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LANGUAGE AND COMMUNICATION: A VITAL COMPONENT OF HEALTH FOR PEOPLE WITH REFUGEE BACKGROUNDS

ABSTRACT

Aim: This article reports on a collaborative project that explored transdisciplinary understandings of the implications of learning English for the health and well-being of people who have come as refugees to Aotearoa New Zealand.

Background: It is important to understand learners' backgrounds and wider social worlds to best offer them opportunities for learning the English language, which is in most cases a significant factor in health literacy and in being able to access health care.

Methodology: Secondary analysis was used to analyse the health implications of an emergent data set from a primary research study with learners who were refugees. Sixty adults of refugee backgrounds participated in the primary research. Ages of participants ranged from 18 to 64 years, and the participants were predominantly female.

Findings: The key themes developed from the secondary analysis were: complexity of life experience, challenges to living and learning, family responsibilities, challenges to "peace of mind" and mental health, and personal agency. Eliciting narratives about who people are, where they are from, and how migration affects them at all levels of daily life, and therefore their health and well-being, is integral to culturally safe practice with people with refugee backgrounds.

Conclusions: The health of new New Zealanders is a social equity issue that nurses and other health and social-care professionals need to be concerned with, especially in creating culturally safe conditions for people with refugee backgrounds to engage well with health services.

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KEY WORDS

Refugee, language development, health and well-being, nursing.

INTRODUCTION

This article argues for professions to work together to better meet language development and health needs of people who migrate to Aotearoa New Zealand as refugees. The article grew out of a conversation at a research seminar where the language teacher authors were presenting the findings of language development research with learners who were refugees. The two nurses present recognised the health implications of these findings and we have undertaken a joint transdisciplinary secondary analysis process to translate the findings of the primary study into a health care context for nursing.

The primary research on language development reported here is

part of a wider research project focused on the learning and teaching needs of learners with emerging literacy (Field, 2019; Kearney, 2019; Field & Kearney, in press). In many cases, new New Zealanders may already be orally fluent in one or more languages or dialects, but need to develop oral and written English language skills to function in our society, which is dominated by English. Many of these people are learning to write in English without having first been able to write in any other language.

This article backgrounds the current situation in Aotearoa New Zealand for arrival of people with refugee backgrounds. It briefly reviews literature on learning a language and a transdisciplinary frame suggested for this, and relevant nursing and health literature. It introduces the researchers, their intentions for the research, methodology and methods and theories underpinning these. Following that, we highlight the voices of some English language learners from refugee backgrounds, and analyse and reflect on these short narratives and their relevance for primary health care and nursing practice.

BACKGROUND

Aotearoa New Zealand had a yearly quota of 750 refugees for more than 30 years, from 1987 to 2018. The number then increased to 1000 people and in July 2020, the quota was scheduled to increase to 1500 (Immigration New Zealand, 2018). This effectively doubles the number of people each year who will require support from education and health services, and to find a home and employment, or to generate income from their own business (Beaglehole, 2005). The United Nations High Commission for Refugees makes a distinction between a "refugee" and a "migrant". A refugee is someone forced from their home by conflict or persecution, whereas a migrant voluntarily moves in search of better fortunes (McNamee, 2017).

These new New Zealanders from refugee backgrounds, who are welcomed into the country under the auspices of Te Tiriti o Waitangi as tauiwi, "people from afar" (Walker, 2004), spend an initial six weeks at Auckland University of Technology's (AUT) Mangere refugee immigration centre in Manukau City. They complete a programme which includes English language and literacy classes, health checks, other skills and an opportunity to reflect on the challenges of moving into a new society (Refugee Education Centre, 2020). Informal reports reveal that the welcoming ceremony, with a formal pōwhiri led by Māori, is a powerful experience for people who have been homeless or in danger in their homelands, moving from country to country, possibly escaping war (Hayward, 2019).

In earlier years, community groups, church groups and individuals took responsibility for helping these people into new homes. As numbers of refugees and migrants have increased, the Government has taken over and now contracts the New Zealand Red Cross and other non-governmental organisations (NGOs) to provide resettlement and employment services for new refugee families and individuals. Eight reception centres have been developed over the decades: Auckland region, Hamilton, Palmerston North, Wellington region, Nelson, Christchurch, Dunedin and Invercargill. The scheduled increase in refugee numbers means that six new settlement centres are being developed: Whanganui, Levin, Masterton, Blenheim, Ashburton and Timaru (Immigration New Zealand, 2018).

