

## Experiences of Health Care among Refugee and Asylum Seeker Residents in Regional Victoria

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### Abstract

**Objective:** This paper explores the role of culture in shaping human experiences related to health. The analysis of interviews with refugee and asylum seekers in a regional area of Australia seeks to give voice to some of the experiences of these residents in resettling and accessing healthcare.

**Methods:** This paper analyses the stories of 31 refugee and asylum seeker residents about their experiences of health care in regional Australia. Community leaders from four groups were employed to assist with recruitment of participants. Participants were interviewed by researchers, sometimes with the assistance of interpreters, about living in the local area and using and accessing health services. All interviews were audio-recorded, transcribed and coded to identify key issues. Findings were discussed among the researchers and with the community leaders.

**Results:** Four themes were identified. The first theme highlighted how participants were pleased to be in Australia and valued the safety and security of Australia. The second theme highlighted the importance of language and English literacy for participation in employment, education, social life and health care. Participants spoke about how a lack of English proficiency makes communication with health professionals difficult and the challenges of using interpreters. The third theme focused on social connection and the desire of participants to have friendships and social supports from across the local community. Social isolation and loneliness impacted wellbeing and was often connected with language. The final theme focused on cultural respect, highlighting examples of feeling judged or discriminated against because of cultural beliefs. Together, these themes illustrate how culture is embedded in access to, use of and negotiation of health services.

**Conclusion:** The analysis demonstrates how experiences of health systems are culturally contingent. Until this is acknowledged, refugees and asylum seekers will struggle to access health services and to settle into Australia with ease.

**Keywords:** Refugee; Asylum seeker; Regional; Health culture; Healthcare; Social isolation; Language

### Introduction

Refugee and asylum seeker residents face particular challenges resettling in Australia [1,2]. Many were forced to flee their home country, have lived as displaced persons in multiple countries on the way to Australia, experienced trauma leaving and/or en route, speak little English, and have limited rights and resources upon arrival. Once arriving, refugees can be simultaneously welcomed and excluded, informed and uninformed, and their experiences can be empowering, belittling and/or confusing. Securing housing, income, friends and social support, along with accessing health services, transportation, social services, places of worship and appropriate food, are among some of the challenges encountered. These are often compounded by overcoming past experiences of trauma and ongoing disconnection from loved ones [3-6]. Understanding the many inter-related challenges of resettling and then accessing healthcare is complex. There are material issues, psychological issues from past experiences and

psychosocial issues emerging from resettlement; accessing appropriate, accessible and affordable healthcare is another complexity. Accessing health services is a complex interplay between expectations, availability, knowledge and experiential learning, and the detail of this is poorly understood [7-10].

Embedded in beliefs about health, health-related practices and, importantly, experiences related to health, including the utilisation of services, is an individual's culture—a shared system of meanings co-created and constantly re-created over time through social interaction that fundamentally informs how the world is viewed, understood, and engaged with [11,12]. What makes the role and analysis of culture within human phenomena intricate and complex is that each individual belongs to multiple cultures that are inherently dynamic, inconsistent and often raggedly stitched together in disjointed, imperfect ways [13]. Thus, while there is an extensive body of knowledge evidencing the role culture plays in human perception and experience more generally [14-21], the role of culture in health care is not usually discussed within the health domain [22,23]. This is particularly the case in relation to an individual's knowledge of health

(literacy), priorities of health (with competing family, financial, social and other priorities), priority of health care (when to seek services and who to see), expectations of health (how healthy one should feel) and expectations of health care (e.g., cost of the service or waiting times or fear of clinicians) [2]. When culture is discussed, it is usually via distinct concepts such as cultural competency and, in mainstream health fields, often in ways that misappropriate the term 'culture' as it is understood and used in social science disciplines [11,12].

Acknowledging the nature and role of culture in shaping human experience, specifically in relation to health, this paper analyses the stories of 31 refugee and asylum seeker residents about their experiences of health care in Australia. This analysis aims to give voice to some of the experiences of these residents and to highlight the intricate role culture plays in shaping human experiences related to health. Before presenting the methods and analysis, an overview of the key literature on the challenges and experiences of refugee and asylum seekers in relation to health and health care is provided.

