

Refugee Health Plan 2011-2016

Summary The NSW Refugee Health Plan (2011-2016) is the statewide plan for improving the health and well-being of refugees and people with refugee-like experiences who have settled in New South Wales. This Plan seeks to ensure the delivery of safe, high quality services to refugees through both refugee-specific health services and through accessible, culturally and linguistically competent mainstream health services. The Plan identifies a range of strategies designed to improve refugee and asylum seeker health and well-being.

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Branch contact 9424 5764

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Audience All staff of NSW Health

NSW REFUGEE HEALTH PLAN 2011-2016

PURPOSE

The *NSW Refugee Health Plan 2011 – 2016* is the state-wide plan for improving the health and wellbeing of refugees and people with refugee-like experiences who have settled in New South Wales. This Plan seeks to ensure the delivery of safe, high quality services to refugees through both refugee-specific health services and through accessible, culturally and linguistically competent mainstream health services. The Plan identifies a range of strategies designed to improve refugee and asylum seeker health and wellbeing.

MANDATORY REQUIREMENTS

Mandatory actions under the *NSW Refugee Health Plan 2011 – 2016* are required across the following eight strategic priorities:

1. To develop health policies and plans which prioritise and are inclusive of refugee health
2. To ensure, in collaboration with General Practitioners and other partners, universal access to health assessment and assertive follow-up for all newly arrived refugee and humanitarian entrants
3. To promote refugee health and wellbeing
4. To provide high quality specialised refugee health services
5. To develop specific targeted responses to refugee need within mainstream services
6. To foster the provision of high quality mainstream care to refugees
7. To foster research and evaluation relevant to the health of refugees
8. To monitor and evaluate the *NSW Refugee Health Plan 2011 – 2016*

Each of the actions has been carefully devised so as to be measurable, action-oriented and feasible. The mandatory actions required of Local Health Networks in implementing the *NSW Refugee Health Plan 2011 – 2016* are listed in the implementation section below.

IMPLEMENTATION

The Department of Health will monitor and provide policy support and guidance to Local Health Networks in implementing the following actions under the *NSW Refugee Health Plan 2011 – 2016*.

Local Health Networks will implement all thirty one strategic actions (including additional sub actions), under the eight strategic priorities as outlined in the *NSW Refugee Health Plan 2011 – 2016*.

The full policy implementation table with actions, responsibilities, indicators, responsibilities and timelines are listed in the *NSW Refugee Health Plan 2011 – 2016* document on page 34.

REVISION HISTORY

Version	Approved by	Amendment notes
February 2011 (PD2011_014)	Deputy Director-General Population Health	Rescinds the 1999 Refugee Health document
1999		1999 Refugee Health document (<i>issued outside the Policy Distribution System</i>)

ATTACHMENTS

1. NSW Refugee Health Plan 2011-2016.

NSW Refugee Health Plan

2011–2016



Health

NSW DEPARTMENT OF HEALTH

73 Miller Street

NORTH SYDNEY NSW 2060

Tel. (02) 9391 9000

Fax. (02) 9391 9101

TTY. (02) 9391 9900

www.health.nsw.gov.au

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Foreword

The health of people arriving in Australia from situations of war, extreme persecution, violence, abuse and abrogation of human rights must remain a clear priority within healthcare. This plan provides a vehicle for addressing the important health issues of this highly vulnerable and diverse population.

This Refugee Health Plan has been developed within the context of international, national and state refugee, multicultural and health plans and legal frameworks. The responsibilities of nations engaged in the resettlement of refugees have been clearly defined by the UNHCR as providing protection and 'access to civil, political, economic, social and cultural rights similar to those enjoyed by nationals' (UNHCR 2004 p.1). Multicultural and diversity policy in Australia and NSW further affirms the right to respect and non-discrimination, cultural and linguistic retention, participation and access to health and human services. Refugees and asylum seekers are priority populations with complex health, social and medical needs.

While it is widely recognised that Australia is now a world leader in refugee resettlement and refugee health service provision, there remain significant areas for improvement and development.

This NSW Refugee Health Plan:

- describes the challenges and health-related issues and needs of refugees and asylum seekers.
- builds upon the achievements of the past ten years in refugee health.
- outlines a feasible and sensible plan for the forthcoming five years.



Dr Greg Stewart

Chair of the NSW Refugee Health Plan
Steering Committee

Executive Summary

The NSW Refugee Health Plan 2011-2016 is the state-wide plan for improving the health and wellbeing of refugees and people with refugee-like experiences who have settled in New South Wales. This Plan seeks to ensure the delivery of safe, high quality services to refugees through refugee-specific health services and through accessible, culturally and linguistically competent mainstream health services. The Plan identifies a range of strategies designed to improve refugee and asylum seeker health and wellbeing.

This second Refugee Health Plan for NSW spans the period 2011-2016. While it concentrates on the needs of newly arrived refugees, including those who have been in Australia up to five years, it recognises that, for many refugees, supportive healthcare services and strategies may be required well beyond that time. This plan seeks to outline the complex needs of refugees and refugee communities and to assess the fit between these needs and the capacity of the available health and human service sectors to respond effectively. It was developed after extensive and comprehensive consultation involving interviews, focus groups, workshops and forums with a wide range of stakeholders.

The plan identifies a number of priority issues. These include the complex medical status of some refugees, immunisation status, emotional and mental health especially related to experiences of torture and trauma, reproductive health, nutrition and food security, oral health, issues associated with preventative health practices and preventative service usage and the importance of social connectedness and community development. Priority refugee populations identified in the plan include families and children, youth, the elderly, asylum seekers and rural and regional settlers.

The plan outlines a model of refugee health care which is based on a commitment to human rights, gender equity and social justice. The model emphasises the importance of early universal assessment and intervention, health promotion, community development, mainstream cultural and linguistic competence, intersectoral co-ordination and human resource development. It affirms the importance of responsive consultation and the involvement of refugees and refugee communities in healthcare planning and delivery.

The plan outlines eight strategic priorities with related strategic actions and indicators. Each of these priority actions has been carefully devised so as to be measurable, action-oriented and feasible. The strategic priorities and related actions are as follows:

STRATEGIC PRIORITY ONE

To develop health policies and plans which prioritise and are inclusive of refugee health.

Strategic Action One: That NSW Health develop a Refugee Health Plan Implementation Group responsible for overseeing the implementation of the NSW Refugee Health Plan.

Strategic Action Two: That each Local Health Network develop an implementation plan for refugee health improvement which is equitable and appropriate to the refugee population and profile and which is consistent with the state plan.

Strategic Action Three: That all relevant NSW and Local Health Network plans consider the special needs of refugees as a target group when devising healthcare plans and policies.

Strategic Action Four: That an annual forum be developed for providers and refugee health policy makers to discuss and inform current policy issues in refugee health.

Strategic Action Five: That refugees or refugee advocates be included in the state-wide Implementation Group and in each Local Health Network's planning and implementation group.

STRATEGIC PRIORITY TWO

To ensure, in collaboration with General Practitioners and other partners, universal access to health assessment and assertive follow-up for all newly arrived refugee and humanitarian entrants.

Strategic Action Six: That the Best Practice Refugee Health Model outlined in this Plan be progressively implemented throughout NSW.

Strategic Action Seven: That STARTTS' role in providing access to early psycho-social assessment and support programs to refugee survivors of torture and trauma be maintained and supported.

Strategic Action Eight: That an operational plan for the provision of specialist refugee health assessment clinics across NSW be developed.

Strategic Action Nine: Through the Divisions of General Practice, that a register of General Practitioners interested in being trained and supported to conduct health assessments and provide ongoing care to refugees, be developed.

Strategic Action Ten: That cultural and refugee health competency training and improvement opportunities for GPs and other providers involved in on-arrival assessment and ongoing care, continue to be provided.

Strategic Action Eleven: That an extended skills post in refugee health be developed collaboratively by a GP Training Provider and the NSW Refugee Health Service to facilitate GP registrar training in refugee health.

STRATEGIC PRIORITY THREE

To promote refugee health and wellbeing.

Strategic Action Twelve: That NSW Health develop a Health Promotion Plan for enhancing the wellbeing of refugees.

Strategic Action Thirteen: That NSW Health and state-wide refugee health services work in collaboration with other government departments and agencies to address the social issues which impact on the health of refugees.

Strategic Action Fourteen: That refugee health services, in collaboration with relevant partners, provide appropriate and up-to-date information to refugee community members about key health issues and available services, including orientation to new arrivals about the health system.

Strategic Action Fifteen: That bilingual community educators (BCEs) be recruited and trained in rural and regional locations (in addition to those already trained in metropolitan areas), as a means of ensuring the availability of personnel able to provide appropriate health education and information to newly arrived refugees.

Strategic Action Sixteen: That refugee social connectedness be recognised as a priority and that a range of strategies be employed to foster such connectedness.

16.1 That RHS, STARTTS, multicultural health, DIAC-funded partners, NGOs and other partners collaborate on health promoting projects to enhance social connectedness.

STRATEGIC PRIORITY FOUR

To provide high quality specialised refugee health services.

Strategic Action Seventeen: That the role of state-wide services such as STARTTS, RHS and others be further supported and developed.

STRATEGIC PRIORITY FIVE

To develop specific targeted responses to refugee need within healthcare services.

Strategic Action Eighteen: That NSW Health continue to support the provision of free and equitable access to hospital services for asylum seekers.

Strategic Action Nineteen: That NSW Health take action to improve the availability and use of professional interpreters:

- 19.1 That NSW Health advocate that DIAC plan for interpreter provision to new communities prior to their migration to Australia.
- 19.2 That the recruitment of new and emerging community interpreters and translators continue to be a priority for health interpreter services.
- 19.3 That technology such as teleconferencing be used to enhance access to professional interpreters, particularly in rural settings.
- 19.4 That ongoing advocacy occur to improve the appropriate access and use of interpreters by private medical practitioners, pharmacists and other healthcare providers.
- 19.5 That advocacy occur to improve the provision of on-site interpreters to private medical practitioners and other providers of healthcare services to refugees.

Strategic Action Twenty: That the special needs of refugees and asylum seekers with mental health problems be considered, particularly through the implementation of refugee-related sections of the NSW Multicultural Mental Health Plan.

Strategic Action Twenty-one: That strategies to address the needs of older refugees, particularly those who are survivors of torture and trauma, be supported.

Strategic Action Twenty-two: That health services facilitate timely access of refugee children to health, developmental and school-based assessments in acknowledgement of their high risk of poor health status and barriers to accessing care.

Strategic Action Twenty-three: That additional actions be undertaken to improve the immunisation status of refugees:

- 23.1 That measures be taken to improve the availability of all vaccines free of charge for catch-up immunisation in refugee children, young people and adults of refugee background.
- 23.2 That opportunistic immunisation by mainstream providers and refugee health clinics be promoted and supported.
- 23.3 That current targeted immunisation programs, such as those conducted in partnership with the Department of Education and Training (DET), be continued, and expanded as required.

Strategic Action Twenty-four: That strategies to address the oral health needs of refugees and asylum seekers be developed:

- 24.1 That a model of care to improve refugee and asylum seeker access to oral health services be developed as a priority. This model should have a focus on early intervention and prevention.
- 24.2 That specific strategies be developed to improve the accessibility of the Early Childhood Oral Health Program to refugee and asylum seeker families.
- 24.3 That refugee-specific dental clinics be developed or enhanced in Local Health Networks with significant refugee populations.
- 24.4 That oral health information and promotion programs continue to be developed.

Strategic Action Twenty-five: That strategies be developed to address issues associated with FGM in refugee communities:

- 25.1 That within Local Health Network refugee health plans, the issue of FGM be canvassed, and that clinical guidelines related to the care and treatment of women affected by FGM, as advised by the NSW Education Program on FGM, be implemented.

- 25.2 That education and support for refugee women and refugee communities where FGM is practised be maintained.
- 25.3 That relevant staff receive training in the care of women affected by FGM.
- 25.4 That the option of developing additional hospital clinic(s) for refugee and other women affected by FGM in NSW be explored, in consultation with the NSW Education Program on FGM.

STRATEGIC PRIORITY SIX

To foster the provision of high quality, accessible mainstream care to refugees.

Strategic Action Twenty-six: That sustained efforts be made in selected mainstream health services to promote accessible and appropriate services for refugees.

Strategic Action Twenty-seven: That education, resources and tools be developed and provided to improve the cultural competency and refugee competency of the NSW healthcare system.

STRATEGIC PRIORITY SEVEN

To foster research and evaluation initiatives pertaining to the health of refugees.

Strategic Action Twenty-eight: That data from refugee health clinics and services across NSW be standardised, collected, analysed and disseminated.

Strategic Action Twenty-nine: That strategies to promote research and evaluation in refugee health in NSW be pursued.

STRATEGIC PRIORITY EIGHT

To monitor and evaluate this plan.

Strategic Action Thirty: That the implementation of this plan take into account the changes in health care structures and systems related to the National Health and Hospital Reform, particularly the development of Local Health Networks and Medicare Locals.

Strategic Action Thirty-one: That progress arising from this plan be reviewed after one year and that the plan be fully reviewed five years after its initial implementation.

Introduction

Background

Since the end of the Second World War, Australia has settled over 685,000 humanitarian entrants, comprising over 10% of the total annual migration intake. It has frequently been noted that these refugees have positively contributed to and enriched Australia's social, cultural and economic fabric (RCOA 2009).

The 1951 *United Nations Convention relating to the Status of Refugees* defines refugees as people who are outside of their country of nationality or habitual residence, and have a well-founded fear of persecution because of their race, religion, nationality, membership of a particular social group or political opinion (UN 1951). The United Nations High Commissioner for Refugees (UNHCR) is currently assisting some 10.5 million refugees. There are over 30 million more people in refugee-like situations being assisted by the United Nations (UNHCR 2009).

Australia is one of about 20 countries that work closely with UNHCR to provide resettlement places to refugees who have been identified as having protection needs that can only be met by moving them away from the country in which they are residing. It is significant to note that Australia currently has the largest per capita resettlement program and for many years has been in the top two (with Canada). The USA has always had the largest numerical resettlement program.

Refugees have fled their country of origin because of persecution. Many have also been exposed to violence, war and civil strife. Some refugees have lived in refugee camps, sometimes for protracted periods and may have experienced malnutrition, high rates of infectious diseases, injuries, stress and trauma (Hale et al 2006). Others have been forced to eke out a precarious existence as 'urban refugees' in countries where their rights may not have been fully respected. All refugees have been traumatised, some have been tortured. They have frequently had poor access to healthcare, although that may be dependent on their country of origin or their country of refuge. Many arrive in Australia with significant health problems which may

require prompt assistance. Others arrive with chronic diseases and illnesses which require more sustained healthcare interventions. Many have limited proficiency in English.

In the past decade, NSW has received over 40,000 refugees, humanitarian entrants and asylum seekers. Asylum seekers are people who have arrived on some form of temporary visa (eg as tourists or students) and have lodged an application for refugee status. Additionally, there are other people who have had refugee-like experiences, some recent, some many years ago, living in NSW. While the focus of this plan is those who are more recently arrived, the plan also recognizes that for some people, the refugee experience may be a defining experience which reverberates throughout their lifetime.

The provision of well organized, accessible and culturally sensitive health and human services is fundamental to successful settlement. Indeed, difficulties encountered during the early settlement period may have a negative effect on long-term health and well-being. Significant stress is associated with forced migration and the re-settlement process.

On-arrival, refugees typically are concentrated in poorly-paid jobs, have low incomes and may at times experience racism, discrimination or barriers associated with language and cultural factors (Murray & Skull 2005). Common settlement challenges encountered by refugees include finding affordable accommodation, acquiring English language skills, finding employment, accessing affordable childcare, enrolling children in school, dealing with changing family structures and social roles, balancing constrained budgets, using public transport, obtaining social support, meeting with members of the community and accessing or understanding health and community information and services. Many refugees have been separated from their family, friends or community and are keen to commence the process of re-uniting. The experience of trauma frequently has a recurring impact on the resettlement experience.

These issues are exacerbated for those who are in the process of seeking refugee status from the Australian government (asylum seekers) (Silove et al 2000; Smith 2001; Silove 2004). Despite recent changes that extended work rights and Medicare eligibility to more asylum seekers, many are still unable to secure employment and, being ineligible for welfare benefits, face financial hardship. This has an impact on their ability to access many healthcare services.

In addition to services which focus on addressing refugee settlement needs, a number of state-wide and area-specific refugee health services have been established in NSW. State-wide services include the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) and the NSW Refugee Health Service (RHS). A number of state-wide multicultural services also focus at times on refugees, including the Transcultural Mental Health Centre (NSW), the NSW Education Program on Female Genital Mutilation (FGM), the NSW Multicultural Health Communication Service, the Multicultural HIV/AIDS and Hepatitis C Service, the Education Centre Against Violence and the Drug and Alcohol Multicultural Education Centre. Local Health Networks providing refugee-specific programs include Hunter New England, South Eastern Sydney, Illawarra Shoalhaven, Mid North Coast, Southern NSW and Northern Sydney. Refugee paediatric clinics have been established by the major children's hospitals and in Liverpool and Fairfield. However, as with the broader community, general practitioners provide the majority of primary medical care for newly arrived and more established refugees.

Despite these services, obtaining access to appropriate health services and health-related information remains difficult for many refugees. Accessing interpreters, using general practitioners, specialists, hospitals and community health services, understanding the way the health system operates, and obtaining information on health issues may be difficult particularly for newly arrived refugees and more so for asylum seekers. Enabling access to timely and appropriate health and medical care for refugees is critical to effective settlement; yet, the health system is unfamiliar to the entrants, can be costly, and may, at times, lack the understanding, service focus or cultural competency required to deal appropriately with their complex and varied needs. Sustainable health improvement, early intervention and prevention strategies are crucial to ensure the long-term well-being of refugees.

