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Fluctuating power in refugee health nursing:

A focused ethnography of the Refugee Health Program in Victoria, Australia.

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Abstract

Background

The Refugee Health Program (RHP) is a nurse-led initiative which was introduced in 2005 with the aim of responding to the complex health issues of refugees arriving in Victoria, Australia. Refugee Health Nurses (RHNs) provide a coordinated model of care, specifically addressing health needs of resettled refugees in the community setting.

Refugees are positioned within the health literature and policy context as a vulnerable population, with RHNs expected to support this vulnerability and meet their needs. Refugees are painted in the literature as a passive group, with a narrative of presumed power imbalance in the nurse/refugee relationship. However, little is known about the cultural phenomenon of refugee health nursing and the impact of dedicated refugee healthcare.

Aim

This study explored the experiences of RHNs, Refugee Health Managers and refugees within the RHP, gaining insight into social and professional relationships and the complexities of offering a specialised health service for resettled refugees.

Methodology and Methods

A focused ethnographic approach incorporated semi-structured interviews with five RHNs, two managers and eight refugees, two focus groups with refugees and participant observations within the RHP between April 2017 and December 2017. Data collection was undertaken across two sites and interviews, focus groups and observations were transcribed and thematically analysed.

Findings

Findings show that rather than a power imbalance in refugee health nursing, power is everywhere, exercised by all actors. Indeed, Foucault (1980) suggests that power is relational and fluctuates within social contexts.

Findings highlight that RHNs operate as street-level bureaucrats in this progressive discipline of contemporary nursing practice (Lipsky 1980). They are gatekeepers to specialised refugee healthcare, providing and rationing access for refugees and powerful in their professional stance. Nevertheless, RHNs are susceptible to weakness, with findings elucidating how their inherent power dissipates. RHNs contend with bureaucracy as put forward by managers, halting their path of autonomy; and they must deal with vicarious trauma and the threat of 'burnout' in caring for refugees. While findings portray how nursing power is destabilised, this study also demonstrates the rise of refugees in laying claim to their own power during resettlement. Foucault (1980) argues that power relations cannot exist unless there is resistance, and refugees employ defiance and negotiation strategies within the nurse/refugee relationship. In this way, power is omnipresent and fluctuating within refugee health nursing.

Conclusion

This study concludes that in a nurse-led refugee health service, power is exercised by RHNs, managers and refugees as all actors lay claim to elements of control.

Although autonomous practitioners, RHNs experience loss of power due to managerial surveillance and contend with secondary trauma through the care of refugees. While construed as vulnerable, refugees can be resilient and perceptive; showing resistance to RHNs or negotiating prolonged specialist care when they recognise the benefits.

Overall, this study has implications for refugee health nursing in improving healthcare delivery for resettled refugees. RHNs are not as powerful as they seem, and require ongoing emotional, psychological and educational support in developing therapeutic relationships with refugees and managing complex, sensitive refugee health issues. Targeted refugee healthcare is beneficial during early resettlement to address specific refugee health issues. However, a supported discharge process

should be incorporated, encouraging refugee integration through assimilation into mainstream community health services, while reducing the ongoing workload of RHNs and preventing burnout.

All newly arrived refugees in high-income host countries could benefit from proactive health support during the first year of resettlement, with culturally competent nurses providing health assessment and early intervention, health promotion and education, orientation of the health system and onward referrals.

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Lay Summary

There are many global conflicts and crises raging around the world, and consequently, numerous people are forced to flee their country of origin, looking for a safer place to live. As a result of displacement, migration and resettlement, refugees can often experience a range of health problems, particularly during the first year of arrival in their new environment.

In response to the poor health and complex needs of newly arrived refugees in Victoria, Australia, the Refugee Health Program was introduced in 2005, which is a nurse-led initiative supporting refugees during the first year of resettlement. Refugee Health Nurses offer a coordinated approach to care, providing holistic assessment, health promotion and education, disease management, as well as onward referral to specialist services and linking refugees with social support in the community. At the end of the one-year resettlement period, refugees are discharged from the Refugee Health Program into mainstream community health services, to encourage integration and assimilation into Australian society.

There is debate in clinical practice and health research about the best way to care for newly arrived refugees in the community. Some hold the view that refugees should undergo a health assessment on arrival in their new country, and thereafter, receive the same level of community healthcare as the host population; this is the model currently used in Scotland. On the contrary, others recommend that due to the complexity and commonplace development of refugee health issues on resettlement, there is a need for specialised healthcare during this period.

This study is based upon the latter approach; focusing on the Refugee Health Program in Victoria, Australia, which incorporates refugee health nursing as a specialised field of practice. Interestingly, dedicated refugee healthcare has not been widely adopted in host countries. Therefore, this study aimed to explore refugee health nursing as an underused field, to determine the value of this discipline in contemporary practice and whether this model of care might be transferable to other resettlement contexts around the globe, particularly Scotland.

The research was undertaken in 2017 at two community health centres in Victoria, Australia offering the Refugee Health Program, one metropolitan site and one rural/regional site. Five Refugee Health Nurses, two Refugee Health Managers and eight refugees took part in semi-structured interviews, two groups of refugees participated in focus group discussions and participant observation was conducted across the two sites, enabling a deeper understanding of everyday practice.

With regards to findings, this study challenged social and cultural assumptions about the phenomenon of refugee health nursing in the community setting.

Refugee Health Nurses are powerful in their professional position, acting as gatekeepers to specialised healthcare and using discretion to bend the rules in meeting refugee needs. However, this study also brings to light the vulnerabilities involved in this role. Refugee Health Managers exert power through the demand that nurses meet targets and appease core bureaucratic structures, threatening the inherent autonomy of these nurse specialists. Refugee Health Nurses are also susceptible to vulnerability through the risk of crossing professional boundaries, as well as experiencing vicarious trauma and symptoms of compassion fatigue, causing them to further lose control of their power. In terms of refugees, while this population are painted as vulnerable in healthcare literature, refugees are often resilient, showing resistance to specialised nursing care or exercising power through negotiation of their care delivery.

Overall, this study found that all actors weave through a complex web of power relations, highlighting that power is both omnipresent and fragile across sub-cultural groups. Exploring refugee health nursing from a range of perspectives and experiences provided valuable insight into this field, allowing for the articulation of important implications for nursing practice, education, further research and refugee health policy.

This study contributes to the knowledge base in refugee health, offering key principles that can be incorporated when considering the provision of healthcare for newly arrived refugees in high-income host countries.

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'The fact is that power is a diverse phenomenon: it may be wielded either consciously or unconsciously; it may be either latent or overt. Therefore, it is important to understand the essence of exercising power'

(Sinivaara et al 2004 p40)

1.1 Chapter one: Thesis introduction

1.2 Introduction

Nurses are at the forefront of healthcare provision for the increasing population of refugees and asylum seekers in host countries, and refugee health is becoming a prominent public health issue, owing to the global rise in the number of refugees and their multifaceted health problems (Ogunsiji et al 2018). Responding to such increases in number and complexity of health conditions poses challenges to healthcare providers supporting resettled refugees in host countries, and this study explores refugee health nursing as an underutilised approach in addressing the health needs of refugees on resettlement.

Impetus for this study came from the suggestion that refugees often receive inadequate health support during the resettlement period (Hahn et al 2019), including in the Scottish resettlement environment (Weir et al 2017). For this reason, this study aims to consider the phenomenon of refugee health nursing, as a viable slant in offering dedicated healthcare for refugees on resettlement, improving health experiences and outcomes for this population (Ogunsiji et al 2018). Having lived and worked as a nurse in Australia, I understood that health systems across Australia offer specialised refugee health programmes for newly arrived refugees, and this sparked curiosity about exploring the option of introducing specialised refugee health programmes to the Scottish resettlement landscape.

During the last four decades, millions of people have fled their homes and sought asylum in other countries and in 2017, an estimated 68.5 million people were forcibly displaced globally, including 25.4 million refugees, due to persecution, conflict, generalised violence or human rights violations (Brandenberger et al 2019). Indeed, forced migration is a global reality and bears influence on health systems of host countries; often struggling to cope with the health needs of asylum seekers and refugees.

With regards to resettlement, nearly 80 per cent of refugees resettle in developing countries, mostly within sub-Saharan Africa and Asia (Amara and Aljunid 2014). However, although estimates indicate that most global migration occurs within low-income and middle-income countries, the most prominent dialogue focuses

almost exclusively on migration from low-income to high-income countries (Abubakar et al 2018). Many people claim asylum and are granted refugee status through humanitarian visas offered by the United Nations High Commissioner for Refugees (UNHCR), enabling refugees to resettle in various high-income countries around the world.

For clarity, low-income, lower middle-income, upper middle-income and high-income countries are outlined by the World Health Organisation through the World Bank Country and Lending Groups country classification (2021). Examples of low-income countries are Afghanistan, Eritrea and Ethiopia, lower middle-income countries include Pakistan, Philippines, Vietnam and Nepal, upper middle-income countries include China, Mexico and Turkey, while high income countries on the World Bank Country and Lending Groups country classification (2021) feature Australia, United Kingdom (UK), Canada, United States of America (USA), Sweden, New Zealand and a range of others.

As this study is centred around refugee resettlement in Australia, discussion within this thesis places emphasis upon the refugee resettlement process in high-income host countries, illustrating how health systems in these countries can best support refugees, in terms of optimising health and well-being on arrival in their new environment.

To offer the circumstances in which this study came to fruition, during 2015-2016, I provided nursing care for refugees in France and the Greek Island of Samos, most of whom were fleeing the ongoing conflict in Syria. Returning home to Edinburgh, I began volunteering with the Scottish Refugee Council and a charity called Re-Act Refugee Action Scotland, supporting the resettlement and integration of refugees into Scottish society.

Through my clinical and volunteer background, I became interested in the health experiences of refugees; in particular, the impact of displacement and claiming asylum, as well as migrating and resettling in host countries. Furthermore, by conducting an extensive search of the literature, I gained insight into how the refugee experience may influence health and well-being. I considered the challenges faced by refugees in accessing healthcare during the resettlement period, leading to a process of discovery and the formulation of this study.

Interestingly, there is debate in clinical practice and health policy research about how care should be provided for resettled refugees in high-income host

countries. On one hand, some advocate that refugees are offered healthcare through mainstream community health services, encouraging integration and assimilation by accessing the same healthcare as available to the host population (Haley et al 2014; Cheng et al 2015; Lionis et al 2018). On the contrary, others suggest that due to the unique and complex health needs of newly arrived refugees, a targeted approach is required, with the incorporation of specialised refugee health clinics, operated by health professionals with specific knowledge of refugee health issues (Joshi et al 2013; McBride et al 2016; Ogunsiji et al 2018). This study will focus on the experiences of those working in, and using, specialist health services.

As mentioned, having lived in Australia prior to undertaking this study, I knew that specialist refugee health services are widely offered in this country for refugees in both primary and secondary care contexts, with the incorporation of the Refugee Health Nurse Liaison role in the hospital setting (Mc Bride et al 2016; 2017). In the state of Victoria, Australia, the pioneering Refugee Health Program (RHP) is a nurse-led community initiative responding to the poor health and complex needs of newly arrived refugees.

This thesis draws attention to the phenomenon of refugee health nursing as an inconsistently implemented discipline within nursing practice, in the context of high-income host countries. Furthermore, consideration is given to the enigmatic status of this field, in a climate where there is debate about the necessity of specialised refugee healthcare on resettlement.

With regards to the structure of this introductory chapter, an overview of the transitional refugee experience is provided, with mention of global circumstances leading to the fleeing of refugees from their country of origin and the journey taken to resettlement. This chapter initiates discussion of refugee health nursing in tackling the multifarious health challenges facing this population during the resettlement period (Halabi 2005).

1.3 Global context

This section offers a brief overview of world events that have led to an increase in the scale of refugee resettlement in recent years.

According to Lionis et al (2018), the current political crises, conflicts and riots in many Middle Eastern and African countries have led to massive waves of forced

migration, with an influx of people seeking asylum from the late 2000s and a rapid increase occurring in 2015. There are several ongoing conflicts in Eastern Mediterranean and North African areas, resulting in displacement and migration of people to other parts of the world (Lionis et al 2018).

In particular, the conflict in Syria between the government of Bashar al-Assad and various other forces, which started in the spring of 2011, continues to cause displacement and forced migration. More than half of Syria's population is displaced, with some four million people having fled the country and seeking refuge, making this one of the biggest refugee crises in history. With regards to Africa, people fleeing conflict and persecution in countries like South Sudan, the Central African Republic, Nigeria and Burundi, have added hundreds of thousands to the longstanding refugee populations from countries such as Somalia, Ethiopia, Sudan and the Democratic Republic of Congo (Lionis et al 2018). There are many other conflicts raging around the globe, with war and persecution fuelling an ever-evolving refugee crisis, but the international community are working together to provide support and resettlement to refugees, offering a passage to safety.

The following section describes the process of people leaving their country of origin and seeking asylum elsewhere, with hope of a safer life.

1.4 The refugee experience

Refugees are people who involuntarily, because of risk of harm and persecution, are forced to leave their country of origin. An asylum seeker is a person seeking protection as a refugee, but whose claim for refugee status has not yet been assessed (Ogunsiji et al 2018).

The refugee journey can span internal displacement in the country of origin to asylum in a second, usually neighbouring country, and for some, to permanent resettlement in a third or 'host' country (Muecke 1992).

This study is based upon refugees who resettle in a high-income host country, having been granted refugee status. Resettlement is the transfer of refugees from a country where they have initially sought asylum, often in the same region as their country of origin, to a third state which has agreed to admit them. It is a life-changing, durable solution for refugees whose life, liberty, health or human rights are at risk in their country of refuge, or for whom relocating to another country is their only hope of

being reunited with their family (Nelson and Saltmarsh 2017). In this context, resettlement offers a vital lifeline for the most vulnerable refugees, to restart their lives in safety and dignity, while avoiding perilous voyages. While some refugees are young adults, an increasing number of children, elderly and disabled people, as well as those with complex health needs, are among the recently arrived refugees in host countries around the world, which has implications for health systems in these resettlement environments.

Refugee health is a convoluted topic and the effects of the migratory process, cultural and environmental determinants of health and the risks and exposures in the origin, transit and destination setting interact with biological and social factors to create varying health outcomes on resettlement.

Refugees can be exposed to various traumatic experiences in all phases of the displacement and migration continuum, not only in their countries of origin, but also during transit and the resettlement period, and these experiences can negatively influence health and well-being (Williams and Thompson 2011). The refugee journey itself, which often extends for a considerable period, can expose refugees to violence, injuries, abuse, confinement in overcrowded settings where they may be deprived of hygiene and proper sanitation, exposure to the elements and transportation-associated risks, as well as lack of adequate nutrition and access to healthcare; often contributing to health issues during the resettlement period (McCann and Mackie 2016). Although some health problems of refugees may correspond with the rest of the population, refugees' prolonged exposure to war, civil unrest and trauma make certain health issues more prevalent among this group (Ogunsiji et al 2018).

1.5 Healthcare for resettled refugees

In terms of healthcare for refugees on resettlement, current practice in various high-income host countries means that refugees undergo an initial health assessment on arrival, and are then offered mainstream community health services, often accessing the same level of healthcare as the host population (Cheng et al 2015; Richard et al 2019). However, although universal healthcare is to be commended, studies highlight that mainstream health services are insufficient in meeting the

complex needs of newly arrived refugees (Chiarenza et al 2019; Hahn et al 2019). Global health strategies advocate that alternative strategies are required in better addressing refugee health needs, recommending that specialised refugee healthcare could optimise the health and well-being of this group on arrival in the host country, targeting refugees through dedicated health programmes (WHO 2016; 2018; 2019). To this end, this study focuses on one such refugee health programme which is based in Victoria, Australia, considering the experiences of those involved in this initiative to gain insight into how care is provided for resettled refugees and the impact of a specialised health service.

1.6 Outline of thesis

I started planning this study in September 2015 while living in Edinburgh, Scotland. I moved to Melbourne, Australia in January 2017 to begin undertaking data collection, which commenced in April 2017. By December 2017, I had reached data sufficiency and data collection came to an end. I remained in Melbourne for the following few months due to clinical nursing commitments and returned to Edinburgh in May 2018 to carry out the latter stages of data analysis, write up findings and to produce this thesis.

This thesis offers insight into the social and cultural phenomenon of refugee health nursing in the resettlement context of Victoria, Australia. Firstly, I draw attention to the existing literature in the field of refugee health, highlighting the impact of the refugee experience on health and well-being. I elucidate the perplexity of refugee health nursing as a modern-day discipline, with regards to the debate about whether resettled refugees should receive mainstream or specialised healthcare. With mention of current practice in Scotland, I offer rationale for undertaking this study, in that by exploring the RHP in Victoria, Australia, this model could potentially be transferred to other resettlement environments with high numbers of newly arrived refugees. Discussion of methodology and methods is provided, and findings of this study are presented with reference to the literature, including in-depth discussion of hidden meanings, drawing connection to Foucauldian theory (Foucault 1980) and street level bureaucracy theory (Lipsky 1980), offering practical implications for refugee health nursing practice, education, research and policy.

1.7 Conclusion

As a nurse with passion for improving health experiences and enhancing outcomes for resettled refugees, I aimed to investigate a specialised refugee health service, as this model of care has not been widely implemented. As such, this study aims to uncover refugee healthcare in the resettlement context, with focus on Victoria, Australia as a trailblazing part of the world in dealing with refugee health as a specialist discipline.

This chapter has offered a preparatory vision of what is to come within this thesis, laying the foundation for qualitative exploration of refugee health nursing.

Many refugees flee from instability caused by conflicts, violence, natural disasters and human rights abuse, '*leaving their countries to protect their life and freedom*' (Hollander et al 2012 p1159). However, on arrival in the host country, refugees can face challenges to health and well-being, often due to pre-migration stress and lack of healthcare, interlinked with the asylum process and social, cultural and environment factors associated with resettlement. The experience of becoming a refugee and settling in a host country can negatively affect health outcomes during the early resettlement period and therefore, the provision of good quality care is essential in tackling health problems and optimising opportunities for refugees to thrive in their new environment (Hahn et al 2019).

Addressing the health needs of the increasing population of resettled refugees is a global challenge for healthcare systems, and the rising numbers of refugees in host countries has put refugee health on the global public health agenda (WHO 2018). While the largest group of displaced refugees are hosted in resource poor countries, the health needs of refugees must be acknowledged in high-income countries of resettlement, to enable more positive health encounters and outcomes (Brandenberger et al 2019). Refugee health nursing is suggested as a feasible option in improving care for refugees on resettlement, and this thesis explores the perspectives and experiences of Refugee Health Nurses, Refugee Health Managers and refugees, to better comprehend the impact of this specialist field in the community setting.

2.1 Chapter Two: Literature Review

2.2 Introduction

Throughout undertaking this study, I continually searched and stayed abreast of past and current research within refugee healthcare, helping me to understand the broader context and developments in this field, while allowing me to gain insight into the current scope of practice worldwide. The purpose of this literature review is to explain my process of searching the literature and to set the stage with regards to the current research landscape and clinical practice in providing healthcare for resettled refugees.

Having considered the refugee journey in chapter one, from the global context of war and conflict; leaving the country of origin, to displacement, migration and resettlement in a host country, this chapter draws attention to the impact of these experiences on the health and well-being of refugees.

As outlined, it is suggested that due to conditions in the country of origin, migration and resettlement process, refugees are at risk of experiencing a range of health problems during the resettlement period and importantly, these are often not identified on initial assessment (Marshall et al 2016). Joshi et al (2013 p2) point out that, *'refugees often have complex and multiple healthcare needs on arrival in the host country, as a consequence of inequities in the social determinants of health; experiences of persecution, torture and other forms of trauma, deprivation, unhealthy environmental conditions and disrupted access to healthcare.'* With limited medical treatment prior to resettlement, refugees can arrive in the host country with complex or undiagnosed health issues, requiring ongoing clinical assessment and care (Hadgkiss and Renzaho 2014). Of note, they may arrive with no evident health problems but issues often develop during the first year of resettlement, as a result of factors related to the migration and resettlement experience (Razavi et al 2011; Norredam et al 2014; Marshall et al 2016). For this reason, there are calls for targeted refugee healthcare during the first year of resettlement in the host country, to monitor the health of refugees as they settle into to their new environment and to allow opportunities for early detection, health promotion and education (Abubakar et al 2018; UNHCR 2018; WHO 2018).

After discussion of refugee health concerns during the resettlement period, I then offer a rundown of current practice in relation to healthcare provision for refugees in various high-income resettlement contexts. Global action plans have set out recommendations for addressing the health needs of resettled refugees and improving the provision of care for this population. Of significance, it is posited in various global refugee health strategies that implementing dedicated health support for refugees on arrival in the destination country is considered best practice in contributing to improved health experiences and outcomes (UNHCR 2018; WHO 2013; 2016; 2018). This strategy is considered in detail, drawing from the literature to establish the evidence base underpinning the notion of specialised healthcare.

As an overview, this chapter provides a synopsis of refugee health issues and current practice in the community setting, laying the groundwork for investigation of refugee health nursing as an under-explored phenomenon. This literature review systematically looked at the research on refugee health issues and healthcare provision for resettled refugees in high-income host countries. The questions I asked of the literature related to 1) how the refugee experience influences health and well-being, and 2) whether specialised healthcare for refugees is necessary and advocated in the literature.

2.3 Searching the literature

Sources for this literature review were identified through electronic databases including CINAHL, Medline and online search engines; Pub Med, Discover Ed and Google Scholar. Community refugee health nursing was introduced in England in 2000 and later in Australia in 2005, and therefore, I applied a date restriction of the year 2000 onwards when searching the refugee health related literature. In addition, only sources written in English were incorporated. Search terms included refugee health, refugee healthcare, refugee health nursing, refugee resettlement, community nursing and specialist nurses. These terms were used in various combinations and were identified as relevant following a general review of the literature, along with meetings and discussions with academic supervisors (Appendix 1).

Research articles were predominantly downloaded through links provided on electronic databases and search engines. For example, articles were downloaded from Wiley Online Library and Science Direct however; some were requested from the

Edinburgh Interlibrary Loan service. The initial review of the literature was conducted in 2015, which was complemented by additional sources in 2019, as the popularity of refugee healthcare continued to grow internationally.

The electronic data search was supplemented by manual searching of the grey literature and reference lists within retrieved articles, offering additional sources. Furthermore, various pieces of policy documentation were integrated to this literature review.

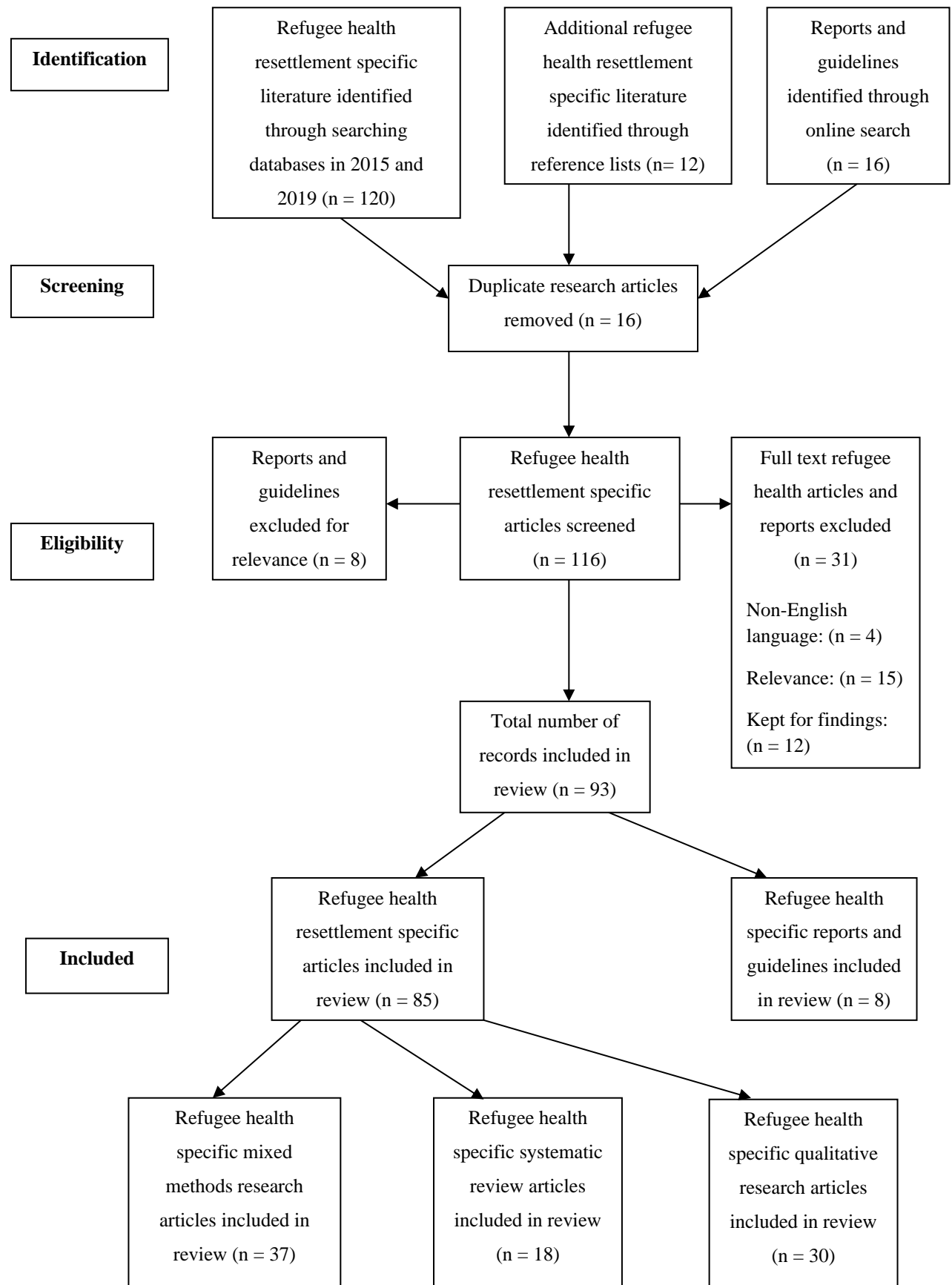
The search strategy generated 120 articles with an additional 12 articles identified from the reference lists of included articles. The overall process of searching the refugee health resettlement literature is presented as a PRISMA type flow diagram in figure 1, adapted from the PRISMA Group diagram used for systematic reviews and meta-analyses (Moher et al 2009). A total of 85 studies were included, comprising of 18 systematic reviews, 37 mixed methods studies, and 30 qualitative studies (Figure 1).

To complement the research studies, I searched for recent global policy reports and guidelines for the provision of healthcare for resettled refugees, using the Google search engine, which generated 16 results. Five reports from the World Health Organisation (WHO) were included in this literature review, one Resolution from the United Nations General Assembly and one global compact from the United Nations High Commissioner for Refugees (UNHCR). In addition, 'The UCL-Lancet Commission on Migration and Health: The health of a world on the move' (Abubakar et al 2018) was incorporated. Hence, eight policy documents were utilised.

Using 85 research articles and eight policy documents, the cumulative total of records included in this review was 93. The full literature search process is outlined in appendix 1.

Of interest, the incorporated literature was considered and critically appraised prior to inclusion in the review, particularly when articles presented empirical research. Critical Appraisal Skills Programme (CASP) criteria were used as a guiding framework for reviewing research papers identified in the search strategy and this influenced inclusion in the literature review (Long et al 2020). The evidence was critically reviewed through judgements based on the reliability, validity, trustworthiness and relevance of identified sources.

Figure 1: Adapted PRISMA flow diagram (Moher et al 2009)



Having described the practicalities of my extensive search of the literature, the following sections present various aspects of the research surrounding refugee health and care provided for refugees, starting with discussion of health issues facing refugees during the resettlement period.

2.4 Impact of the refugee experience on health and well-being

This section brings to life the multifaceted health problems facing resettled refugee groups, due to the complexities of forced migration and resettlement in a new country. This lays the basis for discussion around the need for specialised healthcare for refugees on resettlement, which follows later in this thesis.

Refugees may live through several years of deficient healthcare in their countries of origin and during displacement, which can lead to complex or poorly managed health problems on resettlement (Marshall et al 2016). They can face specific determinants of health in their country of origin or during transit, such as gender based or sexual violence and exploitation, torture, trauma and experiences of war (Abubakar et al 2018).

Interestingly, Marshall et al (2016) report that many refugees arrive in the host country feeling healthy but develop physical or mental health problems during the early period of resettlement, in the first year or shortly after. In consensus, a study by Teodorescu et al (2012) showed that refugees in Norway often arrived in the host country with minimal signs or symptoms of health issues, but that these often materialised during the early resettlement period. In the first year of resettlement, the body and mind may have a chance to process the physical and mental hardships of forced migration, and health issues often come to the surface (Marshall et al 2016).

In terms of mental health, problems may be experienced by refugees during all phases of the migratory process and particularly, on settling in the host country (Woodgate et al 2017). Refugees may have witnessed tragic deaths or experienced torture, with potential exposure to stressful or threatening circumstances (Im and Swan 2020). Consequently, post-traumatic stress disorder (PTSD), mood disorders and depression are frequently reported conditions among resettled refugees (Beiser and Hou 2006; Ahmed et al 2008). Research with Syrian refugees in Sweden estimated a

prevalence rate of 83% with regards to PTSD (Acarturk et al 2017) and co-morbidity is common, with one study linking PTSD in resettled refugee groups to clinical depression (Fazel et al 2005).

According to findings from a study exploring refugee health needs after the first year of resettlement in Scotland, '*experiences of trauma, prolonged periods of stress and anxiety, and complex grief following the death of close relatives and friends, were continuing to affect people's lives*' (Marsden and Harris 2015 p64). In likeness, Frasure and Lesperance (2005) suggest that on refugee resettlement in the host country, pre-migration trauma often leads to prolonged stress and major depressive disorder. Interestingly, findings from Wagner et al (2013) report that resettled refugees in the USA often have ongoing symptoms like tinnitus, headache and dizziness, resulting from prolonged anxiety and panic.

Building upon this notion, extended length of time within the asylum application process has been linked to the development of depression and other mental disorders on resettlement, and mental health conditions are particularly sensitive to any uncertainty over the outcome of asylum claims, housing, work permits and the broader social perspectives in the host country (Wagner et al 2015). In addition, poor socioeconomic conditions on resettlement, such as unemployment or social isolation, are associated with increased rates of depression among refugees and there may be an additional psychological burden through concerns about family who were left behind in the home country (Teodorescu et al 2012; Wagner et al 2015). Findings from Lamkaddem et al (2015) report that loneliness and lack of purpose in daily activities negatively influences mental health on resettlement, which has neuroendocrine effects and is a predictor of morbidity and mortality in refugee groups.

Importantly, at all stages of the migration process, individuals and groups could be affected by the toxic consequences of social exclusion and discrimination on the grounds of ethnicity, race, gender inequalities, and nationality or refugee status. The process of seeking asylum and incidents of racism or prejudice on resettlement can exacerbate existing health problems or create new ones (Abubakar et al 2018). Interestingly, a study by Beiser and Hou (2006) investigated the mental health of refugees resettling in Canada, reporting that refugees regularly experienced racism

and discrimination on arrival in the host country, creating psychological challenges and leading to feelings of anxiety and depression.

With regards to the impact of mental health issues on physical well-being, sleep deficiency is common among resettled refugees (Redditt et al 2015); with poor sleep elevating coronary artery disease through multiple bio-behavioural mechanisms and metabolic imbalances (Buxton and Marcelli 2010). Traumatized individuals may experience sleep disturbance, for example, among resettled Cambodian refugees, common clinical complaints in the study by Hinton et al (2005) include sleep paralysis, dreams of the dead and nightmares.

As well as mental health issues on resettlement, the refugee experience can mean that refugees are susceptible to infectious diseases, often due to lack of healthcare or interrupted care in the country of origin, exposure to infections during transit, and poor living conditions in transit or at the destination country, creating risks for acquiring infections and communicable diseases (Eiset and Wejse 2017). Indeed, refugees are vulnerable to the acquisition of vaccine-preventable diseases and antimicrobial resistance, as breakdown in health systems in the country of origin can lead to lack of immunisation (Pavli and Maltezou 2017).

Refugees may face perilous journeys, pathogenic or environmental exposures, including malaria, tuberculosis (TB), violence, heat exhaustion and dehydration, all of which influence health and well-being (Lamkaddem et al 2015; Chiarenza et al 2019). For example, a study showed that among eight host countries with an implemented screening programme, TB was commonly found, followed by human immunodeficiency virus (HIV) infections, and other sexually transmitted infections (Napoli et al 2015). Of interest, a study in Germany noted the utility of screening for active TB but also that routine screening for other disorders was often of low yield and costly (Bozorgmehr et al 2017). This highlights the point that sometimes, disease and ill-health are missed on initial screening in high-income host countries.

Depending on conditions in the country of origin or during migration, living with poor sanitation and contaminated water can increase the risk for a variety of infections during the early resettlement period, including bacterial, viral and parasitic, which are reported in the study by Semenza et al (2016), who investigated infectious disease development among resettled refugees in Europe. Upper respiratory tract infections,

as well as skin and eye infections, such as scabies and conjunctivitis, are commonly identified in refugees on arrival in the host country, and immediate health concerns reported among resettled refugees also include infectious gastrointestinal and respiratory conditions (Eiset and Wejse 2017).

On another note, the experience of displacement, migration and resettlement in a new country can increase vulnerabilities to the development of chronic disease, or indeed, exacerbate existing conditions, through interruptions in management or loss of medication during travel, and restriction in accessing and utilising necessary care (Gammouh et al 2015). Additionally, as Amara and Aljunid (2014) consider, people are living longer, and more elderly people are seeking refuge from conflict affected areas. Ageing of refugees during humanitarian crises creates an epidemiological shift from infectious to the development of chronic diseases on resettlement, a point which is made by Wagner et al (2015).

As touched upon, Hollander et al (2012) put forward that of particular concern is that refugees who arrive in good physical health often develop chronic conditions that have become common in Western countries during the first year of resettlement. On arrival at a destination, assimilation and acculturation could alter their risk profile to mirror patterns of the host population (Tulloch et al 2016). Significantly, it is suggested that risks for the development of chronic disease can increase among refugees with duration of stay in the host country, with changes in lifestyle and adoption of unhealthy behaviours contributing factors (Norredam et al 2014; Chiarenza et al 2019). The development of obesity in refugees is linked to acculturation during the resettlement period with regards to changes in dietary behaviours, physical activity, social and psychological factors after migration and lack of access to information about health services (Morris et al 2009).

Of interest, according to Hollander et al (2012) and Wagner et al (2015), a high burden of chronic disease exists within refugee resettlement areas, with high rates of new diagnoses of hypertension, diabetes, chronic respiratory disease and cardiovascular disease commonly reported within the first year, often attributed to the stress of seeking asylum and acculturation (Marshall et al 2016). This is supported by Gammouh et al (2015), highlighting that malnutrition and starvation, common occurrences in refugees during transition from country of origin to country of resettlement, are linked to increased risk of subsequent cardiovascular disease during the first year of resettlement. Likewise, exposure to stressful or traumatic life events is

associated with the development of diabetes mellitus and cardiovascular disease further down the track (Joshi et al 2013), as well as newly diagnosed chronic pain and musculoskeletal disease in resettled refugee populations (Wagner et al 2013; Amara and Aljunid 2014).

To expand upon this point, research undertaken by Sohail et al (2015) found that refugee groups originating from South Asia and the Middle East often develop ischaemic heart disease, hypertension and suffer from stroke on resettlement in Western Europe. Fedeli et al (2018) report new diagnoses of cerebrovascular disease, hypertension and heart failure in African refugees during the early resettlement period in Italy, which is interesting, considering the predominant Mediterranean diet. In keeping with this evidence, a study conducted in the Netherlands brings to the fore that many refugees from South Asian Surinamese and African Surinamese backgrounds are diagnosed with cardiovascular diseases during the first few months of resettlement (Perini et al 2018). Moreover, in a study by Yun et al (2012), half of refugee participants who had recently been resettled in the USA, were diagnosed or treated for at least one chronic disease during their first eight months of resettlement, with stress noted as a contributing factor. Reviewing the literature leads to the perception that actively monitoring and supporting the health of refugees during the first year of resettlement would be beneficial, as research demonstrates many new diagnoses of mental and physical health problems during this timeframe.

Linking mental health issues on resettlement to consequent physical problems, Wagner et al (2015) highlight that depression is a risk factor for the development of chronic conditions in resettled refugees, such as coronary artery disease and diabetes mellitus, and rates of major depressive disorder and elevated depressive symptoms are reported as high among refugees on resettlement (Fazel et al 2005). For clarity, psychological arousal may lead to impairment in neuro-chemical signalling in the central and peripheral nervous systems, causing subsequent manifestations that are related to cardiovascular functioning and metabolism. On resettlement, the stress of trauma has the potential to exert powerful effects on diabetes mellitus risk, and PTSD has been linked to type two diabetes and cardiovascular disease in resettled refugee populations (Marshall et al 2016), with more traumatic events increasing likelihood of new diagnosis (Lamkaddem et al 2015). Choukem et al (2014) suggest that refugees are prone to diabetes due to genetic background, lack of preventive measures and socioeconomic factors. Some host countries have also recorded more chronic

complications of diabetes among refugee groups, specifically noting that complications such as nephropathy, diabetic retinopathy and peripheral neuropathy are more prominent in the refugee population (Stirbu et al 2006).

With regards to respiratory conditions, Wagner et al (2015) recognise that refugees' pre-migration experiences, as well as events experienced while leaving their country of origin and seeking refuge, may increase the likelihood of chronic respiratory disease on resettling in the host country. To illustrate this point, the study by Habib et al (2006) highlighted that overcrowding and poor housing conditions pre-migration, characterised by the presence of humidity, mould, indoor pollutants, infestation and the absence of heating, often led to chronic respiratory disease among refugees in the host country. A mixed methods systematic review by Ziersch and Due (2018) investigated the correlation between housing and the health of refugees, reporting that poor housing conditions in the country of origin or refugee camps led to negative consequences on the respiratory health of refugees on resettlement.

In terms of the association between the refugee experience and risk of cancer, similarities in cancer mortality have been observed between refugees and the host population in Denmark (Norredam et al 2014). However, refugees are more likely to be diagnosed with cancers linked to infectious diseases, for example cervical cancer, hepatic cancer, Kaposi sarcoma, nasopharyngeal cancer, stomach cancer and some lymphomas (Arnold et al 2010). The most significant finding regarding cancer among resettled refugees is that it is more likely to be diagnosed at an advanced stage, which can lead to significantly worse health outcomes, compared with host populations (Latif et al 2015).

On arrival in the host country, there are often pregnant refugee women requiring complex antenatal care, as outlined in the Scottish study by Weir et al (2017). In terms of reproductive and sexual health issues, for female refugees, there is a marked trend for worse pregnancy-related indicators on resettlement (Riggs et al 2012). Refugee women are at risk of adverse obstetric and perinatal health outcomes through personal factors such as socioeconomic and educational status, as well as environmental factors experienced through displacement and migration (Riggs et al 2012). An umbrella review (including 19 systematic reviews) of perinatal outcomes among asylum seeker and refugee women compared with the host population generally found worse outcomes among refugees for maternal mortality, maternal mental health,

preterm birth, and congenital anomalies (Heslehurst et al 2018). The reasons for adverse birth outcomes in refugee populations may include underlying conditions in the mother that could be exacerbated by migration, such as heart disease or HIV, poor access to and interaction with the health service, communication problems, socioeconomic deprivation and the stress of forced migration and resettlement (Abubakar et al 2018).

Significantly, migration and resettlement are commonly associated with stressors that can have substantial effects on maternal mental health and post-partum depression. In a meta-analysis of perinatal mental disorders among refugee women from low-income countries living in high-income countries, 31% had symptoms of depressive disorder (Fellmeth et al 2017). Estimates suggest that within the first year after childbirth, the risk of post-partum depression is twice as high in refugee women compared with the host population (Falah-Hassani et al 2015), and risk factors in this study included stress associated with resettlement, lower amounts of social support, difficulties adjusting to the new country and perceived insufficient household income.

As well as problems with maternal health, sexual violence or coercion can occur for refugees in countries of origin, transit settings and in countries of destination, creating increased vulnerability to sexually transmitted infection (Abubakar et al 2018). A systematic review of women and girls in conflict-affected settings indicated their extraordinary vulnerability to various forms of human trafficking and sexual exploitation, frequently occurring as underage or forced marriage, female genital mutilation and forced combatant sexual exploitation (McAlpine et al 2016). These experiences often bear influence on the health and well-being of refugees when they arrive in the host country, and some refugees require specialist care in dealing with traumatic sexual ordeals (WHO 2018). According to the Lancet Commission on Migration and Health (Abubakar et al 2018 p2612), *'among more marginalised groups such as undocumented migrants, refugees, asylum seekers, or displaced populations in humanitarian crisis situations... in whom sexual assault is common, there is an even greater need for readily accessible sexual and reproductive health care.'*

In short, this part of the literature review has demonstrated that the refugee experience can be associated with the development or exacerbation of various mental and physical health issues. Hence, on resettlement in the host country, refugees

require comprehensive and holistic care, particularly as health problems are more likely to manifest during the first year of living in the host country (Marshall et al 2016; WHO 2018). Having offered an overview of the influence of the refugee experience on health and well-being, it is important to consider how healthcare is currently offered for newly arrived refugees in high-income host countries.

2.5 Evaluation of current healthcare provision for refugees on resettlement

As suggested, this section offers discussion of the literature in relation to current practice in delivering community healthcare for resettled refugees within host countries in developed parts of the world. The Alma-Ata Declaration considered primary healthcare as the core element to attainment of the goal of achieving health for all (Declaration of Alma-Ata 1978), and it is important to recognise the health needs of refugees and the role that primary healthcare plays in promoting their health and well-being (WHO 2018). Indeed, community health teams are on the frontline of care provision for refugees that arrive in high-income countries and may include a variety of professional backgrounds, including a core of general practitioners (GPs) and community-based nurses (Williams and Thompson 2011). For clarity, the community healthcare setting can also be described as primary care or general practice.

It is noteworthy to mention that in high-income countries, healthcare is predominantly provided for refugees through mainstream community health services (Weir et al 2017; Hahn et al 2019). This means that GPs or general nurses often undertake an initial health assessment when refugees arrive in the host country, and thereafter, refugees can access healthcare in the same way as the host population. This part of the review considers the literature evaluating care for refugees by means of mainstream community health services, and the effectiveness of this approach.

2.5.1 Mainstream community health services

The provision of healthcare for resettled refugees through general practice in high-income host countries is often reported as insufficient and suboptimal in meeting refugee needs (Omeri et al 2006; Abubakar et al 2018; Richard et al 2019). Of key significance, research shows that mainstream community health services are under-

utilised by refugee groups (Au et al 2019). Refugees are generally offered an initial health assessment on arrival in the host country and are then left to their own devices in terms of making subsequent health appointments or seeking further help (Richard et al 2019).

Somewhat controversially, although dated, according to a study by Beiser and Hou (2006 p137), *'resettlement countries tend to worry most about finding the 'right' people to admit, and far less on what happens afterwards.'* This speaks to the point that governments may be amenable to accept refugees into the country but there is often little planning to support their health needs. Interestingly, Abubakar et al (2018) suggest that those in positions of political and economic power within high-income host countries may restrict subsets of refugee migration to protect their own interests, often not prioritising resources to optimise the health and well-being of resettled refugees who are most in need.

With regards to resettled refugees in England, Fang et al (2015 p9) propose that *'there is the problematic assumption that health issues are individually located and experienced. Such an approach operates within the premise that the asylum seeker or refugee carries with them the problem and the responsibility to solve that problem.'* This viewpoint holds an individualised construction of health, seeking to locate the solution by placing responsibility on the individual refugee. *'Often, these are persons in extremely vulnerable positions who are denied the means to take control of the health and their life circumstances...'* (Fang et al 2015 p9) and therefore, during the initial resettlement period, mainstream community health services *'are neither pragmatically possible nor culturally appropriate'* (Fang et al 2015 p9). Here, the undercurrent relates to the concept that newly arrived refugees may not actively seek health support, due to various vulnerabilities or barriers, and there is therefore a need for healthcare providers to reach out to refugee populations, offering culturally responsive and proactive care. Fang et al (2015) report that health professionals in England display a lack of understanding of global conflicts and associated refugee health issues, and that short appointment times are insufficient for culturally specific communication, leading to inadequate treatment and care.

Hahn et al (2019) performed a systematic review of the literature relating to the quality of care offered for resettled refugees, based on the experiences of community

healthcare staff, concluding that the needs of refugees are too convoluted for mainstream primary care. In consensus, Joshi et al (2013 p11) considered the capacity of mainstream community health professionals to care for refugees, reporting that resettlement *'is influenced by factors including lack of knowledge about available services and how they work, language barriers and lack of appropriate services.'*

In evaluating the provision of healthcare for refugees through mainstream community health services, it is proposed that healthcare providers face significant challenges when caring for refugees on resettlement (McKeary and Newbold 2010; Hahn et al 2019). To take this point further, various studies posit that health professionals encounter specific challenges in dealing with complex physical, psychological and social problems of refugees and do not always feel prepared to meet their needs (Robertshaw et al 2017; Weir et al 2017; Hahn et al 2019).

Suphanchaimat et al (2015) report that challenges include lack of knowledge and skills in dealing with refugee health issues and a lack of resources, including short appointment times and difficulty accessing interpretation services. Health professionals must address the multifarious health and social care needs of refugees, often in cross-cultural interactions and operating within health systems that may not be structurally or politically configured towards this group (Hahn et al 2019). These challenges impact on the ability of community health professionals to provide quality care for resettled refugees (Farley et al 2014). Thus, there have been calls for improvement in the way that care is delivered for refugees in high-income host countries during the early resettlement period (WHO 2018).

As well as challenges facing mainstream healthcare providers, refugees can also struggle to access mainstream health services. A systematic literature review of refugee health service utilisation in Europe showed underutilisation of screening services by refugees and inconsistent patterns for primary healthcare provision (Graetz et al 2017). Indeed, research shows that despite recognition of barriers, refugees continue to face difficulty in accessing mainstream community healthcare in high-income host countries (Shannon et al 2015; Au et al 2019). Woodgate et al (2017) note that refugees in Canada struggle with barriers that impact access to quality community healthcare, with regards to language and cultural differences, as well as challenges related to transportation and trust of healthcare providers, which is in line

with findings from Kumar (2020), who recounts similar barriers facing Burmese refugees in the USA.

In line with these findings, a study by Weir et al (2017) evaluated the care of resettled Syrian refugees in Scotland, highlighting challenges in providing adequate primary care to meet refugee needs. This study demonstrates that although Syrian families were impressed with the free healthcare available, sticking points were found in accessing primary care, lack of interpretation services and lack of understanding of referral pathways. Weir et al (2017 p456) report that in Scotland, a refugee health assessment is undertaken by the GP on arrival, and '*GPs were reported as having been thorough in asking about the patient's situation and attempting to explore all their needs.*' However, this study concludes that refugees find it challenging to communicate with mainstream health services after the initial refugee health assessment. Subsequently, Weir et al (2017) indicate the need for ongoing assessment and targeted care for refugees in Scotland, as oftentimes, health issues are not evident on initial assessment and refugees found difficulty in accessing health support during the early resettlement phase.

Some studies highlight negative health experiences for resettled refugees. For example, Wangdahl et al (2015) investigated resettled refugees' experiences of undergoing a refugee health assessment on arrival in Sweden, undertaken by mainstream community healthcare professionals. Findings from this study elucidate poor quality of communication, reporting that refugees did not receive help with their health problems. A high proportion of participants did not obtain information about where to go if they felt mentally unwell, and many refugees reported not knowing how health care systems in Sweden function, limiting their subsequent use of healthcare (Wangdahl et al 2015). This corresponds to findings from Omeri et al (2006), who reported that general community nurses in Australia were ill-prepared to undertake refugee health assessments for newly arrived Afghan refugees.

A study by Chiarenza et al (2019 p11) examined community healthcare provision for refugees in Europe and found that '*healthcare organisations and systems are still lacking responsive services and processes.*' Corroborating an earlier point, Chiarenza et al (2019) claim that lack of knowledge of refugee health problems, lack of coordination between services and lack of intercultural mediation and interpretation

may lead to poor health outcomes for refugees during the resettlement period. One study evaluating care for refugees in the community reports that greater attention to trust-building is needed for refugees, with healthcare professionals struggling to build trusting relationships with refugees during the resettlement period (Farley et al 2014).

Similarly, a study by Richard et al (2019) examined care provided for refugees through mainstream general practice in New Zealand. This study reported that health professionals encounter challenges with respect to time-limited consultations, variable use of interpreter services, fragmented care and lack of appropriate health infrastructure to ensure continuity of care and access. Community health professionals recognise the importance of building meaningful relational connections with refugees, by acknowledging refugees' journeys and getting to know them as people. However, in the mainstream primary care context, this is often not possible *'leading to providers feeling overwhelmed and uncertain about their ability to provide appropriate care to refugees'* (Richard et al 2019 p15).

Continuing this discussion, a study by Kang et al (2019) considered access to primary healthcare for resettled refugees in the UK, highlighting the inadequacy of community health provision for this population and barriers to care. On the back of this study, Kang et al (2019 p543) advocate wider adoption of specialist refugee clinics in the UK resettlement context, recommending that *'providing accessible patient-centred care for marginalised populations benefits both patients and the care system long-term, including through the reduction of unscheduled care.'* By the same token, Woodgate et al (2017 p10) undertook a qualitative study investigating refugee families' experiences of accessing mainstream community healthcare services in Canada, reporting that mainstream health practitioners are not prepared to meet refugee health needs and that specific refugee programmes are needed in the community health landscape, *'increasing the number of culturally competent healthcare providers.'* Consequently, Woodgate et al (2017) advocate that a point of contact in healthcare, with specific knowledge of refugee health concerns and ability to use translation systems, would be useful for refugees during the resettlement period, encouraging continuity of care and promoting trusting relationships with healthcare providers.

Due to suboptimal care for refugees through mainstream health services, recommendations have been made for targeted refugee healthcare in the community

context. In a scoping review of intersectoral and integrated approaches to community refugee health on resettlement, Ho et al (2019 p12) conclude that high-income host countries should be providing '*culturally sensitive programmes,*' and that '*there is also a need to strengthen the capacities of frontline providers, to improve their knowledge of available services as well as their ability to provide care to specialised vulnerable groups such as refugees.*' To corroborate this notion, Woodland et al (2010 p560) looked at health service delivery for newly arrived refugees in Australia, referring to specialised refugee health services as '*a framework for good practice.*' Woodland et al (2010 p564) report that the provision of care through mainstream community services '*presents a significant burden of coordination to primary care providers,*' and that refugee-specific family clinics may more readily provide culturally competent care and a coordinated approach to referral pathways.

It is noteworthy to take a step back and consider; that with numerous studies highlighting the need for improvement in healthcare models for newly arrived refugees in high-income host countries spanning the last 15 years, most countries are no further forward in implementing positive change for this population.

To summarise this section, healthcare is predominantly provided for resettled refugees through mainstream primary care services. Nevertheless, the literature shines light on the concept that mainstream community health professionals may not have the knowledge, skills or resources to provide adequate support for this group. In addition, resettled refugees continue to face barriers in accessing primary healthcare and therefore, there is scope for improvement in practice.

In response, two suggestions are put forward in the literature to enhance primary healthcare delivery for resettled refugees. These are 1) '*refugee sensitive,*' and 2) '*refugee specific*' approaches (Razum and Spallek 2014). As a '*refugee specific*' approach, refugee health nursing has not been widely or consistently implemented in high-income host countries, despite recommendations from global action plans (UNHCR 2018; WHO 2016; 2018).

2.5.2 'Refugee sensitive' versus 'refugee specific' care

Razum and Spallek (2014) considered health related interventions for refugees in high-income host countries, looking at two approaches to improve current practice, involving 'refugee sensitive' and 'refugee specific' models of care. In likeness, a review by Diaz et al (2017) deliberated upon ways to enhance the provision of community healthcare for resettled refugee populations in high-income host countries, concluding that these two strategies could be employed.

The first approach is to enhance mainstream community health service provision by developing the cultural competence of GPs and general nurses, proposing that, *'health interventions for the majority population could be designed to be sensitive to diversity, so that they can be equally effective for all citizens regardless of their cultural, religious or other background'* (Diaz et al 2017 p436). This 'refugee sensitive' approach involves building the capacity of mainstream community health professionals to better understand the complexities of refugee health and developing cultural competence within mainstream health services. However, refugees have diverse and additional healthcare needs to host populations (Kang et al 2019) and the second approach therefore involves introducing specific culturally adapted services, by way of dedicated health support offered by practitioners specifically trained in managing refugee health issues. This is referred to as 'refugee specific' care, and the two approaches are now considered, in relation to other literature.

With regards to developing the knowledge and skills of mainstream community healthcare providers to offer 'refugee sensitive' care, a study by Lionis et al (2018) reports on methods used for enhancing community healthcare for refugees, through rapid capacity-building actions in the context of a structured European project under the auspices of the European Commission. Methods include assessment of the health needs of refugees arriving in Europe and the identification, development, and implementation of educational tools for community health professionals, to enhance ongoing primary care. This modular refugee health education course has been employed in seven European countries (Austria, Greece, Croatia, Hungary, Italy, Slovenia and the Netherlands) and is described as easy to adapt to local resettlement contexts. The course uses evidence-based approaches to enable community health

professionals involved in refugee care to better understand the refugee experience and associated health needs on resettlement.

Similarly, Haley et al (2014) developed a primary prevention initiative to promote health and well-being of recently arrived refugees in Massachusetts, USA, helping refugees to retain some of their own healthy cultural habits and reducing the tendency to adopt detrimental ones. A health promotion tool was introduced in a mainstream community health setting, prompting health-related topics for discussion and identifying content of interest to refugees. According to Haley et al (2014), using the health promotion tool helped mainstream healthcare practitioners to reach out to refugee populations and to gain insight into the challenges faced by refugees in adapting to life in the USA, enabling a deeper understanding of different health beliefs.

Indeed, some existing literature on primary healthcare for refugees supports an integrated approach, whereby refugees receive care through mainstream community health services, to encourage assimilation into the host country environment from the beginning of resettlement (Feldman et al 2006; Sypek et al 2008; Robertshaw et al 2017). Cheng et al (2015) evaluated mainstream community healthcare for refugees, advocating for this approach to encourage assimilation with the host population, with strategies in place to improve access for refugees and to build upon the provision of culturally competent care. However, through a review of community-based healthcare practices for refugees, Riza et al (2020) highlight that current practice in high-income host countries often involves short appointment times, which are inadequate, with limited capacity for staff to address complex refugee issues. Thus, structural and organisational change would need to take place, for 'refugee sensitive' care to be effectively delivered.

Supporting 'refugee sensitive' care in the community, some host countries incorporate intercultural mediators to act as a bridge between refugee patients and health professionals. In Malmö, Sweden, and Rome, Italy, for example, health advisors with a refugee background perform a similar role to intercultural mediators (WHO 2018). They are refugees who had a medical background prior to their arrival in the host country and are therefore well situated to engage refugees in discussions about nutrition and exercise choices, and to support them in navigating the provisions

available concerning health and well-being (WHO 2018). Indeed, some high-income host countries are taking steps towards a more 'refugee sensitive' model of care.

Nevertheless, in terms of the second approach brought to the fore by Razum and Spallek (2014) and Diaz et al (2017) in improving care for refugees, recommendations are put forward for the incorporation of targeted, or 'refugee specific' care.

This approach is reported to tackle health inequalities in the resettlement context, offering refugees the best opportunity to thrive with their health and well-being in their new host environment (McBride et al 2016; Ogunsiyi et al 2018). 'Refugee specific' care means that there is a specific refugee health programme for resettled refugees in the host country. Joshi et al (2013) posit that during the resettlement period, there is a requirement for specialist refugee health knowledge and cultural competence, along with resources which allow for longer appointment times, continuity of care and targeted health promotion and disease prevention measures. Particularly in areas with high volumes of refugee resettlement, *'some services should develop models of care specifically addressing the needs of refugees because of the demographics of their local communities'* (Joshi et al 2013 p11).

Interestingly, however, it is projected that providing specialist care for refugees may segregate them from general practice on arrival in the host country (Cheng et al 2015; Robertshaw et al 2017), which threatens concepts of inclusion and acculturation (Gungor and Strohmeier 2020). Significantly, a report from the UCL-Lancet Commission on Migration and Health put forward that nationalist movements in high-income host countries *'assert a so-called cultural sovereignty by delineating an us versus them rhetoric, creating a moral emergency'* (Abubakar et al 2018 p2606). By caring for refugees through a specialised channel, there is concern about this model separating refugees from the host population, and thus, contributing to feelings of segregation in society.

Although it is acknowledged that refugee integration into society is important (Ager and Strang 2008; Farley et al 2014), the previous section highlighted that the mainstream community healthcare sector is often ill-equipped to identify and manage multifaceted refugee health issues. Thus, it is largely recommended that refugees should be cared for in a specialist manner, whether this 'segregates' them or not

(Johnson et al 2008; Hahn et al 2019; Richard et al 2019). Taking another stance while speaking to the point of integration, Joshi et al (2013 p2) note; '*optimal health and well-being provide a stronger basis for them to adapt and thrive in their new country.*' In this way, achieving optimal health and well-being through dedicated refugee health programmes at the beginning of resettlement, may aid the integration process in the long run.

In the systematic review by Robertshaw et al (2017), health professionals acknowledge the danger of isolating refugees from the community; but highlight the need for dedicated healthcare for newly arrived refugees, drawing attention to the importance of consistent use of interpreter services, as well as specialised knowledge and skills in refugee health. Essentially, it is proposed that reduction in health inequalities requires targeting specific healthcare resources towards this disadvantaged group for at least during the first year of resettlement (Brandenberger et al 2019). Correspondingly, Fang et al (2015 p9) stress the need for community level interventions in the form of specialised refugee health programmes, '*that are more culturally congruent with the communities' own health constructions.*' Fang et al (2015) recommend that a re-evaluation of community healthcare for refugees is required, accounting for their social disadvantage during the resettlement process and the health inequalities facing this group.

Although dated, Palinkas and Pickwell (1995 p1643) point to '*the need for specific forms of clinical interventions and community-based programs*' to promote wellness and prevent the occurrence of chronic disease in acculturating refugee populations. This is in line with an earlier study by Pickwell (1989), highlighting that a specialised family refugee health programme was effective in providing quality care for Southeast Asian refugees. Evidently, there have been calls for specialised refugee health programmes in the resettlement context for quite some time.

However, even though the literature brings to attention the need for innovation in improving refugee experiences of healthcare on resettlement (Joshi et al 2013; Farley et al 2014; Au et al 2019; Hahn et al 2019), specialised programmes have been inconsistently implemented and few studies have evaluated refugee specific models of care in the community setting.

In terms of finding middle ground, a model introduced in Australia established nurse-led 'beacon practices', which means that after being assessed by a Refugee Health Nurse (RHN) at the beacon practice, the newly arrived refugee is then linked

with a general practice for continuation of their healthcare within the local community (Kay et al 2010). If any health issues arise during the resettlement period that are related to the refugee experience, mainstream community health professionals can refer the refugee back to the beacon practice for targeted support.

With regards to evaluation of 'refugee specific' services, a study by Bernhardt et al (2019) reflected upon an initiative in Baltimore, USA, called the Refugee Health Partnership, which was developed by John Hopkins University School of Medicine students and colleagues at a local refugee resettlement agency. The programme assigns a physician to recently resettled refugees who have special healthcare needs, and after undergoing training in refugee health, monthly home visits are conducted and refugees are accompanied to appointments, assisting them with navigating the healthcare system over a one-year period. From a healthcare provider stance, this study reports improved understanding of refugee patient perspectives, comfort in communicating with refugee patients across cultures and language barriers, as well as improved confidence in identifying and managing refugee health problems (Bernhardt et al 2019).

Another study by Au et al (2019) investigated refugee experiences of the community healthcare system in Australia, and it was reported that specialist refugee health clinics operating in various parts of Australia provide a robust solution to overcome some of the barriers that refugees face, elucidating positive health experiences and outcomes, resulting from targeted refugee healthcare. Indeed, Diaz et al (2017) note that refugees' past experiences, culture, and health literacy levels means that there is an increased time requirement in caring for refugees, and a 'refugee specific' approach would allow early identification and prompt management of emerging health issues, as well as the opportunity for specialised healthcare professionals to build trusting relationships with refugees.

Of note, a scoping literature review conducted by Riza et al (2020) highlights that specialised community-based healthcare initiatives for refugees are best practice, but are often centred upon mental health, concluding that more focus should be placed on specialised refugee health programmes which offer targeted disease prevention and management.

2.5.3 Summary of refugee healthcare provision

To conclude, although refugees often have complex health needs on resettlement in the host country (Wagner et al 2015), it is proposed that current practice in dealing with refugee health issues in the community resettlement environment is below par (Farley et al 2014; Hahn et al 2019). Mainstream health services are often ill-equipped to deal with complex refugee health issues. Thus, in addressing the health needs of this group, two options are put forward; 'refugee sensitive' and 'refugee specific' care (Razum and Spallek 2014; Diaz et al 2017).

