POLICY

Refugee health

<table>
<thead>
<tr>
<th>Scope (Staff)</th>
<th>Child Health, School Health</th>
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</thead>
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<tr>
<td>Scope (Area)</td>
<td>CACH, WACHS</td>
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This document should be read in conjunction with this DISCLAIMER

Background

In the past 60 years, more than 660,000 refugees and displaced people have been resettled in Australia.\(^1\) Australia's Humanitarian Program assists people affected by international humanitarian crises. A sponsorship program also allows resettlement of family members of refugees once they have attained citizenship.

Annually, approximately 20% of humanitarian entrants to Australia settle in the Perth metropolitan area and nearly half of these are children and adolescents.\(^2\) In 2009/10 the Federal Government granted 13,770 visas to refugees under the Humanitarian program.\(^2\) In 2009-10 Western Australia received 3,043 humanitarian settler arrivals from countries including Afghanistan (41.3%), Burma (15.4%) and Sri Lanka (9.7%).\(^2\) In the first half of 2011 alone, over 2000 humanitarian entrant clients were seen by the Child and Adolescent Community Health (CACH) refugee health team and currently the regional focus is on Burma and the Middle East. Within the Perth metropolitan area, approximately half of the humanitarian entrants settle in the northern suburbs (City of Stirling and surrounding areas of the Cities of Bayswater and Wanneroo) and half settle in the southern suburbs (mainly in Cannington and Gosnells). Additionally, secondary migration has already commenced and is being considered in a number of country areas within Western Australia.

The Australian Government requires refugees to undergo a medical examination as part of the visa application. Some refugees have another health check approximately 72 hours pre-departure (Pre-Departure Medical Screening) to assess fitness to travel. After arrival, a voluntary health assessment is offered through the Humanitarian Entrant Health Service (HEHS), Department of Health Western Australia. This includes screening for some infectious and communicable diseases including tuberculosis, and an immunisation catch-up program is commenced. Following this assessment, the majority of children (<16 years) are referred to the Princess Margaret Hospital Refugee Health Clinic for further multidisciplinary assessment and follow-up. In addition, families are referred to the local community health services and a General Practitioner for follow-up as necessary.

The background of refugee children and families is likely to be markedly different to most Western Australians. Many families have experienced long and difficult journeys prior to arriving in Western Australia and can spend months or years in refugee camps or in countries where their basic needs are barely met. Children who are conceived and born in such situations often face deprivation and uncertainty and may have received minimal or no health care, which increases their susceptibility to disease and chronic health conditions.
Due to the difficulties experienced in their home country and the potentially protracted pathway to Western Australia, refugee parents are often vulnerable to mental ill health, overwhelming stress and social disadvantage. Parents experiencing post traumatic symptoms can have poorer impulse control, unstable moods and be extremely irritable which may result in a harsh and inconsistent parenting style. This can lead to an insecure attachment and poor social, cognitive and emotional outcomes for the child. Furthermore, vicarious trauma and/or gender-based violence inflicted on child and/or family members may compound these issues as well as affect a child’s physical and psychological growth and development.

It is common for refugee children to experience anxiety, depression and sleeping disorders in response to traumatic events they may have witnessed. There is a high prevalence of post-traumatic stress disorder (PTSD) among refugee children, which may result in symptoms such as insomnia, flashbacks, nightmares and enuresis. Other common health issues amongst refugee children include poor nutrition and inadequate immunisation. Lack of access to appropriate schooling, language and literacy issues and/or interrupted education can significantly affect a child’s development and socialisation. Developmental assessments may not have been available in the home country and therefore early identification of developmental problems may not have occurred. Children may have some health problems that are unfamiliar to Western Australian health workers.

At considerable risk are those children who are 'unaccompanied minors,' as they have not had the protection or support provided by family members. Some of these children will have experienced gender-based violence/sexual assault or been subjected to engagement in warfare, and this further increases their vulnerability to mental health problems. In addition, the lack of parental support and supervision can make settling into society a difficult process and extra support or guidance is required.

Community Health Nurses (CHN) are in an ideal position to provide holistic health care and assist with integration into the community. Current evidence supports health care frameworks that include key factors for effective primary prevention strategies, such as culturally appropriate service provision, parent education and support, and acknowledging the additional needs of vulnerable and at-risk children.

It is the responsibility of the health professional to provide the best care that maximises outcomes while maintaining cultural integrity. In order to adequately support, effectively communicate with, and access culturally diverse communities, health services and professionals are encouraged to develop a high level of cultural competence.

Refugee Origins

Table 1 indicates the changing proportion of refugees from different continents who settled in Australia from 2006-2010.