The Process of Planning

In 1999 the first plan for Refugee Health in NSW, *The Strategic Directions in Refugee Health Care in NSW* was launched. This plan identified healthcare and health service information, service access, intersectoral collaboration, cultural competency education and improved research into refugee health as the key strategic initiatives. A great many of the initiatives recommended in this strategic plan have been implemented, most notably, on a state-wide basis, the successful establishment of the NSW Refugee Health Service (RHS) and the further development of the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS). This previous plan has been extensively reviewed as part of this planning process. A summary of the review is included at Appendix Two.

Since the strategic directions plan was issued there have been significant changes in national government policies in regard to refugees, major changes in the countries of origin of refugees and many improvements in health and other governmental policies and services. Further, it is timely to broaden the scope of this initial plan. This is particularly pertinent as this plan aims to further address issues associated with health status as well as information and service access issues.

A steering committee comprised of departmental and health service representatives, key refugee health providers and non-government organisations was established to oversee the NSW refugee health planning process. Appendix 1 outlines the membership of the Steering Committee and its sub-committee, the Refugee Health Working Group and the Terms of Reference.

Four background documents were prepared to ensure that the plan was founded on a solid base of both quantitative and qualitative evidence. These four documents include a review of the implementation of the previous refugee health plan, a paper on refugee demography, a comprehensive literature review on refugee health models of care and a paper outlining the outcomes of consultations conducted for the development of the plan.

Planning Principles and Policy Context

Vision: *That the health and wellbeing of people of refugee background living in NSW is improved and protected.*

Principles of this Plan

1. To affirm a strong commitment to human rights, gender equity and social justice.
2. To value and respect refugee resilience, survival and hope for the future.
3. To value cultural, religious and linguistic diversity and recognise the significant cultural, social and economic contribution of refugees to NSW.
4. To affirm the right of refugees as consumers to participate in health service policy, planning and care delivery, to be treated with dignity and respect and to have their privacy respected.
5. To recognise the importance of refugee empowerment and control over their own health and wellbeing.
6. To recognise the right to high quality, accessible, culturally respectful, linguistically appropriate, affordable healthcare services including comprehensive health assessment on arrival, ongoing primary health care and secondary and tertiary services.
7. To emphasise the importance of prevention, health promotion, community development and partnerships as critical for the protection, sustainability and enhancement of refugee health and well-being.

Underpinning these principles are the *NSW Principles of Multiculturalism* stated within the *Community Relations Commission and Principles of Multiculturalism Act* (2000).

The Principles of Multiculturalism	
Principle 1:	the people of New South Wales are of different linguistic, religious, racial and ethnic backgrounds who, either individually or in community with other members of their respective groups, are free to profess, practise and maintain their own linguistic, religious, racial and ethnic heritage.
Principle 2:	all individuals in New South Wales, irrespective of their linguistic, religious, racial and ethnic backgrounds, should demonstrate a unified commitment to Australia, its interests and future and should recognise the importance of shared values governed by the rule of law within a democratic framework.
Principle 3:	all individuals in New South Wales should have the greatest possible opportunity to contribute to, and participate in, all aspects of public life in which they may legally participate.
Principle 4:	all individuals and institutions should respect and make provision for the culture, language and religion of others within an Australian legal and institutional framework where English is the common language.
Principle 5:	all individuals should have the greatest possible opportunity to make use of and participate in relevant activities and programmes provided or administered by the Government of New South Wales.
Principle 6:	all institutions of New South Wales should recognise the linguistic and cultural assets in the population of New South Wales as a valuable resource and promote this resource to maximise the development of the State.

Source: Community Relations Commission and Principles of Multiculturalism Act (2000)

Policy, Planning and Legislative Context

This plan has been developed within the context of a number of international, national, state-wide, health and human service policies, plans and legislation.

Policy	Key Issues
United Nations (UN): Declaration of Human Rights (1948) and Declaration of the Rights of the Child (1959)	<p>The Declaration of Human Rights is a statement of basic human rights and fundamental freedoms owed to all human beings without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status,</p> <p>Article 14.1 states that <i>'Everyone has the right to seek and enjoy in other countries asylum from persecution'</i>.</p> <p>The Declaration of the Rights of the Child is a statement of the fundamental rights of the child. Examples of such rights include love, education, a name, a nationality, protection and relief.</p>
United Nations Convention relating to the Status of Refugees (1951) and the Protocol relating to the Status of Refugees (1967)	<p>The UN Refugee Convention is a legally binding treaty which provides for signatory member states of the UN to provide protection for persons obliged to flee their country because of persecution. Australia ratified the 1951 Convention in 1954 and the 1967 Protocol in 1973. Signatories undertake to provide refugees legal status and appropriate standards of treatment including access to healthcare.</p>
United Nations Convention on the Rights of the Child (UNCRC) (1990)	<p>The UNCRC sets out the civil, political, economic, social and cultural rights of children. The Convention generally defines a child as any human being under the age of eighteen. It is a binding treaty which requires that the best interests of the child be paramount, rather than the interests of the parents/guardian. The two additional optional protocols restrict the involvement of children in military conflicts and prohibit the sale of children, child prostitution and child pornography.</p>
The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) (1979)	<p>CEDAW is a convention based on the equality of men and women, especially focusing on sex-based discrimination, adopted by the United Nations in 1979.</p>
The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984)	<p>The Convention requires states to take effective measures to prevent torture within their borders, and forbids states to return people to their home country if there is reason to believe they will be tortured. Parties are also obliged to prevent other acts of cruel, inhuman or degrading treatment or punishment, and to investigate any allegation of such treatment within their jurisdiction (Article 16).</p>
The UN Millennium Declaration (2000)	<p>The UN Millennium Declaration resulted in eight time-bound goals (2000-2015) providing benchmarks for tackling extreme poverty, including goals and targets on income poverty, education, hunger, maternal and child mortality, disease, inadequate shelter, gender inequality, environmental degradation and the Global Partnership for Development.</p>

Policy	Key Issues
NSW State Plan: Investing in a Better Future (2010)	<p>The NSW State Plan notes seven areas of activity:</p> <ul style="list-style-type: none"> • World class transport network • A stronger economy • Better educated children, more skilled community • Highest quality, accessible health care • Energy is clean, tackle climate change • Strong communities supporting the most vulnerable citizens • Safe community <p>Healthcare is a key priority in the state plan in terms of improving access, improving survival rates for people with chronic illnesses and health improvement strategies. After arrival in Australia, health status is clearly impacted by the broader social determinants of health such as housing, education, income, and nutrition, which feature in the State Plan.</p>
NSW State Health Plan (2007)	<p>The overarching goals of NSW Health inform all healthcare provision in NSW. These are:</p> <ul style="list-style-type: none"> • To keep people healthy • To provide the health care that people need • To deliver high quality services, and • To manage health services well. <p>The importance of equity in healthcare is stressed.</p>
Future Directions for Health in NSW- towards 2025- Fit for the Future (2007)	<p>This plan places equity in health as the fundamental challenge for the future, mentioning in particular the health of refugees as a priority.</p>
NSW Health and Equity Statement: In All Fairness (2004)	<p>The NSW Health equity statement is the key policy concerned with reducing or eliminating differences that are avoidable and unfair and promoting participation and inclusiveness. Key focus areas include; investing in the early years of life, increasing community participation, developing a strong primary care system, planning regionally and intersectorally, building organisational capacity and providing adequate resources to reduce inequalities. The statement recognises that people have varied capacity to deal with health and social issues. Refugees and newly arrived migrants are recognised as being at increased risk of disadvantage and of poorer health and social outcomes. Cultural and linguistic diversity is recognised as a valued asset.</p>
Community Relations Commission and Principles of Multiculturalism Act (2000)	<p>The principles of multiculturalism are the policy of the State, accordingly, each public authority must observe the principles of multiculturalism in conducting its affairs. It is the duty of the chief executive officer of each public authority to implement the provisions of this section within the area of his or her administration.</p>
Multicultural Planning Framework- Community Relations Commission (2009)	<p>Health regions are required to report annually on their outcome performance in a Multicultural Planning Framework, replacing the previous Ethnic Affairs Priorities Statement. This requires each Local Health Network to detail advances in multicultural planning and evaluation, capacity building and resourcing, and programs and services. This framework provides the mechanism for systemic governance and sets in place accountability parameters for all government instrumentalities, including health. Further, this framework provides the opportunity to assume an equitable whole-of-government approach to service provision, settlement and health improvement in relation to refugees.</p>

Policy	Key Issues
NSW Multicultural Mental Health Plan 2008-2012	<p>The Multicultural Mental Health Plan is the state-wide strategic policy and service delivery framework for improving the mental health of culturally and linguistically diverse (CALD) communities. The plan identifies refugees and survivors of torture and trauma as a priority population and supports the development of mental health services targeting refugees. It identifies five strategic priorities which include: policy development, focusing on education, prevention and early intervention, culturally inclusive service development and delivery, and research, evaluation and innovation.</p>
Multicultural Australia: United in Diversity (2003)	<p>United in Diversity is the Commonwealth government's policy outlining a commitment to a multicultural Australia, including fairness, respect and equity.</p>

Refugees in NSW

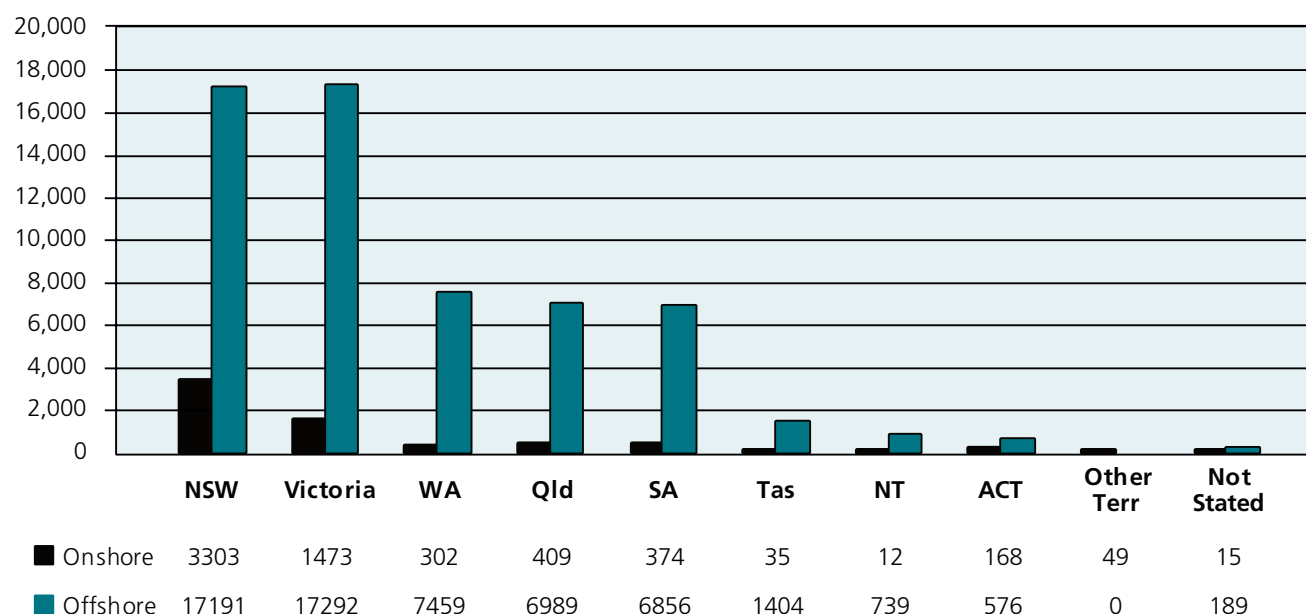
Initial Settlement Patterns of Refugees

The Australian government accepts approximately 13,500 refugee and humanitarian entrants per year. Refugees and other people in humanitarian need arrive in Australia either through the offshore Refugee and Special Humanitarian Program or as onshore asylum seekers (RCOA 2009).

The largest number of refugee and humanitarian entrants to Australia over the past five years has settled in NSW and Victoria. During this period, NSW has received 32% (20,494) of the total number of Australian humanitarian entrants. These newly arrived refugees are highly diverse in respect of their ethnicity, age, class, religion and socio-economic status.

Over the five year period from June 2004 to June 2009, the largest numbers of refugee and humanitarian entrants to NSW have come from Iraq, Sudan, Afghanistan, Sierra Leone and countries designated as 'Other African' countries. The major languages spoken by humanitarian entrants in NSW (offshore applicants) over the last five years were Arabic, Assyrian, African languages (nfd), Dari, Dinka and Burmese. 'Onshore' humanitarian entrants typically have a different linguistic profile, with the major languages spoken being Tamil, Mandarin, Arabic, English, Urdu and Farsi. The majority of humanitarian entrants recorded their religion as Christian, Muslim or Sabaeen/Mandaeen². Most humanitarian entrants speak little or no English on arrival in NSW.

Figure 1: State settlement patterns of humanitarian entrants, Australia June 2004 – June 2009.



Source: DIAC Settlement Database, September 2009.

² Sabaeen/Mandaeen religion is an ancient religion whose teachings are believed to derive from Adam, the first man. Most people of this faith come from either Iraq or Iran.

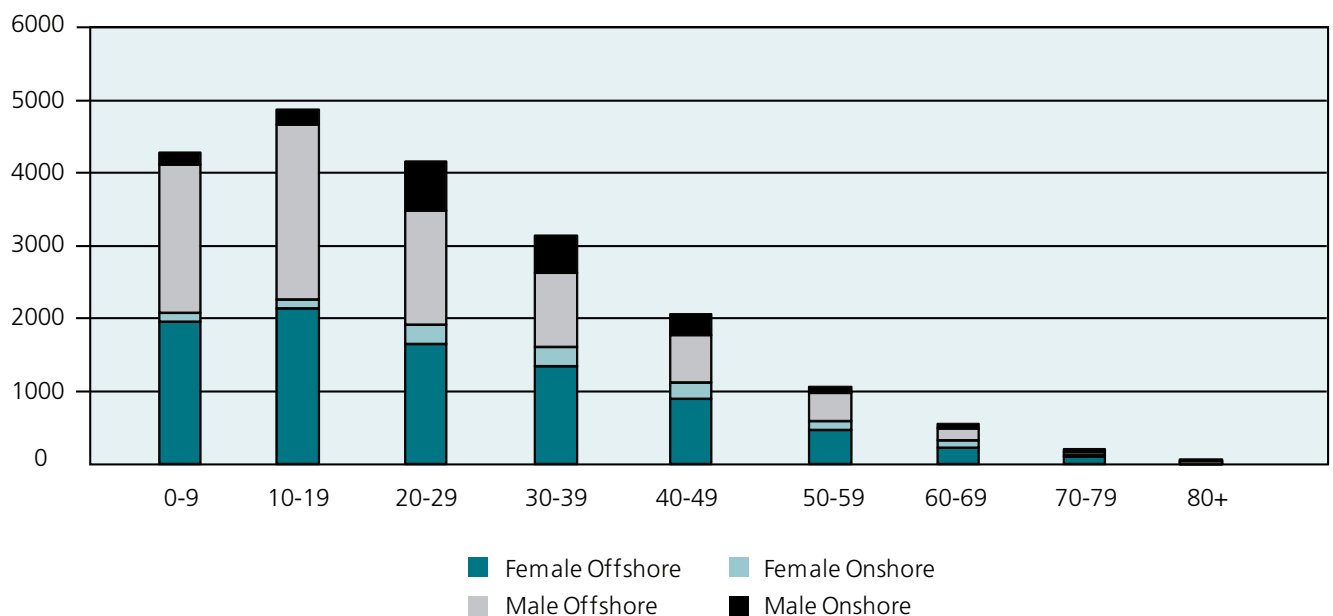
The majority of entrants are young people, with 45% of the total number of newly arrived humanitarian entrants to NSW being aged less than 20 years - over 9,000 children in the past five years. Of the offshore humanitarian entrants, 50% were aged under 20 years and more were male than female, with almost 500 more young males than females. In each of the adult age groupings there are slightly more female entrants than male (see Figure 2).

Over three quarters of refugee and humanitarian entrants to NSW over the past five years have initially settled in the Sydney metropolitan area (DIAC Settlement Database 2009).

Almost a third of newly arrived refugee and humanitarian entrants initially settled in the local government areas of Fairfield and Liverpool in the south west of Sydney. Another third initially settled in the combined western Sydney local government areas of Blacktown, Auburn, Parramatta and Holroyd. The larger component of the Sydney entrants in recent times has been people from Iraq (41.3%), followed by Sudan (16%), Afghanistan (9.4%) and Sierra Leone (5.9%).

Significant numbers of refugee and humanitarian entrants also initially settle in rural and regional areas of NSW. Newcastle, Goulburn, Wollongong, Coffs Harbour, Albury, Lismore, Goulburn, Armidale, Tamworth and Wagga Wagga, have, for example, been the first destination for newly arrived refugees. There are also pockets of secondary settlement in areas such as Orange and Young.

Figure 2: Age and gender of humanitarian entrants to NSW 2004 – 2009.



Source: DIAC Settlement Database, September 2009.

