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Title:
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Date:
2026-06-15

Citation:
Tam, E., Mascarenhas, L., Mynard, A. & Temple-Smith, M. (2026). Qualitative evaluation of a social inclusion program for Karen and Karenni refugees in Victoria, Australia. Australian Journal of Primary Health, 32 (3), https://doi.org/10.1071/py25237.

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RESEARCH ARTICLE
https://doi.org/10.1071/PY25237

Australian Journal of Primary Health
LA TROBE UNIVERSITY

Qualitative evaluation of a social inclusion program for Karen and Karenni refugees in Victoria, Australia

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ABSTRACT

Background. Karen and Karenni refugees from Myanmar face significant barriers to access and engagement in health services due to high levels of vulnerability and disability. Social isolation and limited access to resources have been identified as important barriers to health engagement; however, research on social inclusion programs, which might assist in overcoming poor access, have been limited in number and by methodological constraints This study examined the impact of a social inclusion program on the health-seeking behaviours of Karen and Karenni refugees in Melbourne's western suburbs, by identifying the key enablers and barriers to improving health engagement. **Methods.** Semi-structured interviews were conducted with both refugees and healthcare practitioners, and subsequently analysed with both deductive and inductive thematic analysis. Interviews explored refugees' understanding of their health conditions, and their engagement with the Victorian healthcare system, as well as healthcare practitioners' impressions of the above. **Results.** Health practitioners (5) and refugees (14) had similar perspectives. Outcomes demonstrated partially improved engagement, specifically a greater willingness to seek help for physical compared with mental health complaints, and a clear preference for community-based over hospital care. Enablers included social connection and psychological safety, which fostered a sense of identity that enhanced functioning and health-seeking capacity. Program effectiveness was hampered by refugee-specific and systemic barriers, including cultural differences, low health literacy, social issues and inaccessible hospital systems. **Conclusions.** This research highlights the effectiveness of a community-led, culturally-sensitive intervention in empowering Karen and Karenni refugees to engage in health care. Findings support increased funding for ongoing program delivery, and can inform development of more refugee-specific health services nationwide and globally.

Keywords: asylum seeker health, community empowerment, community health promotion, community-based intervention, health engagement, qualitative methods, refugee health, well-being.

Received: 5 November 2025
Accepted: 31 March 2026
Published: 27 April 2026

Cite this: Tam E *et al*. (2026) Qualitative evaluation of a social inclusion program for Karen and Karenni refugees in Victoria, Australia. *Australian Journal of Primary Health* **32**, PY25237. doi:10.1071/PY25237

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Introduction

Refugees from Myanmar formed one of the largest refugee populations entering Australia in the 2016–2023 period, constituting 10.6% of humanitarian visa recipients (Department of Home Affairs 2024; Victoria State Government 2024). Based on the Australian Census 2021, 39,171 individuals residing in Australia were born in Myanmar, with 13,602 being of refugee background (Australian Bureau of Statistics 2021; Toke *et al.* 2024). Approximately 53% of these reside in Victoria (Toke *et al.* 2024), underscoring the need for local healthcare practitioners to understand the needs of this population.

Myanmar, a Southeast Asian country, has endured decades of civil war and instability since its independence from Britain in the 1940s. Escalating conflicts and political unrest have resulted in widespread displacement of individuals within and beyond Myanmar's borders forming the fourth largest refugee population globally (Refugee Council of Australia 2021). Affected populations fled to refugee camps in surrounding countries, such as Thailand and Bangladesh, before resettling in Western countries, such as the US, Canada and Australia (Davidson *et al.* 2024; UNHCR 2025). Refugee camps on the Thai/Myanmar border mainly consist of people of Karen, Karenni and Burmese ethnicity, with some residents awaiting resettlement since the 1980s (UNHCR 2026).

