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Disability in Displacement:

a critical analysis of the framing of disability in Norwegian refugee policy and practice

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List of abbreviations

A	The Labor Party (Arbeiderpartiet)
CDA	Critical Discourse Analysis
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
DIN	Document Identification Number
EU	European Union
FrP	The Progress Party (Fremskrittspartiet)
H	The Conservative Party (Høyre)
ICERD	The International Convention on the Elimination of Racial Discrimination
IDPs	Internally Displaced Persons
IMDi	Directorate of Integration and Diversity
INT	Interview
KrF	Christian Democratic Party (Kristelig Folkeparti)
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer +
MDG	The Green Party (Miljøpartiet De Grønne)
NSD	Norwegian Centre for Research Data
OPDs	Organizations of Persons with Disabilities
PwD	Persons with Disabilities
Sp	Centre Party (Senterpartiet)
SV	The Socialist Left Party (Sosialistisk Venstreparti)
UDI	Norwegian Directorate of Immigration
UNHCR	United Nations High Commissioner for Refugees
V	The Liberal Party (Venstre)

1 Introduction

"Too often invisible, too often forgotten and too often overlooked, refugees with disabilities are among the most isolated, socially excluded and marginalized of all displaced populations"

António Guterres, UN High Commissioner for Refugees
(Women's Refugee Commission, 2008, p. 1)

The adoption of the Convention on the Rights of Persons with Disabilities (CRPD) in 2008 is considered a milestone. The drafting of the convention heavily involved persons with disabilities (PwD) and Organizations of Persons with Disabilities (OPDs), with an ambitious content highlighting the barriers still faced by this group (Strand, 2014, p. 75). The convention signals a shift from a 'charity' or 'medical' approach to disability; from understanding disability as solely a medical or welfare issue. Rather, all PwD are human rights holders with equal rights and cannot be segregated or discriminated against based on their impairment (Degener, 2017, p. 154). Norway ratified the CRPD in 2013, which has a specific provision for situations of risk, including armed conflict[1]. However, the convention has not been incorporated into national legislation and "the CRPD is clearly put in a weaker position than the other [human rights][2] conventions" (Strand, 2014, p. 80). Conflict, displacement and disability may have various interconnections: disability may be the cause of displacement, and armed conflict and humanitarian crisis has a disproportionate impact on persons with disabilities (UNSC, 2019). Refugees with disabilities are often forgotten and invisible, both during displacement (Crock, Smith-Khan, McCallum & Saul, 2017) and in current research (Pisani, Grech & Mostafa, 2016).

The aim of this research is to provide insights into the national refugee context for refugees with disabilities and how they can be affected by conceptualizations of disability. Drawing on the standards set in the CRPD and disability theory, this study analyzes the official discourse on persons with disabilities in the Norwegian context of refugee policy and practice. The discourse surrounding refugees with disabilities can shed light on underlying assumptions and conceptualizations about this group, and why marginalization seemingly persists despite the ratification of the CRPD. Marginalization is understood as a form of oppression, where a group of people are excluded from full participation in society (El-Lahib & Wehbi, 2011, p. 98).

[1] CRPD art. 11

[2] Author's note.

The following research question will be answered:

To what extent can conceptualizations of disability in relation to refugees[3] impact the marginalization of refugees with disabilities?

Three sub-questions will guide the analysis:

1. What discourses about disability are found in official documents related to refugees and to what extent are these in line with the social understanding of disability found in the CRPD?
2. How do conceptualizations of disability differ depending on which political party the author/document represents?
3. How does the Norwegian government interpret integration and how can this affect refugees with disabilities?

The research questions will be answered by conducting a discourse analysis of how disability is conceptualized in the overarching political discourse found in policies, official documents and parliamentary debates in the context of refugees. To gain a deeper understanding and to triangulate the findings from the document analysis, semi-structured, qualitative interviews will be held with politicians and experts from civil society, primarily OPDs. Three areas of Norwegian immigration laws and policies will be examined: resettlement, particularly the selection criteria used to select refugees prior to arrival, settlement into municipalities after refugee status has been determined and integration policies after settlement into municipalities. The refugee determination process, i.e., the process of determining which asylum seekers are given refugee status and which applications are denied, is outside the scope of this study. Since capacity concerns permeate both the context of resettlement and settlement into municipalities when looking at disability, these areas of refugee policy and practice have been chosen for an in-depth analysis.

My hypothesis is that disabled people in Norway are conceptualized primarily as the beneficiaries of welfare programs and are viewed as patients needing care and rehabilitation. The intersection of disability and refugee status results in the conceptions of refugees with disabilities as economic burdens (Mirza, 2011). This leads to marginalization at the border, but also for refugees that have already been granted permanent residence. Based on the assumption that

[3] Primarily those who have been granted refugee status are examined in this study.

both refugees and persons with disabilities are perceived as burdens for the welfare state (Mirza, 2010; Pisani et al., 2016), this research aims to provide a critique on underlying values and power structures in society. An intersectional approach will be employed, acknowledging that people with disabilities are a diverse group with various impairments and intersecting identities such as gender, age, and ethnicity.

2 Background: refugees with disabilities and the Norwegian context

Michael Oliver notes that "disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society. Disabled people are therefore an oppressed group in society" (1996, p. 22). Disability as a term is therefore best understood as describing a minority group, and as a marker of identity, rather than a set of defined impairments (Linton, 1998, as cited in El-Lahib & Wehbi, 2011, p. 98). Consequently, an all-encompassing definition of disability is difficult to determine. This study will utilize the definition of disability in the CRPD:

> "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others"[4].

This definition is intended to be open-ended: recognizing that disability is a social category that evolves over time. However, disability is limited to "long-term impairments", which excludes those with short-term impairments stemming from injuries and disease[5] (Kayess & French, 2008, p. 23). Drawing a line between disabled and non-disabled people is both difficult and risky, and this ambiguity results in "estimates of the disabled proportion of any population vary considerably, depending not only on the quality of the measurement tools but also on definitions and their interpretations" (Grue, 2019, p. 4).

The World Health Organization estimates that around 15% of the global population has a form of disability today, in total over a billion people (WHO, 2020). 16% of these can be attributed to armed conflict (OCHA, 2020). Statistics on refugees with disabilities do not only vary depending on the definition and interpretation of disability, but also whether migrants, refugees,

[4] CRPD, art. 1

[5] For more on the definition of disability, see chapter 5.1.1

asylum seekers and/or internally displaced people (IDPs) are included. Furthermore, migration categories are fluid and complex, as individuals may experience several categories as they flee (Burns, 2017, p. 1467). Measuring disability in the refugee population is difficult and the numbers therefore vary significantly: the number of disabled migrants has been estimated to be around 38 million (Burns, 2020, p. 231), and 9.7 million persons with disabilities have become forcefully displaced due to conflict and persecution (HRW, 2018). When it comes to refugees with disabilities, "[s]tatistical information is at best poor and at worst non-existent*"* (Crock, Ernst & Ao, 2013, p. 764). The limited existing research suggests that the percentage of PwD within a refugee population is even higher than the estimates for the general population, which might be expected amongst groups fleeing conflict and violence (Crock et al., 2017, p. 4; Pisani et al., 2016, p. 286). A study of Syrian refugees shows that "30 per cent of refugees have specific needs: one in five refugees is affected by physical, sensory or intellectual impairment […]" (HelpAge International & Handicap International, 2014, p. 4). Statistics that measure disabilities among refugees are not available in the Norwegian context. However, available data on immigrants with disabilities shows that, on average, a higher number of men and women with an immigration background have disabilities than the general population (Bufdir, n.d.).

Despite the indications that the percentage of disabilities amongst refugees is high, academic literature has paid relatively little attention to this group (Crock et al., 2013). The two fields of studies rarely intersect, and the barriers that refugees with disabilities face lack scholarly attention (see Burns, 2020; Pisani, et al., 2016; Soldatic, Somers, Buckley & Fleay, 2015). Several studies have examined disability exclusionary measures in both the resettlement and immigration systems of Australia, Canada, and the EU (Anani, 2001; Duell-Piening 2018; El-Lahib & Wehbi, 2011; Saltes, 2013; Soldatic et al., 2015; Soldatic & Fiske, 2009; Straimer, 2011). Existing research also includes experiences of refugees with disabilities (see El-Lahib, 2016; Mirza, 2011). Crock et al. (2017) point out that "resettlement and repatriation are two areas that have attracted relatively little academic attention, either generally or in the context of refugees with disabilities" (p. 238). This study is an attempt to provide insights into the Norwegian refugee context.

2.1 The Norwegian refugee context

In 2015 and 2016, more than a million applications for asylum were registered in Europe (Brekke & Staver, 2018). This is often depicted as a major "refugee crisis" or "migrant crisis" in mass media and by political leaders, although the rhetoric of a "crisis" is criticized (Chetail,

2016). Norway likewise experienced a substantial increase in persons requesting asylum in 2015 with 31 150 applications filed, the highest amount ever recorded in one year (UDI, 2015). Norway responded with policy changes such as increased border controls, restrictive measures in almost all areas of migration policy and the establishment of new reception centers and registration procedures (Brekke & Staver, 2018). In 2019, the amount of asylum applications was significantly lower, with 2305 applications for asylum filed (UDI, 2019). The decreasing arrivals can have several explanations, including the deal between the EU and Turkey: the sealing of the Aegan route used by many refugees, which significantly lowered the number of arrivals to Greece (Sigona, 2017, p. 458). The so-called refugee crisis is not the subject of interest for this study, but forms an important backdrop for the policies analyzed in the selected timeframe (2015-2020).

The Office of the United Nations High Commissioner for Refugees (UNHCR) has the function of providing international protection and finding permanent solutions to people defined as refugees[6]. Finding durable solutions is a central part of the UNHCR and one way to solve the "problem of refugees" (UNHCR, 2011, p. 28). Resettlement is one of three durable solutions[7], where refugees are selected and transferred to a third State from the country of first asylum (Goodwin-Gill & McAdam, 2007, p. 497). Resettlement is not a right and is based on the cooperation of receiving states, meaning that admission criteria of the receiving state determine if a refugee will be resettled (UNHCR, 2011, p. 36). In 2014, Norway rejected 123 Syrian resettlement refugees with various medical needs or disabilities that were requested by the UNHCR, which resulted in strong reactions in the media and by OPDs (Atlas-Alliansen, 2014; Johansen, 2014a). The reason was a lack of capacity in the receiving municipalities, as providing necessary accommodations was deemed too costly. This group included persons with cancer, mental illness, physical disabilities and sensory disabilities such as hearing and visual impairments (Johansen, 2014b). The resettlement selection criteria that Norway employs constitutes the first context which will be examined in this study.

The second context that will be examined is the settlement of refugees into municipalities. Norway has a settlement model with local autonomy, where the state requests municipalities to

[6] Statute of the Office of the UNHCR, 1950, para. 1

[7] The other two durable solutions are voluntary repatriation, where refugees return to their country of origin, and local integration, where refugees integrate into the host country (UNHCR, 2011, p. 28).

settle refugees: the municipal councils decide whether to settle refugees and who they accept (Søholt & Aasland, 2021). The municipalities receive economic support in the first five years to cover housing, integration into the labor market and an introduction program (Søholt & Aasland, 2021, p. 78; Valenta & Bunar, 2010, p. 474). Additionally, grants to cover the additional costs associated with settling refugees with disabilities are available for the first five years (Rambøll Management Consulting & Oslo Economics, 2020, p. 20). An important goal of this process recently has been to ensure fast settlement, to limit the time spent in reception centers (Svendsen & Berg, 2018, p. 5). Søholt & Aasland (2021) found that "the refugee crisis contributed to a policy change in municipal councils, with increased willingness and subsequent ability to settle refugees" (p. 792). For refugees with disabilities, this story plays out differently. A recent report found that refugees with a physical disability, impaired cognitive function, different degrees of mental disorders, as well as complex diagnoses experience substantially longer wait times in reception centers, averaging at 2-4 years compared to 3-7 months for refugees without disabilities. Furthermore, wait times up to 8 years have been recorded (Rambøll Management Consulting & Oslo Economics, 2020, p. 11).

3 Methodological approach

In research, disabled people are too often viewed as objects of research and have historically been marginalized by academia. Prominent researchers in the field of disability have therefore proposed a human rights-based methodology for researching disability. It emphasizes that research should be responding to a human rights concern identified by the disability community (Arstein-Kerslake et al., 2020, p. 413, 427). Unequal treatment of refugees with disabilities in the settlement into municipalities and in resettlement in Norway has been highlighted by OPDs and in the civil society's alternative report to the UN Commission:

> "The Government will only prioritise quota refugees that are most likely to be integrated. That is, obtain an education or find work, which is more difficult for disabled people. Municipalities do not want to settle disabled people, therefore they wait longer than others in reception centres, which might not be adapted to their impairment" (The Civil Society Coalition Norway, 2019, para. 80).

This research project is an empirical case-study with an interdisciplinary approach. It is based on the international human rights' legal framework: primarily the CRPD. The legal foundation is supplemented with a critical social science approach, which aims to address social structures

and power distribution, both to explain the current world and to bring about social change (Nygaard, 2017, p. 27). A qualitative analysis has been conducted using a Critical Discourse Analysis (CDA) approach. CDA provides both an explanatory and a normative critique, which "does not simply describe existing realities but also evaluates them, assesses the extent to which they match up to various values […]" (Fairclough, 2012, p. 9). As disability studies aim at highlighting and changing the framing of disability away from one that is oppressive (Grue, 2011), discourse is highly relevant for this study. Labels and frames uphold power structures and affect the lives of the individuals they attempt to describe (Pisani et al., 2016, p. 289). Using discourse analysis as a methodology is useful to illuminate "problematized objects of study by seeking their description, understanding, and interpretation" (Landman, 2006, p. 63). By problematizing existing accounts of refugees with disabilities, it is possible to examine the underlying social and political logic behind the current understandings. Norway as a single country case study was chosen in this research project as a "least likely" case study, with an assumption that disability rights are protected and promoted in all sectors. A discourse analysis is most suited for researching smaller units, such as single countries, and not for making universal generalizations. Finally, I am not a disabled researcher, nor a refugee, and thus have a limited capacity for understanding the experiences of this group.

