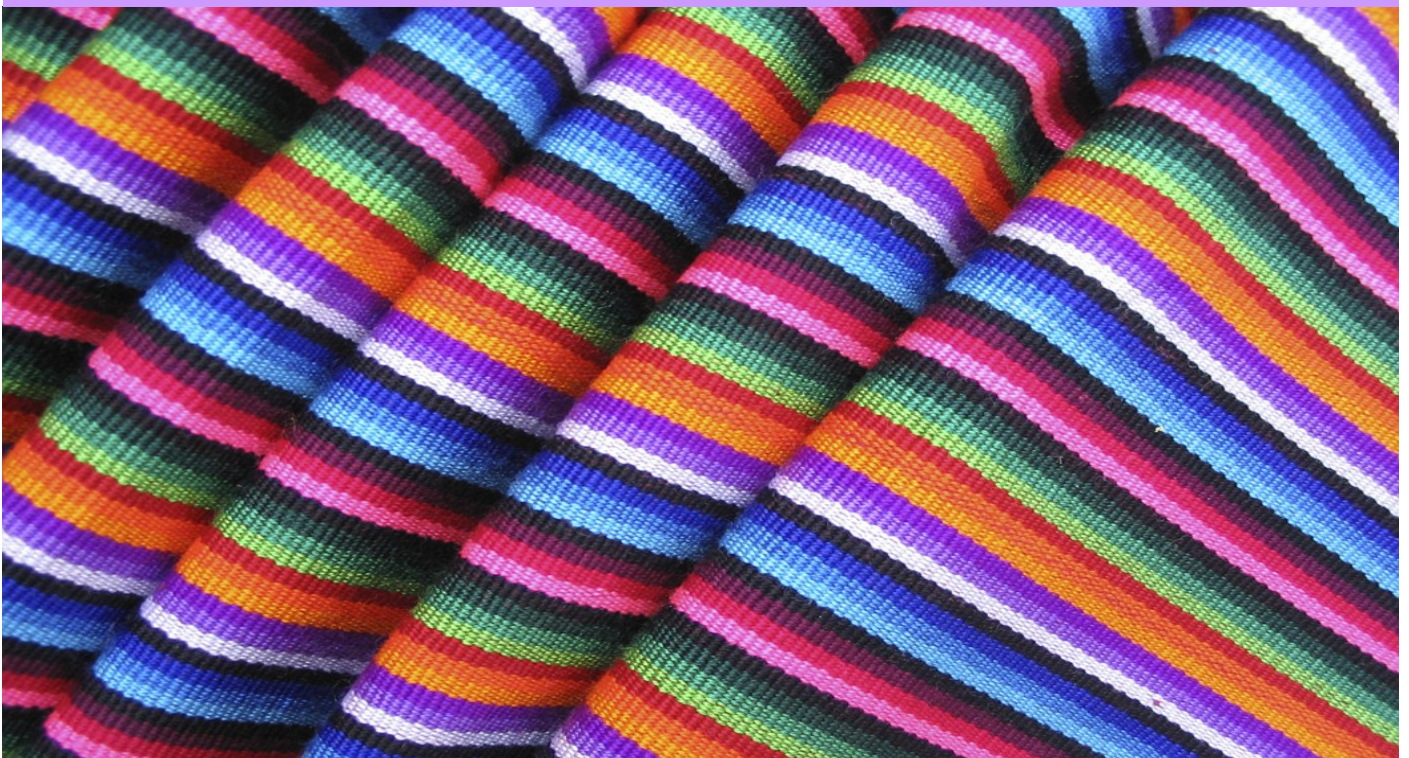
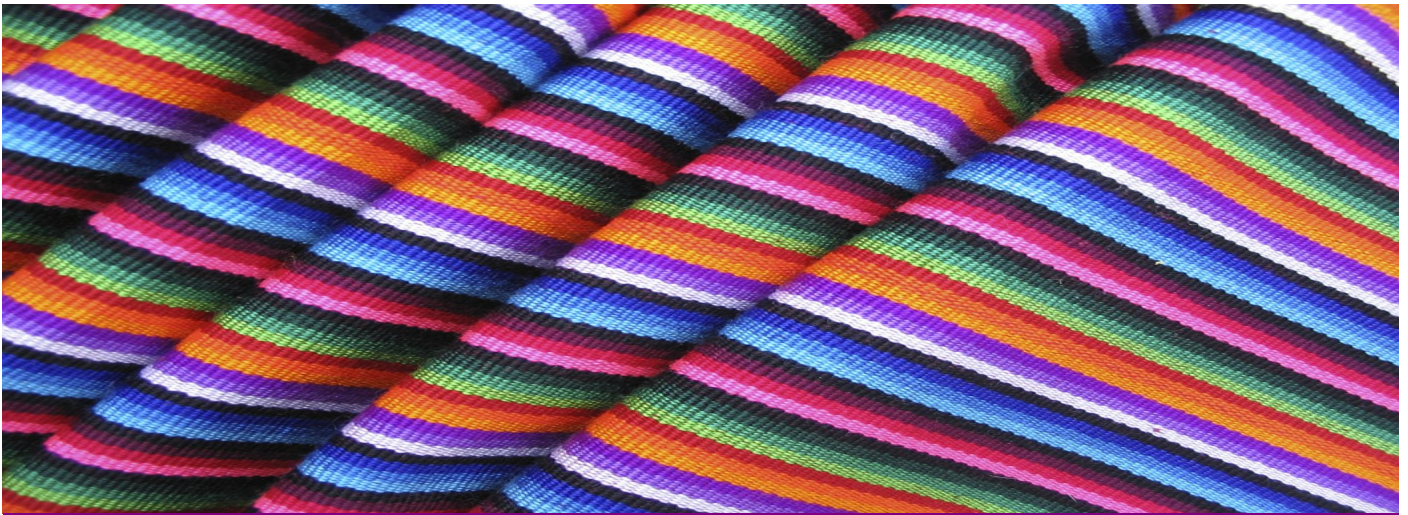


**Aims to improve the  
physical, mental and social well-being  
of  
individuals, families and communities**

# Refugee Health Nurse Program

evaluation project 2011





## acknowledgements

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- External partner agencies representing health, community and educational services working with refugee clients.

## evaluation steering committee

Reverend Japheth Lian

Cha Lu

Heather McMinn

Meg Scolyer

Andree O'Donnell

Robyn Kilpatrick

Jasmina Mulugeta

Chin Community Member

Karen Community Member

EACH Clinical Services Manager

EACH Health Promotion Officer

AMES IHSS Settlement Staff member

MIC SGP Settlement Staff member

Foundation House Eastern Region Coordinator



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# abbreviations and terminology

## abbreviations

CSW	Community Services Worker	LGA	Local Government Area
DoH	Victorian Department of Health	OEMR	Outer Eastern Metropolitan Region
DHS	Victorian Department of Human Services	QUM	Quality Use of Medicines
DPL	Doctor's Priority Line	RHN	Refugee Health Nurse
IHA	Initial Health Assessment	RHNP	Refugee Health Nurse Program
GP	General Practitioner	SGP	Settlement Grants Program

## terminology

Allied Health

Refers to the suite of services offered at EACH including: physiotherapy, occupational therapy, dietetics & podiatry.

Community Services

Refers to staff of community organisations and the local English Language School.



Initial settlement period

Refers to the first 12 month period after refugees arrive in Australia.

Myanmar

Refers to the country previously known as Burma. This report uses the name of Burma to identify this region.

Post-initial settlement period

Refers to the period following the first 12 months after refugees arrive in Australia.

Refugee clients

Refers to service users of EACH who have arrived in the OEMR as refugees or asylum seekers.

Refugee participants

Refers to those refugee clients of EACH who participated in this evaluation project.

