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The Ambiguous Migrant. A Profile of African Refugee Resettlement and Personal Experiences in Southeast Queensland, Australia

Le migrant ambigu. Profil d'établissement et récits d'expériences personnelles de réfugiés africains dans le sud-est du Queensland, Australie

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[See table of contents](#)

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Article abstract

Australian history is marked by immigration control and attempts to exclude foreigners. Exclusionary strategies toward foreigners are expressed in policies that limit numbers and types of migrants and foster exclusionist attitudes amongst the population. Successive Australian prime ministers have won elections based on policies of immigration and border control. Fear and rejection of foreigners characterize current policies toward asylum seekers and refugees; importantly, this stance also affects the allocation of resources to support refugee resettlement. I examine the implications of underfunding health and social support services for African refugees in Brisbane. A profile of this population is provided along with a discussion of resettlement services. Abdominal pain and inadequate responses by the health system serve to exemplify the complex experiences of newcomers who have not yet found their place in Australia.

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ABSTRACT ■ Australian history is marked by immigration control and attempts to exclude foreigners. Exclusionary strategies toward foreigners are expressed in policies that limit numbers and types of migrants and foster exclusionist attitudes amongst the population. Successive Australian prime ministers have won elections based on policies of immigration and border control. Fear and rejection of foreigners characterize current policies toward asylum seekers and refugees; importantly, this stance also affects the allocation of resources to support refugee resettlement. I examine the implications of underfunding health and social support services for African refugees in Brisbane. A profile of this population is provided along with a discussion of resettlement services. Abdominal pain and inadequate responses by the health system serve to exemplify the complex experiences of newcomers who have not yet found their place in Australia.

RÉSUMÉ ■ L'histoire de l'Australie est marquée par le contrôle de l'immigration et par des efforts pour exclure les étrangers. Ces stratégies d'exclusion apparaissent dans des politiques qui limitent tant le nombre que les types de migrants et qui encouragent des attitudes d'exclusion au sein de la population. Plusieurs premiers ministres ont d'ailleurs successivement gagné des élections en misant sur cet appel au contrôle de l'immigration et des frontières. La peur et le rejet des étrangers caractérisent les politiques actuelles envers les demandeurs d'asile et les réfugiés; position qui affecte également les ressources disponibles pour soutenir l'établissement des réfugiés. Cet article examine les implications du sous-financement des services sociaux et de santé destinés aux réfugiés africains à Brisbane. Après avoir dressé le profil de cette population et décrit les services d'établissement, nous montrons que le cas des douleurs abdominales chroniques et des réponses inadéquates du système de santé permet d'illustrer les expériences complexes des arrivants n'ayant pas encore trouvé leur place en Australie.

KEYWORDS ■ Australia, migration policy, refugees, resettlement, health.

MOTS CLÉS ■ Australie, politique d'immigration, réfugiés, santé, services d'établissement.

THE UNITED NATIONS High Commissioner for Refugees reports on a population of 35,833,400 displaced persons of concern worldwide, approximately half of who seek asylum across borders (UNHCR 2014). Despite being a signatory to the 1951 Refugee Convention and its history as a country of migrants, Australia's response to global displacement has been weak. In the period between 1984 and 2012, Australia accepted approximately 14,000 refugees per year through its Humanitarian Program and has had successive policies of deterrence to curb asylum-seeker boat arrivals (see Figure 1 below). The current Liberal government won the 2013 election on a "stop the boats" platform and has made budget cuts that affect resources for resettlement of refugees/asylum-seekers. In reaction, community-based groups, churches and neighbourhood organisations have made up shortfalls in resettlement support. One possible reason for disparities in government and community support may be that approximately 25% of the Australian population was born overseas and 20.4% speak a language other than English at home (Australia Bureau of Statistics 2011). Diversity, while not apparent in government policy, is a feature of everyday life for most Australians.

This paper describes Australia's history of exclusion of non-British migrants and suggests that fear of foreigners underpins current policies toward asylum-seekers and refugees and affects funding of resettlement resources. Experiences of African refugees in Brisbane provide a recent example of how underfunding health and social support services contribute to difficulties in resettlement, specifically in relation to chronic pain as a bodily expression of complex experiences. A profile of this population is provided along with a discussion of resettlement services. Kirmayer (2003) has characterised the inability to understand refugee experiences as a failure of imagination on the part of government officials charged with assessing refugee claims. The same can be said of governments, resettlement and health services that consistently misunderstand and invalidate refugee experiences, often with important implications for individuals' health and well-being.

Background

Despite its history as a colony receptive to convicts, misfits, the British poor, and despite 20th century European and Asian war-impelled migrations, Australia's policies reflect a pervasive ambivalence toward foreigners. The first cohort of migrants was comprised of 230 soldiers and 730 convicts transported from England on 11 ships who arrived in Botany, Sydney Bay in 1788 (Burnside 2002). From then on, Australian immigration policy has been coloured by exclusion of non-British migrants. Notably, the Immigration Restriction Act of 1901-1958 used an English literacy test as the selection criterion, enabling arbitrary exclusion of individuals.