## Literature Review

### Common challenges encountered by refugees and asylum seekers upon arrival

Previous research has identified several common challenges encountered by refugee and asylum seeker residents upon arrival in Australia. These include: language, employment, transportation, mistrust of government services, and acceptability of services [3-6], all of which intersect in multiple ways. Language and communication are frequently framed as the leading barriers to refugees and asylum seekers safely accessing healthcare and navigating health systems [3-6] as well as other services, particularly in rural and regional areas [24]. Further, an inability to communicate with the wider community limits refugees' and asylum seekers' abilities to engage in social networking and build a broader network of relationships, which could elevate feelings of social isolation and assist in gaining general and health-specific knowledge relevant to their new environment [3,4,25]. The importance of language for a refugee's resettlement has been recognised by the Australian government and English language classes have been implemented in many regions. However, a lack of resources has limited the scope and duration of these English language programs and their ability to meet demand [24].

The issue of employment is often discussed by refugee and asylum seeker groups as an important factor in re-settlement because it provides financial independence, increases social contact with the wider community, improves mental health, and offers a greater sense of purpose to the individual [4,25,26]. Relatedly, issues of transportation are also highlighted in previous literature. Not only does transportation refer to availability and cost, it also relates to understanding and navigating how the transport system works and how to access transportation services [27,28]. This may include gaining knowledge, skills, licenses and funds to undertake one's own transportation. Transportation to and from health services has been reported to impede refugees' and asylum seekers' access to healthcare, particularly in rural or regional areas where public transport is limited [27]. This can result in reliance on friends or family to ensure that healthcare needs are met, which may be burdensome or have other financial or social implications [4]. Access to and availability of transportation has been found to open opportunities for employment, reduce isolation and provide a greater sense of freedom [4].

Existing literature indicates that distrust of government services, because of past experiences or oppressive regimes prior to arriving in Australia, is common amongst refugee groups [6]. There may also be confusion or distrust regarding government agencies and entitlements, which can prevent access to services and hinder employment opportunities. For some, this mistrust is a barrier to seeking services [29,30]. In addition, perceived and actual acts of racism, discrimination and/or exploitation are not uncommon and negatively impact upon health, including health service access and utilization [5,29,31,32].

### Common health-related issues facing refugees and asylum seekers

Refugee services have ranked healthcare as the most important matter for refugees in the initial years of resettlement [3]. Refugees have been found to underutilise health services and have difficulty negotiating and advocating for themselves in health environments [4]. In many circumstances, refugees may only access healthcare when ill-health has progressed to a serious level [3,33].

To address some of the challenges encountered by language and communication barriers, interpreting services are increasingly available in Australia. The use of interpreters has enabled more patients to feel respected and better understood within healthcare contexts [5,34]. However, there are a number of challenges within regional settings, including: the availability of female interpreters may be poor or non-existent; the interpreter may be known socially to the patient; interpreter service quality may be less than desirable; the interpreter may speak a different dialect than the patient; and/or the interpreter may be from a different cultural or religious group—all factors that impact upon the patient's ability to communicate with the interpreter and the healthcare provider [3,29]. Alternatives, such as telephone interpreters, have been used. Regardless, communication challenges remain when the patient is required to read or complete medical paperwork, such as informed consent documentation [3,5,28]. It is common that when interpretation issues arise, children, family or friends may volunteer or be asked to step in informally and act as interpreter. Although well-intentioned, these situations can be fraught with misinterpretation, particularly when discussing medical terminology or informed consent. These circumstances can also impact the confidentiality of the healthcare encounter and the privacy of the patient [3].

Refugee patients may choose health professionals who have the ability to speak their first language and encourage them to feel valued and understood [29,34]. However, adequate communication can take precedence over other types of suitability or quality of care, the patient's expectations, or views regarding gender norms, customs and other cultural practices [3,29]. Previous research conducted in regional Victoria (Australia) found that without interpreting services, Iraqi women had to choose between a male Iraqi doctor or a part-time female doctor. In these circumstances, women were choosing between adequate communication and cultural appropriateness [5,24]. This led many of these women to seek care from the nearest hospital, which may be considered a less appropriate service for primary healthcare needs [24,27,29].

