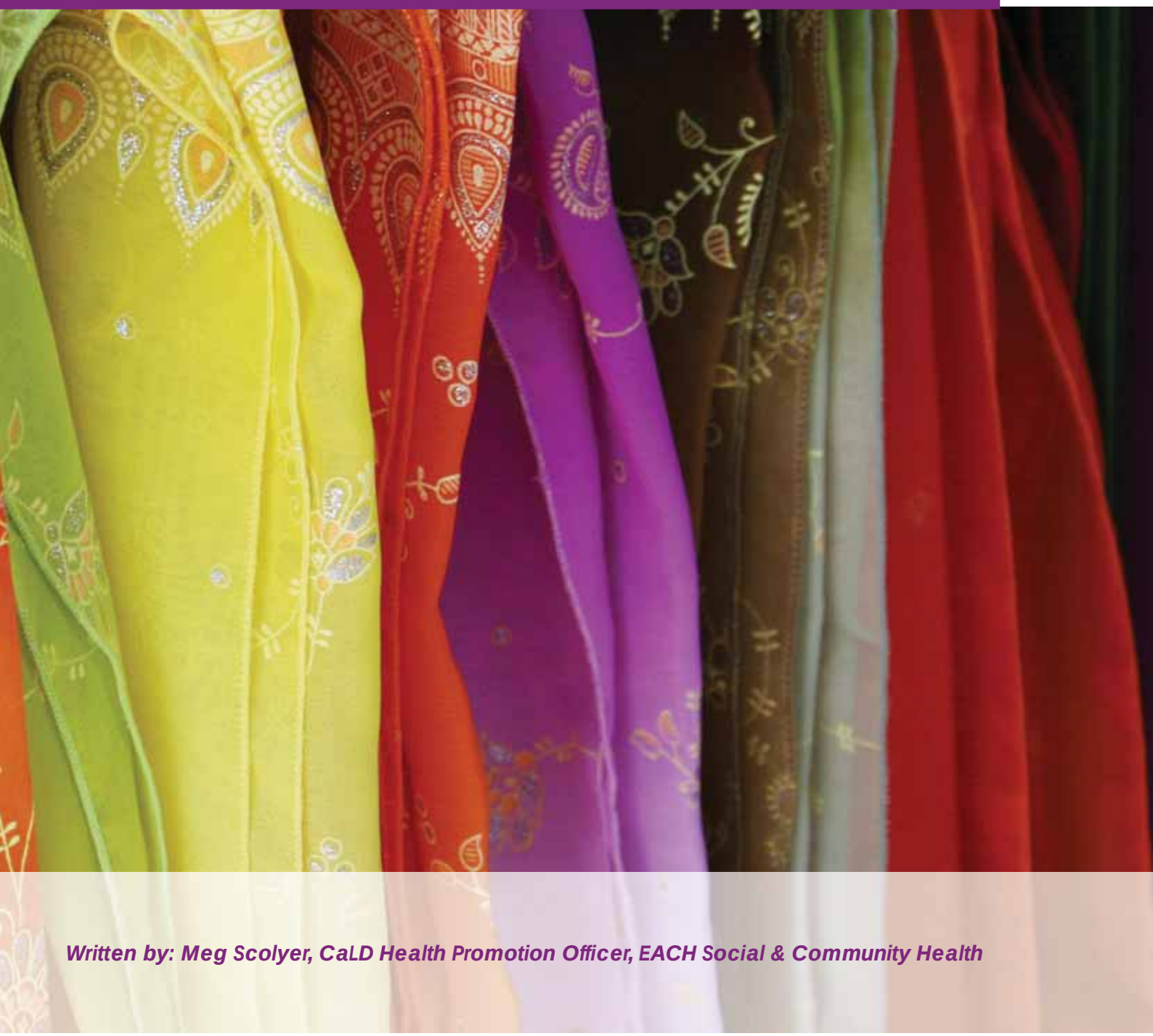
Maroondah City Council

eachsocial and community health

Outer East Health & Community Support Alliance

Factors that impact on access to immunisation in newly arrived refugee communities

Eastern Region Refugee Health Network perspectives



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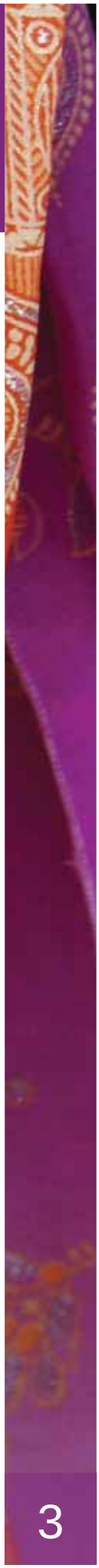


Introduction

Newly arrived refugee communities are one of the most vulnerable, marginalised and disadvantaged population groups in the community. In the face of inequity, it is vital that we ensure access to safe and affordable health care.