Vrachnas *et al.* (2005) has argued that Australian history is characterised by efforts to manage and control non-British immigration due to fear of contamination of the white population, employment of foreigners leading to low wages, and the desire to prevent racial conflicts. The White Australian Policy was, in fact, a series of cumulative policies that were developed in response to fear of the non-British subject, starting with the aforementioned Immigration Restriction Act and including the populist anti-foreigner stances of Prime Ministers Barton (1901), Hughes (1919), and Curtin (World War II). Moderation of these policies started after World War II when successive governments viewed immigration as a solution to labour shortages and means of stimulating business, and a way to fulfill human rights expectations. The Migration Act of 1958 dismantled the White Australia Policy by relaxing entry for non-Europeans. In 1973 the Whitlam government amended immigration legislation to enable all migrants to become citizens and to remove race as a barrier for eligibility to immigrate. The Racial Discrimination Act of 1975 outlawed the use of racial criteria in any government business. Whitlam held a vision of a multicultural society reflecting Australia's population and geography; however, subsequent governments created policies that maligned and excluded refugees (McMaster 2002). In 1981, the Special Humanitarian Assistance Program was created to admit refugees from Asia and Iran.

Despite more liberal policies, Australian governments remained ambivalent toward foreigners, particularly with regard to "irregular" migrants termed variously as asylum seekers, "boat people," "illegals," and "queue jumpers" (Crock *et al.* 2006). During the 1990s and 2000s Australian government policy toward refugees returned to exclusion under Prime Minister John Howard; Pauline Hanson (an influential member of Parliament 1996-1998) expressed the view that newcomers would be a threat to the Australian "way of life."

In Australia, refugee intake has fluctuated with the demand for asylum and the political will to grant it. Significant refugee arrivals began after the

Second World War with an agreement between the Australian government and the International Refugee Organisation to resettle displaced former concentration camp inmates. Between 1947 and 1953, 170,000 refugees arrived mostly from Poland, Yugoslavia, Latvia, Lithuania, Estonia, Ukraine, Czechoslovakia and Hungary. Substantial numbers also arrived after the Hungarian Revolution of 1956 and the invasion of Czechoslovakia in 1968. In 1972, Asians expelled from Idi Amin's Uganda began to arrive and the following year, Chileans escaping the *coup d'État* that ended the Allende government were also accepted. The fall of Saigon prompted the Australian government to address the refugee crisis in the *Australia and the Refugee Problem* report in 1976. By 1974, Greeks fleeing the Turkish invasion of northern Cyprus were accepted, as were 2500 East Timorese evacuees escaping the Indonesian invasion in 1975. Australia accepted about 22,000 refugees from Vietnam, Laos, Cambodia, Chile, El Salvador, and Iraq in the early 1980s. In 1984, 106 Ethiopian refugees were resettled who became the first important African group (Australia's refugee program 2011).

A turning point in refugee policy occurred in 2001 when a Norwegian ship, the MV Tampa rescued 433 asylum seekers from their vessel in waters between Indonesia and Christmas Island (Australian territory). The captain of the Tampa was refused permission to disembark the rescued passengers on Christmas Island and an internationally televised standoff with the Australian government ensued. After one week, New Zealand agreed to accept one third of passengers with the remainder accepted by Nauru in exchange for AUD \$20 million in Australian aid. The effect of the new policy of "offshore" detention and processing of applications was to discourage applications for asylum in Australia (Hatton and Lim 2005).

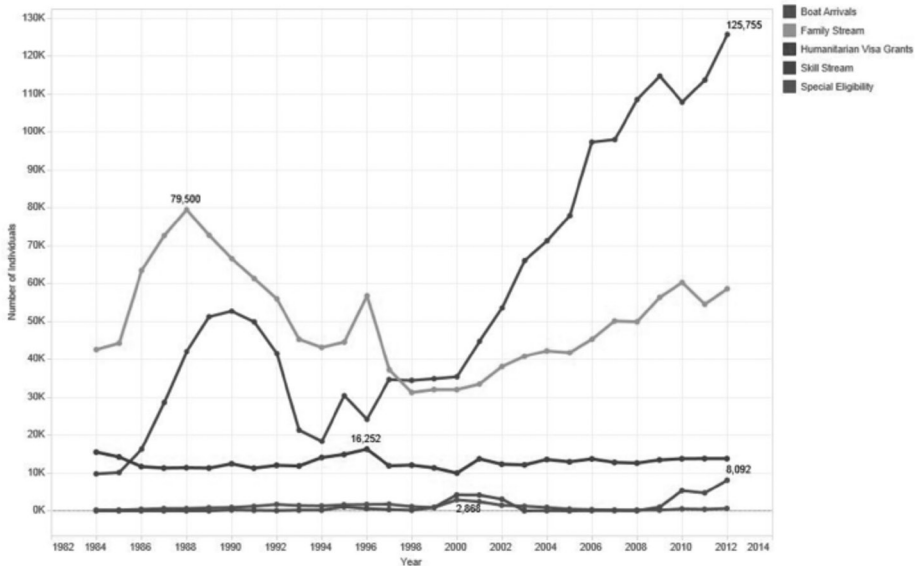
The ensuing policy, a combination of offshore processing, temporary protection, and mandatory detention known as the Pacific Solution, proved to be a successful deterrent to asylum seekers over the following years (McKay 2013). In 2008 the Labour government closed detention centres in Nauru and Papua New Guinea but retained Christmas Island to process boat arrivals. In 2012, responding to public perceptions of poor border security in the wake of increased boat arrivals and deaths at sea, the government appointed an Expert Panel whose recommendations included off-shore processing and detention, essentially a return to the Pacific Solution (McKay 2013).