Other common barriers to accessing health services for refugees have been identified as: hours of service, issues with scheduling, appointment availability, excessive waiting times and childcare requirements [29]. Financial barriers have also been identified in the

literature, particularly in rural or regional areas where bulk billing<sup>1</sup> options tend to be limited [3,29,35]. Healthcare access can also pertain to accessibility of information, such as what health resources are available, the nuances of health language, and potentially unfamiliar health concepts such as 'preventative health' [24]. Further, existing research indicates that there may be a lack of awareness regarding the services that are available and the rights to healthcare that refugees have in Australia [29].

Re-settling in a different country as a refugee is a complex and often distressing process. Refugees continue to experience the economic, social and cultural challenges discussed above well after arrival. These experiences are underpinned by intersecting, often contradictory, cultural frameworks [13]. Thus, refugees and asylum seekers bring a cultural perspective different to 'mainstream' Australia, including different health histories, perspectives of health, and expectations of services and understandings of the health system. This clearly alters how healthcare is accessed, utilized and understood by individuals re-locating to Australia. These issues are explored from the perspectives of refugees and asylum seekers in a regional centre in Victoria, Australia. This research aims to explore the experiences of refugees and asylum seekers seeking, accessing and utilising health services in a regional centre, and the complex role culture plays in shaping these experiences.

## Methods

A qualitative approach was employed to allow for exploration of the cultural and experiential [36]. Ethics approval for the study was gained from The University of Melbourne.

The study was conducted in a regional centre in the state of Victoria (southeast Australia) which has been home to various immigrant groups since post-World War II migration. It is now home to a significant number of refugees and asylum seekers from many different countries with diverse language and histories. Climates, options for work and knowing others who have settled in the area are anecdotally reported as reasons for locating to the region. The refugee and asylum seeker residents in this area represent a diverse group whose particular cultural memberships and experiences, when stitched together, make exceptionally intricate and unusual patchworks.

The region has a range of health services including a 260 bed hospital, General Practitioners (some of whom 'bulk bill' while others charge a fee), a community health centre, an Aboriginal Medical Service and other private specialist medical and allied health clinics. Most health services in the region are generalist services and many immigrants are unable to access specialist cultural services or services specialized in trauma and other particular health needs without travel to a major metropolitan city 200 km away.

The project was conducted in partnership with a local community health centre that had identified four key groups of refugees/asylum seekers who encountered challenges in accessing healthcare, namely those originating from The Congo, Sudan, Iraq and Afghanistan. In 2016, the Australian census estimated that there were 755 residents born in Afghanistan (2.3%), 464 residents born in Iraq (1.3%), and fewer from The Congo and Sudan living in this regional centre [37].

In order to engage with relevant community members, the community health centre provided researchers with community

contacts. Using these contacts, four community leaders (one from each group) were employed to promote the study and assist with participant recruitment. Community leaders utilised their networks and spoke with potential participants, explained the study and asked permission to provide contact details to researchers. Researchers then contacted potential participants to arrange an interview time and location. Researchers met potential participants at health services, in coffee shops, at their homes and at community venues to explain the details of the study and ask for written consent for an interview. If consent was granted, a confidential, individual, semi-structured interview was conducted, sometimes with the assistance of an interpreter [38,39]. All participants were reimbursed \$50 for their time and any travel or childcare costs incurred.

Participants were asked questions about their experiences of coming to Australia, access to services, the need for health services, the use of health services, barriers and enablers to health services and general issues encountered. However, researchers delved into specific issues with individual participants as responses were provided [39]. Interviews ranged in length from 30 to 55 minutes. English was the only shared language between interviewers and participants and the level of English proficiency amongst participants varied. It must be recognised that a lack of a shared, fluent language impacted upon the interviewers' ability to understand the complexity of responses, stories and experiences shared and, despite the use of interpreters, the researchers are keenly aware that some clarity was lost in interpretation. This serves to highlight the critical importance of shared language for meaning exchange [16]. The authors acknowledge that variations between the cultural knowledge and meaning systems of interviewers and participants has limited the depth of researchers' interpretative analysis [16].