English language lessons for people with migrant and refugee backgrounds have been provided by individuals and home tutors for more than 40 years. The national home tutor network for English as a Second Language (ESOL), renamed English Language Partners in the 1990s, is contracted by government to provide community-based classes, as well as home tutors. In 2019, English Language Partners operated 22 centres nationally, had 7199 adult learners and 1705 trained volunteer language teachers (English Language Partners New Zealand, 2019). Language lessons are also offered in government institutions of technology, private educational businesses, and a variety of community-based organisations and communities, such as churches, mosques and temples and a range of NGOs.

LITERATURE REVIEW

Key literature guiding this inquiry includes research on English literacy development in Aotearoa New Zealand and related issues, such as learners' health challenges; a transdisciplinary framework on learning a second language; and cultural safety in the delivery of health care.

Literacy development and related challenges

Research into the broader needs of people with migrant and refugee backgrounds in New Zealand (White et al. 2002) finds that learning a language requires both individual and community investment. Focusing specifically on adults learning English, research by Benseman (2014) and Shamem et al. (2002) has shown that individual language learning trajectories can often be influenced by their previous experiences. This is particularly so for learners from refugee backgrounds, who may be orally fluent in one or two languages, but able to write in neither. It is a longer process to learn to write in English, without being able to write in a first language (Tarone et al. 2009). English language teachers may need to direct learners to health services, for both physical and mental health. Hope's (2013) research into the perceived benefits of a community-based ESOL literacy programme for migrant and former refugee women found that 11 of the 15 participants rated learning communication skills for *"speaking with the doctor"* as a benefit of the programme (p.19).

Elliot (2015) points out that over the last 25 years, people of refugee backgrounds in New Zealand have moved past being passive recipients of welfare assistance and services and being spoken for by others, to having their own strong voice. These include the development in 2009 of the National Refugee Network (NRN), a collective national voice for former refugees. It was composed of representatives from the regional Strengthening Refugee Voices grouping, an initiative of the Immigration Department to strengthen voices at a local level (Elliot & Yusuf, 2014). The Otago Stocktake (Cunningham et al. 2018), which focused on structural determinants of mental health and well-being, highlighted the importance of recognising the resilience and resourcefulness of those who have been displaced and forced to resettle in a new country. They cite Betts et al.'s (2015) emphasis on enabling "bottom-up innovation" in refugee communities and the significant well-being benefits this may provide. Literacy teachers need to be aware of community-based networks which can help learners with their health and other challenges. The stocktake highlighted the importance of language and communication to health and well-being. It cites Shrestha-Ranjit et al. (2017), who identified access to interpreters and culturally-

safe services as key to providing effective care and support. Lack of access to professional interpreters has been identified as a barrier to providing health care, particularly mental health care, for people from refugee backgrounds in Aotearoa New Zealand (Cunningham et al., 2018).

A transdisciplinary frame

As language teachers and health professionals, it is important for us to be aware, as the Douglas Fir Group (2016) explains, that when individuals are moving from the micro-level of social activity to the meso (middle) level of wider family, schools, neighbourhoods and larger institutions and organisations, that social, economic, cultural and political conditions are significant influences on them (p. 37). They also say learners' access to specific types of social experiences, and their ability and willingness to participate, are shaped by these conditions. Organisations at that wider social level would include health-care facilities, including primary health care and mental health services. Educationalist and linguist Bonnie Norton (2000, 2013) says that individuals have multiple aspects to their social identity, which change over time and potentially cause stress in the process of that change. Social identities are aspects of a person that reflect their different relationships to the world (Douglas Fir Group). Learning English is influenced by individuals' senses of identity and agency, and the power dynamics they must negotiate at multiple levels (Norton, 2000, 2013).

Research illustrates the complexity of the social identities and experiences of refugee learners. Isshi (2017) followed one adult male former refugee for 18 months. His findings suggested that migrants' everyday interactions with others shape their perceptions of who they are and their understandings of the community in which they live. Thiruselvam (2019) applies a post-colonial feminist analysis to the New Zealand context after the mosque killings in Christchurch in March 2019. She highlights many challenges that people of refugee and migrant backgrounds face, which she believes are a consequence of New Zealand's colonial settler history. In the face of the violence that she experienced, and her experience of being *"othered"*, she concludes that *"finding a community of people with a shared view and experience of the world is an act of resistance. The care and validation we give and receive within our communities are often so healing"* (p.69). Equally critical is Chile (2002) on the experience of racism and marginalisation experienced by black African communities in this country. These insights about the complexity of experience signpost that it is important to find out about people's backgrounds and wider social worlds. This helps us offer them better opportunities to improve their English and to access health services.