3.1 Methods and data collection

The research questions have been answered by conducting a discourse analysis of relevant documents. This is done in combination with semi-structured expert interviews of two samples: politicians and experts from civil society, primarily from OPDs. The interviews supplement the findings from the documentary analysis: the politicians supplement the relevant discourse and the experts contribute their expertise and reflections. Using multiple sources of data means that the findings can be triangulated, reducing the risk of potential biases and strengthening the trustworthiness of the findings (Bowen, 2009, p. 28, 30). 20 documents were selected for the analysis utilizing a non-probability sample, where each document has given a document identification number (DIN)[8]. The documents were selected using a purposive sample with specific criteria listed below (Grant, 2019, p. 39):

- Official documents published or commissioned by the government, parliament or directories.

[8] Annex 1 gives an overview of the documents selected.

- The document is published between 2015 and 2020.
- The document is related to either the resettlement of refugees, settlement into municipalities or integration.
- Documents which explicitly discusses disability or health among refugees will be prioritized.

The selection of documents is limited to the timeframe of 2015 to 2020. The so-called refugee crisis signaled a shift in the refugee and asylum sector, and likely affected policy and discourse. The documents are heterogenous and vary in type: laws, official policies and white papers represent official Norwegian politics, while debates and questions in the parliament, external reports and opinion pieces rather represent the overarching political discourse. Furthermore, the political discourse embodied in the selected documents represents the frontstage, a metaphor to a performance on the stage, as political discourse is intended for the public. Official discourse does not always represent the underlying understanding and conceptions on the backstage (Wodak, 2012, p. 525). Finally, relevant immigration cases are not available to the public, due to privacy measures caused by medical information. This is acknowledged as a possible limitation for the study, as the findings might not be representative of the discourse as a whole.

Eight semi-structured interviews were conducted between 16. April and 2. May 2021, and each has been given an identifier (INT)[9]. Three interviews were held with parliamentary representatives, and five interviews were held with experts from civil society. All experts, except one, were representatives from OPDs, and the final expert has experience with refugees with disabilities in reception centers. Out of the three interviewed politicians, two represented the Socialist Left Party (SV) and one represented the Progress Party (FrP). Selected representatives from all political parties were invited to participate in the study, and the parliamentary representatives that chose to participate correlate with the most active parties in the debates on this topic. The research project was approved by the Norwegian Centre for Research Data (NSD), and the collection and processing of data was executed in compliance with the data protection legislation. This entails ensuring full, voluntary, and informed consent, confidentiality and following data protection guidelines (Ulrich, 2017).

[9] Annex 2 gives an overview of the interview participants.

The document sample and interviews have been coded using the qualitative data analysis software Nvivo. To uncover meaning in the official documents, an analysis technique of inductive coding was utilized where new codes were created during a thorough reading of the document. The coding of the documents resulted in 82 initial codes which were aggregated if two or more codes were similar. After the initial coding, the codes were sorted into broader themes such as 'discourses on disability' and 'interpretation of integration'. The Nvivo software allows for a summary view of each code, meaning that codes in different documents could easily be compared and analyzed. Furthermore, the statements of each political party was coded separately, which allowed for a word frequency search resulting in Table 1. The same steps were taken when coding the interviews, which resulted in 36 initial codes. These were sorted into the same themes as the documents, and supplemented the findings presented in chapter 6.

4 Conceptual framework

The field of disability studies emerged from disability rights movements in the USA and United Kingdom and has produced several theoretical models of disability (Grue, 2011). A cornerstone in disability studies is the debate surrounding the medical and the social models of disability, which was most prominent in the 70s and 80s, but remains important today (Grue, 2019). The introduction of the CRPD recognizes persons with disabilities as rights holders and represents a paradigm shift from the medical to the social model of disability. The focus has been shifted from the individual person to the surrounding society, by emphasizing the societal barriers persons with disabilities face as the cause of disability, rather than medical impairments (Traustadóttir, 2009). The field of disability studies far from agrees on the social model of disability, and other variations such as the minority model, the British social model, the relational model, and the human rights model exist (Barnes, 2020; Degener, 2017; Mitchell & Snyder, 2020; Oliver, 2013; Tøssebro, 2004). However, common for most interpretations of disability studies is an attempt to explain or define disability as something outside the impairments themselves, but rather as a socially constructed phenomenon. There is almost unanimous agreement in the disability field that the medical model is invalid (Grue, 2011, p 540).

People with disabilities have historically and globally been disadvantaged, and the models attempt to explain and eliminate this disadvantage. Social justice is intrinsically tied to the field of disability studies. Theory in disability research is necessary to go beyond individual experiences to discover and understand the oppressive, socially constructed structures (Grue, 2015, p. 28; Gustavsson, 2004, p. 54). To study discourse and recognize frames and lines of arguments,

this research will be grounded in disability theory. The following chapter will describe the predominant models in disability studies that are relevant for the Norwegian context: the medical model, the social model, the relational model, and a rights-based approach. This chapter will attempt to operationalize these models to use in a discourse context by identifying lines of reasoning and/or themes for each model. Thereafter, the intersection of disability and forced migration will be explored.

4.1 Conceptual models of disability

4.1.1 The medical model

The medical model, sometimes called the individual approach (Oliver, 1996; Tøssebro, 2016), mirrors a historical understanding of disability where the 'problem' of disability is located within the individual, caused by a medical problem or limitations which deviates from normal health status (Degener, 2016, p. 3; Oliver, 1996, p. 32). There is a general agreement in the field of disability studies that the onset of industrial capitalism institutionalized discriminatory practices against disabled people (Arstein-Kerslake et al., 2020; Barnes, 1997; Finkelstein, 1980; Oliver, 1996). The changes in work patterns that industrialization brought was accompanied with ideologies such as social Darwinism and eugenics (Barnes, 2020, p. 29). Historically, the exclusion of PwD from society was caused by disabled people not participating fully in production, thus being forced into situations of dependency (Oliver, 1996, p. 132). "Persons with disability have been treated as objects of pity and as burdens on their families and societies" (Kayess & French, 2008, p. 5). Subsequently, the person needed to be changed to better fit into society and social norms, primarily by medical interventions and rehabilitation (Kayess & French, 2008; Traustadóttir, 2009).

Medical discourse on disability includes the notion that impairments need to be eradicated, fixed, cured, minimized or rehabilitated (Barnes, 2020; Degener, 2016). Where a 'cure' is unattainable, it is assumed that disabled persons automatically need costly care, usually in the form of shelter and welfare. Furthermore, often dangerous assumptions that certain disabilities, in particular intellectual disabilities, can foreclose legal capacity are present (Degener, 2016, p. 3). The medical model in its extreme form only sees people with disabilities as patients trapped in a diagnosis, as fundamentally different from 'normal' people, which has legitimized discrimination and segregation as natural (Skarstad, 2019).

4.1.2 The social model

In contrast to the medical model, the social model of disability explains disability as a social construct. Discrimination, oppression, and disabling barriers cause the exclusion of persons with disabilities from society, rather than individual medical 'problems' (Degener, 2016, p. 3; Oliver, 2013). Based on Marxist sociology, disability is explained as "economic and political oppression enacted on people whose bodies did not conform to the needs of industrial capitalism" (Grue, 2011, p. 538). By shifting the focus away from individual bodies, the social model highlights how systemic factors, such as political economy and disabling environments, shapes disability (Barnes, 2020; Grue, 2015). Following the social model, solutions for the exclusion of disabled people are found by looking at how society functions to marginalize this group, and targets policies, barriers, stigma, and marginalization processes (Grue, 2019, p. 7). "In short, the social model of disability is a tool with which to provide insights into the disabling tendencies of modern society in order to generate policies and practices to facilitate their eradication" (Barnes, 2020, p. 33).

At the heart of the social model is the linguistic distinction between the biological and the social, by distinguishing "impairment" (biological) and "disability" (socio-cultural) (Söder, 2009). This has been compared to the gender/sex distinction in feminist literature (Traustadóttir, 2009). Impairment is related to the bodily (or mental) condition, while disability denotes how society responds to and treats the person because of their impairment, often leading to exclusion and marginalization (Degener, 2016, p. 3). However, impairment and disability are often used interchangeably, especially in everyday discourse. For a long time, the Norwegian language did not have a distinction between these features, and the most common word for both was "funksjonshemming", which directly translates to "function-hindrance". Later, a separate word for impairment, "funksjonsnedsettelse" directly translated to "function-lowering", has been added into the Norwegian discourse on disability. The distinction between disability (funksjonshemming) and impairment (funksjonsnedsettelse) is often not clear and is misused or misunderstood (Grue, 2015, p. 11).

The social model has been immensely influential on discourse related to disability, both nationally and internationally. It has been successful in the sense that its ideas and research have begun to influence mainstream policies and discourse in many areas of the world (Söder, 2009; Watson and Vehmas, 2020). The adoption of the CRPD is an expression of this shift at the multinational level, receiving unprecedented levels of support and subsequent mass ratification. The

social models position over the medical model became solidified during the negotiations, and "[i]f there is one single phrase which summarizes the success story of the CRPD, it is that it manifests the paradigm shift from the medical to the social model of disability in international disability policy" (Degener, 2016, p. 14). Discourse that reflects a social understanding of disability focuses on how the environment creates or reinforces disability. A social discourse would be expected to take various forms of oppression into account when discussing disability, such as economic barriers, attitudes and stigma, political discrimination, cultural images and stereotypes (Traustadóttir, 2009). Finally, a discourse that differentiates between the terminology of impairment vs. disability (and the subsequent translations) is expected to display an understanding of the socially constructed nature of disability.

4.1.3 The relational model

When researching disability in Norway it is imperative to consider the context of the welfare state. The relational model has been used to describe how disability is commonly understood in the Scandinavian context, both in Scandinavian disability studies and in many government policies (Tøssebro, 2004, p. 4). The relational model theorizes disability as the gap between the person's capabilities and the demands of society (Tøssebro, 2004). This gap occurs both as a consequence of the persons capabilities being atypical (usually described as lowered) and because the environment is not adapted (Traustadóttir, 2009). "This model conceptualizes disability as a product of complex person-environment interplay, and integrated knowledge from a medical and a social perspective" (Lid, 2013, p. 205). The relational model is a variation of the social model (Skarstad, 2019), and replaced a medical understanding of disability in Scandinavia during the 70s. The shift to a new relational understanding of disability was partly caused by the strong international influence of the social model at that time, but was perceived as less radical (Tøssebro, 2016, p. 119). By situating the relational model between the social model and the medical model, the dichotomy of either social or medical perspectives can be avoided (Lid, 2013, p. 205; Skarstad, 2019). This means that in practice, this approach often appeals to a medical discourse (Grue, 2015).

Grue (2015) describes the relational model as a practical approach trying to minimize the gap between capabilities and demands of society by using several policy approaches, ranging from economic benefits and medical rehabilitation to broader social change using anti-discrimination legislation. The overall view is that disability could be eliminated by providing individual support and adjusting demands by society, ultimately leading to full participation and inclusion for

persons with disabilities. The relational model conceptualizes PwD as a diverse group with needs that should be addressed whichever way is considered most appropriate or effective. This is in line with broader welfare goals of the state, where citizens in vulnerable stages of their lives should be cared for by their government, including child benefits, health insurance and pensions and homes for senior citizens (Grue, 2015, p. 79).

In the 70s and 80s, the research agenda on disability was largely set by politicians and health professionals, and new researchers in this field often had experience from disability services and limited theoretical knowledge (Gustavsson, 2004, p. 56). Disability studies in Scandinavia has thus been criticized for being too closely affiliated with the welfare state, with research being top-down and focused on measuring impairment and improving rehabilitation programs, instead of focusing on oppression, barriers, and marginalization (Barnes, 2020; Gustavsson, 2004; Roulstone, 2013; Söder, 2009). Scandinavian disability research has often been paternalistic and medically oriented, rather than reflecting the views of persons with disabilities (Roulstone, 2013, p. 3). Grue (2015) claims that "Scandinavian disability studies conceptualizes disabled people as the beneficiaries of welfare state programmes and interventions" (p. 30). Welfare policies continue to rely on medical interpretations and discourses in practice, seeking specialized solutions for various impairments, and medical diagnoses and psychological tests to determine eligibility for welfare services (Traustadóttir, 2009, p. 13). This strategy is not thoroughly compatible with strong anti-discrimination and accessibility measures, meaning that discrimination and exclusion of PwD remain despite the intentions of the welfare system (Barnes, 2020, p. 38; Grue, 2015). An explanation for this is a strong preoccupation with welfare policies and lack of awareness of disability in other policy areas (Tøssebro, 2016).

When referring to people with disabilities as a group in Norwegian, the term "personer med nedsatt funksjonsevne" is often used, which is directly translated to "persons with lowered function-ability". This phrase is used in the official Norwegian translation of the CRPD. Bufdir[10] (2020) states that this formulation is "to make it clear that disability is something you have, not something you are[11]". Bufdir then points out in which contexts "personer med nedsatt funksjonsevne" should be used, namely in relation to living conditions and participation in working life. When discussing barriers and discrimination that a person can face in the work force however,

[10] The Norwegian Directorate for Children, Youth and Family Affairs (Barne-, ungdoms. og familiedirektoratet).

[11] Author's translation.

it could be correct to use the term "funksjonshemmet" (disability) (Bufdir, 2020). This is an interesting distinction made by the directorate that shows where the social model merges into the relational model. Bufdir generally expresses a relational model of lowered ability when meeting a demanding society, while a social understanding of barriers and discrimination creating disability is expressed when using the term "funksjonshemmet".