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These refugees present a unique challenge for health promotion and engagement due to high levels of vulnerability and disability. Limited studies of Myanmar-born refugees have highlighted low health literacy, stemming from minimal opportunities for formal schooling and health education, as well as poor access to health services (Davidson *et al.* 2024). Approximately 45% of Myanmar-born Victorians have no educational attainment, or achieved Year 9 or less (Australian Bureau of Statistics 2021). Poor education, ongoing persecution, discrimination and stigma have affected health utilisation and engagement (Toke *et al.* 2024), and align with refugee health literature reporting low rates of hospital admissions and health-seeking despite a high prevalence of psychological comorbidities (Slewa-Younan *et al.* 2020; Davidson *et al.* 2024). For Myanmar refugees, this includes anxiety, depression, post-traumatic stress disorder, as well as somatisation (Schweitzer *et al.* 2011). Cultural norms (including a propensity for compliance to authority figures) and language barriers constitute further barriers to meaningful and effective health engagement (Power *et al.* 2023).

According to the 1951 Refugee Convention (p. 3), a 'refugee' is an individual who finds themselves 'outside of their home country' due to 'a well-rounded fear of persecut[ion on the basis of] race, religion, nationality, membership of a particular social group, or political opinion' (UNHCR 1951). Refugees experience ongoing poor physical and psychological health outcomes following resettlement, often resulting from cumulative traumatic experiences. This includes pre-migration exposure to violence and unrest, precarious transit journeys, and ongoing post-migration stressors, such as isolation, language differences and limited healthcare access (Davidson *et al.* 2024; Toke *et al.* 2024). This is in contrast with migrants, who can typically move between their migrated country and country of origin freely with no repercussions, and often face fewer barriers in health access and engagement.

Social inclusion programs have been implemented in many countries and have been found to be successful in improving social integration, which assists in healthcare access (Henderson *et al.* 2011). Here, we adopt the United Nations Department of Economic and Social Affairs' definition of social inclusion, and define social inclusion programs as interventions that aim to promote equitable access to services and reduce structural barriers to care, underpinned by the idea that every individual is entitled to the resources needed to reach full potential in their lives (Department of Economic and Social Affairs 2026).

Similar interventions have also been attempted in Australia to improve health literacy, social inclusion and mentoring opportunities for refugee communities (Gower *et al.* 2022*b*; Russo *et al.* 2023). However, there has been a paucity of studies examining the effectiveness of such programs in an Australian context. Most existing literature is focused on describing the current healthcare landscape and its associated challenges, with few exploring enablers in accessing care (Au *et al.* 2019; Dougherty *et al.* 2020; Gower *et al.* 2022*b*). This also holds true for Myanmar refugees. Much previous literature has detailed the health struggles and barriers faced by these communities in accessing health care (Wong *et al.* 2019; Randall *et al.* 2025). An exception is the recently published study protocol of the Ophelia project within a Karen community, which describes the process of implementing a culturally-tailored codesign approach based on the health literacy and needs of the community (Jawahar *et al.* 2023). Overall, there remains a dearth of literature evaluating the effectiveness of interventions in Myanmar-born refugees despite Australia's long history of receiving refugees from this region.

Given the absence of studies in this space, broader studies evaluating refugee health interventions in Australia were examined. In this limited literature, co-design and coproduction were emphasised as key elements to successful interventions, marking a shift from paternalistic models (McKeon *et al.* 2024; Morse *et al.* 2024). Few studies focused solely on refugee participants, with many including migrants from a range of culturally and linguistically diverse backgrounds – an important distinction given the traumatic experiences that specifically affect refugees.

Although studies demonstrated improvements in health outcomes and engagement, many are fraught with methodological limitations. Quantitative studies incorporated large, heterogenous cohorts of migrant participants from different ethnicities, limiting the generalisability of outcomes to individual groups (Gallegos *et al.* 2021; Gower *et al.* 2022*a*, 2022*b*). Low literacy levels coupled with language barriers and cultural differences also complicated data collection, as participants would omit survey sections discussing culturally taboo topics (Gallegos *et al.* 2021). Most studies also focused on outcome evaluation with a pre-test–post-test format, failing to capture the complex, intersectional nature of refugee resettlement and ongoing longitudinal changes in these cohorts (Blignault *et al.* 2021). Moreover, few studies included the perspective of healthcare professionals, which could corroborate refugee-reported outcomes and reduce self-report bias.

Additionally, Australian studies demonstrated an overwhelming focus on direct, short-term information-giving interventions, with outcomes assessed via physiological parameters (Gibbs *et al.* 2015; Gallegos *et al.* 2021), which may not fully capture longitudinal changes relevant to refugee populations. Moreover, in vulnerable, socially isolated populations, such interventions fail to address the underlying drivers of low health engagement, including social isolation and limited access to local resources.

