AUT

Centre
For
Migrant and Refugee Research
Refugee Research Symposium AUT 2015

‘Refugees and Research for Healthy Outcomes’

Programme and Abstracts

3 December 2015

In association with

RASNZ Refugee Health & Wellbeing

Northern Regional Alliance He Hononga o te Raki

RCNZ Refugee Council of New Zealand

ARCC Auckland Refugee Community Coalition Te Roopu Tauawhi Mana Tangata

Welcome Message

Max Abbott
Pro Vice-Chancellor
and Dean,
Faculty of Health and
Environmental Sciences,
AUT University

We extend a warm welcome to all participants.
The world is experiencing unprecedented increases in refugee numbers. Millions of desperate people are fleeing Syria and nearby countries seeking safety and protection. There are also substantial numbers of refugees fleeing horrendous human rights abuses and conflicts closer to home, in parts of Asia.
Some seek asylum in Australia, where their reception is typically hostile and includes ejection to offshore detention centres. In contrast, I have been pleased to see a groundswell of support for refugees emerge in New Zealand. While the recent increase in New Zealand's refugee quota is small in the scheme of things, it will make a huge difference to the lives of the 300 additional people we welcome each year. It is part of our collective global responsibility.
We also have responsibility to provide effective, responsive services. Hence the theme of the 2015 symposium is research and refugee health and well-being. It is an opportunity to consider research undertaken since the last conference in 2009, to identify gaps and priorities, and enhance the process of undertaking research with refugees.
We trust that you will make the most of and enjoy your time with us. We look forward to meeting you.

Symposium Governance Group

Pro Vice-Chancellor Professor Max Abbott	Auckland University of Technology
Dr Grace Wong	Auckland University of Technology
Dr Maria Hayward	Auckland University of Technology
Dr Annette Mortenson	Northern Regional Alliance Limited
Dr Ann Hood	Refugees As Survivors New Zealand
Dr Arif Saeid	Refugees As Survivors New Zealand
Tony Cooper	Refugees As Survivors New Zealand
Kaileshan Thanabalasingham	Refugee Council in New Zealand
Abann Kamyay Ajak Yor	Auckland Refugee Community Coalition

Academic Committee

Pro Vice-Chancellor Professor Max Abbott	Auckland University of Technology
Dr Grace Wong	Auckland University of Technology
Dr Hagyun Kim	Auckland University of Technology
Sue Elliott	Unitec

Messages from Symposium Convenors

What does New Zealand health research and evaluation tell us about how well we are responding to the growing refugee populations we serve? The refugee symposium offers a range of evidence–based models of best practice for the care of refugee clients and families in primary, hospital and community settings. The symposium addresses health, mental health, health promotion and disability services and supports from the perspectives of health researchers and practitioners in the field.

Dr Annette Mortensen, Northern Regional Alliance Limited

With the world's attention keenly focused on refugee issues it is timely that we not only "do our bit" but that we work proactively to enhance the health and wellbeing of people from refugee backgrounds who settle here. I believe this symposium provides an important opportunity for us to advance our understanding of the issues that improve resettlement outcomes in New Zealand. It is then up to each of us to translate our knowledge into action.

Dr Ann Hood, Refugees As Survivors New Zealand

I have been on the Governance Committee of Refugee Research Symposium on behalf of Refugee Council of New Zealand. This symposium is going to bring together some of the research conducted in New Zealand and or overseas on refugee health and resettlement. I strongly believe that this symposium is going to have positive outcomes and influential recommendations on refugee health and wellbeing.

Dr Arif Saeid, Refugee Council of New Zealand

The symposium offers opportunities for the resettlement sector to gather and share previous research evidence and evaluate and reflect on what works and what does not. This will also help navigate any gaps in the health system and help benefit clients from refugee backgrounds as well as other New Zealanders. Importantly it will bring more clarity and understanding between researchers and practitioners in the health and other relevant fields. This is a chance to update the sector on a range of issues and share information and advice with the community families of new settlers from refugee backgrounds.

Abann Kamyay Ajak Yor, Auckland Refugee Community Coalition

Centre for Migrant and Refugee Research (CMRR)

The CMRR undertakes, promotes and distributes research that advances understanding of issues that can improve access to healthcare and promote good health among the migrant and refugee populations in New Zealand. A core aim of the CMRR is to conduct research with migrant and refugee populations, with particular emphasis on studies relevant to public and community health development. All information and research findings are widely disseminated to inform policy development, health care providers, health professionals, students, policy makers and the wider community.

Our Mission

To provide academic leadership through conducting and supporting migrant and refugee research that advances knowledge and contributes both to the health and wellbeing of people living in Aotearoa New Zealand and international understandings of migration and health

Centre Priorities

- Consult and collaborate with service communities to plan and undertake migrant and refugee research
- Establish and develop programmes of migration research
- Develop the Centre as a hub for postgraduate education and research training
- Provide a forum for the translation and dissemination of migrant and refugee research across AUT

Key Staff

Director	Pro Vice-Chancellor Max Abbott
Associate Director	Dr Grace Wong
Research Officer	Dr Hagyun Kim
Administrator	Amor Hirao

CENTRE FOR
MIGRANT & REFUGEE RESEARCH
NATIONAL INSTITUTE FOR PUBLIC HEALTH & MENTAL HEALTH RESEARCH

Symposium Information

General Information

The AUT venue meets strict health and safety regulations. The campus is smokefree. Neither AUT nor the Governance Group accept any liability for loss, theft of personal items or any injury to persons attending the conference. Please keep your valuables with you at all times.

Registration

Is open from 830am – 5pm Thursday 3rd December at AA building foyer.

Timing

Please endeavour to be seated in good time before each session starts. Please refer to your day proceedings for the programme.