4.1.4 A rights-based approach to disability

The social model has often received critique for ignoring the real, often painful, lived experiences of persons with disabilities, stating that these experiences cannot solely be explained by societal barriers (Degener, 2016; Kayess & French, 2008; Söder, 2009). Degener (2016) argues that the introduction of the CRPD does not just solidify the importance of the social model, but also moves beyond it and represents a human rights model of disability. The human rights model goes further than the social model by acknowledging that medical treatment and rehabilitation can be important and necessary to improve the lives of PwD and includes this medical aspect as a part of the human right to health. The rights-based approach is based on the social model and likewise points at structures and barriers in society to blame for marginalization, but acknowledges that impairment might cause pain, deterioration of quality of life and dependency (Degener, 2016, p. 6). Thus, the CRPD can be regarded as an answer to what is required from society to ensure the human rights for persons with disabilities (Skarstad, 2019, p. 47). The rights-based approach differs conceptually from the social model by emphasizing that the State has a duty to ensure that persons with disabilities have the same human rights in practice, rather than merely pointing at society and the need for change.

Degener (2016) underlines that even if a rights-based discourse has often been associated with the social model, the social model is not foremost a right-based approach to disability. The social model is rather aimed at looking at inequality in society. The rights-based discourse that has dominated after the adoption of the CRPD has primarily been focused on negative rights[12], in the form of anti-discrimination legislation and outlawing negative treatment. This has been welcomed by many activists as a counterbalance to the welfare approach that has been prevalent in Scandinavian countries (Söder, 2009). Right-holders can also claim entitlements, such as services and goods from the state, which is an expression of positive rights (Söder, 2009, p. 78).

[12] Rights are often classified as negative or positive, where negative rights mean to refrain from doing something or outlawing negative treatment (discrimination). Positive rights require positive action to be taken to ensure the right (Nickel, 2007, p. 23; Söder, 2009).

A more rights-based approach to disability has emerged in Norwegian discourse, partly explained by a growing disability movement focusing on anti-discrimination and citizenship (Grue, 2015, p. 11).

4.2 Theory at the intersection of forced migration and disability

Moving beyond the conceptual framework on disability to disability in a forced migration context requires an intersectional approach. The disability rights movement was criticized for neglecting how different categories can affect a person differently, and the issue of multi-dimensional oppression was raised (Degener, 2016, p. 9). Intersectionality is not a theory or a set of methods, but is best described as "a perspective that emphasizes the importance of taking different structuring conditions into account" (Söder, 2009, p. 74). This study will attempt to highlight how categories interact, and how power structures can influence the situation of marginalized people. The 'classic' categories are gender, ethnicity, and class, but disability is increasingly being recognized as a category (Söder, 2009). While refugee and asylum status is not commonly seen as an intersectionality category, it falls under the category of ethnicity. However, as a group also often denied the safeguards of citizenship, refugee status (or denial of refugee status) can lead to additional barriers. This study also acknowledges that other or additional categories could lead to different or additional marginalization, as every person also has a gender, sexual orientation and so on.

The struggle for full citizenship has historically been a contentious subject for persons with disabilities, as barriers and discrimination often placed them "out of sight" of society. People forced to flee face a similar battle for citizenship at the border. Immigration and citizenship have increasingly become a key political issue in Europe following 2015, where access to human rights such as health services become limited by citizenship status (Burns, 2017, p. 1466). This twofold issue of citizenship is conflated, and refugees and asylum seekers with disabilities risk facing multiple marginalization (Hughes, 2017, p. 468; Straimer, 2011, p. 538). Viewing citizenship and the ability to claim human rights as something intrinsic to a disabled person does not include migrants and persons forced to flee (Pisani et al., 2016, p. 17-18).

Acknowledging that theory in the intersection of forced migration and disability is lacking, Pisani et al. (2016) attempt to help fill this gap using the concept of the "unproductive foreign body". When ratifying the CRPD, several states included reservations that excluded immigration policies, arguing that non-nationals with disabilities would be an economic and social

burden to the state (Pisani et al., 2016, p. 297). Hughes (2017) describes how migration in the neoliberal era has been portrayed as a parasitic strain on welfare systems, with migrants seeking "a life of hand-outs and state-funded relaxation" (p. 476). In Europe during 2015, forced migrants fleeing war and conflict were 'reclassified' as economic migrants in political and popular discourse (Burns, 2017, p. 1466). A political discourse that invalidates non-citizens, especially disabled migrants, signals a return to a discourse "where inequality is somehow justified as natural", where Western states pick and choose the most desirable, productive refugees instead of the unwanted, burdensome refugees (Pisani et al., 2016, p. 297).

A discourse where health and disability are merged is often found in immigration policies. Furthermore, cost/burden arguments are used to deny entrance to disabled people forced to flee. This reflects a history of eugenics, where disability historically was regarded as burdensome and undesirable in potential citizens (Burns, 2020; Hughes, 2017). Refugees with disabilities often face exclusionary measures such as medical inadmissibility, fees and income requirements, and language tests (Burns, 2020). A dominant discourse where migration to Western countries is regarded as a threat has emerged, where a politics of integration is promoted:

> "A focus on the right 'type' of migrant: young, highly educated/trained and importantly in these neoliberal times, able not only to contribute to society but also to be someone of independent means who will not be burdensome to their host country" (Burns, 2020, p. 336).

Mirza (2014) identifies integration potential as a possible barrier refugees with disabilities face in resettlement policies in receiving countries, along with prospects of recovery and availability of treatment (p. 427). Integration is defined as the complex encounter between a minority and majority population, and is often divided into cultural, residential, economic, and social integration (Valenta & Bunar, 2010, p. 466). Many factors can influence the integration of refugees into the majority population, including the policies of the host government, attitudes and prejudice prevalent in society towards refugees and immigrants, and qualities inherent in the immigrant community (Valenta & Bunar, 2010, p. 467). This study will further explore how politics of integration can indirectly influence refugees with disabilities.

As states want to limit how many people are in the "needs-based" portion of the economy, medical status is used to legitimize and, in some cases, gatekeep disability status. Considerable

scrutiny is given to the resources allocated to the welfare and disability sectors (Grue, 2015, p. 80) and politically, it should not be lucrative to identify as disabled even if the status entails certain privileges (Grue, 2019). This research hypothesizes that similar mechanisms exist at the border, and a reluctancy to admit refugees with disabilities stems from a desire to "protect" the benefits of the welfare system. As both persons with disabilities and refugees are often perceived as costly burdens, the intersection of these statuses result in marginalization. However, there is no legal basis for denying the positive and negative rights in the CRPD to persons who are not citizens, which is further explored in section 5.2.1.

To summarize, looking at how disability in a forced migration context can lead to marginalization requires an intersectional approach. In order to identify how disability is conceptualized, four models stemming from disability theory will be used to identify themes and discourse in the analysis. Firstly, the medical model conceptualizes disability as an individual problem caused by medical impairments, which causes exclusion from society. The impairment therefore needs to be fixed and the person changed to better fit into society and social norms. This manifests itself in discourse as a focus on rehabilitation, fixing or curing the illness or impairment. The social model emerges as a counterargument to the medical model and identifies barriers and discrimination in society as the cause of disability, rather than the impairment itself. The relational model places itself between the social and the medical model by seeing disability as a gap that emerges in the interaction between a person's capabilities and the demands of society. It exists in the context of the welfare state in the Nordic countries and tries to minimize the gap by using both rehabilitation and anti-discrimination policies. Finally, a human-rights based approach has emerged after the adoption of the CRPD and sees a full spectrum of specified human rights as the solution to the discrimination and exclusion disabled people face. A rights-based approach emphasizes that it is the duty of the state to provide these rights to everyone, rather than merely placing the blame on society. These insights from disability theory will be used as an overarching framework for the following analysis. Identifying the prevalent conceptualizations in the official discourse can uncover different lines of reasoning and underlying understandings, and how they can affect the group in question. This will further enable an assessment if the documents and policies reflect a social understanding of disability found in the CRPD. The next chapter will introduce the CRPD and reflect on the obligations enshrined in the convention.

5 International and national legal framework

This chapter outlines the relevant provisions of the CRPD, particularly anti-discrimination. Thereafter, the intersection of the CRPD and refugee law is explored, assessing whether the rights afforded by the CRPD apply to citizens only. Finally, the national implementation of the CRPD in the Norwegian context will be examined. This contributes to the framing of the rest of the thesis, as well as explicating the state obligations enshrined in the convention. Furthermore, to answer the first sub-question, "what discourses about disability are found in official documents related to refugees and to what extent are these in line with the social understanding of disability found in the CRPD?", this chapter investigates and identifies which theoretical model of disability is expressed within the text of the CRPD.

5.1 The Convention on the Rights of Persons with Disabilities

The CRPD is considered a landmark treaty in human rights law, where the struggles that persons with disabilities face are reframed through a human rights lens (Kayess & French, 2008, p. 2). The international convention received widespread support and entered rapidly into force, with a current number of 182 ratifying countries or regional organizations (UN, n.d.a). The CRPD contains several innovative provisions, such as allowing non-state actors like the European Union to become members as a regional integration organization and including provisions on development and situations of conflict (Degener, 2016, p. 2). The CRPD is the first major human rights treaty to be adopted in the 21st century. It is reasonable to ask why this Convention was needed, and why it was adopted so 'late' compared to the other human rights conventions[13]? Kayess & French (2008) explain that "generally speaking, disability has been an invisible element of international human rights law" (p. 12). With one exception[14], none of the eight other core international human rights conventions mention persons with disabilities as a protected group. Disability as a legal issue has traditionally been addressed as part of social security, welfare legislation, and/or health law, which can explain the absence of disability in other human rights conventions (Kayess & French, 2008, p. 14). This demonstrates how the medical model of disability was prevalent at this time. The medical model is also reflected in the earlier instruments that do exist, such as the Declaration on the Rights of Mentally Retarded Persons

[13] For comparison, the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) was adopted in 1965, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) was adopted in 1979 and the Convention on the Rights of the Child (CRC) was adopted in 1989.

[14] The CRC refers to "mentally and physically disabled children" (CRC, art. 23) in the context of special needs and special care, which follows a medical model of disability (Kayess & French, 2008, p. 13).

adopted by the General Assembly in 1971 (Stein & Lord, 2009, p. 21). Onwards, a growing interest in disability issues as human rights issues at the international level can be observed. For instance, the World Programme of Action Concerning Disabled Persons and a global strategy on the prevention of disability was adopted by the General Assembly in 1982 (Barnes, 2020, p. 32).

According to Kayess and French, "the CRPD is regarded as having finally empowered the world's largest minority to claim their rights […]" (2008, p. 1). The CRPD explicates how to achieve all human rights for persons with disabilities and encompasses both civil and political rights (such as freedom of expression[15], freedom from torture[16] and right to life[17]) and economic, social and cultural rights (such as the right to education[18], adequate standard of living[19] and health[20]) (Skarstad, 2018, p. 30). The CRPD extensively emphasizes that persons with disabilities have human rights on an "equal basis" with people without disabilities, which is considered the benchmark of successful implementation of the convention (Series, 2020, p. 94).[21] The UN clearly states that the CRPD does not add any new human rights, but rather clarifies the State obligation to promote, protect and ensure already existing rights for persons with disabilities (UN, n.d.b). The statement that the CRPD does not add any new human rights has been termed 'official fiction' (Kayess & French, 2008, p. 32), as the rights in the CRPD do contain novel formulations that add to and transform several human rights concepts. For example, articles on accessibility[22], living independently and being included in the community[23] and the right to participation in cultural life, recreation, leisure and sport[24] are new formulations within human rights law. Although the formulations are new to human rights treaties, an argument can be made that these 'new' rights were already enjoyed so securely by most non-disabled persons that they became invisible and did not get specific human rights protection before (Series, 2020, p. 94). Furthermore, rights that might have traditionally been regarded as negative rights, such

[15] CRPD, article 21
[16] CRPD, article 15
[17] CRPD, article 10
[18] CRPD, article 24
[19] CRPD, article 28
[20] CRPD, article 25
[21] This is explicitly stated 35 times (Skarstad, 2018, p. 30).
[22] CRPD, article 9
[23] CRPD article 19
[24] CRPD, article 30

as the freedom of expression, would now more clearly include a positive obligation to provide accessible information and translation (Kayess & French, 2008, p. 33).

The CRPD obliges all state parties "[t]o take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities[25]". Discrimination is defined in the CRPD as:

> "*any* distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil *or any other field* […]" [26][27].

This definition of discrimination is built on the definitions in other human rights conventions such as CEDAW and ICERD, but widens it by considering the failure of providing reasonable accommodation as a form of discrimination (Skarstad, 2018, p. 31). Reasonable accommodation is defined as "necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, […]"[28]. Thus, to combat discrimination, positive measures need to be taken to make society more accessible (Degener, 2016, p. 16).

Anti-discrimination measures towards people with impairments can present unique and very different challenges compared to preventing discrimination regarding gender or ethnicity (Grue, 2010, p. 167). As Shakespeare (2006) highlights, "it is no longer possible to argue that women are made less capable by their biology. [...] Similarly, only racists would see the biological differences between ethnic communities as the explanation for their social differences. Nor is it clear why being lesbian or gay would put any individual at a disadvantage, in the absence of prejudice and discrimination" (p. 41). Impairments, however, can be both limiting and difficult even in the absence of discrimination and barriers, meaning that discrimination on the basis of impairment is often due to a lack of positive intervention such as reasonable accommodation or universal design. In contrast, anti-discrimination measures on the basis of gender or ethnicity

[25] CRPD, article 4(b)
[26] CRPD, article 2
[27] Italics added by author.
[28] CRPD, art. 2

are often regarded as a negative intervention, such as anti-harassment measures and equal opportunity measures (Grue, 2010, p. 167-8).