# section one

## 1.1 background

In the years 2005-2010, more than 23,000 people settled in Victoria under the Australian Government's Humanitarian program<sup>1</sup>; almost 30% of humanitarian settlers Australia wide. In addition, Victoria also supports a number of Medicare ineligible asylum seekers.

Many people who seek refuge in Australia have experienced perilous journeys to seek refuge, often following exposure to prolonged hardship in refugee camps, or discrimination and deprivation in urban settings which are typically unwelcoming. Many have experienced years of inadequate access to nutrition and health care. One in three will have been subject to physical violence<sup>2</sup>, often with limited opportunities to properly treat or manage associated physical and emotional injuries.

According to the United Nations High Commissioner for Refugees (UNHCR), some of the most common health problems experienced by refugees are: nutritional deficiencies, mental health issues, intestinal parasitic disease, infectious diseases, injuries sustained in the course of torture and trauma, chronic diseases and childhood development problems<sup>3</sup>.

Whilst health care is only one of a range of needs facing recently-arrived refugees, the timely and accessible provision of such is known to greatly increase the chance of successful resettlement<sup>3,4,5,6</sup>. Conversely, inadequate and inappropriate health care provision can compound previously experienced trauma, thus hampering the settlement process<sup>3</sup>.

The complex nature of refugee health needs represents an area requiring specialisation where the infrastructure, skills and resources evolve to respond over time. As one of the newer settlement areas in Victoria, the Outer Eastern Metropolitan Region (OEMR) faces significant challenges in responding to the often complex health needs of refugees<sup>7</sup>.

The Victorian Government's 'Refugee Health and Wellbeing Action Plan 2008-2010 ties together a decade of policy enhancements in the area of refugee health.

Current strategies include but are not limited to:

- Specialist refugee and immigrant health clinics which work in partnership with RHNs and GPs to provide assessment and treatment for new arrivals presenting with complex health conditions
- School nursing in English Language Schools and Centres
- Locally based Refugee Brokerage Program workers to work with refugees in metropolitan and regional communities
- Priority access for refugees to community health services and dental services under the Demand Management Framework.

The above strategies highlight efforts to increase enhancement of service coordination, language services utility, and capacity building amongst health and community service providers. Combined, the aim is to increase access to, and improve the responsiveness of the primary and specialist health care system in Victoria<sup>4,5</sup>.

# section one

## 1.2 refugee health nurse program

As the centerpiece of the Victorian Government's first Refugee Health and Wellbeing Action, the Refugee Health Nurse Program (RHNP) has grown steadily since its introduction in 2005. The program is now present in 16 locations across the state and receives \$1.9 million in funding per annum<sup>8</sup>.

Whilst the program was initially auspiced under the Department of Human Services portfolio, it was reallocated to the Department of Health in August 2009. In 2010, this funding was used to purchase approximately 17,000 Refugee Health Nursing hours.

The RHNP employs nurses with experience in working with culturally and linguistically diverse, marginalised populations. The target group of the RHNP includes all those arriving under the Australian Government's Humanitarian Program, which encompasses those on refugee visas and those seeking asylum.

In order to ensure a coordinated response, these nurses are based within community health services in areas of high refugee populations.

The Refugee Health Nurse Program has three aims:

1. Increase refugee access to primary health services
2. Improve the response of health services to refugees' needs
3. Enable individuals, families and refugee communities to improve their health and wellbeing

The model of care by the RHNP includes facilitation of holistic health assessment for newly arrived refugees in partnership ideally with a local General Practitioner, (GP), who will provide future health care to the refugee client.

Where a local GP has not been identified this need forms part of the initial RHNP process. When necessary RHN staff are required to provide outreach services which engage with those who are initially unable to access on-site community health services.

Referrals to the RHNP are most often received from local settlement services. Additional referrals come from other organisations involved in providing support to refugee communities, (Victorian Foundation for Survivors of Torture, Asylum Seeker Resource Centre, local councils and other community agencies).

Additional funding is provided for the employment of a RHN Facilitator who works closely with all stakeholders to address the following three aims:

- To increase CHS responsiveness to refugees' needs by providing organisational development, advice and support to agencies
- To provide secondary consultation to refugee health nurses
- To contribute to, and actively promote, the professional development of refugee health nurses.

The RHNP provides additional support for the Refugee Health Nurses through training opportunities run by the Victorian Foundation for Survivors of Torture (Foundation House). Foundation House also auspices the Victorian Refugee Health Network, as well as the many other activities undertaken (direct care, advocacy and research).

Community Health Services are bound by Funding and Service Agreements to provide timely reports on hours and client contacts on a quarterly basis.





# section one

## 1.4 demographics continued

Similar nutritional deprivation has also been observed by the RHN staff in the recently arrived Chin population.



Typically, the major health issues identified for many refugees in the OEMR are<sup>11</sup>:

- Complete lack of or inadequate history of dental care
- A lack of women's health care
- Torture and trauma related mental health issues
- Serious Vitamin D deficiencies
- Hepatitis
- Untreated parasitic infections
- Lack of, or incomplete immunisation histories
- Unspecified 'stomach pains'
- Urinary tract infections
- Slowed development and weight gain in children.





# section two

## 2.1 evaluation process

The evaluation of the EACH RHNP aims to:

- Determine the extent to which the program has met the stated aims
- Gather evidence in regards to the impact which the program has had on refugee health care in the OEMR of Melbourne
- Generate a description of the current activities of the program
- Provide a platform for continuous improvement of the RHN program at EACH
- Make recommendations which will enhance the service provided to refugee clients both of EACH and the RHNP.

The evaluation project also ensured a number of RHNP clients were given the opportunity to provide feedback to EACH about the program. This feedback will be utilised by the EACH RHNP to make adjustments which will benefit the local refugee population.

The evaluation process utilised a combination of qualitative and quantitative approaches, detailed in the following sections.

## 2.2 quantitative data

The RHNP was implemented in February of 2009. Therefore, in order to get an entire 12 months of data, a decision was made for the evaluation project to focus on data which fell within the January to December period of 2010.

The range of data collection processes that support the care of refugees includes:

- SWITCH - Prior to November 2008
- Trakcare 6.9 software
- Practix Medical software
- Titanium Dental software.

The resulting data extracted could not always be matched in detail across software packages and in these instances, some estimations were made.

## 2.3 qualitative data

### Refugee Participants

The EACH Refugee Health Nurse evaluation project sought feedback from refugee clients, community service workers and GPs. This feedback process utilised a combination of focus group discussions and semi-structured interviews.

Refugee participants for the focus groups were selected from the EACH database using purposive random sampling techniques, in order to generate a list according to ethnicity, gender and age.

Given the overwhelming proportion of RHNP clients from the Chin and Karen communities, and in order to work within the available resources of the evaluation it was necessary to limit the focus group participants to members of these communities. Upon advice of community leaders, the evaluation included focus groups for both Chin Hakha and Chin Tedim groups.

Participants were contacted via telephone utilising interpreters where required, and verbal invitations extended to attend the focus groups.

# section two

## 2.3 qualitative data continued

These invitations were then followed up with a brochure mail out and a reminder call a week before the groups took place.

The focus groups were held at the EACH Patterson Street, Ringwood East site. Two hours was allowed for each group, and present were at least one facilitator, (at times two), and a professional interpreter, as well as the participants. Written consent was gained using the assistance of the interpreter, and the sessions were recorded on an audio device to assist with information gathering. These recordings have since been destroyed, as per prior agreement with the refugee participants. Refreshments were provided during the focus group session and refugee participants were given a \$20 Voucher for a local supermarket as a token of appreciation for their time.

### Inclusion criteria set for the refugee participant focus group discussions was:

- Refugee persons who have utilised the service of the RHN and who hail from one of the three chosen cultural backgrounds.