Name Badges

Please wear your name badge at all times during the symposium.

Mobile Phones

As a courtesy to presenters and colleagues, please ensure that all mobile phones are turned onto silent during the symposium sessions.

Catering

All catering breaks - Morning tea, Lunch and Afternoon tea, will be served in AS building (Please follow the signage).

Symposium Themes

- Refugee Experiences (AB219)
- Refugee Services (AA236)
- Refugee Experiences; Research Methods and Refugees (AB220)

Wifi

Complimentary wireless internet connection is available.

- Username: refugeesym@conf
- Password: 38esd711

Prayer Room

Room for those who would like to pray during the symposium is available (AB 212: Research Hub).

Certificate of Participation

A Certificate of Participation will be given when you register in the morning.

Symposium Evaluation

Your views about the symposium are very important to us. We will email you following the symposium asking for your views. Please help us with planning future events by completing the evaluation.

Parking

To park on AUT grounds it is necessary to have a Pay 'n' Display ticket clearly displayed on your vehicle dash board, visible to parking attendants. Limited Pay & Display parking is available on the North Shore Campus at a cost of $1 per hour or $6 per day. Tow away will apply for non-compliance.

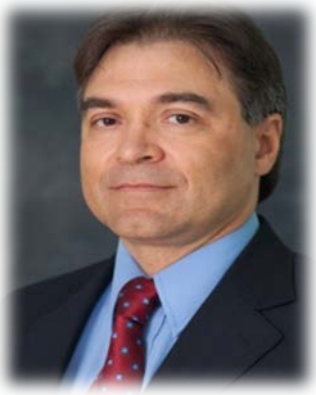
Refugee Research Symposium AUT 2015 Programme

Time	Event/Title	Speaker		Venue
8.30 - 9am	Registration			**AUT North Campus AA236**
9 - 9.05am	MC Mihi Whakatau	Dr Grace Wong Valance Smith		
9.05 - 9.10	Introductory address	Professor Max Abbott		
9.10 - 9.30am	Opening address	Hon Michael Woodhouse -Minister of Immigration		
9.30 - 10.10am	Healing Refugee Trauma: An insider's perspective of an evolving challenge	Jorge Aroche -STARTTS		
10.10 - 10.30	Realising the right to health: Experiences of people from refugee backgrounds through selection/determination and beyond	Michael White -Human Rights Commission		
10.30 - 11.00am	Morning Tea Break			AS136
11.00 - 12.30pm	Breakout Session (Morning)			
	Session I	Session II	Session III	
	Theme: Refugee Experiences	Theme: Refugee Services	Theme: Refugee Experiences; Research Methods and Refugees	
	Chair: Abann Kamyay Ajak Yor	Chair: Samantha Bennett	Chair: Ann Hood	
	Venue: AB219	Venue: AA236	Venue: AB220	
	I-1 An investigation of risk factors for vitamin D deficiency during pregnancy and infancy in Afghani women and their new born infants Maryam Delshad Siyahkaly & Pamela von Hurst Massey University	II-1 Working with Refugees: A Model of Primary Health Care Serena Moran & Jonathan Kennedy Newtown Union Health Service	III-1 Research Refugees, New Migrants & Conflict Resolution Engagement Anet Kate & Jane Verbitsky Auckland University of Technology	
	I-2 From Mama Africa to Papatūānuku: The health and well-being a Group of African Immigrant and Refugee background Mothers living in Auckland, Aotearoa/New Zealand Irene Ayallo, Sue Elliott, & Helene Connor Unitec	II- 2 Refugee Settlement, Belonging and Disaster Risk Reduction: Case studies from Christchurch and Wellington Jay Marlowe University of Auckland	III-2 Resisting the Disempowering Discourses that Dominate Discussions of Refugee Resettlement in New Zealand Marieke Jasperse Otago University	
	I-3 Living in a new Culture: The experiences of African migrant and refugee parents in New Zealand related to sexual health education Fungai Mhlanga Massey University	II-3 In search of a fine balance: Refugee youth, sexual health and cultural competence Sapna Samant General Practitioner	III-3 How do Social Dominance and Minority Influence affect Refugee Services Sarah Hahn Massey University	

	I-4 The challenges of health promotion within African communities in New Zealand **Kudakwashe Tuwe** New Zealand AIDS Foundation		III-4 Immunity to mumps, measles and rubella in forced migrants. **Martin Reeve & Simon Thornley** Auckland Regional Public Health Service	
12.30 - 13.15pm	Lunch			AS136
13.15 - 14.30pm	The New Zealand Refugee Resettlement Strategy – The role of research in the future direction of the Strategy	Andrew Lockhart Immigration New Zealand		AA236
	Ministry of Social Development: Contributing to Refugee Wellbeing	Michael Haw & Jenny Janif Ministry of Social Development		
	Our future together	Lucy Liang Office of Ethnic Communities		
	Ministry of Education support for refugee background students and their families in New Zealand schools	Abdirizak Abdi Ministry of Education		
14.30 - 15.45pm	Breakout Session (Afternoon)			
	Session I	Session II	Session III	
	Theme: Refugee Experiences	Theme: Refugee Services	Theme: Refugee Experiences; Research Methods and Refugees	
	Chair: Tony Cooper	Chair: Kailesh Thanabalasignham	Chair: Jay Marlowe	
	Venue: AB219	Venue: AA236	Venue: AB220	
	I-5 Female Genital Mutilation Education Programme **Melissa Powell & Ayan Said** New Zealand FGM Education Programme	II-4 Opening doors and Crossing Thresholds: Community hospitality for refugees in New Zealand **Cheryl Cockburn-Wootten & Alison McIntosh** Waikato University	III-5 Climate change and migration in the Pacific Island Countries **Ximena Flores-Palacios** Auckland University of Technology	
	I-6 Stories and strategies of women living with Female Genital Mutilation in Auckland communities **Ayan Mohamud Said** Auckland University of Technology	II-5 eCALD™ – Preparing a Culturally Competent Health Workforce for working with clients and families from refugee backgrounds **Sue Lim & Annette Mortensen** Waitemata DHB /Northern Regional Alliance	III-6 Cultural safety as a framework for research with refugees **Charles Mpofu** Auckland University of Technology	
	I-7 Effectiveness of using Eye Movement Desensitization Reprocessing Therapy on Refugees **Sangita Wadnerkar** RASNZ	II-6 Evaluation of the Waitemata District Health Board Child Development Service (WDHB CDS) for Clients and their Families from Culturally and	III-7 Entering the field and eliciting refugee experiences with information and communication technology **Antonio Díaz Andrade**	