Located in the Eastern Metropolitan Region of Melbourne (that is, the local government areas of Boroondara, Whitehorse, Manningham, Monash, Knox, Maroondah and Yarra Ranges); the *Eastern Region Refugee Health Network* is composed of organisations working in refugee health and settlement. This network, based on the premise that immunisation as a public health intervention protects the health of the population; has identified concerns with low rates of immunisation for newly arrived refugees, who fall outside of the eligibility criteria for free catch up immunisations - particularly of Hepatitis B, Meningococcal C, Chicken Pox, and Human Papillomavirus vaccinations.

Currently we have estimated, based on local statistics provided by the Eastern Region Refugee Health Nurse; that for the calendar year of 2010, two hundred and forty nine clients from a refugee background were provided with their initial comprehensive health assessment. Of these 249 clients, 175 people did not have any record of immunisation, and therefore required catch up immunisations – in particular, those vaccines mentioned above incurring a cost to the client. Further research is required to ascertain whether this local data regarding catch up immunisation is reflective of state-wide data.

The *Eastern Region Refugee Health Network* feel the cost of vaccinations placed on newly arrived refugee clients may be a barrier to accessing immunisation. We feel this is a growing concern, as the population of newly arrived refugees in Melbourne's Outer East continues to expand.

This paper explores the possible reasons as to why there was a low uptake of catch up immunisations in the newly arriving refugee community, based on a literature review.

Background

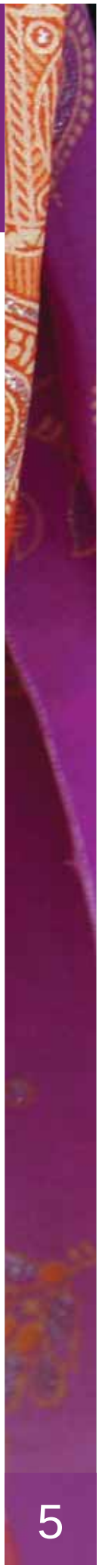
Immunisation, as a public health intervention, ensures a reduction or elimination of communicable disease, and the protection of the health of a population[1]. This understanding is central to our communiqué.

A refugee is a person who has been found by the United Nations High Commission for Refugees (UNHCR) to be outside his or her country of nationality, and unable or unwilling to return to that country, due to a well founded fear of persecution owing to the person's race, religion, nationality, membership of a particular social group, or political opinion[2,3].

Upon obtaining a Protection Visa from the Australian Government, refugees are resettled in Australia under the Humanitarian Program[3]. In the last financial year, 2010-11, Australia had 13, 500 places for people from a refugee background3. Of those, 243 people under the Humanitarian Program were resettled in the Eastern Region of Melbourne; with 158 people settling in the local government areas of Knox, Maroondah and Yarra Ranges, that combined, make up the Outer Eastern region of Melbourne[4,5,6,7]. In the previous year, 2009-2010, 13,500 places were also designated for people from a refuge background3. Of those, 309 people were resettled under the Humanitarian Program in the Eastern Region of Melbourne; with 224 people settling in the Outer Eastern region of Melbourne[8,9,10,11]. Additionally, it is recognised by Murray and Skull, that as well as the Humanitarian entrants, 'a number of people who enter Australia under the mainstream family migration program share "refugee-like" backgrounds and experiences'[12]. This suggests that the number of people settling in the Outer East of Melbourne from a refugee background may actually be higher than the outlined statistics.

As the population of newly arrived refugees in Melbourne's Outer East continues to expand, so too does the need to employ further staff at local agencies to support them. This is demonstrated by increased case manager and support worker positions, specific to Humanitarian Settlement Support in the region.