In light of these gaps, this study aimed to describe and evaluate a social inclusion program designed for Karen and Karenni refugees in Melbourne's western suburbs, to examine its impact on health-seeking behaviours, as well as enablers and barriers to improving health engagement in this highly vulnerable and underrepresented population from both refugee and healthcare practitioner perspectives.

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Methods

Setting

Wyndham, in western Melbourne, is home to a large Burmese population. In 2020, clinicians at Next Door Psychology Clinic (NDP), working with Karen and Karenni refugees, identified the need for a social inclusion program, as linguistic and logistical barriers made accessing existing community resources challenging for their clients. The clinic began offering weekly Tuesday morning backyard sessions to the local Karen and Karenni refugee community, where participants were invited to engage in arts and crafts activities, including weaving, sewing, gardening and woodwork. The program has expanded to >120 participants, with 50–60 attending weekly. Participants were of refugee background. Sessions are facilitated by the lead clinical psychologist, alongside Karen and Karenni bicultural workers. Healthcare professionals are invited to run health promotion sessions during this time, and participants can choose to attend. Participants were informally referred by GPs at Utopia Refugee and Asylum Seeker Health (Utopia) or MyClinic by psychologists at NDP to address social isolation, and improve health and well-being, supplemented by word of mouth. Refugees were simply invited to show up at the location and participate in the activities. This program is partially self-funded, through the sales of the craft products at local markets and fundraising events; supplemented by funding from the Primary Health Network in collaboration with Utopia.

The social inclusion program is underpinned by the following key objectives:

1. to foster social connection among refugees
2. to create psychological safety
3. to engage refugees who typically face barriers in accessing health care.

Evaluation methodology

Recruitment and consent of refugees

Participants in this study are from a highly vulnerable population with comorbid mental health conditions and traumatic pre-migration experiences; hence, extra measures were implemented during recruitment and consent to minimise potential distress. Purposive sampling was utilised, where the psychologist familiar with the participants' trauma history approached individual participants with a bicultural worker during sessions to gauge their interest in participating. Although this selection process may be perceived as biased, it minimised the risk of inadvertently selecting those who might be made uncomfortable by the interview process.

Once selected, a simplified version of the plain language statement and consent form was read to the participant by the primary researcher with the aid of an interpreter, and further consent was obtained in a private room without the psychologist present. Only verbal consent was recorded, due to participants' low literacy levels.

Recruitment and consent of health practitioners

To compare and contrast participant and healthcare practitioner perspectives on the program, healthcare professionals at NDP and Utopia who interacted regularly with the refugee participants in their clinical practice were recruited via direct email. Email addresses were provided by the directors of both practices. Seven healthcare practitioners were recruited, and five of them agreed to participate.

Data collection and analysis

A qualitative study design was used. Semi-structured interviews of 20–30 min were conducted with refugee participants and healthcare practitioners between March and April 2025. Interviews with refugees explored three key areas: (1) demographic information, (2) participants' understanding of their health conditions, and (3) participants' engagement with the Victorian healthcare system and associated supports. Healthcare practitioners were asked to provide demographic information and their insights regarding the above. The interview schedule was developed in collaboration with the lead psychologist to ensure the interview processes reflected the group's cultural and linguistic needs.

The interview guide was developed in consultation with the director of Utopia and the lead psychologist running the program. They created prompts that would be easy for refugees to comprehend, and scenarios that reflected those often seen in their consulting rooms. The interview guide was piloted with a few refugee participants and was found to be appropriate; hence, no alterations were made and the pilot participants were incorporated into the data pool.

Interviews with refugee participants took place at NDP during group sessions, whereas interviews with healthcare practitioners took place via Zoom. Interviews were audio-recorded and transcribed verbatim using the online transcription service Otter.ai. Only the transcription service was utilised. One participant declined to be recorded, and extensive notes were taken during the interview. Data obtained were then coded and analysed by the primary researcher using the program NVivo (Lumivero).

Observational data were also collected via field notes during the primary researcher's visits to the group.

Data were analysed using thematic analysis using both deductive and inductive approaches, with themes generated through an iterative process. The main themes were generated deductively using the main sections in the interview guide, whereas subthemes were generated inductively as the data was analysed.