		Linguistically Diverse (CALD) Backgrounds Abdi Musse & Hanan Ibrahim Omeradin WDHB	Auckland University of Technology	
		II-7 Opportunities and Service Provision Offered by The Umma Trust to Enhance Refugee Women's Settlement and Health in Central Auckland Fetiya Mohammed, Aliyya Bintang Rachmadi & Anne Lee Umma Trust	III-8 Technology-mediated information and communication practices of refugees Antonio Díaz Andrade & Bill Doolin Auckland University of Technology	
15.45 - 16.00pm	Afternoon Tea Break			AS136
16.00 - 16.30pm	Panel Discussion			
	Chair – Dr Arif Saeid Theme: Research methods and Refugee people Panel: Dr Val Wright-St Claire, Mariano Coello, Tayyaba Khan			AA236
16.30 – 17.00	Discussion			
	Chair – Dr Hagyun Kim Feedback: Dr Annette Mortensen, Sue Elliott, Tayyaba Khan Theme: Recommendations for undertaking research with refugee people, and for future research topics; planning for 2016 conference			
17.00	Closing Remarks	Professor Max Abbott		

Keynote Speakers



Jorge G. Aroche

CEO, STARTTS

Jorge G. Aroche is a clinical psychologist and the Chief Executive Officer of the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS). Jorge has worked with migrants and refugee survivors of torture and organized violence since before 1989, when he joined STARTTS. He has led the organization since March 1997, through some of the most challenging times for refugee services in Australia.

Jorge is a member of the Executive Board of the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT), and held until the end of 2012 the posts of Secretary General of the International Society for Health and Human Rights (ISHHR), and Vice President of the International Rehabilitation Council for Torture Victims (IRCT).

In addition to his executive role Jorge continues to be actively involved in clinical and research activities at STARTTS and has presented and published widely on clinical and settlement issues for traumatized refugees on national and international platforms.

Guest Speakers

- Michael White, Human Rights Commission
- Andrew Lockhart, Immigration New Zealand
- Michael Haw & Jenny Janif, Ministry of Social Development
- Lucy Liang, The Office of Ethnic Communities
- Abdirizak Abdi, Ministry of Education

Presentation Abstracts

- ## Session I Refugee Experiences

I-1 An investigation of risk factors for vitamin D deficiency during pregnancy and infancy in Afghani women and their newly born infants

Maryam Delshad Siyahkaly & Pamela von Hurst – Massey University

Muslim women are often vitamin D deficient due to concealing clothing style. Vitamin D is essential during pregnancy for glucose homeostasis, function of the placenta, and protection against infection and inflammation. We investigated risk factors for vitamin D deficiency and barriers for sunlight exposure during pregnancy and infancy in Afghani women living in Auckland and their newborn infants. A semi-structured interview was conducted to investigate Afghani women's socio-cultural barriers to sun exposure. All the records and audiotapes were translated directly from Farsi into English and then fully transcribed. Thematic analysis was used for analysing our results. All the transcripts were manually coded. Our participants and their midwives had limited knowledge about the importance of vitamin D and appropriate sunlight exposure. Barriers preventing adequate sunlight exposure included covering most of the body, lack of privacy, indoor lifestyle and worry about skin cancer. Also vitamin D supplementation and/or vitamin D blood tests were not recommended by participants' General Practitioners (GPs), increasing risk of undetected and untreated vitamin D deficiency in this high-risk group. Our results emphasise the requirement for intervention programs regarding vitamin D among this population subgroup. Consideration of these socio-cultural barriers before developing public health interventions is necessary. Increasing awareness of health-care professionals, especially GPs and midwives, about their patient's culture, religion and lifestyle is important so they can advise them better. Health-care professionals' training, providing enough information for them about different ethnicities, and creating facilities for covered women where they can expose themselves to sunshine are recommended.

I-2 From Mama Africa to Papatūānuku: The health and well-being a Group of African Immigrant and Refugee background Mothers living in Auckland, Aotearoa/New Zealand

Irene Ayallo, Sue Elliott, & Helene Connor – Unitec Institute of Technology

This presentation is based on research with a group of ten African mothers (seven with a refugee background and three who were came to New Zealand as skilled immigrants) living in Auckland, Aotearoa/New Zealand.

The research focused on the mothers' lived experiences and their perceptions of motherhood. Many of the mothers talked about issues to do with their health and well-being and that of their children. Key themes included: post-natal health; emotional and other forms of support for new mothers both within African communities and the wider Auckland public health systems. The mother's wellbeing was also influenced by their children's experiences; particularly pervasive were children's experiences of racism and their mothers attempts to support them through difficult times.

I-3 Living in a new Culture: The experiences of African migrant and refugee parents in New Zealand related to sexual health education.