### Exclusion criteria were as follows:

- Refugee young people and children 17 and below
- Refugees in the OEMR who have not had contact with the RHNP.

The following table shows the numbers of refugee participants who attended the focus groups, rather than the number who were invited to do so.

Focus group participants		
	Female	Male
Karen	4	2
Chin Hakha	5	1
Chin Tedim	7	3
<b>Sub Total:</b>	<b>16</b>	<b>6</b>
<b>Total:</b>	<b>22</b>	

### Partner agencies and practitioners

Participants for the semi-structured interviews were selected from those partner agencies with the highest levels of contact with the RHNP. Invitations were issued via email and telephone.

The semi-structured interviews were held at venues determined by the participants. One hour was allowed for each interview, and present was one facilitator and one or more of either GPs or Community Service Workers.

Two of the GP interviews were conducted via telephone, at the request of the GP. The GPs were all generous enough to provide feedback without any payment. Written or verbal consent was gained, and the sessions were recorded on an audio device. As agreed, these recordings have since been destroyed.

### Inclusion criteria for the interviews were:

- Community Service Workers from one of the following partner agencies who have had interaction with the EACH RHNP;
  - AMES
  - Blackburn Language School
  - MIC
  - Foundation House
- General Practitioners in the OEMR who have interaction with the RHNP.

### Exclusion criteria was as follows:

- General Practitioners and Community Service Workers in the OEMR who have not had an interaction with the EACH RHNP.

Consultations	
General Practice staff (GPs and nurses)	7
Community Service Workers (CSW)	11
Refugee clients	22
Refugee Health Nurses	2
<b>Total:</b>	<b>42</b>

# section two

## 2.4 evaluation limitations

### Focus Group Discussions

Time and resource availability limited the scope of client consultations to the following:

- A focus on clients hailing from Burma, particularly clients of Chin and Karen backgrounds who represented the two majority populations seen by the RHNP. With larger resources, the program would benefit from evaluations capturing the experiences of clients from a broader selection of countries, despite the overall low numbers of refugee clients from these other population groups
- Despite employing interpreters, reminder calls and mail-out strategies, the focus group discussions experienced low attendance rates, as compared with those who indicated their intention to attend.
- Evaluations are not a concept familiar to those from Chin and Karen backgrounds, and it was apparent that the participants were at times uncomfortable being asked for negative feedback, despite assurances

that there would be no repercussions. It should be remembered that speaking critically about those in authority is often times punished severely in the participants' country of origin.

Attempts to mitigate this fear were made by engaging a focus group facilitator external to the RHN program, and excluding the RHNs and the GPs themselves from these sessions.

### Quantitative Data

As with other evaluations in this field, it was incredibly difficult to gain accurate data which would provide a measure of program impact as a result of:

- Data collection systems at EACH do not have the capacity to extract data according to required indicators
- There is no established base line for impact to be measured against.

## 2.5 steering committee

The evaluation process, recommendations and report were guided by representatives from EACH, AMES Settlement Services, Migrant Information Centre, Foundation House as well as a member each from both the Chin and Karen communities in the OEMR of Melbourne.

Steering Committee members were:

- Heather McMinn  
EACH Clinical Services Manager
- Meg Scolyer  
EACH Health Promotion Officer
- Rev. Japeth Lian  
Chin Community Pastor
- Cha Lu  
Karen Community Member
- Andree O'Donnell  
AMES IHSS Settlement Staff member
- Robyn Kilpatrick  
MIC SGP Settlement Staff member
- Jasmina Mulugeta  
Foundation House Regional Coordinator
- Jacqui Robson  
Student Evaluator—RMIT University



# section three

## 3.1 summary of evaluation findings continued

The following section highlights the strengths and challenges of the RHN program at EACH, which were revealed through the focus groups and interviews with staff from partner agencies, GPs and Practice Nurses and the refugee clients themselves, as well as staff from the RHN program and EACH more broadly.

### Strengths:

- The location of the RHNP within EACH allows easy access by the program's refugee clients to a range of multi-disciplinary health professionals
- The staff employed by the RHNP hold a breadth of experience which directly benefits the refugee client group with whom they work
- Local General Practitioners feel that the RHNP has had a positive impact on their ability to provide quality care to their refugee clients
- The EACH RHN is an active advocate for the appropriate use of Language Services by health professionals in the OEMR
- The RHNP has the ability to adapt to identified needs within the community groups it services, through the provision of tailored health education sessions
- Everyone consulted by the RHNP evaluation process was very happy with the referral and communications process of the RHNP. All community service workers and GPs felt confident knowing when and how to contact the RHN program either for health advice or to make referrals.

### Challenges:

- To date there has been no evaluation done of the health information sessions either run by or participated in by the RHN staff. One CSW commented "How can we be sure of how much information is being absorbed at the health education sessions?"
- A major challenge within the region is the engagement and retention of GPs willing to provide ongoing health care to refugee clients
- Current funding does not provide adequate resources to be able to incorporate a "follow-up function" into the RHN role. This was suggested by multiple participants who took part in the evaluation project
- Capacity building opportunities are increased when GPs have a closer relationship with the RHNP; the converse is also true.

Findings from this evaluation have highlighted the critical issue that refugee populations in the OEMR do not receive consistent access to interpreter services. This is despite clear government and professional body policies around this issue, and despite ongoing advocacy for this support through the RHNP. This is discussed in more detail in section 4.2.

# section three

## 3.2 refugee health nurse program at EACH

The RHNP was first implemented at EACH in February 2009, in response to the growing rates of refugee settlement within the Outer Eastern Metropolitan Region of Melbourne (OEMR).

The program is funded for 1 EFT, however operates on 1.6 EFT, which comprises:

- 1 x 1.0 EFT Refugee Health Nurse
- 1 x 0.2 EFT Refugee Health Nurse and
- 1 x 0.4 EFT Administrative Assistant

The RHN program at EACH has been careful to employ nurses with a background in working with diverse communities in various areas of specialization.

One RHN has come to the program with post-graduate education in community health nursing, midwifery, maternal and child health. She has extensive experience working in generalist Community Health Services, Hospital in the Home program, indigenous health and as a remote area nurse in the Northern Territory.

The second RHN employed by the program began her career as a midwife and gained over 35 years experience in the hospital setting before training as a Sexual and Reproductive Health Nurse. She was initially employed by EACH to run the Well Women's Clinic and has since joined the RHN team providing both general and specialized women's health care to the local refugee community.

Given the unfamiliarity of many women from refugee backgrounds with women's health issues, having this expertise available to the local refugee population is invaluable.

Within the year 2010, this pair of health nurses, assisted by additional part-time staff as required, provided services to 433 refugee clients, with an average of seven contacts per client. Of these 433 refugee clients, around 58% were new arrivals, who were automatically referred by AMES.

Under the particular model of care provided by the EACH RHNP, all new arrivals to the OEMR receive a comprehensive Initial Health Assessment by the RHN. Within this arrangement, the RHN will complete the bulk of the IHA up to the point where a GP is required to finalise any specific medical needs.

Where the refugee client has already been able to identify a local GP, usually through a family or community member, who is willing to provide ongoing care, this IHA will be completed by their nominated GP. Where this is not the case, the EACH GP will finalise the IHA before the refugee client is then linked to a community GP who will be responsible for providing ongoing care.

The remaining 50% seen by the RHNP in 2010 were refugee clients in their post-initial settlement period, and were referred by agencies both including and other than AMES (see pg 15 for list).