The first option involves driving forward improvements in the delivery of care for refugees through mainstream community health services, by enhancing capacity; developing the knowledge, skills and cultural competence of general healthcare staff to better understand the needs of refugees; implementing structural and organisational change to allow for longer appointment times. However, the literature '*raises questions about the 'fit' of mainstream general practice to address the complex healthcare needs of refugees*' (Richard et al 2019 p15), with Johnson et al (2008) explicitly arguing that mainstream community health practitioners should not be on the 'frontline' for refugee care. Brandenberger et al (2019 p11) mention that refugees often lack culturally responsive healthcare and a contributing factor is the '*lack of targeted health policies focusing on the most vulnerable.*'

Therefore, the second option implicates specialised refugee healthcare during the resettlement period, offering dedicated, comprehensive health support that is tailored to the needs of this population, provided by healthcare staff specifically trained in the field of refugee health (Joshi et al 2013; McBride et al 2016).

2.6 Refugee health nursing and cultural competence

Various studies call for dedicated refugee health programmes, where care is culturally relevant and refugees are encouraged to feel welcomed and supported in their new community environment (Woodgate et al 2017; Ogunsiyi et al 2018). Indeed, Mutitu et al (2019) acknowledge the importance of specialist nurse-led clinics in providing patient-centred, cost-effective and culturally competent care for refugees in the community setting. Hence, this section outlines how the field of refugee health

nursing can be viewed as a viable 'refugee specific' approach in providing dedicated healthcare for refugees on resettlement (Razum and Spallek 2014), although in current practice, this model is rarely implemented in high-income host countries.

The WHO (2018) puts forward that tailored healthcare for refugees can only be provided if the needs of this population are understood, proposing that specialist healthcare professionals require enhanced training to gain insight into refugee health needs. Indeed, the WHO Strategy and Action Plan for Refugee and Migrant Health (WHO 2016 p17) outlined that in implementing a targeted approach to refugee healthcare, '*training on health equity and human rights-based approaches is a key element for health professionals.*'

RHNs undergo training in the field of refugee health, with the option of undertaking postgraduate nursing courses to enhance their learning, often leading to certification. An example is provided by Im and Swan (2020), who discuss capacity building for refugee healthcare providers, highlighting an interactive training curriculum that is comprised of trauma-informed and culture-informed care. As RHNs require specialised education, workforce planning in this field is important (Ogunsiji et al 2018).

The literature highlights that a key element of refugee health nursing that distinguishes specialist care from general community nursing relates to the concept of cultural competence. In the healthcare setting, cultural competence is defined as an understanding of how social and cultural factors influence the health beliefs and behaviours of patients (Kaihlana et al 2019). RHNs undertake specialist training in cultural competence as part of the role, learning about global affairs and conflicts leading to forced migration, as well as common health issues in refugee groups and cross-cultural communication (Joshi et al 2013). Research shows that the development of intercultural skills may lead to improved health outcomes for refugees (Brandenberger et al 2019; Kaihlana et al 2019). Indeed, knowledge of global health trends, various cultural traditions and health beliefs and how these impact on understanding of health and decision-making around care planning, can allow the formation of trusting professional relationships between nurses and refugees.

RHNs learn how to use interpretation systems to allow efficient cross-cultural communication, and they build understanding of the health needs of people arriving from different countries. They hold knowledge of the appropriate clinical tests and

investigations required on resettlement and can navigate referral pathways, with understanding of refugee and asylum seeker eligibility for services.

RHNs liaise with community leaders, developing knowledge of diverse ethnic and cultural groups in the community, with the ability to link refugees with social connections. In a literature review of cultural competence in nursing, Shen (2015) concludes by highlighting the importance of health knowledge that is used in sensitive and creative ways to fit the needs of refugees for beneficial health and well-being or to face illness. Thus, the goal of culturally competent care is to consider and celebrate the thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group, working in partnership to facilitate safe and meaningful support for refugees (Shen 2015).

In a book about advancing transcultural knowledge in nursing, Giger (2013) proposes that the provision of culturally competent care is a significant aspect in addressing health disparities in the community. RHNs attempt to tackle health inequalities through the provision of holistic care that addresses the diverse health beliefs and customs of refugees, enabling cross-cultural communication through effective interpretation channels and striving for equal opportunities to thrive with health and well-being. Cultural competence frameworks include individual skills such as verbal and non-verbal communication, awareness of the practitioner's own heritage and biases, professional development standards, as well as organisational culture and policies which reflect openness and the promotion of working across cultures without discrimination or racism (Gopalkrishnan 2019).

It is argued that through cultural competence and continuity of care, this leads to the development of trust between refugees and nurses during the resettlement period, which is essential for people with traumatic experiences (Shannon et al 2015; Ogunsiiji et al 2018). Of note, refugees may be reticent in using health services because of fear, distrust, negative experiences and lack of confidence, as well as socio-cultural barriers (Muecke 1992). It is supposed that a trustful relationship based on cultural awareness and sensitivity is required before refugees disclose delicate health information during the resettlement period (Brandenberger et al 2019). In one study, a nurse reports that it took one year to develop a trusting relationship before the refugee patient disclosed domestic violence (Riggs et al 2012). Another study investigating the health needs of Syrian refugees arriving in Scotland highlighted that refugees did not report mental health concerns in the immediate resettlement period (Weir et al 2017). Mental health

carries considerable stigma in many countries that refugees flee from, and *'discussion about such issues is only likely to occur after trust has been established- inevitably, this takes some time. In turn, general practice staff, while alert to the possibility of mental health illness, would be handicapped in its detection... by not having any knowledge of the families'* (Weir et al 2017 p458). Through the development of meaningful connections with refugees, a specialised approach to caring for this group can help with efficient diagnoses of mental health problems during the resettlement period (Joshi et al 2013; Shannon et al 2015).

The literature draws attention to the notion of RHNs as coordinators of refugee health in the community setting, to improve access and facilitate referrals (Joshi et al 2013; McBride et al 2017). For refugees, a key point of contact in community healthcare can ensure regular attendance of follow-up appointments requiring holistic strategies, including home visits, arranging transportation, using reminder phone calls and allowing flexibility in the length of appointment times (Brandenberger et al 2019). In parallel with this idea, Joshi et al (2013) carried out a review considering community healthcare delivery models for resettled refugees, proposing that *'specific strategies are required to provide accessible and well-coordinated care for refugees, such as case management and use of specialised staff'* (Joshi et al 2013 p12).

By incorporating refugee health nursing into the community health landscape, emerging refugee health issues are more likely to be identified, with the possibility of early intervention. It is suggested that refugee health issues predominantly develop during the first year of resettlement (Marshall et al 2016) and therefore, monitoring the health of refugees and providing ongoing health assessment and support during the first year in the host country is recommended (Wagner et al 2015). One of the key aspects of the RHN role is in health promotion and education, and RHNs offer a proactive approach to supporting refugees in adopting a healthy lifestyle on resettlement (McBride et al 2016; Ogunsiyi et al 2018). Although dated, the need for a proactive, not a reactive approach with refugees is highlighted by Palinkas and Pickwell (1995) and a key aspect to promoting the health of refugees on resettlement involves understanding the burden of disease and health risks faced by this group.

However, while the contribution of specialised refugee health nursing is recognised, it is acknowledged that *'clients of refugee-specific services need to be able to transition into ongoing mainstream primary healthcare'* (Joshi et al 2013 p11).

This is in line with earlier recommendations by Le Feuvre (2001 p131), who outlines that *'any specialist service should have the goal of full integration of the refugee into normal general practice.'* Although RHNs offer targeted refugee healthcare on resettlement, this should *'focus on coordination between services and integration of the refugee into long-term care'* (Joshi et al 2013 p12). It is put forward by global refugee health strategies that there should be a seamless transition from specialised care to mainstream community health services after the initial resettlement period, to encourage refugee assimilation into the host country environment (WHO 2018; 2019). As Woodland et al (2010 p564) point out, *'one of the goals of specialised services is to integrate refugees into mainstream health services for ongoing care.'*

Interestingly, there has been debate about the need for refugee specific health services in host countries (Feldman 2006; Riza et al 2020). Refugee health nursing has not been widely adopted in high-income host countries as a model of delivering healthcare for refugees. Although introduced in the UK in 2000 and in Australia in 2005, for example, this specialism has been inconsistently implemented and underutilised in responding to the needs of resettled refugees in the developed world.

Nevertheless, this literature review underscores that specialised nursing care in dealing with refugee health issues during the early resettlement period can be associated with improved communication and coordination between service providers, offering a streamlined approach to care (Omeri et al 2006; Joshi et al 2013; Ogunsiji et al 2018; Richard et al 2019). This can lead to early detection of health problems through ongoing assessment and improved refugee experiences in terms of quality of communication, establishing trust and interpersonal care (Joshi et al 2013; McBride et al 2016). With increasing global migration and rising refugee resettlement in high-income host countries, there have been calls for action (UNHCR 2018; WHO 2018). Having offered an overview of the evidence on this topic, it is appropriate to situate this literature within the broader context of global public health and recommendations for practice.

2.7 Refugee healthcare: Global recommendations for policy and practice

In essence, the health assessment and care of newly arrived refugees represents a crucial challenge for host countries, given the increased rates of population movements to resettlement contexts and the consequent implications for health systems.

Responding to increasing global migration and associated public health issues, the UCL-Lancet Commission on Migration and Health was convened and stepped into the political debate about how to best manage refugee health during the resettlement period (Abubakar et al 2018). According to the UCL-Lancet Commission on Migration and Health (Abubakar et al 2018 p2627), *'health systems require people-centred frameworks that are sensitive to individual and population care needs rather than determined by jurisdiction.'* The Commission made recommendations for refugee healthcare on resettlement, in that *'healthcare provision should be culturally appropriate and sensitive to the individual's understanding of health... and the acceptability of health services for refugees depends on the ability and preparedness of health professionals to provide culturally informed care'* (Abubakar et al 2018 p2631). This report called for refugee healthcare that is centrally coordinated and culturally responsive to the unique and complex needs of newly arrived refugee populations on resettlement.

Due to ongoing debate about delivery of healthcare for refugees, the World Health Organisation (WHO) (WHO 2013; 2016; 2018; 2019) and UNHCR (2018) have produced policies and recommendations to steer practice. International agreements, such as the United Nations Global Compact on Refugees (UNHCR 2018), represent an opportunity to ensure that international solidarity, unity of intent and shared humanity triumphs over nationalist and exclusionary policies, leading to concrete actions to protect the health of resettled refugees (Abubakar et al 2018).

Promoting the health status of refugees has been prioritised by the WHO through the Strategy and Action Plan for Refugee and Migrant Health (WHO 2016). With regards to host countries, this Strategy and Action Plan acknowledges *'the need and opportunity to act now,'* (WHO 2016 p7) as on resettlement, *'refugees experience vulnerability to social adversity and ill-health'* (WHO 2016 p9). The WHO (2016) Strategy and Action Plan elucidates that health systems should offer culturally sensitive and targeted healthcare, supporting resettled refugees in navigating through

the system, overcoming barriers such as language, and responding to the needs of all persons, without discrimination, and with dignity and respect. The key objective outlined in this Strategy and Action Plan relates to core health systems '*responding to the immediate and longer-term health needs of refugees... with special attention to those in vulnerable situations*' (WHO 2016 p17). Significantly, it is proposed that refugees should be provided with dedicated health support at the initial stages in the resettlement process, in terms of '*assistance in overcoming the difficulties of arriving in a new environment and health service; and, subsequently, they should be offered all essential, necessary and appropriate health services, within the available resources*' (WHO 2016 p17).

Furthermore, on a global level, the WHO Executive Board in 2017 adopted the WHO Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants, to guide progress on the health aspects of population movement (WHO 2017). It is recommended that for refugees, healthcare delivery within host countries requires patient-centred, targeted and intercultural approaches, specifically responding to the health needs of this group (WHO 2017).

According to the WHO (2018) '*Report on the health of refugees and migrants in the WHO European region: No public health without refugee and migrant health,*' refugees are entitled to the same universal human rights and fundamental freedoms as all people, which must always be respected, protected and fulfilled. However, the WHO Report (2018) also recognises that refugees are distinct groups governed by separate legal frameworks and have specific health needs, often associated with the process of displacement, migration and resettlement. Of significance, this WHO (2018 p61) Report puts forward that preventive care for resettled refugees in high-income host countries is paramount, and should include '*health services that are used to prevent illness and other health problems or to detect them at an early stage so that treatment can be introduced when it works best.*' Typical examples of preventive care for resettled refugees outlined by the WHO (2018 p61) involve '*regular health checks, patient counselling and health education and promotion*' during the early resettlement period. By '*increasing active outreach for those communities*' and '*making systems more culturally sensitive,*' the WHO (2018 p62) recommends that a dedicated model of care would be a step forward in enhancing the health and well-being of refugees on resettlement. It was also highlighted by the WHO (2018) that continuity of care for

refugees is paramount during the resettlement period, through the creation of routine community health appointments.

Much of the literature focuses on describing barriers experienced by refugees in accessing health services on resettlement (McKeary and Newbold 2010; Hadgkiss and Renzaho 2014). In response, the WHO (2018) recommends that targeted programmes would allow refugees to be properly orientated to the health system in their new host country, with the use of interpreters and cultural mediators consistently employed, eliminating cultural and linguistic barriers impeding refugee access to community healthcare. This involves introducing health services that are refugee focused and '*refugee friendly*', offering a bespoke approach to preventive and curative healthcare for refugees within host countries, depending on the needs of the local refugee population (WHO 2018 p103). The WHO (2016; 2017; 2018; 2019) has specifically called for positive action in improving healthcare for resettled refugees. Nonetheless, calls to action and strategic frameworks have not been widely implemented and more work is urgently needed to ensure existing policies and guidelines around migration and health are fully realised.

Interestingly, health systems in high-income host countries mostly evolve reactively to refugee health needs or emergencies, rather than proactively (Joshi et al 2013; Woodgate et al 2017). Indeed, a more proactive approach, as in targeted prevention programmes, would be beneficial and contribute significantly to tackling health inequalities for vulnerable groups (Abubakar et al 2018; WHO 2018).

It is recommended that host countries offer universal financial coverage for refugee health expenditures wherever possible and cooperation and coordination between different stakeholders is fundamental to meeting refugee health needs on resettlement (Joshi et al 2013; Abubakar et al 2018). '*Ultimately, the cost of failing to be health-inclusive could be more expensive to national economies, health security, and global health than the modest investments required*' (Abubakar et al 2018 p2607). However, whilst this is a logical approach, given that most refugees settle in neighbouring countries, and these countries may be low-income or lower-middle income countries, this may not be realistic. Nevertheless, with regards to refugee resettlement in high-income countries, the United Nations 2030 Sustainable Development Goals advocate for guaranteed universal financial coverage for refugee health expenditure (Tulloch et al 2016).

The vision of the United Nations 2030 Sustainable Development Goals is to leave no one behind and to strive for peace and reduction of inequity (United Nations General Assembly Resolution 2015; Tulloch 2016). These goals have universal health coverage as a central element to tackle global health challenges, and therefore, access to universal healthcare for all migrants and refugees is advocated. With regards to refugees, they have diverse health needs and outcomes, depending on a plethora of individual and process-related factors, and improving health for all, as well as reducing health inequalities, are key parts of many global strategies, action plans and frameworks (UNHCR 2018; WHO 2018). In most high-income countries, although not all, refugees enjoy the same human right to health as everyone else, but as the WHO (2018) points out, the unique challenges faced by refugees must be acknowledged.

In response to growing refugee health challenges, members of the M8 Alliance launched an annual *Expert Meeting on Migrants' and Refugees' Health*, incorporating another global strategy to improve refugee health experiences and outcomes (Bembong et al 2019). Members of the M8 Alliance include Imperial College London, Geneva University Hospitals, Istanbul University, John Hopkins Bloomberg School of Public Health USA and a range of other academic and public health institutions globally, as outlined by the World Health Summit (2021). The *Expert Meeting on Migrants' and Refugees' Health* was shaped by discussions from the second M8 Alliance Expert Meeting in 2018 and offers a framework addressing ongoing critical reflections, challenges and solutions for refugee healthcare, including best practices for increasing access and improving health outcomes on resettlement (Bembong et al 2019). The report suggests that as a complex and cultural phenomenon, the process of refugee resettlement has become increasingly political, '*with adequate healthcare often low on the list of priorities*' (Bembong et al 2019 p1). For this reason, the M8 Alliance recommends that host countries adopt creative and innovative approaches to refugee healthcare through community initiatives, prioritising the health needs of this population.

Furthermore, at its Seventy-second World Health Assembly in May 2019, the Health Assembly discussed a report; '*Promoting the health of refugees and migrants, global action plan 2019-2023*' (WHO 2019). With the aim of harmonising refugee health policy globally, the WHO (2019) prepared this global strategy with regards to

the health of refugees, in line with the health dimensions of the Global Compact on Refugees (UNHCR 2018). The WHO global action plan suggests six action points regarding the health of refugees, covering advocacy and improvement of local healthcare (WHO 2019). This is helping host countries to have a common framework to promote refugee health using high-quality evidence and a collaborative approach to action. Progress has been achieved within some countries in making refugee health part of health policies, and the WHO (2019) has been instrumental in supporting countries to promote refugee health. The WHO calls upon host countries to promote the health of refugees through refugee-specific health policies and healthcare, evidence-informed practice and a tailored approach to meeting refugee health needs (WHO 2016; 2018; 2019), which is echoed by recommendations from the UNHCR (2018) and the UCL-Lancet Commission on Migration and Health (Abubakar et al 2018).

The undertaking is complex, yet the ground-breaking endeavours ongoing in some host countries, such as Australia and the USA, based on a collective awareness of these challenges; is contributing to adjusting global health strategies and visions to the reality of a world on the move (WHO 2019). The key recommendation for improving the health and well-being of refugees on resettlement is the incorporation of a targeted and coordinated approach to healthcare in the community setting (WHO 2018; 2019). Refugees have unique health needs (Halabi 2005), and these can be met by community healthcare providers with specific knowledge and experience of refugee health issues (Joshi et al 2013; McBride et al 2016; Ogunsiji et al 2018). Global refugee health strategies recommend that specialised refugee healthcare is beneficial in the early resettlement context (WHO 2018; 2019), and in line with this concept, it is posited that a coordinated approach to care, '*facilitated by Refugee Health Nurses,*' is the gold standard (Joshi et al 2013 p11).

On these lines, it is appropriate to explore this concept further, probing the idea of specialised healthcare for refugees during the resettlement period, through a model which incorporates refugee health nursing. With a changing landscape in climate and demographics, unpredictable global conflicts and political outcomes and the growing emergence of infectious disease outbreaks; refugee migration and resettlement will continue to occur. Therefore, advocating for improvements in refugee healthcare

delivery and issuing calls for action remain of up most importance (Bempong et al 2019).

By way of conclusion to this section, several global action plans and strategies have been set out in recent years, encouraging precedence to refugee health on the public health agenda within host countries and guiding policy and practice (Tulloch et al 2016; Abubakar et al 2018; UNHCR 2018; WHO 2017; 2018; 2019; Bempong et al 2019). The predominant theme within these action plans revolves around the concept of improving care for resettled refugees, with policy recommendations leaning towards the incorporation of specialised healthcare programmes for refugee groups (WHO 2018).

The call to action has been sounded, and one country that responded is Australia, with various states in Australia now offering specialised refugee health programmes for newly arrived refugees during the first year of resettlement. This will be discussed further in the following chapter, during which I provide the context for this study and set the scene with regards to refugee health nursing in Victoria, Australia.

2.8 Theoretical insights from the literature

In thinking about refugee health nursing, a review of the literature illuminated theoretical insights which helped to form an understanding of this field. The work of Michel Foucault and Michael Lipsky guided my thought process with regards to connecting the findings with abstract theoretical heights, and their theories are used to illustrate the findings and discussion later in this thesis.

Power is a key concept in refugee health nursing, with Refugee Health Nurses (RHNs), Refugee Health Managers (managers) and refugees all laying claim to some element of control. Interestingly, Foucault (1977) stresses the decentralised nature of power, likening power to a general matrix; something that '*circulates*', and a pervasive '*net-like organisation*' that functions in the form of a chain (Foucault 1980 p98). According to Foucault (1977), this means that power is everywhere, not because it embraces everything, but because it stems from everywhere. Foucault (1977) argues that rather than being a motionless target for a single source of power, individuals

move between its threads and are always in a position of simultaneously undergoing and exercising power. People are the elements of articulation of power, its vehicles; and actors can both dominate and be dominated in different contexts. Foucault (1980) refutes claims that any group has domination over power; instead, power circulates via a multitude of social networks and relationships, infiltrating all aspects of social life and bearing influence on the everyday interactions of autonomous individuals.

As well as discussion of power in its oscillating state, other key Foucauldian concepts include that of surveillance and resistance, both of which are used to demonstrate the findings of this thesis.

In portraying the dynamics of power relations and social control, Foucault (1977) drew upon the metaphor of a panopticon or 'carceral archipelago,' as an image of modern society. In the panopticon, prisoners are locked in individual cells, arranged in tiers of a circular structure, which is observed from a central vantage point. The prisoners can be viewed by the guards at any time, and the knowledge of their visibility eventually induces them to monitor and regulate their own actions. As the gaze of surveillance is turned upon oneself, self-scrutiny becomes the most pervasive and effective form of social control (Foucault 1977). Individuals enmeshed in power relations become self-disciplining and self-regulating without the need for constant surveillance and intervention of authorities in every aspect of their lives. The panopticon offers a visual image through which to conceptualise power relations, in that it highlights the decentralised multiplicity of forms and dynamics of power. By being both dispersed and running through the entirety of a society, power relations are not merely a unidirectional 'gaze'; rather, they are the intersecting and crisscrossing lines of socialisation within which people are embedded.

According to Foucault (1977), power is not a property that is fixed to an individual, operating in a structured and unidirectional manner from top to bottom. Instead, Foucault contends that when there is power from above, there is always resistance from below and therefore, he sees power as a process. Indeed, Foucault (1977) posits that power relations cannot exist unless there is resistance. In this sense, Foucault does not see individuals as end points to which power can be applied, but rather, as starting points where power can be resisted and enacted at the same time.

As well as discussion of power to illustrate the findings later in this thesis, 'street-level bureaucracy' is an influential theory for studying frontline encounters in the public sector and is used to frame the everyday practice of RHNs on the frontline. The approach is associated primarily with political scientist Michael Lipsky (1980 p3), who first coined the term street-level bureaucrats to describe '*public officials who grant access to government programs and provide services within them.*' Indeed, as public policy is ultimately enacted in encounters with citizens, Lipsky (1980 p3) famously argued that '*the actions of most public service workers actually constitute the services delivered by the government.*' Lipsky's (1980) street-level bureaucracy theory provides a theoretical framework to examine and analyse the mechanisms by which policy is translated into practice in health and social care contexts (Ellis 2011; Cooper et al 2015) and has previously been applied to nursing (Walker and Gibson 2004; Bergen and While 2005).

According to Lipsky (1980 p3), '*street-level bureaucrats are public service workers who interact with citizens in the course of their jobs and who have substantial discretion in the execution of their work.*' Lipsky (1980) therefore suggests that nurses are an example of archetypal street-level bureaucrats, as they frequently balance high demands for their services with limited supply, negotiating institutional and bureaucratic requirements, whilst seeking to respond flexibly to the needs of patients.

Lipsky's (1980) theory, which was developed from studying the behaviour of frontline staff in public service agencies, challenges 'top down' models of policy creation which suggest that policy is decided by politicians and delivered by administrators. Instead, Lipsky (1980) proposes that nurses, as street-level bureaucrats, act as frontline mediators between policy makers and patients, and use their discretion in practice to decide how care is provided.

Concepts of power (Foucault 1977; 1980) and street-level bureaucracy (Lipsky 1980) are used later to exemplify the findings of this study and to frame an overall discussion of refugee health nursing as a contemporary field of practice.

2.9 Conclusion

Overall, this literature review has portrayed a story of refugee health in the community setting. Through the incorporation of research, current literature and global recommendations for policy and practice, I illustrated the health-related challenges facing refugees on arrival in the host country and the health needs of this group during the early resettlement period. It is proposed that refugees are more likely to have increased morbidity, poor health habits and a decreased life expectancy due to displacement, migration and resettlement in a new country (Williams and Thompson 2011). Of note, in current practice within high-income host countries, the health needs of newly arrived refugees are often inadequately addressed by mainstream community health services (Woodgate et al 2017; Brandenberger et al 2019).

This literature review has laid a solid foundation with regards to the impact of the refugee experience on health and well-being and current practice in the provision of health support for this population during the resettlement period. In recent years, initiatives have been introduced to deal with the complex health needs of refugee populations in some host countries, and tailored refugee health programmes have emerged in contexts with high numbers of resettled refugees, which will be ruminated upon in chapter three.

3.1 Chapter Three: Context and Background

3.2 Introduction

Leading on from the discussion in chapter two, I make known one country which is offering a targeted approach to refugee healthcare in the community setting. Having lived in Australia during 2010-2015, I had prior knowledge of refugee healthcare in this country, with some familiarity in the way that care was provided for newly arrived refugees. While many high-income host countries predominantly offer refugees the same access to health services as native citizens, countries such as Australia, the USA, parts of England, Canada and New Zealand provide dedicated refugee health services for new arrivals. In 2005, the state of Victoria in Australia introduced the Refugee Health Program (RHP), which is a nurse-led initiative offering holistic care for refugees during the first year of resettlement. This section describes the structure and operation of the RHP in Victoria, with reference to the role of Refugee Health Nurses (RHNs). Consideration will be given to the current narrative around refugee health nursing, mentioning the presumed vulnerability of refugees, as well the progression of nursing identity in this field of practice. This chapter also sees contemplation of the rationale behind this study, in terms of whether this model may be beneficial in other resettlement environments globally.

The setting for this study is the RHP in Victoria, Australia, and through exploration of this specialised service, it is possible to gain insight into the phenomenon of refugee health nursing. The purpose of chapter three is to provide background to the RHP in Victoria, Australia, offering context to the landscape in which this study took place.

3.3 Specialised refugee health initiatives

Addressing the poor health of newly arrived refugees, some countries have implemented community refugee health programmes in recent years, offering dedicated healthcare and health education, orientation of the health system and

specialist referrals for refugees during the resettlement period. Indeed, some parts of England introduced refugee health programmes in 2000, some of which continue to operate in Bolton, Leeds, Bristol, Stoke on Trent and various parts of London, in a range of capacities.

In the USA, the Society of Refugee Healthcare Providers brings together many of the refugee health initiatives offered in this country. Refugee health programmes are active in numerous states, such as Wisconsin, Minnesota, Colorado, Boston, Pennsylvania, New Mexico, Florida, California, Washington, Indiana, Utah, Kentucky, Colorado, Virginia and New York (Refugee Society 2020). In Canada, a refugee health programme operates in British Columbia (Refugee Health Program British Columbia 2020), and all the states in Australia offer their own version of community refugee health programmes, summarised by the Refugee Health Network of Australia (2020). These specialised services are run by healthcare professionals with training in refugee health issues, offering targeted healthcare and support during the initial resettlement period, usually lasting one year.

Having lived in Australia previously, I knew that Australia is an example of a host country which is driving a targeted approach to refugee healthcare on resettlement, and in particular, the Victorian State government offers a comprehensive and holistic health service for newly arrived refugees; an initiative called the Refugee Health Program (RHP). With a view to exploring the field of refugee health nursing, this study focuses on the RHP in Victoria, considering the views and experiences of those involved and the impact of a specialised care model on refugee health and well-being, as well as the broader implications for nursing practice.

As Victoria, Australia is a global leader in recognising and addressing health needs of refugees through a specialised state-wide service (Victorian State Government 2014), the following section will provide an overview of refugee resettlement and healthcare in this context.

3.4 Refugee Health Program in Victoria, Australia

The RHP was introduced in 2005 with the aim of responding to the poor health and multifaceted issues of refugees arriving in Victoria, Australia and now operates in 17

community health centres, across both metropolitan and rural/regional settings in areas with high numbers of newly arrived refugees. The RHP is funded through the Victorian State Government, Department of Health and Human Services (DHHS), and aims to support refugees during the first year of resettlement. Refugees are referred to the RHP by AMES Australia Humanitarian Settlement Program Service Delivery Network on arrival in Victoria, and refugees with complex health needs are eligible to access this specialised service.

The nurse-led initiative is delivered by community RHNs with support from allied health professionals, bicultural workers and translators. Specialised healthcare is offered to refugees during the first year of resettlement, with refugees regularly attending appointments with the RHN at their local community health centre and taking part in various health promotion activities. At the end of the one-year resettlement period, refugees should be discharged from the RHP and transitioned into the care of mainstream community health services.

To optimise the long-term health of refugees, RHNs offer a coordinated approach, promoting accessible and culturally appropriate healthcare during the early resettlement period. Before describing the provision of nursing care through the RHP, it is appropriate to consider refugee resettlement in Australia, and then specifically, Victoria, to offer context with regards to the state of play in this part of the world.

3.4.1 Refugee resettlement in Australia

Throughout history, Australia has welcomed refugees, agreeing to host groups of people in response to specific global crises (Au et al 2019). Since the late 1980s, the Australian government puts forward an annual allocation of refugees to be resettled, and the immigration department then decides on how the resettlement effort is arranged, in collaboration with the UNHCR and other local organisations (Parliament of Australia 2016). Australia accepts approximately 13,750 refugees every year, with most people hosted in New South Wales and Victoria (Ogunsiji et al 2018).

It is important to recognise at this point, the treatment of people in '*Australia's off-shore detention regime*' (Holly 2020 p549), and how the delivery of specialised

refugee healthcare on resettlement in Australia differs from the care, or lack of care, provided for asylum seekers offshore. Asylum seekers are people in the quest of refuge but who have not yet been deemed with refugee status. People who come to Australia seeking asylum have a right to search for protection under international law but *'those who arrive in Australia without a visa are subject to mandatory detention'* (Au et al 2019 p2); catered for in offshore detention centres while their requests for refugee status are processed (Parliament of Australia 2015). According to Amnesty International (2018), the Australian government is responsible for the healthcare of asylum seekers in offshore detention centres, however, in these environments, there is reduced access to healthcare and a lack of trauma and counselling services. Due to restricted healthcare and other factors, Amnesty International (2018) claim that the Australian government has created a human rights crisis for asylum seekers in offshore detention centres.

Nonetheless, the focus of this study is resettlement in the Australian context, and the resettled refugee community in Australia is racially, culturally and linguistically diverse, originating from more than 40 different countries. With regards to the process of resettlement in Australia, the UNHCR refers refugees to the Australian government for relocation, and the people who are selected by the UNHCR are some of the most vulnerable refugees claiming asylum. At this point, people are usually still in their country of origin, or in a neighbouring country, while they await refugee status in a host country. They typically fall under certain vulnerability criteria, including women, children and young people at risk, people in severe need of medical care, survivors of torture and violence, refugees with legal or physical protection needs, refugees with medical needs or disabilities, persons at risk due to their sexual orientation or gender identity and refugees with family links in resettlement countries (WHO 2018).

Health policy for refugees and asylum seekers is directly tied to immigration policy and visa types, and while provision of health support to asylum seekers is fragmented in the Australian context (Au et al 2019), healthcare policy for refugees entering Australia on the offshore humanitarian programme is comprehensive, entitling refugees to Medicare, which is like the National Health Service (NHS) in Scotland. Refugees are entitled to early health assessment, specialised torture and trauma services and access to the same health and social care services as other Australians (Au et al 2019). However, in contrast to Scotland, the Australian government

recognises the need for a specialised approach to healthcare for this group in the early period of settlement, with the Victorian State government noting that timely, targeted care is critical, as successful settlement is more likely once health is restored (Victorian State Government 2014).

To offer clarity with regards to the Victorian State Government, the Australian Government is the Federal Government of Australia and is the first level of government division. The states and territories of Australia are the second level of government division in Australia, between the Federal government and local governments. States and territories are self-administered regions with a local legislature, police force and certain civil authorities, and are represented in the Parliament of Australia.

Australia consists of six states, including Victoria, New South Wales, Queensland, South Australia, Tasmania, and Western Australia, and three internal territories, which are the Australian Capital Territory, the Jervis Bay Territory, and the Northern Territory. State and Territory Governments have executive authority to legislate on matters concerning their citizens, with the only limitations being on subjects of national importance, such as defence and foreign policy. Each state and internal territory also has its own legislature, and furthermore, each state has its own constitutions, so that Australia has devolved parliaments (Australian Government 2020).

As this study is based upon the provision of refugee healthcare in Victoria through the RHP, it is significant to consider refugee resettlement in this Australian state. Victoria is a state in the South-East of Australia, and its capital city is Melbourne, which is Australia's second largest city. It is posited that over 4,000 new refugees resettle in the state of Victoria each year, accounting for around one-third of refugee settlement in Australia, hosting the largest intake of refugees in the country (Victorian State Government 2014).

Renowned as a progressive state (Victorian State Government 2015), the RHP was introduced by the Victorian State Government in 2005 to address the complex health needs of newly arrived refugees, and subsequently, other Australian states and territories have since adopted similar models of care. There is now a Refugee Health Network of Australia forum, which brings together RHNs from around Australia on an annual basis to share ideas and experiences about refugee health nursing in the resettlement context.

The RHP was introduced in response to emerging refugee health challenges in Victoria and this nurse-led initiative is a targeted approach which addresses complex refugee health needs, offering disease prevention and management, while promoting general well-being during the resettlement period (Victorian State Government 2005). The following section offers an overview of the structure and scope of the RHP, highlighting the philosophy underpinning this specialised service and the principles guiding practice in the field of refugee health nursing.

3.4.2 Structure of the Refugee Health Program

In line with global public health recommendations and various research studies, the RHP aims to provide a dedicated and coordinated approach to refugee healthcare during the early resettlement period, providing holistic nursing care for refugees through a social model of health (Joshi et al 2013; Ogunsiji et al 2018; WHO 2018). The RHP is led by RHNs who have training and expertise in refugee health, based in community health services with high refugee populations; promoting accessible, culturally appropriate care that is responsive to changing patterns of refugee settlement (Victorian State Government 2005).

The RHP builds the capacity of refugee communities to improve their health through ongoing assessment and disease prevention, the development of referral networks, co-operative relationships with health and social care providers and a connection with social support (Victorian State Government 2005). The RHP is an optional service and targets newly arrived people from a refugee background with complex health needs, with emphasis placed on prompt identification and intervention in health issues during the early stages of settlement. The community initiative promotes health within a social context, recognising that health outcomes are determined by a range of social, environmental and economic factors. The philosophy underpinning the RHP suggests that *'health services for refugees should be accessible, flexible and culturally sensitive...'* *'adopting a holistic approach to health care with targeted health information and access to language services...'* and *'be integrated with mainstream services to enable individuals, families and refugee communities to improve their health and wellbeing'* (Victorian State Government 2005). Refugees can access the RHP during the first year of resettlement in Victoria,

and subsequently, refugees are discharged from the RHP into mainstream community health services, encouraging integration into the Australian community (Donato and Ferris 2020), in line with global strategies and action plans for refugee health in the resettlement context (WHO 2018).

In terms of the social organisation of the RHP, the service is led by RHNs, with managerial support from Refugee Health Managers (managers). Managers also hold responsibility for the operation of other programmes taking place within community health services, and managers do not require experience in healthcare. Managers are accountable for overseeing the RHP budget within the community health centre and ensuring that RHNs are working in line with RHP guidelines, acting as direct line managers.

The State-Wide Facilitator of the RHP holds nursing leadership for the overall functioning of the RHP across all sites in Victoria. This role encompasses an experienced RHN who drives forward the vision of the RHP and is available for advice when RHNs in the community setting require clinical guidance. This role provides a secondary consultation function for RHNs on complex refugee health matters and contributes to, and actively promotes, professional development in refugee health nursing. The State-Wide Facilitator also works collaboratively with other stakeholders including the DHHS, settlement services and other relevant agencies and health organisations, contributing to refugee health policy development and monitoring refugee resettlement in Victoria to ensure that the RHP remains responsive to the ongoing influx of newly arrived refugees.

With regards to the development of specific refugee health policy and guidelines steering the RHP, an organisation called the Victorian Refugee Health Network provides a unique forum bringing together community and specialist services, settlement and support agencies, as well as government departments, to identify and address refugee health issues and priorities and report emerging refugee health issues to the DHHS twice yearly. The Victorian Refugee Health Network works strategically and collaboratively with the DHHS and provides policy and guidance for the operation of the RHP across all community health centres offering this service. This organisation collates and distributes best practice resources that can be shared

with all RHNs in Victoria and is responsible for consulting with RHNs on integrating current research into contemporary refugee health practice.

In terms of professional development for RHNs in learning about refugee health issues and building expertise, the Victorian Refugee Health Network actively promotes professional workforce development and education programmes for RHNs, which take place at Foundation House in Melbourne, some of which lead to certification. RHNs from all over Victoria congregate to undertake training and study days at Foundation House, establishing and maintaining links and relationships within the sector. Training encompasses torture and trauma counselling, management of infectious diseases, health promotion for refugees and building knowledge of the global context in terms of refugee experiences prior to arrival in Victoria, as well as various other optional topical courses. These study days enable RHNs from different community health centres across Victoria to come together and share learning about refugee issues and healthcare. Furthermore, the Victorian Refugee Health Network, in collaboration with the RHP in Victoria, has developed a refugee health and well-being curriculum, currently offered as a post-graduate nursing course at Monash University in Melbourne and RHNs around Victoria are encouraged to partake in this study, although it is not deemed compulsory. However, if a RHN wished to further their career and become a RHN Practitioner, which some RHNs have set the trend, the post-graduate nursing course is a requisite.

RHNs are the driving force of the RHP in Victoria, and nurses working in this discipline are part of a burgeoning movement in Australian community healthcare. Having illustrated the structure and scope of the RHP, the following section offers insight into the complexities of refugee health nursing in the resettlement context.

3.4.3 Role of the Refugee Health Nurse

RHNs are specialist nurses, offering continuity of care and expertise in refugee health (McBride et al 2016; 2017). They are culturally competent practitioners who are trained in identifying and managing refugee health issues, with in depth knowledge of referrals pathways and refugee eligibility for services.

Arriving in Victoria, refugees are assigned a case manager through settlement services; the AMES Australia Humanitarian Settlement Program Service Delivery Network. Case managers welcome refugees into the community through an introduction to the local area and refer refugees to the RHP so that a Refugee Health Assessment (RHA) can be completed (Victorian Refugee Health Network 2012).

RHP guidelines were created by the Victorian Refugee Health Network in 2008, and subsequently updated in 2015 and 2019 (Victorian State Government 2019). Guidelines advise that the role of the RHN is '*to deliver culturally responsive and high-quality refugee health and wellbeing assessment and service provision*' (Victorian State Government 2019). On settlement, the RHN undertakes a RHA within one month of refugee arrival and this initial assessment guides the provision of subsequent health and social care, including referrals to other specialist services. RHP guidelines state that this service is for newly arrived refugees with complex health needs, and the RHA tool is used by RHNs to determine the eligibility of the refugee to receive care through the RHP (Victorian State Government 2019). Otherwise, refugees are supported by local mainstream community health services.

On acceptance into the RHP, subsequent formal health assessments are undertaken by the RHN at three months and twelve months post resettlement, during which time the RHN monitors the progress of refugee health and re-evaluates care plans. At the end of the first year of resettlement, the care of refugees is handed over to mainstream community health services, and this process needs to be planned and managed carefully, to ensure a seamless transition.

Refugees or refugee families are assigned a RHN for the duration of the first year of resettlement, allowing continuity of care and the development of trusting relationships over time. RHNs are well positioned to deliver health support for refugees because they have specialist training and education in refugee health, a close relationship with their community, and they can act as a point of contact, connecting refugees with a broad range of other health and social care services (Victorian State Government 2019). As touched upon earlier, Fang et al (2015) investigated refugee health experiences in England, highlighting that mainstream community healthcare providers often have limited knowledge of the different services that are available for refugees. In contrast, RHNs are well placed to guide refugees to relevant provisions,

with specific knowledge of their eligibility to access a range of services and community support networks (McBride et al 2017).

After the initial RHA on arrival in Victoria, RHNs coordinate mainstream and specialist referrals to health and community service providers, for example, GPs, dental health, nutritionists, physiotherapy and psychologists or torture and trauma counselling, and they deliver health promotion interventions tailored to refugee health needs. Refugees attend clinic appointments with the RHN at the local community health centre, with appointments lasting one to two hours. During the first three months, appointments are scheduled regularly, approximately once weekly or fortnightly, and thereafter, appointments are scheduled depending on the individual needs of refugees or families. If refugees are unable to attend the community health centre, the RHN will visit the refugee in their home environment.

Appointments are informal, during which time RHNs offer an opportunity to explore any symptoms or health issues the refugee may be experiencing during the resettlement period. RHNs have expertise in working with culturally and linguistically diverse and marginalised communities and appointments are often undertaken with the assistance of an accredited translator. RHNs have a streamlined process in utilising the services of accredited translators, either face to face or by means of telephone interpretation (Victorian State Government 2005). Furthermore, RHNs offer bespoke health education for refugees and organise activities to promote the well-being of this community, in terms of exercise groups, healthy dietary advice and social events, such as group picnics and day trips, using an allocated budget. RHNs actively engage local community leaders in consultation to inform the local RHP service response, promoting social connection through referrals to support initiatives, enabling refugees to meet others from similar cultural backgrounds.

RHNs also recognise that refugees may have difficulty navigating the new social support services and health systems in their country of resettlement (Joshi et al 2013), as limited local language proficiency has an impact on health, as well as the quality and accessibility of care (Beiser and Hou 2006). RHNs provide information regarding the rights and entitlements of refugees under the Victorian healthcare system and impart explanation about how the health system operates. This is in consensus with Younge and Norton (2007) and Hopkins and Irvine (2012), who

suggest that specialist nurses in the community help to streamline the care process. RHNs offer orientation of health services and support refugees in learning how to navigate the wider health system, including teaching refugees how to use telephone interpretation services and call an ambulance, for example, as part of accessing healthcare.

As mentioned in chapter two, during discussion of the provision of healthcare for refugees through mainstream community health services, Weir et al (2017) found that Syrian refugees in Scotland lack awareness about how health services function and this is a barrier to accessing community healthcare. Knowledge of the health system in the host country is considered integral to becoming health literate and when this information is not provided and understood, refugees are more likely to present to an emergency department (Beiser and Hou 2006). As Weir et al 2017 (p458) point out, unless refugees are given relevant information, targeted care and very thoroughly orientated about how the healthcare system works, *'there is great potential for confusion and disjointed care.'*

On this thread, RHNs in Victoria, Australia, offer a single point of contact for refugees in accessing community healthcare, with the RHN acting as the coordinator of the care process and guiding onward referrals to appropriate services. Of interest, this mirrors the early notion put forward by Pechansky and Thomas (1981), who suggest that a service coordinator is useful in improving access to a range of community health services for vulnerable groups.

Having considered the role of RHNs in the community, it is important to explore the dominant narrative surrounding refugee health nursing, with consideration of assumptions attached to the vulnerability of refugees on resettlement.

3.5 The refugee health nursing narrative

To establish a deeper understanding of the underlying concepts inherent in the literature, this section offers a brief insight into current discourse surrounding the phenomenon of refugee health nursing.

Resettled refugees are predominantly positioned within the health literature and policy context as a 'vulnerable' population (Nies et al 2016), with RHNs expected to

support their vulnerability and meet their needs Ogunsiji et al (2018). The rhetoric around refugees is based upon exposure to vulnerability and they are often viewed as uniformly powerless on resettlement (Hatoss and Huijser 2010), adopting a '*passive, victim role*' (Colic-Peisker and Tilbury 2003 p61). Indeed, refugees are reported in the literature as among the most vulnerable people in the world (Kurth et al 2010; Carrigan 2014). The narrative encircling refugee health during the resettlement period relates to the idea that health issues are multifaceted and unique to this group (Halabi 2005; Wagner et al 2013), with care of refugees often falling short in meeting their needs (Marshall et al 2016). According to Weir et al (2017 p458), '*this is of concern, given the vulnerability of the population in question.*'

With regards to the nursing discourse in this field of practice, Mutitu et al (2019) acknowledge that while nurse-led refugee health initiatives are valuable in the community health landscape, this field of nursing practice is not widely implemented globally. With relative uncertainty around the speciality of refugee healthcare within the resettlement context, RHNs strive to develop their professional identity and promote the profile of refugee health nursing in contemporary practice (McBride et al 2017).

Various studies highlight the concept of power in nursing, particularly within specialist disciplines (Sepasi et al 2016; Santagelo et al 2018), and with expertise in the field of refugee health, there is some power attached to the RHN role (Ogunsiji et al 2018). With inherent power in a nursing specialism, due to advanced practice and prestige (Santagelo et al 2018); and with the presumed vulnerability of the refugee population, there is a taken for granted conjecture that there is a power imbalance between RHNs and refugees.

Having offered context to the RHP and insight into current narrative around refugee health nursing, it is appropriate to share my motivation and reasoning for investigating this phenomenon.

3.6 Rationale behind this study

Holloway and Todres (2010) put forward that ethnographic research can generate new nursing knowledge and help to improve and change practice. Therefore, using an ethnographic approach not only provides insight into refugee healthcare from the experiences of those involved; but encourages reflection on how nursing practice could be improved, and whether this type of initiative may be considered across other resettlement areas, to optimise refugee health and well-being globally. As a registered nurse with experience in caring for refugees in the context of displacement within refugee camps, I am passionate about exploring the health of refugees and keen to examine innovative practice developments in this field, particularly on resettlement in the host country. To this end, the basis for undertaking this study is two-fold.

Firstly, as refugee health nursing is a field that is inconsistently implemented, it is worthwhile to consider the value of this nursing specialty. Refugee health nursing is one approach to dealing with the complex health needs of refugees on resettlement, but there is limited evaluation of this service to support its use in clinical practice. By dealing with real-life experiences of people involved in refugee health nursing in Victoria, Australia, this helps to illuminate the meaning of this field from different perspectives, considering the effectiveness of a specialised approach, while highlighting any scope for improvement in current practice.

Secondly, as refugee health becomes a more prominent topic in the global resettlement context (UNHCR 2018; WHO 2013; 2016; 2017; 2018; 2019), it is important to contemplate whether the RHP model could be introduced in other host country settings worldwide. As outlined in chapter one, there is ever-growing displacement and global migration, and therefore, high-income host countries must act now, putting in place measures to safeguard the health and well-being of resettled refugees. Part of the rationale underpinning this study is to consider whether the incorporation of the RHP model may be fitting in the Scottish resettlement context, acknowledging the specific health needs of refugees and offering a more targeted slant on healthcare.

3.7 Conclusion

Bearing in mind recommendations and global strategies in driving dedicated health service provision for refugees in host countries, this chapter offered an impression of the RHP, demonstrating the development and advancement of refugee health nursing in addressing the complex health needs of resettled refugees.

Having shed light on the rationale for exploring refugee health nursing through the RHP in Victoria, Australia, the following chapter provides an overview of the research aim and questions associated with this study, along with detailed discussion of methodology and methods.

4.1 Chapter Four: Research Design and Methods

4.2 Introduction

Having set the scene with regards to the rationale for this study, this chapter outlines the approach used to answer the research aim and questions, justifying the research design, and describing how the research was undertaken. The overall research aim and questions are presented, followed by an introduction to the appropriateness of qualitative research and my underlying philosophical assumptions, with consideration of ontology, epistemology and the theoretical perspective underpinning this study. This leads to a discussion of methodology and research methods, with consideration of participation observation and fieldnotes, semi-structured interviews, focus groups, as well as reflecting on refugee health policy and documents used within the RHP. I consider data management and the process of data analysis, and the chapter concludes with discussion of ethical considerations and trustworthiness, as well as acknowledging the importance of reflexivity.

4.3 Research aim and questions

The overall aim of the study was: *'To gain an understanding of perspectives and experiences of refugee health nursing in Victoria, Australia.'* To meet the research aim, overarching research questions were formed:

- *'What is the impact of specialised refugee healthcare in the community setting?'*
- *'How should care be offered for newly arrived refugees in high-income host countries?'*

Five guiding research questions were developed, taking a more specific approach to meeting the research aim:

- 1) *What are the perspectives and experiences of refugees?*
- 2) *What are the perspectives and experiences of Refugee Health Nurses?*

- 3) *What are the perspectives and experiences of Refugee Health Managers?*
- 4) *How can social and professional relationships between refugees, Refugee Health Nurses and Refugee Health Managers be described?*
- 5) *Is a nurse-led refugee health service beneficial in the community setting?*

By answering these questions and meeting the research aim, I gain a better understanding of refugee health nursing as a social phenomenon, offering a meaningful contribution to the body of knowledge within this field. The overall research aim and questions led to the development of the research design and methods, which will now be outlined in detail.

4.4 Qualitative research

With the research aim and questions in mind, a qualitative approach was chosen to explore perspectives, experiences and relationships within refugee health nursing, gaining a deeper understanding of this phenomenon.

As Bazeley (2013 p4) suggests, *'researchers engaging in a qualitative study focus on observing, describing, interpreting, and analysing the way that people experience, act on, or think about themselves and the world around them.'* In this instance, participants can be studied in their natural environment, to interpret and make sense of their experiences in the context of health on resettlement (Denzin and Lincoln 2005).

4.5 Research design

To ensure a strong research design, I chose a research paradigm that is congruent with my beliefs about the nature of reality, and this section outlines my thought process.

Crotty (1998) proposes that four key elements should be contemplated in developing a research proposal. These are 1) ontology and epistemology, 2) theoretical perspective, 3) methodology and 4) methods, although I acknowledge that

ontology and epistemology are separate elements and are presented as such in this thesis.

In devising this study, the research aim and questions were initially formed and subsequently, a qualitative approach to enquiry was deemed appropriate. By reflecting on the research aim and questions, the ontological and epistemological stance underpinning this study was illuminated, followed by deliberation with regards to an appropriate philosophical positioning. I placed my focus within a Symbolic Interactionist theoretical framework, viewing experiences within refugee health nursing as social, relational, shifting, complex, intersecting and situated. Indeed, the key elements of ontology, epistemology, theoretical position, methodology and methods are interrelated (Crotty 1998). The flow of these puzzle pieces represents the sequence that Guba (1990) recommends; suggesting that ontological assumptions should give rise to epistemological ones, which in turn should determine the unfolding of theoretical underpinnings and thus, the range of research practices that can be employed.

Although focused ethnography is the chosen research design, I offer an overview of alternative qualitative approaches that were contemplated during the planning process for this study. Methods will be discussed in detail, with regards to participant observation and fieldnotes, semi-structured interviews, focus groups, as well as consideration of documents used within the RHP and refugee health policy in Victoria, Australia.

Firstly, it is appropriate to consider the vantage point from which this study was undertaken, with consideration of ontology, epistemology and theoretical assumptions underpinning my cogitation.

4.5.1 Ontology

Ontology is '*the study of being*' (Crotty 1998 p10) and it '*raises basic questions about the nature of reality and the nature of the human being in the world*' (Denzin and Lincoln 2005 p183).

Relativist ontology involves the idea that reality is a finite and subjective experience, and that our thoughts encompass our perspective of reality (Denzin and Lincoln 2005). In this way of thinking, the reference frame entails that reality is human

experience, and our human experience constitutes our reality. This means that there is no absolute standard and hence, reality shifts with the person or group under study.

This study is located within a relativist ontological stance, where realities within the RHP are said to '*exist in the form of multiple mental constructions, socially and experientially based, local and specific, dependent for their form and content on the persons who hold them*' (Guba 1990 p27). Relativist ontology posits that there is no objective truth and therefore, the purpose of this study from an ontological standpoint is to gain understanding of the subjective experience of reality from multiple perspectives (Guba 1990).

In line with my beliefs about the nature of the world, relativism puts forward that nothing can ever be known for definite; there are multiple interpretations of reality, none having precedence over the other in terms of claims to represent the truth about social phenomena (Hammersley and Atkinson 2007). As this study aims to explore the various evolving perspectives and experiences within refugee health nursing, it is appropriate to capture the mixture of holistic realities and varied interpretations among RHNs, managers and refugees (Lincoln and Guba 1985), on the premise that the views of all participants across groups are equally significant.

Adopting relativism as a lens to view reality, I began to think about how I wished to uncover new truths about refugee health nursing. Social constructionism is based upon the relativist standpoint, which holds that all knowledge is relative to one's location within a set of social norms (Burr 2003). This relativism motivates a radical scepticism towards all knowledge claims, challenging common assumptions about social phenomena (Burr 2003).

Cruikshank (2011) draws attention to the link between relativist ontology and social constructionism, which will be discussed in the following sub-section with regards to epistemology.

4.5.2 Epistemology

Epistemology is the study of knowledge, dealing with '*how we know what we know*' (Crotty 1998 p8). According to Denzin and Lincoln (2005 p183), epistemological enquiry looks at the relationship between the knower and the knowledge, begging the question, '*how do I know the world?*' This relates to how we make meaningful sense of our realm, and believing, perceiving, imagining and corroborating are examples of

processes included in the scope of epistemology, negotiating the possibilities and limits of human knowing. With consideration of the research aim and questions, the epistemological stance supporting this research study is social constructionism, which is now rationalised.

Although I initially linked social constructionism with constructivism, assuming that they were identical epistemological standpoints, I then grasped that they stem from different schools of thought, which led to a process of learning. Through discussion with my academic supervisors, I realised that this is a common error, acknowledging the confusion it can cause for researchers. Likewise, Burr (2003) suggests that there is a 'family resemblance' or 'fuzzy sets' between these views.

The theme running through both social constructionism and constructivism relates to the notion that knowledge is not found or discovered, rather; it is constructed or created. Of significance though, it is the way in which knowledge is produced that differentiates social constructionism from constructivism, and this relates to whether knowledge is individually or socially generated.

Constructivism is a standpoint that arose in development and cognitive psychology and proposes that each individual mentally creates or constructs the world of experience through cognitive processes. These processes are internal to the individual mind and the focus on learning is based on the interaction of an individual with others. It is an individual standpoint, whereas social constructionism focuses more on the group as an interaction entity (Burr 2003). In the end, these two positions are not clearly separated, but instead, blur quite considerably, although their roots are in different fields.

The epistemological standpoint of this study is social constructionism, which emanates from the field of sociology and has a social, rather than an individual focus (Burr 2003). As an epistemology, social constructionism contends that the focus of enquiry should be on interaction, group processes and social practices.

Social constructionism puts forward that meanings are constructed by human beings as they engage with the world they are interpreting, and that meaning can change through time, depending on engagement in new interactions and experiences (Crotty 1998). A social constructionist perspective suggests that knowledge is essentially social and relational, highlighting that through social relationships; we can make sense of our world (Burr 2003). Of importance, it is possible for multiple knowledge sets to exist simultaneously, leading to the emergence of a range of views,

which is in line with the ontological position of relativism (Guba and Lincoln 1989). Thus, in this study there is a focus on the interactionist and relational aspects of meanings, as interpreted by refugees, RHNs and managers, respectively, delving into social and professional relationships within the RHP.

As touched upon, there is an existing narrative around refugee health nursing in the literature. From a social constructionist standpoint, the task is to unmask truths about reality and challenge supposedly objective knowledge claims by exposing underlying goings on (Burr 2003). Therefore, in contrast to the positive application of knowledge, I adopt the negative approach, whereby I seek to foster a sceptical attitude towards existing knowledge claims and conjecture (Burr 2003).

Fundamentally, social constructionist epistemology takes a critical stance toward taken-for granted knowledge, challenging orthodox assumptions about the social world. Young and Colin (2004 p381) refer to social constructionism as a '*challenging springboard*,' highlighting that it yields alternative discourses on experiences in healthcare. It is assumed in the literature that refugees are a vulnerable group (Nies et al 2016) and specialist nurses are powerful in their professional position (Anderson et al 2020). However, the social constructionist view maintains a suspicion of suppositions in relation to how the world appears to be (Burr 2003).

Having considered my ontological and epistemological stance, I began to contemplate my philosophical positioning as a nurse researcher in this field. With recognition of the overall research aim, I planned how to approach discovery within the phenomenon of refugee health nursing.

4.5.3 Theoretical perspective

The philosophical stance underpinning the methodology uncovers assumptions rooted deep within methodological reasoning. Crotty (1998 p66) puts forward that '*different ways of viewing the world shape different ways of researching the world.*' Therefore, to offer transparency, it is imperative that I can explain the theoretical perspective informing this study, as the way that I view the world of refugee health nursing influences how research is undertaken and subsequently, the findings.

4.5.3.1 Interpretivism

The theoretical position laying groundwork for this study is Interpretivism, which relates to how human beings make sense of and interpret their reality (Holloway and Wheeler 2010). Interpretivism is associated with Max Weber, who proposed that in social science research, understanding is a deeper, more insightful concept than explanation (Holloway and Wheeler 2010). As I aimed to explore refugee health nursing and investigate the multiple meanings that participants assign to their experiences, this was deemed an appropriate lens from which to view the phenomenon under study.

Interpretivism is conceptualised as having relativist ontology with a subjectivist epistemology and is aligned with postmodern thought; thus, it is a fitting theoretical stance for this study. Interpretivist research '*is guided by the researcher's set of beliefs and feelings about the world and how it should be understood and studied*' (Denzin and Lincoln 2005 p22). By adopting an Interpretivist view, I accepted that there are multiple meanings and ways of knowing and I acknowledged that '*objective reality can never be captured. I only know it through representations*' (Denzin and Lincoln 2005 p5).

In fact, I continue to question whether objective reality can ever truly be known. The Interpretivist paradigm focuses on recognising and recounting how RHNs, managers and refugees assign meaning to their experiences, relationships and actions, within the reality of their own worlds.

4.5.3.2 Symbolic Interactionism

The specific feature of Interpretivism employed in this study is Symbolic Interactionism (SI), which helps to develop a deeper understanding of behaviours and hidden meanings within refugee health nursing (Benzies and Allen 2001). This perspective stems from the social sciences and was influenced by George Herbert Mead, a renowned sociologist, who brought to light the initial idea behind the Traditional, or 'Chicago' School of SI. The term SI was coined in 1937 by one of Mead's students, Herbert Blumer, and since then has been used to describe '*a relatively distinctive approach to the study of human group life and human conduct*' (Blumer 1969 p1). Mead was therefore one of the originators and SI was subsequently

developed and pioneered by Blumer through the interpretation, combination and publication of Mead's work after his death (Benzies and Allen 2001).

Since Mead did not put his perspective into writing, formal methodology within the SI framework was non-existent until Blumer began to cultivate an approach using Mead's ideas (Blumer 1969). Blumer interpreted and developed his own version of SI, otherwise known as Traditional or Chicago-style SI, which was documented by notes from Blumer's students and is the version used to guide this study (Carter and Fuller 2016).

Of note, the emergence of SI was a reaction and somewhat opposition to mainstream sociological perspectives. There was previously a focus on dominant, positive approaches which considered society from the 'top down,' emphasising how macro-level institutions and social structures influenced and constrained society. As a more progressive way of thinking, SI was developed to understand the complexities of society from the 'bottom up,' with consideration of how micro-level processes, such as face-to-face encounters, can explain the operation of wider society (Carter and Fuller 2016).

Rather than addressing how refugee health nursing defines and influences RHNs, managers and refugees, I shift my attention to the interpretation of subjective viewpoints and how individuals make sense of their world from their unique perspective. In this way, I consider how the perspectives and experiences of participants shape refugee health nursing and the care delivered for refugees. As the theoretical perspective underpinning this study, SI is concerned with how repeated, meaningful interactions among RHNs, managers and refugees come to define the makeup of refugee health nursing as a field of practice.

Blumer (1969) stressed the importance of studying the empirical social world through human experiences, and from the SI perspective, it is therefore noteworthy to understand what people know about their world and what they believe to be important. Traditional SI affirms that individuals are constantly engaged in thoughtful action, manipulating symbols in their communication and working out the meaning of situations (Carter and Fuller 2016). Interactions within refugee health nursing are constantly in flux and each experience is different from the next. Hence, understanding social behaviour requires an interpretive perspective that examines how behaviour is changing, unpredictable and unique to every social encounter (Carter and Fuller 2016). Traditional SI puts forward that RHNs, managers and refugees are free and

flexible agents, reacting on their own accord and without structural influence, with consideration of how their experiences influence practice and the delivery of care for refugees.

However, the SI perspective is not limited to qualitative approaches. Manford Kuhn (1964) and Sheldon Stryker (1980) are two sociologists who incorporated positivist methods to study the relationship between self and social structure.

Manford Kuhn's positivism influenced a new sociological tradition called the 'Iowa School' of SI, as this was conceived at the University of Iowa. In developing the Iowa School of SI, Kuhn (1964) merged Mead's ideas with rigorous, scientific testing of Symbolic Interactionist principles. The Iowa School perspective highlights the systematic processes involved in interaction, viewing behaviour and social action as socially constructed and coordinated, enacted with purpose and informed by prior events. Kuhn (1964)'s approach is associated with a pragmatic understanding of social phenomena, championing the use of novel experiments and contending that quantitative methods of enquiry can complement Mead's theoretical principles, providing logical testing of these concepts.

Sheldon Stryker's work within SI is like Kuhn's with regards to scope and methods and is referred to as the 'Indiana School' of thought. While Traditional SI emphasises the fluid nature of meanings and the self in interaction (Blumer 1969), Stryker (1980) proposes that social life is consistent, with meanings and interactions contributing to relatively stable patterns that create and uphold more rigid social structures. In likeness to Kuhn (1964), Stryker incorporated elements of theory but extended SI by hypothesising and empirically testing relationships.

