

# **PUBLIC HEALTH SYSTEM RESPONSIVENESS TO REFUGEE GROUPS IN NEW ZEALAND: ACTIVATION FROM THE BOTTOM UP**

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## **Abstract**

From 1987 onwards the New Zealand Government has offered resettlement places to the most vulnerable refugees in refugee camps. These include women at risk, those with medical conditions and disabilities, and those categorised by the United Nations High Commission for Refugees (UNHCR) as having “poor integration potential”; for instance, those who are pre-literate, women-led households with large numbers of children and long-stayers in refugee camps. The changes to refugee resettlement policy have significantly increased the number, dependency and cultural, religious and ethnic diversity of the refugees settled since 1992. However, while specifically prioritising refugees with high health and social needs, New Zealand has not yet developed the institutional means to include diverse ethnic groups in policy, strategy and service planning. This article looks at the role of public institutions in New Zealand, in this case the public health system, in the integration of refugees. The study shows that, for refugee groups, the health sector has developed responses to local needs and demands in highly specific health care settings that are often poorly resourced. Of interest in the study are the interactions between the health practitioners and provider organisations advocating for better services for refugee groups, and the institutional responses to the issues raised by health providers.

## **INTRODUCTION**

New Zealand does not bar any refugees or asylum seekers on the grounds of medical conditions or disabilities (UNHCR 1998:126). Quota refugees are New Zealand residents on arrival and have the same entitlements as all New Zealanders to publicly provided health and disability services, and to subsidised primary health care (Minister of Health 2003). However, for refugees, entitlement to health and disability services does not mean these services are being accessed. A study of health and disability services in the Auckland region, conducted between 2002 and 2006, shows that in practice access for refugee groups is limited and inequitable.

The findings of the qualitative field study indicate that the public health system needs to be “activated” (Penninx 2004) from the “top down” in order to provide accessible and equitable services for refugees, and for their first- and second-generation ethnic communities. The concept of activation is used in the sense that public institutions are important actors in the integration of refugee groups. Penninx’s (2004:4) theoretical perspective on the role of institutional “opportunity structures” provides a means of analysing refugee participation in

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the health system. In this view, public institutions determine the nature and quality of refugee integration through social, cultural, religious and linguistic accommodations.

The public institutions of receiving societies strongly determine the settlement outcomes for refugee groups by either promoting opportunities to participate, or limiting access and equal outcomes for refugee groups. The study draws on theoretical models of newcomer integration in order to promote the development of a more inclusive public health system for refugees. In health and related social policy, the issue of including refugee groups must take into consideration cultural and religious diversity on the one hand, and socio-economic inequality on the other.

## BACKGROUND

In 1987 the New Zealand Government undertook a comprehensive review of the Refugee Quota Programme and increased the number of refugees arriving to an annual quota of 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 and New Zealand Immigration Service 1994). The review removed preferences for specific national, ethnic and religious groups. In the last two decades the refugee groups settled in New Zealand have come from Iran, Iraq, Afghanistan, Sri Lanka, Bosnia, Kosovo, Somalia, Eritrea, Ethiopia, the Sudan, Burma, Bhutan, Burundi, Rwanda, the Democratic Republic of Congo, Brazzaville, Sierra Leone, Zimbabwe, Palestine, Algeria and Colombia. The profile of refugees settled in New Zealand from 1987 has been characterised by ethnic, cultural and religious diversity, and by the number of complex health, disability and psycho-social cases requiring specialised intervention and management.