The Coalition government led by Tony Abbott, elected in 2013, extended the Pacific Solution combining mandatory off-shore detention with naval intervention and a 'turning back the boats' policy which dramatically curbed boat arrivals. The human costs of deterrence are extensive: incarceration, uncertain futures, and poor access to legal

representation. Mental and general health problems are pervasive and well-documented (Loff 2002; Newman *et al.* 2008). In recent testimony to an Australian Human Rights Commission Inquiry, psychiatrist Dr. Peter Young, former director of mental health for International Health Management Services, the private medical contractor for detention centres, asserted that detention inflicts “an environment that is deliberately toxic ” in which health care is delayed and deterioration in mental health is observable (The Guardian Australia 2014).

Currently immigration to Australia falls into four categories: skills, family program, special eligibility, and humanitarian. There are six visa categories under the humanitarian program (200, 201, 202, 203, 204, and 866), one of which allows for applications made within Australia (201) (DIBP 2014). Though technically asylum-seekers, boat arrivals confound this system because recent governments (with a short hiatus during the Rudd/Labour government) have opted for offshore processing, placing these individuals in camps where their status is unclear. They are the most ambiguous category of migrant. A profile of migration to Australia is provided in Figure 1 below highlighting the consistency of refugee intake over a 20-year period.

FIGURE 1
Migrants by category and year



Source: DIBP (2014) <https://www.immi.gov.au/media/statistics/historical-migration-stats.htm> accessed June 18, 2014.

Australia accepts approximately 14,000 refugees annually within its Humanitarian Programme (HP) and according to the Department of Immigration and Border Protection (DIBP) this figure is unlikely to change (DIBP 2014 Ireland & Swan 2013). Recommendations made by the Expert Panel on Asylum seekers in 2012 to increase refugee intake to 20,000 per year have not been accepted by government. African refugees enter Australia under the offshore component of the Humanitarian Programme, which is divided into a number of different categories (DIBP 2013a). 6,718 of the total 13,759 humanitarian visas in the latest annual intake (2011-2012) were granted under the offshore component, and around 17 percent of these were awarded to Africans (DIBP 2013b: 74-76).

Accordingly, resettlement experiences of African refugees in Brisbane reflect the national ambivalence toward migrants. Small numbers of entrants, reduction of government resources for resettlement, and negative depictions in the media that frame asylum-seekers and refugees as threats (Bleiker *et al.* 2013) reflect an unwillingness to accept migrants perceived as different. Further, narratives of resettlement recounted by African refugees reveal experiences of exclusion within Australian society.

Considering this history, where do refugees fit into Australian political space? Refugees are unwilling migrants forced to leave home areas because of conflict, complex emergencies, and significant social ruptures such as genocides, political and gender-based persecution. Refugees often remain in transit in camps and third countries for years until they are resettled. To illustrate the extent of social disorder globally, the United Nations High Commission for Refugees estimated 35,833,400 persons of concern in 2013 (UNHCR 2013 and reported on 612,700 applications for asylum in 44 industrialised countries, with Australia receiving 24,300 of those applications (UNHCR 2013. At present, due to conflict in Iraq, Syria, Central African Republic and Sudan, the numbers of displaced persons have risen to an estimated 35,833,400 (UNHCR, 2014) to 51.2 million (Sherwood, 2014).

The scale of the global refugee predicament leads to the question: does Australia's intake of about 14,000 refugees per year constitute fulfilment of its obligations under the 1951 Refugee Convention? The segmentation of the category of 'forced migrant' into 'queue-jumpers' and 'boat people' inserts a moral dimension into political discourse suggesting categories of 'deserving' and 'undeserving' asylum seekers. For the Australian government, a legitimate asylum seeker applies from abroad without first breaching national boundaries by arriving *sans papiers*.

Clearly Australian immigration policies, historically based on principles of exclusion and supported by voters, would seem to be at odds with the multicultural character of the Australian population of Australia.

These policies are often formulated on emotive and factually inaccurate bases and mainly reflect political expediency and misunderstanding or misuse of historical events (Neumann 2009). International agreements, notably the 1951 Refugee Convention, are ignored or obfuscated in debates, and policy responses do not mirror existing demand for resettlement or the policies of other countries. Because of the Pacific Solution policy, current Australian government approaches to refugees contravene the 1951 Refugee Convention to which Australia is a signatory.