Considering Chicago (Traditional), Iowa and Indiana SI, the key distinctions between these schools of thought originate from the ways in which human group life can be studied. Nonetheless, there is a fundamental belief within all variations of SI that reality is constructed by human beings through a process of interaction with others. Blumer (1969 p2) suggests that there are three core assumptions within SI:

- 1) *'Human beings act towards things on the basis of the meanings that the things have for them.'*
- 2) *'The meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows.'*

- 3) *'These meanings are handled in, and modified through, an interpretive process used by the person in the things he encounters.'*

With regards to this study, Traditional SI is the underlying theoretical position, and the term *'things'* in the three assumptions can relate to other people, institutions and situations encountered in the daily lives of RHNs, managers and refugees (Blumer 1969 p2).

The first principle is that *'human beings act toward things on the basis of the meanings that these have for them'* (Blumer 1969 p2). This means that individuals act towards others because of the meaning we interpret from them. For example, when a refugee arrives in Victoria, there is an expectation that this person has experienced trauma or conflict in their country of origin. Similarly, on entering the RHP, there is an expectation that the specialist RHN has specific knowledge and experience in dealing with refugee health issues.

The second principle is that *'the meaning of such things is derived from, and arises out of, the social interaction that one has with one's fellows'* (Blumer 1969 p2). This means that despite not having any direct experience of this particular social setting, there are things which individuals would expect due to prior social experiences and learning through interaction with others. RHNs may not have experienced war or conflict, but they build an understanding through meaning-making and interaction with refugees. This principle is connected to the source of meaning, which originates from a process of interaction. Blumer (1969 p4) believes that this concept separates SI from other theoretical perspectives as it does not view meaning as stemming from *'the intrinsic makeup of the thing'* or as an expression of *'psychological elements in the person,'* but instead, from *'the ways in which other persons act toward the person with regard to the thing'* (Blumer 1969 p4).

The third principle of SI is that *'these meanings are handled in and modified through an interpretive process used by the person dealing with the things he encounters'* (Blumer 1969 p2). This principle refers to the process of interpretation; in terms of self-interaction, or in other words, communication with oneself. The person becomes mindful of the thing they encounter; the thing that has meaning. The person then manages meanings associated with the thing in the context of the current situation, which then influences action (Blumer 1969). In terms of refugee health nursing, the RHN contemplates the meaning they attach to their specialist role and the meaning

they attach to the refugee experience. Thus, they manage these meanings in the context of the RHP, which then guides their nursing practice and care offered to refugees.

Essentially, meanings are created and modified through the interaction a person has with the self and others, depending on the context of each situation (Serpe and Stryker 2011). Therefore, meaning-making and understanding is a continuing interpretive and abstract process (Blumer 1969). All variations of SI suggest that reality is perceived as a social construct produced through ongoing interaction with others, leading to interpretation and purposeful action.

As I am interested in the social and professional relationships within refugee health nursing and how interactions influence the delivery of care for refugees, Traditional SI is an appropriate stance from which to view the proceedings.

This theoretical positioning means that I must probe the symbolic content and hidden meaning behind social interaction in this field, viewing the world through the eyes of participants (Carter and Fuller 2016). Blumer's (1969) subjective framework refers to this as sympathetic introspection. This can be accomplished by talking to people and developing in-depth understanding of their experiences, constructing social realities through the meanings they develop. SI has been an influential lens throughout the undertaking of this study, uncovering multiple meanings and insights which are continually co-constructed within the social context of the RHP.

To summarise, Traditional SI is the philosophical keystone and undercurrent of this study. Using this lens, an understanding of social life in refugee health nursing can be gained, looking into how RHNs, managers and refugees interpret their situations and experiences, and how this influences the delivery of care for refugees. Indeed, there is recognition that reciprocal social interaction influences behaviour and the character of relationships within this field. Importantly, as Benzies and Allan (2001) point out, the assumptions underlying Traditional SI have profound implications for the design of qualitative nursing research and can contribute significantly to the development of nursing knowledge.

Having demonstrated my reasoning for choices relating to the ontology, epistemology and theoretical standpoint supporting this study, it is now appropriate to address the practicalities of the research process.

4.6 The research process

With consideration of the overall aim and theoretical position as the foundation for this study, I began the process of planning, carrying out and analysing my research. This section outlines the journey I embarked upon to answer the research aim and questions, detailing the steps taken and decisions made to clearly illustrate the research process.

To gain insight into perspectives and experiences within refugee health nursing, it was appropriate to adopt a qualitative approach to enquiry, to build an abstract understanding of this phenomenon. I contemplated the use of various qualitative methodologies while developing the research proposal, before choosing to employ a focused ethnographic approach.

The different stages involved in the research process are addressed in this section, including selecting and gaining access to the fields, sampling strategies, data collection techniques and management, as well as the complex undertaking of data analysis. With a clear notion of Traditional SI as the bedrock of this study, I was ready to ponder the methodological aspects of the research process.

4.6.1 Methodology

To provide a brief overview of the methodology relating to this study, data collection was undertaken through a focused ethnographic approach from April 2017 to December 2017 across two community health centres offering the RHP in Victoria, Australia; one metropolitan site and one rural/regional site. Methods of data collection included 1) participant observations and the generation of fieldnotes, 2) semi-structured interviews with five RHNs, two managers and eight refugees, 3) two focus groups with refugees, and 4) consideration of how RHP documents and refugee health policy is incorporated into nursing practice.

With my aim and philosophical stance in mind, a qualitative research design was reckoned to be fitting. The research aim draws attention to perspectives and experiences, calling for a method of enquiry in which I could build a complex and holistic picture through watching, listening and asking questions to illuminate the field of refugee health nursing (Hammersley and Atkinson 2007). After consideration of

other methodologies, a focused ethnographic approach was chosen to guide this study.

Traditional SI is compatible with focused ethnographic research, as the emphasis in both regards is on putting oneself in the place of others to see the insider's perspective, while uncovering hidden meaning within a specific cultural phenomenon (Carter and Fuller 2016). SI is used as a theoretical angle because it encourages me to take the standpoint of RHNs, managers and refugees, viewing social life within refugee health nursing as continuously newly constructed, based upon the evolving interactions and meaning-making processes of participants (Serpe and Stryker 2011). The aim of this study is to understand everyday practice within refugee health nursing in the community setting by exploring shared experiences; unearthing the meaning of reality as a social construct (Blumer 1969). This is in line with focused ethnography as a methodology, as this approach concentrates on behaviours and shared experiences within a specific phenomenon, based on the supposition that people share a cultural perspective (Wall 2015). I challenge taken for granted assumptions about refugee health nursing, viewing this field as mysterious. In this way, I delve deep into obscurities and discover the true symbolic content of experiences and relationships within the resettlement context.

As focused ethnography stems from ethnography, an overview of ethnography is offered as an introduction to this section.

4.6.1.1 Ethnography

Ethnography grew in popularity during the 19th and 20th century as cultural anthropologists became interested in studying small communities (Morse and Field 1996; Holloway and Todres 2010). Anthropological ethnography was then adapted by sociologists at the University of Chicago who were studying human lived experience, including George Herbert Mead, whose work paved the way to the theoretical perspective of SI. Ethnography has evolved throughout the 21st century and is now used as a research methodology across various disciplines, including nursing (Hammersley and Atkinson (2007).

Morse and Field (1996 p21) suggest that, *'ethnography is a means of gaining access to the health beliefs and practices of a culture and allows the observer to view phenomena in the context in which it occurs, thus facilitating our understanding of*

health and illness behaviour.' Ethnography involves the researcher immersing themselves into the field of study and producing 'a written description of a people that focuses on selected aspects of how they lead their routine, remarkable and ritual lives with each other in their environment and of the beliefs and customs that comprise their common sense about their world' (Muecke 1994 p189-190).

Methods for data collection in ethnography include participant observation, unstructured or semi-structured interviews and the consideration of available documents (Roper and Shapira 2000), all of which were incorporated in the data collection process for this study. Significantly, the in-depth description and rich data that can be generated through ethnography allow for a greater understanding of phenomena in healthcare (Geertz 1973; Cruz and Higginbottom 2013).

Holloway and Todres (2010) posit that ethnographic research can produce new nursing knowledge and help to improve and change practice. Thus, adopting an ethnographic approach not only provides insight into refugee health nursing from the experiences of RHNs, managers and refugees in Victoria Australia, but encourages reflection on how practice could be improved and whether this type of nursing initiative may be considered across similar resettlement areas in countries such as Scotland, to enhance refugee health experiences.

Wall (2015) outlines various approaches within ethnographic research, including traditional ethnography, systematic ethnography, critical ethnography and institutional ethnography and these methodological adaptations correspond to the moments of paradigmatic change described by Denzin and Lincoln (2005), including traditional, modernist, blurred and postmodern and feminist. Nevertheless, all ethnographic approaches are holistic, reflective and contextual, incorporating emic and etic data and offering a final report with thick description.

Ethnography can be broadly classified into two main types (Cruz and Higginbottom 2013). 'Macro-ethnography' is the traditional approach, involving broadly defined cultures, and in this instance, researchers typically do not enter the field with a formally specified research question. On the other hand, 'micro-ethnography,' or 'focused ethnography,' places emphasis on more narrowly defined cultures and is epitomised by short-term field visits, an interest in a specific research question and a researcher with background knowledge of the cultural group (Wall 2015). As Cruz and Higginbottom (2013 p38) suggest, '*focused ethnography has emerged as a useful tool*

in gaining a better understanding of the experiences of specific aspects of people's ways of life and being. Of significance, focused ethnographies have pre-selected topics of enquiry and data can be gathered in a shorter time frame than a traditional ethnographic approach (Morse and Field 1996).

With regards to this study, I had prior knowledge and experience of refugee health nursing in a different setting, and thus, I had an idea about where to look and what to ask; the issue is otherwise one of selection bias. In sum, focused ethnography deals with distinct problems in specific cultural contexts (Wall 2015) and it is deemed particularly useful in evaluating and eliciting information on shared experiences, with research questions relating to the perspectives of participants (Cruz and Higginbottom 2013).

As I aimed to explore the views of RHNs, managers and refugees, who have specific knowledge of refugee health in the context of community resettlement, focused ethnography was selected as the research design for this study. I held prior knowledge of the field and thus, this research design was considered suitable, as it allowed me to better understand the complexities surrounding issues from the participants' perspectives (emic view) in the resettlement context, while concurrently bringing my outsider's knowledge to the study (etic view) (Roper and Shapira 2000).

Focused ethnography was deemed the most appropriate research design for this study and will now be discussed in detail, with reference to my reasoning and the nuances which sets this methodology apart from others.

4.6.1.2 Focused ethnography

Focused ethnography was chosen as the methodology for enquiry, to consider how health practices and beliefs are integrated into people's lives within the RHP. This approach enabled me to understand meanings that members from sub-cultural groups assign to their experiences and to explore refugee health nursing as a social and cultural phenomenon (Roper and Shapira 2000).

I endeavoured to understand this specialist field from the views of participants, which is known as the emic perspective or insider's view (Crotty 1998). This corresponds with the overall aim and philosophical positioning of this study, to gain insight into the perspectives and experiences of RHNs, managers and refugees within

the RHP, as these sub-cultural groups hold insider knowledge of refugee health nursing in the community setting, albeit, experienced from different angles.

As mentioned, focused or micro-ethnography follows some of the customary elements of traditional ethnography, but can allow for research to be undertaken with a pre-formulated question in mind, enabling a focused exploration of a particular phenomenon (Knoblauch 2005). Indeed, focused ethnography can be applied *'to any discipline whenever there is a desire to explore specific cultural perspectives held by sub-groups of people within a context specific and problem-focused framework'* (Higginbottom et al 2013 p1).

In terms of refugee health nursing in Victoria, Australia, the problem relates to a lack of understanding about experiences within this field and the unknown impact of targeted refugee healthcare on refugees, RHNs and managers. Refugee health nursing is a relatively unexplored and underutilised field in the contemporary community health landscape, and there is currently limited insight into how RHNs, managers and refugees are coping in this world of nursing practice. Due to increasing global movement and displacement, there is rationale to consider refugee health nursing as a viable approach to providing quality healthcare for resettled refugees, as it is time that other high-income host countries did something to improve the health experiences of this population. By using a focused ethnographic approach, I acknowledged the different groups who have in-depth knowledge of refugee healthcare, with recognition of social dynamics within the resettlement context.

A focused ethnographic approach was used in this study to understand shared experiences within refugee health nursing, but also to improve and change practice in this field (Cruz and Higginbottom 2013). It was my intention to enhance refugee health nursing by reflecting on current practice in Victoria, Australia, as well as to consider whether the RHP could be transferable to other resettlement areas, such as Scotland. As Higginbottom et al (2013 p2) point out, *'with focused ethnography, the findings are anticipated to have meaningful and useful application in community or hospital healthcare practice.'*

This methodology was judged to be appropriate in its significance to SI and in answering the problem-focused and context-specific research questions. In addition, there were various practical motives underlying the decision to incorporate focused ethnography as the research strategy guiding this study, and I will now offer justification for my thinking.

In contrast with the traditional ethnographic approach, it is proposed that focused ethnographies draw attention to distinct communities or organisations, select particular episodes of participant observation, incorporate semi-structured interviews and involve limited numbers of participants who have been chosen for their precise knowledge and experience of the phenomenon, rather than those the researcher has developed a close, trusting relationship with over time (Muecke 1994). As Cruz and Higginbottom (2013 p38) point out, '*despite being shorter-term studies, a significant amount of data can be collected.*' Intensive data collection is common and compensates for shorter field visits, producing a large amount of data for analysis in a shorter amount of time (Knoblauch 2005). In contrast to the traditional ethnographic style, focused ethnographies are short-ranged and not continual, and field visits are undertaken sporadically in various intervals (Knoblauch 2005). Logistically, this line of enquiry was reckoned to be suitable in exploring social life within the RHP, as I could undertake field visits on a part-time basis during a short-ranged time frame, to fit around part-time PhD study and other professional nursing practice requirements.

While traditional ethnographic research may be called 'open,' in focused ethnography, attention is narrowed, as boundaries are restricted to the substance of situated performance in everyday social interaction. As my motivation was to explore experiences and interactions within the RHP, I '*lay a focus on the particular,*' (Knoblauch 2005 p7), with regards to groups of RHNs, managers and refugees in the community resettlement context.

Knoblauch (2005 p3) suggests that in undertaking traditional ethnography, the researcher is confronted with '*strangeness,*' which is a situation of unfamiliarity with the general culture and participants may appear, therefore, as '*other,*' *different*' or '*alien.*' As a distinction, '*alterity*' is necessary for focused ethnographies, which means that the researcher should have prior knowledge of the culture to be investigated and an understanding of the language used within the culture (Knoblauch 2005 p3). As a nurse with experience in the field of refugee health nursing, albeit in a different context, this allowed me to form a clear focus and research question before I commenced this study, which is one of the major features of focused ethnography. Due to my background knowledge and previous experience in caring for refugees in a nursing capacity, I could zone in on the particulars of this field.

In summary, the fundamental reasons for choosing focused ethnography to guide this study included the ability to concentrate directly on experiences and shared

cultural perspectives within refugee health nursing across specific groups in the resettlement context, as well as the potential for collecting rich data from participants with knowledge of the phenomenon. This approach allowed for significantly less fieldwork and the research to be undertaken within a shorter timeframe, in line with part-time PhD study requirements (Roper and Shapira 2000). Furthermore, focused ethnography is especially relevant when conducting applied social research in highly specialised or fragmented fields of study, such as community refugee health nursing (Knoblauch 2005), and this methodology enabled me to better understand the interrelationship between participants and the resettlement environment, as well as the impact of targeted refugee healthcare.

Nevertheless, as mentioned, alternative methodological approaches were initially considered and these are now addressed to demonstrate the process of deduction.

4.6.1.3 Alternative qualitative approaches considered

During the planning phase of this study, various qualitative approaches were deliberated upon before deciding on focused ethnography. Phenomenology, grounded theory and institutional ethnography were considered as potential research designs and these approaches will now be discussed, illustrating my decision-making in choosing the most appropriate methodology.

I initially considered phenomenology as a suitable research design because this approach is associated with describing and understanding the world of the individual in relation to an experience or phenomenon (Holloway and Wheeler 2010). Conversely, I was interested in understanding experiences and perspectives from distinct but overlapping worlds; that of RHNs, managers and refugees. I am intrigued by the interaction between individuals and groups within refugee health nursing, as well as the context in which these experiences take shape, not simply the lived experience.

I also contemplated grounded theory while planning this study, which involves systematically obtaining data through social research to aid in the discovery of theory. Grounded theory is different from other research designs as it integrates theoretical sampling, constant comparative analysis and the development of theory (Holloway and Wheeler 2010). However, while planning this study, I was concerned about the

practicalities of sampling within grounded theory methodology. Moreover, given my existing knowledge and experience of refugee health nursing, there would have been a conflict with one of the underlying principles in grounded theory; that of being naïve to the proposed research subject.

I then pondered institutional ethnography as a potential strategy, which is a method of enquiry that uses interviews, observations and document analysis to investigate how guidelines and procedures used in organisations coordinate local, lived experiences (Smith 2005). However, although I was interested in the social organisation and makeup of the RHP, my focus was less on structural processes and more on the exploration of experiences and relationships, and how these experiences shape the field of refugee health nursing. Through reading about institutional ethnography and in narrowing my research focus, my academic supervisors advised that I consider focused ethnography as a suitable methodology, as this aligned with my thought process and offered a suitable strategy in meeting the study aim.

Having made the decision to employ focused ethnography as the research design steering this study, I started to think about where I could potentially undertake this research, to ensure that I could access appropriate study sites and participants that could help in answering the research questions.

4.6.2 Selecting the fields

The process of identifying and selecting the fields started in June 2016, when I contacted the State-Wide Facilitator of the RHP through an email address that was available on the RHP website. I explained my interest in refugee health nursing and my ideas with regards to developing a research study to explore experiences within the RHP in Victoria.

As I was still based in Edinburgh, Scotland and the State-Wide Facilitator lived in Melbourne, Australia, she kindly replied by email to offer discussing my proposal via telephone call. The State-Wide Facilitator was helpful, and we continued our discussions during subsequent emails, telephone and video calls over the following months. I expressed that I wished to explore the RHP from both a metropolitan and rural/regional perspective, to gain insight into experiences of refugee health across diverse settings and thus, enable findings to be more transferable to various refugee resettlement areas in countries such as Scotland.

From our initial email conversation, the State-Wide Facilitator suggested one metropolitan site and one rural/regional site offering the RHP which would be suitable in exploring the experiences of RHNs, managers and refugees. The rationale for proposing these sites related to the size of the refugee health teams and the scope for recruiting potential participants, as well as her notion that managers and RHNs at these two sites may be amenable to participate in this study.

Therefore, fields for the study included one community health centre in a metropolitan part of Victoria and one community health centre in a rural/regional part of Victoria offering the RHP for newly arrived refugees with complex health needs. Hammersley and Atkinson (2007) suggest that researchers should try to engage in a process of casing the joint, finding out about potential settings to help inform decisions about the suitability of the field and the feasibility of undertaking research in this setting. However, as I lived in Scotland and the research sites were in Australia, I relied upon the advice and guidance of the State-Wide Facilitator in selecting appropriate fields for this study.

4.6.3 Gaining access

Negotiating access is often one of the first research obstacles to surmount, and Gelling (2010) identifies some of the practical and social difficulties involved in this process.

An ethnographic researcher must negotiate entrance to the field, usually through a gatekeeper, who provides permission and facilitates access to the field site and potential participants (Gelling 2010). In this study, the gatekeeper was the State-Wide Facilitator of the RHP, who was supportive of the research proposal and offered advice with regards to the process of applying for ethical permission at both sites. Although the RHP is a state-wide service offered across various geographical areas in Victoria, each community health centre offering the RHP is operated by an independent community health organisation.

The local Research and Development department for the metropolitan community health centre was contacted in January 2017 to determine the process for ethical approval for this study. The ethical committee review and approval process for research to be conducted at the metropolitan site took place on the 6th of February

2017 by the local Human Ethics Advisory Group (HEAG) and a favourable ethical opinion was granted (Reference 1701).

On the 14th of February 2017, the Chief Executive Officer (CEO) of the rural/regional community health centre agreed that if the metropolitan site ethics was approved, then the rural/regional site would accept this approval. The CEO therefore granted permission for the rural/regional site to participate in this study, based on ethical approval from the HEAG at the metropolitan site. Thus, ethical approval to undertake this study was granted at both metropolitan and rural/regional sites.

Subsequently, two ethical amendments were made to this study. Initially, I planned to undertake semi-structured interviews with refugees and RHNs. However, as I spent more time in the field, I came to realise the important role played by managers working within the RHP and it was agreed with my academic supervisors and the State-Wide Facilitator that the experiences and perspectives of managers could contribute to a more holistic insight into social life within the RHP. On the 18th of July 2017, an ethical amendment was granted to allow for semi-structured interviews to be undertaken with managers at both sites.

Furthermore, as I progressed with data collection, it became apparent that some non-English speaking refugees were interested in participating in this study. On the 13th of October 2017, a second ethical amendment was granted to allow for interviews to be conducted with non-English speaking refugees across both sites, with the assistance of accredited interpreters.

4.6.4 Entering the field and setting boundaries

Having undertaken the planning process for this study, I arrived in Victoria, Australia on the 14th of January 2017 and arranged to meet with the State-Wide Facilitator of the RHP on the 16th of January 2017. The meeting took place at the metropolitan community health centre and I was introduced to the manager at this site.

During the meeting, we discussed progress with the ethics application associated with this study and it was agreed that after ethical approval was granted by the metropolitan site Human Ethics Advisory Group (HEAG), (Reference: 1701) and the University of Edinburgh (Reference: NURS020) I could return to the community health centre to speak with the manager and RHNs in more detail about the study. The manager advised that there was an upcoming RHN team meeting

scheduled and invited me to attend, allowing time within this meeting for me to present information about the study. In the meantime, I sent formal letters of invitation to the Refugee Health Managers at both sites (Appendix 6).

As planned, I returned to the metropolitan site after ethical approval was given and attended the team meeting. I presented the study to the manager and the four RHNs working at this site, offering study information sheets for the manager and RHNs at the end of this presentation and answering any questions (Appendix 7). To provide ample opportunity for potential participants to think about the study, I explained that I would return to the community health centre in two weeks and at that point, I would ask if the manager and RHNs would like to take part.

With ethical approval granted at the rural/regional site, the State-Wide Facilitator of the RHP liaised with the manager at the rural/regional community health centre and advised that I could contact this manager via email to arrange a suitable date and time to present the study information. I visited the rural/regional community health centre and described the study to the manager and the two RHNs working at this site. In likeness with the metropolitan site, I offered study information sheets to the manager and RHNs and answered any questions, elucidating that I would return in two weeks to ask if they might be interested in participating.

Study information sheets were also produced for potential refugee participants, although due to limited funding, these were only available in English (Appendix 8). I found that although some refugees could speak English, most could not read and write in English. Therefore, study information was predominantly communicated to refugees verbally, with the assistance of an accredited translator when required, which is discussed in detail during the overview of ethical considerations later in the thesis.

On returning to the metropolitan site, the manager and three of four RHNs agreed to take part. The remaining RHN did not offer reasoning as to why they refused to participate. When I returned to the rural/regional site, the manager and both RHNs agreed to take part. Therefore, two managers and five RHNs were recruited as participants in this study. Consent forms were signed accordingly, and it was decided that I could begin undertaking my research at any point thereafter (Appendix 9). I commenced data collection at both sites in April 2017. The recruitment of refugee participants occurred after I was immersed in the field, with eight refugees agreeing to participate in semi-structured interviews and nine refugees taking part in two focus groups, the first with four refugees and the second with five refugees (Appendix 10).

I designed a poster to inform staff within the community health centres about the study, as I understood that my continued presence at these sites may have caused some intrigue; and this was displayed in the reception areas of the community health centres. I was granted formal access at both sites with a visitor ID badge, and this was issued by the receptionist at each site, both of whom I became familiar with as data collection progressed, due to regular field visits. On average, visits were twice weekly as the PhD was being undertaken part-time. I visited the metropolitan site once per week and the rural/regional site once per week.

With regards to setting boundaries for the metropolitan and rural/regional fields, I undertook ethnographic research in line with ethical stipulations outlined in the approval. I was able to observe clinic appointments with refugees, as well as to observe the daily happenings within the RHP, such as organised social activities. I spent time with RHNs, becoming familiar with the routine and nursing processes undertaken within the community health centres. Furthermore, I joined the RHNs for lunch breaks, providing additional opportunities to discuss the study whilst allowing an opportunity to get to know the teams and become accepted as a researcher. Likewise, RHNs used this time to ask questions about the study and find out about my interest in refugee healthcare.

As Dewalt et al (1998) consider, it is essential for the ethnographic researcher to establish affinity and become familiar with the setting, including the daily practices, routines and language used, showing interest in the field to develop trust and respect from participants.

4.6.5 Researcher role and identity

I have experience within refugee health, in a nursing capacity across refugee camps in Europe, and through supporting refugees with practicalities and social engagement on resettlement in Edinburgh. This background meant that I was familiar with refugee health issues, although I had no experience of community refugee health nursing in the resettlement context and no experience within the RHP in Australia. I could therefore be considered as an outsider (Hammersley and Atkinson 2007). This ethnographic position of being an outsider was a privileged stance and supported objectivity, as I did not have prior status in the group under study which may have affected my discovery or subsequent interpretation of the findings (Hammersley and

Atkinson 2007). Indeed, focused ethnographic research is advocated in exploring the complexities of nursing practice, due to the insider/outsider aspect of this approach (Cruz and Higginbottom 2013).

In speaking with participants, I was open about my background in refugee health nursing, although I did not provide any care for refugees during my time as a nurse researcher.

Significantly, the appearance of an ethnographic researcher in a setting requires consideration prior to conducting the research (Hammersley and Atkinson 2007). Managers and RHNs wore smart, casual clothes at both sites, and I wore similar attire, allowing me to fit in to the organisational culture. According to Agar (1996), presentation of self or impression management is an important aspect of ethnographic research.

I also kept a reflective diary in the form of fieldnotes, enabling me to document thoughts and feelings throughout the research process; reflecting on my academic and professional role as nurse researcher.

With regards to conducting the data collection for this study, I used a purposive sampling strategy due to the nature of the RHP across both sites. Having obtained informed consent from managers and RHNs before entering the field, I then used a snowballing sampling strategy to recruit refugee participants. Holloway and Wheeler (2010) suggest that sampling is a key part of the research process and this will now be described in detail.

4.6.6 Sampling

Qualitative research incorporates non-probability sampling, in that rather than generalisability, there is a preference for rich data that is specific to the population under study (Higginbottom et al 2013).

In terms of focused ethnography, the most common type of non-probability sampling strategy is purposive sampling. Of note, Higginbottom et al (2013 p4) put forward that, '*purposive sampling stems from the fact that participants have specific knowledge or experience which is judged to be of interest to the investigation,*' which is applicable to this study. By incorporating a purposive sampling technique, participants were selected with certain criteria in mind, guided by the research aim and questions. To explore perspectives of refugee health nursing, RHN, manager and

refugee participants were included, who have personal knowledge and experience of the phenomenon under study (Endacott and Botti 2007).

Holloway and Wheeler (2010) propose that purposive sampling can also involve selection of the research site or field. For example, in this study, it was important to find one metropolitan community health centre and one rural/regional community health centre offering the RHP, to gain insight into refugee health nursing across diverse settings; thus, allowing transferability to a range of other resettlement contexts.

In consultation with the State-Wide Facilitator of the RHP, my academic supervisors and I agreed to aim for a sample size of approximately 14 participants for individual semi-structured interviews. I planned to include six refugees, six RHNs and two managers, who were to be recruited across the two sites. Managers and RHNs were purposively recruited prior to entering the field, whereas refugees were invited to participate in semi-structured interviews and focus groups further down the track.

To offer more detail, purpose sampling in this study was complemented by an additional strategy called snowballing, which is also referred to as opportunistic or nominated sampling. Snowballing takes shape when participants act as recruitment or referral agents for further participation, which was employed in this study (Higginbottom et al 2013). Once I was immersed in the field, RHN participants agreed to act as referrals agents for refugees, recommending potential refugee participants for semi-structured interviews and focus groups, who were then invited to take part.

To recruit participants who could help in answering the research aim and questions, eligibility criteria specific to groups of RHNs, managers and refugees were used to steer appropriate participation in semi-structured interviews, as outlined in table 1.

Table 1: Eligibility criteria

Inclusion Criteria	Exclusion Criteria
Refugee Health Nurses offering support to refugees through the Victorian Refugee Health Program.	Refugees who lack the capacity to consent to this study under the Victorian Mental Health Act 2014.
Refugee Health Managers involved in the local management of the Victorian Refugee Health Program.	Refugees under the age of 18 years old.
Refugees involved in the Victorian Refugee Health Program who are aged 18 and over.	

With regards to managers and RHNs, the availability of potential participants was limited and therefore, variety in these samples was constrained. However, a range of refugee participants were sought to achieve multiplicity in this sample, for example by gender, age, country of origin and time spent living in Australia. To allow for flexibility in the selection of refugee participants, I obtained permission from the ethics committee to be able to recruit 12 refugees for semi-structured interviews, six from each site. Indeed, according to Higginbottom et al (2013), focused ethnographies typically involve a limited number of participants.

To ensure adequacy of the study sample in relation to undertaking interviews, it was useful to consider the concept of data sufficiency, which added to the integrity of the research (Endacott and Botti 2007). Data sufficiency often dictates the sample size, in that participants are recruited until the topic has been fully explored and no new codes are developed from additional interviews. Of significance, codes do not necessarily hold meaning, and therefore it is not the codes, but rather the new insights that result from analysis. With regards to the snowballing sampling technique for refugees, there was a larger selection of potential participants than for managers and RHNs and data sufficiency determined the sample size of refugees in this instance. Through the process of thematic analysis (TA), inductive thematic sufficiency was

achieved (Braun and Clarke 2006). As data collection and analysis were conducted simultaneously, I reached a point during data analysis where new codes, ideas and themes no longer emerged from the data.

Sufficiency can be achieved through the incorporation of multiple data collection methods, lengthy time in the field and a sample that is typical of the culture under study (Endacott and Botti 2007). However, the level of data analysis is paramount in reaching sufficiency, as this is not a data quantity issue, but a data quality issue. Fusch and Ness (2015) note that triangulation can assist in ensuring sufficiency of data, which means the inclusion of different groups and methods during data collection.

Importantly, sampling in focused ethnography *'includes both individuals in the culture and events which occur within the group that add to the researcher's understanding of the values and norms'* (Morse and Field 1996 p127). I understood the impossibility of the implicit aspiration of trying to describe everything through an all-seeing ethnographic and theoretical eye, so as I could not be in many different places at once, inevitably then, I made conscious decisions about where and who to observe, as well as when and how to record data.

Having determined the sampling strategy for this study and gained access to the fields, it was time to begin collecting data and this was undertaken through participant observation and the generation of fieldnotes, semi-structured interviews with eight refugees, five RHNs and two managers, two focus groups with four refugees and five refugees, respectively, as well as consideration of documents and policy relevant to refugee health nursing in Victoria, Australia.

4.6.7 Data collection strategies

To meet the overall research aim and questions, ethnographic data were generated through a combination of methods. The following section offers a detailed overview of these methods and the ways in which they were employed.

I gained ethical approval from the University of Edinburgh in January 2017 (Reference: NURS020), and from the metropolitan site Human Ethics Advisory Group (HEAG) to access both fields, in February 2017 (Reference: 1701). I obtained informed consent for full participation from managers and RHNs in April 2017. Subsequently, I began data collection in April 2017 and obtained informed consent from refugees at

various times thereafter. I left the field in December 2017, when sufficiency of the data was evident.

I will now outline the methods used to gather ethnographic data during my time in the field, addressing participation observation and fieldnotes, semi-structured interviews, focus groups and consideration of documents used within the RHP.

4.6.7.1 Participant observation

Participant observation has been described as the centrepiece of ethnographic research; indeed, in undertaking observation, the ethnographer is a human instrument (Atkinson 2015).

Adler and Adler (1998 p81) suggest that '*qualitative observation is fundamentally naturalistic in essence; it occurs in the natural context of occurrence, among the actors who would naturally be participating in the interaction, and follows the natural stream of everyday life.*'

As I had previous experience in refugee health nursing practice but out-with the community setting, it was anticipated that observation sessions would allow me to better understand the resettlement environment; hence, offering context to inform and guide the interviews. The main purpose of the observations was to gain insight into everyday activities undertaken within refugee health nursing practice, as well as to establish trust and build rapport with RHNs, managers and refugees. Thus, the observations were important in collecting rich information about processes and relationships within the RHP, as well as discovering meanings that participants assigned to their experiences and providing contextual data about the resettlement environment.

As an observer-as-participant, researchers undertake observations or interviews on the outside looking in, allowing research to be undertaken with less interference in the natural environment (Morse and Field 1996). However, a drawback of the observer-as-participant perspective is being viewed as an outsider, and therefore, not building a trusting rapport with participants (Roper and Shapira 2000). In a purely observational capacity, this may also lead to unfair interpretations of the event, action or behaviour being studied, without being able to confirm what has been observed.

In this study, I occupied the role of peripheral-member researcher, because *'an insider's perspective is vital to forming an accurate appraisal of human group life, so they observe and interact closely enough with members to establish an insider's identity without participating in those activities constituting the core of group membership'* (Adler and Adler 1998 p85). With a nursing background, as I immersed myself into the field, I naturally gravitated towards the RHNs and soon became accustomed to observing and participating in their everyday practice. During observation sessions with RHNs, I was exposed to their interactions with managers and refugees, allowing me to gain insight into professional and social relationships. Managers and refugees did not come into contact, so RHNs were intermediaries between the primary sub-cultural groups.

In terms of the identification of fields under study, this involved the comings and goings of the RHP within the metropolitan and rural/regional sites. At some points during the research, for example, during refugee clinic appointments, I was in the field in a purely observational role, watching and listening to the participants and taking notes in the form of fieldnotes. Other times, I was able to engage with refugees, RHNs and managers during fieldwork. O'Reilly (2012) acknowledges the alchemy of being an observer and participant in ethnographic observation, continuously shifting depending on the situation. The flexibility of the researcher to adapt their role and extent of participation is important when conducting ethnographic research, particularly in healthcare contexts, where participation might be inappropriate or insensitive. Key to being able to participate in participant observation, I became part of the group, gaining trust and therefore being able to access more observational data (O'Reilly 2012).

It is important to acknowledge the boundaries of this ethnographic research, with regards to the metropolitan and rural/regional fields. Ethical approval for this study permitted observation of activities associated with the RHP, and working alongside RHNs allowed me to observe their everyday practices. Verbal consent for all varieties of participant observation conducted in this study was obtained prior to observation. Spradley (1980) recommends that observation should begin with descriptive general observations, which will then become more focused and selective as the research progresses. In this study, observations were initially unstructured, as I was guided by the practices of RHNs in the field and remained open to an array of opportunities to observe activities within the RHP. As the data collection process continued, I started

to focus my attention on specific aspects of refugee health nursing, to achieve data sufficiency on certain topics. I remained open-minded with regards to other scenarios, but there was an emerging focus over time.

With regards to RHN appointments with refugees, when RHNs met with refugees, the RHN would ask the refugee at the beginning of the appointment if I could observe. During refugee clinic appointments or home visits, I observed these interactions, and I could ask the RHN questions afterwards to clarify any confusion and solidify my understanding of the interaction. Importantly, this added to the credibility and trustworthiness of observational data. Indeed, observations allowed for the '*interweaving of looking, listening, and asking*' (Lofland 1971 p109), linking what I had seen and heard (Roper and Shapira 2000).

Over time, the fields under study were expanded, which is a normal process in this methodology. Typically, at the start of focused ethnographic research, consent is both tentative and limited, and my access to sensitive aspects of the setting was in some ways, restricted. Over time, as trust between myself and the hosts developed, access was granted to previously restricted areas or interactions (Murphy and Dingwall 2007). Appropriate consent for observation was achieved through an ongoing and developmental negotiation of my relationship with research participants (Parker 2007), and all observations were undertaken ethically.

I conducted participant observation twice weekly during data collection for this study. I spent one day per week at the metropolitan site and one day per week at the rural/regional site for 35 weeks from April 2017 until December 2017, with field visits lasting approximately six hours. During this time, I was open to opportunities to observe daily activities and appointments within the RHP and joined the RHNs for breaks, allowing me to speak with them about the study in more detail. This allowed a trusting relationship to develop with RHNs and enabled me to set boundaries on my role as researcher. As I spent more time with RHNs, we developed a friendly relationship, and I reflected upon this regularly with my academic supervisors, who provided advice with regards to maintaining professional boundaries, while also allowing myself to become part of the social group to collect data.

Adler and Adler (1998 p81) highlight that, '*simple observers follow the flow of events. Behaviour and interaction occur as they would without the presence of the researcher.*' I tried not to disrupt normal activity within the community health centres,

observing nursing practice and the various interactions between refugees, RHNs and managers. Indeed, Adler and Adler (1998 p101) posit that observing as a method of data collection in the social sciences is described as the '*least obtrusive*' method but recognise the ethical considerations around invasion of privacy. RHNs were encouraged to let me know if my presence was altering the care they were delivering for refugees. Likewise, it was made clear to refugees through the study information sheet discussions that I would discontinue my observation if they felt uncomfortable or changed their minds about allowing me to observe appointments (Appendix 8).

In addition, I developed observation schedules to maintain an accurate record of my time in the field, including details about the environment and activities I observed, who was involved and interactions between RHN, managers and refugees. Rough notes were made before, during and after each observation session in the field and these notes did not include any identifiable information. I regularly shared fieldnotes with my academic supervisors, who provided feedback and advice for further reflection on my observations. In relation to this point, I now draw attention to the ways in which I generated fieldnotes during data collection for this study.

4.6.7.2 Fieldnotes

Fieldnotes are the documentation of observations and conversations from time spent in the field, helping to describe the researcher's experience (Atkinson 2011). Fieldnotes are a way of formally keeping tabs on what has been observed and offer a 'thick description' of the fieldwork (Geertz 1973), which is discussed in more detail later.

I used fieldnotes to write down all the information I thought was relevant or interesting, creating a descriptive narrative of people, scenes and conversations, along with my personal experiences, thoughts and reactions (Atkinson et al 2011). Pointedly, in their guide to qualitative observation and analysis, Lofland and Lofland (1995 p93) offer helpful advice in that, '*The writing of running descriptions is guided by at least two rules of thumb: 1) Be concrete, and 2) distinguish verbatim accounts from those that are paraphrased or based on general recall.*' This proved useful in creating an accurate record of observations and recounting my own perceptions. Within my fieldnotes, I captured flashes of insight and intrigue, encouraging reflexive practice and helping me to remember key moments (O'Reilly 2012).

In this study, fieldnotes were taken as soon as data collection began; documenting observations, dialogue, feelings and interpretations, and this raw data were then transcribed and used for analysis. I documented who was interviewed and where, different responses and comments made during participant interactions, as this information helped to bring data to life, in terms of telling a more comprehensive story. I noted my observations of refugee clinic appointments, social activities and events that occurred and various meetings within the RHP, to establish the context of the research and keep track of all the different experiences within the field work.

Fieldnotes were written into a notebook using pseudonyms and then transcribed and stored securely, in line with ethical approval. The fieldnotes were transcribed as soon as possible after leaving the field, within 24 hours of the observation period, to ensure that data were recorded accurately.

Participant observation continued throughout the data collection process, however, as Roper and Shapira (2000) point out, thoughts and feelings cannot be observed. Therefore, it was important to begin the undertaking of semi-structured interviews, digging deeper into how participants were feeling and exploring views and experiences of refugee health nursing as a social and cultural phenomenon. Observations aided my understanding and provided inspiration for subsequent interviews with participants, to gain clarity or to investigate topics of interest.

4.6.7.3 Semi-structured interviews

It is proposed that *'interviews will help validate observations and provide directions for future observations, collect data on issues that cannot or have not been observed, and collect data on non-observable phenomena including feelings'* (Higginbottom et al 2013 p5).

Interestingly, structured interviews can be described as a *'verbal questionnaire'* (Newell and Burnard 2006 p60), consisting of a series of questions to be answered by the participant. This format of interview sticks rigidly to the interview schedule, without permitting an exploration of responses. In contrast, dialogue within an unstructured interview can move fluidly through topics as the interview develops, and no precise pathway is followed. Unstructured interviews can be difficult to manage as they are guided by the participant's responses, and this form of interview may lose focus (Rubin and Rubin 2012).

Finding middle-ground, semi-structured interviews offer flexibility, which is essential in exploring unexpected issues raised by participants, while at the same time, covering topics within the interview guide (Holloway and Wheeler 2010).

In this study, semi-structured interviews were conducted with five RHNs, two managers and eight refugees and typically lasted for one hour. Two semi-structured interviews with refugees were conducted in English and six interviews with refugees, as well as both focus groups, were conducted with the assistance of an accredited translator. Ethical considerations with regards to the use of interpretation services in cross-language research are address in section 4.6.10.4, which speaks to the concept of justice. One interview was undertaken with two refugees simultaneously at their request, as these participants were family members.

Semi-structured interviews were performed with the use of a topic interview guide, containing themes, questions and ideas for conversations that were relevant to the research questions. I prepared some lines of enquiry for each group, prompting and probing the participant to reveal more in their responses when interesting ideas emerged. This approach allowed me to focus on certain topics but also to gain in-depth information and pay attention to what was important and meaningful for participants, enabling a smooth flow of conversation as I listened and let participants introduce topics of their own.

Interview guides contained a list of topic areas and questions, and interview guides for all three groups of participants were reviewed prior to recruitment by my academic supervisors. Additionally, questions for RHNs were reviewed by a nursing colleague in a different clinical area, questions for managers were reviewed by a fellow PhD student at the University of Edinburgh and questions for refugees were reviewed by a refugee that I was befriending in Edinburgh through a local charity at the time of planning this study. This process was critical, as it is suggested that credibility of the researcher can be established through asking questions which are meaningful to participants and relevant to the phenomenon under study (Legard et al 2003). In particular, review of the refugee interview questions proved useful, as it became apparent during this process that the wording of some of the original questions was too complex and thus, I changed the format and language used for refugee participants, as is demonstrated in appendix 3.

As data collection progressed, interview questions changed over time, linking with the concept of data sufficiency. Through gaining insight into refugee health nursing experiences, I narrowed my focus slightly but allowed flexibility in the topics which emerged during interviews.

According to Rubin and Rubin (2012 p6), qualitative interviewing *'requires intense listening, a respect for and curiosity about people's experiences and perspectives, and the ability to ask about what is not yet understood.'* Therefore, I was invested in the process of establishing rapport with RHNs, managers and refugees, creating a respectful environment for interview. Indeed, there was a need to develop a *'trusting personal relationship'* with participants, encouraging open, candid and rich accounts, especially when exploring peoples' personal experiences in refugee health nursing, which were often of a sensitive nature (Rubin and Rubin 2012 p6).

While it is possible to build up relationships over time in traditional ethnography, in this focused ethnographic study, I spent less time in the field, with visits taking place in weekly intervals at each site, rather than being continual (Knoblauch 2005). I got to know the RHNs and managers working in the RHP from repeated field visits, however different refugees attended the community health centres during each of my visits and therefore, it proved challenging to build trusting relationships with refugee participants prior to interviews.

Legard et al (2003) highlight various strategies to facilitate an effective relationship with participants during interviews, including expressing an interest in what is being said, observing body language and listening for clues in tone of voice, allowing people time to think and reply, pacing the interview and approaching the subject afresh with each participant. I drew upon my experience as a nurse to develop trusting relationships with participants, as facilitating open-ended communication is fundamental to nursing practice. I found that as I became more accustomed to undertaking interviews, I became more confident and relaxed in this process. Interestingly, as interviews became more conversation-like, I was able to probe deeper into arising issues as it felt more natural to follow the flow of discussion. This led to the exposure and discovery of topics that I had not considered prior to undertaking interviews, which reminded me to keep an open mind when undertaking subsequent interviews.

Sometimes, the direction of enquiry was informed by my own knowledge of refugee health nursing; knowing the relative norms of practice meant that I was able to delve into any deviations from this. As Field (1991) points out, a researcher with experience of the phenomenon can enhance the richness of the data.

In addition to interview questions, of significance is the environment in which an interview takes place. It is suggested that accessibility, comfort, and a minimal level of distraction are essential components in maintaining an appropriate environment for interview (Holloway and Todres 2010). At both the metropolitan and rural/regional sites, I was offered private access to the clinic rooms in which RHNs usually undertake appointments with refugees. These rooms were suitable for interviewing as there were comfortable sofas, natural light and RHNs and refugees were familiar with this environment. Interviews with managers at both sites were carried out in the manager's offices within the community health centres.

There were no interruptions to interviews conducted within the community health centres; however, while undertaking an interview in the home was more appropriate for some refugees, there were minor challenges with this environment, in terms of background noise and family distractions. Nevertheless, I found that refugees felt comfortable in their home setting and welcomed me into their space, on both occasions offering refreshments prior to and after the interview.

To capture the data presented during interviews, an encrypted digital voice recorder was used. This allowed me to listen to the participant's narrative and be present in the moment, as well as facilitating transcription and analysis. This method of recording data preserves the exact words in the interview. In addition, fieldnotes were created before and after interviews to provide context and allow reflection; aiding the process of data analysis and helping me to remain mindful of my role as nurse researcher. The files of the interviews were uploaded securely and then deleted from the voice recorder. To maintain the anonymity of participants, all data were anonymised when transcribed and pseudonyms are used when presenting the data in this thesis.

I was aware from my own experience as a nurse in refugee healthcare that participant experiences could be highly emotive. I was therefore cognisant that some participants may become distressed as they reflected upon their views and experiences, particularly refugees. Bearing this in mind, I reminded participants at the beginning of interviews about the voluntary nature of this study, and if there were any

questions that sparked feelings of discomfort, there was no need to answer. Details were included in the study protocol with regards to managing distress, and I felt confident in my ability to navigate these challenges. There were some refugee interviews in which participants became upset and I offered them time and empathy, with the option to pause, discontinue or postpone the interview. Nevertheless, all participants who became upset wished to continue with the interview process, and I became acutely aware that refugees relished the opportunity to have their voices heard, even if this caused emotional expression. Ethical considerations associated with interviewing will be discussed later in section 4.6.10.

At the end of each interview, I offered the participant an opportunity to mention anything else of interest. For some refugee participants, this appeared to be a chance to share stories from their countries of origin, with regards to ongoing crises in some parts of the world; explaining ongoing conditions of conflict and reflecting on past experiences.

With regards to the use of accredited translators in interpreting some refugee interviews, this process was straightforward to organise and I gained ethical approval for this amendment. When refugees attended clinic appointments with the RHN and required the assistance of a translator, the translator was booked by the community health organisation for 90 minutes. When a refugee agreed to take part in the study, the interview was planned to take place directly after their appointment with the RHN, so that the same translator could be used during the interview. On these occasions, the RHN reduced appointment times with refugees to 30 minutes, meaning that I could use the translator for one hour in undertaking the interview. As I became immersed in the field, I got to know the range of translators usually booked for sessions within the RHP and was able to develop professional working relationships. Translators were supportive of the study and helpful in acting as the mediator during interviews with non-English speaking refugees.

Interestingly, some refugees were eager to participate in the study but felt more comfortable undertaking an interview in group format. For this reason, two refugee focus groups were facilitated, with four participants and five participants, and focus group discussions were undertaken in line with ethical considerations for this study. Translators were utilised in both focus groups in the same way as they had been for semi-structured interviews, and therefore, no additional cost was incurred to me or the community health organisations for interpretation services.

4.6.7.4 Focus groups

As mentioned, RHNs acted as referral agents in this study and recommended refugees who they believed would be suitable participants. Interestingly, at the rural/regional site, some refugees agreed to take part in the study but requested that the interview be conducted alongside other refugees, as this concept felt more relaxed. In both instances, the groups of refugees were friends and from the same countries of origin, although had met in Australia.

To facilitate this process, focus group discussions were undertaken with the two groups on separate occasions, both of which lasting approximately one hour. Both focus group discussions were digitally recorded and conducted with the assistance of an accredited translator. Of note, none of these participants took part in semi-structured interviews. RHNs acted as referral agents in nominating these participants for focus group participation, based upon their conversations with refugees. Study information was communicated to potential focus group participants verbally through the RHN and accredited translator, and verbal informed consent from all participants was given at the beginning of both focus groups.

Powell and Single (1996 p499) define a focus group as *'a group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research.'* Of key significance, Morgan (1997) highlights the major component of participant interaction as a source of data in focus groups, and the active role of the researcher in creating group discussion. According to Morgan (1997), the main purpose of focus groups is to draw upon participants' attitudes, feelings, beliefs, and experiences, as these are more likely to be revealed via a social gathering and through interaction with others. As moderator of the focus groups, I held responsibility for steering conversation and challenging participants, especially to draw out people's differences and to tease out a diverse range of meanings within refugee health experiences.

In this study, the use of an accredited translator to facilitate communication between myself and the participants meant that the flow of discussion between participants was somewhat stilted. Kitzinger (1994) argues that interaction is the crucial feature of focus groups because the interaction between participants highlights their view of the world, the language they use about an issue and their values and beliefs about a situation or phenomenon. Interaction allows participants to ask

questions of each other, as well as to reconsider their own understandings of their specific experiences. During the focus groups, there were some breaks in conversation, due to the need for translation. Nevertheless, although the flow of discussion was affected at times and slower than it would have been otherwise, the interaction between participants in these focus groups remained evident and gives this method a high level of face validity, because what participants said could be confirmed, reinforced or contradicted within the group discussion (Webb and Kevern 2001). Furthermore, both focus group discussions generated a large amount of data in a short period of time.

Focus groups can be intimidating, especially for shy or inarticulate members (Sim 1998), but in this study, all participants were equally vocal and opinionated. As participants in each group were friends, there was already an established trust and ease of relationship, which led to the creation of a '*safe forum for the expression of views*' (Sim 1998 p346). Refugee participants in both focus groups engaged in discussion and debate. Interestingly, some were eager to raise issues or problems with the RHP, compared with individual interviews, and participants seemed to be more confident in voicing complaints with the support and encouragement of their peers.

This leads to reflection on the type of data that was generated from focus groups in this study, in comparison to data from semi-structured interviews. Participants in focus group discussions asked each other questions and probed one another to discover more about their opinions on certain matters, and sensitive data was revealed in this environment. With a social constructionist epistemology underpinning this study, knowledge is considered social and relational; highlighting that through social relationships and interaction, participants can make sense of their world (Burr 2003). Refugees were curious to find out if their peers shared views and similar experiences during the resettlement period. In this way, data from the focus groups reflects an interactive, experiential view of the RHP, including a variety of opinions and multiple realities within one conversation.

This notion also needs to be addressed on the analytical level and I will outline how I analysed focus group data in section 4.6.9.1.

In summary, although the use of an interpreter brought challenges to the nature of both focus groups, in terms of fluid interaction; rich data were indeed still generated from this method, as participants felt comfortable in sharing their honest perspectives,

focusing on shared experiences and challenges within refugee healthcare during the resettlement period.

Another fundamental component of focused ethnographic data collection involves the consideration of documents relevant to the phenomenon under study. Hence, I reflected upon how local refugee health policy, guidelines and assessment documents influence refugee health nursing practice, to get a fuller grasp of this field in the resettlement context. In this way, looking at documents offered some perspective on the culture of refugee health nursing, and paved the way to some interesting points with regards to undertaking observation, semi-structured interviews and focus groups.

4.6.7.5 The use of documents in offering context

According to Roper and Shapira (2000), the collection and analysis of documents such as policies, procedures, patient records, assessments or reviews can help to understand a community and to validate participant observations and interview findings. *'The amount, variety and depth of information obtained from these sources provide valuable data that can be used by the researcher to make sense of the culture being investigated'* (Cruz and Higginbottom 2013 p37). Although documents were not analysed in this study, I ruminated on the use of policies and guidelines to better understand how these influenced nursing practice and the care of refugees.

In line with recommendations by Higginbottom et al (2013), the use of a variety of documents were considered, including Victorian refugee health policy, procedural documents and refugee assessment and review documents. As highlighted, these documents were not analysed, but rather, used to confirm or contrast interview and observation findings, by considering the ways in which these documents were incorporated by study participants.

With regards to refugee health policy, the Victorian state government has produced guidelines for the operation of the RHP across metropolitan and rural/regional community health centres. I was concerned with how RHNs and managers use these guidelines to steer their everyday practice in refugee health. During observation sessions with RHNs and managers, I paid attention to the occasions in which clarity was sought from guidelines or these were mentioned in conversation. The following policy documents were considered in this study:

- Refugee Health Service Coordination for Victoria (Victorian State Government 2009)
- Refugee and Asylum Seeker Health Services: Guidelines for the Community Health Program (Victorian State Government 2019)
- The Victorian Refugee and Asylum Seeker Health Action Plan 2014-2018 (Victorian State Government 2014)

In relation to procedural and assessment documents, the Victorian Refugee Health Network has produced various documents to guide refugee health nursing practice and to provide structure to the service. These key documents were considered during this study:

- Refugee Health Program Eligibility Criteria, Victorian Refugee Health Network (Appendix 2)
- Refugee Health Assessment (Victorian Refugee Health Network 2012)
- Refugee Health Program: Three Month Review (Appendix 4)
- Refugee Health Program: Discharge and Review (Appendix 5)

I was interested in how RHNs utilised these templates in practice and how these documents were monitored by managers. I hoped to discover how policy and procedural documents influenced nursing practice and care within the RHP. I was also curious about refugee reaction to these documents, with regards to their understanding of documents used in the planning and evaluating of their care. During observation sessions, it became clear that these documents offered a model for nursing care, shaping the organisation of refugee health appointments in terms of providing a timeline for care planning. I became aware of the ways in which these documents were used in nursing practice and was attentive to the opinions of RHNs and managers about the usefulness and practicalities of these documents in planning and evaluating refugee care.

To conclude, in line with the focused ethnographic approach to qualitative research, I considered the use of various documents within the RHP and the ways in which refugees, RHNs and managers use and respond to guidelines and policies.

4.6.7.6 Summary of data collection

In summary, I employed a range of strategies to gather multifaceted data in relation to perspectives and experiences of refugee health nursing, gaining insight into the worlds of RHNs, managers and refugees. By incorporating participant observation and the generation of fieldnotes, semi-structured interviews and focus groups, as well as the consideration of how documents may influence nursing practice and refugee care, I collected rich data from a variety of sources, helping me to build a deeper understanding of the phenomenon under study.

4.6.8 Data management

The following sections on data management give a detailed overview of how data were collected and organised in preparation for data analysis.

4.6.8.1 Recording interviews and focus groups

Interviews were recorded using an encrypted audio digital recorder, on loan from the University of Edinburgh. By recording interviews and focus groups, I was able to offer all my attention to participants during these sessions and facilitate the selection of direct quotes to illustrate the findings. By using an audio digital recorder, I could be fully present; maintaining eye contact with participants and giving my full focus to our conversations, making occasional notes as a reminder to discuss certain topics further as the interview or focus group took shape. There are advantages to recording interviews, in that, *'before analysing the data, researchers must preserve the participants' words as accurately as possible. The best form of recording interview data is tape-recording'* (Holloway and Wheeler 2010 p95). In this study, the digital format allowed me to upload this as an audio file, which then helped with analysis as it was a straightforward process to back-up the recordings, listen, reflect and replay sections again, assisting with transcription and accuracy of findings (Bryman 2008).

In this study, participants were informed that the interview would be recorded, and this was explained in the study information sheets (Appendices 7 and 8) and consent forms (Appendices 9 and 10). Moreover, there was a clear understanding that recording could be stopped at any time. I understood the ethical principle of respect

for autonomy, in that some participants may not have been content to be recorded, although all participants in this study were agreeable.

Prior to attending an interview or focus group, I checked the battery life and record function on the audio recorder. Additionally, during each interview and focus group, I checked the recorder after a few minutes to ensure that the recording light was on. This notion of checking before and during interviews and focus groups stemmed from my experience working as a Senior Clinical Research Nurse at the University of Edinburgh during 2015-2016.

In terms of recording interviews, Rubin and Rubin (2012 p100) posit that *'recording should be as smooth and unobtrusive as possible so that it does not distract either you or your interviewee.'* With this in mind, I strategically placed the audio digital recorder in obscurity, therefore, limiting the distraction to participants. This technique worked well, with participants taking little note of the recorder during interviews and focus groups. When each interview or focus group was complete, the digital file was saved with the interview or focus group number and date. This was later backed up by uploading the audio file to a password protected folder, highlighting the secure way in which data in this study was managed.

4.6.8.2 Preparing interview and focus group data for analysis

With regards to preparing the data for analysis, the process involved transcribing audio-recordings verbatim.

Importantly, there were various factors to consider in relation to the process of transcribing interviews and focus groups, including what to transcribe from the interviews and how this should be represented (Lapadat and Lindsay 1999). In this study, I held responsibility for transcribing, which proved helpful, as I could get familiar with the data from the outset. Through the process of transcription, I began to immerse myself in interviews and focus groups, developing an in-depth understanding and becoming aware of meaningful insights (Holloway and Wheeler 2010). Transcribing the interviews and focus groups verbatim took a significant amount of time, as interviews and focus groups lasted approximately one hour, which meant that on average, eight hours were spent transcribing per interview and focus group.

Bazeley (2013) recommends that after the interview has been transcribed, the researcher should check this against the audio recording of the interview, and this was

undertaken to ensure accuracy. Benefits of early transcription included being able to remember what was said, which helped if parts of the recording were unclear, as well as ascertaining interesting issues to be explored further in upcoming interviews (Rubin and Rubin 2012). Of significance, all participants and people mentioned in each interview or focus group were given pseudonyms at this stage.

Transcribing verbatim is endorsed to gain full, rich and accurate data (Holloway and Wheeler 2010), and as the research aim and questions in this study related to people's experiences, the decision was made to include all content from the interviews and focus groups in the transcript. This enabled full exploration of experiences, and a consistent approach was taken during the transcription process.

Oliver et al (2005 p1273-1274) provide useful discussion in the sphere of transcription schemes, remarking that transcription practices can be viewed from two standpoints. These are, '*naturalism, in which every utterance is transcribed in as much detail as possible, and de-naturalism, in which idiosyncratic elements of speech (e.g., stutters, pauses, nonverbal, involuntary vocalisations) are removed.*' I reflected upon my transcription choice, in relation to how this decision may influence the presentation of findings.

As I was keen to learn about the transcription process and was interested in the intricacies of maintaining a naturalist approach, I adopted this method of transcribing; for my own development as a researcher and to provide a full account of each interview and focus group story. I used the guidelines put forward by Hepburn and Bolden (2017) to guide my practice, as their book, '*Transcribing Social Research*' proved to be a helpful resource in outlining the complexities of this activity. This allowed me to preserve the natural language and idiosyncrasies of each participant, with inclusion of pauses, louder or quieter speech, slowed or stretched sounds, intonation and aspiration, as well as non-speech sounds, for example, crying, sniffing or laughing. The process of naturalist transcription of semi-structured interviews and focus groups required time and effort, but this was a worthwhile exercise in terms of enabling comprehensive analysis of the data, while contributing to my professional development.

In addition to the transcription of interview and focus group data, I also undertook a process of transcription with regards to observation and fieldnotes.

4.6.8.3 Transcription of observations and fieldnotes

Observations and fieldnotes were transcribed directly from the original written source notebook into Microsoft word documents, organised sequentially so this read like a story of my time in the field. Fieldnotes were transcribed as soon as possible after the event, within 24 hours of observation sessions. Fieldnotes contained no identifiable data, as I filtered this out during the creation of notes, but it is important to consider how I maintained the confidentiality of participants during all aspects of the data collection and management process.

4.6.8.4 Maintaining confidentiality and anonymity

Ethical considerations of the study will be discussed later in section 4.6.10, however, this sub-section covers strategies which were in place during data management to preserve and maintain the confidentiality of research participants. For instance, all interview and focus group participants, as well as the State-Wide Facilitator of the RHP, were allocated a pseudonym, and the community health organisations taking part in this study remain confidential. I was the only person to access the original interview and focus group audio recordings, and all recordings were uploaded to a secure, password protected file and deleted from the audio digital recorder. During transcription, identifiable information such as names and places were changed and replaced with pseudonyms to ensure anonymity.

With regards to observations, sessions were labelled in the format of metro 01, (DD/MM/YY) metro 02 (DD/MM/YY), and rural 01 (DD/MM/YY), rural 02 (DD/MM/YY) in sequential order, to illustrate whether observations were undertaken at the metropolitan or rural/regional site. As mentioned, written fieldnotes from observation sessions included no identifiable information, as I used pseudonyms while writing these notes; a process that became second nature quickly in the research process.

4.6.8.5 Summary of data management

In summary, a range of measures were employed to manage and prepare the data for analysis, reflecting the multiple sources involved in data collection for this study. All data were anonymised, uploaded into an electronic format and labelled appropriately in preparation for the process of data analysis.

4.6.9 Data analysis

Qualitative data analysis is viewed as a complex and intellectually challenging aspect of the research process (Bazeley 2013). Consistent with an inductive approach to qualitative research, data were collected and analysed concurrently (Knoblauch 2005), and Thematic Analysis (TA) identified key themes. This form of analysis is in line with the social constructionist view with regards to how knowledge can be generated, acknowledging that in different groups, a variety of views may be found.