Table 1. Changing compositions of Australian Humanitarian populations

<table>
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<tr>
<th>Region</th>
<th>2006/07 Proportion</th>
<th>2009/10 Proportion</th>
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<tbody>
<tr>
<td>Africa</td>
<td>50%</td>
<td>30%</td>
</tr>
<tr>
<td>Burundians, Sierra Leoneans, Congolese, Somalis, Ethiopians, Eritreans, Sudanese, Rwandans, Liberians</td>
<td>50%</td>
<td>30%</td>
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The humanitarian entrants' country of origin have changed over time due to global events. The changes over time include:

- 1970’s and 80’s - most refugees were from South East Asia
- Mid 1990’s - increasing numbers of Burmese, Bosnians, Serbians, Croatians and Iraqis
- 2000’s - most refugees were from sub-Saharan Africa (mainly Sudan)
- Present - the humanitarian entrants are arriving from Burma and the Middle East.

The evolving nature of the humanitarian entrant population highlights the imperative for health services to be flexible and dynamic to meet the specific needs of the clients.

**Visa categories**

Upon entering Australia, the Federal Government grants limited numbers of visas in each of the visa categories. CHNs provide services to clients with (but are not limited to) the visas listed in Table 2.

**Table 2. Visa categories**

<table>
<thead>
<tr>
<th>Visa number</th>
<th>Details</th>
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<tbody>
<tr>
<td>200</td>
<td>Refugee visa - those in need of resettlement from their home country.</td>
</tr>
<tr>
<td>201</td>
<td>Refugee visa - those in their home country in need of resettlement. They have not been able to seek refuge elsewhere.</td>
</tr>
<tr>
<td>202</td>
<td>Special Humanitarian Program (SHP) sponsored visa class arrivals</td>
</tr>
<tr>
<td>203</td>
<td>Emergency rescue visa - for those whose lives are dependent on urgent resettlement</td>
</tr>
<tr>
<td>204</td>
<td>Women at risk visa – for females and their dependents</td>
</tr>
<tr>
<td>117</td>
<td>Orphan refugee sponsored visa class - refugee children under 17 years sponsored by a family (as per 202)</td>
</tr>
<tr>
<td>866</td>
<td>Refugee visa – mostly refugee arrivals from Christmas Island</td>
</tr>
</tbody>
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**Definitions**

**The community health professional**

The community health professional providing care to the client will be referred to as the Community Health Nurse (CHN) throughout the policy, which encompasses refugee health nurses, community health nurses, remote area nurses and ethnic health workers.

As outlined in the Policy for Universal Child Health Service in Western Australia, the minimum qualifications for community health staff employed to deliver the community health Universal Contact Schedule is a registered nurse with qualifications in child and family health. School health nurses are required to be registered nurses.
The client

In the context of this policy, the ‘client’ refers to children under the age of 18 years (at the time of entry into Australia) and their carers who are humanitarian entrants, alternatively known as refugees, receiving health care from the CHNs.

Ethnic health worker

Ethnic health workers provide specific support to different ethnic groups by mediating between clients and the health system. By having cultural knowledge and understanding, they are able to develop a trusting relationship with the client and support the implementation of their health care plan.

CACH Service Refugee Health Team

The CACH Service Refugee Health Team is a metropolitan-based multidisciplinary team of staff with diverse skills who provide holistic care to families with children to meet their specific needs. Whist benefiting the clients in terms of greater adherence to care plans, increased support and potential for streamlined care, this team approach can also benefit staff by providing support and education.

The CACH service Refugee Health Team includes community health nurses and ethnic health workers.

Refugee

A ‘refugee’ is described by the United Nations Refugee Convention (1951) as ‘owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or owing to such fear, is unwilling to avail himself of the protection of that country, or who not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear is unwilling to return to it’.

Refugees are fleeing from their country in desperation, hence the majority know little about their destination. They usually go via a neighbouring country to apply for refugee status.

Migrant

A migrant makes a conscious decision to come to Australia and has time to learn about the country before making the decision to relocate.⁶

Asylum seeker

An asylum seeker is a person who, from fear of persecution for reasons of race, religion, social group, or political opinion, has crossed an international frontier into a country in which he or she hopes to be granted refugee status.

Asylum seekers usually come directly to Australia, without going via a neighbouring country out of fear it will also be unsafe. They usually arrive in Australia with a visitor, student or other temporary visa, or with false or no documentation at all. People arriving without valid documentation are initially detained until appropriate checks are carried out.⁷

Culturally and linguistically diverse (CALD)

The term CALD replaced the previously used term Non-English Speaking Background (NESB). It refers to the wide range of cultural groups that make up the Australian
population and communities. The term acknowledges that groups and individuals differ according to religion and spirituality, racial backgrounds and ethnicity as well as language.  