One area of the CRPD that is especially relevant to this study is the notion of multiple discrimination. Multiple discrimination is acknowledged in the preamble: "Concerned about the difficult conditions faced by persons with disabilities who are subject to multiple or aggravated forms of discrimination on the basis of race, colour, […], *national, ethnic, indigenous or social origin*, […]."[29][30] General Comment No. 3 was released to assist with the interpretation of this article, and defines multiple discrimination as the following:

> "Multiple discrimination" refers to a situation in which a person experiences discrimination on two or more grounds, leading to discrimination that is compounded or aggravated. […] Grounds for discrimination include age, disability, ethnic, indigenous, national or social origin, gender identity, political or other opinion, race, *refugee, migrant or asylum seeker status*, religion, sex and sexual orientation"[31] (Committee on the Rights of Persons with Disabilities, 2016, para. 4(c)).

Not only is national and ethnic origin recognized by the convention as a ground for multiple discrimination, but the Committee also recognizes that refugee and asylum seeker status combined with disability can lead to aggravated discrimination and additional barriers (Duell-Piening, 2018, p. 667).

5.1.1 Which theoretical understanding of disability is established in the CRPD?

The CRPD employs the following definition of disability:

> "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in *interaction with various barriers* may hinder their full and effective participation in society on an equal basis with others"[32][33].

This definition clearly encompasses a social understanding of disability, as it identifies that barriers may hinder full and equal participation in society. Furthermore, this definition is also

[29] CRPD, preamble, (p)
[30] Italics added by author.
[31] Italics added by author.
[32] CRPD, art. 1
[33] Italics added by author.

based on a distinction between impairment and disability, which is central to a social understanding of disability (Grue, 2019, p. 8). The social understanding of disability is made even clearer in the preamble:

> "Recognizing that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others"[34].

The definition of disability in the CRPD has been described as not being a definition at all, but rather an open-ended description of the target population (Series, 2020, p. 97). This was done intentionally, as disability as a concept is constantly evolving and what is considered a disability likewise so. Defining disability as an 'evolving concept' demonstrates an understanding of the social nature of disability (Kayess & French, 2008, p. 23). Furthermore, the CRPD attempts to steer the focus away from impairments and the definition of a disability, towards how society can include all individuals (Skarstad. 2018, p. 30).

Article 8 of the CRPD on awareness-raising is the first of its kind in an international human rights treaty. The state parties have an obligation to "raise awareness throughout society, including at the family level […]"[35], and "to combat stereotypes, prejudices and harmful practices relating to persons with disabilities […]"[36]. The following provisions elaborate extensively on the measures to achieve this. This signals that changing the way people and society think and respond to disability is essential for realizing the convention. "Implicit in the CRPD is an understanding by those who framed it that how we understand disability transforms how we respond to it" (Series, 2020, p. 92). This focus on stereotypes and prejudices is yet another indicative of the strong emphasis the CRPD puts on wide-ranging changes in all parts of society, and not on impairments themselves (Skarstad, 2018, p. 31).

This section has established that the CRPD is based on an understanding of disability that follows a social constructionist way of thinking, as barriers and discrimination rather than impairments are understood as the cause of the marginalization of this group (Stein & Lord, 2009, p.

[34] CRPD, preamble, para. e
[35] CRPD, article 8.1.(a)
[36] CRPD, article 8.1.(b)

33; Degener, 2016). However, if the CRPD reflects a particular theoretical model of disability is a topic for debate (Series, 2020, p. 97). The CRPD is undeniably grounded in the social model (Stein & Lord, 2009, p. 25), but it has been argued that the CRPD goes even further and represents a 'human rights model' (Degener, 2017). However, according to Degener (2017), the social model has legally been primarily preoccupied with anti-discrimination legislation. The CRPD goes beyond anti-discrimination legislation by also including economic, social and cultural rights, which is important especially for PwD, as they often require additional assistance (p. 5). Furthermore, by acknowledging intersectional oppression and multiple discrimination as described above, the CRPD goes further than the social model to cover diverse, complex experiences and identities beyond disability (Degener, 2016, p. 9).

However, not all scholars agree that the CRPD is strictly in accordance with the social model. Kayess & French (2008) argue that the CRPD confuses impairment and disability and uses the term 'persons with disabilities' where 'persons with impairment' is meant. This would mean that human rights protection is not triggered by a person having an impairment and being at risk for discrimination and oppression, but that protection is rather post-facto and available only to people already experiencing barriers and discrimination. The authors argue that this confusion between impairment and disability has become entrenched by the CRPD, and a purposive interpretation of the convention is required because of this (p. 21-22). Not all scholars agree with this interpretation however, as Grue (2019) points out that the wording of "may hinder" in art. 1 means that it is not the interaction with barriers that produce disability and human rights protection, but "it is sufficient for disablement to be hypothetically possible" (p. 10). Furthermore, he argues that the provision of "reasonable accommodation" means that the CRPD does not actually enable full and equal participation on an equal basis with others (p. 11). If accommodation is only to be provided where it does not impose an undue burden means that "the needs and preferences of those who govern existing systems are pitted against the needs and preferences of disabled people" (Grue, 2019, p. 13), resulting in inclusion without genuine equality (Grue, 2019, p. 11). Moreover, the wording of "undue burden" is regrettable, as it reiterates the familiar narrative that persons with disabilities are burdens on society (Burns, 2020, p. 330; Kayess & French, 2008, p. 27).

In conclusion, the CRPD represents a shift to a social understanding of disability. Here my use of the word "understanding" and not "model" is vital – I do not try to claim that the CRPD clearly represents the social model of disability. However, the wording of the CRPD at a

minimum requires a social *understanding* of disability as caused by disabling barriers and discrimination in society, and not by impairments and medical problems themselves. When conducting a discourse analysis to answer the first sub-question, such an underlying social understanding of disability will be regarded as a minimum requirement in order to be in line with the convention.

5.2 Implications of the CRPD for refugee law and practice

Shifting our focus to refugees means leaving the international human rights legal framework and looking at another branch of international law, referred to as refugee law. 'The 1951 Convention relating to the Status of Refugees' and the 1967 Protocol (hereafter the 1951 Refugee Convention) is the primary international treaty for defining refugee status (Goodwin-Gill & McAdam, 2007, p. 35). Although refugee law falls under a different branch of international law than international human rights law (and consequently the CRPD), the drafters of the 1951 Refugee Convention intended for its interpretation to consider developing standards of human rights law and discourse (Dimopoulos, 2016, p. 253; Duell-Piening, 2018, p. 662). Moreover, "the UNHCR has acknowledged that the CRPD has implications for virtually every aspect of its policy and field operations – from the collection of statistical information; the conduct of refugee status determinations; and *the selection of refugees for resettlement*[37] […]" (Crock et al. 2013, p. 737).

After the CRPD was introduced, the UNHCR changed their discourse to include PwD, adapted their routines to consider the protection needs of PwD, and revised its Resettlement Handbook (Crock et al. 2013, p. 737; Duell-Piening, 2018, p. 662). The Executive Committee (ExCom) of the High Commissioner's Programme's 'Conclusion on refugees with disabilities and other persons with disabilities protected and assisted by UNHCR' recognizes "that refugees with disabilities […] often have fewer opportunities for other durable solutions, namely local integration and resettlement" and "*Recommends* that States, in cooperation with UNHCR and relevant partners, ensure that refugees with disabilities have equality of opportunity for durable solutions and are provided appropriate support" (ExCom, 2010).

Prior to the revision of the Resettlement Handbook, refugees with disabilities without an immediate medical need were not to be considered for resettlement: "Disabled refugees who are

[37] Italics added by author.

well adjusted to their disability and are functioning at a satisfactory level are generally not to be considered for resettlement" (UNHCR, 2004, chapter 4.4.4). Crock et al. (2013) refers to this formulation as an "egregious manifestation of the 'medical' approach to disability" (p. 737). In the revised edition, the Resettlement Handbook has a more inclusive approach. The revision is recent, and it is perhaps not surprising that policies of receiving countries often mirror a similar approach with admission criteria restricting resettlement of disabled refugees (Mirza, 2011; Crock et al. 2017).

5.2.1 Disability rights for all people, or only for citizens?

The question of whether the human rights in the CRPD applies to refugees was raised during the drafting of the convention. Some claimed that only nationals could receive the kind of support envisioned in the CRPD due to the economic conditions in their countries, especially developing countries with a large displaced population (Crock et al., 2013, p. 739). There is ultimately little legal support for a claim that the CRPD should only apply to nationals. Firstly, the CRPD contains an article explicitly for "[s]ituations of risk and humanitarian emergencies", where state parties are required to "ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters"[38]. This is a novel provision in human rights law, which by expressly referring to these situations without the distinction of citizens and non-citizens supports the conclusion that the CRPD applies to all people (Crock et al., 2013, p. 741). Secondly, there is no clause allowing for derogation from the convention during an emergency situation (Crock et al., 2017, p. 26). Finally, the wording of the text of the CRPD suggest that universality was the intention of the drafters (Crock et al, 2013, p. 740), with "[t]he purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of *all* human rights and fundamental freedoms by *all* persons with disabilities"[39][40].

5.3 National implementation of the CRPD: the Norwegian context

Norway ratified the CRPD in 2013, which was considered relatively late compared to the speed of ratifications elsewhere. Strand (2014) argues that this must be seen as a part of an ongoing discourse in the country, where the division of power between national legislators and international courts and supervisory bodies is debated. Some argue that the international human rights

[38] CRPD, article 11

[39] CRPD, article 1

[40] Italics added by author.

regime is gaining too much power, which might have influenced the more restrictive policy choices concerning the CRPD (p. 76). Norway has not signed nor ratified the optional protocol to the convention, which establishes the competence for a monitoring body to receive and consider individual and group complaints from alleged victims of violations of the convention (Strand, 2014). Comparing Norway to the other Nordic countries: Sweden, Denmark and Finland have all ratified the optional protocol, and Iceland is a signatory, demonstrating an intent to ratify in the future (UNTC, n.d.). Another restrictive policy choice is the fact that the CRPD has not been incorporated into national legislation. As Norway has a dualistic legal system, international conventions need to be incorporated into national legislation, thus applying directly as Norwegian law as well as having precedence over existing legislation if there is a conflict (Strand, 2014, p. 79). Ultimately, the CRPD is put in a weaker position compared to other major human rights treaties such as the CRC or CEDAW (Strand, 2014, p. 80).

The incorporation of the CRPD into Norwegian national legislation was again proposed in the parliament in March 2021, but did not get the majority vote (Stortinget, n.d.). This sparked renewed interest for the debate as many civil society organizations and activists recommend incorporation of the convention. Moreover, the Norwegian National Human Rights Institution and The Equality and Anti-Discrimination Ombud sent a join letter encouraging incorporation into Norwegian legislation. The letter expresses concern over the fact that the CRPD is the only human rights convention not incorporated in national legislation, and the signal that this sends. While Norway is nevertheless a state party of the convention[41], the lack of incorporation in itself is perceived as discriminatory to the groups that already face discrimination and barriers in society (Mestad & Bjurstrøm, 2020).

The Anti-discrimination and Accessibility Act[42][43] was adopted in 2008, and broadly approached non-discrimination and equality in a way that was clearly influenced by international human rights obligations and developments in other countries such as American anti-discrimination legislation (Strand, 2014, p. 79; Tøssebro, 2016, p. 119). Prior to this, "the only legislation

[41] Norway is still legally bound by the provisions in the CRPD regardless of incorporation. The consequences of the CRPD not being incorporated will be visible only in a Norwegian court if there is a conflict between Norwegian law and a provision of the CRPD, where Norwegian law will have precedence (Mestad & Mjurstrøm, 2020).

[42] Author's translation.

[43] Lov om forbud mot diskriminering på grunn av nedsatt funksjonsevne (diskriminerings- og tilgjengelighetsloven)

applicable to persons with disabilities was in the employment sector" (Strand, 2014, p. 80) and the welfare sector (Tøssebro, 2016, p. 119). This Act encompassed a relational model of disability, and incorporated both medical and social themes (Grue, 2010, p. 171). It has now been replaced by the Equality and Anti-Discrimination Act[44], which covers all forms of discrimination but has a particular objective towards gender and ethnicity. Furthermore, the Acts purpose is to "help to dismantle disabling barriers created by society and prevent new ones from being created"[45].

To conclude, this section has found that while the UNHCR has until quite recently followed an exclusionary, medical model of disability, the introduction of the CRPD has had a considerable impact on policies and practice. If this development has influenced the policies on refugees in receiving countries will be examined in the next section, using Norway as a case study. Secondly, there is no legal basis to deny rights afforded in the CRPD to refugees, despite political resistance. Finally, the Norwegian government has implemented the CRPD into national legislation with a restrictive approach, resulting in a weaker position compared to other human rights conventions.

6 Presentation and analysis of empirical evidence

The empirical evidence collected for this research project consists of two distinct datasets. The first contains 20 documents that were selected using the criteria listed in chapter 3.1, and includes policy documents, parliamentarian debates and questions raised in the parliament, official reports, annual reports of UDI[46] and IMDi[47] and one opinion piece. The second dataset consists of eight qualitative, semi-structured interviews. Out of the interviewees, three are parliamentary representatives and five are experts from civil society and OPDs. The following subquestions guided the discourse analysis and interpretation of the documents and interviews:

1. What discourses about disability are found in official documents related to refugees and to what extent are these in line with the social understanding of disability found in the CRPD?

[44] Lov om likestilling og forbud mot diskriminering (likestillings- og diskrimineringsloven)
[45] Ibid. chapter 1, section 1
[46] The Norwegian Directorate of Immigration (Utlendingsdirektoratet)
[47] The Directorate of Integration and Diversity (Integrerings- og mangfoldsdirektoratet)

2. How do conceptualizations of disability differ depending on which political party the politician/document represents?
3. How does the Norwegian government interpret integration and how can this affect refugees with disabilities?

