CSIRO PUBLISHING

Australian Journal of Primary Health, 2020, **26**, 367–373
https://doi.org/10.1071/PY20045

Research

The Rohingya Little Local: exploring innovative models of refugee engagement in Sydney, Australia

Amy Bestman [A,B,F], *Jane Lloyd* [B], *Barbara Hawkshaw* [C,E], *Jawat Kabir* [D] *and Elizabeth Harris* [B]

[A]The George Institute for Global Health, UNSW Medicine, University of New South Wales.
[B]Centre for Primary Healthcare and Equity, UNSW Medicine, University of New South Wales.
[C]Central and Eastern Sydney Primary Health Network, Tower A Level 5/197–201 Coward Street, Mascot, NSW 2020, Australia.
[D]Burmese Rohingya Community in Australia.
[E]Present address: Retired.
[F]Corresponding author. Email: abestman@georgeinstitute.org.au

Abstract. The Rohingya community living in the City of Canterbury-Bankstown in Sydney have been identified as a priority population with complex health needs. As part of ongoing work, AU$10 000 was provided to the community to address important, self-determined, health priorities through the Can Get Health in Canterbury program. Program staff worked with community members to support the planning and implementation of two community-led events: a soccer (football) tournament and a picnic day. This paper explores the potential for this funding model and the effect of the project on both the community and health services. Data were qualitatively analysed using a range of data sources within the project. These included, attendance sheets, meeting minutes, qualitative field notes, staff reflections and transcripts of focus group and individual discussions. This analysis identified that the project: (1) enabled community empowerment and collective control over funding decisions relating to their health; (2) supported social connection among the Australian Rohingya community; (3) built capacity in the community welfare organisation –Burmese Rohingya Community Australia; and (4) enabled reflective practice and learnings. This paper presents an innovative model for engaging with refugee communities. Although this project was a pilot in the Canterbury community, it provides knowledge and learnings on the engagement of refugee communities with the health system in Australia.

Keywords: co-design, community engagement, health promotion, refugee health.

Received 4 March 2020, accepted 11 August 2020, published online 2 October 2020

Introduction

The Rohingya people, a minority group from Buddhist-majority Myanmar (Burma), are considered illegal immigrants within Myanmar by the Myanmar government. The Rohingya people are described by the United Nations as 'the most persecuted people in the world' (USA for United Nations High Commissioner for Refugees (UNHCR) 2020). As a result of this persecution, there is a growing Rohingya community in Australia (Arraf 2018), including a significant proportion who are on temporary or refugee visas (Australian Bureau of Statistics 2016). International literature states that the Rohingya people experience high mental health effects from their trauma (Islam and Nuzhath 2018). This includes post-traumatic stress disorder, emotional distress, anxiety and depression (Tay *et al.* 2018). However, despite high levels of need, Rohingya people often face difficulties accessing care. Consistent with research on the health of newly arrived refugees in Australia (Davidson *et al.* 2004; Parajuli and Horey 2019), individuals from a Rohingya background face cultural, language and financial barriers, in addition to a lack of healthcare system knowledge, which affects their ability to access health care (Tay *et al.* 2019). Other factors affecting the Rohingya community include cultural stigma around mental health, fear of arrest by authorities such as police or immigration and a mistrust of formal institutions (Tay *et al.* 2018).

A strong evidence base supports the ethical and functional importance of community engagement in the design and delivery of public health interventions for refugee populations (Nierkens *et al.* 2013). More recently, there is evidence of a paradigm shift from community engagement, towards community-developed (or co-designed) health programs (Signorelli *et al.* 2017). Co-design is increasingly expected as part of health program development and practice and, as a result, the evidence base for conducting authentic and effective co-design has begun to emerge (Nguyen *et al.* 2009; Kandula *et al.* 2013; Kim *et al.* 2014).

In the city of Canterbury Bankstown in South-West Sydney (Australia), there has been ongoing work to support marginalised

communities, including the Rohingya, through the Can Get Health in Canterbury (CGHiC) program. CGHiC is a location-specific, population-based program that aims to: (1) improve access to comprehensive primary healthcare services; (2) increase individual and community health literacy; and (3) identify and work with relevant stakeholders to address at least one social determinant of health (Central and Eastern Sydney PHN 2019). The CGHiC program is a partnership of the Sydney Local Health District, Central and Eastern Sydney Primary Health Network and The University of New South Wales. Alongside other organisations in South Western Sydney (Némorin *et al.* 2019), the CGHiC program has been working with the Rohingya community in the area since 2014. The range of engagement with this community has been summarised in Table 1. In 2018, in response to community consultation, the CGHiC program sought to undertake a project that: (1) deepened our understanding of the cultural context of the Rohingya community in Canterbury; and (2) further develop the relationship between the community and the healthcare system to bridge the cultural gap.