Fungai Mhlanga - Massey University

African parents who settled in New Zealand face challenges when communicating HIV and sexual health messages to young family members. This is because, in many African communities, it is taboo for parents to discuss sexual matters with their teenage children. It is the responsibility of extended family members such as aunties and uncles who in most cases are not present in New Zealand. The researcher used secondary data sources and explored how parents are bridging this gap in their families while coping with the new culture.

The main findings from the study showed that the dynamics in many African family structures have changed as a result of migration and settlement in New Zealand. There have been changes in values which have seen more young people taking up the host culture while a majority of the parents have retained their culture. Parents are reluctant to have, and avoid, direct communication about sex with their children. Culture and religion have a strong influence on the African community beliefs around sex education. African migrants and refugees bring strengths and resilience to New Zealand which helps them cope with the new culture and have been adopting new ways of keeping their culture alive in a foreign land.

The recommendations from this research include the need for HIV and AIDS Health Promoters to explore ways of increasing their relationship with parents, community and religious leaders as well as further research into ways to develop the skills and confidence of parents around sex education in a new culture in order to protect the health and wellbeing of young people.

I-4 The challenges of health promotion within African communities in New Zealand

Kudakwashe Tuwe – New Zealand AIDS Foundation

This completed Master of Philosophy (MPhil) study (2012) identified key health promotion challenges faced by New Zealand African communities. The researcher used a phenomenological approach to critically examine the meanings and experiences of African participants on health promotion. The use of the phenomenological approach enabled participants to share their “lived” experiences regarding the health promotion challenges within African communities in New Zealand.

In addition, ethno-methodology was also used to help understand how cultural norms, values, beliefs and practices impact on awareness and acceptance of health promotion practices by African individuals and communities in New Zealand.

In-depth interviews with 20 African community leaders, 10 service providers and one focus group with African community members critically examined participants’ personal experiences of health promotion by African communities in New Zealand.

Eight key health promotion challenges faced by African communities’ were identified, namely: African communities’ understanding of the concept of public health; African communities’ access to health services; Language barrier as a main challenge to accessing health promotion; Spirituality and traditional beliefs of African health consumers; Lack of understanding of the cultural context of African communities by health practitioners; Racism and discrimination within the health sector; Housing issues as a challenge to the promotion of health within African communities and HIV and AIDS related-Stigma as a challenge to health promotion within the African communities.

The study concludes that health promotion within African communities in New Zealand can only be effective when these issues are addressed within the African communities as well as the public health sector and institutional systematic levels.

I-5 Female Genital Mutilation Education Programme

Melissa Powell & Ayan Said - New Zealand FGM Education Programme

As a result of the growing number of migration flows from Africa, the practice of Female Genital Mutilation (FGM) has become an issue of increasing concern and attention in host countries such as New Zealand. Many refugee women come from the Horn of Africa where the most severe type of FGM occurs and FGM has become an important issue for New Zealand Public Health Services as women have presented within obstetric, gynecology and other sexual health services.

In response to this the NZ government made the practice of FGM illegal and the NZ FGM Education Programme was established. The Programme aims are to improve the sexual and reproductive health outcomes of women affected by FGM and to contribute to preventing the occurrence of FGM in New Zealand. The Programme's core activities include: the development of a wide range of national FGM resources including clinical guidelines, website, recommended best practices, resource kits, manuals and pamphlets; the provision of FGM training, support and technical assistance to health and child protection agencies; and the implementation of FGM Educator workshops and community education campaigns.

The Programme has worked alongside key community leaders and stakeholders, using a threefold community based approach; consultation, train the trainers and community health education implementation. An integral part of this, Community leaders and educators have designed, developed and delivered tailored FGM campaigns to targeted community groups.

In addition, the Programme has also undertaken two FGM research projects in Auckland amongst women affected by FGM, with the aim of assessing women's reproductive health care needs, attitudes towards FGM and experiences within public health care services. The research findings have in turn, informed the Programme's direction and outcomes.

This presentation is focused on sharing the experience of working with refugee communities in a culturally taboo and sensitive area for over 18 years and bringing the gap between the community and health and child protection professionals and services.

I-6 Stories and strategies of women living with Female Genital Mutilation in Auckland communities

Ayan Mohamud Said – Auckland University of Technology

Female genital mutilation (FGM) is a significant health problem for young girls and women; it is a harmful cultural practice that involves the cutting of the external genitalia. Many communities around the world have been practicing FGM for thousands of years. However, given the longstanding and socio-cultural nature of FGM it is a difficult problem to address. FGM become an increase concern for New Zealand in the early 90's with the growing number of refugees and migrants from countries that practice FGM.

This study explores the stories of women living with FGM in Auckland, to capture the strategies they propose for addressing FGM, with a focus on the Somali, Eritrean, Indonesian and Kurdish communities. In this study the method that was utilized was a qualitative descriptive methodology, using semi-structured individual interviews and one focus group discussion with one woman from each of the communities. The finding in this study highlighted that those participants who remembered the experience (2 women) spoke of the physical and emotional trauma of the event. All discussed long-term socio-cultural and health effects. One person gave details of their experiences with the New Zealand healthcare system. The participants mainly consider education as central to prevention; also the law is seen as a deterrent to FGM practice but they had little knowledge of the rights' debates. In Conclusion despite decades of prevention programmes and global rights based legislation and targets there has been little shift in FGM prevalence internationally. This thesis argues that there is a need for strategies to prevent FGM that use a more culturally appropriate and community based approaches, moving beyond global statements. These strategies also apply to the New Zealand context, which needs to take into consideration the diversity of FGM practicing communities.