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Ethics approval

Study design, consent process and interview schedule were approved by the University of Melbourne Human Research Ethics Committee [Ethics ID: 30775].

Results

A total of 14 refugee participants (nine male, five female) and five healthcare practitioners (all female) were interviewed. Due to a lack of appropriate interpreters on specific days, 11 refugee participants were Karenni and only three were Karen. Their time in Australia ranged from <1 year to 10 years, with the exception of one participant who arrived in 2007. Their program attendance spanned from several months to 2 years, with one person having only attended for a few weeks. Healthcare practitioners included two GPs from a refugee health-focused primary care service, one mental health nurse, one clinical psychologist and one bicultural worker. All had extensive experience working with Karen and Karenni refugee participants, ranging from 1 year to >10 years. It should be noted that the clinical psychologist was the professional who is running the program.

Coding and analysis yielded three themes and nine subthemes with respect to the research question (Table 1), which explored whether this social inclusion program encouraged health-seeking behaviours, and the enablers and barriers to this engagement (Table 2).

Table 2. Themes and subthemes.

Themes	Subthemes
Partially improved engagement	• Tendency to seek help for physical health over mental health • Preference for community-based care over hospital treatment
Program elements enabling health engagement	• Social connection and community • Psychological safety and trauma processing • Sense of identity and purpose • Improved functioning
Ongoing systemic and refugee-specific barriers to health engagement	• Inaccessible hospital systems • Cultural differences • Low health literacy, compounded by social issues

Partially improved engagement

Tendency to seek help for physical health over mental health issues

When presented with hypothetical healthcare scenarios of varying severity and nature (Table 1), all refugee participants expressed that they would seek help, typically from their usual GP at Utopia, or less commonly, from other GP clinics in the city of Wyndham. They expected to be prescribed medication, or referred for specialist care. Most displayed basic understanding of their physical health, being able to name their diagnoses (most commonly asthma) and describe symptoms of flare ups. Some also understood the importance of medication adherence, especially during illness.

Table 1. Example healthcare scenarios given to participants.

Severity	Example physical health scenarios	Example mental health scenarios
Mild	Experiencing mild viral respiratory tract infection symptoms e.g. runny nose, cough for 3 days	Experiencing some low mood and anxiety for a few days, presented as commonly reported somatic symptomology e.g. chest feeling heavy, heart feels racing
Severe	Experiencing severe abdominal pain in past 3 days, with nausea, vomiting, diarrhoea and anorexia	Experiencing severe mood disturbances impacting daily functioning e.g. insomnia and restlessness

However, a stark dichotomy emerged between participant responses towards physical health and mental health scenarios, with participants expressing more hesitancy and reluctance to seek help for mental health concerns, unless severely impacting daily functioning or being explicitly prompted by a family member. Even then, they would address this person's concerns directly rather than involve a clinician, despite clearly experiencing psychological distress. Participants were reluctant to visit hospital or a clinic to address a mental health issue. Healthcare practitioner interviews anticipated similar responses, with low mental health literacy and different cultural understandings of mental health being cited as potential reasons for this hesitancy. This divergence between physical and mental health was further exemplified during the closing of interviews – many participants volunteered additional information about physical health symptoms or treatment concerns, whereas only two out of the 14 participants mentioned their mental health concerns unprompted. Of these, only one was able to name their mental health condition and describe the prescribed treatment. Even when participants raised concerns that appeared to be psychological in nature, they were frequently framed as somatic symptoms (commonly dizziness and chronic pain), which are known to be associated with depression and PTSD in this population. This contrast underscores a dichotomy in health engagement, with greater tendency to engage in physical over mental health issues.

> [In response to deteriorating mental health scenario] [I'm] gonna keep it to [myself]. [I don't] want other people to worry about [me]. (Refugee Participant 11)

Preference for community-based care over hospital treatment

Participants expressed a clear preference for community-based care over hospital care, specifically through refugee-focused primary care services, such as Utopia. Attending

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hospital was considered a last resort if their health deteriorated severely. Although participants acknowledged receiving adequate care from medical staff, many referenced previous experiences in hospitals where incorrect or no interpreters were provided, and expressed general anxiety towards being in unfamiliar hospital environments.