Firstly, the findings of the first and second sub-questions will be presented due to the interconnectedness of the two questions. Thereafter the findings to the first and second sub-questions related to the two contexts will be examined: resettlement policies and the settlement of refugees with disabilities into municipalities. Finally, the findings of the third sub-question will be presented. The overarching interpretation and discussion of the main research question is found in chapter 6.5.

6.1 Discourse surrounding refugees with disabilities

This section presents the main discursive themes identified from the document analysis and the interviews. Through language and the construction of discourses, societies attach values and meaning to the world around us. "Language does not explain the world as much as it produces it" (Dunn & Neumann, 2016, p. 2). The view that discourse produces 'reality' emphasizes the link between discourse, knowledge, and power (Dunn & Neumann, 2016, p. 3). As the analysis is primarily conducted on 'official' discourses stemming from official documents, laws and policies, debates by politicians and reports issued on the request of directories, these are people and institutions that society generally regard as instilled with political power. A CDA approach is concerned with structural relationships between power, discrimination, and control as it is manifested in language (Wodak & Meyer, 2001, p. 2). A critical approach is not just concerned with the text itself, but also the process of the production of a text (Wodak & Meyer, 2001, p. 3), which is why political debates and the reports that inform the process of producing laws and policies were also selected for the document analysis. The identification of emerging discourses is guided by the conceptual models of disability presented in chapter 4.1: medical, social, relational and rights-based approach. The limitations of these models are that none can provide a full account of disability, as socioeconomic explanations of disability can never be completely separated from the bodily impairment. Consequently, any empirical findings or examples will seldom precisely fit any normative theory of disability (Grue, 2011, p. 542-44). The following sections will provide an overview and analysis of the overarching political discourse found in the documents and interviews, followed by a deeper investigation of the three contexts.

6.1.1 Medical discourse

Medical or health related discourse is prevalent throughout the documents, with 14 out of 20 documents containing references that are health or medically related. Medical discourse in the documents can be separated into two themes. The first is medical discourse which specifically refers to refugees with disabilities and is present in official policy documents relating to resettlement (DIN1, DIN3), parliamentary debates and questions (DIN7, DIN8, DIN11, DIN16), annual reports of IMDi and UDI (DIN13, DIN20), a report ordered by IMDi (DIN4) and an opinion piece written by the leaders of IMDi and UDI (DIN14). For instance, "persons with especially large health challenges[48]" is used interchangeably with "refugees with special needs" in the same document by the same person (DIN7). Refugees with health challenges are described as "complex and compounded" (DIN14), in need of "comprehensive healthcare for life" (DIN14), and as "care patients" (DIN3). An expert from a OPD comments: "It is thought that people with disabilities equals people with lack of settlement ability, as sick people in need of care" (INT3). This shows that an understanding of disability through a medical lens is still prevalent in the documents analyzed. However, a medical discourse often appears in conjunction with other prevailing discourses, especially economic discourse. For instance, in an opinion piece written by the directors of UDI and IMDi (DIN14) where they propose that the government should to a greater degree compensate municipalities for settling PwD, solely medical discourse is used to describe this group.

The second instance of medical discourse is more prevalent in the documents which are related to the integration of refugees rather than specifically to refugees with disabilities. Here the health-related discourse is related to the general refugee population without reference to impairments or disability. For instance, the lack of information about the health of refugees is a recurrent theme and has caused challenges when requesting municipalities to settle refugees with disabilities (DIN4, DIN6). The discourse on refugees with health challenges is similar to that on refugees with disabilities: both are described as a vulnerable group struggling to enter into the workforce and needing rehabilitation for their health problems (DIN6). Medical care

[48] This quote has been translated from Norwegian to English by the author. The same applies to all following quotes, as all interviews were conducted in Norwegian and all documents, except DIN1, are originally written in Norwegian.

such as vaccinations and access to health care systems is acknowledged as a human right for refugees and asylum seekers, especially regarding children[49] (DIN6, INT8, FrP).

Mental illness, intellectual disabilities and 'traumatized refugees' are mentioned in eight of the documents analyzed. It is presumed that refugees and asylum seekers have a higher risk of mental disorders due to their experiences with war, torture, and from living in refugee camps (DIN5, DIN6). Termed "migration stress" (DIN5), this disproportionally affects women (DIN15) and children (DIN5). The experts highlighted how trauma and PTSD[50] frequently occurs among refugees (INT6): "trauma is, in a way, something you have to reckon with" (INT2). Trauma from refuge is acknowledged as an obstacle to integration and participating in the work force (DIN15): "Some people are exposed to completely inhuman things on the run and on the way here. This means that one can be so hurt that it is impossible to work" (DIN15). In most cases, mental illness and trauma is related to health care and medical discourse. In some cases, however, trauma and mental illness are discursively connected to the concept of disability. Although not widespread, an understanding of disability that encompasses both physical and mental disabilities is observable both in statements by politicians (DIN16) and in official reports (DIN4, DIN13). It was observed that "part of the issue was that there were no official tools for defining or not defining refugees with trauma or PTSD, and whether it is part of disability or not" (INT2).

This section has shown that medical conceptualizations of disability still prevails in the context of refugees; the framing of disabled refugees is still often situated within the medical sphere (Soldatic, et al., 2015). Furthermore, health-issues regarding refugees in general occur without a reference to disability, although similar discourse such as issues with entering the workforce are mentioned. While there are some examples of policies and discourse that unmistakably follow a medical model of disability (for instance see section 6.3), generally speaking, medical discourse seems to be primarily intertwined with other, more dominant conceptualizations of disability, which leads us to the following section on economic discourse.

[49] An interviewed politician highlighted that limitations on the right to health exists among undocumented migrants, where only emergency assistance is provided (INT1, SV).

[50] Post-traumatic stress disorder.

6.1.2 Economic discourse

A prominent theme throughout the documents analyzed is economic discourse. In several instances, the term "resource-intensive refugees" (DIN8, DIN13, DIN16, DIN19) is used to describe refugees with disabilities. The economic discourse is closely tied with the special needs discourse, and often appears simultaneously with a medical discourse as shown above. Discourse which specifically refer to PwD as costly or resource-intensive is found in parliamentary debates and questions (DIN7, DIN8, DIN16), annual reports of IMDi and UDI (DIN13, DIN20), and an official parliamentary report (DIN5). In a report ordered by IMDi, refugees with disabilities are not directly described as costly, but their definition is tied to the costs and resources the impairment is assumed to trigger[51]. This is demonstrative of a broader trend in the economic discourse, where it is not the impairment itself, but the potential costs associated with conditions/impairments that define this group. The particular emphasis on potential economic costs results in a sub-group of PwD which are particularly focused on, namely those with "lasting multi-disabilities, great health challenges and need for assistance" (DIN13). Conversely, impairments that require less assistance and care are more likely to be overlooked in the context. For instance, lack of information about individuals with lesser follow-up needs results in the delay of settlement due to less initial mapping of this group's needs (DIN4). The context of settlement into municipalities in particular shows a widespread economic discourse throughout, with 11 out of 20 documents referring to the additional costs and resources associated with this group.

Central to the economic discourse is the familiar notion that PwD are burdens to society or their families (Barnes, 2020). When discussing the case of a young, successful disabled entrepreneur who arrived in Norway as a refugee, a politician (A) states that: "She shows that the people we are talking about here *are not only a burden*, but can in fact also add something positive to the Norwegian society in the form of their resources[52]" (DIN16). The discourse rarely refers to PwD as burdens this directly; this quote is an explicit example of an underlying assumption that refugees with disabilities are burdens on society. Although it is acknowledged that this group may have valuable resources, this is presented as an exception from the norm. Discourses of burden are a common theme within disability studies and has shown to be especially relevant in the intersection of forced migration and disability (Burns, 2020, p. 341). An expert states that

[51] See section 6.1.4 for the full definition.

[52] Italics added by author.

"we have been following the political conversation surrounding refugees and people with disabilities, precisely because that conversation constantly paints a picture of disabled people as a burden, a nuisance, a strain, a cost" (INT3). Reinforcing this finding, El-Lahib & Wehbi argue that economic motivations are central to immigration policies under neo-liberalism, resulting in a conceptualization of people with disabilities as economic burdens on the system (2011, p. 96).

The effects of economic discourse on refugees with disabilities are discernible in an example from the UDI annual report concerning assisted returns. Assisted returns is a scheme that offers practical and economic support for people to return to their home country and is targeted towards those whose asylum application have been rejected, will likely be rejected, or those who are staying in Norway without legal residence (DIN20). This scheme has several target groups, including 'especially resource-intensive persons': "these are persons who constitute large expenses for the Norwegian society due to living in facilitated sections[53], having special living- or care services or i.e., are imprisoned" (DIN20). Furthermore, "[t]his is a target group which can be especially resource-intensive to return, however each return provides significant reduced expenditure for society. It also contributes to UDIs goal of a more cost-effective reception system" (DIN20). It is notable that refugees with disabilities are specifically targeted for the assisted return scheme, motivated by cost-reduction and the cost-effectiveness of the system. Furthermore, refugees with disabilities are grouped into the same category as those who are convicted criminals, which carries a negative connotation that both groups are perceived as economic burdens and thus unwanted in Norwegian society. Exclusively economic discourse is used in this section, with no mention of how being returned to their home country might disproportionally affect the people who are living in facilitated sections or need care services, i.e., people with disabilities.

6.1.3 Rights-based discourse

11 out of 20 documents refer to human rights in some way, either in relation to refugees in general or specifically to refugees with disabilities. Four documents contain rights-based discourse specifically relating to refugees with disabilities and two of them directly refer to the CRPD (DIN11, DIN16). One document refers to the responsibility of the state to ensure non-

[53] 'Tilrettelagt avdeling' is provided for refugees with health challenges, which consists of people who are sick and people with disabilities (Lillevik, Sønsterudbråten & Tyldum, 2017).

discrimination and equality for disabled refugees (DIN19) and one report mentions how people with disabilities might be exposed to multiple discrimination (DIN4). The rights-based discourse is noticeable in the statements of politicians belonging to the Labor Party (A) (DIN11, DIN16) and the Socialist Left Party (SV) (DIN19), in addition to a report written on the order of IMDi (DIN4). Ultimately, a rights-based discourse is rarely used in relation to refugees with disabilities in this context.

Rights-based discourses concerning refugees in general are more frequent, such as the right to health services (DIN4, DIN5, DIN6), education (DIN1, DIN5) and equality (DIN5, DIN10). The most recurrent reference is the rights of children stemming from the Convention on the Right of the Child (CRC) (DIN1, DIN5, DIN6, DIN13, DIN20). The CRC and ICERD are the only international human rights conventions mentioned in the official documents related to refugees[54]. The numerous references to the CRC and not to other human rights documents such as the CEDAW and CRPD shows the more extensive influence of the CRC. Although right-based discourse is present in more than half the documents, this is primarily based on the CRC and related to refugees in general. The limited instances of rights-based discourse related to PwD in comparison shows that a rights-based approach to disability is rarely present in the Norwegian refugee context.

6.1.4 Special needs discourse

The most prevalent discourse found surrounding refugees with disabilities is the use of a special needs discourse. Out of the 20 documents analyzed, 12 mention refugees with special needs[55]. The special needs discourse is present in official policy documents relating to resettlement (DIN1, DIN2, DIN3), white papers (DIN5), parliamentary debates and questions (DIN7, DIN8, DIN11, DIN16, DIN17), annual reports of IMDi and UDI (DIN13, DIN20) and a report ordered by IMDi (DIN4). Additionally, the special needs discourse is used by most political parties (Sp, KrF, V, SV, A, FrP). The most noticeable document using a special needs discourse is the report ordered by IMDi, titled "Governmental instruments for the settlement of refugees with special needs" which defines refugees with special needs as: "[r]efugees with disabilities and/or behavioral difficulties etc. which trigger or are assumed to trigger long-lasting, resource-demanding

[54] Except the two references to the CRPD mentioned above.

[55] Here 'spesielle', 'særskilte' and 'særlige' are all translated to and counted under the «special needs» category. 'Særskilte' and 'særlige' could also be translated to 'particular' or 'separate' needs, however the meaning is the same and the words are used interchangeably.

health- and care measures in the settling municipality" (DIN4). The same document also refers to refugees with special needs as "refugees with great needs for health and care services" (DIN4). These definitions show how the special needs language is tied to both economic discourse and medical discourse, with the discursive connection between special needs and economic discourse being particularly prominent throughout the analyzed documents.

The Minister of Education and Integration[56] (V) stated that "[t]he wait times in reception centers for *normal refugees without special needs*, but also for those with special needs, has gone down[57]" (DIN8). The Minister thus forms a dichotomy between normal and "not normal" refugees, contrasting those with and without special needs. Viewing disability as something deviating from normality is a topic that is widely discussed in disability studies (Barnes, 2020; Grue, 2015; Kayess & French, 2008; Oliver, 1996). The view of disability as being caused by abnormal health status has historically been prominent, where "the boundaries of the concept of normal were restricted by the individual's capacity to participate in economic life" (Kayess & French, 2008, p. 5). The classification of people into normal and abnormal is an expression of the medical model (Grue, 2011, p. 543).

> "Refugees with disabilities are persons with special needs. […] It is important to recognize that different degrees of impairments can encompass a wide range of conditions and care needs as a result. The condition can be both physical and psychological in nature, but with facilitation the impairment will be less noticeable for the individual. They will then to a larger degree be able to actively partake in society" (DIN16).

In this quote, the Minister of Integration's[58] (FrP) discourse mirrors the relational model, by viewing disability as a diverse group needing facilitation to partake in society by minimizing their impairment. This is in line with the conceptualization of disability as a gap between the person's capabilities and full participation in society, following a relational model. It is important to note that both physical and psychological disabilities are included.

