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Regionalizing Immigration, Health and Inequality: Iraqi Refugees in Australia

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Abstract: Humanitarian immigrants and refugees face multiple adjustment tasks and post-settlement support services concentrated in metropolitan areas play an important role. As part of an ongoing commitment, the Australian Government has increasingly supported resettlement in rural and regional areas of the country. Drawing on the experience of Iraqi migrants in Victoria, Australia, we examine some of the conditions that characterize regional resettlement and raise key questions for public health policy. Structural vulnerabilities and discriminations impact upon physical, mental and social wellbeing, leading to further exclusion, with negative long-term implications. The discussion throws light on the issues that migrants and refugees may encounter in other parts within Australia, but are also germane in many countries and highlight the resulting complexity for policy-making.

Keywords: Australia; refugees; regional resettlement; support services; vulnerability

1. Introduction

In recent decades, migration across and within borders has both intensified and diversified, raising significant questions concerning the health and wellbeing of mobile populations and host communities. Most host governments with major immigration programs recognize health as an essential human right, and acknowledge the importance of providing services to people and communities of diverse

racial, ethnocultural and language backgrounds [1–3]. However, important questions remain on the extent to which humanitarian immigrants and refugees share the same basic rights and entitlements as citizens in relation to accessing social and health care services [4,5]. The asylum policies of successive Australian governments, and the effects of these policies on individual rights and entitlements, are widely documented and continue to be contested in contemporary politics [6]. Further, even immigrants with rights and entitlements can face a range of barriers which limit their access to, and use of, health care services in host countries. Access is influenced by the economic status of immigrants, their lack of familiarity with the language and culture as well as services, and the official policy criteria by which support is provided [5,7,8]. For some, too, poor access is related to the precarious civil status of other family members [5].

One example influencing immigrant rights and entitlements is the consequence of the dispersal of refugees in receiving countries from urban areas, where new immigrants tend to concentrate, to regional and rural areas. This policy has been implemented to some extent in the United States, Canada, the United Kingdom, Germany, the Netherlands, Denmark, Portugal and Australia [9–16]. To date, research on regional resettlement has been limited, although in Australia, both scholarly studies and research projects commissioned by government (by the federal Department of Immigration and Citizenship [DIAC] and its predecessors) have focused on the effectiveness of existing policy schemes and on labor market integration, income, education and training [17,18]. The planning and implementation of regional refugee resettlement, its administrative structures and processes, service delivery, and its gaps have also been explored [19,20]. Recent studies have investigated the outcomes of regional (re)settlement for the migrants and particularly refugee settlers themselves, related to inclusion, social integration, health and wellbeing, and service support [6,21–23]. In this article, we begin to address a gap in the literature on regional resettlement by exploring factors that render immigrants structurally vulnerable to ill health.

Drawing on the experiences of refugee Iraqi men and women resettled in regional Victoria, Australia, we aim to contribute to research on more recent migration policies, by analysing how dispersal influences the integration experiences of these refugees. Although the focus is on regional Australia, the issues discussed can inform policy in countries where migrant settlement away from major cities is an increasingly relevant settlement trend. In particular, we consider how such policies can induce physical and emotional suffering in patterned ways on specific population groups and individuals, as a product of class-based economic exploitation and cultural, gender/sexual, and racialized discrimination. In doing so, we raise important questions concerning the wellbeing of refugee populations both in Australia and in other refugee receiving countries, so providing an essential evidence base for targeted public health policies and programs.

2. Regionalizing Refugee Immigration in Australia

Over the last several decades, Australia's immigration environment has changed significantly [16], with the increasing diversity of intake, and changing patterns of growth and ageing within already established migrant communities. Australia's migration intake has mainly focused on skilled migrants [16], although in response to the global economic crisis and the resultant rise in unemployment, the skilled stream has declined from 133,000 to 115,000 in 2009. In contrast, the intake under the Humanitarian

Program has increased from 12,000 places in 1998–1999, to 13,500 places in 2008–2009, to currently 13,750 places annually [24]. This includes both offshore places (that is, applications are processed overseas) and onshore places (refugees are accepted following assessment for asylum status in Australia). Recent arrivals have included people from Burma, Afghanistan, Iraq, Iran, and Sudan, and from temporary refugee settlements in transit countries. There are also growing numbers of humanitarian settlers from other African countries. With the exception of Afghanistan, these immigrants are from countries with little history of earlier migration and settlement to Australia, and accordingly, without established populations, ethnic community organizations, or government experience. For example, only 288 Iraqi people had arrived in Australia before 1981. By the end of the Gulf War in 1991, the size of the Iraqi-born community in Australia was 5186 [25]. Since then, Australia has accepted increasing numbers of Iraqi refugees and asylum seekers, fleeing gross violations of human rights, violence, civil war, socio-economic disasters, life threatening circumstances and destitution, under the rule of Saddam Hussein of the Ba'athist party and following the 2003 invasion [6]. From 2000 until 2010, Iraqi refugees were among the top four nationalities accepted under the Humanitarian Program [24]. Refugee-receiving states such as the United States and Australia have introduced increasingly restrictive migration legislation and policies [26]. This can be attributed to an increasingly xenophobic socio-political atmosphere, which intensified in the aftermath of the destruction of the World Trade Towers and the War on Terror [8], the global increase in the number of asylum seekers in the late 1990s, and as a result of associating forced migrants with security risks. The aim of this new wave of migration reform is to tighten controls on people's movement and reduce the burden of asylum seekers and refugees in host societies. In Australia under the Howard Government (Liberal Party, 1996–2007), this included mandatory detention, temporary protection visas, and offshore processing of asylum seekers under the Pacific Solution. Most recently, the Gillard Government (Labor Party, 2010) proposed the 'Malaysian Solution' to continue the system of 'offshore' processing introduced by Howard. Under the plan, Australia proposed to send to Malaysia the next 800 asylum seekers intercepted while trying to reach Australia by boat, with their claims for asylum heard offshore. In return, Australia would accept 4000 UNHCR-certified refugees residing in Malaysia for permanent resettlement. This solution was ruled unlawful by the High Court in August 2011 and was rejected in Parliament in October 2011. The decision was subsequently made, with continued controversy, to process people seeking asylum, reaching Australian waters, on shore.