TA is described as '*a method for identifying, analysing and reporting patterns (themes) within data*' (Braun and Clarke 2006 p79) and it is suggested that this form of analysis provides a rich, detailed and nuanced account of data, involving the search for and identification of common threads and latent themes that extend across an entire set of data.

Interestingly, Thorne (2020) suggests that finding themes is a way to describe one part of an inductive analytic process, but that this relates to surface-level considerations. I understood that TA does not need to use coding as a process, as this can be done in a more narrative form, by writing summaries, for example. However, I found that coding was helpful in getting to know the data and I therefore incorporated this process.

Finding codes and categories allowed me to notice commonalities in the data and as a starting point for analysis, this exercise helped me to organise my thoughts about the phenomenon under study, laying the groundwork for the creation of meaningful themes. However, I was aware that stopping at naming key themes does not necessarily add insight to refugee health nursing, and I aimed to take knowledge and understanding of this field into a dimension beyond what is already known. Sandelowski (2007 p129) highlights that codes, categories and themes are terms '*that refer to the work of analysis, and not to any dimension of the findings, are used to present the findings and thereby ironically obscure them.*' I recognised that as well as generating codes, categories and themes, intellectual effort was required in reflecting new and interesting insight into refugee health nursing, illuminating an overall storyline of the data and offering meaningful implications for practice.

After careful consideration, I decided not to employ the use of computer assisted qualitative data analysis software (CAQDAS). This software allows the researcher to identify a piece of text and assign it a code or label (Bazeley 2013). The

label can then be selected and all pieces of text which have been given that label can be identified. It is proposed that this type of electronic pattern recognition is quick and efficient (Davies 2007), however in qualitative analysis, intellectual thinking and interpretation are paramount.

An early criticism of using software for qualitative data analysis is that researchers can feel distant from their data, and I wanted to stay close to the data as the story unfolded (Gibbs et al 2002). Furthermore, Thorne (2020) suggests that the notion of pattern recognition evident in CAQDAS is like the use of pattern recognition on the journey from novice to expert in nursing (Benner 1984). Benner (1984) posited that expert thinking in nursing practice was not just a matter of learning new facts, but rather an expanding capacity to interpret variations and anticipate their implications by having critically reflected on an extended set of complex case examples and thus, identifying patterns. This is known as pattern recognition and became a means by which to consider how clinical wisdom develops over time. Thorne (2020) proposes that TA may have merged with pattern recognition, such that the reporting of patterns within a data set may seem in and of itself to be a relevant exercise. Nonetheless, I chose to undertake pattern recognition as a starting point for analysis, using charts and diagrams, which I presented and discussed with my academic supervisors. As a creative person with a more visual way of looking at data, software packages simply did not fit with my thinking. I wanted to stay close to the data, and I therefore chose to undertake data analysis using a thematic approach, without the incorporation of CAQDAS, and extending pattern recognition and the presentation of themes to a more meaningful level of interpretation, using theoretical insight to illustrate the findings.

As qualitative research is intended to add value to a field, rather than simply reporting what can be detected about it in terms of the qualities of a pattern, I aimed to produce a convincing account of refugee health nursing, beyond what would be self-evident to a practitioner in the field or anyone with a scholarly reading knowledge of this discipline. I aspired to demonstrate that in answering the research aim and questions, I could extend knowledge of refugee health nursing beyond naming categories and themes and reporting on patterns, adding to the body of knowledge in this field in some significant and philosophical manner.

My challenge was to guide refugee health nursing practice into a new level of understanding, based upon an auditable explanation of the research process through collecting, sorting, and interpreting data. Although I followed the steps outlined by

Braun and Clarke (2006) in undertaking TA, I considered this as one aspect of a complex and intellectually challenging process of genuine discovery. This involved interrogating the data, reflecting on its inter-relationships and thinking about potential interpretations, which led to insightful reporting, as presented in the findings and discussion chapter.

At this point, it is worthwhile to consider the journey I embarked upon with regards to analysing data and I will now describe the steps I took in relation to the messy undertaking of TA, leading to the achievement of abstract theoretical heights (Thorne et al 2016).

4.6.9.1 Thematic analysis

Braun and Clarke (2006) developed TA in a '*systematic*' and '*sophisticated*' way (Howitt and Cramer 2008 p341), proposing an analytic path to identify, organise and offer insight into patterns of meaning, or 'themes' across a dataset, as portrayed in table 2. Through focusing on meaning across a dataset, TA allowed me to see and make sense of collective or shared meanings and experiences within refugee health nursing. This approach to data analysis was deemed appropriate in this instance due to its accessibility and flexibility, offering a route into qualitative research that teaches the mechanics of coding and analysing qualitative data systematically, which I then linked to broader theoretical and conceptual notions (Braun and Clarke 2012).

The research aim and questions are experiential and exploratory, and therefore, data analysis illustrates a primarily experiential form of TA within a contextualist framework. This assumes that truth and reality can be accessed through language but that accounts and experiences of refugee health nursing are socially mediated (Braun and Clarke 2012). Data analysis within this study incorporated a combination of inductive and deductive TA; inductive as I coded data based on the experiences of participants, and deductive as I drew upon theoretical constructs from Foucauldian scholarship to render visible issues that participants did not explicitly articulate. This means that data were broadly interpreted within a Foucauldian theoretical and ideological framework.

In terms of the systematic approach to TA, the six phases as outlined by Braun and Clarke (2006) were used to guide my thought process, as put forward in table 2.

Table 2: Phases of thematic analysis (Braun and Clarke 2006 p97)

Phase	Description of the Process
1) Familiarising yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2) Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3) Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4) Reviewing potential themes:	Checking if the themes work in relation to the coded extracts and the entire data set, generating a thematic 'map' of the analysis.
5) Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6) Producing the report:	The final opportunity for analysis, selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research questions and literature, producing a scholarly report of the analysis.

In line with focused ethnographic methodology, data collection and analysis occurred simultaneously as a linear process (Higginbottom et al 2013). I absorbed myself in the data through the lengthy transcription process for interviews, focus groups and fieldnotes, becoming familiar with the intricacies and nuances of the data, and getting a feel for the emerging story as data collection unfolded.

With regards to familiarising myself with the data, I read and re-read textual data, in terms of transcripts of interviews, focus groups and fieldnotes, as well as listening to audio-recordings, highlighting items of potential interest. Making notes in an observational and casual manner at this point helped me to read and listen actively, analytically and critically, thinking about what the data meant and what kind of world was revealed through participant accounts.

Initially, I became acquainted with the dataset's content and noticed elements that were relevant to my research questions. At this stage, I was not coding, and therefore, my notes were used as memory aids and triggers for analysis, consisting of a stream of consciousness, a muddled 'rush of ideas,' as opposed to polished thought (Braun and Clarke 2012).

I then began systematic analysis of the data through coding, using codes as the building blocks of my analysis, capturing both diversity and patterns within the data. The mechanism of organising data into groupings is recognised as coding, although coding is a way of grouping, but grouping does not necessarily involve coding (Saldana 2009). I initially identified interesting topics from the data and produced preliminary codes as descriptive words and phrases, which were integrated across the data set into more central categories or themes as these emerged over time.

All interviews in the same group of participants were coded before moving onto the next group and subsequently, focus groups and fieldnotes were then coded. As interviews with RHNs were conducted first, this was the initial group to be coded, followed by managers and refugees, in line with the order in which interviews were carried out. Coding involved labelling sections of text based on my understanding of that section, although Saldana (2009) highlights that coding is not just about labelling, it is also about developing ideas and linking pieces of data together.

Descriptive coding allowed the storage of facts, for example, information about refugee participants such as country of origin and length of time living in Australia. In this study, descriptive coding was applied to interviews, focus groups and

observations, relating to the participants involved, the event and the context in which this took place.

Topic coding involved creating categories and was useful in the early stages of analysis to think about what was in the data. In this study, topic codes were both descriptive and interpretative and occasionally, participants' own words were used to create codes. These are called 'in vivo' codes and there was a mix of in vivo codes and more descriptive codes, particular at the beginning (Saldana 2009).

As I analysed the data, sections of data and codes were reviewed with my academic supervisors on a regular basis. This strategy is known as 'peer debriefing' (Lincoln and Guba 1985) or 'peer review' (Holloway and Wheeler 2010); and helps to support the trustworthiness of the research process and findings. I plunged into the data during a period of several months, and reflected on topic codes as they emerged, changed, developed into insightful and in-depth ideas, or were removed if deemed insignificant, after all.

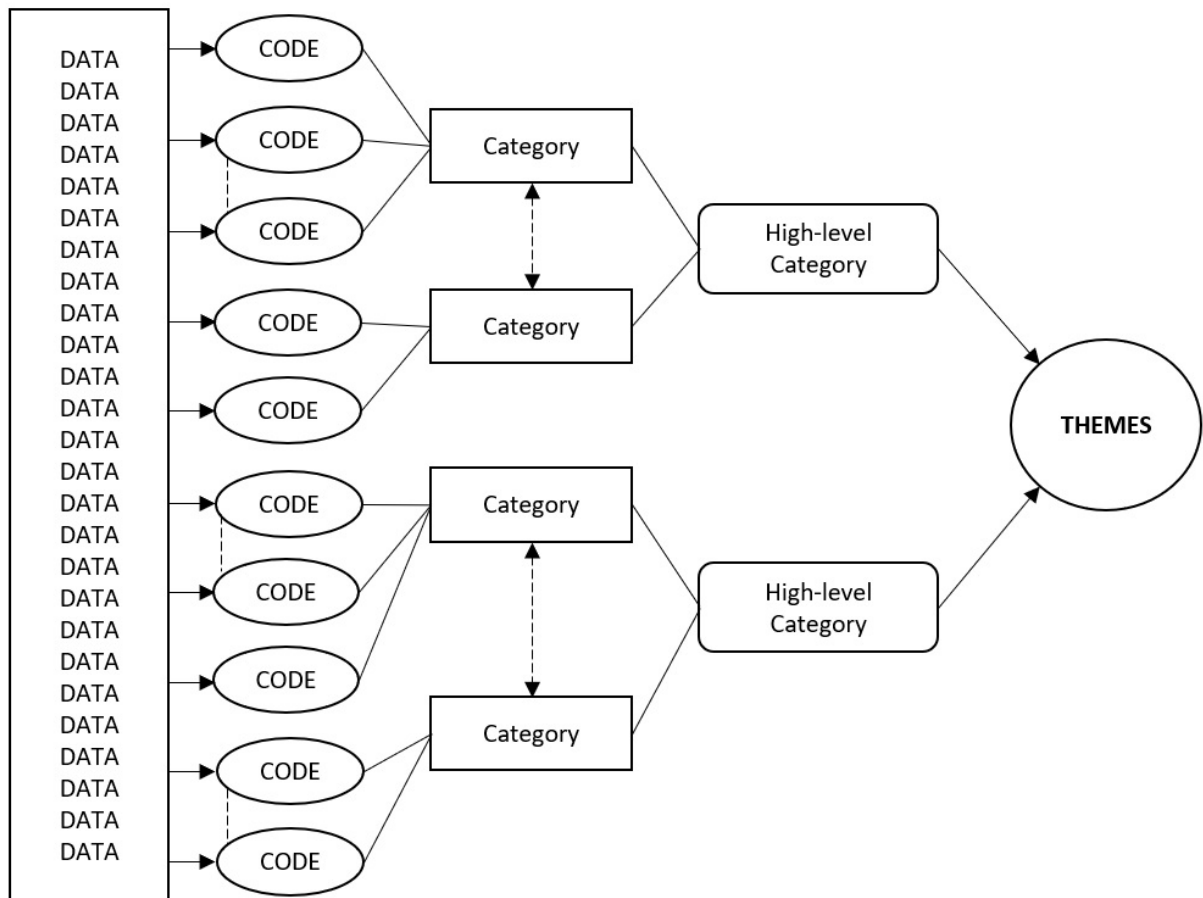
I created mind maps to illustrate thought processes and was immersed in iterative, forward-back movements in relation to the whole data, contemplating and uncovering meanings and revealing hidden ambiguities, coding and re-coding as new categories or codes took shape. I used a thematic map as a visual tool to organise the facets of my developing analysis and to identify main themes, sub-themes and their interconnections (Braun and Clarke 2012). This was a messy and intellectual process, and as coding continued and categories were created, the process of coding became more analytic.

As I revisited previously analysed data to review it, further codes, categories, and potential themes came to light (Braun and Clarke 2006). Phase three involved reviewing the coded data to identify areas of similarity and overlap between codes, identifying any broad issues, collapsing or clustering codes that shared some unifying feature, so that they reflected and described a coherent and meaningful pattern in the data. Searching for themes was an active process, in that I generated or constructed themes, rather than discovering them. The analysis process continued over a period of several months and the story underlying the data became more refined. I acted as a sculptor; making choices about how to shape and craft the raw data into a work of art (Braun and Clarke 2012).

The thematic analysis approach as outlined by Saldana (2015) also inspired the process of data analysis. In line with Braun and Clarke (2006; 2012), Saldana

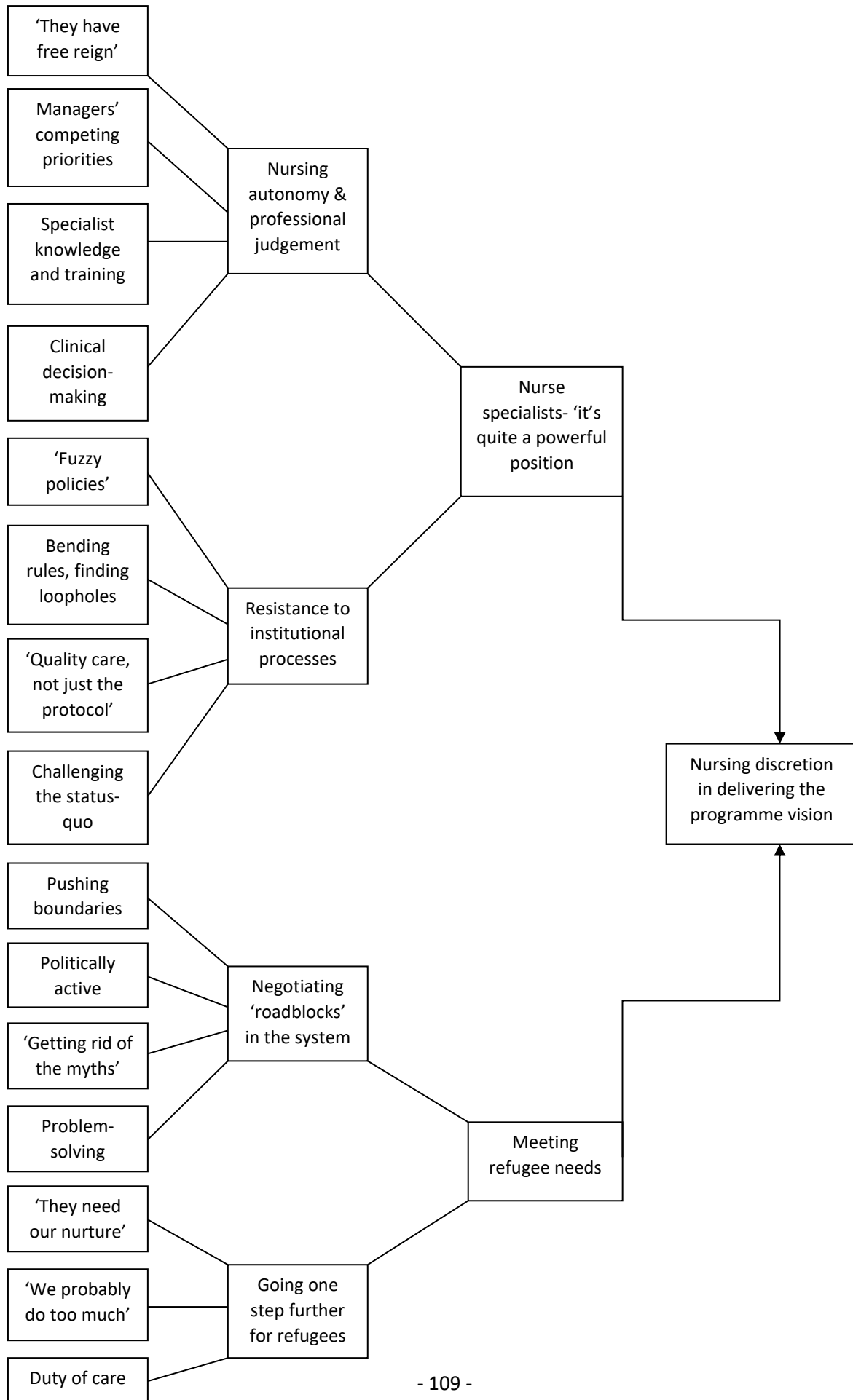
(2015) suggests identifying codes in the data, categorising related codes and developing broader themes relevant to the enquiry through high-level categorisation, as portrayed in figure 2.

Figure 2: Illustration of thematic analysis approach, adapted from Saldana (2015).



Using this strategy, figure 3 illustrates an example of the journey I took during data analysis, from creating codes to developing a theoretically informed theme.

Figure 3: Thematic analysis in action *Theme Two: Nursing discretion in delivering the programme vision*



Analytic coding helped to identify new meanings and themes in the data, enabling the development of new ideas while seeking underlying symbols and significances. This level of coding was performed with interview, focus group and observation data sets, generating categories and themes to help in the philosophical process of discovering meaning within the data.

Morse (2008 p727) describes categories as collections of similar data sorted into the same place, and themes as a more meaningful 'essence' that runs through the data. Morse (2008 p727) conveys a theme as '*the basic topic that the narrative is about, overall*' and it was my aim to bring to life the overall essence and narrative of data in this study. I explored the relationship between themes and considered how these ideas worked together in telling a story about the data, fitting like pieces of a jigsaw puzzle to provide an eloquent and lucid picture.

Interestingly, Braun and Clark (2006 p82) propose that '*a theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set.*' However, as emphasised, a theme is theoretically informed, which is an important distinction. Braun and Clarke (2006; 2012) and Saldana (2015) are not particularly clear on this point, as their definition of theme remains on the descriptive level.

In analysing the data, it was important to contemplate the significance and implications of emerging themes in each group of participants and across groups, to ensure that I was answering the research questions and meeting the overall aim. I was particularly interested in relationships within refugee health nursing, and analysis of focus groups enabled me to capture real-life interaction between refugee participants, obtaining a glimpse into their social lives and how their shared and contrasting views influence behaviour. Intriguingly, on an analytical level, analysis of focus group material led me to a place of interactive perceptiveness, as ideas developed through the nuances of social interaction, with participants able to support another's comment or disagree, opening opportunity for debate and discussion of concepts, while allowing insight into the group dynamic and social relationships.

A key phase in the process of analysis related to defining and naming themes and Braun and Clark (2006 p92) highlight that this is about '*determining what aspect of the data each theme captures.*' I generated final names for each theme in the later stages of analysis and it was critical that these themes were reviewed and interconnected (Saldana 2015). My analytic narrative interpreted and connected the

data to my broader research questions, using themes to communicate what is interesting about the data and why. The overarching essence of refugee health nursing became clear through the development and linking of theoretical insight within each theme, with Foucauldian theory as the backbone structure in describing the overall account of data (Foucault 1980).

Producing the final report involved presentation of findings and discussion, to illustrate the story of the data in a clear and interesting format. Data from fieldnotes and participant observation sessions, interviews and focus groups are used to illustrate themes and to shed light on refugee health nursing. Writing and analysis were interwoven, and the purpose of the report was to provide a compelling, convincing, clear, yet complex story about the data, based on comprehensive analysis and embedded in this scholarly field of nursing practice.

4.6.9.2 Summary of data analysis

Despite incorporating the seemingly systematic approach of TA, data analysis was a chaotic and muddled undertaking, moving through a continual process of abstraction and creativity in dealing with empirical data, going beyond the current stance of knowledge in refugee health nursing and presenting relevant, inspired themes in response to the research aim. All sources of data were amalgamated in the final stages of analysis when reviewing and defining themes and writing the report, which is presented in the findings and discussion chapter.

Considering multiple realities; categorising, and finding themes through analytical insights, an overall storyline of data is presented later in this thesis, enabling a meaningful contribution to the body of knowledge in refugee healthcare.

4.6.10 Ethical considerations

Importantly, ethics was an ever-present concern in undertaking this study, pervading every aspect of the research process from conception and design through to data collection, analysis and presentation of findings.

As Allbutt and Masters (2010) point out, the purpose of a Research Ethics Committee is to provide robust, independent and timely review of proposed studies and to protect the dignity, rights, safety and well-being of potential research

participants. I obtained ethical approval for this study from the University of Edinburgh, School of Health in Social Science, through the Research Governance Coordinator, on 23rd of January 2017 (Reference: NURS020). With regards to obtaining ethical permission to conduct this study across the two study sites, a favourable ethical approval was gained from the metropolitan site Human Ethics Advisory Group (HEAG) on the 6th of February 2017 (Reference 1701). On the 14th of February 2017, the CEO of the rural/regional site agreed that if the metropolitan site ethics application was approved by the HEAG, then the rural/regional site would accept this approval. Furthermore, requests were made for two ethical amendments across both sites while undertaking data collection for this study. In July 2017, ethical permission was granted to undertake semi-structured interviews with managers of the RHP and in October 2017, ethical permission was given to conduct semi-structured interviews with non-English speaking refugees, with the assistance of accredited translators. With regards to protecting the anonymity and privacy of focus group participants, all participants and translators were reminded that discussions were confidential.

In terms of ethical considerations, I acknowledged any biases and emotional responses that I may bring to the study from my experiences, as these can affect observations, interpretations and the way that findings are presented (Roper and Shapira 2000). In this study, my fieldnotes acted as a reflective diary, recording my thoughts, ideas and emotions; reflecting on decisions made throughout the research process. This elucidated any biases and allowed me to understand when my bias may be influencing decisions regarding data collection and analysis.

Ethnographic research in nursing can involve ethical issues arising from the close relationships developed with participants, and these challenges are '*unlike that found in other research designs*' (Roper and Shapira 2000 p113). To this end, Beauchamp and Childress (2013) offer a framework to consider the ethical components of the research process, with reference to the four moral principles of 1) respect for autonomy, 2) non-maleficence, 3) beneficence and 4) justice, each of which will be described in relation to this study.

4.6.10.1 Respect for autonomy

The principle of respect for autonomy relates to a person's '*right to hold views, to make choices, and to take actions based on their values and beliefs*' (Beauchamp and Childress 2013 p106).

Beauchamp and Childress (2013) note that the promotion of autonomy relates to various moral rules, including telling people the truth, respecting privacy and confidentiality and obtaining consent.

With regards to participation in this study, I respected the autonomy of potential research participants, in terms of whether they wished to take part. Indeed, I was dependent on the cooperation and goodwill of RHNs, managers and refugees to offer their time and views (Murphy and Dingwall 2007). This study was contingent on establishing trusting relationships and reciprocity with RHNs, managers and refugees and as such, it was imperative that I articulated my background and the purpose of the research, so that potential participants could make a well-informed decision about taking part. In this way, they became research '*partners*' or '*collaborators*,' rather than merely '*participants*' (Allbutt and Masters 2010 p212).

Pertaining to recruitment into this study, I considered how information was disclosed to potential participants, encouraging autonomous decision making (Beauchamp and Childress 2013). This process involved providing full and transparent information about the practicalities of the study, so that people understood what was being asked of them. Of note, I described the purpose as '*gaining an understanding of refugee health nursing*,' and this inclusive formation gave me freedom to develop lines of enquiry and analysis that had not been fully anticipated at the outset (Murphy and Dingwall 2007).

Importantly, during the process of gaining informed consent, there were no controlling influences that may have impacted on the decisions made, and potential participants understood that they could refuse without any consequence (Beauchamp and Childress 2013). For instance, it was explained to refugees that if they decided not to take part, this would not affect their care through the RHP, and this was clearly detailed within the study information sheet and consent form. Furthermore, it was conveyed within study information sheets and consent forms for each group that taking part was voluntary and that participants could withdraw from the study at any time (Appendices 7, 8 9 and 10).

In terms of the consenting process, there was ongoing dialogue with the individuals under study, accounting for the continued development of methods, questions and instruments of enquiry as the research unfolded and interaction with participants evolved (Murphy and Dingwall 2007). While written consent was obtained for all semi-structured interviews, verbal consent was given for observation and focus groups.

Regarding obtaining informed consent to undertake observation, Endacott and Botti (2007) suggest that verbal consent is common in healthcare environments, in asking to observe nursing practice. In this qualitative study, verbal consent was obtained at every opportunity from all concerned, and this was recorded via audio digital recorder in relation to focus groups. This was often not a fixed event, but rather, a negotiated and sometimes re-negotiated process as relationships developed in the field. As Parker (2007 p2252) highlights, '*consent needs to be thought of differently in ethnography, where the research undertaken is based upon the tentative development of research questions and analysis in the context of emergent relationships of trust.*' Murphy and Dingwall (2007) agree, suggesting that ethnographic consent is not a contractual agreement, but rather, a relational and sequential process which spans the period of research. On some occasions, consent for observation was implied rather than stated, but consistently operated within a context where participants could withdraw cooperation at any time.

It is proposed that placing the interests of research participants at the centre of decision-making is based upon the principles of non-maleficence, that is, '*to do no harm*' and beneficence, meaning, '*to do good*' (Allbutt and Masters 2010 p211). These concepts will now be explained in relation to this research in refugee health nursing.

4.6.10.2 Non-maleficence

The second ethical principle of non-maleficence '*obligates us to abstain from causing harm to others*' (Beauchamp and Childress 2013 p150).

Most commonly, risks in ethnographic research can involve psychological or social harm, in that participants may become upset, worried or offended during fieldwork (Murphy and Dingwall 2007). In this way, I took ethical accountability in

ensuring that participants came to no harm. Indeed, it is postulated that '*interviewees should be no worse off, and ideally should be better off, for having taken the time to talk with you*' (Rubin and Rubin 2012 p89).

As discussed earlier in this thesis, the refugee experience can lead to psychological and emotional problems during resettlement (Mutitu et al 2019), and therefore, this group was potentially vulnerable when entering the research process. In this study, refugee participants were asked to share information about their health and resettlement experiences, which raised concerns about the possible re-awakening of memories and consequent re-victimisation of those who may have experienced difficult or traumatic circumstances prior to resettlement, or who continue to suffer from ill health or trauma.

Rubin and Rubin (2012) propose avoiding interview questions that could cause emotional or psychological discomfort, and therefore, interview questions were focused on the refugee resettlement experience and health and well-being during this period, avoiding reflection on past events that may trigger traumatic memories. Nevertheless, sometimes interviews prompted tormenting thoughts or memories through discussing experiences associated with the resettlement process, calling to mind conditions of conflict, ongoing health issues or concerns about family and friends who remained in their country of origin.

On some occasions, refugees shared sensitive information and harrowing stories about events of their past, often leading to mental and physical health problems experienced during resettlement. However, refugees chose freely to disclose this information and some such disclosures in this study appeared to be cathartic. In all cases, participants were treated with decency and respect, with the offer of access to whatever support they may subsequently need (Murphy and Dingwall 2007).

Study information sheets mentioned the potential risk of psychological harm and in the study protocol, I outlined the measures I would take if a participant became distressed. If unwarranted stress was placed on a participant or if someone became distressed, I temporarily ceased data collection and after some time, asked the participant if they would like to continue. Some refugees became upset during interviews, due to reflection upon their refugee journey and experiences, however, all

participants wished to continue after pausing for a short time and were eager to keep sharing their stories.

In terms of doing no harm in unsettling the care provided for refugees, interviews with RHNs did not take them away from their care responsibilities. The care provided for refugees within the RHP was not disrupted due to this study, and thus, no harm was done to the refugee care experience.

Also, in the '*risky climate*' of today's healthcare organisations, nursing research may be perceived to result in disclosure of confidential material about organisational issues and a fear that the researcher could make public the concerns expressed by participants (Toffoli and Rudge 2006 p603). For this reason, the managerial team can sometimes be nervous about what is uncovered and the potentially harmful outcomes for their organisation (Van Maanen 1983). However, this study did not result in exposure of the finer workings of community health organisations and therefore, no harm was done to the institution of the RHP or to the professional reputation of the State-Wide Facilitator, managers or RHNs.

With regards to maintaining the confidentiality of participants, as highlighted, all data were anonymised, and no information has been shared with regards to the location or name of community health organisations taking part in this study. However, due to the relatively small sample size of RHNs and managers, '*complete anonymity for participants is impossible in such intimate settings*' (Toffoli and Rudge 2006 p604). As Van Maanen (1983 p282) highlights in his long-ago research, participants are sometimes, '*at best, thinly disguised and hence recognisable to intimates*' within an organisation. Of note, Van den Hoonaard (2003) hypothesised that what may preserve participants' anonymity may be the public's profound disinterest in social and nursing research. In addition, the time lapse between data collection and presentation of findings in this study may help in preserving the anonymity of participants within the RHP (Toffoli and Rudge 2006).

On a slightly different tangent, Holloway and Wheeler (2010) elucidate that the safety of the researcher is a key ethical concern in undertaking interviews, bringing attention to the well-being of researchers in dealing with sensitive topics. With regards to this study, I was familiar with the refugee health experience, having spent time in refugee camps and with previous exposure to complex and traumatic stories. I was therefore somewhat mentally and emotionally prepared for the disclosure of potentially sensitive or distressing information during data collection. In terms of interviewing

refugees in the home environment, I was accompanied by accredited translators on these occasions and therefore, did not employ lone working procedures.

In any case, as well as consideration of doing no harm, it was also important to ensure that I was doing some good (Allbutt and Masters 2010), and the following subsection describes how this study benefits the wider society by advancing knowledge and building understanding of refugee health nursing practice.

4.6.10.3 Beneficence

According to Beauchamp and Childress (2013 p203) the principle of beneficence means '*to act for the benefit of others.*' It is proposed that if there is no expected benefit to others, including the individual and wider society, then it is unethical to involve people in the study. Moreover, benefits should be more substantial than the risks in research (Holloway and Wheeler 2010).

While there was no direct benefit to individuals taking part in this study, the opportunity to share experiences in an interview may be valuable to RHNs, managers and refugees, which is in line with recommendations from Rubin and Rubin (2012). This study offered participants the chance to discuss their views and experiences on refugee healthcare during the resettlement period; to have their voices heard and opinions respected.

The main rationale for undertaking this study was to gain an understanding of different people's experiences within refugee health nursing, thus offering a meaningful contribution to the current knowledge base and informing practice. Without further research into this field, existing practice may not improve or be more widely implemented in other resettlement contexts. Therefore, it was anticipated that participation in this study may help to enhance the ways in which community healthcare is provided for resettled refugees in Australia and beyond, and thus, benefit the wider society.

With regards to good ethical research practice, I maintained up to date training in Good Clinical Practice (GCP) throughout the research process. Although predominantly concerned with clinical trials, GCP training was a mandatory requirement of my role as Senior Clinical Research Nurse at the University of Edinburgh, a position I held during 2015-2016 while planning this study, and an understanding of GCP principles provided me with a solid foundation from which to

understand the protection of the rights, safety and well-being of research participants (Noorzurani et al 2009). Another element of doing good related to my adherence to the Nursing and Midwifery Board of Australia Code of Conduct for Nurses (NMBA 2018) and Nursing and Midwifery Council Professional Code of Conduct (NMC 2015), as I have been registered as a nurse in both Scotland and Australia for the duration of this study.

Having contemplated how respect for autonomy, non-maleficence and beneficence were integrated into this study, I will now outline the ways in which I considered the principle of justice.

4.6.10.4 Justice

The fourth ethical principle relates to the concept of justice, which is concerned with being equal and fair (Beauchamp and Childress 2013).

With regards to this study, Orb et al (2001 p96) suggest that one way of implementing this principle is through *'listening to the voices of the minority and disadvantaged groups, as well as protecting those who are most vulnerable, such as children, prisoners, the mentally ill, and the elderly.'*

In terms of access, I made the decision to exclude refugees who were under the age of 18 and those who did not have the mental capacity to participate in the informed consent process. With regards to facilitating fair and equal access for refugees, I offered home visits for refugee interviews, allowing participation for those who were unable or did not wish to attend the community health centre.

Speaking to ethical considerations in the use of interpretation services, there were various factors to mull over. Accredited translators were offered refugee participant study information sheets and I explained the study verbally to the translator before each interview. As the same translators were used on a regular basis within the RHP, I was able to build professional relationships with these individuals and they were aware that the study was taking place.

Interestingly, RHNs advised that as some of the diverse cultural communities in certain parts of Victoria are small, sometimes, the accredited translators came from the same communities and knew the refugee on a personal level. I became aware that the relationship between refugee and translator may influence the way in which non-English speaking refugees answered interview questions, as refugees might not have

communicated certain aspects of their health or resettlement experience, with concern that this information could be passed on to others in their local cultural community. This issue is highlighted by Blay et al (2018), who recognise that in health research, maintaining confidentiality can be difficult when the translator is already familiar with the patient.

An effort was made to ensure that accredited translators understood the importance of maintaining confidentiality while assisting with interpretation of interviews and focus groups, and refugees were advised that all information shared would remain confidential.

Of note, there were some challenges in incorporating the use of accredited translators, in that I suspected some words and phrases used by refugees may have been changed or misrepresented during translation, although Temple (2002) recognises that concepts do not move unproblematically across cultures. Researchers often think of translators as if they were transmitters of neutral messages across languages, ignoring the linguistic imperialism central to an unquestioning use of English as a baseline language (Piazzoli 2015). I therefore learned to trust the interpretation of the translators, thinking about translation as '*a truly associative process, an ongoing appeal to memory and to a private thesaurus, a ping-pong of potentially infinite rebounds*' (Simon 1996 p23), meaning that I acknowledged the somewhat relational and subjective aspects of the translation process.

Furthermore, translators and refugees appeared to have their own conversations within interviews, as translators asked further questions to find out more from refugees. Hadziabdic and Hjelm (2013 p72) asserts that the role of the interpreter in health research '*is to provide a translation between two languages and maintain a disengaged presence.*' However, Weir (2017 p458) highlights that while translators are trained to act as conduits between patient and professional, they '*are used to their role being extended from direct interpreting to becoming cultural mediators or advocates for their clients.*' As Brandenberger et al (2019 p7) point out in relation to health research with refugees, '*beyond transmission of information, the interpreting individual is reported to influence relationships, judgements and decisions*' and therefore, I took the presence and contribution of the translator into account during data analysis.

Building on this notion, from a social constructionist epistemological standpoint, I recognise that as well as my own effect on the study as a researcher, the translators

also influenced the research process and generation of knowledge through cross-language data collection. As Temple (2002 p846) considers, '*translators are active producers in research rather than neutral conveyors of messages.*' Translation is '*more than words*;' it is also about interpretation, and therefore, I needed to acknowledge the perspective and impact of the translator on interviews and focus groups with refugees (Temple 2002 p847).

Interestingly, during interviews and focus groups with non-English speaking refugees and accredited translators, I became more aware of the tone and pace of the refugee voice, as well as body language and emotional responses. While I waited for translation, I tuned into the behavioural aspects of refugee communication and this added to my insight into the psychological interpretation of interviews and focus groups.

Another consideration of justice lies in an ethical discussion of whether to include controversial data in the analysis and presentation of findings. As mentioned during discussion of participant observation in section 4.6.7.1, I spent much time with RHNs during fieldwork and developed friendly relationships with these participants. I reflected upon this regularly with my academic supervisors, who provided advice with regards to allowing myself to become part of the social group to collect data, but also maintaining professional boundaries so that I was not 'going native' (Hammersley and Atkinson 2007).

Some casual conversations took place while we were driving together to visit a refugee at home, or during lunches, for example. Although I considered this to be informal data collection and fundamental to my fieldwork, it seemed that oftentimes, RHNs did not realise that these unprompted, natural conversations contributed to the data. Dingwall (1980 p879) describes this process as recording the '*backstage*' events and conversations. Remarkably, '*the line between researcher and friend or confidante becomes blurred*' during '*off-duty occasions*' (Murphy and Dingwall 2007 p2226) and RHN participants disclosed information that they did not recognise as relevant to the study, but that I considered interesting. This raised a question about the extent to which prior consent for observation justified the use of such disclosures as data.

Indeed, some data that were gathered during observations of RHNs were omitted from the presentation of findings, as it was felt that certain pieces of information were disclosed to me in confidence. Considerable attention was therefore focused on addressing concepts of trust, confidentiality and betrayal, in line with

recommendations by Holloway and Jefferson (2000), as I was concerned about exploiting the professional, friendly relationships that I had established with RHNs. Goodwin et al (2003) propose that this relates to a matter of trust, in that participants surmised that I would use my discretion and draw a line between public and private data in reporting findings of this study. As De Laine (1997 p322) points out, *'the fieldworker, in the informed sympathetic role... is free to examine the make-up and props of the members and confirm the worthiness of their craft, but allies are expected to keep secrets and respect the proprietary boundaries between public and private.'*

There is an acknowledgement in ethnography that dilemmas of this kind are an accepted feature of fieldwork (Goodwin et al 2003) and Dingwall (1980 p882) talks of the *'endemic moral complexity of field research,'* with regards to which elements of data can be incorporated ethically in the findings and which data should be kept *'secret.'* Dewalt et al (1998 p273) suggest that *'it is the ethnographer's responsibility not only to think a bit first, but to make conscious decisions on what to report and what to decline to report based on careful consideration of the ethical dimensions of the impact of the information on those who provide it, and the goals of the research.'*

However, the mention of *'secrets'* hints at the issue of collusion, in that by not reporting informal conversations with RHNs during fieldwork, I may have fallen prey to the accusation of colluding with RHNs to portray only the publicly acceptable face or *'rosy version'* of refugee health nursing; *'cleaning up those unsightly elements that exist in every community'* (Goodwin et al 2003 p575). I had to consider whether this was a matter of trust or collusion, maintaining their privacy or keeping their secrets. Furthermore, by not subjecting this information to the analysis and presentation of findings, I had to determine whether I was jeopardising the rigor of this study.

In making the decision not to include certain elements of observational data in data analysis and findings, I chose to uphold the privacy of RHN participants, so as not to compromise trusting professional relationships. Moreover, by describing my thought process in this discussion of justice, I offer transparency in the way that the data were shaped in line with ethical and moral considerations. This experience illustrates how the process of shaping the data was a symbiotic one, in which I interacted with the community under study to mould the findings.

4.6.10.5 Summary of ethical considerations

As I have demonstrated, ethical behaviour in ethnographic research is situational and located, depending on the field and context of the phenomenon under study. Due to the constant adjustments in maintaining access to participants, with regards to sustaining trusting relationships and rapport, avoiding 'going native' and in preserving anonymity, open discussion has been offered in this section to present a complete picture of this study. Throughout the research process, I considered the welfare, beliefs, perceptions, customs and cultural sensitivities of all participants across groups, and ethical considerations were at the heart of each step I took in uncovering the phenomenon of refugee health nursing.

4.6.11 Trustworthiness

The standards used to assess the integrity of qualitative research are based upon the concept of trustworthiness, and Lincoln and Guba (1985) offer a suitable framework to guide consideration of this concept by means of Trustworthiness Criteria.

While positivist benchmarks include internal validity, external validity, reliability and objectivity, Trustworthiness Criteria involve deliberation upon four key components, that of 1) credibility, 2) transferability, 3) dependability, and 4) confirmability, each of which will be discussed in this section, in relation to the strategies employed to meet these criteria in this study. Holloway and Wheeler (2010) highlight that there are different ways to judge and assess the integrity of qualitative research. However, I have sound understanding of the Trustworthiness Criteria outlined by Lincoln and Guba (1985) and these standards were used to steer methodological and analytical quality and validity in this instance.

4.6.11.1 Credibility

The concept of credibility means being able to demonstrate that participants' views have been appropriately represented, and the findings and interpretations are '*credible to the constructors of the original multiple realities*' (Lincoln and Guba 1985 p296). Discussion of credibility will be centred around three key factors, including 1) prolonged engagement, 2) triangulation and 3) member checking.

Of note, I spent nine months in the field undertaking recruitment and data collection. This was on a part-time basis, however, symbolises significant prolonged engagement, which correlates to the likelihood of producing credible findings (Lincoln and Guba 1985). Spending prolonged time in the field added to my understanding of experiences within refugee health nursing and enabled the development of trust and rapport with participants. As Polit and Beck (2013 p26) highlight, prolonged engagement *'makes it more likely that useful and rich information will be obtained.'* The longer I spent in the field, the more I felt accepted as a visiting member of the RHP team, with managers and RHNs inviting me to take part in various team activities and refugees becoming more comfortable with my presence.

The second method used in enhancing the trustworthiness of this qualitative study is triangulation, which allows data collected from various sources, at a range of points and from different participants to be compared on the same phenomenon (Hammersley and Atkinson 2007). Triangulation of data and methods was used to explore experiences of refugee health nursing from different viewpoints, to achieve data sufficiency (Fusch and Ness 2015).

This study incorporated multiple methods of data collection, including observation and the generation of fieldnotes, semi-structured interviews and focus groups, as well as the consideration of how documents are used in practice. In this way, triangulation enabled me to gain a comprehensive picture of refugee health nursing within the context of resettlement (Polit and Beck 2013). Moreover, this strategy allowed findings to be compared across participant groups and data collection methods, to check for consistencies and discrepancies in the data.

Thirdly, member checking is a process *'whereby data, analytic categories, interpretations, and conclusions are tested with members of those stake-holding groups from whom the data were originally collected'* (Lincoln and Guba 1985 p314). Lincoln and Guba (1985 p314) suggest that member checking is a *'crucial technique for establishing credibility,'* particularly following qualitative interviews. This is a continuous process and can be undertaken formally or informally.

Informal member checking was undertaken during interviews and focus groups with participants through deliberate probing and summarising, or deliberately repeating information back to participants, to make sure that I understood what was said. Additionally, after observation sessions, there was an opportunity to discuss with the RHN what happened during the observed activity.

However, although these informal checks were carried out, formal methods of member checking were not employed in this study. In keeping with a social constructionist epistemology, I collected and co-constructed knowledge (data) with the participants. Perhaps then, it is argued that the joint building of knowledge with participants should span the research process, including data analysis and writing of findings. This type of formal member checking involves giving the participant either the transcribed interview or data following analysis, to confirm the credibility of the account (Creswell and Miller 2000).

Nevertheless, one reason for not incorporating formal member checking related to concern around participants' perceptions and experiences of refugee health nursing changing through time, which is a key issue highlighted by Holloway and Wheeler (2010). In this study, it was important to interview and observe refugees, RHNs and managers while they were engaged and involved in the RHP. In keeping with the Traditional SI theoretical perspective, mindsets and perceptions of reality can change over time, as new experiences and encounters occur, and therefore, participant views and feelings about refugee healthcare may have changed by the time I offered formal member checking. Rashid et al (2015) report that in their study, when they returned to participants for verification of the data, the participants had moved on with their lives and did not want to revisit the interview data. Indeed, Morse (2015) does not recommend member checking as a strategy for ensuring the trustworthiness of qualitative research, asserting that checking with participants post-analysis is not practical.

The act of reading a transcript for accuracy might also cause '*the member to revise his or her views and/or influence events still to be experiences in the course of the study*' (Sandelowski 1993 p6). Willis (2010) argues that participants' perspectives should be frozen in time and unaltered, which would be problematic if presented back to participants for member checking. Further issues with member checking include different perceptions between the researcher and participants, participants adopting a defensive stance or being unable to develop a critical viewpoint of the study phenomenon (Holloway and Wheeler 2010; Polit and Beck 2013). On this point, I acknowledge that I moved beyond individual perspectives and took data to a deeper theoretical level, incorporating a more abstract and nuanced interpretation of accounts (Holloway and Wheeler 2010).

Having deliberated upon the concept of establishing credibility in this study, I will now describe the process of illustrating transferability to other contexts.

4.6.11.2 Transferability

Transferability relates to the ability to transfer the findings, which are time and context dependent, to other similar situations (Lincoln and Guba 1985). This component was fundamental to this study, as part of the rationale for exploring refugee health nursing was to determine whether the RHP model in Victoria, Australia should be introduced in other resettlement contexts. Transferability depends on the offering of comprehensive detail, so that a judgement can be made on the similarity of other resettlement contexts and hence, whether findings of this study are transferrable (Topping 2010).

To enhance the quality of this study, I offer a detailed, 'thick description' of the RHP in Victoria, Australia. This thick description of resettlement in Victoria, Australia, and more specifically, the structure of the RHP, allows for consideration of the programme in other community resettlement areas globally and sparks confidence in the findings and my interpretation of the data (Geertz 1973). In terms of the transferability of this study, a comprehensive overview of the research process is provided, outlining the methods of data collection and analysis, thus, offering a transparent record of the proceedings.

4.6.11.3 Dependability

Dependability relates to the steadiness of data over time (Guba and Lincoln 1989), '*taking into account both factors of instability and factors of phenomenal or design induced change*' (Lincoln and Guba 1985 p299).

To this end, I have been transparent about the research process and my decisions, offering a thorough audit trail (Topping 2010). Lincoln and Guba (1985) propose that an audit trail can be examined to determine if the research process and findings are acceptable. Changes occurred as this study evolved, for example, with the inclusion of semi-structured interviews with managers and the inclusion of interviews with non-English speaking refugees. Furthermore, observations took place in a wider range of areas and across a more varied scope of activities than originally

anticipated, due to my evolving relationship with participants and the invitation to participate in an extended array of on-goings.

Of relevance here, the research process is associated with dependability, while the research findings are associated with confirmability; a notion that will now be considered.

4.6.11.4 Confirmability

Confirmability involves ensuring that the data, findings and interpretations are *'rooted in contexts and persons apart from the evaluator and are not simply figments of the evaluator's imagination'* (Guba and Lincoln 1989 p243). To achieve confirmability, I must demonstrate that findings have been established from the data (Lincoln and Guba 1985). As mentioned, an audit trail can provide necessary detail to help the reader make a judgement about the acceptability of research findings, and there are other factors.

In addition to the audit trail, peer debriefing was undertaken regularly with my academic supervisors throughout the period of data collection and analysis, as well as during the process of writing the findings (Lincoln and Guba 1985). This included presenting and discussing raw data such as interview transcripts and fieldnotes, reviewing the emerging codes, categories and themes, as well as my interpretations of the data. Notes from these discussions were written and stored accordingly, thus, adding to the audit trail and confirmability of findings.

4.6.11.5 Summary of trustworthiness

In sum, this section has demonstrated how I incorporated concepts of credibility, transferability, dependability and confirmability in ensuring the integrity of this study. Having explored the trustworthiness of this study in detail, the following section offers discussion of reflexivity during the research process.

4.6.12 Reflexivity

Reflexivity involves acknowledging the relationship that I share with the world I am investigating. As an ethnographic researcher, I am imbued with ideologies, values and belief systems, and in this section, I recognise and make transparent my effect on the research process and findings, as well as the impact of this study on my personal, professional and academic development. I consider how my background and interests brought me to this area of research and how the theoretical lens of Traditional SI affords a certain view of events within refugee health nursing.

4.6.12.1 Reflexivity within ethnographic research

Pellatt (2003 p29) quotes reflexivity as a way of adding '*plausibility or rigour to the ethnographic research,*' proposing that reflexivity in qualitative research is one of the major criteria for assessing quality.

In undertaking this study, I considered my own '*embodied, sensual, thinking, critical and positioned self*' (O' Reilly 2012 p100), acknowledging that my presence influenced the findings. Reflexivity does not remove bias, but rather, recognises that bias exists. With conscious self-awareness of my impact, this allows the study to be transparent, with no information obscured to cause concern over the reliability of methods or findings (Freshwater 2005).

To offer a holistic understanding of my decision-making in relation to the process of this research, I created a reflexive epilogue, which can be found in appendix 11.

In the planning phase of this study, I considered my clinical background and examined my motivations and interest in refugee health nursing. I discussed some of my preconceived ideas about this field during PhD supervision sessions and contemplated my assumptions about what I might find if I chose to explore this area of nursing practice.

During data collection, I remained mindful of my thought processes, leading to a complex line of intrigue. With genuine clinical curiosity, I asked myself why I noticed certain patterns or similarities in the data, and what they might mean (Thorne et al 2016). I reflected upon how the data were generated, in terms of what was seen and heard, but also noticing what may have been missed, and the impact of my presence, thoughts and actions on the data. Often, by taking note of what came first to mind, I

was reminded of the biases I may have brought into this study and the assumptions I may have had as to what was there to be found. I consciously examined my response, keeping an open mind and trying not to let preconceived ideas of what I might find, dictate the way in which I viewed the data.

Having found similarities in the data to my previous suppositions, I then had an obligation to purposively orient my thinking to diversities and contradictions. Furthermore, because this study was undertaken in a field in which there is a wider contextual frame than what emerged from the data, I had inspiration for additional critical reflection on previous research undertaken in refugee health nursing. I thought about which aspects of the wider clinical world of refugee health nursing did not become apparent in this study and whether this was important (Thorne 2020).

I recognise that findings from this study do not represent the whole field, however, I feel confident that the findings make a meaningful contribution to the clinical and research community. Having spent time in the field and in undertaking data analysis, alongside continued reading of the literature and staying abreast of global events leading to an increase in forced migration and refugee resettlement, my insight into refugee health nursing has developed significantly through undertaking this study. Consequently, I am more inspired now, than ever, to continue learning and improving practice in this specialised and much needed field.

4.6.12.2 Summary of reflexivity

According to Denzin and Lincoln (2005), reflexivity refers to a process by which researchers are obliged to clearly delineate the interactions that have occurred between themselves, their methodology and setting, as well as participants studied. This process is focused on making clear and transparent the effect of the researcher, research design and methods of data collection and analysis on the study findings (Cruz and Higginbottom 2013). I understand reflexivity to be thoughtful, conscious self-awareness, and I have demonstrated how I shaped and have been shaped by the research process, analysis and research findings.

4.7 Conclusion

This chapter has offered a discussion of methodology, with consideration of the theoretical stance underpinning this study, as well as the research design, methods and process of data analysis. I illustrated how by adopting a focused ethnographic approach, I could uncover meanings about refugee health nursing, against the backdrop of the RHP and refugee resettlement.

I described ethical considerations and the trustworthiness of this study, concluding this section with an overview of reflexivity. At this point in the thesis, I present the findings and associated discussion, offering an evocative contribution to refugee health nursing scholarship.

Interestingly, ethnography can reveal tacit complexities and discretion in nursing and reveal 'hidden agendas' about how power and control are sustained (Wall 2015). This concept mirrors the epistemological stance of this study, in that I aim to uncover taken for granted assumptions about power dynamics in the field of refugee health nursing. The fundamental question in the study of culture through ethnography is, '*What is going on here?*' (Wolcott 1999 p69), and this thesis captures what is going on within refugee health nursing in Victoria, Australia.

5.1 Chapter Five: Findings and Discussion

5.2 Introduction

This chapter offers detailed discussion of the findings, with in-depth analysis of meanings found within the data and consideration of how findings relate to the literature. Data was gathered from RHNs, managers and refugees, all of whom were given pseudonyms, illustrated in table 3.

Table 3: Participant pseudonyms

Refugee Health Nurse Participant Pseudonyms	Pat, Sal, Meg, Liz, Ann
Refugee Interview Participant Pseudonyms	Len, Joe, Amy, Lou, Suz, Dot, Kat, Jes
Refugee Focus Group Participant Pseudonyms	Group 1: Sue, Mia, Jan, Lyn Group 2: Maz, Nat, Rea, Jaq, Bet
Refugee Health Manager Participant Pseudonyms	Ash, Ali

Purposive sampling for refugees was representative of gender and countries of origin across both sites. Refugee participants were from a broad spectrum of Asian and African countries. Refugees taking part in interviews had been living in Australia from less than one year to five years, four of whom were based at the metropolitan site and four at the rural/regional site. In the interests of protecting and maintaining confidentiality, refugee participants' countries of origin, as well as details about RHN and manager participants, are not disclosed. Pseudonyms are utilised for RHNs, managers and refugees throughout.

The aim of this study was to investigate views and experiences within refugee health nursing, to gain insight into how nursing care is delivered for refugees and the impact of specialised healthcare for this population.

In line with the theoretical perspective underpinning this study, the presumed vulnerability of resettled refugees, warrants investigation and by the same token, I question the inherent power held by RHNs. With traditional SI guiding my thought process, I uncover hidden meanings within refugee health nursing, rooting deep into the everyday practices of RHNs and exploring the health experiences of resettled refugees. In line with Burr (2003), I use the social constructionist standpoint to challenge taken for granted assumptions, looking beyond existing dialogue to unearth the symbolic significance of social and professional relationships, and the impact of these relationships on the delivery of care for refugees.

The overall outcome of this study relates to the concept that power is omnipresent in refugee health nursing. Power oscillates between RHNs, managers and refugees, as all parties lay claim to some element of control.'

Interestingly, it materialised from the findings that RHNs, managers and refugees all 'circulate' between the threads of power that are exercised in their everyday worlds (Foucault 1980), contradicting the notion of nursing dominance in the nurse/refugee relationship.

Four key themes became evident in the findings, each theme relating to the idea of variable and shifting power.

The story begins by describing the power held by RHNs, as gatekeepers and coordinators of the RHP in Victoria, using their discretion to influence how care is delivered for refugees. As the story unfolds, findings highlight that although autonomous practitioners, RHNs are employees of an organisation, and as such, they must meet targets, adhering to guidelines and complying with policy. Nursing vulnerability also stems from the development of therapeutic intimate relationships with refugees, challenging professional boundaries and often leading to symptoms of compassion fatigue.

Interestingly, Foucault (1977) implies that power is both repressive and a creative force, underpinned by 'resistance' practices. Although typically regarded as a vulnerable population, findings draw attention to refugees claiming power in the nurse/refugee relationship, with the final theme centred around the subject matter of resistance.

Discussion of the findings takes place through an examination of the presuppositions that are embedded within refugee health nursing, showing how power shapes the delivery of care for refugees. The concept of ubiquitous and ever-fluctuating power, as put forward by Foucault (1980), will be used to frame and support discussion of the findings. I offer an inspired account of refugee health nursing through detailed description of key themes, linking the four inter-related ideas with the overall concept of power in its omnipresent state, with reference to the data and relevant literature. Table 4 outlines the four the key themes which emerged from the data, along with associated sub-themes.

In this section, the four themes are described in detail, illustrating how concepts of power, vulnerability, resistance and negotiation interweave among actors, forming an ever-evolving cycle that emanates between RHNs, managers and refugees.

For clarity, quotes from interviews and focus groups, as well as fieldnotes from observation sessions are highlighted in **bold text**.

Table 4: Themes and sub-themes

Theme	Sub-themes
<p>Theme One:</p> <p>Gatekeeping practices of Refugee Health Nurses</p>	<p>Sub-theme one: Controlling information flow</p> <p>Sub-theme two: Providing and rationing resources</p> <p>Sub-theme three: Guarding professional position and developing identity</p>
<p>Theme Two:</p> <p>Nursing discretion in delivering the programme vision</p>	<p>Sub-theme one: Nursing autonomy and managerial support</p> <p>Sub-theme two: Frustration with barriers in the health system</p> <p>Sub-theme three: Bending the rules</p>
<p>Theme Three:</p> <p>Vulnerability in refugee health nursing: Losing control of power</p>	<p>Sub-theme one: Surrendering to institutional demands and appeasing bureaucracy</p> <p>Sub-theme two: Therapeutic intimacy and crossing professional boundaries</p> <p>Sub-theme three: Vicarious trauma and burnout</p>
<p>Theme Four:</p> <p>Refugee power: Resilience, resistance and negotiation</p>	<p>Sub-theme one: Agency in managing priorities</p> <p>Sub-theme two: Refugee opposition to specialised healthcare</p> <p>Sub-theme three: Entitlement and negotiating prolonged access</p>

5.3 Theme one: Gatekeeping practices of Refugee Health Nurses

This account of refugee health nursing begins with recognition of the power that is intrinsic to the RHN role. In essence, it emerged from the findings that RHNs exert power within social and professional relationships by adopting a gatekeeping stance; guardians of the RHP and at the epicentre of refugee healthcare in the community. As a nurse-led initiative, RHNs use specialist knowledge to coordinate the operation of the RHP and are seen to be in a position of authority and control. Prior to more elaborate discussion, it is appropriate to describe the concept of gatekeeping, providing context to this theme.

The term gatekeeping was first coined in relation to housewives, with responsibility for deciding which kinds of food was served for the family. It was proposed that this notion of decision-making extended beyond food choices and that providing or rationing certain foods could be applied to the flow of news, in the ways that pieces are chosen or rejected, and people are therefore only exposed to particular items that others deem as news worthy (Riley and Manias 2009). In terms of communication on a wider societal level, gatekeeping came to be understood as *'the process by which billions of messages that are available in the world get cut down and transformed into the hundreds of messages that reach a given person on a given day'* (Shoemaker 1991 p1). Ideas about gatekeeping have progressed in various scholarly disciplines and can be understood as all forms of control and decision-making that shape, display or withhold information and resources.

The traditional view of gatekeeping looks at this control as a one-way, top-down selection process in which gatekeepers are the rulers (Shoemaker 1991). However, this view does not take into account the impact on those who are gated, considering them as passive recipients (Riley and Manias 2009). To this end, Barzilai-Nahon (2008) expanded the traditional theory of gatekeeping, positing that a network model is a more appropriate stance for analysis, encompassing a myriad of dimensions and focusing on the relationship between the gatekeeper and those whom gatekeeping is exercised. The underlying processes and activities in gatekeeping are relevant, in terms of the response of those who are gated and how this influences further practices. Processes in network gatekeeping include the selection of one message over another, withholding or rationing services, manipulation, deletion, censorship or changing

information for target audiences, and importantly, Barzilai-Nahon (2008) considers the effect of these strategies on individuals and society. Network gatekeeping places more focus on the 'gated' or the 'entity subjected to gatekeeping' (Barzilai-Nahon 2008 p1496) and the power relationships between the gatekeeper and the gated, and thus, this view of gatekeeping is appropriate in exploring relationships within refugee health nursing. It is proposed that gatekeeping is a flexible process of control, often including discretion in practice, where the level of gatekeeping can be adapted depending on the people involved and the context of interaction (Riley and Manias 2009). Accordingly, findings of this study draw upon network gatekeeping to explore the ways in which RHNs exercise power, shaping nursing practice in this field and the delivery of care for refugees.

According to Gross et al (2000 p222), the task of a healthcare professional who serves as a gatekeeper *'is to manage and co-ordinate a patient's care, as well as to be the sole referring agent to specialists.'* Ultimately, *'the gatekeeper is the patient's health adviser'*. In this study, the theme 'gatekeeping practices of Refugee Health Nurses' relates to various aspects of gatekeeping, illustrated through the following sub-themes, each of which will be considered in sequence.

- ***Sub-theme one: Controlling information flow***
- ***Sub-theme two: Providing and rationing resources***
- ***Sub-theme three: Guarding professional position and developing identity***

These sub-themes relate to the concept of power held by RHNs, who use gatekeeping as a strategy to maintain control.

5.3.1 Sub-theme one: Controlling information flow

Gatekeeping encompasses a myriad of elements, but it can be described as a communication tactic, that involves limiting or facilitating access to information (Riley and Manias 2009).

As mentioned in chapter three, which offered context and background to this study, refugees are referred to the RHP by AMES Australia Humanitarian Settlement Program Service Delivery Network on arrival in Victoria. Having been referred, refugees attend an initial appointment with the RHN at their local community health centre. Sal, one of the RHNs, highlights that:

‘There’s clients who come in and they have no knowledge of the health system or anything, so we are their first contact’ (Sal, RHN).

RHNs are at the core of refugee healthcare in the community setting, assessing health needs of refugees on arrival in Victoria and coordinating subsequent care and referrals. Appointments with RHNs are scheduled to last between one and two hours, during which time comprehensive data is obtained about the refugee’s experiences and health issues. RHNs recognise the importance of building trusting relationships with refugees, gaining deep understanding of each individual experience so that they can provide a person-centred approach to care.

Pat (RHN) mentions that in obtaining information about newly arrived refugees, her role involves detective work, with regards to reading between the lines. She explains that refugees can be reserved in speak of their health concerns during initial meetings, with anxiety about disclosing an illness or disability, with fear of deportation. Similarly, Robertshaw et al (2017 p12) investigated the challenges of primary care teams supporting refugees during resettlement in the UK, reporting that *‘trust was threatened when refugees or asylum seekers thought that healthcare professionals were associated with immigration authorities,’* highlighting *‘suspicion of authorities’* (p10) as an obstacle in gaining adequate levels of disclosure in terms of health concerns.

With regards to undertaking the Refugee Health Assessment (RHA) on arrival in Victoria, Pat says:

‘What you find is, at the start, they might not volunteer much information, but towards the end, there’ll be information that’s relevant to the first few questions that you’ve asked... I mean... clients will tell me some of the stuff... And if you pull it all together, you might get the whole story’ (Pat, RHN).

Having a compassionate, empathetic disposition is seen as important in relationship building and in encouraging refugees to divulge information of a sensitive nature. In line with this, Kat (refugee) confides in the RHN, explaining that:

'It feels like just a member of family, and I feel completely comfortable in telling her everything' (Kat, refugee).

It is interesting to consider the ethical implications of creating this family feel within refugee health nursing, and this leads to discussion of pushing professional boundaries, which follows in section 5.5.2.

Due to the context of appointments with refugees and continuity of care, RHNs can build trust and rapport with refugees, and thus, extract rich information. As the primary health contact, RHNs hold a wealth of data about their clients and subsequently, control how this information is communicated to others during the resettlement process, by sharing, filtering and withholding aspects of information, as well as communicating on behalf of refugees.

