The Roles of Health and Health Care Services in Social and Cultural Integration of Ethnic Minority African Migrants: The Case of the Luo Community of Wellington

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Abstract

This research provides anthropological analysis into the intersection between migrants' health, healthcare services, and the concept of migrant integration, focusing on the Luo community of Wellington as an ethnic minority African immigrant community. Spurred by current trends in global migration, social and cultural integration of immigrants in host countries has become a critical global issue. The relationship between migration and health is an under researched topic both in New Zealand and elsewhere. The social aspects of health that effect processes of adaptation and integration of migrants are also not yet widely acknowledged. The members of the Luo community of Wellington face adaptation and integration challenges related to both their premigration and postmigration experiences that continue to affect their sociocultural integration in New Zealand. The premigration experiences highlight the dynamics of community members' country of origin and the social and health impacts on individuals and on the family group. The postmigration experiences relates to the social and health impacts of resettlement and adaptation to life in New Zealand, associated with processes of acculturation and its related stress factors – language, as well as cultural and social barriers to integration.

Based on ethnographic research with the Luo community of Wellington, this research contributes to anthropological research on migration, immigration, refugee and ethnic minority experiences, health and well-being, culture and social policy. Health is key to successful integration, however, ideas about health vary widely across cultures and societies, and this research shows that health is primarily measured in biomedical terms, neglecting the social spheres that are core to well-being for migrants (and others). Intergenerational differences in the rate of acculturation results in intergenerational cultural dissonance which leads to friction within families. Institutional and personal racism experienced by members of the Luo community within health care settings negatively affects the doctor-patient relationships, increasing vulnerability to poor health outcomes. The issues of cultural competence experienced by community members within health care settings, affect doctor-patient communication crucial to intercultural healthcare provision. All work in this thesis is that of the author, except where otherwise stated.

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Chapter One: Introduction

Background and Context

This introductory chapter outlines the research topic conception, background, context, and research significance, as well as presents the research question. The chapter also offers a brief outline of the structure of New Zealand's health care sector to contextualize health care service provision.

Spurred by the increasing number of migrants across the globe, socio-cultural integration of migrants into host societies has become an issue that has attracted widespread scholarly attention. Within the European Union, some member states have, in recent years, developed policy documents introducing economic, social, and political integration models. See for example; social integration of migrants and ethnic minorities within the European Union member states (Rudiger and Spencer, 2003), economic, social, cultural and political dimensions of migrant integration (Penninx, 2004), social integration of migrants in Europe (Spencer, 2006), the role of the state in cultural integration of migrants (Joppke, 2012), and migration policy versus migrant integration across the EU member states (Craig, 2015).

Migrant integration has become a subject of both academic and policy discussions in New Zealand as well: for instance; a review of migrant settlement literature and its relevance to New Zealand (Fletcher, 1999), migrants and refugees' experiences of discrimination and social exclusion in New Zealand (Butcher et al, 2006), local attitudes towards immigrants, immigration, and multiculturalism in New Zealand (Ward and Masgoret, 2008), new migrant settlement and integration strategy (Controller and Auditor General, 2015), supporting new migrants to settle and work (Immigration New Zealand, 2016), experiences of African immigrant and refugee background mothers living in Auckland (Ed: Schultes and Vallianatos, 2016) and integration of new migrants into labour markets (Labour and Immigration Research Centre, 2018).

Whilst migrant settlement and integration literature in New Zealand and other countries covers diverse topics ranging from access to social institutional structures to socio-political issues such as institutional racism and social exclusion, the literature on the impact of health on migrant integration is still scarce.

This research provides anthropological analysis into the ways in which members of the Luo community of Wellington (a predominantly refugee background ethnic minority African migrant community) individually and collectively experience and negotiate the process of adapting to life in Wellington (and New Zealand). In particular, this research focuses on the roles played by people's health status and their interactions with health care services in this process. Without good health, socialization can be difficult, even for members of the non-migrant population. Moreover, migrants (particularly refugee background migrants) are more vulnerable to poor health due to past traumatic experiences, environmental and socio-cultural changes, as well as adaption-related stress (Johnson, 2005, De Angelis, 2009, Henley and Robinson, 2011, Kleber and Jongmans, 2013, Poindexter, 2013, Alegria et al, 2017, Mapuranga, 2017).

Research Question

In light of the above outline, this research seeks to address the following two-part question:

How do members of the Luo community experience social and cultural integration in New Zealand as ethnic minority African migrants? And what role does health play in this process?

Research Significance

This research contributes towards current anthropological and other social scientific research related to the areas of migration, migrant integration, ethnic minority and refugee experience, health and well-being as well as social policy. The interconnected relationships between aspects of migration and health remains an under researched area despite the current high level of international migration. The continuing growth of New Zealand's cultural diversity calls for a renewed look at local and universal conceptual interpretation of migrant integration. Common theoretical assumptions of migrant integration also need to be critically weighed against practical realities of migrants' adaptation to new socio-cultural environments. Thus, this research also aims to make a

contribution towards achievement of clear theoretical understanding and appreciation of practicalities of migrant experiences and integration in New Zealand. This will not only improve migrant experiences, it will also enhance inter-ethnic relations, thereby adding value to people's social well-being and sense of security.

The social aspects of health that affect migrants and their families also require urgent attention. Migration affects health in various ways through, for example, loss of familiar environments, change in diets, loss of social connections, and the stress related to adapting to new social and cultural environments. Refugee migrants are often more exposed to poor health due to a variety of factors - forced migration, vulnerability to violence, and negative effects of displacement (Fonceca and Melheiros, 2005). All these factors impact people's physical, emotional and social well-being. Hence, incorporating them in this research is hoped to shed light on the extent to which migration (particularly refugee status migration) impacts people's health and well-being, which in turn affects the integration process. The extent to which processes of adaptation and acculturation impact people's emotional and physical health is also currently overlooked and requires reconsideration (Algan et al, 2013, Kia-Keating et al, 2016). For many migrants, including members of the Luo community of Wellington, there are multiple social, cultural and institutional barriers[1] to adaptation and integration - learning a new language and adapting to new socio-cultural and institutional environments, for example. These have serious implications for people's health and social wellbeing. Acculturative stress can affect intergenerational relations in migrant families. For instance, the differences of the acculturation rate between the younger and older generations may result in intergenerational cultural dissonance, leading to intergenerational conflict and loss of family bonds (Choi et al, 2008, Birman and Poff, 2011, Renzaho et al, 2017). This will be examined later in this thesis.

Although Māori and Pasifika cultural values have been largely integrated into the New Zealand health care system (or at least acknowledged and some efforts made), many of the other ethnic minority cultural groups currently living in New Zealand are

[11] For detailed readings on issues of health equity, ethnic health inequality, and other institutional and structural issues related to the New Zealand health sector see: Ministry of Health, 2002, Hefford et al, 2005, Reid and Robinson, 2006, New Zealand Medical Association, 2011 Came, 2014.

still on the margins of institutional cultural-difference acknowledgement. This is reflected in the available literature on ethnic health inequalities, which is primarily concerned disparities between Pākehā, Māori and Pacific Island ethnicities. As a result, there are some deficiencies in relation to cultural competencies within the health care workforce. This research also attempts to address that gap. By drawing attention to the significance of culture and cultural competence in health care provision this research will contribute towards transforming cultural competence, and therefore improving intercultural communication. An improvement in intercultural communication between migrants and health care workers will increase the chances of achieving positive health outcomes for migrants and ethnic minority groups in New Zealand (see Durie, 2001, Medical Council of New Zealand, 2006, Napier et al, 2014).

The Luo Peoples

> Luo peoples are one of the two branches of the Western Nilotic tribal groups, the other being Dinka-Nuer. But there is very little written history of the Luo peoples and their migration […] Most of the Luo history that I know is from oral tradition. But what I have heard is that, we originated from Sudan […] and we migrated down southwards due to various factors such as; wars, famine, searching for new fishing grounds, agriculture, and later colonization. The Luo people followed the Nile river […] some say we originated from Bahr el Ghazal region in North-western Sudan, and others say that we came from further up North of Sudan (Personal Interview: Francis, June 16, 2018, Lower Hutt)

Francis, one of the Luo community leaders, is a Ugandan Alur who arrived in New Zealand in 2003 under the UNHCR quota programme. The Alur are part of the Luo peoples who occupy parts of north-western Uganda and north-eastern Democratic Republic of Congo. As he stated, the Luo peoples are part of the Nilotic group of tribes that occupy parts of the East and Central African regions, stretching from Sudan, through the Nile Basin, to as far down as Lake Victoria (Uganda, Kenya, and Tanzania)

(Figure 1). Due to migration over the centuries, today, pockets of the Luo population span at least six countries in the East and Central African countries, including; South Sudan, Uganda, Democratic Republic of Congo, Kenya, Ethiopia, and Tanzania (Blount, 1972: 235-48).

Figure 1: Regional map of East and Central Africa – Luo peoples home region. (Source: Black History Heroes, 2018)

The Luo do not follow one specific religious ideology. They have adopted diverse religious beliefs, including Islam, Christianity, and various traditional African religions. Linguistic commonality and ethnic history are the common identifiers among the Luo across the borders of the various Eastern African countries (Okong'o, 2011, Personal interviews with members of the Luo community, 2017, 2018). The ethnonym "Luo" refers to a linguistically related family of tribes, and depending on the country, is varyingly spelled "Luo" "Lwo" or "Lwoo," but with the same pronunciation (Shipton, 2007: 45, 2009: 59-63). Not all peoples who identify as Luo, necessarily call themselves or are called by others "Luo" first, unless when talking about tribal migratory history.

For instance; the Acholi people both in South Sudan and Uganda, the Jhopadhola and the Alur of Uganda and Democratic Republic of Congo, the Anuak of Ethiopia, the Dholuo of Tanzania, and the Kenyan Luo, are all Luo peoples, but are commonly known by these respective sub-tribal names (see Blount, 1972: 235-48, Ocholla-Ayayo, 1979: 173-93). Shipton (2009: 62)'s work with Kenyan Luo highlighted the fact that only the Luo of Kenya and Northern Tanzania identify themselves as Luo first, while others primarily add Luo as a second ethnonym. However, for the sake of conventionality and consistency, I will only use the term "Luo" throughout this paper when referring to all Luo peoples, including the Luo community of Wellington.

The Impact of Political Conflict on Luo People in South Sudan and Northern Uganda

> One of the first things history reveals is that war and mass forced displacements in this region of Africa are much older than they appear. Armed traders, mostly Arabs, who infiltrated the Upper Nile region from Khartoum ravaged the lands of what has become the Uganda-Sudan border from the mid-nineteenth century. Their incursions were fuelled by an insatiable demand in industrializing countries for ivory in the manufacture of billiard balls, piano keys, and other luxury items. In addition to purchasing ivory, the traders raided the population - often with the assistance of local allies - in order to procure slaves, who served as porters to transport the ivory north, but were also sold as sex slaves and trained as soldiers in the traders' private militias and the Egyptian army (Kustenbauder, 2010:453).

Although Luo groups are spread across several countries in East Africa, members of the Luo community of Wellington are primarily South Sudanese and Northern Ugandan Luo, who came to Wellington after escaping the conflicts in their own countries. While interethnic and interclan conflict and other acts of violence have existed in almost all societies for as long as history can recall, political conflict has intensified and plagued the East and Central African regions throughout the 1990s and continues to this day in

some countries in the region. Almost all of these conflicts can be associated in one way or another to the region's encounter with certain outside forces, in particular; activities of Arab traders and Arab socio-political influence in Sudan and Uganda, paralleled with European imperial expansionist ideas, such as slave trade, Christianization, and colonization, followed by the subsequent democratization of the two countries (and indeed, of the East African region). See for example; the political and economic history of Uganda (Sejjaaka, 2004), ethnic fragmentation and political instability in post-colonial Uganda (Tornberg, 2012), Great Britain's policy on the Ugandan-Tanzanian war of 1978-1979 (Skaar, 2015), governance and ethnic politics in Sudan (Kon, 2015), the history of conflict in Sudan (Ottawa and El-Sadannay, 2012), the division of Sudan into two states (Musso, 2011). While these earlier influences may be considered long past, they continue to influence relations between people. For example, Nunn and Wantchekon (2011) conclude that a culture of mistrust which persists to this day between ethnic groups throughout the African continent may have evolved as a result of the business of slavery, because, as Nunn (2008: 142) noted:

> Africa's slave trades were also unique because, unlike previous slave trades, individuals of the same or similar ethnicities enslaved one another. This had particularly detrimental consequences, including social and ethnic fragmentation, political instability and a weakening of states, and the corruption of judicial institutions.

Colonization of the African continent has had a profoundly negative impact on ethnic relations across the continent for a variety of reasons- including unfairly apportioned lands that previously belonged to whole tribes or communities, as well as cases where colonial administrations have installed individuals of their choosing in positions of authority against local cultural norms and traditions, resulting in social disintegration between tribes, even clans. One example of this is the current South Sudan/Northern Ugandan border, part of a colonial subdivision delimited by the Anglo-Belgian agreement in 1915 that runs through Luo country; at the time of deciding on the border, the regional population was not considered, and today parts of this border are a source of ongoing land conflict in the area (see Khandiagala, 2009: 267, Leornadi and Santschi, 2016).

Conflict in Sudan

The conflict in Sudan is multifaceted with a long and complicated history. Sudan was originally controlled by neighbouring Egypt for centuries. Arabic language and Islam were common in the North, while the South was dominated by diverse African ethnic groups who practiced mainly African religions (Ryle, 2011: 70-87). However, developments of the late nineteenth century impacted negatively on the country's socio-cultural and political relations. The Anglo-Egyptian joint rule of Sudan (1878-1956) saw increasing numbers of European explorers and rapid growth and dominance of Arab trade. Arrival of European missionaries (particularly in the south) also saw an increase in the development of the Christian faith (see Abushouk, 2010: 207-236, Woodward, 2011: 149-163). As traders, explorers, and missionaries forged alliances with certain clans and ethnic groups, often supplying arms and ammunition to tribal and clan leaders in exchange for ivory and slaves, they fuelled ethnic rivalries (see James, 2011: 130-48).

Sudan gained independence in 1956. However, this was followed by intense fighting, believed to have been provoked by the then Arab dominated government's attempts to turn the country into a culturally Arabic state (Gueye, 1978: 150-215, Allen, 1991:64-91, Lodhi, 1994: 90). Today Sudan is split into two countries: South Sudan (which gained autonomy from The Republic of Sudan following a referendum in July 2011 (Rolandsen et al, 2010))[2] remains predominantly Christian, while the North (the Republic of Sudan) predominantly Islamic. The first civil war began in 1955 (around the time of independence) and lasted until 1972. But the mostly Muslim government of North attempted to impose Islamic law on the South, which eventually led to the eruption of the second civil war in 1983, which ravaged the country until 2005, until the signing of another peace agreement (see Gebbede, 1997: 15-31). The Sudanese People's Liberation Army (SPLA) the main rebel force, represents the diverse ethnic groups of

[2] This has not been without issue - shortly following independence, a new ethnically aligned political power struggle emerged in South Sudan (see Johnson, 2016).

the South (including the Acholi Luo, Dinka, Nuer and others) in the fight against Northern government army. The civil war is believed to have caused more than two million deaths, and displacement of more than four million people (see Musso, 2011: 1-28, World Vision, 2018). All my South Sudanese Luo friends fled from this second civil war, which lasted twenty-two years (1983-2005).

Joyce is one of my Luo community friends, and she was only seven years old when Sudan's second civil war (1983-2005) broke out. The following is an account from Joyce, as she recalled her experiences of the South Sudanese conflict and the events that led to her fleeing the country as a sixteen-year old college student in 1992:

> The biggest problem in Sudan at the time was the government soldiers fighting with the rebels […] The government just wanted to change everything into Arabic, the school was closed because they wanted every subject to be taught in Arabic language, which was very difficult because before, everything was taught in English and local native languages […] And on top of that, the books, including history books written in English were all damaged and burned off […] and everything changed into Arabic […] All English teachers were sacked, and they brought their Arabic teachers from Khartoum to teach English. That didn't work, and the students didn't like that […] Plus, a lot of fighting, hunger, no money for us, suffering, shooting and death every day […] And then they started arresting students […] they used to kidnap kids from their houses at night and take them to some far-away place to kill them […] so many people were disappearing. So, that is how we started planning to leave Juba.

While Joyce's account indicates on one hand, her understanding of the twenty-two-year-old Sudanese civil war as a direct result of politically motivated tensions between the rebel forces and the Sudanese government, she also clearly highlights the socio-cultural and ethnic complexities that fuelled the violence, namely the government's attempt at Arabization of the country, through the education system, which Allen (1991: 64) also discusses as one of the principal courses of violent political conflict that has plagued the country for decades.

Conflict in Uganda

[3]Armed conflict in Uganda has had effects on Luo people in that country, similar to the Sudanese conflict did on the Acholi Luos of South Sudan. The Northern regions of Uganda which makes part of the Luo country was particularly affected. One other common denominator which may explain similarities in ethnic relations policies in the two countries, and the reasons for South Sudan and Northern Ugandan region's marginalisation, is that both Uganda and Sudan are former British colonies (Uganda was under British rule from 1894 to 1962). Precolonial Uganda was primarily inhabited by the Bantu tribes in the south and the Nilotic tribe in the north, who were organized into five (mainly agriculturalist) kingdoms; Buganda, Bunyoro, Busoga, Ankle and Toro, while the North was occupied by several ethnically diverse, pastoralist clan groups including the Luo groups; the Alur, the Acholi, the Langi and others. Foreign traders and missionaries reached Uganda around the mid-nineteenth century (see Baker, 2001, Uganda Bureau of Statistics, 2014, Amone, 2015).

When the British colonial administrators came to Uganda, they favoured the more organized, agriculturalist kingdoms of the South (especially Buganda), and treated the Northern tribes and clans as slightly backward. Because the colonial administration was based in Kampala, the capital of the Baganda people, the Buganda kingdom became a power base from which other kingdoms were annexed. This created a culture of mistrust between the Bangda and other ethnic groups that remains to date (see Golooba-Mutebi, 2008: 1-27). At independence in 1962, King Mutesa of the Baganda was appointed as the country's first president while Milton Obote, himself a Luo from the North, became the first prime minister (Kintu, 1995). The first decade of Uganda's independence was a time of significant socio-political changes that brought with them increased ethnic tensions, leading to extreme ethnicization of the country's politics (Fredrick, 2009). Within four years of independence (in 1966), Obote deposed Mutesa and took control of

[3] The Luo peoples occupy both sides of the Uganda-South Sudan border. And as a consequence, the intensification war on both sides of the border significantly affected the Luo peoples much more. For further reading on the Northern Uganda-South Sudan cross border ethnic relations, see (Allen, 1991: 63-91, Ochan, 2009: 1-23, Leornardi and Santschi, 2016)

the government as executive president, and shortly afterwards he introduced new constitutional laws, including abolition of kingdoms and monarchies (Habyarimana et al, 2007).

However, after only five years following his power takeover, Obote was also deposed in a military coup by one of his generals, Idi Amin. Idi Amin's eight-year rule of Uganda has been described as one of the darkest episodes in the country's modern political history (Personal Interview: Francis, 2018). Amin is believed to be responsible for the deaths of an estimated 300,000 people in Uganda, during his time as president (see Martin, 1072, de Hoyos, 1995, Nurnberger, 2003: 1-2). The Acholi, Langi, Alur, and other Northern tribes were particularly targeted, as Amin accused them of supporting Obote (himself a Northern Luo). Idi Amin was deposed in 1979, with help from the Tanzanian army, and Obote came back to lead the country once again (see Skaar, 2015). However, the political culture of ethnic violence continued, and in 1985 Obote was once again ousted from office by yet another army general Tito Okello, a fellow Luo (an Acholi from North).

My friend Francis is now sixty-nine years old. Born and raised in Northern Uganda, he was only thirty years old with a young family when Amin was finally forced out of the country in 1979. He became actively involved in politics as a youth leader in Obote's post-Amin government, but when Obote was deposed by Museveni in 1985, the political situation in Uganda became too unsafe for him, so he fled the country and sought refuge in Sudan:

> I went into exile in 1985, shortly after Obote was ousted by general Okello because then I had been an active supporter of the Obote government […] I was part of the ruling party's youth leadership, so I was involved with organising political rallies and so on. But because of the violent political culture that had emerged during Amin's rule, many of the people who were supporters of the ousted government were killed […] Many people were [4]hunted down and murdered, so I

[4] The introduction of the 1987 Immigration Act saw the elimination of both the discrimination against some races and nationalities and the preference for others. Three categories of incoming migrant admission were established under the Immigration Act of 1987. These are: Skills and business stream, Family Stream and Humanitarian Stream (New Zealand Immigration Service, 1987)

> knew of many people who had been killed […] We just getting ready for general elections in that year when general Okello staged the coup, and I was one of those who were arrested for being an Obote's supporter. I was put in military detention in Gulu for ten days, and I was only helped by a lieutenant who sympathised with the ousted Obote government after telling him where I came from, and what I had been doing.

The long history of conflict situation in Uganda has had lasting effects on the people of that country. According to the Norwegian Refugee Council (2016), an estimated 42,786 people have been displaced by the ongoing conflicts in Uganda, including 30,000 internally displaced people and 12,786 currently resettled in various countries around the world, including New Zealand.

African Migrants in New Zealand

The African immigrant community in New Zealand form one of the many ethnic minority population groups in the country. However, because of the size of the African continent, there are numerous, even smaller, ethnically diverse groups within the larger African immigrant community (particularly amongst black African migrants). To contextualize the Luo community of Wellington, this section will briefly discuss the African peoples' migration to New Zealand (drawn from the little existing official records). Black Africans are amongst newer arrivals to New Zealand, notably from the early 1960s (see Williams, 1965: 7) The Special Commonwealth African Assistance Plan (SCAAP)). Until a change of immigration policy in the mid-1980s, New Zealand had the "traditional source country" immigration policy, which favoured mostly immigrants from the United Kingdom, Ireland and Northern Europe, only a limited number of African migrants came to New Zealand (see New Zealand Immigration Act, 1987, Bedford et al 2005, Warlrond, 2005, Carl, 2009, Statistics New Zealand, 2010).

Records show that the first few black African migrants arrived during the early to mid-1960s, mostly as assisted students under the Special Commonwealth African

Assistance Plan (SCAAP), commonly known as the Colombo Plan (Williams, 1965: 7, Chile, 1996: 151, Lowe, 2010, Collins, 2012, Adeleke, 2013).[5] Lyson Banda, who now lives in Auckland with his family, is a former Colombo Plan student who came from Zambia in the mid-1960s. When I interviewed him in 2017, he thought that while most of the Colombo students returned to Africa at the end of their studies, a handful may have stayed, had families and settled.

In 1987 New Zealand adopted a new Immigration Act changing the earlier focus on nationality and ethnic origin as the basis for admitting migrants. This led to inclusion of refugee status migrants in the immigration policy, which at the same time ensured that New Zealand meets its obligations under the Refugee Convention (Immigration Act 1987: 242-53). A formal annual refugee quota was adopted, which allowed 750 refugees to be settled in New Zealand each year (Immigration New Zealand, 2018).

Although there are many African migrants who came to New Zealand voluntarily, there are many black Africans currently living in New Zealand who arrived in the country either as refugees or asylum seekers, as a result of a series of violent armed conflicts that erupted in several African countries during the early 1990s. By 1994 continental Africa had over six million refugees and fifteen million internally displaced people (Chile, 2002).[6]

The Luo Community of Wellington

I was first introduced to the Luo community of Wellington by my friend Francis, one of the community leaders, who I worked with for an Honours paper in anthropology in 2017, investigating the ways in which members of different African immigrant communities experience cultural integration in New Zealand. Members of the Luo

[5] It is possible that the SCAAP students were not the only migrant group from continental Africa at the time, but as mentioned before, earlier records of African migration to New Zealand are difficult to find as Africans and other ethnic minority migrant groups were (and are still) often recorded as "other" ethnic groups, or combined with several different groups, for example; Statistics New Zealand (2013) records Middle Eastern, Latin Americans and African migrants under one category as "MELAA".

6 Between 1990 and 1994 Ethiopia and Rwanda are believed to have generated an estimated 4.2 million refugees between just the two of them (Tuwe, 2012).

community of Wellington started organising themselves as a community in 2016.[7] The community itself consists of eight families (roughly around fifty individuals) of predominantly quota refugee immigrant background, mostly originating from South Sudan and Uganda.

One of the reasons I felt compelled to look at the role of health in the Luo community's integration process is because health was raised as one of the primary factors affecting the adaptation process in my Honours research in 2017. When I posed the question of integration experiences, a few of my research participants, including my Luo friend, highlighted challenges regarding interactions with health care professionals when seeking health care services. Some of the issues raised at the time included; language barriers (particularly among the elders), discrimination, and lack of cultural consideration.

All members of the Luo community arrived in Wellington under the Refugee Quota Programme, between 2003 and 2009, mostly from South Sudan and Northern Uganda, where many people have been displaced by regional civil wars since mid-1980s. While the Luo have reimagined themselves as a community in Wellington (Anderson, 1983), the fact that community members have come to New Zealand with different nationality backgrounds means that, in addition to their effort to build community agency within the Wellington region and the wider New Zealand society, they are faced with the task of having to renegotiate their national differences to maintain community social cohesion:

> I came to New Zealand in 2003 under the Refugee Quota programme, with my six children; two girls and four boys. Almost everyone in my community came under the Refugee Quota. To start with, I didn't know anything about New Zealand […] We were put in an aeroplane to take us from Kenya to South Africa. Even then, I had no idea where I was going; I had never been on an aeroplane in my life before then, but once I was in the plane, I realized that I had left my country […]. You know, your own place is your own place. I was upset, I prayed,

[7] Nearly all other African ethnic migrant communities around the Wellington region are mainly made up of people who come from the same country, and therefore, their community identities are generally based on home country national identity.

> and I also cried during the aeroplane trip until we got to Australia, it was very difficult. (Personal Interview: Margaret, 22 June 2018, Upper Hutt).

During the ten-year period between 1992 and 2002, about 3000 refugees from the East African region were resettled in New Zealand under the United Nations High Commissioner for Refugees (UNHCR) quota system[8] (Immigration New Zealand, 2004). Although some of the Luo community members arrived under the Family Reunification programme[9], the majority of those I spoke to came with some of these groups under this quota programme. In Francis's words:

> I came to New Zealand from Ethiopia in 2003 under the UNHCR quota programme, after spending eighteen years in refugee camps between South Sudan and Ethiopia. So, I have been here for fifteen years now […] It's quite a long time. But because of the new culture that we came to, we are not able to exercise all our culture, which is difficult […] But now we are trying to bring the New Zealand culture to our culture through the Luo community […] to integrate New Zealand culture into our culture was a problem from the start […] and it is a problem up to today, especially for families. One of the problems is that our community is small. Perhaps if we were a bigger community, we would have made a big difference […] But because our community is so small, we can't do much. The larger community is eating us up (Personal Interview: Francis, June 16, 2018, Lower Hutt).

[8] Quota Refugees are people who are registered as refugees by the UNHCR, but who cannot be offered a permanent solution in the country they are in and as a result are offered resettlement in a third country.
[9] The United Nations High Commissioner for Refugees (UNHCR) promotes and assists with the reunification of families of people who are outside their country of origin who are refugees as recognised by the UNHR statute of the UN Refugee Convention 1951 (see Refugee Convention, 1951, UNHCR, 1983).

The Significance of Health in Migrant Integration

Although being a migrant could not be viewed as a health risk, the process of migration may increase people's vulnerability to poor health. There are several contributory factors to this, particularly when migrants are moving to a completely new and foreign socio-cultural environment. Firstly, there is often heightened anxiety due to loss of the familiar (cultural and physical environments), loss of home, social connections and sometimes material possessions. The form and course of migration can positively or negatively impact health, and health status plays a significant role in how people adapt to a new environment. Forced migration for instance, often leads people to conditions of displacement (such as detention centres, refugee camps, poor diet and housing) that may increase people's vulnerability to poor health (see Wickramage et all, 2018).

Adapting to life in a new environment has challenges that may impact health outcomes. For many migrants, (especially refugees) who come from socio-cultural and political backgrounds that are different from those of the host nation, there are often multiple social and cultural barriers to integration that also impact health. Low socio-economic status, language and communication barriers, acculturation stress, loss of family and friendship network support and sometimes discrimination and exclusion can all increase vulnerability to poor health (WHO European Region, 2018). Language and communication barriers have been discussed by some researchers as key contributory factors to migrants' vulnerability to poor health, as well as primary barriers to integration, for example; significance of language and cultural comprehension on migrant integration (Ministry of Health, 2012, Human rights Commission, 2009), the impact of culture on health and health promotion (Napier et al, 2014, WHO Regional Office for Europe, 2018). Bradby et al (2015: 12)'s work which looked at evidence of health status for refugees and asylum seekers across the EU member states found that lack of common language between health care staff and patient is associated with decreased symptom reporting and fewer referrals to secondary and specialist care. While some people may argue that it is the migrants' onus to learn their new country's language and culture, integration is not, and should not be viewed as a one-way process. It involves migrants' interactions with locals, and as such locals' effort to learn and

understand aspects of migrants' cultural values is equally crucial to migrants' development of sense of belonging (see Spencer, 2006).

