of these approaches dissipate due to turf tensions, differing inter-agency expectations and a lack of clarification of critical tasks or a sense of mission (Humpage, 2005). These studies show that strong central government leadership is 'vital to ensuring that the necessary cultural, structural and accountability shifts are made to support a whole-of-government approach' (Humpage, 2005, p.55). Ultimately, 'top-down' activation from the state sector is needed before public institutions can become socially and culturally responsive to refugee groups.

Cultural Competence

Kymlicka's (2001a) model of multicultural citizenship, discussed in chapter four, offers a rationale for how and why groups such as refugees should be culturally recognised by the state and its institutions. Accommodating the distinctive identities and needs of refugee groups is a means of ensuring equitable access to public services and their integration into the state and its institutions. Kymlicka (2001a) argues that immigrant minority rights are best represented within specific multiculturalism policies, for example, mandating cultural diversity training for health care workers and providing interpreting services to all health care providers. In this section, examples are given, from the few available, of the cultural accommodations that are occurring that indicate potential openings for wider responsiveness in the health sector.

National Responsiveness

The first example given is a resource book produced by the Ministry of Health (2001), *Refugee Health care: A Handbook for Health Professionals* which defines the components of effective care for refugees. The book begins (Ministry of Health, 2001c, p.i):

Providing effective refugee health care involves...

- Understanding the ‘refugee experience’
- Recognising the physical, psychological and emotional sequelae associated with the refugee experience
- Learning about clients’ religious and cultural backgrounds and the communities in which they live, so as to provide safe, culturally appropriate care
- Enhancing holistic care and continuity of care through a team approach; for example, working together with other health professionals and services, refugee support agencies, and ethnic associations
- Empowering refugee clients to take responsibility for their own health. This requires a proactive approach, for example:
 - offering health education
 - seeking community solutions to community problems
 - capitalising on the many skills within ethnic groups

There were no other examples available at a national level of responsiveness to cultural diversity in health care.

Regional Responsiveness

The following examples show that some services have developed the capacity to respond culturally to refugee groups. However, these examples are characteristically discrete, service-led initiatives in local areas. For example, the Auckland District Health

Board Community Mental Health Service had set up an adult Transcultural Mental Health Service (ADHB, 2004a). The service principles stated that (ADHB, 2004a):

- This service is for clients from a refugee or migrant background who have a mental illness AND significant trans-cultural issues that impact on their ability to access or participate in the clinical mental health service.
- All clinical staff should possess the necessary skills to work effectively with clients who have cultural backgrounds other than their own. The trans-cultural team will provide clinical services to clients with significant cultural issues that impact on their ability to access mental health services and act as a consultation resource to clinical staff within the CMHC teams ...

In the study, although individual services recognised the need for cultural responsiveness to refugee groups, there was no consistent response nationally, or regionally, in terms of workforce development and training programmes. For instance, the Waitemata District Health Board as an:

...organisation has made a huge commitment to... diversity training...We all have to go, all managers have to attend... (Mary, 1: 266).

However, Auckland and Counties Manukau District Health Boards did not provide the same cultural diversity training for their workforce.

In another example, a Ministry of Health initiative to improve access to mental health care for hard-to-reach populations, DHBs had funded a number of primary mental health projects in Primary Health Organisations. The aim of this funding was to assist PHOs in (Ministry of Health, 2001a, p. 21):

- developing activities to reduce the prevalence and

impact of mental health problems on their enrolled population, specifically education, prevention, early intervention and treatment activities

- developing the skill mix of primary health care practitioners and their ability to respond effectively to the majority of mental health problems that can be managed in primary health settings ...

In practice Primary Health Organisations reported that they had only been able to provide limited primary mental health care for refugee groups because there was:

...very little in the way of education for practitioners in terms of refugee health and what has been the experiences of others and how do you do it well. To a certain extent we have been developing it as we go along, based on, if we do it one way and it works we keep doing it...it doesn't work and then you try something else. It is a bit of an ad hoc approach but there needs to be some continuing education around that... (Kate 1: 164).

In other examples some health services had recognised the value of employing people from refugee backgrounds to provide support for refugee families. For example, the Auckland District Health Board (2002b) Community Child Health and Disability Service (CCH&Ds) had employed three refugee community health workers to specifically address the needs of refugee families and communities. The CCH&D services included early childhood, child development, child and youth, nutrition, social work and child disability care teams (ADHB, 2002b). The service reported significant improvements in the acceptability of the service to refugee families as demonstrated by these comments from one Public Health nurse:

...I think it has made a huge difference in terms of the fact that the communities are much more willing to be honest and open and I think it has meant that someone has been

working that is one of them, been there, done that and really knows how it feels... It has been good... (Jill, 1: 100).

Other services, reported that having refugee community health workers had made a marked difference in responding to refugee families so that:

... if it was social issues, that was best handled by C [a refugee community health worker]. If it was a child and family issue, I would refer it to the nurses down the road, so that they could coordinate their refugee workers...if it was an issue that they needed to deal with, they could deal with it... (Jill, 1: 91).

A key component in the integration of refugee groups in the health sector is ensuring that health services are culturally responsive. While the study found a few examples of cultural competency training programmes for health workers that were specific to working with refugee groups these were not supported by an overall policy framework for managing cultural diversity in the health sector. Although the *Ethnic Perspectives in Policy Framework* (OEA, 2002b) offer a model for cultural responsiveness there was no indication in the study that cultural diversity was valued in the health sector. Further, there was little evidence to justify the view that the health system was taking any significant steps to recognise culturally and linguistically diverse peoples in workforce policy.

Quality of Service

Monitoring and Evaluating Service Provision

In the study, the 'quality of service' received by refugees in the health sector was poor and inequitable compared to the services given to other groups. A framework for monitoring and evaluating service provision for culturally diverse groups was found to be needed to ensure 'quality of service' in the health sector. Participants reported that there was no monitoring of health contracts to ensure that services were providing

adequate care for refugee groups. For example, in the following case a Child and Family health service was contracted specifically to work with:

...refugees and migrants. It is actually stated in the contract that we work with those groups of people ...
(Mary, 1: 03).

However, the service was not expected to monitor or report on the services delivered to refugees. As the manager of the service said:

...we don't report on anything specifically, other than population stuff, like immunisation status, how many children are immunised...and then we collect Maori, Pacific and Other... (Mary, 1: 17).

In most cases, workers in the health services interviewed did not have the capacity to provide targeted programmes for refugee communities. Typically, the services provided to refugee groups were those that were available to all groups. Most providers like this Child and Family health service did not:

...have any service that is specifically directed to refugee clients
...We have a nurse within our service, that I send off to all the refugee training programmes that are on or whatever and feed back to the whole group. Basically, other than accepting referrals like we would for anyone else, there is nothing else that is done except using the obvious things like translators when we need to... (Mary, 1: 29).