Introduction

Health services in Western Australia (WA) have had a key role in monitoring the healthy development and wellbeing of refugee infants, children and families. Community health staff support parents/carers by empowering them to gain skills and knowledge which will enhance their child’s health and development.

It is essential that health professionals engage with and work in partnership with refugee families using a strengths-based approach to affect behaviour and health outcomes. Flexibility in service delivery will allow staff to deliver care tailored and responsive to individual needs.

CHNs need to be empathetic, non-judgemental and build trusting relationships with refugee families. Refugee family units are often diverse and dynamic groups. It is not unusual to have refugee families who comprise of extended family members and close friends. Families can provide financial and emotional support to one another and assist with the general integration into the Australian society.

A comprehensive schedule of contacts ensures that health issues are identified and addressed early which maximises positive outcomes for families with children. Health professionals working with refugee families provide referral in and out of health services and support families to navigate their way through the health system.

Upon arrival to Australia, most refugee families will have contact with the CACH Service Refugee Health Team and services outlined in this policy. Services may continue to be offered by CHN wherever families settle within WA, including services that are provided as part of the Birth to School Entry Universal Contact Schedule or the School Health system.

There is a range of skills and knowledge required to deliver refugee health. Staff must work within their scope of practice, and only perform the tasks in which they have been appropriately trained and deemed competent. Skills required include relevant expertise in preventative health, child development, health assessment and the use of interpreters. Staff will provide culturally appropriate guidance, health information and support parent and carer decision making using a family centred approach.

Although the aim is to assist the family to integrate into the community and use local community health services when appropriate, all CHN can contact the CACH Service Refugee Health Team for further support or information if required (via ‘CACH, Refugee Health’ on the WA Health global address list).

Additional support with clinical issues can be accessed from the Clinical Lead at the PMH Refugee Health Clinic or the Medical Director at Humanitarian Entrant Health Service (HEHS).

Pathway through the health system

The aim of a refugee health service is to assist with transitioning families to independently access local health services and for young children to enter the Community Health Universal Contact Schedule.

Upon arrival to Australia, refugees who have been granted a visa by the Commonwealth are allocated a case worker by the Humanitarian Settlement Services (HSS) who assists them with essential services such as banking, Medicare, accommodation, sourcing food
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and health care. If a family is sponsored, the sponsor is responsible for providing this assistance.

Initially, refugees are offered comprehensive health screening where they have their weight, immunisation status, infections and early developmental milestones monitored by a primary health care service – the HEHS. Health issues and referrals are recorded in a Health Screening Summary which is placed in the client’s file.

Families are referred to mainstream health services, including specialist medical care, public hospitals, PMH Refugee Health Clinic (children <16 years), allied health (dependent on Medicare status) and/or GP as appropriate as well as to community health services. The CHN is sent a copy of the Health Screening Summary.

Within community health, there are several examples of services that provide localised, flexible and integrated service delivery. These are designed to improve access to health care and hence vary between sites. One example is the Integrated Service Centres (ISC) in metropolitan Perth which provide a range of services at the schools, involving collaboration and partnership between the Office of Multicultural Interests, Department of Education and Department of Health. In the ISC, specialist refugee health nurses provide additional support to the school nurse including re-testing and follow-up appointments.

Currently a small, but significantly increasing proportion of families move to country areas after the first 6 months. In these cases, community health staff see clients as required.

See Appendix 1: Health Services Pathway.

Policy Statement

This policy guides the practice of community health staff: refugee health nurses, community health nurses, remote area nurses and ethnic health workers in delivering comprehensive services to refugee families with children. This is enabled by providing health care including prevention, early detection and early intervention services and support to navigate the health system from the time they enter Western Australia.

Policy Outcomes

The aim of the Policy for refugee health services in WA is to promote the health and wellbeing of refugee infants, children and families through the following strategies:

- Provide a culturally sensitive approach to service delivery;
- Offer early identification of physical, developmental, social and emotional needs and enable access to timely and appropriate interventions and or referral to specialist services;
- Deliver public health strategies including immunisation, women’s health programs and screening;
- Provide early support and brief interventions to families with identified needs;
- Facilitate family access to relevant community resources and agencies;
- Deliver Child Health services to meet the client’s health and development needs;
- Provide multidisciplinary and inter-sectorial collaboration and liaison.
Policy Interpretation

Scope

This policy is relevant for all community health staff working with humanitarian entrants, for example refugee health nurses, community health nurses, remote area nurses, allied health staff and ethnic health workers.

