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Comprehensive Refugee Health Assessments
An investment in prevention and early intervention

A data analysis of the EACH Refugee Health program, refugee clients' health assessments completed in full within the EACH Primary Health Care program.

(EACH Ltd, formally known as Eastern Access Community Health Service)

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Executive Summary

The decision to conduct a client file audit on the initial health assessments of the refugee clients who had been seen as part of the EACH Refugee Health (RH) program arose as a quality improvement initiative. The aim was to identify improvements to the processes and practices involved in the assessments.

The EACH Clinical Services Manager, also a student of Latrobe University Health Sciences School in the Master of Public Health degree carried out the audit as part of an action learning course within the program. The eventual scope of the audit exceeded the initial smaller action learning project and developed instead into a two year research process.

The file audit included de-identified documentation of all the data arising during the Initial Health Assessment process of 98 clients (9% of total refugee referrals) who had been seen within the EACH RH team. The recommended General Practice Victoria and Victorian Refugee Health Network health assessment tool was used as the initial guide for the data items.[1] The file review included hard copy and electronic data from the client software programs used within the EACH Primary Health Care services, TRAK care, Titanium and Practix.

All results and the associated discussion were reviewed in relation to the current recommendations for refugee health practice in Victoria and took into consideration recent literature regarding similar population groups and the issues presented. The final data and results were reviewed by the existing Refugee Health Nurse Co-ordinator and General Practitioner (GP) working within EACH at the time the data was collected and a further GP who had extensive experiences in refugee health in Victoria.

Language issues

Appropriate language support is crucial to every aspect of the health-care process, beginning with the initial assessment through to treatment and subsequent consultations. Refugees and health professionals need to be able to communicate with one another to ensure that decisions and actions are not based on misunderstood information. Access to and availability of language support remain ongoing issues for refugee health (RH) teams, especially when referring to external services, where time and cost constraints have been identified as barriers to the use of interpreters.

While the EACH RH program has access to Victorian Government block funding for language support the costs involved presently exceed the funding allocated.

Quality improvement strategies:

- EACH staff are encouraged to make block bookings of interpreters wherever possible with the RH team working with local settlement services to identify opportunities for doing so.
- EACH RH team has continued to work with local service providers to encourage the use of interpreters for all clinical consultations. These service providers are reminded of the benefits involved, including the medico legal protection offered to the clinician and the long term positive outcomes for the individual they are working with.
- The EACH RH team participates in discussions with state-wide refugee health networks and government representatives to identify how access to interpreters might be improved. The team is also pressing for data to be collected on the demand for interpreter support and its true costs.

Discussion of results and quality improvement strategies

Settlement type and issues arising

The majority of the EACH refugee client files included in the audit were individuals and families who had been granted humanitarian visas through the United Nations High Commissioner for Refugees (UNHCR) on-shore program that Australia is a signatory to. These included visa types 200, 202, and 204. A small number (8) of asylum seekers were also included.

The predominant ethnic groups identified in the data collection were Karen ethnicity and Haka Chin ethnicity, followed by Falum Chin and Tedim Chin; all are groups from distinct regions within Myanmar. Smaller numbers of other ethnicities were also represented, including refugees from India, the continent of Africa, Pakistan , Iran, Iraq and Vietnam.

Most of the new arrivals were living with family groups, whereas unaccompanied individuals were either living with people from their own community in boarding houses or in emergency accommodation. The shortage of housing and the high cost of rental was an issue that was discussed as part of the settlement process, and was found to be a cause of significant stress, especially for individuals lacking the support and security that a family or community group can provide.

Quality improvement strategies:

- Ongoing EACH participation in advocacy through the Victorian Refugee Health Network for recognition of the complexity of needs related to housing and isolation.
- EACH participation at a state level in the strengthening of partnerships with the Red Cross and the International Health and Medical Service (IHMS) with regard to housing and education opportunities.
- EACH RH team maintain contact with the relevant asylum seeker service providers to identify any issues airing with this population group settling in the east to enable coordinated solutions to be identified.

Social and psychological health

Life experiences

The social and psychological history of clients forms an important part of the initial health assessment. It requires the nurse or General Practitioner (GP) to sensitively question the client in a manner that provides safety and support for the issues that may be identified or revisited in the process of the assessment. This is critical for identifying victims of torture or trauma, who need to be prioritised for specialist counselling and support through programs conducted by the Victorian Foundation for the Survivors of Torture (VFST). It is also critical in the identification of any physical health symptoms that have underlying psychological causes.