I-7 Effectiveness of using Eye Movement Desensitization Reprocessing Therapy on Refugees

Sangita Wadnerkar - RASNZ

Aim- EMDR is an integrative psychotherapy approach and is effective treatment for traumas. It is widely researched and used by mental health clinicians all over the world. It was discovered and developed by Francine Shapiro in 1987. The paper is a compilation of use of EMDR therapy on refugees residing in Auckland, with their outcome and case studies.

Method-The writer used EMDR on clients with diagnosis such as post-traumatic stress disorder, major depressive disorder & panic disorder etc. The clients presented with issues such as, sexual abuse, grief issues, torture, war traumas, domestic violence, somatic complaints, dissociation, and physical issues (ulcerative colitis, chronic headaches and chronic pain). Some of the clients have witnessed gruesome traumas such as genocide, witness of family members/ friends being killed in front of them, physically tortured by police, gang rape etc.

Results- The symptoms reduced post EMDR sessions and the clients have been able to cope with their life more effectively, study as well as seek employment. Their self-confidence and self-esteem increased drastically and have been able to lead a normal life.

Conclusion -EMDR is effective therapy as it avoids clients from being re- traumatized. The clients don't need to discuss the details of the trauma in order to process the memory of the trauma. It can help in processing the distressing memories and allow a natural healing process of assimilation and adjustment

to function. Clients report that EMDR therapy actually empowers the very experiences that once controlled them negatively. EMDR may involve use of fewer sessions compared to interventions such as cognitive behavior therapy. It is easier for clients who are illiterate or clients belonging to different cultures.

Notes

- Session II Refugee Services

II-1 Working with Refugees: A Model of Primary Health Care

Serena Moran & Jonathan Kennedy - Newtown Union Health Service

Newtown Union Health Service (NUHS), established in 1987, is a not-for-profit, low cost primary healthcare service with two clinics located in the Wellington suburbs of Newtown and Strathmore. Since its inception NUHS has been providing primary health care to people from refugee backgrounds living in the southern and eastern suburbs of Wellington. Beginning with the Cambodian community in the 1980's an increasing ethnic diversity has emerged over the years with the arrival of communities from Iraq, Somali, Ethiopia, Eritrea, Myanmar, Afghanistan and most recently Columbia and Syria.

NUHS has developed an integrated model of primary health care which aims to enhance health outcomes for refugees and is based on the four dimensions of health: physical, mental, social and spiritual. Key elements include development and maintenance of the therapeutic relationship, interagency and interdisciplinary collaboration, advocacy, social support, health education & promotion, health screening & long term condition management, working from a strengths and rights based approach.

II-2 Refugee Settlement, Belonging and Disaster Risk Reduction: Case studies from Christchurch and Wellington

Jay Marlowe – University of Auckland

Recognising that protracted global conflicts have now created nearly 60 million forced migrants, there is an urgent need to develop greater understandings of what informs recovery in disaster contexts with such groups. By providing a local New Zealand context in which international refugee resettlement occurs, this presentation discusses the possibilities, implications and barriers to effective disaster risk reduction with culturally and linguistically diverse populations.

This paper first presents a qualitative study with refugee background participants (34 semi-structured interviews and 11 focus group discussions comprising 112 participants) from varying communities living in Christchurch about their perspectives and responses to the Canterbury earthquakes of 2010–11. Participants spoke of how a sense of belonging as individuals and as a wider community was important in the recovery effort, and highlighted the multiple ways in which they understood this concept. Their comments demonstrate how belonging can have contextual, chronological and gendered dimensions that can help inform effective and resonant disaster responses with culturally and linguistically diverse populations. This analysis also illustrates how the participants' perspectives of belonging shifted over time, and illustrates the corresponding role of supporting post-disaster recovery through the concepts of civic, ethno and ethnic-based belonging. These findings from the Canterbury context are then used as a case study to examine how well several refugee communities settled in Wellington (5 focus groups and 5 semi-structured interviews comprising 52 participants) understand the associated risks to natural hazards in the area and how they might respond. Overall, this presentation will endeavour to make stronger linkages between belonging and the social capital literature to identify relevant considerations for effective disaster risk reduction relating to communication strategies, gender, leadership, community politics and wider societal relations.

II-3 In search of a fine balance: Refugee youth, sexual health and cultural competence

Sapna Samant – General Practitioner

To focus on cultural competence towards the diverse refugee communities in Aotearoa New Zealand with an emphasis on sexual health and behaviours of young refugees within the context of primary care (general practice).

Porirua Union Community Health Service is a group general practice in Cannons Creek, Porirua, that caters to a large and diverse population of refugee background. It is only one of three practices in the Wellington region that accepts new patients undergoing the resettlement process. Among the many services offered is Hype, a clinic for young people between the ages of 18-23. This is a nurse led clinic to which doctors can refer patients. Young people can self-refer or nurses can suggest the clinic to patients.

This paper will look at two case studies, one from the Burmese community and the other from the Colombian community.

The aim is to reflect on our current experience with our patients from refugee backgrounds in the youth group and seek to improve cultural competence by using a document on cultural competence published by the Royal New Zealand College of General Practitioners (http://www.rnzcgp.org.nz/assets/documents/Publications/College-Resources/Cultural-Competence.pdf) as the main resource, and with reflections/learnings from similar contexts overseas.