Service Planning

The quality of information available to inform health providers about refugee population health issues was also poor. For example, in the case of the Ministry of Health (2003a) *Healthy Eating Healthy Action* strategy—a national programme to improve nutrition and physical activity—it was acknowledged that refugees were an

increasing group that needed specific consideration in health promotion programmes. The *Healthy Eating Healthy Action* strategy cited an increase of 33 per cent of people born overseas between 1991 and 2001, the biggest increases came from people from North-East Africa, sub-Saharan Africa, North Africa–Middle East and Southern–Central Asia (Ministry of Health, 2003a, p.13). The strategy noted that, of the limited reliable data available, surveys showed that the health status of smaller ethnic groups compared poorly with Maori, European, and Pacific peoples (Ministry of Health, 2003). Language, comprehension and cultural differences were cited to be the main barriers to the dissemination of health information to ethnic minority groups (Ministry of Health, 2003a). The Ministry of Health recommendations were that the design and delivery of nutrition programmes should be appropriate for groups from culturally diverse backgrounds. However, in practice, the community nutritionists interviewed found that providing healthy eating programmes for refugee groups:

...in the absence of research and the absence of a proper needs assessment...in all areas and a mandate from our funding... [or] from the communities, it is fuzzy... (Rose, 1:250).

The nutritionists interviewed questioned the quality of programmes being delivered to refugee groups:

...how effective you can be... [having] to tag on to existing programmes without the ability to do a proper evaluation. And I guess it might not feel that you are making a difference, that anyone is getting any nutritional information but you have to start somewhere and in a few years down the track you just might have gleaned a bit of information and people might just be starting to...it is probably worth while from that perspective as a starting point... (Rose, 1: 34).

The manager of a women's health service summarised the challenges that providers

faced in maintaining targeted health programmes for refugee women in the following quotation:

... it is not good enough that we haven't got a format. You are on a wing and a prayer for them. It is totally insufficient and you really feel torn as a health promoter and a manager, by your ethics of how much you can give them, you can't promise them anything and it doesn't feel right sometimes but you are better giving them something and getting them started than giving them nothing, hoping things will develop for them. Sometimes you have got to be really careful that you are not leading them up...that they are things that you can't carry on with (Ruth, 1: 281).

Because health service managers were not required to monitor or to report on health outcomes for refugee groups in their contracts they were overlooked as groups with high health needs. Without information on health service utilisation and health outcomes for refugee groups there was no means of evaluating service provision, or of planning services for refugees. The services interviewed stated that there would be no change until there was certainty that:

... people [are] actually...collecting the data... (Mary, 1: 272).

To summarise the findings of this chapter, in total there were very few health programmes in the Auckland region targeted to refugee groups. Those that had been developed were generally one-off, short-term, or pilot projects. These services had been the result of health workers identifying gaps in services at a local level. There was little evidence at a national level of any overall programme for the integration of refugee populations in health policy or strategy. The data available in the study did not allow for the assessment of health outcomes for refugee groups. Significantly, what the study did show was the sustained local efforts by front-line practitioners to 'activate' the health sector to respond to refugee groups despite the lack of national direction. The examples

of culturally responsive services given in the study represent some important models of inclusion for refugee groups in the health sector. This evidence of activation from below gives further impetus to the need for an overarching framework for managing cultural diversity at a national level in health and the other public service sectors. To answer directly each of the questions that were posed at the beginning of this chapter:

- How accessible is the health system for refugees?

Refugee groups are eligible for all publicly provided health services but New Zealand health services are not readily accessible to refugee groups. Largely, health service providers are unable to accommodate the psycho-social, cultural, religious and in some cases linguistic diversity of refugee groups. In the last decade the New Zealand health system has shown some signs of cultural and linguistic responsiveness but in general it remains substantially ‘closed’ in terms of the overall systemic integration of refugee groups.

- How far it can be activated in the future?

How far the health system can be activated in the future will depend on how and when the state sector and its institutions incorporate cultural diversity and social policy frameworks that are inclusive of refugee groups.

- How far are refugee groups able to participate in mainstream health structures?

Using Samer’s (1998) definition of social exclusion (discussed in chapter one), refugee groups—while entitled to publicly provided health services—remain substantively, materially and discursively overlooked in the health sector.

- What is the content of these participatory efforts in terms of the socio-economic/cultural/religious domains of citizenship?

How far refugee groups are able to participate as socio-economic, cultural and religious citizens in health and other public sectors in the future will depend on state sector

leadership and institutional responsiveness to the systemic integration of refugee groups.

- How equitable is participation in terms of the quality of services provided and the social and cultural capacity of services to respond?

The quality of services provided for refugee groups in New Zealand is poor and there is little capacity for the health sector to respond socially or culturally to refugee groups.

Conclusion

This chapter concludes the five data analysis chapters. The main finding of the analysis of participant interviews is that refugees are overlooked as social and cultural citizens in the health sector. Significantly though, there has been some strategic response from District Health Boards but little direction at a national level. In the case of national strategies of inclusion, such as *The Auckland Regional Settlement Strategy* and the *Ethnic Perspectives in Policy*, there is conflict with the social policy and population health priorities identified by the Ministry of Health. In this context at an institutional level there is ambiguity and conflict surrounding the integration of refugee groups in the public service sector.

In the study, the signs of activation in the New Zealand health system are limited. The examples given in the data analysis chapters indicate that in areas such as mental health there is some responsiveness but that overall the ‘opportunity structures’ in the health sector are restricted. The refugee health services that were available had developed in response to health providers identifying health needs and initiating specific projects to address these locally. Many such projects had been funded through voluntary fundraising, charitable grants, or out of baseline health agency budgets. These activities are significant as they signal some potential openings in the health structure for accommodating cultural diversity. However, what is lacking is an overarching response to cultural diversity that sets general frameworks and rules for the operation of the health system and makes instruments and resources available to carry out this work.

A conceptual reformulation of the universal provision of publicly provided health care

is needed which will encompass the particular provisions for refugee groups that have been discussed. Returning to the fundamental question that was posed in chapter four —‘how basic democratic values can and should be combined with cultural and religious diversity on the one hand and socio-economic inequality on the other?’ (Penninx, 2000, p.4) —this thesis has taken the view that, in addition to state led policies for managing cultural diversity, the concept of social citizenry for refugee groups needs revision in New Zealand. In the theoretical framework for integration that was proposed in chapter four, substantive citizenship is viewed in the broadest sense of full social, political, economic, cultural and religious rights. The public institutions of the nation-state have a key role in accommodating membership rights in these domains. The integration framework that has been put forward emphasises the importance of the cultural, religious and linguistic rights of citizenship as they form the basis of a two-way integration process for refugee groups (Kymlicka, 2001a; Penninx, 2000, 2004).

In chapter fourteen conclusions are drawn from the study by combining the intersecting theoretical strands with the research findings that have been discussed in chapters nine to thirteen. Some possible directions and opportunities, highlighted by the study, are indicated for the development of a more inclusive health system in New Zealand.