Refugee families with children (<18 years) will be offered:

- A comprehensive schedule of health checks commencing from the time they enter the WA health system upon arrival to Australia;
- Assessment of family risks, growth and development monitoring (surveillance), immunisation and parenting support;
- The Child Health Universal Contact Schedule with a local community child health nurse where relevant;
- Health care in the mainstream school setting as per the school health policies and guidelines;
- Follow-up health care.

Service delivery should be flexible and responsive to the needs of refugee families. If a health, developmental or support need is identified, refugee health services should provide appropriate pathways for response. This response will depend on the complexity of the identified need or issue and the capacity of the service from which it is being delivered.

Possible pathways for response include:

- Providing a brief structured intervention (e.g. sleep management);
- Referral to a specialist service (e.g. paediatrics, child development service);
- Referral to specialist community agency for interventions (e.g. Ishar Multicultural Women’s Health Centre).

The aim of the service is to assist refugee families with children to integrate into mainstream health care services to become independent community members. CHNs act as advocates in empowering families to take responsibility for their own health and wellbeing. They identify health concerns and direct families via referral processes to appropriate services, rather than providing the service itself.

Social determinants of health

The framework which guides the scope of practice of refugee CHN relates to improving the client’s social determinants of health. Each determinant has an impact on the client’s health status and can be addressed by CHNs. These include:

- Social gradient - Likelihood of reduced health is greater for people who are members of groups or communities of lower social and economic standing in a society.
- Stress - Stressful circumstances are damaging to health.
- Early life - The health impact of early development lasts a lifetime.
- Social exclusion - Poverty, social exclusion and discrimination reduce the lifespan.
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- Work - Stressful work can lead to disease; those with control over their work have improved health.
- Unemployment - Job security increases health and wellbeing.
- Social support - Friendship, good social relations and supportive networks improve health.
- Addiction - Individuals suffer by using harmful substances.
- Food - Adequate food supply is central to health and wellbeing.
- Transport - Walking, cycling and the use of public transport promote health.

(Source: WHO, 2003)

Primary Health Care Principles

Service provision is based on the Australian Primary Health Care principles as CHNs often provide the first level of contact that families have with the health system. The service needs to be appropriate, accessible, offered by suitably trained professionals, giving priority to those that need it the most.

The principles include:

- Equity
- Access
- Empowerment
- Community self-determination
- Inter-sectoral collaboration.10

Role of the Community Health Nurse

The CHN can assist refugee families with children to access appropriate health and community services, can ensure they understand the benefits of accessing these services and are aware of services that are culturally appropriate and best suited to their needs.

CHN’s must demonstrate an awareness and appreciation of culture. Both family and CHN benefit from working in collaboration with experienced CALD workers.

Due to the high rates of psychological distress experienced by refugees, it is important to monitor the emotional health and wellbeing of the parents and the children. Acculturation stressors may also manifest some months following initial resettlement, particularly between adolescents and parents, hence longer term follow-up of refugee families in the community may be required. This may involve the CHN facilitating access to culturally appropriate information and support services that are available in local communities.

Practice Guidelines11

- Provide an initial contact with a needs assessment, education and counselling;
- Provide appropriately targeted information about key health issues to refugee families;
• Coordinate service provision including working with settlement agencies to assist with access to health services;

• Form partnerships with health workers and transfer information, with consent, to other relevant services;

• Endeavour to ensure health issues identified in the Health Screening Summary are followed up by providers;

• Empower newly arrived humanitarian entrants to access mainstream health services and learn how to access health services independently;

• Provide advice to service providers regarding the health and non-health needs of their clients and to provide advice on access to services;

• Consider if the child is at risk of neglect, physical/sexual abuse (including female genital mutilation (FGM), or emotional maltreatment. Refer to the Department of Health guidelines and notify via Health Service if necessary;

• Explore and discuss the types of physical and mental health problems that refugees commonly face and their current treatment;

• Explore and discuss the cultural traditions of refugee families and how this impacts on communication about sensitive issues such as mental health and sexual health;

• Develop an understanding of the way in which media depictions, events happening in the country of origin and poverty can affect refugee families;

• Identify the barriers that restrict refugee families from accessing health services and programs and develop strategies to overcome them.

**Proposed contacts with refugee families with children**

**Key issues addressed by the CHN include:**

• parental physical and emotional well being

• breastfeeding

• parenting

• infant nutrition

• child health

• oral health

• behaviour

• injury prevention

• child development

• safety

• immunisation

The CHN will use the Indicators of Need or other approved client need tool to determine the client’s level of need and follow up once an assessment is made during a health check.
The parent/caregiver and CHN will develop a plan outlining the frequency of visits, venue, and any referral needs. For those families considered to have high needs, referral to specialist services will be offered according to the client need tool.