Health Status of Refugees

Overview

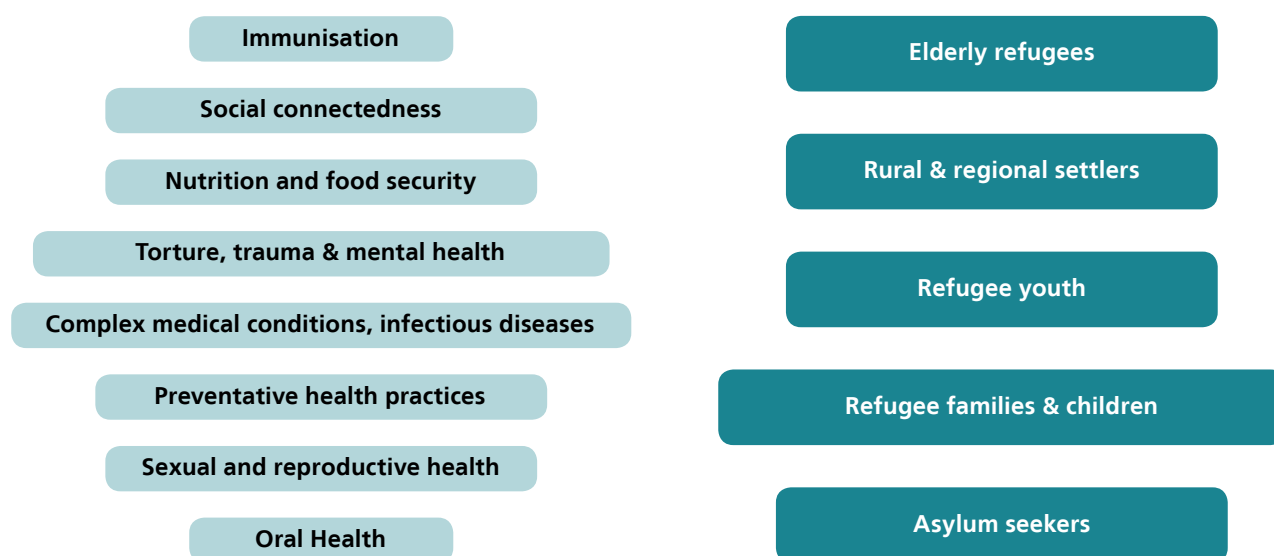
Refugees have typically suffered threats to their lives, separation from and loss of family members, separation from their homeland and loss of many of their cultural traditions. Many refugees have experienced highly traumatic events such as persecution or torture, physical and mental deprivation and human rights abuses. Many have experienced war or civil unrest, famine, poverty and displacement. These pre-migration experiences have a well-documented impact on the physical and emotional health of refugees. Although refugees are not a homogenous group, health needs which have commonly been identified after arrival in Australia include psychological issues, nutritional deficiencies, infectious diseases, under-immunisation, poor dental and optical health, poorly managed chronic diseases, delayed growth and development in children and the physical consequences of torture. Some refugee women may have reproductive health needs, some may have undergone female genital mutilation (FGM) and/

or have suffered sexual harassment or rape (Allotey 2003; Smith 2003; Burnett & Peel 2001; Aroche & Coello 2004; Benson & Smith 2007). The similarity between the health status of asylum seekers and that of refugees has been noted in a number of studies (Harris & Telfer 2001; Smith 2001; Sinnerbrink et al 1996).

After arrival in Australia, the health status of people arriving as refugees and asylum seekers may be further influenced by factors such as housing, education, safety and security, working conditions and health system access. These factors, frequently termed the social determinants of health, are primarily shaped by socio-economic status and access to health and social capital.

The following figure (Figure 3) summarises the priority health status issues and population groups identified for this plan. This does not imply that these are the only issues or population groups considered in the plan.

Figure 3: Priority refugee health status issues and priority population groups



Health Status Issues

Complex medical conditions, infectious diseases

Refugees may have complex medical needs derived from the poor conditions they have lived in, and the traumas they have experienced. The prevalence of some infectious disease in refugee communities is frequently higher than in the Australian-born population. This may include tropical infections such as malaria and parasitic infections (such as intestinal helminth, schistosomiasis, strongyloides, and giardia). Vaccine-preventable diseases such as measles, rubella, varicella and hepatitis B may be evident. Hepatitis C, tuberculosis (TB) and sexually transmitted infections have also been diagnosed in refugee populations (King & Vodicka 2001; Tiong 2006; Benson & Smith 2007). Some of these conditions may be asymptomatic. Many of these conditions respond to treatments, however, if left untreated, may result in cancer, disability or death (McPherson et al 2008b; O'Sullivan et al 2004; Nightingale et al 2009).

The vitamin D and iron status of refugee populations in Australia is often poor (Raman et al 2009). Refugees are at greater risk of vitamin deficiencies when famine or starvation has been an issue in early childhood, when Vitamin D deficient women breastfeed their infants, or amongst refugees with darker skins or who are veiled and who lack exposure to sunlight. Rickets and osteoporosis may result from low Vitamin D and the condition is now being associated with a range of other health problems. Iron deficiency may cause anaemia and related issues.

A wide range of chronic disease may also be present, including heart disease, diabetes, hypertension and peptic ulcer disease (Harris & Zwar 2005). Although little has been published about the chronic conditions of refugees living in Australia, a US study found the prevalence of diabetes and hypertension was higher in a high-trauma (refugee) group as compared with a low-trauma group (Kinzie et al. 2008 p 108) a result likely to be generalisable to Australian conditions (Owen et al 2009). The cost of specialist care and medications can be prohibitive for newly arrived refugees with complex or chronic medical needs and for those asylum seekers without work rights and Medicare access.

Refugee children may develop disabilities or growth retardation as a result of malnutrition, stress, lack of (or interrupted) schooling or stimulation and exposure to disease. Raman et al (2009) reported that while NSW

received 1,557 refugee children (<14 years) in 2005, only about one in five (n=331) was seen in a refugee specific clinic. Of those assessed, 25% had anaemia, 27% were serology positive for schistosomiasis, 16% had evidence of current or recent malaria, 25% were tuberculin skin test positive, 69% were hepatitis B non-immune and 20% had low vitamin D levels. Most children needed 'catch up' immunisation. Other concerns included chronic health, developmental and behavioural issues. A study based on the HARK Clinic at The Children's Hospital Westmead (Sheikh et al. 2009) reported similar findings. Conditions such as anaemia, schistosomiasis and vitamin D deficiency flagged in the literature are, appropriately, not included in overseas health screening as they are not communicable diseases, yet warrant early detection and treatment (Smith 2006; Owen et al 2009). Children receive limited pre-departure screening and therefore, their physical, emotional and developmental issues are important to assess (Raman et al 2009). Cooke et al (2004) reported that in a population of 199 East African children attending a hospital clinic in Melbourne, 77% reported outstanding health issues, even though 63% had had previous medical consultations since their arrival in Australia.

Although refugees may have higher rates of some conditions there is little risk to the public from these various conditions provided access to services is provided (Leask et al 2006; Kisely et al 2002).

However, this complex array of possible medical issues, beyond those that are assessed in the pre-departure screening, requires a comprehensive clinical assessment on arrival in NSW (Martin & Mak 2006; McPherson et al 2008b; Raman et al 2009).

Torture and trauma, mental health

The refugee experience can foster resilience, family commitment, strength, courage, humour, hopefulness and fortitude.

However, posttraumatic stress disorders, depression, panic attacks, sleeping difficulties and anxiety are well-recognised issues in refugee communities related to the refugee experience, most particularly to the experience of torture and trauma (Refugee Council of Australia 2009; Aroche & Coello 2004; Silove 2004; Sultan & O' Sullivan 2001; Smith 2003; Steel & Silove 2001; Silove et al 1997; Harris & Zwar 2005). Mental wellbeing may be negatively affected by a range of factors including family separation, grief and loss,

migration stress, settlement difficulties, racism, role changes and financial and social issues (Harris & Zwar 2005) and by the experience of detention, especially prolonged detention (Steel et al 2001; Steel et al 2004; Zwi et al 2003; Green & Eagar 2010). Uncertainty about the future, such as is experienced typically by asylum seekers can especially provoke stress and anxiety. Memory may be poor and small issues may at times result in considerable stress and tension. For some, these experiences can reverberate throughout their lifetime and may impact in a range of different ways.

Physical effects of torture may also present. Such sequelae include broken bones, epilepsy, deafness or non-specific musculoskeletal pain or weakness (Harris & Zwar 2005). Mental health services are not a familiar service type for many refugee communities. Cross-cultural differences in understanding and responding to mental health issues, compounded by language barriers pose considerable challenges in service delivery. Further, in some groups there is a lack of understanding of counselling, and there may be considerable stigma associated with mental health issues (Burnett & Peel 2001). Eligibility for these services may be also mitigated by visa class (see Appendix 4).

As a result of trauma experiences refugee resettlement may be difficult. Refugees, for example, may not trust healthcare services; some may have difficulty in establishing relationships with family, healthcare providers, teachers and community members; others may have a deep distrust of governments or institutions.

There is now a strong body of evidence linking racial discrimination and poor health, including poor mental health (Krieger 2003; Paradies 2006).

Preventative health practices

As a result of the poor conditions in which they have lived, refugees may have a range of risk factors which place them at a relatively higher risk of poor health. These risk factors derive from the interaction of their health history, (western) health literacy, poor proficiency in English and behaviours and attitudes derived from their previous experiences of health care which may mean that preventative health practices are not taken up and that preventative health care is not accessed.

Refugees may lack information about the Australian healthcare system and their rights as a consumer (Benson & Smith 2007). Preventative health services, such as breast and cervical screening may be unfamiliar to them. Indeed,

health screening or medical checks may even be perceived as yet another 'test' which they have to 'pass' in order to stay in Australia. Asylum seekers may especially believe that they will be returned if they have poor health. Some refugees may be distrustful of doctors and healthcare professionals as health professionals were involved in torture and repression in their country of origin (RHS 2004). Indeed, the impact of torture and trauma, deprivation, sexual violence, human rights abuse, grief and loss may be palpable (RHS 2004).

Early intervention and prevention services therefore may need to develop specific access strategies targeting newly arrived refugees.

Immunisation

Refugees often originate from countries where immunisation coverage is poor and thus the potential burden of disease is greater than for other Australians (Parsons et al 2007). Systematic immunisation catch-up does not occur for many refugee children or adults following arrival in NSW. Few refugee children who arrive in NSW have had hepatitis B vaccination or varicella vaccine (chicken pox) and some may require measles-mumps-rubella (MMR) vaccination. Newly arrived young women are unlikely to have had access to Gardasil for prevention of human papilloma virus (HPV).

Refugees and sponsored humanitarian entrants (202 visa entrants) aged between 9 months and 30 years who undergo a pre-departure medical screening prior to departure (the 'fit-to-fly assessment'), are given MMR immunisation. This is documented. However, documentation of vaccinations given at other times is usually unavailable. For some, doubling up of immunisations may occur, while others may not receive required follow-up immunisations.

NSW Health provides a number of vaccines free-of-charge for refugees, to promote catch-up (http://www.health.nsw.gov.au/PublicHealth/Immunisation/programs/vaccine_access.asp). These vaccines are; ADT, hepatitis B and polio. Additionally, a number of vaccines given through the schools program can be accessed if students enter the appropriate school year and have missed out.

Immunisation staff from Public Health Units provide immunisations for students at Intensive English Centres located in a number of high schools, where non-English-speaking students may attend before moving into mainstream classes.

Of note is that the Commonwealth government immunisation program provides funds for NSW based on its 2006 census population, therefore, NSW is not funded for its refugee and new migrant populations.

There is limited NSW-based research documenting the immunisation status of refugees. It is considered that babies have generally been immunised as there are Medicare-related incentives and checks in place. However, clinicians suggest that some primary school students may not be immunised, especially if they enter school in the later years. Immunisation staff suggest that adults and adolescents may be at risk of under-immunisation.

Parsons et al (2007) in a study of 35 refugee children in Newcastle found that only two had returned to their GP for additional vaccinations. The factors suggested for this included lack of knowledge of the healthcare system, lack of transport, no local council or community vaccination services and lack of bulk billing by general practices.

Social connectedness

Social support and connectedness is a crucial factor contributing to positive settlement and the health and wellbeing of refugees and asylum seekers. Such social support may derive from family, linkages within one's own ethnic community and links with the wider 'host' community. Social support, by reducing isolation and disconnectedness promotes social, emotional and psychological wellbeing. It may also contribute to promoting opportunities to access employment, housing, child care, health services and other settlement requirements (McMichael & Manderson 2004; McDonald et al 2008). Social support may also be critical for developing a greater sense of control and the restoration of a person's and a community's identity which can be disrupted or damaged as an outcome of persecution, entrenched trauma, separation and human rights abuse (Benson 2004). Social connectedness is particularly critical where loss of family, community leaders and significant social structures has disrupted the capacity to deal with life issues such as intergenerational conflict and family issues. Thus, strengthening community capacity promotes significant opportunities for refugee resettlement issues to be advocated, understood and positively addressed.

Positive attitudes and support from the 'host community' has been cited by the UNHCR as one of the major factors influencing the outcome of refugee resettlement (UNHCR

2002) and has been noted in a number of studies in Australia (Piper 2009; McDonald et al 2008).

Oral health

Poor nutrition, poor hygiene, lack of dental care and the lack of fluoride and toothpaste in camps or in the country of origin may all contribute to poor oral health (Davidson et al 2007). The effects of torture or traumas to the face may further compromise oral health status. For some refugees the practice of chewing betel nut may impact on oral health. Once in Australia, teachers and health workers report that dental health may deteriorate further as a result of poor (western) diet, a reliance on convenience and 'junk' foods and overeating. Smith and Sjusta (2000) in a study at the Sydney Dental Hospital measured the dental health of refugees from former Yugoslavia and Iraq and found it was considerably poorer than that of a matched group of social security recipients. This finding has been supported by Davidson et al (2006) who found refugee oral health status was worse than that of Indigenous Australians and other special needs groups. This has also been found in international studies (Singh et al 2008).

The poor oral health status of refugees has been noted in the National Oral Health Plan. The National Oral Health Plan recommends the collaboration of NGOs and other agencies to improve refugee oral health (NACOH 2004, p 29). The New South Wales Child Dental Health Survey found that children aged 5 and 6 years of age whose mother was born in a non-English speaking country, had significantly higher decay rates (dmft = 2.34) than children whose mother was born in an English speaking country (dmft = 1.36) (COHS 2009). Further, the untreated decay rates were also higher.

Affordability of private dental services and accessing public dental services are particular issues for newly arrived refugees and asylum seekers.

Nutrition and food security

The consequences of food insecurity may include reduced physical, mental and social wellbeing. Refugees often come from situations such as camps where there were few food options. In Australia, teachers and service providers note a growing reliance on convenience foods, 'junk foods' and sugary drinks. This may result from difficulties in shopping for healthy food, in food preparation, storage and lunch preparation. Some refugees may also see these foods as a desirable part of the Australian lifestyle. High consumption

of affordable, dense, low nutrient foods may contribute to obesity, diabetes and ultimately heart disease or chronic health issues.

A study by the NSW Refugee Health Service (RHS) found that African refugees who had settled in the Fairfield local government area were 8 to 16 times more likely to experience food insecurity than the greater Australian population. Other refugee groups who had settled in the same local government area report either no food insecurity, or levels similar to the Australian population. A number of factors contributing to poor food security were identified, including poverty, distance from shops, a lack of access to affordable transport and for some groups the unavailability of culturally preferred foods (Southcombe 2008). Research has established that disadvantaged areas tend to have more availability of takeaway food outlets and fewer fresh food outlets (Reidpath et al 2002). Asylum seekers without secure income support can have especially poor food security. Food insecurity, and its more severe form, hunger, are associated with depression and behavioural disorders, overweight and morbidity (Southcombe 2008). Research has shown that children who miss breakfast are less able to concentrate, more prone to fidgeting and find learning difficult by mid-morning (Resincow 1991).

Sexual and reproductive health

Refugee women are more likely than men to have minimal or no education and to have limited English proficiency; they have at times been the survivors of violence, extreme poverty, sexual torture and rape (Costa 2007). Many refugee women have reproductive health issues (Krause et al 2002) including higher risk pregnancies and complications from gynaecological surgery (Costa 2007). Late attendance at antenatal care can be an issue.

Female genital mutilation (FGM) is practiced in many parts of the world and particularly in some of the areas from which refugees are drawn. There are special healthcare needs of girls and women related to FGM, particularly when they become pregnant (WHO 1997).

For adult refugee men, women and for young people, reproductive and sexual health may be significant issues. Knowledge and information about modes of transmission, symptoms, and prevention of sexually transmitted infections may be limited. In some communities, there may be a strong association between HIV/AIDS and death due to the high mortality rates in their country of origin (McMichael

2008). Studies have found that refugee youth lack knowledge about the most common infections such as chlamydia, herpes simplex virus and gonorrhoea (McMichael 2008).

Contraception options may be constrained by religious and cultural preferences, shame and stigma. Access to sexual health information, including contraception, positive relationship building and sexual safety was repeatedly mentioned by teachers and health workers in consultations.

Priority Refugee Populations

Refugee families and children

Support and empowerment of refugee families within a community context is important for successful settlement. Families may be separated; members may have died or disappeared, may still be in camps or may not have been granted refugee status.

Intergenerational conflict within families arising from discipline issues, role changes, shifts in values, exposure to 'western morality', tension and stress may lead at times to conflict, family violence and child protection issues.

Refugee children make up a significant proportion of the refugee population and have been recognised as being at risk of poor health status, nutritional deficiencies, poor immunisation status, poor oral health, growth and developmental issues and limited access to health services (Raman et al 2009; RACP 2007; Woodland et al 2010). Diverse approaches to child rearing in Australia as compared with their country of origin may also pose difficulties in some refugee families.

Refugee men and women must adjust to considerable change in their role and social status, especially if the male is unemployed and their partner has found work. This loss or change of identity associated with resettlement may be exacerbated by exposure to a culture which gives women and children increased rights. Sexual problems, depression or even family violence may be related to this experience of change and to a history of trauma and torture. Refugee men and boys, some of whom may have been soldiers, are likely to have been exposed to more injuries and traumas than other refugees (RHS 2006).