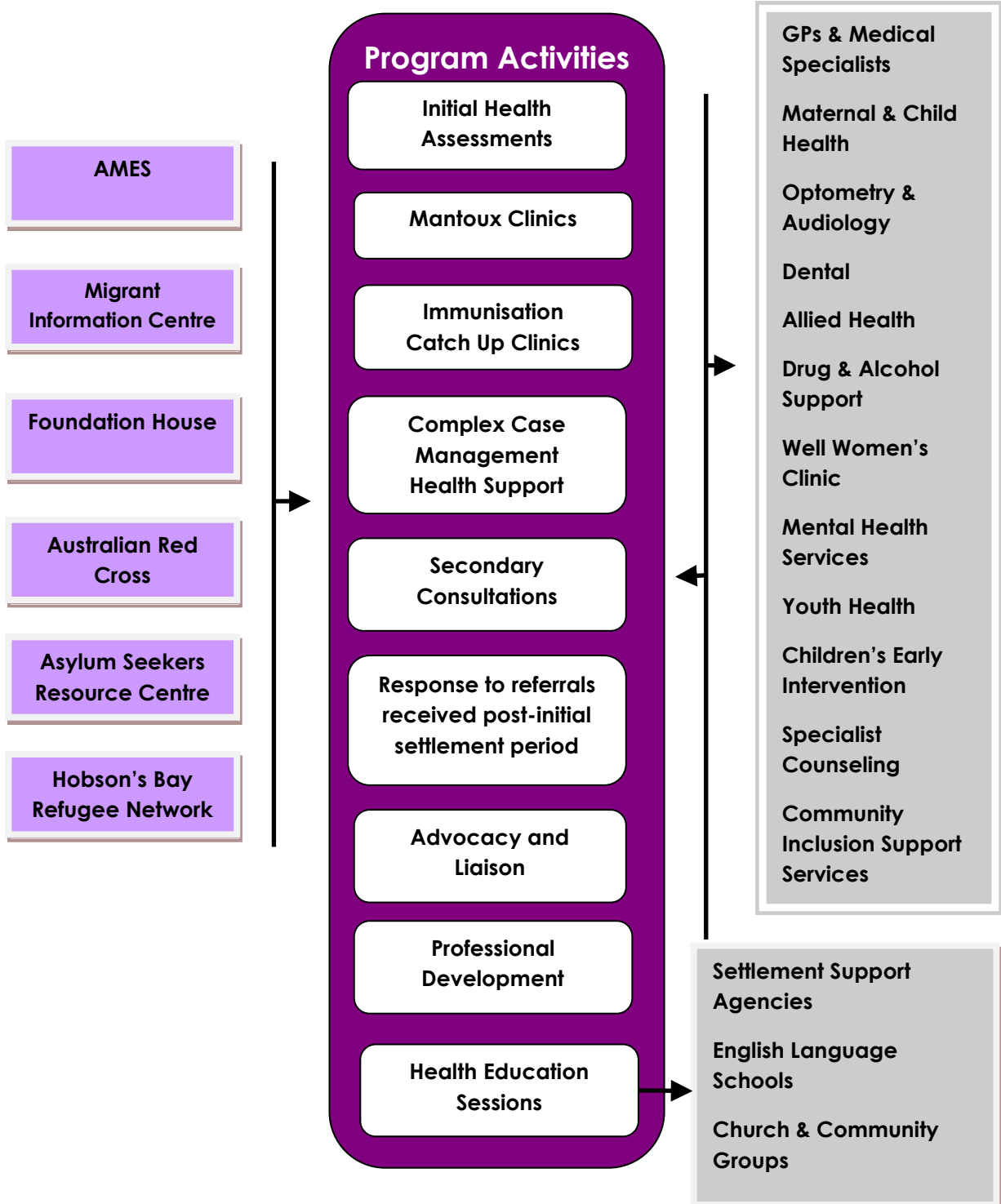
Within the year 2010, the RHNP made approximately 216 referrals to other EACH services. Of these, around 51% were referrals to the EACH Dental service, around 28% were to the Well Women's Clinic and the remaining 21% were to Allied Health Services.

The RHNP works in partnership with:

- Eastern Health
- Local private General Practitioners
- EACH Allied Health services
- EACH Dental
- EACH Well Women's Clinic
- EACH GP
- EACH Health Promotion Unit
- AMES
- Migrant Information Centre– East
- Blackburn English Language School
- Foundation House
- Australian School of Optometry
- Australian Hearing Service.

# section three

## 3.3 health access pathways



The above diagram is a representation of the common daily activities undertaken by the staff of the Refugee Health Nurse program at EACH. The boxes on the left show those agencies who commonly refer *into* the program. The large box on the right hand side shows the types of services which the RHN staff refer *on to* and for whom they also provide a *range of supports around refugee health needs*. The box at the bottom shows settings where the RHNs often participate in or facilitate Health Education Sessions.



# section three

## 3.4 program activities

### 3.4.1 initial health assessments

AIM 1	-	✓
AIM 2	-	✓
AIM 3	-	

Within the year 2010, the RHNP provided Initial Health Assessments (IHA) to 253 new arrivals in the Eastern region of Melbourne. This includes the 218 new arrivals in the OEMR, as well as occasional referrals received for clients living in the Cities of Monash and Whitehorse.

It is estimated that the IHAs take around 2 hours per person, which includes face-to-face contact time, travel and administration time. The majority of these assessments are completed in clients' homes, and are often the first contact had by the client with the Victorian Health System.

As part of the IHAs, the RHN takes a general and physical health history, records height and weight as well as blood sugar and blood pressure levels.

The assessments also include enquiry into the client's immunization history, following which a catch up plan is prepared and provided to a GP. The Mantoux testing is also included routinely as an extension of the IHA.

In addition to completing the health assessment, the RHN is often able to include information provision to the client about relevant services offered by EACH Community Health.

### 3.4.2 mantoux clinics

AIM 1	-	✓
AIM 2	-	✓
AIM 3	-	

Whilst tuberculosis (TB) is uncommon in Australia, it is less so in many of the developing countries from which Australia receives refugees<sup>12</sup>. Although pre-departure health screens uncover active TB, latent TB is not tested for. The Australasian Society for Infectious Diseases recommends post-arrival screening, and notes that it is a cost-effective measure, which assists with the prevention of TB transmission to the wider community<sup>12</sup>.

In the course of their work, staff at the RHNP at EACH observed that clients were having difficulty accessing Mantoux tests, given the need to travel long distances to participating pathology centres. Although these tests were being offered free, the centres only have the capacity to offer 2-3 tests per week, which falls well below the number of refugee clients

settling in the region. This is particularly inconvenient for large families, who may need to return at least 4 weeks in a row in order for each member to receive the service.

EACH recent arrivals 2010	RHN Mantoux tested	% indicating latent TB
January	19	0%
February	13	31%
March	7	29%
April	24	33%
May	22	10%
June	18	22%
July	22	23%
August	27	7%
September	24	13%
October	20	5%
November	27	8%
December	6	50%
<b>Totals</b>	<b>229</b>	<b>16%</b>

# section three

## 3.4.2 mantoux clinics continued

In response to these difficulties, EACH arranged for the RHN staff to receive specialised training by the DHS TB Clinic. This then allowed for the establishment of the Mantoux Testing clinic to be established towards the end of 2009.

The Mantoux tests are now performed as a part of the IHA and offered to every new humanitarian arrival in the OEMR. Tests are also available to asylum seekers who are clients of the EACH RHN.

The Mantoux clinic is run once a month. Using the services of an interpreter clients are given an explanation of the reasons and

procedures behind the test and what to look out for regarding physical reactions. The test is then administered and clients are booked to return to the clinic three days later for a reading of their results.

In the year 2010, the RHN provided the Mantoux test to a total of 229 refugee clients. Of these 16% of results indicated the presence of latent TB. The RHN then notifies the treating GP of the results, allowing the GP to decide on the best course of treatment for their client to ensure the TB remains in latent status.