An evaluation of the CGHiC program in 2016 recommended that activities moved from a community engagement model to a community-led model. In response to this recommendation, international literature relating to community empowerment programs were examined. The UK-based Big Local project (Orton *et al.* 2017) was identified as a potential model that could be used in Canterbury. The Big Local is an area-based initiative, funded by the Big Lottery Fund and designed and delivered by an independent national charity, Local Trust (Local Trust 2019). This long-term initiative to strengthen community and improve social connections and wellbeing provided 150 disadvantaged neighbourhoods across England with at least £1 million to spend over 10–15 years (Local Trust 2019). Within each geographical community, residents were invited to form a voluntary committee that identified local priorities and plans to address these (Reynolds 2018). Evaluations identified that the community-led program enabled the development of community skills and partnerships to support future action (Orton *et al.* 2017).

Late in 2018, the CGHiC program worked with the local organisation, the Burmese Rohingya Community in Australia (BRCA), and established the Rohingya Little Local project based on the Big Local model. This project provided AU $10 000 funding to the Rohingya community in Canterbury. The Little Local model of community engagement encouraged the Rohingya community to work with the health system (through CGHiC) to address a health priority (as chosen by the community itself). An organising committee was formed to facilitate ongoing discussions with CGHiC staff and community representatives from the BRCA during the planning and implementation of the project. The representatives decided that mental health was a key issue they wanted to address. The committee chose to improve mental health through increased social connection. Additionally, the community used their existing governance structures to discuss their priorities and decide on how best to invest the project funding to improve the health of the community. These governance structures followed gender lines. Although CGHiC staff were part of the organising committee for the project, they took a 'back seat' approach allowing community members to make key decisions around the project, providing guidance when required. The community representatives chose to hold two events, the first was a soccer day for men in the community and the second, a community picnic with activities for women, children and men in the Rohingya community. The current exploratory study was guided by the following research questions:

1. Is the Rohingya Little Local model feasible for community empowerment and development of projects in the area?
2. What was the value of the project for the Rohingya community?
3. What lessons can be learnt from working with the Rohingya community?

Table 1. Summary of the Can Get Health in Canterbury (CGHiC) program activities with the Rohingya population before 2019

Date	Activity
2014–15	Consultations with community
2016	Women's Health course to provide information about physical activity and nutrition for good health for 15 Rohingya women
	'Kids First Aid' program to provide information about first aid for children with 30 Rohingya women
2017	A tour of the local Community Health Services and Hospital with nine Rohingya women
	A trip to the Zoo with 135 community members to support social connection and reduce psychological distress at traumatic overseas events in Myanmar that involved extended families
2018	Community consultation with 23 adults and 11 children to explore the health needs and barriers to accessing health care within the area
	Involvement in the local interagency for the Rohingya community
	Oral Health Day assessing 27 children's teeth and providing health education to their families at the local school. Follow-up dental appointments for 19 (70%) children at the local Hospital (for filling and assessment, X-rays, tooth extraction and treatment)

Methods

Approach

The current exploratory study utilised a constructivist approach (Mills *et al.* 2006). A qualitative approach was used to examine three main data sources (qualitative focus groups, field notes and meeting notes) to increase the depth of understanding around the effect of the current project (Hesse-Biber 2010). This pragmatic approach was chosen to allow the development of different perspectives and support the transfer of meaning within the project. Consistent with a constructivist approach (Mills *et al.* 2006), researchers ensured they developed and maintained relationships with participants to mitigate power imbalances and provide a reciprocated sense of cultural understanding. Ethics approval was obtained from the University of New South Wales Human Research Ethics Committee.