Methods

Two main research methods were employed to gather information for this study. A socio-geographic mapping of African migrants and government/community resettlement services in Brisbane area was conducted as part of the author's postdoctoral fellowship project on the health of African refugees in Southeast Queensland. Specifically, data on African migration were sought from the Department of Immigration and Border Protection and the Australian Bureau of Statistics. 180 of 567 organisations (both mainstream and migration specific organisations) were mapped to gauge accessibility to African refugee clients. The author also conducted ethnographic fieldwork amongst African refugee groups in Brisbane consisting of participant-observation at community fairs, performances, and in two suburbs where Africans predominantly live. The author participated in 6 community meetings at which African refugees discussed topical issues related to health, migration, resettlement, youth and women. The informality of meetings, their prolonged nature (between 2-5 hours) meant that participant numbers fluctuated but are estimated at between 60 and 80 individuals in attendance. A further 12 in-depth interviews were conducted with health providers and community workers. Community leaders provided guidance for the researcher and occasionally translated for participants, but most study participants spoke English.

African migrants in Brisbane: a profile

African refugee settlement in Brisbane is relatively recent, with individuals and families resettled in the area through joint federal and state government initiatives. These newcomers were displaced by war, natural disasters, and complex emergencies to refugee camps in countries such as Uganda and Kenya where they often stayed for extended periods with average worldwide internment estimated at approximately 20 years (Loescher and Milner 2009: 9). A refugee is a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership

of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country..." (1951 Refugee Convention).

According to the 2011 census, there were 3032 African refugees in Brisbane from 11 countries of origin. These constitute a fraction of the total African population of Brisbane, which consists predominantly of migrants who arrived under skills and family categories. Half of all African migrants are from South Africa.

TABLE 1

Population from Refugee Focus countries in Brisbane

Country of Origin	Population in Brisbane (ABS 2011)	% of Total Population of Africa Focus Countries
Burundi	133	4%
DR of Congo	204	7%
Congo	47	2%
Eritrea	183	6%
Ethiopia	387	13%
Liberia	248	8%
Rwanda	47	2%
Sierra Leone	176	6%
Somalia	359	12%
South Sudan	251	8%
Sudan	997	33%
Total Africa Focus Population	3,032	13.5% of Total Population from Africa
Total Population from Africa	22,376	2% of Total Brisbane Population
Total Population of Brisbane	1,110,888	

Source: *Australian Census of Population and Housing* (ABS 2011a).

Settlement services for refugees are delivered through the Integrated Humanitarian Settlement Strategy that coordinates agencies providing assistance on arrival, trauma counselling, accommodation services and other information. The Settlement Grants program provides assistance for up to five years after arrival. Additionally, requirements such as housing, education, legal aid, and support to families, is provided by a number of non-governmental organizations contracted by government. Refugee health is addressed on arrival by Refugee Health Queensland, a service that conducts initial health assessments, screening for disease, immunization, coordination of immediate health management, and referral to a general practitioner (Queensland Government 2008). After

the initial health assessment, health care of refugees is left to local general practitioners who find themselves relatively unsupported for giving care to patients who present complex health needs related to flight and transition (e.g., malnourishment, trauma, infectious disease) and resettlement (for example, change of diet, stress related to work and family issues, racism and exclusion). In addition, culturally-based health beliefs and descriptions of afflictions, which cannot be addressed through the biopsychosocial model typically used to record patient histories, present general practitioners with great challenges in addressing the pressing health needs of refugees. Refugee status confers residency and eligibility for state-funded health and social services.

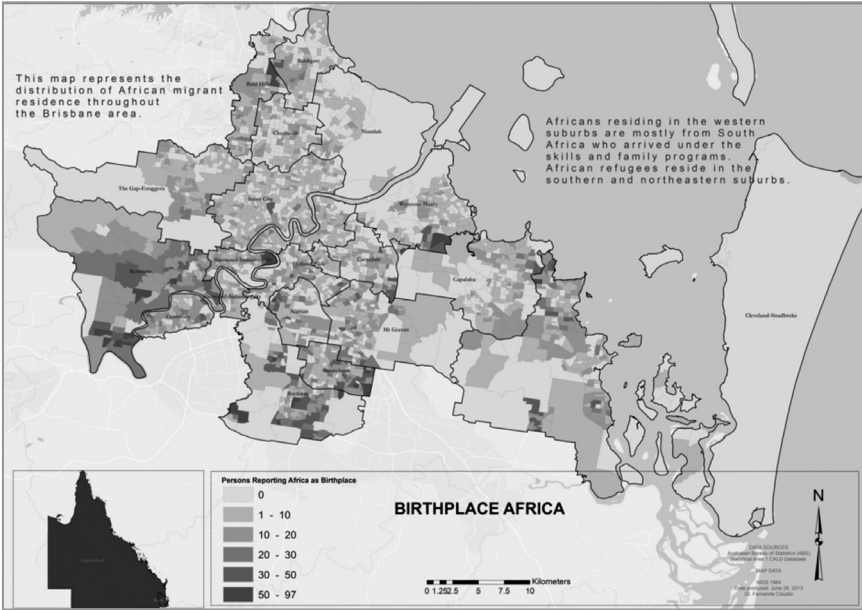
Gauging numbers of African refugees in Brisbane is challenging for a number of reasons related to categories of measurement. Australian Bureau of Statistics (ABS) data is based on country of birth and port of embarkation, which does not capture individuals born outside of Africa and also does not account for ethnic identification. Further, information on numbers of refugees is gathered by the Department of Immigration and Border Protection (DIBP) according to visa class and it is often difficult to accord this data with that of the ABS to gauge numbers of Africans in Australia who arrived as refugees. The design of research instruments to measure group size and composition and specific issues is also fraught with challenges related to sampling, consent and validity (Gifford *et al.* 2007).