It was revealed in the findings that RHNs see themselves as intercessors between refugees and other service providers, coordinating the care process and governing the flow of communication. Likewise, May et al (2001 p370) considered gatekeeping in nursing practice and found that nurses often assert their ability to make decisions on behalf of the multidisciplinary team, thinking of themselves as *'knowledgeable intermediaries.'* From a nursing perspective, Pat affirms that:

'I'm the conduit to the services... The GPs and the allied health team; they can't do their work without me, pushing the clients through' (Pat, RHN).

According to Australian federal government targets, within the first month of arrival in Victoria, a RHA should be completed and refugees should be registered with a GP. According to one of the managers, the nursing process is:

'To engage with clients when they're newly arrived and commence the refugee health assessment- which I guess is to identify their health and social needs. But yeh- it's to initiate that assessment, and to work with the GP around the findings of their assessment' (Ash, manager).

Hence, it is the responsibility of the RHN to conduct the initial RHA and feed this information to physicians to assist with subsequent medical assessment. This finding relates to the work of Hewison (1995 p79), who shines light on power and knowledge in nursing practice, and the way that nurses '*control the agenda.*'

Interestingly, RHNs decide which aspects of the RHA are shared with physicians, facilitating ongoing care. Fieldnotes taken from the metropolitan site convey that:

'The RHN liaises with the GP about anything significant that has arisen during her assessment, passing on key data that she feels is pivotal to planning care. She says that physicians don't have time 'to listen to the refugees' life stories,' so it's her job to provide the 'nitty gritty,' the important stuff' (Fieldnotes, 21st June 2017).

Physicians undertake a basic physical assessment of refugees during the first month of arrival and rely on data from RHNs to guide their practice, with regards to which aspects of the refugee's health and well-being to focus on and the ordering of clinical tests or investigations. The set time frame for appointments with physicians is approximately 10 minutes, and therefore, physicians lack the time to explore refugee health issues in detail. In this way, RHNs use their clinical judgement to decide which information is important to share, influencing the focus of medical appointments. As Farley (1987) put forward in her study, individual nurses recognise the value of possessing and controlling patient information, indicating that control of information in nursing is a major source of power in healthcare organisations.

With regards to sharing information about refugees with physicians, Meg (RHN) says:

'The GPs I work with are really good. They'll check eyesight, but also, in the conversation prior, I would have been like, 'Do you have issues with your sight? Do you have issues with your hearing?' And then- I tend to do an email before they go. So, my way of doing it is- from the conversation I have, I take out particular points that I think the GP should know, and I'll send it on' (Meg, RHN).

Meg (RHN) feels that this practice is beneficial, as it spares refugees from repetitively telling their stories, and it also saves time for busy physicians. RHNs choose to attend the physician appointment with refugees to summarise their findings and recommendations directly. It came to light that RHNs take satisfaction in deciding which aspects of their assessment are worthy of sharing with physicians and feel that their contributions are valued, with one RHN suggesting that:

'They'd be lost without us' (Pat, RHN).

Ann is a RHN and is passionate about tackling health inequalities. Ann speaks of relationship building with refugees in the community and feels that her role is one of advocacy, explaining that she attends physician appointments with refugees on the basis that she has previously gained knowledge of their health needs. Ann (RHN) proposes:

'If they're going to see a GP and they don't speak the language, and we've already done a screen and we've had an interpreter, and we know the information, it's probably more productive if we go with them. And it also helps build up that relationship, that trust... If I take a client who's got back pain I can say, 'Well, he's a labourer, he did manual digging, or a farmer or whatever it is, and, he's had x-rays, CT's and ultrasounds, and hopefully we've got copies of those and if not, we get them' (Ann, RHN).

Similarly, Liz (RHN) talks about how she speaks on behalf of refugees during appointments with physicians, highlighting that:

'We're providing advocacy for them, because I feel like they- they don't have a voice often' (Liz, RHN).

Len, a refugee, reports that:

'Sometimes the nurses are going with us to the GP, and supporting, translating, supporting us, helping with the language' (Len, refugee).

Interestingly, it emerged from the data analysis that refugee stories and health concerns are often shared with clinicians from the nursing perspective.

RHNs attempt to shelter refugees from being re-traumatised, by limiting how many times they need to share their stories and experiences. RHNs therefore attend

appointments with refugees and share information with service providers, on their behalf. To take this point further, it emerged from the findings that RHNs exercise power over refugees by limiting unnecessary conversations with physicians and other service providers. The effect is to silence refugees by preventing them from conveying information. In the study by Griscti et al (2017 p238), patients reported not being able to *'have their voice heard'* and *'the hierarchical structure of hospital supported these dynamics by privileging nurses as gatekeepers of service, by excluding the patients' input in the nursing notes and through a process of self-regulation.'* Nevertheless, in parallel with the study by Riley and Manias (2009 p218), the rationale for RHNs doing so is embedded in protecting refugees from the burden of repeating stories of traumatic experiences.

Of note, RHNs portray a positive aspect of withholding and filtering information, in terms of helping physicians to focus on what RHNs deem as important health issues. Nevertheless, much of the literature has reported negative components to gatekeeping in relation to the flow of communication. In a critical ethnography by Street (1992), it was found that gatekeeping involved nurses withholding patient information and providing incomplete data to colleagues about the location of patient supplies, as they felt that this information was insignificant to others. Advantage was gained by *'creating a dependence on the owner of the knowledge for ongoing information necessary to engage in effective clinical practice'* (Street 1992 p109), with nurses wielding power over those who did not hold specific information about patients. Furthermore, in an ethnographic study examining the interrelationship between knowledge and decision-making in a critical care unit, Manias and Street (2001) describe how nurses engaged in gatekeeping practices to help them remain in control. Nurses staged the release of information to medical staff by selectively imparting and filtering their knowledge about patients. Manias and Street (2001) report that this encouraged inexperienced critical care doctors to make decisions that worked in favour of nurses, as nurses guided doctors towards a pre-determined outcome.

In terms of the flow of information within the RHP, one of the managers suggests that there is concern around communication between RHNs and physicians, with some physicians uncomfortable in accepting their advice and recommendations. Ash (manager) concedes that:

‘GPs are really resistant to having anybody looking over their shoulder, and making recommendations about their treatments... I think in some regards, there’s a bit of ego there’ (Ash, manager).

Furthermore, with regards to consequences of filtering or withholding information in nursing, Kowalski and Anthony (2017) explored this type of gatekeeping and showed a possible impact on patient safety, with elements of patient information not communicated. One RHN points out:

‘There’s not much communication between us and the GPs and- some of the GPs and the nurses, so things get lost in the system’ (Pat, RHN).

As RHNs decide which aspects of information are important enough to share with clinicians, some data about refugee health concerns may be forgotten about.

Along these lines, Alvarez and Coiera (2005) found that inadequate communication and dissemination of patient information among the multidisciplinary team can lead to disruption in clinical practice. Likewise, in their study of nurses’ gatekeeping practices in operating rooms, Riley and Manias (2009) showed the ways in which nurses facilitate, disseminate and withhold information can have practical and ethical ramifications for patient care, clinical outcomes and professional relationships. Riley and Manias (2009 p218) suggest that *‘nurses can act as gatekeepers by controlling information,’* and that there is frustration in the operating room setting with nurses’ poor dissemination of information to other team members.

In terms of RHNs withholding information from management, managers of the RHP do not have nursing backgrounds and they lead on various other projects within the community health centres. As managers view RHNs as experts in this field, they trust RHNs to coordinate the service and rely on their expertise. Ali (manager) acknowledges:

‘Well, sometimes the nurses help me, because they’re totally, you know- very current, with sort of- current information and legislation changes, and around immigration and so forth. So sometimes they- yeh, they feed up and, you know’ (Ali, manager).

It materialised from the findings that because RHNs understand that managers have limited knowledge of health-related issues, they often refrain from sharing clinical information with them. According to the other manager:

'I don't have a health background... I don't have very good knowledge of the health system, and I guess medical, clinical approaches. So, yeh- that's not where my skills lie' (Ash, manager).

This bears symmetry to findings from the study by Cooper and Urquhart (2008 p63), who report that nurses *'often took full responsibility for a clients' problems and perceived it to be unnecessary for care managers to be involved in a particular situation.'* By gathering detailed health information about refugees and having autonomy in deciding how this information is shared, RHNs are empowered in their practice. Indeed, nursing autonomy and professional judgement is explored further in section 5.4.1.

With regards to sharing information with patients, Sinivaara et al (2004 p34) highlight that *'professionals can keep patients under their power either by applying information or by withholding it,'* and that *'nurses may have power over patients' autonomy by regulating information and making decisions for them'* (p35). They describe how midwives withhold information about managing labour when communicating with women in delivery rooms. In consensus, RHNs in this study are selective in sharing aspects of health information with refugees.

According to Johnson and Webb (1995), nurses exert power by withholding information from patients. From a nursing perspective in this study, Pat (RHN) says:

'If there's a complex, umm, you know, chronic disease in a client- in adults, then you would automatically stress the importance of maintaining those appointments and why. But you don't go straight into frightening them, talking about the complications of those diseases if they're not looked after, particularly diabetes' (Pat, RHN).

Liz (RHN), agrees, portraying that she keeps certain clinical information from refugees during the resettlement period, as she feels that they lack understanding, commenting that:

‘They’re coming from areas where they don’t understand a lot about health- they have low health literacy’ (Liz, RHN).

Edwin (2008 p156) puts forward that *‘therapeutic privilege refers to the withholding of information by the clinician... in the belief that disclosure of this information would lead to the harm or suffering of the patient.’* In some instances, RHNs believe that it is in the refugee’s best interests not to fully explain health conditions, to avoid frightening them. As Sarafis et al (2014 p133) point out, *‘sometimes too much information can be overwhelming.’* In sharing information with patients, it is proposed that healthcare professionals should consider the characteristics, personal needs, preferences and beliefs of the individual.

Similarly, Pat (RHN) has lived in many countries around the world and has worked as a nurse in a range of environments, speaking numerous languages and with exposure to an array of cultures. It is suggested that the first step towards improving cross-cultural communication is to raise awareness of one’s own verbal and nonverbal communication styles (Kaihlainen et al 2019). In line with this, Pat (RHN) shares some insight, in that:

‘I don’t fill them with jargon about science and life- it’s not going to work. You know, if I started straight into the medical terminology- ‘Look at me, how informed I am and how much I know,’ they would never come back to see me’ (Pat, RHN).

Pat (RHN) withholds scientific and clinical information from refugees, wishing not to overwhelm or intimidate them with medical terms; consciously moving away from the medical model of nursing.

During an appointment at the rural/regional site, Liz (RHN) assured a refugee that she was doing everything that she could to help resolve a housing situation. Fieldnotes report that:

‘She said it was best not to disclose the length of the housing wait list to her client, as this may increase stress levels and be detrimental to his health and well-being’ (Fieldnotes, 26th September 2017).

This concept is in line with Sarafis et al (2014 p132), who suggest that *'withholding the truth is based in the fear that bad news will drastically and negatively alter a patient's view of their future. Moreover, it is an attempt to foster hope and to protect patients from unpleasant and difficult emotions.'*

Interestingly, Too (1996) acknowledges that not all patients want to be involved in decision-making and some prefer to leave it up to nurses to decide what is best for them. One refugee comments that:

'I'm happy with the workers, because we know nothing... They welcome us, and treat us, and give us attention, everything that we need' (Suz, refugee).

According to Sinivaara et al (2004 p34), relationships between nurses and patients may be described as ones of unequal dependency, suggesting that *'patients are more vulnerable than nurses... patients have a more marginal role, and they have less scope to influence the course of discussion and express their views.'* In the study by May (1992), nurses were observed to hold on to control by manipulating the form of interaction they had with patients, and similarly, RHNs in this study use power in ensuring that refugees become dependent on them for 'everything' they need.

To summarise, it became apparent through data analysis that RHNs act as gatekeepers of information, deciding how and which information is shared, withheld or filtered for physicians and managers, as well as how information is presented to refugees, controlling the transmission of communication and exerting power.

5.3.2 Sub-theme two: Providing and rationing resources

As specialist nurses, RHNs deem themselves to be doyens in this field, controlling the operation of the RHP in Victoria and determining how care is delivered for resettled refugees. RHNs are intermediaries between refugees and other professionals, at the gate of which refugees must pass to access a range of services during the resettlement process. RHNs exercise power in making decisions regarding the eligibility of refugees to access the programme, referrals to specialised services and allocating resources.

As McEvoy and Richards (2007) consider, gatekeeping access to resources in primary care has been identified as a key issue for community specialist nurses, highlighting the power held by nurses in this context. RHNs are on the frontline, using their clinical judgement to determine how care is delivered and the extent of referral pathways, as well as deciding when to discharge refugees into the mainstream community health setting. Pat (RHN), suggests that:

***'Systematically, I'm set up to have control- power over them (refugees)...
'It's the position I have. It's quite a powerful position' (Pat, RHN).***

Gross et al (2000 p222), discuss the power held by health professionals in providing and rationing resources, putting forward that *'a healthcare professional who is adopting the role of gatekeeper can make judicious decisions about the best and most appropriate use of medical services.'* The term 'gatekeeping' creates an image of the RHN *'positioned at an entry point, or gate, through which patients must pass to receive care or services'* (Riley and Manias 2009 p216). According to fieldnotes taken after a conversation with Sal (RHN) at the metropolitan site:

'RHNs decide whether the refugee can access the programme and can refer refugees to other services. Sal says that 'they need a doorway,' and 'we are the gateway' (Fieldnotes, 1st June 2017).

In gatekeeping, *'the idea is to suggest a figure with a significant social role to control access to resources. This may involve the screening of individuals seeking entry and allowing only some to pass 'beyond the gate' (Collyer et al 2017 p97).* Refugees are referred to the RHP and then RHNs undertake an eligibility assessment, to determine whether to accept the refugee into their care. Significantly, McEvoy and Richards (2007 p393) point out that nurses in their study *'feared that they could be hoisted by their own petard if they took on more work than they could reasonably manage.'* RHNs should decide upon the eligibility of the refugee based on specified eligibility criteria, considering the extent of complex health needs, and whether there is capacity within the RHP to accept a new client or family. Nevertheless, as gatekeepers, RHNs are lax in their approach, often allowing refugees who do not meet criteria to access the service. By the same token, a study by Ellis (2011) investigated the significance of autonomy in determining eligibility for social work services, highlighting that professionals are often lenient in adhering to criteria.

As well as acting as gatekeepers to the RHP, Ali (manager) reports that RHNs permit access for refugees into the wider healthcare landscape:

‘through facilitating people to have refugee health assessment, through nurses providing care coordination, and enabling clients to access, you know the health system’ (Ali, manager).

RHNs are responsible for planning care and working collaboratively with other services to meet the needs of refugees. Pat (RHN) summarises by saying that:

‘My role is to initiate the refugee health assessment... and also, to coordinate services with other community based and the acute sector’ (Pat, RHN).

Likewise, another RHN suggests:

‘Our role is a lot of case management- care coordination and referrals’ (Sal, RHN).

They use their clinical judgement to decide which services are required for refugees and make onward referrals, as they deem fit.

With regards to referral to GPs, RHNs decide which physicians to refer refugees to, depending on their perception of the GP’s willingness to engage with refugees. As one RHN puts forward:

‘Of course, I have to weigh up which doctor sees the client’ (Pat, RHN).

Likewise, another RHN says:

‘You identify what their health needs are, and you link them in with the right GP’ (Sal, RHN).

On a similar thread, nurses in the study by Riley and Manias (2009 p218) were sensitive to the nuances of individual physicians’ demeanours, *‘knowing them as approachable or unapproachable.’* Gross et al 2000 (p225) concur, highlighting that *‘this involves not only the physicians’ formal knowledge, but also their approach and attitude toward patients.’*

RHNs use their knowledge of local physicians to inform decisions about referrals of refugees and protect clients from potentially negative health experiences.

In this sense, gatekeeping relies on the personal judgement of RHNs, as they try to link refugees with a physician that they feel will be empathetic to, and knowledgeable about refugee health needs, and a physician that regularly employs the use of interpreters. Similarly, in the study by Riley and Manias (2009), nurses could sense the physicians' mood and they used this knowledge to inform their decisions about how they would interact with them, altering their approach and choosing an appropriate physician to ask questions to or refer accordingly.

With regards to offering referral to specialists, Liz (RHN) believes that her role involves identifying refugee health issues and thinking about services that may be useful during the resettlement period.

'I refer them on to other services, so it's keeping your mind out for those services that they might be needing. Umm, you know, the counselling- the torture and trauma counselling' (Liz, RHN).

Likewise, Pat (RHN) agrees, noting the importance of staying alert to potential signs and symptoms during the resettlement period, adding that:

'When you go into their psychological health, which is are they sleeping, are they eating, are they tired all the time? Their energy levels and all that- that's where you pick up PTSD signs and symptoms. Is it interrupting their life? Is it bothering them enough to warrant a referral to Foundation House, who are the counsellor advocates- for umm, torture and trauma? So, it's that kind of stuff' (Pat, RHN).

As coordinators of the RHP, RHNs are responsible for recognising the need for input from health and social care professionals and are the gateway to specialist services. RHNs refer refugees to members of the multidisciplinary team within the community health centres, with one RHN commenting that:

'The physiotherapists that we have here are fantastic. They really understand a lot about the chronic pain... Umm, the dietician is another one we'll refer to- she's really good... There's also- we have, the respiratory nurse, diabetic nurse as well- we refer on to her a little bit... Well, it's all helpful because you can then sort of link them in with services that we feel they need to be linked in with' (Liz, RHN).

With regards to referrals, Liz (RHN) mentions the importance of having knowledge of referrals pathways and building strong professional relationships with the multidisciplinary team to facilitate efficiency.

In consensus, one manager talks about the importance of RHNs working well with the wider team, reporting that:

'We refer- so there's a lot of cross-referral from the organisation. Umm, we've got financial counsellors here, so there's really easy pathways into see, you know- if somebody's experiencing financial difficulty- and it's appropriate to see a financial counsellor, we can get them into one of those appointments'
(Ash, manager).

However, it also emerged that RHNs are aware of high demands on various services, highlighting the waiting lists for specialists such as physiotherapists, for example, which is in likeness to problems with waiting lists for specialists in Scotland (McIntyre and Chow 2020). RHNs can be hesitant to refer all refugees to the necessary service, depending on activity and strains within the organisation. This is in line with gatekeeping pressures highlighted in the studies by Rissbacher et al (2011) and Godager et al (2015), who discuss the intricacies of balancing client need with the interests of the organisation. Although RHNs exert power in making referrals, this is undertaken within the constraints of the institution. With regards to nurses as gatekeepers, Riley and Manias (2009 p219) draw attention to the concept that *'decision-making involved logistical information about access... the availability of appropriate resources.'* RHNs decide whether refugees merit referral to specialist services, depending on their personal reasoning and appraisal of each situation. Nevertheless, they must balance refugee need with being mindful of the organisation's waiting lists and pressures, and therefore, RHNs circulate between threads of power. Similarly, with regards to rationing resources, healthcare professionals in the study by Chiarello (2013 p325) *'struggle to balance the patient's interests with those of the hospital.'* In consensus, Willems (2001 p29) refers to gatekeepers performing a *'balancing act.'*

Interestingly, in responding to institutional pressures, RHNs often consider support available within the refugee's community, before referring to a specialist. One RHN conveys that:

'If (the refugee) is getting a bit confused and doesn't have the support systems in place to teach her or to say 'look, this is what I've tried,'- because the community usually support each other. If she doesn't have that and she's isolated on her own, then I'll refer them to the dietician' (Pat, RHN).

In this way, RHNs recognise the value of cultural communities in supporting new arrivals, taking account of the input on offer from these sources before referring to the multidisciplinary team.

With regards to negotiating refugee access to external services, such as dental or radiology, Meg (RHN) provides advocacy, if she feels the service is necessary.

'We advocate for them to get the appropriate services, because in many circumstances, they're just not eligible, umm, whether it be cost or they're not- they don't have Medicare services and things like that. So, we're advocating for their needs, and that's a massive part of the role' (Meg, RHN).

Similarly, healthcare professionals in the study by Chiarello (2013 p324) have 'freedom to advocate for patients,' and are 'taking extra steps for patients... although they acknowledged (and often tried to work around) organisational limitations.' As Ali (manager), points out, RHNs use problem-solving and negotiation skills to fight for the rights of refugees in accessing services.

'I think it's continual. Someone who has this health issue, or housing issue, or whatever, umm- what service do I refer them to? How do they access it? And then enabling the client to access that service, knowing how to get there, you know- it's all those things' (Ali, manager).

In terms of referral and providing access to services, one refugee comments:

'Here, the Refugee Health Nurse helped us. Like, she first made a check of everything in our bodies... like- lots of blood tests, urine tests, everything! Mammography for my breasts, and pap smears- and, umm- everything! It's like, someone wants to check that every part of your body is working good. Even our teeth- we got a referral to a medical centre for the dental, to check our teeth and oral health... For my mother in law- she has diabetes, they looked at her with a diabetes specialist, looked after her health, someone to look after her feet- podiatrist, to check her legs. Pat is referring us, yes. Like, my father-in-law has-

it's a liver issue. Because he has this problem- Pat referred him to a specialist, here- he now has like, a regular appointment with this specialist' (Jes, refugee).

Similarly, Sue is a refugee and talks about the referrals that were made for her by the RHNs.

'The first person I saw was Liz, and after that, Ann. And I was introduced to- last year we had a yoga instructor here, who showed us yoga, and it helped me a lot, mentally and physically. And other than that, they gave me- there were physios- umm physiotherapists here for my physio exercise' (Sue, refugee).

However, RHNs decide which refugees can access these services, depending on their health needs, and this is continually re-evaluated depending on demands on the service. Garrido et al (2011) investigated patient satisfaction and health outcomes associated with gatekeeping processes in a systematic review of the literature but found that evidence on the effects of gatekeeping in this context is limited. As Chiarello (2013 p320) points out, *'it is on the ground, as professionals exercise discretion in distinct organisational settings, that gatekeeping impacts patient care. The array of gatekeeping processes that healthcare workers engage in requires a complicated negotiation of healthcare provision.'* The use of discretion in refugee health nursing is discussed further in theme two.

As well as providing and rationing access to services, RHNs also control the provision of resources for refugees. Fieldnotes from the metropolitan site report that:

'A refugee mentioned that she had a problem with her hearing and the RHN referred her to a specialist hearing clinic. The clinic was far away, but the nurse gave the refugee a travel voucher to catch a taxi there and back, to ensure that she could make the appointment and receive treatment. This comes from the budget for the RHP, and the nurse can decide which refugees are in most need of these travel vouchers' (Fieldnotes, 13th November 2017).

In this way, RHNs are trusted by managers to rule whether refugees should receive extra support, depending on the circumstances.

Fieldnotes taken at the metropolitan site provide further insight into the ways in which RHNs use their professional judgement in providing and rationing resources.

‘Pat talked about giving her clients up to \$100 worth of food vouchers, if she feels that it could help with their mental and physical health, and this comes from the RHP budget. The decision to offer these vouchers is based upon her professional judgement, providing additional support to refugees that she feels are in greatest need’ (Fieldnotes, 6th June 2017).

There are no explicit criteria that must be met to provide food vouchers but RHNs advise that they are cautious in offering food vouchers, as they are mindful of the RHP budget.

As touched upon, and building on Macklin’s (1993) work, gatekeeping can be described as the process by which healthcare providers attempt to meet patient need while attending to the economic interests of their organisation when deciding which resources to provide. According to Brekke et al (2007 p166), *‘the conventional wisdom is that gatekeeping contributes to cost control.’* RHNs are resigned to the view that the requirement for *‘defensive gatekeeping or rationing is inevitable’* (McEvoy and Richards 2007 p393), due to organisational constraints impinging upon their practice. Interestingly, in the context of gatekeeping, Willems (2001) advises that trust-based relationships risk being eroded by the nurse’s economic position in providing and rationing resources. Willems (2001) suggests that gatekeeping in healthcare is underscored by the need for budget restraints and in addition, the need for justice in distributing resources. In the context of refugee health nursing, RHNs determine which refugees are most in need of support or services.

Chiarello (2013 p324) highlights that for frontline workers who have *‘time constraints and heavy client loads, it would be reasonable to expect them to advocate for only a select few patients, but for those patients to greatly benefit.’* Fieldnotes obtained from the rural/regional site offer further perspective on this notion.

‘I was invited by one of the RHNs to a lunch by the lake today with a group of Afghani women. Money from the RHP budget was used to buy food from a local Afghani café and we had a picnic together. The RHNs choose refugees to be included in these social lunches, and it sounds like many of the same women are invited regularly as they get on well as a group’ (Fieldnotes, 21st November 2017).

Notably, RHNs focus on refugees who are responsive to social events. Furthermore, there are activities such as swimming at the local pool, day trips to various country parks for barbeques and organised walks around the town. RHNs decide which refugees are invited to take part in these activities and observation showed that many of the same refugees are invited on a regular basis, with some refugees vocal in advising RHNs that they would like to attend. Correspondingly, as Willems (2001 p26) suggests, *'patient preferences are, or should provide, important guidance in the allocation of health care.'*

McEvoy and Richards (2007 p388) describe gatekeeping as arbitrary and subjective, with healthcare professionals *'muddling through,'* and that patterns of practice are *'determined by individual clinicians and teams, rather than through formal strategic control.'* Of note, this concept is corroborated by Wells (1997). In terms of refugee health nursing, most gatekeeping decisions are based on altruistic motives, which is echoed by the study undertaken by Brown and Crawford (2003). Willems (2001 p27) points out that, *'giving priority to one patient in one's waiting room will keep the others waiting... justice would demand that care should primarily be assigned to those who are most in need of it.'* However, within refugee health nursing, priority for social activities is often given to refugees based on social relationships and the idea that certain refugees get along well in a group setting.

With regards to providing and rationing access to services, Charles-Jones et al (2003) discuss the hierarchy of appropriateness, which has four dimensions: severity, risk, beneficence and a moral aspect. Beneficence and the moral dimension are most evident when RHNs make decisions about allocation of resources. If there is an opportunity to help alleviate a refugee's health issues and prevent any further deterioration by engaging in short-term interventions, then the refugee is more likely to be offered specialist support. Lou, a refugee, comments that:

'Everything is really good and useful at the Refugee Program- especially like, if there is someone who has bad depression, they would refer him to a counsellor' (Lou, refugee).

With regards to the moral dimension, distinctions are made between refugees based on how genuinely deserving RHNs perceive them to be. In likeness to findings of the study by McEvoy and Richards (2007 p390), *'at one end of the spectrum were*

patients who were thought to be accessing services under a false pretext. They were less likely to be offered support. At the other end of the spectrum, clinicians sometimes went beyond their strictly defined remit because they felt that they had a moral duty to act in the patient's best interests.' The kinds of services and activities that are offered to refugees are influenced by the value judgements made by RHNs, which is consistent with Hughes and Griffiths (1997), who talk about the use of value judgements in 'ruling in' and 'ruling out' patients with regards to micro-rationing in the healthcare environment. This is also echoed by Walzer's (1993) idea that there are different '*spheres of justice,*' in gatekeeping, with regards to value, morality and goodness. Interestingly, Wells (1997) suggests that the client who demonstrates compliance is rewarded with access to resources, whilst the non-complaint client receives a negative and sometimes draconian response.

To offer a summary, it emerged from the findings that RHNs are in a position of control, as they afford refugees access to services and resources. Willems (2001 p25) draws attention to the notion that '*a gatekeeper is a defined point of entry each time care is needed for a health problem.*' The following sub-theme considers another aspect of gatekeeping in refugee health nursing; that of protecting specialist knowledge and ensuring the continuation of the RHN role.

5.3.3 Sub-theme three: Guarding professional position and developing identity

As highlighted in the literature review, there is ongoing discussion in healthcare practice and policy about whether there is a requirement for specialist healthcare for resettled refugees (Section 2.5.2). To this end, RHNs in Victoria justify their professional position and try to distinguish themselves from other care providers in the community, to sustain their rank in the community health hierarchy. As culturally competent practitioners, RHNs believe that they are best placed to effectively respond to the health needs of refugees. With the view that mainstream service providers are ill-equipped to offer the same level of culturally competent care, RHNs are tentative in discharging refugees at the end of the one-year resettlement process. Thus, RHNs act as gatekeepers of refugee health knowledge and skills, preventing other community healthcare professionals from gaining experience in caring for refugees. It is suggested that there are benefits to working in a specialist area of nursing practice,

including prestige, development of advanced skills and higher salary than general nurses (Vidall et al 2011), and RHNs are keen to ferment their place as specialist practitioners.

So, what makes the RHN role different from other nursing disciplines? How do RHNs set themselves apart in everyday practice, to develop their professional identity? Santangelo et al (2018) seek to define the 'special' in specialist nursing practice, and in defining the 'special' component of refugee health nursing, RHNs refer to their cultural competence, enabling them to provide care for refugees in a sensitive and thoughtful manner. RHNs are recognised locally as inclusive practitioners who tackle health inequalities in the community, developing their reputation as a group of nurses with socialist, forward moving ideology.

RHNs are of the opinion that as specialist nurses in this field, they hold deeper insight into the refugee experience than other service providers. One RHN suggests:

'Look, we get it, and we understand' (Ann, RHN).

Importantly, the notion that RHNs understand the experiences of refugees may be viewed negatively by some refugees, who have been through traumatic situations, although this was not evident in the findings. Nonetheless, in line with this idea, Cooper and Urquhart (2008) found that gatekeeping practices of healthcare workers led to a feeling that nobody else could understand the health needs of their clients in the same way, echoing the findings. Similarly, Skar (2010 p2231) argues that nurses *'regard themselves as the main person responsible in the healthcare team when it comes to understanding what the patient needs.'*

The attitude of RHNs towards refugees has an impact on the decisions they take and how nursing care is delivered through the RHP. RHNs believe that because refugees have often experienced trauma and conflict, they are therefore worthy of nurture and empathy. It is interesting to consider that being a refugee brings with it the burden of an intensified sensitivity and vulnerability and *'perhaps nurses are drawn more to care for individuals who are needy of such care'* (Dowling 2004 p1291). By means of their attitudinal dispositions, nursing psychological simplifications of refugees emerge that *'redefine... the nature of the clientele to be served'* (Lipsky 1980 p141). As a result, RHNs' attitude towards refugees introduces bias to the nursing encounter and its outcomes, with RHNs of the view that refugees deserve a greater

level of care than the average population. Interestingly, some RHNs mention a maternal instinct towards refugees in their care. One remarks that:

'My background is paediatric nursing, so I liken it to children. I hold their hand while they learn to walk again' (Ann, RHN).

Predominantly from white Caucasian backgrounds, RHNs believe that refugees are a vulnerable group in wider society and are often treated unfairly. They feel a sense of responsibility in ensuring the safety and well-being of refugees. Pat (RHN) considers:

'Are they feeling safe in the country? Are they doing their physical activity, without any threat from the surrounding area, from the people around them?' (Pat, RHN).

Therefore, RHNs promote a sense of inclusiveness within the RHP, and are eager to campaign against racism and discrimination.

With regards to progressing their professional identity, RHNs are politically active in confronting issues of racism and tackling health inequalities in the community. According to Ali (manager):

'I think it's as much a part of them as it is their structured, you know-workload, in terms of being politically active with that kind of thing' (Ali, manager).

Likewise, Ann (RHN) reveals that:

'And because- a lot of people sort of are 'ooh a refugee. What do I do with it- or them? But we can be creative, and we can get on to a soap box' (Ann, RHN).

By soap box, Ann means that RHNs have an elevated platform, attempting to tell the world about the plight of refugees and make known the need to care for this population. She says that:

'I see my role as one of advocating for newly arrived people... and it's getting rid of some of the myths' (Ann, RHN).

Nowadays, populist discourse often demonises refugees, while these are the same individuals who uphold economies, bolster social services, contribute to health services and bring cultural diversity to host countries (Abubakar et al 2018). In the current political climate, the term refugee *'raises a litany of myths and inaccurate stereotypes,'* and while often used for political gain, falsehoods about refugees have frequently become publicly accepted (Abubakar et al 2018 p2610). Dot, a refugee, says:

'I think it's just- they make us feel like we're all the same- equal' (Dot, refugee).

Len, another refugee, highlights how he is treated by the RHNs, reporting that:

'They are very equal to everybody- it doesn't matter where the people come from- their services are available for everybody' (Len, refugee).

In consensus, another refugee draws attention to the importance of respect for her cultural beliefs, mentioning that:

'One of the most important stuff would be their manners, and their respect, and that friendliness- no racism' (Lou, refugee).

According to Jes (refugee), as opposed to care she has received from other healthcare providers on arrival in Victoria:

'Here, no one wants to harm me. Everyone supports... No one makes fun of me. No one discriminates me or treats me badly' (Jes, refugee).

The way that RHNs deliver culturally competent care contributes to their professional identity within nursing practice. Drawing attention to this point, Pat (RHN) says:

'They've been through so much. Forget about all the knowledge and skills that you have. They will come into play subtly in the background; people just want to be respected. They want their dignity maintained' (Pat, RHN).

This idea about having dignity maintained is extremely relevant, particularly in the current global climate, with refugees renowned for losing dignity through war and conflict.

In terms of fostering cultural competence in delivering care, RHNs across Victoria undertake bespoke training courses and study days, predominantly operated by the Victorian Refugee Health Network at Foundation House in Melbourne, building a specialist knowledge base and learning about how to respond appropriately and respectfully to refugee health issues. According to a manager, RHNs acquire:

'An understanding- I guess, of the refugee experience, and what it means for a refugee to be going through settlement here in Australia. An understanding of past trauma, an understanding of, I guess- the health needs and risks of people coming out of war zones, refugee camps, and the vulnerabilities that they may have in relation to their health' (Ash, manager).

Of importance, RHNs adopt a culturally responsive approach to care, engaging in efforts to support refugees in incorporating their own cultural beliefs into the care process during resettlement and providing a comfortable, safe space for refugees to reflect and share their experiences. RHNs actively learn about different cultures and traditions as part of their specialist training, embracing cultural awareness and creating opportunities for compassionate care. Ann (RHN) tries to communicate in the native language of refugees. She highlights that:

'I've made a point of learning the greetings in their language, and they all laugh- but at least it's a smile, and it's some way of engaging. Yeh, so that's fun' (Ann, RHN).

It came to light from the data that refugees appreciate the effort made by RHNs to meet them half-way with communication and this helps with building trust.

As RHNs attend training courses through the Victorian Refugee Health Network, they learn about global problems and perspectives and gain insight into various aspects of the refugee experience. RHNs are aware of potential situations that refugees may have encountered due to conflict in their countries of origin and in transit but are cautious in the way that they explore this with refugees. As a RHN suggests:

'I don't go into the event unless it's volunteered' (Pat, RHN).

Ann (RHN) talks about training she attended, reiterating the need to incorporate cultural traditions into the provision of nursing support.

'This morning, we were talking about the Prophet Mohammed and his daughter Zara, and in the context of the suppressed life of the Afghan woman. But it really makes sense, because then you understand how, you know, occasionally you get an Afghan woman who comes, and her husband insists on staying in the room. And to say no would break down any trust, and they would turn on their back and go, they wouldn't stay' (Ann, RHN).

In terms of cultural sensitivity in distinguishing themselves from general nurses, it became apparent from the data that RHNs are eager to learn about the cultures of refugees and encourage them to incorporate cultural traditions into their lives in Australia. The notion is illustrated well by Pat, one of the RHNs.

'They've got traditional medicine and they've got traditional beliefs... They believe- you know like, the evil eye. They believe in mystical causes of illness and health. All those things have to be taken into consideration. Otherwise, Western medicine is just not going to work. If they really do believe that somebody is sick and is going to be sick for a long time, simply because of an evil eye. And if the only way that they're going to get rid of this evil eye, is to sacrifice a goat, then you have to say, 'Why don't you do that? What's stopping you from sacrificing a goat? Can you go to the Mosque, organise it with the Iman there? Can we organise it within the community, or their community of faith? We help them do that ritual' (Pat, RHN).

Mutitu et al (2019) discuss the relevancy of healthcare providers in promoting culture preservation for resettled refugees in the community, referring to actions that allow individuals from any culture to retain and preserve values. According to Len (refugee):

'All the staff are well behaved with the clients, and also- they're all so supportive. Whenever we need support, that's the reason we come here' (Len, refugee).

The RHNs encourage refugees to integrate their customs into life in Australia.

‘When you ask, ‘How would you deal with grief if you were in your home country? Usually, it’s a group of women getting together and just wailing. Why don’t you do that here?’ ‘Because people would think we’ve gone mad.’ But if most of the people would, in your neighbourhood, from the horn of Africa, we say; that’s how you should do it!’ (Pat, RHN).

RHNs incorporate traditional rituals into the care they provide to help refugees feel more at home in Australia, and they believe this cultural competence makes them better placed to care for refugees than mainstream community practitioners.

Fieldnotes taken from the rural/regional site reflect this cultural sensitivity.

‘RHNs immerse themselves in the Afghani culture, organising social lunches with refugees and learning from them, eating traditional food and taking part in Afghani dances’ (Fieldnotes, 21st November 2017).

According to Papadopoulos et al (2016 p5), *‘meaningful contact with different ethnic groups can enhance knowledge around their health beliefs and behaviours, as well as raise understanding around the problems they face.’* Further fieldnotes obtained at the rural/regional site build upon this concept, reporting that:

‘The RHNs organised an Eid celebration within the community health centre for the local refugee community, using money from the RHP budget for a range of culturally diverse food and party supplies. They socialised with the help of interpreters and there was a fun atmosphere, with traditional music and dancing’ (Fieldnotes, 5th July 2017).

While RHNs immerse themselves in the cultures of refugees and respect the diverse health beliefs of clients, they imply that other service providers are incapable of offering the same standard of culturally competent care for refugees. This notion is supported by managers, with Ash (manager) acknowledging the need for specialised nursing care for refugees.

‘A lot of the clients don’t fit into mainstream community health, whether they’re not getting language support- they’re not getting the right care through nurses. So, we’re providing what we see as a more holistic service for refugees’ (Ash, manager).

This view is supported by other studies, which highlight the requirement for specialist nursing care to support specific groups in the community (Younge and Norton 2007; Bostrum et al 2012).

In consensus, Ali (manager) supports the development of the specialist RHN role and recognises the value of expertise within this field, proposing that:

'In terms of having the specialist roles, I think it's important, because there's a whole lot of knowledge and skills that people have when they're specifically in those roles... in terms of understanding the need of the client group, but also, you know, skills around navigation, different services that clients can access- all that kind of knowledge' (Ali, manager).

Jes (refugee) differentiates the RHN from other nurses, highlighting the proficiency of RHNs and suggesting that:

'Another nurse would never know. The people who are here- they know our rights' (Jes, refugee).

Correspondingly, Hopkins and Irvine (2012) recognise that community nurse specialists provide invaluable care and have greater understanding of patient need and referral pathways.

It became apparent from the findings that as RHNs are the primary care providers for this group, refugees are often hesitant to respond to other professionals, which gives RHNs an impression of power. Pat (RHN) elucidates that:

'If they get a phone call from a total stranger, they're just not going to respond. 'I've never met you; I don't know who you are- I'm not coming to your service' (Pat, RHN).

Pat (RHN) claims that having formed a bond with refugees through continuity of care during the resettlement period, RHNs are the only health professionals that refugees trust to deliver good quality care. This feeling creates a sense of empowerment for RHNs, with Pat (RHN) noting that it validates her as a person, as well as her specialist nursing skills.

Managers appreciate competing priorities of other professionals in the community setting but feel that the care offered out-with refugee health nursing can be sub-optimal. According to one of the managers:

'Where somebody might have a chronic health issue, or a critical health issue that needs some support, needs some health literacy or education... supporting them to understand the diagnoses, because we know, sometimes GPs and specialists are very time poor. They don't, sort of, especially when there's a language barrier, they don't necessarily do any teach back or anything like that. And our experience is, our clients will just go, 'Yes, yes, yes,' and agree, and then come out not really being informed about what's happening. So, yeh, that's why people need our programme, because there's a bit of a need for more thorough health support' (Ash, manager).

RHNs have more flexibility with regards to appointment times, continuity of care and cultural competence, which differentiates the level of care provided by RHNs from that of mainstream community health services. With reference to the RHN, Jaq (refugee) reports that:

'She makes sure that I understand my problem, and to make sure that I understand why I've been to the doctor, and why I've done the x-ray, or MRI or anything like that. Or what the doctor explained to me' (Jaq, refugee).

Likewise, Pat (RHN) mirrors this concept, highlighting that:

'If they're seeing the specialist services, which is maybe the infectious disease specialist, they have to understand why they have to come back, and why it's important for them to be there, to return' (Pat, RHN).

Cribb and Entwistle (2011) draw attention to the importance of an emotionally supportive client–professional partnership to aid meaningful participation and to promote the client's understanding of the care process. One refugee suggests that:

'When I was seeing a women's health doctor, a specialist for pregnancy, so, some stuff I wouldn't understand. Liz would book an appointment with me to sit down and talk to me- tell me what it is about' (Amy, refugee).

Mindful of varying levels of health literacy, as culturally competent practitioners, RHNs help refugees to understand the care process.

As other professionals are time poor, RHNs explain that they pick up the pieces in cases where refugees slip through the cracks.

'We're about- I suppose, identifying those people at risk... who are refugees and asylum seekers who just do not receive the attention that they should be, and actually assisting them to have- to find, you know- get good healthcare' (Meg, RHN).

Brown and Crawford (2003) report similar findings in their study of gatekeeping practices within community mental health teams, elucidating the ways in which specialist staff feel that they often rescue patients who are drowning in the health system. Meg (RHN) suggests that:

'It's just- a lot of responsibility, it's- a lot of our work is ethical as well. You can't just leave people to get left behind, you know?' (Meg, RHN).

This sub-theme encapsulates the idea that RHNs feel they are the only care providers who can offer good quality, culturally relevant support for refugees, and they highlight that other service providers lack insight into caring for this group. From a nursing perspective, Meg (RHN) comments that:

'Sometimes, it's the ignorance of others. I went to an appointment with a client and I had an interpreter there. And the specialist said to me, 'Oh, I don't need an interpreter. She was like, 'Oh I work with people all the time who don't speak English very well.' And it was that idea that she doesn't need the interpreter. Well, the fact is that the client needs an interpreter. The client needs to understand what's going on. It's just that person obviously not realising, basically, her duty of care. Legally, the interpreter needs to be used. Well, just ethically, it's just really quite shocking actually' (Meg, RHN).

Problems related to language and cultural issues are recognised as a threat to patient safety and the concept of cultural competence has gained attention as a strategy to provide equal and quality healthcare services for culturally diverse patient groups (Kaihlainen et al 2019).

RHNs highlight the lack of cultural competence among other health and social care professionals, underscoring that there is an ongoing demand for the RHN role in supporting resettled refugees. Pat (RHN) mentions that other professionals should have more empathy in caring for refugees, suggesting that:

'They need to, I suppose, walk in their shoes, and not speak the language for a day. Perhaps that would help them understand' (Pat, RHN).

This comes back to the point that RHNs believe they understand the refugee experience better than other healthcare providers.

This resonates with a study by Dubov and Fraenkel (2018 p4), who found that nurses acted as gatekeepers in the field of transgender health, to protect their patients from *'prevailing stigma and mistreatment.'* In likeness, Meg (RHN) proposes that:

'You've got to be a really strong advocate... that's your duty of- I interpret it as our duty of care' (Meg, RHN).

According to Sinivaara et al (2004 p40), *'The exercise of power is not only negative in nature... in situations where the client's well-being is threatened it is crucial that the professional takes control and makes decisions immediately- and in this sense exercises power over the client.'*

In developing their professional identity in nursing practice, RHNs are eager to call other service providers out on their unfavourable behaviour, in the context of caring for refugees. Some health professionals *'witness moral challenges and develop opinions about them but are unable to act on them because they lack power in the organisation'* (Chiarello 2013 p327). This is in line with the description of moral distress as experienced by surgical nurses who are unable to act on their ethical beliefs and moral standing due to organisation constraints (DeKeyser Ganz and Berkovitz 2012). In contrast, RHNs have the freedom to act upon moral challenges and it emerged from the findings that RHNs confront practice that they feel may be detrimental to the well-being of refugees.

'You've got to really stick up for people's rights and say 'Hey! It's not ok to speak to people or to treat people like this'' (Meg, RHN).

This is in line with Hopkins and Irvine (2012), who discuss the importance of specialist nurses preventing unnecessary stress for patients, advocating on their behalf and shielding them from harm. In essence, the ways in which RHNs are

politically active in advocating and standing up for refugees in Victoria, contributes to their sense of nursing identity in the community setting, and differentiates this role from others in clinical practice.

Crucially, RHNs do not trust other service providers to offer culturally competent care for refugees, and thus, they are reluctant to discharge them into mainstream community health services, gatekeeping the ongoing care of refugees. However, this denies general staff the opportunity to learn about refugee health issues and build adequate knowledge and experience to effectively care for this population. As RHNs are the primary care providers for refugees, other health and social care professionals become dependent upon the expertise of RHNs, which means that RHNs can preserve their power as specialist practitioners in the community.

Riley and Manias (2009 p218) draw attention to *'the power that is available to nurses and colleagues as they engage in gatekeeping, the professional ethics of the practice and inter-professional and social relationships.'* RHNs are aware that service providers rely on their guidance to influence their practice in offering help to refugees, putting RHNs in a position of power within the community health pecking order. Observation data elucidates that RHNs are experienced, senior registered nurses, employed with a higher salary than general community nurses. They receive specific training and education in managing refugee health issues and allegorically separate themselves from general nurses in clinical practice, developing their identity as specialist practitioners.

Managers validate this distinction, with the view that RHNs offer a more holistic and proactive approach to care for the refugee population. Ali (manager) comments:

'You know- clinic nurses can do clinic work. They're employed to do that. But, to me, we're using the funding, and we're best using it in a way that involves, you know- really holistic care coordination. And also, looking at health education, because I figure, you know- there's lots of clinic nurses, so...' (Ali, manager).

In consensus with findings of this study, Anderson et al (2020 p1196) suggest that specialist nurses *'differentiate themselves from other nurses by identifying themselves as elite and consider themselves to be held in higher regard than the broader nursing profession.'* This point applies to specialism in nursing practice

overall, rather than the context of community refugee health nursing, although the broad skill set of generalist community nurses is often under-appreciated (Harris et al 2013).

Underscoring the dissimilarity from general community nurses, Sal (RHN) points out that:

'We don't do a blood pressure, you know. Our team doesn't do anything clinical' (Sal, RHN).

As May et al (2001) consider, gatekeeping of specialist knowledge influences how social relationships are framed in healthcare settings, as some professionals in specialist roles view themselves as influential.

To further the discussion of professional identity in refugee health nursing, according to May et al (2001 p373), the construction of nursing identity in an emerging field is *'engineered through the interactional accomplishment of co-membership and solidarity.'* In 2016, Refugee Nurses Australia (RNA) was formed by a group of RHNs around the country. In establishing the RNA forum, RHNs have a platform for sharing ideas, experiences, and creating a presence to the wider community as a specialist group of nurses. This is in line with Hoeve et al (2013 p295), who propose that *'to improve their public image and to obtain a stronger position in healthcare organisations, nurses need to increase their visibility.'* According to Hoeve et al (2013), public image influences nurses' self-concept and professional identity. The promotion of refugee health nursing as a specialty, with underlying socialist views and liberal thinking, tackling health inequalities among refugee groups; contributes to feelings of doing good among RHNs.

In terms of furthering professional identity in refugee health nursing, Social Identity Theory offers an explanation about how professional group identity is embraced, focusing on the individual nurse as part of a collective, with group cohesion creating a sense of belonging (Willets and Clarke 2014). As Hogg (2006) points out simply, group membership in nursing is emotionally valuable. RHNs value camaraderie and unity in their societal and political views, and this leads to the development of professional identity as a specialist group of nurses in the field of refugee health. Along these lines, MacDonald et al (2006 p178) discuss the significance of unification in nursing practice through shared experiences and a

common identity, with specialist nurses sharing many '*areas of sameness*' and a '*common knowledge base*.'

In addition, to take the point of professional identity further, universities across Australia offer post-graduate courses in refugee health nursing, and RHNs have clear progression pathways, with opportunities for study to become a refugee health nurse practitioner or settlement health coordinator. These prospects for additional study and progression sustain refugee health knowledge within this speciality, furthering the reputation of this field in current nursing practice as a fundamental part of the community health landscape, and gatekeeping refugee health as a specialist discipline.

To summarise, gatekeeping is used by RHNs to preserve their dedicated knowledge of refugee health, and to subsequently cement their position as nurse specialists. RHNs understand the benefits of working in a specialist field and are keen to distinguish themselves from other nurses and healthcare professionals:

'Because they provide a space- they provide something unique in the health system' (Ali, manager).

This sub-theme considered how RHNs justify the need for refugee health nursing as a specialised field, and why they are hesitant to discharge refugees from their care into mainstream health services, thus acting as gatekeepers to the field of refugee health.

5.3.4 Summary of theme one

Theme one has introduced the concept of power through gatekeeping, as held and exercised by RHNs in the community healthcare environment. Indeed, there is a dimension of power held by RHNs as a more systemic force, with power as a group of specialist nurses who guard their professional position.

Leading on from this discussion, theme two expands upon the notion of this inherent power, drawing attention to the ways in which RHNs employ discretion in their practice; frustrated with elements of refugee health policy and barriers in the health system, but using their autonomy to find loopholes in meeting the needs of refugees.

5.4 Theme two: Nursing discretion in delivering the programme vision

This second theme continues the discussion of power within refugee health nursing, highlighting the autonomy held by RHNs as experts in this field and the flexibility in their practice. Findings suggest that as practitioners on the frontline, RHNs operate as street-level bureaucrats; a concept which was introduced in the literature review and will now be discussed in detail, linking findings from this study with relevant literature.

While gatekeeping and street-level bureaucracy share similar features, these are distinct concepts in healthcare literature (Johannessen 2019). Indeed, RHNs are responsible for assessing the health needs of refugees, using gatekeeping strategies to label refugees' behaviour and subsequently grant or withhold access to resources within the institutional domain of the RHP, as well as gatekeeping their specialist knowledge. However, by engaging in interactions with refugees and having significant discretion in their work, these nurses fulfil the two main criteria of street-level bureaucrats, while also meeting additional criteria, in that they work under significant resource and bureaucratic constraints and face conflicting expectations from refugees and management (Johannessen 2019).

Based on the findings, street-level bureaucracy can contribute to an understanding of power within refugee health nursing. Of significance, the RHP is a bureaucratic organisation in which RHNs '*have considerably more power and discretion in decision-making than a strict conformity to a set of rules, procedures and subordination to hierarchical supervision*' (Piore 2011 p148).

RHNs believe that some features of RHP guidelines are not person-centred and therefore, decide to use discretion in their practice; modifying policy and manipulating guidelines to better meet the individual needs of refugees. In sum, they are seen to '*negotiate, adapt, subvert and sometimes even resist elements of the policies they are tasked with implementing, in order to make them fit the complex lives of individual members of the public that they work with on a daily basis*' (Crossley 2016 p193).

The previous theme addressed ways in which RHNs sustain their powerful position by gatekeeping access to information, rationing limited resources and preserving their specialist knowledge. Theme one touched upon the ways in which

RHNs use discretion in their gatekeeping strategies, and theme two unpicks this concept further, delving into the complexities of discretion in professional nursing practice. As mentioned in discussion of data analysis using TA, themes arising from the data are interconnected and as such, ideas within each theme can overlap in describing a theoretical construct from a different tangent (Section 4.6.9.1).

Although there are guidelines which govern the RHP, in practice, RHNs have an element of freedom to form and act on their own professional wisdom. To have discretion involves having a space of autonomous decision-making surrounded by a belt of restrictions (Johannessen 2019).

Discretion can arise from a budgetary shortfall, which makes it impossible for workers to behave in the prescribed manner. Discretion can also arise from the incompleteness of rules, indeterminacy of language or the failure to cover all possible contingencies, as in Crozier's (1964) classic study of maintenance workers in the French match factory. Meg (RHN) reflects on the difference between the RHP environment and nursing in the acute care sector.

'It's been a massive change for me though, because I worked in a clinical environment, which is very, umm policy and umm- structure- lots of instructions of like, what to do in every kind of sense. Whereas here, there's a lot more fuzzy-kind of, grey area, in that we grow in what we do' (Meg, RHN).

It came to light from the findings that in the instance of the RHP, nursing discretion stems from fuzzy policy, as well as the deep level of autonomy afforded to RHNs by managers.

Foucault (1977) suggests that power is relational, and RHNs are in a position of power as managers rely on their clinical expertise in supporting refugees. The outcome of this relational power creates possibilities, maintaining a level of uncertainty and unpredictability within the RHN/manager relationship; and this provides opportunity for the exercise of discretion.

The theme 'nursing discretion in delivering the programme vision' relates to various aspects of discretion in refugee health nursing, illustrated through the following sub-themes:

- **Sub-theme one:** *Nursing autonomy and managerial support*
- **Sub-theme two:** *Frustration with barriers in the health system*
- **Sub-theme three:** *Bending the rules*

Theme two reflects on how power is pushed to the limit by RHNs. The sub-themes are inter-related and presented sequentially, beginning with discussion of RHNs as autonomous, self-ruling practitioners, with permission from managers.

5.4.1 Sub-theme one: Nursing autonomy and managerial support

For Lipsky (1980), discretion occurs in a context of conflict between frontline workers and managers; between a desire for top-down control and local opposition to it. In contrast to this concept, it is significant to note that in this study of refugee health nursing, managers are supportive of RHNs in their use of discretion, so long as core bureaucratic targets are met. Lipsky (1980) points out that those who work at the sharp end of service delivery have considerable jurisdiction over how they manage their work and this sub-theme considers autonomous practice in refugee health nursing.

Evans (2011) notes that for employees, discretion is viewed as the extent of freedom he or she can exercise in a specific context, and practitioners often expect to control their own practice. With regards to RHNs, they '*have considerable autonomy in making decisions and often their activities are unsupervised*' (Bosma et al 2018 p1005). It emerged from the data that as a nurse-led service, RHNs are afforded a great level of self-determination, with Ali (manager), highlighting that:

'There's definitely autonomy in practice.'

According to Skar (2010 p2227), '*autonomy means that nurses should have sufficient knowledge, power and authority to make a difference in what may happen to the patient.*'

Of interest, street-level bureaucracies are typically described as organisations controlled by managers, where there is concern for what is produced, not the process (Lipsky 1980). '*Workers are resource units to be applied to achieve the organisation's goals. Managers are concerned with achieving agency objectives*' (Evans 2011 p370).

In Lipsky's (1980) account of street-level bureaucracies, the key regulators of discretion are managers. Lipsky views managers as best placed to make decisions about legitimate and illegitimate discretion and as seeking to constrain their staff's discretion. Evans (2011) suggests that the nursing role is focused on care management, with a concern for client need, while managers endorse the promotion of efficiency and effectiveness.

Nonetheless, in contrast to this typical view held in street-level bureaucracy literature, managers of the RHP are primarily concerned with the needs of refugees, and thus, encourage the use of discretion in nursing practice, where there is benefit to refugees. Managers rely on RHNs to coordinate the RHP and therefore, allow autonomy and judgement in practice, encouraging a positive professional culture within the organisation (Piore 2011) and ensuring that the operation of the RHP runs smoothly. In line with this notion, Wells (1997 p336) puts forward that, managers '*have to meet contracts and manage resources against a backdrop of complex and sometimes contradictory policy. At the same time, managers are reliant on the support of practitioners to carry out their function. If policy objectives are to be achieved, it is important for managers to avoid conflicts at the practice level.*'

Interestingly, with regards to managers, Evans (2011 p371) suggests that, '*they manage discretion in the interest of the organisation. But they are also pragmatists and will encourage discretion where it works for the organisation. Their key guide is the spirit, rather than the letter of policy.*' It emerged from the data that managers in this study believe flexibility in interpretation and enactment of policy contributes to the high standard of care delivered for refugees and the efficient running of the programme. Managers support RHNs in their use of discretion, as there is consensus among RHNs that modifying policy can be justified on the grounds of seeking greater benefit for refugees in the community, assisting in the effectiveness and reputation of the organisation. As Piore (2011 p148) suggests, '*in a street-level bureaucracy... the response is not to try to eliminate the discretion or to minimise it, but to manage it.*'

Lipsky (1980) assumes that managers act as policy lieutenants, taking and applying policy as best they can. However, managers of the RHP tend not to define their loyalties in exclusively organisational terms, which is in line with findings from Hughes and Condon (2016). The view that policy is produced and communicated in a

pristine state has been described as unrealistic. *'Policy has been percolated through several political levels before it reaches street level and has been the subject of argument, dispute and compromise'* (Evans 2011 p373). Policy is indeed, *'often rhetorical or speculative... augmentation is central to all stages of the policy process'* (Pawson et al 2003 p53). Managers agree with RHNs, in that aspects of policy and documentation associated with the RHP may be unsuitable in meeting the needs of refugees, and they are therefore lenient in their approach to governing RHN discretion. Brodtkin (2011 p1274) refers to this notion as *'management-by-enabling,'* indicating a range of acts that enable street-level bureaucrats to fulfil their tasks for the benefit of the organisation.

Pointedly, street-level bureaucrats commonly work within a situation of low support, in terms of lack of supervision in everyday practice (Hughes and Condon 2016). According to one of the managers:

'I guess it's not clinically stringent... in terms of umm, you know- strong, kind of- clinical supervision, not- not really' (Ali, manager).

Hence, RHNs are given latitude to make clinical decisions and plan care as they see fit, exercising power through their use of professional judgement and discretion.

Indeed, with regards to the relationship between RHNs and managers, managers afford RHNs a great level of self-governance. May et al (2001 p370) put forward that, *'the maintenance of health care workers as gatekeepers is achieved by the collaborative use of a polite discourse.'* May et al (2001 p373) go on to say that *'gatekeeping discourse represents a strategy used to articulate the division of labour and distribution of authority'* between nurses and other professionals. One of the most significant findings is that the accomplishment of discretion is largely a collaborative undertaking on the part of both RHNs and managers. Managers of the programme offer RHNs autonomy in their practice, as they lack clinical knowledge and healthcare experience. It emerged from the findings that managers encourage RHNs to run the service, so long as RHP targets and bureaucratic needs of the organisation are met. As Ash (manager) concedes:

'I see this as being quite flexible. They get a fair bit of autonomy to make the decisions around how the programme evolves, and that is based upon what

***we're seeing the trends and needs are in the refugee community, so they are trying to be responsive to the needs here'* (Ash, manager).**

In addition to managing the RHP, managers also lead and contribute towards various other programmes operating through the community health centres, so managers have competing priorities.

Additionally, it became apparent from the data that managers lack backgrounds in healthcare and are therefore unable to provide advice and clinical supervision.

***'I guess this is consistent through community settings in Australia- that there's much less kind of clinical support. So, I clearly can't give them clinical support'* (Ali, manager).**

According to another manager:

***'In terms of the health stuff, I don't know it, and I don't pretend to know it. So, it can be a challenge. It always usually entails some questions around, well what is that diagnosis that they have, you know- because, I'll have no idea'* (Ash, manager).**

Findings draw attention to the idea that managers rely on RHNs for advice with regards to refugee health issues.

***'It's good umm, they have that health lens, and can help me with the interface- that's quite good'* (Ali, manager).**

Therefore, managers place trust in the knowledge and skills of RHNs to coordinate care for refugees. This allows RHNs to feel encouraged in their self-rule, contributing to their identity as specialist nurses operating at an advanced level of practice, and enabling confidence in their discretion.

In contrast, the study by McEvoy and Richards (2007) investigated gatekeeping practices in the community health setting and found that managers and healthcare professionals had different agendas. With regards to managers in this study, *'they were seeking to develop a more distinctive managerial culture and keen to implement strategic policy directives. Clinicians tend to be much more preoccupied with the 'coal face' issues of their heavy workloads. They were irritated by what they saw as unnecessary managerial interference and sought to defend their professional culture'*

(McEvoy and Richards 2007 p392). As opposed to this notion of managerial interference, RHNs are valued in their self-sufficiency:

'There's definitely autonomy in their practice' (Ali, manager).

In this study, RHNs govern their nursing practice, with managers dealing more with the business end of the service, managing finances and reporting to government. Ash (manager) talks about the confidence managers have in RHNs.

'I think they're quite competent. I mean, I guess there needs to be a level of trust- you know' (Ash, manager).

Managers rely on the expertise of RHNs to coordinate the RHP effectively, and RHNs enjoy being largely left to their own devices, with Ann (RHN) highlighting that:

'It makes a HUGE difference. It makes a HUGE difference having a manager who understands what you're talking about. Huge difference' (Ann, RHN).

According to Sarkoohijabalbarezi et al (2017), efficient management structures are crucial to achieving progress in the nursing profession, and the support and encouragement of managers can be effective in promoting a positive culture within a healthcare organisation. RHNs appreciate the freedom of this role, compared with other nursing positions. One RHN comments that:

'There's an assumption that you're an autonomous practitioner- umm, and that you can respond to your clients' needs. And, you know- that's great. You don't always have that in nursing' (Sal, RHN).

Ann (RHN) suggests that she works with minimal supervision and that if she needs clinical support or clarity in practice, she can contact the State-Wide Facilitator of the RHP, who has a RHN background.