## 3.4.3 immunisation catch up clinics

Due to the often poor health resources of refugee source countries, those who arrive in Australia as humanitarian entrants have either incomplete or non-existent immunisation histories.


In response to this difficulty and inconsistent approaches to immunisation catch up taken by some community GPs, the RHN at EACH has incorporated an immunisation catch up clinic into the IHA process.

This involves the RHN taking an immunisation

history during the IHA process, after which a catch up plan is then prepared.

If the refugee client is to be linked into a local GP, this catch up plan is then provided to the GP for follow up. For those clients who will be seen initially by the GP at EACH, the RHN undertakes the administering of the catch up program vaccines.

In the year 2010, the RHNs within EACH administered catch up immunisation vaccines to approximately 106 refugee clients.

AIM 1 -   
AIM 2 -   
AIM 3 -



## 3.4.4 complex case management support

Complex Case Support (CCS) is an intensive program available through the Department of Immigration and Citizenship (DIAC). It provides specialized case management services to humanitarian entrants with complex needs.

Although the number of clients requiring Complex Case Support through DIAC are fairly low, the RHN staff are available to provide secondary consultations and Chronic Disease

Management for clients as needed.

This may involve the RHNs providing chronic disease management plans, secondary consultations to the Complex Case Managers, or participation in case conferences and face-to-face consultations with refugee clients to ensure their understanding of the health issues they face.

AIM 1 -   
AIM 2 -   
AIM 3 -

# section three

## 3.4.5 secondary consultations

AIM 1	-
AIM 2	✓
AIM 3	-

The secondary consultation function of the RHN role provides the means for the staff to provide input and expertise to a broad range of service providers, both internal and external to EACH.

Secondary consultations were seen by the GPs and CSWs, who participated in the

evaluation project, as an important function provided by the RHNs.

The RHNs are available to GPs and CSWs to seek their advice on appropriate referral points, and for clarification of detailed health information and medical terminology.

## 3.4.6 post-initial settlement referrals

AIM 1	✓
AIM 2	✓
AIM 3	-

Of the 433 clients seen by the RHN staff in 2010, 42% were comprised of refugee clients who have passed their initial-settlement period and are into their 2nd-4th years in Australia.

Dependant on needs, the response to these post-initial settlement period referrals may include, but is not limited to, a combination of the following:

- chronic disease management
- referral to EACH services within Allied

Health, Dental or Well Women's Clinic as needed

- liaison between GP clinic and refugee client to improve communication of health issues and treatment.
- secondary consultations with the referring organizations or staff.
- consultation with the refugee client to clarify health issues
- referral to Foundation House for specialist counselling support.

## 3.4.7 advocacy and liaison

AIM 1	✓
AIM 2	✓
AIM 3	-

A large portion of the staff time of the RHNP at EACH is spent advocating for interpreters to be used appropriately. This is one of the challenges of the RHN program state wide and as such, the RHNs across Victoria participate in similar advocacy roles.

In undertaking this advocacy work, the RHNs maintain close relationships with the local GP network, often by telephone, email and occasionally through practice visits to the local clinics. In this way, they are well respected and often positively responded to when advocating systems change or improved responses to a particular case involving a refugee client.

basis to requests made by CSWs in the area. The RHNP has been active in advocating with the Department of Health for increased access to free immunisations for particular client groups.





# section three

## 3.4.7 advocacy and liaison continued

Whereas advocacy of this nature is often targeted and specific, the liaison and networking undertaken as part of the role of the RHNs is done with the aim of strengthening the capacity of the broader health and community sector to improve the responses to refugee and asylum seeker clients.

One successful platform to date has been the Eastern Region Refugee Health Network which is overseen by the RHN. Meeting quarterly, the network allows workers from multidisciplinary backgrounds to meet, network and share information and concerns facing their clients.

## 3.4.8 professional development

In addition to participating in ongoing professional development for themselves, the RHNs at EACH also provide training to CSWs as needed.


Within this function of the RHN role, the RHN keeps local refugee support agencies informed of relevant upcoming training. This is often generalised, such as the Refugee Health talks provided to service providers such as Centrelink and other Community Health Services located in the East, however specific sessions are provided as needed within the workforce.

An example of this more targeted response was the Hepatitis training which was arranged by

the RHN in 2010. After noticing a lack of knowledge amongst direct practice staff, the RHN organised for training to be provided by the DHS Hepatitis Clinic. The aim of the training was to increase accurate knowledge of symptoms, transmission, prevention and reduce stigma.

At other times, if appropriate, the RHN provides direct training to CSWs by way of interactive information sessions.

Further to the above, the RHN makes a practice of disseminating new literature relating to refugee health with a couple of the local GPs. For an extended discussion of the capacity building role, please refer to Section 4.24.

AIM 1	-
AIM 2	- 
AIM 3	-

## 3.4.9 health education talks



Since the implementation of the RHNP at EACH, health education talks have been an important way of building health capacity within the recently arrived communities in the OEMR, and have reached groups from Karen, Matu, Zomi, Hakha and Tibetan backgrounds.

Some presentations by the RHNs are arranged in house and provide a platform for the staff to speak with community groups about issues nominated as concern to them, whilst others feature as a small part of a broader series run by partner agencies such as AMES, MIC and Blackburn English Language School.

The RHNs also play a role in the Cultural Awareness Training which is run by the Health Promotion Unit for the broader EACH staff base.

The RHNP is incredibly fortunate to be able to draw on the women's health expertise held by one of the nurses. This is utilised in the presentation of health talks for refugee women focusing on breast health, pap smears, contraception and STIs when requested.

As above, for an extended discussion of the capacity building role of the RHNP at EACH, please refer to Section 4.24.

AIM 1	-
AIM 2	- 
	- 

# section 4: evaluation themes

## 4.1 initial health assessments

As one of the cornerstones of the RHN program at EACH, Initial Health Assessments (IHAs) are undertaken for every new arrival in the OEMR of Melbourne. These IHAs are estimated to take around 25% of the RHNs' time. Over the 2010 year, the RHNPs completed approximately 215 IHAs, each taking around one hour per person to complete, with the use of a qualified interpreter. Another hour of indirect follow-up and administration is carried out for each client.

The EACH RHNPs aim to provide a comprehensive IHA on an outreach basis to every new humanitarian settler in the OEMR within 4 weeks of their arrival. The IHA is partially completed by the RHN, who then forwards this information in a standardised report format to the client's GP for completion.

GPs who participated in the evaluation project were unanimous in their support for the OEMR RHNPs' focus on IHAs. GPs noted that in a time poor environment, one of the main challenges in working with newly arrived refugee clients was the time intensive nature of the initial health assessments required, especially when communicating through an interpreter. One GP went so far as to call the IHAs "torturous".

The introduction of the RHNPs at EACH has made the work of those GPs who participated in the project easier, and for this reason they value the program highly.

Having had clients' major health issues identified by the RHN, GPs are able to focus on these issues and provide targeted care to their refugee clients earlier than would otherwise be possible.

One GP commented that prior to the RHN's participation in the IHAs, it was very difficult to comprehensively identify all of a refugee client's health needs. Similar sentiments were

shared by many of the CSWs who participated in the evaluation project. They believe that the RHNs' participation in the IHAs has helped to ensure their clients receive a more uniform service by GPs. One worker noted the tendency in the past for GPs to follow up on only a portion of issues, observing that some clients would receive mantoux testing and immunisations, while others missed out.

Some CSWs commented that they now feel confident that the health issues experienced by their refugee clients will be identified by the RHN. One stated that this comprehensiveness is "incredibly valuable for clients, and makes my job easier".

### **Community Service Worker:**

"I was working with a large family where the mother suffered from multiple and complex health complaints.

With the focus of the my intervention directed at the mother, I forgot about one of the children and was so relieved when the RHN reminded me about immunisations and a hearing problem.