II-4 Opening doors and Crossing Thresholds: Community hospitality for refugees in New Zealand

Cheryl Cockburn-Wootten & Alison McIntosh - Waikato University

A challenge for many community and not-for-profit organisations is finding the time and resources to consider collaborative projects, communication and strategically thinking through how to respond to issues. To respond to this need, the Network for Community Hospitality was established in late 2013 as a direct call from a workshop with local community and not-for-profit (NFP) organisations in the Waikato area. The Network creates civic and meaningful connections between the community groups themselves as well as bridging the campus to actively engage with issues facing NZ society. Facilitated by the two authors, NFPs breakdown the silos between themselves, collaborate, share knowledge and created a mutual learning space. The network members can also draw on university resources in order to access expertise, research skills, volunteers and create awareness around their social issues. The Network's aim is to tackle social issues such around inclusion, advocacy, vulnerability and change. One key area has been the NFP organisations that provide and coordinate services to welcome and support refugees. We would like to present two empirical projects that have been supported through the Network. These projects involved refugee and other NFP organisations. One project is the 'Circles of Support' for refugee families with a family member with a health issue. The other is the 'Think Tank' series that enables members to collaborative think through with invited individuals, how we can partner and use our collective knowledge to create inclusion and welcome to refugees in NZ.

II-5 eCALD™ – Preparing a Culturally Competent Health Workforce for working with clients and families from refugee backgrounds

Sue Lim & Annette Mortensen - Waitemata DHB/Northern Regional Alliance

Background
The health and disability workforce in New Zealand is becoming increasing ethnically diverse reflecting trends in immigration and the changing demography of the Auckland region. The increasing trends highlight the need to prepare the workforce to be culturally competent to manage cross-cultural interactions between employers and employees, as well as between patients and health and disability service providers to provide culturally appropriate and safe services.

With the growing diversity of the population in New Zealand, health practitioners are experiencing more cross-cultural interactions with migrant and refugee patients from linguistic, cultural and religiously diverse backgrounds. As a result, the Ministry of Health now requires District Health Boards to provide services that acknowledge the diversity of cultures and ensure services are accessible, culturally appropriate, effective and safe.

In New Zealand, the Health Practitioners Competence Assurance Act 2003 (HPCAA) requires registration authorities to set standards of clinical competence and cultural competence. Cultural competence refers to an ability to communicate and interact effectively with people of different cultures and comprises four key components of cultural awareness, sensitivity, knowledge and skills.

Body of Discussion
The CALD Resources website have been developed and managed by Waitemata DHB since 2010. It provides a platform for health practitioners to access resources to (a) e**stablish cultural competence and (b) support and enable cultural and language appropriate interactions with Culturally and Linguistically Diverse (CALD) patients**. This web portal www.eCALD.com offers the following range of resources:

- CALD Courses
- CALD Resources
- CALD Online Forum
- CALD News

The website is innovative and is intended to be the single platform for all health practitioners looking for resources to continue developing cultural awareness, knowledge and skills.

The presenters will present the range of resources within this web portal in greater detail.

Conclusion
The feedback and endorsements from various clinicians, management and Human Rights Commission evidence the importance of such an innovative production of resources to meet the current and future needs of the diverse workforce.

II-6 Evaluation of the Waitemata District Health Board Child Development Service (WDHB CDS) for Clients and their Families from Culturally and Linguistically Diverse (CALD) Backgrounds

Abdi Musse & Hanan Ibrahim Omeradin - Waitemata DHB

The Waitemata District Health Board Child Development Service (WDHB CDS) for Clients and their Families from Culturally and Linguistically Diverse (CALD) backgrounds was established with funding from the Northern Regional Alliance in 2009. The Programme, was evaluated in 2011. Cultural caseworkers, also known as cultural brokers mediate between clients/families and services to improve access and health and social outcomes for CALD families. The aim of the CALD CCW programme is to provide service that are culturally appropriate for the care of children and families from refugee and CALD migrant backgrounds. The service users are children and young people and their families from refugee and CALD migrant backgrounds with disability or development concerns.

The evaluation

The evaluation sought to qualitatively evaluate the Programmes progress in establishing the service and internal and external networks; provision of advice and support to Child Health team members; provision of cultural support services to children and their families; and, building cultural competence of the Child Health teams. The evaluation employed a mixed-methods approach involving three stages of data collection including: document review, face-to-face semi-structured interviews with 25 key informants, and case studies involving five families who had accessed the project. **Key findings:** The evaluation gathered information on the experiences and needs of CALD families who have relocated to New Zealand, with a child with specific health needs. It identified differences in migrant and refugee families in terms of their needs, and the resources they are likely to have available to them when arriving in New Zealand – and highlighted the importance of services adjusting to these. Children and adults from refugee families may enter New Zealand with pre-existing mental health issues due to the trauma they have experienced, compounded by adjusting to life in a new country. For both migrant and refugee families, there is a need for health and disability support services to consider the cultural and familial dynamics in operation within CALD families.

II-7 Opportunities and Service Provision Offered by The Umma Trust to Enhance Refugee Women's Settlement and Health in Central Auckland

Fetiya Mohammed, Aliyya Bintang Rachmadi & Anne Lee - UMMA Trust

This paper will detail the essential components that enable engagement; ensure programme participation; build leadership skills; and produce positive health and settlement outcomes for refugee women including young women from refugee Muslim communities.

Umma Trust was established in 2003 to work with refugee populations that are predominantly Muslim with a large proportion of African ethnicities. Since 2008 Auckland Council has provided a venue in Ferndale House centrally located in the Albert/Roskill area to support settlement services to the **largest number of refugee background peoples in New Zealand**, many of whom are Muslim and African. This area has the **highest deprivation score within Auckland City (9.5-10)** These families are amongst the highest child poverty group in New Zealand.