Cultural safety

Cultural safety guidelines were first written by Irihapeti Ramsden in 1991, informed by Māori experiences of health services, and adopted by the New Zealand Nursing Council in 1992. Cultural safety is defined as: *"The effective nursing practice of a person or family from another culture and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability"* (Nursing Council of New Zealand, 2012). Ramsden highlighted the importance of nurses' behaviour and attitudes towards patients, and their ability, or otherwise, to create trust (Manchester, 2002, p.21). De Souza (2015) has a chapter on culturally safe care for ethnically and religiously diverse communities, in an edited collection of professional perspectives on cultural safety in Aotearoa New Zealand. This acknowledges the need for New Zealand nurses to be able to respond appropriately to the growing and varied communities of people with migrant or refugee backgrounds in Aotearoa.

Clendon and Munns (2018) highlight the importance of cultural safety in the delivery of primary health care. They recommend viewing culture through a critical lens, suggesting *"understanding individuals comes from exploring their history, behaviour and particular view of the world as it is embedded in their culture, but distinctive in their patterns of attitude and behaviour"* (p. 248). We believe willingness to understand and respect cultural differences is as important in teaching literacy as it is in delivering primary health care. As teachers, we need to be aware of learners' backgrounds and take this into account where possible in the classroom. As health professionals, we also need to understand the consequences of the life experiences of former refugees who are using health services.

METHODOLOGY

The primary research

Participants in the primary study (2017-2019) were 60 adults of refugee backgrounds from Somalia, Cambodia, Colombia, Pakistan, Democratic Republic of Congo and Afghanistan. Ages ranged from 18 to 64 years old, and participants were predominantly female. They were invited to participate in the research because they had been attending ESOL literacy classes provided through English Language Partners, or at a government-funded tertiary institute in one provincial city.

The secondary research

Secondary research involves analysing data that were originally collected for another purpose. The supplementary analysis approach to secondary research involves a deeper analysis of aspects of the data that were not fully explored in the original study (Heaton, 2008; Johnston, 2014). Finding a good fit between the primary research dataset and a new research question for the secondary analysis is key to using that existing data well. The specific area of interest for the secondary analysis was identified because data from the research interviews indicated potential influences on health and well-being, and factors affecting access to health care. Our secondary analysis focused on the research question: *What are the health impacts of migration as a former refugee?*

An inductive approach to thematic analysis (Flick, 2018; Patton, 2015) provided the methodological framework. We read and re-read the transcribed responses to the interview questions, initially colour-coding to identify categories. In this article, we highlight constraints to accessing health services, which fell into broad areas: health, family and learning challenges. We chose narratives from the primary research interviews that clearly articulated health challenges in the participants' accounts of their experiences. In the secondary analysis, we found that the participants whose data we had selected for analysis shared the same country of origin. As Table 1 (see p46) shows, they were predominantly women, which was to be expected as the 60 learners interviewed for the primary research were predominantly female.

ETHICS

Ethical approval to conduct the primary research was obtained from the Wintec Human Ethics Research Committee. In collecting data for the research, particular attention was given to the potential vulnerability of the participants, including challenges with language in the process of seeking consent. A translator explained the research to the class, the language of the consent form was simplified, and written consent was obtained from each participant before commencing data collection. Pseudonyms were used for the participants' names.

FINDINGS

The key themes developed from the secondary analysis were: complexity of life experience, challenges to living and learning, family responsibilities, challenges to "peace of mind" and mental health, and personal agency.

Complexity of life experience

We offer two short narratives first, to illustrate the complexity of life experience of two women (women were the predominant participants in this inquiry):

> *"I left school early as I needed to look after my three siblings and my father. My mother died when I was eight. After the children grew up, I married at 30. No school for me. Then my husband passed away and I needed to work. I had children then so needed to work to provide for them. I was in Pakistan for five years and then came to New Zealand. I can read the Quran in Dari. I used to read it with my neighbour in Afghanistan."* (Shantika)

> *"I have lived in New Zealand for 10 months. I have six children. They are all living here. 20, 16, 14, 12 and six and three. I didn't go to school. There was no school available. I can read Dari but can't write. I think it will take about four years to do everything by myself such as taking children to the doctors and solving my problems."* (Sabina)

These narratives illustrate that, for these two women, their caring roles within their family, and later for their own children, have largely shaped their lives. Neither narratives reveals any formal schooling, though both can read some Dari. Consequently, embarking now on formal classes in English, they have the added challenge of learning to write in another language, without having learned that skill in their earlier language/s. New Zealand research (Benseman 2014; Shamem et al., 2002) shows that learners like these women take longer to learn English, as their progress is often interrupted by responsibilities for children and family.