All interviews were audio-recorded and transcribed [40]. All transcripts were then coded through a process of reading and re-reading and assigning provisional codes to sections of data. The researchers then convened to share, discuss and reconcile the coding of data. The resulting codes were then reviewed and related to one another to identify broader patterns in relation to participants' experiences of resettlement and accessing and utilising health services [41]. The analysis of interview data was then formulated into a draft written report and presented to the community leaders who had assisted with participant recruitment. Community leaders reviewed and provided feedback and interpretation from their own cultural lenses [42]. Researchers then returned to the analysed data and focused in detail on four themes relating to experiences of resettlement and healthcare.

## Results

### Participants

Of the 31 participants, six were from Sudan, seven were from The Congo, eight were from Iraq and 10 were from Afghanistan. Further, 14 participants were women and 17 were men. Participants came from culturally diverse backgrounds and length of residence in the region varied. Some had left their home country within a few years and settled in the region, while others had experiences in refugee camps, detention centres and/or travelling through other countries for 15 years or more prior to arrival in Australia. Some participants had previously lived in other areas of Australia. The multiple routes to this regional centre

<sup>1</sup>

meant that experiences of, and need for, health and social services upon arrival, as well as English proficiency and experiences of trauma, varied. In the stories of these 31 participants, four themes were identified that underpinned their experiences of healthcare in Australia: safety and opportunity, language, social isolation and cultural respect. Each of the themes presented highlights the role of culture in accessing healthcare for these participants.

### Safety and opportunity

Prior to exploring key challenges, it is important to situate a narrative of safety, opportunity and relief to be in Australia throughout the interviews: '...it's safe country. And also, we love it, we love this country, we like it. And it's like it's a mix country, multicultural.' In talking about their past and countries they had fled, Australia was described as: '...a safe country, the freedom, the government which has been provided for people all the time. Yeah that's what we like.' Many indicated their motivation for relocation was a better life for their children and so, their children's welfare, education and quality of life were paramount. No comparison could be drawn between the war zones and/or refugee camps that participants had experienced prior to arriving in Australia and their lives now. '...our country, there's a lot of trouble, fighting, war, bomb blasting and like; Australia is a good country.' While there were issues with health services, many expressed:

*There is no comparison between the service here and there because there, back home, you can't go to the doctor if you don't have money; they are not going to deal with you and even if they give you a prescription to buy medicine, you will never buy it because it's expensive and you don't have money to do that. So there is no government support back home so it's different. There is a big difference...*

Despite this positive overlay, the transition to Australia and participants lives had not been without challenges, as elaborated below.

### Language and literacy

**The importance of English proficiency:** Language emerged as a systemic and complex obstacle for the four refugee groups. As noted by one participant: 'the language is the problem.' Most participants had attended English language classes and had found these to be useful: 'when I learn English, I found many thing easy...first thing must be the language.' Navigating the health system and negotiating health-related consultations were shaped by English proficiency. One participant noted this when trying to address a paperwork problem: '...which is what I want to explain to them, but the language is too hard for me, just, I just say which I can't explain in English.' The ability to communicate in English was described as central to all components of participants' daily life.

*You know, when we came here, we were just new and we did not know anything...when you're new you don't know where to go, you don't know where the markets are, you don't even know where the shops are...that was a big, big thing for me [not having English language] but you know, when you're here, you're new in a place, you don't want to communicate with other people because you don't have the language, it becomes a barrier...*

Not only was language a barrier, but not knowing where to go, what to ask for and how the health systems worked also restricted access; not knowing and not being able impacted on healthcare.

Participants' experiences also highlighted the potential for English language proficiency to be overestimated by healthcare professionals and services, even for those who had been in Australia for more than a decade. This has the potential to compromise informed consent and clients' awareness of health-related matters. For example, a number of participants recounted having procedures and surgeries in Australia for reasons they did not understand. One stated: 'I spent three days in hospital...the doctor said, [I] almost died...they should have explained [what it was].'