Data collection

Members of the research team were involved in all components of the Rohingya Little Local and took detailed field notes and reflections during the planning of the project, community events

Table 2. Timeline for Rohingya Little Local event

Where relevant, genders of individuals have been included. CGHiC, Can Get Health in Canterbury; BRCA, Burmese Rohingya Community in Australia

Date	Description of activity	CGHiC staff[A]	Rohingya community members	Data collected
Mar. 2018	Discussion of Little Local at CGHiC Advisory Committee meeting	14 staff	Nil[B]	Meeting minutes
Apr. 2018	Discussion at CGHiC Management meeting	13 staff	Nil	Meeting minutes
June 2018	Decision to fund project (CGHiC Management committee)	13 staff	Nil	Meeting minutes
Aug. 2018	Meeting with BRCA and CGHiC staff during day to outline offer of funding	2 women	9 men	Meeting minutes
Oct. 2018	Meeting in evening to discuss the proposal details	2 women	4 men in person, 1 man on phone	Meeting minutes. Project proposal
Nov. 2018	Meeting in evening to discuss progress	2 women	5 men	Meeting minutes
Jan. 2019	Meeting 1 week before first event. Discussion on planned events, logistics, what is still needed to be done	2 women	4 men	Meeting minutes
	Event 1a: Pre-soccer event dinner (held night before soccer day)	3 women, 1 man	Estimated to be 200 men by BRCA staff	Staff reflection notes
	Event 1b: Soccer day	3 women	172 adults in total (143 men and 29 women)	Staff reflection notes, attendance sheet
	Meeting in late afternoon to discuss plans for event two	2 women	5 women	Meeting notes
Feb. 2019	Event debrief (2 weeks after event). Discussion of what went well and things to change, learnings and event meaning (for BRCA and the broader community)	3 women	6 men, 3 women	Meeting minutes debrief notes
Mar. 2019	Planning for second event	3 women	5 men, 1 woman	Meeting minutes
May 2019	Meeting 1 week before second event. Discussion on planned events, logistics, what is still needed to be done	3 women	1 man, 3women	Meeting minutes
June 2019	Event 2: Picnic day	5 women	Estimated to be 300 by community members/staff	Staff reflection notes
	Event debrief (2 weeks after event). Discussion on what went well and things to change, learnings and event meaning (for BRCA and the broader community)	2 women	2 men, 1 woman	Qualitative notes by CGHiC staff, transcript of audio from meeting
July 2019	Meeting with BRCA to support youth-focussed grant development for external project	1 woman	7 men, (four aged 16–23 years)	Staff reflection notes
Aug. 2019	Phone interview with an organiser of picnic event (who was unable to attend debrief meeting)	1 woman	1 woman	Qualitative notes of interview

[A]CGHiC staff or partner health organisation (not part of Rohingya community).
[B]Rohingya community members had been invited to attend, but representatives were not available to attend during the study period.

and debrief meetings. As outlined in the introduction, the project reported in this paper was the result of multiple activities with the Rohingya community over a period of several years. Additionally, members of the research team attended interagency meetings with other organisations (including health, local council and social services), working with the Rohingya community in Sydney.

Data collection was planned to collect demographic information on the number of people in attendance at the second event; however, due to logistical factors, including the number of people and fluidity of the event, we were unable to capture this information for the entire group. Both researchers and community members estimate there were 300 people in attendance at the picnic.

Data were collected between March 2018 and August 2019 (Table 2). Data were collected from attendance sheets, meeting minutes, qualitative field notes, staff reflections and transcripts of focus group and individual discussions. Following meetings, community members were given copies of debrief notes and meeting minutes and asked to comment if there were any inaccuracies; however, no changes were made.

Data analysis

Data analysis occurred throughout the project, drawing from a sequential exploratory mixed-methods research design (Hesse-Biber 2010). As stated above, members of the research team took field notes and made reflections on the data collected during the project. Additionally, authors held debrief sessions after each phase of the research to discuss individual interpretations of the data. When analysing the data to write the manuscript, data sources were combined and key themes were identified (Miles and Huberman 1994). These themes were further discussed within the research team, including how individual findings fit into the broader themes identified.

Results

Table 2 contains the range of activities that were involved with the Rohingya Little Local project. The following text presents the findings relating to four key themes.