While it is not always possible or appropriate to ask an individual for a social history at the time of the first contact, in most cases the nurse is able to establish a relationship of trust before the full health assessment is completed. This enables early referrals to occur when additional mental health support may be needed.

A total of 210 issues related to life experiences were identified in the audit. The following five themes were detected, in order of most common to least common:

- Threats to the individual personally or to a family member
- Perilous journey
- Separation from family; referring to family members either remaining in the country of origin still in a refugee camp, or in another country of safety. It also includes people separated from a family member who has disappeared and it is not known whether they are alive or dead
- Assault including torture and sexual assault
- Witness to assault including witness to military conflict, torture, murder and any form of attack on a person or group.

The experiences included in the data were only those reported during the initial health assessment and it is possible these did not reflect the full extent of the trauma suffered by the refugees - some may not have felt sufficiently comfortable to disclose all that had occurred at that stage.

Symptoms of stress or concern

Forty refugees identified concerns or symptoms indicative of some level of stress. One hundred and five separate issues were documented, with 23% of individuals reporting four or more issues. The EACH RH nurse and GP use this information, and any additional emerging data, to identify clients who require a referral to specialist torture and trauma counselling.

Age and gender-specific issues can also require support. These include parent to child relationship breakdowns and family violence. While the initial health assessment data did not identify issues such as these, the RH team advises that they tend to emerge later, in the first twelve months of settlement.

Quality improvement strategies:

- EACH to up-skill RH staff on the psychological and emotional health needs of children. Identify the potential for a recall assessment and interview within the first six to twelve months of settlement.
- EACH RH program to determine whether early intervention might be improved by using the recently developed Monash Health RH mental health assessment indicator tool, as an addition to the existing initial health assessment procedures.
- Explore the provision of gender sensitive services to both females and males to identify emerging symptoms of psychological stress.
- EACH RH team to support the capacity of local services across the eastern region of Melbourne to deal with the mental health needs of refugees and asylum seekers.

Physical health

The report focuses on a number of different aspects of the physical health outcomes arising from the initial health assessments. Physical health issues are documented by the RH nurse during the initial contact with refugees. Parents indicate any concerns they have about their children's health. Added to this are the nurse's observations and data related to age, height, weight, body mass index (BMI) etc.

Access to optical assessment and specialist services

Access to affordable optometry services was identified as a common area of concern. An outreach clinic at EACH was established by the Australian School of Optometry during the time this report was being prepared. Since that time there has been an increase in the number of refugees referred for visual screening. The visiting optometry clinic now operates twice monthly, with eight appointments each day and these are now booked seven months in advance, with 90% of the referrals coming from the RH team.

Quality improvement strategies:

- The EACH RH team will also explore opportunities for additional optometry clinics with partner organisations in the eastern region to alleviate the long waiting times that presently exist.

Height, weight and body mass index

The initial health assessment tool includes the recording of the height, weight and body mass index (BMI) of each individual. The EACH RH nurse only records a BMI for individuals over 18 years of age.

Child development and growth

Eleven of 25 girls included in the sample were at the 3rd percentile for height or weight or lower. Of the 11, seven registered lower than the 3rd percentile, pointing to a need for further investigation to determine whether dietary related conditions of underweight or overweight were present. A percentile of three or less for growth or weight is not always indicative of an immediate concern, but it must be taken into consideration by the nurse and GP in the context of the child's ethnicity. Of 13 young males assessed, seven were at the 3rd percentile or lower for height or weight, pointing to the need for further investigation.

Quality improvement strategies:

- Explore the establishment of an outreach Royal Children's Hospital Immigrant Health Service at EACH.
- Explore options for the Paediatric Refugee Health Fellow from the Immigrant Health Clinic to provide some professional development for clinicians in the EMR working with refugee children.
- EACH RH team and English language school nurses to discuss the possibility of coordinating information and timing of strategies to focus on healthy eating and lifestyle during the intensive 12 month school period.

Adult growth and Body Mass Index (BMI)

The World Health Organisation (WHO) now recommends that the BMI range for optimum health amongst Asian population groups is between 18.5 and 23 [2]. Thirty-nine percent of the refugees included in the EACH data were over the recommended upper limit of 23. With the changes to diet and lifestyle that accompany living in a new country, the EACH RH team believes there is a strong need for targeted support by health practitioners, beginning in the initial settlement stage.

Adult growth and Body Mass Index (BMI) cont.