[56] Guri Melby (V) served as the Minister of Education and Integration from March 2020.
[57] Italics added by author.
[58] Sylvi Listhaug served as the Minister of Immigration and Integration from 2015-2018.

Two of the experts interviewed elaborate on the expression 'special needs' and explain that the label implies that PwD have needs that are different from others:

> "we often see disabled people as having special needs. But all people have needs, I also have needs. I do not have a disability, but I also have needs, so what disabled people have is really needs in the same way as absolutely everyone else" (INT6).

Another expert elaborates on how 'special needs' is not used about the majority population that get accommodations, with the example that pregnant women in the workplace are not seen as having special needs, because having children is accepted as commonplace as opposed to having a disability (INT3). The tie between a special needs discourse and an economic discourse is reinforced as well: "But I can probably imagine that the reason why the word special needs is used to such an extent is that it is about the fact that the needs may cost something more." (INT6).

In the Norwegian context, the special needs discourse is arguably a reflection of the relational model. There has long been a tendency of discourse surrounding PwD to follow a language of special accommodations in Norway (Grue, 2015, p. 76). This is also visible in the academic field, where a higher number of articles on special needs education are published in Scandinavian journals compared to other contexts (Grue, 2015, p. 31). The safeguards of the welfare state are highly relevant in the Norwegian context, and the use of a special needs discourse reflects the relational model by placing PwD in a special category of citizens needing extra accommodations (Grue, 2015, p. 81).

6.1.5 Vulnerability

The theme of vulnerability when referring to refugees with disabilities is present in seven of the documents analyzed, while two documents refer to refugees in general as vulnerable. With two exceptions (DIN4, DIN20), all the references to vulnerability regarding refugees with disabilities stem from either the political debates (DIN16, DIN8), questions asked in the parliament (DIN11, DIN12) or from an opinion piece by the leaders of UDI and IMDi (DIN14). Common for these documents is the oral and/or more informal context compared to public policies, official reports or annual reports, where vulnerability as a theme is mostly absent. Refugees with disabilities are referred to as "an especially vulnerable group" (DIN8), "the most vulnerable group among the world's refugees, namely refugees with impairments" (DIN16), "the group that needs us the very most. They do not march, they have no one to speak for their cause"

(DIN16) and "disabled refugees and asylum seekers are the most vulnerable of the vulnerable" (DIN16). This vulnerability is used as an argument for receiving more refugees with disabilities by some politicians (DIN11, DIN12, DIN16).

The discourse surrounding refugees with disabilities in these political debates borders on paternalism and is observable across the political spectrum. Some politicians use storytelling of individual cases that strongly portrays refugees with disabilities as vulnerable and hopeless using emotional language:

"Sara is not well in the refugee camp she is in, in Ethiopia, because evil also exists there. She was raped in the camp, got pregnant. Now she is a disabled mom and without hope. We could give people like her hope. We could give Sara hope" (DIN16).

The quote seems to follow a so-called 'charity' approach which reflects a traditional understanding of refugee law where PwD have been treated as people needing medical assistance or as objects of charity, with obligations grounded in notions of vulnerability rather than human rights (Crock et al. 2017, p. 17). Furthermore "constant association of disability with the notion of 'vulnerability' suggests that people with disabilities are essentially weak and needy. Given cost-burden arguments used by states against accepting disabled refugees and asylum seekers, portraying them as vulnerable defeats the purpose […]" (Mirza, 2014, p. 427).

6.1.6 Use of terminology surrounding refugees with disabilities

The difference between disability ('funksjonshemning') and impairment ('funksjonsnedsettelse'), as well as the use of 'nedsatt funksjonsevne', in the Norwegian language has been described in section 4.1.2 above. The language in the texts did not reveal any pronounced distinction between the use of 'funksjonsnedsettelse' and 'funksjonshemning'; the two terms seem to be used interchangeably. The same result appears when comparing the spectrum of political parties, as all[59] parties vary between the three terms when referring to refugees with disabilities. Some political parties have identifiable tendencies in their language surrounding PwD. For instance, The Liberal Party (V) uses the above terminology only to a limited extent, and a deviating discourse emerges: the term 'bruker' is used in four instances to describe PwD, which can be translated as beneficiary or user. By referring to PwD as 'users', they are conceptualized primarily as beneficiaries of the welfare state (Grue, 2015).

[59] The Green Party (MDG) is not included, as no politicians were present in the political debates discussing PwD.

The table below shows the distribution of the terminology surrounding refugees with disabilities among four political parties[60] in the document sample:

	A	**FrP**	**SV**	**V**
Impairment (funksjonsnedsettelse)	23	9	4	1
Disability (funksjonshemning)	5	2	5	0
'Nedsatt funksjonsevne'	7	1	1	1

Figure 1: The table demonstrates that the parties, except for SV, broadly use 'funksjonsnedsettelse'. However, the use of terminology varies within the parties.

To explain this phenomenon, a broader focus on the general discourse on persons with disabilities in Norway is illuminating. When asked about the terminology surrounding PwD, several of the persons interviewed state that they prefer to use the word 'funksjonsnedsettelse' (impairment) (INT1, INT2, INT4, INT5). The word 'funksjonshemning', or rather the shortened version 'hemma', is described as carrying a negative connotation by one of the interviewees who has a disability themselves (INT1, SV), and that they prefer the use of 'funksjonsnedsettelse'. This preference by the politician representing SV compared to the party's overall use of 'funksjonshemning' could demonstrate that there is a low level of awareness on the terminological distinction. Another expert expressed that "I find that 'funksjonsnedsettelse' is a more inclusive terminology than 'funksjonshemning', that there is less prejudice attached to the word" (INT2). One expert expressed the view that they attempt to use the word 'funksjonsnedsettelse', but sometimes misspeak by saying 'funksjonshemning' (INT4), which implies that one term is regarded as more 'correct'. Ultimately, several express the sentiment that using a specific terminology is not emphasized anymore and the terms are used interchangeably (INT3, INT5, INT6, INT7, SV).

The important linguistic distinction between impairment and disability which is central to the social model does not translate to the Norwegian context, due to the contextual connotations to the terminology in Norwegian. Additionally, the shared first component of the two words in

[60] The findings regarding the four most relevant parties in this context is presented. These parties (SV, V, A, and FrP) were selected because their politicians were the most active participants in the debates surrounding refugees with disabilities, resulting in more available data to analyze, for more accurate results.

Norwegian adds to the confusion (Grue, 2015, p. 11). The use of either of these terms seems to signal an understanding of disability that recognizes this group as a distinct social or minority group, rather than merely individuals with health challenges. Economic or medical descriptions such as "resource-intensive" or "persons with health challenges" seems to be used in contexts where the marker of disability, and the rights this label entails, are avoided. Alternatively, the person could simply be unaware of disability as either a social or rights-based concept.

An example which clarifies how the use of disability terminology differs depending on the context is the annual reports of IMDi and UDI[61] (DIN13, DIN20). IMDi has a section on "settlement of persons with special needs", which is described as "some refugees have special follow-up needs related to either physical or psychological health challenges". The group is identified as resource-intensive and is defined as those with "lasting multi-disabilities, large health challenges and need for assistance". This is the only instance where disability is mentioned in the annual report, with one notable exception: the section for "management and control of the organization". Here a government initiative, "the inclusion dugnad", states that 5% of all new hires in the state sector should be either persons with disabilities[62] or have a gap in their CV. The UDI annual report likewise has a section on the "inclusion dugnad" which directly refers to PwD, while other parts of the report primarily use medical, special needs and economic discourse to refer to this group. This shows us how the discourse changes in the section related to equal opportunity hiring practices in their own organization; people with disabilities are only used in the section containing official anti-discrimination measures. Conversely, an economic discourse with elements of medical discourse is dominant in the section related to refugees with disabilities. The annual reports of UDI and IMDi exemplifies a stark contrast between the discourse used surrounding PwD in general, which is rights-based by referring to anti-discrimination measures, and the economic discourse in the context of refugees.

6.1.7 Overarching political discourse surrounding refugees with disabilities

Two conflicting discourses can be identified surrounding refugees with disabilities: on one hand they are conceptualized as the most vulnerable of the vulnerable refugees, and on the other they are viewed as costly care patients and an economic burden. Furthermore, notions of charity are more common than those of human rights in the narratives surrounding this group. A

[61] The annual reports from 2019 were selected for the sample.

[62] 'Personer med nedsatt funksjonsevne'

conceptualization of refugees with disabilities based on the potential economic costs and care services they may require is recurring in the documents analyzed, where economic and medical discourses are the most prevalent. This is often expressed as persons having special needs or as being resource intensive. Closely tied with the context of the welfare state, a discourse of being a burden on society emerges. Furthermore, the overarching discourse often merges health and disability, where definitions of PwD as 'persons with health challenges' is widespread. However, these references are often seen in relation to economic conceptualizations of disabilities rather than as an expression of the medical model. Refugees with disabilities are thus not discursively defined by the barriers or oppression they may face (disability), the biological condition (impairment), but by the health care, services, and expenses that their condition may entail. While the use of disability terminology arguably signals an understanding of disability as a social or minority group to some extent, a conceptual shift to a social understanding of disability as caused by barriers and discrimination in society rather than by impairments is not discernible in the refugee context in Norway.

Finally, this study has found that the overarching discourse in the refugee sector does not dramatically differ depending on the political party the politician represents. The major discursive themes identified, including the discourse related to special needs, economic reasoning and vulnerability are visible across the political spectrum. Some divergent discourses can be discerned, such as the tendency for the Liberal Party to refer to PwD as beneficiaries, and the right-based approach to disability is only expressed by the Socialist Left Party and the Labor Party. Furthermore, the Progress Party more frequently employs a medical model of disability (see section 6.3).

6.2 Conceptualizations of disability: the context of settlement into municipalities

The first context that will be examined is the process of settlement of refugees into local municipalities after being granted residence in Norway. It is voluntary for municipalities to receive refugees and generally they are both able and willing to receive refugees (DIN8, DIN14, DIN15, DIN19). The municipalities receive a grant in two parts when settling persons with disabilities, which consists of a one-time grant and an annual grant up to five years (DIN5). It is widely recognized throughout the documents that persons with disabilities experience longer wait-times in reception centers than other refugees, and as many as 11 out of the 20 total documents discuss this topic. Refugees in the ordinary section wait on average between 3-7 months

on receiving a municipality, compared to 2-4 years for refugees with disabilities (DIN4). The documents analyzed state that fast settlement is important for integration and entering the work force (DIN5, DIN7), for becoming established in the local communities (DIN5), contributes to increased quality of life (DIN4), and is "essential for a good life" (DIN7). Contrastingly, long wait times in reception centers are generally a negative, stressful experience for refugees, characterized by uncertainty, unpredictability and little information about their future (DIN4). Furthermore, long wait-times can lead to lost vocational competencies, demotivation (DIN15) and increased or new health challenges (DIN4). Refugees with disabilities do not get the help they need, as processes are not started until a person is settled into a municipality (INT2). One of the interviewees express:

> "Before you get a place to live in a Norwegian municipality, your whole life is on hold […]. You don't know where you will live, you don't really know what your life is going to be like, so I think it is, to be honest, a human rights violation that some are sitting so long in uncertainty" (INT6).

This study has identified two main themes identifying and explaining the substantially longer wait-times for PwD in the documents. The first explanation is bureaucratic in nature: cooperation between agencies and directories in settlement of refugees with disabilities is limited and non-systematic, and the administrative system surrounding grants and settlements is difficult to navigate with non-flexible deadlines, making it harder to plan (DIN4, INT5, INT7, SV). Additionally, many municipalities do not apply for the available grants, as employees in the municipalities lack information (DIN4, INT2).

The second explanation for the delays in settlement of PwD is tied to the capacity of municipalities and the Norwegian health care system, as well as economic insecurity when settling refugees with disabilities. Capacity in municipalities and the healthcare system as a reason for municipalities rejecting refugees with special needs appears in 7 different documents. 'Capacity' in this context refers both to a lack of resources in local municipalities (DIN1, DIN2, DIN4, DIN5, DIN16) and a lack of competencies regarding treatment (DIN3, DIN4). Economic insecurity when settling PwD is the most recurring line of argument to why refugees with disabilities are rejected by municipalities, and it is mentioned in a total of 11 documents. "Municipalities resist settlement of this group of persons. This is justified by the fact that these individuals incur considerable costs and resources" (DIN11), "it emerges that municipalities have refused

to settle disabled people. The rationale for this is mainly the financial burdens" (DIN4). The explanation of the anticipated additional costs is given by several of the people interviewed as well (INT2, INT4, INT5, INT7, SV):

> "We believe that people with disabilities are discriminated against in the settlement queue because the municipalities that are the most eager to settle are concerned about the individuals that they make money from is our claim, and not perhaps those who most need the help and support and care" (INT8, FrP).

Refugees with disabilities face the negative consequences of longer wait-times in receptions due to structural factors, such as a complicated bureaucracy and lack of knowledge about grants. Additionally, requests for settlement of people with disabilities are directly rejected by municipalities because of their disability and the anticipated costs. Consequently, refugees with disabilities experience both direct and structural discrimination. Capacity in the municipalities and economic insecurity are the primary explanations for this unwillingness. Economic insecurity and capacity as the cause of longer wait-times is identifiable throughout the selected time-period (2015-2021): both during the height of the so-called refugee crisis (2015/2016 – DIN16, DIN11, DIN6) as well at the end of the time period, when significantly fewer asylum seekers were entering Norway (2019/2020 – DIN13, DIN14, DIN17, DIN19, DIN4, DIN7). This finding suggests that there are other factors that go beyond capacity concerns that could be contributing to the marginalization of PwD in the context of settlement of refugees. Ultimately, conceptualizations of refugees as economic burdens result in the unwillingness of municipalities to accept refugees with disabilities, and they are thus marginalized and face the negative consequences of long stays in reception centers.