The unique niche that Umma Trust represents:

1. A woman's organization that offers women only health and settlement programmes for Muslim women who may never attend mainstream programmes
2. A place of trust where women know they will be welcomed by Muslim women
3. An opportunity for isolated marginalized women to work as volunteers, gain skills and training and become leaders in their own communities.
4. A Muslim youth mentoring and development programme
5. A service that networks and supports the work of ethnic refugee associations but is itself independent of any one ethnic association

The services provided include running a food bank; nutrition and health workshops; advice on positive parenting in a New Zealand context and child abuse prevention; Family Violence Awareness in NZ context, Forced Under Aged Marriage, Rights of Children & Women, women's groups to reduce social isolation and enhance wellbeing; and addressing issues of housing and employment.

The trust has charted new territory in the provision of social services and programmes to Muslim families from refugee and migrant backgrounds.

- Session III Refugee Experiences: Research methods and Refugee people

III-1 Research Refugees, New Migrants & Conflict Resolution Engagement

Anet Kate & Jane Verbitsky – Auckland University of Technology

The aim of this project was to examine contemporary dispute resolution mechanisms utilised by refugee and migrant communities in Auckland, to investigate whether these provide satisfactory outcomes for the communities involved, and to explore options and preferences nominated by community members themselves. Among difficulties encountered by new migrants are problems in accessing formal justice mechanisms and institutions, and engaging in forms of dispute resolution that are culturally relevant, and appropriate for the communities involved.

This project examines provisions for appropriate inter-cultural conflict resolution, analyses whether such mechanisms deliver appropriate, relevant & culturally sensitive processes or outcome in the view of the consumers and leaders, policy analysts and the professionals involved. It then explores possible ADR alternatives for these communities.

III-2 Resisting the Disempowering Discourses that Dominate Discussions of Refugee Resettlement in New Zealand

Marieke Jasperse - University of Otago

Discourses of psychopathology and burden dominate discussions of refugee resettlement. The psychological literature has a tendency to focus on trauma and the risks of trauma work, effectively pathologising refugees in addition to those who work with them.

The preoccupation with trauma does not allow for alternative discourses of survival and resilience and ignores the detrimental effects of negative resettlement experiences such as poverty, prejudice, and isolation. It also disregards the opportunities for personal and professional growth documented in studies exploring the experiences of professionals working in resettlement.

This presentation, informed by Foucauldian Discourse Analysis, will demonstrate the way in which professionals and volunteers engaged in resettlement in Wellington, New Zealand, resist the disempowering discourses that dominate discussions of resettlement. The importance of reflecting upon the representation of resettling refugees will be reiterated and implications for successful resettlement discussed.

III-3 How do Social Dominance and Minority Influence affect Refugee Services?

Sarah Hahn - Massey University

Social Dominance Theory has problematic implications for humanitarian work: It suggests that stakeholders of the humanitarian sector collectively maintain the social hierarchies that disadvantage the very minorities that they are supposed to empower. Minority Influence Theory, on the other hand, suggests that social innovation in the humanitarian sector emerges from the bottom-up, thus against the grain of social hierarchies. This thesis explores for the refugee service sector of Auckland, New Zealand, (a) if former refugees are indeed marginalised within the inter-organisational context that is supposed to empower them, (b) if this has detrimental effects on the sector's performance, and (c) if fostering minority influence might alleviate such effects. A stakeholder analysis revealed that the social hierarchies within the resettlement sector indeed mirror the marginalisation of former refugees in general New Zealand society. Stories of positive and negative incidents of collaboration in the sector were collected from 14 key stakeholders of the resettlement sector and thematically analysed. Narratives of negative incidents of collaboration included discourses of different legitimising myths that keep social hierarchies intact. These concerned the inaccessibility of services, confounding participation with collaboration, voluntarism as unambiguously positive, feelings of indebtedness among former refugees, and the false belief in opportunities in New Zealand. The findings support the idea that legitimising myths perpetuate social hierarchies in the refugee service sector and thereby negatively affect its performance. Narratives of successful collaboration involved factors that facilitate minority influence, such as finding consistency, appealing to common values, enough time, bottom-up accountability in the form of community ownership, and trust. This suggests that facilitating minority influence in the Auckland refugee service sector simultaneously facilitates collaboration. Social Dominance Theory and Minority Influence Theory proved to be instrumental to analysing problems within the inter-organisational context of refugee services and for finding indications for future research and better practice.

III-4 Immunity to mumps, measles and rubella in forced migrants. Can immunity to one be used as a surrogate for immunity to the others?

Martin Reeve & Simon Thornley - Auckland Regional Public Health Service

Mumps measles and rubella are important infectious diseases, and for which there is a single vaccination, MMR. MMR cannot be given under some circumstances, for example to women who are or may become pregnant within 6 weeks of the vaccination.

Blood tests are available to show whether or not a person is immune to each of these diseases. This study answers the question whether it is necessary to test for all three, or can immunity to one be taken to show that there is immunity to all three.

The results of immunity tests for 117 quota refugees and asylum seekers was analysed. This showed that immunity to one diseases is not a good predictor of immunity to the others, and the degree of error explained.

III-5 Climate change and migration in the Pacific Island Countries

Ximena Flores-Palacios – Auckland University of Technology

Background. A number of studies and press reports portray Pacific people, particularly those living in small low-lying islands, such as Tuvalu, Kiribati, and the Marshal Islands, as the “miner’s canary” of global climate change. Catastrophic scenarios like sinking islands and the so called “climate change refugees” (people forced to abandon their lands with no other option than to migrate) are narratives that circulate often in scientific publications, media and political discourses. This image is also extended to the rest of the small islands in the Pacific that have coastal features and characteristics that make them particularly vulnerable to climate change variability and sea level raise.

There are undoubtedly regions more vulnerable than others to the impacts of climate change, and the Pacific region is one of them. However, instead of portraying Pacific islanders as victims of climate change or as a security problem it is necessary to give greater visibility to people’s perspectives on environmental migration that add values, beliefs and everyday practices to the debate. Dominant global narratives, such as climate refugee discourses, can put vulnerable communities in unequal power relations to decide their own future.