CHAPTER FOURTEEN

CONCLUSIONS

Introduction

The purpose of this thesis has been to examine the interaction between refugee resettlement, integration and social policy in New Zealand in the context of the theoretical debates about the nature of citizenship in receiving societies. Because New Zealand refugee policy specifically prioritises refugees with high health and social needs, the research has focused primarily on integration in the health system. In the study, I have sought to develop a critical analysis of the interplay between refugee and social policy and the processes of integration/exclusion in the institutions of health, education, income support and the labour market. International studies of social, educational and employment outcomes for immigrant groups show that receiving societies' integration and social policies impact on long-term settlement outcomes (Banting & Kymlicka, 2003; Castles et al.,2002; Jean, 2006; Lemaitre, 2006; Schierup et al.,2006; Zetter et al.,2002). However, few studies have focused specifically on refugee integration and no previous studies have related New Zealand refugee policy, institutional frameworks and social policy to settlement outcomes.

The concluding chapter is organised around the three central dimensions of the thesis which are the theory, the method used in the study and the social policy implications of the findings for the integration of refugees in New Zealand society. The first section will address the key theoretical questions in the thesis and how these both informed and were informed by the study. Importantly, the research undertaken suggests some new questions to be considered for future theoretical work in the area of refugee integration in receiving societies. In the second section, a brief overview is given of the key methodological issues raised by the study. In the last section, the implications of the study for future New Zealand social policy and practice are outlined.

Sociology from a Critical Perspective

This study has given me the opportunity to reflect on the practice of sociological critique, in particular, in the fields of postcolonialism, migration and refugee studies.

Refugees as a group pose particular challenges to theories of immigrant integration. As a reminder of the discussion in chapter one, integration has been defined in this thesis as a two-way process between refugees and receiving societies. However, refugees are unequal partners in the integration process as the receiving society and its institutional structures will determine long-term settlement outcomes for refugee groups. The relationship between refugee groups and receiving societies is a complex one. Refugees are a politicised group and, in the context of politics and policy-making, governments are often unresponsive to issues related to refugee settlement due to anti-immigration electoral pressures (Bauböck, 2002, 2005a; Penninx, 2004).

The liberal democratic perspectives on substantive citizenship discussed in chapter four are central to the study of refugee integration (Bauböck, 2004, 2005b; Kymlicka, 2001a; Penninx, 2000, 2004; Schierup et al., 2006; Young, 1998). Kymlicka's (2001a) model of immigrant multiculturalism provides a framework for the types of cultural and religious rights that underpin access to social rights for refugees. But it has been argued in this thesis that immigrant multiculturalism perspectives have paid insufficient attention to the significantly disadvantaged position of refugees in receiving societies (Bauböck, 1996b; Kymlicka, 2001a, 2001b; Taylor, 1994; Tully, 1995). For refugees to participate as full members of society, conceptions of citizenship that recognise cultural diversity cannot be isolated from frameworks to remove social and economic inequalities. To what extent there is long-term social and economic participation by refugee groups will depend on appropriate structures and processes in the public institutions and on equitable access to services. The institutional framework of the receiving society can therefore be viewed as a starting point for the social, cultural and economic integration for refugee groups (Penninx, 2004). The question raised in this study is: how far are New Zealand's public institutional frameworks open for participation by refugee groups, or are able to be activated in the course of time? The theoretical approach taken focuses on the institutional 'opportunity structures' that are available for refugee group membership in the social, economic, and cultural domains of New Zealand society. In this context the role of central government in New Zealand in providing leadership through institutional reform and inclusive social policy was highlighted in chapters five and six in this thesis.

There are patterns of long-term social and economic exclusion occurring in refugee groups in all receiving societies (Council of Europe, 2004). New Zealand and international studies have highlighted the risks to social cohesion when social disparities between groups, such as refugees and others in society, are excessive or tending to increase (Papillon, 2002; Penninx, 2003b; Schierup et al., 2006; Spoonley et al., 2005). In chapter one, social exclusion was defined as the substantial negation of the right and ability of refugee groups to participate as full members of the receiving society (Samers, 1998; Schierup et al., 2006). Samer's (1998) concept of social exclusion which links discursive processes to material exclusions was utilised in the study to analyse the multiple barriers to refugee participation in the social, cultural, religious and economic domains of society. In this context, New Zealand society has offered a unique setting for studying the possibilities of social, cultural and economic rights for refugee groups. First, we have a set of historic and social circumstances which differentiate us from other refugee resettlement countries. In chapter two, the historic precedents which have continued to underpin the selection criteria for refugee selection to New Zealand were discussed. After World War II the New Zealand Government—while offering markedly fewer places for resettlement compared to counterparts Australia and Canada—were by comparison more humanitarian in its selection processes (Beaglehole, 1988; Belich, 2001; McKinnon, 1993). Notably, successive New Zealand Governments, since the 1959 Labour Government, have not restricted the entry of those with medical conditions or disabilities (Department of Labour, 1994; UNHCR, 1959).

Second, New Zealand is also unique in the sense that although we have followed similar trends in immigration policies to those of Australia and Canada (but thirty years later), the Government has not adopted similar policy frameworks for immigrant integration such as official multiculturalism policies (Canadian *Multiculturalism Act*, 1988; Kymlicka, 2001a, 2001b; Pearson, 2001b). As this study has shown, the state sector and the public service sector in New Zealand do not have a framework for cultural accommodation for groups such as refugees of the type outlined in the official multiculturalism policies of the Canadian and Australian Governments (Banting & Kymlicka, 2003; Hiebert et al., 2003; Kymlicka, 2001a; 2001b). I have argued that institutional structures and social policy in New Zealand overlooks refugee groups as social and cultural members of society.

Third, the neo-liberal arguments used to advance radical changes to immigration policies from 1987 onwards subjected refugees, who had been resettled on humanitarian grounds, to adverse political and public pressure. The changes to immigration policy were designed to stimulate New Zealand's declining economic growth by attracting business and skilled migrants and in this environment, refugees were targeted by anti-immigrant political parties as being a drain on the welfare system. Chapters one and two outlined the comprehensive review of the Refugee Quota Programme in 1987 which for the first time committed New Zealand to accepting an annual quota of 800 (later reduced to 750) places, reserved for the most vulnerable refugees (Department of Labour, 1994). The profile of refugees resettled from the time of the review onwards has been characterised by new and diverse ethnic groups and by more complex health and social issues that require specialised interventions.

The fourth circumstance is that the neo-liberal arguments were also used to reform public institutions and social policy. From 1987 onwards, radical market-led reform in the public sector limited state provision of health care, education, housing and income support. There has been a partial return to state provision of these social services since 1999 with the return of the Labour-led coalition, a social democratic government (Cheyne et al., 2004). However, the reduction of service provision in health, housing, welfare and education, has had a long-term impact on the integration of refugees and particularly in regard to their participation in the labour market (Fisk, 2003; NZIS, 2004b). Ultimately, the answer to the problem of refugee integration in New Zealand society lies in a citizenship model that introduces, within a bicultural context, a framework for social, economic and cultural membership for refugee groups. To maintain a sustainable commitment to the refugee resettlement policy put in place in 1987, there will need to be leadership from government in defining the policy goals for long-term integration and the setting of strategic priorities to correspond with the specific situation and needs of refugee groups.