6.3 Conceptualizations of disability: Resettlement policies

Resettlement is a voluntary instrument which Norway supports as a durable solution for refugees (DIN1), with the goal of sharing the burden and responsibility with large host countries in the Global South (DIN2). Norway has a great freedom of choice when it comes to selection of resettlement refugees (DIN2) and receiving 'those who need it the most' (DIN11) and the most vulnerable refugees (DIN11) is a recurring theme. Several interviewees shared the same sentiment that Norway's participation in the resettlement program is based on a humanitarian tradition (INT2, INT4) and wish to help the most vulnerable (INT7, SV, INT8, FrP): "These are people that the UN selects, those who needs it the very most" (INT1, SV). This section will

look specifically at the selection criteria that UDI employs when deciding which of the refugees that the UNHCR nominates should be accepted for resettlement in Norway.

As a part of the resettlement criteria, Norway gives priority to vulnerable refugees, which include vulnerable women and children and LGBTQ+ persons (DIN2). Additionally, priority is given to families with children under the age of 18 (DIN1). Also, women are given priority over men, except men and boys who are vulnerable due to their sexual or gender identity (DIN1). Adult applicants are not prioritized (DIN3). These selection criteria display the commitment to accepting vulnerable refugees. However, disability is notable by its absence, despite the substantial discursive link between disability and vulnerability that has been established above. Although PwD are widely referred to as the most vulnerable refugees in parliamentary debates by politicians, this is not reflected in the resettlement selection criteria in practice. Recently, a proposal to prioritize Christian refugees as a vulnerable group received the majority vote in the parliament, which received widespread criticism (Johnsen, Høydal, Mosveen & Kristiansen, 2020). The composition of the resettlement quota thus seems to be politically controlled, and vulnerability in the resettlement selection criteria is not a neutral term.

Neither the main policy document (DIN3) nor the accompanying documents describing the policies (DIN1, DIN2) mention disability or any synonyms directly. However, Norway has a sub-quota for refugees with medical needs which fluctuates between 20 and 60 refugees per year (DIN1, DIN16, DIN11). This medical quota is also referred to as "specific needs cases" and "refugees with special needs" (DIN1). While recognizing that the medical discourse does not automatically refer to persons with disabilities, the use of a special needs discourse links the medical quota to disability. The quote below further demonstrates how the medical quota is understood to encompass PwD, when the Integration Minister (FrP) was asked if Norway should receive a higher number of refugees with disabilities:

> "When it comes to the quota for resettlement refugees, it is the case that both Norway and other countries accept refugees with different forms and degrees of impairments. Norway has a sub-quota for refugees with a large need for medical treatment, which has 60 spots this year" (DIN16).

For refugees to be accepted on the medical quota, "they must have good prospects of recovery after receiving medical treatment in Norway" (DIN1). The theme of recovery is furthermore

mentioned by the integration minister in relation to the medical sub-quota: "Priority is here given to refugees who with specialized treatment in Norway can recover or get rid of impairments" (DIN16). These quotes demonstrate how disability in the resettlement context is understood through a medical conceptualization. The view that an impairment needs to be cured or fixed for the person to be considered for entry is a central notion of the medical model of disability, which is observable both in the policy itself and in the discourse of the integration minister. Lastly, it should be noted that Norway does not have any specific health criteria for resettlement. Health criteria have historically excluded refugees with disabilities and have previously been present in other countries such as Australia (Duell-Piening, 2018; Hughes, 2017). Finally, an integration perspective (DIN1, DIN3) is a selection criterion in addition to the vulnerable groups. Section 6.4 will examine how this integration criterion might affect refugees with disabilities.

6.3.1 Exclusion from resettlement

Norway's resettlement policy contains several "circumstances that as a general rule will lead to exclusion" from resettlement (DIN3). Firstly, this includes persons who should be excluded from refugee status according to article 1F of the Refugee Convention, which include persons who have committed a war crime, crime against peace or humanity[63] or a serious, non-political crime outside of the country of refuge[64]. Secondly, "unwanted behaviour or attitudes" can lead to exclusion[65]. Lastly, and most relevant for this study, is exclusion based on "lack of Norwegian settlement capacity". This is based on the municipalities ability to provide a suitable solution for settlement, based on the individuals need for follow-up care (DIN3). Exclusion from the resettlement quota in practice might affect several groups, amongst others:

1. «Care patients[66] or persons with a large, long-lasting medical follow-up needs which are not to be considered for the medical quota".

[63] Refugee Convention, article 1F(a)

[64] Refugee Convention, article 1F(b)

[65] It is here important to note that the policy document is not fully available to the public, and the rest of this section had been withheld/censored. This is recognized as a limitation for this study, as the contents is not available for analysis.

[66] The Norwegian word «pleiepasient» does not have a direct translation, but the closest translation is either "nursing patients" or "care patients". The word refers to a person requiring short- or long-term care from health personnel, but not hospitalization (SNL, 2019).

2. “Persons with severe mental disorders that lead to dysfunctional behavior, for instance psychoses and where it is not possible to complete the obligatory introduction program and training in Norwegian language and civic life”

Recollecting the definition of disability in the CRPD, people with disabilities are defined as “those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder full and effective participation […]”[67]. When comparing this definition with the first quote above, there are clear similarities, notably “long-lasting medicinal follow-up needs which are not considered for the medical quota”. As the medical quota stipulates that the illness or disability ought to be treatable, it is reasonable to assert that the first policy encompasses those with a long-term disability. Although medical discourse occurs here, the reasoning behind this exclusion category seems to be based on economic factors as it is based on a lack of capacity and specifically mentions those that require care and/or accommodations. In other words, refugees with disabilities are conceptualized as potential economic burdens on welfare services and can thus be denied entry through the resettlement scheme. The perceived future economic burden is used as a justification for the differential treatment of persons with disabilities. An expert comments on the policy: “this is the clearest example of what characterizes all Norwegian politics, I think. Here it is said so clearly. […] that it is written there is because we think that disabled people equal sick people, in need of care” (INT3).

The CRPD definition of disability also includes mental and intellectual disabilities, meaning that the second quote referring to severe mental disorders also falls under the disability definition. Furthermore, ‘traumatized refugees’ are specifically mentioned as a group to which it is often not possible to provide sufficient services for, in which case the application will be rejected (DIN1). Rather than addressing barriers in society, the second quote seems to point at the impairment itself as the reason for not being able to complete language and cultural training, rather than the program. The perception that a mental impairment in itself causes barriers and exclusion does not follow a social understanding of disability and is the reasoning behind excluding this group from resettlement.

[67] CRPD, art. 1

This section has shown that despite the intention to receive the most vulnerable refugees, the resettlement criteria do not consider PwD to be part of a vulnerable group. They are consequently not given priority. The medical quota, also referred to as 'special needs cases', is understood to encompass refugees with disabilities and has between 20 and 60 spots per year. For refugees with disabilities to be accepted through the medical quota, however, there is a stipulation that the impairment must be curable. This follows a medical conceptualization of disability which is not in line with a social understanding of disability that the CRPD stipulates. Furthermore, the resettlement policy has circumstances that generally lead to exclusion from the quota, where lack of capacity in municipalities is one such circumstance: the potential economic burden warrants exclusion from the resettlement quota. Ultimately, the exclusion clause in the resettlement policy makes it permissible to discriminate against people with certain types of disabilities, namely refugees with physical long-term impairments and severe mental disabilities.

6.4 Interpretations of integration

This section shifts the focus from conceptualizations of disabilities to integration by examining how the Norwegian government interprets integration and how this can affect refugees with disabilities. "The most important change in Norwegian Integration Policy" (IMDi, 2021): the new Integration Act[6869], entered into force on 1. January 2021, replacing the previous Introduction Act[7071]. The purpose of the Integration Act is "that immigrants are integrated early into Norwegian society and become financially independent[7273]". Self-sufficiency is highlighted as one of the most important objectives of the integration politics, which is to be achieved through language training and entering the work force: "The key for good integration is to learn Norwegian and get to work – and not least to stay there. Only this way can we ensure one of the most important objectives in the integration policy, namely self-sufficiency" (DIN15). Examining the 2015-2016 report to the parliament (white paper) on integration sheds light on how integration was interpreted by the government earlier in the relevant time period. Firstly, the name is telling: "From reception centers to working life: an effective integration policy", which demonstrates that the overarching goal of integration is to enter the work force (DIN5).

[68] Author's translation.

[69] Lov om integrering gjennom opplæring, utdanning og arbeid (integreringsloven)

[70] Author's translation.

[71] Lov om introduksjonsordning og norskopplæring for nyankomne innvandrere (introduksjonsloven)

[72] Author's translation.

[73] Lov om integrering gjennom opplæring, utdanning og arbeid (integreringsloven), §1

Furthermore, the introduction adds that "[t]he Norwegian welfare-model is dependent on high participation in the labor force" (DIN5).

The importance of obtaining work and learning the language is emphasized both throughout the time-period analyzed and by all the political parties. While the focus on labor market participation and language learning is very persistent throughout the documents analyzed, some diverging discourses are present as well. For instance, the Labor Party occasionally uses the term 'inclusion' in place of integration, and it is emphasized that the way the majority population responds to refugees, either with trust and a 'welcoming culture' or with fear and prejudice, is influential to their integration (DIN15). However, an economic discourse is simultaneously present: "The Labor Party's ambition is that Norway shall become the world's most inclusive society. We will make diversity an attractive resource for economic growth and cultural development" (DIN15). Inclusion and integration with a social profile is also highlighted by parties such as KrF (DIN10), MDG (DIN15) and SV (DIN10). Exclusion and discrimination, especially in relation to the work force, is highlighted by the Conservative Party (DIN15) and the Socialist Left Party (DIN10). The discourse of one party, the Progress Party, diverges from the rest. While the dominant discourse of self-reliance by obtaining work and learning the language is still present (DIN9, DIN10, DIN15), politicians put the main responsibility of integration on the individual by using a language of demands and duties on immigrants (DIN10): "The Welfare model that is developed in Norway through generations, requires that we create taxpayers out of those who are to live in Norway" (DIN15).

An emerging example is what is referred to as 'symbolic intimidation policies' and is directly translated as 'fear politics' (DIN15). These are policies where welfare arrangements and immigration policies, such as fast return schemes, are restricted to make it less economic lucrative to enter Norway as an asylum seeker (DIN5). These policies are designed to signalize Norway as a less attractive country, and thus receive fewer asylum seekers (DIN20). These measures could negatively affect refugees with disabilities, as it has been established that they are largely conceptualized as economic burdens. Moreover, section 6.1.3 showed that PwD are in fact specifically targeted for assisted return schemes (DIN20), due to cost-saving arguments. Besides, it has been pointed out that arguments against accepting refugees with disabilities have been put forth, precisely fearing the signal effect this could have on future arrivals: "Then the arguments were the same as those I hear today: if we gave residency to this person, then all blind

child soldiers in the whole world would come to Norway and seek asylum, and we had to avoid this[74]" (DIN16).

Integration perspective is a selection criterion for resettlement (DIN3), meaning that "Norway gives priority to persons who will make best use of the services for integration […]" (DIN1). People with relevant education or work experience may be prioritized (DIN1, DIN3), and are one of the groups that Norway requests from UNHCR (DIN3). This criterion applies to all adult refugees except vulnerable women and families with minor children (DIN1). Successful integration is primarily interpreted as participating in the workforce and becoming self-sufficient and refugees with disabilities are commonly conceptualized as costly patients requiring long-term care; this compounded makes it reasonable to assume that refugees with disabilities are seen as 'less desirable' refugees. This was raised as a concern by one politician (A), who asked if the priority given to those who are most likely to be successfully integrated would negatively affect refugees with disabilities. The answer from the Minister of Immigration[75] referred first to the medical quota, before stating that people with medical needs and special accommodations are also accepted on the ordinary quota (DIN16).

The integration perspective as a resettlement criterion combined with the exclusion clause of refugees with disabilities due to capacity concerns, demonstrates a partiality towards refugees who are perceived as not likely to be burdens on the Norwegian welfare system. Discourses of burden, self-sufficiency, contributions to society and the importance of entering the workforce, combined with complex refugee policies, function to marginalize refugees with disabilities (Burns, 2020, p. 336). Refugees can be denied resettlement because of their disability, and those who have entered Norway may face discrimination and long wait times in reception centers or be targeted for assisted returns. Finally, a politician commented on how persons with disabilities are generally missing from the discourse on refugees:

> "We don't talk about it, it's only 'we need people who can work their whole lives in Norway'. And then they have chosen not to talk about those who need help perhaps the most. And if there is no discourse about it, it is very difficult to change the policy […]" (INT1, SV).

[74] It is important to note that the politician here gives an exaggerated account of what they perceived these arguments to be.

[75] Sylvi Listhaug (FrP)

6.5 Discussion: marginalization of refugees with disabilities in the Norwegian context

The findings to the three sub-questions in this chapter allows for the discussion and interpretation of the overarching research question: *To what extent can conceptualizations of disability in relation to refugees impact the marginalization of refugees with disabilities?* This study has found that conceptualizations of refugees with disabilities as beneficiaries of the welfare state and thus as potential economic burdens have practical implications in two areas of interest.

Firstly, refugees with disabilities face directly discriminatory measures at the border such as the possible exclusion from resettlement due to capacity concerns. Additionally, the stipulation that an impairment can be treated and cured to be considered for the medical quota excludes refugees with severe or long-term disabilities and mirrors a medical model of disability. Furthermore, discourses on self-sufficiency, the importance of participation in the workforce and contributing to society can function to further exclude those who are seen as having costly special needs, especially considering the integration perspective as a resettlement criterion. Despite the humanitarian tradition and intention to receive the most vulnerable, the resettlement policies do not include refugees with disabilities as a priority group. Previous research has pointed out that there has been a history of excluding those seen as burdensome, and thus undesirable, from entering countries of refuge, and that modern immigration policies mimic this by ensuring admission of those refugees who are deemed economically productive (Burns, 2020; Duell-Piening, 2018; Hughes, 2017). Ultimately, the perception of persons with disabilities through an economic lens, with a preoccupation with health issues and special needs, results in exclusion and marginalization at the border. This conceptualization seems to conflict with the rhetoric placing refugees with disabilities amongst the most vulnerable.