> Scared to go emergency. Maybe check with GP first... I'm scared they will [tell] me off and say speak to GP first.
>
> [In response to when the participant would consider going to hospital]. To the point where I can't move. (Refugee Participant 12)

Similar responses were echoed in clinician interviews, where the lack of interpreters, an oversubscribed hospital system and overwhelming hospital settings were cited as potential reasons for participants' preference.

> It's creating that sense of safety so you know [you'll] recognise the face of the person who's at the desk... whereas going to the hospital is unpredictable. Where do you go? Who are you going to see?.. Interpreters are really variable in terms of who's there, or are they on the phone? Are they not there at all? So I definitely think that continuity and safety in place is really different. (Health Practitioner 06)

Program elements enabling health engagement

Social connection and community

Consistent across both refugee and clinician interviews is the theme of social connection and community. Almost all refugee participants described the biggest benefit of the group as the opportunity to socialise with friends, particularly people from similar backgrounds who spoke the same language, which differentiated this program from other community groups where individuals from a range of ethnicities were invited.

> Yeah, [I] just enjoy [my]self because [I] get to see [my] friend[s], get to talk to people that speak the same language as [me], instead of staying inside and get[ting] depressed. (Refugee Participant 11)

Psychological safety and trauma processing

Psychological safety was consistently identified by healthcare professionals as an important precursor to health engagement. The group, held in a familiar and private community setting, was perceived by participants as a safe space that cultivated psychological safety and familiarity – something refugees rarely experienced amidst their tumultuous resettlement journeys. Cultivation of this psychological safety was perceived as foundational to promoting health engagement and subsequent therapeutic processes.

Clinicians described psychological safety as the first step towards trauma processing and treatment. After resettlement, refugees often remain in a heightened state of arousal, frequently showing fight or flight behaviour and general hypervigilance, exacerbated by the ongoing challenges of navigating an unfamiliar environment. The psychologically safe group environment enables participants to engage in mindfulness through craft activities, serving as a stepping stone towards any effective therapy or mental health progress. This sentiment was echoed in participants' responses, where they all expressed how much they looked forward to coming to the group.

> They put their bags down... they do some kind of craft, which is very unusual, because usually they wouldn't be able to sit and concentrate, because they'd be checking and on alert. To see them there, smiling, laughing, talking to each other, doing a craft, having their bags down... it's like a miracle that they are able to have that safety. And the first step to trauma treatment, is safety. (Health Practitioner 02)

Promoting psychological safety at this location (in the backyard of NDP) also built familiarity and connection with the mental health practitioners at the practice. This translated to a greater willingness among participants to engage with clinicians whom they had met in the group sessions. This was described by many as a soft introduction to psychological support that refugees would otherwise avoid due to fear or stigma. Clinicians also noted greater receptivity to discussions surrounding mental health or psychologist referrals, particularly after participants attended the group for some time.

> This familiarisation with the location, having somewhere that people feel comfortable going with familiar faces help[s] with that one-on-one psychology... it creates a comfort with the people and the place. (Health Practitioner 06)

Finally, the sense of psychological safety fostered by the staff and location enabled participants to seek practical support more readily. Clinicians discussed assisting participants in sessions with applications for support services, such as the National Disability Insurance Scheme and Disability Support Pension, and how the group was a conduit through which participants sought help in navigating ongoing acculturation challenges.

> [Someone] the other day had a parking infringement notice and couldn't understand... So instead of doing beading, we spent half an hour writing an appeal letter. (Health Practitioner 05)

Sense of identity and purpose

Clinicians and participants alike believed the program provided participants with a newfound sense of identity

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and purpose. Participants stated it motivated them to leave the house and engage in skill-building activities; a critical shift for many refugees unable to work who would otherwise remain isolated at home.

> I'm not able to work... Instead of not doing anything, come to this group and learn some things. (Refugee Participant 14)

Similar sentiments were shared by clinicians, stating how the group gave participants meaning and the ability to look forward – a prerequisite to social integration and subsequent health seeking.

> It was never really about the craft, more about getting our beautiful patients out, just socialising and out into the community, give [them] something to focus on. (Health Practitioner 05)

Being part of a supportive community also enhanced their sense of identity and connectedness, making participants feel seen and heard. This, coupled with the knowledge that help is readily available, increased their confidence in being able to integrate into Australian society and health care.