Approximately 1,500 refugees are settled in New Zealand every year, 60% of whom will reside in the Auckland region (New Zealand Immigration Service 2004:44). This number includes the annual quota of 750 refugees, family reunion members, and convention refugees (former asylum seekers). The Auckland District Health Board (ADHB) estimated in 2002 that a population of 40,000 people from refugee backgrounds was resident in the greater Auckland region (ADHB 2002b). While these are small numbers, refugee groups present cumulatively significant high-health-needs populations. Refugee groups demonstrate health disparities and a unique set of health needs in New Zealand health populations (Ministry of Health 2001, Solomon 1999). Poor health on arrival in New Zealand 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 (Hamilton et al. 2001, Hobbs et al. 2002, McLeod and Reeve 2005, Ministry of Health 2001). In the longer term, the indications are that the same patterns of poor health that are occurring in other low socio-economic groups, particularly those of Pacific peoples, are being replicated in refugee groups, including diabetes, obesity, cardiovascular disease, poor mental health and oral health, and high smoking rates (Solomon 1997, 1999).

## METHODOLOGY

The study, which was undertaken between 2002 and 2006, used a qualitative research methodology. A critical social theoretical approach was taken to the interpretation of the data used in the study. The method of analysis used is critical hermeneutics. 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. A variety of empirical materials

informed the study, including the findings of quantitative and qualitative research studies, historical material, health and social policy, interviews, media analysis and personal observations.

### Study Participants

Because over 60% of the refugees settled in New Zealand are resident in the Auckland region, it was decided to focus this study on health and disability services in this region. During field work, 28 in-depth semi-structured interviews were conducted with service providers in community, primary and secondary health care sectors, in both governmental and non-governmental agencies. The services approached were either known to have significant numbers of clients from refugee backgrounds, or to be located in areas where refugee communities were settled. The services that participated in the study included: primary health, child and family health, public health, disability support services, mental health, women's health, HIV/AIDS services, drug and alcohol services, hearing and vision services, health promotion providers and not-for-profit community care agencies. Those interviewed included nurses, doctors, midwives, health educators and health promoters, nutritionists, social workers, community health workers, hearing/vision testers, reception staff and managers. In addition, three focus groups were held: two for those working in child health services and one for a health promotion service. The study received ethics approval in December 2002 from the Massey Human Ethics Committee, the Auckland Health and Disability Ethics Committee, and the Plunket Society Ethics Committee. (When participants are quoted in this paper, pseudonyms are used.)

### Data Analysis

The process of analysis used to interpret data in the study is called the "hermeneutical circle" (Kincheloe and McLaren 2005). 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. 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 and McLaren 2005:286–287).

Using constant comparative analysis, from the beginning transcripts of recorded interviews were compared and recurring concepts identified, which were then organised into themes and sub-themes. The processes of data collection (including interviews with health and disability service providers, and review of relevant literature and governmental policies and strategies) and data analysis occurred simultaneously. During data analysis, the macro-dynamics of the structural forces that were identified in the operation of the New Zealand public health system were connected to the micro-dynamics of the everyday interactions between health care workers and refugees.

## THE ROLE OF PUBLIC INSTITUTIONS IN THE INTEGRATION OF REFUGEE GROUPS

The successful integration of refugee groups as effective social, cultural and economic members of society in first and second generations depends on the availability of appropriate institutional structures and processes in their countries of settlement. The process of integration takes place not only at the level of the individual refugee in terms of gaining

employment, housing and education; accessing health care; and making social and cultural adaptations. It also takes place at the collective level of the refugee group. In this sense, refugee groups and their associations may also integrate; that is, they can become a potential partner in the provision of health services and programmes, and can mobilise communities to engage with health promotion and prevention campaigns. Penninx (2005:1) clearly defines the role of public institutions in the integration of immigrants 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.