The process for adult preliterate learners in learning to read and write is very different from the process for children in a print-literate culture. Adult language learners with no experience of print literacy have to learn to understand that marks on a page can become letters and words, and that written words can represent a story or a message, just as spoken words and pictures can.

Other conventions associated with written English – such as written texts having a beginning, middle and end; and that English is read from left to right and from top to bottom of the page – all need to be acquired (Burt et al., 2008). Phonemic awareness – the connection between letters and sounds – is also a pre-reading skill. These concepts take time to learn and progress can be incremental, but in time these literacy concepts will be built. The implication for this in the health sector is that during the first years of resettlement, people may need to bring family members to fill in health forms, or need an interpreter. Participant responses revealed that 45 percent of the 60 participants in the primary study experienced physical or mental health challenges that had an impact on their learning. The four following themes emerged from participants' responses relating to health.

Challenges to living and learning

Managing health challenges had an impact on how participants were able to learn, to support their future. Similarly, other family members' health influenced whether or not participants were able to attend English language class.

> *"If I am well, I am learning well. Sometimes I am not well. I was in a lot of pain. I had an x-ray for my stomach and my back."* (Haleema)

> *"I come every day, but I have two children and if they are sick I can't come. The other time I get stressed is if I phone my parents and if they are not doing well, then I get stressed."* (Soraya)

Given the experiences described in these two responses, and many others, language teachers need to allow for irregular attendance by some learners because they are ill, or because family members are sick. This can mean their learning progress is continually interrupted, making development of skills slower. Slower progress has implications for how people with refugee backgrounds are able to interact with people in social institutions. It is important that challenges to living and learning for people with refugee backgrounds are recognised and understood by the representatives of social institutions who interact with them. Living with the consequences of trauma and illness experienced before, or in the process of migration, may have an impact on how they are able to take up opportunities offered to them in their host country. They may also struggle to develop the language and educational skills they need to navigate their new life.

Family responsibilities

Being responsible for family members, having health problems, and depending on children for help to meet activities of daily living, all affect a migrant or refugee's ability to interact with social institutions, including health services. Learning English is key to finding work.

> *"I rely on my sons for everything. I want to be independent. If my sons are not there, I can't go out, like go to the doctor."* (Hindra)

> *"I am aware how the building procedure goes. My problem is my health. If my health improves, I might look at building or business and of course when my English is better. Stopping learning. I live with my elderly mum and I get worried when she gets sick. My mum is very old. She recently had an eye operation. She is 83."* (Ahmed)

> *"My difficulty is I can't talk so whenever I go somewhere, I have to take my daughters with me. So I have to wait for a chance to*

Table 1. Background information for participants who made contributions about their experiences (2017-2019)

Pseudonym	Age	Gender	Country of origin	Languages spoken on arrival	Years of prior education	Years living in NZ	Other features of interest
Shantika	48	F	Afghanistan	Dari Urdu	0	2	Lived in Pakistan for 5 years. Learned Urdu.
Sabina	38	F	Afghanistan	Dari	0	6 months	
Haleema	57	F	Afghanistan	Dari	4	3	Lived in Pakistan for some years.
Soraya	30	F	Afghanistan	Pashto	0	2	
Hindra	57	F	Afghanistan	Dari	0	2	
Ahmed	45	M	Afghanistan	Dari	8	2	Learned to read and write in Dari at the Madrasa. Leg injuries from the conflict.
Rani	31	F	Afghanistan	Dari	0	2	Lived in Pakistan for 9 years.
Bira	42	F	Afghanistan	Dari	0	3	
Fatima	53	F	Afghanistan	Dari	6 months	3	

do this as I have a health problem." (Rani)

These three narratives, related to health and well-being, illustrate how responsibility for and dependence on family members can constrain opportunities in life. The two women rely on their children to accompany them to a doctor or health-care appointment because their language skills are not sufficient to understand or communicate. These participants are engaged in family roles as mothers and caregivers with little potential time or other resources for self-care. The male participant also notes his family responsibilities and concerns about his ageing mother. What seems significant for these participants is that migration has distanced them from the family and other social support that may have been available to them in their home country.