Importance of the research topic. Even though there is clear evidence that climate change is stimulating population movements, the interaction between climate change and migration is little understood. In the case of the Pacific island countries, there are some studies focused on atoll territories, but there is little empirical research on the "middle sized" Pacific nations. There is an urgent need to listen to the people’s voices to understand how climate change is affecting peoples’ lives and livelihoods in these countries and how it impacts on migration.

Proposal for the presentation at the Refugee Research Symposium 2015 AUT. The proposed topics to include in the presentation are: (a) Overview of climate change and migration in the Pacific island countries, (b) climate refugee concept, (c) implications for research and policy.

The presentation is based on the preliminary findings of my PhD study (Samoa. Exploring the linkages between climate change and population movements) to be submitted in December 2015.

III-6 Cultural safety as a framework for research with refugees

Charles Mpofu – Auckland University of Technology

Recent scholarly literature on refugee research ethics has tended to draw attention to the ethical issues unique to this population group. This paper extends such scholarship by proposing a conceptual argument for the use of cultural safety principles as a framework for translating into practice the ethical principles of respect for persons and beneficence- originally enshrined in the Nuremberg Code (1949). In research practice, these two ethical principles oblige those who interact with participants to assess the potential harms and benefits to prospective participants prior to carrying out a research project. This presentation considers issues of harm, vulnerability and voluntariness in the context culturally safe research with refugees. Cultural safety in refugee services work is an expectation that outcomes of any interaction enables a safe, appropriate and acceptable service that has been defined by those who receive it. In this context it is therefore argued that established western ethical protocols can neither be effective nor be appropriate in the practice of refugee research.

III-7 Entering the field and eliciting refugee experiences with information and communication technology

Antonio Díaz Andrade – Auckland University of Technology

The exceptional circumstances refugees face as forced migrants make them potentially rich informants yet simultaneously impose practical challenges during the fieldwork. As part of a research project intended to understand their use of information and communication technology to navigate an unfamiliar information environment, I interacted with a number of individuals of refugee background between July 2012 and July 2013 in four different locations across New Zealand: Auckland, Hamilton, Nelson and Palmerston North.

In this presentation, I reflect about the researcher-participant interaction based on 39 in-depth, face-to-face interview sessions conducted with 53 refugees from Bhutan, Burma, Colombia, Democratic Republic of Congo, Eritrea, Ethiopia, Iraq and Rwanda. I was mindful that during the interviews, their personal – sometimes tragic – stories would inevitably come up. However, interviewing individuals who were forced to leave their countries of origin was not the only challenge. Asking them to elaborate on their purpose of using information and communication technology in a language – English – with which they have differential levels of confidence, added to the complications of peering into their lives. In fact, six interview sessions required the assistance of an interpreter for the length of the interview, while in many cases participants' children helped in translating specific explanations that participants found hard to express in English. In order to mitigate these challenges, I strived to make the participants feel comfortable to share their experiences. I describe my interaction with the participants as a family conversation rather than a formal interview. Indeed, most of the interviews were conducted at the participants' houses, where the interviewees' family members were directly involved in the discussion and everyone shared their experiences about using information and communication technology in a congenial way. While I had planned to audio record all interviews, whenever I deemed that introducing a recorder would hamper the natural flow of the conversation, I engaged in the conversation without it. In hindsight, I believe that my flexible and ad-hoc approach allowed me to elicit rich data from the participants.

III-8 Technology-mediated information and communication practices of refugees

Antonio Díaz Andrade & Bill Doolin – Auckland University of Technology

We investigate the temporal dimensions of information and communication technology use of a group of resettled refugees in New Zealand. We analyse how they enact technology-mediated information and communication practices in dealing with the everyday challenges they face in a new and unfamiliar information environment. In-depth interviews conducted between 2012 and 2013 with 53 participants of refugee background in Auckland, Hamilton, Nelson and Palmerston North provide the empirical data for our analysis. Based on our analysis, we categorise their information and communication practices into three modes: orienting, instrumental and expressive. Further, we draw on a temporal theory of human agency to examine how these technology-mediated information and communication practices are oriented towards the present, past and future. As forced migrants move between multiple and overlapping temporal-relational contexts in their everyday lives, their enactment of these practices is the outcome of a complex recursive interaction with their circumstances, encompassing current contingencies, past connections and future expectations.

Protocols for Research with Refugee people

Working with former refugees

Values and attitudes

If you:

- Work *with* us, not *on* us,
- Respect us,
- Build on our strengths,
- Contribute to our wellbeing as individuals and communities,
- Recognise and accept that we former refugees come from a very wide range of countries, cultures and religions; that we come from a wide range of educational and employment backgrounds; that we have all suffered trauma; and that our experiences of settlement in New Zealand are varied,

And accept

- That while some of us have always spoken English, others have had to learn English on arrival in New Zealand, and even those of us for whom English is a first language struggle with your accents,
- That many of us have had bad experiences with authorities that make us suspicious and nervous about answering some questions,
- That written forms are extremely difficult if not impossible for many of us,
- That most of our communities are small and our day to day lives are demanding, and
- That while we may look and sound different to you, we are human beings just like you,

We have a good chance of working together well.

For more guidelines for research with former refugees in New Zealand, please visit http://crf.org.nz/

Notes

Notes

RASNZ
Refugee Health & Wellbeing

Northern
Regional Alliance
He Hononga o te Raki

RCNZ
REFUGEE COUNCIL OF
NEW ZEALAND

ARCC
Auckland Refugee Community Coalition
Te Roopu Tauawhi Mana Tangata