Towards better health for refugee children and young people in Australia and New Zealand

The RACP perspective
Acknowledgements

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We gratefully acknowledge feedback from the following:
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Suggested citation: The Royal Australasian College of Physicians “Towards better health for refugee children and young people in Australia and New Zealand: The RACP perspective” 2007 Sydney

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Foreword

This document collates current literature and proposes recommendations that have the potential to significantly improve the delivery of health care to refugee children and young people. Fellows from the Royal Australasian College of Physicians have consulted widely to produce this innovative policy document.

I am pleased to be part of a College that has played a solid advocacy role for refugee children and children in detention. During 2002 and 2004, the RACP was part of an alliance of health care professionals that presented a key report to the Human Rights and Equal Opportunities Commission (HREOC) on children in detention. Subsequently, the Australian and New Zealand College of Psychiatrists, the RACP and others undertook a successful advocacy campaign for the release of children from detention centres. Other medical professional bodies, local and international, have also been active in advocacy to address the health of refugees.

In this document, particular attention is given to the importance of accessible health care delivery and the care required for health services to meet the complex health needs of refugee children and young people. It makes explicit the importance of the College working alongside governments to improve health service delivery to refugee children and young people. Furthermore, it highlights the missed opportunities to provide preventive, early intervention and health promotion strategies known to yield effective health and social outcomes. The need for research and data collection to inform policy and practice is emphasised, as is the College’s role in training and professional development. I am hopeful that individual Fellows will refer to this document to meet their responsibilities in promoting the health and well-being of refugee children and young people within their jurisdictions.

The development of resilience, and thus successful adult participation in society, depends on optimising physical health as early as possible, as well as providing nurturing and supportive environments for children to grow up in. While these principles apply to all children, refugee children are particularly vulnerable in that they have frequently experienced traumatic life events and may have received little or no medical care. They require even more concerted efforts to redirect their life course to that of health and resilience.

There is much to learn about coping and resilience from refugee communities, who, when properly supported, can do remarkably well in health and educational outcomes. Accessible and comprehensive health care and a spirit of welcoming will improve health outcomes and the overall well-being of refugees settling in Australia and New Zealand.

Professor Fiona Stanley AC
1. Executive Summary

Children and young people make up a significant proportion of the humanitarian refugee intake in Australia and New Zealand and are arguably the most vulnerable subgroup. The health needs of refugee children and young people have been well documented and include high rates of preventable conditions including psychosocial morbidity and sequelae, due to poor access to health services. Of particular concern are those children and young people who are ‘unaccompanied minors’, who lack the protection and support of their families.

Despite complex health needs in refugee children and young people, service delivery is fragmented and there are many barriers to providing the most effective health care. There are wide local variations in the health care provided, and preventive activities known to be highly effective, such as immunisation and early detection of infectious disease, are not routinely offered. Health care delivery is further complicated by the shifting responsibility between state and federal governments, and Governmental and non-governmental organisations.

The primary aim of this document is to advocate for timely and high quality health care for every refugee child and young person living in Australia and New Zealand. It complements existing College policy documents addressing equity, cultural competence and safeguarding children’s well-being. The target audience is primarily individual Fellows but also includes health services, policy-makers and governments responsible for providing health care in Australia and New Zealand.

This policy was developed by drawing on the scientific literature, international guidelines and policy documents, and the expertise of local field workers. Evidence derived from good quality, randomised controlled trials does not yet exist in this area. However, there is considerable documentation about the health problems faced by refugees and their difficulties in accessing health services in Australia, New Zealand and elsewhere. Recent publications highlight recommendations based on the experience of health care delivery to refugee families in Australia. Cost effectiveness of provision of early malaria and tuberculosis treatment has been explored, and the professional skill base required to address refugee health is evident from the literature.

This document recommends that the following are required in order to deliver the most effective health care to refugee children and young people (i) health service enhancement, (ii) the promotion of research and development of the evidence base, (iii) dedicated training, and (iv) professional practice. The recommendations range from interventions that involve government leadership to interventions directed at health services and professionals. General management issues are discussed, but specific guidelines addressing medical investigations and treatments recommended for refugee children and young people can be accessed via http://health.gov.au/internet/wcms/publishing.nsf/Content/cda-cdi29041.htm guidelines
Where to from here?

The College can take a lead role in implementing the recommendations presented in this document in order to address the health of refugee children and young people. One of the major responsibilities for the College is to ensure that all Fellows in Australia and New Zealand have access to appropriate training and professional development programs. Other key areas are (i) advocating for the relevant government policy changes required, (ii) supporting special interest groups to monitor change and update recommendations based on emerging evidence, and (iii) facilitating widespread dissemination of the recommendations amongst relevant parties, from decision-makers down to local level.

This policy document will be updated on a bi-annual basis to keep abreast of changes in government policy and to present new evidence as it becomes available. This document will be widely disseminated to all those working with refugee children and families, and to key organisations and policy-makers. It is intended for use as an advocacy tool to motivate for changes in policy and practice that will improve the health of refugee children and their families. Fellows are encouraged to advocate for the implementation of the recommendations presented and to advocate for best practice for refugee children.

This document is available at http://www.racp.edu.au/hpu/policy/index.htm
2. Recommendations

Health Service Enhancement

The RACP believes that health services need to be enhanced in order to address the complex health needs of refugee children, young people and their families.

Accordingly, the RACP recommends that the Australian and New Zealand governments* should:

1. Develop services that consistently affirm the dignity of refugees.
2. Develop a whole-of-government approach to best address the health and well-being of refugees settling in Australia and New Zealand.
3. Provide publicly funded health care to all refugees, with a mixture of targeted and mainstream services, independent of their visa status.
4. Provide high quality, accessible, culturally respectful and affordable health care for refugee families.
5. Offer comprehensive health assessments post arrival (addressing physical and psychosocial needs) and appropriate follow-up care for every refugee who arrives in Australia or New Zealand.
6. Develop services with appropriately trained, multidisciplinary team members, multicultural health workers, refugee workers and readily available professional interpreters.
7. Abolish the differential access to health services based on visa category.
8. Abolish current Australian legislation that allows children to be housed in detention centres.
9. Ensure that previous health records are made available and provide personal health records for refugee children, to allow for improved communication of their health needs.

Research and data collection

The RACP believes that all agencies involved in refugee health should promote research and the collection of data in order to develop an evidence base for the provision of optimal care.

Accordingly, governments, institutions, health service providers and practitioners should:

1. Support and conduct nationally coordinated, clinically relevant and culturally appropriate research that will inform best practice and service development.
2. Develop research methods that encourage participation of refugees (including children and young people).
3. Collaborate to address specific research questions that inform future policy and practice in refugee health, including long-term health outcomes and cost-effective service delivery models.

* Governments in this document refers to both Australian (Federal as well as States and Territories) and New Zealand.
Training

The RACP believes that training in refugee health, multicultural health and human rights approaches to health are key to improving the quality of services for refugee populations.