Challenges to 'peace of mind' and mental health

Participants associated challenges to "peace of mind" and mental health with complex and threatening experiences involving the loss of family members and the stress of living in a country at war. This stress was complicated when family members had been left behind.

"My mind is not settled. My mind is in …. (home country). I think about my children and how they doing. During the whole of my life I have been in war. I am thinking about my daughters. When they go out the door I don't know if they will come back. My family who have been killed. My sister and my brother are lost. We don't know where he is. Until today I am still waiting." (Bira)

"At school we learn something but when we go home we forget. We are thinking of our families back home when we go home and so our memory is affected." (Fatima)

These narratives show that participants' minds are occupied with deep and lasting concerns, focused on the loved ones they have lost, and the worry and grief associated with that loss, while at the same time endeavouring to find a place in their host country. As language teachers, we need to try to understand learners' backgrounds. And we need to adapt our teaching style to create a safe, accepting environment in class, where each learner can feel respected and accepted, with supportive cooperative engagement between teacher and learners. Understanding the unique circumstances that have brought former refugees to New Zealand and the mental health impact of those experiences is also critical for health professionals.

Personal agency

We have chosen this short narrative because it clearly illustrates the power of human agency, as Norton (2013) describes it. This participant has decided that attending class is the way forward to create change in her circumstances, so she attends, despite her health challenges:

(Soraya) "I am sick, but I still come because if I sit at home nothing will change."

This narrative shows how the participant is courageous in her daily life and understands that even while experiencing challenges to her health, she has power to influence her circumstances through her own actions.

DISCUSSION

People who migrate to New Zealand as refugees are likely to experience profound challenges to their social identity (Norton, 2000, 2013). As migrants, refugees are likely to have less power in relationships with people and institutions in their host country, and as Thiruselyam (2019) and Chile (2002) clearly illustrate, particularly when accessing health care. It is important that nurses are aware of refugee populations and the challenges they face in becoming new New Zealanders. Primary health care workers need to find out from former refugees information about their background, where they are from, and how their experiences have affected them, including effects

on their health and well-being. This is a skill that health professionals need to deploy with sensitivity, so the individual can feel safe and trust the health-care worker. As we explain later in the discussion, this understanding of who people are is particularly important for culturally safe practice with people of migrant or refugee backgrounds. This is important, because migration results in a far-reaching reordering of migrants' daily lives at all levels of social activity (Douglas Fir Group, 2016), which has significant health consequences. These health consequences may be amplified for people who have experienced significant trauma while leaving their home countries. While migrants have chosen to relocate, refugees may have had little choice in leaving their home country (McNamee, 2017).

The impact of experiences before migration is a potential negative influence on health (Castaneda et al., 2015). One participant in this study noted, *"my mind is not settled",* indicating the impact of past trauma and worry about family left behind in their country of origin. Many people with refugee backgrounds have experienced traumatic events that have an ongoing impact on their mental health. They may also have physical health conditions that require long-term support from health-care services. Participants in this study shared how the negative health effects of prior events and experiences are ongoing, even after they have settled in a country where previously experienced threats no longer exist. The effect of past trauma on people with refugee backgrounds should not be under-estimated (George, 2010). Research in Canada (Pottie et al., 2011) found that all migrants, even those who were healthy on arrival, had a subsequent decline in health. This finding was attributed to differing health needs of migrants, owing to exposure to disease, migration experiences, genetic predispositions and living conditions in the host country.

Social isolation or exclusion in the process of becoming settled in their host country have negative impacts on the health of people with refugee backgrounds. Separation from family, and the loss of familar social norms and cultural practices, may affect their mental health, causing anxiety and depression. Davies et al. (2009) acknowledge that migrants' ongoing health may be determined by their ability to be included in communities and access appropriate and acceptable health services in their host country. The demands of daily living, family responsibilites and communication barriers can impede migrants' ability to feel at home in a community and to seek help to manage their health and living requirements. Davies et al. also note that cultural differences in understanding of mental health may also affect health-seeking behaviour. Where family are present or have migrated together, the support that family provide may ease migrants' worries. However, for people with refugee backgrounds, migrating with family members is not always possible.