Theme one: enabling community control

Following the CGHiC program decision to provide support for projects that were community designed, rather than informed, the Rohingya Little Local project was developed by the organising committee. The community group told staff the events were aimed at addressing mental health needs by bringing the community together to connect and to deal with some of the grief and loss caused by traumatic events that occurred in 2017 in Myanmar (Arraf 2018). The group had previously been involved in local soccer competitions (for more information see Bossi (2016)) and believed that organising a soccer competition for Rohingya people would provide the social connection they wanted to achieve. Due to cultural constructs around gender, it was decided that two events would be planned; men would be the target group for the soccer event in early 2019 and women and children would be the target participants for a second event, a family picnic organised later in 2019. Two smaller groups consisting of community members were established to coordinate the planning and activities for the two events, one men's group and one women's group, with designated individuals working on each event.

Each group reported back to the main organising committee on the progress of their event planning. The first event (soccer tournament) was organised by the men's group. This included organising the dinner the night before the event (with ~200 mostly male community members in attendance), planning the tournament (including organising the venue, security, first aid officers, promotion and trophies) and running the tournament (which included eight teams and was attended by 172 individuals). Although the project was initially planned for the Rohingya community within South Western Sydney, the community representatives chose to invite Rohingya groups from Sydney, Melbourne and Queensland. For the soccer tournament, there were a small number of women who assisted with organising the food for participants. The food at this event was used to fundraise additional funds for the picnic.

Following the soccer tournament, both groups worked separately to organise the picnic. It was decided by the community representatives that the men's group would coordinate the food and men's activities at the event, whereas the women's group organised activities for women and children (including organising gift bags for children). One man, who was regarded as a senior figure in the community and the husband of one of the women's group organisers, acted as a liaison between the two groups. The main organising committee met regularly during the planning phase. Although meetings were originally planned so that CGHiC program staff could provide support in the organising of the events, community members were well organised. As such, the community did not require extensive support from the CGHiC program. Meetings involved members of the group providing updates to CGHiC program staff and general discussions around the progression of the project. During the project planning phase, CGHiC program staff highlighted that community representatives could make decisions around the use of project funds, provided that the overarching principles of the project were maintained. As a result, the group sourced in-kind support for the project (e.g. venue hire at the local indoor soccer courts).

Theme two: supporting social connection

Following the first event, one male senior member of the organising group gave deeper insight into the importance of building social connections for the community. He described that within the Canterbury Rohingya cohort, there were recent refugee arrivals who were new to the health system and the cultural context in Australia. However, there were also individuals who had been settled in Australia for several years. Prior to the Little Local project, community members had little opportunity to gather to consolidate the local Rohingya community. The two events created a greater awareness of the work of the BRCA among the Rohingya community and resulted in an increase in memberships.

This social connection was viewed as important in supporting the community, but also to ensure that the Rohingya culture was maintained. As stated above, the community invited Rohingya people from interstate to the soccer tournament, with 19 men travelling from Queensland to attend. During the event debrief, community members explained that the Rohingya population in Brisbane was settled a few years prior and had not travelled to meet with the Sydney Rohingya community. One senior male member said that the soccer event was important as they were 'long time missing each other, we don't see them'. Another male member noted the interstate team members had said 'this [tournament] is something we have been dreaming of for 10 years'.

During the second debrief, community members provided deeper insights into the cultural nuances across the community. Some participants described how Rohingya individuals had married individuals from other cultural backgrounds (including Bangladeshi, Malaysian, Indonesian, Arabic and Burmese). The community organisers of the Little Local wanted to find a way to include these individuals in the Australian-Rohingya community and overcome language and cultural barriers. The picnic provided the opportunity for families to attend and develop 'good relations, friendship(s)'. One woman believed this was particularly important for young people who did not know other young Rohingya people in their community. Younger community member inclusion in the picnic event was facilitated through the organising of events; for example, younger girls assisted in preparation of children's gifts and other picnic activities.

Additionally, the debrief gave context to gender expectations within the Rohingya culture. One woman explained that culturally, women and men do not socialise together. When planning for the picnic, women reached out to other women to invite them to the event. The organiser told researchers she had made multiple phone calls to community members to reassure women that there would be an appropriate area for the women's activities. Following the event, women who attended the picnic were positive about the activities. One female recalled a conversation with a woman (non-Rohingya) who was married to a Rohingya man, '[I said] your husband is the leader so come join all the time. She says, 'now I know the people, I'm coming, I'm interested''.