Drug and alcohol issues may emerge in newly arrived communities as the stress of settlement, unfamiliar cultures and the pain associated with loss and with past experiences

may lead to negative feelings, depression, anxiety and loneliness. Harmful use of alcohol, cannabis, heroin and other drugs has been noted. Smoking is a particular problem especially in some refugee men (Harris & Zwar 2005). Problem gambling has also been seen as a particular risk for some refugee families.

Refugee youth

Young people who are refugees may face a complex array of issues on arrival in Australia. They may possibly be entering school for the first time; they may need to adjust to a different schooling system and a different set of expectations of young people. Their personal response to a history of torture and trauma, displacement, loss or interruption to family life intertwined with adolescent uncertainty may lead to particular challenges. This may be exacerbated when young people are seen by their families to be assuming western values, ideas and habits.

Some refugee young people may arrive in Australia without their parents. These children are called 'unaccompanied minors' and may arrive as a humanitarian entrant or as asylum seekers. Some may be alone and will be made a ward under the guardianship of the Minister for Immigration and Citizenship. Others may be living with their extended family or relatives aged over 21 years. These children require considerable support and care

Older people who have been refugees

Although comprising a smaller proportion of those directly arriving under humanitarian programs, the needs of refugees aged over 60 years and the elderly who have had refugee-like experiences arriving under family reunion or other programs, was raised in many consultations. The discussion paper, *Caring for Older Refugees in NSW* (RHS 2007) notes that many of the older refugees in NSW have grown old in NSW, some have arrived under refugee and humanitarian programs while others have been re-united with their children through the broader migration program. The paper outlines the needs of older refugees including the importance of social connectedness to reduce isolation, the need for specialised torture and trauma-related services, the need to improve accessibility to aged care services and the importance of improving information and understanding about health services and health improvement and protection. The needs of older refugees may be unrecognised by policy, research, planning and service delivery agencies and government services.

Asylum seekers

Asylum seekers are people within Australia who have applied to the Australian Government for recognition as a refugee. They are sometimes referred to as 'on-shore applicants'. The health status of asylum seekers is generally similar to that of refugees who have been assessed 'off-shore'. The stress and anxiety experienced by some asylum seekers who do not have the right to work may further contribute to their poor physical and mental health (Smith 2003; Aroche & Coello 2004). The combination of fear of deportation, an uncertain future, lack of resources and little access to healthcare can compound their poor health status (Harris & Telfer 2001; Sinnerbrink et al 1996).

Rural and regional refugee settlers

DIAC has actively encouraged refugee settlement in a number of regional locations including Newcastle, Coffs Harbour, Wollongong, Goulburn and Wagga Wagga. While these initial settlement patterns are consciously planned and implemented, challenges are associated with secondary (unplanned) migration. Newly arrived refugees may move in response to social support, employment opportunities, housing affordability and other factors. Secondary settlements of significant numbers of refugees have occurred in some regional centres and other people who initially settled in regional areas have migrated to Sydney or Newcastle. In some of these areas of secondary settlement, appropriate health and human services may initially not be available.

The lack of predictability in refugee numbers, profile and needs provides challenges for rural healthcare provision, including service development, cultural competency and the deployment of staff such as refugee health nurses.

Issues for rural services which were repeatedly mentioned during consultations include lack of equity in access to on-site interpreters and lack of bilingual, refugee or multicultural healthcare services. The relative isolation of refugee communities in rural locations can also pose challenges in accessing health services. Many doctors and health providers are reportedly poor users of even telephone interpreters. Further there is frequently a lack of choice of primary care provider (GP), with 'closed books', a lack of surgeries that will bulk bill and a lack of appropriate speciality or tertiary services (Sypek et al 2008).

Current Service Context

Introduction

To assist in the settlement process, refugees and humanitarian entrants to NSW receive specialised services provided on contract from the Department of Immigration and Citizenship (DIAC) by a Humanitarian Settlement Services (HSS) provider. Early settlement support provided includes case co-ordination, airport reception, provision of settlement information, help in finding accommodation, help in arranging income support and enrolling in Medicare and help in accessing English classes (DIAC 2010). The HSS service is provided for a six to twelve month period after a refugee arrives in Australia. The aim is to assist newly arrived humanitarian entrants to become self-sufficient and to access mainstream services. Within a month of arrival humanitarian entrants should have an appointment with a GP or refugee health clinic. Appendix 4 lists the eligibility of various visa class entrants for settlement and health services.

The settlement services provide referral to short-term torture and trauma counselling services which are generally provided by the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), funded by The Commonwealth Department of Health and Ageing (DOHA). They also provide referral to state-funded refugee health services.

DIAC, through its Settlement Grants Program, provides discretionary grants to organisations to implement programs to assist the orientation, development and social participation of humanitarian entrants (DIAC 2010). English language tuition and translating and interpreting services are also funded by DIAC. The DIAC Complex Case Support services deliver intensive case management services to humanitarian entrants with 'special needs', often health-related, which are not able to be supplied by core settlement services.

Prior to a migration, medical staff, approved by the Commonwealth, perform medical history and examination, urinalysis (aged 5 years and above), chest x-ray for TB screening (11 years and above), syphilis serological testing and HIV serology testing (15 years and above). This medical

check is commonly called the 'visa medical'. Since 2005, humanitarian entrants receive an additional pre-departure medical screen (PDMS), 72 hours before departure, for malaria, presumptive treatment for parasitic infection, tuberculosis, an initial measles-mumps-rubella vaccine (if aged between 9 months and 30 years) and a physical examination (DIAC 2009). If problems are identified then some people may receive immediate treatment prior to flying. Others will be required to attend follow up treatment on arrival in Australia. If a refugee arrives with such 'health undertakings' resulting from pre-departure medical screening, then a medical appointment will be arranged either within 24 or 72 hours, as required.

State-wide Refugee Health Services

- The NSW Refugee Health Service (RHS) provides state-wide consultation, support, education and advocacy in respect of refugees and asylum seekers. Health promotion, policy advocacy, GP education, resource development, research, on-arrival health information provision, health promotion and provider and community education are core services. Three general practice clinics, supported by refugee health nurses are provided by RHS in the greater west of Sydney.
- The Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) provides individual and group counselling, therapy, information, support, activities and policy advocacy for refugee survivors of torture and trauma experiences, their families and their communities. Community development, community education and improving social connectedness are core activities. Education, training and support are provided to people working with refugees. A range of clinics and services are available across NSW. Research is a key priority.
- A number of state-wide multicultural services provide services and strategies which at times target refugees. These include the Transcultural Mental Health Centre (NSW), The NSW Multicultural Health Communication Service, The Multicultural HIV/AIDS and Hep C Service, the Education Centre Against Violence and the Drug and Alcohol Multicultural Education Centre. The NSW

Education Program on Female Genital Mutilation (FGM) works with communities which practice FGM, to facilitate education, child protection and appropriate health and human service provision.

Local Health Network Refugee Health Services

Some health services, particularly those in rural and regional areas, have established refugee health programs, services and clinics. On-arrival health screening, assessment and support programs are offered in:

- **Hunter New England** Refugee families in Newcastle are referred by the local HSS provider and offered a free comprehensive medical assessment, investigations, follow-up treatment, immunisations, oral health education, hearing and optometry screening and referral. Refugee Health Nurses form a key component of the service.
- **South Eastern Sydney and Illawarra Shoalhaven** Refugee families are visited at home by the Refugee Health Nurse and a Multicultural Health Worker who discuss health needs and provide introductory information about the health system. Refugees are linked to identified, trained and supported local General Practitioners by the HSS settlement service caseworkers. The GPs provide comprehensive health assessment, follow up treatment and referral to specialised refugee health clinics. GPs are supported by the Refugee Health Nurse and specialists at the Sydney Children's Hospital and The Wollongong Hospital.
- **Mid North Coast** Humanitarian entrants are referred by the local HSS to the Coffs Harbour Refugee Health Clinic staffed by General Practitioners on a rotating roster, a Clinical Nurse Consultant (CNC), a registered nurse and administrative officer. The clinic offers comprehensive health assessment and follow-up to newly- arrived humanitarian entrants and health care to humanitarian entrants who access the clinic for other medical issues.
- **Northern Sydney** Humanitarian entrants are referred by the local HSS provider to the Multicultural Health Service. A Multicultural Health worker meets with the entrants and coordinates a health check-up program which includes a comprehensive health assessment by a GP, an oral health assessment and assistance obtaining glasses, if required. Children receive an assessment by an early childhood nurse. An information session on the Australian health system is provided in a community venue.

- **Southern NSW** Wagga Wagga Health Service working in collaboration with the Riverina Division of General Practice has established a refugee health clinic to address the medical issues of refugees arriving within the past five years. The GP has been trained in refugee health. The LHN provides nursing support with a focus on early assessment, intervention and intersectoral collaboration.
- In other rural areas, health care assessment may be provided by local General Practitioners.

A number of refugee paediatric clinics are provided by specialist child health staff. These include the HARK Clinic (Children's Hospital, Westmead), Sydney Children's Hospital, Liverpool Hospital, Fairfield Refugee Youth Health Clinic, Mt Druitt Hospital and John Hunter Hospital. The NSW Asylum Seekers Centre provides a pro-bono assessment clinic for asylum seekers with health problems.

Multicultural Health Services provide supportive services and strategies which frequently target refugees. Key services include healthcare interpreter services, Multicultural Health Promotion Officers, and Bilingual Community Educators (BCEs).

A number of non-government organisations, community organisations and other agencies are involved in, or provide, health-related services and strategies targeting refugee communities. Many of these organisations have partnership arrangements with refugee providers in the health sector. These include ACL, Anglicare, the Asylum Seekers Centre, The Australian Red Cross, The House of Welcome, Migrant Resource Centres, Family Planning and ethno-specific organisations.

Primary Care Services

General Practitioners provide primary medical care for refugees and are often the first point of contact with the healthcare system. For non-English-speaking communities, including refugee communities, the (private) bilingual GP is frequently sought as the preferred primary care provider (Knox & Britt 2002; Stuart et al. 1996).

Until 2010, two Medicare Item numbers were available for GPs to access when they provided comprehensive medical assessments to refugees and other humanitarian entrants. These assessments are not available to asylum seekers (see Appendix 4). From May, 2010, these item numbers were replaced by generic assessment item numbers.

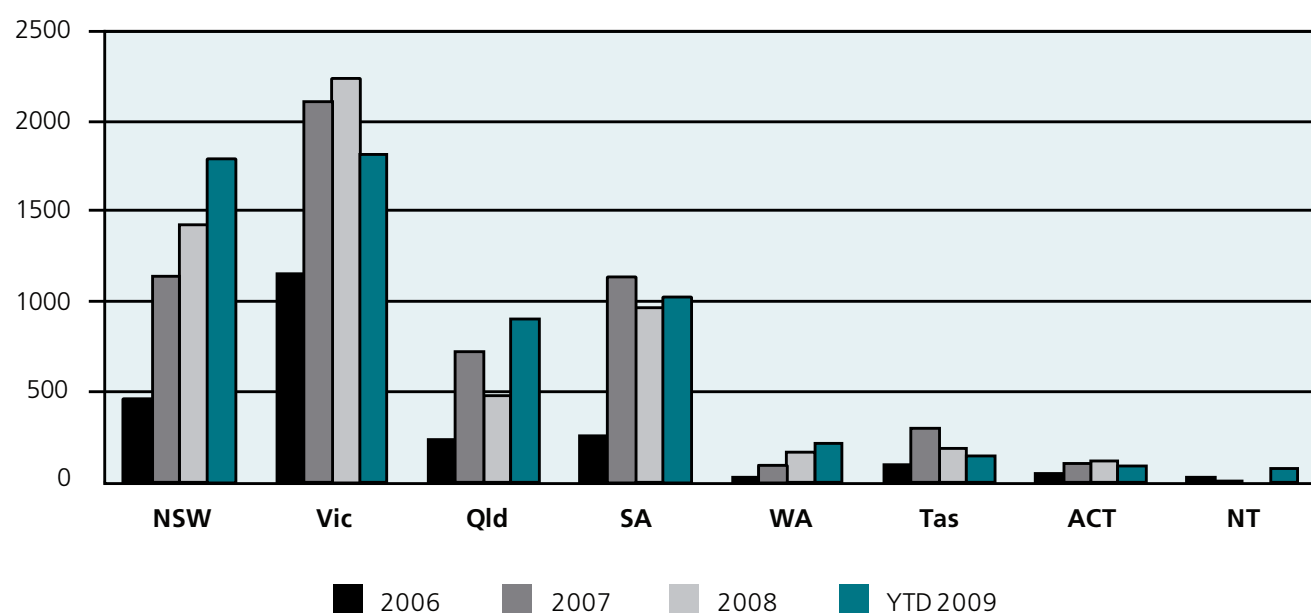
An assessment requires the following be undertaken: medical history, physical examination, investigations as required, assessment of patient, the development of a management plan and additional matters of particular relevance to refugees and other humanitarian entrants. Recent evidence suggests that GPs believe that they are under resourced in the provision of effective initial assessment and care for refugees (Johnson et al 2008). The range of pathology, bloods and diagnostic services required is viewed as time-consuming and some may be unfamiliar to some doctors.

'Consultation and screening of refugee families is time consuming and complex, nearly always requires interpreters, cultural awareness and sensitivity, and lengthy explanation to parents about the results of screening tests and about treatment prescribed. This is logistically difficult to achieve in busy general practices' (Raman et al. 2009, p. 469).

Figure 4 shows the use of Medicare Item 714, refugee assessment, in NSW as compared with other states. The relative usage of this item number has been increasing in NSW.

- Refugee Health Nurses (RHNs) are available as the first point of contact with the healthcare system in some areas of NSW. Their role may include an initial basic health assessment of newly arrived refugees. This assessment forms the basis of referral to General Practitioners, specialised clinics and/or the torture and trauma service. RHNs collaborate with GPs to promote health literacy, return visits, compliance with treatments and related tasks.
- Other providers who provide basic level healthcare to refugees include, community health services, pharmacists and complementary healthcare providers such as herbalists, naturopaths and acupuncturists.

Figure 4: Use of Medicare Item 714 by Australian states January 2006-September 2009



Secondary and Tertiary Care Services

- As refugees may have complex health and medical issues mainstream providers frequently have contact with refugees. Common referral services include medical specialists (for example cardiologists, endocrinologists), maternity and child health services, paediatric services, mental health services, sexual health services, infectious diseases services and sexual assault services.

Visa status and health service access

Refugees and others included within the Humanitarian Program are issued with a variety of visas dependent on their circumstances, vulnerability and place of visa issue.

All of the visa subclasses in the table below give holders permanent residence and entitlement to the full range of services available to other permanent residents, including Medicare.

All refugee visa holders (visa subclasses 200, 201, 203 and 204) and some protection visa holders receive initial assistance from a DIAC-funded orientation program (HSS). This includes linking the person to a GP and following up on any health undertakings. Special humanitarian visa holders (subclass 202), however, are dependent on their proposer (the person who sponsored them to come to Australia) for post arrival assistance and in some cases are not immediately linked to health services. So too, the circumstances of those granted onshore protection visas will vary and some will have received very little information about, or orientation to, the health system. (Appendix 4

outlines the diverse health and human service access according to visa class).

Asylum seekers constitute a distinct category to those mentioned above. As previously outlined, they are people within Australia who have applied to the Australian Government for recognition as a refugee. They are sometimes referred to as 'on-shore applicants'. Their claims for protection are assessed under the criteria established in the 1951 United Nations Convention and the 1967 Protocol relating to the Status of Refugees. If successful they will be granted permanent protection and residency in Australia (NSW Health 2009).

Persons seeking asylum in Australia who originally arrived with a valid visa are permitted to live in the community while their application for asylum is processed. Some asylum seekers are provided with assistance by the Australian government, which may include the right to work and the right to receive Medicare benefits. Others, including those not provided with these rights, may be eligible for health and welfare services under an assistance scheme provided by the Red Cross (Asylum Seekers Assistance Scheme). Others are not permitted to work and may be ineligible for Medicare. Further, some asylum seekers who had eligibility for Medicare may lose this right once they reach a particular stage in the appeals process (NSW Health 2009). Being Medicare ineligible means that hospital care, ambulance services, public dental services and pharmaceuticals are charged at the full cost. In 2009, NSW Health approved fee waivers for specified public health services to community based asylum seekers who are Medicare ineligible (NSW Health PD2009_068. 2009).

Table 1: Australian Humanitarian Program Visa Names and Subclasses.

Where Visa Issued	Component	Visa Subclass Number	Visa Name
OFFSHORE	REFUGEE	200	Refugee
		201	In Country Special Humanitarian
		203	Emergency Rescue
		204	Women at Risk
	SPECIAL HUMANITARIAN	202	Special Humanitarian Program
ONSHORE	ONSHORE PROTECTION	866	Permanent Protection

Asylum seekers who arrive without a visa are typically placed in immigration detention facilities. These could be either a high security Immigration Detention Centre, Immigration Residential Housing or Immigration Transit Accommodation. In such cases, health screening is conducted soon after arrival. The companies responsible for the management of the detention facilities employ their own health staff who refer to the state health system as required. New South Wales has two such facilities, a detention centre and a residential housing unit at Villawood in south-western Sydney. Children of asylum seekers are not held in detention centres but instead live either in the community ('under residence determinations') or in Immigration Residential Housing (DIAC 2010).

Best Practice Refugee Healthcare

Introduction

Principles governing best practice refugee healthcare include:

- Commitment to human rights, gender equity and social justice.
- Valuing and respecting diversity, refugee resilience and survival.
- Affirming refugee empowerment over their own health, the right of refugees as consumers to participate in policy, planning and care delivery and to have their privacy respected.