'We see (the State-Wide Facilitator of the Refugee Health Program) at our network meetings. And certainly, if there was an issue, I would email her and ask her what she would suggest. But we're pretty- I mean that's what the beauty of this job is- we are autonomous' (Ann, RHN).

The concept of nursing autonomy is echoed by Sal (RHN), who says:

‘So, at (this organisation), and this is my impression- I don’t know a lot about other services, there’s a lot of- our nurses have a lot of autonomy and umm- flexibility to respond. It’s great, it is really good’ (Sal, RHN).

As Evans (2011 p378) suggests with regards to professional freedom, *‘it is dependent on having management structures that aren’t overly bureaucratic.’*

Ali (manager) points out that it can take some RHNs time to adapt to the new level of autonomy in practice.

‘They (RHNs) are quite flexible. So, if people have come from, like, a hospital setting, to this community setting, then there is more latitude in the role. So, I think that just takes time’ (Ali, manager).

Liz (RHN), is in consensus, highlighting that:

‘It took a little bit of time to develop a relationship and work out what sort of things (the manager) is happy for me to do on my own, and what sort of things they would expect me to ask to- if I could do that’ (Liz, RHN).

Management is often presented as a coherent system of control in which managers *‘complete such roles as regulating the duties of subordinates, survey the stricter eligibility criteria applied to clients during assessment and also guard finite resources against claims for assistance from outside’* (Carey 2003 p122). Interestingly, although managers within the RHP control expenditure and encourage RHNs to meet monthly performance targets in terms of how many refugees attend appointments, they do little to regulate the everyday practice of RHNs. As opposed to *‘operating in a policy vacuum’* (Evans 2011 p376), managers value the clinical judgement of RHNs and trust them to engage appropriately with refugees.

It is argued that at an operational level, management’s role is to ensure practitioners’ compliance with policy, however, the accountable relationship to management can be weak. Crucially, *‘there may be little the manager can do, particularly as any such interference could be portrayed as an attack on clinical discretion’* (Wells 1997 p337). In this study, managers deal with this issue by setting in place the necessary systems to meet the core agenda of government but limiting the pursuit of precise compliance. According to Onyett et al (1996), it is understandable that managers are found to avoid challenging the traditional culture of

democratic healthcare teams, to dodge looking closely at practice. Managers of the RHP have competing priorities, and therefore, they set in place the necessary system to meet core bureaucratic targets set by the DHHS but delegate care delivery to RHNs. As Tummers and Bekkers (2014) point out, Lipsky did not consider the notion that discretion may indeed be functional to managers.

Lipsky's (1980) work on street-level bureaucracy punctures the rhetoric of managerial control, pointing to fragility. At the same time, street-level bureaucracy theory puts forward the assumption that managers and workers are separate and fundamentally antagonistic categories. This is not the case in the context of the RHP, as the ethos of professionalism permeates and breaks down the barriers between managers and RHNs, providing a significant resource to support the exercise of nursing discretion. RHNs do not use their discretion in rebellion; instead, they are permitted to use discretion. RHNs talk about managers in terms of their support and ability to provide autonomy in practice, rather than as agents of hierarchical control. RHNs and managers work together to promote professionalism, in the sense of a shared commitment to the needs of refugees and to advancing the nursing role. There is a professional culture within the RHP and RHNs see themselves employed as specialised practitioners to exercise their judgement.

Regarding the nursing tasks involved in the RHP, these *'call for sensitive observation and judgement, which are not reducible to programmed formats'* (Lipsky 1980 p15). The RHN role encompasses a range of activities, from health promotion and management of chronic disease to the development of referral networks. However, it emerged from the data that with the support of managers, RHNs self-govern and extend their scope of practice, depending on the needs of refugees. As Pat (RHN) considers:

'So, one day, you're working with housing officers, the day next day you're working with legal people, you know- lawyers, the next day you're working with acute health services, out-patient specialist appointments, that kind of stuff... They (refugees) can't differentiate the role of the RHN from the role of the social worker, who advocates for their housing benefits. So, they'll often come to you for everything- which is why I'm filling out a housing form now' (Pat, RHN).

It is noteworthy to consider that due to autonomy and using discretion in practice, RHNs operate in different ways, and view the scope of the role through their own individual lens. It became clear from the data that this can lead to a lack of consistency in nursing practice across sites, which resonates with the study by Bosma et al (2018 p1026) who reported '*a large proportion of variance in treatment allocation*' for clients. One of the managers highlights the concept that care provided to refugees in the community is dependent upon the RHN assigned to that person or family.

'There's definitely autonomy in practice. And because it's not a clinical setting- you know, I think it will vary in terms of how much, depending on the individual nurse, and also- how much the client needs... I think it depends how the clinicians work. In terms of health education, around healthy eating, physical activity, mental health... I think it would depend on the nurse, as to how much they do that work' (Ali, manager).

It emerged from the findings that this contributes to a franchise effect within the RHP, with RHNs adopting their own style of practice and working to their own rhythm. Of significance, Ash (manager) comments that:

'So, I think the role evolves based on the workers existing in the programme- I think they pretty much have free reign, and I think that's probably based on what each nurse wants to do' (Ash, manager).

Along similar lines, Piore (2011 p150) suggests that '*Rules are embedded in the organisational culture; they evolve as that culture evolves and are passed on from one generation of agents to the next through the process of socialisation.*'

On the point of the franchise effect, one RHN highlights that:

'It depends very much on where the positions are and what kind of model is set up. Even within (this organisation), there's different ways of how we work. There's no consistency' (Pat, RHN).

According to another RHN,

'It's care coordination. But that might be different to another Refugee Health Nurse somewhere. So, Pat... she- she does things differently at her clinic' (Sal, RHN).

This point is echoed by one of the managers, who says:

'I think it's pretty independent, like- a lot of- I think the programmes have developed very differently, depending on where- which centre they've been in, and their staffing and their managers. Yeh, it's very different, and- some are quite medical models, and very clinical, whereas ours is more of a social model of health, and more outreach based' (Ali, manager).

As Tummers and Bekkers (2014) suggest, discretion could possibly harm the position of refugees, as varying interpretations of how care should be delivered may prevent refugees being treated equally. Nevertheless, Murphy and Skillen (2015) highlight that discretion can in other ways, have positive effects for clients, stressing that a 'one size fits all' approach can be inappropriate.

To provide a summary, RHNs exert power through autonomy in practice, using critical reasoning to prioritise aspects of care and extending the scope of their practice to meet the variable needs of refugees. The attitudes of RHNs and their local managers to organisational policy moves the analysis beyond Lipsky's (1980) framework, highlighting the role of shared professional commitments, and transcending the distinction between managers and street-level practitioners.

5.4.2 Sub-theme two: Frustration with barriers in the health system

Although RHNs have flexibility in their practice to use clinical judgement in decision-making, it became apparent from the data that they also face struggles in providing care for refugees during the resettlement period, due to organisational and external constraints. As a RHN points out with regards to caring for refugees:

'It's not as easy as it should be' (Meg, RHN).

RHNs are frustrated with internal structures within the RHP, as well as external factors. RHNs claim that many services in Victoria do not function in a way that is conducive to providing appropriate support for refugees. This section addresses some of the reasons as to why they feel the need to use discretion in their practice.

In terms of the internal workings of the RHP, it became evident from the data that RHNs are exasperated by certain rules and guidelines which are in place. According to Pat (RHN):

'The systems are set up to fit us, not our clients. So, it's very... time consuming- is the word. We've got a process in place that is inflexible. It doesn't look at the individual client. Our appointments are all inflexible. You know what I mean? Like, the appointment system that we have set up suits us as providers, not our clients' (Pat, RHN).

For example, working hours within community health centres are 9-5pm weekdays and RHNs feel that this prevents people from accessing the refugee health service. This is an interesting point, considering the continual rhetoric in healthcare policy advocating 'patient-centred care.'

Another frustration voiced by RHNs relates to the wording and content of documentation used within community healthcare. Fieldnotes taken at the rural/regional site are in consensus, reporting frustration felt by RHNs.

'RHNs say that the assessment and review documents 'are like an interrogation.' RHNs feel that there are questions within the refugee health assessment that are irrelevant for the development of an initial care plan for the refugee. For example, they don't think that it's appropriate to ask a refugee about their drinking and smoking habits during initial meetings' (Fieldnotes, 20th November 2017).

'Do we really need to ask about this? I don't think so' (Pat, RHN).

Ann (RHN) also talks about her discontent with the documentation used for refugee health assessments.

'I've never been very keen on, you know, if you say to someone who's a refugee, 'What would be the best thing? Or what goal would you like?' Well, that's kind of obvious. I want my family to come over to Australia. So, do we really want to sort of, put pins in that doll? Knowing it may never happen? Because that's setting them up to fail' (Ann, RHN).

Fieldnotes obtained from the rural/regional site corroborate this concept.

‘While on a car journey to visit a refugee at home, the RHN talked about the three-month review process and the goal orientated care plans to be completed. She views setting goals as a Western concept and thinks that this format is inappropriate, as it puts pressure on refugees to succeed. RHNs feel that management have introduced this follow-up document because there is an increasing need to show evidence of the RHN role, to maintain funding for the RHP. They think that the document is more to fulfil the needs of bureaucracy, than to help refugees. This document involves tick box questions, which they say is not useful in gaining holistic insight into the progress of refugees and is ‘not client-centred’. It’s exhausting for refugees to answer all the questions’ (Fieldnotes, 9th November 2017).

The three-month review and twelve-month review documents can be found in appendices 4 and 5 of this thesis.

In line with this notion, in a study by Hughes and Condon (2016), health visitors criticised the substance of policy and what they saw as managers’ priority on meeting performance targets before meeting the individual needs of patients. Similarly, Cowley and Houston (2003) found that undertaking health needs assessment using an overly structured tick box approach undermines the development of partnership working and holistic, patient-centred care.

According to further fieldnotes from the rural/regional site:

‘The documents are a burden to nursing practice, preventing RHNs from being able to support refugees in a practical way’ (Fieldnotes, 9th November 2017).

Brown (2007 p10) argues that the bureaucratic drain on healthcare professionals *‘dramatically reduces the time available to sit down with the patient, answer questions and provide comfort and reassurance.’* With regards to dealing with concerns of clients, a study by Murphy and Skillen (2015 p635) puts forward that, *‘the need to achieve and complete accountability-related tasks, whether in relation to inspections, audits, evaluations or performance indicators, has significant consequences for their ability to complete what they consider core professional tasks.’*

Within the RHP, there are documents to be completed for continual assessment and review, as well as in discharging refugees from the RHP into mainstream

community health services. Liz (RHN) talks about her irritation with these documents, highlighting a lack of user-friendly interface.

'There's a system that we use, and there's just some information on there to say why you're discharging them, and then- so there's the 'official' documents- ah yeh, the 'official' things that they use here. And then you fill in the fields that you need to. But it's very tricky- I struggle finding my way around' (Liz, RHN).

The documents are in place to establish accountability, but the amount of paperwork can be overwhelming for RHNs, while they would prefer to focus their time on caring for refugees. Thompson (2003 p118) notes that *'struggle is necessarily intrinsic to the constitution of power relations,'* highlighting *'the element of friction'* for *'those under the sway of power's domination.'* According to Meg (RHN):

'You should see the system- the health system- the amount of paperwork, I could be a bit negative' (Meg, RHN).

With regards to organisational limitations, healthcare professionals in one study *'told stories of patient care, but most often these stories revealed a strong orientation toward the interests of the hospital and how their ability to act was hampered by organisational constraints'* (Chiarello 2013 p325).

In terms of external constraints, another challenge in refugee health nursing relates to the constant changing of immigration information and eligibility of asylum seekers and refugees to access health and social care services. Continuous changes in policy leads to confusion amongst RHNs, with regards to which services can be offered to their clients, and they find it testing to keep up to date. Liz (RHN) comments:

'I find it really difficult. It wasn't something I was overly up to date with and at the end of the day, my role is to help them in health. But all of those factors affect them deeply. The immigration information can have a huge impact on their lives, so that's really big to them, and I kind of need to be on top of it a little bit, so that I can provide them with the correct information. But at the end of the day, I'm flat out trying to sort out the health stuff, let alone the migration information' (Liz, RHN).

This is in line with a view expressed by one of the managers, who says that:

'The frustrating parts- I suppose, are, you know- there is ever changing policy, which means that they need to change quite quickly sometimes what they're doing. They are working with other agencies around client access. You know- that can be hard, and the nurses do that incredibly well' (Ali, manager).

RHNs are exasperated by roadblocks in healthcare, put in place by the Australian federal government, limiting asylum seeker and refugee eligibility to access services. Meg (RHN), comments:

'Because for a lot of people, it changes quite often. In recent months, the federal government have failed all those people, given them those new visas and taken all their healthcare rights away. Things like that crop up all the time, like the government things shift politically, and it tends never to be for the good' (Meg, RHN).

In response to these issues, RHNs find ways to negotiate the system, which is discussed further in sub-theme three; 'bending the rules.'

Pat (RHN) talks about her frustration with obtaining access to essential services for refugees, with some providers charging refugees for services which are free for Australian citizens. She suggests:

'The challenges are the systems we work with. I find it more challenging to work with service providers than I do with my clients! You still have challenges with some agencies, which are predominantly private agencies, pathology and radiology, people like that, but I think it's more to do with their lack of umm, you know- they are a business. They're in the business of making money' (Pat, RHN).

This is in line with findings from the study by Hughes and Condon (2016 p593), who report that *'the impact of limited resources and organisational constraints influenced the level and scope of service provision offered.'*

'I feel like, sometimes, the hardest thing is when you find roadblocks or things, with the services. I think the difficulty is the system that we work within' (Meg, RHN).

Another RHN argues that service providers should be more accommodating.

'It varies, depending on the client, what their needs are and what the outcome is. And people need to be a lot more flexible with that kind of stuff' (Pat, RHN).

Although RHNs have autonomy in practice, sometimes there are institutional constraints, with regards to how much they can do to help refugees. Certainly, Bosma et al (2018) emphasise that organisational circumstances influence how street-level bureaucrats can support clients. Pat (RHN) comments:

'There's a lot of system change that needs to happen to accommodate these clients' (Pat, RHN).

However, as RHNs are unable to change bureaucratic systems, they are finding ways to use their discretion in manipulating the ways in which the system operates, to provide client-centred care and ensure that refugees receive optimal support during the resettlement period. The following sub-theme brings to light an interesting finding of this study, which encompasses RHNs using their discretion to flex the rules of the system, benefiting refugees in their care.

5.4.3 Sub-theme three: Bending the rules

In response to roadblocks in the system, RHNs find ways to manipulate policy to better meet the needs of refugees, and this sub-theme considers how, as autonomous practitioners with the support of managers, RHNs are able to bend the rules. In this way, RHN use their inherent power as street-level bureaucrats, ducking and diving through an entanglement of policy and procedure, to deliver the care that they feel refugees deserve.

Of relevance to this sub-theme, Bosma et al (2018) suggest that government employees do not always perform policies as prescribed. The sense of irritation with bureaucracy and the need to make policy workable is reflected in street-level bureaucracy theory (Evans 2011) and it came to fruition from the findings that RHNs make policy workable by using their discretion.

RHNs report that refugees are not passive recipients of services, but instead, have ideas themselves, which do not necessarily match RHP priorities. As Tummers and Bekkers (2014 p528) point out, *'very often the rules the street-level bureaucrats*

have to follow do not correspond to the specific situation of the involved citizen.' Therefore, in line with findings from the study by Hughes and Condon (2016 p594), RHNs '*felt it necessary to step outside the service offer and respond directly to the priorities of clients.*' RHNs interpret and twist the rules of the RHP to achieve their preferred ends and serve the needs of refugees, which is in consensus with findings from Rowe (2012).

It is worthwhile to observe why RHNs are often able to exercise discretion. Crucially, policies and guidelines associated with the RHP vary significantly in terms of how strictly, unambiguously or exhaustively they specify prescribed practices, leaving them somewhat open to interpretation.

Pat (RHN) refers to the RHP guidelines as '*adaptable,*' while another RHN compares nursing in the hospital setting with nursing in the community.

'I just think you probably, you have a lot more- there's a lot more rules, or you kind of like- umm not rules, but, I suppose, policies about every single little thing, you know? Yeh. Whereas like, you know- here, it's less minutely policy driven' (Meg, RHN).

Interestingly, Ali (manager) refers to the guidelines as a '*template*' for practice, not letter of the law. This corresponds with a study undertaken by Bergen and While (2005), who found that there is significant room for bending the rules in nursing practice and service delivery, depending on the environment and differing interpretations of policy. They conclude; '*the margin for variation in policy interpretation allows community nurses to work within a nursing framework consistent with their own vision for practice*' (Bergen and While 2005 p6).

While street-level practice occurs within a framework that is shaped by law, policy, management and broader cultural structures, it would be an unwarranted assumption '*to present this framework as coherent, complete and unambiguous and as being understood in exactly the same way by all those involved with it*' (Evans and Harris 2004 p887). Tummers and Bekkers (2014 p530) surmise that street-level bureaucrats can use discretion when '*they possess more knowledge on loopholes in the rules*' or '*they have a better relationship with their manager which enables them to adjust the policy to circumstances.*' Evidently, findings show that a discourse of

professional accountability is well established within refugee health nursing, and RHNs get creative with guidelines to meet the needs of refugees.

It became apparent from the data that due to frustration with the internal workings of the RHP and broader bureaucratic structures, RHNs often use discretion to curve prescribed rubrics in providing a more holistic approach to care. This is in line with findings from Bosma et al (2018 p1008), who report that *'moving towards clients, which means frontline workers adjusting to meet the needs of clients, e.g., by bending/breaking the rules, was found the most frequent coping strategy.'*

One example of ambiguous policy is the RHP guideline, which recommends that this service is for 'newly arrived' refugees with 'complex health needs,' as outlined in the eligibility criteria in appendix 2.

'It's really about improving the health and well-being of- of people from refugee and asylum seeker backgrounds. But particularly with a focus on newly arrived people' (Ali, manager).

It came to light, however, that RHNs often accept refugees into the RHP who have been living in Australia for many years but who may be experiencing an acute problem.

In the study by Evans (2011), it was reported that practitioners found eligibility criteria to access community services to be impractical. With regards to eligibility criteria, Evans (2011 p376) suggests that *'while, on paper, practice appeared to be constrained by an iron cage of policy directions, it was generally understood as abstract, sometimes relevant, sometimes irrelevant, requiring interpretation and discretion to make it practicable.'*

RHNs advise that this guideline is somewhat open to interpretation, as 'complex' is not clearly defined, leaving the situation in the hands of RHNs in deciding to offer care to a wider range of refugees. Furthermore, they often disregard eligibility criteria and accept newly arrived refugees who are in good health, or with minimal care needs, as RHNs understand that health issues can develop during the resettlement period. This is in consensus with a study undertaken by McEvoy and Richards (2007 p391) who report that; *'Clinicians accepted some patients with common mental health*

problems on to their caseloads for short-term work, as they felt obliged to intervene to deal with crises. This added to their workload and created extra pressures as it disrupted the scheduling of their work.' This echoes the practice of RHNs, who feel obliged to help all refugees, but end up with overwhelming caseloads of refugee clients, due to their inability to turn people away. Undeniably, findings elucidate that despite RHP policy commitment to prioritisation of those who are newly arrived in Victoria with complex health needs, there is an inevitable '*implementation deficit*' (Bergen and While 2005 p5), in terms of a policy failing to contribute more than symbolically to problem solving.

Interestingly, it transpired that the discretion employed by RHNs undermines the implementation of wider RHP policy at local level. Not only this, but in exercising discretion to benefit refugees, RHNs end up:

'getting caught out and doing too much' (Liz, RHN).

They take on too many clients, work extended hours, practise out-with the scope of their role and fail to discharge refugees at the end of the one-year resettlement period.

With regards to refugees who have been in Australia for some time, Meg (RHN) comments:

'So when we meet clients, sometimes they come back. Or they've been here three or four years and they've slipped through the cracks- things have just gone wrong, and it's spiralled. It's gone wrong or become worse. So, in that sense, those people have kind of settled into their community a little bit more, but their health needs have just been neglected and got more complex. There are people who may be socially isolated as well. So, there are- it's very different, and I think it depends' (Meg, RHN).

Managers understand the need to consider the circumstances of individual refugees, encouraging RHNs to use their discretion with regards to eligibility criteria.

'We'll take anyone... Look, if somebody has been here for five or six years and they're from a refugee background- and their language is limited, umm, they have little ability to advocate for themselves, umm- or to be assertive in the health system, and they need that health support, then absolutely. We won't- we can't say no' (Ash, manager).

Some refugees would rather receive specialist care than through mainstream community health services, which is discussed further in section 5.6.3. Interestingly, managers and RHNs share a professional commitment to caring for refugees in the community, criticising the substance of policy. Managers concede to nursing discretion, as they fundamentally agree with the rationale behind their decisions and understand that the use of discretion benefits refugees. In line with the concept put forward by Evans (2011), local logic of street-level bureaucrats reflects a professional commitment; an idea of practice and values that involves stepping outside organisationally prescribed goals.

Of interest, RHNs use their discretion in working out-with specified days and times to accommodate refugees.

'We need to be able to work around the client, rather than the client work around us. If you want them to respond and be receptive of the service that you provide, then you have to make sure that it is at a time that suits them as a family. So, if I got strict, and said 'Ok, I work 9-5pm Monday to Friday, and I'm not seeing anyone without an appointment, that's not flexible. People don't organise chaos in their lives. Chaos just happens! So, the flexibility and the responsiveness have to be built in with these communities' (Pat, RHN).

As Evans (2011 p377) proposes, street-level bureaucrats have *'freedom within constraints- operating with discretion.'*

Fieldnotes obtained at the metropolitan site report:

'The RHN is picking up her refugee client when she's finished shopping for groceries, to take her home. She uses these opportunities to check how her clients are doing. The RHN explained that she can sometimes find out more about the client's progress through these informal interactions than in the clinic environment, so it's beneficial from a nursing perspective' (Fieldnotes, 17th July 2017).

Similarly, community nurse participants in the study by Hughes and Condon (2016) experienced time pressures but found that they could offer an extra visit to families if required. Some participants in this study *'worked out how to offer more to clients within the organisational system'* and *'bent the rules'* by concealing the real

purpose of visits, ascribing them instead to an activity considered acceptable to managers or local commissioners (Hughes and Condon 2016 p593).

Furthermore, although RHP policy stipulates that refugees should be discharged from the RHP after the one-year resettlement period, it became apparent from the findings that RHNs can be reluctant to formally transfer refugees from their care, continuing to provide specialist support long after the one-year resettlement process. As Ali (manager) considers:

'The idea was, if the client's gone through their refugee health assessment process, they've had their health needs met, in terms of- they're linked in with the practitioners that they need to be linked in, they have an understanding of their condition, they can get to their appointments, they understand the system, then, at that point, we can discharge them... What we've done is, we developed a discharge indicator tool. Umm, but- I'm sure you know-again, it's kind of been varying in practice as to how much that's been used' (Ali, manager).

RHNs suggest that refugees can become dependent on their support, and report that in practice, even if they formally discharge a refugee, they allow the refugee to come back and continue to receive specialised care, as they know that refugees find comfort in attending this service. Liz (RHN) acknowledges the 'official rule' about discharging refugees after one year of resettlement, but says that:

'It depends, it's as long as they need. Sometimes it's quickly, sometimes, you know-but sometimes- I've had clients since I've started here, so it just depends... And sometimes they'll come and move on, and then come back, yeh. So, there is some 'official rule,' like you have to... but yeh' (Liz, RHN).

Likewise, Meg (RHN) explains that after discharge from the programme:

'I say, if any time you've got concerns, then I'm more than happy for you to contact me. They've got my work mobile number, so, I'm happy to be contacted by people at any time' (Meg, RHN).

With regards to discharging refugees, the margin for variation in policy interpretation allows RHNs to work within a nursing framework consistent with their

own vision for practice, which is supported by Bergen and While's (2005) assertion that nursing theory and vision itself is often defined by practitioners.

The RHNs elucidate that even if they discharge clients, they welcome refugees back to the service if the need arises.

'Most of the clients would come with an acute reason, you know, 'I need this because I'm having this problem' or whatever. But they might come back later on, once you haven't seen them for a while, and say, 'I don't understand this- can you help me?' So, we're available. There's no cut-off point with our service, so you can have been in the country for ten years, but if you need help, we're available. We shouldn't have a discharge date' (Ann, RHN).

However, cultural competence involves encouraging the empowerment of people from different cultures (Shen 2015). Although RHNs deem themselves to be culturally competent practitioners, RHNs are hesitant to discharge refugees from their care and promote independence from the service; thus, preventing cultural integration in community healthcare.

Pat, one of the RHNs comments that:

'They have my contact number, my name, so they can come back to see me any time that they want. They are officially discharged from the programme, but they do have access to me if they go into strife... we're keeping the door open for them to come back when they need it. So that's always been there and continues to be there' (Pat, RHN).

This interpretation of the guideline is in keeping with a study by McEvoy and Richards (2007 p392), who found that *'it was anticipated that community mental health teams would retain a key role in supporting patients with serious mental illness and that they would continue to be used as a default option.'* The use of nursing discretion is accepted by managers of the RHP.

'Occasionally, there might be a couple of clients that- you know, are coming back for longer periods. Or the wheels fall off a bit, and they'll let them come back' (Ali, manager).

Nonetheless, it is important to consider the potential consequences of discretion in practice. Interestingly, it became apparent from the findings that failure to discharge refugees from the RHP can be detrimental to integration into Australian society and perpetuate the refugee identity. Furthermore, as RHNs flex the rules by failing to transfer refugees into mainstream community health services, this has consequences for their ever-increasing workload, with new refugees arriving, but few refugees moving on from their care.

On another note, Meg (RHN) talks about using discretion in negotiating policy to benefit refugees.

'We're trying to push the boundaries. Yeh, we wanna push as much as possible. The policy will say, 'You're on the waitlist,' that kind of thing. But you know that for that person or that client, that's not gonna be beneficial. So, you have to go a little bit- one step further, I think' (Meg, RHN).

As a manager, Ali encourages RHNs to break boundaries and find ways to work around policy for the benefit of refugees.

'They're looking at other ways to meet the need, which I think is important' (Ali, manager).

RHNs are challenging the status-quo. Indeed, it has been proposed that discretion operates in spaces governed by uncertainty, involving bargaining and negotiation (Evans and Harris 2004).

Ann (RHN) points out that:

'You have to think outside the square. Not, you know- if you go to the day procedure unit in many hospitals, it's like a meat market. That's not what- that's not what this is about. This is about actual quality care that is fitted- or fits the client's needs, not the hospital protocol' (Ann, RHN).

'Meat market' is an interesting term, and Ann (RHN) highlights the flexibility and more person-centred stance within refugee health nursing, compared with the conveyor belt, task-orientated and systematic approach often found in the acute setting.

Interestingly, RHNs are not considered to be part of the policy process, when in fact they are perhaps the ultimate policy makers; active players in forming policy on the ground (Lipsky 1980). Pat (RHN) talks about the work that RHNs undertake beyond their scope and which the RHP receives no funding for, but she highlights that RHNs must be adaptable and accommodating to the needs of refugees.

'There's a lot of other work, like social work in some cases, although we don't get funding for that. Umm, and advocacy involved with working with these clients, so you have to be flexible- you can't be rigid' (Pat, RHN).

'There's different needs, so, depending on what's going on, you're responding to the needs of the family' (Sal, RHN).

However, this leads to an expectation among refugees that RHNs can help them with everything, and refugees may then feel disappointed when the RHN cannot meet unrealistic needs, for example, in helping refugees to bring family members to Australia. The farther RHNs go in extending their scope of practice into an all-encompassing nurse, social worker, immigration specialist, housing officer, activity coordinator and more; refugee expectations grow, placing RHNs under constant pressure to deliver.

Resettlement case managers are supposed to undertake tasks such as helping refugees to find appropriate housing and employment, but that they are often too busy, with hundreds of refugees on their caseloads. Therefore, RHNs informally adopt this role instead.

'Look, I go pretty easy on settlement services, because I mean, there's a lot to criticise, but they are under the pump. They have to do so much. They're under the pump and so I don't give them too much grief' (Ash, manager).

As a RHN puts forward:

'It means that I need to advocate for the client, for their rights- maybe in the areas of housing, employment, Centrelink access... but it basically has to go in any direction the client wants it to' (Pat, RHN).

In agreement, McEvoy and Richards (2007 p390) undertook a qualitative study to investigate decision-making within community mental health teams and found that

'clinicians sometimes went beyond their strictly defined remit because they felt that they had a moral duty to act in the patient's best interests.'

Findings show that RHNs frequently deviate from prescribed standards, biasing the implementation of policy (Lipsky 1980). Significantly, what refugee health nursing 'looks like' on any given day, is not associated with RHP guidelines, but rather, at the discretion of how RHNs perceive the needs of refugees. A refugee reports that:

'They take us around to show us the shops, to show us the Afghan shops or the doctors or even the Mosque- our Afghan Mosque. And other than that, they help me- umm, everyone like me, in any ways that we need help. For example, Ann, Liz, and so many other ones who work in the refugee team- they've helped us in any way that we could- that we could think of' (Lyn, refugee).

This notion is in consensus with Chiarello (2013 p324), who investigated working processes among pharmacists and concluded that *'even when they had to do things they considered outside of their scope of practice... they justified it on the grounds that they were contributing to patient care.'* Wells (1997) suggests that as street-level bureaucrats, healthcare professionals in the community use their discretion to make their own rules. For Rowe (2012 p11), *'more interesting is the way in which street-level bureaucrats use and interpret those rules and constraints that are externally imposed upon them to achieve their preferred ends. That is, they use the spaces between and the ambiguities within rules and systems to serve their clients in ways that might not always be strictly within the rules.'*

RHNs take responsibility for ensuring that refugees attend appointments with other service providers, which is out-with their role. Likewise, in a systematic review of the effects of gatekeeping in primary care, Garrido et al (2011) highlighted that staff working in primary care environments often ensure that patients attend their health appointments, with reminder phone calls and organising transport. One of the RHNs comments:

'I think they should be responsible- but, you know, sometimes we get a little bit umm, oh, we pick them up. And we pick them up to make sure that they get to appointments, because they wouldn't get there otherwise. I probably get caught out and do a bit more than I should, outside of those specifics. In fact, sometimes I think we probably over-do it' (Liz, RHN).

Bending the rules bears consequence on the engulfing workload of RHNs as they offer to do more and more for refugees, which has implications for refugee health nursing as a field with various grey areas in practice and a growing number of resettled refugees globally.

Interestingly, Maynard-Moody and Portillo (2010 p259) note that '*street-level bureaucrats rely on their discretion to manage the physical and emotional demands of their jobs.*' In likeness, Rowe (2012 p11) points out that, '*street-level bureaucrats develop systems, processes and rules of thumb to help them in their work.*' However, findings of this study imply that in fact, it is *because* of the actions taken by RHNs themselves, that the physical and emotional demands of this role are so intense. Operating as street-level bureaucrats with limited supervision, RHNs take it upon themselves to offer care that is beyond the scope of their practice, and this leads to an increase in the demands of their jobs.

By way of summarising this sub-theme, there is always some degree of fluidity and uncertainty around expectations of refugee health nursing and therefore, there is space for discretion. The problem with using discretion, is that once RHNs start bending the rules, where do they draw the line? They cannot bend the rules for one refugee, and not the next; therefore, they embark upon a spiralling journey, during which they often forget what the rules were in the first place.

In using their discretion to please refugees, the data highlights that RHNs end up getting caught out and doing too much, going one step further in meeting refugee needs; but is this one step too far? Lack of managerial supervision and an ever-increasing workload leads to the risk of burnout in this field of practice, which is discussed further in section 5.5.3.

5.4.4 Summary of theme two

This theme has considered the ways in which RHNs use autonomy and discretion in responding to the needs of refugees. RHNs voice frustration with organisational aspects of the RHP and broader constraints in providing appropriate care for refugees, and because of these frustrations, they bend the rules in finding ways to meet the needs of refugees in their care. Street-level bureaucrats can exert

significant influence on how '*policy as written*' is transformed into '*policy as performed*' (Lipsky 1980 p xvii) and it is proposed that RHNs can be considered informal policy makers, whose actions ultimately define the culture and operation of the RHP, and therefore, shape the delivery of care for refugees.

It is suggested that as street-level bureaucrats, RHNs '*operate simultaneously in two interdependent worlds*' (Prottas 1979 p87). There is the internal world of organisational rules and procedures and the external world of refugee demands. While management and refugees inhabit only one or other of these worlds, RHNs have routine access to both, affording them a powerful '*boundary-spanning role*' (Prottas 1979 p87). As street-level bureaucrats, RHNs occupy a dual stance of '*agent of the state*' and '*agent of the citizen*' (Rowe 2012 p14), meeting government targets but bending the rules to benefit clients. A picture emerges of the RHP in flux; resistance and cooperation co-exist, and what the RHP policy looks like at any one moment is dependent upon the decisions of RHNs, as they negotiate and mediate organisational demands with their professional values, emerging identity and the needs of refugees. With regards to refugee health policy in Victoria, it transpired from the findings that '*what you see may not be what you get*' (Brodkin 2012 p943).

5.5 Theme three: Vulnerability in refugee health nursing: Losing control of power

To recap on the story so far, in exploring refugee health nursing as a phenomenon in the resettlement context, the overarching finding of this study relates to the concept of power in its ubiquitous state. RHNs exert power as gatekeepers of the RHP, viewed as expert and autonomous practitioners who wield control over refugee healthcare in the community.

Nevertheless, instead of asking '*Who has power and who does not?*', Street (1995 p44) suggests that through a Foucauldian lens, I need to ask, '*How is power functioning... how is it being produced and how are relationships being structured?*' Through analysis of the data, it came to light that power in refugee health nursing is fragile and delicate, functioning in way that easily crumbles under threat; making way

for other actors to exercise their control too. In this way, we start to see the equilibrium of power between groups.

With regards to theme three, as employees of an organisation, RHNs must meet targets and follow certain rules to sustain their employment, putting a dampener on their innate authority. In appeasing bureaucracy, RHNs lose their fundamental power to regulate the operation of refugee healthcare. Moreover, this theme elucidates that through continuity of care and the development of trusting professional relationships, RHNs must contend with the complexities of therapeutic intimacy with refugees, and additionally, there lies an association with compassion fatigue and the risk of burnout in this field of practice. RHNs are susceptible to vulnerability in this context and power is in a state of flux, as RHNs struggle with consistent exposure to traumatic accounts, as well as an extensive workload.

Using a Foucauldian perspective to frame this theme is a demanding intellectual exercise, rethinking the foundations of nursing science and searching for alternatives in a web of micro-powers that constitute everyday practice. Nursing theory points to the construction of the nurse as in control of patient care, in a position of inherent power (Hewison 1995; Henderson 2003; Sinivaara et al 2004; Sepasi et al 2016; Griscti et al 2017). However, '*a Foucauldian analysis places the nurse at the centre of power relations in society, subscribing to regimes of truth and power that define professionals, nursing knowledge and our societies*' (Gastaldo and Holmes 2002 p14). In other words, Foucault (1980) restructures our thinking to understand that power is everywhere, exercised by all actors in some way or another. Foucault (1980) draws attention to the fragility of power, suggesting that one may hold dominance, but power is easily broken and challenged by others in our social world.

- **Sub-theme one:** *Surrendering to institutional demands and appeasing bureaucracy*
- **Sub-theme two:** *Therapeutic intimacy and crossing professional boundaries*
- **Sub-theme three:** *Vicarious trauma and burnout*

The three sub-themes are linked to the idea of vulnerability within the RHN role, illustrating how RHNs are not at the top of a power hierarchy but in fact, are at the epicentre of complex power relations.

5.5.1 Sub-theme one: Surrendering to institutional demands and appeasing bureaucracy

Although RHNs use discretion, they remain employees of an organisation and with this in mind, they must adhere to elements of bureaucratic rule to retain their employment. RHNs are eager to help refugees but must concomitantly meet targets and provide evidence of their work, and these institutional processes call into question their professional power, as RHNs are under surveillance of managers, at the mercy of bureaucracy. RHNs must acknowledge '*policy goals, organisational objectives and performance targets, but also norms from peers and expectations from societal actors*' (Hupe and Buffat 2014 p556).

Of note, RHNs hold responsibility for carrying out policy directives and meeting targets, in terms of how many refugees access the service, how many refugees remain a part of the RHP for the one-year resettlement period and how many hours they spend with refugee clients. In the instance of the RHP, these are known as key performance indicator (KPI) targets, set by the government DHHS.

Managers monitor the performance of RHNs with regards to how many refugees are on their caseloads and whether they are meeting KPIs, ensuring that expenditure is within budget constraints. As Lipsky (1980) suggests, the work of RHNs is characterised by an implicit tension between policy constraints and the inexorable demands of clients, and the nature of these constraints may be '*formal rules, stemming from public administration; professional norms, such as occupational guidelines*' (Hupe and Buffat 2014 p556).

Although autonomous in managing their workload, RHNs must be cognisant of performance targets and working within budget constraints, which are monitored by managers. Managers ensure that targets guide underlying practice:

'I oversee the funding and service agreement... So that we're fulfilling the obligations of that- from our funding body... And meeting- meeting our KPIs, meeting our targets' (Ash, manger).

For example, there is a structured approach to referral to the RHP and the Refugee Health Assessment (RHA) must be completed within a specific timeframe.

'The way that settlement is funded and organised... it's very outcome driven and very sort of KPI driven, paid by the government per service... A humanitarian arrival arrives, and within two weeks, they have to, as part of the KPIs by the federal government- they have to be referred for a Refugee Health Assessment within two weeks' (Ash, manager).

Some RHNs describe conflict between professional challenges and bureaucratic structures. For instance, one RHN mentions the pressure to manage a busy workload.

'Look, the only thing that would be great would be more hours, more time, you know- like, we are pretty flat chat.'

Although she feels supported by management, Liz (RHN) believes that managers may not have full insight into the complexities of the RHN role and often underestimate the depth of refugee health issues.

'It is really hard to do everything that they (managers) want us to do within a time limit. And you know, like, you just don't know what's gonna happen on any given day, you know. Like, they (refugees) might ring up and say, 'Well, I need to see you today, or you know- like today, you just don't know if there's a mental health crisis, on any given day, that can take up your entire day. And you know, a mental health crisis is something that really can't wait, you know? Those sorts of things' (Liz, RHN).

In consensus, with regards to specialist nursing care in the community, McEvoy and Richards (2007 p392) found that *'managers underestimated the importance of the maintenance work that was done with this group of patients.'*

Interestingly, it came to light that although managers are supportive of RHNs in their autonomous practice and rely on their expertise, managers do show signs of frustration with the lack of structure and consistency within the RHP.

'I always think, we're definitely on the flexible side of things, which is really good for our clients. But sometimes I feel like, you know, it might be good to get a little bit more structure, with, you know- with some things' (Ali, manager).

By the same token, the other manager concedes:

'So, (managing the RHNs) can pose some challenges' (Ash, manager).

On a similar trend, according to fieldnotes:

'I met with the State-Wide Facilitator of the RHP today and she expressed her frustration with the lack of consistency across the community health centres. She says that RHNs have their 'own little kingdoms' (Fieldnotes, 11th September 2017).

Piore (2011 p153) talks about the need for '*ensuring standardisation and replicability in the disposition of similar situations,*' and the study by Bosma et al (2018) revealed that street-level bureaucracy, causing nonconformity to prescribed policies, can lead to disparities in the provision of services.

Crucially, it became apparent from the findings that the State-Wide Facilitator and local managers of the RHP call for more structure and standardisation in the provision of nursing care as in fact, they feel this would benefit RHNs. It transpired that management are not attempting to take control away from RHNs, but rather, believe that in adhering to guidelines and adopting a standardised approach, this may help RHNs to work systematically, targeting care for the newly arrived refugees who require this most. Through observation of refugee health nursing practice, I understood that rules are in place for a reason, and this involves protecting RHNs from over-working. Guidelines focus the attention of RHNs in dealing with newly arrived refugees with more complex health needs, but in bending these rules to offer ongoing care to all refugees, RHNs put themselves in a position of jeopardy, as they lack capacity to manage this workload.

In terms balancing their discretion with appeasing bureaucracy, it emerged from the findings that on the most part, managers are content with RHNs having free reign, so long as core bureaucratic needs and RHP targets are met.

'Who makes the targets? Hmm, the Department of Health and Human Services (DHHS), yep. So, they're the governing body for the Program. The Victorian Refugee Health Network provides up-to-date literature, up-to-date policy developments, guidelines, recommendations and overarching governance' (Ash, manager).

There is also a requirement to provide qualitative narrative accounts of example client cases, illustrating the refugee's health issues and the nursing care and referrals that were made to improve health outcomes or quality of life. In this way, the DHHS require evidence of work processes within refugee health nursing, and therefore, RHNs yield control to bureaucracy.

Ali (manager) clarifies that:

'We need to- at the moment, show evidence of the hours of work that we do. Umm, and now there's a narrative evaluation tool that's been developed, so we can report in more depth about some of the work we do- like capacity building, or you know- building referral pathways' (Ali, manager).

Of significance, Heartfield (1996 p101) used Foucauldian theory to address bureaucracy in this field, highlighting that *'the economic value derived from nurses' documentation advantages institutional bodies and/or disciplines other than nursing.'* Heartfield (1996) argues that nursing documentation allows clinical practice to become subject to power relations, as dominant institutional processes are evident in the way that nursing is mediated through regular reporting to managers. Henderson (1994 p936) refers to this as *'hierarchical observation'* and *'surveillance of activities, normalising judgement whereby individuals are required to conform'* in nursing practice. This concept of surveillance or 'normalising gaze' relates to the image of a panopticon as described by Foucault (1977), in terms of maintaining social order and control.

Essentially, it transpired that professional judgement and decision-making in refugee health nursing is unavoidably couched in a world of multiple regulatory

mechanisms. However, as Evans (2011 p370) suggests, it is imperative that *'managers employ performance indicators to measure'* the work of street-level bureaucrats.

The dilemma posed by Lipsky's (1980) work is how to manage street-level bureaucrats; to control their independence (Rowe 2012). Indeed, Evans (2011 p370) highlights that discretion *'is the lubricant in the public policy machine. But it is also difficult to control and could easily overheat the engine.'* Evans and Harris (2004) are critical of the view of managerial omnipotence, expressing scepticism about the managerial rhetoric of control. Tummers and Bekkers (2014 p530) on the other hand, highlight that *'control mechanisms are often put in place in order to achieve compliance.'* As part of the RHP, managers undertake monthly supervision sessions with RHNs, during which time they discuss performance targets, the workload of each RHN, progress made with refugee clients and any challenges in practice. In this way, they ensure that nursing discretion does not become out of control and *'overheat the engine'* (Evans 2011 p370).

A RHN puts forward that:

'And then, (the manager) gives me work supervision, about the amount of work that I've got on board, clients getting through, and that kind of stuff' (Pat, RHN).

Indeed, one of the managers says: ***'We have a supervision process once a month, so that would just be with them bringing challenges that they have, or they would sometimes bring- talk about a case- a client that they might be having some challenges with. Or other agencies, or whatever. So that is once a month. And then, there's a performance development review process, which is also again about them setting objectives, and then they're reviewed... We have like a monthly review, you know- a check. In terms of- has this occurred? Have you had this conversation? You know- that kind of thing'*** (Ali, manager).

This manager highlights that work processes are monitored, thus, limiting the supposed control that is intrinsic to the RHN role.

RHNs must contribute to the supervision process and show evidence of care plans and a breakdown of hours spent with refugee clients. The concept of inspection

and audit systems to oversee the decisions of street-level bureaucrats is in line with recommendations from Rowe (2012), and RHNs must give in to these institutional pressures.

Interestingly, one RHN explains that the mandatory supervision sessions are in some ways, beneficial, in talking things through.

'I think, like, that overarching kind of umbrella kind of support. Particularly, I had a few difficult cases earlier on in the year, that I needed a little bit more assistance, or guidance with, but they're not necessarily telling you what to do' (Meg, RHN).

With regards to supervision sessions, Sal (RHN) agrees, noting that:

'Ali is our direct programme manager. So umm, yes. We just- you know, we are in touch regularly, and they (supervision sessions) are just kind of, our touch point for stuff' (Sal, RHN).

Although instruments of classic, hierarchical and bureaucratic control, the supervision sessions can be considered as useful for stimulating conversation between RHNs and managers, while evaluating performance.

In terms of fluctuating power, as postulated by Foucault (1977) in discussion of the panopticon analogy, managers scrutinise the work of RHNs, keeping tabs on their employees through surveillance strategies. Although managers do not look through all refugee notes, assessments and reviews, managers have access to this documentation and audits are performed to ensure that RHNs are completing documentation appropriately.

'We have a monthly report that each staff member provides to me at the end of each month. So that's looking at basics of their day-to-day requirements. So, each staff member in the Program will be reporting, you know, their targets for that month. Umm, so in terms of numbers, but also in their work plan, what have they done in those? You know- if we're talking purely numbers, you know, say they've got a target of 46 hours of something per month, they'll report against those hours, and then they say if they're up or down, and they explain why they might be up or down. Umm, then, in terms of their work plan, it might be to, you know- participate in this particular activity, with this particular

community... and, you know, what they've done. We also audit in terms of professional development they may have attended' (Ash, manager).

In this way, RHNs are kept accountable by managers, and are forced to comply with these surveillance procedures. This is in line with Foucault's (1977) image of the panopticon, in that that modern social life is a world in which surveillance and social regulation are deployed to control, modify and train people to perform and behave in particular ways.

With regards to street-level workers evidencing practice and meeting targets, Lipsky (1980 p81) highlights the '*conflicting or ambiguous goals that evenly guide their work*' and the '*uncertainties that arise from difficulties measuring and evaluating work performances.*' Nevertheless, within refugee health nursing, managers try to outline clear processes by which to monitor the performance of RHNs. Murphy and Skillen (2015 p634) point out that street-level bureaucrats such as nurses are '*increasingly obliged to account for their actions in various time-consuming ways and to illustrate how they are meeting their targets and responding to evaluations of one sort or another.*' Despite the level of freedom afforded to RHNs by managers, their practice is censored and evaluated.

'We do file audits as well, internal file audits, so we have an electronic filing system here. So, we go through- we have a look at umm, you know- how they case note, making sure that their assessment care plan is all up-to-date, and appropriately filled out consent forms are filled, those sorts of things' (Ash, manager).

This is in consensus with the study by Walker and Gibson (2004), who found that nurses in South Africa had formal responsibilities and decisional autonomy but had to provide information on their activities to managers. It is noteworthy to consider that the pronounced presence of accountability and quality assurance casts doubt over the capacity for street-level bureaucrats to exercise professional discretion (Murphy and Skillen 2015). While acknowledging that refugee health nursing is a dual aspect activity (Prottas 1979), in that it involves service coordination, as well as face-to-face interaction with refugees, responding to accountability in the forms of inspection and evaluation is a subsequent layer of administration and can threaten autonomous, professional practice and power (Murphy and Skillen 2015).

Notably, it came to light from the findings that there are incentives for both managers and RHNs to surrender to bureaucratic demands and implement strategic planning directives set out by the DHHS, as this sustains funding for the RHP and keeps them in employment. Interestingly, according to Jones (2001), professionals have always tended to readily conform to externally dictated organisational policy and procedures, if it means that they maintain stability and retain their employment. It emerged from the findings that although RHNs feel that they are in control, they acknowledge policy in some regard and are aware of their targets.

'Well, it is our job to have a very minimal waiting list. We have to get people off our waiting list. That's one of our requirements here at this organisation; we're not to have a long waiting list. So, it's one of our umm- that's one of our targets. So, if there's waiting lists there, we need to see them, so that people don't wait' (Liz, RHN).

It became apparent from the data that Lipsky's (1991) assumption that street-level practitioners are not committed to organisational goals is too sweeping.

Although some RHNs are lenient with regards to accepting any refugee into the RHP, Sal (RHN) concedes policy in some respect.

'I do try and keep referrals to within five years post arrival. For example, a doctor referred a refugee to me recently, and this person had been in the country for about ten years, but was having problems, mental health issues related to his experience as a refugee. So, I did see him, but it should be about linking him in again with mainstream services, that are not necessarily refugee specific' (Sal, RHN).

From a managerial perspective:

'The flip side of it is- we can't continue to see all clients, all the time. Otherwise, we can't see new clients, so- yeh, it's trying to work out where- where do you best fit in the system?' (Ali, manager).

Ali (manager) raises a key point, in that RHNs need to discharge refugees from their care after one year, to create capacity in caring for new arrivals.

As highlighted in theme one, RHNs use gatekeeping techniques by monitoring the number of refugees on their caseloads and focusing on clients who are responsive to care. Concentrating their resources upon refugees who regularly attend appointments and cooperate with advice and referrals makes it easier for RHNs to achieve their performance targets and limits the liabilities that could arise for RHNs if they overstretch their resources. Bosma et al (2018 p1026) mention '*easier clients*' as opposed to clients with more severe needs, which indicates coping and creaming, which means giving priority to decisions that involve easier, more manageable clients (Lipsky 1980). This concept of creaming resonates with findings reported in social care (Ellis 2011), with the suggestion that '*giving more attention to easy clients*' is '*aimed at creating a manageable workload*' (Hupe and Buffat 2014 p551).

Thus, the RHP policy agenda and performance targets may appear to be met, but in fact can be significantly distorted at the '*felt*' end of the refugee experience (Wells 1997 p334). It became apparent from the findings that RHNs are highly competent and caring, and yet may contribute to a system which does not always operate most effectively for the refugees for whom it is designed. Offering specialised care for refugees who have lived in Australia for some time, may mean that new arrivals with complex needs are not accepted into the programme, due to lack of capacity. Nevertheless, RHNs give way to bureaucracy and do enough to meet core targets; thus, sustaining their employment. Formal feedback from refugees accessing the service is continually positive, and therefore, RHNs are seen to perform well.

To summarise, although powerful in their professional position as specialist practitioners, RHNs must show accountability for their practice, outlining evidence of their activities and providing narrative as to what their work processes involve. Findings of this study imply that RHNs are both the instrument and the subject of government; the governor and the governed. Although RHNs feel self-ruling in their practice, it came to light that they compete with institutional constraints and must surrender to bureaucratic measures. Power therefore fluctuates in refugee health nursing, shifting from RHNs to bureaucratic structures in the form of government control, as RHNs work to balance their discretion with appeasing bureaucracy. As Lipsky (1991) puts forward, the nursing profession is a paradox, as nurses' ability to manage complex and unpredictable situations is met with the focus on disciplinary technologies and patterns of accountability that somewhat target, limit and control the

exercise of autonomy. The following sub-theme continues discussion of vulnerability in refugee health nursing.

5.5.2 Sub-theme two: Therapeutic intimacy and crossing professional boundaries

It surfaced from the findings that due to continuity of care and the development of trusting relationships, therapeutic intimacy can take shape between RHNs and refugees, which can be described as psychological, spiritual or emotional closeness that develops over time between nurses and patients (Bennett 2011). Therapeutic intimate relationships can wield a positive impact on health experiences for patients, however, in the context of refugee health nursing, RHNs must be aware of professional barriers; otherwise, they risk the professional sanctity of this field.

When refugees are accepted into the RHP, they are assigned a RHN and this nurse provides ongoing care throughout the resettlement period.

‘If you keep tracking them every visit and making sure that everything is ok, then the relationship automatically develops. We’re the contact person that they’ve met the first time they’ve arrived, that is consistent... so it’s about trusting me’ (Pat, RHN).

Pat (RHN) recognises the benefits of continuity of care in developing trust. Indeed, according to Mutitu et al (2019 p37), ‘*Continuity of care with refugee patients enhances trust.*’ It became apparent in this study that RHNs build meaningful relationships with refugees during the resettlement period, and subsequently, offer care that goes one step further.

Interestingly, RHNs provide a family feel for refugees. For example, according to one RHN, who says with a smile:

‘We don’t do their shopping, but that doesn’t mean we don’t stop at the shops with them on the way home from the doctor’ (Ann, RHN).

Another example is illustrated in fieldnotes obtained from the metropolitan site.

'The RHN brings sweets and chocolates for refugees to take home for their children and often gives them little presents, which helps to cheer them up' (Fieldnotes, 13th November 2017).

One RHN points out that they are happy to offer gestures of kindness, noting that:

'These communities are grateful for everything- everything that you give them. So, it doesn't matter how small it is, it's like part of my job' (Pat, RHN).

With regards to blurred professional boundaries in refugee health nursing, it emerged from the findings that refugees often find friendship within nursing relationships, raising questions about the ethical component of nursing care. Len (refugee) talks about his relationship with the RHN and the benefits of this friendship.

'They distract us from our distress, our anxiety, our depression, and also to just- having some fun with them, and like- making social connection- you know? And we're just playing, or having fun, or laughing... which is very good for us' (Len, refugee).

Interestingly, Brandenberger et al (2019 p7) investigated healthcare delivery for refugees during resettlement and reported that *'the real treatment was not medical, but friendship.'* Likewise, an Iranian study by Babaei et al (2016) found that the therapeutic power of love, humour and kindness should be valued within the nurse/patient relationship. Nevertheless, it came to light in this study, that as RHNs become 'friends' for refugees, there is an ethical question about the function of the nursing relationship. Interestingly, a study by Tehranineshat et al (2019) reported that due to continuity of care and the building of trusting relationships, nurses can find difficulty in balancing professional ethical standards with developing friendship with patients. Indeed, Ogunsiji et al (2018) talk about the ethical dilemmas faced by specialist RHNs who provide care and advocacy for refugees, in terms of this unique relationship in healthcare practice.

Contemporary perspectives in nursing reflect a firm belief that the nurse/patient relationship is central to nursing's contribution to patient health and well-being (Bennett 2011). Such therapeutic effect is suggested to be intrinsically related to the

level of intimacy between the nurse and patient (Kadner 1994) and as Williams (2001) brings to the fore, patients may benefit from the opportunity to develop an intimate relationship with the nurse. Of significance, however, is that in establishing therapeutic intimate relationships with refugees during the resettlement period, RHNs practise on the peripheries of professional boundaries.

Kirk's (2007) model of interactional intimacy within the context of the therapeutic relationship offers a framework to demonstrate RHNs' engagement in intimate interactions with refugees. Expanding upon emotional intimacy within nursing, Kirk (2007) suggests that interactions in the nurse/patient relationship allow for meaningful and trusting exchanges that permit intimacy. Indeed, East and Hutchinson (2013 p3573) propose that, *'in everyday nursing practice, intimacy can be a situated communicative act.'*

It became evident from the findings that the interactional form of empathy in refugee health nursing can lead to an emotional and psychological closeness within the nurse/refugee relationship, which is the premise of therapeutic intimacy.

'I feel like she's my mother. I feel she's- she's really caring with me' (Lou, refugee).

'It's just that- I don't feel when I walk in to here, as I'm walking to a clinic. I'm actually- I feel like I'm walking home. Umm, I'm walking to my house- they're all like my family, my friends' (Dot, refugee).

This idea mirrors fieldnotes obtained from the rural/regional site.

'One of the RHNs says that 'the clients feel safe here;' 'we are their family' (Fieldnotes, 25th September 2017).

To take therapeutic intimacy further, Jes (refugee) comments:

'I love her. She is like my sister. She is part of my settlement in Australia, Pat. She will always be...With people like Pat, always checking on us... it doesn't stop with our health... I consider her like, a friend' (Jes, refugee).

Data like these raise important ethical issues for nurses, and it is contestable whether love is indeed part of the picture. It is argued that caring, love and intimacy

are at the heart of the therapeutic nurse/patient relationship and represent everyday nursing practice, which is complex and often taken for granted (Savage 1995). Intriguingly, a study by Fitzgerald and van Hooft (2000) reports that current Western-style healthcare systems restrict the practice of nursing in such a way as to limit possibilities of caring and loving relationships with patients. They argue that loving relationships within nursing are beneficial, suggesting that *'nurses who love in the practice of caring go beyond the role definition of the duty of care; they are people who are prepared to think differently about their practice as professionals and are identified as competent risk takers, committed to the betterment of the other before themselves'* (Fitzgerald and van Hooft 2000 p481-482). However, although the concept of 'love' in this study stems from refugees, it must be recognised that in establishing a somewhat loving relationship with patients, this calls for deep reflection on professional nursing practice.

RHNs allow refugees the space and time for therapeutic interaction, sharing sensitive information about past experiences, and when RHNs respond with empathy and validation, a relationship based on therapeutic intimacy takes form. Refugees puts forward that:

'She likes to help us from her heart, like- from inside- yeh. She is working from her heart, like she's- I can feel it' (Joe, refugee).

'She is a friend, and a person that would help me and support me all the time' (Lou, refugee).

It transpired from the findings that RHNs enjoy developing therapeutic intimacy and psychological closeness with refugees, as they feel that this facilitates trust and openness, allowing refugees to disclose intimate symptoms and sensitive experiences. According to Dowling (2004), increased emotional involvement with patients does bring a sense of satisfaction in nursing; or 'compassion satisfaction.'

A key finding, however, relates to the notion that aspects of therapeutic intimacy *'can be problematic and may be in danger of breaching personal and professional boundaries,'* a concept which is echoed in another study (East and Hutchinson 2013 p3572). It surfaced from the findings that therapeutic intimacy during the resettlement period can lead to ethical issues in the nurse/refugee relationship. According to a RHN:

'One of the challenges of our job is actually crossing what a lot of people would see as professional boundaries. Like, when you go to do a home visit, you always stay longer and you are always given tea and biscuits and cakes and umm, it's fun, you know' (Ann, RHN).

Invitations to socialise can also be out-with the RHP.

'I think she enjoys it. We are nice people! Like, my mother-in-law, she likes Pat! She said, 'Please come and visit us! Please come and visit us at our home!' Yes, come and visit us! I would like to cook for you! You can taste our food!' Yes, yes' (Jes, refugee).

Of note, Muetzel (1988) proposed a model of the nurse/patient relationship characterised by intimacy and partnership, describing intimacy in nursing as closeness on psychological and spiritual levels. Muetzel (1988) talks about unity and connectedness between the nurse and patient, implying that intimacy refers to nurses 'being there' and spending quality time with patients.

Jes (refugee) mentions keeping in touch with the RHN after she was discharged from the RHP, inviting her for coffee to practise her English-speaking skills.

'For me, Pat is a great support, because even, like, when she finished everything- all the programme for me and for my husband and my kids, we keep in touch. And actually now, I'm still nervous, I'm not sure about my level- my English level. So, she said, 'I can meet you.' She took a break, and she went out, and she invited me to have coffee' (Jes, refugee).

Indeed, although formally discharged from the programme, this refugee continues to access support from the RHN. Of relevance to this sub-theme, it is proposed that professional intimacy is intrinsic to the type of care and services that nurses provide, involving psychological, spiritual and social elements that allow meaningful connections to be formed between nurses and patients, and sometimes lasting after the care process (Antonytheva et al 2020).

According to Principle Four of the Code of Conduct for Nurses, which discusses 'Professional Relationships,' nurses must 'recognise the inherent power imbalance

that exists between nurses, people in their care and significant others and establish and maintain professional boundaries' (NMBA 2018). In line with this notion, Antonytheva et al (2020 p3) discuss therapeutic and emotional intimacy in nursing but mention '*boundary setting,*' otherwise, it '*may be problematic.* Of significance, although dated, Peplau's (1988) conceptual understanding of closeness is constrained by the professional role, and she goes as far as to recommend that nurses be emotionally detached and distant from their patients. This is however an old-fashioned view, and there is a difference in clinical practice between compassion and empathy, and love. Refugee health nursing involves the fostering of therapeutic intimacy through caring, empathetic relationships, highlighting emotional closeness and friendship as key components, from the refugee perspective. A takeaway from the findings would be that the nurse/refugee friendly relationship is a slippery slope and managing that boundary is challenging, as is evident in the data and discussion.

It became apparent that RHNs are aware of the complexities of blurred professional boundaries in establishing therapeutic intimate relationships but believe that professional intimacy in the form of trust, respect and empathy improves quality of care for refugees, as well as health outcomes, which is in line with the notion portrayed by Antonytheva et al (2020). Principle Four of the Code of Conduct for Nurses recommends that nurses should '*actively manage the person's expectations and be clear about professional boundaries that must exist in professional relationships for objectivity in care*' (NMBA 2018). Therefore, RHNs should be cognisant of their position of power in the context of facilitating therapeutic intimate relationships with refugees, and mindful of crossing professional boundaries. Findings highlight that professional boundaries in refugee health nursing are blurred, and this could jeopardise the professional standing and power held by RHNs as pioneers of refugee healthcare.

To summarise, through continuity of care and the development of meaningful relationships between RHNs and refugees, therapeutic intimacy can blossom, signifying a psychological or emotional closeness (Kirk 2007; Bennett 2011). Therapeutic intimacy can be beneficial in fostering trusting professional relationships, allowing refugees to feel comfortable in sharing personal experiences and information of a sensitive nature. However, findings from this study imply that close ties between

RHNs and refugees can lead to feelings of 'love,' 'family' and 'friendship' and '*crossing what a lot of people would see as professional boundaries*' (Ann, RHN). RHNs navigate the complexity of the nurse/refugee relationship, offering compassionate care while negotiating professional limits. As RHNs find themselves in this position, they are exposed to vulnerability, and must contemplate the ethical ramifications of therapeutic intimate relationships with refugees and the boundaries they wish to set in maintaining professionalism.