Methodological Issues

The study that informs this thesis relies on a multimethod approach. The methodological strategy of bricolage was applied to the research as confrontation with difference and diversity is basic to the concept (Kincheloe & McLaren, 2005). The role

of the bricoleur, as they discern new topics to be researched, is to reshape research methods and interpretive strategies. In this study, a variety of empirical materials have been used, including the following: the findings of quantitative and qualitative research studies; historical materials; social policy; interviews and personal observations. A deductive approach was taken to analysing data in the design of the study. This approach was indicated, as the area was well known to the researcher and the theories of citizenship and of integration/social exclusion were well delineated as underpinning concepts. In the study the process of data analysis took an explanatory stance based on the multiple comparable cases presented in the research.

The chief concern in this study was with just social change for refugee groups in New Zealand. In the thesis the macro-dynamics of structural forces that are identified in the first section of the thesis (chapters one to eight) are connected to the experiences of health care workers with refugees in the second section of the thesis (chapters nine to fourteen). The method of analysis used in the study, critical hermeneutics, connects the everyday issues that health practitioners face in health care settings, to institutional power structures and the rights of refugee groups to social and cultural citizenship. The concepts of substantive citizenship and its negative social exclusion, informed an understanding of the hidden structures and tacit social and cultural dynamics that circumscribe refugee membership in New Zealand society.

In the first section of the thesis there were analytical challenges related to gaps in the ethnic data for refugee groups in New Zealand health and social reports. In this context, the use of quantitative measurement is essential for policy analysts and governments to determine long-term trends and patterns of refugee settlement outcomes. Changes made to Statistics New Zealand ethnicity data collection coding systems between 2001 and 2006 mean that the demographic data on the refugee groups was unreliable. Consistent and accurate baseline data on refugee groups in regard to income support, educational performance, employment and health status was not available in Government reports. Therefore, the analysis in the study was reliant on the small-scale, one-off, studies and the limited data sets that were available.

In the second section of the thesis, the structural processes identified during the data

analysis of participant interviews provided the logic for applying Penninx's (2000, 2004) model of integration and Samers (1998) theoretical critique of social exclusion to the health system in New Zealand. The data analysis chapters were organised around five interlinking processes that related to the integration/social exclusion of refugees in the health system. Significantly there are some signs of activation in the health system, largely at a regional level, which indicate that measures are being introduced to provide a structural framework for refugee integration. These processes were mapped diagrammatically in Figure 9.1: 'Social and Cultural Citizenship Rights for Refugees in New Zealand Health Services'.

The Policy and Practice Implications of the Study

In this section, there are four subsections: refugee integration policy; the implications for practice; specific issues for health care; and suggestions on future directions for research on refugee integration in New Zealand. I have argued in this thesis that there has been insufficient alignment between refugee selection policies, integration policies and social policies in New Zealand. In substantive terms, the legal rights of citizenship afforded refugee groups have yet to be accompanied by determined social policy measures and an expanded commitment to social equality to ensure that there is access to social, cultural and economic membership. This section addresses the implications of harmonising refugee policy with coherent long-term refugee integration and social policy.

It is acknowledged in the study that there are many actors involved in the integration process including: refugee communities; the non-governmental sector and civil society; the New Zealand Government and its institutions. It has been argued that what matters most for long-term integration are effective institutional responses, particularly in the public sector. The greatest attention in the study has been focused on the institutional level; as institutional arrangements determine to a great extent the opportunities for action for individuals, communities, refugee and non governmental organisations (Penninx, 2004).

Refugee Integration Policy

While there is formal access to health and welfare systems in New Zealand, in practice

refugee social and cultural rights are limited by inequitable access and poor quality service provision. New Zealand institutions have potentially 'open' opportunity structures capable of accommodating social, cultural and linguistic diversity. For instance, there are signs of 'activation' in the health system but mainly from the 'bottom up' efforts of practitioners in 'front-line' services, rather than the 'top-down' leadership which is needed to address long-term institutional change.

Refugee integration policies are part of the institutional arrangements in the receiving society. Such policies need to be reflected in national social policies. The integration of second generation refugee groups is dependent on the effectiveness of integration policies for the first generation. In this context, refugee integration in the economic and social policy domains of the labour market, education, housing, and health is a high priority. The development of an overarching cultural diversity policy is essential to participation in these key institutions of integration. However, the forms that such cultural accommodations take are strongly dependent on the New Zealand's historic and bicultural institutional arrangements and on the political willingness to become more inclusive over time.

The study has shown that there are lessons to be learned from the experiences of other resettlement countries in regard to policies to promote the long-term integration of refugee groups. Some good examples of these are: Canadian language policies and multiculturalism policies (Kymlicka, 2001a; Mahtani, 2001; Mahtani, & Mountz, 2002); Danish labour market integration policies (Bassanini & Duval, 2006; Kvist, & Jæger, 2004); and Australian preschool and school educational policies for culturally and linguistically diverse groups (Machin, 2006). The usefulness of, for instance, the Canadian language policy is in the guiding of language developments in the preschool, school, tertiary and employment sectors in a way that is consistent with a national policy on language. Kymlicka (2001a) gives sound evidence for the success of Canadian multiculturalism policies according to the criteria that should matter: peace, democracy, individual freedom, economic integration and inter-group equality. In the context of labour market integration, chapter four demonstrated that Danish active labour market policies had been relatively successful for the long-term economic integration of some, although not all refugee groups (Husted et al., 2000). Machin

(2006) and Schleicher (2006), in comparative studies of OECD countries give evidence that in Australia and Canada the performance gaps for second-generation refugee and migrant students are significantly reduced compared to those observed for first-generation students. This is related to well-established language support programmes with relatively clearly defined goals and standards (Schleicher, 2006) and to the provision of programmes targeted to pre-school children from disadvantaged backgrounds (Machin, 2006).

The responses of central government and its institutions to refugees are instrumental in structuring integration in social, economic, and cultural citizenship domains (Penninx, 2004). This study shows that leadership from central government for a framework for long-term integration is lacking in New Zealand. Our public institutions reflect our colonialist past through modes of operation, which have historically excluded cultural, religious and linguistic diversity. There is little responsiveness institutionally to the diversity of refugee groups or to their specific social/psychological circumstances. Refugee groups are not incorporated into social policies as high priority groups. It is suggested that membership for refugee groups can be substantially improved through social, cultural and linguistic accommodations in public institutions, equitable access to the labour market and integration into all social policy.

The Implications for Practice

Refugee Settlement Policies and Practice

In New Zealand, governmental responses to refugee resettlement policies and practices have been ad hoc, reactive and piecemeal by comparison with the more explicit and proactive settlement, language, labour market and ESOL policies of other resettlement countries such as Canada and Australia. Further, these 'classical' immigration countries have applied multiculturalism policies to their institutional settings in order to accommodate the social, cultural and linguistic diversity of the refugee peoples that they have resettled. In New Zealand, refugees are overlooked in national social policy concerning labour market, social development, and the reduction of inequalities. In this context, a social well-being framework that is inclusive of refugee groups has yet to be addressed in social policy.

The Department of Labour national and regional *Immigration Settlement Strategies* are an insufficient response to the long-term integration of refugee groups in New Zealand. Instead, sustainable, pro-active, comprehensive policies of integration will need to be promoted by central government and implemented through the institutional frameworks of the New Zealand public sector. Penninx (2004, p.3) suggests the following logic for integration policies: policy should be supported by evidence-based studies of the processes of integration and/or exclusion for refugee groups in the receiving society in question; national social policy should be informed by ‘a clear idea with which instruments it can possibly intervene, in which part of the process, at what particular moment’. Integration frameworks need to recognise that it is social policy that steers integration processes and that both integration and social policy will need to be linked in order to achieve a coordinated response across government sectors.