She picked up on issues which I had missed."

Whilst to professionals working in partnership with the RHNs, the IHAs mean increased ease and efficiency of roles, to refugee arrivals they mean much more.

As the first point of contact with the Victorian Primary Health Care system, the empathy and thoroughness with which the IHAs are carried out convey to new arrivals that their new Government places value on their wellbeing.

Present in the evaluation focus group were two clients who had arrived before the RHNPs began at EACH, attending the evaluation focus groups with their friends. Their comments have been included as they provide an insight into

# section 4: evaluation themes

## 4.1 initial health assessments continued

the initial experience of refugees of the health system before the RHNP was established.

These women stated "when we arrived, we didn't see anyone to help us for 3 months". In contrast, a refugee client who had his IHA during a home visit by the RHN stated that this helped him to feel "genuinely cared for and supported".

### Refugee Participant

"When such a service is provided, this shows the true character of the Australian government. Back home, you are not prioritised, you have to wait on the road and when the road is clear, you cross. Here, there is a zebra crossing, so you cross and the cars wait."

Refugee participants were grateful for the outreach model of the IHAs, given the uncertainty held around public transport in the initial settlement period.

The comprehensive nature of the assessment was noted by many, with one stating that she had been "checked from head to toe".

In harmony with findings by a recent study undertaken with Sudanese refugees<sup>13</sup>, the majority of participants from the Chin and Karen communities noted that receiving an explanation about the process of clinical tests conducted, and any available results was very

important to them, as it often relieved long held anxiety about their health status.

When asked what was remembered about the visit by the nurse, one woman replied that she "felt free to talk about all of her concerns", and she attributed this to the fact that the visit took place in their home. A similar comment was made by another participant who told that she remembered that the RHN had not only assessed her health, but had tried to help her emotionally as well.

One participant summarised the above by stating that the home visits and the explanations about procedures were stand-out.

### Refugee Participants

Two refugee women who had arrived in the OEMR prior to the introduction of the RHNP at EACH had their initial health assessments done at a hospital, and commented that it was a scary process. The women were told there would not be an interpreter available, and one woman was forced to rely on her youngest son to interpret. This was an uncomfortable process for mother and son, particularly in regards to 'women's issues'.

From that day forward, whenever there were health appointments to attend, her son would say "make sure there's an interpreter; I don't want to do it". The woman told that these experiences left her feeling as though "I just want to go back to my country".

## 4.2 interpreters

Of the various themes identified through this evaluation project, that of interpreter use was raised by participants most often and with the most concern of all.

Whilst medical practitioners have had access to free telephone interpreting services for over 20 years, a more targeted approach was

introduced by the then Department of Immigration in the year 2000. With the

introduction of the TIS Doctor's Priority Line (DPL) Australia became the only Anglophone country to provide GPs with priority access to a nationwide pool of interpreters 24 hours, 7 days a week for the cost of a local call.

AIM 1	-	✓
AIM 2	-	✓
AIM 3	-	✓



# section 4 :evaluation themes

## 4.2 interpreters continued

Failing to engage interpreters within primary health care settings is known to compromise the quality of care, increase the likelihood of clinical errors and leave patients unable to understand important decisions being made about their health care<sup>14,15,16,17</sup>. Instances of such were reported by refugee participants, GPs and CSWs alike during the process of this evaluation project.

The obligation for General Practice staff to use appropriately qualified interpreters when required is laid out in both the National Code of Conduct for Doctors in Australia<sup>18</sup> (see 3.3.8 & 3.3.9) and The Royal Australian College of General Practitioners: Standards for General Practice<sup>19</sup> (see criterion 1.2.3).

Despite the known risks associated with not using interpreters when needed, GPs continue to underutilise interpreter services<sup>20</sup>, often relying on family or friends to supply ad hoc assistance<sup>15,17,20</sup>. Only 61% of General Practices surveyed recently were aware of the free TIS services<sup>17</sup>. Other barriers to interpreter usage within General Practice staff are: time-linked billing for refugee clients, the misconception that family members are preferred by patients, and a deferral of the decision to engage interpreters in the first instance<sup>20</sup>.

Interestingly, some of the GPs who participated in this evaluation study did not perceive interpreter access as a barrier to providing adequate care to their refugee clients. One noted that when interpreters were pre-booked, there was difficulty with clients not attending on time, thus the clinic was left to pay the costs of a service not received. For this reason, this GP chose to use telephone

interpreters wherever possible, which avoids the need to pre-book in most instances.

Participating GPs and CSWs did note that they feel additional health specific training is required for interpreters, particularly those from new and emerging languages such as the Chin and Karen language groups.

Consistent with reports nationally, refugee clients in the OEMR report difficulty accessing interpreter services when visiting their local GPs. Participants were often forced to resort to using family, friends or lesser known community members to assist with interpreting, at times passing mobile phones back and forth in order to communicate with health professionals or reception staff.

Depending on the sensitivity of health issues, this is not always appropriate for the clients to have others involved in this way. It also leaves patients at risk of engaging the assistance of those who speak different dialects and which can have serious consequences.

### Refugee Participant

"The possibility of mistakes because of the language makes me worry"

*Chin woman—6 months pregnant*

A number of the refugee clients who participated in the evaluation focus groups were not aware of their right to have an interpreter present at medical appointments. Many also said that they had not ever seen or been given one of the "I need an interpreter" card resources.

# section 4

## evaluation themes

### 4.2 interpreters continued

Despite refugee support agencies' practice of providing these cards, it is of concern that those refugees who participated in the evaluation were not remembering to show these cards or had not understood their use.

The Community Services Workers (CSWs) who were interviewed were generally aware of the DPL available to GPs, and are frustrated by local GPs who they feel are often unwilling to provide interpreters. They warn against GPs' tendency to fall back on friends, family and at times Community Guides.

The use of Community Guides as interpreters is completely unacceptable as it poses risks to patient confidentiality and, as with family members, the accuracy of information exchanged cannot be guaranteed. This leaves GPs open for medical negligence claims<sup>15</sup>. GPs cannot be sure that the Community Guide has the appropriate English language skills to deal with medical terminology, nor can they be sure that the Community Guide and the refugee patient speak the same dialect.

#### Refugee Participant

A client told of waiting in a GP clinic for 4 hours, as the clinic has a policy of not engaging interpreters. When another community member arrived for their own appointment and offered to help the participant with translation, the assistance was gladly accepted.

Unfortunately, the community member incorrectly interprets that the medication being prescribed is in order to help the client put on weight. The client refuses to take the medication as a result of this misinformation. A subsequent visit to her GP with the use of an interpreter revealed that the medication was actually to reduce cholesterol.

"Very dangerous" said the GP involved.

Of particular concern were reports by many refugee participants of having been instructed by one General Practice clinic in the OEMR to provide their own interpreters as the clinic is "not funded to do so".

Whether due to the failure to engage an interpreter, failure to ensure the interpreter engaged speaks the correct dialect, or the engagement of a lay person to provide Interpreting assistance, CSWs are aware of multiple incidences where miscommunication within consultation rooms and hospital settings have had negative impacts on clients' health outcomes.

CSWs believe there needs to be some form of consequences for those GPs who do not abide by this aspect of their professional code; one researcher suggests that general practice accreditation standards should include "standards that indicate a proactive, informed approach to accessing interpreters"<sup>20p446</sup>.

Aside from the risk of mistakes, CSWs and refugee participants reported that the absence of interpreter services during consultations leaves refugee clients feeling confused and ultimately disempowered about their own health issues. They do not know what the GP has 'done' to them, reasons why, how much medication they are required to take and for how long, or what side effects they can expect from the medication. For a further discussion on medication, see Section 4.22.