**Use of interpreters:** While interpreters were generally available, participants highlighted the many complexities of interpretation that are not always considered by health services. Several participants shared their experience of starting a consultation with an interpreter via telephone, where the interpreter would ask what language the participant/client speaks and confirm that this too is their language. However, during the course of the consultation, it would become apparent to the client that the interpreter spoke a different dialect or was not proficient in their language.

*You will find the translator will ask what language you are speaking and...you will find that they will still have limited language in your language, that the translator will say, 'Yes I know,' but you find... they are telling the doctor different things than what you say.*

For some, this led them to seek out doctors who spoke their first language or to use family members or friends as interpreters. All compromised quality of care in some ways. Some participants were concerned about breaches of confidentiality in regard to interpretative services. This was particularly the case with an in-person interpreter, who some participants believed had shared confidential information with others outside of the consultation.

**Knowledge of the Australian healthcare system:** While most did not describe navigating the Australian healthcare system as difficult, there were varying levels of understanding about how the system works. Some participants reported having little interaction with health professionals while others had extensive contact with a variety of health professionals and services and, as a consequence, had knowledge of the hospital and broader healthcare systems. Relatedly, several accounts demonstrated a lack of understanding regarding standard protocols and processes operating within the healthcare system that had led to negative experiences and, consequently, poor health seeking behaviours. Generally, local health services were perceived to be accessible. However, participants did report some difficulties related to appointment procedures, uncertainties about how health professionals 'really feel' about them, and confusion regarding choice in relation to general practitioners (GPs).

Several participants did not recognise the term 'general practitioner' or 'GP', but many indicated they had a good relationship with their primary healthcare providers. The accounts of participants suggest that most had developed strategies to navigate the healthcare system, which usually involved relying on others or, sometimes, trial and error. For example, one participant described how they went to the local hospital for oral care and were then directed to a dentist. Often, learning about the health system occurred at the point of access through a health event that required interaction with health professionals or the health system. These events included acute illnesses, injuries, accidents or pregnancy and childbirth. For example, one woman said, 'When I was carrying my baby (pregnant), that is when I knew more or less about the health system and how it can be applied [to] me.'



**Accessing healthcare:** Many participants explained how they relied on family and friends who arrived earlier to explain the health system. Choice of doctor was largely influenced by family and friends in the first few months: 'I had family here, I asked them. Because it is the same GP they used...I said okay, I can go there too...' Another participant stated: 'One of my relatives, they take me to their GP...and she became my family doctor.' For others, the initial choice of GP was related to the ability to communicate directly with the GP using a shared language, such as Arabic. Sometimes, participants reported a preference for an 'Australian' GP despite some concern about communication while others worried about the cultural assumptions of Australian-born doctors about members of the Islamic community.

Beyond initial contact with and use of a GP, some participants chose to change to a different GP because of choice or because of a difficult health encounter with the initial GP. Other participants were unsure if they could ask to see another doctor, such as asking for a female doctor. There was another group of participants who were currently unhappy with their GP due to the interaction or care they were receiving. However, these participants had not changed GPs because of a perceived lack of choice. 'A woman would be better; I would feel more comfortable...I can't speak with a man...but...there is not much choice.'

Other aspects of health literacy centred on understanding the protocols and processes that lead to interacting with health professionals. For example, discussion about emergency departments (ED) demonstrated a mismatch between participant understandings/expectations and the actual healthcare encounter at the emergency department. 'If you get to the hospital you just see people waiting, just waiting.' There was little understanding of the triage process or primary and secondary care. Understandings stemmed from how services were accessed in their birth countries, which for most were based on the ability to pay for services. Furthermore, the experience of waiting hours for healthcare as well as participants' trust in the services reduced their desire to seek care.