Some clients will become independent, integrate into the community in a short period of time and any health issues resolved quickly, where others may require support for a longer duration. Clinical judgement should be exercised in setting and amending health care plans according to client needs. Being flexible to meet individual needs is essential to service provision.

Where relevant, the CHN will also follow the guidelines outlined in the Universal Contact Schedule in regard to contacts and documentation.

All health staff working with refugees should have a good knowledge and understanding of cultural issues that may influence the client’s health. Being familiar with the support agencies that provide services to humanitarian entrants is essential to providing holistic, comprehensive health care.

**Initial contact and initial home visit**

Initial contact with the family will be made shortly after arrival to WA, primarily by the CACH Service Refugee Health Team.

- The client is contacted via phone (using an interpreter if required) to set up the first appointment;
- This first visit is offered as soon as possible after the health file is received from the HEHS;
- The initial contact will be delivered predominantly using the home visiting model in recognition of the difficulties in attending appointments in the early period of settlement (families are then encouraged and supported to attend appointments in health care centres);
- Discussions include:
  - issues identified in the Health Screening Summary, medical results and health implications;
  - dental care options, including the pre-school refugee referral pathway, school dental program and assist with registration process if required;
  - the importance of self care;
  - information on utilising local health services, including pending medical appointments and ambulance cover;
  - follow-up catch-up immunisations;
  - relevant health promotion issues;
  - differences in parenting styles in Australia (including child protection issues);
- The client is assisted to make an appointment with a local General Practitioner (GP).

**Follow-up contacts**
Refugee health

At each follow-up contact, health issues are reviewed, health education is provided and assistance to access any health services required is offered. The number of contacts a client will receive will vary due to differing family dynamics, individual health needs, coping skills and general ability to settle.

Additional contacts should be offered as appropriate and where resources allow to:

- Monitor the health and development of children and identify key early interventions or referral for those who face difficulty;
- Utilise referral pathways for families with additional needs within health and other agencies;
- Assist parents with young children to overcome barriers to accessing health services.

Documentation

- All ‘occasions of service’ are entered into a relevant database;
- Staff can request a copy of client records when clients transition between community health services and the CACH Refugee Health Team where relevant;
- Once clients exit the service, all documentation is to be archived, as per the WA Health Policy (Health Records: Descriptions and guidelines for use, retention and disposal).

Scope of practice

The following aspects are included in the scope of community refugee health practice:

Community integration and advocacy

- referrals to mainstream agencies
- education about WA health systems and how to navigate them
- assistance with overcoming practical barriers to integration
- use of interpreters to facilitate access/inclusion

Health and lifestyle education

- women’s health care for the mothers of child refugees, including demonstrating an interest in the progress of any pregnancies and support the continuing uptake of appropriate maternity services
- nutrition, including accessing, preparing and storing food
- sexual health and FGM
- general health care
- personal care
- presenting education material in appropriate languages and formats
- child development
• child behaviour management, parenting and discipline
• sleep and settling
• injury prevention and safety
• staff education on refugee/migrant issues

*Illness prevention*
• immunisation - refer to relevant immunisation schedules
• provide disease education/monitoring
• monitor treatment compliance

*Assessment and screening*
• immunisation status
• psychosocial assessment
• child development (use of PEDS, ASQ, ASQ:SE where appropriate)
• physical assessment of child
• growth assessment (height, weight, head circumference and interpret results on the appropriate growth charts or take note of trends)
• vision and hearing screening for child (otoscopic examination and tympanometry)
• chronic disease management
• general health screening
• mental health assessment (EPDS for parents)
• injury/first aid
• assessment of risk and protective factors and indicators of need
• identification of the factors indicative of child abuse and neglect and take early and effective action.

### Related internal policies, procedures and guidelines

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<td>Refugees (school-aged children) guideline</td>
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### References

Review

Feedback from service providers regarding the implementation of this policy will be monitored by the Child and Adolescent Community Health Policy Unit (Statewide).

This Policy shall be reviewed by the Statewide Birth to School Entry Reference Group and Statewide School Health Reference Group in 2014.

Author

Child and Adolescent Community Health Policy Unit (Statewide), in collaboration with the Statewide Refugee Policy Sub Working Group.
Appendix 1: Health Services Pathway
This document can be made available in alternative formats on request for a person with a disability.

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<td>Senior Portfolio Policy Officer</td>
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<tr>
<td>Reviewer / Team:</td>
<td>Birth to School Entry Reference Group, School-aged Health Reference Group</td>
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