One CSW in the area has been hearing such complaints from the community that she was moved to invite a local MP to a community group session to draw their attention to the issue. Despite the MP taking copious amounts of

# section 4: evaluation themes

## 4.2 interpreters continued

notes, the CSW has not heard anything further from the MP in regards to this issue.

These issues are ongoing for the RHNP state wide, with many of the nurses forced to spend a lot of time advocating with GPs who have poor knowledge of the interpreter services available to them or do not perceive that use of trained interpreters is a critical need for their work with non English speaking clients.

Findings from this evaluation confirm that the refugee population in the OEMR, outside of the RHNP, and the key refugee funded services, are not receiving the appropriate interpreter support they are entitled to. This inequity to clear information about their health needs and treatment continues despite the allocated interpreter service funding and clear government and professional body policies

### Refugee Participants

Multiple participants spoke of an incident in a local hospital, where a refugee client was awaiting surgery to remove a pin from inside one of their limbs. The interpreter provided was of a different dialect, and incorrectly interpreted that the surgeon needed to remove the limb.

The patient was prepped and about to be given anaesthetic. Faced with a sudden and unnecessary amputation, the patient became extremely distressed. It was not until another concerned passer by investigated further that the dialect mismatch was discovered.

An interpreter from the correct dialect was then engaged and the situation which had caused this patient such unnecessary distress was resolved.

## 4.3 medications

The Quality Use of Medicine (QUM) is one of the central objectives of Australia's National Medicine Policy, and states that medicines should be used "judiciously, appropriately, safely and efficaciously"<sup>21</sup>.

Estimates suggest around 140,000 visits to hospital each year are medicine related, with around 50-75% of these being potentially preventable<sup>22</sup>. It is statistics such as these that drive the current National Prescription Service (NPS) 'Medicinewise' campaign, which aims to help consumers "make better decisions" about their medicines<sup>23</sup>.

Whilst no doubt an important issue in mainstream Australian society, it is well documented that "language barriers, low levels of cultural competency of health systems and the experience of navigating an unfamiliar medicines system"<sup>22, p.10</sup> all impact on the QUM

amongst CALD communities and leave humanitarian entrants at risk of "medicine related harm"<sup>24</sup>.

Medicine related problems are most commonly contributed to through "poor communication between health professionals and their clients"<sup>24</sup>. Considering the issues raised regarding the lack of use of trained interpreters during health consultations, there is little wonder that discussions with refugee participants around medications revealed much confusion.

Likewise, some GPs and CSWs were similarly concerned, with both groups able to provide examples of situations where refugee clients had not understood what was expected of them with regard to their medication regimes.

CSWs stated that many of their clients did not understand what the medication they had been prescribed was intended to treat,



# section 4: evaluation themes

## 4.3 medications continued

while others felt they did not properly understand the full instructions. In addition, CSWs report being aware of clients who arrive in Australia with medications from overseas, and then continue to take these in conjunction with medications prescribed by the GP in Australia.

One bi-lingual worker believes that GPs rely on the pharmacist to properly explain the medication regime. Whilst pharmacists now have access to free interpreting services via TIS for these purposes, most rely on family and friends to fill the interpreter role rather than perceiving the importance of accessing the trained interpreters via the telephone.

The CSW stresses the importance of a client's GP properly explaining their treatment regime before giving the prescription. Her suggestion for ensuring patients have understood what is required of them is to use an interpreter to explain the regime, and then ask clients to write it down in their own language and read it back for a check for comprehension.

The issue of non-compliance to medication regimes was highlighted by GPs as an area of particular concern to them. One noted that they have had refugee patients return for

repeat tests for iron and vitamin D deficiencies, with the results indicating that their levels are lower than previously recorded. This reveals that patients are not taking their supplements as instructed. Whilst repeat appointments were suggested as a step towards overcoming this, one GP highlighted the need to balance benefit versus imposition on the client.

One GP suggested that reasons behind the non-compliance include cost and patients not understanding the repeat nature of some prescriptions. Another GP was aware of instances when refugee patients have ceased taking their medication because they're feeling better, or choosing to use their friend's leftover medication as it 'seems to fit their symptoms', rather than filling their own prescription.

GPs noted the need to improve their communication with patients about the importance of adhering to treatment, and suggested their adherence to patient reviews was pivotal in this communication strategy. However if by their own admission that the time to billing formula for refugees is a constraint to use of interpreters the issue of clear communication will continue to be a barrier to any improvement is this area.

## 4.4 capacity building

As settlement patterns across Victoria change over time, so too does the expertise required of the primary health care providers in order to respond to the needs of newly arriving refugee communities. In recent decades, numerous developments across Victoria have seen improvements in the way health and human services respond to these needs<sup>25</sup>.

Over the past 5 years, rising numbers of refugees settling in the OEMR have highlighted the need for an improvement in the quality of services and increased coordination amongst health and wellbeing providers<sup>11</sup>.

These strategies are consistent with the Department of Human Services' Refugee Health and Wellbeing Action Plan objectives for system capacity building<sup>25, p. 24</sup>.

Attainment of such improvements is supported in the OEMR by DoH funding of the Outer East Primary Care Partnership (OEPCP) which aims to "to improve the health and wellbeing of consumers through an integrated, cooperative and coordinated approach to service planning and delivery within the community health and primary care services sector"<sup>26</sup>.

# section 4: evaluation themes

## 4.4 capacity building continued

Capacity building relates directly to the second and third aims of the RHNP, to improve the response of services to the needs of refugees, and to enable individuals, families and communities to better improve their health. Successful capacity building will also indirectly address the first aim of the program, that of improved access to the primary health care system for people of a refugee background.

As part of the capacity building component of the role, the staff within the RHNP at EACH engage with numerous agencies in order to:

- Improve cultural awareness
- Increase knowledge and understanding of health issues facing this population
- Increase awareness of the needs of refugees in the areas of health and wellbeing
- Enhance agencies' abilities to meet these needs.

The RHNP staff work to meet these aims through various activities. As noted earlier, one successful strategy to date has been the quarterly Eastern Region Refugee Health Network (ERRHN), which is attended by staff from; primary health, mental health, community services and education sectors. The RHN convenes these meetings and provides administrative support in the form of minute taking and circulation.

Whilst no formal evaluation has been done regarding the impact of participation within this network, comments provided by one GP and multiple CSWs, in the context of the RHN

evaluation project, indicated this is seen as a valuable forum. They note this forum increases capacity to respond to refugee populations and linking to the broader refugee support system in the region. Such multi-disciplinary networks are also known to “enhance communication, mutual understanding, coordination and referrals between providers”<sup>3, p.205</sup>.

In addition to the Eastern Region Refugee Health Network, the RHNP at EACH participates in the following activities to further build the capacity of the local service sector:

- Attendance and presentation at regional health forums
- Sharing of relevant literature with other health professionals
- Informing other health professionals of relevant professional development opportunities
- Participation when possible in the bi-monthly EACH CALD Working Group.

An important part of building the capacity of the local service sector is increasing the awareness of refugee needs and relevant health knowledge of those staff within the sector, be they GPs or CSWs.

Local GPs who participated in the evaluation noted a sense of disconnection from the broader refugee support system. One GP commented that the RHN had assisted to alleviate this sense by facilitating connections to other refugee service agencies and acting as an information and referral point for the GP.

**Community Service Workers reported increased knowledge in the following areas as a result of working with staff from the RHNP at EACH**

<b>Australian Health Care System</b>	<b>TB and Mantoux testing</b>
<b>Hepatitis &amp; HIV</b>	<b>Safe practices with communicable diseases</b>
<b>Medical terminology</b>	<b>Immunisations and vaccinations</b>
<b>Pathology tests</b>	<b>Healthy living practices</b>

# section 4: evaluation themes

## 4.4 capacity building continued

Of those GPs who participated, the highest concentration of capacity building strategies existed with the GP who is co-located at EACH. This is a mutually beneficial relationship enabling an exchange of knowledge and skills. The nurses and GP share literature, make visits to relevant health services such as Hepatitis Clinics, and attend relevant training sessions together.