Best practice refugee healthcare requires that each level of the healthcare system takes responsibility for important aspects of refugee health.

Role of NSW Health

NSW Health is responsible through the Minister for Health for promoting, protecting, maintaining and improving the health and well-being of the population of NSW. This includes ensuring policy coherence in respect of priority populations such as refugees and ensuring that Local Health Networks respond appropriately to such populations.

A central role of NSW Health and the state-wide refugee health services is collaboration, co-ordination and joint planning with other government departments and agencies. Such planning is fundamental to addressing the needs and issues of refugees as agencies responsible for immigration, housing, education, community services, ageing and disability, juvenile justice, police and others have an important impact on the well-being of refugees.

Role of State-wide Refugee Health Services

The state-wide roles of the NSW Refugee Health Service (RHS) and the Service for the Rehabilitation of Torture and Trauma Survivors (STARTTS) include policy, planning,

education, information, refugee advocacy and the development of resources and tools for health services and related agencies. STARTTS directly manages and holds the budget for torture and trauma services across NSW. RHS negotiates with and supports refugee providers within Local Health Networks and provides clinical and service development leadership.

The quality and sustainability of refugee health clinical interventions and services should be assured by collaborative partnerships between the two state-wide refugee health services, NSW Health and Local Health Networks. Specific responsibilities of state-wide services, in addition to their core service responsibilities, include development of:

- Clinical guidelines for the consistent provision of clinics and services.
- Provider education, particularly targeting GPs.
- Regular provider forums for case discussion, support and supervision.
- An annual meeting of refugee health providers across NSW.
- A central register of GPs who have indicated an interest in refugee health and have been trained by the Refugee Health Service and STARTTS.
- An annual report on refugee health service provision in each relevant Local Health Network.
- Information about refugee communities, their needs and issues in formats suitable for healthcare providers.
- Resources and tools to assist health services to provide accessible and appropriate services to refugees and asylum seekers.
- Resources and tools to assist health services to promote refugee participation in health services and in relevant health planning and policy.
- Negotiations with Local Health Networks for the provision of appropriate refugee health services.
- Research and evidence to support service delivery, planning and policy.

Local Health Network Model of Best Practice

The approach to best practice in refugee health at a local health service level requires an integration of high quality service provision, supportive infrastructure and health and wellbeing promotion. This model of care has been supported in the refugee health models of care literature review (Owen et al 2009), in regional areas of NSW (Gould et al 2010; Woodland et al 2010), in available literature evaluating the Victorian Refugee Health model (WRHC 2009), and in evaluations undertaken of rural and regional settlement programs (Piper 2007, Piper 2008, Piper 2009). Appendix 5 outlines more detailed issues associated with the implementation of this model. The local context and available services and resources may determine the way the model is operationalised especially in rural and remote areas.

This model is outlined in Figure 5. The components are:

- A. High Quality Health Service Provision
- B. Supportive Infrastructure
- C. Health Promotion and Improvement.

The aspect of the best practice model related to 'high quality service provision' has the following elements:

- On-arrival primary care assessment.
- Comprehensive health assessment.
- Psycho-social and torture and trauma assessment, treatment and complementary services.
- Linkage and access to primary care services including GPs, nurses and multicultural healthcare personnel.
- Referral to culturally competent mainstream health services.
- Systems for quality improvement, data collection, research and evaluation.

This model assumes a strong relationship between Humanitarian Settlement Services and health assessment services. It is based on co-ordination and collaboration between services.

Figure 5: Overview model of best practice refugee health service provision.

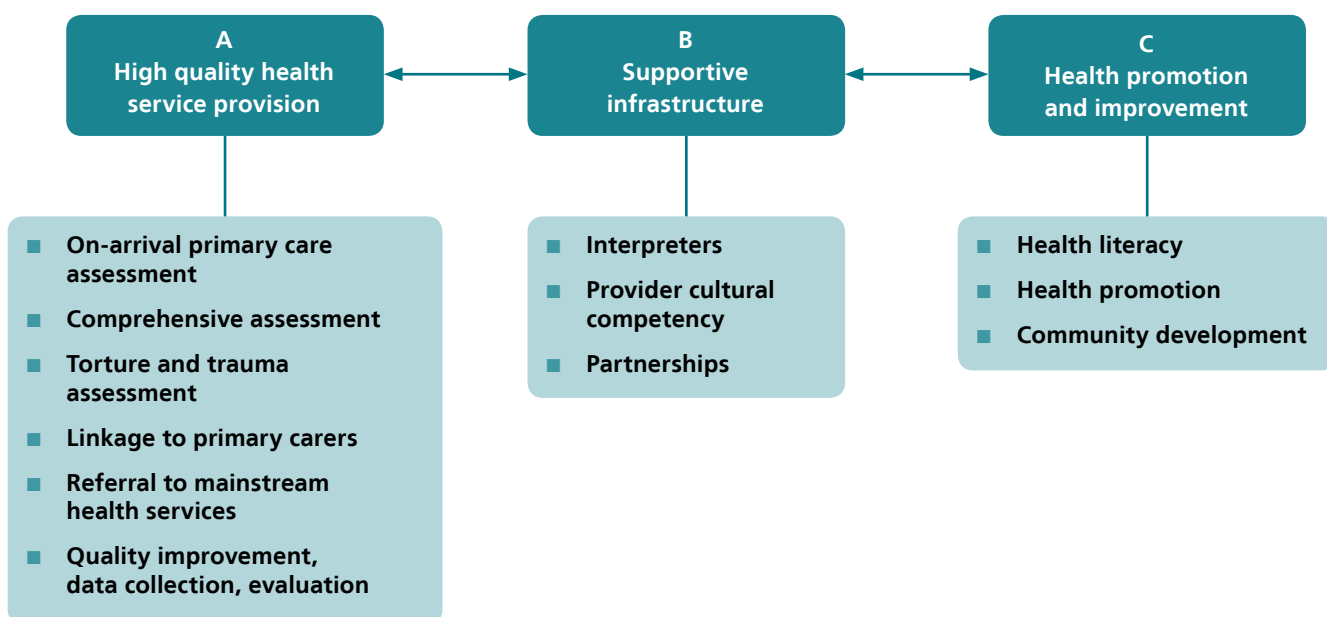
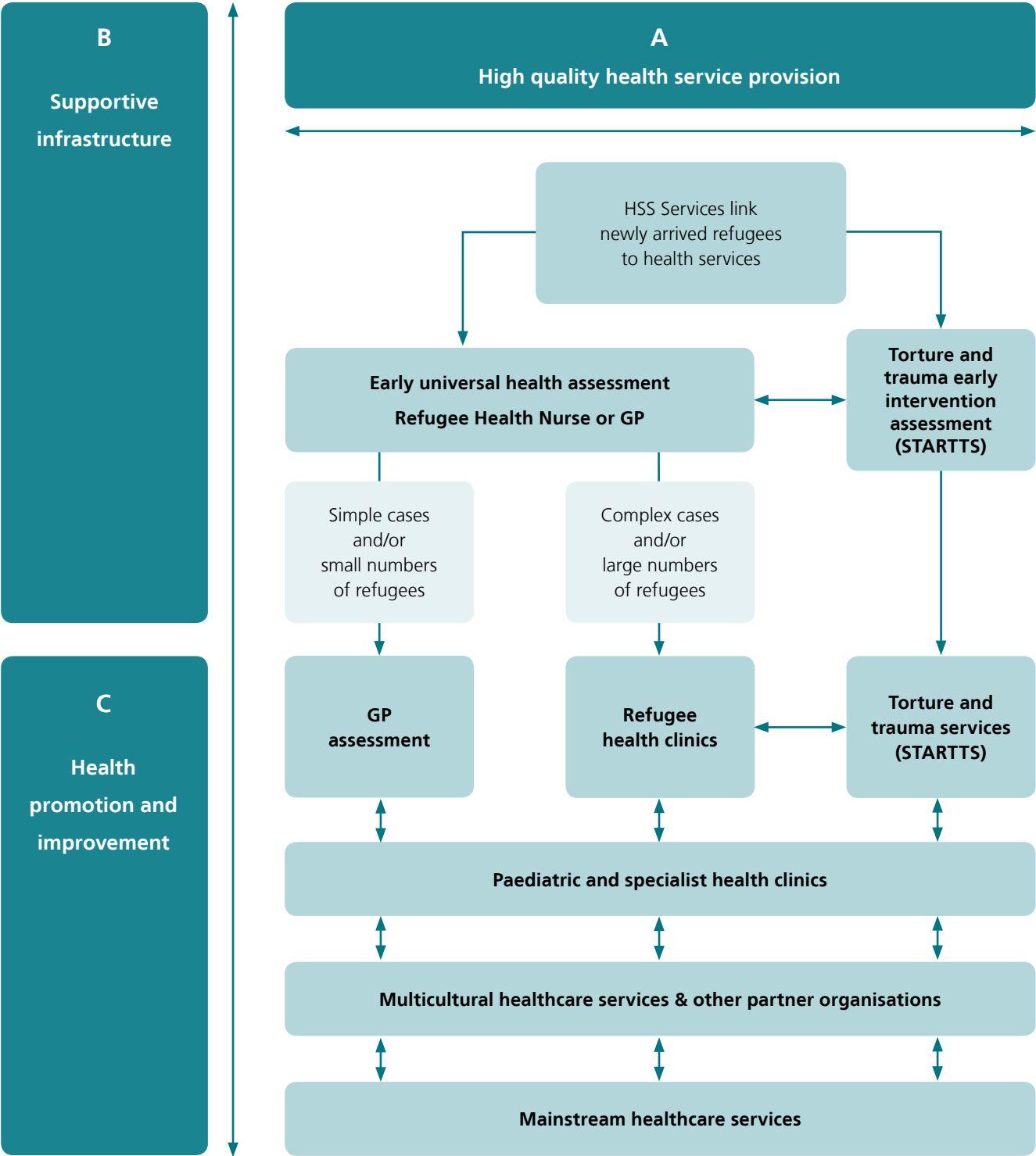


Figure 6: Model of best practice refugee health – focusing on health service provision.



A-1. Early universal health assessment

The initial health assessment is designed to provide a first health service point of contact and to identify health issues which need to be more comprehensively assessed. This should ideally be undertaken by a Refugee Health Nurse.

Where there is no Refugee Health Nurse, then a GP should undertake the assessment. While this initial health assessment should be available to all refugees within four weeks of arrival, the nature of the next stage, the comprehensive assessment, should be determined based on the assessed health profile of the newly arrived refugee.

If the healthcare needs of a refugee are clinically straightforward or the number of refugees requiring care is small (for example in some rural areas) then the initial assessment would result in a referral to a General Practitioner. If clinical needs are more 'complex', that is requiring a range of assessments, tests and return visits or if there are a large number of refugees requiring assessment, then referral should ideally be to a refugee health clinic.

The specially trained and supported Refugee Health Nurse (RHN) would, over time, assume a prominent role in this care model. Presenting problems would be assessed using a standardised assessment tool. The assessment would ideally be conducted in nurse-run clinics backed up by medical practitioners with training in refugee health practice. The nurse would initiate the required diagnostic tests based on clinical guidelines (eg ASID 2009; VFST 2010; RACP 2007). Beyond the initial health assessment the nurse would also be actively involved in referral, arranging the comprehensive assessment, follow-up, health promotion, liaison with providers and overall care co-ordination. RHNs should be supported through professional clinical supervision. With the agreement of the patient, initial assessment information would be shared with the health referral body (GP or clinic) so as to streamline and co-ordinate care provision. In settings where the employment of an RHN is not feasible, this function would be GP-led.

A-2. Comprehensive health assessment

The comprehensive assessment should be undertaken either by a:

- Refugee Health (medical) Clinic, or a
- General Practitioner.

The Royal Australasian College of Physicians (RACP 2007), the Australasian Society for Infectious Diseases (ASID 2009, p.7) and the Royal Australian College of General Practice (VFST 2010) guidelines and policies recommend that refugees be offered a thorough and comprehensive health assessment which includes:

- General health and medical assessment including for example, hearing, nutrition, family planning etc. The RACP guidelines outline important additional requirements relevant to children such as appropriate developmental and behavioural assessments.
- Assessment of immunisation status and catch-up immunisations where appropriate.
- Screening for, and treatment of, tuberculosis, malaria, blood-borne viral infections, schistosomiasis, helminth infection and sexually transmitted infections, if required.

- Testing for, and treatment of, other infections (eg *Helicobacter pylori*) as indicated by clinical assessment.

A management plan should then be developed, consistent with the requirements of relevant Medicare health assessment items. The assessment should be provided by GPs who have completed training in refugee competency and have requested to be listed on a state-wide register of refugee GPs. The Refugee Health Nurse would be involved in follow-up and care coordination.

A-3. Paediatric and specialist health clinics

Paediatric and other specialist health clinics provide a referral tier for assessment of particular population groups or people with specific health needs.

A-4. Early psycho-social and torture and trauma assessment and follow-up

Torture and trauma assessment and counselling, should be provided early in the settlement period. Refugee and humanitarian entrants should be offered the option of an initial assessment. Except in cases where trauma is evident, these referrals typically occur after basic settlement tasks such as finding accommodation and employment have been achieved. The client's psychosocial and emotional health should be assessed and, where appropriate, clients may be offered short to medium term individual, family and/or group counselling or services such as physiotherapy, social support groups, orientation to Australia programs or activity groups such as English and art classes. Entrants accessing counselling services would usually receive an average of six sessions. Specialist child and adolescent counsellors should work with recently arrived refugee children and young people in collaboration with paediatric and adolescent services. Specialist services for other age groups should also be available. STARTTS is the major provider of these services in NSW and Local Health Networks should work in partnership with STARTTS for this component of service delivery.

A-5. Multicultural health services and partner organisations

Collaboration with multicultural services, relevant NGOs and other partner organisations may take a variety of forms in different Local Health Networks. This may include, for example, health information, health promotion, referral, community development and capacity building activities.

A-6. Mainstream health services

Many refugees are routinely referred to mainstream health services such as maternal and child health services, chest clinics, immunisation clinics, oral health services, infectious diseases services, sexual health services, sexual assault services, aged care and mental health services. It is important that these and other mainstream services are culturally competent and understand the health needs and issues of refugees.

A-7. Data collection and evaluation

Linking these services, there should be state-wide common data collected in relation to both refugee health service provision issues and health status issues. Examples of data that should be collected include visa subclass data, ethnicity, country of birth, language spoken at home and health status information. This data should be centrally reported, collated and made available at the health service, Local Health Network and State level. The data reporting should be undertaken by the NSW Refugee Health Service.

Research and evaluation should also inform service provision, planning and policy.

B. Supportive Infrastructure

Major requirements for effective health service delivery to refugees are that:

- The communication barrier is bridged.
- Health providers, services and health organisations are competent and are supported to become culturally competent and to deliver high quality services.
- Strong partnerships are developed with community and refugee organisations.

B-1. Interpreters

Bridging the language barrier is clearly fundamental to effective communication as most refugees arrive in Australia unable to speak English well or at all (DIAC Settlement Database 2009). It is well known that professional interpreter usage results in increased patient satisfaction, improved understanding, greater participation in decision-making, higher levels of compliance with recommended treatments, improved access to services, and fewer medical or health service errors or adverse events (Karliner et al. 2007; Brach & Fraser 2000; Timmins 2002; Jacobs et al. 2001; Flores et al 2003; Baker et al. 1996).

However, access to interpreters in new and emerging communities may pose particular difficulties because of

lack of trained interpreters and translators. There may be limited or no capacity for interpreter services to provide interpreters and translators. Frequently this gap is most pressing when the relevant language group initially arrives in Australia. Thus, active recruitment of interpreters in these communities is essential. Issues associated with gender, religion, ethnicity and dialect may be important factors to consider, and thus, a number of interpreters may be required. Training and educational opportunities, support and de-briefing may be particularly important issues for interpreters from refugee communities.

The Commonwealth Translating and Interpreting Service (TIS) provides 24 hour a day, 7 day per week access to telephone interpreting services through the Doctor's Priority Line and on-site access to interpreters during the day. Health providers working in public healthcare services may access a healthcare interpreter service at any time. Pharmacists may access the free TIS service.

Available evidence, however, indicates that the use of interpreters by private doctors and in public healthcare services remains sub-optimal (Bird 2008; Atkin 2008; Huang & Phillips 2009; Garrett et al 2008a; Kazzi and Cooper 2003) and needs to be addressed.

B-2. Provider cultural competency

Fundamental to provider cultural competency is the recognition that cross-cultural communication in a health setting may be affected by differences in the way the health and illness is experienced, understood and constructed (Bhui & Bhugra 2004). People are known to hold cross-culturally varied beliefs about the nature of a health problem, its cause, the perception of its severity and prognosis, and expectations for treatment and care. The role of the family may vary as may expectations of the roles of healthcare providers (Baer et al. 2003; Kleinman & Benson 2006). These differences may be particularly evident in the provision of healthcare to refugees in relation to attitudes to medications, use of 'complementary' medicines, gender roles, female modesty, religious practices, appointment making, body language or health literacy (Benson & Smith 2007; Garrett et al 2008b). Competent health care provision to refugees may frequently require an understanding of the effects of cultural dislocation, geo-political issues of relevance, loss, severe persecution and trauma, stress, role and identity changes, and the immediate challenges associated with re-starting life in an entirely different cultural, social and political context (Aroche & Coello 2004; Silove 2004).

For effective communication, healthcare providers need to recognise and understand the implications of their own cultural and religious beliefs about health and illness.