Secondly, persons with disabilities that have received refugee status and permanent residency in Norway face the negative consequences of long wait-times in reception centers. Structural factors, such as a lack of knowledge of grants and a complicated bureaucracy, and municipalities directly rejecting requests to settle refugees with disabilities, constitute direct and structural discrimination. The unwillingness of municipalities to accept PwD can be traced back to concerns with the anticipated costs associated with certain types of disabilities. As these explanations are present throughout the time-period analyzed, with a higher numbers of asylum seekers arriving in the beginning and comparatively few at the end, other factors than capacity issues must be considered. In sum, discrimination due to economic factors also affects refugees with

disabilities that have entered Norway and received permanent residency, as the long wait-times in reception centers effectively exclude this group from participating in society.

Crock et al. argued in 2013 that the application of the CRPD to refugees will continue to be met with political resistance, and that "[t]his is particularly so in a climate such as the present, where asylum seekers are seen as a burden on already overstretched economies, and border control mechanisms are being tightened to stem the inflow of forced migrants." (p. 742). In the current political climate following the so-called refugee crisis, this might be even more relevant. The framing of the 'crisis' in mass media and by politicians "spread a sense of panic and urgency among public opinion" (Chetail, 2016, p. 584). The increasing numbers of arrivals in Norway resulted in a pressure to regain control of the situation and national border controls were reintroduced (Brekke & Staver, 2018). Some of the experts interviewed further mention how a particularly negative focus on refugees emerged in political discourse during this time-period (INT5, INT7, SV). For instance, this study found examples of policies designed to make it less economically lucrative to enter as an asylum seeker, to deter asylum seekers from seeking protection in Norway. El-Lahib & Wehbi (2009) argue that immigration policies are affected by economic motivations, and that in Canada, "[p]eople with disabilities have been considered an economic burden on the system, which has resulted in their exclusion and marginalization in the immigration process" (p. 96). This study has found similar conceptualizations in the Norwegian context, resulting in marginalization and discrimination of refugees with disabilities.

As the CRPD is becoming more influential in international human rights law, its core provisions such as a social understanding of disability, have begun to permeate refugee law. The UNHCR revision of their Resettlement Handbook is an example of this progress (Crock et al. 2013). A key finding in this study is that a shift from a medical model of disability to a social understanding or a rights-based approach to disability is not discernible in the refugee context in Norway. A traditional, charity-based understanding rather than obligations rooted in human rights persists. Recollecting the restrictive national implementation of the CRPD, especially the fact that it has not been incorporated into national legislation, may explain the limited influence of the CRPD in the refugee sector in Norway. The convention has a weaker position in Norway than other human rights conventions, and an interviewee pointed out that many in the state administration have never heard of the CRPD (INT6). The weaker position of the convention, both legally and the lower levels of awareness surrounding the CRPD could contribute to the findings in this study.

7 Conclusion

Refugees with disabilities often experience multiple disadvantages due to their intersecting categories as both refugees and persons with a disability. This thesis attempts to shed light on this group by examining the marginalization of refugees with disabilities in the national refugee context, with Norway as a case study. By drawing on theoretical models of disability and the principles of the CRPD, a critical discourse analysis of 20 documents and 8 interviews has been conducted. The analysis found that refugees with disabilities are often conceptualized as potential economic burdens on the welfare state. Furthermore, the framing of refugees with disabilities is still done primarily through a medical lens. A key finding is that a discursive shift from the medical model to a social understanding or rights-based approach to disability is not discernible.

This conceptualization of refugees with disabilities in political discourse has real-life implications in both policy and practice. Refugees with disabilities experience marginalization and discrimination at the border through the resettlement policies, despite the intention to receive the most vulnerable refugees. Furthermore, this study found that refugees with disabilities that have entered Norway and received permanent residency experience considerably longer waittimes in reception centers due to an unwillingness of municipalities to settle them due to their disability. Finally, the Governments interpretation of integration relies heavily on discourses of self-reliance and entering the workforce. This could demonstrate a preference for receiving refugees that are perceived as not likely to be burdens on the Norwegian welfare system.

The discourse in the documents and interviews has painted a picture of how persons with disabilities are conceptualized and marginalized in the Norwegian refugee context and found that the influence of the CRPD is limited. Based on these findings, an evaluation of how the CRPD is implemented in policy and practice in the Norwegian context of refugee and asylum policies would be recommended. Furthermore, highlighting refugees with disabilities' own experiences after being granted asylum or arriving as resettled refugees with an intersectional approach, would add valuable insights.

The resettlement selection criteria were updated in May 2021, after the data collection and analysis was conducted. The integration perspective as a resettlement criterion has been removed and replaced with "Potential for integration shall be considered, including competency […]. This means that there should be a balance between vulnerable refugees and resourceful

refugees". Although a distinction between vulnerable and resourceful refugees is still apparent, this could be interpreted as a step in the right direction. Finally, there is a need to evaluate Norwegian policies and reassess public commitment to the rights and values enshrined in the CRPD in the refugee context, to ensure the protection and inclusion of refugees with disabilities.

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Convention on the Elimination of All Forms of Discrimination Against Women, 18 December 1979, United Nations, Treaty Series, vol. 1249, p. 13

Convention on the Rights of the Child, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3

Convention on the Rights of Persons with Disabilities, 24 January 2007, A/RES/61/106

Convention Relating to the Status of Refugees, 28 July 1951, United Nations, Treaty Series, vol. 189, p. 137

Declaration on the Rights of Mentally Retarded Persons, 20 December 1971, A/RES/2856(XXVI)

Implementation of the World Programme of Action concerning Disabled Persons, 3 December 1982, A/RES/37/53

International Convention on the Elimination of All Forms of Racial Discrimination, 21 December 1965, United Nations, Treaty Series, vol. 660, p. 195

Optional Protocol Relating to the Status of Refugees, 31 January 1967, United Nations, Treaty Series, vol. 606, p. 267

Statute of the Office of the United Nations High Commissioner for Refugees, 14 December 1950, A/RES/428(V)

Norwegian legislation

2003 Lov 1. september 2003 nr. 80 Lov om introduksjonsordning og norskopplæring for nyankomne innvandrere (introduksjonsloven)

2008 Lov 20. juni 2008 nr. 42 Lov om forbud mot diskriminering på grunn av nedsatt funksjonsevne (diskriminerings- og tilgjengelighetsloven).

2018 Lov 1. januar 2018 nr. 51 Lov om likestilling og forbud mot diskriminering (likestillings- og diskrimineringsloven)

2020 Lov 6. november 2020 nr. 127 Lov om integrering gjennom opplæring, utdanning og arbeid (integreringsloven)

Appendix 1: List of documents

All documents were accessed on 2. March 2021.

Document Identification Number	Published date	Published by	Title of document	Link to document
DIN1	2018	UNHCR (Resettlement Handbook)	Country Chapter Norway	https://www.unhcr.org/protection/resettlement/3c5e59835/unhcr-resettlement-handbook-country-chapter-norway.html
DIN2	01.07.2020	Justis- og beredskapsdepartementet	Rundskriv G-15/2020: Retningslinjer for arbeidet med overføringsflyktninger jf. utlendingsloven § 35	rundskriv-g-15-2020---retningslinjer-for-arbeidet-med-overforingsflyktninger.pdf (regjeringen.no)
DIN3	19.04.2016	Utlendingsdirektoratet	UDI 2016-015 Anvendelse av uttakskriteriene for overføringsflyktninger	https://www.udiregelverk.no/rettskilder/udi-retningslinjer/udi-2016-015/
DIN4	2020	Rambøll Management Consulting og Oslo Economics, for Integrerings- og mangfoldsdirektoratet	Statlige virkemidler ved bosetting av flyktninger med særlige behov	https://www.imdi.no/content-assets/1824485965a740a5a5d8cdb0dd4ceeff/statlige-virkemidler-ved-bosetting-av-flyktninger-med-sarlige-behov.pdf
DIN5	2016	Justis- og beredskapsdepartementet	Meld. St. 30: Fra mottak til arbeidsliv – en effektiv integreringspolitikk. Stortingsmelding	https://www.regjeringen.no/no/dokumenter/meld.-st.-30-20152016/id2499847/

DIN6	2016	Arbeids- og sosialdepartementet	Flyktninger og arbeid: Rapport fra arbeidsgruppe	https://www.regjeringen.no/contentassets/f0707078220a4d499fce2bbef7cdb37d/flyktninger_og_arbeid_rapport_2016.pdf
DIN7	01.12.2020	Stortinget	Innst. 113 S, om å sikre bosetting av alle mennesker som får opphold	https://stortinget.no/globalassets/pdf/innstillinger/stortinget/2020-2021/inns-202021-113s.pdf
DIN8	01.12.2020	Stortinget	Debatt om å sikre bosetting av alle mennesker som får opphold	https://stortinget.no/no/Saker-og-publikasjoner/Publikasjoner/Referater/Stortinget/2020-2021/refs-202021-12-01?m=9
DIN9	13.10.2020	Stortinget	Innstilling fra kommunal- og forvaltningskomiteen om Lov om integrering gjennom opplæring, utdanning og arbeid (integreringsloven)	https://www.stortinget.no/globalassets/pdf/innstillinger/stortinget/2019-2020/inns-201920-389l.pdf
DIN10	13.10.2020	Stortinget	Debatt om Innstilling fra kommunal- og forvaltningskomiteen om Lov om integrering gjennom opplæring, utdanning og arbeid (integreringsloven)	https://www.stortinget.no/no/Saker-og-publikasjoner/Publikasjoner/Referater/Stortinget/2020-2021/refs-202021-10-13?m=7

DIN11	06.04. 2016	Stortinget	Spørsmål 13 - Ordinær spørretime	https://www.stortinget.no/nn/Saker-og-publikasjonar/publikasjonar/Referat/Stortinget/2015-2016/160406/ordinar-sporretime/13/
DIN12	24.02. 2016	Stortinget	Skriftlig spørsmål fra Lise Christoffersen (A) til innvandrings- og integreringsministeren	https://www.stortinget.no/no/Saker-og-publikasjoner/Sporsmal/Skriftlige-sporsmal-og-svar/Skriftlig-sporsmal/?qid=64745
DIN13	2020	Integrerings- og mangfoldsdirektoratet	Årsrapport 2019	https://www.imdi.no/globalassets/dokumenter/arsrapporter-og-styrende-dokumenter/arsrapport-2019/arsrapport_2019.pdf
DIN14	27.10. 2020	Integrerings- og mangfoldsdirektoratet	Flyktninger med helseutfordringer trenger også en kommune	https://www.imdi.no/om-imdi/aktuelt-na/flyktninger-med-helseutfordringer-trenger-ogsa-en-kommune/
DIN15	16.06. 2016	Stortinget	Debatt om Innstilling fra kommunal- og forvaltningskomiteen om Fra mottak til arbeidsliv – en effektiv integreringspolitikk	https://www.stortinget.no/no/Saker-og-publikasjoner/Publikasjoner/Referater/Stortinget/2015-2016/160616/1
DIN16	19.01. 2016	Stortinget	Interpellasjon fra representanten Lise Christoffersen til innvandrings- og integreringsministeren	https://www.stortinget.no/no/Saker-og-publikasjoner/Publikasjoner/Referater/Stortinget/2015-2016/160119/12

DIN17	26.10. 2020	Stortinget	Skriftlig spørsmål fra Jon Engen-Helgheim (FrP) til kunnskaps- og integreringsministeren	https://www.stortinget.no/no/Saker-og-publikasjoner/Sporsmal/Skriftlige-sporsmal-og-svar/Skriftlig-sporsmal/?qid=81709
DIN18	31.01. 2018	Stortinget	Skriftlig spørsmål fra Karin Andersen (SV) til justis-, beredskaps- og innvandringsministeren	https://www.stortinget.no/no/Saker-og-publikasjoner/Sporsmal/Skriftlige-sporsmal-og-svar/Skriftlig-sporsmal/?qid=71039
DIN19	23.06. 2020	Stortinget	Skriftlig spørsmål fra Katrine Boel Gregussen (SV) til barne- og familieministeren	https://www.stortinget.no/no/Saker-og-publikasjoner/Sporsmal/Skriftlige-sporsmal-og-svar/Skriftlig-sporsmal/?qid=80185
DIN20	2019	Utlendingsdirektoratet	Virksomhetsrapport 2019	https://www.udi.no/globalassets/global/aarsrapporter_i/virksomhetsrapport-udi-2019.pdf

Appendix 2: List of interview participants

All interviews were conducted between 16. April and 03. May 2021.

Parliamentary representatives

Interview Number	Name	Political Party	Date of interview
INT1	Nicholas Wilkinson	Socialist Left Party (SV)	16.04.2021
INT7	Karin Andersen	Socialist Left Party (SV)	29.04.2021
INT8	Jon Engen-Helgheim	The Progress Party (FrP)	03.05.2021

The parliamentary representatives have explicitly consented to be named in the thesis.

Experts from civil society

Interview Number	Position	Date of interview
INT2	Professional experience working with refugees with disabilities in reception centers and integration of refugees	20.04.2021
INT3	Leader of a Norwegian OPD	21.04.2021
INT4	Representative of a Norwegian OPD	21.04.2021
INT5	Leader of a Norwegian OPD	22.04.2021
INT6	Representative of a Norwegian OPD	23.04.2021

All participants from civil society represent different organizations and have been anonymized for this thesis.