A total of 22,376 persons who reported an African country as their place of birth reside in the City of Brisbane, only 2.01% of the total population of Brisbane. This figure does not include individuals who identify as African but were not born in an African country. Africans constitute a young population in Brisbane with roughly equal numbers of males and females. Since the conflicts that precipitated initial displacement have been raging for years, high numbers in the 15-19 and 20-24 age groups include a number of individuals born in camps and in third countries in Africa. Older individuals were born in the country with which they primarily identify (through kinship, place, or culture) (see Figure 2 below).

African refugees are concentrated in suburbs south of the Brisbane River where they were initially resettled and where communities have formed around businesses, churches and clubs. These suburbs have multicultural populations and are of lower socio-economic status. They are situated close to health and social services that cater to refugees. Recently, a trend to moving to the southwest part of the city has been noted due to increases in property prices that price rentals out of the reach of many refugee families (see Figure 4 below).

FIGURE 2

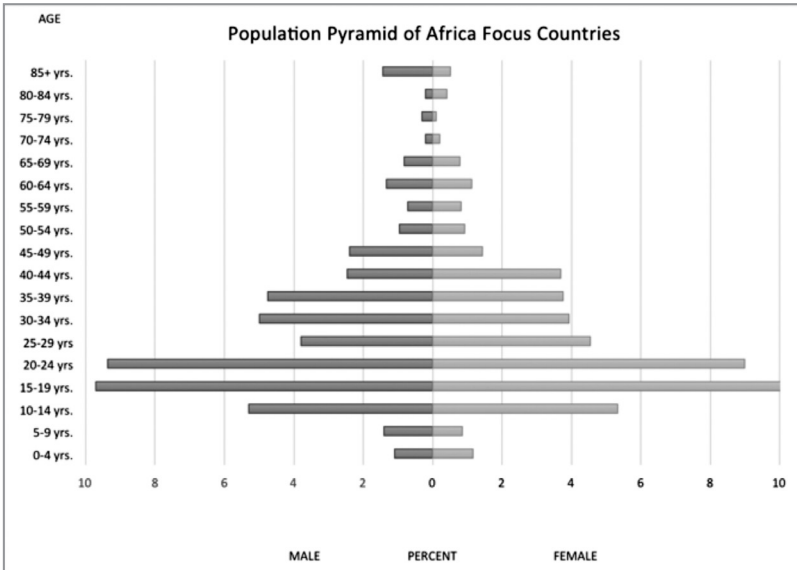
Number of persons who reported any African country as their birthplace and their geographic distribution in Brisbane



Map and Data sources: Australian Bureau of Statistics (ABS 2011b)

FIGURE 3

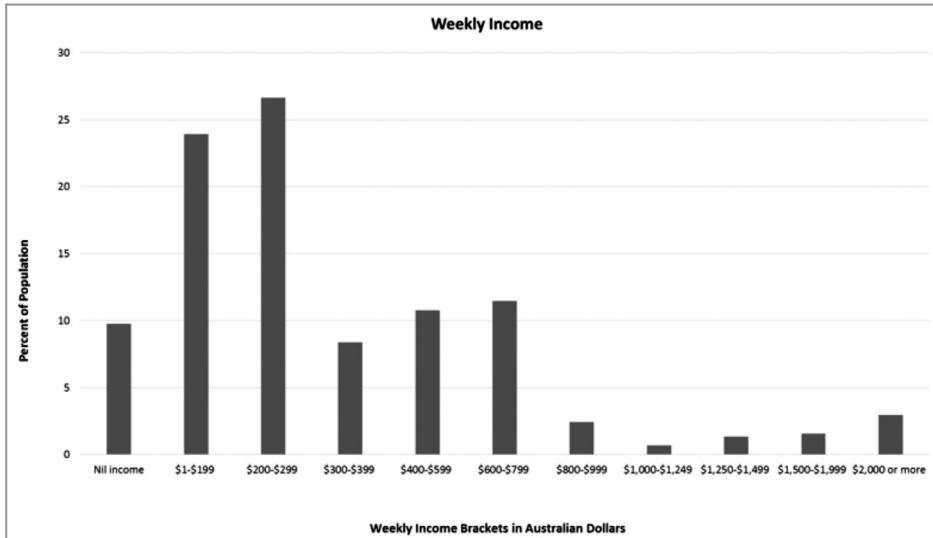
Population pyramid constructed for the Africa focus countries



Data source: Australian Bureau of Statistics (ABS 2011b)

FIGURE 4

Weekly income brackets by percentage of African population



Data Source: Australian Bureau of Statistics (ABS 2011b)*

The Brisbane African refugee population is characterised by its young demographic, low incomes, clustered residence patterns, ethnic diversity and complex health and social needs. Their stories of migration are typical of refugee experiences but exceptional within the context of Australia, a wealthy and peaceful country.