Accordingly the RACP will work with professional bodies to:

1. Promote the importance of cultural competency, human rights and advocacy training at all levels.
2. Create and facilitate the development of training opportunities that expose trainees to multicultural health, refugee health and related fields.
3. Promote continuing professional development for Fellows in cultural and linguistic competence (including working with interpreters), human rights and advocacy for disadvantaged groups, and provide regular opportunities for professionals to update their skills.
4. Support the establishment of training Fellowships in Refugee and Multicultural Health to build capacity and expertise in the workforce.

Professional practice

The RACP believes that individual Fellows have a respected role in the community and an important voice in advocating for their patients and for refugee communities.

Accordingly Fellows should continue to:

1. Be aware that financial, linguistic, cultural and social factors can prevent refugee children and families from accessing health care.
2. Be informed about the specific physical and health problems faced by refugees, the appropriate screening assessments and management issues pertaining to health problems, as well as the local health and welfare services available to assist refugee families.
3. Adopt a compassionate and respectful approach to refugee children, young people and their families.
4. Advocate strongly as individuals and within organisations to promote high quality care for refugee families.
5. Monitor change (through special interest groups) in refugee health policy and practice.
3. Background

This chapter provides demographic information about refugees arriving in Australia and New Zealand and their pathways to refugee status. It also provides definitions for the commonly used terms relating to refugees. As suggested by the United Nations High Commissioner for Refugees (UNHCR), this document uses the term “refugee” in relation to asylum seekers, refugees and all those with refugee-like status.26

Australia and New Zealand are amongst the 71 countries that accept refugees and asylum seekers; 15 of these have a specific refugee program. In 2004, Australia increased its annual quota of new places for refugees from 12 000 to 13 000; refugees constitute about 10 per cent of all settlers migrating to Australia.27 Up to 50 per cent of these refugees are under 20 years old. There are approximately 60 unaccompanied refugee minors arriving in Australia each year (Table 1). New Zealand accepts 700 to 800 refugees per year, as well as several thousands of additional people from refugee-like backgrounds, such as people seeking family reunification and asylum seekers.

Table 1: Refugees arriving in Australia from 1 January 2001 to 31 December 2005

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Number</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 9</td>
<td>12 404</td>
<td>25.2 per cent</td>
</tr>
<tr>
<td>10 – 19</td>
<td>12 817</td>
<td>26.1 per cent</td>
</tr>
<tr>
<td>Unaccompanied minors (&lt;18 years)</td>
<td>300</td>
<td>0.6 per cent</td>
</tr>
<tr>
<td>Adults (≥ 20)</td>
<td>23 645</td>
<td>48.1 per cent</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>49 166</strong></td>
<td><strong>100 per cent</strong></td>
</tr>
</tbody>
</table>

Source: DIMA website28

The regional focus of the resettlement program has changed over the last few decades. Refugees mainly originated in South East Asia and Europe in the 1980s and 1990s, but around 70 per cent of those currently settling in Australia come from African countries. The country of origin has important implications for the health needs of refugees in terms of their susceptibility to disease and prior access to services.

Since 2003-2004 Sudanese refugees have constituted the highest single group of refugees settling in Australia, with large groups from other African countries and the Middle East (Figure 1). In New Zealand, the majority of refugees and asylum seekers are from the Middle East and South West Asia (Iraq, Afghanistan and Iran); significant numbers come from sub-Saharan Africa.

The Department of Immigration and Citizenship (DIAC) in Australia has been supporting a systematic study of immigrant settlement outcomes. The Longitudinal Survey of Immigrants to Australia (LSIA) compares the experiences of two cohorts of migrants and refugees to Australia (1993-1995, 1999-2000). LSIA analysis reveals that outcomes for refugees are generally poorer than for other groups of immigrants and that the second cohort has poorer outcomes than the first. Refugees have had more complex health problems in recent years, largely due to poor health status in their countries of origin.29
Figure 1: Australian resettlement program by region of origin and year of settlement 2000-2005

Source: Refugee and Humanitarian Issues: Australia’s response. DIMIA/DIMA 2005
*SW Asia refers to Iraq, Afghanistan and Iran

Figure 2: New Zealand refugee intake program 2001 – 2006 by region of origin, refugee category and age

<table>
<thead>
<tr>
<th>New Zealand Refugee Quota*</th>
<th>TOTAL 2001/02**</th>
<th>TOTAL 2002/03</th>
<th>TOTAL 2003/04</th>
<th>TOTAL 2004/05</th>
<th>TOTAL 2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BY NATIONALITY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African Region</td>
<td>137</td>
<td>27</td>
<td>145</td>
<td>165</td>
<td>155</td>
</tr>
<tr>
<td>Eastern Mediterranean Region</td>
<td>582</td>
<td>528</td>
<td>627</td>
<td>590</td>
<td>387</td>
</tr>
<tr>
<td>European Region</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>SE Asian Region</td>
<td>30</td>
<td>31</td>
<td>31</td>
<td>5</td>
<td>184</td>
</tr>
<tr>
<td>Western Pacific Region</td>
<td>0</td>
<td>11</td>
<td>3</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Stateless</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL BY NATIONALITY</td>
<td>750</td>
<td>604</td>
<td>812</td>
<td>761</td>
<td>741</td>
</tr>
<tr>
<td><strong>CATEGORIES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical / Disabled</td>
<td>28</td>
<td>23</td>
<td>17</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>Protection</td>
<td>432</td>
<td>535</td>
<td>243</td>
<td>46</td>
<td>409</td>
</tr>
<tr>
<td>Women at Risk</td>
<td>33</td>
<td>10</td>
<td>53</td>
<td>9</td>
<td>73</td>
</tr>
<tr>
<td>Family Reunion</td>
<td>107</td>
<td>32</td>
<td>459</td>
<td>682</td>
<td>232</td>
</tr>
<tr>
<td>Emergency</td>
<td>150</td>
<td>4</td>
<td>40</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>TOTAL BY CATEGORY</td>
<td>750</td>
<td>604</td>
<td>812</td>
<td>761</td>
<td>741</td>
</tr>
<tr>
<td><strong>AGES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - 5</td>
<td>68</td>
<td>45</td>
<td>64</td>
<td>79</td>
<td>82</td>
</tr>
<tr>
<td>6 - 11</td>
<td>139</td>
<td>82</td>
<td>187</td>
<td>161</td>
<td>137</td>
</tr>
<tr>
<td>12 - 17</td>
<td>167</td>
<td>73</td>
<td>153</td>
<td>163</td>
<td>147</td>
</tr>
<tr>
<td>18 +</td>
<td>376</td>
<td>404</td>
<td>408</td>
<td>358</td>
<td>375</td>
</tr>
<tr>
<td>TOTAL AGE</td>
<td>750</td>
<td>604</td>
<td>812</td>
<td>761</td>
<td>741</td>
</tr>
</tbody>
</table>

NOTE: * This does not include family reunification and asylum seekers
** Time periods include July to June of following year
Source: Immigration New Zealand
Definitions
These definitions apply to the Australian and New Zealand contexts.

1. REFUGEE:
The United Nation Convention defines refugees as people who are outside their country of nationality or their usual country of residence and who are unable or unwilling to return or to seek the protection of that country due to a well-founded fear of being persecuted for reasons of race, religion, nationality, political opinion, membership of a particular social group, and among other things, are not war criminals or people who have committed serious non-political crimes.  