Without adequate communication, people who are faced with language and cultural barriers (particularly refugees and asylum seekers) receive poor health care. According to WHO (2018), culturally competent health services should offer more than just minimal communication. Health care professionals should grasp not only the social and political situation of the migrant's country of origin, but how migrants perceive health and well-being. Bradby et al (2015: 11) have noted that "where migrants (refugees) perception of health differs from those of health care professionals, appropriate care may be difficult to achieve". The authors argue health and welfare services are constructed around the bio-medical definition, which may differ from immigrant's cultural perceptions of good health. Hence cultural competence in health care service is imperative to achieving positive health outcomes for migrants.

Using a bio-cultural approach to investigate the effect of cultural beliefs and practices on health status among the Luo people of western Kenya, medical anthropologists Tamer Rahed and Mohamed Galal (2015), found that the daily life events of their study participants were hinged on many cultural beliefs and practices that directly impact health status of individuals. The study concludes that "the health of a given population is not a function of biological aspects only, but it is affected by the cultural elements as well" (703). So, cultural influence (on both patient and health care professional) should be considered as a key element in cross cultural health care provision.

In New Zealand the health care sector is linked to language interpretation services to address the language barrier that some migrants face. Non-governmental and voluntary agencies also often bridge the communication gap and issues of access, particularly in relation aspects of refugee migrants' resettlement, health and integration. However, despite these efforts, issues such as institutional racism, exclusion, and lack of cultural consideration, continue to be highlighted as barriers, not only to integration, but to positive health outcomes as well. Whilst the New Zealand government, and the Ministry of Health in particular, recognises and acknowledge existence of inequalities within the health care system, more work is still required in terms of policy and cultural

competence education to transform these issues. See for example; The New Zealand Health Strategy: addressing issues of health inequality (Ministry of Health, 2000: 4-6), how institutional racism is enshrined in some aspects of public health policy making in New Zealand (Came, 2014: 214-220), the significance of cultural competence in medical practice in New Zealand (Durie, 2001: 1-15)

Institutional racism has been identified as an issue in New Zealand for decades, particularly racism against Māori people - not only in health, but within other institutional frameworks, such as social welfare and housing. See for example; the report of the ministerial advisory committee on a Māori perspective for the department of social affairs (The Māori Perspective Advisory Committee, 1971: 1-92), institutional racism and dynamics of privilege in public health (Came, 2012), Māori experiences and responses to racism in Aotearoa New Zealand (McCreanor, 2013), racism and health in New Zealand (Harris et al, 2018).

Institutionalised racism has led to ethnic health inequalities which has also been a highly debated topic in New Zealand. See for instance; monitoring Māori health and ethnic inequalities (Cormack and Robson, 2010), health inequity in the New Zealand health care system (Sheridan et al, 2011, the impact of health inequality on children (Duggan, 2011), reducing inequalities in health (Ministry of Health, 2002). While the Te Tiriti o Waitangi provides commitment from the New Zealand government to protect Māori people's social and cultural rights, these issues call for urgent need to develop an inclusive health and social policy that explicitly reflects New Zealand's growing socio-cultural diversity. This will improve integration of migrants into all aspects of society.

Research Methods

> Ethnography provides rich and wide-ranging insights into actual reality, ways of life, social interactions and peoples' perceptions as expressed by the actions and the surroundings in which they live. It enables seeing entire phenomena, understanding their complexity and significance, and making generalizations on human behaviour" (Shagrir, 2017: 9)

This research is an ethnographic study, and as such, employs qualitative research methodology. I gave preference to qualitative methodology over quantitative, because I find it more interpretive, pragmatic and grounded in lived human experiences (Marshall and Rossman, 1999, Mayson, 2002: 2), and as such more suitable for this type of research. As Pope and Mays (1995: 42-5) have stated, "the goal of qualitative research is to develop concepts which help us to understand social phenomena in a natural (rather than experimental) setting, giving due emphasis to the meanings, experiences, and views of all participants". This is particularly important given the focus of my research – understanding and interpreting the lived experiences and ongoing health-related impacts on people's integration process.

Through face-to-face interviews, and observation in natural settings such as at home, qualitative research allows for more direct and humanistic interactions between researcher and participants. The rapport built in these interactions is an invaluable tool for unconstrained flow of information (Leech, 2002). Another advantage is that, through Qualitative Description (QD), participants use their own words to describe their experiences and perceptions, and because of the direct nature of interactions, in addition to being able to observe non-verbal communication, the researcher is also compelled to think about their own position, and to reflect on how it impacts on the research process (Emmerson, 2011). I have concealed the participants' identities in the study to protect their privacy.

Qualitative research methods facilitate rich, holistic information for studies related to social phenomena, as it deals with what people are experiencing (or have experienced), how they feel, and their views and aspirations (Jackson et al, 2007: 21-2). Put in this light, employing qualitative research methods in this project provide an insight into the lived experiences and perceptions of ethnic minority African immigrants (particularly former refugees), as well as show how these impact the adaptation and integration processes. Methods of data collection included; semi-structured in-depth interviews (including one focus group interview), conversations (including by telephone and email and informal), observation (through ongoing social relationships), fieldnotes, and library and online database research.

Participant Recruitment

Two primary recruitment methods were employed; direct recruitment and snowballing (see Kuper et al, 2008: 688, Kubicek and Robles, 2016). I conducted my initial enquiries by way of direct telephone calls to a few government agencies and NGOs whose functions I intuitively believed were relevant to the study. In most cases, I was provided either with a name and an email address or a telephone number of potential participants within the organization, following which I sent the study summary, accompanied by an invitation to participate in the study. While a few of these initial contacts ended up participating in the study, others referred me elsewhere.

The majority of members of the Luo community were recruited through snowballing. Initially I knew only one of the Luo community leaders, but he was able to recommend two other members of the Luo community as potential participants, through whom I managed to meet and recruit a few more people from the community. The two methods effectively complemented one another. The direct telephone and email enquiries functioned as a way of communicating the study summary as well as establishing individual relationships of trust, which enabled the snowball effect, where those I contacted initially were able to recommend participants more relevant to specific aspects of the study.

Primary criteria for initial communication was based on my understanding of functions of certain government agencies and NGOs and their relevance to the research question. All preliminary enquiries were targeted towards recruiting potential participants in middle to senior management positions, as well as those in certain specialized positions, (such as doctors and other health care professionals), because of their understanding of the functionalities of their organizations, and the possibility that some might be willing to share information autonomously, as compared to none-specialized professionals and less senior staff members.

In addition to self-identification as Luo, criteria for selection of participants from the Luo community of Wellington were based on demographic grouping according to age and gender, as well as country of origin (although this did not work as initially envisaged). Initially, I had planned to recruit Luo community participants comprising of a balanced mix of gender and nationality. However, due to the regionalized nature of the

Luo community of Wellington, my participants from this community comprise of Northern Ugandan and South Sudanese Luo men and women.

Data Collection

Interviews

I decided to employ semi-structured interviews as the primary method of data collection because they provide a platform for detailed information directly from research participants. Interviews provide interviewees with the chance to explain their meanings, express their views and perceptions, as well as to provide their own interpretations of issues, and to reframe and describe their social experiences in their own words (Shagrir, 2017: 12). Additionally, face-to-face interviews allow the researcher to observe unspoken communication, such as body language, silences, hesitations or contradictions. Semi-structured interviews also allow for flexibility and instantaneous responsiveness to any emergent themes for both interviewer and interviewee (Jackson et al, 2007: 25). Interviewers have the opportunity to seek clarifications and to ask further questions if needed, and thereby "building a comprehensive picture, as well as broad and rich insights about participants, their experiences and their conduct" (Reeves et al, 2008) in Shagrir (2017: 12).

A total of fourteen semi structured interviews, including a focus group were conducted. These include; eleven interviews conducted with six individual members of the Luo community, three men and three women, ranging in age from early twenties to late sixties, one interview with the practice manager of the Wellington branch of Red Cross New Zealand's Refugee Trauma Recovery Unit, one interview with a senior medical officer at the Hutt Valley Regional Health, and one focus group interview with a three-member team of two health care professionals and a senior health care administrator, all members of the Communicable Disease and Housing team, based at the Hutt Valley Regional Public Health.

Five of the six members of the Luo community were interviewed twice, four of them at their homes at the Hutt Valley (Taita, Naenae, Lower Hutt, and Upper Hutt), while the fifth was interviewed in my office at Victoria University. The sixth Luo community

member was interviewed once at my home office in Mornington, Wellington. The Red Cross Refugee Trauma Recovery Unit practice manager was interviewed once at his office in Wellington city. Both the senior medical officer and the three-member team at the Hutt Valley Regional Health were also interviewed once on different dates at the Agency's premises in Lower Hutt. The longest interview took eighty minutes and the shortest was forty-five minutes.

I also conducted a focus group interview of a three-member team, of two health professionals and an administrator, who are all members of the Hutt Valley Regional Public Health-based team focussing on Communicable Disease and Housing. There are several reasons why I employed this method in addition to one-to-one interviews. Firstly, I found both methods having advantages as well as disadvantages, and therefore, employing both helped rectify issues of disadvantages as they complement one another. For example, while one-on-one interview obtains a perspective from one individual, focus group obtains multiple perspectives and understandings at once. Secondly; conducting a focus group interview is timesaving in the sense that several people are interviewed in one session, as opposed to several individual interview sessions.

I also decided to conduct a focus group interview for this particular team because they are already an established team and so, recruitment was less difficult. Once I had made the initial contact with the team leader, she was able to communicate with other team members. While one of the main disadvantages of focus group interviews is that some group members may become quieter in the face of group hierarchy, this method's major advantage, as Isaacs (2014) noted, is that it affords the researcher an opportunity to gain more in-depth information without excessive time expenditure. For example, the collective understanding that emerged during our group conversation highlighted the various operational, as well as functional aspects of the Hutt Valley Regional Health, and offered a window into the overall functioning of the health sector. Throughout the discussion, group members constantly checked and verified certain facts with one another and added certain relevant points to each other's responses.

Interview follow-ups by email or telephone calls were also used as further means of data collection where new questions emerged during transcription or listening back to interview recordings. Although email communication was generally useful for saving

travel costs and time, it had a few disadvantages. Firstly, interviewees tend to provide short responses to questions, and sometimes they would direct me to secondary sources without responding to some questions. Secondly, it often took several days, and sometimes up to a few weeks before I receive responses to my questions, which can be time consuming when working on a short research schedule such as the Masters' research project. However, one of the advantages of using email for communication was that it enabled some of the study participants (particularly those from government agencies and large NGOs such as Red Cross) to email weblinks back to me when they thought a question needed a broad understanding of certain areas of the topic.

The field data collection includes two rounds of individual interviews with six members of the Luo community who were recruited in accordance with demographic variability; three men and three women whose ages range between twenty-one and sixty-nine years old. They are all African-born New Zealand citizens, originally from Northern Uganda and South Sudan. Some of the participants were as young as six years old when they first arrived in New Zealand, whilst others came as adults. The community members' length of residence range from as recent as nine years, to as long as fifteen years. Both older women who participated in the study are single mothers who arrived in New Zealand with four and six children respectively. Two of the participating young adults also came from single parent families. Most of the participants have been given pseudonyms to protect their identities.

Fieldnotes

Fieldnotes have been described as a fundamental condition of an ethnographic research, alongside exploring insider perspectives through interacting and conversing with participants (Emerson, 1995). Taking notes on the research field entails recording of the researcher's experiences (challenges, triumphs, anxieties, struggles, and so on), accounts of interactions, descriptions of spaces of interactions and other field activities, as well as unspoken communications. Fieldnotes are also part of the researcher's reflexivity; they are useful for evoking memories for the researcher to reflect on. As Mullick and Mukherjee (2018: 31-2) put it, fieldnotes are not merely the experiences of human interactive phenomena, they are "a way for the researcher to situate and relate

the “self” within and beyond the theoretical and methodological milieu of the study concerned”. Moreover, fieldnotes are a resource through which the ethnographer preserves experiences and observations close to the time of occurrence, thus enhancing reflection, as well as accumulating written record of those occurrences and experiences (Emerson et al, 2011, Eriksson et al, 2012).

In addition to interviews, I recorded my accounts of interactions with research participants. These include; my personal observations, my feelings and experiences as well as my reflections on encounters and conversations. These notes were helpful in recalling the field events of each day. I conducted library-based and online research through database resources, including; journal articles, websites, and other digitally archived resources, as well as print resources such as books, informational reports and conference proceedings. Digitally archived resources were primarily used as a source of data for the literature associated with theoretical and analytical frameworks as well as case studies and previous research relevant to this research.

Data Analysis

Analysis of data in this study followed two primary approaches. Firstly, framework analysis of data (Pope et al, 2001) was followed throughout the transcription process. Taking all aspects of the research question as well as the aims and objectives of the study into consideration, emerging themes were highlighted as data transcription process progressed. All impressions that were believed to shed light on the research question were also highlighted throughout both data collection and transcription processes.

Secondly, thematic network analysis (Astride-Stirling, 2001) was also employed. Following thematic data analysis, transcripts of data collected through all interviews, including the focus group interview as well as through field observations, were revised and coded, allowing themes and trends to emerge. The analysis focuses primarily on the narratives of the participating members of the Luo community of Wellington as primary subjects of the research question. Their voices, perceptions, views and concerns given centre stage, which allows them to be heard (Ellis and Berger, 2002). Furthermore, to

ensure that the views and concerns of members of the Luo community are understood beyond their immediate contexts (immediate context being the community itself), the analysis has considered the views and perceptions of the participating health care service providers as well for comparison and contextualization. This provides a wider context to understanding of the concerns and views of members of the Luo community of Wellington (Strauss and Corbin, 1998, Tuwe, 2012).

The data analysis took into consideration underlying patterns such as participants' demographic variations. For example; the Luo community members' response differences, contradictions and similarities were highlighted according to age, gender and length of time lived in New Zealand. This was useful in identifying any underlying patterns between demographic groups within the community. Data collected from the Hutt Valley Regional Public Health and the New Zealand Red Cross's Refugee Trauma Recovery service were considered in relation to the wider migrant health and integration context, which was useful in going beyond as well as contextualizing the voices of the Luo community members within the wider regional and national health care networks. Linking the Luo community members' views and perceptions to the workings of the regional health care system is also useful in shedding light on the roles played by health care services in community member's experiences of adaptation and integration.

Key Themes

Six key themes emerged from this research:

- The impact of forced migration and displacement on the individual's emotional and physical health;
- The effects of resettlement and acculturation-related stress on the individual's sense of health and well-being;
- The impacts of displacement, and perceived multiple losses on the family unit cohesion;
- A sense of social and cultural identity loss, due to issues related to; early childhood disruptions, emergence of contemporary diasporic identities due to

acculturation and intergenerational cultural dissonance due to acculturative gap (intergenerational differences in acculturation rate), increasing vulnerability to mental health problems among the younger members of the Luo community.

- Experience of racism and discrimination within the school and health care systems (perceived at both institutional and personal levels)

- Perceived lack of cultural consideration by some health care professionals (doctors and other health care workers).

Following on impressions gained from interviews with members of the Luo community that; migrant experiences in a host situation are partly influenced by the home country dynamics, the above themes were further compressed down to three broad themes that form the basis for the three empirical chapters (3, 4, and 5) of this thesis. This was particularly useful in bringing together and clarifying the connections between home country dynamics, individual experiences and host country conditions, which this research has identified as influential factors in the adaptation and integration experiences of members of the Luo community:

1. The social and health impacts of pre-migration experiences of forced migration and displacement on the individual- physical and emotional health impacts due to multiple losses, physical and psychological impacts of refugee camp-living conditions, psychological effects of the liminal nature of the refugee camp on people's individual and social identities as well as their sense of belonging.

2. The health and social impacts of resettlement and adaptation experiences at individual and group levels- effects of acculturative stress on individuals, intergenerational cultural dissonance (due to acculturative gap) leading to intergenerational conflict. The process of acculturation produces new social and cultural identities which impact familial relationship dynamics – this can increase emotional health problems (particularly on the younger generation as they find themselves negotiating between two cultures with unwanted results at family level).

3. Experiences of racism within the school system – while experiencing racism at school may be viewed by some as not directly related to health, this research found it to have had lasting social and emotional health impacts on people. Impacts of racism and issues of cultural competence we also found to exist within the health care sector. Although not raised by many, bureaucratic issues related to patient referrals from primary to secondary care was also highlighted as a concern by some community members.

Researcher's Positionality and Reflexivity

My interest in conducting this particular research with the Luo community of Wellington was sparked by my personal experiences of integration in New Zealand as a part of an ethnic minority migrant group from Africa. Initially, I had concerns as to how my identity as part of the collective African immigrant community would impact this study. For this reason, I engaged a high degree of reflexivity to minimise the impact my identity may have on this research.

Any researcher, (particularly within the social science fields) needs to reflect on any possible impact their position may have on their research. My feeling of apprehensive self-consciousness about reflexivity undoubtedly stems mainly from my early understanding of anthropology as a field mainly occupied by European folk with condescendingly ethnocentric concepts of other cultures such as; "primitives", "natives" or "savages." See for example; primitive culture (Tylor, 1871, 1873, 1889, primitive classification (Durkheim and Mauss, 1963, history of anthropology, culture and society (Ericksen and Nielsen, 2013). As a native African, until recently I had perceived the image of a typical anthropologist to be a European (usually male) person, whose job is to study non-European tribes in remote locations, particularly those of strategic concern in the overseas colonies of European empires.

Throughout the early decades of anthropology (particularly ethnographic fieldwork), cultural alterity, and differential positioning of the anthropologist as the "ethnographic self", whose job was to document socio-cultural activities of the "native other" was the widely accepted norm for ethnographic knowledge production (Kim, 1990). In this

imagination, real anthropologists were supposed to study "others", whose social and cultural worlds are foreign to them. However, since the mid-20th century, some anthropologists have questioned and challenged this norm (Gwaltney, 1976: 236-42, Todorova-Pirgova, 1999: 171-90, Bunzl, 2004: 435-42, Hage, 2012: 285-308), and contemporary anthropology has opened up to new and diverse researchers and subjects. Accordingly, the normative traditional anthropological idea that emphasized cultural alterity as a constitutive element of ethnographic study has been identified as erroneous, while the opportunities provided by being an insider can be vast (Narayan, 1993, Ranco, 2006).

The fetishization of cultural difference in 19th century anthropology led to labels such as "native anthropologist" or "native ethnographer", being given to those who conduct ethnographic studies within their societies, communities or those whose geo-cultural identities were thought of, as similar to that of their study subjects. However, the notion of native anthropologist has been questioned by some modern scholars, including Narayan (1993) and Jacobs-Huey (2002), who have highlighted that differences within populations and cultures are often wider than they are between them, and that while an outsider perspectives can offer some advantages, so too can being an insider, particularly for sensitive or difficult to access communities.

In addition, the ethnographer's professional identity that enables him/her to record and problematize others' lived reality inevitably creates a distance. Therefore, in deciding to study an ethnic minority African migrant community, as an ethnic minority African migrant myself, I have consciously taken the position of "native anthropologist" (someone who studies their own community and/or culture) within the context of a 21st century ethnographic fieldwork, specifically to guard against any possible cultural bias or the perception thereof, and as a self-reminder for me as an ethnographer, to maintain a high level of reflexivity throughout the research process. Being an African migrant in New Zealand, and not being a Luo gives me a native, yet neutral perspective.

Thesis Layout

This introductory chapter has outlined the topic conceptualization, background, context, and significance of the research, as well as the research questions. A brief introduction of the Luo peoples of East Africa was presented for context. A concise description of the conflicts in Uganda and Sudan (the two countries of origin for members of the Luo community of Wellington) was brought in to put the Luo community members pre-resettlement experiences within broader context. Lastly, the research methodology and data analysis have been outlined.

Chapter Two will outline the conceptual framework that guides the research, as well as present a review of available literature on the subjects of migration and health, as well as social and cultural integration of migrants in host countries. The chapter will also present a brief summary of research on issues of social, cultural, institutional and structural barriers in the New Zealand health care sector to contextualize the Luo community's New Zealand experiences. The principal concepts covered include; integration, health, cultural capital, social capital, acculturation and acculturative stress. The concept of integration in relation to migrant settlement and adaptation is multi-dimensional and context dependent. It depends on the context of the host society's socio-political and economic policies. In this research, migrant integration is presented as a three-way process, involving migrants and their life experiences, home country dynamics and the host country socio-cultural and institutional structural conditions. Integration in a host country does not only depend on migrants' efforts to fit in, it builds on reciprocal interrelationships between migrants and the host population.

Whilst widely accepted conceptualizations and interpretations of health are those offered by clinical practices based on bio-medical knowledge, there is a body of health-related literature that acknowledges culture as a primary factor that influences ways by which people understand and conceptualise health (including those in bio-medical clinical practice). As such, for clinical practice to achieve positive health outcomes, the influence of culture on health should not be ignored. The value of social connections and cultural goods (such as education achievements), have been found to promote social mobility and to contribute to people's sense of security, social well-being and a sense

belonging. Thus, migrants' accumulation of both social capital and cultural capital within the host population is crucial for their adaptation and integration processes.

Chapter Three focuses on the Luo community members' pre-migration experiences of war and displacement. This highlights the impact of these pre-migration experiences on the physical and psychological health and well-being of individual community members. The chapter offers an analysis on the possible effects of pre-migration displacement on community members' contemporary identities, as well as on how this impacts the process of integrating in New Zealand. Pre-migration experiences of displacement and extended periods of time in refugee camps affect people both physically and psychologically. Displacement interrupts people's lives - the sense of home, the family unit and children's childhood are interrupted. This means in addition to the socio-cultural challenges of resettling in a new country, refugee migrants are often faced with the challenge of reinventing their social, cultural and personal identities.

Chapter Four discusses the Luo community's resettlement experiences and how they are linked to pre-migration experiences. More specifically, the chapter looks at acculturative stress-related issues, such as perceived intergenerational cultural discord and perceived loss of identity, as well as their effects on family relationships, people's health outcomes and consequently their adaptation and integration processes. The challenges associated with loss of familiar environment and adapting to new social and cultural environments have been shown to produce stress symptoms - (acculturative stress) which can affect people physically, mentally and socially. If unrecognised, acculturative stress can increase vulnerability to poor social and health outcomes, which may hinder the adaptation process.

Chapter Five will present the Luo community members' post-resettlement interactions within the New Zealand social and cultural institutions (specifically the school and health care systems). However, particular attention is drawn to the health interaction within the health care services sector. Experiences of racism at school are discussed (albeit briefly) to highlight the lasting social and psychological health of this phenomenon on people's adaptation and integration processes. Experiences of institutional and personal racism as well as issues of cultural competency within the

health care system will discussed in detail to highlight their impediment to integration. The possible impact of these issues on the emotional and psychological health of individual community members will be analysed too. The chapter will conclude with an analysis of how these factors affect the Luo community members' integration process in Wellington. Institutional racism, not only within the health care services, but within other institutional structures has been shown to increase racial exclusion and vulnerability to poor health outcomes, as well as obstructing integration. Lack of cultural consideration increases marginalization and diminishes integration into the cultural sphere, as well as increasing social exclusion and susceptibility to poor health.

The final chapter will offer an analytic discussion on the research findings. A brief summary of the policy implications of the socio-cultural integration of the Luo community (and other ethnic minority immigrant communities) is examined and highlighted. The chapter highlights contributions towards further studies, and improvements to the New Zealand resettlement and integration policies with respect to former refugee and ethnic minority population groups. Integration of migrants is not only dependent on migrants' efforts and ability to learn and adapt to the host society's institutional structures and societal cultural systems of values.

The host country's policy and institutional structures, as well as the host population should be receptive for migrants to achieve a sense of belonging. Although migrants' post-migration socio-cultural experiences play a role in their adaptation, their pre-migration experiences also contribute in shaping people's new social identities. Whilst issues of negative ethnic relations such as racism and discrimination between New Zealand Māori and Europeans have been highlighted and widely discussed, more work is still required to establish the extent to which ethnic inequalities affect other ethnic minority population groups (African migrants in particular) in New Zealand. Despite health being recognised widely as a valuable resource for people's adaptation to a new environment, more research on the intersection of migration and health is still required. This helps immigration and migrant settlement policy makers to fully appreciate the complex relationships between migration, health and migrant integration.

Chapter Two: Theoretical Framework and Literature Review

At the core of this current research is the desire to develop a clear conceptual understanding of integration as a social process. But as the current literature clearly shows, immigrant integration is multi-dimensional (Berenevičiūté, 2003, Lindo, 2005: 7-22). It occurs simultaneously, within the socio-political as well as economic and cultural spheres (Algan et al, 2012). It has also been discussed by some as a three-way process, involving the dynamics between migrants, their country of origin and the host country (for example Gsir, 2017: 149).

Hence this chapter will briefly introduce current theories and literature on integration, followed by related social concepts that impact its facilitation. These include; conceptions of culture and social connections as forms of capital, conceptions of health, both as a bio-medical and socio-cultural phenomenon. The links between migration, health and migrant integration will also be highlighted. The chapter will then conclude by briefly examination of migrant's conditions in New Zealand and the significance of the New Zealand health care sector in the process of migrant integration.

Integration: Conceptual and Theoretical Frameworks

Immigrant integration is the process through which new immigrants adapt and become a (functioning) part of a new society. It has been described by some as a three-way process involving migrants, migrants' home country dynamics (social, political, economic) and host society conditions (policies, institutional structures and the host population's attitudes) (Mascareñas and Penninx, 2016: 1-10, Weinar et al, 2017). Social inclusion and economic mobility in particular have been discussed as key to facilitating the development of a sense of belonging in new migrants.

One other key theme that stands out across the migrant integration literature is the lack of a single agreed-upon definition of the concept of integration. This problem is primarily presented by the fact that human inter-cultural interaction and socialization is multi-dimensional. It stretches across the cultural, social, political and economic

societal spectrums. Thus, conceptually, definitions of migrant integration vary according to the dimension of integration, migrants' circumstances, home country conditions and the host country's socio-political contexts. See for example; approaches and issues of social integration (Alcántara, 1995), economic, social, cultural and political dimensions of integration (Rudiger and Spencer, 2003; Penninx, 2004), social integration of migrants in Europe (Spencer, 2006), the role of the state in cultural integration (Joppke, 2012), the factors facilitating or impeding integration of migrants (Craig, 2015).

Bearing this background in mind, this research approaches socio-cultural integration of migrants as a three-way process. As such it takes the following three broad aspects of migration into consideration. Firstly, the effects of homeland dynamics (socio-political, economic and cultural) on individual community members and how these may affect people's post-migration experiences. Secondly, it considers people's individual experiences and challenges of resettlement and adapting to life in New Zealand. And thirdly, it will look at the roles played by New Zealand's socio-political conditions as well as institutional structures on the process of integration. In all three areas, I will focus on the social processes of health, which have been identified as a valuable resource for full human functionality.

The current mass migrations of people around the globe due to various issues; political, economic and human life-threatening natural events, makes integration of migrants into host populations a subject of global public and political discourse, as well as a policy issue throughout the world. Across Europe and elsewhere, many migrants have suffered economic and social disadvantages, including exclusion from civic and political participation as well as discrimination, racism and xenophobia. Because of this, the European Union has over the past few decades commissioned a number of studies directed towards integration of immigrants.

In its usage in immigrant settlement and ethnic studies, the concept of integration is often used interchangeably alongside a family of inter-related theories such as assimilation, adaptation, incorporation, inclusion, biculturalism or multiculturalism. Integration in this context derives its meaning from classical sociological theory of evolution, indicating a progressive change from a less coherent, to a more coherent state

(Dobzansky, 1973, Kaplan et al, 2000, Lindo, 2005, Scott-Phillips et al, 2011). Several contemporary scholars and researchers across the migration literature have used integration to describe the different strategies and processes through which new immigrants settle and become functional members in a new society. In addition to its usage pertaining to immigrant settlement, integration is also often used to describe the processes of strengthening of social relations within a society. Heckman (2004: 4) explained these parallel usages of integration when he noted that, "as a process, the concept of integration signifies on one hand, the further strengthening of existing relations within a social system, and on the other hand, relates to insertion of additional actors into an existing social system." Immigrant integration outcomes are measured in accordance with the above-mentioned societal domains of integration (see Alcántara, 1995, Schultze et al, 1997, Fonseca et al, 2005).

Regarding immigration policy (and assessments of success), two theories have been dominant: assimilation theory and multiculturism.[10] Assimilation has three dominant features. Firstly, the implication is that new arrivals, and often ethnic minorities, are encouraged to share one common culture; normally the cultural values of the host society's dominant ethnic group. The second feature of assimilation is gradual loss of immigrants' or less dominant ethnic minorities' original cultures in favour of the mainstream cultural values. And finally, complete assimilation is achieved through a process of inter-generational acculturation which is facilitated by progressive trends such as dominant ethnic language proficiency, intermarriage, social mobility, and so on. See for instance; segmented assimilation and its variants (Portes and Zhou, 1993: 74-96), assimilation and its discontents, (Rambaut, 1997), empirical and theoretical challenges of immigrant assimilation (Waters et al, 2005), assimilation process through intermarriage, language and economic activity (Meng and Meurs, 2006: 1-29).