The following sub-theme considers another component of vulnerability within this field of nursing practice. Sub-theme three highlights that by operating as street-level bureaucrats and bending the rules to benefit refugees, RHNs can be overwhelmed with an ever-increasing burden of clients on their caseloads, and the ever-growing expectations of refugees. Moreover, in developing close connections with refugees, RHNs are susceptible to vicarious trauma and symptoms of compassion fatigue; spiralling this group of nurses into the risk category for burnout.

5.5.3 Sub-theme three: Vicarious trauma and burnout

Of significance, RHNs assert power by allowing refugees to become dependent on them during the resettlement period. However, this dependency comes back to weaken RHNs, as they find difficulty in discharging refugees from their care and subsequently, have too many refugees on their caseloads. Likewise, in developing psychological closeness with refugees through therapeutic intimacy, this can be detrimental to the well-being of RHNs, who encounter symptoms of compassion fatigue, calling into question their powerful position. This third sub-theme illustrates how RHNs may become fatigued and lose control of their power.

In taking this point further, findings show that RHNs are vulnerable to burnout due to their own actions as street-level bureaucrats on the frontline. RHNs believe that after experiencing distressing circumstances, refugees are deserving of care that goes above and beyond, offering help that is beyond their scope.

'I think by the time they've arrived... they go through that process of trying to settle themselves. And so, it's ok to be helped and nurtured' (Ann, RHN).

Findings make known that RHNs '*go beyond the routines*' (Valizadeh et al 2015 p31) for refugees, expanding upon their prescribed role and taking on extended responsibilities, assisting refugees with finding housing, employment and doing the little things, like helping with shopping or with children's appointments at the local school. The little things add up, meaning that RHNs are consumed with these extra tasks.

RHNs take on too many refugee clients and are hesitant to discharge refugees to mainstream community health services, which increases their workload.

'We're flat chat busy; we're tired' (Ann, RHN).

Of relevance, findings show that managers lack insight into the everyday worlds of RHNs, while RHNs struggle to keep up with the self-declared demands of this role. With nobody enforcing rules about eligibility, the care process and discharge, RHNs are left to their own devices.

'I mean, you sort of think, 'When is enough, enough?' When is enough clients? When can I just say- like, I can't do any more?' (Liz, RHN).

Findings highlight that RHNs take on too much, leading to feelings of burnout. Interestingly, a study by Zakeri et al (2021) highlights the correlation between fatigue, burnout and clinical competence in nursing, reporting that when nurses take on too much; this can influence effective care giving. Reflecting on refugee health nursing, Ogunsiji et al (2018) highlight that RHNs may feel incapacitated by the various impacts that they encounter when working with refugees, observing the outcome of physical abuse on them and leading to secondary post-traumatic stress, negatively affecting the mental health of these nurses.

During observation sessions, RHNs commonly described feeling overwhelmed, tired and grappling to cope with the workload, often worried about the well-being of refugees in their care.

'We find it challenging to 'switch off' after appointments' (Meg, RHN).

RHNs discuss the risk of burnout, which is defined as *'a psychological syndrome emerging as a prolonged response to chronic interpersonal stressors on the job'* (Maslach and Leiter 2016 p103) and according to Ray et al (2013 p256), *'emotional exhaustion is considered the central element of burnout.'*

As well as the unmanageable workload, evidently from the findings, RHNs are consistently uncovered to the traumatic circumstances of their clients' lives and subsequently, are exposed to secondary trauma. Indeed, Dinc and Gastmans (2013) posit that nurses can become vulnerable as they develop emotional connections with their patients.

As RHNs form therapeutic intimate relationships, they expose themselves to the experiences of refugees; oftentimes causing distress. This echoes findings from a study by Mishori et al (2014), who report vicarious trauma in professionals caring for asylum seekers. Indeed, Dowling et al (2004 p1291) suggest that *'by participating in the vulnerability in others, nurses cultivate their own vulnerability.'*

It became evident that RHNs give so much of themselves in developing therapeutic relationships with refugees and offering empathy, that they can experience stress, fatigue and potentially, *'nurse burnout'* (Mudallal et al 2017 p1). It emerged from the findings that the therapeutic relationship often leads to emotional weakness among RHNs, as they struggle to deal with challenges of consistent exposure to upsetting stories.

To expand upon this idea, Coetzee and Klopper (2010 p235) propose that specialist nurses have a duty to provide compassionate care, *'which personally exposes them to patients' pain, trauma, and suffering on a daily basis,'* and the therapeutic relationship between RHNs and refugees means that refugees rely on the RHN to discuss intimate and difficult aspects of their lives. This concept is explored by Ray et al (2013), who address the challenges this poses to healthcare providers. According to Coetzee and Klopper (2010), one of the primary effects of compassion fatigue is being emotionally overwhelmed, and this was evident in the data, particularly during observation.

Fieldnotes from the metropolitan site report:

'The refugee had recently arrived from Syria with her child, having lost her husband and parents in the conflict. She is struggling to cope with grief and post-traumatic stress, expressing her anxiety and reporting regular nightmares, sharing stories about recent terrifying events in Syria. The RHN was upset after the appointment, as the images portrayed by the refugee were graphic in nature. She explained that she feels overwhelmed sometimes, as she comes from a clinical background where nursing interactions are more task orientated. She enjoys building relationships with refugees but finds it difficult to separate her work and home life' (Fieldnotes, 5th June 2017).

To take this point further, fieldnotes taken from the metropolitan site illustrate an example of secondary trauma due to emotional closeness with refugee clients, highlighting that RHNs can feel like part of the family when caring for refugees.

'The RHN is supporting a refugee from Kenya who arrived in Australia last year, fleeing persecution. The refugee's daughter has recently died back in Kenya, and as the refugee shared this news with the RHN, they both began to cry, holding each other together in grief. The RHN says she feels like part of the family with some clients, as they don't have much social support in Australia' (Fieldnotes, 29th June 2017).

In this line of nursing, the act of being compassionate and '*bearing the suffering of others*' (Figley 2002 p1434) has implications such as becoming preoccupied with traumatised patients, which may lead to symptoms of compassion fatigue (Ray et al 2013). Compassion fatigue was first introduced by Joinson (1992), who investigated the nature of burnout in nurses within an emergency department. This phenomenon is defined as '*a state of tension and preoccupation with traumatised patients by re-experiencing the traumatic events, avoidance/numbing of reminders and persistent arousal associated with the patient*' (Figley 2002 p1435). It transpired from the data that RHNs experience emotional stress and risk secondary trauma in their everyday practice, usually due to '*specific exposure to the trauma and suffering of a specific client*' (Figley 2002 p1436). It is noteworthy to mention that RHNs talk about refugee health nursing in a positive light.

'These communities are grateful for everything that you give them, and that's what makes it- you know, a nice area to work in' (Pat, RHN).

Fieldnotes taken from the rural/regional site report that:

'The RHN says that she loves her job and that 'helping people to make the transition to living in Australia is a privilege' (Fieldnotes, 20th November 2017).

This is in line with Sacco and Copel (2018), who address the value of compassion satisfaction in nursing and acknowledge the positivity involved in caring.

Significantly, however, the weight of emotional fatigue bears heavy on the shoulders of RHNs. It became apparent from the findings that although RHNs enjoy caring for refugees, they highlight elements of compassion fatigue as a challenge of this role.

'It is hard to listen to the stories' (Meg, RHN).

'You know- it's- it's quite umm, challenging as well. It's not just your normal 'go to work and go home' type of role. It's very complex needs clients, and you do get to hear a lot of stories that you didn't expect you might hear, you know? It's quite- it can be quite traumatic on your own self as well' (Liz, RHN).

These views reflect the description offered by van Lieshout et al (2015 p2), who suggest that compassion *'involves experiencing an emotional reaction when noticing someone suffering.'*

Ann (RHN) explains the difficulties of discussing sensitive topics with refugees.

'We can take that home with us. And you can, you know- you might say something in a consultation or a meeting with a client, and without knowing, you've pressed a button that triggers memories, and you might get over it at the end of the session and go upstairs and it's all finished. But you can take that home and ruminate on it for days and you don't want that to happen' (Ann, RHN).

Fieldnotes taken from the rural/regional site elucidate this concept.

'One of the RHNs explained that she is struggling to care for a refugee, who is having a hard time settling in Victoria and has thought about ending his life. After the appointment, the RHN became emotional and admitted that she found

these situations difficult to manage. She worries about this clients' well-being' (Fieldnotes, 30th May 2017).

The therapeutic intimate relationship means that refugees rely on the RHN to discuss intimate and difficult aspects of their lives. This concept is explored by Donnelly et al (2011), who reported that refugee participants in their study suffered from mood disorders, anxiety and post-traumatic stress, with many complaining of lack of sleep, fatigue, paranoid feelings, psychosis and suicidal thoughts, addressing the emotional challenges this poses to nurses providing care. It is interesting to consider that RHN participants have limited understanding of mental health, with participants coming from general adult and paediatric nursing backgrounds, which perhaps contributes to feelings of overwhelm.

With regards to dealing with refugee stories of a sensitive nature, Pat (RHN) talks about secondary trauma and the need to separate her work with refugees from her personal life.

'The other challenges, I suppose, would be the stories that you hear and how you put those stories away and tell yourself, 'they're not your stories, they're your client's stories.' And you feel for them, but you don't have to own them, or lift them, or work through them. So, it's about separating that. And I think that debriefing, whether it's formal or informal, the secondary consultations that I get help me to separate that' (Pat, RHN).

It surfaced that RHNs experience challenges associated with emotional exhaustion and are aware that they require an opportunity to seek assistance in dealing with the psychological burden of their work, to prevent the development and progression of compassion fatigue.

'I had a good dose of vicarious trauma when I first started, and that taught me an awful lot. Not always very positive! But umm, the one I see now is a counsellor- a generalist counsellor, and she's challenged some of my work practices' (Ann, RHN).

Figley (2002) talks about 'compassion stress' and the chronic lack of self-care and support for health professionals dealing with exposure to the trauma of their patients.

'You need colleagues who you can debrief with, because you're hearing these stories all the time. I suppose what we could have is a buddy system here... I need debriefing... you know- like we all need to debrief- informal debriefing. But I also get monthly supervision for my own mental health, which helps me separate work from life, so I don't burnout' (Pat, RHN).

Counselling and de-brief sessions could be paramount in helping RHNs to cope with vicarious trauma. Emphasis is placed on self-care, as well as the idea that RHNs could support each other to prevent compassion fatigue. This mirrors advice put forward by Coetzee and Klopper (2010 p241), who suggest that *'the increase in knowledge of the existence of compassion fatigue and its manifestations would enable nurses to become aware of others who might be suffering from compassion fatigue and would facilitate the development of a peer support network, which will make it possible for nurses to seek assistance in dealing with the detrimental effects of compassion fatigue.'* Similarly, a study by Aycock and Boyle (2009) investigated ways to deal with compassion fatigue and burnout in oncology nursing, acknowledging the perils of inattention to this frequent phenomenon. They report that cumulative work-related stress and distress emanating from interpersonal contact with patients may result in physical, emotional, social and spiritual adversity for nurses, depicting the result of longitudinal workplace ramifications of sadness and despair. Aycock and Boyle (2009) advocate that healthcare organisations should be encouraged to increase support for nurses, lobbying for workplace interventions to manage this critical work-related issue.

To offer a summary, as street-level bureaucrats performing autonomously, RHNs make decisions which impact their daily work routines, creating an overwhelming workload as they are reluctant to discharge refugees from their care. Moreover, due to the development of therapeutic intimate relationships with refugees, RHNs are exposed to hearing stories of a personal and often traumatic nature. Although they enjoy caring for refugees during the resettlement period, it emerged from the findings that vicarious trauma and burnout threaten the longevity of the RHN role. In fermenting psychological closeness with refugees, there can be detrimental effects to their own mental well-being, with mention of the emotional burden through continuous exposure to harrowing stories.

5.5.4 Summary of theme three

By way of conclusion, it was revealed from the findings that through appeasing institutional structures and adhering to government rule, RHNs lose some of their control over practice. Furthermore, due to continuity of care and the development of close ties with refugees, RHNs bare themselves to the risks of crossing professional boundaries, as well as the threat of secondary trauma and burnout. Theme three has exposed the vulnerability in refugee health nursing, as this group of nurses struggle to meet targets and retain their professionalism in the face of therapeutic intimacy and compassion fatigue.

5.6 Theme four: Refugee power: Resilience, resistance and negotiation

The fourth and final theme brings this chapter to a close, with an overview of findings that relate to power exercised by refugees. Foucault (1977) puts forward the idea that power is everywhere, circulating between all groups in society. This theme calls attention to the power of the underdogs in this scenario, the refugees, the patients; and how this power can be used to shape the delivery of their care.

Refugees in the resettlement environment are often looked upon as uniformly powerless and vulnerable (Hatoss and Huijser 2010), adopting a '*passive, victim role*' (Colic-Peisker and Tilbury 2003 p61). Nevertheless, it surfaced that refugees often use agency, resistance and negotiation in exerting power in the healthcare context. Having experienced the difficulties of conflict, war or persecution, leaving countries of origin and making their way to Australia in search of safety, refugees often display strength, resilience and capability during the resettlement process (Wood et al 2019). Evidence from this study contests common myths and highlights the diversity, dynamics and active role in which refugees can play in determining their own health trajectory in modern migration and resettlement.

Foucault gives a theoretical basis for questioning the authority of the 'expert' nurse, suggesting that patients are not passive, but instead, may actively resist oppression. In relation to nursing practice, one may conclude that '*nurse-patient*

relationships during the negotiation of patient care are not monolithic and do not flow in one direction. Rather, the negotiation of patient care is shaped by multiple discourses, each pushing and pulling nurses and patients in all directions. At any moment, both parties may be in a position of power, or in a position of powerlessness' Griscti et al (2017 p239).

This final theme brings light upon refugees claiming power within the sphere of resettlement, expressing independence and resilience in managing their own health concerns, showing resistance towards RHNs, while negotiating the terms of their care. These concepts are described in the following sub-themes, connecting the notion of refugee power in the findings to relevant literature.

- ***Sub-theme one:*** *Agency in managing priorities*
- ***Sub-theme two:*** *Refugee opposition to specialised healthcare*
- ***Sub-theme three:*** *Entitlement and negotiating prolonged access*

This section begins by underlining the autonomy of refugees in deciding whether to participate in, and continue taking part in, the RHP during the one-year resettlement period, which is crucial in the demonstration of their power.

5.6.1 Sub-theme one: Agency in managing priorities

The RHP is an optional service to promote health and well-being for newly arrived refugee populations and refugees are free to decide whether they would like to access this specialised healthcare. Significantly, it became apparent from the data that newly arrived refugees often have different priorities during this time, and refugees exert power in this process by taking control of decision-making, sometimes choosing to concentrate on matters of greater importance to them. RHNs rely on refugees to access the RHP for the continued operation of this service, but refugees are free agents in choosing whether to accept the offer of help.

Crucially, it emerged that some refugees believe support from RHNs is unnecessary because they feel that they have no health problems.

'I don't need any help- I don't have any health problems' (Joe, refugee).

Some refugees have no symptoms of ill-health on arrival in Australia and therefore see no point in receiving healthcare.

'Yeh, even at the beginning, like, it is good that we don't- none of us have any big problems or health issues' (Mia, refugee).

Having experienced the difficulties of conflict or persecution, leaving countries of origin in search of safety, refugees often display resilience and capability (Gungor and Strohmeier 2020).

However, in line with the study by Marshall et al (2016), it became apparent from the findings that although refugees can arrive with no health problems, and nothing of relevance is picked up during the initial RHA, health problems, in particular chronic disease and mental health issues, often arise during the resettlement period. Although RHP guidelines recommend that refugee health nursing care should be offered to those newly arrived refugees with complex health needs, RHNs bend the rules to allow all kinds of refugees to access this service. Consequently, RHNs can efficiently identify health issues as they emerge, with prompt implementation of the appropriate care pathway.

This concept is illustrated by Dot (refugee), who suggests that although feeling fine when she arrived in Victoria, health problems arose during resettlement.

'I didn't have any problems. But from the first month I arrived, I started with all the health problem stuff- asthma, diabetes, liver, heart, and problems with my vertebrae, and my brain- what do you call it? A lump in the brain. She discovered all these problems, but I didn't realise I have all these problems' (Dot, refugee).

As one RHN points out:

'Most of them don't think they are unwell' (Pat, RHN).

It appears that sometimes, RHNs look for health problems that may not in fact be there. However, it came to light that in most cases, refugees can suffer with underlying chronic conditions with minimal symptoms, and these are often missed during the initial RHA. Interestingly, when refugees have no symptoms of ill-health, they can be reticent to engage with community health services.

‘Because they can’t see it, they don’t know... I suppose when you’re struggling to survive from one day to the next, diabetes is not your priority. It may be to me and the doctors, but it’s not to them. It’s priorities elsewhere’ (Pat, RHN).

Interestingly, although refugees can exert power in refusing specialist support through the RHP, this may be detrimental in the longer term, as they could have benefitted from health promotion, education and ongoing assessment.

Nevertheless, when refugees feel well, they are often more interested in thinking about other aspects of the resettlement process. Tinetti et al (2019 p7) describe *‘differences in perspectives of what mattered most between patients and clinicians,’* with regards to healthcare professionals and patients focusing on different priorities. From a managerial perspective, Ali (manager) acknowledges that some refugees are unreceptive to the RHP.

‘The client need often earlier on, is quite pressing, but they’re not open, necessarily to thinking about some of the broader health education’ (Ali, manager).

In relation to Foucauldian theory, Thompson (2003 p123) speaks to the idea of autonomy and *‘self-formation,’* suggesting that *‘resistance is no longer merely the sabotaging of a reigning epoch’s agenda. It is concerned, rather, with the constitution of novel sorts of subjectivity, forms of agency... that develop viable alternatives to contemporary fascistic life.’* In this way, refugees can be seen to *‘cultivate new forms of being and doing,’* as they choose how to live their lives on resettlement (Thompson 2003 p123).

Interestingly, Suz (refugee) is perplexed with how often she is asked to visit the community health centre when she has no immediate health concerns.

'And (at home), just- people go to see a doctor if something gets worse, or if they feel concerned about something. And once they see a doctor or are getting treatment, you don't have a follow up, like here. Here, it's appointments with appointments- you see a doctor every now and then. And umm... more appointments! It's just a big difference with back home' (Suz, refugee).

This mirrors the point put forward by Morris et al (2009 p535), who with regards to refugees during resettlement, recognise that *'they had a whole different way of taking care of issues back home...they went to the hospital only when they were sick, accessing health services for prevention was not commonly available to the majority of refugee groups in their home country.'* The RHP is aimed at refugees with complex health needs, but as street-level bureaucrats, RHNs often offer their care to most newly arrived refugees, as they understand that health problems can develop on resettlement. Although refugees are often initially enthusiastic about receiving specialist support, if they experience no symptoms of ill-health, they can lose interest and be unforthcoming in attending subsequent appointments, leading to RHNs not meeting targets.

Some refugees decide to prioritise more immediate concerns.

'A lot of them tend to become very independent of the medical service... Because their priority is school, their priority is their life outside' (Pat, RHN).

This is in line with another RHN, who suggests that:

'I think sometimes it's really hard for anyone to think about anything else, other than having a safe- like where can I live? Do I have a house? A roof over my head, that type of thing' (Meg, RHN).

The effect that housing has on refugees' overall physical and emotional well-being, as well as on their ability to feel 'at home', is highlighted by Ager and Strang (2008). Indeed, RHNs recognise that refugees may not engage with the RHP as they are busy with other commitments during resettlement.

'We know that refugees often arrive with significant health issues, due to their previous experience, they've had little or no medical care. And we know that after they arrive, it's necessary. But they often- they might have trouble engaging in services, due to a variety of things' (Sal, RHN).

Sal's (RHN) point about the lack of medical care before resettlement is corroborated by refugee participants in the studies by Razavi et al (2011) and Hadgkiss and Renzaho (2014).

As another RHN brings to the fore:

'It depends very much... how much they prioritise health over work, over education' (Pat, RHN).

An evaluation of Syrian refugee resettlement in Scotland found that *'in the initial arrival phase, arranging housing, sorting out documentation, social security arrangements and registering with a general practice were more prominent concerns than any specific medical problems'* and there are *'a lot of bureaucratic processes to be completed within a short time frame'* (Weir et al 2017 p457).

Jes (refugee), illustrates some of the complexities of the resettlement process and the difficulty she faces in juggling competing priorities.

'I have to drive on the left side of the road. This makes me crazy! I have to learn English; the accent with Australian people makes me crazy! I can't understand their letters, I need to learn how to shop for my family, how to cook for us, like the- the usual food we used to eat... how to make new friends, and it's a new country. It is very hard... I have to attend the English classes, because without English, I cannot live - I can't survive in Australia. I have to attend many appointments for the immigration, for my permanent residency. And umm, for the job seeker, because I was on Centrelink payment- I have to attend appointments for the job provider. This makes lots of stress on us, for me- especially me, and the family, yes' (Jes, refugee).

Sal (RHN), acknowledges that refugees are often busy during the first year of resettlement, attending meetings about employment, housing and welfare and may not have time for the RHP.

'You know, I think people usually have so many appointments and so many things going on, that we might not fit into their ideas' (Sal, RHN).

Of note, Wood et al (2019) found that participating in education and finding suitable employment were priorities for refugees in Australia and assisted in improving

settlement outcomes, including psychological adjustment. Likewise, a study by Haj-Younes et al (2020) considered Syrian refugee priorities on resettlement in Norway and reported that perceptions of positive quality of life were associated with quality relationships and participation in leisure or employment activities, and refugees wanted most to 'catch up' with their education. Therefore, although refugees often prioritise English language lessons and finding employment over attending community health appointments with the RHN, refugees can see the secondary benefits to their health and well-being through integration in the community, building their self-esteem and contributing to the workforce.

To expand upon the notion of alternative priorities, refugees can be distracted from health concerns by worries about a range of other issues impacting their daily lives, which are viewed by refugees as more pressing matters of survival. In agreement, Haley et al (2014) implemented a health promotion tool for resettled refugees in the USA, but refugees were often too preoccupied with issues of housing, education and finding employment to attend this primary care service. Suz (refugee) reflects on her health but explains that she cannot focus on her health concerns until she is granted permanent accommodation.

'Some of the challenges is, for example, accommodation. I haven't got my own accommodation yet. I'm waiting. It's in the process; it takes time...Health wise- I have some problems... But- still, until I get the principal or the necessary- the basic things, I can't stress about health. As I mentioned before, I'm still waiting for accommodation' (Suz, refugee).

The refugee requirement for basic things is outlined by Woodgate et al (2017), who highlight that accessing primary healthcare services on resettlement may not be a priority for refugees in Canada.

As well as waiting for accommodation, refugees can be preoccupied with happenings in their countries of origin. For some, their family members are in conflict or war zones and therefore, refugees often prioritise supporting family overseas.

'I'm always thinking- 'Did I take the right decision? Am I right to come to Australia, to leave everything behind me?' Lots of people stay there. Why didn't I stay there? Always looking back. And what's going on there? Because the time is different between Australia and the other world. It's the end of the world. So

always like, trying not to sleep during the night, just to wake up in the night, to be the daylight in Syria, just to talk to my friends, ask what's going on. 'Everything is fine?' Just to make sure the family is- the people I left there- they are fine. So yes, it affects me... We had a great life, great dreams. When you have to leave everything behind you to just ask for a safe place to raise your kids, it's not easy' (Jes, refugee).

It is noteworthy to mention the impact of leaving their country of origin and the time it may take refugees to accept this decision. Killikelly et al (2018 p8) talk about the complexities of the grieving process experienced by refugees, post-conflict, in that; *'Refugees experience many losses, not only the loss of a loved one, but also the loss of homeland, cultural group, employment, housing, and security.'* Weir et al (2017) found that refugees in Scotland remained concerned about family members who were still in the Syria region and this preoccupation often hindered access to healthcare during resettlement. Morris et al (2009 p535) highlight that refugees struggle with *'stress related depression and guilt for leaving their old lives.'* Refugees often need time to process feelings of guilt and grief during the resettlement period and therefore might not place focus on health promotion or chronic disease prevention and management.

Omeri et al (2006) acknowledge the importance of identifying and accepting refugee priorities and acknowledging what matters most to them, even if this does not align with the healthcare provider's priorities. Similarly, RHNs must accept that the RHP may not take precedence in the lives of resettled refugees. The decision to participate in the RHP lies in the hands of refugees and thus, refugees are in a position of power.

Having described refugee autonomy in the context of healthcare during resettlement, the following section offers an overview of the ways in which refugees exercise power through their resistance to specialised care.

5.6.2 Sub-theme two: Refugee opposition to specialised healthcare

According to Kettunen et al (2002 p102), *'most patients are seen as helpless and passive recipients of knowledge who rarely request explanations and ask very few questions.'* However, in the context of the RHP, refugees challenge the power held by RHNs through their opposition to advice and resistance to care. Keen et al (2019 p390) argue that, *'nurses are often faced with subtle and overt patient resistance when implementing prevention strategies'* and findings of this study are in consensus. Refugees exert power through non-attendance at scheduled appointments, refusal to adhere to nursing advice and withholding information from RHNs.

While the literature paints a picture of vulnerability among resettled refugees, it surfaced from the data that some are resilient on resettlement and reject specialised support when this is offered on arrival. This notion is in line with Muecke (1992 p515), who suggests an alternative paradigm for understanding refugee health on resettlement, highlighting that *'refugees are prototypes of resilience, despite major losses and stressors.'* One refugee highlights her independence in managing her own health and well-being on arrival in Australia.

'I've grown up; now I help myself a lot' (Bet, refugee).

Liz (RHN) explains this concept, highlighting that:

'Some people, umm- when they first arrive, they're so grateful for your help. Other people, umm, just want to be really resilient, and they feel a little bit ashamed. You know? It just depends on their personalities. They feel a bit ashamed and want to stand on their own two feet and- and that sort of thing. They don't want to accept help sometimes. They don't want that' (Liz, RHN).

Managers also recognise the ingenuity of some refugees:

'Support can be provided, but our clients can be really resourceful' (Ali, manager).

Sue (refugee) is comfortable in navigating the health system, reporting that she requires minimal support.

'There is nothing that I can't provide for my children, and there's nothing I can't provide for myself. Just like, we've learnt a few English words, and we

***can find our way about, we can go to the family doctors, we can find our way out to the hospital, to specialists that we are referred to, for example, other health services here- we're all comfortable finding it ourselves'* (Sue, refugee).**

Interestingly, although Sue (refugee) reports managing independently, she required the assistance of an accredited translator for our discussion.

RHNs highlight the determination of some refugees.

***'You become disempowered when you go into hospital... All of a sudden, you're this sort of, person with a gown on, and probably no underwear on, and you lose any sense of control over what's happening to you. Well, that's not what refugees are about'* (Ann, RHN).**

Ann (RHN) implies that having experienced war and conflict, surviving persecution and other distressing circumstances, some refugees are strong-minded and repudiate the 'sick role' (Sakalys 2000; Shilling 2002).

With regards to refugee expectations not being met in the community health environment, Van Heelsum (2017) found that there was mistrust among resettled refugees in response to healthcare providers' restraint in prescribing antibiotics and there was discontent about the treatment of pregnant women and birth. In addition, Ahmed et al (2008) found that some refugee participants in their study felt discouraged by the care staff that did not seem interested in them. Along these lines, Joe (refugee) explains his frustration with the difference in care offered in Australia, compared to what he was accustomed to before the war.

***'It's a bit different here. (In Syria), they would really take care. They would like- for my daughter, she was really sick over there, so they took her in straight way, they put oxygen on her, it made us feel relieved- over there in Syria. But over here- it is just like, us waiting and waiting and waiting, and they send us back home. Even, not giving any oxygen, yeh... like they don't really care'* (Joe, refugee).**

This mirrors a concept put forward in the study by Woodgate et al (2017 p4), who mention refugee expectations of care being '*not quite met*' during the resettlement period. They highlight that refugees '*may expect to be given medication following their interaction with the care provider and, if not provided, may be upset and perhaps not*

seek care in future...' *'When no one seems to care, they can get agitated'* (Woodgate et al 2017 p5). As Mutitu et al (2019 p37) found in their study investigating refugee perceptions of nurse-led clinics in primary care, *'refugees expect a diagnosis, treatment, and resolution of health conditions.'*

It is significant to note that some refugees hold expectations of care on arrival in Australia and can be dissatisfied with the way in which they are supported during resettlement. In this way, RHNs are not the almighty saviours for refugees that they perhaps wish to be. Through the expression of discontent, refugees speak up and claim power within the social dynamic of refugee health nursing. According to one refugee:

'At the moment, there is nothing done for me by the refugee nurses' (Nat, refugee).

As mentioned, this is in line with findings from the study by Woodgate et al (2017), who found that refugees felt the care provider did not perform their role as expected. Due to dissatisfaction, some refugees seek support from elsewhere, exerting power in making this decision.

Expanding upon this notion, Maz (refugee) talks about her experience of coping with headaches during the resettlement period and suggests that the RHNs have been unable to help.

'The nurses never help with the headaches and everything. I'm asking for further help, asking to find further health systems, like other places I might be able to get help from' (Maz, refugee).

Maz (refugee) feels that her health concerns are not addressed by RHNs, so has sought help from other service providers, taking control of the situation and choosing to seek a different route in obtaining support. This echoes the study by Panagiota (2008), who reported that the needs of refugees in Greece undergoing maternity care were not met, with staff focused on bureaucratic concerns and unable to resolve issues regarding health. Refugee participants in the study by Morris et al (2009 p535) highlighted *'how frustrated and disappointed they were when their health did not immediately improve upon arrival in the U.S. This disappointment made many reluctant to seek care because their expectations were not met.'* Similarly, Mangrio

and Forss (2017) conducted a review of refugee experiences of healthcare in the host country and found that care offered for refugees was often inadequate, with refugees experiencing discrimination in the health system due to their race, accent or low proficiency in English language. Importantly, this review reported that *'if the experience of seeking care is negative... this might prevent the refugees from seeking care in the future* (Mangrio and Forss 2017 p2).

According to findings from a study by Kumar (2020), who explored experiences of resettled Burmese refugees in the USA, there is an innate understanding among community members of the necessity of the informal network of family, friends and neighbours. For this reason, Kumar (2020) claims that refugees are more likely to seek health advice from people in this community, as there are pre-existing channels of health communication. Interestingly, along the same lines, refugees sometimes renounce help from RHNs and seek health support from other avenues where they can communicate in their native languages.

'It's just like, a couple of families, they arrive with a family background from Iraq and they have quite a wealth of information already. And they have an Arabic speaking GP that they like to see instead' (Meg, RHN).

In consensus, some refugees draw attention to the benefits of seeking healthcare from providers who speak the same language.

'So, stuff like this, if they are simple, we go to the GP, because especially-the GP talks Arabic, so we can communicate straight way' (Joe, refugee).

This is in line with findings from the study by Omeri et al (2006), who report that Afghani refugees in Australia complained about the lack of health-related information and communication in the Dari language, so preferred to seek help from culturally similar health providers. Indeed, Ogunsiji et al (2018) raise the point that stigma and discrimination is not uncommon in this field, as new refugees may be apprehensive of nurses based on their culture, race or gender differences. In this way, some refugees may not wish to accept care from RHNs.

Although RHNs deem themselves to be culturally competent practitioners, cultural differences can affect more than the understanding of meaning and causes of illness. They also affect one's understanding of how symptoms or illnesses should be

managed. It became apparent from the findings that some refugees feel more comfortable receiving community health support from healthcare providers of a similar ethnic and cultural background.

In line with this concept, some refugees exert power by opposing the specialised health service and instead; choosing to access traditional healers. For example, a refugee suggests that it is more helpful to seek health advice from someone who understands certain cultural beliefs and herbal remedies.

‘We have to get the right information from the right people, so like here, because we have specific customs and traditional things like that- traditions where we do things our way. Do things- like we have, maybe, different, like umm, herbal remedies or something like this. Do that. Do your own stuff or your own research, because of the customs and traditions that we use to do things’ (Dot, refugee).

In agreement, findings from Morris et al (2009 p535) highlight that, *‘providers made references to refugees relying on homeopathic treatments and spiritual healers.’*

‘You know... there are health beliefs that influence how people see that they- their health problems may originate from, and how they should be treated... It’s all the elements of their past experiences-and how culture, umm, culture and religion can influence health beliefs, and knowledge’ (Ash, manager).

Oftentimes, refugees are dissatisfied with Western healthcare strategies and rely more heavily on traditional remedies (Wodniak 2018).

It is also worthy of note that some refugees exercise power by not attending scheduled appointments with RHNs. As a RHN considers bluntly:

‘Your service is for them. If they don’t want your service, that’s absolutely fine’ (Meg, RHN).

According to Morris et al (2009) refugees may have problems keeping health appointments because they do not have access to reliable transportation or because other resettlement matters arise. Nonetheless, RHNs are powerless when refugees fail to attend. Refugees have the upper hand as they control the state of play within

refugee health nursing, with RHNs imploring their presence at appointments, in order to meet their targets and strive for optimal refugee health and well-being.

Moreover, managers point out that some refugees do not show up for exercise groups and therapies organised by RHNs, which makes it difficult for these activities to continue.

'So, we did have yoga therapy as part of our Refugee Health Program as well. But that wasn't as successful as I'd hoped. It was really relevant, but we didn't- it wasn't able to reach- there were a number of factors that I won't go into, but it wasn't able to reach as many people as we had hoped, so we've stopped that... We're seeing the need for physical exercise and supported physical exercise. So, for years, we've been trying to run Afghani men's exercise groups for older Afghani men. We've been doing it for Afghani women- we've done it for Arabic-speaking women. But, umm, they've dropped off the ball this year, pretty much, just due to circumstances, but we are trying so much' (Ash, manager).

It came to light that refugees show opposition to specialised healthcare by not attending exercise sessions, but perhaps this comes back to the point that understanding a culture means appreciating how things are done. Although RHNs and managers see a need for exercise groups, refugees may not view things in the same way. This mirrors findings by Barnes and Almasry (2005), who studied refugees' perceptions of healthy behaviours and reported that health behaviour interventions must be specific to ethnicity to be effective. An example comes from the study by Sheikh and MacIntyre (2009), who evaluated the implementation of intensive health promotion to a targeted African refugee population in England, which was introduced with the assistance of refugees who had been resettled for some time. This study reported a significant change in knowledge, attitudes and beliefs about infectious diseases after attending health promotion activities at the clinic (Sheikh and MacIntyre 2009).

Leading on from this idea, refugees also claim power through their refusal to share information with RHNs. It transpired from the findings that some refugees are suspicious of the RHN role and may feel that information shared with the RHN could affect their refugee status in Australia.

‘Some people, when they came, they thought like, if they discover they have cancer, they will send them back to their country. They are afraid to affect their situation, or their residency in Australia. So, they don’t want anyone to know anything about their health. They are afraid that maybe this information goes to the immigration, and they will cancel my visa and they send me back’ (Jes, refugee).

As McKeary and Newbold (2010) consider, refugees may resist accessing health services in case their immigration status is questioned and reported to law enforcement authorities, with care being denied. Significantly, and sometimes to their detriment, resettled refugees can be suspicious of the healthcare system and unwilling to engage with healthcare professionals (Hadgkiss and Renzaho 2014).

One RHN suggests that some refugees find it challenging to trust her in disclosing sensitive information about health and this process can take time.

‘What you find is, at the start, they might not volunteer much information... Like I said before, they are assessing me as much as I’m assessing them. Can we trust her? Can we tell her everything?’ (Pat, RHN).

Another RHN also refers to the barrier between her and refugees, highlighting that some refugees refuse to share their whole story.

‘You know, there are some that- I’m sure they only tell you a little bit. The old ice-berg’ (Ann, RHN).

Pat (RHN) considers that some refugees may be suspicious of RHNs and perhaps associate this role with officialdom. She suggests:

‘I represent bureaucracy as far as they’re concerned’ (Pat, RHN).

In addition, it became apparent from the data that some refugees refuse to disclose information about their health as they may feel uncomfortable in talking about intimate bodily details.

‘It’s those sorts of things, down to really basic stuff, like describing bowel actions and things. That’s not something that they would normally do, and therefore ‘I’m not really going to tell you the truth’ (Ann, RHN).

Sypek et al (2008) also draw attention to the notion that some refugees are uncertain about using interpreters in conversations of a sensitive nature, citing concerns about privacy and being misrepresented, leading to the withholding of information. Of importance to this theme, Thompson (2003 p117) suggests that *'resistance cannot be conceived as opposed to power, but instead must be thought as intrinsic to it,'* and the ways that refugees show resistance shape how RHNs can offer nursing care to this group.

Furthermore, it materialised from the data that some refugees claim power in the context of resettlement through non-compliance with health advice offered by RHNs, repudiating instructions with regards to taking medication.

'They don't take their medication as prescribed, so they don't get any symptomatic relief... So, I had a client who was on anti-depressant medication, but he- because they send all their money home to their families, they live on virtually nothing. So, he and his friend shared the anti-depressant medication. So, he took it one day, and his friend took it the other, because it cost less that way' (Ann, RHN).

Similarly, a study by Shahin et al (2020) found that refugees in Australia show resistance in taking hypertensive medication as prescribed, due to medication beliefs. Of note, it has been proposed that patients may be non-compliant with medication due to problems with health literacy, in terms of understanding what the medication is for and the importance of taking the correct dosage (Murray et al 2018).

One refugee in this study says that she tried medication for a short while and this did not work, so she decided to discontinue this prescription, going against the advice of the RHN.

'For some of us- we just take a tablet for three days and it doesn't work, and we say, 'It doesn't work.' Because you know how they say, 'You have to finish the tablets, and then you will see the effect of it.' But then, when we take a few tablets, we say it doesn't work. So, we stop it' (Mia, refugee).

Correspondingly, Ibrahim et al (2015) reported on non-compliance in chronic haemodialysis patients and found that if patients feel no improvement through

treatment, they are likely to think that this is ineffective. By defying RHNs, refugees take control of the power dynamic within refugee health nursing, although this can have negative consequences in the longer term.

On a different tangent, refugees can be opposed to accepting support with mental health issues on resettlement. Interestingly, psychological disorders are often associated with chronic pain (Frasure-Smith and Lespérance 2005), however, this often goes untreated, perhaps because refugees refuse psychological input, fearing a stigma of mental illness (Shannon et al 2015). Fieldnotes obtained at the metropolitan site highlight the way in which some refugees snub the advice of RHNs, as they disagree with their recommendations.

‘One refugee from South Sudan talked about aches and pains in his body, but he has undergone physiotherapy and tests at the hospital and there is no problem. The RHN suggested that perhaps his chronic pain was psycho-somatic and explained what this meant. She advised that she could refer him to a psychologist to talk about his pain, but the refugee could not understand this referral, and so refused. For him, the discomfort was a physical sensation and he felt that the RHN was not listening to him’ (Fieldnotes, 4th June 2017).

In this situation, the refugee rejected the RHN’s proposal of mental health support as he felt adamant that his pain was of a physical nature. This reflects findings from the study by Kaur et al (2020), who investigated the complexities of diagnosing and treating persistent pain in refugees who are survivors of torture. Morris et al (2009 p535) suggest that mental health services are extremely under-utilised by refugees, yet of great need, highlighting that *‘stigma and lack of understanding of what mental health conditions are has made it difficult to serve the refugee population.’*

Remarkably, RHNs reference refugees becoming independent during the resettlement period and rejecting their advice.

‘They disagree with you... and you see them progress with their own lives, making their own decisions, speaking English... They become much more confident... they start arguing with me. They say to me, ‘that’s NOT going to

***work, Pat, I'm not going to do that... So, they're actively identifying the barriers to what I'm recommending- barriers to my recommendations'* (Pat, RHN).**

Keen et al (2019 p391) investigated 'distress experienced by nurses involved with patient refusal' and suggest that 'moral distress may arise when the goals of patient and clinician differ, resulting in frustration from both parties.' In consensus, the case review by Dudzinski and Shannon (2006) captured the potential angst and distress experienced by nurses, resulting from patient refusal of care. With refugees resisting the recommendations of RHNs, 'the contestable nature of dominant forms of knowledge and hegemonic assumptions inherent in nursing representations have been challenged' (Huntington and Gilmour 2001 p904).

Refugees can also be resistant to health promotion advice through the specialised programme, in terms of maintaining a healthy diet and undertaking exercise.

***'I was good, feeling relaxed. But they called- so Ann called me. She called me and told me that I am one of the families that needs extra support for our health, so we're going to come to your home and visit you. So, she's telling me to 'take more care of myself,' but I'm doing some stuff that I like!'* (Lou, refugee).**

This study found that in refugee health nursing, adherence to recommendations involving lifestyle changes such as exercise and healthy diet frequently poses significant difficulties for refugees, perhaps due to cultural differences. As touched upon, although RHNs implement preventative mental and physical health interventions for resettled refugees, Weine (2011) argues that these preventative measures should be tailored to the individual refugee or refugee family, incorporating the ideas and cultural preferences of the refugee. Likewise, in the study by Kumar (2020), refugee participant narratives in the USA articulated health as communal and familial safety, in contrast to the mainstream Western discourse of disease prevention and individual lifestyle choices.

It transpired from the data that some refugees become frustrated with RHNs setting them goals during the resettlement period. With regards to the programme:

***'She puts too many targets for me, she wants me to follow these targets. But I say no'* (Dot, refugee).**

Refugees can be non-compliant with advice offered by RHNs, which mirrors findings by Jansen (2008), who highlights assertiveness in resettled refugees. Indeed, chronically ill patients in the study by Griscti et al (2017 p238) reported that their voices were often unheard by nurses, but they *'were not passive recipients of care and used their agency creatively to resist these discourses.'*

In summary, some refugees use opposition and resistance strategies in refusing support from RHNs or disagreeing with their advice. Significantly, *'nurses are taught how to provide care and promote patient autonomy but are not taught how to negotiate when a patient refuses nursing care'* (Keen et al 2019 p394). Refugees are at liberty to repudiate specialised care, and thus, refugees exercise power, challenging the inherent control of RHNs.

The following section brings theme four to a close, with consideration of the ways in which some refugees recognise the benefits of dedicated healthcare and use negotiation techniques to bargain and extend their care after the one-year resettlement period. In this regard, refugees are seen to exert power through persuasion and manipulation of the community health system.

5.6.3 Sub-theme three: Entitlement and negotiating prolonged access

While some refugees show resistance to specialised healthcare, others understand the advantages of this dedicated service. In terms of refugee power, it surfaced from the findings that because RHNs need refugees to access the service to ensure bureaucratic targets are met, RHNs must gratify refugees, keeping them interested and engaged in the programme. This allows refugees the opportunity to negotiate the terms of their care. In addition, some refugees use the therapeutic intimate relationship with RHNs to influence the health system, continuing to receive targeted healthcare for longer than the first year of resettlement.

RHNs acknowledge the need to keep refugees coming back to their service, to meet targets and secure continued government funding. Interestingly, observational data leads to the assumption that most refugees are unaware of this link. Nevertheless, as one RHN considers:

***'If you don't offer them that individualised service, which is centred around them and their needs, they're not going to come back'* (Pat, RHN).**

Pat (RHN) talks about the need to earn the trust of refugees, challenging the idea that RHNs primarily hold power in this relationship.

***'I have learnt that; one- you have to earn their trust. Don't demand it because you are in that position of, you know, knowing more. Systematically, I'm set up to have power over them. Don't believe that- not with this family, not with refugee clients. They will soon tell you where to go, directly or indirectly! So, I think that respect is one big thing you have to remember. Umm, trust is another thing that you have to build. And trust doesn't come easily; you have to work at it'* (Pat, RHN).**

Dinc and Gastmans (2013 p501) investigated the development of trust in nursing, with regards to *'the imbalances of power in nurse-patient relationships that increase vulnerability and dependency.'* However, it was found in this study, that vulnerability lies deep within nursing practice, as RHNs work hard to win the trust of refugees in their care. If anything, RHNs become dependent on refugees, as they need refugees to continue accessing the service for the one-year duration on resettlement, to meet government targets and show evidence of the programme's effectiveness.

RHNs mention the importance of establishing a good reputation among local refugee communities, to encourage refugees to continue accessing the service.

***'Nothing works until you've got their trust. Because we're quite well-known now in the community, again through the sort of- Chinese whispers, for want of a better way of putting it. Yeh, 'It's ok, she's- she's ok'* (Ann, RHN).**

***'Once they come here, whether you keep them engaged, or whether they want to be engaged, depends very much on how much they trust you, and whether they want to come back'* (Pat, RHN).**

One of the targets for the RHP involves the continuation of care for refugees during the first year of resettlement, and RHNs imply that they must please and indulge refugees to sustain their participation in the programme.

Fieldnotes from the metropolitan site reflect upon this concept.

'The RHN explains that *'she feels a responsibility to provide a service that suits refugees' wishes and keeps them happy, so that they will want to return. She feels pressure to ensure clients come back and use the service, as the organisation has targets to meet, in terms of engagement for the one-year resettlement period'* (Fieldnotes, 1st June 2017).

Interestingly, RHNs need to negotiate the terms of care with refugees, as they are concerned about losing clients.

***'Waiting lists don't work for them, because if they're waiting for six months to be seen by somebody, something else has become a priority. So, it's pretty arrogant of us to make them wait six months. If we're that important, why couldn't we just give them an appointment? Once you do a referral for the client, you've identified how important it is that this client gets this service. And then if you don't give them an appointment, they're not going to come back'* (Pat RHN).**

Pat (RHN) feels that she must make special arrangements for refugees to attend referral appointments promptly, because if there is a long waiting list, the refugee may not attend. Fieldnotes from at the metropolitan site draw attention to the negotiation of care in favour of refugees.

***'The reason the RHN was going to the refugee's home was because the client had previously failed to attend a scheduled appointment at the community health centre, and she would not participate in an appointment unless it was offered in her home'* (Fieldnotes, 9th November 2017).**

This situation highlights the notion that RHNs attempt to compromise with refugees to ensure that they continue accessing support through the RHP. This facilitates refugee power, as refugees hold sway in negotiating the conditions of their care.

Furthermore, a key finding relates to refugees capitalising on the benefits of specialist healthcare. It came to light that some refugees claim power through bargaining and persuasion, with regards to extending their care through the RHP for longer than the one-year resettlement period. Through word of mouth, it is understood among refugee communities that there is wiggle room for prolonged dedicated care,

at the discretion of RHNs. It is interesting to consider that knowledge in which refugees are party to, can have a diminishing effect on RHNs' dominance.

Refugees acknowledge that there are advantages to receiving specialist support, in comparison to attending mainstream community health services. Benefits of receiving specialist nursing care are well documented and outlined by Younge and Norton (2007) and Vidall et al (2011). Bostrum et al (2012) found that specialist nursing care leads to improved physical and psychological symptoms and reduced social isolation for patients, while Santangelo et al (2018) suggest that specialist nurses offer better support and management of care. In the sphere of refugee health nursing, benefits to refugees include longer and more flexible appointment times, efficient referrals with shorter wait lists, continuity of care and consistent access to interpretation services.

It is noteworthy to highlight that some refugees talk about their inability to cope without the support of RHNs, as they become accustomed to receiving their help with a range of everyday matters. In this way, refugees can manipulate the RHP guidelines to receive longer-term specialist care, implying that they would not manage without the care provided by RHNs.

'They always call us to remind us of our appointments, and when to get there, and what time it is, and if we need assistance with the driving- going there, so it's been, yeh, easy. It would be very hard, (without the Refugee Health Nurse), because yeh- it would be very hard. Like- yeh, and because of the interpreting- she organises all of that too, so yeh' (Amy, refugee).

'I don't think I could do it by myself if there is no refugee support here. It's much easier for us, for example- the Refugee Health Nurse, and bi-cultural workers. Sometimes the nurses are going with us to the GP, and supporting, translating, supporting us, helping with the transport and with the language. And also, umm, the nurse just trying to navigate with the doctor and also, trying to refer us in the right way. It's very important, there should be this service. They help us with everything' (Len, refugee).

Refugees become comfortable with the help provided by RHNs during the initial resettlement period, and then cannot fathom how they would manage without this support.

'If we don't look after ourselves and we just lay down at home and stay at home and shut the doors all the time, then we wouldn't be healthy. What keeps us healthy is the fact that we go out, the fact that we're coming to groups here' (Lyn, refugee).

In this way, refugees induce feelings of guilt for RHNs, as it is suggested that the RHP gives them a sense of purpose and this would be taken away if they are discharged from the programme.

'If we keep ourselves at home and keep thinking and worrying, our mental health is getting worse. And we will get the depression and anxiety and we will become isolated. Yeh, the reason we are trying to keep this programme, is to just come and distract ourselves from our minds' (Len, refugee).

Of interest, Mueke (1992) speaks to the polyvocality of refugees on resettlement, coming together as a group to have their voices heard and advocating for shared benefits, and this was evident during focus group discussions in this study.

'The nurses come to my house, to my place, and if they don't have time to come to my place, they come and bring me here (to the community health centre). And for my appointments, for exercise appointments, so physio appointments, they come and pick me up from my house and drop me here and then take me back to my house. It's been like that for all- most of us clients' (Sue, refugee).

Indeed, refugees come to expect this level of help. If refugees are transferred from the RHP into mainstream community health services, there would be limited capacity to support refugees in the same practical manner in ensuring they attend appointments, and therefore, RHNs are somewhat backed into a corner, in terms of the continuation of their care for refugees.

Although emotional closeness and therapeutic intimacy permit feelings of safety and comfort in refugees, some clients can become reliant on the support of RHNs.

‘Basically, I try to make sure that people are not dependent on me, but it’s very easy to do’ (Ann, RHN).

Another RHN draws attention to the notion that sometimes RHNs overcompensate and refugees can become needy with regards to help and advice during the resettlement process.

‘There is that kind of ‘well, she’s a professional, she knows what she’s talking about, I would never question her,’ and so they feel quite comfortable just sort of settling into that- ‘Someone else can make the decision for me’ (Pat, RHN).

In a study by Eldh et al (2006), it was found that patients with chronic heart failure can become dependent on nurse specialists, often leaving decision-making to the nurse, choosing to decline participation, deferring decisions or feeling unable to participate in care processes. Interestingly, it is suggested that traditional paternalistic philosophy has been so dominant in healthcare that patients are accustomed to leaving matters to nurses; *‘some patients relinquish the control over their lives or illnesses to professionals, and they even speak of passivity as a privilege of patients’* (Kettunen et al 2002 p102). In this way, refugees use power to place their dependence on RHNs, avoiding taking responsibility for themselves as this may seem like the easier option.

Another fascinating point, in relation to the power exercised by refugees in negotiating long-term specialist care, relates to the idea that some refugees believe that due to their traumatic experiences and associated health needs, they should be entitled to ongoing targeted support. This is in consensus with findings from the study by Jansen (2008), who talks about refugee assertiveness and the expanded knowledge of entitlements. Jes (refugee) has been living in Australia for two years.

‘We get a lot of support, because of the government. I think the Australian government should keep taking care of their refugees, and we should still get lots of support by the Refugee Health Nurse’ (Jes, refugee).

Along these lines, the sense of entitlement to welfare among refugees during the resettlement period is considered by Ager and Strang (2008).

Significantly, some refugees feel that without the support of RHNs, they would abandon thoughts of health and well-being, with associated problems subsequently arising.

‘Sometimes, people, when they finish the steps with the RHN, it’s like-disconnect... ‘You are fine, you can go, and you can- if you feel not well, you can, like, see your GP.’ At this stage, some people maybe neglect their health. So, it should be more to check about people. A follow-up, yeh. Maybe- every six months. ‘Come again, we want to make sure you are fine, you are doing everything. You are doing, like- your blood tests, the routine checks.’ Yeh, because some people, like, they are not highly educated. They cannot look after themselves’ (Jes refugee).

Some refugees propose that they are not well equipped to manage their own health and well-being and support from mainstream community health services is inadequate; therefore, the RHN should continue to follow-up on refugees to check their progress and offer prolonged support with healthcare. In this way, refugees can pressure RHNs to sustain the benefits of accessing specialist health support. Of note, a study by Woodland et al (2010) recognises that a challenge facing specialised refugee health services in Australia, is linking refugees with mainstream primary care providers after the initial resettlement period.

Many refugees have been living in Victoria for some time, but negotiate longer term access to the specialist refugee health service as they recognise the benefits.

‘Liz organises our problems, our appointments, because we have so much appointments, and we don’t know how to get there, how to talk to them, how to- So Liz is the one who, umm, gets in contact with us, to see where is the referral at, or why we haven’t got an appointment yet at the hospital. For the hospital, she organises for us to go at times that are suitable for us. And she will take us to the appointments’ (Joe, refugee).

‘She helps if we have any appointments at the hospital, for the children at schools, if we need to do something, like talk to the school about something, she’ll support us with the school as well. It’s not easy to do, umm, arrange the

appointments, but when I'm with this organisation, the Refugee Health Nurse, I can feel that they are organising all the stuff for me' (Lou, refugee).

As RHNs are concerned about the well-being of refugees and enjoy the close relationships with clients, oftentimes, refugees can continue accessing the programme after the one-year resettlement process. Somewhat controversially, a study by Kibreab (2004) considered refugees' cavalier attitudes towards rules and the ways in which refugees cheat the system, pulling the wool over the eyes of service providers, in the context of complex, informal institutional constraints. Slightly similarly, in this study, refugees take control of the length of their care and negotiate the system to continue receiving specialist support.

According to Jes (refugee), support from mainstream community health services is insufficient and refugees therefore require a continuous specialist service to meet their health needs.

'I think with this programme, it's more supportive. Because the GP will do what you ask him, and you need to go to him, you need to ask. But when, like, the nurse says, 'We have to do this, and this and this and this.' And you follow those steps, it's sometimes better. I think it's perfect... Because sometimes people are suffering, and they are ashamed to say, 'I'm suffering.' But when someone puts you there and they say, 'You have to do that.' It's better' (Jes, refugee).

Due to cultural differences or lack of understanding of the health system, refugees may not seek help for health concerns, whereas as part of the RHP, refugees proactively attend regular appointments with the RHN, and health matters come to the surface naturally.

Interestingly, it emerged from the findings that some refugees believe mainstream care providers may lack the knowledge of local referral pathways and have limited experience in managing refugee health issues. In comparison with other community health services, one refugee suggests:

'Here, it's more better... 'With this visa, I can refer Jes for this kind of service, and it's free for her.' So, they know that I'm eligible for these services.

But like, if I went to, umm- another medical centre? They don't know that, because of my visa, I'm eligible for this for free' (Jes, refugee).

This is in line with Van Heelsum (2017), who suggests that it can be difficult for nurses to understand the rules, for instance, in terms of which treatments are insured and affordable for patients and which are not.

As opposed to findings from Cheng et al (2015), most refugees in this study feel well supported with their health and well-being during resettlement and are grateful for the help provided by RHNs. One refugee compares the care of RHNs with other nurses.

'She likes her job. You can see the difference between that nurse that just doesn't explain to you, and she's not happy with her job and she just turns around and goes. But with a nurse like Ann, you know- she will sit down and explain slowly to me with that smile, and you can feel that comfort' (Lou, refugee).

In consensus, another refugee explains that RHNs are specifically concerned with the health of refugees and thus, care is more targeted.

'This is a programme that is only thinking about our well-being. Whatever they do, it's about our well-being, so it's good for us, that they try their best to help us only' (Lyn, refugee).

It became apparent from the findings that refugees enjoy feeling special and having experienced past trauma; reveal a sense of entitlement with regards to accessing care that is specifically for them. Some refugees draw attention to the advantages of continuity of care within refugee health nursing, as RHNs gain deeper insight into refugee health needs, in comparison with visiting mainstream community health services.

'It's like, because every appointment, different GP. Not always the same... It is different people, different GPs. But with the nurse, because she has all the files, and she is doing the referrals... So, 'Hello Pat, I need to do this and this, I'm suffering from this.' 'Ok, I'll make an appointment for you' (Jes, refugee).

The emotional attachment some refugees feel towards RHNs can create a dependency on this specialist support and a reluctance to seek help from other service

providers. A refugee explains that she would rather come to see the RHN than talk with another health professional.

'I feel like, this is much better. I feel more comfortable, umm, you know- I like this more... I feel like I am more relaxed, and I don't have to worry a lot, because I have someone, you know, on my back, someone who supports me' (Kat, refugee).

As demonstrated through the discussion of therapeutic intimacy and the development of an emotional closeness within refugee health nursing, a number of refugees use these ties to buy more time within the RHP, in the knowledge that RHNs find it challenging to discharge them from the programme.

Significantly, some refugees want to stay in the RHP and maintain a relationship with RHNs because they become familiar with the easiness of this rapport.

'I just received a letter, and I want to call her to come and read it for me. She explains about my appointments, and- yeh. I like to talk to the nurse because I feel comfortable with her' (Lou, refugee).

RHNs enjoy the meaningful relationships they establish with refugees and are likely to continue the client's care. Jan is a refugee who has been living in Australia for more than one year. With regards to her relationship with the RHN, she says:

'If we know that we have a problem, we know that, we know them personally, so if we get to see them, then why not? Why not share our experiences... we'd all rather share with them than keep it to ourselves' (Jan, refugee).

In practical terms, managers consider the challenges of discharging refugees into mainstream community health services.

'I think it can depend on the client. You know, for more complex clients, that can be a hard transition. Here, it's very flexible, but some services are more structured, and that can be difficult. How do people transition? Look, that is hard, it is hard' (Ali, manager).

Nevertheless, it must be considered that as refugees continue to receive specialist healthcare on a longer-term basis, this may perpetuate the refugee identity and prevent assimilation into the host country society. Daley (2009) reports that refugees

tend to keep within their comfort zones in terms of culture, religion and language and of significance, many refugees do not seek to open themselves to the challenge of integrating into their new community (Strang and Ager 2010). Although beneficial in improving refugee health outcomes, the study by Au et al (2019) identifies that removing refugees from primary care into specialist clinics may pose challenges, such as reliance on specialist services and failure to integrate into Australian society.

In line with this concept, concerns have been expressed about the development of 'parallel lives' in multicultural communities (Cantle 2005). In investigating refugee integration in Canada, Europe and the USA, Donato and Ferris (2020) found that underlying tension and few opportunities for inter-group contact added significantly to cohesion breakdown between refugees and native citizens. Negative public attitudes towards asylum seekers and refugees have become widespread, often linked to and influenced by perceived abuse of the system (Strang and Ager 2010). Gopalkrishnan (2019 p29) considered intercultural interactions in the refugee resettlement environment, highlighting that: *'Where there are distinct cultural groups with differing access to power and resources, members of the majority cultural groups may perceive other cultures as sources of threat, or as disruptive of the norms of society that are set by the majority group.'*

Therefore, while refugees negotiate prolonged specialist healthcare, this might negatively affect the reputation of refugee communities locally. Native citizens may feel perplexed as to why refugees receive special or preferential treatment, with refugees *'being blamed for resource depletion'* (Daley 2009 p168). It may be beneficial from an acculturation and assimilation point of view, for refugees to receive care through mainstream community health services after the initial one-year resettlement period. As Daley (2009 p167) puts forward, *'the more the community blends together and handles problems, the less jealousy and problems.'*

In summary of this sub-theme, it transpired from the findings that refugees recognise the benefits to dedicated healthcare. To this end, in some instances, refugees use the emotional closeness within the nursing relationship as a means of negotiating the continuation of specialist support, taking control over the delivery of their care.

5.6.4 Summary of theme four

As demonstrated in providing context and background for this study in chapter three, the rhetoric in refugee health nursing relates to an inequity of power, with resettled refugees painted as a vulnerable group, predominantly due to traumatic experiences prior to resettlement. Indeed, Henderson (2003) proposes that there is an inherent power imbalance in the dynamic between nurses and patients, with nurses feeling that they are in a position of power (Sepasi et al 2016). Nevertheless, through data analysis and in the interpretation of hidden meanings within refugee health nursing, this study brought to the fore the concept that power is everywhere, circulating between RHNs, managers and refugees and thus, balanced and equalised in nature.

It became apparent that refugees exercise power in the community health landscape, claiming authority through a range of mechanisms and challenging the intrinsic power held by RHNs. Findings of this study contest taken for granted assumptions about power relations in the field of refugee health nursing, and theme four has illustrated how refugees use agency and resistance, as well as negotiation and persuasion, to take control of their healthcare during resettlement. This final theme draws attention to the ways in which refugees hold influence, and how the views and actions of refugees shape their health experiences. Foucault (1980) put forward that power is an all-encompassing force, evident in all aspects of an organisation and exercised by all groups at varying times. This section has brought to light the power of refugees, calling into question their presumed vulnerability and opening the possibility of a change in narrative within the field of refugee health nursing.

5.7 Conclusion

Using a focused ethnographic approach to unpick refugee healthcare in Victoria, Australia, I asked the question, '*What is going on here?*' (Wolcott 1999 p69). Chapter five has presented the findings of this study and through exploration of all four themes, I have offered a comprehensive account of what is going on within refugee health nursing. As an overall finding, I elucidate the ways in which power is found in every aspect of this field in the context of community resettlement.

Refugee health nursing is an underutilised and inconsistently implemented discipline in the community setting, and a byzantine cultural phenomenon. Findings from this study offer a valuable insight into the complexities of this field in the resettlement environment, bringing to the fore various challenges, as well as opportunities for reflection and improvement in clinical practice. In the context of the RHP in Victoria, findings expound that power is an omnipresent energy, fluctuating between RHNs, managers and refugees. Control is in a constant state of movement as power is everywhere, with all parties laying claim to elements of rule and bearing some effect on the way that care is delivered for refugees.