2. ASYLUM SEEKER:
An asylum seeker is a person who has left their country of origin, has applied for recognition as a refugee in another country, and is awaiting a decision on their application. The UNHCR acknowledges the right of every individual to seek asylum.

3. INTERNALLY DISPLACED PERSON:
An Internally Displaced Person (IDP) may have been forced to flee their home for the same reasons as a refugee, but has not crossed an internationally recognised border. Many IDPs are in refugee-like situations and face the same problems as refugees.

4. UNACCOMPANIED MINOR:
UNHCR and UNICEF define unaccompanied minors as those children and young people under the age of 18 years who have been separated from both parents and who are not being cared for by an adult who, by law or by custom, is responsible for doing so.

5. VISA OVERSTAYER:
Visa overstayers are people suspected of remaining in the Australian community unlawfully after their temporary visa expires.

Entitlement of Protection Visa applicants

In New Zealand, refugees and asylum seekers have access to the full range of publicly funded health and disability services. This is in contrast to the Australian context, where the entitlements of the various visa holders are extremely complex (see Appendix 2). The manner of arrival and time taken to apply for refugee status (whether within 45 days of arrival) is a key factor in determining entitlements and access to services in Australia. This is despite international law (to which Australia and New Zealand are signatories) that states that no refugee applicant is “illegal”, and all should be entitled to equivalent services. Some asylum seekers are ineligible for Medicare, have limited entitlements and are not permitted to work, resulting in negative impacts on their physical and mental health. In Australia, many refugees and asylum seekers have been forcibly detained, often for prolonged periods, while their asylum claims are being processed. The adverse impact of immigration detention on the well-being of children and young people has been well documented.

Access to the full range of public health care services is dependent on visa category in Australia. (Table 2) Even where refugees have entitlements to all aspects of health care, the availability of health services varies across Australia, as further outlined in chapter 5.
Table 2: Access to health care for various refugee visa categories

<table>
<thead>
<tr>
<th></th>
<th>Refugees (PPV holders)</th>
<th>TPV holders</th>
<th>Asylum seekers – living in the community</th>
<th>Asylum seekers – housed in detention centres</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>YES</td>
<td>YES</td>
<td>1/3 have access</td>
<td>N/A</td>
</tr>
<tr>
<td>Pharmaceutical Benefits Scheme</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
<tr>
<td>Telephone Interpreter Service</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>YES *</td>
</tr>
<tr>
<td>Commonwealth programs eg hearing screening</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Public Dental Service</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Notes:*level of utilisation by staff unknown

Pathway for Refugee Entrants to Australia and New Zealand

In New Zealand, visa categories and the pathway to being granted refugee status are less complex than in Australia. Most asylum seekers are granted visitor’s visas while their applications are being processed. The Temporary Protection Visa category does not exist. Most of what follows applies to Australia.

In Australia, the Humanitarian Program comprises two components: (1) offshore resettlement for people in humanitarian need overseas; and (2) onshore protection for those people already in Australia who arrived on temporary visas or in an “unauthorised manner” (such as by boat), and who claim Australia’s protection.

Offshore resettlement

The pathway for offshore resettlement for people in humanitarian need entering Australia and New Zealand is outlined in Appendix 1. People in exile overseas who are granted refugee status by the UNHCR may be resettled in certain countries negotiated by the UN. Others are proposed by individuals or groups in Australia or New Zealand. If character and medical check criteria are met, they are granted a permanent visa and flown to Australia or New Zealand. In Australia, they are usually met at the airport by Department of Immigration funded services workers or by their proposer. The Department of Immigration contract requires service staff to assist with Medicare enrolment and link refugee entrants with local health providers.

The offshore resettlement program can result in the granting of either permanent or temporary protection visas. The permanent humanitarian visa categories are:

1. Refugee visa category for people who are subject to persecution in their home country and who are in need of resettlement. The majority of applicants considered under this
category are identified by the United Nations High Commissioner for Refugees (UNHCR) and subsequently referred by UNHCR to Australia or New Zealand.

2. **Special Humanitarian Program (SHP)** for people outside their home country who are subject to substantial discrimination (amounting to gross violation of human rights) in their home country. The application must be sponsored by an Australian or New Zealand citizen or permanent resident, or an organisation based in either country. They usually settle in places where the sponsors reside and are less easily traced or offered refugee health services.

The offshore temporary humanitarian visas are for people who have by-passed or abandoned effective protection in another country en route to Australia, and for whom humanitarian entry to Australia is appropriate. It comprises two sub-categories (subclass 447 and 451 visa) with various conditions and entitlements, including access to Medicare benefits, Maternity Allowance and Maternity Immunisation Allowance.

**Onshore resettlement**

Onshore resettlement offers protection to people already in Australia who apply for refugee status and are found to meet the definition of refugee. Two types of visas may be granted:

1. **Permanent Protection Visas (PPV)** are granted if applicants arrive with a valid visa to Australia and are found to be entitled to protection.

2. **Temporary Protection Visas (TPV)** are granted if applicants arrive in an “unauthorised manner” to Australia and are found to be entitled to protection. Currently they provide temporary residence for three years.

After 3 years, TPV holders who are still in need of protection can apply for a further Protection Visa. Access to a permanent visa is dependent on an ongoing need for protection, and whether or not the person has had access to effective protection in another country en route to Australia.
4. Underlying Principles

1. A Human Rights Issue

*Everyone has the right to seek and enjoy in other countries asylum from persecution.*
Article 14, Universal Declaration of Human Rights (signed by member countries in 1948, including Australia and New Zealand).³⁹

Refugee children have the same rights to health care, education and safety as do other children in Australia and New Zealand. These rights are not always supported by the current policies and there are many examples of human rights violations occurring in the Australasian context.

The principle of equity in health, which focuses on reducing health disparities, is pertinent as refugee children (like other sub-populations of children) have greater health and social-emotional needs, and therefore have greater requirements for care and services than the general population. This increased need is not reflected in the way services are currently delivered. Services for refugees tend to be fragmented, reactive, non-government organisation-funded,¹³ and reliant on the development of services by interested individuals, as opposed to systematically provided, co-ordinated long-term services.

One of the key documents providing guidance on meeting the health needs of refugee children is the UN Convention on the Rights of the Child (1989). Article 3 states that on all actions concerning children, the best interests of the child shall be the primary consideration. Article 39 states that a child “victim of...torture or any form of cruel or degrading treatment or punishment, or armed conflicts” has a right to “physical and psychological recovery, and social integration”. Health services and health professionals have a responsibility to meet the needs of children as far as possible, and to ensure that adverse legislation and economic and resource barriers do not impede the provision of humane and appropriate care.

2. Social Justice

Refugee children and their families have frequently experienced multiple relocations, prolonged periods in refugee camps and detention centres, loss of family members, cultural dislocation, inadequate access to health, education and other services, and often torture. They are seeking protection from Australia and New Zealand; the United Nations High Commissioner for Refugees recommends that “effective protection and assistance should be delivered...in a systematic, comprehensive and integrated manner”.