Guided by the principles of diversity, equality and reciprocity, multiculturalist theory supports cultural pluralism (Rudiger and Spencer, 2003), where cultural differences

10 Hamberger (2009) traces the conceptualization and popularization of the terms, "integration" and "assimilation" back to the early twentieth century Chicago School of Urban Sociology (see also, Fonseca et al, 2005). For more detailed discussions on the conceptions of integration and its related theories see; Rudiger and Spencer, 2003, Spencer, 2006, Ager and Strang, 2008, Koopmans, 2009, Hamberger, 2009, Algan et al, 2012, Craig, 2015, Şahin, 2016.

between ethnic groups is acknowledged and valued. Multiculturalist theorists believe that as an approach to integration, multiculturalism facilitates participation of all ethnic population groups in all socio-cultural, political, and economic activities in a society. See for example; meanings of multiculturalism (Gingrich, 2003: 1-32), successes, failures and the future of multiculturalism (Kymlica, 2012: 1-37), evidence-based multicultural policy making (Spoonley, 2014: 1-10), managing multicultural human resources (Progoulaski and Roe, 2011: 7-23).

In New Zealand, active promotion of multiculturalism grew from the late 1980s, prompted by the growth of new immigrant population, which saw an increase in ethnic and cultural diversity in the country (May, 2002: 1-26, Multicultural New Zealand, 2015, 2018). However, the unique bicultural socio-political arrangements between Māori and Pākehā, as backed by Te Tiriti o Waitangi, has prompted concerns regarding the possible impacts of multiculturalism on this historical bicultural arrangement. See for example; concerns for multicultural policy implications for indigenous rights (Lowe, 2015: 496-512), the possible consequences of fitting multiculturalism into Te Tiriti o Waitangi as the country's foundational document (Hill, 2010: 291-319).

Both theories have critiques. One of the critiques of assimilation theory is that it presents integration as a one-way linear process, through which minority cultural groups are expected to integrate into the dominant culture, presumed to be good for all (see Rumbaut, 1994, Green and Xie, 2006). Spencer (2006) has echoed a similar critique when she noted that assimilation implies that society has a homogenous culture, and as such, diverse immigrant population groups are expected to gradually melt into one homogenous culture. Rudiger and Spencer's (2003) study of integration of immigrants across the European Union member likewise argues that "in many European countries, the idea of integrating migrants is viewed simply as assimilation of migrants into pre-existing unified social order, with a homogenous culture and set of values" (4). They, and others (Fonseca et al, 2005, Hamberger, 2009, Algan et al, 2013) highlight the way this is a one-way process, in which migrants are expected to undergo a unilateral process of change so that they can fit into a given order.

These studies show that because societies are dynamic, with many different values, lifestyles and constantly changing institutional processes. Some researchers have even

argued that virtually, no country has monolithic culture or social order to assimilate to (see Foseca et al, 2005: 7-10). This renders the conformity, implied by assimilation, faulty as integration under this strategy does not consider societal variations. As a result, the notion of assimilation systematically marginalizes migrants, making them easy targets for scape-goating, particularly by far-right political parties, thereby inciting fear and general public resentment (Beresnevičiūté, 2003). Rather than formulating policies that may be necessary to facilitate the inclusion and participation of new immigrants, the propensity by many of the European countries to measure integration in relation to the existing social order, with its hegemonic practices and values, causes the focus of the process to be on migrants' adaptation. The failure of immigrant integration in many European countries is, therefore, a result of the host societies' resistance to change rather than a fault of the immigrants (Penninx, 2004). To sum it up; the assimilation approach to integration places strong emphasis on the idea of one collective identity, and as a consequence, new immigrants are expected to gradually move away from their original cultural identities and norms in favour of those of the host society.[11]

To transform the inequality problems presented by the assimilationist approach to migrant integration, some authors recommend a multiculturalist approach, stating that, while this strategy has been criticized by some who fear that it has the potential to produce social divisions along cultural lines (Singham. 2006, Johnson, 2008, Koopmans, 2010, Lowe, 2015), it is important to understand that multiculturalism is guided by principles of reciprocity, equality, diversity and cohesion, hence, they argue, it is more compatible with principles of modern democracies (Levey, 2011: 7):

Multiculturalism entails the recognition of an ever-present cultural plurality in modern societies, and the regulation of this plurality through the principle of equality. Multicultural integration policies support neither the crossing of boundaries from one culture to another, as do assimilation policies, nor the preservation of these boundaries, as does segregation, but aim to foster their permeability. By facilitating participation of all groups in all social, economic and political spheres, such policies encourage the

[11] For further reading on the assimilation theory see (Gordon, 1964, Algan et al, 2012).

[12]continual development and cross-fertilisation of cultures and identities and can therefore help overcome divisions and segregation.

Some of the criticisms of multiculturalism specific to New Zealand, come respectively from Johnson (2008) and Lowe (2015). Both highlight the struggle between indigenous peoples' call for collective rights and the pluralistic ideas presented by multicultural theory. Both argue that multiculturalism is limited by liberal theories. Johnson specifically highlights the impact of multicultural theory on the collective civil and political rights concerns of the indigenous people of host societies (particularly colonial settler states where discourses on self-determination and sovereignty are ongoing concerns). Using New Zealand, Australia and Canada as examples, Johnson argues that "liberal multiculturalists" call to address the individual issues of too many groups, is a hinderance to the collective rights called for by indigenous communities (2008: 31-3). Following the same thought and advocating for cosmopolitanism instead, Lowe views multiculturalism as potentially divisive and hostile to biculturalism (2008: 500-502).

Processes of Socio-cultural Integration and Acculturation

In New Zealand (and elsewhere), widely acknowledged common indicators of immigrant integration include: employment, health, housing, and education (see Penninx, 2004, Grewal, 2012, Algan et al, 2012). However, as previously mentioned, the success of all of these indicators relies on a variety of things. Hamberger (2009) identifies phases and stages of the integration process. She considers cultural and social integration as the first steps towards immigrant integration (particularly regarding refugee background immigrants), with acquisition of the host society's language[13] being

[12] For further reading on multiculturalism and assimilation theories, see Singham, 2006, Johnson, 2008, Human Rights Commission, 2008, McIntyre, 2008, Maré et al, 2015, Multicultural New Zealand, 2015, Lowe, 2015.

[13] Hamberger (2009: 2-21) highlights a significant number of common barriers in acquiring the host society's language which are often overlooked by researchers, including: linguistic distance between the immigrants' native language and the language of the host country, exposure (or the lack thereof) to the language of the host society, the age of the immigrant at the time of immigration, the education of the immigrant and the geographic distance between the immigrant's country of origin and the host country.

the first step towards cultural integration. She considers the political dimension of integration as the final step in the process of integrating immigrants into the host country.

Cultural integration has been described as a process through which new immigrants experience cultural change, adopting aspects of the host society's cultural patterns and values. *Acculturation* is a sub-process of cultural integration, and it occurs from the point at which new migrants begin to adopt cultural elements of the host society, such as language, diet, and certain behavioural standards (Hamberger, 2009: 2-20). The process of acculturation is closely associated with the theory of assimilation, implying gradual, intergenerational strengthening of identification with host culture, and weakening of association with the original culture.

Hamberger argues that "cultural integration is not necessarily a group phenomenon, but there is variation and different adaptation patterns depending on the individual migrant and his/her human capital which should be taken into consideration" (6-8). Thus, legally defined and policy related integration strategies do not always produce positive outcomes for all immigrants. For example, while legally defined mechanisms such as acquisition of citizenship and its associated rights and responsibilities are crucial for integrating immigrants into a civic society, they are not entirely sufficient to match the practicalities of integration, and the issues some might face, such as negative attitudes and social exclusion at community level. Knowledge and acceptance of host society's cultural norms, values and language, as well as a sense of being accepted, and belonging to local communities are equally important components of immigrant integration.

However, in contradiction to Hamberger's approach to integration, which presents it as a linear process, that occurs at a similar rate across all aspects of migrant life, Fletcher, (1999: 48), states that the rate at which migrants integrate into different societal dimensions can differ, adding that settlement issues can arise long after arrival when migrants become elderly and start to experience new health and social challenges

(especially those from non-English speaking backgrounds). In addition, as some have pointed out, positive integration outcomes require meaningful, reciprocal interactions between the host population and immigrants (See Rudiger and Spencer, 2003: 5). Although acquisition of citizenship may guarantee protection of migrants' legal rights, some of the expectations and responsibilities are aligned with specific notions of national identity such as a nation being a socio-culturally homogenous entity, as well as expectations related to the uniformity of certain normative socio-cultural practices. Consequently, integration strategies adopted by a country are largely informed by its sense of nationhood. Taken for granted, some ideas about nationhood and national identity may work against appreciation of diversity, hindering integration. Joyce is one of my Luo community friends, with full New Zealand citizenship. She made the following statement, which exemplifies the notion that without a reciprocal relationship between migrants and host society, it may be difficult for migrants to achieve a sense of belonging:

> I got my citizenship, and I became a citizen […] but I still feel, I am not a citizen of New Zealand […] I just feel I am here like, temporary […] and anytime I will go back home when the time comes. But so far everything is ok […] I am living in a house, I am working, kids go to school, and the hospital is alright […] when we make an appointment, we go, and our health complaints get attended to by our doctor (Personal Interview: Joyce, July 24, 2018, Taita, Lower Hutt)

As I have shown, integrating into systems of social relations requires conditions that determine certain positions in the social environment (Beresnevičiute, 2003). Hewitt de Alcántara, (1995: 61-3) noted at least three different ways to understand the concept of social integration; firstly, as *Inclusion,* which implies equal rights and opportunities for all, secondly, secondly, *Exclusion*, which represents negative connotations of social integration as an unwanted imposition of sameness. Alcántara offers the third conceptual way of understanding social integration rather, as a way of describing the established patterns of human relation in a society. Nonetheless, aspects of human interaction and social formation are varied in nature and quality, and they are facilitated and determined by multiple dimensions that range across cultural, societal, and

institutional perspectives, down to individuals' social, physical and mental conditions such as health. As this research is primarily concerned with investigating the place of health in integrating members of the Luo community into the social and cultural domains, the following section will look at the various conceptions of health, and how these conceptions might impact on processes and experiences of socio-cultural integration.

Conceptual Dimensions of Health

> Health is a resource that permits people to lead individually, socially, and economically productive lives. It is a positive concept emphasising social, and personal resources as well as physical capabilities (Seedhouse, 2004: 36)

Health is broadly defined by the World Health Organization (WHO) as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (see World Health Organization, 1948; Kallahan, 1973). The World Health Organization recognizes health and wellbeing as resources for everyday life. According to WHO, for an individual or a group to reach a complete state of physical, mental and social wellbeing, they must be able to identify and realize aspirations, satisfy needs and to cope with or change the environment in which they live (World Health Organization, 1986). WHO's definition of health is good as a starting point because it presents three interrelated components that are central to health: the physical, social, and mental. It signifies recognition of health not only as implying biological soundness of the body, but as linked to behavioural and psychological status as well.

The concept of health is dynamic and has multiple meanings across cultures and even within communities and societies. Depending on context and the person or people using it, health is often variably used to refer to physical, emotional, social, environmental and even economic status. For this reason, it has to be noted that health is not an easy-to-define concept, because it is not one thing, but a vast phenomenon with multi usages. A further layer of the conceptual complexity of health is that it is, on one hand, linked to

positive concepts of well-being, and on the other, to negative concepts of illness. For instance; in medicine, health is commonly used in relation to the physical and mental states relatable to concepts of disease and illness (see Alker, 1965, Denzer et al, 2002, Immigration New Zealand, 2012). However, health is also often used to explain other states of being, for example; the state of the environment or social relationships and economic status relatable to concepts of well-being. People in all societies, cultures, communities and social groups see health as a valuable aspect of well-being (see Callahan, 1973, Rumbaut, 1994, World Health Organization, 2998, Frenk and Gómeze-Dantés, 2014).

Because health is such a widely varied and complex phenomenon, there is no single agreed-upon concept of health. People define and interpret concepts of health and well-being according to their knowledge and experience, as well as their social and cultural understanding (see Tuwe, 2012, Amzat and Razum, 2014, Napeir et al, 2014, Keleher and MacDougall, 2016). Rather than recommending one particular conceptual definition of health, some scholars have recommended an understanding of the concept that accounts for human diversity. In particular, I find most compelling Napier et al (2014)'s view that culture should be a key component in the promotion and maintenance of health, because how people understand and interpret health and well-being is intrinsically connected to their cultural systems of value.

Over the years, anthropologists have defined culture in variable ways, in addition to the foundational definition of the phenomenon offered by nineteenth century British anthropologist Edward Burnett Tylor (1870), which depicts culture as what people do and think as members of a society. Bodley (2011: 10) describes culture as "socially transmitted information that shapes human behaviour".

Following on Redfield (1947: 293-308)'s definition which presents culture as conventional understandings as well as the facts and objects through which these understandings are expressed from generation to another, anthropologist David Napier and his team of interdisciplinary scholars in their Lancet Commissions report on culture and health, view culture not only as shaped by shared understandings, but also practices that are influenced by those understandings. Within this frame, Napier and others highlight the fact that since all people have cultural systems of value, including those in

institutions established to advance health, cultural dimensions of scientific training and practice should also be taken into consideration. They therefore propose a "broad view of culture that embraces not only social systems of beliefs as cultural, but also presumptions of objectivities that permeate views of local and global health, health care and health-care delivery" (see Napier et al, 2014: 1607).

In the same vein, Patterson, (2014:8) views culture as "the lens through which a person views their world". Put in this light, it makes sense to conclude that ideas about health and well-being are cultural. Nonetheless, as discussed, the concept of health itself is complex and difficult to describe. In a broad sense, concepts of health can be understood in terms of a number of approaches and frame works that fall within the bio-medical, psychological, sociological and ecological fields (see Alker, 1965, Frenk and Gómez-Dantés, 2014, Keleher and MacDougall, 2016).

Luo Cultural Conceptions of Health, Illness and Wellbeing

> The effect of cultural systems of value on health outcomes is huge, within and across cultures, in multicultural settings, and even within the cultures of institutions established to advance health. In all cultural settings; local, national, worldwide, and even bio-medical – the need to understand the relationship between culture and health, especially the cultural factors that affect health-improving behaviours, is now crucial (Rashed and Hussien, 2015)

In Luo culture, (and perhaps in other cultures elsewhere) health and illness are viewed not only as related to a person's physical and biological aspects. Certain forms of illnesses can be linked to a person's social world. The Luo believe that some illnesses are present in the healthy body in a dormant state and they may occasionally emerge naturally or on being provoked externally through an individual's social and behavioural actions, or through malevolent spirits and evil intent perpetrated by others (Geissler et al, 2002, Nyakiti-Orawo, 2012). Although many people today, including Luo communities, generally attend clinical practices using bio-medical understandings and interpretation of health, all peoples have cultural understanding and interpretations

of health and illness. It is not uncommon (particularly in African and Asian cultures) for people to take cultural approach to resolve health issues alongside bio-medical treatments. See for example; an analysis of folk theories of mental illness and traditional forms of psychotherapy (Rubin, 1983), how Indian culture influences the expression, prevalence and treatment practices on mental health (Subudhi, 2014), using cultural contexts of health approach to enhance policy making (Napier, 2017).

> The health of an individual depends not only on physical wellness, but on the manner in which the individual socializes and behaves in relation to others. Animosity, jealousy, dishonesty, bad-mouthing others, or infidelity can all have dire consequences for one's physical health (Personal interview: Francis, June 16, 2018, Lower Hutt).

The following are examples of some of the Luo peoples' cultural conceptions of health, illness and health care. This section serves to illustrate that while bio-medical clinical care is widely used today, it not the only way through which people understand and explain health and well-being. All cultures have their own ways of understanding and explaining health, as well as health care provision. The word *yamo* is used by the Luo people of Western Kenya to talk about specific illnesses, as well as to describe different illness symptoms. The Luo believe that the energies that occasionally emerge as *yamo* reside in a person's abdomen (*ich*). And therefore, treatment (especially of infants) is carried out regularly to keep the inner forces at bay and to maintain a healthy balance in the childs body (Prince and Giessler, 2001: 440)).

Sihoho and Dhoho

The Luo believe that some people possess the evil eye (*sihoho*) which causes illness - commonly stomach aches and other abdominal complaints - because negative thoughts towards the victim. Young children are especially believed to be prone to *sihoho* (Parkin, 1978, Abe, 1981). Evil eye attacks are generally believed to be a result of personal animosity. However, *sihoho* is easy to treat if a person who caused it is identified and they are willing to admit to having brought it, in which case treatment

would involve a ritual retraction of the illness through sharing of food (*hoso*) between the accused person and the victim, and restoration of the relationship. *Dhoho (evil mouth)* is related to *sihoho,* but in *dhoho* illness is believed to be caused by words uttered jealously or enviously. (Geissler et al, 2002: 47).

Chira

Chira is considered the most serious of all Luo illnesses with serious social and cultural implications. *Chira* is believed to be caused by transgression of traditional rules of conduct (*kwer*), usually the ones related to sexuality and kinship relationships (Prince and Geissler, 2001: 458). *Chira* usually befalls sexually active adults as well as children, but it is not common amongst the elderly (Muriungi, 2008: 172). In contrast to ordinary illnesses and treatments, *chira* is not usually openly discussed, and its treatment is carried out by a well-known specialist healer, often in private.

Use of Herbal Remedies and Social Approaches to Health Care

As in other parts of Africa, use of herbal remedies for both oral and topical treatment of illnesses is widespread, and common medicinal knowledge is shared (Johns et al, 1990: 369-81, Prince and Geissler, 2012: 453). In terms of treating socially inflicted forms of illnesses, such as *sihoho* or *dhoho*, sometimes a specialist healer is called in to use herbal remedies where reconciliatory healing has failed (see Prince and Geissler, 2012: 447-71). Thus, just as conceptualizations of health and illness are viewed as both biological and socio-cultural in Luo culture, so are some of the approaches to health care provision and healing. Depending on the perceived source of ill health, healing may include; calling of the spirits, social reconciliation between individuals, herbal remedies, bio-medicine or combinations of any of these approaches. Song and dance are also employed as a form of therapeutic health improvement (Darkwa, 1985).

Singing, dancing, drumming and other musical activities are an essential part of Luo cultural approach to social well-being. There are ceremonial songs, ritual songs, healing songs, religious songs and there are songs and dances that are performed to invoke or even to appease ancestral spirits. For example; according to Nyakiti-Orawo, (2012: 153) *mwazindika* ceremonial song and dance is traditionally believed to be a body regulator

(particularly for women). Mwazindika, which combines drumming and dancing, is still widely practiced as a form of psychological and physical therapy across Luo populations (Nyakiti-Orawo, 2012). In most postcolonial Luo communities, Christian rituals which were introduced by missionaries during colonial rule, have also been incorporated into Luo cultural healing ceremonies. See; music and dance in Luo community life (Darkwa, 1985), death and healing rituals among the Luo of South Nyanza, Kenya (Shino, 1997), the influence of Luo traditional religion on Christian church healing ceremonies in Kenya (Omondi et al, 2017)

Links between Migration, Health and Migrant Integration

> The links between human mobility, health and migration management are unequivocally important when considering universal health coverage (UHC), global health security, public health, human rights, gender, equity, and human and sustainable development. Unprecedented migration flows and globalization have brought new challenges to addressing the health needs of migrants and refugees, particularly when part of large population movements, which require innovative solutions and new partnerships. Both migrants and refugees have human rights which should be respected, protected and fulfilled, and the right to health has been well stipulated within the WHO Constitution since 1948 (WHO, 2016: 2)

During September 2016 the United Nations General Assembly called for a high-level summit of heads of states and government to address the issue of the health of migrants and refugees, which the organization described as 'urgent'. The summit, which was hosted by the World Health Organization, the International Organization for Migration and the United Nations High Commission for Refugees, was an historic event as this was the first time the organization had called for a world summit on the topic. Following realization that unprecedented migration flows, and globalization have brought new challenges to addressing the health needs of migrants and refugees, the

United Nations organized the event to address the question of health of migrant population groups.

According to the UN, "despite health being a prerequisite for sustainable development and inclusive growth, the health of migrants and refugees has not been extensively debated outside of the health sector and within the 2030 Sustainable Development Agenda" (UN 2030 Agenda for Sustainable Development, WHO, 2016). The emphasis of the summit was on sharing of responsibility in promoting the health of migrants and refugees, which the organization views as "a prerequisite for achieving universal health coverage (UHC) for all, regardless of status" (World Health Organization, 2016: 1-22). As highlighted by this, health is one of the most crucial aspects of immigrant integration.

The Effects of Migration on Health

While there is much more to be done, health has been identified across the integration literature as one of the four core factors in the process of immigrant integration, alongside employment, housing and education (Fonseca et al, 2005, Spencer, 2006, Napier et al, 2014, Craig, 2015). Good health in particular is widely seen as an important resource for active participation in a new society, in both community life and labour markets (see North et al, 2006, Fortier, 2010, Herrero et al, 2011, Tuwe, 2012, Poindexter et al, 2013, Abou-Saleh and Christodoulou, 2016, Quosh et al, 2016, Li et al, 2016, Alegria et al, 2017, Mapuranga, 2017, World Health Organization, 2018). Immigrants with health problems are hindered in the process of integration, irrespective of whether the problems in question may be suffered by the people who depend on them, or those upon whom the migrant is dependent (see Ingleby et al, 2005, Spencer, 2006, Craig, 2015). The UN summit mentioned above identified the following issues (among a significant number of others) as some of the key challenges facing immigrants and refugees globally: lack of access to health services; little health monitoring to assess the real situations and properly inform evidence-based policy making; and xenophobic attitudes informed by dialogue focusing on the "burden" of migrants and refugees. They provided recommendations for addressing these, including acknowledgement of their existence in the first place.

Recent research conducted in the United Kingdom and other European countries, suggest that migrants are among those groups who are prone to physical and mental health problems due to several factors, including acculturation related stress, dietary and lifestyle changes, as well as socio-economic marginalization (Rudiger and Spencer, 2003). When people migrate to a new country, they do not only lose familiar environments, but also social networks. Because of this in many cases they are more likely to experience adaptation and acculturation-related mental stress issues, as well as ongoing impacts of the physical impacts of migration, once they start settling in a new environment. Hence it is crucial to consider the impact of migration on migrants' health when discussing their integration into a new society. Despite this evidence, it appears that literature identifying the links between health and immigrant integration is still relatively sparse, including in New Zealand.

The Significance of Health on Migrant Integration

In a report that looked at the most recent developments in social integration of immigrants across Europe, and in particular, the role of health in this process, Ingleby et al (2005: 101) wrote the following:

> Migrants who are burdened or handicapped by health problems are hampered in the task of integration. The problems in question do not have to be their own; they can also be those suffered by people upon whom the migrant is dependent, or people who depend on him or her. Illness exacerbates marginalization and marginalization exacerbates illness, creating a downward spiral.

Mental health issues in particular were a common finding across the literature. According to Spencer (2003: 43-4), mental health appears to be a growing concern, particularly for refugees and asylum seekers who may have experienced trauma (Ehnthol and Yule, 2006, Siriwardhana and Stewart, 2012). Stress-related symptoms, alcohol and drug abuse have also been listed as not uncommon among some migrant groups (see Council of Europe, 2000, Weilandt et al, 2000). Because of this, some

researchers have highlighted the need for more studies regarding the implications of mental health provision on migrant health. However, evidence from research in the UK found that prevalence of racial discrimination and harassment of ethnic minority patients exacerbated their health status (see National Health Service, 2001). In New Zealand while some research has been in relation to the impacts of racism on Māori people's health outcomes, little research has been done to ascertain the extent to which racism and discrimination in mental health work and the health care sector in general affect ethnic minority migrant groups' health.

Likewise, in a report presented at the European Commission and the OECD conference on the economic and social aspects of migration, Rudiger and Spencer (2003) revealed that migrants and ethnic minority populations throughout Europe bear a disproportionate share of health problems, citing ethnicity as a primary contributing factor in determining poor health outcomes. The report concluded that it is likely that the ways institutions, policies and practices organise and deliver health services negatively affect the health of migrants and ethnic minorities:

> Firstly, health varies in relation to socio-economic status, with housing, education, income and working conditions all affecting the standard of living, emotional well-being and behavioural patterns. Secondly cultural factors require attention, as perceptions of health and health care, interpretations of physical and mental well-being as well as communication patterns vary between cultures. Finally, maltreatment within the care process, such as inappropriate or discriminatory services, can adversely affect migrants' health (Rudiger and Spencer, 2003: 34)

Craig (2015) echoes similar sentiments, highlighting research evidence showing that the health of migrants may deteriorate due to acculturation stress, which health systems tend to not recognise, adding that this often leads to health threatening behaviours. The paper concludes by pointing out a number of barriers to good health, which include poor housing, income poverty, poor health practices in many places employing migrants, poor information on the availability of health services, a lack of knowledge related to

health care for some migrant groups, language difficulties, cultural insensitivity on the part of some health care providers and structural and individual racism among other factors (see also Hawkins et al, 2008). To draw further attention to the significance as well as the values of the social and cultural domains for health and well-being, the following section presents a brief discussion on the concepts of cultural and social capital, and links them to individual and collective social well-being.

Cultural and Social Capital: Value of the Social and Cultural Domains on Health and Well-being

A final aspect related to migrants' health and sense of well-being in the process of adaptation in a new society are the values related to social connections and the associated cultural expression. According to a discussion paper published by the Commonwealth of Australia (2002), there is a link between social capital and lower morbidity. The research indicates that people with higher levels of social interaction and participation are likely to enjoy better health and lower their risk of premature morbidity. Collective social capital can be drawn on when communities are faced with difficult times such as natural disasters or any other problems of communal significance (Cox, 2000). French sociologist Pierre Bourdieu (1986), developed the theory of capital within the social and cultural worlds, significantly influencing contemporary social scientific thinking on the concept of capital. Bourdieu described capital as accumulated labour, which presents itself as "materialized or incorporated (embodied) forms, thereby enabling agents to profit in the form of social mobility" (Bourdieu, 1986: 46).

Cultural Capital

Bourdieu defines cultural capital as "a result of accumulated skills, knowledge, behaviours, and norms that can be taped into to demonstrate one's cultural competence, thereby, improving one's social and economic status or standing in a society" (48). Because culture is built on collective relationships based on shared values and understandings, it has a direct impact on ways in which people interact and socialize in a community or a society. Hence cultural capital can have positive effects on the

individual's social well-being. For example; accumulation of cultural capital, such as education can improve socioeconomic status, which in turn can have positive effects on the health outcomes.

Social Capital

Social capital refers to the value of social networks, i.e. how people benefit from the various ways of interacting with each other. For instance, reciprocal bonds between members of exclusive identity groups, and links between diverse people and groups. Adler and Kwon (2002: 23) eloquently describe social capital as "the goodwill that is engendered by the fabric of social relations, and that can be mobilized to facilitate action". The reciprocal nature of social networks makes it a valuable resource for individual sense of security and social well-being.

In immigrant integration studies, social networks such as volunteers support groups and co-ethnicity have been found to play an important role in establishing a sense of belonging among new immigrants (Kinder et al, 2015). In New Zealand, Connor et al (2016), conducted a study among a group of African immigrant and refugee-background single mothers living in Auckland to find out how they (the mothers) had been able to overcome the challenges that they faced during and after birth in the absence of extended family. The majority of the study participants spoke of forming new connections and social bonds in places, such as the church and children's play groups. Thus social, and cultural capital have an influence on well-being, and thus health and integration. These factors all have particular significance for African ethnic minority immigrants to New Zealand, who are coming into a sometimes very different social, cultural, and political system, which they have to navigate outside their normal social spheres, often following traumatic refugee and historical experiences.

Migrant Integration in New Zealand

In a review commissioned by the New Zealand Immigration Service to assist it to operationalize policy concepts, and to identify factors affecting immigrant settlement, Fletcher (1999), indicates that although the concept of immigrant integration has been debated both academically and in official reports elsewhere, the process of immigrant settlement has not been widely discussed as a concept in New Zealand.

According to Fletcher's report, during the period of post war migration of the 20th century, the prevailing approach to immigrant settlement in New Zealand was the assimilation strategy (1999: 6-7):

> The objective was that migrants should assimilate into their new society, without significantly altering it or requiring active change on its part. Successful settlement was the achievement of invisibility by the migrant, that is neither migrants as a whole, or individual national groups should not remain visible in the sense of having special needs beyond the initial period of arrival.

However, as indicated earlier, by the 1960s many academics as well as migrants and officials in other countries, especially in Australia, North America, Canada and Western Europe, began to question the appropriateness of assimilation as an attainable objective of migrant settlement. During this period, many of the post war migrants in these regions appeared to be not assimilating materially, in terms of attaining comparable social outcomes (see Morrisey et al, 1991, Franseca et al, 2005, Hamberger, 2009, Algan et al, 2019).