Origins and transitions

African refugees in Australia fled war in their home countries often leaving family members behind, losing possessions, and experiencing or witnessing violence. Their stories of flight depict long walks to safety, encounters with armed groups, fleeing wild animals, and experiencing prolonged fear.

An account from a community worker who was a refugee:

Because with flight in a war area, whenever the shooting starts, you have to take cover and run for your life. So most of them just left leaving the family not even knowing where they are. During their flight they encounter a lot of things, some of them are captured, some of them are killed, some of them,

* Figures 2, 3, 4. Australian Bureau of Statistics 2011 Census, 'Greater Brisbane Area (Statistical Area 1), Cultural and Language Diversity, accessed 2 June 2013: <http://www.abs.gov.au/websitedbs/censushome.nsf/home/datapacks?opendocument&navpos=250>

their husbands or children are killed in front of them. So some of them are really – they face a lot of torture, trauma on their way through their flight. (Sudanese female)

All the African refugees who were interviewed had transitioned through a third country before their arrival in Australia. Many had spent years in refugee camps in Uganda and Kenya, while others lived in Egypt and other countries awaiting an Australian visa. Transition was experienced as a time of great uncertainty due to poor security, lack of resources and social support networks and uncertain futures.

An account of attack on a camp from a former refugee who was also an aid worker:

There were interned and displaced people.... Then the army came and told them that okay, now you people are here, say if you gather in one big hut. So they collected all them women and their children and put them all in a big hut – which is a mud house. Then at night they send it a blast. All of them were burned to death. This affected most of the husbands in their community. (Sudanese female)

These stories of social rupture and escape, of violence and survival constitute the backdrop of the lives of many African refugees in Brisbane. Such experiences are often silenced in the quest to live normal lives, but beyond the notion of trauma, they are a normalised (for this group) version of existence and find expression in bodily conditions. These conditions are invariably misunderstood by health and social service systems that are too under-resourced to apprehend the needs of the clients they serve. Community organisations, churches, and volunteer groups that provide household materials, clothing, advice, homework support, prayer groups, and advice on access to available services often meet shortfalls in care.

Resettlement services available to Africans in Brisbane

While some African refugees arriving in Brisbane have local contacts in the form of friends or family, most are in need of help from government. The federal government funds the Humanitarian Settlement Service (HSS) program and the corresponding Settlement Grants program (SGP) (DIPB 2014b). Services provided include reception and assistance at arrival to find accommodation, provide food and household goods, help to register with Centrelink (social services), Medicare, find health services, banking and education. In Brisbane these services are delivered through the Multicultural Development Association, which holds a government contract.

As part of a larger study of health of African refugees in Brisbane, we mapped 180 of 567 identified organizations that provide social, health, legal and advocacy services to immigrant communities in Brisbane and compared these against areas of settlement of African refugees. Our intent was to gauge physical accessibility (driving time) of services by African refugees. Results are below:

TABLE 2

Accessibility of social services to percentage of population of interest and to Brisbane population

Social Service Accessibility Status	Asia (N and SE) %	Africa %	Total %	Brisbane Pop %
Accessible to (10 minutes)	49.12	49.71	49.24	40.31
Less accessible to (20 minutes)	45.82	45.72	45.80	41.15
Least accessible to (20 minutes or more)	5.05	4.55	4.94	18.52

(Note: The wider Brisbane population is unlikely to use social services tailored to immigrant communities; values are provided for comparison only).

The research results show that there is moderately good physical accessibility to services but that this does not, in itself, correlate with service use. Poor uptake may be related to language barriers (older Africans speak a variety of languages including Dinka, Nuer, Arabic, French, Kinyarwanda and others), poor understanding of available services, dissatisfaction with outcomes, and under-resourcing such that specific organisations may have long waiting lists or provide only minimal versions of their service. For example, mental health organisations are typically funded to assess clients but not to provide extensive therapy so that outcomes for refugees are often unsatisfactory.

Health and pain

Health is a primary concern of African refugees and it is known that both pre-migration and resettlement experiences can affect their health over time (Marlowe 2009). African refugees most likely experienced forced displacement and violence, and like other refugees, can present mental health problems such as post-traumatic stress, anxiety, and depression (Gwahirisa 2009: 40; Murray *et al.* 2008: 6).