2.1. Refugee Dispersal

Another example of restrictive immigration policy in receiving countries is the dispersal of refugees away from urban areas. The impetus for this settlement strategy was the need to share the 'burden' of hosting new arrivals among different administrative areas, to prevent the concentration of immigrants in certain localities which might as a consequence of concentration result in social disharmony [27], and to help build regional economies [28]. The subject at the center of this assumed burden, the 'refugee', stigmatized as 'draining the welfare system' due to the difficulties that she or he faced in being integrated into the labor market, is frequently juxtaposed to the figure of the skilled 'useful' immigrant, able to contribute both to the labor market and pay taxes [29].

In Australia, the information provided by the DIAC on the background of regional humanitarian settlement refers to the interests of refugees rather than those of the host community, by pointing to the good settlement prospects regional Australia can provide for some humanitarian entrants, particularly those from a rural background [30]. At the time of writing, in response to the failed 'Malaysia Solution', and following the dismantling of mandatory detention, many new asylum seekers are now detained for short periods and then release them into the community on bridging visas. A new policy was being explored by the government which aimed to place asylum seekers in regional towns with labor shortages, where (in theory) they would find work and support themselves [31].

Strategies to encourage settlement to regional or rural towns evoke the tension inherent in the immigration policy arena in refugee-receiving countries between economic demands for immigrant labor and political fears of xenophobia [32]. Traditionally, refugee housing and settlement has been concentrated in large cities [33], with a range of social, cultural and economic resources, including migrant/refugee specific services provided by social welfare NGOs and government agencies. In cities, ethnic organizations and informal support systems also provide support to most legal refugees and immigrants to encourage them to access services as a right, for example, to attend English language classes, seek employment advice, and access trauma counseling offered by dedicated non-government programs. Access, supported by entitlement to government aid for such services, is limited in many cases to five years post-arrival. Non-metropolitan areas generally have limited capacity to meet the diverse language, health, housing, education and employment needs of new settlers. In these areas, there are relatively few community development and immigrant support services of any kind, and even basic services may be difficult to access or are unavailable. In these areas, too, despite shifts in patterns of migration and attitudes to population diversity, there has been considerable distrust of migrants of all backgrounds, and instances of (usually covert) discrimination. This is compounded by practical difficulties. For many, lack of employment opportunities commensurate with prior occupation, education, and skills place the burden of settlement largely on refugees, contingent on their capacity to fit in.

Since 2004, however, the Australian Government has actively resettled to regional towns and rural areas refugee and humanitarian entrants without existing social or family links elsewhere in Australia [17,34], and there has been a steady increase in the number of regional resettlement sites, programs and financial support for resettlement [35]. Locations for new settlements are chosen on the basis of employment opportunities, 'adequate' population size (greater than 20,000 to ensure adequate infrastructure to meet the specialized needs of humanitarian entrants) and population diversity, available and affordable rental housing, established mainstream and specialist services, and the ability of the host community to demonstrate a 'welcoming environment' [28]. By 2008 (most recent available data), refugee regional resettlement initiatives had been implemented in almost all states and territories [17], with approximately 7.5 per cent of entrants settled in regional areas [28,36,37].

2.2. Refugee Entitlements

Refugees are particularly vulnerable, with multiple health risks [3]. They have greater health needs than most voluntary immigrant arrivals, influenced by individual pre-migration circumstances and experiences, factors precipitating flight, differences in selection criteria, and the resettlement process including an often extended period of detention [38]. Refugees may therefore require greater health

services on acceptance for resettlement, including for mental health. The Victorian Foundation for Survivors of Torture (VFST), located in metropolitan Melbourne, provides a range of services to people who have survived torture or war-related trauma, but has limited outreach services across rural and regional areas of the state. No other dedicated services are available, despite growing evidence and increasingly despairing advocacy by mental health professionals of this need [38]. In addition to mental health services, refugees and other humanitarian settlers may also require greater access to employment services, shelter, and social care, as occurs both for women who migrate alone or with children only (women at risk) [39], and for refugee minors [37]. Refugees often face further hurdles impeding their ability to access support services as they struggle with low socio-economic status and so poverty, which leads to increased health problems and higher rates of chronic illness and disability, weak social and cultural supports, and difficulties understanding the health care systems and communicating their needs properly with doctors and other professionals [3].