Similar instances of capacity building by the RHNs were noted by the CSWs interviewed for the evaluation project including:

- Effectively allaying fears of CSWs by dispelling health myths and providing accurate health information (re: HIV and Hepatitis)
- Presenting at refugee groups in the community focussing on health and wellbeing
- Providing contact details for appropriate speakers to present at these health and wellbeing groups.

When asked if the CSWs had increased their knowledge as a result of interactions with the RHN program, workers were able to list numerous areas in which they felt they had learnt from the RHNP, (see table on previous page). This increased knowledge allows CSWs to be more skilled in supporting their clients to better understand any procedures required as part of their health investigation or treatment.

This learning often comes through secondary consultations with the RHN staff, as well as attendance at professional development sessions which focus on specific issues. An example being the professional development sessions arranged by the RHN for staff in partner agencies as a response to the prevalence of Hepatitis in newly arrived refugee communities.

The third aim of the RHNP is that of better enabling individuals, families and communities to improve health and wellbeing.

### Community Services Worker Participant

One CSW told of a case where a school was responding inappropriately to the fact that one of their young refugee students was infected with Hepatitis B.

The worker was able to have a conversation around this with RHN. The RHN provided the worker with the latest health information around Hepatitis B, its effects and transmissions, thus up-skilling the worker.

The RHN then engaged the school around the issue and went on to do some Health Promotion work with the staff.

This form of capacity building uses health promotion approaches, with the aim of increasing clients' levels of health literacy.

Health literacy refers to a person's knowledge about bodily functions and indications of dysfunction as well as their ability to "find, interpret and understand" health information, and where to seek further assistance if needed<sup>27</sup>.

Whilst high levels of education are not necessarily an indicator of health competency, it is known that culture, language differences and low-socio economic status contribute to low health literacy levels<sup>28</sup>.

Upon arrival, it is possible that refugee populations experience a reduced capacity for self-care and the skills needed to actively participate in health care<sup>20</sup>. Health literacy is not a concept that is easily understood with most refugees coming from populations with low levels of health literacy.

Whilst the concept of health literacy may not be familiar to the refugee population, a great many refugee participants commented that their knowledge about health issues was inadequate, and expressed a desire to learn more.



# section 4: evaluation themes

## 4.4 capacity building continued

Some newly arrived refugees reported that they appreciated the feedback received from the RHN about their health status, as it was often the first opportunity they'd been given by a health professional to do so. Many reported they would like to learn more about their health issues so they could make adjustments to their lifestyles to support their health needs.

### Refugee Participant

"The RHN taught me a lot about the other services available in the community, and now I know where to go if I need more help with my health"

This desire for knowledge not only included information about health conditions, but also practical details regarding the navigation of the Victorian health care system. Some refugee participants felt disempowered in this area, noting the tendency for CSWs to 'take care' of the logistics associated with their health needs, particularly when these appointments are reached by car.

Whilst the assistance from these support agencies is valued by refugee clients, their preference is to be supported to participate in the process rather than have everything from the appointment booking to the transport taken care of.

Despite some frustration around logistical disempowerment, those who had participated in health education sessions run by MIC, AMES, EACH or BELS, were full of praise for these initiatives and felt they had learnt a lot about various health issues.

Although participants commented that the education sessions are a good format for learning about health and wellbeing issues, CSWs questioned whether a more interactive format might be more beneficial. They noted the difficulty for some clients, to retain a lot of information, particularly those experiencing trauma symptomology. Increased use of very basic visuals about health conditions was suggested as a tool to increasing understanding and retention.

Refugee participants were quick to note a range of areas of health education that they would appreciate the opportunity to learn more about. (see table below for details)

In addition, GPs and CSWs together noted the need for more community education around the following:

- Hepatitis and HIV – contraction and contamination, (in order to reduce fear and stigmatisation of those community members carrying these diseases)
- Preventive medicine and care
- Emergency department - guidelines for attendance
- Importance of adhering to medication regimes
- Contraception and family planning.

### Refugee participants identified the following health education needs

<b>Ante and post-natal information</b>	<b>Children's health</b>
<b>Chronic diseases and management</b>	<b>Health care system in Victoria</b>
<b>Healthy living</b>	<b>Infectious diseases</b>
<b>Mental health issues</b>	<b>Safe use of medications and prescriptions</b>

# section five

## 5.1 recommendations

### **EACH Refugee Health Nurse Program**

**1. Employment of a community member with a health background to the RHN program at EACH.**

Their role could be vital in designing appropriate cross-cultural sessions aimed at improving health literacy amongst newly arriving communities. This could be based on a model similar to the role of Aboriginal Health Workers or Bi-lingual Community Development Workers.

**2. Extend client eligibility to those who've been settled in Australia for up to 5 years.**

This would bring the program in line with the eligibility for the Settlement Grants Program, (SGP) provider in the area.

**3. Incorporation of a 'follow up function' into the current RHN role.**

This is estimated to be necessary in around only 5% of cases. The RHN could meet with the more complex clients or those experiencing chronic health complaints at the 6 month point after their arrival. This would coincide with the refugee clients transfer from the AMES program to their SGP provider. This would enable the RHN to provide valuable information about the refugee client's health needs to the agency who will be responsible for providing on-going support. (With appropriate client consent)

**4. Provision of "I need an interpreter card".**

Refugees are often not aware of their rights to request an interpreter at health consultations. This right should continue to be highlighted by the RHN at the Initial Health Assessment, and subsequent consultations.

**5. Provision of EACH brochures outlining the broader services available through EACH Social and community health.**

Many participants at the evaluation were not aware of the breadth of services available through EACH. The provision of translated EACH brochures would further increase access for this client group to the primary health system, enabling them to make informed choices about services they choose to engage with. These brochures could be provided at the Initial Health Assessment Sessions.

### **EACH Social and Community Health Service**

**6. Creation of translated health resources**

Despite the availability of many health resources in languages other than English, at present there are very few available in the community languages of the Chin and Karen ethnic groups. The creation of such could be the focus of future student placements at EACH. Partnerships could be formed between two students, (one from a university, the other a community member from AMEP) who could then work together on creating the resources.

# section five

## 5.1 recommendations continued

### General Practice

#### 7. Creation of a GP resource kit

Some GPs who participated in the project expressed a lack of confidence in working with refugee clients. Literature also reveals a lack of knowledge amongst many in the GP community about eligibility for and how to access interpreter services for their refugee clients. The creation of a resource kit containing this information would be useful when advocating for new clinics to accept refugee patients

The kit would include the following:

- Interpreter service details and obligation
  - DPL details (Free TIS service)
  - Provide application form for clinics to register for DPL
- Refugee service system information sheet
- Links to GP resources for working with refugee population
  - Victorian Refugee Health Network training calendar
  - Foundation House GP tools

#### 8. Creation of an A3 poster informing people from NESB backgrounds of their right to an interpreter for GP consultations

Whilst this is similar to the TIS posters which are already in existence, this version could have an emphasis on the clients' rights to have an interpreter engaged, and the GPs obligation to engage one when requested.

### Networks or Divisions of General Practice

#### 9. Research by the GP networks or divisions in the OEMR

The Networks or Divisions of General Practice in the OEMR are encouraged to undertake research which would explore levels of awareness and understanding of DPL services and knowledge of how to use them amongst staff and MDs in General Practice clinics in the region. The research would assist to uncover barriers and enabling factors to for General Practices engaging interpreters within the region.



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