3. Access and Equity

Access by refugees to appropriate health assessment and care after arrival is often limited by cultural, language or financial constraints.⁴¹⁴² Financial constraints can be prohibitive, especially in accessing medication, specialists and therapists. Additional barriers to access for refugee families have been extensively described, and include: (i) parents usually prioritise settling their children in an educational setting over addressing health issues if they appear well; (ii) children’s own health needs may not be addressed in consultations as they frequently act as interpreters for their parents; and (iii) transport problems.⁷²⁰ As with other migrant groups, the diversity of options and lack of co-ordination results in confusion and
impedes access. Many refugees have a fundamental distrust of government agencies following previous adverse experiences, such as imprisonment or torture. Refugee families are not proactively contacted by generic health care providers as they may not be on public registers (such as Australian Childhood Immunisation Register) unless entered at the first encounter. As indicated earlier, asylum seekers may not have access to Medicare.

4. Health as Holistic Care

The health status of children and their families is only partly dependent on health services and is strongly affected by other factors such as family wellbeing, education, housing, employment and community acceptance. Integration into the community and ongoing support during the settling-in period has been shown to be helpful in producing better health outcomes in refugee children and youth. This requires a co-ordinated whole-of-government approach with a range of agencies involved. Refugee communities should be assisted in implementing community development and early childhood programs known to be effective in improving social capital and child health outcomes.

5. Early Intervention and Cost Benefit

There is growing international evidence that interventions in early childhood that focus on good quality early childhood care and education have beneficial effects on the social and emotional development of children, and lead to improved resilience, academic achievement and mental health. Investing in children’s health has been shown to produce sound economic benefits. There is good evidence that preventive immunisation represents a cost saving to the health service in Australia, especially for measles immunisation. Early detection and treatment of infectious diseases, such as tuberculosis and malaria, are cost effective in immigrants from high prevalence countries. It is highly likely that early comprehensive medical assessment of refugee children and young people, and rapid identification of their needs, will produce better health outcomes and will be cost effective. The provision of programs addressing malnutrition, literacy, facilitating the entry of older children and adolescents into the educational system and early identification of learning difficulties is also important.


One of the most notable barriers to accessing appropriate care is communication with health providers. Apart from the language discordance between practitioner and patient, there may be cultural differences in communication styles, differing expectations of the clinical encounter, cultural beliefs about illness causation and management, and views about gender roles, customs and practices. Refugee families may have difficulty in exploring or acknowledging sensitive health issues such as sexual abuse, sexually transmitted disease, domestic violence, alcohol or substance abuse and mental health issues.

5. Resilience

Studies that have looked into the outcomes of refugee children have documented the benefits of early intervention and early disease identification and management. Intensive support early after arrival appears to be highly beneficial. In one of the few longitudinal studies, Sudanese refugee youths placed in foster care in the USA (who had arrived unaccompanied and were particularly vulnerable) were given considerable support, and followed up for 12-18 months after resettlement. Youth and foster parents received financial assistance and
services as well as home visits by agency caseworkers. The youth also received group education, tutoring, social activities with Sudanese and American peers, and access to a youth recreation centre. Overall, the youth experienced considerable success 12-18 months after resettlement, with 98 per cent attending school, 95 per cent reporting they had someone to help them solve problems, 93 per cent belonging to a church, and 68 per cent talking regularly to someone about their feelings.

Studies of risk and resilience are particularly important in understanding refugee children and young people. Resilience is a term used to explain the phenomena of how children defy expectation by developing into well-adapted individuals despite challenging or threatening circumstances. It refers to the interaction of risk factors and protective factors and the ability of a child to recover from or adjust to misfortune and change. The central axiom that emerges from the literature is that risk accumulates, opportunities ameliorate. Refugee children have experienced many of the risk factors for adverse outcomes, often simultaneously; these have cumulative effects over time. However, anecdotal reports on the resilience of refugee children abound; many children are highly adaptable and able to adjust. Factors critical to the promotion of resilience in children and young people include ‘feeling loved and connected to family’ and ‘feeling connected to peers and school’. Child health workers have a role in advocating for the provision of favourable circumstances in order for refugee children to develop resilience.
5. Refugee Health Services

Public health principles recognise the need to plan health services to meet the needs of specific sub-groups within populations. Whilst the literature on health service delivery for refugees in resettlement countries highlights some useful principles and approaches, it does not provide high quality evidence; further research is required. Modelling of health care costs using different models of service delivery and their relative cost-effectiveness is also of importance. This chapter deals with current service provision in Australia and New Zealand and highlights a range of considerations that may be useful in planning health service delivery for refugee populations.


The majority of health care for refugees, including children, occurs within mainstream health systems. However, targeting recently arrived refugees occurs in some contexts. This is most marked in New Zealand, where newly arrived refugees spend six weeks at a reception centre at which early settlement services, including health assessment and initial care, are provided. In New Zealand those entering under family reunification and asylum seekers are encouraged to undergo health screening. Services for refugees settling in Australia vary between jurisdictions (and within them), and the country lacks a systematic, co-ordinated approach to the flow of refugees through the health system. The proportion of refugees who are offered comprehensive health assessments after arrival varies considerably across Australia. In addition, services are seldom protected by dedicated funding and may be required to compete for funds to sustain essential services.

Health assessments for newly arrived refugees take place in Australia and New Zealand in the following settings:

- Screening clinics based in specialised children’s hospitals, focusing on disease detection and preventive health care (e.g. Children’s Hospitals in Sydney, Newcastle, Perth and Melbourne).
- Refugee clinics (for screening and/or specialist referral) run by mainstream health services, based either in hospitals or community health centres (Western Australia, Tasmania, Queensland, and rural/regional New South Wales).
- Family-centred assessment clinics run by specialised refugee/migrant health services (e.g. Sydney, Adelaide).
- Medical services based with local Torture and Trauma Services (ACT).
- GPs in private practice (Victoria, Northern Territory) or community health centres (Victoria), assisted in the latter case by nurse practitioners and/or case managers (Victoria).
- A refugee reception centre in Auckland, New Zealand where a range of activities to assist early settlement, including health assessments, are provided in the one location.

For psychological health assessment and care, each state and territory in Australia has a specialised refugee torture and trauma service, catering for both adults and children (see Appendix 3).
Most of the services listed above offer assistance to both refugees and asylum seekers (those in the process of applying for refugee status) living in the community, some of whom do not have public health insurance. Alternatively, care is provided to asylum seeker children and adults through networks of volunteer health professionals, but coverage is incomplete.


A comprehensive initial health assessment for newly arrived refugee children is considered beneficial.\textsuperscript{12,25,61} This can be provided in a range of settings and using various service delivery models.

Key considerations in health care delivery are the advantages and disadvantages of:

(i) mainstream as opposed to targeted care specifically for refugees;
(ii) child centred, adult-centred or family-focused services;
(iii) community-based as compared with tertiary service locations; and,
(iv) public-funded clinics versus assessments in the private sector.