Humanitarian entrants are entitled to various services provided through settlement assistance programs to aid them in “participating equitably in Australia society as soon as possible” [34]. The Integrated Humanitarian Settlement Strategy (IHSS) provides initial intensive settlement support and orientation to newly arrived entrants for a period of six months. These services include on-arrival reception and assistance; accommodation services; case coordination, information, and referrals; short-term torture and trauma counseling; and emergency medical needs [24]. Humanitarian entrants are then referred to general settlement services provided through migrant service agencies and organizations funded under the Australian Government’s Settlement Grants Program [40]. Other settlement services are provided by community groups, faith-based services, and secular local and national NGOs. People who enter Australia as part of the resettlement program are entitled to these services for up to five years, after which they are expected to access mainstream services, which include Migrant Resource Centers (MRCs), Migrant Service Agencies (MSAs) and the Community Settlement Services Scheme (CSSS). They also include the Translating and Interpreting Service (TIS), health allowances such as Medicare and the Health Care Card (providing subsidization of health care and pharmaceuticals), social security benefits and employment support, material aid and emergency relief, and state-funded public housing [40]. However, not all humanitarian settlers are eligible for support within the service system. For example, limited assistance for some asylum seekers is provided while their applications for protection are processed. This includes health and welfare services, assistance with protection visa applications, work rights and temporary eligibility for Medicare [35]. Sponsored refugees also have limited entitlements, as the sponsoring families themselves are expected to assist with their settlement needs. In addition, settlement service provision is not fully developed even in urban areas, and a greater problem in regional and rural areas. Numerous small NGOs provide fragmentary support determined by their own capacities and experience, but again, these are concentrated in metropolitan areas. There are gaps in most areas [22,40].

3. Methods and Study Participants

The case material presented below derives from an ethnographic study conducted between 2003 and 2007 with refugee Iraqi men and women in a regional town in Victoria, Australia, referred to pseudonymously as Taraville, where, for the last 15 years, there has been a steady flow of Iraqi

settlers. All entered Australia under the Refugee and Humanitarian Program. The key research methods included group discussions and participant observation, as well as in-depth interviews conducted over a period of 15 months with 36 Iraqi women and men, 16 service providers, and members of the wider community. To preserve confidentiality, people's names and identifying details have been changed. Despite the common humanitarian roots of the refugee participants in Tarville, their backgrounds were diverse [23]. All settlers had initially arrived in Australian capital cities, and subsequently moved to Tarville not as part of the government settlement strategy, but because of a small pre-established Iraqi community in the region and the availability of seasonal work and public housing. Several were employed either on a permanent basis or seasonally in the agricultural industry, but the vast majority of participants were welfare-dependent. The experiences of these refugees, located in an area where other recent refugees have settled in the wider region illustrate the broader challenges related to regional settlement.

4. Experiences of Regional Resettlement

4.1. Employment: Quality and Quantity

In Australia, successful economic adjustment is central to refugee resettlement policy [41], as gaining stable, adequately remunerated, fulfilling employment is a significant contributor towards successful resettlement [42]. However, many regional areas in Australia have struggled economically in recent years. When the ethnography was being conducted, much of Australia was experiencing one of the worst and most prolonged droughts on record [43], which significantly impacted upon primary producers, particularly affecting rural exports and employment opportunities [44]. Growing inequality between urban and metropolitan areas is evidenced by the fact that while only 18 per cent of the Australian population lives in regional areas, these localities make up 39 per cent of all areas in poverty [45]. Reflecting these difficulties, regional Australians experience higher than average rates of suicide, risky alcohol consumption, and sexual and domestic violence, are less likely to have access to non-state schools, and less likely to be educated beyond Year 10 (age 16) [46]. Regional and rural areas of Australia continue to experience a chronic medical workforce shortage [47], and the recruitment, retention and training of mental health workers is a major concern [48].

The environmental unpredictability, economic volatility and limited services translate to a significant discrepancy in some areas between the support to which refugees are entitled officially under the regional resettlement scheme [40], and what is available to them on the ground. Although policy documents emphasize adequate employment opportunities in regional areas, for example, the options available to the Iraqi refugees were limited to primary industry, mainly seasonal fruit picking, work often considered unattractive to the local labor force. The majority of Iraqi women were not working nor were they actively looking for work, due to household and childcare responsibilities. Many Iraqi men relied on seasonal fruit picking work to supplement welfare payments, despite the fact that some had qualifications and had worked as highly trained professionals in Iraq. They commonly stated that they found the wages poor and the work demanding and demeaning. According to local perceptions, the work is available for people who make the effort, but the onus is on individual Iraqi men to get the work.

Other factors come into play for men trying to secure employment, such as lack of English, recency of arrival, non-transferability of qualifications [40], unfamiliarity with the labor market, and likely Post Traumatic Stress Disorder (PTSD), depression, and other mental health problems. As one Iraqi woman described in a focus group, “no one will give us jobs, because we do not speak the language well, we do not have any qualifications, any certificates, any experience, no one will give us jobs.” Given the limited employment opportunities in regional areas, Iraqi refugees are potentially vulnerable to exploitation too, as Nicole, a service provider, commented in regards to basic working rights and entitlements:

The orchardists do abuse the Arabic workers because they are literally saying to them ‘you work for \$10 cash in hand or you have no job’. Now, they can’t do that with the Australian workers, you know they have to pay them whatever the going rate is. But these people are equally entitled to earn a proper hourly rate, to have superannuation or sick leave.