Quality improvement strategies:

- EACH RH nurse coordinator will continue to impress upon new nurses in the RH team the importance of height, weight, BMI and waist measurements of refugees. The measurements provide a baseline for individuals to be monitored, and should assist in reducing future health risks.
- EACH RH team to identify more intensive approaches to disease prevention and health education with refugees following the initial settlement period.
- EACH RH team to discuss with EMR Regional RH Network of service providers, the need to identify consistency in the health messages provided to the catchment population group.
- Explore the feasibility of a three or six monthly review appointment or education session for individuals and families, including an after business hours option.

Urine and faecal investigations

The EACH data indicated there was a high incidence of contamination in these investigations samples. Fifty-three percent of the refugee's screened had a positive result that required some form of treatment or monitoring.

Quality improvement strategies:

- EACH to develop and implement visual instructions to support refugees with the collection of urine and faecal samples to improve early identification of health concerns and treatment needs.

Vitamin D

The EACH data points to the need for Vitamin D status to be determined as part of the initial health assessment. Only 46% of adults tested had a level equal to or greater than the minimum recommended 50nmol/L.

Quality improvement strategies:

- EACH RH team to develop strategies for education focussed on the importance of treatment for identified Vitamin D deficiency and health education with regard to exposure to safe amounts of sunlight.

Iron deficiency

Testing for an iron deficiency is required to identify clients either at risk of developing anaemia or already suffering from it. Severe anaemia is a serious medical condition requiring urgent medical treatment. It increases the risk of morbidity or mortality, especially in children and pregnant women. The EACH data revealed that 27% of those tested returned a result indicative of an iron deficiency that required additional review.

Quality improvement strategies:

EACH RH team to establish a routine referral to a dietician for tailored health education at different stages of settlement, including sessions or groups outside of business hours.

Screening for parasites

Schistosomiasis

Screening for schistosomiasis is one of the recommended tests for refugees arriving from either Africa or South East Asia. A blood screen and urine and faecal samples are required. The parasite can remain in an individual's system for many years following treatment, so monitoring of their serology is important even when treatment has been prescribed. Thirty-six percent of those tested returned a positive reading (i.e. parasitical condition requiring treatment). Two percent of the results were equivocal and required further testing. The incidence of parasitical conditions was much higher than that found in two previous studies,

Strongyloides

Positive results for Strongyloides were found to be spread across all age groups for both females and males, with a positive result of fourteen percent. Twelve percent of the people returned equivocal results. Larvae invasion of the lungs can be the result of chronic infection; individuals who are immuno-compromised are at the greatest risk. Strongyloides can be quite mild, although severe or chronic Strongyloides can lead to life-threatening haematological diseases.

Giardia

The numbers of refugees identified with Giardia was very low, however given that only two refugees in the sample of 98 were tested, the results do not provide any insight into prevalence of the condition. The EACH RH GPs now include this test as part of the routine faecal testing for all refugees, children and adults.

Malaria

Screening for malaria was carried out as a routine test for 78 of the clients included in the audit. All returned a negative result. As this was not based on the presence of any symptoms but simply a routine screen, the possibility of the existence of malaria in any of those refugees tested cannot be ruled out, as individuals can be living with an asymptomatic chronic infection. Encouraging clients to return to the GP should symptoms of active malaria become evident would provide another route to treatment, rather than relying on the screening alone.

Quality improvement strategies:

- EACH RH GPs now consistently order investigations in line with the current recommendations in *Promoting Refugee Health; a guide for doctors, nurses and other health care providers caring for people from refugee backgrounds.* [3].
- EACH RH team to continue supporting local community practitioners with regular links to current information about refugee specific conditions such as malaria.
- EACH RH team to explore options of improved health literacy for refugees in regard to symptoms of active malaria and the need for immediate medical attention.

Helicobacter pylori

The Clinician's Refugee Health Guide has reported that helicobacter pylori has been found in 50% to 80% of refugee population groups, compared to an incidence of 30% in the Australian population. [3]

The EACH data indicated that only nine refugees were screened for helicobacter pylori with two returning a positive result. Notwithstanding the small sample size, the higher reported incidence of up to 80% for refugees suggests that the EACH RH team may be missing other individuals infected with this condition, especially as it can be asymptomatic.

Quality improvement strategies:

- EACH RH GPs now consistently order investigations in line with the current recommendations in *Promoting Refugee Health; a guide for doctors, nurses and other health care providers caring for people from refugee backgrounds.* [3].