Mainstream or targeted

Services developed specifically to address the needs of refugees have advantages in the staff and expertise offered, coordination with referral agencies and specialist services, and the possibility of collecting data to inform service development. However, they have the disadvantage of being resource intensive, possibly reliant on short term funding and at risk of being unsustainable. On the other hand, mainstream services may lack the flexibility and expertise required to manage the high levels of need seen in newly arrived refugees and it may be difficult to develop a coordinated and comprehensive approach (Table 3). Close linkages between refugee-specific and mainstream health services are required, as refugees may move between these services for different health needs. All current dedicated refugee services in Australia and New Zealand offer short- to medium-term care with the aim of integrating refugees into the mainstream.

A model of targeted, multidisciplinary health teams providing assessment and care is used in Auckland, New Zealand and some North American settings.\textsuperscript{62,63} Health teams are co-located with workers who provide employment, welfare and language services for new arrivals, thereby providing a “one-stop shop” capable of addressing multiple issues at any visit. These services can be supported with transport assistance by volunteers, on-site interpreters, health education initiatives and outreach programs (such as home visiting) to improve accessibility.
### Table 3: Characteristics of targeted as compared with mainstream services

<table>
<thead>
<tr>
<th></th>
<th>Targeted</th>
<th>Mainstream</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expertise</strong></td>
<td>Staff are highly skilled, with experience in refugee health.</td>
<td>The skill base is more generic and variable in relation to refugee issues. This may be partly overcome by training.</td>
</tr>
<tr>
<td><strong>Nature of assessments</strong></td>
<td>Assessments are more likely to be comprehensive, including preventive activities.</td>
<td>Appropriate assessment and investigations may be difficult in GP context unless GPs have received specific training on the health needs of refugees.</td>
</tr>
<tr>
<td><strong>Resources</strong></td>
<td>This is a resource intensive model (with healthcare interpreters, bicultural workers, and multi-disciplinary teams) to provide holistic care.</td>
<td>The specific resources required are difficult to access (e.g. community development workers, interpreters, refugee health workers) and may result in multiple referrals and fragmentation of care. Services are competing with other interest groups to harness resources. In Australia, a specific Medicare item number is available to fund comprehensive refugee health assessments by GPs – this item is not available for services provided by specialists.</td>
</tr>
<tr>
<td><strong>Data collation</strong></td>
<td>Ability to acquire refugee-specific data to inform services.</td>
<td>Reduced capacity to acquire and collate refugee-specific data; few routine data collection systems identify refugees.</td>
</tr>
<tr>
<td><strong>Management support</strong></td>
<td>Frequently lack infrastructure support, are required to develop their own policies and procedures, and have consistent pressure to compete for funding.</td>
<td>Generic infrastructure support is generally available, but service delivery may require considerable organisational change to respond flexibly and appropriately to refugee needs.</td>
</tr>
</tbody>
</table>

Source: Adapted from Finney, Lamb & Smith

**Child-centred, adult-centred or family-focussed**

Services may target children or adults specifically, or offer care to the family as a whole. Whilst the family-focussed model is likely to be most convenient for families, it is often difficult to provide in hospital settings. Services targeting refugee children alone have noted that accompanying family members often have obvious health needs that cannot be addressed and require subsequent referral. For example, Vitamin D deficiency is a common finding in young infants of breast-feeding mothers. Paediatric services can manage the infant, but are often constrained in managing the mother’s likely Vitamin D deficiency.

**Community based primary care or tertiary care**

Whilst many refugee children have problems common in childhood that are frequently seen in primary care settings, some will present with conditions unfamiliar to Australian clinicians.
and will require specialised services or expert advice to their primary carer. Screening of children for occult disease acquired in countries of origin and transit also requires knowledge of disease epidemiology in those countries. However, there is expert consensus that efficient, timely integration of refugee children into mainstream primary health care is important for continuity of care and accessibility. Concerns exist about centralised service provision in tertiary referral hospitals, particularly due to transport and access difficulties for refugees settled in rural and regional areas of Australia.

Public or private
Public-private partnerships are used for health screening of refugees in some settings. There are current partnership models in Australia (Newcastle and Coffs Harbour), where GPs are funded by Medicare to provide care within a hospital-based clinic setting. The HIC recently released a new Medicare item number in Australia to promote comprehensive assessments of newly arrived refugees by general practitioners. However, a number of challenges remain for GPs providing care to a client group with complex problems and high levels of need. Whilst free interpreters are available in Australia, many GPs (and specialists) appear reluctant to use them.

Decisions about the best model of care will depend on a range of factors, including population numbers, geographic dispersal, existing infrastructure, political aspects and funding. It has been proposed that certain characteristics of the target group, such as their health literacy levels will determine the most appropriate service model to match their needs. The more complex the needs of the group, the harder it may be for mainstream services to meet those needs. Settlement agencies should consider the specific refugee population’s health needs when making decisions about their place of settlement (i.e. regional or metropolitan areas) as this has implications for availability of services.

Within any particular jurisdiction, it is likely that a mix of service models is likely to be needed to meet the health needs of refugee populations. Whatever the model, there should be timely and comprehensive assessment of all refugees and asylum seekers, with clear pathways for referral and management.

As a general principle, services provision in refugee populations should occur within a human rights framework that affirms the dignity of clients, and respects their right to informed consent and choice regarding health care. At a practical level, services should offer the use of professional interpreters (who are preferably health-trained). Specifically, it is not appropriate to use children as interpreters. Suitable training and professional support of staff working with refugee children develops staff skills and prevents burn-out. Case workers and/or volunteers play an important role by assisting refugees to negotiate the complex health system, attend appointments and access their entitlements. The provision of hand-held health records to refugee clients is a useful tool to provide communication between service providers. Service providers should inform themselves of the State-funded services and other refugee agencies offering care to this population.
6. Refugee Health – Clinical Considerations

This chapter addresses the general principles of management in dealing with refugee children, as well as the health screening that may have occurred prior to their arrival in Australia or New Zealand. It does not aim to be a clinical guideline recommending specific investigations and treatment options. Such clinical guidelines are available; the most recent consensus document produced in Australia can be accessed via http://health.gov.au/internet/wcms/publishing.nsf/Content/cda-cdi29041.htm

Pre-departure assessment and treatment

Prior to arriving in Australia or New Zealand, refugees have often spent prolonged periods of time in refugee camps and in transit. In refugee camps, the provision of basic safety, adequate nutrition and health care is variable.

Both the Australian and New Zealand governments aim to provide basic health screening for accepted refugees prior to departure. However, screening is limited in scope and not all refugees and asylum seekers in Australia and New Zealand have been screened, including those arriving without prior acceptance as refugees (onshore asylum seekers).

The pre-departure screening generally includes an assessment of fitness to travel, and may include screening for malaria and tuberculosis, a chest X-ray in children over 11 years and HIV testing in those over 15 years. As required, treatment for malaria and intestinal helminths is administered. The programmes are coordinated by the International Office of Migration (IOM) on behalf of governments of resettlement countries. Some region-specific protocols have been developed.

Notably, children are not required to be fully immunised prior to departure. The health and cost-benefits of these pre-departure interventions remain unproven.

In practice, pre-departure interventions and their documentation may be incomplete. Severe disease is possible even in those who have reportedly received appropriate treatment and health providers need to remain vigilant for life-threatening illnesses such as malaria and sickle-cell disease, irrespective of reported pre-departure management. It is important to recognise that prior off-shore health interventions do not remove the necessity for a timely and comprehensive health assessment on arrival, as the health status of refugee children may deteriorate in the period following resettlement.