**Acceptability of healthcare:** Participants described healthcare access as good in terms of cost and the acceptability of healthcare professionals. In many cases, participants had good relationships with their healthcare providers. However, when accessing GPs or specialists, there was much discussion concerning appointment times. In some cases, appointments were too far into the future for participants to remember to attend them. In other cases, appointments were scheduled during the wrong part of the day, particularly for those participants who were engaged in paid work. Some viewed healthcare in Australia as requiring money, identifying the importance of income for getting to and accessing healthcare, including eye care, dentists and mental health specialists. Some participants attached cost with quality of care: '...when you have money, you find a good doctor.' Thus language and cultural understandings influenced understanding of, access to and use of healthcare.

### Connection and isolation

Many participants spoke about the importance of social connection and the isolation they experienced; both women and men stating they felt 'stuck' by their circumstances. The accounts of women participants emphasised a radical change in social environment since moving to Australia. Many of these female participants described feeling socially isolated, and 'stuck at home', a situation often accentuated by a language barrier. There was a similar sense of stuck-ness in men's accounts of being separated from immediate family and sometimes

simultaneously jobless. In these circumstances, a series of interconnected factors, including language, led to feelings of entrapment, hopelessness and/or frustration. The feelings generated by these circumstances, for both women and men, were felt by participants to be compromising health in ways not easily remedied by health services.

**Social connection:** Participants' experiences highlighted the importance of considering personal context in discussions of health. Several women expressed how different Australian society is compared to that of their birth countries. Establishing friendships was described as difficult by these women. Younger women without spouses or children described having 'nowhere' to go. Other women described how their husbands and children had established social lives and had a busy-ness with school, friendships and sometimes paid employment, but that they often felt 'stuck at home': '...it difficult for me like staying home, I don't like it...I don't have anywhere to go, so I just stay home.' Another woman commented:

*...as a mum and my family they are busy, my children they are busy at school even most of the time they're busy either at school or either...for the sports. Sometime they're visiting their cousins...or they visiting their friends so I'm going to be alone at home and this loneliness actually, being isolated, being isolated it's much affecting my health and my well-being.*

A language barrier between participants and the wider community was almost always salient in participants' experiences. Not sharing a language made it difficult for women to communicate with people around them and establish social connections; there were feelings of frustration and sadness attached to this. One woman participant talked about 'the first day when I come I feel depressed and here I didn't have friend, I didn't speak English, I far away from my family, yeah all the time I cry yeah.' Participants emphasised their desire to connect, not only with others who share their language and specific cultural background, but also 'Australian' women. The inability of these women to connect with local, long-term, 'Australian' communities had psychosocial impacts of depression, isolation and loneliness.

Similarly, men often felt isolated, lacking in purpose and lonely. Employment provided a sense of purpose and connection with other men. Some men spoke about the stigma of not working and its relationship to (un)happiness and wellbeing: '...if I work, it can just make things better'. Another said, 'Yeah, if you work, you're happy. Why you're happy? Because you pay the rent and then you're eating and you're waiting for your application.' Language barriers were frequently described as a critical component in being unable to find employment. Some of the women participants worked or had worked, some had sought education and training with the aim of employment and others wanted to work. However, they did not report experiencing the stigma or loss of self-worth that men reported experiencing.

Some male participants described how their family was fragmented and they were separated from spouses, children and parents who remained in war zones: '...I've been separated from my family, my wife and my children, all of them overseas...there is sort of disorder, depression start with me because my family overseas.' Men in these circumstances described feeling '...pressure from all sides', receiving pleas for help from family abroad and worrying about the safety of wives and children. At the same time, these men were under pressure from government departments to meet certain criteria to bring their immediate families to Australia, sometimes at a significant financial cost which, with limited employment, was expressed as unattainable.

The effect of these relations was extensive and reactionary; pressure and mental illness affected these men's ability to 'concentrate' to improve their English which, in turn, affected their ability to find employment, limiting their ability to earn money and delaying security and safety for their wives and children. For example, one man participant shared his feelings of pressure:

*At the same time, the language which I have actually is limited or less than limited; it actually does not exist at all, that's why I couldn't find it [a job]. Also, the disorder and sleeping disorder and thinking all that which is considered a barrier to find a job and continue...of course employment opportunity is considered one of the requirements...when I lodged my application, some of the applications need a fee for all the family and that's heaps of money, big amount of money...So all that considered a huge pressure on my health...how I'm going to learn and study if my health in that situation and my well-being. I cannot concentrate to memorise, I cannot concentrate to practice English.*

For these participants, there was a salient sense of entrapment and hopelessness, and awareness that their mental and psychosocial health was compromised by these circumstances.