Statistical Data Gathering

In chapter seven it was demonstrated that the ethnic data collection systems used in health care do not consistently monitor or report on health outcomes for ethnic minority groups in New Zealand. The inherent discrepancies and oversights in New Zealand ethnic data collection systems have social policy impacts for refugee groups. For example, Ministry of Health (2002f) population-based and capitation-based funding formula systems for calculating funding for population health needs apply only to a limited set of qualifying conditions for ethnic inclusion. In the health sector in ethnic data sets, refugees are classified as ‘Other’, which is a composite ethnic group made up of European, Asian, Middle Eastern, African, and Latin American groups (Statistics New Zealand, 2006). The groups in this category do not qualify for additional health funding on the basis of health need although studies show refugee groups to have patterns of poor health similar to those of Pacific peoples (Solomon, 1993, 1995, 1997, 1999).

The Ministry of Health (2004d) has recommended that there have been improvements to ethnic data collection systems and to monitoring the impact of ethnic inequalities in health. The recommendations are that appropriate statistical methods should be developed to better understand the interaction of age, gender, ethnicity, socioeconomic position and region in generating health inequalities. This statistical information, if

inclusive of refugee groups, could provide reliable ethnic data about the health status of refugee groups in New Zealand.

Specific Policy Requirements

The logical outcome of the findings of the study is to inform the development of specific policies that represent more inclusive terms of integration for refugees than are available at present in New Zealand.

1. Long-Term Settlement Support

Settlement support in New Zealand is too short and too little. There needs to be a long-term investment in specific refugee settlement services to counter long-term patterns of social and economic exclusion. The types of long-term integration support to be included in settlement programmes are intensive language training, job training services and employment assistance. In this respect, New Zealand could gain from the adoption of Australian and Canadian models of work-based language instruction to improve English-language skills once people are in employment (Citizenship and Immigration Canada, 2000; White et al., 2002).

Language policies are a critical element in both social and cultural domains: that is, the ability to access publicly provided services in one's mother tongue and the ability to maintain one's language in first, second and successive generations. The formation of language policies that include bilingual education beginning in early childhood are particularly important (May, 2001). There is clear evidence that this leads to greater educational achievement for refugee children (Machin, 2006).

2. Institutional Reform

Refugee groups need institutional accommodations. To summarise the kinds of institutional reforms that would support long-term integration in New Zealand there are lessons to be learned from the Canadian agenda for maintaining social cohesion and the inclusion of new comers (Jenson, 2001a, 2001b, 2001c; Papillon, 2002): that is, service delivery should be through publicly provided services; central government should demonstrate leadership in achieving social goals for refugee integration and apply these consistently across the key institutions of integration, health, education, welfare and employment; these institutions need to have the capacity to accommodate the cultural,

religious, and linguistic diversity of refugee groups (Jenson, 2001b).

Specific Issues for Health Care

Health rights are particularly important for the refugee groups settled in New Zealand. The policy of selecting refugees with high and complex health and social needs has been discussed in detail in the thesis in chapters one and two. The experience of refugee flight often results in refugees requiring long-term, intensive support from health and social service providers. In this context access to healthcare is an important enabling factor for participation in social and economic life in New Zealand. New Zealand studies show that the refugee experience, post arrival stressors, and socioeconomic factors make refugees high health needs groups (Solomon, 1999). Some key objectives for ensuring equitable access and inclusive health services for refugees are the inclusion of refugees in targeted strategies for the reduction of inequalities and ensuring that services have the capacity to respond to the cultural, religious, and linguistic diversity of refugee groups.

Refugee Inclusion in Health Strategies

The examples of targeted refugee health programmes given in the study—while mostly small-scale, localised, one-off initiatives—offer models for the future development of more inclusive health services. These include: the development of practice guidelines for health professionals on refugee health care (Ministry of Health, 2001d); the transcultural mental health care models developed by the Auckland District Health Board (ADHB, 2004a; Shaw et al., 2005); the employment of refugee community workers in mainstream Community Child Health and Disability services (ADHB, 2002c) and; the development of culturally and linguistically appropriate health promotion programmes, such as the African HIV prevention programme (Worth, Denholm & Bannister, 2003) and the nutrition, smokefree and oral health resources for refugee communities (Ministry of Health, 2002e, 2004b, 2004c). The processes of refugee inclusion in these initiatives provide guidance for further integration in health care planning and service provision.

Culturally Responsive Health Services

There are some key recommendations arising from the study that would improve the institutional capacity in the health sector to be culturally responsive to refugee groups.

These are: the recognition of cultural and linguistic diversity in all sectors of the New Zealand health system; the provision of cultural diversity training for primary and secondary health sectors; the introduction of transcultural models of health care; the inclusion of refugee groups in strategies targeted at reducing inequalities; and the inclusion of refugee groups in health research. District Health Boards need work force strategies that are responsive to the ethnic diversity in the populations that they serve. To improve the participation of refugee groups, health services need to be planned and monitored with input from refugee communities.

An Inclusive Cultural Safety Paradigm

The New Zealand cultural safety paradigm presents both unique tensions and opportunities for studying the integration of refugees in receiving societies. As explained in chapter eight, the Nursing Council of New Zealand (1996, 2002) developed a cultural safety model based on the bicultural principles of the Treaty of Waitangi which has become the basis of cultural care in health services. The cultural safety paradigm is a post colonial analytical model which interprets contemporary New Zealand socio-cultural relations as the result of the disproportionate power exerted historically by the colonial over the indigenous peoples (Wood & Schwass, 1993). The introduction of cultural safety practices in health care occurred just as new and diverse refugee groups began arriving in New Zealand. However, the socio-cultural needs of refugee groups have yet to be addressed within this cultural paradigm. The New Zealand cultural safety model is defined as a broadly inclusive concept which provides the opportunity for the integration of diverse cultural groups.

Future Directions for Research

In this section possible directions and opportunities for the development of future refugee research in New Zealand are indicated. The significant gaps in the international and New Zealand literature on long-term settlement outcomes for refugee groups have been highlighted in the study. In this context, there are volumes of research on immigration and integration related to migrant groups in the international and, increasingly, in New Zealand literature. Notably, the websites of the Metropolis (*Centre of Excellence Research on Immigration and Integration*), and the Migration Policy Institute, document an enormous volume of empirical investigations of immigrant

integration in many specific communities. Comparatively, there are few studies in the international literature on refugee integration in resettlement countries. There is much potential for future refugee research that focuses on models of long-term social, economic, and cultural integration and citizenship in receiving societies.