Latent tuberculosis infection testing

Screening for latent tuberculosis infection (LTBI) is a critical part of the initial health assessment given the high incidence of LTBI among refugee population groups. Individuals can be infected with mycobacterium tuberculosis without any obvious symptoms and once identified this can be easily treated to prevent future development into active tuberculosis. Thirty-two percent of the refugees screened were identified as having a positive Mantoux result, indicating the existence of latent infection and requiring further investigation.

Quality improvement strategies:

- EACH RH nurse and GPs continue to provide an initial Mantoux screening test for new arrivals in the eastern metropolitan region.
- Impress upon refugees the benefits of completing the screening process and notifying their GP or the RH nurse should any changes in symptoms occur (e.g.; cough, haemoptysis, dyspnoea). [4]
- EACH RH team to continue work with state-wide refugee health networks and service providers, to identify solutions to the problem of refugee or asylum seeker clients being missed from screening or not completing the full Mantoux test.

Hepatitis A, B and C

Screening for Hepatitis B

The incidence of Hepatitis B across the world is difficult to estimate due to the number of individuals who have mild symptoms or are asymptomatic. It has become widespread because it is easily transmitted through contact with the blood or body fluids of an infected person. It is a high risk condition for people who share intravenous needles or engage in unprotected sex. Infected mothers can also pass the disease on to their unborn baby during a vaginal birth; this is the most common form of transmission in developing countries [4]. Four percent of the EACH client's who were tested were identified as having a chronic infection, and 9% were found to be infected but asymptomatic; the latter condition has been found to be indicative of someone who is a silent carrier of Hepatitis B.

Access to free protective vaccinations for Hepatitis B is an ongoing issue for the EACH RH nurse and GP. Current criteria restrict their availability to immediate family members of an individual suffering from Hepatitis B. This places the burden of cost on community members where the criteria are not met. When vaccination is recommended by the EACH GP, the cost of the three vaccinations required is discussed with clients, who may not be in a position to fund them.

Hepatitis A and C

Six individuals in the EACH sample needed testing for Hepatitis A; three returned a positive result requiring treatment and support. Screening for Hepatitis C is performed on a routine basis; three individuals tested positive for Hepatitis C and one returned an equivocal result requiring further investigation.

Quality improvement strategies:

- EACH RH team continue to provide health information to refugee population groups about Hepatitis in all its forms and how infection can be managed.
- Continue pressuring for the availability of free vaccinations for Hepatitis B to be available to all newly arrived refugees as a preventative health action.

Additional sexually transmitted infection screening

At the time the data for the audit was collected, screening for other sexually transmitted infections (STI) occurred for all adult refugees and all sexually active adolescents, including those suspected of being sexually active.

Refugees in the audit were tested for Human Immunodeficiency Virus (HIV), Syphilis, Gonorrhoea and Chlamydia. The results were generally negative (i.e. no infection), although some instances of Chlamydia were diagnosed.

Quality improvement strategies:

- Establish a system of an additional STI screening appointment to be made for all individuals, declared or suspected of being sexually active or over a particular age, a few weeks after the initial assessment to discuss these infections and how to minimise risk.
- The EACH RH team and the Blackburn English Language School and the EACH Youth clinic to identify possibility of offering outreach nurse appointments for adolescents at the school.
- EMR Refugee Health Network to identify the various service providers engaged with these age groups with the aim of adopting consistent messages.

Reproductive health and family planning

Females

The EACH RHN program enables female refugees to meet with specialist women's health nurses or a specialist women's health GP. Many female refugees have availed themselves of the opportunity, following the nurse's explanation that the consultation makes it possible for them to discuss family planning, contraception, screening for disease and specific issues surrounding women's health.

Two nurses in the RH team at EACH are credentialed PAP test providers; they work sensitively with women who have recently arrived to provide education on female anatomy and physiology, and the importance of screening and the process involved. The data collected revealed that 44% of the newly arrived females had not previously received a PAP test.

Males

The EACH file audit did not contain any data related to the sexual and reproductive health of males. This was due to a lack of confidence on the part of staff in discussing such issues with newly arrived males, especially when the assessment occurred in a family situation and a private space was not available. RH nurses do not want to appear culturally inappropriate with male clients, who tend to be less comfortable with female practitioners. However, following some recent adverse diagnoses of HIV or Hepatitis B, RH nurses have taken steps to increase their skills and knowledge in this area, and now initiate more regular discussions of sexual health.

Catch up vaccinations

Identification of the vaccinations available in Australia that have not been available to refugees in their countries of origin is an important part of the initial health assessment. Refugees often arrive with little if any documentation of previous immunisations. Documentation that is provided is often ambiguous, and in one instance was provided in another language.