> Often they feel very helpless to change their condition or pain. And sometimes they can't, but being cared for by myself, the GPs, or a physio, for people who look after them, I think that['s] the key. They want to be important, and for someone to be interested and help, even if it doesn't always fix it, to be there to listen. (Health Practitioner 02)

Improved functioning

Clinicians unanimously agreed that the group improved participants' overall functioning by improving their mental health and well-being.

Chronic pain, often from significant past trauma and sensitisation, was common among refugees, leaving them feeling helpless.

> When there's pain, I can't do anything . . . And with the pain, especially night-time . . . I always have nightmare[s] about pain and all this stress, past history, my experience . . . I'm crying in my dream but I crying [on] the outside. (Refugee Participant 12)

According to clinicians, having the opportunity in group sessions to socialise with like-minded peers enabled participants to engage in mindfulness and temporarily distracted them from their physical pain – a sentiment echoed by participants.

> My goal for this group is to help people get out of their house, because often they sit at home think[ing] all day about their pain and they feel terrible about it because they don't know what to do. And that's partly trauma as well as learned helplessness. They then come to the group, and they're connected with others. They're not thinking about their pain for a little while. I think [many] participants have improved in managing their pain quite significantly . . . Then their mood improves [and] you manage better, because you feel more in control, and you feel better about life. So managing physical, medical symptoms, [is a] big payoff for many in the group. (Health Practitioner 02)

> Being alone at home, have a lot of stress, thinking of past experience. So being in group here, distract my stress and all my feelings. I didn't feel any pain when staying in a group, but feel pain again [when home]. (Refugee Participant 12)

As noted previously, the ability to engage in mindfulness activities is often the initial step to trauma processing and improved mental health. Clinicians highlighted how the combination of social interaction, mindfulness, and a sense of purpose resulted in dramatic improvements in participants' mental health and well-being, creating a positive feedback cycle that increased participants' confidence and subsequent capacity to function. This confidence in turn enhanced their feelings of competency to problem solve and seek help.

> With their mental health being more stable, their chronic pain has become more stable, and they['re] able to identify that link between their mood and pain. And then people can be a bit more physically active because they're feeling mentally well. So people are now able to go out for a walk because they're feeling less anxious and safe. (Health Practitioner 06)

One clinician also emphasised the role of accomplishment in improving confidence.

> The physical crafting benefit is huge. I think that sense of accomplishment of making something is really positive [for] mental health. (Health Practitioner 06)

Ongoing systemic and refugee-specific barriers to health engagement

Inaccessible hospital systems

Both clinician and participant responses identified several recurring challenges when navigating hospitals, with the most prominent being inappropriate interpreter services. Most interviewees reported either the lack of Karen/Karenni interpreters or being provided a Burmese interpreter during previous hospitalisations, leaving participants to rely on non-verbal cues or untrained family members for interpretation.

> The doctor look after [me] very well, but they can't find an interpreter. So [my] children just tried their best to speak, but they're not fluent. (Refugee Participant 10)

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Many others expressed anxiety regarding the overwhelming hospital environment, often exacerbated by high staff turnover and lack of continuity in care, which were seen as strong deterrents for hospital utilisation.

> They're really afraid to go to hospital. Even with the doctor, they [don't] feel comfortable. Also because of language barrier, they don't want to say too much. (Health Practitioner 01)

Cultural differences

Ingrained cultural differences were cited as a potential barrier to health engagement, particularly regarding mental health concerns. It is well-established that mental health problems are conceptualised differently in non-Western cultures. It is still stigmatised in Karen/Karenni culture, with individuals being labelled as 'crazy', contributing to reluctance to seek help for mental health concerns and frequent somatic complaints.

> People just label them as crazy and don't accept them. The people [with] these issues [are] quite shunned by the rest of the community. (Health Practitioner 02)

Stoicism is also a commonly upheld value in Karen/Karenni culture, where participants expressed the desire to not burden family members.

> [I] gonna keep it to [my]self. [I don't] want other people to worry about [me]. (Refugee Participant 11)

Low health literacy, compounded by social issues

Clinicians identified poor health literacy as a significant barrier to health engagement. Refugees often have limited opportunities for formal schooling and health education in their home countries, contributing to ongoing misconceptions regarding ill-health and treatment. One clinician offered examples of medication non-adherence, where participants discontinued psychotropic medications without concrete plans for follow-up care.