Initial Assessment

General issues: overall approach, guardianship, confidentiality and consent:
The initial health assessment should have a structured approach, initially identifying acute, potentially severe conditions, such as infectious diseases, severe psychopathology, haemoglobinopathies and nutritional deficiencies. The management of chronic conditions including psychological morbidity and developmental issues should also be addressed, either initially or subsequently as appropriate. A thorough history and examination is essential.

Sensitivity to cultural and gender issues is important to optimise continuity of care. Rapport should be established before exploring potentially difficult issues directly related to the
refugee experience. Since many children have lost family members to violence or disease, it is important to establish who is attending the consultation and their biological relationship with the refugee child. This is of particular importance when seeking consent for investigations or treatment, which should be obtained from the legal guardian.

It is essential to inform families that maintaining doctor-patient confidentiality is the norm. Although on-site interpreters have many advantages, it may be more appropriate in small refugee communities to use state telephone interpreters to maintain confidentiality. It is helpful to explain the purpose of the consultation as refugees’ previous interactions with health professionals may have been limited, or may have occurred in the context of torture.

Although many issues in refugee health are generic, some understanding of the disease epidemiology of the countries of origin and transit (where most refugee children have grown up) is helpful. For example, Vitamin D deficiency is highly prevalent in Sudanese refugees who have lived in Egypt, because of severe lack of sunlight exposure.

Unless medically indicated, hospital admission of the newly resettled refugee child should be avoided as it is disruptive for families. However, it is important that families know how to access immediate medical assistance and have the resources to do so.

Many health interventions in resettled refugees lack an evidence base. However, there is good evidence for the cost-effectiveness of immunisation and early detection and treatment of infectious disease. Expert consensus exists regarding both the need for a comprehensive health assessment and the efficient integration of refugees into mainstream primary care. Generic guidelines for health assessments in refugee adults and children have been developed. However, there are virtually no prospective data addressing the appropriate and effective management of the health needs of resettled refugees. Clinically-orientated research in refugee health that will inform policy and practice is therefore a high priority.

**Specific Health Issues:**

**Nutrition**

Nutritional deficiencies prior to resettlement may be compounded by gastrointestinal infections, a lack of access to appropriate foods, nutritional deficiencies in breast-feeding women and weaning practices. Community groups and child health nurses are important resources for ensuring appropriate nutrition information and access to appropriate foods. Serial growth measurements are useful, and markedly abnormal growth parameters can be identified despite inaccurate records of dates of birth of some refugees. *Iron deficiency* is highly prevalent and anaemia may be severe. In infants it is often exacerbated by over-reliance on cow’s milk and in some cultures by drinking black tea, which chelates iron. *Vitamin D deficiency* is common, with 40 per cent of refugees from East Africa affected, and may present with hypocalcaemic seizures, tetany and rickets. Bone chemistry and alkaline phosphatase are poorly predictive of Vitamin D status, which should be measured directly. Anti-tuberculous medication inhibits Vitamin D metabolism and may worsen deficiency. Management of Vitamin D deficient breastfed infants should address the nutritional status of their mothers.71

**Infectious Diseases and Immunisation**

The initial health assessment should identify and manage important infectious diseases in refugee children. Screening for specific infections within Australia and New Zealand is highly variable. In a recent study from Melbourne, only one third of African patients
presenting to GPs were screened for tuberculosis, and one third for malaria. Emphasis should be given to potentially life-threatening infections, such as malaria, which should be excluded in all febrile refugee children from endemic areas regardless of pre-departure testing or prior treatment. Tuberculosis (both latent infection and active disease) is commonly encountered, but diagnostic tests lack sensitivity in young children. Empiric treatment of helminths may be warranted, as these are extremely prevalent and a single diagnostic stool sample is insensitive and expensive. Gastro-intestinal infections, such as schistosomiasis and strongyloidiosis, should be specifically sought. In contrast to adult refugees, pre-departure testing for blood born viruses (viral hepatitis and HIV) is not mandatory in children. Such testing should be performed following informed consent and counselling, which may include explanation regarding the availability of treatment and reassurance that a positive result does not alter visa status.

Many refugee children have received some immunisations in refugee camps, but high proportions (around 56 per cent for measles) have been found to be non-immune to common vaccine-preventable disease. There is poor correlation between immunisation history, written documentation and serology. It may be necessary to start refugees on an appropriate immunisation catch-up program. Refugee families are eligible for the Immunisation Allowance if children are fully immunised before two years of age.

**Mental health**
A refugee, by definition under the UN Convention for Refugees, has a genuine fear of persecution and many have suffered extreme violence, even within refugee camps. As many as 40 per cent of refugees have experienced or witnessed high levels of trauma and violence. Refugee children and adolescents are at high risk of depression, anxiety, suicidality, post-traumatic stress disorder (PTSD); detention of refugee children following arrival in Australia worsens their mental health. The prevalence of PTSD in refugees is high, but there are few validated tools for its identification in children. Symptoms may include nightmares and insomnia, enuresis, flashbacks, inability to concentrate and depression. These symptoms should be specifically sought when taking a history. All states and territories have dedicated services to manage psychological distress in refugees (see Appendix 3).

**Behaviour and Development**
Refugee children are vulnerable to developmental disabilities due to a combination of biological, environmental, social and emotional factors. There are no prevalence data, but developmental and behavioural issues appear to be more common in refugee children than in children born in Australia and New Zealand, and tend to become evident several months after arrival. Refugee children may not have had access to newborn screening programs, such as thyroid function testing and newborn hearing screening. Early identification and appropriate intervention maximises the chances of refugee children achieving their full potential, but the optimal developmental assessment tools and timing of assessment post-arrival remain unclear.

**Child Protection and Sexual Violence**
Severe poverty and exposure to violence increase the risk of physical and sexual abuse in refugee children, although data are lacking. Child abuse is prevalent in refugee camps and unaccompanied children are particularly vulnerable. Assessment is complicated by cultural differences in acceptable practice. Female genital mutilation (female circumcision) is widely practised in some African countries, but is illegal in Australia and New Zealand.

**Surgical/Orthopaedic Issues**
Surgical and orthopaedic conditions as a result of illness and physical trauma may be seen in refugees and previous management may have been suboptimal. Para-umbilical hernias are common in Africans and may resolve spontaneously in younger children.

**Dental Health**

Dental disease, including caries, periodontitis and anatomical or post-trauma problems are extremely common in refugee children and are compounded by poor nutrition and lack of access to dental services. Although dental health often receives low priority, it may contribute to poor nutrition and chronic pain post-arrival. Accessing affordable dental care is a major issue for all low-income families, including refugees.

**Adolescent Health**

Refugee youth, and unaccompanied minors in particular, may be at heightened risk of health and psychosocial problems. Unaccompanied youth experience high rates of mental health problems, sexual assault and incomplete immunisation. Issues for female adolescents include rape, sexually transmitted infections, the effects of female genital mutilation (female circumcision) and psychological sequelae of past physical and sexual abuse. On the other hand, a study of Vietnamese unaccompanied refugee minors found no increase in mental health problems compared to their peers, and well-supported unaccompanied minors have been shown to do well.