Anderson (2008) suggests that migrants use multiple strategies to navigate the New Zealand health-care system, but this ability is influenced by their knowledge and experience of health services before migrating. For people with refugee backgrounds, barriers to engagement with health services may be related to language problems, health literacy and a lack of understanding about how the New Zealand health system works and what they are entitled to. Social networks provide essential support when migrants do not know where to go for help when they get sick, or how to engage with health services. The level of comfort people with refugee backgrounds have with specific health services may be informed by their experiences of health services in their own country. This may also be true for how they evaluate which health services they prefer to attend.

Health literacy – the ability to access, understand or apply health information – is a key factor in the health of people with refugee backgrounds (Davies et al., 2009; Wångdahl et al., 2014). Some participants in this study were illiterate in their own language, having had limited opportunities for schooling in their home countries. They were learning to read for the first time in English, a process that may take them a number of years to achieve some proficiency. People with refugee backgrounds who have lower levels of education, or less cultural knowledge of the host country, may be less likely to seek health care and engage in healthy behaviour (Dowling et al., 2019). They highlight the importance of supporting the education needs and health literacy of migrants to help prevent their health declining.

Nurses need to engage with people who have refugee backgrounds in culturally safe ways to support them in managing their health and well-being (de Souza, 2015; Nursing Council of New Zealand, 2012). The health inequalities that exist between migrants and other populations in New Zealand are partly attributable to lower use of the health service. However, providing culturally safe care for people with refugee backgrounds can be complex. It is challenging for health professionals to overcome language barriers and to fully understand the experiences migrants bring to health-care encounters. The availability of high quality translation is essential for working with migrants who are not yet fluent in English (Suphanchaimat et al., 2015). While some people with refugee backgrounds rely on family members to interpret for them, positioning family members in this way carries its own challenges in terms of confidentiality and the power dynamics in family relationships. The use of male interpreters for women seeking health care may constrain the ability of these women to communicate with health-care providers, particularly concerning women's health issues. The same concerns may arise for male migrants with female interpreters. Gaining the trust of people with refugee backgrounds, and developing personalised relationships with them, is essential for nurses to provide them with the best care (Ministry of Health, 2012).

CONCLUSIONS

This transdisciplinary inquiry has been transformational for the researchers, because it has taken us beyond the scope of our own disciplines. The narratives have allowed us insight into aspects of the participants' lives. People with migrant backgrounds, especially people who come to New Zealand as refugees, are exposed to unique factors affecting their physical and mental health, and consequently their ability to learn a new language. The health of these new New Zealanders is a social equity issue that nurses need to be concerned with. They need to create culturally safe conditions so migrant populations can engage effectively with health services. An understanding of the specific challenges relating to migration and the unique experiences of new New Zealanders would enhance these encounters.

RECOMMENDATIONS

Promoting community-level engagement with primary-care services may help to reduce inequalities for refugee populations. As advocates for people with refugee backgrounds, nurses need to

influence policy makers to recognise the individual, social, cultural and historical factors that affect the health of migrants. Following the Otago Stocktake (Cunningham et al., 2017), this will require an acknowledgement of the multi-lingual environment in New Zealand and explicit policy to ensure that important signs are regularly reproduced in several languages, including te reo Māori.

Health services should engage with people with refugee backgrounds in culturally safe and responsive ways, showing understanding of their unique experiences. This requires a diverse health workforce, both at policy development level and at on-the-ground service level.

Nurses should also recognise the importance of social networks in overcoming the unique constraints migrants encounter in using health services. These constraints include communication barriers, challenges in attending appointments, and different cultural and social interpretations of health and illness. Nurses, and other health professionals, also require contemporary evidence-based clinical guidelines to inform how they work with migrants and refugees.

LIMITATIONS

This study involved a relatively small sample of people who came to New Zealand as refugees, so the findings of this research may not be generalisable to other migrant populations either here or overseas.

However, the stories told by the participants are likely to be echoed in the lives of refugees who are yet to settle in Aotearoa New Zealand. Data for this study were originally gathered to understand more about how learners with refugee backgrounds experience learning English, rather than having a specific focus on health. This secondary analysis of an existing data set could be considered a limitation in the methodology. The importance of language skills, both written and spoken, is a key factor which links both disciplines. This, in our opinion, reduces the limitation. However, this analysis provides a stepping-off point – a potential focus for further research on the relationships between people with refugee or migrant backgrounds and the health services and health professionals they engage with. Further research may point the way to a greater level of equity in our primary health care services.

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