This portrayal of assimilation as a negative theory led to some countries adopting the idea of a multicultural society. Multiculturalism has its emphasis on every person's right to maintain their cultural identity without being socially or politically disadvantaged. This is in line with the principles of liberal democracy in the way of equality and freedom of expression. It appears that the concept of multiculturalism appealed to many, and it has effectively replaced assimilationism in many. For example, both Canada and Australia adopted multiculturalism as official policy in the 1970s (ibid). However, in

New Zealand, while official statements on the objectives of immigration have tended to move towards acknowledgement of a multicultural society, multiculturalism was never adopted as official policy. Some authors have suggested that this reflects New Zealand's previous approach to 'non-traditional' immigration, and also the ongoing debate in New Zealand over the dynamics between biculturalism and the growing state of multiculturalism. See for instance; changes in New Zealand's migrant selection policies (Fletcher, 1999: 6), social dominance status and Pākehā attitudes towards the principles and resource-specific aspects of bicultural policy (Sibley and Liu, 2004), socio-political negotiations of biculturalism in New Zealand (Campbell, 2005), challenges of international migration in New Zealand (Ed: Trlin et al, 2010: 136-158), challenges of multiculturalism to biculturalism and the role of Māori as tangata whenua (New Zealand Federation of Multicultural Councils, 2015: 7).

Issues of Institutional Racism and Discrimination

While it is acknowledged that reasons for health inequalities are complex, current debates have highlighted that in New Zealand, Māori, Pacific Islanders, and people from lower socio-economic population groups, have worse health status (Ministry of Health, 2000, 2002, 2017). In countries such as New Zealand and others with a history of colonization, indigeneity, ethnic identities and socioeconomic determinants of health have been proven to be intertwined (Howden-Chapman and Tobias, 2000, Dutton, 2009, Curtis, 2007, Matheson and Loring, 2011, Duggan, 2011, Sheridan et al, 2011, New Zealand Medical Association, 2011, Tuwe, 2012, Came, 2013).

One of the factors identified as contributing to health inequity and poor immigrant health outcomes is institutional racism and discrimination. This has been found in New Zealand as well. In an article based on a survey of public health providers and informed by her wider study into institutional racism, Came, (2012: 5) describes institutional racism as "a pattern of differential access to material resources and power determined by race which advantages one sector of the population while disadvantaging another." Although not readily visible, institutional racism has been pointed out as one of the pervasive aspects of the New Zealand society that exacerbates poor health among Māori and Pacific population groups. For example; the ongoing historical effects of

colonization and confiscations of Māori land that started from the mid-nineteenth century, have significantly diminished Māori economic base and political influence (Mar 1997, Jones, 2000, Howden-Chapman and Tobias, 2000). Racism affects health of minority population groups as it generally produces less favourable socioeconomic conditions, which result in psychosocial stress and physical health deterioration (Davey-Smith, 2000, Westbrooke et al, 2001, Ministry of Health, 2002).

One of the long-term goals of the Ministry of Health is reducing health inequities between Māori and non-Māori, and as such both DHBs and the Ministry of Health have put prioritisation processes in place to health inequities are addressed (see Salmond, 1986, Ministry of Health, 2004, Joint DHB and Ministry of Health Working Group on Prioritisation, 2005). In order to assess this, Came carried out a survey of public health providers to compare their experiences in dealing with the Ministry of Health and their respective District Health Board funders. The survey, of which questions were informed by collaborative storytelling with Māori health stakeholders, focussed on the broad areas of contracting and monitoring, relationships and levels of influence, and it included in total, fifty-six public health providers nation-wide. These ranged from Public Health Units (PHUs), Public Health Organizations (PHOs), Māori Health Providers to Non-Governmental Organizations (NGOs). However, according to Came's study, public health planning and health funders' funding capacity have become gravely compromised, and she argues that these capacity issues, combined with both the failure of quality assurance processes and compromised public health leadership, have contributed to an environment where institutional racism has been allowed to flourish (Came 2013: II):

> The findings of this survey in relationship to access and representation show significant variations in the experiences of Māori providers versus other providers. Some of this variation is normal and can be explained away in a case by case basis, the rest I assert is evidence of institutional racism. -Institutional racism occurs when there are patterns of behaviour that advantage one group while disadvantaging another.

The findings of this study have some serious implications for non-Māori ethnic minority groups as well. Many immigrants living within the lower socio-economic spectrum including refugee background immigrants such as members of the Luo community are mainly enrolled with community-based health providers including some Māori providers, and they are therefore most likely to be also negatively impacted by the already existing institutional racism.

Health Inequity in New Zealand

The New Zealand health care sector is made up of a broad and complex network of organizations (including NGOs) and specialist services agencies, each with its set of roles and responsibilities, some operating under certain funding contracts linking the state and Crown owned entities (see figure 2). Hinged on intersecting organizational functions between; government institutions, parastatal bodies, private and public service providers, this structural matrix provides health care related services, ranging from national down to regional and localized operational levels. Within these organisational networks, there are interconnected networks of human resources that include; governing and funding bodies, specialist units, and teams of professionals with specific roles and responsibilities (European Observatory on Health Care Systems, 2001, NZ Public Health Clinical Network, 2011, Waitemata District Health Board, 2014: 1-9, Ministry of Health 2017). It is thus a complex system of provision, whose outcomes are related to the interactions between different sectors with different priorities and targets.

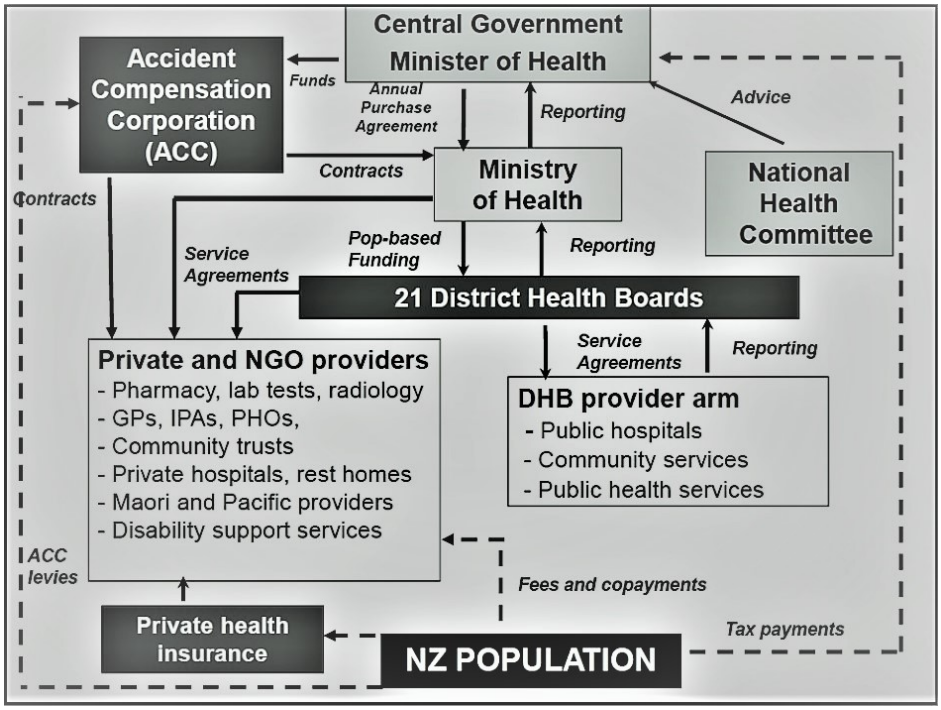


Figure 2: The Systemic Structure of the New Zealand Health and Disability System (Source: Ministry of Health, 2017)

In March 2017 the Organisation for Economic Co-operation and Development (OECD) published a new health policy overview which presented an overview of health policy challenges facing its member states. Whilst New Zealand was presented as having 'a generally high performing health system, there were a number of health policy challenges posed by among others: an ageing population, health inequality, as well as the burden of non-communicable and chronic diseases (OECD, Health Policy Overview, 2017: 1-2).

Furthermore, despite New Zealand's household spending being listed as one of the lowest in the OECD countries, a significant proportion of the population reported unmet health needs due to cost. The publication indicated that people in the lowest socio-economic categories, and those from Māori and Pacific Island backgrounds, are particularly at risk from holding off seeking health care when they need it, which may jeopardise their health status. The publication concluded by making the following recommendations for the New Zealand health system:

- To continue to monitor inequality in healthcare access and utilization.

- To improve access to health care for the disadvantaged or the underserved population groups
- To identify and address financial and non-financial barriers to health care services (OECD Health Policy Overview, 2017)

Evidence from literature and ongoing socio-political debates in New Zealand indicate that significant health inequalities exist among the different population groups, including; socio-economic divides, ethnic groups, gender and age groups, and different geographical area groups. Matheson and Loring (2011) argue that health inequity issues that are currently impacting the health of many New Zealanders are growing but unseen problems. They attribute this invisibility to the fact that health inequity largely evolves from social conditions other than health itself, citing rising unemployment, reduction in incomes for low income families and reduced access to social housing, as some of the key factors contributing to the widening health inequalities between different population groups. The authors contend that there is need for strong commitment from government backed by an equally strong support from the health sector, for health equity to happen in New Zealand:

> Unless equity is explicitly considered, even the best-intentioned policies are likely to inadvertently widen rather than reduce health inequities. To not consider the impacts that new policies have on health inequities is now hard to justify (Matheson and Loring, 2011: 9).

According to Matheson and Loring, health inequities cannot be addressed the health sector alone, but needs to be addressed across social and political spheres. As such, they call for the health sector to lead by example in urging other sectors to consider the impact of their policies on health equity.

Current New Zealand Health Research on African Migrant Population Group

Beyond the existence of institutionalized racism, some studies conducted in New Zealand have identified existence of discriminatory and racist attitudes within the health care system. One of these has particular interest for this thesis. Led by a public health medicine specialist Dr Lavinia Perumal, this report presented results of research commissioned by the Auckland District Health Board on behalf of Auckland Regional Settlement Strategy Health Steering Group, investigating the health needs of Middle Eastern, Latin American and African (MELAA) immigrant population groups living in the Auckland region. At the time of its publication (2013), it was the first and only report to present the Middle Eastern, Latin American and African migrant population groups health trends in New Zealand. The African people are the second largest of the MELAA group in the Auckland region, after Middle Eastern, mostly coming as refugees from the horn of Africa starting from the late 1980s. It should be noted here that although there is a significant number of African migrants of European descent (mainly from Zimbabwe and South Africa) currently living throughout New Zealand, this group is classified as 'European' in New Zealand (ibid: xi). Therefore, Perumal's report makes a distinction between 'African' and 'European-African' immigrant groups, with the latter being referred to as 'European.' This in itself indicates institutional attitudes towards different ethnic groups, and racist undertones of reporting. The word 'African' comes to mean 'Black Africans' in reporting in New Zealand, while white Africans are included as Europeans, and therefore data skewed.

The research looked at the possible determinants of health ranging from; group demography, socio-economic determinants, utilization of health services to types of health conditions. It found that in comparison to Europeans, Africans are a relatively young population, but they have the greatest proportion of people living in the most deprived areas within the MELAA group and the greatest disparity in deprivation distribution. Many live in more crowded circumstances compared with all other ethnicities, and they have the highest proportion of one parent households. Although they were found to have similar school qualifications to Europeans, they also have a higher unemployment rate, lower mean annual income and a higher proportion of people on the unemployment benefit.

The African people had lower than expected proportions of people with a community services card (CSC), and the lowest breast cancer screening coverage of all compared ethnicities, and a much lower unadjusted cervical screening coverage than Europeans (in women). A higher proportion of African patients did not attend specialist outpatient clinics than Europeans in all three Auckland District Health Boards. The research also revealed that they have a higher cost of dispensed pharmaceuticals per person from age 10 to 59 years (due to HIV medications) but a lower value of nominal costs per person for laboratory tests compared with all others.

In addition, the African populations in Auckland were also found to have a reduced utilisation rate of secondary mental health services but a higher proportion needing acute inpatient admission at contact compared with others, a lower prevalence of cardiovascular diseases but a higher prevalence of diabetes compared with Europeans, a much higher rate of hospitalisations from respiratory diseases (asthma, pneumonia and bronchiolitis) than others. They also had the second highest proportion of people diagnosed with HIV and AIDS compared with all other ethnicities, after Europeans. African women were the highest proportion diagnosed with HIV/AIDS of all ethnicities, the highest hospitalisation rate for tuberculosis, a higher rate of termination of pregnancies and a higher hospitalisation rate from sexually transmitted infections than others (in women). Related to this issue, Poindexter (2013)'s study of experiences of HIV positive African women in New Zealand revealed that participants reported "inappropriate use of universal precautions, violation of confidentiality rights, discriminatory comments about Africans and/or persons living with HIV, as well as misinformation about HIV transmission" (Poindexter, 3013: 704).

Conclusion

This chapter has introduced theoretical conceptions of integration and health alongside relevant literature on these concepts, as well as literature related to the links between migration, health and migrant integration. I have highlighted the complexity of integration as a multidimensional process involving social, cultural, political and economic societal dimensions. I have also outlined the difficulties presented by this complexity in defining migrant integration as a concept. However, following the various

conceptual understandings of integration, I have argued that it is a three-way dynamic process, involving migrants, their country of origin and the host country.

I have briefly explained the conceptual dimension of health and the essence of culture in understanding the various conceptions of health and well-being. I offered two examples of Luo cultural conceptions of health to highlight the connections between culture and health, discussing the concepts of cultural capital and social capital and linking them to migrant integration. I have highlighted the importance of social networks and culture to the integration of migrants. I have particularly drawn attention the significance of culture in health care provision.

Lastly, this chapter has briefly examined the New Zealand conditions of migrant integration and how the New Zealand health care sector and other institutional structures may affect migrants' integration. A body of New Zealand literature on the topics of ethnic relations and health has highlighted a number of institutional and ethnic relations issues impacting the health outcomes of a section of the country's population.

Although some work has been done in relation to some social and institutional aspects of refugee migrant resettlement, more research is still required to fully comprehend and appreciate the place of health in this group's adaptation process. Drawing from ethnographic data and applying the concept of integration as a three-way process, the following chapters will explore some of the Luo community of Wellington members' experiences of migrating from their homelands, their resettlement and the process of adapting to life in New Zealand, as well as the place of health in this process.

Chapter Three: Pre-migration Experiences of Forced Displacement

> Refugees and asylum seekers experience the profound loss of their home and their homeland as well as the stress and alienation of resettlement in a new country and culture. There is evidence of a strong relation between the multiple and chronic extreme experiences of refugees and the diagnosis of Posttraumatic Stress Disorder (PTSD), which is defined as the consequence of a traumatic event or series of these events characterized by intrusive memories of the trauma and symptoms of avoidance and hyper-arousal (Van Ee et al, 2013: 120)

This chapter presents interviews with three of the Luo community elders; Francis, Joyce and Margaret. Francis fled Uganda in 1985 had spent eighteen years in refugee camps between South Sudan and Ethiopia before he was resettled in New Zealand in 2003. Joyce fled South Sudan in 1992 as a sixteen-year old child and had spent seventeen years in Achol-pii refugee camp (Northern Uganda, where all her three children were born) before resettlement in New Zealand in 2009. Margaret fled South Sudan in 1994 and she had lived in Adjumani refugee camp (also Northern Uganda, where three of her six children were born) for nine years, before she too was resettled in New Zealand in 2003. All three participants express emotional feelings of frustration and despair during these extended periods of time in displacement camps due to sustained uncertainty as to whether they would ever go back to their homes and their families. The chapter discusses the general impacts of forced migration on the participants' individual lives, home country dynamics, physical and mental health effects of living conditions in refugee camps, as well as the psychological effects of prolonged liminal existence in displacement.

The impact of forced migration on immigrants' health and sense of well-being has been identified as one of the greatest challenges across the migrant settlement and integration literature. This has also emerged from my research. Thus, this first section of this chapter will focus on the Luo community members' narratives of forced migration and the social, psychological and health issues they encountered as a result of being

forced to leave their homes. The chapter will also shed light on the experiences of life in displacement prior to their resettlement in New Zealand.

The majority of the Luo community members that I interviewed recounted the physical and emotional difficulties they faced due to conflict in their respective countries of origin. Many spoke of the emotional hurt of being forced to flee their homes, leaving their communities behind, and being separated from their families due to war. Prolonged displacement and life in refugee camps have also had lasting and indelible physical, emotional and psychological impacts on those who recounted stories of having lived in refugee camps for long periods of time. The majority of my participants (but particularly older community members who had spent considerable lengths of time in refugee camps prior to resettlement), recounted experiences of physical and emotional difficulties during the initial escape from the war. Some talked about perpetual physical insecurities of life in a refugee camp, such as experiences of regular violent camp raids by rebels and armed robbers in which lives were often lost. They discussed how these effected their settlement in New Zealand.

More specifically, issues covered in this chapter include; negative effects of fragmentation of the family unit, loss of social capital and diminished cultural capital, as well as the negative consequences of life in refugee camps. Health deterioration caused by prolonged emotional stress, lack of food, psychological trauma due to exposure to violence and other insecurities. The physical and psychological impacts of sustained sense of liminal existence on people's sense of identity, belonging are self-esteem are also highlighted. It is my conviction that it is crucial to unearth and untangle these issues as they affect a person's ability to function effectively in a new society, more especially because of their impact the individual's health.

The Relevance of Home Country Dynamics in Shaping Migrant's Integration Experiences

When I sat down with both Margaret and Joyce to talk about their respective experiences of resettlement in New Zealand so far, they started from when they first fled their homes. They view these experiences as part of who they are, and the journey

that eventually took them to New Zealand does not start when they boarded the plane, but at the point when they first fled their homes. These experiences and their memories of them are etched deep in the experiences of moving to New Zealand and have become an indelible part of their contemporary identity. Both Margaret and Joyce are Acholi Luos from South Sudan, and both are both single mothers who were forced to live their respective countries decades before they were eventually resettled in New Zealand together with their children.

Joyce is a forty two-year old mother of three. She currently lives in a modest three-bedroom house in Lower Hutt with her children (24, 18 and 16), and a young grandson. Joyce's two older children, Emma and Paul are both doing tertiary studies, and Isabella, her younger daughter is still at high school. Paul is studying bio-medical security, while Emma, Joyce's oldest child, who is also the mother of her young grandson, is doing a computer course. Joyce first fled South Sudan across the border to Uganda in 1992 as a sixteen-year old girl with a group of other former students, who decided to flee the daily persecution by the Sudanese government armed forces. I met Joyce for the first time when I first interviewed her in late July 2018 at her home. A soft spoken, shy looking, slightly built woman, Joyce's lounge is decorated in the typical African-style urban home with bright colours; almost like permanent Christmas décor. A string of red and yellow plastic flowers circle the entire room along the cornice joint, where the ceiling meets the walls. The sofas have big soft bright green cushions symmetrically placed on them, and the back rests are also covered with matching bright green, white-laced cotton cloths. Her framed Care Worker qualification certificate hangs prominently on the wall above the large television screen, and pictures of her family can be seen hanging in different places along the walls.

Before we talked about her New Zealand resettlement experiences, I asked her to describe the events that led to her fleeing her home in South Sudan, as well as what life was like for her as a refugee, to try and understand her pre-migration experiences. The following interview excerpts cover parts of Joyce's descriptions of her experience of fleeing her home in Juba, South Sudan to seek refugeedom in neighbouring Northern Uganda:

We fled Sudan as a group of students. Our plan to leave Sudan came because the war in Sudan had been going on for a long time, and it didn't seem like it was going to stop […] And for us students, the school wasn't there anymore […] it had stopped. So, you find that most of us the kids were just staying at home and doing nothing […] and there was fighting, and we were always hiding […] there were gunshots, killing and a lot of bad things going on like hunger […] so it was really a hard life in the city, that is in Juba. So, children just started to plan […] I don't know they hear from where that people can go out and leave the country as a refugee in Uganda (Joyce, 2018)

[Judah] - So, how was it like to leave your home and your parents behind to become a refugee at the age of sixteen?

[Joyce] - At that night during Christmas of 1992, we celebrated Christmas in Juba…then on the 26th, midnight we escaped […] there were three girls in my group, and the rest were boys. The group was divided into two groups…because we knew that somewhere in the middle here, there was an army barracks…so, one group went this way, and the other group the other way…so that we meet each other once we have walked past the barracks. So, we started walking […] we walked in the bush, no road, nothing there, you have to be careful where you step […] just follow the leader in front of you. We walked the whole night, until the following morning […] We arrived at the SPLA area where we found that they had just burned the bush, and the fire was still going, but we kept on walking. We were going to cross the Nile river. But by the time we arrived at the SPLA site, they already knew […] because we were the third group. The first group was already in Uganda, and the second group- caught by the SPLA rebels. And they had already told the rebels that "other groups are coming".

[Judah] – Can you walk me through the experience of being caught by rebels? What did they do or say to you?

[Joyce] - It was very scary […] they came and surrounded us and started talking and scaring us. And then they divided us into groups- 'you girls go there' […] There were two boys in the group who had

light brown skins that made them look like Arabs, but they were not Arabs. So, they took them and put them aside. But the boys were from the same town as me and others, and so they spoke Acholi language like everyone else. So, the soldiers stared talking to us and asking us if we were Arabs, but we told them we were students […] they asked us where we were going, and we said - "we are coming to join you, because we can't handle the situation with the government anymore". And they said to the two boys, "what about you two boys? You look like Arabs", but the boys spoke to the them in Acholi and said, "we are not Arabs" […] Among the soldiers there were people who also came from our area, who spoke the same language as us. And knew from the boys' dialect that they were not Arabs, so they spared their lives.

[Judah] - So, what happened once you were in the rebel's hands?

[Joyce] – They told us to contribute things to them; like clothes, soap, salt and so on. We had to do this very quickly. Everyone opened their packs and gave the soldiers whatever supplies they had, like salt, sugar, cloth, bedcovers […] they don't have these things…and sometimes they raid villages for supplies like that. Afterwards they took us to their camp, where we found another group of other boy-student there […] then we stayed there with them in the bush for four days- waiting for the rest of the people coming. Then after that they took us to their big barracks […]. We were so tired, feet swollen, shoes finished […] we suffered a lot.

[Judah] – What happened once you were in the barracks?

[Joyce] - The commanders came and talked to us. They said, "as you say you are coming to join us, we are happy [...] From now on, you will be trained to become soldiers, so that you can go back and capture Juba". At this stage we all felt like things had changed for the worse for us […] our plan for escaping the fighting were destroyed. Then from there they took us to the training field […] and we started training. Most of the students in that group became soldiers […] they fought, they died, and few of us, especially the girls- there were twelve girls by then, and a few of the seminarian boys who were

> studying to become priests before we ran from Juba, we were taken in by the Catholic bishop who ran a mission near the rebel camp […] and we remained ordinary mission students. Some of the soldier students escaped […] my younger brother was one of them. He escaped to Uganda, but later went to back to Sudan, and he got killed fighting there. But some of them stayed, completed their training and became part of the rebel army and went to the war front.
>
> **[Judah]** – How long did you stay in the mission for?
>
> **[Joyce]** - Because we left home at the end of the year, around Christmas time- we spent most 1993 in a rebel-controlled mission station in Uganda […] and it was at the end of 1993 that we were sent to the camp, and then we were registered as refugees.

When I asked Joyce, what happened to the father of her children, she seemed a bit uncomfortable. For a moment, she looked down and avoided eye contact. When she finally looked up, she asked me why I am asking about him. But before she asked me not to record our conversation about him, she added that he is a Ugandan who worked for one of the humanitarian organizations, and they broke up before she left, so she does not know his whereabouts. Although I had questions about Joyce's children's father, I avoided asking about him during our second interview as I sensed that she did not want to talk about him. The issue of missing family members and familial relational complexities was raised by other community members as a "sensitive issue" and will be discussed in more detail in the following chapter.

Margaret, now in her late fifties, lives in Upper Hutt with two of her six children. She told me that her oldest daughter took off to the US with her two kids against her (Margaret's) will to join her partner who lives there. Her two older boys have moved out and now live in Wellington, and one son is in prison. I was introduced to Margaret by another member of the Luo community participating in the study. Margaret lives in Māoribank, one of the outer suburbs of the Hutt Valley, her moderate house sits at the end of a cul-de-sac one of several short streets at the foot of the Māoribank hill. As Josephine, Margaret's younger daughter, welcomed me into the house, the first thing I

noticed was the brightness of the colours in the room, just like Joyce's lounge. Two sides of the room are occupied by sofas, on which sat large bright orange cushions, and matching sofa covers. A large television sat prominently at one end of the room facing the sitting area. Margaret looked strong and dignified as she sat on one of the single sofas facing the doorway. She reminded me of my own mother as she stood up to shake my hand. As I glanced around the room, I noticed that Margaret also has a Care Worker qualification. Her framed Care Worker certificate hangs on the wall above the door. The rest of the walls are dotted with family photos and a few African-style art works and crafty decorations.

After we had exchanged greetings and introduced each other, I asked Margaret to describe her journey from East Africa to New Zealand, and her experiences of resettlement so far. 'It was a big process…' she said. She started from the time when she fled South Sudan in 1994 before describing her journey through the South Sudanese jungle, the loss of an unborn baby, the malnourishment her living children faced, life in a refugee camp (including once being held at gun point in a camp raid) and the emotional roller coaster as she eventually found herself on an aeroplane to New Zealand, albeit having no idea where New Zealand might be. The following excerpt was taken from our first interview which lasted over one hour:

> **[Judah]** - Can you describe your journey from East Africa to New Zealand, and your settlement experiences so far?
>
> **[Margaret]** – It was in 1994 when the fighting started to get really bad- life was not easy […] because first of all when we ran from Sudan, I was a pregnant woman […] and we walked until I was so tired. And that time also the baby was coming. I was exhausted, and the baby was also tired, so, I couldn't do it […] so people saved my life. They held my legs and pulled the baby out […] the baby just breathed twice and then died […] I didn't even see where they buried it. Somebody told me that they buried it and have put a stone on top of the tomb […] I couldn't walk anymore, so they cut some tree branches and carried me.
>
> **[Judah]** – Did you have any other children with you when you left Sudan?

[Margaret] – My oldest daughter was about seven, and my two older boys were two years and one and a half at the time […] the other three were born in the camp. The boys were both very malnourished, they became very thin, and people did not like me sitting with me because my babies were crying all the time […] everyone was trying to hide, no one wanted crying babies near them. Sometimes I used to get up in the night, wishing that some animal could kill me and my kids […] One day one of the men said to me "why are you keeping those two children because they are going to die"? You should just throw them in the water for crocodiles" By, that time, my babies were like skeletons.

[Judah] – So, how did you manage to keep going with your children?

[Margaret] - It was very difficult […] they were still breathing, and I couldn't just throw them in the water, so we kept walking everyday like that, until we reached the Ugandan border, and the message got to the UNHCR that there were refugees at the border. So, they came and picked me with the kids immediately to keep them alive […] and I was also very weak too.

Margaret also talked about how she lost her husband in the war before she fled South Sudan and she also described how she lost her mother as well as all of her sister's children during the time she has been in New Zealand.

[Judah] – What about your children's father? What happened to him?

[Margaret] - My husband was fighting in the war - he was a soldier. You know, so many soldiers died […] For us we were lucky to get where we are now […] All my group, most of the people who used to live in my small community died […] they are dead. And I think I have stayed alive by the will of God. So, after I reached here, I also lost all my family back home - my mum, and my sister's children were all killed since I have been here […] So, my mum died from sorrow - she was over seventy, and after all her grandchildren were killed, she refused to eat until she died.

Margaret's story of loss and grief has been echoed by other community members. For instance, both Joyce and Francis, as well as other community members talked about experiences of losing homes, family members, neighbours and friends. This is also a typical narrative of the South Sudan/Northern Ugandan conflict region as discussed earlier in this chapter in relation to regional conflict and insurgent operatives. While they managed to escape the conflicts in their countries, life was still difficult in the refugee camps, and continued to impact their sense of security as well as their health and well-being.

Social and Health effects of Forced Migration and Displacement on Individual

As discussed in the first chapter, Northern Uganda and South Sudan, both Luo regions, have been under political repression for decades. In Sudan the political tension between the mostly Arabic Northern Sudan and the African tribes of the South have been ongoing since the late 1950s following the country's independence from the joint British and Egyptian rule in 1956. The resistance of Arab influence from the North by mostly African peoples of South led to the birth of the South Sudanese rebel movement, Sudan People's Liberation Army (SPLA) in the early 1980s. Consequently, South Sudan has been a battle ground between the Sudanese government and the armed rebel movement for several decades which has seen many people lose their lives, and many more displaced (see Johnson, 2013, Snyder, 2013, Rolandsen et al, 2015, Tounsel, 2016, Leonardi and Santschi, 2016).

In Uganda, the massive political repression that started with rule of General Amin in the early 1970s did not end with his demise at the end of that decade. The ousting of his successor (a Northern Ugandan himself) only a few years into his leadership saw an intensified assault on the people of Northern Uganda that led to many people fleeing the country, and the rise of the Northern rebel movement, the Lord's Resistance Army (LRA) during the 1980s (see Golooba-Mutebi, 2008, Ochan, 2009, Tornberg, 2012) for more details on conflict in Uganda.