**Asylum Seekers and Children released from detention**

There is widespread concern that detaining refugee children contributes to psychological morbidity and deteriorating health status. Although there are currently no refugee children in detention within Australia, current legislation does not preclude this and refugee children may still be detained in offshore processing centres. Children released from detention may continue to have psychological sequelae into the long term. For asylum seekers and those on temporary protection visas, insecurity regarding the family’s residency, and lack of access to services may aggravate psychological morbidity.
7. Training

The RACP has recently developed the Professional Qualities Curriculum\(^{81}\), which complements Basic and Advanced Training Curricula. This aims to equip emerging graduates (physicians and paediatricians) with the skills to function effectively within the current and emerging professional, medical and societal contexts. In addition to clinical skills and theoretical knowledge required for competent practice, physicians and paediatricians are required to develop skills, attitudes and behaviours that include the following of relevance to refugee health:

- be able to communicate effectively and sensitively with patients and their families, colleagues and other allied health professionals;
- be aware of, and sensitive to, the special needs of patients from culturally- and linguistically-diverse backgrounds;
- understand and acknowledge the importance of the various socio-economic factors that contribute to illness and vulnerability;
- be able to work within and lead multi-disciplinary team-based approaches to the assessment, management and care of their patients;
- recognise the need for and be able to apply appropriate patient advocacy skills;
- develop the skills required to promote and maintain excellence through actively supporting or participating in research and programs of continuing professional development;
- understand and apply ethical principles in clinical practice and in the conduct of research.

While all nine domains addressed in the Professional Qualities Curriculum (including Communication, Quality and Safety, Teaching and Learning, Clinical Decision-Making, Leadership and Management, and The Broader Context of Health) are essential for quality care for refugee children, those most pertinent are the domains addressing Cultural Competency, Ethics and Health Advocacy. Cultural competency involves a commitment to gaining an understanding of the impact of culture on health outcomes. This includes becoming acquainted with the cultural perception of illness, cultural aspects of family, and cultural attitudes toward death and illness held by patients. Physicians have a responsibility to manage their own development of cultural competency and familiarise themselves with the differing cultures within the community.

The Ethics and Advocacy themes address the ability to apply relevant legislation and ethical frameworks to interactions outside the direct physician-patient relationship. The curriculum states that physicians have an obligation, both as individuals and as a profession, to positively influence the health circumstances of a patient. Opportunities for this may lie outside the immediate clinical context, and may involve advocating for the quality and safety of care for vulnerable patients. Physicians are encouraged within the Curriculum to pro-actively identify and be an advocate for the social, environmental and political factors that impact upon the health and well-being of their patients and the broader community.

The College plays an important role in providing oversight of Basic and Advanced training curricula for Physicians and Paediatricians. These curricula reinforce the importance of the skills and attitudes described above. In addition, the College-run Annual Scientific Meeting provides opportunities for further education in areas related to refugee child health.
8. The Way Forward

The RACP acknowledges the significant health needs of refugee children, young people and their families. The College would like to see an organised and co-ordinated approach that will provide appropriate and accessible services for this population. The RACP considers it important to deliver initial health care to all refugee children and young people soon after their arrival, and to provide an appropriate mix of adequately funded services to meet their needs in the longer term. In addition, since health is impacted upon by access to education, employment, housing and other support, and the RACP proposes multi-agency, whole-of-government approaches to refugee populations.

The needs of refugee children and refugee young people should inform planning for health services at national, state and local levels. Refugee health should be given high priority in budget considerations, in the development of specialised health services, in the availability of interpreters, and in training. The RACP supports the development of multi-agency and whole of government strategies (national and regional) for all of Australia and New Zealand, to address health care as well as educational, welfare and social support for refugee populations. Governments should allocate funding, on a recurring basis, to allow for implementation of the recommendations included in this policy document.

Most asylum seekers and refugees adapt successfully to life in Australia and New Zealand. However, many face extraordinary challenges as a result of government policies and practices. In contrast to a welcoming, supportive environment aimed at building resilience, access to health care is erratic, entitlements are variable, and some are denied rights to both employment and welfare benefits. The RACP supports the provision of multi-agency support early after resettlement and over the long term to ensure that refugee families can optimise their potential in Australian and New Zealand society.

Current legislation in Australia still allows for the detention of children, and there are major differentials in access to services and support for refugees depending on visa category. The RACP challenges the Australian government to effect the legislative and policy changes required to ensure that all people seeking asylum have access to appropriate health care and are afforded the human rights and dignity that international law dictates.

Existing strategies and services which aim to protect and promote the health of refugees have been poorly evaluated to date. The RACP supports dedicated government funding to research best practice, models of care and cost effectiveness such that future service provision can be developed informatively.

The RACP has a major role to play in ensuring that cultural competency and skills in advocacy are fostered at all levels, including trainees and physicians. We look forward to a growth in training opportunities, funded Fellowship programs and learning opportunities in the field of refugee health.

Finally, the development of a culture in Australia and New Zealand where refugees are valued for their skills and diversity, and where politicians and the community at large demonstrate compassion and goodwill would contribute to the health and well-being of the refugee population.
9. Appendices

1. Pathway & health processes for Humanitarian Program entrants to Australia
2. Entitlements of Protection Visa Applicants
3. Resources and Key Agencies in Australia and New Zealand
Appendix 1:  
Pathway and health processes for humanitarian program entrants to Australia

Persons in exile overseas, granted **refugee status** via UNHCR

- **Resettlement** in certain western countries negotiated by UN for those with no other option  
  (Refugee Program)

- Others at risk of violation of human rights, and **proposed** by an individual or group in Australia  
  (Special Humanitarian Program – SHP)

Apply for resettlement in Australia as part of 13,000 annual quota

- Interviewed; must undertake character & medical checks

Proportion of applicants undergo **pre-departure medical screening (PDMS)**, 72 hrs pre-flight

Visa Medical  
(Australian Government pays)
- Medical examination
- Chest X-ray (if 11 years or over)
- HIV test (if 15 years or over)
- Syphilis test (15 years or over, & from a refugee camp)

- This ‘PDMS’ check was introduced mid-2005
- Currently conducted in East & West Africa, Egypt, Sudan & Thailand for refugees & some humanitarian entrants
- IOM doctors perform check of symptoms, order rapid malaria test, intestinal parasite treatment, and MMR vaccine if <30 years
- Recorded on an electronic “Health Manifest” document, and on a patient-held record
- Entrants needing follow-up are identified on the manifest.

Fly to Australian destination. Met at airport by DIAC-funded settlement services worker or by Proposer

Prior to arrival, health manifests (for entrants who undergo PDMS) are emailed to DIAC Canberra. They are forwarded to State and Territory health departments and to local settlement service providers.