The limited research undertaken in regional areas indicates that refugees are overrepresented among the underemployed, low-paid, low-skilled, precariously employed and casualized members of the labor force [49-51]. While refugees in major cities are also vulnerable, the limited labor market means exposure is more cogent for refugees in these areas [6]. There is also a perception locally that Iraqi refugees are in this position as a result of their own ‘shortage of human capital and low productivity’ rather than structural forces. As one local man explained, “these people don’t seem to want to create something, you see them up the street, they don’t seem to be working to me. These people don’t want to work”.

4.2. Discrimination

Owing to the multiple barriers faced by recent immigrants in Taraville in integrating into the labor market, many Iraqi families depend on routine government (Centrelink) welfare payments. For a single person, this payment is \$456 per fortnight compared to the minimum wage of \$589.30 per week. In addition to supporting families in Australia, many Iraqis in this study were sending remittances to family members in Iraq and other countries of exile and so often struggled financially. However, the myth that refugees receive generous assistance is widespread. For example, in Taraville the general perception concerning Iraqi people and welfare assistance was as follows: “We know you don’t have a job, so how much money is the government giving you that you can afford a new car or to put a satellite dish on your commission home”?

Over 25 years ago, Hawthorne [52] commented that migrants living in regional areas were under surveillance from the wider community. This is still the case. While refugees in cities are subject more to the scrutiny of fellow travelers than other residents, those living in small country towns are under regular informal surveillance and suspicion, perceived as freeloaders on the welfare safety net. As one local Anglo-Australian resident described it, “I heard that many families went to Mecca this year. How can they afford to go to Mecca when they are all collecting unemployment benefits, what do they do, how can they go, and they reckon they are refugees”?

Perceptions of Iraqi immigrants draining the welfare system are compounded by some local perceptions that Iraqi refugees are taking scarce resources, such as public housing, competing with the poor Australian-born population. With the Iraqi community expanding, members of the wider

community feel more limited in their ability to access government services. For example, Sarah, a community development employee, said:

They have come up here and they have got the housing but not the work, and so that causes bitterness and discontent in the wider community, because, once again, you have got the Australian people sitting there going, great, nobody gave me a helping hand.

Haleem and Nalan, an Iraqi couple, opened a small shop to cater for the grocery needs of the Iraqi community. The shop was located on a fairly busy street, nestled between a fish and chips shop and a photography shop. It was clean, neat and spacious, with two aisles for Australian produce and two aisles for Mediterranean and Middle Eastern imports. Although the shop was thriving with Iraqi customers, other townsfolk were ambivalent, as Nalan described:

We haven't been welcomed in this town, you know. A couple of things have happen—the window was broken and we were burgled and people pass through and drop cigarette butts inside the shop. This is very sad, you know, the door is open and when they pass they just flick the cigarette in the shop.

A few months later, on the anniversary of the Bali Bombing (carried out by the Indonesian Islamic militant group Jemaah Islamiyah in October 2002, killing 88 Australians and injuring many more), the shop was burnt down in suspicious circumstances, completely destroying the business Haleem and Nalan started six months previously. Various rumors circulated among townsfolk as to who had caused the fire; initially the gossip was that Haleem himself had set it alight to collect insurance, then that the fire was caused by fractions and tensions between the Muslim and Christian Arabs in the area—although there were very few Christian Arabs in the town. As another example of ambivalence if not hostility towards Iraqi settlers, an Iraqi couple made enquiries about renting an empty shop to start a restaurant serving Arabic food, but as they reported, they were told that it was not for rent, despite the sign in the window advertising the shop for lease.

Through the everyday conversations with local community members, there was much evidence to suggest that Iraqi refugees are vulnerable to discrimination and harassment. Regional areas in Australia generally lack the culturally diversity of major cities, and perceived cultural differences can provide the foundations and justification for exclusion [53]. Iraqi people living in Taraville are often perceived as non-nationals, as foreigners, as people from a country where Australians are fighting (and dying), and as Muslims. These discursive strategies help to legitimize inequality, alienation, and powerlessness, and serve to disenfranchise Iraqi people from full participation in Australian life.

4.3. Access to Services

Taraville is approximately 220 kilometers (136 miles) from Melbourne, Victoria's capital city, and sixty kilometers (36 miles) from the nearest large regional town with facilities such as a Centrelink office (for income support and assistance with employment, provided by the federal government), health specialists, fully operational English language classes for adults, and intensive English classes for school-age children. There is limited public transport to this larger town. Accessing facilities, resources, and official government agencies in this town imposes hardships on migrants, and others,

with limited mobility, language barriers, who are caring for young children or sick relatives, or who have mental and/or physical health issues that make travel difficult. As Sarah, a service provider, noted:

We have outreach posts, but we don't have a Centrelink officer. So if you have problems with Centrelink, you have to go to the next largest town. Same with specialists: from mental health, to gynaecologists to ophthalmologists, you can't get those sort of services here.

This regional town is responsible for allocating certain funds and resources such as the provision of language lessons (ESL—English as a Second Language) through the local post-secondary technical and further education college (TAFE). Participants reiterated the need for adequate provision of English language lessons, yet this need was not being met by resource allocations. This funding and resource problem relates in part to the fact that the regional town, with a large immigrant and refugee population of its own, is already stretched in its capacity to offer services. Laura was an ESL teacher employed by the TAFE to teach the Iraqi women English, and she saw little local support: “There wasn't much support because it [language tuition] was centralized in [the next largest town] and that's where the main emphasis was; we just got left out of the loop. There was not the recognition of the Iraqi community in Taraville.”