The Victorian Government Department of Health has a strict schedule of vaccinations that are available at no cost to refugees. These include, amongst others, adult diphtheria and tetanus, measles, mumps, and rubella. Vaccinations listed on the free-of-charge schedule were required across all age groups. In addition to these, several refugees from the EACH database required vaccinations outside the free-of-charge list.

Quality improvement strategies:

- EMR RH network to advocate with state-wide refugee health organisations for additional vaccines to be made available at no cost to refugee and asylum seeker population groups, as soon as possible after their arrival in the country.
- The development of a national immunisation record for all individuals over the age of seven years is another development the EMR and state-wide refugee health networks are promoting. This would reduce the costs associated with refugee clients receiving multiple doses due to a lack of easily accessible information indicating what they have received, especially when seeing a new GP.
- RH clinicians to be trained in gender equity to ensure they have the skills to promote the rights of women and girls within the context of varying cultural traditions.
- All RH clinicians to be aware of the referral pathway for refugee women to appropriate services for ongoing support.

- RH clinician training to address skills in discussion with male refugees and asylum seekers in relation to the health and well-being of their female partners and daughters.
- The EACH RH team to recall adult males for a second consultation with a nurse who has specialist experience in discussing male sexual health needs and issues.
- Establish an EACH GP clinic with a practitioner experienced in male and female sexual health.
- The RH team to work with other refugee service providers such as MIC and the English Language Schools to provide support for male health information sessions or groups.

Oral health

Poor oral health contributes to disability and unsatisfactory health outcomes. Early attention helps to minimise the risk of chronic disease. There were significant oral health treatment needs identified across the age range of those refugees for whom the data was available, thus highlighting the need for early screening and treatment as required. The most serious issues identified included bleeding gums, very decayed teeth, and bone loss. Bottle caries in children were also found, leading to advice from the dental staff and RH team to parents to limit sugary drinks and to offer more tap water, given the safety of water in Australia.

Quality improvement strategies:

- The EACH dental clinician's to focus on providing early access to oral health education and screening.
- The EMR and state-wide RH Networks continue to advocate appropriate interpreter support given the clinical and invasive nature of many dental procedures.

Conclusion

Despite the small size of the sample, the results of the audit show that a comprehensive initial health assessment for newly arrived refugees improves the chances of early intervention in a number of health issues and conditions. Comprehensive early assessment also helps to identify clients at risk of chronic ill-health, thereby providing an opportunity for preventative health strategies.

The audit also identified areas for improvement to the services delivered by EACH. Some of the improvements needed were due to the relative inexperience of staff in working with refugees at the time the data was collected. These were able to be addressed by a combination of ongoing professional development provided by the Victorian Refugee Health Network and peer support by the EACH RH nurse coordinator. It is very important that community health clinicians have access to, and a strong relationship with, the RH nurse teams, such as that located at EACH; this helps them to increase their knowledge, skills and to access support with issues and conditions that are unfamiliar.

The results of the audit also highlight the need for RH clinicians to allow sufficient time for all aspects of the health assessment to be completed. A sense of urgency and the need to complete the assessment in a minimum number of appointments due to costs of interpreters and the time involved for the refugee individual have been identified as barriers to organising additional appointments. However, allowing additional time in the early assessment and establishing recalls for discussion of issues such as sexual health and mental health concerns may be more cost effective in the long term, by reducing the risk of emerging or developing conditions going undetected.

Since this initial data for the audit was collected, the EACH RH team and particularly the Nurse Coordinator and GPs, have established themselves as a source of support, knowledge and expertise to their peers in the eastern metropolitan region, internal and external to EACH. While the EACH RH team has no authority to ask service providers outside of EACH to carry out recommendations based on the outcomes of this data review, or other emerging evidence, improvements in practice can be encouraged.

The relationships that have evolved over the time since the refugee health nurse program was implemented in 2009 have developed into a strong multi-disciplinary network. This has included the involvement of the EACH RH team and broader EACH services such as the Health Promotion Team and the EACH Cultural and Linguistically Diverse Working Group, in state and commonwealth working groups, focussed on meeting the health and settlement needs of refugees settling in the Australia.

While EACH RH services only form one small part of the Australian network of services engaged with refugees and asylum seekers, there is a strong commitment to working with peer service providers and policy makers, to assist individuals and families who settle in Australia from refugee backgrounds begin their new life with the best start possible.

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