The sociological concept of an institution is “a standardized, structured and common way of acting in a socio-cultural setting” (Penninx 2004:13). The functioning of the public institutions of receiving societies, such as public health systems, is supposed to serve all citizens equally. However, public institutions may hinder access or equal outcomes for refugee groups and their descendants in two ways. First, they may partially exclude refugee groups; for example, their health and welfare systems may offer unequal or restricted access to services (Penninx 2004). Second, even if access for all residents is in principle guaranteed, such institutions may in practice hinder access and/or equal outcomes for refugee groups; for instance, by not offering interpreting services. This may occur because of the institution’s historically and culturally determined ways of operating, or by not taking into account the specific cultural, linguistic and psycho-social characteristics of refugee groups. The functioning of public institutions and their ability to make cultural and linguistic accommodations is instrumental for refugee integration. Institutional arrangements will also determine, to a great extent, the opportunities and scope for action for non-governmental organisations, including refugee organisations. Institutions, such as the public health system, and organisations together create the structure of opportunities and limitations for individual refugees and their ethnic communities.

## RESPONSIVENESS IN THE NEW ZEALAND PUBLIC HEALTH SYSTEM

The following sections of this paper summarise the findings of the study. The results are grouped into three levels of responsiveness in the public health system:

- responsiveness at a national level
- responsiveness at a regional level
- responsiveness at a local level.

### Responsiveness at a National Level

In New Zealand at an institutional level there is ambiguity and ambivalence surrounding the inclusion of refugees and their ethnic groups as health populations into the public health system. At the “top-down” level the health system has been largely unresponsive to refugee groups and their ethnic communities. In the study there were few signs that health planners and strategists at a national level are attempting to grapple structurally with the disparities in the health and social status of refugee groups. The national policy environment gives inconsistent directions on the inclusion of refugee groups (ADHB 2002b), and the study revealed the tension between national and local strategic health goals. In the next section this

tension is demonstrated when District Health Board health needs analysis for the populations in its region identified substantial unmet health need in refugee groups. The District Health Board's ability to act was limited because refugee groups were not recognised as a priority group in national health policy and reducing inequalities strategies, or in a population-based funding formula.

### Responsiveness at a Regional Level

Significantly, there is evidence of strategic responses to refugee groups from District Health Boards. District Health Boards are required to conduct health needs assessments for their local populations. For example, the ADHB identified the following issues for the refugee groups in their *Strategic Plan 2005–2010* (ADHB 2005:35–36).

- 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.

The ADHB had limited capacity to address these identified health needs because there were no national policy frameworks, resources or funding available for refugee groups.

### Responsiveness at a Local Level

This section demonstrates at a service level the tensions between national- and local-level responsiveness to refugee groups. Refugees and their ethnic groups are systemically overlooked in health policy, ethnicity data collection systems, population-based funding formulas, health research and reducing inequalities strategies. The following examples demonstrate the impacts on service providers and their refugee client groups.

Hauora o Puketapapa or Roskill Union and Community Health Centre (HoP/Roskill) is a general practice in central Auckland, established in 2002, which was chosen through a process of identifying population groups that were medically under-served (Lawrence and Kearns 2005). When HoP/Roskill was established, an analysis of the most recent data indicated that the Mt Roskill area had significantly fewer general practices available per head of population compared to other Auckland suburbs. The analysis showed that the population comprised Europeans/Pākehā (38.2%), Pacific peoples (25.9%), Asian groups (18.6%), Māori (11.2%) and Others (6.1%) (Exeter et al. 1999). The “Others” comprised refugee families from Afghanistan, Ethiopia, Iran, Iraq and Somalia, who had been settled in the area since 1992, and who had not been recorded in health or demographic studies as anything other than “Other”. In 2003, 46% of HoP/Roskill’s enrolled population were from refugee backgrounds (Lawrence and Kearns 2005). When interviewed, a practice nurse working at HoP/Roskill stated that when the health centre started they were not prepared for refugee families. They were expecting to see:

“completely different demographics and it wasn’t until a few months later that we realised [that a significant proportion of the clients were refugees] and we didn’t have the resources, any knowledge ... cultural, the whole thing.” (Jane)