Upon arrival to Australia, it is recommended that refugees attend a comprehensive health assessment[1,13,14,15]. Generally, refugees tend to be highly susceptible to vaccine preventable diseases; and subsequently, an initial health assessment should involve screening for infection, in addition to an assessment of immunisation status and the development of a catch-up immunisation regime[13,14,16,17,18]. The Australian Immunisation Handbook recommends that catch up immunisations be provided to all refugees who cannot provide documented evidence of previous vaccination[17,18]. This is of particular relevance, as people from a refugee background are likely to be unsure of their vaccination history or hold incomplete records, if indeed any record[12,13,17,19,20,21].



Catch up Immunisation Concerns

Strict guidelines surrounding catch up immunisation schedules have been provided by the Victorian Government Department of Health. Guiding documents outline the criteria for use of government vaccines[13,17,22]. This includes the rigid eligibility criteria that must be met to receive immunisations free of charge.

One example to demonstrate our concern follows.

The Victorian Department of Health (DoH) has outlined *Criteria for use of Government Vaccine* in a document of the same title[23]. This document states that to receive Gardasil, a young female must be in Year 7 of secondary school or age equivalent[23]. The document goes on to state that catch up immunisation of Gardasil can be given to a young female in year 8 or age equivalent for a course that commenced in the previous year[23].

In the calendar year of 2010, the Eastern Region Refugee Health Nurse recorded at least 36 females arriving in Australia from a refugee background between the ages of 14yrs – 26yrs. These young women fall outside of the Victorian DoH criteria for free catch up immunisation of Gardasil, but are however within the recommended age range to receive Gardasil[24]. Gardasil, the vaccine for the prevention of cervical and vaginal cancers and genital warts caused by human papillomavirus (HPV); works by developing protection against the HPV types that account for 70 percent of cervical cancer cases, 90 percent of genital wart cases, and a significant proportion of cervical abnormalities[24]. In worldwide clinical trials involving over 20,000 women aged 16 to 26 years, Gardasil was 100 percent effective in preventing high-grade cervical pre-cancers and cancers due to the vaccine HPV types[24].

The *Eastern Region Refugee Health Network* feels that not immunising all young women potentially puts the community at risk of an increased incidence of the development of HPV and possibly cervical cancers.

A further example to demonstrate our concern follows.

In Victoria, the highest risk groups for meningococcal disease are children under five years of age and young adults aged 15 to 24 years. In 2010, 42 per cent of suspected and confirmed cases of meningococcal disease in Victoria were aged 20 years or older[30]. A majority of people arriving to Melbourne's Outer East from a refugee background fall within this age bracket. The infection can develop quickly and can cause serious illness or death[30].

It could be said therefore, that the strict eligibility criteria for receiving free immunisations can act not only as a barrier to accessing affordable health care, but potentially can systematically put the community at risk of developing life threatening diseases.

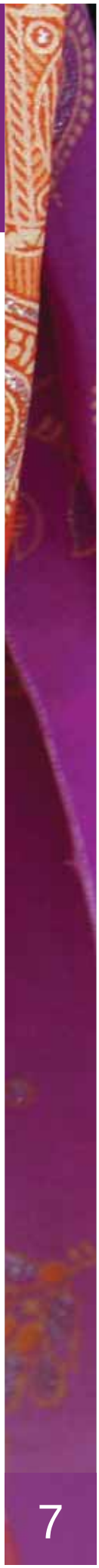
Barriers to accessing health care, including the financial constraints

A range of theoretical and practice based papers were analysed regarding the barriers to immunisation faced by people from a refugee background. These papers were mostly specific to Australia, with one from America. Five of the major barriers to accessing health care, and immunisation, taken from the data are listed below:

- Seven of the analysed papers identified sociocultural differences between the home country and Australia as a main factor impacting on access to health care by recently arrived refugees[12,15,21,25,26,27,28] . Key themes were mostly centred on cultural understandings and perspectives of health, but went further to include the mistrust of authority figures due to previous experiences of torture. Henderson & Kendall[27], identified these themes through qualitative focus group questioning, with the questions developed in partnership with ethno specific health workers and community leaders, and implemented with qualified interpreters. Other practice articles however, were not explicit in identifying how this information was gathered.
- Eight papers noted language needs, particularly regarding the use of qualified and confidential interpreters for communication, but also including English literacy levels[12,15,20,21,25,26,27,28]
- Six articles mentioned awareness of local health services and how the Australian health system operates as a barrier to accessing health care[12,15,25,26,27,29]
- Six papers noted a systemic lack of understanding of the complex issues faced by refugees in the mainstream population, resulting in a lack of culturally sensitive care[12,21,25,26,27,28], and
- Eight papers noted financial constraints as a barrier to accessing health care[12,15,18,21,25,26,27,28]. Milledge *et. al.*[29] in their practice article from Sydney, outline their study method as a cross-sectional questionnaire of GPs in Fairfield to identify attitudes about varicella vaccine. Interestingly, the authors state 'The 'cost-to-parent' of the vaccine and an 'extra needle' were deterrents to the uptake of varicella vaccine by 77% and 28% of respondents, respectively'[29]. Similarly, Milne *et. al*. in their paper *Immunisation of refugee and migrant young people: can schools do the job?* mention that 'the perceived cost of the vaccine may have been a barrier for some students presenting to the GP'[18]. The authors go on to state, that 'NSW health made the vaccine free of charge for this program'[18]. This ethical consideration bodes well for the participants of this research, however there are no recommendations to ensure all students across the State, or even Australia, are provided with free vaccines.

The Victorian Immunisation Strategy 2009 – 2012, also makes a small mention of the lack of funding for immunisation in the refugee population, by stating that 'there have been shortfalls in Commonwealth Government funding for vaccines for this group (sic.) that have led to less than optimal coverage'[1]. The strategy goes further, in Action 2.5, by planning to 'continue to lobby at Commonwealth level for sustainable funding of vaccines for refugees'[1]. Interestingly, it seems that the structural financial barriers to people from a refugee background accessing affordable health care has already been bought to the attention of relevant government departments.

Such barriers to accessing affordable, safe, and culturally acceptable health care; may prevent people from a refugee background in taking the necessary steps to protect their own health and the health of their families through immunisation.



Conclusion & Recommendations

This communiqué, (based on a detailed literature review which can be provided upon request), has attempted to understand why there is a low uptake of particular catch immunisations in newly arriving refugee communities in Melbourne's Eastern Metropolitan Region. More specifically, those vaccinations that require payment such as Hepatitis B, Meningococcal C, Chicken Pox, and Human Papillomavirus vaccinations.

We have demonstrated our concerns via the use of detailed examples regarding Gardasil and meningococcal vaccination in the 'catch up immunisation concerns' section on page 6, and chicken pox as outlined in the 'financial barriers to health care' section on page 7.

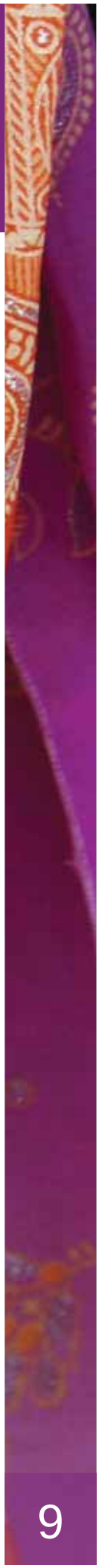
The *Eastern Region Refugee Health Network* is particularly concerned with the financial barriers to health care for newly arrived refugee communities in the area. The Eastern Region Refugee Heath Nurse buys in each of the three doses of a Gardasil regime at an average cost of $152 per vaccine, and recognises that the price of a Gardasil vaccination regime at $456 is inaccessible to most young women from a refugee background. Additionally, Chicken Pox at $65 per dose (2 doses required after the age of 14 years), Hepatitis B at $15 per dose (with 3 doses required), and Meningococcal at $85 per dose; puts a large and unnecessary financial strain on Australia's newest community members, already struggling to learn the English language, find a job, and settle into Australian life.

Both local data and a literature review have provided part of the picture in highlighting potential barriers to health care, including immunisation, for the local refugee communities. To understand this issue further it would be of benefit to action the following recommendations.

Recommendations:

- Analysis of state-wide data regarding uptake of catch-up Hepatitis B, Meningococcal C, Chicken Pox, and Human Papillomavirus vaccinations in newly arrived refugee communities; including models of catch up immunisation provision.
- Further research with people from a refugee background regarding their experience of accessing vital immunisations.
- Further research is required to identify which of the barriers to health care identified in the literature are important in both the local context, and throughout Victoria.
- Cost effectiveness studies into providing Hepatitis B, Meningococcal C, Chicken Pox, and Human Papillomavirus vaccinations free of charge as part of the catch up immunisation schedule.

Notes



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