Theme three: building capacity

The Little Local model provided the opportunity for community members to plan and run two community events. Although the Little Local project funded AU$10 000 towards the activities,

the final cost of the project was AU$19 229. Additional costs were covered by in-kind local sponsorship (such as venue hire by the local area) and through in-kind BRCA staff time before and during events to assist with activities such as catering and transporting community members. Following the Little Local project, the community discussed seeking additional funding from other sources to organise a larger soccer tournament. Community members proposed to invite Rohingya people from Canada and New Zealand to participate in a global Rohingya soccer tournament. Additionally, following the events, the community identified state government youth funding to support other health priorities in their community (in this instance, supporting Rohingya youth). The CGHiC program supported the development of the project and funding proposal by providing feedback and advice on the project; they were not listed as a partner organisation on the project. Both CGHiC program staff and the community representatives (through the BRCA) perceived that the community had the capacity to manage the project without CGHiC program support if funded.

Despite building capacity in their ability to plan and deliver community-based events, community representatives indicated that there were other areas in which they required additional support. It was through the ongoing work between the CGHiC program (on behalf of the health system) and community members that enabled an open discussion around specific health and social issues that needed to be addressed. During meetings relating to the Little Local project, the community group raised other issues with CGHiC program staff that affected their community; for example, the need for permanent office space (the BRCA supports community members to gather documentation for visa and citizenship purposes for government departments). Regular meetings with the group through the Little Local project enabled staff to provide support to the community to work towards solutions for these issues.

Theme four: learnings and challenges for the research team

The final theme related to the reflective practice and learnings associated with this project. The project enabled the CGHiC program to slowly build upon existing relationships with the community. In undertaking this work, the research team faced personal and professional challenges. These included the role of women in the process, being confronted by the effects of Australian immigration policy on communities we worked with and challenging normal funding processes. Initially, we (as female researchers, see Table 2 for more detail) faced personal challenges responding to the role delineations within the community, with women seemingly excluded from decision-making processes and the gendered nature of the events. However, more experienced colleagues encouraged a long-term approach to engaging with the community and to understand that women had an important 'behind the scene' role.

Another challenge related to the need for project staff to change their practices and adapt to the informal meeting style, which was held in the evening on a weeknight and where individuals translated the conversation into Rohingya to clarify content between community members. This created an informal open meeting space and as the project progressed, the community shared insight into the issues they faced (both health related and more broadly relating to the social determinants of health) and sought guidance from CGHiC program staff to address these issues. Also important to note was the growth of the research relationship as the project progressed. Early- and middle-stage meetings with the organising group (including the first debrief meeting) were recorded through note taking by CGHiC program staff. However, in the last debrief meeting and phone interview, community members were comfortable with staff audio recording conversations for use in research.

The innovative model required organisational process changes to facilitate the transfer of funding to the community. Traditionally, and including in the CGHiC program, government processes require that funds are not given to a community group. Therefore, the funding mechanisms needed to be adapted to provide funds to a community entity. The belief that the BRCA could manage the project independently and have the freedom to act in consultation with CGHiC program staff was a novel approach to some managers within the organisations of CGHiC, as this differed from the standard process whereby specific contracts and deliverables were identified before the start of the project. The nature of the project required flexibility in funding with minimal constraints on what could be spent. Additionally, as there was no open tender process, a structured workplan and a memorandum of understanding was developed to support the project; however, ultimately no issues arose.

Finally, the sustainability of the Little Local model is a challenge. Although the infrastructure for the project has now been established, this model relies on continued funding, which presents an ongoing issue. The organising group has considered whether additional funding is used to continue supporting the community development in the Rohingya group or whether funding should be directed to implement the model in another cohort within the community. Most importantly, there are questions around support from CGHiC program funding organisations (the local health district and Primary Health Network) to continue the program. If these organisations do not continue to fund the project, alternative sources of funding will be needed.

Discussion

In the context of the project, the Little Local model was an effective method to support and engage with the Rohingya community and enable community empowerment over healthcare priority setting and action. The Little Local model shows 'proof of concept' in the implementation of similar projects that seek to be community-led and that support community control over funding decisions relating to their health. The approach taken in this work is consistent with evidence for successful community-based mental health interventions for refugees, including that interventions are culturally sensitive; a safe environment for individuals to share their thoughts needs to be provided; local professionals or leaders need to be empowered to shape the program; and community involvement and a multidisciplinary approach are required (Williams and Thompson 2011). It is important to acknowledge that this model required flexibility by the health system in their acceptance of self-determined goals by the Rohingya community. For example, one of the funders needed to modify its standard procedure for fund allocation to facilitate the transfer of funds to a community organisation (the BRCA), agreeing to a letter of intent for the project funds.