There are some 250 cultural and linguistic groups in Australia [54]. Yet Australia functions as a monolingual society and English language skills are imperative to successful settlement. Without language skills, refugees are excluded from many aspects of life, including employment, education, access to services, and social interaction [3]. However, as Jennifer, another ESL teacher, commented, refugees faced significant difficulties in gaining English language proficiency: “The main issue here is access to English, because it drops in and out. There has been no consistency, and you can't learn a language without consistency, so access to English is probably the biggest issue that Iraqi people face here”.

During the period of field research, the English classes stopped altogether when the childcare worker, available to care for the children of women attending English classes, found other employment, and a replacement could not be found. After this, many Iraqi women stopped attending classes because they had pre-school aged children and had no childcare. This example indicates the disjuncture between refugee settlement entitlements and the reality of resettling in regional areas, where there is often a shortage of resources and qualified personnel. Some Iraqi women were forced to seek medical care from the emergency department at the nearest hospital, and to incur the cost of this personally, as a result of multiple factors that inhibited their access to appropriate services. These included the availability of only one part-time woman doctor, only one Iraqi (male) doctor who was excessively overworked, a lack of interpreting services within the local social and health sectors, and limited options through Medicare, the universal health insurance system which enables Australians to have access to free or low-cost medical, optometry and hospital care. Shama, an Iraqi woman in her early twenties, reiterated the difficulties she and her compatriots faced in accessing medical services in Taraville:

The problem is if we have a health problem or if we need an operation we have to go to Melbourne. In Melbourne you can find the doctors all around you at the hospital, in Taraville this is not the case. In Melbourne, most of the doctors use Medicare ‘bulk billing’, which covers the costs, but here sometimes no, like the dentist is too expensive in Taraville.

Do you get your teeth seen regularly?

If I have a problem, if I have pain in my teeth, then I go to the dentist.

But what about check ups?

We have no check-ups in our diary; only when we have a problem we go.

In Taraville, people lack dental services subsidized under Medicare; this is a common problem in regional Australia. They also lack specialist health services, a local Centrelink office and comprehensive English language classes. In addition, no agencies were available to deal with acute problems such as domestic violence and emergency housing, either for refugees or for anybody else in the community. Government and health related services information was not available in translation. In addition, the capacity of the health care workers in the town to provide comprehensive care was threatened by low numbers of practitioners and high turnover of health care staff.

4.4. Mental Health

As previously mentioned, the majority of Iraqi immigrants in Taraville have entered Australia through the humanitarian program. The major risks to immigrant and refugees physical and psychological health owing to torture and trauma as well as those forced to flee their homes due to war, chaos and threat of persecution are well documented [55].

In addition, post immigration—the period that marks the arrival of the new immigrant to the host country—is often experienced as a time of crisis, stress and adjustment resulting from language difficulties, social and economic strain, social and cultural alienation, discrimination and status loss [56]. The crisis is even more striking for asylum seekers held in detention, as the long delay in status determination (and security clearance once refugee status is determined) is often accompanied by deterioration in mental health due to anxiety, depression, and the worsening of PTSD symptoms.

Some among the Iraqi community suffer from depression and other mental health problems. One service provider spoke of both men and women she knew suffering variously with mild depression, anxiety, bipolar disorder, and one who had ‘psychotic episode’ in a language class she was teaching. Similarly, Iraqi women recognized various mental health issues, as Zara explained:

Here it is more [depression], I think. I know friends, they are sick, Iraqi people, they are sick. They didn’t have this when they were in Iraq, but when they came to Australia they have this thing. They are always desperate, miserable and nervous. They are lonely in Australia; they don’t go out a lot and mix with other people.

The town, and other rural centers with growing numbers of refugee settlers, lack the specific counseling and psychiatric services needed to treat those suffering from serious mental health problems, and are unable to meet the unique needs of victims of torture and trauma. Whilst general medical services are available to Iraqis, more specialized facilities are not always easily accessible, as Anne, a maternal and child health nurse, described:

It is a problem with every depressed lady, doing something about it, there are no options in Taraville. We got to the stage that we would send people to a counselor and she would do an initial counseling session and then she would say, ‘there is an 18 months waiting list’, and that wasn’t her fault either. But when someone has actually made the effort when they are depressed

to go and see a counselor then that does nothing for their confidence in the system and that someone is going to help them. Then we have the mental health team, and the mental health team has got very strict criteria, and if they don't fit into those criteria, they say 'No we can't see them'. Then you think—what am I going to do with them? To me, that's not a very good service, because you're not helping them, you are actually making it worse.

Yet even if such specialized facilities were available, there is also a perception that non-Iraqi counselors, psychologists and psychiatrists may be unskilled in recognizing and treating Iraqi people. In addition, Iraqi people did not perceive loneliness and depression as matters warranting discussion with health professionals, as these were considered to be 'personal' rather than medical problems.