The Lord Resistance Army (LRA) in Northern Uganda came to prominence in the mid-1980s as an armed resistance against persecution of that region by the Ugandan government forces following a violent government power take over by the current Ugandan president, Yoweri Museveni's forces in 1985 (see Sejjaaka, 2004, Quinn, 2004, Golooba-Mutebi, 2008, Amone, 2015). In South Sudan, the rebel group that rose to prominence around the same was the Sudan People's Liberation Army (SPLA). Both SPLA and LRA are renowned for terrorising those considered as government supporters or traitors if they were local communities suspected of collaborating with government forces. They also regularly raided towns and villages for supplies, burned down whole communities, murdered men and women and kidnapped children (often to train them as child soldiers). Both groups continue to be active and a constant threat to the people of these two regions.

As well as operating in their own countries, the two rebel groups often cross the border to raid communities on the other side for supplies. Government forces also frequently raid communities suspected of harbouring or supporting rebels. As a result, both regions were treated as rebel territories by the governments of both countries, thus many of the communities in the region were subjected to regular raids, murders, burn-downs and subsequent mass displacement. Current research evidence shows that this sustained persecution has devastating physical and psychological consequences for many of its survivors. For more details on the impact of armed conflict on the people of South Sudan see Musso, 2011, Ottaway and El-Sadanay, 2012, Snyder, 2013, Makori, 2015, Tounsel, 2016, World Vision Australia, 2018.

The following excerpts are taken from my interviews with Francis, an Alur Luo from Northern Uganda and one of the Luo community leaders. Having arrived in New Zealand in 2003, Francis is one of the earlier arrivals of the Luo migrants. I sat down with him in one June afternoon in his house in Lower Hutt, where he lives with his wife Grace. He recounted his personal experience of being forced to flee into exile back in 1985, leaving his home, his wife and seven children as well as his country behind, with no knowledge of whether he would ever be able to go back, and how this experience would impact on his emotional and physical health. Francis, now in his late sixties, spent over seventeen years in refugee camps between South Sudan and Ethiopia before finally being resettled.

His wife Grace joined him in New Zealand in 2005 under the family reunion programme, after a twenty-year forced separation. Grace also told me that at one point, during her husband's absence, she and the children were forced to go into temporary exile into the neighbouring Democratic Republic of Congo (DRC) due to constant harassment by the government agents. Two of Francis' and Grace's seven children have since joined them in New Zealand, (although they tell me that sadly, their youngest son died of drowning in an Auckland beach two years ago) while their remaining children still live in Uganda with their families:

> **[Francis]** - Leaving my home as a refugee was very difficult […] And life in refugee camps is an experience I will never forget […] it was hard, it was difficult, and it was miserable because of so many factors- there were diseases, famine, hunger […] and we didn't even have basic resources […] it was quite a harsh environment.
>
> **[Judah]** – Would you say this experience has had any bearing on your overall health and well-being?
>
> **[Francis]** - I think I would have been much healthier had that not happened. Because in the end I suffered from many ailments […] such as disease and from lack of food. In fact, lack of food was one of the greatest challenges […] All of us who were there at that time had lost weight. We so extremely malnourished to an extent that you could see your friend's last bone […] we had no clothes, no beds and no proper blankets, we had gunny sacks for blankets […] and there were mosquitoes as well. So, health-wise we also had people suffering from mosquito bites and water-borne diseases. Diarrhoea was continuous, and this was part of the reason many people lost so much weight.

Prior to fleeing Uganda, Francis had a good, stable job working for the Ugandan Civil Aviation Authority. Leaving his home put him in a precarious position, but it also affected his wife – leaving her with their seven children meant that she was faced with the challenging task of bringing them up in a highly unstable and hostile environment on her own. Both Francis and Grace express the enduring emotional stress they and their children experienced as a result of the family life disruption caused by conflict in

Uganda. The following quote details a series of events that led Francis to flee into exile, and how this experience impacted his family:

> **[Francis]** - At the time, I had just completed my O-Levels. I was put in military detention in Gulu for ten days, and I was only helped by a lieutenant who sympathized with the ousted Obote government after telling him where I came from and what I had been doing […] The day he came to release me he said to me; "man, just get yourself out of here. I will organize people to take you to the Sudanese border and leave you there. You need to just go and stay in Sudan […] I know that if I leave you here, you won't last long because they are going to kill you". And that's how I managed to escape into Sudan.
>
> **[Judah]** – So, what did all this do to you and your family?
>
> **[Francis]** – I think if I had been there all those years I spent as a refugee, my children could have had a better education, and better life chances […] So, going into exile made life very difficult for my family. I would say, even the suffering that my children are going through now is directly related to the fact that I was absent when they were growing up […] and their mother couldn't do much by herself. Being separated from my family was one of the most difficult, and emotionally distressing experiences I have gone through.

A recent review of long-term studies of the mental health of the war refugees (Bogic et al, 2015) found that at least one in five war refugees suffer from PTSD or anxiety disorders, and that exposure to pre-migration traumatic experiences and post-migration stress was most consistently associated with the forms of mental health problems, while poor post-migration socio-economic status was most associated with depression. In a study conducted with Congolese refugee women living in a Rwanda camp, Puvlish (2005) highlighted that most of the participants reported suffering from chronic sadness about the past and the daily struggle for survival. Reporting on the Syrian refugee crises Abou-Saleh and Christodoulou (2016) noted that refugees have high rates of mental health morbidity as a result of conflict, and that while refugees are often screened and treated for health care needs including communicable and non-communicable diseases,

their mental health care and psychological support needs are often unmet. In a study conducted to determine the health conditions of people living in refugee camps across countries in Sub-Saharan Africa (Lori and Boyle, 2015: 3) summarized the impact of forced migration on people in the following statement:

> The trauma of fleeing one's country under fear of persecution cannot be overemphasized. There are numerous physical and psychological dangers of flight. The journey itself may be through treacherous territory. Those fleeing may encounter many dangers including lack of clean drinking water, lack of food, and the danger of being captured by enemies. Sometimes family members are left behind or become separated from loved ones during flight.

This statement rings true to most within the Luo community of Wellington that I worked with as people have described the various degrees of precarities, insecurities and vulnerabilities associated with both their time of flight from home countries and time spent in displacement in refugee camps.

Effects of Refugee Camp-Living Conditions on the Individual's Health Status

> I lost so much weight, and I became completely weak […] and you could see that everyone in the camp was starving because there was not enough food- you ate once in a while. If you had strength you could walk along the riverbank and look for anything edible […] It was the most difficult time of my life. I don't think I can forget it because I was able to see my skin change. It was so bad that you could even feel the last tail bone […] If you sat down, your head would start spinning when you try to stand up because you are so weak just from lack of food (Personal interview: Francis, June 16 2018, Lower Hutt).

Despite the difficulties they encountered during their respective escape journeys from South Sudan, Margaret, Joyce, and Francis, all made it across the border into Uganda, and were placed in refugee camps in Northern Uganda. Joyce spent seventeen years in Achol-Pii refugee settlement where all her three children were born, whilst

Margaret spent nine years in Adjumani refugee camp, where three of her six children were born. Both women talked about their experiences of hard conditions of life in a refugee camp. Echoing some of Francis's refugee camp life experiences, the two women's stories cover issues of overcrowding, food shortage, nutrition deficiency and sanitation-related diseases, fear of death and incidences of violent camp raids by rebels or armed robbers.

As stated earlier, to this date, the two rebel groups continue to operate along the South Sudan-Northern Uganda border, the Sudan People's Liberation Army (SPLA) on the South Sudanese side of the border, and the Lord's Resistance Army (LRA) on the Ugandan side. According to the participants' narratives as well as literature on the regional conflict, each of the two rebel groups often cross borders to raid communities for supplies such as food, cash, weapons, clothes and so on. Both rebel groups and government forces often raid and destroy villages on their own side of the border if they suspect them of collaborating with the enemy. This situation put many of the Luo communities who straddle this border line (including those living in refugee camps in the region), in a constantly precarious and psychologically stressful living condition.

To gain a better understanding of the impact of prolonged displacement and living in the harsh conditions of the refugee camp environment, when I met up with Joyce for our second interview, I asked her to describe her life experiences in a refugee camp, and the following are excerpts from our conversation:

> **[Joyce]** - One of the big problems was getting some money to buy some of the things that we didn't get from the humanitarian organizations- like salt, clothes and things like that. And we also had to contribute to the running of the camp school too […] Sometimes you had to sell some of your food rations to go and buy something.
>
> **[Judah]** – How much food rations did you receive from the humanitarian organisations?
>
> **[Joyce]** - We received twelve kilograms of food per person a month- not enough. Sometimes even that was reduced to six kilograms if UNHCR did not receive enough food donations from wherever they got it […] There was also a lot of sickness - malaria, diarrhoea,

sometimes an outbreak of cholera or measles - a lot of children died. And there was also a lot of malnutrition - many children died of malnutrition.

[Judah] - What kind of houses did you live in while in a refugee camp?

[Joyce] - The refugee settlement in Uganda was like - we were just given a small piece of scrub land, which was subdivided into smaller plots […] but we had to clear the bushes, make our own tracks and build our own shelters. The government dug the borehole for our water supply and build a centre - like an office where we all registered our complaints or obtained a permit to go into the city if you needed to - like going shopping and come back.

[Judah] - Since there was also a civil war in Uganda, were there any Ugandan refugees in the camp as well or was it just South Sudanese?

[Joyce] - In Acholpi we were all Luo people […] but there was a mixture of Ugandan and Sudanese Luo. But one day the Ugandan rebels came to the camp, and they killed many refugees. So, many of the refugees took off - many wanted to go back to Sudan. But the Ugandan government refused to let anyone go back to Sudan. That was in 1996 […] they came at night and entered one of the blocks-block 11. They captured everyone and killed many […] only a few people from that block managed to escape with their lives - thousands were killed, mostly Sudanese.

The physical and psychological impact of experiences on the lives of people who lived for extended periods of time in displacement camps within conflict zones prior to migration, have been discussed across the migration and immigrant integration literature, particularly in discussions focussing on forced migrant population groups such as the Luo community of Wellington. As Elbert and Schauer (2002: 883) note, "a cut into the soul as a result of a horrifying experience can persist as a crippling disease with its core conceptualized as post-traumatic stress disorder."

Margaret recounts a similar experience at Adjumani refugee camp in the following interview excerpts. Although not as many lives were lost in Margaret's camp raid, she remembers the event as terrifying and extremely stressful as she and her neighbours were held and robbed at gun point. For a while, Margaret worked as a maternity assistant in the camp clinic. She saved some of the money she earned from her job inside the thatched roof of her hut, and when I asked her to describe her experiences of life in the refugee camp, Margaret's story was not dissimilar to Joyce's:

> **[Judah]** - You have spent nine years in a refugee camp in Uganda. Can you tell me about your experiences of this period?
>
> **[Margaret]** - So, life in a refugee camp was not easy at all […] The food rations were also just dried foods like dried corn, beans and things like that. So, one needs to find firewood to cook it. A lot of people died - many people in the camp died from cholera […] the camp was very dirty […] We used to go far away in the morning. Like 4 or 5 am to go and collect fire wood […] and we would come back to the camp about 1 pm […] by then we were always hungry and thirsty- sometimes you swap fire wood for food from those with a bit of surplus or those who could afford to buy food - and sometimes I made coins by weeding other people's backyards.

Although UNHCR and some NGOs often assist refugees with food and medicine, many of my Luo community participants who have lived in refugee camps in Northern Uganda and South Sudan for several years said that the food rations they received from the UNHCR was 'not enough.' In addition, living on the same diet for months resulted in nutrition deficiencies and sickness.

There was often episodes of violence in refugee camps as well. Margaret described one such violent episode at Adjumani camp, which shows how vulnerable and uncertain life can be in conflict situations, even when people have supposedly escaped to the safety of a refugee camp. Although people flee their homes to seek safety, life in these places is precarious, and there are many insecurities. It is often difficult to ascertain who the perpetrators of violence are. For instance, people who flee from their own countries

into neighbouring countries (such as the situation with Uganda and South Sudan), are often faced with the challenges of being stateless and hence more vulnerable to acts of violence from rebel groups and armed robbers especially if the country of refuge is also going through conflict. As explained earlier in this section, both Uganda and South Sudan were going through civil war at the time when some of the members of the Luo community of Wellington became refugees:

> **[Margaret]** - We had been living at Adjumani refugee camp for five years [...] But again, the Lord's Resistance Army started fighting. At one point I was held at gun point, with my two-year old daughter in my arms. It was around 7 pm when they arrived. I thought they were going kill us […] I gave them the little bit of money I had, but they said it wasn't enough. So, they pulled me out of the yard, with my baby still clinging on to me […] she was frightened, but she never cried. Since that incident, she never wanted me to put her down, she wanted me to hold her all the time, even when I was sitting down, she would sit on my leg.
>
> **[Judah]** - Can you tell me what happened after they pulled you out of your yard?
>
> **[Margaret]** - So, on that evening I was sitting outside with my baby Josephine, because it was hot. I also had an orphaned boy whom I looked after at the time [...] My other kids were inside, and so the rebels took the three of us. My place was on the edge camp closer to the forest, and that's why they came there first. They came from my back […] I thought someone was trying to play a joke on me […] they said to me; "get up quickly"! and when I turned around, I saw a gun barrel, pointing at the back of my head […] then I knew it was serious.

Her attackers, whose language she could not understand, marched her and the two babies to her neighbour's house before she eventually managed to escape and ran into the forest with her children, alongside other people who managed to escape the attack. They hid in the forest all night before the Ugandan army responded to the incident the

following day. When they returned, they found that the attackers had robbed many people and left three dead:

> So, we ran through the forest, and as we ran we kept meeting other people also running out from other parts of the camp […] So, by time the rebels finished searching my neighbour's house, they realized that people were running out, and so they started shooting, and three people were killed that night […] The following morning the Ugandan police and army came to investigate, but by then, the rebels were long gone […] And shortly after this happened, the UN also started saying there was not enough money and my work at the hospital ended […] It was a desperate situation, and I wanted to go back to Sudan because we were near the border, but it was too unsafe.

The stories of perpetual insecurities from physical violence and fear of being killed have been told by other community members as well. These stories add to other precarities of life in displacement, such as; lack of food, poor nutrition, subminimal-standard shelter, poor sanitation, over-crowding and feelings of helplessness. Enduring these conditions for long periods of time can have negative impacts on people's physical and emotional health, as well as their sense of well-being. Hence, it is crucial that when resettling people from refugee backgrounds in new countries, considerations should be made to support their health and well-being on an ongoing basis if they are to successfully integrate into a new society. Because displacement affects people both physically and emotionally, it is important for health care providers to be sensitive to the potential impacts of displacement on people's lives beyond physical ailments. Living in refugee camps for long periods also affects people socially - it affects people's sense of social identity and belonging.

Social and Health Impacts of Prolonged Displacement: Liminal Existence

> Liminal entities are neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention and ceremonial. As such their attributes are ambiguous

> and indeterminate. Thus, liminality is frequently likened to death, to being in the womb, to invisibility, to darkness, to the wilderness and to an eclipse of the sun or moon (Turner, 1969: 81)

In addition to the enduring experiences of being separated from their families and their communities, the emotionally and psychologically stressful experiences of the flight from violence, and the constant struggle for survival that accompanies life in refugee camps, there is the general impact of sustained uncertainty emanating from liminal refugee identity/existence. All three above-mentioned members of the Luo community have lived for extended periods of time in refugee camps not knowing how long they would stay there and what would happen to them once they left the camps.

The concept of liminality was introduced by the Belgian social anthropologist Arnold van Gennep ([873-1957) to describe stages in life transitions. According to van Gennep, the rites of passage are rites which accompany every change of place, status, social position, age and so on. He sees life transitions as marked by three phases; separation, marginality/liminality, and reincorporation. During the liminal period the position of the ritual subject is ambiguous and unstable, with no attributes of the past or the coming status, a period van Gennep describes as social death (see van Gennep, 1960: 1-14, Turner, 1969). I equate forced migration and displacement with separation and marginality described in van Gennep's rites of passage, and in particular, I view displacement as symbolic social death.

Although the forced migration endured by members of the Luo community was not part of a socio-cultural ritual in the sense described by van Gennep, the reality of their extended and uncertain stay in refugee camps is symbolically and practically liminal. All of the elders who spent at least a decade or more in refugee camps described this time as a transit period that seemed to have no end - a long state of temporality with no defined timeline, which their lives on hold while they waited to go home. They belonged neither to their country of birth, nor to any new country of resettlement, a situation which has some serious implications for people's health status. Joyce summed up these feelings in the following statement:

> Life in a refugee camp is tough […] it never feels like home. It feels like you are in transit, you can't settle - you live on a very small piece

> of land - and that's where your life is. A small hut, a pit latrine and a small garden if you can do gardening […] and as a refugee you don't really think about citizenship - you have lost your country and you know you don't even belong where you are [….] it's all about staying alive and hoping to go back home someday.

Joyce's statement could not have summed up the liminality of living in displacement better. People do not choose to become refugees, people become refugees because they have been forced out of their homes. All of my Luo participants became refugees as a result of fleeing violence. Even people who are sometimes described as "having chosen to seek asylum" often do so as a last resort.

The idea of a refugee camp as a liminal space and the refugee as a liminal being has been discussed by several scholars before. In his study with long-term Palestinian refugees living in refugee camps in Lebanon, Ramadan (2012: 75), described a refugee camp as "a space of enduring liminality circumscribed by a particular temporality that limits development and insists refugees seek home elsewhere". The impact of prolonged periods of liminality (loss of connection to place and individual cultural identity) has been one of the strong themes that was reverberated by members of the Luo community. As stories told by my participants illustrate, once people flee their homes to find refuge elsewhere, their lives are disrupted and they are faced with ambiguity, precarity and insecurity. In many cases, people flee their homes without any travel or identification documents. This puts them in a precarious situation even before they reach refugee camps as they cannot prove their registration of citizenship to authorities. For many refugees, the moment they flee their homes is entry into the liminal state, and the spatial constraints and temporariness of refugee camps are both symbolic and material manifestations of liminal existence. People who live in refugee camps are excluded from the political order of the nation state system (of both their countries of origin and the country of refuge) hence, they are in a threshold "a time-space betweenness of the passage" to borrow the words of Ramadan (2012: 72).

For refugees who spend long periods of time in the temporal liminality of refugee camps, the impact of this state on socio-cultural identity, ideas about home, as well as

on physical and emotional health and well-being is multilevel. For example; those Luo community members who arrived and lived in refugee camps as adults had a different sense of identity as well as ideas about home from those who were born in refugee camps. The impact of living in temporary conditions for long periods of time was also described by some of my participants as having had negative impact on their physical health as well. All these factors impact on members of the Luo community's contemporary identities and ways in which they negotiate these identities throughout their resettlement and integration processes.

Conclusion

This chapter has highlighted and discussed pre-migration experiences and the relevance of home country dynamic to migrants' integration in a host country. I have discussed the social and health impacts of forced migration to illuminate the effects of my Luo participants' migration on their identity and ongoing health. This chapter has also covered discussions on the physical and emotional health effects of refugee camp-living conditions, as well as the social and psychological health impacts of the liminal state of prolonged displacement.

Being displaced by war and becoming a refugee comes with multiple insecurities. In addition to emotional health impacts, people's lives are disrupted on many levels. The family unit, which forms the foundation for individuals' social security, is disrupted, alongside its environs and the routines through which people make sense of life. As my participants' stories have highlighted, loss of life is often inevitable. People's livelihoods are destabilized; jobs, means of production, property and belongings are lost, and vital aspects of life such as childhood, education and social connections are also disrupted.

The insecurities of displacement continue even when people have fled their homes to the safety of refugee camps. Life in refugee camps is laced with spatial confinement, precarity and a sense of liminality. Likewise, countries of asylum set up refugee camps as temporary safe spaces. Refugee camps are temporary spaces in their nature, and people fleeing violence to become refugees do so with the hope of returning home or

moving to a safer locale. As many of my participants described, there are often issues of over-crowding, shortage of food, malnutrition, poor sanitation and violence. Hence, the longer they remain in refugee camps, the worse the conditions become. The spatial marginality and temporariness of the refugee camp, their statelessness, and the precarity of the refugee status, make refugees liminal beings.

Refugee camps are not planned like normal towns or cities because they are intended as temporary. Their symbolic spatial exclusion from normal infrastructural order means they are also marginal, insecure spaces even though they are intended to be safe spaces. As highlighted by my participants refugee camps are often rife with violence and physical suffering. Refugee status, as Ramadan (2012: 75) commented, "is an embodiment of this liminal temporality, it is not a normal life to be lived, but an enduring struggle for survival and return to the time and place of meaning." For some of my Luo participants who have spent nearly two decades in refugee camps this liminal period has impacted on people's identities (particularly those who were born in refugee camps), ideas about home, familial relationships, and physical and emotional health and well-being which all affect their experiences of resettlement and integration in New Zealand.

Living in refugee camps for long periods of time affect people both physically and emotionally. From fear of violence in their countries of origin, to fleeing the violence to the safety of refugee camps, war refugees and other people living for long periods in forced displacement are often faced with multiple insecurities and vulnerabilities prior to resettlement, and (as highlighted by Francis's, Joyce's and Margaret's accounts earlier in this chapter) have significant associated health issues.

My Luo participants' stories of their experiences prior to migrating to New Zealand clearly show not only the emotional and physical health impacts of forced migration and displacement, but also the significance of the socio-political dynamics of their home countries, and how these dynamics shape their resettlement and integration experiences. The living conditions in refugee camps affect people's physical and emotional health in many ways, which impact on their resettlement, particularly in a new socio-cultural environment. By insisting on retelling stories of their pre-migration experiences while responding to questions about their experiences of resettlement in New Zealand, the

members of the Luo community of Wellington have indicated that the factors of their pre-migration experiences of forced migration and the liminality of life in refugeedom cannot be entirely divorced from their contemporary identities.[14] As such, integration success in New Zealand requires policy makers' full comprehension and appreciation of their individual experiences as well as a grasp of their home country dynamics. Following on from this chapter's discussion the displacement and migration experience of my participants, the following chapter will cover the Luo community members' experiences of resettlement and adjusting to life in New Zealand as a formerly displaced population group.

[14] The notion of contemporary identity refers to migrants' new socio-cultural identities that emerge in a host country as a result of the acculturation process. Use of this phrase in this research was inspired by my supervisor, Dr Caroline Bennett when she used the phase in reference to the Luo community's intergenerational cultural renegotiations.

Chapter Four: Post-migration Challenges of Resettlement and Adaptation

This chapter will focus on the Luo community members' experiences of resettlement and adapting to a new socio-cultural environment. It will also highlight some of the possible links between their past experiences of displacement and current experiences in New Zealand. The chapter covers challenges of acculturation and enculturation-related stress factors (particularly those experienced by community elders), including language and cultural barriers, as well as issues of unexplained instances of missing family members, familial relational complexities, and the impact of such issues on the family unit cohesion and individual emotional health and well-being. The chapter will then offer an analysis of how these factors affect the overall integration experience of the Luo community in Wellington. Finally, this chapter will briefly discuss the processes of health screening of incoming UNHCR refugees by Immigration New Zealand and the place of refugee children in this process as well as how these affect their integration experiences.

The process of adapting to a new environment, learning new cultural norms and a new language, and losing aspects of one's own culture and becoming part of a new society (acculturation/enculturation) have been identified across the immigration literature as emotionally challenging. This chapter will present and highlight the evidence of possible relationships between acculturation stress and the emerging health issues within the Luo community in Wellington, and how these might affect the Luo community members' ability to fully integrate into New Zealand society. Acculturation stress has been identified as one among the many challenges that new migrants face, particularly during the early stages of the settlement and integration process.

Acculturation

The concept of acculturation was first proposed in the mid-1930s by anthropologist Robert Redfield and others, as a group-level phenomenon. It was defined as "the

phenomena which result when groups of individuals come into continuous first-hand [15]contact, with subsequent changes in the original culture patterns of either or both groups" (Redfield et al, 1936: 149-52). Hamberger (2009), describes acculturation as a sub-process of cultural integration. According to Hamberger, as newly arrived immigrants begin to adopt elements of the host society's culture, they begin to lose certain elements of their original culture at the same time.

It is not uncommon for newly arrived immigrants to feel homesick even after living in the host culture for decades. Older migrants in particular are more acculturated to the heritage culture than their children, while children on the other hand tend to acculturate to the host culture rapidly as they are often less acculturated heritage culture (Lim et al, 2009). This is believed to have negative effects on the intergenerational relationships which may increase the stress already inflicted by other aspects of adaptation. The differences in acculturation rates brings intergenerational differences in cultural values, which may lead to older migrants feeling isolated and rejected by their youth (see Jung, 2013). For example, when asked about their resettlement experiences, the majority of the Luo community elders (particularly parents) described experiencing distress due to their relationship struggles with their children.

The process of acculturation has an impact on both social and psychological well-being. In addition to recounting experiences of physical and environmental challenges, such as cold weather, adapting to city life, and getting used to new types of food, nearly all interviewed members of the Luo community talked about experiences of struggling with aspects of the New Zealand culture. For instance, all of the community elders said they felt strange and uncomfortable if they did not know their next-door neighbour's name because in most African communal traditions, people in one's immediate neighbourhood are often treated as extended family. The two single mothers who took part in the study also recounted struggling with the New Zealand rules around childcare, such as being unable leave younger children at home under the care of their older siblings when they went shopping. Most also said they felt isolated. All of the older

[15] For further reading on acculturation gap, acculturative stress and intergenerational cultural dissonance see; acculturation, social identity and social cognition (Padilla and Perez, 2003), youth as contested sites of culture (Ranzaho et al, 2017).

community members also mentioned struggling with the idea that in New Zealand culture, eighteen-year olds were seen as adult enough to leave home if they chose to, because in Luo cultural traditions, offsprings are expected to stay at their parental home until they are old enough to get married.

Although I found that the younger Luo community members have high English language proficiency, and nearly all participating community members communicated reasonably well in English, the majority of my Luo participants discussed feeling anxious before going to the doctors because of the challenges they faced in communicating in English, especially during the first few years of resettlement in New Zealand. Some of the parents (especially those with young-adult children) talked about experiencing emotional stress because they felt culturally disconnected to their children. For example; during one of my interviews with Margaret (included in this chapter) she expressed concern that her children did not understand her, and she believes that this is because, in her words, "they have taken up Kiwi culture and have forgotten their own culture".

All interviewed members of the Luo community are New Zealand citizens, and all acknowledge being supported by community volunteers during their early days of arrival. Still some (particularly among the elders), described feeling as though they are only living in the country temporarily, and feeling like they are "waiting to go back home someday". Some of the younger community members, including those who were not part of the study, but whom I had the opportunity to engage with in casual conversations, described feelings of being unsure about their identity. One described how she and her siblings were all given Christian names when they came to New Zealand, completely erasing their African names. They also do not know their real birth dates. The majority of my Luo participants also pointed out mental health issues as a challenge for the community's young-adult demographic group. Additionally, some community members across the demographic groups (men, women, young adults and older community members) felt that they did not know much about the New Zealand health care system. This contradicted information provided by all of my participants from the Hutt Valley Regional Public Health who described the region as having systems of information sharing with specific population groups, including refugee background people.

Social and Health Impacts of Acculturation- Acculturative Stress

> **[Francis]** - We come from a culture where the peoples are bound, we bond as a tribe together […] we live in communities, and we live in clans. But when we came here, we found a different culture […] a culture of isolation, where you can't even approach your neighbour easily […] whereas in Luo culture where we came from, you can roam and go everywhere. Here, was a culture that was very restrictive […] so, that was a problem.

The social bonding and spirit of togetherness that Francis is describing in the above interview excerpt is common amongst many tribal societies and it is an important resource for both individual and collective social well-being. Francis's comment of being able to "roam and go everywhere" also highlights the importance of familiarity of the physical environment to his sense of well-being.

The anxiety and the varying degrees of stress that people experience as a result of loss of familiar cultural environment and adapting to a new one has been variably described as; culture shock, homesickness, and acculturative stress (see Oberg, 1994, Van Tilburg et al, 1996, Lackey, 2003, Tartakovkey, 2007, Gebregergis, 2018). As Moufakkir (2016: 323) comments; "as a consequence of exposure to novel and unfamiliar cultural environment, people experience psychological distress, friction and hostility. And this is even more the case following a traumatic displacement experience, which others cannot understand".

The concept of culture shock was introduced by Oberg (1954) describing the anxiety that people experience as a result of loss of familiar environment and has since been discussed by several other scholars (Selmer, 1999, Rajasekar and Renand, 2013, Moufakkir, 2016). According to Oberg (1954: 3), language knowledge and one's ability to communicate with people in the new environment is key to recovering from culture shock, which unmitigated can lead to nervous breakdown. This, unsurprisingly, parallels findings about immigrant integration, but the two concepts are rarely linked, and more contemporary study is still required to validate culture shock as a health issue

for new migrants.[16] It is equally not uncommon to hear people who are away from their home talking about feeling homesick. Some of my Luo friends also talked about often feeling homesick. For example; during one of my interviews with Joyce, I asked her how she is managing to be a Kiwi and at the same time maintain her Luo identity:

> Um, that is hard, like in my heart, I can't say I am a Kiwi […] I am a Luo. The way I live now, I get homesick. I miss speaking language, and I miss my family and friends too. Sometimes I tell my kids that maybe one day the situation in our country will be better and we will go back (Personal Interview: Joyce, July 24, 2018, Taita, Lower Hutt)

According to Van Tilburg et al (1996:899), "home sickness refers to the commonly experienced state of distress among those who have left their home and find themselves in a new and unfamiliar environment". According to Van Tilburg and his co-authors, the emotional manifestations of homesickness are mainly characterised by an intensive longing for home, accompanied a by depressive mood. They describe some of the common symptoms of homesickness as; feelings of loneliness, insecurity and loss of control (Van Tilburg et al, 902). Due to lack of room and project time constraints, I do not intend to fully explore the concepts of culture shock and homesickness as these are entire-topic concepts, that deserve specific research. Instead, I have found it appropriate to give them a fleeting glimpse, so as to highlight them as contributory factors to acculturative stress, which is the topic of this section.