**Isolation:** Many participants talked about their relocation to Australia being 'difficult', 'hard' and having 'no one' to talk to at first. The isolation experienced from not knowing who to talk to, what to ask for or what could be available left participants to 'look after just my family' without language, income or advice. As adults, these participants were used to making their own decisions, choosing their own options, being in control of routine aspects of daily living and not having the validity of their personal decisions questioned by others. For some, recovering from experiences of trauma, having partners or family in other regions, and/or not knowing others made their first years lonely, and these participants reflected on feeling a lack of control.

Consequently, embedded in many participants' experiences, especially in the first 12–24 months of Australian residency, was a loss of autonomy and control; suddenly, they were in a position where they had to rely heavily on others for basic communication, and many aspects of daily adult life were managed for them by others, in a similar fashion to how adults manage the daily lives of children. This lack of control, coupled with a lack of English, social support and social connection, was described as lonely, depressing and challenging to one's mental health. The implication is that their cultural position coupled to a lack of language is detrimental to their own health, particularly in the early years of re-settlement.

### **Cultural respect**

Some participants discussed experiences of disrespect and disregard for personal and cultural choices. For example, one participant described how a local school had tried to dismiss her decision not to allow her children to participate in certain extracurricular activities, despite her giving quite explicit directives to the relevant staff:

*At school sometime we have a problem...Because we are Muslim we didn't accept the music...and the swimming for the girls...They said you have to go, you have to listen to music, you have to...I go to the music class and I see the children sit down and teacher dancing [laughing] and I said 'I'm not accept it'...I said 'No'. She feel angry and many time she like to...encourage my children to go to music...*

There were other stories where parents and children felt pushed into activities they were not comfortable doing. One parent participant felt

that the teacher resented her girls not swimming and consequently raised other issues (e.g., homework) about her children. She confronted the teacher and then the principal to address this as she felt it was discrimination. Other participants talked about challenging the teachers to avoid pressure on their daughters: 'I didn't like to complain to anyone, but she force me to complain because I didn't...because my children feel sad, because not happy; the teacher and principal, they didn't like them.' Some mothers were assertive in negotiations with schools but still did not feel respected for their choices. Such experiences question how refugees are listened to by the broader community during this early period of resettlement.

A few participants had directly experienced explicit discrimination from health professionals. Usually, these participants did not challenge this but on occasion challenged statements or actions that intended to exclude or disrespect. Most, however, indicated that healthcare professionals were respectful and kind, although some participants questioned if this was genuine: 'When I first seen the doctor and the nurses face-to-face [they] can't say anything...But I don't know when I give him or her my back, I don't know what they said behind me...'. In some circumstances, participants reported feeling as though the health professional was not listening to their health needs or issues. Women who identified as Islamic remarked that a number of health professionals were aware of their religious need while others, particularly those who had experienced violence or trauma prior to arriving in Australia, did not feel their cultural needs were known or respected.

**Gender in healthcare:** Women's responses indicated that the gender of the interpreter in any medium can constrain the kinds of issues women feel comfortable raising in health-related consultations. Some women participants explained how there are certain intimate issues that they would prefer to communicate directly with a female health professional, even if this compromised the quality of communication.

*...Like if you need to see a doctor then you know, your doctor is like man, yeah is a man but you just feel shy and too like you know, the girls have the like the secret sometimes, you can be have some pain down here, then you just, you don't—you just feel like feeling, you feel ashamed to tell, to tell him so what can you do...it's very shame to tell...*

Women participants expressed that using an interpreter on the phone was still another person who would know this private information. As one woman participant stated: 'But there is something just, I don't know how to say it, they like, there is something which I can't, I can't like say even to interpreter...be like a secret for myself and they tell the doctor...find it hard to say.' Other experiences suggested that if the interpreter is a woman, women may feel more comfortable to raise intimate issues with a female health professional.