This work contributes to the literature about the role of participatory community initiatives such as the Little Local in reducing health inequalities via increasing collective control (Whitehead *et al.* 2016). Additional research is required into the long-term effect of community-led models such as this, and the specific mechanisms that enable health equity. Although the model was successful in delivering community-developed activities in this case study, we would caution others looking to implement such a program. Considerations such as the time and relationship building to develop the foundations for the project (built over a period of 5 years) and the existing community and health system infrastructure to support the project should not be minimised. Others looking to use this model should not rush the implementation of a Little Local-style program and should ensure that any program is culturally and contextually appropriate. Other health-promotion interventions using this model need to ensure that projects are evaluated and that results are published in a format that is publicly accessible for other practitioners and researchers.

Although the project was initially planned for the Rohingya community in Canterbury only, the relationships of community members enabled the engagement with the wider Rohingya community across Sydney and Brisbane. The role of social networks in providing emotional and practical support to assist in the integration of refugees and asylum seekers into a new community is established in the literature (Beirens *et al.* 2007). However, the Little Local model of engagement raises implications around definitions of 'community'. Within the health system that the CGHiC program operates, community is often classified within specific geographic boundaries. Although consideration of cultural communities is included, allocation of resources often relies on location. Consistent with the themes identified by Reynolds (2018), the current project introduced challenges around defining 'community' and the eligibility of which groups are eligible or should benefit from the project. For example, following the inclusion of Rohingya communities from other states, the organising committee considered the benefits of using future funds to support interstate communities to travel to Sydney. Although other Australian research has identified the importance of sport on the integration and social inclusion of refugees, particularly as a way to participate in Australian culture (Block and Gibbs 2017), the loss of the Rohingya culture was a key concern of individuals within this study. This project demonstrated the value of the Little Local model in connecting community members and supporting community development to help preserve culture and make decisions around their health. Continued engagement with this community and evaluation of health outcomes will be important in understanding the long-term effect of community-controlled health programs, such as the Little Local.

The Rohingya Little Local model provided a pathway for the health system to better engage, understand and work with the Rohingya community. The authors recognise the potential for this model to engage with specific communities, but also to develop the knowledge of the health system of the cultural groups they work with (bidirectional learning). An important learning from this project was the feasibility of the model to enable communities to determine their health priorities and to develop actions. This approach is consistent with the principles of co-design (Donetto *et al.* 2015); however, researchers and health organisations also demonstrated reflexivity by acknowledging the personal, social and cultural contexts that all parties bring (Wilson 2014). Additionally, the research phase of the project was done in conjunction with community members who assisted in data collection and were involved in the publication process. The Little Local model incorporated concepts of reciprocity in ensuring that the research and the health promotion intervention developed was meaningful to the community and did not only serve the purposes of the researchers and/or funders (Wilson 2014). Future work using this model should ensure the principles of reflexivity and reciprocity are maintained.

The Little Local model has the potential for expansion beyond health promotion interventions into programs where community members choose how funding within the health system is directed (i.e. the services funded), which often are designed by and for the predominant cultural group. This can result in minority groups facing difficulty in accessing adequate health care (Clark *et al.* 2014). Removing organisational barriers and supporting consumer-led decision-making and ownership is a promising pathway to improve healthcare access for disadvantaged populations and reduce health inequities.

Study limitations and rigour

This paper reports the finding of a relatively small pilot project. Although this exploratory study has shown positive indications that this model may be useful for small-scale community empowerment projects, further investigation is required. The study would have been strengthened by the inclusion of community capacity building theories, frameworks and measures. This paper reports the findings from a short-term time point only (observations before, during and immediately after the intervention). Repeated observations and ongoing connection to the community will provide greater insight into the program effects.

Conclusion

The Rohingya Little Local provides an innovative model for engaging with marginalised communities. This model is a promising and pragmatic approach to support community-led projects within location specific, population-based interventions such as the CGHiC program. Although this project was a pilot in the Canterbury community in Sydney, it provides knowledge and learnings on the engagement of refugee communities with the healthcare system in Australia. This exploratory study also provides insight into the cultural nuances within the Rohingya community and the need for any programs or interventions to be developed and led by communities.