Cultural competence has been described by the National Health and Medical Research Council (NHMRC) as having four interrelated dimensions - systemic, organisational, professional and individual (NHMRC 2005). Regular, targeted cultural competency education and professional development for providers working with refugees and students training to be health providers is important. Beyond the cross-cultural skills of health professionals, health organisations and systems need to update and develop appropriate and accessible systems and services. This requires ongoing consultation and negotiation between ethno-specific organisations, refugee communities, refugee providers and healthcare services.

B-3. Partnerships

At the Local Health Network level partnerships and collaborations with a range of settlement and service providers, government agencies, non-government organisations and ethno-specific organisations facilitate quality and co-ordinated service provision, co-ordinated referral mechanisms and refugee involvement in health and human service policy and planning. Such collaborations work towards addressing the social factors which contribute to poor health.

C. Health Promotion and Improvement

C-1. Health literacy and health system information provision

Gaining an understanding of how the healthcare system functions is a fundamental settlement requirement for newly arrived refugees. On arrival in NSW, all humanitarian entrants should receive information on the NSW healthcare system through a variety of mediums including, translated written information, multilingual DVDs, discussion groups and radio programs. Innovative approaches to educating newly arrived communities can be required. There may be a need for culturally relevant strategies to reach newly arrived refugees who have traditions of exchanging information through oral storytelling, or who are not literate in their own language.

Some refugees, particularly those from developing and rural areas may arrive with limited biomedical and anatomical health literacy; especially when they originate from regions

with poor access to western healthcare, where 'popular' or 'folk' medical traditions are especially strong. The provision of information to improve health literacy should not be limited to information targeting only newly arrived refugees. More diverse information is required at different stages of settlement.

As refugee communities are sometimes numerically small, it can be challenging to provide language-specific health education and promotion opportunities. Multilingual resources need to be developed that are appropriate to the needs and issues of refugee communities. Each health area should ideally have available trained bilingual community educators (BCEs) who can organise and conduct culturally and linguistically appropriate programs developed by state-wide refugee health services (RHS and STARTTS), multicultural health and health promotion personnel. BCEs from relevant language groups should be employed on a sessional basis by each health area, as a key measure to improve health and wellbeing. In some cases it may be more feasible for such programs to be provided by general health promotion, multicultural or mainstream staff using an interpreter. In other cases, where the training of local BCEs is not feasible, then efforts could be made to facilitate BCEs travelling to conduct programs. Strategies should also be devised to ensure the sustainability of these groups. For example, programs should be devised in collaboration with multicultural health workers, health promotion personnel or NGOs to shift these education programs into a community development and empowerment framework.

C-2. Health education and promotion targeting the specific needs of refugees

Health and community education and health promotion strategies may be required in areas such as child and adolescent health, men's health, women's health, youth health, health of refugees who are older, ante-natal and post-natal education, parenting and family relationships, vitamin D deficiency, immunisation, oral health, sexual health, nutrition and preventive healthcare. Use of audio-visual material, translated materials, radio programs, the Internet, social networking media, mobile phones and other means may be usefully employed for health improvement. There is an ongoing need to develop tools and resources in relevant refugee languages. Such programs, projects and strategies may be conducted in collaboration with relevant non-government organisations. Some health education can be provided through BCE's or by multicultural, health promotion or mainstream personnel using interpreters.

C-3. Community development, attention to the social determinants of health and social connectedness

Integral to a community development approach is the building of positive relationships within the refugee community, with the host community and with related agencies and groups. Community development approaches recognise the importance of self-determination and collective participation. For refugees, who may have experienced persecution and trauma, and whose homes, families and communities may have been lost or fractured, such approaches may help to rebuild trust, connectedness, personal and social support, leadership skills and may help re-establish individual and community identity. Community development, therefore, may assist resettlement and the re-establishment of social structures.

Community strength can be harnessed for a range of purposes. These may include: education and training; improving health and human service access; building organisations; networking; and, addressing basic health and human service needs.

Such approaches are grounded in attention to the broad social determinants of health. Examples of such determinants include income, housing, food security, education, justice, safety and social relationships. Interagency and intersectoral partnerships may also be integral to developing community capacity.

STARTTS has a major focus on community development and empowerment as a core component of its service base. RHS, women's health services and multicultural health services have provided health promotion programs through Bilingual Community Educators (BCEs). Other projects with strong social connectedness focus have been developed through local health services, DIAC funded projects and through NGOs.

Strategic Priorities

Strategic Priorities

1. To develop health policies and plans which prioritise and are inclusive of refugee health.
2. To ensure, in collaboration with General Practitioners and other partners, universal access to health assessment and assertive follow-up for all newly arrived refugee and humanitarian entrants.
3. To promote refugee health and wellbeing.
4. To provide high quality specialised refugee health services.
5. To develop specific targeted responses to refugee need within mainstream services.
6. To foster the provision of high quality mainstream care to refugees.
7. To foster research and evaluation relevant to the health of refugees.
8. To monitor and evaluate this plan.

STRATEGIC PRIORITY ONE

To develop health policies and plans which prioritise and are inclusive of refugee health.

Strategic Action One: That NSW Health develop a Refugee Health Plan Implementation Group responsible for overseeing the implementation of the NSW Refugee Health Plan.

This group should monitor progress and report once every two years to NSW Health on each of the following key issues outlined in the Plan:

- Public health issues associated with refugees including immunisation.
- Newly arrived refugee access to comprehensive physical, psychological and developmental assessment.
- Refugee access to selected healthcare services such as oral health, mental health, maternal health, chest clinics, torture and trauma services and aged care services.
- Refugee and asylum seeker access to required medications.
- The NSW refugee health promotion plan, focusing on the agreed priority areas (see Strategic Action 11).

- Refugee health data, information and research development.
- Local Health Network Refugee Health Implementation Plans, including progress in enacting these plans (see Strategic Action 2).

Strategic Action Two: That each Local Health Network develop an implementation plan for refugee health improvement which is equitable and appropriate to the local refugee population and profile and which is consistent with the state plan.

Implementation plans should contain the following:

- a) A brief overview of refugee demography.
- b) A strategy for the physical and emotional assessment and referral of newly arrived refugees which is consistent with the NSW Health Best Practice Model of Refugee Health Care.
- c) A strategy for linking with STARTTS to ensure the provision of torture and trauma services.
- d) A strategy for linking with RHS to ensure provision of data, resources and best practice in the provision of health care to refugees and asylum seekers.
- e) A strategy for improving the health and wellbeing of refugees resident within the Local Health Network.
- f) A strategy for supporting the cultural and refugee competency of providers.
- g) Clear performance indicators.

Local Health Networks should nominate a senior person as the contact for refugee health. Plans should be submitted to, and reported upon, through the NSW Health Refugee Health Plan Implementation Group.

Strategic Action Three: That all relevant NSW and Local Health Network plans consider the special needs of refugees as a target group when devising healthcare plans and policies.

Strategic Action Four: That an annual forum be developed for providers and refugee health policy makers to discuss and inform current policy and service delivery issues in refugee health.

Strategic Action Five: That refugees or refugee advocates be included in the state-wide Implementation Group and in each Local Health Network's Planning and Implementation Group.

STRATEGIC PRIORITY TWO

To ensure, in collaboration with General Practitioners and other partners, universal access to health assessment and assertive follow-up for all newly arrived refugee and humanitarian entrants.

Strategic Action Six: That the Best Practice Refugee Health Model outlined in this Plan be progressively implemented throughout NSW.

Strategic Action Seven: That STARTTS' role in providing access to early psycho-social assessment and support programs to refugee survivors of torture and trauma be maintained and supported.

Strategic Action Eight: That an operational plan for the provision of specialist refugee health assessment clinics across NSW be developed.

Strategic Action Nine: Through the Divisions of General Practice, that a register of General Practitioners interested in being trained and supported to conduct health assessments and provide ongoing care to refugees, be developed.

Strategic Action Ten: That cultural and refugee health competency training and improvement opportunities for GPs and other providers involved in on-arrival assessment and ongoing care, continue to be provided.

Strategic Action Eleven: That an extended skills post in refugee health be developed collaboratively by a GP Training Provider and the NSW Refugee Health Service to facilitate GP registrar training in refugee health.

STRATEGIC PRIORITY THREE

To promote refugee health and wellbeing.

Strategic Action Twelve: That NSW Health develop a Health Promotion Plan for enhancing the wellbeing of refugees. In the first instance, the plan should focus on:

- nutrition, obesity and food security, including issues associated with Vitamin D and iron deficiency
- sexual and reproductive health
- parenting, family relationships and cultural transitions
- mental health and drug and alcohol
- oral health.

These priorities should be reflected in each Local Health Network's Implementation Plan.

Strategic Action Thirteen: That NSW Health and state-wide refugee health services work in collaboration with other government departments and agencies to address social issues which impact on the health of refugees.

Strategic Action Fourteen: That refugee health services, in collaboration with relevant partners, provide appropriate and up-to-date information to refugee community members about key health issues and available services, including orientation to new arrivals about the health system.

Strategic Action Fifteen: That bilingual community educators (BCEs) be recruited and trained in rural and regional locations (in addition to those already trained in metropolitan areas), as a means of ensuring the availability of personnel able to provide appropriate health education and information to newly arrived refugees.

Strategic Action Sixteen: That refugee social connectedness be recognised as a priority and that a range of strategies be employed to foster such connectedness.

16.1 That RHS, STARTTS, multicultural health, DIAC-funded partners, NGOs and other partners collaborate on health promoting projects to enhance social connectedness.

STRATEGIC PRIORITY FOUR

To provide high quality specialised refugee health services.

Strategic Action Seventeen: That the role of state-wide services such as STARTTS, RHS and others be further supported and developed.

Specific responsibilities of state-wide services, in addition to their core service responsibilities, include development of:

- clinical guidelines for the consistent provision of clinics and services
- provider education, particularly targeting GPs
- regular provider forums for case discussion, support and supervision
- an annual meeting of refugee health providers across NSW
- a central register of GPs who have indicated an interest in refugee health and have been trained by the Refugee Health Service and STARTTS

- an annual report on refugee health service provision in each Local Health Network
- information about refugee communities, their needs and issues in formats suitable for healthcare providers
- resources and tools to assist health services to provide accessible and appropriate services to refugees and asylum seekers
- resources and tools to assist health services to promote refugee participation in health services and in relevant health planning and policy
- negotiations with Local Health Networks for the provision of appropriate refugee health services
- research and evidence to support service delivery, planning and policy.

STRATEGIC PRIORITY FIVE

To develop specific targeted responses to refugee need within healthcare services.

Strategic Action Eighteen: That NSW Health continue to support the provision of free and equitable access to hospital services for asylum seekers.

Policy directive PD 2009_068 Asylum Seekers- Medicare Ineligible- Provision of Specified Public Health Services (NSW Health 2009) provides an example of the means of ensuring such access.

Strategic Action Nineteen: That NSW Health take action to improve the availability and use of professional interpreters:

- 19.1 That NSW Health advocate that DIAC plan for interpreter provision to new communities prior to their migration to Australia.
For example, a small number of interpreters speaking the community language could be granted migration under the skills component of the migration program.
- 19.2 That the recruitment of new and emerging community interpreters and translators continue to be a priority for health interpreter services.
- 19.3 That technology such as teleconferencing be used to enhance access to professional interpreters, particularly in rural settings.
- 19.4 That ongoing advocacy occur to improve the appropriate access and use of interpreters by private medical practitioners, pharmacists and other healthcare providers.

- 19.5 That advocacy occur to improve the provision of on-site interpreters to private medical practitioners and other providers of healthcare services to refugees.

Strategic Action Twenty: That the special needs of refugees and asylum seekers with mental health problems be considered, particularly through the implementation of refugee-related sections of the NSW Multicultural Mental Health Plan.

Strategic Action Twenty-one: That strategies to address the needs of older refugees, particularly those who are survivors of torture and trauma, be supported.

Strategic Action Twenty-two: That health services facilitate timely access of refugee children to health, developmental and school-based assessments in acknowledgement of their high risk of poor health status and barriers to accessing care.

Strategic Action Twenty-three: That additional action be undertaken to improve the immunisation status of refugees:

- 23.1 That measures be taken to improve the availability of all vaccines free of charge for catch-up immunisation in refugee children, young people and adults of refugee background.
- 23.2 That opportunistic immunisation by mainstream providers and refugee health clinics be promoted and supported.
- 23.3 That current targeted immunisation programs, such as those conducted in partnership with the Department of Education and Training (DET), be continued, and expanded as required.

Strategic Action Twenty-four: That strategies to address the oral health needs of refugees and asylum seekers be developed:

- 24.1 That a model of care to improve refugee and asylum seeker access to oral health services be developed as a priority. This model should have a focus on early intervention and prevention.
- 24.2 That specific strategies be developed to improve the accessibility of the Early Childhood Oral Health Program to refugee and asylum seeker families.
- 24.3 That refugee-specific dental clinics be developed or enhanced in Local Health Networks with significant refugee populations.
- 24.4 That oral health information and promotion programs continue to be developed.

Strategic Action Twenty-five: That strategies be developed to address issues associated with FGM in refugee communities:

- 25.1 That within Local Health Network refugee health plans, the issue of FGM be canvassed, and that clinical guidelines related to the care of women affected by FGM, as advised by the NSW Education Centre on FGM, be implemented.
- 25.2 That education and support for refugee women and refugee communities where FGM is practised be maintained.
- 25.3 That relevant staff receive training in the care of women affected by FGM.
- 25.4 That the option of developing additional hospital clinic(s) for refugee and other women affected by FGM in NSW be explored, in consultation with the NSW Education Centre on FGM.

STRATEGIC PRIORITY SIX

To foster the provision of high quality, accessible mainstream care to refugees.

Strategic Action Twenty-six: That sustained efforts be made in selected mainstream health services to promote accessible and appropriate services for refugees.

These priority service areas include:

- mental health
- sexual and reproductive health
- maternal and child health
- aged care
- chest clinics
- immunisation services
- sexual assault and family violence services
- oral health.

Strategic Action Twenty-seven: That education, resources and tools be developed and provided to improve the cultural competency and refugee competency of the NSW healthcare system.

STRATEGIC PRIORITY SEVEN

To foster research and evaluation initiatives pertaining to the health of refugees.

Strategic Action Twenty-eight: That data from refugee health clinics and services across NSW be standardised, collected, analysed and disseminated.

Strategic Action Twenty-nine: That strategies to promote research and evaluation in refugee health in NSW be pursued.

Priority areas for refugee research include:

- General Practice and refugees
- longitudinal studies of refugee and asylum seeker health
- studies using the new data-linkage capability of the Centre for Health Record Linkage in NSW Health
- immunisation status studies
- studies examining medication usage
- studies targeting key population groups such as children, youth, women, men, the elderly and asylum seekers
- studies examining the effects of racism and discrimination on health and wellbeing
- studies evaluating refugee health practice.

STRATEGIC PRIORITY EIGHT

To monitor and evaluate this plan.

Strategic Action Thirty: That the implementation of this plan take into account the changes in health care structures and systems related to the National Health and Hospital Reform, particularly the development of Local Health Networks and Medicare Locals.

Strategic Action Thirty-one: That progress arising from this plan be reviewed one year after implementation and that the plan be fully reviewed five years after implementation.

Table 1: Strategic Priorities, Actions, Indicators, Responsibility and Timeframe.