Until June 2012, refugees were provided with a health assessment through Refugee Health Queensland (RHQ), a program of health screening and referral that, in 2011-12, assessed 86% of all refugee arrivals in Queensland. They were then referred to a local GP and other health providers (dentists, optometrists) according to need. This also meant that

medical records were kept from upon arrival and available to subsequent carers. RHQ was de-funded in 2012 by the incoming Queensland state government whose funding priorities shifted and as part of more general funding cuts made within the health sector. A reduced version of RHQ is currently delivered by a private hospital with a social justice mission, however, reduced scope means that refugees now seek health care from clinics and general practitioners who may not have expertise in refugee health. Additionally, although doctors can bill Medicare for assessments of refugees, time constraints, language barriers, poor knowledge of specific refugee health needs, complex cases, and tropical diseases can negatively affect diagnosis and treatment. Manderson & Allotey (2002) similarly found lack of time in the clinic and poor language skills to affect health assessments of refugee patients. The result of de-funding RHQ is the fragmentation of care, such that African refugees resort to consulting a number of doctors and health specialists, often without appropriate care pathways, and with frustrating results. African refugees report that while they are treated with respect by health practitioners, and feel that Australian health care is very good, consistent misunderstanding and lack of redress of their health conditions are common.

Abdominal pain is one complex health complaint that could benefit from better coordination within health services and more extensive knowledge of the circumstances of refugees by health practitioners. It appears to be pervasive amongst Africans as described by one male refugee: *“Maybe 6-7 of every 10 men and women (have abdominal pains). They eat the same food and drink the same water.”* Community workers estimated that between one quarter and half of African adult clients were afflicted by abdominal pain. This pain is described as chronic, acute and sometimes disabling, such that afflicted individuals become unable to work. The pain is invariably described as air in the intestines, pain in the stomach, a *“burning in my heart,”* and constipation. It is sometimes accompanied by muscle contractions and difficulties with walking.

One community worker recounted the following:

To be honest with you I've been confronted with so many people through my health education that issue has come up, but honestly I told them I don't know, because it is everywhere. The people who suffer from that, they say they have seen their doctor more than – many times, but it yields no good result. So I don't know what is causing the pain in their stomach. Even me, up to now I don't know the answer for that. Some of them have gone back home and they ended up with treatment and they come back they are better, so some of them are saying maybe water, maybe food, maybe this, maybe that, I don't know. To be honest with you I don't know. (Female Sudanese community worker and former refugee)

One doctor, who worked with refugees for most of her career, believes that abdominal pain is a manifestation of combinations of anxiety, trauma, psychological distress and physical conditions requiring investigation. She describes abdominal pain as “a gateway” to understanding the broader circumstances of refugees. Her views are mirrored in the accounts of African refugees who described a variety of situations that, in their view, contributed to chronic pain. Importantly, their accounts point to the cumulative effects of the whole of the refugee experience as factors in creating a physical pain that represents a deeper psychic pain. Notably, the experience of flight was described as traumatic by refugees:

We run from water, we drink dirty water with the elephant walking in [it]. Sometimes [there was] no food. We walk many kilometres for food, but [it was] just for the children. (Middle-aged Sudanese woman).

[In Uganda] there was a lack of food, people thinking too much....When you are a mother, you sleep two hours a night. You have rebels, you don't sleep, you run to hide. If you are running in the bush, there is no clean water, no doctor. You drink water from rivers.... Then you arrive here, but still thinking of children and husband and others at home. One sister dies, a child is left there.... (Woman from Sudan).

Refugees describe the time spent in camps in Uganda as difficult:

In Uganda I wanted to die (from abdominal pain). Doctor here told me allergic, medicine does not help, (I have) difficulty in going to the toilet. (Sudanese woman).

In Uganda, the food was dried, the maize needed to be ground and we boiled the maize kernels. We got food rations and the milk products were poor. (Sudanese woman).

In Africa I was drinking contaminated water used by animals – which causes diarrhea – eating contaminated food, doing excessive exercise, walking and carrying weight. (Middle-aged Sudanese man).

Other informants were clear in their view that the condition had started after arrival in Australia:

I arrived healthy but then got the pain after two months. It started with an itchy foot, attacks on nerves and then can't walk. I was 2 months in hospital, now I take pain medication. I go to the doctor when pain starts because I have no one to assist me here. Traditional herbs don't exist here. (Sudanese man).

After a few months, the food here, very bad, had blood in faeces and was vomiting blood, but there was no diagnosis. (Sudanese man).

Three Sudanese women mentioned their perceptions of discrimination as a contributing factor to abdominal pain:

- *People pretend they don't see you.*
- *There is bullying at school and I removed my son.*
- *My son was told to go back where he came from.*

Abdominal and other persistent pain amongst refugees represent more than a physical ailment, they are embodied signals of suffering within the predicament of refugee life. Coker (2004) described how Sudanese refugees in Cairo interrelate narratives of ailments with histories of displacement to create accounts that describe, in physical terms, perceived assaults on their sense of self as human beings and members of communities. Thus, the body speaks of the loss certain worlds, of family, community and culture. In these terms it is understandable that when pain becomes intolerable, those who can afford to do so, return to an African country (not necessarily that of their birth) to consult with a healer. Those who cannot travel, either because of finances or legal status, consult African traditional healers in Brisbane who prescribe African medicines and herbs.