> Two patients recently, one stopped her SSRI, because it made her too tired. [It's] just that health literacy around compliance. Compliance is a bad word, taking your medication. And another gentleman had misunderstood an appointment. He was on an antipsychotic and had stopped it. (Health Practitioner 05)

Participants were reported to have very little awareness or understanding of mental health conditions and their treatment, making it difficult for participants to identify their own mental health struggles and know when to seek help. Only one participant of 14 was able to name her mental health diagnosis and prescribed treatment.

Social issues were identified as another common barrier to health engagement, especially when compounded by aforementioned low education levels, limited problem-solving capacity and language barriers.

For example, one participant, discussing her ongoing concerns regarding chronic pain and treatment failure over a month ago, mentioned how she was waiting for someone to book an appointment before she could see the GP. This was also echoed in clinician responses, with social responsibilities and logistical barriers, such as childcare, often cited as reasons for being unable to attend an appointment or visit hospital.

> There's social issues. [One] person this week couldn't go [to hospital] because no one could look after their kids. They also didn't have [the] mental capacity to figure that out. (Health Practitioner 06)

Discussion

Research in Australia on indirect interventions aiming to improve health engagement of refugees remains limited. This study aimed to address this gap by examining the impact of a social inclusion program on the health-seeking behaviours of Karen and Karenni refugees in Melbourne's western suburbs, and identifying enablers and barriers to meaningful and ongoing health engagement.

Consistent with refugee health literature, comments from both refugees and health practitioners suggested positive impacts on participants' mental health and well-being. However, this study endeavoured to go beyond these direct outcomes, and examine the intersectional, multifaceted relationship between improved mental health and health-seeking behaviours. Health-seeking behaviour has been defined as any reactive or preventative measure to maintain and enhance good health (MacKian 2003; Latunji and Akinyemi 2018). In this study, this term refers to health service utilisation, which comprises four elements: (1) awareness and identification of symptoms, (2) capacity to seek help, (3) access to health services, and (4) capacity to navigate the healthcare system.

Refugees experience persistent mental health challenges stemming from pre-resettlement trauma and constant instability, which may lead to a disrupted sense of self and fragmented attachments (Rabiau 2019). Prior refugee research has highlighted the importance of new social networks in identity reconstruction post-migration (Shahimi *et al.* 2024). Although social connection and improved psychological safety are identified as standalone benefits to the program, the combination of these elements may represent a plausible mechanism that facilitates true mental health progress – specifically the reconstruction of a multifaceted identity within a refugee community that encompasses both Karen/Karenni and Australian cultures.

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Engaging with a community of like-minded individuals in a psychologically safe, low-pressure space appears to have encouraged participants to establish new social connections. The group was also described to be a judgement-free, holding environment enabling participants to explore mindfulness, manage hypervigilance and emotional regulation, and seek help – all prerequisites to identity and attachment formation. The program's fixed time and location also provided a sense of purpose, structure and meaning, which participants associated with increased feelings of self-worth. Given the known linkage between social inclusion, well-being and health engagement in previous refugee research, it is reasonable to anticipate that over time, this renewed sense of identity may improve confidence and daily functioning, and mitigate feelings of learned helplessness – a common presentation in refugees due to prolonged exposure to trauma. This reflects a potential pathway that then empowers participants to initiate health-seeing behaviours independently in healthcare contexts and lays the foundation for future therapeutic progress. The interplay of all these components highlights the importance of fostering identity and independence in a refugee's recovery and integration – something often overlooked by many existing short-term interventions that target physiological measures.

This program is also anticipated to improve health engagement by providing easy access to healthcare services. Fostering familiarity and psychological safety with the location and clinician staff led to easier conversations surrounding mental health support, and provided a more direct channel for participants to seek help.

Nonetheless, ongoing refugee-specific and systemic barriers continue to hamper the effectiveness of this program in improving health engagement. Cultural differences, including stoicism and suppression of emotions, are common among refugees (Artingstoll 2023). Mental health, a concept framed predominantly in Western medicine, is often absent or highly stigmatised in non-Western cultures, with individuals with mental health illnesses being labelled as 'crazy'. This coupled with limited access to education, ingrained stigma and low mental health literacy contributed to limited awareness of mental health symptoms, resulting in participants being more likely to seek care for physical over mental health complaints, or present with somatic symptoms – a persistent trend despite ongoing gentle psychoeducation provided in the group sessions and from regular interactions with clinicians.