Strategic Priority	Strategic Actions	Indicator	Responsibility	Timeframe
1. To develop health policies and plans which prioritise and are inclusive of refugee health	1. That NSW Health develop a Refugee Health Plan Implementation Group responsible for overseeing the implementation of the NSW Refugee Health Plan	Implementation Group convened and regular meetings held	NSW Health in consultation with RHS, STARTTS	2011-2016
	2. That each Local Health Network develop an implementation plan for refugee health improvement which is equitable and appropriate to its refugee population and profile and which is consistent with the state plan	Requirement for plan included in CEs performance agreements. Plan developed and issued to the NSW Refugee Health Plan Implementation Group	NSW Health to initiate. CE's of LHNs to develop plans	Initial Plan due 2011-12. Annual reporting until 2016.
	3. That all relevant NSW and Local Health Network plans consider the special needs of refugees as a target group when devising healthcare plans and policies	Number of plans which prioritise refugees as a priority population within mainstream services	NSW Health, LHNs	Ongoing
	4. That an annual forum be developed for providers and refugee health policy makers to discuss and inform current policy and service delivery issues in refugee health	Annual forums held	RHS, STARTTS, NSW Health	Annually
	5. That refugees or refugee advocates be included in the state-wide Implementation Group and in each LHN's planning and implementation group	Refugee representation on implementation groups	NSW Health, LHNs	Ongoing
2. To ensure, in collaboration with General Practitioners and other partners, universal access to health assessment and assertive follow-up for all newly arrived refugee and humanitarian entrants	6. That the Best Practice Refugee Health Model outlined in this Plan be progressively implemented throughout NSW	Local Health Networks report on progress in implementing the model. Progress documented in their annual report on their Implementation Plans	LHNs	2011-2016
	7. That STARTTS' role in providing access to early psycho-social assessment and support programs to refugee survivors of torture and trauma be maintained and supported	Early assessment and support programs in place	NSW Health	2011-2016
	8. That an operational plan for the provision of specialist refugee health assessment clinics across NSW be developed	Operational Plan developed	NSW Health in consultation with RHS, and relevant LHNs	2011
	9. Through the Divisions of General Practice, that a register of General Practitioners interested in being trained and supported to conduct health assessments and provide ongoing care to refugees, be developed	GP register developed	RHS, Divisions of General Practice	2013
	10. That cultural and refugee health competency training and improvement opportunities for GPs and other providers involved in on-arrival assessment and ongoing care, continue to be provided	Number of training programs and opportunities provided	RHS, STARTTS, Divisions of General Practice	Ongoing

	11. That an extended skills post in refugee health be developed collaboratively by a GP Training Provider and the NSW Refugee Health Service to facilitate GP registrar training in refugee health	Extended skills post developed	NSW Health, RHS	2013	
3. To promote refugee health and wellbeing	12. That NSW Health develop a Health Promotion Plan for enhancing the wellbeing of refugees	Plan developed and implemented	NSW Health, RHS, STARTTS	2013	
	13. That NSW Health and state-wide refugee health services work in collaboration with other government departments and agencies to address the social issues which impact on the health of refugees	Number of intersectoral collaborative projects undertaken by NSW Health and state-wide refugee health services	NSW Health, RHS, STARTTS	Ongoing	
	14. That refugee health services, in collaboration with relevant partners, provide appropriate and up-to-date information to refugee community members about key health issues and available services, including orientation to new arrivals about the health system	Number of information sessions, range of methods	RHS, STARTTS, Multicultural Health, other state-wide multicultural health services	Ongoing	
	15. That bilingual community educators (BCEs) be recruited and trained in rural and regional locations, in addition to those already trained in metropolitan areas, as a means of ensuring the availability of personnel able to provide appropriate health education and information to newly arrived refugees	Number of BCEs in rural and regional health networks	RHS, LHNs	2012	
	16. That refugee social connectedness be recognised as a priority and that a range of strategies be employed to actively foster such connectedness				
4. To provide high quality specialised refugee health services	16.1 That RHS, STARTTS, multicultural health, DIAC-funded partners, NGOs and other partners collaborate on health promoting projects to enhance social connectedness	Additional community connectedness and refugees projects established	STARTTS, RHS, Multicultural Health Services	2011 and ongoing	
	17. That the role of state-wide services such as STARTTS, RHS and others be further supported and developed	RHS and STARTTS continue	NSW Health	Ongoing	
	18. That NSW Health continue to support the provision of free and equitable access to hospital services for asylum seekers	Asylum seekers have access to necessary health and hospital care	NSW Health	Ongoing	
5. To develop specific targeted responses to refugee need within healthcare services	19. That NSW Health take action to improve the usage and availability of professional interpreters				
	19.1 That NSW Health advocate that DIAC plan for interpreter provision to new communities prior to their migration to Australia	Letter written to DIAC outlining the issues	NSW Health	2011	
	19.2 That recruitment of new and emerging community interpreters and translators continue to be a priority for health interpreter services	New and emerging community interpreters continue to be appointed	Healthcare interpreter services	Ongoing	

Table 1: Strategic Priorities, Actions, Indicators, Responsibility and Timeframe. continued.

Strategic Priority	Strategic Actions	Indicator	Responsibility	Timeframe
5. To develop specific targeted responses to refugee need within healthcare services <i>continued</i>	19.3 That technology, such as teleconferencing be used to enhance access to professional interpreters, particularly in rural settings	Health language data demonstrates increased usage of technology	Healthcare interpreter services	Ongoing
	19.4 That ongoing advocacy occur to improve the appropriate access and use of interpreters by private medical practitioners, pharmacists and other healthcare providers	Evidence of actions taken to improve interpreter usage	RHS, Healthcare interpreter services	Ongoing
	19.5 That advocacy occur to improve the provision of on-site interpreters to private medical practitioners and other providers of healthcare services to refugees	Letter issued to TIS advocating increased face-to-face service provision	NSW Health	Ongoing
	20. That the special needs of refugees and asylum seekers suffering mental health be considered, particularly through the implementation of the NSW Multicultural Mental Health Plan (MMHP)	Review of MMHP demonstrates improvement	NSW Health, LHNs	Ongoing
	21. That strategies to address the needs of older refugees, particularly those who are survivors of torture and trauma, be supported	Report developed and issued to NSW Health	STARTTS, Multicultural Aged Care Services	Ongoing
	22. That health services facilitate timely access of refugee children to health, developmental and school-based assessments in acknowledgement of their high risk of poor health status and barriers to accessing care	Refugee children receive developmental assessments	NSW Health, LHNs	2012
	23. That additional actions be undertaken to improve the immunisation status of refugees			
	23.1 That measures be taken to improve the availability of all vaccines free of charge for catch-up immunisation in refugee children, young people and adults of refugee background	Vaccines such as Gardisal provided to relevant clinics and services targeting refugees	NSW Health, LHNs	2011
	23.2 That opportunistic immunisation by mainstream providers and refugee health clinics be promoted and supported	Number of opportunistic vaccinations undertaken annually	NSW Health, LHNs, RHS	2011
	23.3 That current targeted immunisation programs, such as those conducted in partnership with the Department of Education and Training (DET), be continued, and expanded as required.	Increase in targeted programs between 2011-2016.	LHNs	Ongoing
	24. That strategies to address the oral health needs of refugees and asylum seekers be developed			
	24.1 That a model to improve refugee and asylum seeker access to oral health services be developed as a priority. This model should focus on early intervention and prevention	Model developed and presented to NSW Refugee Health Implementation Group	NSW Health Centre for Oral Health, RHS, STARTTS	2013
	24.2 That specific strategies be developed to improve the accessibility of the Early Childhood Oral Health Program to refugee and asylum seeker families	Model developed and presented to NSW Refugee Health Implementation Group	NSW Health Centre for Oral Health, RHS, STARTTS, LHNs	2013

	NSW Health Centre for Oral Health, RHS, LHNs, STARTTS	Additional clinics developed		NSW Health Centre for Oral Health, RHS, STARTTS, LHNs	2012
	NSW Health Centre for Oral Health, RHS, STARTTS, LHNs	Number of health promotion programs conducted		Ongoing	Ongoing
25. That strategies be developed to address issues associated with FGM in refugee communities					
6. To foster the provision of high quality, accessible mainstream care to refugees	24.3 That refugee-specific dental clinics be developed or enhanced in Local Health Networks with significant refugee populations			Local Health Network refugee plans incorporate FGM and the clinical guidelines	NSW Education Centre on FGM, NSW Health, LHNs
	24.4 That oral health information and promotion programs continue to be developed			Number of programs conducted	NSW Education Centre on FGM, RHS, STARTTS, LHNs
				Number of programs conducted	NSW Education Centre on FGM, RHS, STARTTS, LHNs
	25.1 That within Local Health Network refugee health plans, the issue of FGM be canvassed, and that clinical guidelines related to the care and treatment of women affected by FGM, as advised by the NSW Education Centre on FGM, be implemented			Need for extra clinics explored and report developed	NSW Education Centre on FGM, RHS, STARTTS, LHNs
	25.2 That education and support for refugee women and refugee communities where FGM is practiced be maintained			Evidence of innovative strategies to improve service accessibility and cultural competency	RHS, STARTTS, Multicultural Health Services, NSW Health, LHNs
	25.3 That relevant staff receive training in the care of women affected by FGM			Common data set devised.	Refugee Health Service, LHNs, NSW Health
	25.4 That the option of developing additional hospital clinic(s) for refugee and other women affected by FGM in NSW be explored, in consultation with the NSW Education Program on FGM			Number of refugee research projects	NSW Health, RHS, STARTTS, LHNs
	26. That sustained efforts be made in selected mainstream health services to promote accessible and appropriate services for refugees. Priority areas include mental health, sexual and reproductive health, maternal and child health, aged care, chest clinics, immunisation services, oral health			Implementation plans of Local Health Networks and NSW Health reflect the new structures	NSW Health, LHNs
7. To foster research and evaluation relevant to the health of refugees	28. That data from refugee clinics and services across NSW be standardised, collected, analysed and disseminated			Progress report issued to Implementation Group	NSW Health
	29. That strategies to promote research and evaluation in refugee health in NSW be pursued			Plan fully reviewed	NSW Health
8. To monitor and evaluate this plan	30. That the implementation of this plan take into account the changes in health care structures and systems related to the National Health and Hospital Reform, particularly the development of Local Health Networks and Medicare Locals				2012
	31. That progress arising from this plan be reviewed after one year and that the plan be fully reviewed five years after implementation				2012
					2016

Acknowledgements

The NSW Refugee Health Plan was guided by the NSW Refugee Health Plan Steering Committee and a sub-committee of that group, The NSW Refugee Health Plan Working Group. A large number of community, provider and departmental personnel contributed in many ways to the development of this plan.

NSW Refugee Health Plan Steering Committee

Chair: Dr Greg Stewart	Director of Population Health, Planning and Performance, Sydney South West Area Health Service
Members Mr Jorge Aroche	Chief Executive Officer, Service for the Treatment & Rehabilitation of Torture and Trauma Survivors (STARTTS)
Ms Ricci Bartels	Migrant Resource Centre Coordinators' Forum
Ms Maria Cassaniti	Director, Transcultural Mental Health Centre
Dr Kerry Chant	NSW Health, Chief Health Officer
Ms April Deering	NSW Health, Primary Health and Community Partnerships Branch
Dr Pamela Garrett	Senior Planner, Sydney South West Area Health Service
Ms Prabha Gulati	Director, Asylum Seekers Centre
Ms Sally Harold	Asylum Seekers Centre
Dr Tadgh McMahon	Multicultural HIV and Hep C Service
Ms Clarissa Mulas	Sydney West Area Health Service
Ms Anne-Maree Nicholls	Greater Southern Area Health Service
Dr Astrid Perry	South Eastern Sydney Illawarra Health Service
Ms Karen Peters	NSW Health, Primary Care and Community Partnerships
Mr Paul Power	CEO, Refugee Council of Australia
Ms Margaret Piper	Consultant
Dr Vahid Saberi	Director of Population Health, Planning and Performance, North Coast Area Health Service
Ms Marisa Salem	Deputy Director, NSW Refugee Health Service
Dr Mitchell Smith	Director, NSW Refugee Health Service
Mr Peter Todaro	Director, Multicultural Communications Service
Dr Murray Webber	Hunter New England Area Health Service
Dr Nicholas Wood	The Children's Hospital, Westmead
Ms Olivia Wood	Wentwest, Division of General Practice

NSW Refugee Health Plan Working Group

Chair: Dr Greg Stewart	Director of Population Health, Planning and Performance, Sydney South West Area Health Service
Members Mr Jorge Aroche	Chief Executive Officer, Service for the Treatment & Rehabilitation of Torture and Trauma Survivors (STARTTS)
Ms Ricci Bartels	Migrant Resource Centre Coordinators' Forum
Mr Fred Foster	NSW Health, Primary Health and Community Partnerships Branch
Dr Pamela Garrett	Senior Planner, Sydney South West Area Health Service
Ms Clarissa Mulas	Sydney West Area Health Service
Dr Astrid Perry	South Eastern Sydney Illawarra Health Service
Dr Mitchell Smith	Director, NSW Refugee Health Service

Note: Local Health Networks have been established and began on 1 January 2011. The Area Health Service titles listed above were current at the time the committee was being convened to develop the Plan.

Terms of Reference

1. To review the activities and outcomes resulting from the *Strategic Directions In Refugee Health Care* (1999).
2. To assess models of care, both nationally and internationally, and to determine best practice approaches to providing holistic refugee health care in NSW.
3. To consult widely with refugee communities, refugee providers, mainstream healthcare services and other relevant agencies to develop the plan.
4. The NSW refugee health plan will:
 - a. determine the current and projected health needs and service demands of refugees in NSW.
 - b. describe and evaluate current health service capacity, health improvement strategies and models of care available for refugees in NSW.
 - c. determine the adequacy of, and priorities for, refugee health research.
 - d. determine strategies and actions required to provide best practice health care and health improvement for refugees in NSW to 2015.
 - h. describe the process for implementation, outcomes monitoring and evaluation of the plan.

Summary of The Review of *NSW Health Strategic Directions in Refugee Health 1999-2009: A Decade of Change*

Introduction

The review of *Strategic Directions in Refugee Health* was undertaken during 2009. It included interviews with the major service providers and those responsible for implementation. This Appendix summarises the major findings.

The *Strategic Directions in Refugee Health Care in NSW* (1999) lists five major strategic directions. The outcomes under each of these strategic directions are outlined.

1. Enable refugee communities to make choices conducive to their health

Information packages suitable to the needs of newly arrived refugees have been developed and provided in a variety of ways by key providers such as Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) and the NSW Refugee Health Service (RHS). This includes face-to-face sessions and programs, media (radio) sessions, DVDs, posters, community consultations, youth camps and translated pamphlets.

A large number of on-arrival and settlement education programs and resources have been conducted with a view to improving health literacy and promoting health for example, the *Community Health Education Program (CHEP)* provided by RHS and the *Families in Cultural Transition Program (FICT)* and *Settling In* a kit for schools provided by STARTTS. The RHS booklet, the *NSW Health Care System* offers information about the health care system in NSW.

The Refugee Health Improvement Network (RHIN) promotes information sharing, discusses key refugee health issues and has had an advocacy and policy development role.

Collaborative programs with other government departments include for example: RHS's *The Community Health Education Program*, STARTTS' *Families in Cultural Transition Program (FICT)*, *The Southern Sudanese Women's Group*, the *Settling In* program developed by STARTTS in conjunction with NSW Department of Education (DET),

Transcultural Mental Health Centre's resource *Depression in Young People from Culturally and Linguistically Diverse Backgrounds*.

Health promotion programs targeting refugees have been conducted but these tend not to constitute a cohesive, state-wide or comprehensive approach to refugee health status improvement.

Multicultural health promotion projects such as the Arabic Tobacco Project or HIV/Hep C programs have at times targeted refugee communities. In the greater west and inner west of Sydney BCE programs have been run on topics such as nutrition, diabetes, breast screen education, health of older women and parenting. The NSW Education Centre on FGM runs women's health programs for refugee communities. RHS has conducted programs such as food security/nutrition and women's' health through BCEs.

Sustained community development approaches may be more efficacious than one-off health education programs. Programs and strategies are needed in child and adolescent health, men's health, women's health, health of elderly refugees, Vitamin D deficiency, oral health, nutrition and preventative healthcare.

2. Improve access for refugees to a range of health services

The state-wide Refugee Health Service (RHS) was established in April 1999, providing advocacy, information, resources, education, consultation and research. RHS provides one (weekly) clinic in Liverpool, and two (weekly) clinics located in Blacktown and Auburn Community Health Centres.

The former Area Health Services in NSW developed and funded some refugee clinics and services, in response to need in their areas. Programs and clinics were developed in Newcastle, Wollongong, North Sydney, Coffs Harbour and Wagga Wagga. Each of these services has developed its own standards, data collection systems, staffing, management structure,

models of care, procedures, objectives, and budget. RHS has provided support and advice to these services.

There is considerable debate amongst senior public health, refugee health and human service providers suggesting public medical assessment should aim to be universal for humanitarian entrants for both personal and public health reasons.

STARTTS provides clinical services at Coffs Harbour, Wollongong and Newcastle, with outreach services to other rural areas. The Transcultural Mental Health Centre provides rural and remote outreach services, programs and training.

Specialist paediatric services have been established at the Children's Hospital, Westmead (HARK Clinic), Sydney Children's Hospital, Liverpool Hospital and John Hunter Hospital. A specialist youth health clinic has been developed at Fairfield. However, there is no state-wide approach or universal co-ordination of refugee paediatric care. STARTTS have developed a clinical strategy to meet the needs of refugee children who have been tortured or traumatised.

Up skilling General Practitioners remains a key priority. In regard to mainstream services, mental health, sexual health, maternal health, child health, youth health, aged care, emergency services and sexual assault services are priority areas for education.

Access to oral health care remains a priority.

Planning for, recruiting and training interpreters in new and emerging language groups remains a challenge. Usage of interpreters by medical practitioners, access to interpreters for allied health and related services funded under Medicare and usage of interpreters in hospitals also remain issues.

Rural services may lack access to a range of multicultural services and educational opportunities. Further primary care and speciality services required for complex medical care may be unavailable.

Some groups such as asylum seekers may have limited healthcare rights by virtue of their visa class.

No areas have refugee health plans aside from HNEAHS and SESIH. WSAHS has a draft strategy.

3. Enhance collaboration between health services directed to refugees within NSW, in partnership with community organisations and other government agencies

There are a number of examples of collaborative relationships being established between government departments as needs and issues arise. Examples include RHS, STARTTS and DADAHC collaboration on older refugees.

4. Enhance the skills of health professionals in refugee health care

Resource materials for health professionals include Fact Sheets, health assessment protocols, service guidelines, DVDs, referral manuals, training manuals, posters, and academic and health service publications. Specialised resources have been developed for child health and youth workers, social workers, general practitioners and people working with older refugees and other audiences.

Refugee health providers have participated in undergraduate and postgraduate healthcare academic programs. RHS, STARTTS and other refugee services have conducted a large number of training programs for health professionals, including GPs. The NSW Education Centre on Female Genital Mutilation (FGM) provides education for providers. Training offered covers clinical case management and counselling responses to FGM.

5. Promote research into refugee health

There is limited evidence that refugee research has been prioritised. The (then) proposed centre for Multicultural Health was established at the UNSW but has since been abandoned. A number of publications and research projects have been undertaken by STARTTS, TMHC and RHS within their current budgets. In addition, a number of refugee providers and policy staff have published in the area of refugee health. However, such research is piecemeal.

Conclusion

Considerable advances have been made in NSW in the field of refugee health over the past ten years. Indeed, it has been a decade of enormous change and of a great many successful programs, health care service developments, policy changes and the successful settlement of diverse refugee communities.

Summary of Consultations Related to the Development of The Plan

Consultation methods included meetings, inter-agencies, focus groups, brief on-line surveys, interviews, letters to hospital managers inviting comment and a review of consultations undertaken, for other related purposes.