6.1 Chapter Six: Implications for practice, research, education and policy

6.2 Introduction

The result of this study is a thesis that is a call to action for civil society, health leaders, academics, and policy makers to optimise the health and well-being of resettled refugees in high-income host countries. The outputs of this study relate to implications for nursing practice, further research, education and policy, and this section brings together these implications, which are tied into the overarching themes of the findings and discussion.

6.3 Implications for refugee health nursing practice

Dedicated refugee healthcare is beneficial during early resettlement to address specific refugee health issues. However, of paramount importance, this study adds to the refugee health literature advocating for refugee transition into mainstream health services. For refugees who access specialist healthcare, if not discharged into mainstream community health services after the initial resettlement period, there is a risk of dependency upon this level of care and perpetuation of the refugee identity, preventing integration into the host country society. In addition, as RHNs are hesitant to discharge refugees from their care at the end of the one-year resettlement process, this has practical ramifications for their ever-increasing workload.

It is proposed, therefore, that a supported discharge process should be embraced by RHNs and overseen by managers, boosting refugee integration into Australian society through staggered transfer into mainstream community health services. Importantly, managers of refugee health services must work together with RHNs in encouraging the discharge of refugees into mainstream community health services after one year, in line with global health strategies.

Significantly, findings highlight that RHNs believe mainstream community health services are ill-prepared to manage the care of refugees. Thus, RHNs could employ capacity building in the community, helping other health and social care professionals

to gain knowledge and insight into how best to care for resettled refugees after the initial resettlement period; sharing their knowledge, and sharing their workload. In areas with lower levels of refugee resettlement, this study implicates that general community nurses could offer health support for refugees during the resettlement period. This approach would enable a structured approach to proactive healthcare, ensuring a supportive community health environment for newly arrived refugees. This concept relates to 'refugee sensitive' care, as outlined in the discussion of the literature in chapter two, as opposed to 'refugee specific' care, as offered through a specialised refugee health service.

In terms of the specialist refugee care, findings illustrate that RHNs require a deeper level of guidance and managerial input in their practice, to protect their well-being. Perhaps psychotherapeutic clinical supervision may be helpful, as outlined by Loewenthal (2019), in relation to healthcare staff on the frontline, encouraging well-being in nursing and willingness to remain in the profession. To cope with the effects of therapeutic intimate relationships with refugees, RHNs require ongoing emotional, psychological and educational support, as they continue to build their knowledge and skills in managing sensitive refugee health issues and deal with symptoms of compassion fatigue and secondary trauma. RHNs should be made aware of formal and informal support that is available to them, and further research into other areas to ameliorate vicarious trauma is recommended. Michalec et al (2013 p319) talk about the '*calm before the storm*' in recognising symptoms of emotional exhaustion and compassion fatigue, and it is suggested that in refugee health nursing, steps should be taken now to address these symptoms before the storm takes hold.

RHNs are nurses, gatekeepers, street-level bureaucrats and political activists who are pioneering an underutilised field of clinical practice, but most importantly, they are human beings who are doing their best to help refugees. As this role continues to take shape, there is a need for further refinement in defining the scope of practice, and perhaps RHNs require more nurture and practical guidance in balancing the health and well-being of refugees, with that of their own.

6.4 Implications for further research

With regards to further research, it may be interesting to consider a pilot study of the RHP model in the Scottish resettlement context, offering targeted healthcare for newly arrived refugees and evaluating this initiative at the end of one year. It is worthwhile to consider how the RHP model may function in different countries around the world, depending on tax funded or insurance funded systems and this could be an area for further investigation.

6.5 Implications for nursing education

As global migration continues to rise, this bears consequences on health systems within refugee host countries, and healthcare professionals must be educated about the complexities of refugee health (Abubakar et al 2018). This study proposes that it is imperative for refugee health to become an essential element of the nursing curriculum in higher education. As alluded to previously, in Victoria, Australia, refugee health is a core part of the undergraduate nursing curriculum across a range of universities, with nursing student placements offered in community health centres offering the RHP and in hospitals with Refugee Health Nurse Liaisons. Postgraduate diploma and Master of Science courses are available in Refugee Health Nursing across Australian universities, setting the precedent for nursing education in other high-income countries hosting resettled refugee populations.

6.6 Implications for refugee health policy

With regards to refugee health policy in Victoria, Australia, although RHP eligibility criteria specifies that the service is aimed at refugees with complex health needs (Appendix 2), RHNs are bending the rules to allow all newly arrived refugees to participate. It is suggested here that this may actually be an effective strategy, as complex health needs are often not evident on initial assessment. Indeed, as highlighted in the literature review, refugees continue to face barriers in accessing health services on arrival, and many refugee health issues develop or become evident

during the first year of resettlement. For this reason, this study recommends that, where possible, policy makers in high-income host countries should consider the incorporation of specialised healthcare for all newly arrived refugees during the first year of resettlement, regardless of health status on arrival.

Moreover, part of the rationale for undertaking this study included consideration of the transferability of the RHP to other resettlement contexts, such as areas in Scotland with high numbers of newly arrived refugees. This study therefore has implications for refugee healthcare policy in Scotland, and the following section offers insight into the evidence base underpinning these recommendations. In pondering the transferability of the RHP, I consider current provision of healthcare for resettled refugees in Scotland, offering an overview of resettlement in this country and the evidence underpinning a call for innovation in managing refugee health.

As a Scottish registered nurse, I am passionate about improving the health and well-being of refugees who settle in this country, promoting positive health experiences and ensuring that refugees are supported to thrive in their new environment. Through exploring the RHP in Victoria, Australia, this may lead to the adoption of a similar model in other resettlement host countries, such as Scotland. It is therefore appropriate to consider the Scottish resettlement context and offer some background to current health support provided for newly arrived refugees in this setting.

The NHS Scotland *'2020 Vision: Achieving Sustainable Quality in Scotland's Healthcare'* sets out the need for a healthcare system with integrated health and social care, a focus on prevention, anticipation, supported self-management and reduction in health inequalities (NHS Scotland 2020). A focus of this 2020 Vision is aimed at improving healthcare for refugees in Scotland, tackling health inequalities in this population and offering improved service delivery to better support newly arrived refugees, in line with global strategy recommendations (UNHCR 2018; WHO 2016; 2018). In recent years, Scotland has accepted an influx of newly arrived refugees from around the world, and the refugee population in this country is likely to continue to grow.

6.6.1 Refugee resettlement in Scotland

Scotland has a long history of welcoming refugees from across the world, as outlined by Wong's (2019) detailed account. In 1985, the Scottish Refugee Council was established in Edinburgh, with the help of the British Refugee Council and Refugee Action, in response to a growing need for refugee assistance; moving to Glasgow in 1999 as this became a primary dispersal area (Wong 2019).

In the 2010s, Syrian refugees started arriving in Scotland, fleeing the ongoing conflict. In 2013, the New Scots programme for 2014-2017 was developed, mainly accommodating refugees from the Middle East and North Africa (Scottish Government 2017). In the past decade, there has been an increase of arrivals settling in other parts of Scotland, such as many Congolese in South Lanarkshire, and Syrian refugees dispersed across all local authorities (Scottish Government 2017).

In September 2015, Scotland committed to supporting people affected and displaced by the civil war in Syria, introducing the Syrian Vulnerable Persons Resettlement Scheme (VPRS) (Scottish Government 2018). The UK pledged to host 20,000 Syrian refugees and the Scottish Government offered to accept at least ten per cent, proportionate to Scotland's population within the UK (Scottish Refugee Council 2020a). In 2017, the Syrian VPRS was stretched to include people of other nationalities who are displaced by the Syrian conflict (Scottish Government 2018). Since then, the Scottish Refugee Council (2020) reports that refugees have continued to settle in Scotland and by March 2020, 3,569 refugees had arrived in this country across all 32 local authority areas; representing 16% of the total (21,833) resettled to the UK under these schemes.

It is noteworthy to mention that with the complexities of the global covid-19 pandemic, refugee resettlement in the UK was temporarily on hold from March 2020 but resumed in December 2020 (House of Commons 2021). The VPRS had an overall target to resettle 20,000 refugees and 19,768 had been resettled by March 2020, with the remaining small number of people entering the UK through the scheme in early 2021 (House of Commons 2021).

The UK Government has reiterated its commitment to the resettlement of refugees after 2020. A new scheme will consolidate the VPRS, the Vulnerable Children's Resettlement Scheme and the Gateway Protection Programme into one

global scheme; called the UK Resettlement Scheme (UKRS) (Scottish Refugee Council 2020a). As with previous schemes, the UKRS will prioritise the most vulnerable refugees, and there are plans for it to take shape in wider geographical areas than previous schemes. Through the UKRS, the UK aims to resettle approximately 5,000 of the world's most vulnerable people in the first year, and Scottish local authorities have offered to continue taking part (Scottish Refugee Council 2020a).

With an ever-increasing number of newly arrived refugees in Scotland, it is important to consider the provision of healthcare for this population.

6.6.2 Current provision of healthcare for refugees in Scotland

NHS Scotland provides health services for all refugees and asylum seekers, including people whose claim for asylum has been refused, on the same basis as anyone legally resident in Scotland. With regards to healthcare for newly arrived refugees, *'refugees and asylum seekers living in Scotland are entitled to register with a GP, to access emergency health services, to register with a dentist and to have eye tests. They can access specialist healthcare, as any other patient can, often through a GP referral. This includes maternity care, mental health services and any other services for specific conditions'* (Scottish Government 2018). While universal healthcare in Scotland is to be commended, as opposed to Victoria, Australia, there is no targeted refugee health service for new arrivals with complex health needs.

Significantly, as an area with high dispersal of refugees, some specialist health care services have developed in Glasgow over the last 15 years to meet the psychological needs of refugees and asylum seekers, including the Compass Mental Health Team, which is now the Glasgow Psychological Trauma Service and the Asylum Health Bridging Team within Greater Glasgow and Clyde Health Board. The Asylum Health Bridging Team offers an initial health assessment for newly arrived asylum seekers and a nurse-led daily drop-in service for asylum seekers. Of note, NHS Scotland and other agencies, such as the Mental Health Foundation and Rape Crisis, work alongside the Scottish Refugee Council in identifying opportunities to meet urgent mental health needs of refugees and asylum seekers. However, there is a lack

of systematic approach in proactively supporting refugees with their holistic health needs when they settle in Scotland.

Of relevance, the '*New Scots Refugee Integration Strategy 2018-2022*' highlights the importance of resettled refugees being able to access well-coordinated health and social care services (Scottish Government 2018). It is interesting to note that, according to this strategy, '*although refugees may have vulnerabilities, they are also resilient*' (Scottish Government 2018). When refugees arrive in Scotland and other parts of the UK, the advice is to offer refugees '*the same basic new patient check as for all registering patients*' (Public Health England 2019). Nevertheless, it is acknowledged that in addition to typical new patient health checks, refugee patients '*may have additional health care needs, stemming from their life experiences prior to migration, circumstances of their migration, circumstances in which they are living in the UK*' (Public Health England 2019). This being said, there is not a national strategy to guide the assessment and provision of community healthcare for newly arrived refugees in Scotland.

As a result of current practice, during the resettlement period in Scotland, '*some refugees and asylum seekers continue to face barriers to accessing services for a range of reasons*' (Scottish Government 2018). Interestingly, a Scottish Public Health Network Report based on a study about refugee integration in Scotland, highlights that while refugees may not have a large impact on healthcare systems in Scotland, '*one reason for this may be a lack of insight or understanding of how the healthcare system in Scotland works*' (McCann and Mackie 2016 p18). This report states that new arrivals in Scotland with immediate health issues or long-term support needs face delays in accessing appropriate services and suggests that complex refugee health needs are often unidentified during the resettlement process (McCann and Mackie 2016). The report found that several refugee families experience problems registering with GP practices because interpreters are not provided to complete registration forms and highlights that, '*many new arrivals have little knowledge or understanding about how the health system in Scotland works*' and '*families require more information not only about where to go, but also about how to engage with health services and expectations around timescales of referrals*' (McCann and Mackie 2016 p68).

In agreement, according to a British Red Cross Research Report on Integration Experiences in Glasgow and West of Scotland, most newly arrived refugees did not report immediate health issues, however, health concerns developed throughout the resettlement period, often due to the situations they were fleeing (Marsden and Harris 2015). For some refugees, long-term conditions were exacerbated by the new environment and in others, new conditions developed after arrival (Marsden and Harris 2015). According to an evaluation from Argyll and Bute Council in 2019, many refugees are in poor health when they arrive in Scotland and some resettled refugees report dissatisfaction with healthcare provided during the resettlement period (Argyll and Bute Council 2019). Indeed, recommendations from the Scottish Public Health Network Report on refugee integration in Scotland portray that Scottish NHS Health Boards with a high prevalence of resettlement should '*provide specialist therapeutic support to refugees*' (McCann and Mackie 2016 p19).

Of interest, the Scottish Refugee Council (2020b) undertook a mixed methods study during 2019-2020, investigating refugee experiences and integration in Scotland. One of the key findings elucidated that, '*Playing too much on Scotland being welcoming can backfire as it glosses over problems and inequalities and encourages people to feel "everything is alright" when it often is not*' (Scottish Refugee Council 2020b p26). Indeed, this study simply states that, '*there is work to be done*' (Scottish Refugee Council 2020b p26).

6.6.3 Policy and practice directives for improving care of refugees in Scotland

With regards to the future of refugee healthcare in Scotland, recommendations for practice have been outlined by the British Red Cross (Marsden and Harris 2015), Scottish Public Health Network (McCann and Mackie 2016), UNHCR UK (Nelson and Saltmarsh 2017) and the Scottish Government, through the '*New Scots Refugee Integration Strategy 2018-2022*' (Scottish Government 2018).

The Scottish Public Health Network recommends that, with regards to newly arrived refugees in Scotland, '*a nationally developed health needs assessment template may need to be developed to allow consistency*' (McCann and Mackie 2016 p15). Moreover, a recent UNHCR study of the Resettlement Scheme in Scotland found that more targeted support in language and healthcare would assist refugee

integration and well-being (Nelson and Saltmarsh 2017). According to the Scottish Refugee Council, it is *'crucial that there is a joined-up approach beyond just welcoming these people, who often have complex needs, to make sure that their rights and needs are met and that they can rebuild their lives here to their benefit and the benefit of Scotland'* (Scottish Refugee Council 2017).

In the New Scots: Integrating Refugees in Scotland's Communities Final Report (Scottish Government 2017), it was proposed that, *'access to good quality healthcare is important for people who may arrive in Scotland with physical or mental health needs associated with the reasons they were forced to resettle in Scotland. This includes gender-based violence, sexual violence, torture and other degrading treatment.'* Importantly, the New Scots integration strategy recognised the need to improve resources available in addressing the health needs of refugees (Scottish Government 2017). Interestingly, however, the Scottish Refugee Council (2020b p26) highlighted that *'New Scots' is a positive and welcomed concept – but some tend to focus on 'New Scots' "fitting in" and assimilating rather than bringing their own diversity and experience to Scotland.'* Therefore, health initiatives are required which take into account the variety of health beliefs and cultures of refugees in Scotland, allowing people the opportunity to thrive in their health and well-being.

As plans evolve for continued refugee resettlement in Scotland, the Scottish Government has addressed the health needs of refugees through the New Scots Refugee Integration Strategy 2018-2022 (Scottish Government 2018). The key objective of the Strategy is that *'refugees and asylum seekers, who use health and social care services, have positive experiences of those services, and have their dignity respected and that services are more responsive to the needs of refugees and asylum seekers... This includes access to specialist services, as well as broader health and well-being support available through public services and the third sector'* (Scottish Government 2018).

The Scottish Public Health Network offers health recommendations for all NHS Boards in Scotland, outlining that, *'NHS Health Boards should establish a 'single point of contact' with an understanding of the refugee journey, to enable prompt and smooth registration with health services for new arrivals, early identification of health issues or*

long-term support needs to ensure they are linked into appropriate services as soon as possible, and efficient interpreting support (McCann and Mackie 2016 p69).

The New Scots Evaluation Report '*highlights the lack of a systematic approach*' to current healthcare provision for newly arrived refugees in Scotland and recommends that a more structured and targeted approach to care during the resettlement period is needed in areas with high numbers of newly arrived refugees (Scottish Government 2017). The Scottish Government acknowledges that Scotland is increasingly a destination for refugees and this trend is likely to continue (Scottish Government 2018; Scottish Refugee Council 2020). Therefore, scaling up action to address refugee health needs is an inevitable and far-sighted strategy for this host country, to safeguard refugee health and well-being during the resettlement process (WHO 2018; 2019). The RHP in Victoria, Australia, emerged in response to the needs of local communities, and as a country with areas of increasing refugee resettlement; Scotland should be ready to better respond to the needs of refugees.

6.7 Contribution to knowledge: Principles for refugee healthcare provision

This section makes clear my contribution to knowledge in the field of refugee health nursing, based on the findings of this study. The following principles may be applied in offering targeted refugee healthcare during the first year of resettlement in high-income host countries:

- In areas of high volume refugee resettlement, a specialised nurse-led refugee health service is recommended, coordinated by specialist RHNs ('refugee specific' care).
- In areas with lower volume or intermittent refugee resettlement, proactive refugee healthcare can be provided by community nurses, with training in cultural competence and refugee health needs ('refugee sensitive' care).
- During the first year of resettlement, community health appointments with refugees should be scheduled to last approximately 30 minutes to one hour, with the assistance of an accredited translator, as required.

- Appointments with newly arrived refugees should be made within one month of arrival, after three months, six months and twelve months, as a minimum requirement.
- Some refugees may refuse targeted health support initially, but contact details for the RHN or community nurse may be offered to the refugee on arrival in the host country, with the option to receive support later in the one year resettlement period.
- During appointments, nurses caring for refugees can offer health assessment and early intervention, disease management and referral pathways, health promotion and education, and orientation of the health system, improving access to primary care.
- At the end of the one year resettlement process, the RHN should facilitate transition of the refugee into mainstream community health services. The community nurse allows the refugee to make appointments with primary care as required.
- Nurses caring for refugee groups require ongoing emotional and psychological support to deal with complex and sensitive refugee health issues. Access to peer-debriefing, counselling or psychotherapeutic clinical supervision is suggested to cope with vicarious trauma, protect nurse well-being and retain this workforce.
- Although RHNs are autonomous practitioners, managers of specialist refugee health services should have oversight of the nursing workload and monitor the transition of refugees into mainstream community health services, offering professional support for RHNs.

6.8 Conclusion

As demonstrated, this study has important implications for refugee health nursing practice and education, as well as further research and policy in the refugee resettlement context.

7.1 Chapter Seven: Thesis Conclusion

All in all, this study sheds light on a field of nursing practice that is relatively unexplored and inconsistently implemented in high-income host countries, offering discussion of real-life accounts and stimulating further debate about the incorporation of specialised healthcare for resettled refugees. Evidence from this study can contribute to synergistic and equitable refugee health policies within high-income host countries, with a feasible strategy to inform and inspire action by policy makers and nurses.

International agreements, such as the UN Global Compact on Refugees (UNHCR 2018), represent an opportunity to ensure that international solidarity, unity of intent, and our shared humanity triumphs over nationalist and exclusionary policies, leading to concrete actions to protect the health and well-being of resettled refugees. Of particular importance, the WHO Report (2018) suggests that displacement, migration and the resettlement process in a host country can negatively influence the health status of refugees. Therefore, commitments to the health of resettled refugee populations should be considered across all Sustainable Development Goals (Tulloch et al 2016). High-income host countries should act now in developing sustainable, targeted pathways for refugee healthcare. To achieve this aim, RHNs are well placed to offer dedicated, culturally competent care for refugees, optimising health and well-being during the resettlement period and contributing to a reality of good health for all.

This study aimed to explore the views of RHNs, managers and refugees within refugee health nursing in Victoria, Australia, gaining insight into social and professional relationships and the complexities of offering a specialised health service for refugees. The rationale behind this study related to the paucity in literature with regards to what is known about refugee health nursing in the resettlement context, with a view to considering whether this service may be an effective model of care for refugees who resettle in other parts of the world. Indeed, Halabi (2005) called for more qualitative approaches in nursing which explore the health experiences of refugees, and this study has answered that call.

By adopting a focused ethnographic approach to enquiry, I was able to gain insight into the views and experiences of those involved in the RHP in Victoria, Australia. Through interviews, focus groups and observation of everyday nursing practice, I

immersed myself in the culture of refugee health nursing. I perceived this field as a social construct produced through ongoing interaction between participants, leading to their interpretation of specialised refugee healthcare and purposeful action.

I began by offering an overview of literature in the field of refugee healthcare in the resettlement environment, pointing towards the debate that is evident in current practice and research, with regards to improvements in care for resettled refugees through either 'refugee sensitive' or 'refugee specific approaches. One example of a 'refugee specific' approach takes shape in Victoria, Australia, with the RHP offering specialised community healthcare for refugees during the first year of resettlement.

A focused ethnographic approach incorporated semi-structured interviews with five RHNs, two managers and eight refugees, two focus groups with refugees and participant observation within the RHP between April 2017 and December 2017. Data collection was undertaken across two community health centres in Victoria; one metropolitan site and one rural/regional site, and interviews and observations were transcribed and thematically analysed.

The literature posits a taken for granted supposition about power dynamics in refugee health nursing, with an imbalance of power; refugees a vulnerable, passive and needy group (Nies et al 2016), while specialist nurses are powerful in their autonomous, professional position (Hewison 1995). Nonetheless, as Sakalys (2000 p1474) notes, '*we need to recognise that no single narrative possesses privileged claim to authenticity.*' Taking a social constructionist standpoint and investigating refugee health nursing through a traditional SI lens, I questioned these assumptions. Through deep exploration and insightful data analysis, the overall outcome of this study relates to the concept of power as an omnipresent and wavering force. Power is exercised by all actors within refugee health nursing, and while power in this context is fragile; it is shared between RHNs, managers and refugees, with all parties laying claim to some element of control.

Findings from this study highlight the powerful role of RHNs, acting as coordinators and gatekeepers of refugee healthcare. With the relative novelty of this speciality within the global resettlement context, due to its underutilisation in host countries, RHNs in Victoria, Australia operate as street-level bureaucrats, with

managers allowing autonomy in decision-making and RHNs subsequently taking liberty in bending the rules to meet the needs of refugees. However, as discussed in the findings, the decisions and actions of RHNs as street-level bureaucrats can lead to an intense workload, with demand for their service outweighing supply.

The reality of refugee health nursing sees power not only in the hands of RHNs but circulating between other actors. Managers exert power through their insistence on RHNs meeting targets and adhering to employee responsibilities, putting in place measures which mean that the work of RHNs is under surveillance (Foucault 1977). RHNs move between threads of power in their everyday practice, contending with the task of appeasing bureaucratic structures to sustain their employment, while struggling to maintain professional boundaries with refugees. Findings uncovered the inherent vulnerabilities evident within this role, as RHNs are faced with continual exposure to vicarious trauma and the risk of burnout.

According to Foucault (1980), power relations cannot exist unless there is resistance. The presumed vulnerability of refugees is called into question, with refugees seen to be resilient, exercising power in the form of resistance and negotiation strategies; making known their demands and taking control of the way that care is delivered. This study therefore challenges suppositions about refugees in the resettlement environment and portrays this group in an assertive light.

Interestingly, Foucault (1980) stressed the devolved nature of power, suggesting that power is relational and ebbs and flows within social relationships. The concept of ubiquitous and vacillating power, as put forward by Foucault (1980), was used to frame and support discussion of the findings, offering a valuable insight into the intricacies of refugee health nursing as a controversial phenomenon in contemporary practice, and the ambivalent nature of the nurse/refugee relationship. Power is a substance that flows fluidly between all actors, depending on the situation or opportunities which arise in the context of the RHP. As opposed to the prevailing discourse in the literature, which views refugees as vulnerable and specialist nurses as influential and commanding, this study brings to light the fluctuating and global nature of power within refugee health nursing.

7.2 Returning to research aim and questions

In concluding this thesis, it is appropriate to return to the research aim and questions highlighted in section 4.3. The overall aim of the study was: ***'To gain an understanding of perspectives and experiences of refugee health nursing in Victoria, Australia.'*** To meet the research aim, overarching research questions were formed:

- *'What is the impact of specialised refugee healthcare in the community setting?'*
- *'How should care be offered for newly arrived refugees in high-income host countries?'*

By exploring perspectives and experiences, I aimed to understand the health needs of refugees and the impact of a specialised refugee health service in the community resettlement context, in terms of how this service influences the lives of refugees, RHNs and managers and whether specialised care is beneficial in the community.

Findings of this study demonstrate the positive impact of targeted healthcare for resettled refugees. Most refugees feel supported and allude to the culturally competent care provided by RHNs. They receive health promotion and education to help acclimatise to the host country environment, early detection and intervention in health issues and thorough orientation of the health system, with guidance on making primary care appointments and calling an ambulance using telephone interpretation services, for example. Refugees develop trusting relationships with RHNs through continuity of care during the resettlement period, allowing the disclosure of health problems and discussion of sensitive topics. Although some refugees do not feel the need for specialised healthcare on arrival in Australia, most refugees recognise the benefits of this service later in the resettlement period. Refugees in this study enjoy the support offered by RHNs, reporting positive health experiences as a result of accessing the RHP.

However, without transition into mainstream health services after initial resettlement, the impact of prolonged specialist refugee healthcare can perpetuate the

refugee identity. Some refugees in this study remain dependent on the RHN, accessing specialist support for many years. This has a detrimental impact on refugees, with regards to integration into Australian society and empowerment to manage their own health and well-being. Specialist refugee health support should therefore be limited to the first year of resettlement, in line with global health policy.

In terms of the impact of refugee health nursing on nurses, working within a nurse-led specialised refugee health service has a profound impact on the nursing workforce. With exposure to sensitive or distressing information on a regular basis, RHNs experience vicarious trauma and symptoms of compassion fatigue. RHNs enjoy the autonomy afforded to them but struggle with a heavy workload and are hesitant to ask managers for help, as managers lack a clinical background. RHNs are reluctant to discharge refugees into mainstream health services, with concern about whether other health professionals are equipped to care for refugee groups. RHNs report feeling tired, as they are in a perpetual cycle of accepting refugees into the service, without discharges. They carry a burden of responsibility in the perceived duty of care to provide support for all refugees in the community, leading to potential burnout.

The impact of this service on broader nursing practice means that general community nurses are somewhat deprived of the opportunity to support refugees with healthcare needs. This study proposes that if RHNs discharge refugees into mainstream community health services after one year, general community nurses will have more exposure to refugee groups, with potential to develop knowledge and expertise through capacity building and experience.

Based on findings of this study, the impact of a specialist refugee service on managers is minimal, with RHNs coordinating operational processes on the frontline. With competing responsibilities, managers do not take an active role in the RHP, delegating responsibility for the coordination of the service to RHNs. However, findings suggest that RHNs would benefit from more managerial input, with regards to improved oversight of the service and monitoring of refugee discharge into mainstream community healthcare. Managers lack insight into the emotional and psychological needs of RHNs, and going forward, managers of a specialist refugee health service should facilitate improved access to formal and informal support for nurses, safeguarding the well-being of this workforce.

As well as the impact on refugees, RHNs and managers, the nurse-led refugee health service also bears impact on the broader community context.

The State-Wide Facilitator of the RHP suggests that specialised refugee health services lead to less frequent attendances at accident and emergency departments and more refined care pathways, as refugees develop a sound understanding of how to access primary healthcare. This study corroborates this concept, as through proactive appointments with the RHN and orientation of the health system, findings show that refugees understand how to seek healthcare from the appropriate avenues and feel supported with their health in the community.

However, specialised refugee healthcare is a controversial topic in the wider Australian community, with RHNs suggesting that refugee resettlement is not well regarded in some local areas, with some citizens voicing dissatisfaction with preferential treatment for refugee groups. The impact of a refugee health service is therefore a contentious issue in the broader community context. This study suggests that if RHNs discharge refugees into mainstream services in a timely manner, this may alleviate some of the tension, supporting refugee integration into the community by encouraging them to access the same level of healthcare as the host population.

In answering the research aim and questions, I have gained an understanding of perspectives and experiences of a nurse-led refugee health service. This knowledge will help to improve current nursing practice in Victoria, Australia, as well as to guide positive change in offering effective health support for newly arrived refugees in other resettlement environments globally.

Based on the findings, this study recommends that high-income host countries with areas of high refugee resettlement may consider providing a specialised refugee health service for newly arrived refugees, for the duration of the first year of resettlement. The literature highlights this approach as 'refugee specific' care, as outlined in chapter two.

In the instance of resettlement contexts with lower numbers of newly arrived refugees; targeted, proactive health support could be provided by general community nurses. Appointments may be made with refugees during the first year of resettlement to orientate people to the health system and undertake health assessment, ensuring

prompt identification and management of physical or mental health problems. This 'refugee sensitive' approach to care is advocated in high-income country host environments with lower volume of refugee resettlement.

The impact of structured, targeted healthcare for newly arrived refugees has an overall positive impact on the health and well-being of refugee groups and specialist nurses enjoy working in this field. In line with RHP policy in Victoria, Australia, this study recommends that proactive appointments be made with all newly arrived refugees in high-income host countries within one month of arrival, after three months, six months and twelve months, ensuring a supportive community healthcare environment and positive health experiences for resettled refugees.

This section has outlined how I met the aim of this study, through exploring experiences and perspectives of refugee health nursing. My research questions have been answered through discussion of the impact of targeted refugee healthcare on refugees, RHNs and managers, as well as the wider community context. Having considered the impact of a nurse-led refugee health service, this thesis has outlined recommendations for the care of resettled refugees in high-income host countries. While a specialised refugee health service may be beneficial in contexts with high numbers of newly arrived refugees, there is potential for community nurses to offer proactive health support for refugees at incremental stages of the one year resettlement process.

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Appendix 1: Literature Search Strategy

Phase	Literature Search Activity
Identification	<ul style="list-style-type: none"> • Initial search strategy in 2015 generated 73 articles. • Search term inclusion: refugee health, refugee healthcare, refugee health nursing, refugee resettlement, community nursing; specialist nurses • 9 research articles located from searching reference lists. • Total number of research articles identified in 2015: 82.
Identification	<ul style="list-style-type: none"> • Second search strategy in 2019 generated a further 47 articles. • Search term inclusion: refugee health, refugee healthcare, refugee health nursing, refugee resettlement, community nursing; specialist nurses • 3 articles located from searching reference lists. • Total number of research articles identified in 2019: 50. • Total number of research articles identified through searching the literature: 132.
Identification	<ul style="list-style-type: none"> • Search for global reports and guidelines in the field of refugee healthcare in the resettlement context (2019). • Search term inclusion: World Health Organisation refugee health and resettlement; United Nations High Commissioner for Refugees health and resettlement • 16 reports and guidelines generated.
Screening	<ul style="list-style-type: none"> • 16 duplicate research articles removed based on title or abstract. • Total number of research articles after screening: (132 – 16): 116.

Eligibility	<ul style="list-style-type: none"> • Of the screened research articles (116), 31 of these were excluded. • (4 articles were excluded as not in English, 15 articles were not relevant to this study and 12 studies were kept back to support findings and discussion). • Total number of research articles eligible for inclusion in literature review: 85
Eligibility	<ul style="list-style-type: none"> • Of the reports and guidelines (16), 8 were excluded, due to irrelevance to the high-income country refugee resettlement context, or irrelevance to refugee health. • Total number of reports and guidelines eligible for inclusion in literature review: 8
Included	<ul style="list-style-type: none"> • Total number of research articles included across literature searches spanning 2015 and 2019: 85. (37 mixed methods research studies, 18 systematic reviews and 30 qualitative research studies) • Total number of reports and guidelines included from literature search in 2019: 8. (5 from the WHO, 1 from the UNHCR, 1 from the United Nations General Assembly and 1 from the UCL Lancet Commission on Migration and Health).
Included	<ul style="list-style-type: none"> • Total number of records included in literature review, including research articles and reports and guidelines from literature searches undertaken in 2015 and 2019: 93 (85+8).

Appendix 2: Refugee Health Program Eligibility Criteria

Eligibility Criteria:	<p>People who are from a refugee or asylum seeker background (including those on the HSS, and Asylum Seeker programs) and who have/are:</p> <ul style="list-style-type: none">• a health undertaking• complex medical needs including asthma, epilepsy and diabetes• complex mental health issues• pregnant women• a disability• families with children
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Appendix 3: Interview Guide for Refugee Participants: Example Questions

Original interview questions	Revised interview questions
<ul style="list-style-type: none"> • How are you finding the experience of resettlement in Australia? 	<ul style="list-style-type: none"> • How is life here in Australia?
<ul style="list-style-type: none"> • In what ways have you found resettlement in Australia challenging, and has the Refugee Health Program been beneficial? 	<ul style="list-style-type: none"> • What have been the challenges? Is this service helpful?
<ul style="list-style-type: none"> • How do you feel your health has been since arriving in Australia? 	<ul style="list-style-type: none"> • How is your health?
<ul style="list-style-type: none"> • Do you notice any improvement in your health with taking part in the Refugee Health Program? 	<ul style="list-style-type: none"> • Are you feeling better, with help from the nurse?
<ul style="list-style-type: none"> • What kinds of things does the nurse do for you? 	<ul style="list-style-type: none"> • How does the nurse help you?
<ul style="list-style-type: none"> • Thinking about your integration into Australian society, how do you feel having a specialised health service for refugees influences this? Do you think that it's a good idea to have separate health support for refugees? 	<ul style="list-style-type: none"> • Do you think that this service is good for refugees?
<ul style="list-style-type: none"> • How do you feel about your discharge from the Refugee Health Program at the end of the first year of your resettlement? 	<ul style="list-style-type: none"> • How do you feel about leaving this service, and visiting the GP instead?

2. Thinking about the last month, how much did health problems stop you from doing your usual activities? For example, moving around, going to work or school, or doing things that you would like to do). Please circle one.

- Not at all
- Rarely
- Some of the time
- A lot of the time

2.b In the last month how much did health issues stop each of your children from doing their usual activities?

List of children (<i>child 1, child 2, etc.</i> – <i>in order of age</i>)	Not at all	Rarely	Some of the time	A lot of the time

3. Thinking about your own health, do you know the things that you can do to manage your health needs?

Yes, I am confident managing this

I partly know what I can do

No, I'm not sure what to do

3.b For each of your children, do you know the things that you / they can do to manage their health needs?

List of children (<i>child 1, child 2, etc.</i> – <i>in order of age</i>)	Yes, I am confident managing this	I partly know what I can do	No, I'm not sure what I can do

4. I would like to understand how much you know about how to get medical help if you need.

Do you know:	Yes, I am confident with this	I partly know	No, I am not sure what to do
How and when to call an ambulance			
How/ when to use a Medicare card			
How to make or cancel an appointment with the GP			
How to access a medical specialist or allied health (e.g. physiotherapist, occupational therapist)			

5. Since first coming to this organisation, are there things that you do differently now in your daily life, to support your / your family's health? (*For example, might be diet, lifestyle.*)

Yes

No

5.b Record any changes the client describes:

6. The Refugee Health team has referred you to (*write number here*): _____

(health related) services (*internal and external*). The next questions are about how these services have been for you.

Referrals made (<i>list the referrals below, prior to the review meeting</i>)	Client has attended	Client has not attended	Client has not yet attended <i>e.g. on waiting list</i>	How happy were you with the service received?
				Happy It was just OK Not happy
				Happy It was just OK Not happy
				Happy It was just OK Not happy
				Happy It was just OK Not happy
				Happy It was just OK Not happy
				Happy It was just OK Not happy
				Happy It was just OK Not happy
				Happy It was just OK Not happy
				Happy It was just OK Not happy

7. The next section is to understand how you feel about your ability to deal with difficult things. There are ten statements, I would like you to rate each one as 'not at all true; 'hardly true'; 'moderately true'; or 'exactly true'.

Statement	Not at all true (1)	Hardly true (2)	Moderately True (3)	Exactly True (4)
I can always manage to solve difficult problems if I try.				

If someone challenges me, I can find the means and ways to get what I want.				
It is easy for me to stick to my aims and achieve my goals.				
I am confident that I could deal successfully with unexpected events.				
Thanks to my resourcefulness, I know how to handle unforeseen situations				
I can solve most problems if I make the necessary effort.				
I can remain calm when facing difficulties because I can rely on my coping abilities.				
When I face a problem, I can usually find several solutions.				
If I am in trouble, I can usually think of a solution.				

I can usually handle whatever comes my way.				
---	--	--	--	--

LIVING IN THIS COMMUNITY The next questions are about being here in Australia, and how easy it is for you to understand how things work so that you can get what you need for you and your family.

8. How confident are you to access services within the health system?

- Very Confident
- Confident
- A little
- Not at all

9. How confident are you to access services within other systems (for which this organisation supported them e.g. housing, education, employment/ Centrelink)?

- Very Confident
- Confident
- A little
- Not at all

10. Thinking about when you need something for you or your family, how easy is it for you to know where to go and what to do?

- It's fine for me now
- It's OK, I am getting familiar with it
- It's quite hard, I need someone to help know what to do
- Very difficult, I don't understand how things work

11. How confident are you to express your wishes to or ask questions of people such as doctors, nurses and teachers in Australia?

I am confident to do this:

- All the time
- Most of the time
- Sometimes
- Never

12. Nurse assessment: based on your observations, does this client demonstrate a basic knowledge of rights and citizenship in Australia (e.g. rights around safety, right to vote, children's and women's rights? *Circle one, based on your observations:* Yes No

SOCIAL CONNECTIONS

An important part of our work is helping people

to feel connected to communities for support and for social activities. The next questions are about how connected you feel to communities or people here.

13. Do you feel part of the local community where you live?

- Yes, very much
- Mostly, yes
- Only Sometimes
- No, not at all

13.b How important is this to you?

- Very much
- Somewhat
- Not at all

14. Separate to the local community in which you live, do you feel part of any other community? (*for example religious, sports, professional, etc.*)

- Yes, very much

- Mostly, yes
- Only Sometimes
- No, not at all

14.b How important is this to you?

- Very much
- Somewhat
- Not at all

15. Do you belong to an organised group? (for example, sports, religious, professional association, community group etc)

- Yes
- No

15.b For each child, do they belong to an organised group?

List of children (child 1, child 2 etc – in order of age)	Yes	No

16. Have you participated in any activities in the community that are important to you in the last month?

- Yes
- No

15.b For each child, have they participated in any activities in the community that are important to them in the last month?

List of children (child 1, child 2 etc – in order of age)	Yes	No

17. Have you attended an arts activity in the last 3 months, or participated in a cultural activity in the last 12 months?

- Yes
- No

17.b For each child, have they attended an arts activity in the last 3 months, or a cultural activity in the last 12 months?

List of children (child 1, child 2 etc – in order of age)	Yes	No

18. Do you have someone, a friend or family member not living with you, that you can rely on to care for/ assist you or your children in an emergency?

- Yes
- No

19. Is there anything else that you would like to discuss, or any feedback that you would like to give?

Appendix 5: Refugee Health Program: Discharge and Review

REFUGEE HEALTH NURSE CLIENT DISCHARGE & REVIEW

INTRODUCTION AND CONSENT

The questionnaire will take approximately 20 minutes to complete. If you experience any distress during or following the questionnaire, we can arrange confidential access to qualified counselling staff. Do you agree to start the questionnaire?

- Yes
- No

GENERAL *(to be completed by interviewer)*

UR number:

Children's/ dependants' UR numbers *(as agreed with client)*:

Date of interview:

WELLBEING The next questions are to understand how you are feeling about your health and that of your family, and how easy it is for you to seek healthcare and other support.

1. In general, would you say that your health is *(circle one)*:

Excellent Good Just OK Poor

1.b Rate the general health of each additional family member:

List of children <i>(child 1, child 2, etc. – in order of age)</i>	Excellent	Good	Just OK	Poor

2. Thinking about the last month, how much did health problems stop you from doing your usual activities? (*For example, moving around, work or school, or doing things that you would like to do*). Please select one.

- Not at all
- Rarely
- Some of the time
- A lot of the time

2.b In the last month how much did health problems stop family members from doing their usual activities?

List of children (<i>child 1, child 2, etc. – in order of age</i>)	Not at all	Rarely	Some of the time	A lot of the time

3. Thinking about your own health, do you know the things that you can do to manage your health needs?

- Yes, I am confident managing this*
- I partly know what I can do*
- No, I'm not sure what to do.*

3.b For members of your family, do you know the things that you/ they can do to manage their health needs?

List of children (<i>child 1, child 2, etc. – in order of age</i>)	Yes, I am confident managing this	I partly know what I can do	No, I'm not sure what I can do

4. I would like to understand how much you know about how to get medical help if you need.

Do you know:	Yes, I am confident with this	I partly know	No, I am not sure what to do
How and when to call an ambulance			
How/ when to use a Medicare card			
How to make or cancel an appointment with the GP			
How to access a medical specialist, or allied health (e.g. physiotherapist, occupational therapist)			

5. Since first coming to this organisation, are there things that you do differently now in your daily life, to support your / your family's health? *(For example, might be diet, lifestyle.)*

- Yes
- No

5.b Record any changes the client describes: *(free text)*

6. The Refugee Health team has referred you to (health related) services.

The next questions are about how these services have been for you.

Referrals made (<i>list the referrals for client and family below, prior to the review meeting</i>)	Client has attended	Client has not attended	Client has not yet attended <i>e.g. on waiting list</i>	For attended referrals, how happy were you with the service received?
				Happy It was just OK Not happy
				Happy It was just OK Not happy
				Happy It was just OK Not happy
				Happy It was just OK Not happy
				Happy It was just OK Not happy
				Happy It was just OK Not happy
				Happy It was just OK Not happy
				Happy It was just OK Not happy
				Happy It was just OK Not happy

7. The next section is to understand how you feel about your ability to deal with difficult things. There are ten statements, I would like you to assess each one as 'not at all true'; 'hardly true'; 'moderately true'; or 'exactly true'.

Statement	Not at all true (1)	Hardly true (2)	Moderately True (3)	Exactly True (4)
I can always manage to solve difficult problems if I try.				
If someone challenges me, I can find the means and ways to get what I want.				
It is easy for me to stick to my aims and achieve my goals.				
I am confident that I could deal sufficiently with unexpected events.				
Thanks to my resourcefulness, I know how to handle unforeseen situations				
I can solve most problems if I make the necessary effort.				
I can remain calm when facing difficulties because I can rely on my coping abilities.				
When I face a problem, I can usually find several solutions.				
If I am in trouble, I can usually think of a solution.				
I can usually handle whatever comes my way.				

LIVING IN THIS COMMUNITY The next questions are about being here in Australia, and how easy it is for you to understand how things work so that you can get what you need for you and your family.

8. How confident are you to access services within the health system?

- Very Confident
- Confident
- A little
- Not at all

9. How confident are you to access services within other systems (for which this organisation supported them, e.g. housing, education, employment/ Centrelink)?

- Very Confident
- Confident
- A little
- Not at all

10. Thinking about when you need something for you or your family, how easy is it for you to know where to go and what to do?

- It's fine for me now
- It's OK, I am getting familiar with it
- It's quite hard, I need someone to help me know where to go
- Very difficult, I don't understand how things work

11. How confident are you to express your wishes to or ask questions of people such as doctors, nurses and teachers in Australia?

I am confident to do this:

- All the time
- Most of the time
- Sometimes
- Never

12. Nurse assessment: based on your observations, does this client demonstrate a basic knowledge of rights and citizenship in Australia? (e.g. rights around safety, right to vote, child rights (e.g. education), women's rights?)
Circle one, based on your observations:

YES NO

SOCIAL CONNECTIONS An important part of our work is helping people to feel connected to communities for support and for social activities.

The next questions are about how connected you feel to communities or people here.

13. Do you feel part of the local community where you live?

- Yes, very much
- Mostly, yes
- Only Sometimes
- No, not at all

13.b How important is this to you?

- Very much
- Somewhat
- Not at all

14. Separate to the local community in which you live, do you feel part of any other community? (for example, religious, sports, professional, etc.)

- Yes, very much
- Mostly, yes
- Only Sometimes
- No, not at all

14.b How important is this to you?

- Very much
- Somewhat
- Not at all

15. Do you belong to an organised group? (for example, sports, religious, professional association, community group etc)

- Yes
- No

15.b (for each child): Do they belong to an organised group?

List of children (child 1, child 2 etc – in order of age)	Yes	No

16. Have you participated in any activities in the community that are important to you in the last month?

- Yes
- No

16.b For each child, have they participated in any activities in the community that are important to them in the last month?

List of children (child 1, child 2 etc – in order of age)	Yes	No

17. Have you attended an arts activity in the last 3 months, or participated in a cultural activity in the last 12 months?

- Yes
- No

17.b For each child, have they attended an arts activity in the last 3 months, or a cultural activity in the last 12 months?

List of children (child 1, child 2 etc – in order of age)	Yes	No

18. Do you have someone, a friend or family member not living with you, that you can rely on to care for/ assist you or your children in an emergency?

- Yes
- No

19. Is there anything else that you would like to discuss, or any feedback that you would like to give?

20. We like to contact some clients after they have left our service to see how things are going. This would involve having a discussion like this one.

Are you happy for us to contact you again?

- Yes
- No

Appendix 6: Letter of invitation for Refugee Health Managers



Nursing Studies
School of Health in Social Science
University of Edinburgh

Victorian Refugee Health Program: An Institutional Ethnography
Researcher: Ms Emma Hughes
Email: E.C.Hughes@sms.ed.ac.uk

DATE:

Dear (Refugee Health Manager),

Re: An investigation into the social organisation & service delivery of the Victorian Refugee Health Program.

As a Nursing PhD Student from the University of Edinburgh in Scotland with a special interest in health support for refugees during the resettlement process, I am interested in undertaking research within this community health centre.

The study will involve speaking with patients who are currently receiving health support through the Refugee Health Program in Victoria, as well as Refugee Health Nurses who are currently providing care through this specialised service. As part of the research, I would like to observe routine Refugee Health Program clinic appointments, in order to gain further insight into the structure of this service and the relationships between refugees and Refugee Health Nurses.

Ethical approval for this study has been sought from the University of Edinburgh, as well as the community health organisation Human Ethics Advisory Group prior to commencement of this research, and covers both metropolitan and rural sites.

Further details are provided in the information sheets, copies of which are enclosed for your information. Should you have any questions regarding this study, please do not hesitate to get in touch with myself, Ms Emma Hughes using the contact details below.

As a PhD Student, I am supervised and supported in my study by three academic Nursing Lecturers from the University of Edinburgh. Should you wish to make contact with my supervisors with regards to this project, details are below:

Dr Susanne Kean	Susanne.Kean@ed.ac.uk	+44 131 650 4028
Dr Fiona Cuthill	Fiona.Cuthill@ed.ac.uk	+44 131 650 3888
Dr Sheila Rodgers	S.Rodgers@ed.ac.uk	+44 131 651 3940

Yours sincerely,

Ms Emma Hughes
PhD Nursing Researcher
University of Edinburgh
Email: E.C.Hughes@sms.ed.ac.uk

Appendix 7: Study Information for Refugee Health Nurses and Managers



Nursing Studies
School of Health in Social Science
University of Edinburgh

Victorian Refugee Health Program: An Institutional Ethnography
Researcher: Ms Emma Hughes
Email: E.C.Hughes@sms.ed.ac.uk

Victorian Refugee Health Program: An institutional ethnography INFORMATION FOR NURSES VERSION 1.0, 17/11/2016

What is the purpose of this study?

To understand the structure & delivery of the Refugee Health Program in Victoria. I hope to learn about what is needed to support refugees with their health during the process of re-settlement, how the Program might be improved in Victoria, and how a similar Program may be adopted to help refugees in other countries.

Do I have to take part?

No. It is up to you to decide whether you wish to take part in this research or not. Should you wish to participate and later change your mind, you can withdraw at any time.

What will happen if I take part?

I will provide information about the study & discuss this with you, offering the opportunity for you to ask any questions. If you agree to take part, you will be asked to sign a consent form to confirm your agreement to participate in the study. During an interview, we can discuss your views and experiences with regards to the Refugee Health Program. This interview will be digitally recorded, & I will ask permission to approach you about a second discussion, only if it is felt that there are further questions or themes to be explored. In addition, I will ask if it might be possible to attend and observe one or more of your routine appointments with refugee patients at the community health centre. If you would rather not consent to the observation part of this study, that is perfectly fine. Simply do not sign this part of the consent form.

Will my taking part in the study be kept confidential?

Yes. Your identity in study reports and publications will be anonymous.

What are the possible benefits of taking part?

There are no direct benefits to you in participating in this study. However, by taking part in this research, you will help me to understand the structure of the Refugee Health Program in Victoria. I will use this information to think about how improvements may be made to the Program in Victoria, and how other countries could benefit from using a similar Program.

What happens when the study is finished?

I will write a thesis which will be submitted to the University of Edinburgh. The findings of this study will be written up for publication as journal articles and presented at national conferences and worldwide. On completion of my research, I will provide you with an overview of the findings and explain how to gain access to the full report. You will not be identifiable in any reports or published results. Transcripts & recordings will be stored securely in line with the University of Edinburgh data management policy.

Who is overseeing the research?

The study will be undertaken by Emma Hughes, with support from supervisors at the University of Edinburgh, as well as the State-Wide Facilitator of the Refugee Health Programme in Victoria. The research has been considered by an independent group of people, called a Research Ethics Committee (REC) prior to commencement of this research, both from the University of Edinburgh, and in Victoria.

The Researcher

I am a registered nurse from Edinburgh in Scotland, and have a special interest in the health and well-being of refugees and asylum seekers. I have experience in working with refugees, and I am undertaking my doctoral study (PhD) through the University of Edinburgh. I am eager to find out more about the Refugee Health Program in Victoria, as I hope to learn about what is needed for refugee health support during re-settlement, how services can be improved in Victoria, and how a similar Program might be adopted in other countries to provide similar services.

What if there is a problem?

If you have a concern about any part of this study, please contact the researcher, Emma Hughes, who will do her best to answer your questions. If you wish to make a complaint, this can be done by contacting the University's Research Governance Team as follows:

Email: researchgovernance@ed.ac.uk Telephone: (Scotland) +44 131 650 4327

Please find below the link to the University of Edinburgh Complaint Form:

<http://www.ed.ac.uk/files/imports/fileManager/WEB%20Complaint%20Form.pdf>

Thank you for taking the time to read this information leaflet.

If you would like further information, please contact the researcher:

Ms Emma Hughes

Email: E.C.Hughes@sms.ed.ac.uk Telephone: 0416 489 564

Supervisors at the University of Edinburgh:

Dr Susanne Kean	Susanne.Kean@ed.ac.uk	+44 131 650 4028
Dr Fiona Cuthill	Fiona.Cuthill@ed.ac.uk	+44 131 650 3888
Dr Sheila Rodgers	S.Rodgers@ed.ac.uk	+44 131 651 3940

Appendix 8: Study Information for Refugees



Nursing Studies
School of Health in Social Science
University of Edinburgh

Victorian Refugee Health Program: An Institutional Ethnography
Researcher: Ms Emma Hughes
Email: E.C.Hughes@sms.ed.ac.uk

Victorian Refugee Health Program: An institutional ethnography

INFORMATION FOR PATIENTS VERSION 1.0, 17/11/2016

What is the purpose of this study?

To understand the structure & delivery of the Refugee Health Program. I hope to learn about what is needed to support refugees with their health during the process of re-settlement, how the Program may be improved in Victoria, and how a similar Program may be adopted to help refugees in other countries.

Do I have to take part?

No. It is up to you to decide whether you wish to take part in this research or not. Should you wish to participate and later change your mind, you can withdraw at any time & this will not affect your care.

What is involved if I choose to take part?

If you agree to take part, we will arrange a suitable date & time, and we can talk about how you feel about the Refugee Health Program. We will have an initial conversation which will be recorded, and I will ask permission to approach you about a second discussion, if it is felt that there are further questions or themes to be explored. Also, if you agree, I would like to observe your routine appointment at the community health centre with the Refugee Health Nurse.

Will my taking part in the study be kept confidential?

Yes. Your identity in study reports and publications will be anonymous.

What are the possible benefits of taking part?

There are no direct benefits to you in participating in this study. However, by taking part in this research, you will help me to understand the structure of the Refugee Health Program in Victoria. I will use this information to think about how

the Program might be improved for people in Victoria, and how other countries could benefit from using a similar Program.

What happens when the study is finished?

I will write a thesis which will be submitted to the University of Edinburgh. The findings of the study will be written up for publication as journal articles and presented at national conferences and worldwide. As a thank you for taking part in the study, I will offer you a summary of the findings and explain how to gain access to the full thesis. You will not be identifiable in any reports or published results. Transcripts & recordings will be stored securely in line with the University of Edinburgh data management policy.

Who is managing the research?

The study will be carried out by Emma Hughes, with support from supervisors at the University of Edinburgh, as well as the State-Wide Facilitator of the Refugee Health Program in Victoria, Lindy Marlow.

The Researcher

I am a nurse from Scotland and have a special interest in the health of refugees and asylum seekers. I have worked as a nurse in refugee camps around the world, and currently work with refugees in Scotland. I would like to find out more about the Refugee Health Program in Victoria.

What if there is a problem?

If you have a concern about any part of this study, please contact the researcher, Emma Hughes, who will do her best to answer your questions. If you wish to make a complaint, this can be done by contacting the University's Research Governance Team as follows:

Email: researchgovernance@ed.ac.uk Telephone: (Scotland) +44 131 650 4327

Please find below the link to the University of Edinburgh Complaint Form:

<http://www.ed.ac.uk/files/imports/fileManager/WEB%20Complaint%20Form.pdf>

Thank you for taking the time to read this information leaflet.

If you would like further information, please contact the researcher:

Ms Emma Hughes

Email: E.C.Hughes@sms.ed.ac.uk Telephone: 0416 489 564

Supervisors at the University of Edinburgh:

Dr Susanne Kean	Susanne.Kean@ed.ac.uk	+44 131 650 4028
Dr Fiona Cuthill	Fiona.Cuthill@ed.ac.uk	+44 131 650 3888
Dr Sheila Rodgers	S.Rodgers@ed.ac.uk	+44 131 651 3940

Appendix 9: Consent Form for Refugee Health Nurses and Managers



Victorian Refugee Health Program: Institutional Ethnography CONSENT FORM: Nurse Version 1.0 (17/11/2016)



Researcher: Ms Emma Hughes
Nursing Studies, School of Health in Social Science

Name of community health centre:

Name of Refugee Health Nurse:Participant ID:.....

1. I confirm that I have read and understood the Information For Nurses sheet dated 17/11/2016 version 1.0 for the above study and have had the opportunity to consider the information and ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my professional nursing status or legal rights being affected.
3. I understand that my personal details, and information about my role within the Refugee Health Program will be held by the researcher in a study file. This will be securely stored and not shared with other parties, in order to protect my right to anonymity.
4. I agree to allowing the researcher to ask me questions with regards to the support I provide to patients through the Refugee Health Program, and for this interview to be digitally recorded. If necessary, I agree to allowing the researcher to approach me a second time for an additional interview, if further information is deemed to be useful.
5. I agree to allowing the researcher to undertake observation during my clinic appointments with patients as part of the Refugee Health Program. I understand that information collected during this observation process will be anonymised.
6. I agree to take part in the above study.

Name of Participant Date Signature

Name of Person taking consent Date Signature

If you would like to make a complaint, please find below the link to the University of Edinburgh Complaint Form, which should be addressed to Professor Charlotte Clarke:

<http://www.ed.ac.uk/files/imports/fileManager/WEB%20Complaint%20Form.pdf>

Alternatively, you can contact the Head of the School of Health in Social Science at the University of Edinburgh, Professor Charlotte Clarke, on +44 131 650 4327 or Charlotte.Clarke@ed.ac.uk

Appendix 10: Consent Form for Refugees



Victorian Refugee Health Program: An Institutional Ethnography CONSENT FORM: Patient Version 1.0 (17/11/2016)



Study Principal Investigator: Ms Emma Hughes
Nursing Studies, School of Health in Social Science

Name of community health centre:.....

Name of patient: Participant ID:.....

1. I confirm that I have read and understood the Information For Patients sheet dated 17/11/2016, version 1.0 for this study and have had the opportunity to consider the information and ask questions.
2. I understand that I am volunteering to take part in this study, and that I am free to withdraw at any time without giving any reason, without this affecting my care.
3. I understand that my personal details, and details of support given to me through the Refugee Health Program will be held securely by the researcher in accordance with the University of Edinburgh data management policy.
4. I agree to allowing the researcher to ask me questions about the support I receive through the Refugee Health Program, & for this interview to be digitally recorded. If necessary, I agree to allowing the researcher to approach me a second time for an additional interview, if further information is deemed to be useful.
5. I understand that I do not need to answer all questions put forward by the researcher.
6. I agree to allowing the researcher to observe my clinic appointment with the Refugee Health Nurse. I understand that information collected during this observation process will be anonymised during reporting and publication of findings.
7. I agree to take part in this study.

Name of Participant

Date

Signature

Name of Person taking consent

Date

Signature

If you would like to make a complaint, please contact the Research Governance Team at the University of Edinburgh.

Email: researchgovernance@ed.ac.uk

Appendix 11: Reflexive Epilogue

During all stages of planning, undertaking and analysing this study, I made decisions which may have influenced the presentation of findings. This reflexive epilogue offers insight into my thought processes, allowing transparency and a holistic understanding of my decision-making.

Contemplating ideas for my PhD topic, I landed upon refugee healthcare. Throughout my nursing career I have been interested in health inequalities and the impact of social determinants of health, with conscious awareness of certain groups in society experiencing difficulties in accessing healthcare. When I decided to embark upon this PhD journey, I had recently returned from nursing in refugee camps and felt inspired to understand and improve the health experiences of refugees who are resettled in a host country.

In planning this research, I chose to include one metropolitan and one rural/regional community health centre offering the specialised refugee health service, two sites in total. I wanted to discover how the Refugee Health Program (RHP) operates in both contexts, to allow transferability of the study findings to both city and rural settings in other countries.

The State-Wide Facilitator of the RHP suggested two community health centres for inclusion. On reflection, the State-Wide Facilitator may have proposed these two sites in the knowledge that the service runs smoothly within these settings. As the State-Wide Facilitator introduced the RHP in Victoria in 2005, they might have wished me to observe what they consider to be best practice, in order for me to present findings that positively reflect this specialised refugee health programme. The decision to include these two sites lay in the hands of the State-Wide Facilitator, but I acknowledge that there could have been some bias in the selection process and this may have influenced my perception of the RHP and thus, the presentation of findings. Perhaps if I had chosen and approached the community health centres at random, findings may have reflected a different story of specialised refugee healthcare in Victoria.

With regards to undertaking interviews, I acknowledge that the timing of interviews with different sub-cultural groups may have impacted on the substance and quality of data generated. At the beginning of the study, I gained informed consent

from Refugee Health Nurses (RHNs) at both sites. As I gained consent from RHNs early on, I began undertaking semi-structured interviews with this sub-cultural group first. At this introductory point in the study, I had not yet fully immersed myself in the field and therefore, had not formed trusting relationships with RHNs.

The timing of interviews bears influence on the findings, in terms of my professional relationships with participants. As discussed in the main body of this thesis, as I spent longer in the field, I developed trusting, friendly relationships with RHNs. On reflection, I wonder whether I may have collected more sensitive or insightful data from RHNs if I had conducted interviews with this group later in the study. As I undertook interviews with RHNs and Refugee Health Managers (managers) at the beginning, I was yet to establish trust with these groups and therefore, participants may not have confided in me with their honest views and experiences of the refugee health service.

After conducting interviews with RHNs and managers across both sites, RHNs began to liaise with refugees about potentially taking part in the study. Interviews with refugees were therefore conducted last, towards the end of my time in the field. In likeness to the potential bias in the selection of study sites, I recognise that there could have been bias in the way in which RHNs invited refugees to take part in the study. RHNs may have recommended certain refugees based on their perceived positive experience of the service and thus, promoting an encouraging representation of specialised nursing care.

In terms of decision-making around interviews with refugees, the decision to include non-English speaking participants may have influenced the findings, as concepts do not move un-problematically across cultures. By deciding to include refugees who could not speak English, I opened up cross-cultural dialogue and invited the interpretation of a translator. Therefore, I understand that the translation process shaped the generation of data from some refugees. Collecting data from the perspective of non-English speaking refugees was a useful exercise with regards to my professional development; collaborating with accredited translators in undertaking health research.

With regards to analysing the data, I employed a Symbolic Interactionist theoretical perspective, viewing specialised refugee healthcare as a social construct.

This allowed me to place focus on the interaction between participants and how these interactions shape the field of refugee health nursing. As I aimed to understand the social dynamic between sub-cultural groups, I paid attention to the relationships within refugee health nursing and how social interactions enabled meaning-making. The decision to focus on social and professional relationships shaped the findings with regards to the emphasis on how sub-cultural groups exert power over another. Findings are presented in a way that illuminates the constant push and pull of power and resistance between groups of RHNs, managers and refugees.

Reflecting upon the analysis process, I decided not to employ the use of computer assisted qualitative data analysis software (CAQDAS), as I aspired to stay close to the data and use creative ways to decipher patterns. I decided to concentrate on the nuance of social dynamics between sub-cultural groups, with intellectual thinking and interpretation of interaction as paramount. Nevertheless, I realise that in terms of my professional development, I may have benefited from using CAQDAS to further my practical learning of this software, broadening my skill set for future research projects.