There also remains the question of whether the imposition of Western mental health labels is truly beneficial or paternalistic, and whether the measure of participants' ability to name their mental health condition is a true reflection of their health literacy and engagement in this context. Although we acknowledge the limitations of Western conceptualisations of mental health, participants' descriptions of not seeking care despite ongoing emotional distress and functional impairment, as well as their struggle in articulating their mental health challenges and how they are managed even in their own words, appeared to be present in lieu of diagnostic understanding, which suggests a clear ongoing barrier towards their health engagement. Additionally, this disconnect between the Western biomedical model of health and cultural models of emotional distress in these communities also further impede access to health care.

Given the participants' clear improvements in daily functioning, symptomology and health engagement that occurred outside of diagnostic understanding, it is important to explore how future interventions can be implemented in lieu of applying Western biomedical deficit-based labels. Despite the program's effectiveness in improving daily functioning, many participants still faced difficulties in health engagement due to social responsibilities and practical barriers. Many refugees were unable to work, and had minimal social supports and childcaring responsibilities, making it difficult to attend appointments and navigate a complex healthcare system.

Ongoing systemic barriers also hindered program effectiveness. The program's positive impacts were mostly limited to refugee-specific services. Failure to extend this impact into broader hospital systems were largely due to ingrained structural inaccessibility, including a lack of appropriate interpreters and oversubscribed hospital systems. For a refugee with limited knowledge of the hospital system and language barriers, these challenges were often too overwhelming to overcome.

Strengths and limitations

This study is one of the first in Australia to examine the long-term impact of a social inclusion program on Karen and Karenni refugees, an underresearched population, utilising both refugee and clinician perspectives. Several limitations should be acknowledged. Purposive sampling to protect the vulnerable meant only the most stable participants were selected. Inclusion of participants with greater psychosocial vulnerability may have elicited different findings. Although efforts were made to mitigate the language barrier, the primary researcher had to rely on interpreters used to interpreting in a medical setting, so the extent of inadvertent paraphrasing or misrepresentation of participant responses is unknown.

Future research involving a larger sample, involving more diverse patients, as well as the co-design of research content with community members may potentially alleviate these limitations.

Conclusion

Australia's current healthcare landscape places disproportionate onus on the patient to navigate an oversubscribed, complicated healthcare system – a significant challenge for refugees who face multiple barriers to care, shared by refugee communities worldwide. Although this program has highlighted the importance of a

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community-led, culturally-sensitive intervention in fostering positive benefits to mental health, well-being and subsequent health-seeking behaviours in a refugee population, its effectiveness in empowering refugees to engage in broader health care will need to be followed up over time.

However, long-term change will require a systemic commitment to wider structural reforms within the public system to ensure equitable healthcare access for all.

Supplementary material

Supplementary material can be accessed from the article page online.

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Reflexivity statement. This statement was written by the primary author ET. As a woman from a culturally and linguistically diverse background distinct from the Burmese community, I acknowledge that my upbringing, cultural heritage, and personal experiences of immigration will inevitably influence my interpretation of data and generation of themes. Although I have had clinical experience and medical training in working with refugees, I recognise that I do not share the same lived experience of displacement, trauma and ongoing systemic barriers faced by participants in this study.As a medical student, I also recognise the inherent power dynamic of my position, which is particularly pertinent when working with vulnerable populations. I acknowledge that by being a member of the medical profession, I too form part of a healthcare system that has at times failed to reflect the unique needs and interests of this population. I understand that despite my efforts to practice a participant-centred approach, I remain an outsider to the community, and my presence itself may impact participants' willingness to share information and experiences.

Data availability. The data underlying this article cannot be shared publicly due to the ethical and confidentiality considerations for refugee participants. Data may be shared on reasonable request to the corresponding author.

Conflicts of interest. The authors declare no conflicts of interest.

Declaration of funding. This research did not receive any specific funding.

Acknowledgements. The authors thank the Department of General Practice and Primary Care at the University of Melbourne, Next Door Psychology, and Utopia Refugee Health for their support. This research did not receive any specific funding.

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