Refugee health policy issues

The major policy issue raised was the need to monitor and ensure accountability for the provision of an agreed set of responses to refugee populations within Local Health Networks. Related policy issues included immunisation issues, access to medications, prohibitive costs of some services, poor access to dental services and the varied access of some people to healthcare dependent on their visa class.

Needs of Refugee Groups

Rural and regional humanitarian settlement

In some rural areas of initial or secondary settlement, few appropriate health and human services may initially be available, including on-site interpreters, bilingual services, general practitioners and speciality services.

Issues for refugee families and young people:

One bilingual worker discussed the settlement difficulties associated with role changes in families:

'At home the man is the director, he works for the family. The woman stays at home. But here, it is a culture shock. The woman has her own account at Centrelink. The woman has the money and the man; he has to ask for it.'

Elderly refugees

The needs of refugees who arrived several years ago were noted. An Aged Care Worker said:

'When they become old and frail or demented, the refugee trauma experience re-emerges as a major issue.'

202 Visa holders, asylum seekers and people living in community detention

The isolation of some refugees who had been proposed through philanthropic or church groups was mentioned by some mental health providers. People seeking asylum in Australia sometimes had very complex healthcare access issues and health needs. People in community detention still consider themselves detained.

'They may be separated from family. They can't work or access services. They live every day with the stress and uncertainty about their future.'

Health Status of Refugees

Complex medical conditions and infectious diseases

Refugees may have complex medical and healthcare issues including vitamin deficiencies, infectious diseases, and (sometimes) undiagnosed or asymptomatic conditions.

Health literacy

Understanding the Australian health system, language barriers and poor health literacy were sometimes evident.

'The information about health care and medications is often totally overwhelming for the newly arrived patient. It's too much to take in all at once.'
Assyrian/Arabic worker.

Oral health

Refugees are afforded varied access to public dental care dependent on the access policies of the local health service. Oral health is a problem for many refugees.

Nutrition and food security

Obesity and diabetes were mentioned as issues.

A Creole interpreter noted that:

'The services are targeting sick refugees. They should target physical activity and diet. Africans are getting fat all of a sudden.'

Torture and trauma, mental health

The effects of torture and trauma on mental health and wellbeing were noted. Mental health issues were also mentioned.

A teacher said:

'Depression in secondary students is prevalent. Students are disengaging; some are even seen as possessed. Some of the students have experienced very significant trauma which impacts on their capacity to concentrate, learn and sometimes to form attachments'.

Sexual and reproductive health, women's health

Refugee women have at times been the survivors of sexual torture and rape. The importance of women's health information, language-specific antenatal education and access to pap test, mammography, reproductive and sexual health services was repeatedly mentioned. The access of young people to sexual and reproductive health information was also mentioned many times. Women who have been affected by FGM discussed their embarrassment and alienation in using healthcare and the need for provider education on FGM.

Refugee Health Service Provision Issues

Universal access and model of care

Providers noted that across NSW there are varied models of refugee medical assessment. Systematising the model and the data collection approaches was recommended. General practitioners often found consultation with newly arrived refugees to be long, under remunerated, involved, family-centred and requiring the services of an interpreter.

Interpreters

The importance of trained, professional interpreters was regularly emphasised. GPs, specialists and emergency departments were cited as being poor users of interpreters at times.

'GPs want the provider number to incorporate interpreter usage'.

Refugee health related services

There was very strong support for the healthcare services provided by RHS, STARTTS and other refugee health providers. Refugee communities suggested a need for more bilingual workers.

Data and research

There is no state-wide or national data set on refugee health status or outcomes of initial refugee assessments. A number of senior clinicians suggested that improved research would inform policy, planning and strategy development, particularly in areas such as immunisation, nutritional disorders and chronic conditions.

Visa Class and Health Access Rights – An Overview and Summary

APPENDIX 4

Table 3: Eligibility for Health and Settlement Services by Selected Visa Class.

Visa Class	On-Arrival Settlement Support	Amp (English Classes)	Settlement Grants Program	Complex Case Support	Medic/Re	Gps	Private Health Insurance *	Refugee Health Clinics	Private Medical Specialist *	Public Hospitals	On Arrival Health Assessment - Screening - if available	torture and trauma services	Interpret. Services @ DPL, HCIS, TIS
Refugee and related (Subclasses 200, 201, 203 & 204)	Y	Y	Y	Y	Y	Y	Y*	Y	Y*	Y	Y	Y	YYY
Global special humanitarian (subclass 202) – sponsored by proposer	Y	Y	Y	Y	Y	Y	Y*	Y	Y*	Y	Y	Y	YYY
Family stream migrants	N	Y	Y	N	Y	Y	Y*	Y	Y*	Y	N	Y	YYY
Family stream migrants (subclasses 143, 864)	N	Y	N	N	Y	Y	Y*	Y	Y*	Y	N	Y	YYY
People in detention centres	N	N	N	N	N	Y*	N	N	Y*	Y*	Y*	N	NYN
***People in community detention	N	N	N	N	N	Y*	N	N	Y*	Y*	Y	N	NYN
Asylum seekers who have work rights	N	N	N	N	Y	Y	N	Y	Y*	Y	Y	Y	NYN
++Asylum seekers without work rights - eligible for asylum seekers assistance scheme (asas)	N	N	N	N	N	Y (ASAS)	N	Y	Y (ASAS)	Y (as per pd NSW Health)	Y	Y	NYN

Implementation Issues Associated with the Best Practice Model

Introduction

The following components of the Best Practice Model have implementation issues:

- The role of the Refugee Health Nurse
- Increasing and developing the role of the Refugee Health Nurse
- Ensuring adequate specialist referral clinics.

Refugee Health Nurses

Refugee Health Nurses (RHNs) have been identified as a key component of an effective best practice model in refugee health care. There are, however, a variety of roles which the nurse may productively assume within refugee health. Existing RHNs in NSW Local Health Networks, in Victoria and in other Australian states have somewhat different roles. In part the diversity of roles reflects contextual differences, especially rural versus metropolitan, and in part is a reflection of different sets of service structures and philosophies. There is therefore a case for a core role and then for variations based on contextual differences.

Rationale for More Prominent Role for Refugee Health Nurses in NSW

1. The lack of single early point of contact is leading to doubling up of tests and immunisations in some cases, while conversely other refugees are not being assessed at all. Thus, the current arrangement lacks efficiency, effectiveness and equity.
2. After accessing a GP, newly arrived refugees may not attend a follow-up visit unless they are supported. Yet, this return visit is where test results are discussed and treatment or care pathways are negotiated. Thus, refugees can miss crucial health assessment outcome information.
3. Similarly, medication access and encouraging adherence to therapy is a particular issue.
4. Research is demonstrating that GPs experience difficulties in seeing refugees especially those who have more complex health profiles, those who speak little/no English and those in large families.

5. In some rural areas there are few or no GPs able to accept new patient bookings: thus they do not have the capacity to accept refugee referrals.

Core role

The following are considered core RHN roles:

- **First point of health contact** for newly arrived refugees with a role of initial assessment, community triage and referral to appropriate medical and health services as required.
- **Screening** newly arrived refugees using standardised assessment tools, as a part of a screening/assessment service. The nurse would initiate the required diagnostic tests based on clinical guidelines (eg RACP 2007; ASID 2009; VFST 2010) and epidemiological advice relating to country of origin, age, special circumstances of refugee groups etc. This would be in preparation for a follow-up refugee health clinic or when a GP/paediatrician/infectious diseases specialist sees the patient/family. With the agreement of the patient, initial assessment information would be shared with a suitable GP or clinic to facilitate ongoing care.
- **Care Coordination**, working in partnership with GPs and relevant organisations to ensure appropriate care is delivered over a period of time. Liaison, assertive follow-up, advocacy and case management are key aspects of this role.

Role in Particular Rural Areas or Specific Contexts

- **Nurse practitioner**, especially in the absence of GP services, or working in close co-operation with GPs. This role may include providing clinics, ordering required tests, undertaking standard assessments, ordering medications and referring to GPs or other relevant medical services.

This approach is supported by reports evaluating the Victorian Refugee Health model (WRHC 2009), outlining rural refugee models of care in NSW (Gould et al 2010), in evaluations of regional settlement programs (Piper 2009)

and in the literature review commissioned for this plan (Owen et al 2009).

Current Refugee Health Nurse Capacity

The following table shows the current refugee health nurse positions in NSW and estimates the requirement as health services move toward a model of universal on-arrival health assessment for refugees.

NSW on average accepts an average of about 4,000 humanitarian entrants per year. These people initially settle as per Table 4, although fluctuations in settlement numbers, changing mix of on-shore and off-shore entrants and a wide range of health and social issues and needs are features of the humanitarian program.

The requirement for refugee health nurses has been estimated based on the numbers of new humanitarian arrivals per local health network, assuming that 1 nurse, in the metropolitan area, working 40 weeks per year (taking into account leave, staff development time, meeting time and service development time) can see and follow up about 7 new humanitarian entrants per week, together with ongoing casework with people who arrived in the previous weeks. This would be reasonable in the greater west of Sydney where multicultural and health service infrastructure

is more developed and with greater access to specialist services. So, for the average number of humanitarian arrivals in greater Western Sydney (3,300), approximately 12 FTE RHNs are required.

A further check can be made by comparison with the Victorian refugee health nurse program. Victoria has a slightly smaller refugee entry per year and smaller distances to travel and currently employs 16 FTE nurses, plus the community nurse and locum nurse services provided at the Asylum Seekers Resource Centre in Victoria.

Secondly, although working with a somewhat different model, the RHS is currently assessing about 20% of the humanitarian entrants to the greater west of Sydney, with 2.4 nurses. To see 100%, therefore, approximately 12 FTE positions would be required for the greater west of Sydney.

In rural and regional areas there is a need to take into account the spread of areas in which refugees are settling and the poor availability of multicultural and health infrastructure. Thus, a smaller number of cases can be assessed and followed up. In areas such as Northern NSW, there is a need to extend outreach services to Lismore and to areas where church and philanthropic organisations are settling small numbers of refugees.

Table 4: Current RHN positions by Local Health Network (LHN) and positions required for universal health assessment.

Local Health Network	Current RHN positions (FTE)	Number of Humanitarian settlers June 2004- June 2009	Estimated requirement to achieve best practice model by 2016
Southern Sydney & Western Sydney	2.4	16,526	12.35
Illawarra Shoalhaven & South Eastern Sydney	1.0	1062	2.00
Hunter New England	1.2	600	1.50
Mid North Coast & Northern NSW	0.4	398	1.50
Murrumbidgee	0.2	355	1.00
Central Coast & Northern Sydney	0	515	0.20
Western NSW	0	NA	0.20
Asylum Seekers Centre (NGO)	0.6	2 – 3,000 clients	1.60
Management/clinical supervision and administration support	0	20,500 (5 years)	1.00
Total (inc NGO)	5.8		21.35
TOTAL (public health)	5.2		19.75

Note: RHN's at times, work across more than one LHN. For example, services in the greater west of Sydney are provided by the state-wide NSW Refugee Health Service (RHS).

The table has included the services provided at the Asylum Seekers Centre, an NGO providing health services to people in the process of seeking recognition as refugees.

To fulfil this role effectively, nurses will need clinical back-up or supervision. Indeed, as the model is progressively implemented there will be a need for a senior position responsible not only for development and management of the program, but also to ensure overall quality, safety and professional development.

Further enhancements of the state health service interpreter resources will be required with the development of the Refugee Health Nurse Program in NSW.

Refugee Health Clinics

In addition to refugee health nurses, the Best Practice Model requires that nurses and general practitioners be backed-up by a network of Refugee Health Clinics, which are especially skilled in working with the complex health problems and assessment processes required for refugees. Such clinics may need to be developed flexibly, with community involvement, as needs and demographics change.

Gould et al (2010) suggest that refugee health clinics should be based on an "integrated care model", with a sustainable funding base, community involvement in planning, multidisciplinary staffing, interpreters, transport and pharmaceutical access, appropriate physical premises and coordinated links with other agencies and services. Such clinics may be appropriate models for rural areas, especially where critical health infrastructure may be limited (Sypek et al 2008).

In order to provide back-up and support for the Refugee Health Nurses, an appropriate network of clinics should be available, modelled on the services currently provided by the NSW RHS and some local health networks.

Specialist Refugee Health Clinics

Referral clinics are integral to the best practice model of care. To date, the specialist clinics include paediatric clinics provided by the metropolitan tertiary children's hospitals, a refugee youth clinic and an infectious diseases clinic, at a regional referral hospital (Wollongong).

Table 5: Current refugee health clinics by Local Health Network (LHN) and clinics positions required for universal health assessment.

Local Health Network	Current General Refugee Health Clinics	Paediatric (P) Youth (Y) Asylum Seekers (As) and Infectious Disease (Id) Specialty Clinics
South Western Sydney	1 (Liverpool/ Fairfield)	1 (Y) (Fairfield) 1(P) (Liverpool)
Western Sydney	2 (Auburn and Blacktown/Mt Druitt)	
Illawarra Shoalhaven	0	1 (Id) (Wollongong)
Sydney Children's Network	0	1 (P) (Children's Hospital, Westmead-HARK Clinic) 1 (P) (Sydney Children's Hospital)
Hunter New England	1 (Newcastle)	
Mid North Coast	1 (Coffs Harbour)	
Murrumbidgee	1 (Wagga Wagga)	
NGOS		1 (As) (Surry Hills) (Unfunded- Pro-Bono)

Note: The clinics at South Western Sydney and Western Sydney are conducted by the state-wide NSW Refugee Health Service (RHS).

Abbreviations

ASID	Australasian Society for Infectious Diseases
BCE	Bilingual Community Educator
CALD	Culturally and Linguistically Diverse
CEDAW	The Convention on the Elimination of all Forms of Discrimination against Women
COHS	NSW Centre for Oral Health Strategy
CNC	Clinical Nurse Consultant
CRC	Community Relations Commission
DIAC	Department of Immigration and Citizenship
DOHA	Department of Health and Ageing
DMFT	Decayed/Missing/Filed Teeth
FGM	Female Genital Mutilation
GP	General Practitioner
HPV	Human Papilloma Virus
HSS	Human Settlement Service
LHN	Local Health Network
MMR	Measles-Mumps-Rubella
Nfd	Not further defined
NACOH	National Advisory Committee on Oral Health
NHMRC	National Health and Medical Research Centre
PBS	Pharmaceutical Benefits Scheme
PDMS	Pre-departure Medical Screening
RACP	Royal Australasian College of Physicians
RCOA	Refugee Council of Australia
RHN	Refugee Health Nurse
RHS	NSW Refugee Health Service
STARTTS	NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
SHP	Special Humanitarian Program
TB	Tuberculosis
TIS	Translating and Interpreting Service
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
UNHCR	United Nations High Commissioner for Refugees
VFST	Victorian Foundation for Survivors of Torture
WHO	World Health Organization

Glossary of Terms

Asylum Seeker	A person who has applied for protection from within Australia as a refugee but has not yet received a determination about their status. According to the UNHCR, an asylum seeker is “an individual who is seeking international protection. In countries with individualised procedures, an asylum seeker is someone whose claim has not yet been finally decided on by the country in which he or she submitted it. Not every asylum seeker will ultimately be recognised as a refugee, but every refugee is initially an asylum seeker’ (UNHCR 2006).
Cultural competence	A set of behaviours, attitudes and policies that support a negotiated process of appropriately caring for people across languages and cultures (Cross et al. 1989). Cultural competence has four interrelated dimensions- systemic, organisational, professional and individual (NHMRC 2005).
Displaced person	A general term for someone who has been forced to leave his or her place or home. Internally Displaced Person (IDP) is a person who has been forced to leave their home, often for the same reasons as a refugee, but they have not crossed into another country.
Diversity	The wide range of cultures, beliefs, values and ideas in a population.
Humanitarian entrant	A person who migrates to Australia under one of three migration programs: <ul style="list-style-type: none">■ the Refugee Program■ the Special Humanitarian Program (SHP): people who are outside their country of origin and have been identified as having experienced, or fear, gross discrimination amounting to a substantial violation of their human rights may be granted a Class 202 Visa■ the Special Assistance Category : groups with close family or community links to Australia who are in particularly vulnerable situations overseas and who do not meet the criteria for the other categories.
Female Genital Mutilation (FGM)	<p>“Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.</p> <p>The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. Increasingly, however, FGM is being performed by health care providers.</p> <p>FGM is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death.” WHO Fact Sheet, 2010.</p>
Pre-departure medical screening (PDMS)	Pre-departure medical screening is a voluntary health check typically undertaken around three days before travel to Australia. It is in addition to the ‘visa’ medical check undertaken before a visa is granted.

Refugee	Any person who has a well founded fear of being persecuted for reasons of religion, nationality, membership of a particular social group or political opinion; is outside their own country; is unable or unwilling to return to that country because of fear of persecution; and is not a war criminal or person who has committed a serious non-political crime.
Refugee Competency	A term which has been developed for the purposes of this plan which describes the particular skills and competencies associated with providing and negotiating appropriate and accessible health care for people who have had refugee-like experiences.
Resettlement	‘Resettlement involves the selection and transfer of refugees from a State in which they have sought protection to a third State which has agreed to admit them – as refugees - with permanent residence status. The status provided should ensure protection against refoulement and provide a resettled refugee and his/her family or dependants with access to civil, political, economic, social and cultural rights similar to those enjoyed by nationals. It should also carry with it the opportunity to eventually become a naturalized citizen of the resettlement country.’ UNHCR 2004, p 1.
UNHCR	The UNHCR, established in 1950, leads and coordinates international efforts to protect refugees and resolve refugee problems world-wide.
Torture	‘...any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him, or a third person, information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to, lawful sanctions’ — UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) Article 1.

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