Conflicts of interest

The authors declare no conflicts of interest.

Acknowledgements

The authors acknowledge the Rohingya community who were involved in the project. This project received funding from the Sydney Local Health District and Central and Eastern Sydney Primary Health Network.

References

Arraf R (2018) Australia has an obligation to the Rohingya people: so why is the federal government prevaricating? ABC Online: ABC Religion and Ethics. Available at https://www.abc.net.au/religion/australias-obligation-to-rohingya/10334312 [Verified 18 September 2020]

Australian Bureau of Statistics (2016) Census of Population and Housing, 2016, TableBuilder (Dataset: 2016 Census – Cultural Diversity) (Australian Bureau of Statistics: Canberra, ACT, Australia) Available at https://auth.censusdata.abs.gov.au/webapi/jsf/tableView/tableView.xhtml [Verified 2 March 2020]

Beirens H, Hughes N, Hek R, Spicer N (2007) Preventing social exclusion of refugee and asylum seeking children: building new networks. *Social Policy and Society* **6**, 219–229. doi:10.1017/S1474746406003484

Block K, Gibbs L (2017) Promoting social inclusion through sport for refugee-background youth in Australia: analysing different participation models. *Social Inclusion (Lisboa)* **5**, 91–100. doi:10.17645/si.v5i2.903

Bossi D (2016) How football gave Rohingya refugees hope and purpose. *Sydney Morning Herald* 29 July. Available at https://www.smh.com.au/sport/soccer/how-football-gave-rohingyan-refugees-hope-and-purpose-20160729-gqgxz4.html [Verified 2 March 2020]

Central and Eastern Sydney PHN (2019) Can Get Health. (Central and Eastern Sydney PHN: Mascot, NSW, Australia) Available at https://www.cesphn.org.au/general-practice/help-my-patients-with/can-get-health [Verified 2 March 2020]

Clark A, Gilbert A, Rao D, Kerr L (2014) 'Excuse me, do any of you ladies speak English?' Perspectives of refugee women living in South Australia: barriers to accessing primary health care and achieving the Quality Use of Medicines. *Australian Journal of Primary Health* **20**, 92–97. doi:10.1071/PY11118

Davidson N, Skull S, Burgner D, Kelly P, Raman S, Silove D, Steel Z, Vora R, Smith M (2004) An issue of access: delivering equitable health care for newly arrived refugee children in Australia. *Journal of Paediatrics and Child Health* **40**, 569–575. doi:10.1111/j.1440-1754.2004.00466.x

Donetto S, Pierri P, Tsianakas V, Robert G (2015) Experience-based co-design and healthcare improvement: realizing participatory design in the public sector. *The Design Journal* **18**, 227–248. doi:10.2752/175630615X14212498964312

Hesse-Biber S (2010) Qualitative approaches to mixed methods practice. *Qualitative Inquiry* **16**, 455–468. doi:10.1177/1077800410364611

Islam MM, Nuzhath T (2018) Health risks of Rohingya refugee population in Bangladesh: a call for global attention. *Journal of Global Health* **8**, 020309. doi:10.7189/jogh.08.020309

Kandula NR, Patel Y, Dave S, Seguil P, Kumar S, Baker DW, Spring B, Siddique J (2013) The South Asian Heart Lifestyle Intervention (SAHELI) study to improve cardiovascular risk factors in a community setting: design and methods. *Contemporary Clinical Trials* **36**, 479–487. doi:10.1016/j.cct.2013.09.007

Kim KB, Han H-R, Huh B, Nguyen T, Lee H, Kim MT (2014) The effect of a community-based self-help multimodal behavioral intervention in Korean American seniors with high blood pressure. *American Journal of Hypertension* **27**, 1199–1208. doi:10.1093/ajh/hpu041

Local Trust (2019) The halfway point: reflections on Big Local. Available at https://localtrust.org.uk/wp-content/uploads/2019/11/Local-Trust-The-Halfway-Point-19-November-2019.pdf [Verified 2 March 2020]

Miles MB, Huberman AM (1994) 'Qualitative data analysis: an expanded sourcebook.' (Sage Publications: CA, USA)