In these ways, culture, manifested through language, gender relations and communication in healthcare, impacted communication between healthcare provider and patient and the care received. Coupled with language barriers, lack of understanding of the Australian healthcare system, social isolation and issues of respect, many of the participants failed to receive adequate healthcare.

### **Discussion and Conclusion**

Interviews with 31 refugee and asylum seeker residents identified diverse experiences of settling in Australia. Most were pleased and relieved to be in Australia and spoke of safety and opportunities for children. While a few praised the broader community and spoke of

positive experiences, others highlighted difficulties with services, relationships, or accessing quality healthcare. Underpinning these difficulties were proficiency in English language as well as health literacy, social isolation, and cultural disrespect. These stories highlight the importance of culture in understanding the experiences of refugee and asylum seekers and the interconnectedness of many issues that impact how these new residents access and utilize healthcare.

Like earlier studies, English proficiency was identified as a major issue for refugee and asylum seeker residents in accessing healthcare, navigating the health system and feeling culturally safe in Australian-based services [3-6]. Interpreters and multi-lingual doctors sometimes assisted with access, but interpretations were not always accurate and other cultural institutions, including gender, could detract from the care received. In this study, there were concerns about trust and confidentiality as well as issues with accurate and culturally appropriate translation [29]. Further, expectations of services often stemmed from experiences prior to Australia, which shaped use (or lack of use) of services and could lead to a lack of confidence in the services received [42]. For most, the health system was learned when needed; some had accessed a range of services while others had limited knowledge of the available services and the choices available to them [4,29]. A lack of English also limited social interaction, the development of new relationships and increased isolation [3,4,43].

A range of social issues were reflected in the stories of participants' health and wellbeing. Participants desired social connection and wanted relationships with members of the broader community. Social connection was impacted by language barriers, cultural differences and lack of paid work. On the other hand, English proficiency and employment provided avenues for social connection, a sense of mastery and cultural engagement. In particular, work provided social connection, income, status and self-worth. For men, employment could assist in moving on with their lives while unemployment could lead to isolation and depression. Relatedly, participants spoke of the psychological issues they experienced in Australia, again reinforcing the importance of social connection, belonging or isolation.

What became clear in participants' stories was the complex interplay of many issues that resulted in individuals' choices, experiences and challenges. Language was particularly important, and most participants wanted to speak English fluently. They also needed English to navigate health systems, build social connections, seek employment, advocate for their family and prevent isolation. On the other hand, a lack of English may lead to friends becoming interpreters and compromising confidential healthcare. In addition, the inability to complete forms and inquire about services resulted in individuals feeling belittled, inept and frustrated. While English language classes were well used, the extent of these classes did not result in individuals being proficient enough in English to secure employment, navigate the health system or make broader social connections.

New cultural systems take time to learn—adapting to Australian society was stressful for most participants. Even for some who developed proficiency in English, understanding how to navigate health and employment systems was difficult and few indicated strong connections with long-term 'White' residents. Many participants felt disrespected for their lack of English and/or their religious beliefs and these resulted in frustration and further isolation. Such experiences illustrate the complexities involved for individuals in negotiating between the multiple cultures in which they are simultaneously situated.

Refugees and asylum seekers do not arrive in their host countries devoid of healthcare knowledge. They come with diverse health beliefs and understandings that are informed by prior culturally situated knowledges and culturally informed experiences of health [42]. This is especially the case for refugees and asylum seekers in Australia who are often operating within and negotiating between quite different cultural systems. This paper has drawn on the stories of refugee and asylum seeker participants living in a regional centre to illustrate some of the complexities involved in the cultural negotiations of accessing and utilising health services. For those in the mainstream health sector, this work offers insights into the experiences of refugees and asylum seekers in accessing and using health services, which could potentially foster greater cross-cultural understanding, respect and empathy. It also highlights the role of culture in accessing and using healthcare, suggesting we need healthcare systems that are culturally diverse and inclusive.

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