Gebregergis's (2018: 400-402) study which examined the main sources of acculturative stress among international students studying in Chinese universities, described acculturative stress as "a process in which an individual undergoes psychological changes as a result of unceasing first-hand contact with people of different cultures". Cumulative pressure to adjust to a new a new socio-cultural environment, learning a language, adapting to new cultural values and social norms augmenting feelings of stress or fear in new migrants. Gebregergis believes that it is this pressure that leads individuals to experience and exhibit certain stress behaviours such

[16] For more nuanced discussions on the communication-acculturative stress nexus, see also Kim et al, 2012, Chan, 2014, Goforth et al, 2014.

as alienation, depression, anxiety, marginalization, heightened psychosomatic symptoms and identity confusion (400). The study also likened acculturative stress to depression. Homesickness, culture shock and discrimination were found to be the leading stress-causing factors among migrant students in China.

One of the stress causing factors in integration of migrants is issues of communication. If people cannot communicate well, it becomes more difficult for them adapt, and they may feel isolated. Lakey (2003: 103) states that "every immigrant is acculturated into the new host society through communication." Lakey believes that the immigrants' communication competence facilitates all other aspects of adjustment in the host country environment, and as such communication is viewed as the major underlying process, as well as an outcome of the acculturation process.

The attention directed to the physical health screening of new migrants is paramount to ensuring migrants' good health and protecting host communities from the possibility of communicable diseases. However, an awareness of the potential stress caused by resettlement and readjusting to a new environment is as crucial for achieving both positive health and integration outcomes. Although migrants (particularly those with refugee backgrounds) may pass the screening as "healthy" on arrival, it is clear that they are more vulnerable to suffering from acculturation-related stress which can lead to psychosomatic health problems (Tartakovsky, 2007: 486). Tartakovsky views both acculturative stress and homesickness as reactions to cross cultural transitions, and associates them with conditions such as increased psychological distress, decline in social functioning and in severe cases, psychiatric disorders among immigrants:

> Two hazards of immigration are most often mentioned. The first is a massive loss of the familiar environment, including mother tongue, food, social networks, geographic environment, architectural environment, and the arts. The second is the difficulty of adjustment to the host country, including difficulties in acquiring a new language, mastering new patterns of behaviour, and forming a new social network, while withstanding the often, negative attitude of the local population (Taratakovsky, 2007: 485)

Language and cultural barriers are among the key themes that emerged strongly across my interviews with members of the Luo community. Both lack of English language skills (especially during the crucial early days of settlement) and lack of cultural understanding were strongly associated with communication difficulties. Some people described frustrations and feelings of isolation due communication impediments. For example, during our first interview, Margaret talked about some of the difficulties she has experienced following her resettlement in New Zealand; being unable to speak or read English language during the first weeks and month of arrival, the challenges of bringing up children in a new culture, frustration and dismay as she increasingly found it difficult to communicate with her children as they grow older, as well as communication challenges within health care settings. Currently, one of Margaret's younger sons is serving a ten-year prison sentence, a situation Margaret blames on the emotional struggles of adapting to a new culture, that she and her family have gone through. Her younger daughter, (who also one of my research participants) has ongoing struggles with emotional health issues:

> When I first arrived in Wellington, I had ten New Zealanders from the local community supporting me […] I couldn't speak English at all […] sometimes I would just point at things. The volunteers helped me with taking the children to school and things like shopping because I didn't know much about New Zealand food […] everything was in containers, and I didn't know what things were […] Because in Sudan, you buy most food from the market, outside […] so it is easy to see what things are. But when I got here, it looked like everything was in containers, I couldn't read and it was difficult to know what to buy (Personal Interview: Margaret, June 29, 2018, Upper Hutt).

> **[Judah]** - Now that you have been living in New Zealand for the past fifteen years, can you describe your resettlement experiences so far?

> **[Margaret]** - Only one thing which I am not happy with […] because our culture is different from the New Zealand culture […] So, I came here with young children, and now they don't like my culture […] they took the culture of the Kiwi, which has affected me at home. Up to this point, I am not feeling happy with the culture because it has affected me in a negative way.

> **[Judah]** - What do you mean when you say your children don't like your culture?
>
> **[Margaret]** - The kids get all the information at school, and so when I raise my voice like any other mother, the kids don't like it […] because at school they are told that if someone abuse you, even your parent, call 111 - so, I can't do much as a parent, and I can't win […] When your children call the police on you, the police listen to the kid, and not you the parent. So, when my kids got to college, they started smoking […] I have never smoked- and they started taking drugs, which has affected me up to this day. Sometimes I regret coming to New Zealand, I might have been better off just dying in my country […] Because when my kids were young, I looked after them, and I had hopes that they will grow up and maybe one day look after me when that time comes.

This section from Margaret highlights one of the key aspects of discomfort with adapting to life New Zealand for many of my older Luo participants – a feeling of disconnection from their children and the younger generation. The young people have grown up in New Zealand, and so are more acculturated here than the older people.

Focusing on the impact of acculturation on an individual, Berry's (2006) research on acculturative stress which concentrates on issues of psychological well-being and life satisfaction, highlights affective perspectives of the acculturation process. Berry writes that acculturation experiences may qualify as stressors and provoke stress reaction in an individual if the appropriate coping strategies and social supports are lacking. Furthermore, Berry's study also concludes that more acculturative stress has been found among older immigrants, females and those lacking in social support (see Berry, 1997, 2006b), something also highlighted by Mui and Kang (2006: 244), who note that "the acculturation process is multidimensional, including physical, psychological, financial, spiritual, social, language, and family adjustment. This process can be very stressful for immigrant elders if they have fewer resources, such as income, education, and English proficiency, to assist them in adapting to their new life situation."

Mui and Kang's (2006) study, which examines the association between acculturative stress and depressive symptoms among Asian immigrant elders living in the US, found that depression is prevalent among Asian immigrant elders in that country, which was linked to stress caused by the elders' perception of cultural gap between themselves and their adult children. While social conditions in the US may be dissimilar to those of New Zealand, these findings echo Margaret's perceived cultural gap between her and her grown up children as voiced in her concerns above. Margaret is not the only Luo community elder concerned about the intergenerational cultural gap and the resulting familial disconnect and communication breakdown. Both Francis and Joyce also recounted similar sentiments. For example, when talking about some of the challenges facing the Luo community of Wellington during our first interview, Francis made the following statement regarding the community's younger generation:

> The children who came here when they were young and the ones who are being born here are taking European culture, and they are forgetting our culture […] We are trying to combat that, and that's why we have formed this Luo community - to try and ensure that our children understand us.

Joyce also voiced similar concerns of perceived intergenerational cultural gap in the following excerpt taken from our first interview. While Joyce describes New Zealand culture as a good culture, she admits struggling with certain aspects, particularly regarding relationships between parents and young adult children, and government policy in relation to adulthood:

> **[Judah]** - How have your experiences of adapting to life in New Zealand been so far?
>
> **[Joyce]** - It's hard being here […] I have seen New Zealand culture, and I think it's not good for me. It is a good culture- but it is not the same as being in my own culture […] it is a different culture.
>
> **[Judah]** - Can you explain what you mean by that? How is New Zealand culture not good for you?

> **[Joyce]** - back home, a child can stay at home for as long as they want […] but here they say at eighteen years a child is an adult and is free to leave home and do whatever they want. I find that hard […]. And children don't have enough respect for their parents- they put their parents down […] and they don't listen to their parents' advice. Children here think everything is about their rights [...] If you mess with your children, they can take you to court or call the police on you at any time. So, you just shut your mouth if don't want a police record.

Whilst all participating members of the Luo community of Wellington talked about language barriers as one of the initial challenges of their move to New Zealand, there is also clear indication that the acculturative stress experienced by many of the Luo community members goes beyond cross-cultural interactions. International migration affects many aspects of the self, requiring significant redefinition and reconstruction of both social and personal identities and immigrants continuously reorganize the delicate structure of their various social identities in new cultural context (Padilla and Perez, 2003: 43). The complex issues of displacement, loss of home, the resulting disintegration of the family unit and interrupted childhood also have a negative impact on intergenerational relationships. The parent/child communication breakdown described above, for example, has more to do with issues of displacement - the stress emanating from loss of familiar environment and the multiple challenges of adapting to a new one - rather than just language. Losing familiar environments (particularly under conditions of war and violence) affects people in multiple levels; the family unit is disrupted, family members are often lost, and in cases of those who spend long periods of time in displacement, aspects of their lives such as childhood and people's sense of identity are also impacted. All these factors have implications for people's health and sense of well-being, which impact on their experiences of resettling and integrating in a new socio-cultural environment. Margaret made the following statement in response to my question about her experiences of resettling and adapting to New Zealand cultural norms:

> New Zealand culture is affecting me, I can't win […] I have tried, but I can't win. I have gone to the police, I have gone to talk to different people, asking for help with my kids - but I have not found any change with my kids. Even my younger daughter doesn't know me […] and she is confused about everything- even now she is still confused. She doesn't even want me to talk to her about her mental illness, and every time I try to talk to her, she tells me she is ok […] but I know she is not ok.

Although Margaret started off by pointing out her struggle with New Zealand culture, it is clear that her expression of dismay at being unable to communicate with her children is due to perceived cultural gap rather than an issue of language.

Sociopsychological Health Challenges Associated with Emergence of Contemporary Identities

Margaret's descriptions of intergenerational social and cultural challenges have been echoed by other community elders. For instance, both Francis and Joyce raised concerns about the prevalence of parent-child relationship problems in the community. This has led to most community elders' perceptions of the problem as a result of intergenerational cultural value dissonance. However, the elders were not the only section of the community who raised intergenerational cultural dissonance as a concern. The younger community members that I spoke to also voiced frustration about the impact of perceived social and cultural value difference with community elders. For example; Josephine, (Margaret's daughter), talked about her struggles with communication issues between her and her mother that continue to have negative effects on how she feels about her identity and sense of belonging. She talked about issues of uncertainty about her birth date, name change at six (nearly seven after arrival in New Zealand), her mother's refusal to answer questions about who her father is or what happened to him, as well as unanswered questions regarding her relationships with both her mother and her older sister. These issues are linked to the cultural dissonance resulting from intergenerational acculturation gaps.

Intergenerational cultural dissonance issues are one added layer on top of a multiplicity of stressors related to adapting to a new socio-cultural environment. The following section presents issues of intergenerational acculturation gaps and cultural dissonance and how they affect people's contemporary identities as well as emotional health. Linking these discussions with pre-migration experiences, the section will explain how refugee-status migration and acculturation families and individuals. Interviews with Josephine and David are included to highlight my Luo participants' experiences.

> **[Josephine]** - What I remember is the image of escaping in the night, and we had to hide and things like that […] it was not an easy move. I remember my siblings getting quite badly sick […] There was a group of us […] I think we all came from the same place […] It's just so different because, we are not all like my mum's biological kids, you know what I mean? […] We all kind of got there, but I don't know how the whole thing worked out […] But I think some of my mum's kids are either her sister's kids or somebody else's in the family's kids.

Both twenty-two years old, David and Josephine are the youngest of my Luo community research participants. Both Josephine and David came to New Zealand in the company of a single parent family (with their mothers and siblings). While David knows who his father is, and that he has remarried and now has another family back in Uganda, Josephine has never seen or known who her father is. An interesting aspect of the Luo community of Wellington is the prevalence of single parent families with missing fathers. Both Joyce and Margaret are single mothers who arrived in New Zealand with several children, and David's family also arrived with a single mother. Although I cannot ascertain how widespread this phenomenon is, it raised unanswered questions for the study. When I questioned Joyce as to what happened to the father of her children, she became visibly uncomfortable, and whilst she told me a little bit, she asked me not to write anything about the father of her children, whilst Margaret on the other hand, simply said "he was a soldier and he died while fighting". Her daughter,

Josephine, described being banned by her mother from asking any questions about her father, which caused her ongoing distress in her adulthood:

> **[Josephine]** - I feel like I haven't transitioned properly […] like I am mature, but I am also not mature […] because, like I struggle with relationships and all that stuff […] I have never met my father, and it's quite difficult.
>
> **[Judah]** - So, has your mother never explained to you what happened to your dad?
>
> **[Josephine]** – No, I remember when I was about eight years old, I asked my mum about my dad, I said, "mum how come I don't have a dad"? She literally like, told me not to ask her "that question again". So, I have always had had that fear of asking questions about my dad. And I have carried it out throughout my years […] like even till now. It is a very sensitive topic.
>
> **[Judah]** - What about your siblings? Did any of them ever ask about your guys' father?
>
> **[Josephine]** - When we got here my mum sat us all down and said, "you don't talk about your dad, and if anybody asks you, ask me […] you know, those kind of things - it's always been like a secret she never told us […] It's really frustrating for me because I feel like I can't move forward until I have kind of- asked those questions, and got some answers.

Josephine was born at Adjumani refugee camp in Northern Uganda, where her mother, Margaret spent nine years as a refugee. Although she was born in Uganda, she identifies herself as South Sudanese Acholi Luo. She is the younger of Margaret's two daughters and the fifth of her six children. Josephine was only a little over six years when she and her family arrived in New Zealand in 2003. I first met Josephine at her mother's house during my first meeting with Margaret. She happened to be present in the living room when I explained my research to Margaret, and she asked me if she "could please participate in the research as well?" Although I had initially not set out to

interview any other members of Margaret's family besides her, Josephine insisted that she would like to talk to me about her refugee and resettlement experiences.

Consequently, as I was at the time still in the recruiting phase, and she was within the study's demographic target, I made the decision to include her in the study. It was Josephine who eventually introduced me to David. I met up with Josephine in my office at Victoria University Campus for our first interview during the second week in July 2018, two weeks following the first interview with her mother Margaret. Although she does not remember some of the events described by her mother, Josephine likes to talk, and she describes some of her early childhood memories going back to parts of her in the refugee camp.

Currently a university student in New Zealand, Josephine talked about her memories of escaping violence from Uganda's Adjumani refugee camp with her mother and her siblings and some details of their initial arrival in New Zealand. She also described her struggles with self-identity, not knowing who her father is, her real age, name changes, and being confused as to who, between her mother and older her sister is her biological parent, as well as the strains in her relationship with her mother. In contradictory to her mother's story, Josephine tells me that of the six children, only two are Margaret's biological children. The following section presents excerpts from my two interviews with Josephine:

> **[Judah]** - When we first met you mentioned that you were only six years when you arrived in New Zealand fifteen years ago. How has your resettlement experience been so far?
>
> **[Josephine]** - I dream of going back to Africa one day […]. I feel like we are losing our identity here - I can't remember much about our myths and legends […] we need to study ourselves […] But here, you can't do that - all you know is your parents […] but back in Africa, I could have been able to learn about our roots from other people - about who we are, our ancestors. I dream of going back to live one day […] I speak English, I grew up here, but I still feel empty […] I just want to be where I will feel like I belong.

[Judah] - What do you think is causing you to feel empty and like you don't belong?

[Josephine] - Because when we came here, we were kind of given Christian names, and we were given birth dates- and that's not our actual birth dates […] Like all my siblings we all have January 1st as our birthday - and maybe if you talk to other people, they'll say 'we were born on January 1st'. So, we were given that birthday, and it's really difficult not knowing […] and also, I have got an African name- if you talk to my mum, she'll tell you [...] But it's not even there anymore.

[Judah] - What's your African name?

[Josephine] - I am Opacho

[Judah] - Do you know why your names and dates of birth were changed?

[Josephine] - I really don't know - I will have to ask my mum […] but I think because we are Catholics, so it just made sense to have an English name […] Maybe we did have these English name s- but I have always known myself as Opacho […] like I have always been called that until I came here.

[Judah] - So, do you mean you got given your name after you arrived in New Zealand?

[Josephine] - That was the first time I heard it […] so at age six, going to seven. I think the other thing was that, maybe it was done to make it easy for people here to remember our names […] maybe the birthday thing as well. And so, it's just- when you have things like your birthday and your name changed- it's kind of like […] some people would say, "who are you"? And you would say 'oh my name is so and so' or what your birthday? It's a big deal here you know […] and so I have always felt like that isn't really me you know. I mean like I have to pretend […] and also like with my family situation.

Although Margaret did not talk about any of the family's relational complexities described by Josephine, other participating elder community members have also highlighted the problems experienced by younger community members, particularly those who arrived in New Zealand as young children, from coming from refugee camps. Although none of the elder community members have given that much details regarding the extent of psychological problems faced by younger former refugee community members, both Francis and Joyce have highlighted this issue as an existing challenge to the community. During my interviews with Margaret, she also expressed concerns about the state of her relationship with her younger children, as well as struggles with mental health issues. For example, according to Margaret, both her two younger children have struggled with behavioural problems throughout high school. Josephine is still in and out of hospital with mental health issues, while Margaret's youngest son, twenty-four-year old Pascal is currently serving a prison sentence. Margaret made the following statement in relation to her frustration and despair in trying to deal with her then thirteen-year old son's behavioural issues:

> I became frustrated and desperate about the way my younger son was going. I am not sure what my boy is going to do next […] but some people say, "you leave him". When all this happened, he was only thirteen years old. Again, I talked to some people for help, and some suggested that I take him for counselling […] But when I took him for counselling, the counsellor was talking to me and not him. So, he didn't even know that people were talking to me, or what they were saying. So, because they were talking to me and not him, counselling didn't help […] And this is the reason I am still feeling angry and frustrated about the culture here. Until now they have put him in jail […] and this is affecting me badly.

Talking about another Luo family who are in a similar situation to Margaret's family, Francis echoes Margaret's concerns:

> I think issues of families falling apart is one other challenge facing our community […] a good number of children have strayed away from their families. For example; one of the women in our community came

> here with her children when they were still young, but none of them seem to have gone much further than getting into trouble […] they all seem to end up running into all sorts of problems, one even has mental health problems. I don't understand why.

Studies on the impact of traumatic events experienced by parents on the health and adjustment of their children has shown that trauma experienced by parents can be transmitted to their children, a phenomenon described by Van Ee et al. (2013) as "intergenerational transmission or secondary trauma". Several studies on Holocaust survivors have documented a transmission effect going across two generations (see Solomon et al, 1998, Daniel, 1998, Van Tjzendoorn, 2003). Traumatic events can also affect parent-child relationships: studies conducted by Ruscio et al. (2002) among American veterans of Vietnam war concluded that severe emotional numbing is significantly related to a perceived lower quality of the parent-child relationship, while a study conducted by Cohen et al. (2008) with asylum seekers and refugee mothers in the Netherlands revealed that cumulative trauma and trauma-related symptoms are associated with insensitive child caregiving such as increased hostile-intrusive behaviour.

As a consequence, parent-child relationship disfunction forms a risk factor for psychopathology such as relationship disorders, emotional and behavioural disorders and dissociation. Whilst this current study does not seek to establish participant's health diagnosis, evidence from the Luo community members' life stories highlights experiences of traumatic events (for both parents and children in some families) impact on relationships as well as physical and mental health (for more detailed discussions on the impact of cumulative trauma on the parent-child relationship, see Skovgaard et al, 2008, Dutra et al, 2009).

Some of my participants had attempted to access counselling for themselves and their children. Margaret, for example, had both tried to get help for her son (as will be discussed in the next chapter), but also for herself. Neither sessions were successful for her. An early counselling session that was meant for herself shortly after her arrival in Wellington. In that earlier session, Margaret described the counsellors' approach as

alien to her, and said that in the end it had to be discontinued as she found the counselling quite upsetting and felt that it was working against her recovery efforts. The following is Margaret's response when I asked her if she ever sought psychological counselling for herself:

> **[Judah]** - What about counselling for yourself? Have you received any counselling since you resettled in New Zealand?
>
> **[Margaret]** - I got one lady coming to my place to do counselling […] she said to me "can you tell me what was in the refugee camp"? And she wanted me to draw the pictures of anything that may have happened while I was in the refugee camp […] Although I attended these sessions, I found them quite upsetting […] I said to her that I had already lived through that sort of a thing […] I needed something new. I didn't want to go back to those experiences. So, I talked to the counsellor, and we stopped that thing. I didn't want to draw pictures of what happened to me and my kids, that was not helping me at all […] I needed something new to clear it up.

Margaret's description of her counselling experience highlights not only the significance of pre-migration experiences discussed in the previous chapters, it also indicates the cultural communication barriers discussed earlier, especially issues of cultural difference and language difficulties. Margaret did not want to go back to the refugee experience, and be reminded of refugee camps, thus she resisted drawing images of her refugee experiences. This underlines the ongoing influences of home country pre-migration experiences on the processes of resettlement and integration (particularly refugee migrants). Secondly, it highlights the significance of the notion contemporary identities that emerge as a result of acculturation - Margaret states that she wanted something new, she wants a new life in this new country. As alluded to earlier, the socio-cultural barriers discussed above are not only due to migrants' lack of local cultural knowledge, it also reflects lack comprehension of migrants' culture by locals. The cultural competence barriers will be discussed in more detail in the next chapter.

These difficulties have also affected Josephine. In addition to the challenges of learning to express herself in English language for the first time at the age of seven years old (discussed in the next chapter), she described not knowing how to deal with her past:

> **[Josephine]** - It was tough because my mum couldn't speak English- she couldn't say, I have been traumatised […] It's like we just had to bottle it all up and continue. We didn't stop […] there was no real evaluation of how the whole thing had affected my mum or us the kids. There was no time to process the whole thing […] we just got here, and "boom", now we are in a new place and we just have to forget about what happened to us and concentrate on trying to fit in […] So, we kind of didn't deal with trauma, and I feel like now, fifteen years later, we are seeing this problem coming back […] and it's not just me. I see it in my community […] I see young people doing drugs and I feel like it's because of trauma […] the kids had absorbed that and the parents too, but it was never dealt with.
>
> **[Judah]** - Have you ever had any counselling since you came to New Zealand?
>
> **[Josephine]** - I have been to counselling sessions […] but I think because I never dramatized my feelings, it might have not been taken seriously or the counsellor never really understood the extent of my trauma […] I think us Africans have a different way of expressing sadness or difficult emotions […] it's not common for adults to just cry like that. But now I realize that you need to deal with that because, no matter how you try, if you bottle up something, it's never going to just go away like that. So, I feel like when it comes to trauma, our mental health has never really been properly addressed […] and we don't know how to deal with it. Our parents don't even sit down with us and ask like- "how was school today"? […] because in Africa, you must be strong […] it's almost like- you feel kind of isolated. Like when I came here, I was six, so there were not many kids that were African at the school I went to […] and so I was called weird names and things like that […] it just feels like you are isolated.

As discussed earlier, migrants experience stress as a result of the acculturation process. Current research literature related to the effects of acculturation on migrant family dynamics suggest that acculturation can act as a socio-cultural stressor in families when there is a gap between how quickly migrant parents and their children acculturate (see Kia-Keating et al, 2017). This parent-child acculturation difference is termed by different scholars as; acculturation gap, cultural dissonance or family acculturative distance. See for example; how intergenerational dissonance contributes to migrant youth problem behaviour and parent-child conflict (Choi et al, 2008), intergenerational conflict and youth distress in migrant families (Lim et al, 2009), the role of intergenerational gap in the adjustment of migrant youth (Jung, 2013), how migrant youth cope with acculturative stress and intergenerational conflict (Renzaho et al, 2017).

The acculturation gap hypothesis states that because immigrant children and their parents acculturate at different rates, acculturation gaps emerge between them. The mechanisms through which acculturation gaps occur is that parents are more acculturated to the heritage culture than their children, while children are more acculturated to host culture than their parents (Birman and Poff, 2011). Such acculturation dissonance is thought to give rise to family misunderstandings and conflict, which have a negative impact on immigrant children. Renzaho and others' (2017: 1) study which explored how migrant youth in Western Sydney, Australia, coped with acculturative stress and intergenerational conflict, found that youth in new migrant families become contested sites of culture as the families try to balance integration into the new culture while maintaining values of their original culture. As a result, youth find themselves caught between and negotiating two cultures, "often with unwanted consequences at family level in the form of intergenerational conflict" (1).

The issue raised by both Margaret and Josephine highlight the reality that refugee migrant families in particular, face the challenges of re-establishing family roles in an unfamiliar socio-cultural environment. This is especially challenging for this population group because of their pre-migration experiences of displacement which is highly interruptive to the family unit. Intergenerational cultural dissonance further disrupts family processes and complicates the typical generational gap by amplifying misunderstandings and miscommunications. Josephine and Margaret's descriptions of

their interaction with psychological counsellors further highlight the cultural communication barriers mentioned earlier, as well as the issues of cultural competency within health care provision, which will be addressed in the next chapter. Just as Margaret's experiences with hers and her younger son's counselling sessions, Josephine told me that she discontinued her counselling sessions because she felt that there were communication deficiencies between her and the counsellor.

Conclusion

This chapter has covered some of the major socio-cultural and health challenges that members of the Luo community of Wellington face as they adapt to life in New Zealand. These include the general challenges presented by acculturation - adapting to a new socio-cultural environment, learning a new language and integrating into new civic structures. Adapting to a new socio-cultural environment also has an impact on people's sense of identity as they are compelled to rethink and reshape their social and cultural systems of value (Lackey, 2003; Chan, 2014). As outlined in this chapter, the concept of acculturative stress refers to a type of stress, where the stress factors are identified as related to the process of cultural adjustment or acculturation. Berry et al (1987: 492) outline a particular set of stress behaviours which often occur during acculturation which include; lowered mental health status (confusion, anxiety or depression), feelings of marginality and alienation, heightened psychosomatic symptom levels and identity confusion.

Data collected through interviews and field interactions with members of the Luo community show that acculturative stress is impacting some community member's health at multiple levels, including physical, psychological and social. Intergenerational relationships in particular have been affected, leading to communication breakdown and (in some cases) family disconnections. For the Luo community of Wellington, as a formerly displaced population the cultural adjustment stress is augmented by past experiences of displacement, as laid out in the previous chapter. For example; unresolved issues of missing family members have an impact on people's contemporary identities, which affects family relationships and individuals' emotional health.

Processes of learning a new language in a new socio-cultural environment as well as adapting to new social and cultural norms put pressure on individuals, which leads to acculturative stress. Most of the members of the Luo community have indicated that a considerable part of the stress experience is due to barriers related to language challenges and issues of cultural comprehension. Language and cultural barriers have been identified as two main issues that negatively affect the doctor-patient relationships, particularly among the community elders. Despite availability of language interpretation services, a common perception among the elders is that lack of direct communication with health care professionals is alienating and can create anxiety as people are often unsure whether their health complaints had been relayed accurately.

The above issues are key to understanding the health status of my participants in New Zealand. These are compounded by barriers faced on accessing health services, such as a lack of cultural understanding by some doctors causing poor doctor-patient relationships. Minimal technological knowledge (particularly among the elders) was also highlighted as a barrier to accessing online health care information. All these factors contribute to acculturative stress, causing a reduction in physical, psychological and social aspects of individual's health status, which eventually affects their prospects of integration into New Zealand, and will be discussed in the next chapter.

Chapter Five: Institutional Interaction Experiences of Socio-cultural Integration

This chapter presents the Luo community members' integration experiences with socio-cultural institutions in New Zealand. These include opinions, perspectives and experiences of interactions with professionals and other members of local communities, particularly within the school and health care settings.

The health impacts of general and institutionalised racism are one the primary barriers to migrants' integration in New Zealand. These will be highlighted throughout the Luo community members' descriptions of their experiences of institutional and personal interactions in this chapter, particularly their interactional experiences within the health care sector, including with doctors and other health care professionals. This will include excerpts from interviews with three members of the Luo community; Margaret, David, Josephine and Francis, as well as a focus group interview with three members of the Public Health Protection team from the Hutt Valley Regional Public Health service. Inclusion of interviews with health care professionals will help to ascertain gaps between my Luo participants' perceptions and current structural policies guiding migrant health care provision.

While this research is primarily concerned with the health care sector, I have found it appropriate to include a brief discussion on the role of school system in this chapter, particularly experiences of racism at school. This is primarily because my younger Luo participants who arrived in New Zealand as school-age children described some of their earliest integration experiences from their school days' perspective. Although typical junior school experiences may be regarded by some as not significant to health and well-being, my Luo participants made strong links between their experiences of racism in their early years of school in New Zealand and their ongoing integration and sense of belonging and well-being in the country. Issues of bullying and racism within children's learning environment do not only affect their learning and sense of well-being, but also affect parents and care givers. In the case of the Luo children, some of whose early childhood had already been disrupted by war and displacement, experiencing racism at school may have jeopardised their progress towards recovery. All of these combine to create a system that while pertaining to treat people arriving in New Zealand with equity

and care, actually create barriers to access that compound already damaging refugee experiences for many people.