Mills J, Bonner A, Francis K (2006) Adopting a constructivist approach to grounded theory: implications for research design. *International Journal of Nursing Practice* **12**, 8–13. doi:10.1111/j.1440-172X.2006.00543.x

Némorin S, Momartin S, Junaid M (2019) Community partnership with Rohingya refugees in Sydney, Australia: a systemic approach towards healing and recovery. *Intervention (Amstelveen, The Netherlands)* **17**, 225–230. doi:10.4103/INTV.INTV_31_19

Nguyen TT, Le G, Nguyen T, Le K, Lai K, Gildengorin G, Tsoh J, Bui-Tong N, McPhee SJ (2009) Breast cancer screening among Vietnamese Americans: a randomized controlled trial of lay health worker outreach. *American Journal of Preventive Medicine* **37**, 306–313. doi:10.1016/j.amepre.2009.06.009

Nierkens V, Hartman MA, Nicolaou M, Vissenberg C, Beune E, Hosper K, van Valkengoed I, Stronks K (2013) Effectiveness of cultural adaptations of interventions aimed at smoking cessation, diet, and/or physical activity in ethnic minorities. a systematic review. *PLoS One* **8**, e73373. doi:10.1371/journal.pone.0073373

Orton L, Halliday E, Collins M, Egan M, Lewis S, Ponsford R, Powell K, Salway S, Townsend A, Whitehead M, Popay J (2017) Putting context centre stage: evidence from a systems evaluation of an area based empowerment initiative in England. *Critical Public Health* **27**, 477–489. doi:10.1080/09581596.2016.1250868

Parajuli J, Horey D (2019) How can healthcare professionals address poor health service utilisation among refugees after resettlement in Australia? A narrative systematic review of recent evidence. *Australian Journal of Primary Health* **25**, 205–213. doi:10.1071/PY18120

Reynolds J (2018) Boundary work: understanding enactments of 'community' in an area-based, empowerment initiative. *Critical Public Health* **28**, 201–212. doi:10.1080/09581596.2017.1371276

Signorelli R, Gluckman N, Hassan N, Coello M, Momartin S (2017) Relationship building, collaboration and flexible service delivery: the path to engagement of refugee families and communities in early childhood trauma recovery services. *Children Australia* **42**, 142–158. doi:10.1017/cha.2017.30

Tay AK, Islam R, Riley A, Welton-Mitchell C, Duchesne B, Waters V, Varner A, Silove D, Ventevogel P (2018) Culture, Context and Mental Health of Rohingya Refugees: a review for staff in mental health and psychosocial support programmes for Rohingya refugees. (United Nations High Commissioner for Refugees (UNHCR): Geneva, Switzerland) Available at https://www.unhcr.org/5bbc6f014.pdf [Verified 20 August 2019]

Tay AK, Rees S, Miah MAA, Khan S, Badrudduza M, Morgan K, Azim DF, Balasundaram S, Silove D (2019) Functional impairment as a proxy measure indicating high rates of trauma exposure, post-migration living difficulties, common mental disorders, and poor health amongst Rohingya refugees in Malaysia. *Translational Psychiatry* **9**, 213. doi:10.1038/s41398-019-0537-z

USA for United Nations High Commissioner for Refugees (UNHCR) (2020) Rohingya refugee crisis. (UN Refugee Agency: Washington, DC, USA) Available at https://www.unrefugees.org/emergencies/rohingya/ [Verified 2 March 2020]

Whitehead M, Pennington A, Orton L, Nayak S, Petticrew M, Sowden A, White M (2016) How could differences in 'control over destiny' lead to socio-economic inequalities in health? A synthesis of theories and pathways in the living environment. *Health & Place* **39**, 51–61. doi:10.1016/j.healthplace.2016.02.002

Williams ME, Thompson SC (2011) The use of community-based interventions in reducing morbidity from the psychological impact of conflict-related trauma among refugee populations: a systematic review of the literature. *Journal of Immigrant and Minority Health* **13**, 780–794. doi:10.1007/s10903-010-9417-6

Wilson A (2014) Addressing uncomfortable issues: reflexivity as a tool for culturally safe practice in Aboriginal and Torres Strait Islander health. *The Australian Journal of Indigenous Education* **43**, 218–230. doi:10.1017/jie.2014.24