5. Discussion

Many migrants and refugees have settled successfully and remain in regional locations in Australia, attributed to a welcoming community, strong local networks of volunteers, and access to employment. A closer look at the settlement experience of some seemingly well settled and employed newcomers reveals the challenges that often come along with settling in a regional location. A growing number of refugees have resettled in locations that have seen demographic decline and out-migration due to limited opportunities. Here, they are expected to accept and retain low skilled jobs, with poor working conditions and discrimination. Such circumstances reflect structural vulnerabilities that combine to constrain life possibilities and impact upon physical, mental and social wellbeing, resulting in poor health outcomes. Difficulties that are particularly prevalent in the lives of the participants in this study included barriers to health and welfare services, but also, as we have noted, access to language classes and interpreters, and the challenges of social isolation and poverty. Participants often experienced overt discrimination due to perceived cultural differences and were perceived as unfair competitors and freeloaders on the limited welfare safety system. In combination, such forces help to legitimize inequality, alienation, and powerlessness, raising key questions of the health-related rights of any population. The public provision of support services to meet the needs of specific refugee groups is highly problematic, given the diversity of languages in Australia. An additional difficulty exists with the provision of mainstream services to refugees and other humanitarian settlers who do not perceive that they are entitled to services and lack the knowledge to access them, raising the question as to whether they are being adequately served by the needs-based and targeted system of service delivery of both specialized settlement and mainstream services. Following Cartwright [5], much of what we have explored in this article can be regarded as a result of "the consequence of institutional or organizational practices and policies that have unequal effects on certain groups though they are neither designed nor intended to have such effects" [57]. The intention of regional and rural resettlement was to ensure that migrants participate equitably in Australian society as soon as possible. Instead, however, they are subjected to limited access to employment, social services and health care provisions that expose them to various health hazards, and discrimination which alters the social opportunities for them to function as citizens.

Regional settlement of migrants and refugees is promoted by the Australia government as defusing pressures of congestion and negative reaction in metropolitan cities, while assisting population decline and skills shortages in regional and rural areas [58]. Regional settlement, however, is not an easy

policy domain, in terms of population management, basic rights and entitlements and their associated public health implications. Yet despite the shortcomings outlined in this paper, regional and rural settlement of migrants and refugees in Australia is so far a success, compared to the resistance to immigration and multiculturalism from local governments and small town and rural communities in the United States [58,59]. In Australia, resettling migrants and refugees and building sustainable communities in regional and rural areas are major migration and settlement policy goals for all levels of Australian government [59]. However, our research presents evidence of substantial gaps between policy rhetoric and reality. Research into regional refugee settlement is in its infancy in Australia and elsewhere, but it is commonly acknowledged that successful regional settlement is dependent on economic and social capacity building, and integrated needs-based settlement services. These include adequate service provision specific for refugee needs, employment and housing opportunities, adequate mainstream services (health and education) supportive host community and involvement of both host and refugee communities in the planning and implementation of settlement programs [21,22,59]. Regional settlement is complex, and the challenges faced by resettling communities draw attention to the structural disadvantages and constraints experienced by all people in rural areas.

6. Conclusions

Following the 2010 federal election in Australia, rural and regional issues received much attention because three independent members of parliament from rural electorates hold the balance of power. These members have lobbied for a ‘better deal for the bush’, for more funding for rural development, including to address problems associated with structural adjustment, and have taken advantage of their strength in parliament to press for political promises to be met [60]. Their focus on rural and regional communities served to highlight rural concerns, including broadband internet delivery, bush suicide, rural health and hospital closures, rural debt, and rural education. Refugee resettlement was another explicit concern at the time of the concern, and has continued to be a field of controversy with respect to how and where asylum seekers should be assessed, as well as to their settlement and support. The decisions made in these domains have political and policy ramifications, in Australia and in other host countries. But they also have human rights dimensions which to date have received little public attention, and everywhere, the operationalization of these rights have implications for public health professionals and the administrative systems within which we work.

In this article, we have highlighted some of the structural vulnerabilities faced by refugees resettled in regional areas. Low socio-economic status, language dispossession, and insufficient and poor familiarity of health, welfare and other services (e.g., housing assistance) inhibit successful resettlement. These factors compound to reinforce social disadvantage and a poorer standard of living. In the context of questioning the rights of refugees, both to refugee status and to standard government support, the contributions they might bring to their new home are largely overlooked [61]. However, the gains of migration cannot be accrued unless investment is made in their settlement. This investment needs to be formulated with the ultimate goals of social inclusion, freedom from discrimination and access to economic resources. In this sense, there is a critical need for the recognition of the effects of social positioning on health and well being, legitimized through evidence-based practice to increase the

allocation of resources (medical, social service, and political) [8] to improve the settlement experiences of refugees.

