
CONFERENCE ABSTRACT**Using a peer led researcher model to connect with vulnerable communities
around health**4th World Congress on Integrated Care, Wellington, NZ, 23-25 Nov 2016Paula Peterson¹, Donata Sackey¹, Margaret Kay^{1,2}, Ignacio Correa-Velez³, Caroline
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Introduction: Many humanitarian refugees are resettled in Australia experience barriers to accessing health services due to cultural and linguistic as well as complex health presentations including torture and trauma.

There has been little research undertaken into the experience of people from refugee backgrounds and their usage of health services. Prior research suggests that there is poor service knowledge, distrust of services and social and cultural factors which prevent access to health care. There is a need to tap into the lived experience of people from refugee backgrounds to enable their voices to inform the development of appropriate health care.

Methods: Research was conducted using an innovative model of accessing the voices people from refugee backgrounds. The peer research model assisted researchers to identify their health needs with a specific focus on the barriers and enablers to accessing effective primary health care.

Three qualitative projects were undertaken in Brisbane, Australia. Two were formal research studies and the third involved extensive community consultation. All investigations used the peer researcher model. Researchers were recruited from the refugee communities. Key to the methodology was the inclusion of a training program (including research methods and principles delivered over 10 weeks) and ongoing support and mentor ship throughout the projects.

In the first project, five peer researchers documented the experience of refugee families who had recently arrived in Australia. The second project involved three young adults from refugee backgrounds who documented the experiences of young people from their communities. Ethics approval was granted for these research projects. The third project involved extensive community consultations with women from refugee backgrounds.

Results: People arriving in Australia from refugee backgrounds expressed considerable confusion with the complexity of the health system. Cultural issues impeded health

consultations. Efforts to build trust often misfired or were misconstrued. Racism was commonly reported. The building of trust between refugee communities and health providers and enhancing health literacy were identified as essential elements for a successful model of care.

Discussion: This peer led research is a novel strategy that gave voice to the lived experience of many refugee communities. Enhancing the research capacity within the refugee communities, has also enabled genuine community engagement with the health providers, offering opportunities to enhance community capacity, improve health literacy and build trust with a focus on improving health outcomes.

The peer researchers played a critical role not only in providing a conduit for the voices of the community to be heard in health service development. They were also engaged to play a role in training clinicians about patient needs, effective patient care, and clinical policies and practices.

Conclusion: Partners remains committed to embedding a system of engaging with vulnerable and hard to reach communities. Funding to date to employ refugee health leaders has been sourced from various philanthropic sources. Much has been learnt about how to manage and nurture a community engagement strategy that relies on accessing that community through individuals who share the same histories and experiences of the community they represent.

Keywords: refugee health; community; engagement