The health service was funded on a fixed capitation rate based on standard consultation times of 15 minutes. A significant proportion of the case load was non-English speaking, the practice was not funded for interpreters, and many client consultations involved complex health and psychosocial issues. The manager of the service at the time stated that funding levels were in no way adequate to cover the costs of providing primary health care for refugees and asylum seekers. National population-based funding formulas, which do not prioritise refugee groups, had presented financial constraints on the level of service that could be provided. The manager of the service stated that:

“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 [low decile] street, they get the money, if they happened to live in the next street across, which is not [low] decile ... they miss out on any specific funding load, based on deprivation. It is a huge issue.” (Kate)

In another example, in 2000 the Plunket Society was given additional funding to improve child health in high-need areas of the Auckland region. One area chosen on the basis of the New Zealand Deprivation Index (NZDep) was Owairaka (a suburb in Mt Albert). Again, the area is home to high numbers of Somali, Ethiopian, Afghan and other families from refugee backgrounds. The Plunket nurses in the area described setting up Whanau Awhina, a project for more intensive care for families in areas of poverty. The socio-demographic data used as the basis for allocating the additional child health funding was the NZDep96 (Salmond et al. 1998), which indicated that areas such as Mt Roskill, Owairaka and Avondale are areas of poverty. However, the data did not reveal that many of the families were from refugee backgrounds. Plunket subsequently adapted the project to work more intensively with refugee families in the area. Although services such as Plunket had specific funding for high-needs families, nurses’ workloads were calculated nationally on the average time needed for appointments with English-speaking clients. For Plunket nurses working in areas such as Owairaka and Mt Roskill, this meant unmanageable case loads because a high proportion of clients were non-English-speaking:

"We have got this target each day of seeing six or seven core contacts a day. In my area I only have 20 per cent 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)

Plunket service managers said that when negotiating contracts with national funders, attempts to gain recognition for the additional costs of services for refugee groups were rejected. The experience was that:

"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)

Organisations described being caught in a double bind of having to either ignore the additional needs of refugee groups, or to provide services without the funding to do so. This situation was summarised by a service manager, who said:

"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 [between front-line staff and] ... the Ministry of Health who fund us and also people wanting us to meet targets." (Sue)

## LOCAL SIGNS OF ACTIVATION

The research did discover that at the local level of service provision there were signs of "activation" (Penninx 2004:4); i.e. approaches that had been developed by health practitioners to improve the quality and accessibility of services to refugee groups. The examples that follow are the result of the "bottom-up" efforts of the front-line staff in services located in areas where there were sizeable refugee populations.

### Health Promotion

A programme that did recognise the specific needs of refugee groups nationally was the Ministry of Health-funded New Zealand HIV/AIDS Refugee Health Education Programme (RHEP), started in 2002 (Worth et al. 2003). By the end of 2002, 134 people of African ethnicities had been diagnosed with HIV, representing 22% of all new HIV diagnoses since 1996 (Mills et al. 2002). The project resulted from considerable lobbying from front-line staff, including infectious disease physicians, HIV/AIDS service providers, researchers, academics and non-government organisations. The Refugee Health Education Programme provides culturally appropriate HIV/AIDS, safer sex health promotion activities, trained health educators from refugee communities, and community support networks for refugees with HIV/AIDS. The programme works as a collaboration between communities, community leaders, elders, religious leaders, and the HIV/AIDS community educators employed by the New Zealand AIDS Foundation, who are from diverse African backgrounds.

In other national health promotion strategies, such as Healthy Eating – Healthy Action (Ministry of Health 2003), refugee groups were not included as priority populations. The nutritionists interviewed in the study had conducted their own needs analysis with Muslim, African and Middle Eastern communities, undertaken literature reviews and community consultations, and developed resources in Arabic, Farsi and African languages, because in their words, "You had to start somewhere" (Rose).