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References

1. Allotey, P.; Manderson, L.; Reidpath, D. Addressing cultural and linguistic diversity in Australian health services. *Health Promot. J. Aust.* **2003**, *13*, 29–33.
2. Murry, S.; Skull, S. Hurdles to health: Immigrant and refugee health care in Australia. *Aust. Health Rev.* **2005**, *29*, 25–29.
3. Vasey, K.; Manderson, L. The social and cultural context of immigration and stress. In *Immigration and Mental Health: Stress, Psychiatric Disorders and Suicidal Behavior Among Immigrants and Refugees*; Sher, L., Vilens, A., Eds.; Nova Science Publishers: New York, NY, USA, 2010; pp. 295–311.
4. Miklavcic, A. Canada's non-status immigrants: Negotiating access to health care and citizenship. *Med. Anthropol.* **2011**, *30*, 496–517.
5. Cartwright, E. Immigrant dreams: Legal pathologies and structural vulnerabilities along the immigration continuum. *Med. Anthropol.* **2011**, *30*, 475–495.
6. Johnston, V. Australian asylum policies: Have they violated the right to health of asylum seekers? *Aust. N. Z. J. Public Health* **2009**, *33*, 40–46.
7. Cartwright, E.; Manderson, L. Diagnosing the structure: Immigrant vulnerabilities in global perspective. *Med. Anthropol.* **2011**, *30*, 451–453.
8. Quesada, J.; Hart, L.; Bourgois, P. Structural vulnerability and health: Latino migrant laborers in the United States. *Med. Anthropol.* **2011**, *30*, 339–362.
9. Zarrugh, L. The latinization of the central shenandoah valley. *Int. Migr.* **2008**, *46*, 19–58.
10. Lusi, T.; Bauder, H. *Provincial Immigrants: The Social, Economic, and Transnational Experiences of the Filipino Canadian Community in Three Ontario Cities*; CERIS Working Paper No. 62; The Ontario Metropolis Centre: Toronto, ON, Canada, 2008.
11. Walton-Roberts, M. Regional immigration and dispersal: Lessons from small- and medium-sized urban centres in British Columbia. *Can. Ethn. Stud.* **2005**, *37*, 12–34.
12. Larsen, B. Becoming part of welfare scandinavia: Integration through the spatial dispersal of newly arrived refugees in Denmark. *J. Ethn. Migr. Stud.* **2011**, *37*, 333–350.
13. Fonseca, M. New waves of immigration to small towns and rural areas in Portugal. *Popul. Space Place* **2008**, *14*, 525–535.
14. Andersson, R. *Settlement Dispersal of Immigrants and Refugees in Europe: Policy and Outcomes*; Working Paper Series No. 03–08; Vancouver Centre of Excellence Research on Immigration and Integration in the Metropolis: Vancouver, BC, Canada, 2003.

15. Boswell, C. *Spreading the Cost of Asylum Seekers: A Critical Assessment of Dispersal Policies in Germany and the UK*; Anglo-German Foundation: London, UK, 2001.
16. Hugo, G. Immigrant settlement outside of Australia's Capital Cities. *Popul. Space Place* **2008**, *14*, 553–571.
17. McDonald-Wilmsen, B.; Gifford, S.M.; Webster, K.; Wiseman, J.; Casey, S. Resettling refugees in rural and regional Australia: Learning from recent policy and program initiatives. *Aust. J. Public Adm.* **2009**, *68*, 97–111.
18. Richardson, S.; Lester, L.A. *Comparison of Australian and Canadian Immigration Policies and Labour Market Outcomes*; Report to the Department of Immigration and Multicultural and Indigenous Affairs; Commonwealth of Australia: Canberra, Australia, 2004.
19. Piper, M. *Evaluation of Shepparton Humanitarian Settlement Pilot for the Department of Immigration and Citizenship*; Department of Immigration and Citizenship: Canberra, Australia, 2007.
20. Piper, M. *Evaluation of Mount Gambier Humanitarian Settlement Pilot, for the Department of Immigration and Citizenship*; Department of Immigration and Citizenship: Canberra, Australia, 2008.
21. McDonald, B.; Gifford, S.M.; Webster, K.; Wiseman, J.; Casey, S. *Refugee Resettlement in Regional and Rural Victoria: Impacts and Policy Issues 2008*; Victorian Health Promotion Foundation: Melbourne, Australia, 2008.
22. Taylor, J.; Stanovic, D. *Refugees and Regional Resettlement: Balancing Priorities*; Brotherhood of St. Laurence: Melbourne, Australia, 2005.
23. Vasey, K.; Manderson, L. The paradox of integration: Iraqi women and service support in regional Australia. *Int. J. Migr. Health Soc. Care* **2008**, *4*, 21–32.
24. *Australia's Humanitarian Program—Information Paper*; Department of Immigration and Citizenship (DIAC): Canberra, Australia, 2011.
25. *Victorian Community Profiles 2006 Census: Iraq-Born*; Victorian Office of Multicultural Affairs (VOMA): Melbourne, Australia, 2007.
26. Kampmark, B. 'Spying for Hitler' and 'Working for Bin Laden': Comparative Australian discourses on refugees. *J. Refug. Stud.* **2006**, *19*, 1–21.
27. Robinson, V.; Andersson, R.; Musterd, S. *Spreading the 'Burden'. A Review of Policies to Disperse Asylum Seekers and Refugees*; Policy Press: Bristol, UK, 2003.
28. *Fact Sheet 97—Humanitarian Settlement in Regional Australia*; Department of Immigration and Citizenship (DIAC): Canberra, Australia, 2007.
29. Menz, G. *The Political Economy of Migration Management*; Oxford University Press: Oxford, UK, 2009.
30. *Process for Establishing New Regional Humanitarian Settlement Locations*; Department of Immigration and Citizenship (DIAC): Canberra, Australia, 2010.
31. Schubert, M. Off the boat, into the bush. *The Age*, 16 October 2011.
32. Piguet, E. Economy versus the people? Swiss immigration policy, policy between economic demand, xenophobia, and international constraint. In *Dialogues on Migration Policy*; Guigni, M., Passy, F., Eds.; Lexington Books: Oxford, UK, 2006; pp. 67–89.