Chapters five and six showed refugee groups to be significant populations with low socio-economic status in New Zealand. For this reason they are of considerable social policy interest in the areas of health, education, welfare, housing and employment. Research about the health and social disparities between refugee groups and other groups in New Zealand is needed to address social inequalities. There are many areas where health and social research could inform an analysis of long-term settlement outcomes in refugee groups. Chapter five discussed the gaps in the data from government sectors to inform a settlement indicator framework in New Zealand (Peace et al., 2005). The *Longitudinal Immigration Survey: New Zealand* (NZIS, 2004a) is an important source of information on migrant participation in tertiary and adult education, literacy skills in English, unemployment rates, welfare benefit receipt, home ownership and surveys on racism and discrimination. Longitudinal data on social, cultural, and economic participation is needed to inform social policy and social protection measures for refugee groups in New Zealand.

Long -Term Settlement Outcomes for Refugees in New Zealand?

This research has focused on the social phenomenon of integrating refugees into the health system in New Zealand. Future research in New Zealand in other key domains such as the education, housing, labour market, and income support systems is needed to explore more fully the concept of a substantive citizenship for refugee groups which has been advanced in this thesis. An adequate political definition of social, cultural and economic membership for diverse cultural groups in New Zealand society is needed before a coherent indicator framework to monitor the impact of settlement policies on refugee groups can be developed. The study has indicated that there are activation points where public institutions are able to respond to refugee groups. In this context, the shape and direction of social and cultural inclusion for culturally and linguistically diverse groups in the public sector is of critical interest and merits further study. The societal outcomes of the *Immigration Settlement Strategies* and of the *Ethnic*

Perspectives in Policy frameworks—which aim to systematically recognise ethnic communities in social policy and public services, warrant close scholarly attention from social researchers. Ultimately, the sustainability of the New Zealand refugee policy depends upon the responsiveness of all sectors of society but, leadership from the state and public sectors is vital. Importantly, long-term integration and social policy is needed for local communities to remain viable and liveable for all New Zealanders.

APPENDICES

APPENDIX ONE

MAJOR REFUGEE GROUPS SETTLED IN NEW ZEALAND

1944-2005

(The numbers of annual arrivals are provided between 1944 and 1987. After this time an annual quota of 750 places was established).

Table 1: Major Refugee Groups Resettled in New Zealand 1944-2006

1944	Polish children and their guardians	(860)
1949-52	Displaced persons from Europe	(4,582)
1956-58	Hungarians	(1,117)
1959 onwards	“Handicapped” Refugees	(by 1963, 200 families)
1962	Chinese orphans from Hong Kong	(50)
1965	Russian Christian “Old Believers” from China	(80)
1965-70	Chinese refugees from Hong Kong	(24 families)
1967-71	Chinese refugees from Indonesia	(54 families)
1968-71	Czechoslovaks	(125)
1972-73	Ugandan Asians	(244)
1974-81	Chileans	(354)
1974-86	Soviet Jews	(335)
1974-91	Eastern Europeans-predominantly Polish, Czechoslovak, Hungarian, Bulgarian, Romanian, Yugoslav and Soviet refugees	(507)
1975-94 (10,900)	Indo-Chinese: Vietnamese, Cambodians and Laotians	
1979	Iranian Baha’is	(200)
1985	Iraqi Assyrian Christians	(139)
1987	Refugee Quota of 750 established	
1992-2000	Somali, Bosnian, Sri Lankan, Ethiopian, Sudanese, Kosovan	
1999-2005	Afghan, Burmese, Iraqi, Eritrean, Somali, Ethiopian, Sudanese	

Source: Department of Labour, 1994, p. 15; NZIS, 2004b

APPENDIX TWO

LETTER TO MANAGERS OF AUCKLAND HEALTH SERVICES

2002

Title

To The Manager,

Health Service

«Address1»

«City»

Dear «Title» «LastName»

My name is Annette Mortensen. I am undertaking a doctoral study of refugee health care in Auckland health and related services. The supervisors of this project are Professor Paul Spoonley and Associate Professor Mike O'Brien of the College of Humanities and Social Science, Massey University. I am seeking access to healthcare workers in health services to research their experience of providing healthcare for people from refugee backgrounds. I will be using a qualitative methodology.

A summary of the research proposal is enclosed. This has been approved by the Human Ethics Committee at Massey University. The Massey Human Ethics Committee is accredited by the Health Research Council. I would like your permission to approach members of staff who work in your service, to discuss their experience of health care for people from refugee backgrounds. This letter has been sent to a number of Health Services in the Auckland region. I am currently employed by the Public Health Service of Auckland District Health Board as the Refugee Health Coordinator.

I would be grateful if you would consider my proposal and would very much appreciate your support for this research if this is possible. If you agree to your organisation taking part in this research could you please forward the enclosed letters of introduction and

information to the appropriate nurses, social workers, community workers and any other relevant members of staff in your area. I look forward to hearing from you.

My contact details are:

Annette Mortensen
Refugee Health Coordinator
Public Health
Private Bag 92605
Symonds St
Auckland 1001

 09 2621855 ext 5821

 Mobile 021442 590

fax 09 630 7431

email amortensen@adhb.govt.nz

The supervisors of this project are :

Professor Paul Spoonley

 09 4418170

fax 09 441 8169

email P.Spoonley@massey.ac.nz

Associate Professor Mike O'Brien

 09 4418170

fax 09 441 8169

email M.A.OBrien@massey.ac.nz

Yours sincerely

Annette Mortensen

APPENDIX THREE

Letter of Introduction

RESEARCH INTO REFUGEE HEALTH CARE

REQUEST FOR VOLUNTEERS

My name is Annette Mortensen. I am undertaking a doctoral study of refugee health management in Auckland health and related services. The supervisors of this project are Professor Paul Spoonley and Associate Professor Mike O'Brien of the College of Humanities and Social Science, Massey University. I am currently employed by the Public Health Service of Auckland District Health Board as the Refugee Health Coordinator.

I would like to invite you to consider participation in this research. I am seeking staff including medical, nursing, social work, community work and other staff who have current or recent experience working in the area of health care for people from refugee backgrounds. The possible outcomes from this research may include: advancing knowledge of the health care needed by refugee populations and assisting health care professionals to manage and develop appropriate services. The exploration of health promotion programmes will have importance in reducing health inequalities for refugee communities. This letter has been sent to a number of health and other related services.

Your input into the research would be in the form of taped interview of one to two hours at a suitable time from October 2002 to May 2003. Interviews will take place at a time and place selected by you for your convenience. If you wish to consider taking part in this research, or would like to hear more about it, please contact me or my supervisors, Professor Paul Spoonley and Assoc. Professor Mike O'Brien, preferably by telephone:

My contact details are:

Annette Mortensen
Refugee Health Coordinator
Public Health
Private Bag 92605
Symonds St
Auckland 1001

☎ 09 2621855 ext 5821

☎ Mobile 021442 590

fax 09 630 7431

email amortensen@adhb.govt.nz

The supervisors of this project are :

Professor Paul Spoonley

☎ 09 4418170

fax 09 441 8169

email P.Spoonley@massey.ac.nz

Associate Professor Mike O'Brien

☎ 09 4418170

fax 09 441 8169

email M.A.OBrien@massey.ac.nz

Yours sincerely

Annette Mortensen

APPENDIX FOUR
Information Sheet for Research Participants
Undertaking an Interview

RESEARCH INTO
REFUGEE HEALTH CARE

INFORMATION SHEET FOR HEALTHCARE WORKERS

Thank you for your interest in the proposed research project which will examine health care service provision for refugees resettled in Auckland. This part of the study will involve separate taped interviews with up to eighteen health care workers about their experiences of managing health care for people from refugee backgrounds. This letter has been sent to a number of health services. Interviews will take place at a time and place selected by you for your convenience.