Constraints in understanding the refugee experience begin with the process of categorisation of refugees. Refugee law and the specific national guidelines and tribunals that decide who is a refugee also determine what are the acceptable frameworks within which narratives of flight and displacement must be framed. Thus human narratives must fit both Australian visa categories and the expectations of assessors. Individuals only gain refugee visas when there are shared and accepted understandings of their predicament. Incongruent accounts are risky, despite their truth for the refugee, and are held in abeyance until they resurface after resettlement as psychological and bodily manifestations. Kirmayer (2003) has argued that inability to understand refugee narratives are three-fold failures of the imagination: of the refugee's inability to construct an account that bridges the old and new (resettled) lives which may be separated by a traumatic act of violence; of the clinician's failure to understand the refugee's situation; and, of refugee assessors who look for inconsistencies in stories to identify fake accounts. Inconsistent accounts that represent both experiences and memories fragmented by trauma are excluded from the neat and understandable narratives expected of refugees. When avenues to acknowledge and express the alternate experiences of refugees are limited, expression takes place through the body. Constraints on the refugee self are myriad in the resettlement process and continue long after the visa assessment is done. These occur within the broader Australian community that consistently votes for politicians who stand for immigration control, and within under-resourced social and health systems that fail to apprehend and address complex refugee needs.

Social exclusion: perceptions and experiences

Fozdar and Torezani (2008) found that despite various obstacles related to niche employment, low incomes, and discrimination, refugees in Western Australia did not report significant dissatisfaction with life (76.7% reported satisfaction). The authors attributed these results to mitigating factors such as culturally conditioned politeness, personality, social support, and the belief that despite experiences of discrimination, Australians are basically good people. African refugees approached in Brisbane provided mixed responses to the question of discrimination. While most individuals could recite experiences of subtle and/or overt exclusion, the impact of such experiences varied by age and gender. The young appeared more philosophical about the issue. One man in his early 20s stated that:

What Africans experience today they face the same as other migrant communities. Italians faced racism but worked together. It is a matter of establishing our own identity. One of our greatest achievements is the QACC (Queensland African Communities Council). We are working in line with the system here. We need to introduce a youth element.

In contrast, an older woman described her sense of exclusion as follows: *“Australians do not like outsiders. I do not have a good appetite to stay in Australia.”*

The difference in these accounts relates to age, gender, life-experience and perceived ‘fit’ in Australian society. The young man was educated in Brisbane, had made Australian friends and adopted similar values and ways. The older woman had experienced camp life and challenges of supporting children in a new school system. She found fewer mechanisms to express her identity wrought from the sum of her pre- and post-resettlement experiences. Like other refugees with similar experiences, she also suffered from chronic abdominal pain.

Being an African refugee in Brisbane is characterised by oscillation between loyalty to Australia and perceptions and experiences of exclusion and hardship. The real and symbolic pull of Africa, as the seminal place of origin, in terms of kinship relations and notions of health, welfare, and happiness, plays a part in difficulties of adaptation. At the same time it is important to remember that Australia is exclusionary toward foreigners, as evidenced in its history and current debates regarding refugees. This oscillation between Australia and Africa, described by informants as a collection of uncertainties, is nowhere more apparent than on the body of African refugees.

A sense of belongingness appears to be important to African migrants in Brisbane since 69% are Australian citizens (figure derived from DIBP).

Citizenship represents the certainties of legal status including rights and protections that many refugees never had, and ability to travel. Africans become emplaced in Australia, yet the families left behind and the failures of welfare and happiness in Australia lead to maintenance and strengthening of familial, political, health-seeking, entrepreneurial, and cultural connections with African countries.

Conclusion: the politics of ambivalence

Ambivalence is the opposite of commitment, yet this has been the stance of much of Australian immigration policy throughout the country's history. At the political level, acceptance rather than vilification of asylum-seekers and refugees would set a standard for policies that address their health and social support needs. In the current political climate, services have been reduced, and those that still exist are plagued by short-term funding, uncertainties about the future, and insufficient resources to provide effective supports. Poor uptake of some services may be related to unsatisfactory understandings of client's needs and poor outcomes. African refugee populations in Australia are young, are willing to become citizens, and feel hopeful about the future. Yet they struggle constantly against social exclusion and poor livelihood prospects demonstrated through low incomes.

Early resettlement experiences can affect migrants' functioning within Australia and the futures they imagine for themselves and their children. Health and social supports are the gateway to proper inclusion and should be invested in rather than reduced in terms of the practical support they offer, but also as a gesture of acceptance of the refugee other.

Neumann *et al.* (2014) found that scholarship on refugees in Australia contains 'blind spots': it is predominantly ethno-specific and ahistorical with a focus on the problematic (e.g., trauma), thereby missing opportunities to address issues such as refugee transnationalism, and to relate the extensive work on resettlement with government policy. Scholars have an important role in representing refugees on their terms by accepting that while their stories may be incongruent with Australian experiences, nevertheless, whether told with words or bodies, they constitute an important addition to its society. Indeed, it would seem, as Kirmayer (2003) puts it, that excluding newcomers is a failure of the imagination.

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