33. Castles, S.; Miller, M. *The Age of Migration: International Population Movements in the Modern World*; Palgrave MacMillan: New York, NY, USA, 2009.
34. *National Framework for Settlement Planning*; Department of Immigration and Multicultural and Indigenous Affairs (DIMIA): Canberra, Australia, 2006; p. 2.
35. *Fact Sheet 61—Seeking Asylum within Australia*; Department of Immigration and Citizenship (DIAC): Canberra, Australia, 2009.
36. *Refugee and Humanitarian Entrants 1 July 2006 to 30 June 2007 by Local Government Area*; Department of Immigration and Citizenship (DIAC): Canberra, Australia, 2007.
37. *Refugee Status Report: A Report on How Refugee Children and Young People in Victoria are Faring*; State of Victoria (Department of Education and Early Childhood Development): Melbourne, Australia, 2011.
38. Newman, L.K.; Dudley, M.; Steel, Z. Asylum, detention, and mental health in Australia. *Refug. Surv. Q.* **2008**, *27*, 110–127.
39. Manderson, L.; Kelaher, M.; Markovic, M.; McManus, K.A. A woman without a man is a woman at risk: Women at risk in Australian Humanitarian Programs. *J. Refug. Stud.* **1998**, *11*, 267–283.
40. Taylor, J.; Stanovic, D. Services and entitlements: Refugees, migrants and asylum seekers. *Migr. Action* **2004**, *XXVI*, 32–35.
41. Carr, J. Given the chance: Creating employment and education pathways for refugees. *Migr. Action* **2004**, *26*, 33–40.
42. Waxman, P. The economic adjustment of recently arrived bosnian, afghan and Iraqi refugees in Sydney, Australia. *Int. Migr. Rev.* **2001**, *35*, 472–505.
43. National Climate Centre. *Six Years of Widespread Drought in Southern and Eastern Australia, November 2001–October 2007 (Special Climate Statement 14)*; National Climate Centre: Canberra, Australia, 2007.
44. Marangos, J.; Williams, C. The effect of drought on uncertainty and agricultural investment in Australia. *J. Post Keynes. Econ.* **2005**, *27*, 575–594.
45. Withers, G.; Powall, M. *Immigration and the Regions: Taking Regional Australia Seriously*; prepared for the Chifley Research Centre by Applied Economics: Sydney, Australia, 2003.
46. Carrington, K.; Hogg, R. Benefits and burdens of the mining boom for rural communities. *Hum. Rights Def.* **2011**, *20*, 9–12.
47. McGrail, M.; Humphreys, J.; Joyce, C.; Scott, A.; Kalb, G. Rural amenity and medical workforce shortage: Is there a relationship? *Geogr. Res.* **2011**, *49*, 192–202.
48. Moore, T.; Sutton, K.; Maybery, D. Rural mental health workforce difficulties: A management perspective. *Rural Remote Health* **2010**, *10*, 1519:–1519:10.
49. Refugee Council of Australia. *Economic, Civic and Social Contributions of Refugees and Humanitarian Entrants—A Literature Review*; Refugee Council of Australia: Sydney, Australia, 2010.
50. Carrington, K.; McIntosh, A.; Walmsley, J. *The Social Costs and Benefits of Migration to Australia*; Centre for Applied Research in Social Science, University of New England, Commonwealth of Australia: Armidale, Australia, 2007.
51. Flanagan, J. *Dropped from the Moon: The Settlement Experiences of Refugee Communities in Tasmania*; Social Action and Research Centre: Anglicare Tasmania, Australia, 2007.

52. Hawthorne, L. The refugees. *The National Times*, 27 April 27–3 May 1984, pp. 25–27.
53. Grillo, R. An excess of alterity? Debating difference in a multicultural society. *Ethnic Racial Stud.* **2007**, *30*, 979–998.
54. *Multicultural Australia United in Diversity, Updating the 1999 New Agenda for Multicultural Australia Strategic directions for 2003-2006*; Commonwealth of Australia: Canberra, Australia, 2007.
55. Costa, D. Health care of refugee women. *Aust. Fam. Physician* **2007**, *36*, 151–154.
56. Kirmayer, L.; Narasiah, L.; Munoz, M.; Rashid, M.; Ryder, A. Common mental health problems in immigrants and refugees: General approach in primary care. *Can. Med. Assoc. J.* **2011**, *183*, 959–967.
57. “Trading Action for Access”: The myth of meritocracy and the failure to remedy structural discrimination. *Harv. Law Rev.* **2008**, *121*, 2156–2177.
58. Gilbert, L. Immigration as local politics: Re-bordering immigration and multiculturalism through deterrence and incapacitation. *Int. J. Urban Reg. Res.* **2009**, *33*, 26–42.
59. Galligan, B.; Horvath, D. Regionalizing settlement policy: The Victorian case. In *Proceedings of APSA Conference*, Sydney, Australia, 27–30 September 2009.
60. Gray, J. Political representation and rural and regional Australia—Editorial. *Hum. Rights Def.* **2011**, *20*, 1.
61. Harrell-Bond, B. *The Economic and Social ‘integration’ of Refugee Populations in Host Countries in Africa*; Stanley Foundation: Entebbe, Uganda, 2002.

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