Typical questions that you may be asked will include:

“Tell me about your experiences of working with the people from refugee backgrounds?”

“Tell me about the particular needs of refugee families and how your service meets those needs?”

“Tell me about health promotion and community participation for families from refugee backgrounds in our health services?”

“Tell me about managing safety in relation to the culture of the client and their family from refugee backgrounds?”

“Tell me about any problems which you may have had in communicating with non-English speaking clients?”

“Tell me about the perceptions that others in health care and in society in general have towards your work?”

If you decide to take part in this study, you will be invited to ask any further questions you may have, about your input in the project, and to sign a Consent Form. If you then wish to proceed, a taped interview with the researcher, of between 1 and 2 hours in duration will be arranged. The initial interview may be followed up in order to verify my interpretation of the data collected. At this subsequent interview you will be welcome to add or to delete comments. Each interview will be audio taped, with your permission, to allow transcription of the data at a later time. It is expected that interviews will be conducted between December 2002 and May 2003.

The research data gathered from you will be treated with confidentiality. Your name or other identifiable material will not be available to anyone other than the researcher and the transcriber of the tapes. The transcriber of the cassette tapes will sign a separate confidentiality agreement before commencing. While I cannot absolutely guarantee your anonymity, every effort will be made by the researcher to maintain this throughout the research project. Each participant will be referred to only by a pseudonym or a number. Patient names or any other identifying information will not be used during interviews.

If you decide to take part in this research, then you are reminded that:

- a) You have the right to decline to take part or to withdraw from the research.
- b) You have the right at any time during your participation
 - to ask any questions about the research
 - to refuse to answer any question
 - to ask that the cassette recorder be turned off
 - to examine any notes taken
 - to read your own subsequent transcriptions
 - to terminate the meeting
 - to be informed of the results (on completion of the research).
- c) The proposed research may be of benefit to you, in that it might assist you to reflect on your practice. Should material discussed in regard to the management of health care for people from refugee backgrounds cause distress, measures will

be suggested to help you cope with this. If you require support in this regard, it will be given or sought on your behalf with your permission.

- d) Any cassette tapes, notes or other material relating to you will be stored for the duration of the research in a secure place. On submission of the research, the cassette tapes will be returned to you, or, if you desire, will be destroyed. All other materials used in data gathering, such as transcripts or notes, will be stored in a safe place and either returned to you or destroyed following the usual requirements of research protocol.

- e) A summary of the research will be made available to you at the end of the study.

A doctoral thesis will be prepared from the completed research, and academic papers, journal articles and conference material based upon this research may follow this. If you wish to consider taking part in this research, or would like to hear more about it, please contact me, preferably by telephone:

Annette Mortensen
Refugee Health Coordinator
Public Health
Private Bag 92605
Symonds St
Auckland 1001

 09 2621855 ext 5821

 Mobile 021442 590

fax 09 630 7431

email amortensen@adhb.govt.nz

You may contact the following supervisors
regarding this research:

Professor Paul Spoonley

 09 4418170

fax 09 441 8169

email P.Spoonley@massey.ac.nz

Associate Professor Mike O'Brien

 09 4418170

fax 09 441 8169

email M.A.O'Brien@massey.ac.nz

Thank you for your interest in this project and for taking the time to read this
information. Massey University Human Ethics Committee has approved this protocol.

Yours sincerely

Annette Mortensen

APPENDIX FIVE
Consent Form
RESEARCH INTO
REFUGEE HEALTH CARE

1. I have read the information sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction and I understand that I may ask further questions at any time.
2. I understand that I have the right to withdraw from the study at any time and to decline to answer any particular questions.
3. I agree to provide information to the researcher on the understanding that my name will not be used without my permission. The only people who will listen to the tapes will be myself, the transcriber and the supervisors. The information will be used only for this research and publication arising from this research study.
4. I agree to maintain confidentiality regarding the interview and the study.
5. I understand that the anonymity and confidentiality of my participation in the research cannot be guaranteed as it may prove difficult keeping this knowledge from other refugee health workers in New Zealand.
6. I agree that my consent form will be lodged with Annette Mortensen, the researcher, who will take all steps to ensure that participant anonymity is protected.
7. I agree / do not agree to being audiotaped.
8. I also understand that I have the right to ask for the audiotape to be turned off at any time during the session.

9. I agree to participate in this study under the conditions set out in the Information Sheet.

Signed _____ Date _____

APPENDIX SIX
Confidentiality Agreement

RESEARCH INTO
REFUGEE HEALTH CARE

I, have accepted the task of word processing the research data collected by Annette Mortensen in order to complete a Doctor of Philosophy at Massey University.

I understand that the data gathered for this research is confidential, and agree to take all necessary steps to ensure that any material on cassette tapes or computer disk containing data from interviews relating to the research will be:

- a) Heard only by me, and transcribed to disk in private
- b) Stored safely until return to the researcher
- c) Treated as confidential in all respects
- d) All copies of transcripts and computer discs will be returned and no material will be retained on my computer

Signed _____

Witnessed _____

Date _____

APPENDIX SEVEN
LETTER TO PARTICIPANTS

RESEARCH INTO REFUGEE HEALTH CARE

Massey University letterhead

Researcher's address

Telephone Number

Dear

Further to our telephone conversation this letter confirms the details which we discussed. I am inviting voluntary participation in this research project, which is part of my doctoral thesis at Massey University. The focus of the study will be refugee health care.

I would like to interview you and discuss with you your experiences in providing health care for people from refugee backgrounds as a health care worker. If you agree the interview, which will be an informal conversation, will be taped. We may meet for one to two hours. Questions may become more specific in follow up interviews, as I collect more data. I may ask to interview you more than once. The number of times I interview you will depend on your willingness to continue to participate, which will be renegotiated with you. At times phone follow up may be necessary. I will contact you in regard to a convenient time and place to meet with you.

To protect your privacy your name will not be used in the research. Your true identity will be known only to me and to my supervisor, who will retain your consent form for security purposes. I will ask you to choose a pseudonym that you will be known by. Your place of work will also be anonymous. The information you share with me will remain confidential.

Only my thesis supervisors Professor Paul Spoonley, Associate Mike O'Brien and the confidential typist will have access to this information. All taped interviews will be stored securely. There will be no direct benefit to you from participation in this project. It is hoped however that this work will make an important contribution to documenting the importance of health care work with people from refugee backgrounds. It is possible that sensitive issues may be raised during the process of interviewing. To address this possibility and any other issues that may arise, time for debriefing will be included in every session. Should you encounter any emotional distress through this process I would offer support at the time. Counselling at your place of work or at some other acceptable venue would be arranged if it was needed.