Experience of Racism within the School System: Social and Health Effects

> I have a big struggle with my children going to school here […] one never even finished college […] he dropped out. The other finished primary and went to intermediate for only one term […] He said other kids were bullying him. He got to a point where he just lay in bed […] and when I tried to get him to go to school, he would get up and go and stand on the street. Sometimes I would take him straight to class, but at break time he would leave and started walking around until school is out and then he would come home (Margaret, 2018).

Margaret expressed her frustration caused by her children's struggles with adapting to the New Zealand school system to me in our interviews. She talked about reaching out to the police trying to reach out to the police, emotional counsellors and other people in the community for help with her children, to no avail. Although her three oldest children are now grown up people with their own families, Margaret described having ongoing problems with her three younger children. Both her two younger sons dropped out of school at an early age. The youngest son, now nearly twenty-four is doing a ten-year prison sentence. Joseph left school when he was just thirteen years old. Pascal, Joseph's older brother works as a construction labourer in the Hutt Valley area, and still lives at home. I briefly met Pascal when I went to Margaret's house for our first interview. He left the room soon after we had exchanged greetings, never saw him again in the few times I have visited Margaret's house. Josephine, Margaret's youngest daughter also still lives at home and she told me that she has recurring emotional-related health problems. Joseph is not the only Luo young adult who is said to have been bullied at school because of his skin colour and refugee background, both Josephine and David described experiencing racism and being bullied at school.

> **[Josephine]** - When I first came here, and I was like six years old […] We would go to school, and at school we had hard out

> bullying because we were the first black kids in the school, and then when we caught a bus home after school, people would call out all types of stuff like "oh you nigga", "you black piece of shit", and all other sorts of insults at us. We always tried to ignore it […] but it still hurt so bad […] It's like, I am not any of those things […] it was degrading, I mean I have always gotten in these sorts of scenarios- even when I was older. I think when you get older it becomes more subtle.

The school grounds is the place where lasting social bonds and lasting memories are created. Many people would recall their primary school experiences for most of their life. Both David and Josephine started with primary school years to describe their experiences of adapting to life in New Zealand. with their primary school experience. Being bullied by others at school can have long lasting consequences, not only on the child's learning, but also on their physical, mental and social well-being. Recent studies on the relationship between school bullying and health problems found that students exposed to bullying have more health problems than the bullying students (Seixas et al, 2013: 81). Health behaviours such as self-esteem issues, mental health psychosomatic symptoms and substance abuse have been found to be related to bullying at school (Seixas et al, 2013: 81). Racism has also been identified by some as an important determinant of health and the root course of racial and ethnic health inequalities, as Harris et al (2018: 2) noted, "there are many expressions of racism at structural and individual levels that can affect health through a number of pathways."

David also gave accounts of name-calling experiences at high school and other incidents of racism. He too never completed high school and he told me that the environment was not nice. David is a similar age to Josephine, (twenty-two years of age), and it was Josephine who recommended that I spoke to David, who I then had one forty-five minutes interview session with. He was a lot more reserved than Josephine, but just like Josephine he described his experience of racism at school - mainly from other students. Although he said he thought people would be better informed at school, he said he experienced a lot of racism, but believes it is better now.

[Judah] - So, how old were you when you and your family arrived in New Zealand?

[David] - I think I was thirteen […] So, I went straight into college

[Judah] – When you say that you experienced racism, what do you mean? Can you give an example of what those experiences were?

[David] - Racism was just things like […] people telling you who you are you know what I mean? Without even knowing who you are […] Because if someone just met you on the street and they start insulting you or someone at school try to put you down because of the colour of your skin […] that was some of the things that I frequently experienced at school- people who didn't even know me calling me insulting names and things like that.

[Judah] - So, with all the experiences of racism you are talking about, did you get any intervention from the school or anybody else? Did you ever tell the teachers about any of these insults?

[David] - There were few students who sometimes would try and stand up for me when stuff like that happened […] even sometimes people I didn't know helped me. But it didn't stop people from being rude to me […] There were some teachers who were also racist you know. Like, I had one teacher who was really mean to me […] She was an older person, so I think she had that old school mentality.

[Judah] - What sort of things did she say to you that made you think that she was mean or racist?

[David] - She didn't really insult me as such, but she would use […] she constantly picked on me in such a way that I knew that was racist, because I already knew what racism sounds like.

David told me that he does not want to impose his Ugandan culture and experience on his New Zealand-born friends, so his strategy of adapting to life in New Zealand is "to try and fit in". But as we continued to talk about aspects of his New Zealand experience it became clear that he, like Josephine and other young adult Luo community

members who were born in Africa, childhood experiences of war have had a lasting impact on his contemporary identity. For example; at the start of our conversation David described his early childhood back in Gulu, (Northern Uganda) as "a scary time". It is more than likely that the combination these experiences; of early childhood spent in the war front and eventually moving into a new environment where he felt to some extent unwelcome, may have further affected his social and emotional sense of well-being. I asked David how he is managing to be a New Zealander on one hand, and still keep his Luo identity on the other, and this is his response:

> Coming from a different country and culture, you always want to fit in, right? So, for me fitting in is always the best way for people to […] you know, like I don't want to bring my Ugandan culture and just try and push it onto people […] but I want to learn from what they know, and keep my own culture and that to myself.

The experiences of racism described by both David and Josephine as minority immigrant students at school in a new socio-cultural environment, have potential to induce high levels of acculturative stress. This may have long-term detrimental effects on psychological heath as well as social relationships outside the school environment (including their parent-child relationships at home). Ranzaho et al (2017: 1)'s study of the influence of migration of family dynamics found that migrant youth are particularly vulnerable to acculturative stress. In addition to negotiating the host culture, they are often faced with intergenerational conflict. Racism and discrimination have also been found to foster the development social stigma[17] and stereotypes.

A study of psychological acculturation (the internal processes of change that migrants experience when they come into direct contact with members of the host culture (Padilla and Perez, 2003:35)) among migrant students in North American universities found that social stigma affects the acculturation and adaptation of

[17] The concept of social stigma was developed by American sociologist, Erving Goffman (1963). Goffman conceptualised stigma to an attribute that is perceived as deeply discrediting. According to Goffman stigma can be viewed in a two-way perspective: the discredited (due to physical deformities of perceived character blemishes) and the discreditable (may be due to tribal, racial, national or religious identities).

migrants. According to the study, "if newcomers are aware their social identity is devalued, this will affect the strategies employed in the acculturation process, and consequently, the cultural competences they are willing and or able to develop" (see Padilla and Perez, 2003:51). The authors further argue that acculturation is more difficult for migrants who are more distinct from the dominant host group (for example; skin colour, or distinctive religious identities).

Viewed from this perspective, migrants may be less motivated to attempt acculturation if they believe that discrimination by the dominant social group exists against their group. Hence, while racism experienced by migrant children at school may be viewed by some as unrelated to the broader migrant integration discussions, it creates social stigma which may carry long-term social and emotional health impacts. As alluded at the start of this chapter, the racism theme is not confined only to the school system, experiences of racism extended to professional interactions with welfare agencies, in particular doctors and other health care professionals. The following section presents discussions on experiences of racism within health care settings by some Luo community members.

Experiences of Racism within the Health Care System

> **[Francis]** - When we got to our settlement areas there were volunteers who helped us to register with local medical centres, and that was when we now start working with local doctors. But, dealing with doctors here I personally met some challenges […] And then to make it worse, there is often a problem of language barrier […] I found that the doctors I met when I first arrived at the Mangere Refugee Centre had different attitudes from the ones I have met in my health centre. I think the doctors in Mangere understand refugees better. They know the kinds health problems that refugees usually have, and so they are more compassionate, they are patient, and they listen carefully.

My first round of interviews with members of the Luo community focused their individual experiences of resettlement and integration in New Zealand, with particular

emphasis on their interactions within the health care service sector. This is particularly important in shedding light on the roles played by health care services in the socio-cultural integration of the Luo community members. When I sat down with Francis for our first interview in June of 2018, he described his earliest interaction with Immigration New Zealand health assessment professionals at Mangere Refugee reception centre in Auckland. He highlighted the differences in attitudes between that earlier interaction and the interactions he has had with health care professionals at his health care centre in Lower Hutt.

Initially Francis talked about the challenges of a language barrier and feelings of anxiety and frustration even when interpreters are provided for those who need them, due to having someone else talk about their health issues and not knowing whether the interpreter is giving the doctor the right description of those health issues:

> Many of the mothers in our community still struggle with English […] and some find it very hard when it comes to going to the doctors. They find it difficult to explain their health problems or their kids' health problems in English language […] Often someone else would be there to interpret for them. And sometimes it gets difficult because you never know if the person interpreting is giving the doctor the right description of your health problems or saying exactly what you wanted to say. People often come from the doctors feeling angry and disappointed […] thinking "the doctor didn't even listen to what I was saying" because they believe that the interpreter hadn't given the doctor the right description of their health complaint.

This was something felt by all the community. Although the majority of the younger community members that I interacted with speak English language fluently, they all described their initial language challenges in addition to experiences of discrimination and racism (discussed below). It is possible that these initial English language difficulties coupled with experiences of racism may have had lasting impact on both their educational outcome and self-esteem, a situation which is has a high likelihood of negatively impacting on emotional health. The following is David's description of his initial experiences of resettlement in New Zealand. As well as the racism already

mentioned above, he also noted, 'it was really hard for me at the start when I first arrived - I couldn't speak English, and so, I couldn't understand people, and I still had that African vibe with me too' (Personal Interview: David, August 18, 2018). Language difficulties were more pronounced among the South Sudanese community elders than their Ugandan counterparts, primarily because, whilst most South Sudanese speak Arabic as a second language Ugandans mostly speak English. Although perhaps not as impactful as it was fifteen years ago when the first Luo families arrived, self-expression in English language is still a challenge for some elders in the Luo community. For some elders, the initial language difficulties have had a lasting impact, particularly with regards to situations of communicating health issues and navigating the systems.

One other strong theme related to race and ethnic relations within health care settings is perceived lack of consideration for cultural difference by some health care professional (doctors and other health care workers). As outlined in the previous chapters, culture plays a significant role in people's health. Culture has also been recognised by many as a lens through which people understand, interpret and explain health. Napier et al (2014: 1607) stated that, "ideas about health are cultural and they vary widely across societies, hence should not merely be defined by clinical measures of care and disease."[18]

Although the New Zealand health care sector has links to language interpretation services, the lack of direct communication with a health care professional (particularly a doctor) presents a deficiency in intercultural communication. Some of the Luo community elders have described feeling helpless, and often uncertain whether the interpreter had described their health issue accurately or whether the doctor had understood their health issues. They also faced issues related to different norms of practice, communication norms, and differing expectations related to cultural understandings of care. These were compounded by experiences of institutional racism and deficiencies in cultural competence within the New Zealand health care sector as highlighted through interviews with Francis, Margaret, Josephine and David.

[18] For further reading on health inequity and the importance cultural competence as a transformative factor in the New Zealand health care see; statement of cultural competence (Medical Council of New Zealand, 2006: 1-3), Pacific Cultural Competencies (Tistia, 2008), health equity in the New Zealand health care system (Sheridan et al)

[Francis] - From the first day that New Zealand government decided to take me for resettlement […] unlike other countries whereby the process of medical assessment for refugees was quite lengthy, with New Zealand government all medical examinations were done after my arrival here […] so, before I left Ethiopia I got blood tests and x-rays, and that was it […] But on arrival at the Mangere Refugee Centre, that's when we got thorough medical examination […] and that was excellent. And people who had any health issues were treated. And those who had complications or issues that needed longer treatment were left behind at Mangere to receive further treatment […] And those who had infectious diseases were informed of their status.

[Judah] - So, what happens once you arrive in your settlement area? Did you have to find the local health care providers or did someone else help you with that process?

[Francis] - When we got to our settlement areas there were volunteers who helped us to register with local medical centres, and that was when we now start working with local doctors […] But, dealing with doctors here I personally met some challenges […] And then to make it worse, there is often a problem of language barrier […] I found that the doctors I met when I first arrived at the Mangere Refugee Centre had different attitudes from the ones I have met in my health centre […] I think the doctors in Mangere understand refugees better. They know the kinds health problems that refugees usually have, and so they are more compassionate […] they are patient, and they listen carefully.

[Judah] - Can you explain that a bit more? What do you mean when you say you have met some challenges? What kinds of challenges were or are they?

[Francis] - I think the first problem starts with consultation time […] So, it is always just you and your doctor alone, and he/she would write very quickly because the consultation time is very limited […] as you have only fifteen minutes. So, the problem of language barrier, very little investigation and then delayed specialist referrals […] sometimes

you get prescribed the same medications even when you keep coming back with the same complaint.

[Judah] - You mentioned earlier that you have experienced an incident of racism from a doctor. Can you describe the incident, and why you thought it was racism?

[Francis] - He is an Asian doctor […] and he works at the medical centre where we go […] I don't know whether his utterances were based on racism or whether it was just an innocent view […] but when he told me that "your skin is so dark that I cannot really diagnose anything", to me it came as an insult. I was speaking to him in clear English language, and I didn't even need interpreters. And any doctor could have understood me very well […] also I had clearly visible skin problem. But he said that my skin was too dark, so he was unable to see what I was talking about […] And that really, annoyed me.

[Judah] - Did you ever tell him how his remarks made you feel? or did you raise the matter with the Health Centre administration at all?

[Francis] - I didn't raise the matter with the practice administration […] I just left it at that, and I simply avoid him whenever I have any health issues. I have a low opinion on him. Even if I end up at the point of death, I don't want to see him […] He has given me a very bad impression of a doctor that I will never forget. So, that's what happened between me and that doctor […] because he was unable to diagnose me. As a medical professional, he could have easily referred me to someone who would be able to see what was wrong with my skin […] but to say what he said to me was quite offensive to me.

Francis is not the only member of the Luo community who described experiencing challenges of perceived lack of interest from health care professionals and issues of racism or discrimination within the health care settings. Other community members also talked about interactions with health series that presented what they perceived as discriminatory attitudes from some health care professionals. Both Margaret and Josephine described similar incidences. While currently there is no way of telling how

widespread these issues are, the fact that at least three out of the six Luo community members participating in this study described experiencing racism and discriminatory attitudes from within the health care services is an indication that this may be a problem. Margaret too gave an account relating to similar experiences of perceived racist or discriminatory attitude from her local health centre's staff member:

> **[Margaret]** - My family doctor is good I have never felt like I was being treated differently by my doctor. But I have had issues with one lady at the reception, who seemed to always shout at me whenever I go to see the doctor. "Do you want to pay today?" and often when I don't have money I would ask for the payment to be added to my account for me to pay it later […] At one time the same lady said to me, "go and sit down, a doctor will call you in when they are ready", but she never sent the appointment paper in to let the doctor know that I was waiting […] and so, I ended up waiting for a very long time.
>
> **[Judah]** - Have you ever complained or let the health centre's management know that you are not happy with the way this lady treats you?
>
> **[Margaret]** - No, I didn't, but now I avoid this lady whenever I go to see a doctor, she is not good to me […] one day when I went in to see a doctor, there were not many people, just me and another patient at the reception. So, this lady asked if she can help me, I said I will go to the other receptionist […] At this stage she knew that we are enemies […] even sometimes when I call to make an appointment to see my doctor, if she answers the phone she would tell me that my family doctor is away for a few weeks […] So, to this day, I don't trust her.

Josephine echoed similar views:

> I have been to a few medical health services and doctors when I was younger. I felt like- it was just like "come in, but I don't really want to serve you" kind of attitude […] I was always confused- I didn't know what it was because I was young, and I used to think that maybe I was misinterpreting the scenario […] But as I grew older I just realized that sometimes people are just not interested in serving you. For instance- I went to get my blood test the other time […] and the lady

> who was doing my blood didn't tell me that because I am under twenty-four, I could go to family planning and they could organize for it to be done for free [...] So, I paid quite a lot for my budget, but later, when I was talking to someone they said, "why did she do that to you"? And I was like - I didn't know. So, our people need that information […] not just about availability of these services, but also how to access them, and who qualifies for which services.

Research on ethnic health inequities in New Zealand has identified the prevalence of racism within the health care sector as an important determinant that contributes to ethnic health inequities. Despite Te Tiriti o Waitangi guarantees to protect Māori rights and interests, prevalence of racism has been, and continue to be reported in many aspects of New Zealand society, including within the health care sector (Ministerial Advisory Committee on Māori perspective on Social Welfare, 1988, Came, 2012, 2014, Barnes et al, 2013).

During the late 1980s the Ministry of Social Development set up a Ministerial Advisory Committee to advise the Minister on the most appropriate means to meet Māori needs in policy, planning and service delivery in the department of social welfare. Charged with investigating aspects of the social welfare which were detrimental to Māori people, the committee identified institutional racism as the main barrier to service delivery. The committee described institutional racism as:

> The outcome of monocultural institutions which simply ignore and freeze out the cultures of those who do not belong to the majority. One in which national structures are rooted in the values, systems and viewpoints of one culture only. Participation by minority is conditional on their subjugation of their own values and systems to those of "the system" of the power culture" (Ministerial Advisory Committee on Māori Perspectives on Social Welfare, 1988:19).

Came's (2012) research on institutional racism within the New Zealand public health sector found that New Zealand health policy is still a mainly mono-cultural domain,

"dominated by western bio-medical discourses that preclude and undervalue Māori in its conceptualization, structure and content" (2). These contribute to ethnic health inequities. Harris et al (2018) also found that experiences of racism within the health care sector in New Zealand remains an issue among non-European population groups, and that its potential effects on health may contribute to ethnic health inequities. Institutional racism has been described as the most insidious and destructive form of racism (Came, 2014: 2).

The Ministerial Committee on Māori perspectives on social welfare (1988: 18-19) identified the prevalence of other forms of racism in New Zealand including; personal racism, which is manifested by individual attitudes or actions, and cultural racism, manifested by negative attitudes to the culture and lifestyle of minority culture or domination of that culture in its efforts to define itself by the power culture. This literature confirms the concerns of experiences of racism raised by my Luo participants. In addition to their concerns regarding experiences of racism, the members of the Luo community also raised issues of perceived lack of cultural consideration by some health care professionals. The following section will present some of the culture-related issues raised by my Luo participants.

Cultural Competence

While racism was noted by all, and more practical issues related to language barriers and different expectations of health care, such as waiting times, referrals, and so on, some have blamed their perceived poor doctor-patient relationship on problems of intercultural communication and the lack of cultural consideration for cultural difference. This was highlighted as a major factor for all my research participants. Cultural competence is used to define the health worker's capacity to improve health status by means of integrating culture into clinical contexts (Durie, 2001: 3). Durie contends that unless interaction with patients recognises and builds on cultural realities, chances for the improvement of health outcomes may be diminished or lost. In recognition of the centrality of culture in health care, the Ministry of Health introduced cultural competence as part of the health policy under the Health Practitioners Competence Assurance Act 2003 (APCAA).

Margaret described situations where cultural miscomprehension and differences in cultural approaches had been barriers to communication during some of her interactions with the school system, the police, and psychological health counsellors. Due to these initial cultural communication barriers, Margaret says that she has lost hope of ever successfully utilizing emotional counselling services:

> **[Margaret]** - My son finished primary and went to intermediate for only one term…he said other kids were bullying him. He got to a point where he just lay in bed…and when I tried to get him to go to school, he would get up and go and stand on the street […] I tried to force him one day, but then he didn't come back home, and that night he went to sleep at the car park at Rimutaka, it was winter, and he almost froze to death. I had no idea where he was, and so I rang the police and reported him missing. So, the police started looking for him, and they found him at 2 am, lying at Rimutaka car park, very cold and almost hypothermic […] so they brought him home, and said "put him close to a heater, we don't want to say anything" […].
>
> **[Judah]** - Did you ever try talking to the school for help with your son?
>
> **[Margaret]** - I talked to the school…and I also took him for counselling […] but the counsellor was talking to me, and not him […] He didn't even know that people were talking to me. So, counselling didn't help my son.

It is evident that the communication difficulties experienced did not just stem from language barriers, but by lack of cultural understanding and competency (an awareness of the cultural factors that influence another's views and attitudes, and an assimilation of that awareness into professional practice (Napier et al, 2014)), particularly on the part of the counsellors. According to O'Connell et al (2007) a culturally competent health care system acknowledges and incorporates, at all levels, the importance of culture. This means among other things that cross-cultural relationships within the system are regularly assessed, cultural knowledge is constantly expanded, cultural differences are

given necessary attention and the services are also adapted to meet culturally unique needs. Thus, the authors view cultural competency in health care provision as:

> The ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, and religions in a manner that recognizes, affirms, and values the cultural differences and similarities as well as the worth of individuals, families, and communities and protects and preserves the dignity of each (O'Connell et al, 2007: 1064).

Medical Anthropologist David Napier's (2014) Lancet Commission report on Culture and Health argued that "the systematic neglect of culture in health and health care is the single biggest barrier to the advancement of the highest standard of health worldwide" (Napier et al, 2014:1607). In 2015, the World Health Organization (WHO) acknowledged the importance of culture to health and well-being, and the organization's Regional Office for Europe convened its first expert group on the cultural contexts of health and well-being which culminated in WHO's 2016 publication of its '2030 Agenda for Sustainable Development' of which health goal (SDG 3) is "to achieve Universal Health Coverage (UHC) for all, and to ensure healthy lives and promote well-being for all at all ages" (WHO, 2016).

In 2017 the World Health Organization developed a policy brief, specific to the inclusion of the cultural context of health and wellbeing in its health promotion policy framework as part of the organization's 2030 Sustainable Development project. The organization's project on the cultural contexts of health and well-being argues that "incorporating cultural awareness into policy-making is critical to the development of adaptive, equitable and sustainable health care systems, and to making general improvements in many areas of population health and well-being" (WHO, 2017: vi-vii). Contrary to the commonly held belief that cultural values are subjective and therefore in opposition to the scientific objectivity, Napier et al (2014: 1606-8) argue that all people have systems of value, including those making health care decisions, and as such "ideas about health care are therefore, cultural". Napier and others further argue that because ideas about health care vary across societies and cultures they should not be merely

defined by measure of disease or clinical care but should also be culturally contextualised:

> The effect of cultural systems of values on health outcomes is huge, within and across cultures, in multicultural settings, and even within the cultures of institutions established to advance health. In all cultural settings—local, national, worldwide, and even bio-medical—the need to understand the relation between culture and health, especially the cultural factors that affect health-improving behaviours, is now crucial (Napier et al, 2014: 1607).

My Luo community participants' perceptions on the place of culture in health care provision are a further validation of the above views. The impressions from both Margaret and Francis's statement are that there is need for a more culturally balanced approach to the doctor-patient interactions. This would be more beneficial to the development of a trust-based doctor-patient relationship which would improve the quality of the health care service delivery. Although Margaret described her initial struggles with English language as a major communication barrier, it is clear that her communication issues with the counsellor had more to do with the cultural context of the counsellor's approach to service delivery than language.

In reiteration of the importance of culture in health and health care provision, all participating members of the Luo community commented on the issue of lack of cultural consideration when describing their interactions with health care providers. In agreement with the common opinion expressed by Francis and other community members earlier in this section (that some health care providers have not shown interest in understanding their cultural values and beliefs), the following interview excerpt is David's description of his experiences with health care providers in New Zealand. Although David describes a respectful interaction, he acknowledges experiencing lack of cultural comprehension on the part of some health care providers:

> **[Judah]** - Can you describe your interactions with health care providers since your resettlement in New Zealand?

> **[David]** - I would just say, if I am going to a family doctor […] they have assured me that everything I discuss with them will be kept confidential, that gives me trust on them. As for the interaction experience, for me […] I always feel like I am being treated with respect. In terms of cultural consideration, I would say the Ugandan system observes and respects cultural norms more than the NZ system […] I mean to a certain extent […] I think NZ deals with cultural consideration in health care, but they don't know much about us Africans so, that can be difficult sometime.

Kreuter and McClure's (2004) study of the roles of culture as a factor in enhancing the effectiveness of health communication programmes in St Louis, USA, identified the importance of the role of culture, not only as an influencing factor in health and health related behaviours, but also as a possible means of improving the efficacy of communications in health intervention programs. Audience segmentation in health communication is the process of partitioning large, culturally diverse population groups into smaller, more homogenous sub-groups, and it is useful as a way of understanding health-related outcomes and behaviours as well as addressing issues of health disparities between population sub-groups (O'Sullivan et al, 2003, Slater, 2015: 267-83). The study concludes that, "the cultural characteristics of any given group may be directly or indirectly associated with health-related priorities, decisions, behaviours, and/or with acceptance and adoption of health education and health communication programs and messages" (Kreuter and McClure, 2004: 443-49). Hence, comprehension of cultural characteristics of population groups in any given society by both policy makers and health care providers is crucial for effective health care provision for all. One of the advantages of a culturally competent health care system is that communication of health can be customized to better meet the needs of specific cultural groups.

Some of my participants highlighted one other culture-related problem that impacts on the efficacy of language interpretation services, citing lack of direct communication with the doctor an alienating factor in the doctor-patient relationship. Francis summed up his perception of the place of culture in the New Zealand health care services in the following statement:

> While in New Zealand, health policy and regulations are strictly monitored and enforced, there is an element of cultural negligence in some places […] You find that although certain cultural norms especially regarding those of particular ethnicities, are spelt out and respected, for our culture they don't know, and often doctors and other health professionals here don't even ask whether certain procedures and interactions are culturally appropriate for us […] For us Africans, most doctors don't know what is culturally appropriate and what's not, and we have nothing to say, and no one is interested to ask us before we are given treatment.

This statement links to Margaret's description of her interaction with the counsellor. Both Francis and Margaret highlight the importance of cultural comprehension as a communication-facilitating resource. As outlined in the second chapter of this thesis, and confirmed through evidence from available literature, culture has been identified as playing a crucial role in the way peoples understand health and wellbeing. Research on the relationship between culture and health has shown that different cultures have different ways of understanding, interpreting and dealing with health issues. Perceptions of physical and psychological well-being differ substantially across human diversity. Hence it is important for health care providers to consider cultural perceptions of health and well-being when delivering health care to people from cultures other than theirs (see Marsella and White, 1983, O'Connell et al, 2007, Hecker et al, 2017). As WHO (2017: vii) point out, 'our experiences of health and well-being are fundamentally influenced by the cultural contexts from which we make meaning.

Institutional Issues of Cultural Competence

> **[Francis]** - Although in New Zealand, health policy and regulations around culture are often emphasised- there is an element of cultural negligence in many places […] While certain cultural norms of particular ethnicities, including Māori and Pacific Island cultures, are spelt out and respected, for our culture they don't know, and often

> doctors and other health professionals here don't even ask whether certain procedures and approaches are culturally appropriate for us.

The Ministry of Health introduced the Health Practitioners Competence Assurance Act 2003 (HPCAA), as part of a framework for the regulation of health care practitioners in order to protect the public from the risk of harm. Durie (2001: 4) states that cultural competence is about recognising other people's belief systems without needing to defend science as the only legitimate way of looking at the world. According to the Medical Council of New Zealand's statement on cultural competence:

> A culturally competent doctor will acknowledge; - that New Zealand has a culturally diverse population, that a doctor's culture and belief systems influence his or her interactions with patients, and accepts this may impact on the doctor-patient relationship, and that a positive patient outcome is achieved when a doctor and patient have mutual respect and understanding (Medical Council of New Zealand, 2006: 1-3)

Despite these statement and other initiatives other policy initiatives such as the Ministry of Health's HPCAA outlined above, lack of cultural competence within the health care sector was a common perception among the Luo community members. As outlined, culture has been described by the majority of the community members as one of the major barriers to adapting to life in New Zealand, alongside language and racism. Some of the communication issues (particularly relating to psychological counselling sessions) were clearly identified as culturally related communication issues. For instance, both Margaret and Josephine abandoned their counselling sessions primarily because the counselling approach used was at odds with their cultural understandings of their situation. Echoing Francis's statement at opening of this section, David also commented on the issue of the lack of cultural comprehension by some doctors:

> In terms of doctors' consideration of culture - I would say the Ugandan health system observes and respects cultural norms more than the New Zealand system […] I mean - I think NZ deals with

> culture in health care to a certain extent […] but they don't know much about us Africans […] so, that can be difficult sometimes.

The perceived lack of cultural consideration by some health care professionals as described by some members of the Luo community contradict impressions given by some of the participating health professionals. According to my research participants from the Hutt Valley Regional Public Health service, health care professionals are required to undergo a cultural competency training. The Hutt Valley Regional Public Health (HVRPH) is the business arm of the Hutt Valley District Health Board (DHB). The Communicable Diseases and Housing team (three of which members I conducted a focus group interview) is part of the Health Protection Cluster, one of HVRPH's four clusters.