The adaptation of health promotion resources had required more than a simple translation of messages, such as “eat more fruit and vegetables”. To be meaningful to the African and Middle Eastern groups, resources needed to recognise traditional diets and cultural and religious requirements, such as halal dietary guidelines. For Muslim, Middle Eastern and African groups who are at risk of Vitamin D deficiency, the national SunSmart campaign gave the wrong messages (Wishart et al. 2007). As a 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, the need instead [is] for exposure to sunshine.” (Rose)

The nutritionist had produced Vitamin D fact sheets in Arabic, Farsi and Somali and had promoted the recognition and treatment of Vitamin D deficiency in general practice in the Auckland region.

### Mental Health Services

In the study, the refugee-focused services that were occurring provided important models but were characteristically short-term, small-scale, stand-alone pilots. These services had been developed because agencies had identified gaps and advocated for the funding of targeted projects. One example was On TRACC, a trans-cultural care service for children and young people from refugee backgrounds who have high and complex needs. On TRACC was an intersectoral mental health, educational and social service, which started in central Auckland in 2003. The project was funded by the national High and Complex Needs Unit (High and Complex Needs Unit 2005). The service brought together the Kari Centre (ADHB Child, Adolescent and Family Mental Health Service), Central Auckland Special Education Services and Royal Oak Child Youth and Family services, to provide a co-ordinated 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 the service because, in the words of the manager of the service (Shaw et al. 2005: 25):

“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 families and provided workforce development programmes in health, education and social service sectors in the Auckland region. On TRACC had been a finalist in 2006 for the New Zealand Health Innovation Awards, where it was reported that refugee children with problems were now benefiting from an integrated trans-cultural service in Auckland (Ministry of Health and Accident Compensation Commission 2006). 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. 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.



A sustainable example of the inclusion of refugee populations in mental health service provision was the setting up in 2004 of the Transcultural Mental Health Team to resource the ADHB Community Mental Health Centres (ADHB 2004). The service is for adult clients from refugee or migrant backgrounds who have a mental illness and significant trans-cultural issues that affect their ability to access or participate in clinical mental health services. Members of the Transcultural Mental Health Team are skilled in working with clients from culturally diverse backgrounds, and act as consultants to clinical staff within the Community Mental Health Centre teams in the ADHB.

### Community-based Health Services

Community-based health services have a key role in reaching refugee families. 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)

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 health 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 families, 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.” (Lisa-May)

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)

Public health nursing services in schools were also an important means of providing health care for refugee 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)

In other examples community health services had recognised the value of employing people from refugee backgrounds to provide support for refugee families. For example, the ADHB (2002a) Community Child Health and Disability Service had employed refugee community health workers to specifically address the needs of the refugee families referred to them. The services included early childhood, child development, child and youth, nutrition, social work

and child disability care teams. Staff in the service reported significant improvements in the acceptability of the service to refugee families:

“I think it has made a huge difference ... [refugee] communities are much more willing to be honest and open [because] someone has been working that is one of them, been there, done that and really knows how it feels ... It has been good.” (Jill)

However, such examples were characteristically discrete, service-led initiatives in specific health settings.

### Cultural Diversity Training

Waitemata District Health Board alone had recognised the need for cultural diversity training and as an “organisation has made a huge commitment to ... diversity training ... We all have to go, all managers have to attend” (Mary 1). In total, there were very few health programmes in the Auckland region targeted at refugee groups. Those that had been developed were generally one-off, short-term or pilot projects. Significantly, what the study did show was the sustained local efforts by front-line practitioners to “activate” the health sector. However, the service-led developments were not necessarily integrated into service planning at the regional District Health Board level, and were almost entirely neglected at the national health and disability policy and strategy level.

### CONCLUSION

The study revealed that at a local level there are some signs of activation in the health sector, but that overall the “opportunity structures” in the public health system are restricted. The services that were available to refugees 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 because they signal potential openings in the health structure for accommodating refugee groups and their ethnic communities. However, what is required to achieve a more responsive public health system are national changes to the ethnicity classification system used in health, an overarching framework for addressing cultural diversity, and the instruments and resources (such as policy and funding formulas) that recognise high needs in refugee groups.

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