The information that you share with me for this study will be used in the publication of a doctoral thesis that will be kept on file at Massey University. I would anticipate publication of the findings in a professional journal. Opportunities to present this material at conferences, workshops and seminars would also be sought. A summarised report of the research findings will be sent to you on completion.

Thankyou for your interest in this project. I enclose two copies of the consent form. If you would like to work with me on this project could you please return the signed copy of your consent to participate, to me at the above address. If you have any further questions, please do not hesitate to telephone me on 092621855 x 5821.

Yours sincerely,

Annette Mortensen.

APPENDIX EIGHT

RESEARCH INTO THE REFUGEE HEALTH CARE

Initial interview Guide

The interviews will be minimally structured. A general theme will be introduced for each interview with an open-ended question. This is intended to focus participant's thoughts and to minimise the researcher's interference with the natural flow of the conversation. In some interviews more probes and prompts may be required than in others. The content and direction of each interview will vary with participant's responses.

General theme

The internal and external experience of the health worker.

Initiating Question "Tell me about your role"

Probes: The every day work of the health care worker
 Patient encounters
 Health care interventions

Secondary theme

The personal impact of this work on the health care worker. The nature and consequences of the problems encountered.

Initiating Question "How do you manage difficult situations. Reflect for a moment on some recent examples and how you managed them"

Probes: Managing difficult situations.
 Encountering cultural difference
 Making a difference for refugee clients, families and communities
 Self care

APPENDIX NINE

RESEARCH INTO REFUGEE HEALTH CARE

ETHICAL CONSIDERATIONS

Informed Consent

The process and procedures of gaining informed consent by participants to this project followed the guidelines of Massey University (2002), revised *Code of ethical conduct for research and teaching involving human subjects* and of the Auckland Ethics Committees (2002) accredited by the Health Research Council (HRC) (1997; 2002) (See Appendix Four).

Anonymity and Confidentiality

All processes and procedures possible occurred to maintain the anonymity and confidentiality of participants, who wished to remain anonymous, including the use of pseudonyms. However, a number of participants were emphatic that their own name was used in the transcriptions of interviews cited in the text.

Potential Harm to Participants

For participants the process of reflection on their client interactions may have been psychologically sensitive. Every care was taken in conducting interviews to ensure that the process was not damaging to the participants personally or professionally. The participants understood that counselling services would be made available if this was encountered. At no time throughout the study was this required.

Potential Harm to Clients

To ensure that client anonymity and confidentiality was maintained, participants were informed in the subject information sheet that no identifying information would be used (Appendix Two). This was further explained prior to interviewing, when participants were requested not to use client names or to give details, descriptions or locations, which could be recognisable.

The Participants Right to Decline to Take Part

Participants were informed of their rights to decline to continue to take part at any time during the research in both the subject information sheet (Appendix Three) and the Consent Form (Appendix Four). Further, this was discussed with participants prior to the interviews.

APPENDIX TEN

RESEARCH INTO REFUGEE HEALTH CARE

SECOND INTERVIEW GUIDE

Subsequent Interviews

Following analysis of the first three interviews some initial themes began to emerge.

These were:

1. There was no planning or provision specific to refugee population needs.
2. Inadequate funding to meet additional costs, such as health interpreting services
3. Health services coping with unmet basic resettlement needs.
4. Refugee families presented complexity that required additional staff time and resources.

Subsequent interviews, which were semi-structured, explored preliminary theoretical leads. The following questions were asked.

“ Tell me about your experiences working with refugees”

“What are the particular difficulties that you have had (in your particular service or setting) in delivering care for peoples from refugee backgrounds?”

“ Does providing care for refugee peoples differ from care for other New Zealand populations and in what ways?”

“What perceptions of refugees do you see reflected in the behaviours and attitudes of health care workers?”

“ Tell me about good experiences providing care for refugee families?”

“ Tell me about bad experiences providing care for refugee families?”

“ Tell me about what you see as the impact of New Zealand health policies and strategies on the health and well being of refugee families?”

“How do you think that changes to health services, such as the development of Primary Health Organisations and any other new initiatives in your area of work, will impact on refugee families?”

“Tell me about your experiences of community consultation with refugee communities in regard to health planning and service development?”

“ What particular difficulties has your service had in gaining adequate funding to meet the particular needs of refugee families?”

“What needs to happen differently for refugee families so that they have health service provision that is equitable to other New Zealanders on low incomes?”

APPENDIX ELEVEN
RESEARCH INTO REFUGEE HEALTH CARE
DATA COLLECTION METHODS

Data Collection Methods

Data collection included participant interviews in Auckland health services. Interviewing was chosen as the most effective method to get at the experiences of those engaged in the care of refugees in health care services. Twenty three interviews were conducted and three of these were focus groups for those employed in the same work site. Each of the participants was interviewed once over a period of six months. Interviews lasted from one to two hours. Analysis was set in motion with the first interviews. Participant accounts were compared, meanings clarified and variance in the data explored. After the first round of interviews, later participants were able to expand on the theoretical leads established in the earlier interviews.

Interview Structure

Initial interviews were minimally structured (Appendix Eight). Following the analysis of the first three interviews, initial themes began to emerge. Subsequent interviews were therefore semi-structured to explore preliminary theoretical leads (Appendix Ten). Initial questions related to the participant's experience of client interactions and progressed to areas of difficulty, strategies used to manage contexts and variations and the conditions under which these occurred (Appendix Eight). The interviews allowed time for participants to question the researcher and for information from the session to be clarified.

The purpose of the interviews was to obtain adequate descriptions and interpretations in the participant's own words for data analysis. In the initiating stage of the interview administrative matters provided a 'warming up' period. The interview began with an introduction and the signing of informed consent. A general theme was introduced for each interview with open-ended questions. It was essential that participants could talk openly and honestly with minimal intrusion from the interviewer. In some interviews more probes and prompts were required than in others to enable exploration of

particular issues and to meet the timeframe of the interview. The content and direction of each interview was varied according to participant's responses.

After the first six initial interviews, further participants were presented with the emerging themes, for comparison with their own experiences. This allowed further exploration of the phenomenon under study. Constant comparisons established commonalities and differences in the management of refugee health care between different services. This process continued until 'saturation' was achieved and the information confirmed the data collected.

Throughout the research project, informal discussions with refugee health services in Hamilton, Wellington and Christchurch, refugee resettlement agencies, related government agencies such as the Department of Child Youth and Family Services, Ministry of Education, New Zealand Immigration Service and Housing New Zealand, were also held which gave more scope, meaning and accuracy to the data. The purpose of informal discussion was to stay informed about the new policies and programmes that were being developed in the regions and within the various government departments. This provided useful comparative data with the process of integration occurring in Auckland health services. Ongoing reading of the literature was also used in constant comparative analysis.

Memoing

As ideas about interrelationships in the data occurred, they were noted down. These were my reflections on the conceptual meanings of the data. Memoing started early in the process of the constant comparison of data, as patterns and themes emerged. Initial memos were tentative and were confirmed or discarded as memos were sorted and ordered to cluster concepts into categories. This process continued until 'interpretive sufficiency' was achieved.

APPENDIX TWELVE
MINISTRY OF HEALTH POLICIES AND STRATEGIES
ANALYSED IN THE STUDY

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