During my focus interview with the team, I asked them questions about the role of their unit (the health protection unit) as well as role played by the wider regional public health in integrating refugee background migrant. I also asked about their relationship with primary health care providers in order to better understand the power relationships within the system. As the issue of cultural competency was raised during my sessions with the Luo community members, I also raised the question of cultural awareness. Participants' names have been changed to protect their identities. Ms G is the team leader and Ms C and Ms E are community nurses. Ms C is also team leader for the refugee health team.

Although the team agreed that indeed, there is a cultural and linguistic diversity (CALD) training in place for all health care professionals, a slight inconsistency in their response to my question on the cultural competency issue arose. Furthermore, the team seemed to distance themselves from the socio-cultural aspect of integration when I raised a question of the Regional Public Health position on this aspect of refugee migrants' integration, citing their contract with the Ministry of Health as "tailored to the health aspects". This explicit separation of the social and cultural aspects of refugee migrants from their health raised further questions with respect to adherence to cultural consideration by health care professionals. Additionally, despite the team's stated adherence to the guarantees provided by Te Tiriti o Waitangi to protect Māori interest,

the New Zealand health policy has been critiqued for being a monocultural domain, and lack of cultural competence has also been identified as a contributory factor to ethnic health inequalities in New Zealand (Came, 2012, Torrie et al, 2015, Medical Council of New Zealand, 2017).

The following section presents excerpts from my focus group interview with health care professionals from the Hutt Valley Regional Public Health service. The interview revealed that there are some deficiencies in the level of emphasis prioritisation of resources for refugee migrants' health care. For example; there appears to be an overemphasis for physical health screening and care (particularly related to communicable diseases), while the level of emphasis and resource allocation for refugee mental health is inadequate. This interview has also showed that health care workers (at least this team) view health care service provision as separate from people's social and cultural spheres:

> **[Ms G]** - I know you are talking specifically about the role of health in terms of social and cultural integration […] But our contracts with the Ministry of Health in terms of refugee health and well-being are more tailored to the health aspects of the refugees that have been resettled in the greater Wellington area […]. In terms of holding their hands- with the cultural and social side they have volunteers and Red Cross.
>
> **[Judah]** - How do you connect with the refugees when they first arrive in their resettlement communities?
>
> **[Ms C]** - We do what we call transition visit or home visits to the family or the individuals at home, usually with the interpreter if needed. And basically, what we are doing is going through all of the health notes from Mangere and making sure that people are connected with the health services that they need to be connected with […] and if there has been any referrals that have been made from Mangere that they are being actioned.
>
> **[Judah]** - Now, because refugee migrants often come from different cultural backgrounds, how do you ensure that you understand their interpretations of aspects of health and well-being? Does the Hutt

Valley Regional Public Health have a specific policy for cultural competence?

[Ms G] - I would say at the DHB level, I am pretty sure there would be a policy, although I can't put a finger on it […] but in terms of cultural competency here at regional Public Health the management actually put processes in place especially training. I think it is important that we are aware of cultural competencies - I think a lot of that is specific to The Treaty of Waitangi […] and what our obligations for Māori people under The Treaty of Waitangi are. So, in terms of other ethnic groups, there is not a lot of training for us.

[Ms C] - We have all gone through the CALD- cultural and linguistic diversity training […] So, I guess that's a specific cultural competency training that all of our team would have done. There is also online training for cultural competency [...] it is important to understand other people's cultures.

[Judah] - You mentioned earlier that your department's role is to connect incoming refugees with primary health providers. Is this where your dealing with them ends or do you have a way of monitoring their integration progress?

[Ms C] - Yes, our primary role is to ensure that newly settled refugees are connected to the primary health care in their communities […] just to ensure that, that transition has been made.

[Ms E] - I guess the only reason that they would stay with us is if they are a latent tuberculosis infection (LTBI) client [….] and we may be with them for the treatment period.

[Judah] - How about mental or psychological health? Does the refugee health screening in Mangere include psychological health screening? And how does the Regional Public Health deal with people who may be struggling with mental health issues?

[Ms E] - There is a service in Mangere called Refugees as Survivors-(RAS) which does psychological screening […] And there is a partner service here in Wellington called Refugee Trauma Recovery (RTR).

> So, we can refer as well to Refugee Trauma Recovery if required […] But all the mental health screening is done in Mangere- and if there is a waiting list already at the RTR, and someone has an acute mental health needs, then they can be referred to community Mental Health or to Acute Mental Health Service in Wellington. But if it's psychological needs related to trauma, then the service they would be going to would be Refugee Trauma Recovery.

Although the regional public health service plays a role in connecting the incoming refugee background migrants with primary health providers, the impressions gained from the above interview is that once people have been registered with primary health care providers, there is no defined processes of monitoring their integration, particularly in relation to their socio-cultural integration into the health system. Whilst my participants from the HVPH's health protection team stated undergoing a cultural awareness training, their responses to the cultural competency question were inconsistent. Moreover, the fact that employees of the regional public health service seem to not recognise connections between health care and the social and cultural aspects of refugee migrants may indicate a gap in this area. These factors may be a signal that there are deficiencies in relation to cultural competency policy implementation. Furthermore, the team's response to the question of mental health indicated that there is over-emphasis on communicable diseases which may be causing the health sector to overlook other health aspects such as psychological health and sense of well-being for those of refugee backgrounds.

Cultural competency is crucial for health care professionals' effective communication with patients. When patients do not understand what their health care provider is telling them, or when the provider is insensitive to cultural differences, the quality of health care can be compromised (Anderson et al, 2003: 68). As highlighted in the previous chapter, cultural awareness is even more critical when providing care for mental health issues. Every culture has its own way of understanding and explaining mental illness, and as such explanation of mental illness should not be isolated from the individual's social and cultural context (Subudhi, 2015: 132). Francis noted the

importance of a doctor's understanding of the patient as a human beyond just clinical treatment:

> If your GP doesn't understand you from early on, they might be treating you for the wrong ailment […] And if your GP understands you as a person, and is interested in understanding your sickness, it makes a big difference in the type of medical treatment you end up getting.

The regional health sector's isolation of health from cultural context runs the risk of missing a point the significance of psychological health needs of resettled refugee background migrants (especially refugee children). This was highlighted by Dr D (pseudonym). Dr D is part of the Medical Officers team at the Hutt Valley Regional Public Health, and his main focus is on the treatment of infectious diseases. I interviewed Dr D in early September 2018, a week or so before my focus group interview with the health protection and housing team. Although he acknowledged the importance of culture in health service provision, as well as the significance of health care services in immigrant integration, Dr D admitted that the regional public health service does not have specific resources for refugee migrants' mental health, especially for refugee children. When I asked Dr D what resources the regional public health has for refugee children's emotional health this was his response:

> I am not sure whether we have specific resources for refugee background children's mental health, but I understand that many of these children went through various stressful situations in their lives […] Basically, we try to screen the children as well as adults for various infectious diseases and other health situations […] and if the nurses suspect that there might be some mental health issues or psychiatric problems or psychological problems, whether it is with children or adults. Then they would channel them to the appropriate professionals; i.e. paediatricians, developmental paediatricians.

Whilst the initial psychological health screening is carried out at the Mangere Refugee Centre, the question of cultural awareness remains. The incoming refugees spend only six weeks at the centre, a time too brief for health professional operating

there to comprehend the refugees' cultural understanding of mental health. Cultural dynamics play an important role in shaping people's perceptions and beliefs towards health and well-being, and as such every culture has its own way of explaining physical and mental health issues.

As outlined earlier in this thesis, ideas about health are cultural, and therefore should not merely be defined by measures of clinical care and disease. Napier et al. (2014) argue that failure to understand the intersection of culture with other structural and societal factors creates and compounds poor health outcomes. It is clear that the regional public health service's isolation of health from the Luo community members' cultural understanding of it is impacting negatively on the community's health and well-being. The majority of my Luo community participants have pointed out psychological health issues as a concern within the community, particularly among the young-adult demographic group.

Although the regional public health service connects the incoming refugees with primary health care providers in their settlement communities, the problem of cultural contexts of communication and understanding of health issues by members of the Luo community are left largely unaddressed. The designation of social and cultural integration to volunteer services means there is a gap in this area with respect professional health service provision. Whilst interpretation services are provided to address issues of language barrier, the doctor-patient relationship for some of the Luo community members appear to remain a hurdle with cultural barriers, perceptions of racist and discriminatory attitudes leading to mistrust.

The issues of xenophobia, racism and discrimination against migrants and immigrant population groups have been discussed and identified as a challenge across the migration and migrant integration literature both within the New Zealand context and elsewhere (see Fletcher, 1999, Rudiger and Spencer, 2003, WHO, 2016). Whilst there is evidence that the New Zealand government is aware of these issues, and all successive governments have worked hard towards reducing them, including through specific policy measures (see Mortensen, 2011, Ministry of Health, 2012), nearly all of the Luo respondents described experiences of discrimination and racism within the school system, health care settings and at work places.

Conclusion

This chapter has covered institutional issues related to interracial and intercultural interactions as experienced by members of Luo community. These experiences of racism within the school system, perceived institutional and personal racism within the health care sector, issues of cultural competency and perceived bureaucratic issues related to patient referrals from primary to secondary health care. Racism experienced by the Luo community youth during their early years in the New Zealand school system has had lasting social and health impacts (such as behavioural issues, impact on educational outcomes and lessened opportunities for social mobility) that continue to affect their adaptation processes. Racism has been found to create social stigma and a sense of devalued social identity for its victims. Social stigma presents a potential threat to individual sense of safety, hence affecting the acculturation and adaptation of migrants (children included).

Racism within healthcare settings is a source of health inequality and as such, a barrier to achieving positive health outcomes for the non-dominant groups. Lack of recognition of the influence of culture on health and communication compounds poor health outcomes, hence, to increase opportunities for positive health outcomes, health workers should strive to acquire skills to gain a better understanding of the cultures the people with whom they interact. While it was not possible to measure the extent of perceived bureaucratic issues related to patient referral, cultural and communication barriers may be to blame. However, this is a complex topic that may require specific research to be fully understood.

Institutional racism within the New Zealand health care sector has been a subject of research for decades, however, it has primarily addressed issues for Māori and Pasifika populations. This chapter has extended this to consider refugees from Africa. For the members of the Luo community, experiences of racism have affected the vital doctor-patient relationships, leading to feelings of mistrust towards the system and poor health outcomes. Racial discrimination also affects people's sense of belonging in general, and people who have been displaced are especially vulnerable as their sense of belonging had been previously affected by displacement. Research on racial discrimination against

minority groups in New Zealand has been found to be a significant determinant of health and well-being, generating negative health outcomes.

The negative effect of racism is compounded by the lack of cultural consideration by some health care professionals. Lack of cultural understanding and competency is a barrier to effective communication between doctor and patient and can lead to poor health outcomes. Durie (2001: 3) argues that "unless interaction with patients recognizes and builds on cultural realities, opportunities to gain positive health outcomes may be lost." For Napier et al (2014) cultural competence is an integral part of clinical competence. The mutual cultural considerations between the patient and the doctor are crucial for positive health outcomes.

Although my health professional-participants from the Hutt Valley Regional Public Health have described the existence of policies and training related to cultural competency in health care provision, the factors stated by members of the Luo community indicate that gaps still exist within the sector and were confirmed by the focus group interviews. The issues of racism towards immigrants and minority groups as well as lack of cultural consideration in clinical practices need to be highlighted and addressed. This would facilitate positive migrant integration experience and improved health outcomes.

Chapter Six: Conclusion

Summary of Key Points

This research set out to address the two-part primary question how do members of the Luo community of Wellington experience social and cultural integration in New Zealand as ethnic minority African immigrants? And what role does health play in this process.

By drawing attention to health as a culturally understood and socially experienced phenomenon, this research has attempted to shed light on the relationship between migration and health status, as well as the significance of health on migrants' adaptation, integration and full functionality in a new country. To address the primary question posed by this research, I have documented and analysed the pre-migration, resettlement, adaptation and integration experiences of members of the Luo community of Wellington - an ethnic minority African immigrant group.

Although a body of literature exists on integration of migrants in New Zealand and elsewhere, the bulk of research work in this area tends to lean heavily towards the socio-political and economic impacts or benefits associated with arrival and settlement of new migrants. Discussions on the integration of migrants in relation to the socio-cultural domains are relatively sparse. Equally, the crucial relationship between international migration and health is still an under researched area. Depending on the trajectory of migration, migrants face multiple health and social vulnerabilities. The process of deciding to leave one's home, social connections and familiar socio-cultural environment alone can be emotionally taxing. The socio-political dynamics of the home country (for instance; political and economic conditions, armed conflict or foreign policy arrangements) can also have an impact on migration experiences. When migrants arrive in host countries, they are also faced with the challenge of adapting to new physical, political and socio-cultural environments. For many migrants, the process of adjusting to a life in a new country may present multiple challenges and barriers – ranging from adapting to new diets, learning a new language, adapting to new social and cultural environments, to challenges of integrating into unfamiliar institutional

structures. For family groups, the adaptation related-stress emanating from these challenges and barriers (acculturative stress) can have negative effects on family relationships (especially the parent-child relationship), often leading to intergenerational conflict.

Refugee migrants face even greater insecurities - war refugees in particular are often forced to flee their homes unprepared. They suffer multiple losses; they lose their homes, possessions, communities, social networks and often family members too. For those who end up in refugee camps (such as some of my Luo participants), there is a constant threat of violence and death, and the general insecurities presented by the spatial confinement and marginalising nature of the camp. Life in refugee camps also present multiple vulnerabilities to poor health - overcrowding, poor sanitation, food shortages and bare-minimum or non-existent health care. Consequently, people who live for extended periods of time in refugee camps become more exposed to poor health. As shown in this thesis, these experiences continue to impact health and well-being long after people are resettled in new countries.

In this thesis, I have shown how integration is a complex and multidimensional concept, involving social, cultural, economic and political dimensions. Considering migrant integration as a three-way, multidimensional process, the research has found that the rate at which migrants acculturate and integrate into a new country is affected, not only by the relationship between migrants and the host country, but by their pre-migration experiences and the socio-political conditions of their originating country as well. Language difficulty and cultural difference have been widely recognised as potential barriers to integration of some migrants (particularly refugee migrants) in New Zealand. However, much of the literature on refugee migrant resettlement tend to overlook the significance of this group's pre-migration experiences of displacement, and their impacts on people's physical, mental and social health.

More specifically, this research has highlighted the Luo community's pre-migration experiences of war, displacement and multiple losses, showing how these experiences affect the individual's health and sense of well-being. I argue that these factors, (alongside the socio-cultural and institutional challenges of adaptation) influence how members of the Luo community experience integration in New Zealand.

By highlighting individual pre-migration experiences, this thesis has also linked the enduring physical and emotional health impacts of these experiences on people's contemporary social and personal identities. I have outlined and shown how intergenerational difference in the rate of acculturation (acculturation gap), leads to intergenerational differences in cultural values (intergenerational cultural dissonance), which in turn leads to parent-child conflict. These factors increase people's vulnerability to poor emotional health, which affect the process of adapting to a new socio-cultural environment. The assumption enshrined within the current refugee resettlement programs that adaptation and integration of refugee children is determined by their parents' adaptation has also been highlighted as erroneous. Parents and children have different acculturation experiences. Thus, they have been found to acculturate at different rates.

Some of the Luo children who came to New Zealand with their families under the UNHCR refugee quota programme had had pre-migration experiences of displacement which may have negative effects on their social cognition; interrupted childhood (education), loss home stability and sense of security. These factors affect people's integration process at an individual level, and therefore require resettlement policy structures that recognise refugee children's pre-migration experience and the ongoing impacts these experiences may have on their health.

Moreover, the research has highlighted the issues of institutional racism and lack of consideration for cultural difference that exist within the New Zealand health care sector, as well as how these affect people's health outcomes. Institutional racism and lack of consideration for cultural difference against Māori and Pasifika people as well as other ethnic minority groups, (such as Asians) have been well documented in New Zealand. However, not much research has been done on the same topic in relation to African migrants yet. This thesis, however, has shown that some members of the Luo community of Wellington perceive experiences of racism and lack of cultural competence by some health care professionals. Although this is only a small research sample, it is an indication that the issue may be widespread. Despite efforts being made through various government policy structures as well as by community volunteers services to enhance integration of refugee migrants, my research, backed by available literature shows that there are ongoing ethnic inequality issues in New Zealand, which

affects new migrants. Unequal service delivery (particularly in the health sector and other welfare structures) has been found to increase vulnerability to poor health outcomes.

Key Findings

The Social and Health Impacts of Pre-migration Experiences on Individuals

By considering the Luo community members' originating countries socio-political dynamics, this research has found that the home countries continue to play a significant role in their integration experiences in New Zealand. The Luo community members' pre-migration experiences of war forced migration and displacement have significantly affected some of the community members' physical, emotional and social well-being. Forced migration has resulted in multiple losses – loss of familiar environment, home, social connections livelihoods, family structure as well as disruption of childhoods. Displacement and refugee camp-living conditions have also had long-lasting negative effects on individuals' physical and emotional health. The liminal nature refugeedom and the spatial marginalisation of the refugee camp have also been found to have lasting impact on people's contemporary social and personal identities, which continue affect their emotional health and sense of belonging, and as such impede their adaptation and integration processes.

The Social and Health Impacts of Post-migration Experiences at Individual and Group levels

This research has found that processes of resettlement and adaptation to a new socio-cultural environment have ongoing impacts on the Luo community members' social and psychological health, both at individual and group levels. Acculturation related stress has been found to have ongoing emotional and social health impacts on individual community members, which hinders the adaptation and integration for some people. At group level (specifically, the family group) the differences in the rate at which individuals acculturate (in particular the differences between the younger and older

family members) has been found to create an intergenerational cultural dissonance, which leads to intergenerational conflict and emotional health problems.

As new contemporary socio-cultural identities emerge due to acculturation process, the Luo community's younger generation (in particular, those who arrived in New Zealand as children) find themselves caught between and negotiating two cultures, with undesired negative repercussions at family level in the form of cultural discord, intergenerational conflict and loss of family bonds. These issues increase vulnerability to social, emotional and psychological health problems which negatively affect this demographic group's adaptation and integration processes.

Institutional and Personal Racism

This research has also identified possible physical, emotional and social health impacts of some experiences of institutional and personal interactions on some of the Luo community members. Specifically, experiences of racism at school, racism within health care setting and issues of lack of consideration for cultural difference (cultural competence). While experiencing racism at school may not be viewed by some as not directly related to health, my research participants described ongoing social and emotional health impacts of being racially discriminated against, during their early years of schooling in New Zealand. Racism (particularly skin colour-based racism) has been found to create social stigma for the victims, marginalising people and thus affecting acculturation and adaptation processes, and my research found this to be the case with some of my participants as shown above.

Racism within health care settings was also found to be an issue experienced by some of my research participants. Institutional racism does not only affect people's emotional health, it creates inequalities too. Institutional racism within health care provision has been found to increase health inequities as well as to impede achievement of positive health outcomes and increase racial health inequities. My research found that those community members who have described experiences of racism within health care setting also described diminished trust in the health care system. This has negative

implications for achieving positive health outcomes, which is necessary for gaining desirable integration outcomes.

This thesis has also found that, despite culture having been identified both in New Zealand and elsewhere as a crucial factor for understanding and communicating people's health, issues of cultural competence exist within the health care system. The majority of my Luo research participants described perceived lack of cultural considerations by some health care professional. This issue was found to have been a barrier that affects the communication that maintains the crucial doctor-patient relationship essential for health care.

Research Limitations

Limitations include lack of space and time constraints to engage the full spectrum of immigrant integration conceptual framework. Immigrant integration is a complex, multidimensional concept with context-dependant definitions. The conceptual dimensions of immigrant integration include social, cultural, economic, and political integration. To privilege one dimension over others puts limitations on the vital linkages between various aspects of the integration process. This research has focussed attention primarily on the social and cultural dimensions of immigrant integration. This means that the research has largely excluded the economic and political dimensions of integration even though they can also impact people's health and well-being as well as their sense of belonging and identity. A further, larger study than the MA permitted, considering these issues would be of benefit to understanding better the situation. The New Zealand context-specific literature on the relationship between health and immigrant integration is also limited, which compelled the researcher to rely heavily on examples from overseas.

One other limitation was presented by the small size of the Luo community in Wellington. Since the Luo community includes eight to ten families, even though the research findings may be an indication of widespread phenomena, this research cannot be accurately generalized in relation to the broader African immigrant or refugee populations in New Zealand. However, being able to focus on this community, who

share different types of experiences from the initial displacement right up to current day, allows me to show some findings which, if accounted for, would help improve immigration experiences of refugees in general, and perhaps all immigrants as well as host countries' integration policies.

Recommendations

This thesis has highlighted several issues related to migration (in particular refugee migration) and settlement of migrants in a new country and has drawn attention to the interconnected relatedness of these issues to social aspects of health and well-being. At the moment people are not being adequately supported, and to do so, the immigration, healthcare, and wider social services are recommended to do the following:

The sparsity of the New Zealand literature on the relationship between health and immigrant integration is an indication that this is an under-researched topic, particularly in the field of anthropology. Therefore, more extensive research is required on this topic, not only in New Zealand, but in immigration and migrant integration studies in general.

While Te Tiriti o Waitangi-supported ethnic relations policy structure is already in place for protection of Māori people's rights to health and other aspects of human social security such as tangata whenua, this remains a bicultural arrangement. In light of New Zealand's ongoing growth in ethnic and cultural diversity, it is increasingly becoming necessary for policy makers to formulate policy structure that reflects and complements the country's growing cultural diversity.

Although the health screening of incoming quota refugee immigrants is reasonably comprehensive, there is over-privileging of physical health screening, which may be compromising early detection of mental health issues within this population group.

Current health care programmes aimed at integration of resettled refugee background migrants' families tend to focus on integrating parents with an assumption that children will automatically adapt and integrate alongside their parents. This situation leads to unintentional marginalization of refugee background people who arrive in New Zealand with their parents as dependents. While children depend on their parents for

resettlement, it has to be borne in mind that they too are individuals – they may go through similar social and cultural barriers as their parents. Furthermore, people acculturate differently. Children often acculturate at a faster rate than their parent. This can create an intergenerational cultural dissonance which often leads to parent-child conflict. While both the parent and the child are affected, children are especially more vulnerable to emotional health issues if exposed to sustained distress. Hence, there is urgent need for refugee children to be adequately protected through resettlement and integration policies. Current refugee resettlement and integration policies do not adequately protect resettled refugee children.

There is need to reformulate refugee resettlement programmes in a way that they would seriously consider the pre-settlement experiences of displacement and the possible impacts of these experiences on people's health and sense of well-being. Recognising the significance of health care services on the social and cultural integration of previously displaced population groups is necessary to improve their health status as well as to enhance their sense of belonging in New Zealand.

In the face of the current state of international migration, where diverse individual and population groups traverse the globe on daily basis, there is growing need to redefine the concept of integration in order to fully grasp not only its theoretical assumptions, but its practical implications as well. The current deficiencies regarding the definitional clarity of migrant integration concept calls for more conceptual improvement. This will also help improve integration policies to align them more with practical realities of migrant integration.

This thesis is the first research to be conducted with the Luo people in relation to their migration, resettlement and integration in New Zealand. It is also among a very small number of research projects conducted in New Zealand linking health to migration and migrants' adaptation and integration (particularly those specific to ethnic minority African immigrants). It is my hope that this research will contribute towards shedding further light the interconnected relationships between migration and the social aspects of health, and ways by which these impact migrant integration processes in a host country. Furthermore, by drawing attention to the socio-cultural and institutional

challenges facing migrants (ethnic minority African migrants in particular) this research contributes towards improving migrant integration experiences in New Zealand.

However, future research is still required to fully realise the social impacts of health on migrant adaptation and integration processes. This would help address the socio-cultural challenges as well as the institutional and structural barriers that migrants often face in host countries. Further research on ways in which ethnic minority migrant groups experience integration in New Zealand will not only improve migrants' integration experiences, it will also help improve ethnic and race relations, thus improving the socio-political stability and human security in the country.

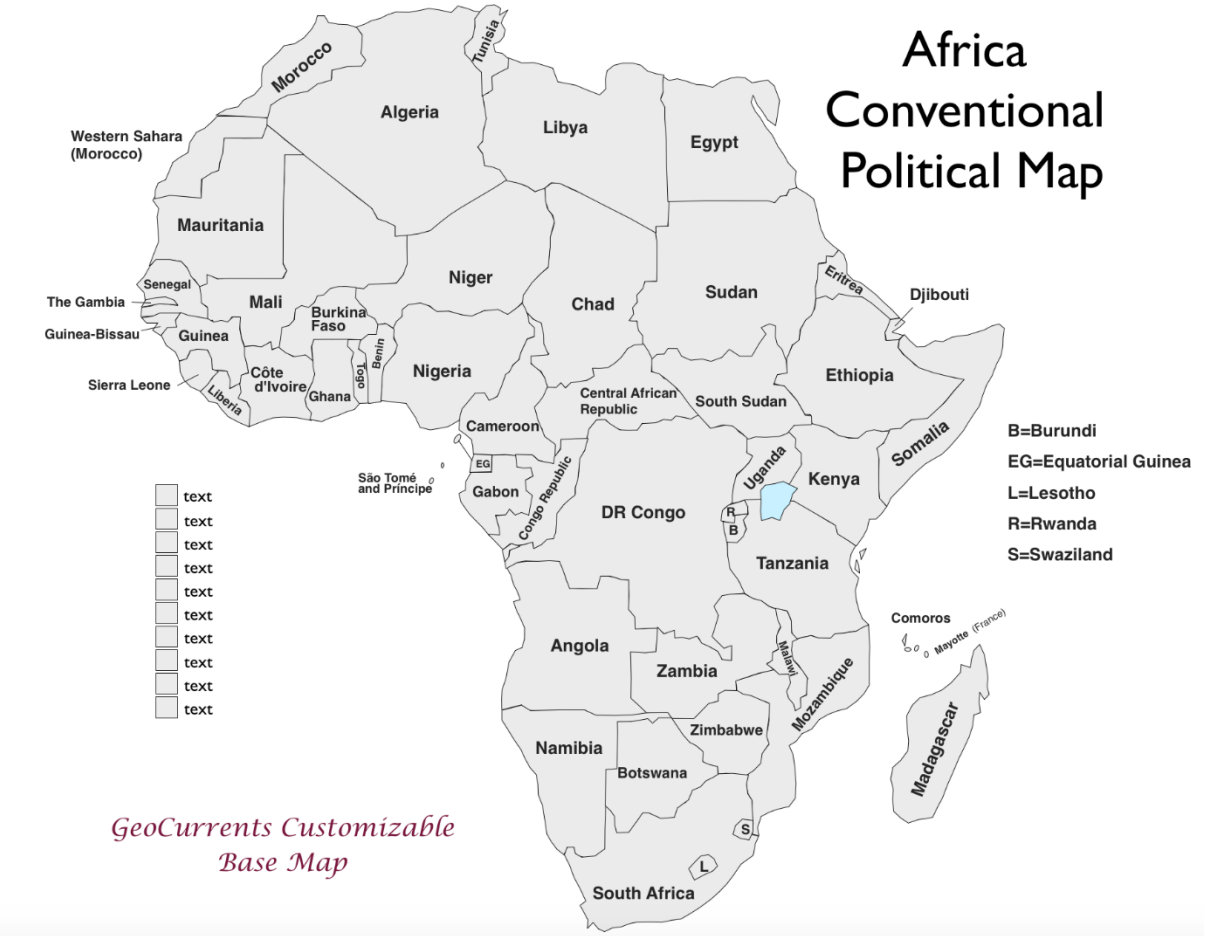
Appendix A: List of Research Participants

Members of the Luo community of Wellington		
Name	**Gender**	**Demographic Group**
Margaret	F	Community Elder
Francis	M	Community Elder/ Leader
David	M	Young Adult
Josephine	F	Young Adult
Joyce	F	Community Elder
Jude	M	Young Adult Community Leader
Hutt Valley Regional Public Health Service Health Professionals		
Name	**Position**	**Unit/Team**
Ms G	Team Leader	Public Health Protection
Ms C	Community Nurse/Refugee Health	Public Health Protection
Ms E	Community Nurse	Public Health Protection
Dr D	Medical Officer	Communicable Diseases
Refuge Trauma Recovery – New Zealand Red Cross (Wellington)		
Name	**Position**	**Unit/Team**
Mr C	Practice Manager	Refugee Trauma Recovery Team

Appendix B: Native African Migrants Population by Region 2013 New Zealand Population Census (Statistics New Zealand, 2013)

Select Group	**African**
Age Group: All Ages	**Total People/Age Groups**
Year	**2013**
Area	**Population**
Northern Region	156
Auckland Region	3402
Waikato Region	681
Bay of Plenty Region	162
Gisborne Region	18
Hawkes Bay Region	81
Taranaki region	93
Manawatu/Wanganui Region	270
Wellington region	927
Tasman Region	18
Nelson Region	18
Marlborough Region	6
West Coast Region	27
Canterbury Region	636
Otago Region	249
Southland Region	78
All Regions	6819

Appendix C: Continetal Map of Africa – All Regions



Credit: (Lewis, 2015 – GeoCurrents)

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Figure 1

- Reginal map of East and Central Africa

Figure 2

- The Systemic Structure of the New Zealand Health and Disability System

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