Settlement services, other agencies or individuals can make arrangements for new arrivals to attend a GP, refugee health clinic where available, dental clinics etc

- Any refugee **unwell on arrival** is assisted by settlement service (IHSS) providers to receive early medical attention
- The DIMA contract requires IHSS staff to assist with Medicare enrolment and link refugee entrants with local health providers (GPs or refugee/migrant health services)
- ‘Alert’ cases identified on manifests are prioritised
- SHP entrants are assisted by their Proposers to enrol with Medicare and to seek health care as required.

Humanitarian Program entrants (refugee & SHP) are eligible for a psychosocial health assessment by a contracted torture/trauma service. Short term interventions are available where relevant.

Entrants on **Health Undertakings** call a central phone number
Appendix 2:
Entitlements of Protection Visa applicants
The entitlements of protection visa applicants are complex and change frequently. Up to date information is available from the DIAC and HREOC websites.

Visa categories, conditions and entitlements for protection visas

<table>
<thead>
<tr>
<th>Who is eligible?</th>
<th>Temporary Visas</th>
<th>Permanent Visas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asylum seeker arriving in Australia without a valid visa after October 1999. Asylum seeker arriving in Australia with a visa applying for protection after September 2001, and has spent seven days in a country where he or she could have obtained effective protection.</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>Asylum seeker arriving at an 'excised offshore place' or intercepted in Australian waters without a valid visa, after September 2001.</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>Asylum seeker applying after September 2001 who has not entered Australian territory and has not spent seven days in a country where he or she could have obtained effective protection. May have been intercepted in international waters.</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>Asylum seeker arriving in Australia with a valid visa.</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>Asylum seeker who has applied from overseas for protection in Australia.</td>
<td>No.</td>
<td>No.</td>
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</table>

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<tr>
<th>Automatic right to visa if meet criteria?</th>
<th>Temporary Visas</th>
<th>Permanent Visas</th>
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</thead>
<tbody>
<tr>
<td>Yes, as long as pass security and health checks.</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>No.</td>
<td>No.</td>
<td>Yes.</td>
</tr>
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<td>No.</td>
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<tr>
<th>Detention during processing?</th>
<th>Temporary Visas</th>
<th>Permanent Visas</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>No.</td>
<td>No.</td>
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<table>
<thead>
<tr>
<th>Release from detention if found to be a refugee?</th>
<th>Temporary Visas</th>
<th>Permanent Visas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, as soon as pass security and health checks.</td>
<td>No. Must wait for Australia or another country to grant a visa.</td>
<td>No. Must wait for Australia or another country to grant a visa.</td>
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<td>No.</td>
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<th>Visa duration?</th>
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<th>Permanent Visas</th>
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<tr>
<th>Further visas available on expiry of visa? current</th>
<th>Temporary Visas</th>
<th>Permanent Visas</th>
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</thead>
<tbody>
<tr>
<td>After September 2001, only eligible for consideration for a permanent protection visa if, since leaving their home country, the applicant has not resided for more</td>
<td>Only eligible to apply for a further TPV unless the Minister exercises discretion to permit application for a PPV.</td>
<td>Eligible to apply for a PPV.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th></th>
<th>Temporary Visas</th>
<th>Permanent Visas</th>
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<tbody>
<tr>
<td><strong>Temporary Protection Visa 785</strong></td>
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<tr>
<td>(Onshore unauthorised arrivals)</td>
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<tr>
<td><strong>Secondary Movement Offshore Entry</strong></td>
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<tr>
<td>Visa 447 (Temporary)</td>
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<td><strong>Secondary Movement Relocation</strong></td>
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<td>Visa 451 (Temporary)</td>
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<tr>
<td><strong>Permanent Protection Visa 866</strong></td>
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<tr>
<td>(Onshore authorised arrivals)</td>
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<tr>
<td><strong>Humanitarian Visas 200-204</strong></td>
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<tr>
<td>(Offshore)</td>
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</tbody>
</table>

than seven days in a country where they could have sought and obtained effective protection, unless the Minister exercises discretion to permit application for a PPV. Otherwise only eligible for successive TPVs.

**Right to family reunion?**

- Temporary Visas: No.
- Permanent Visas: Yes.

**Travel outside Australia?**

- Temporary Visas: Single entry visa. May depart Australia but have no automatic right of return.
- Permanent Visas: Yes. Able to leave Australia and return without jeopardising visa.

Source: HREOC
Appendix 3:
Websites of Key Agencies in Australia and New Zealand

AUSTRALIA

Edmund Rice Centre for Justice and Community Education
www.erc.org.au

NSW Refugee Health Service
www.refugeehealth.org.au

The Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) (a coalition of agencies that respond to the needs of survivors of torture and trauma who have come to Australia from overseas). There is an agency in each state and territory of Australia (listed below).

Western Australia: Association for Services to Torture and Trauma Survivors
www.asetts.org.au

ACT: Companion House
http://www.companionhouse.org.au/

Tasmania: Phoenix Support Service for Survivors of Torture and Trauma

Queensland Program of Assistance to Survivors of Torture and Trauma
www.qpastt.org.au

NSW: Service for the Treatment and Rehabilitation of Torture and Trauma Survivors in New South Wales
www.startts.org

South Australia: Survivors of Torture and Trauma Assistance and Rehabilitation Service in South Australia
www.sttars.org.au

Northern Territory: Melaleuca Refugee Centre (Torture and Trauma Survivors Service of the Northern Territory)
admin@melaleuca.org.au (Email)

Victorian Foundation for Survivors of Torture
www.foundationhouse.org.au

Refugee Council of Australia
http://www.refugeecouncil.org.au/

**Federation of Ethnic Communities Councils of Australia Inc (FECCA)** (national body which advocates for the rights and entitlements of Australians from diverse cultural and linguistic backgrounds).

**Human Rights and Equal Opportunity Commission**

**Refugee Review Tribunal (RRT)**
www.rrt.gov.au/

AUSTCARE
www.austcare.org.au/

The Australian Trauma Web
http://www.swin.edu.au/bioscieleceng/neuropsych/ptsd/

Australian Transcultural Mental Health Network
http://www.austehc.unimelb.edu.au/asaw/biogs/A002027b.htm

Royal Australasian College of General Practitioners (RACGP)

Royal Australasian and New Zealand College of Psychiatrists (RANZCP)
http://www.ranzcp.org/

University of New South Wales Centre for Refugee Research
www.crr.unsw.edu.au/

La Trobe University Refugee Health Research Centre

NEW ZEALAND

www.moh.govt.nz/moh.nsf/49ba80e00757b8804c256673001d47d0/d85ce7ed090f4aa4cc256b05007d7cb?OpenDocument

Refugee Council of New Zealand
www.supportfind.com/rcnz/

New Zealand Refugee Law
www.refugee.org.nz

Refugee Status Appeals Authority
www.nzrefugeecases.govt.nz

RMS Refugee Resettlement
www.rms.org.nz

Auckland Refugee Council
www.supportfind.com/arci/index.htm

Auckland Regional Public Health Service—refugee health
www.refugeehealth.govt.nz

Refugees as Survivors New Zealand
www.aucklandras.org.nz
10. References


36 Harris MF, Telfer BL. The health needs of asylum seekers living in the community. *MJA* 2001; 175:589-592.


Gilbert E. Female genital mutilation Information for Australian health professionals. RANZCOG 1997


