



Refugee youth

Immunisation status and GP attendance

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BACKGROUND

We describe reported immunisation status and primary health care utilisation in refugee and migrant young people in western Sydney, New South Wales.

METHOD

Students attending an Intensive English Centre (IEC) high school in western Sydney were surveyed for self reported general health, immunisation status of hepatitis B and measles, mumps and rubella and attendance at general practice following arrival in Australia.

RESULTS

Of 165 respondents, 68 (41%) had a named general practitioner and 66 (40%) reported seeing a doctor in Australia. Students who had not seen a doctor in Australia were significantly more likely to request immunisation.

DISCUSSION

Refugee and migrant young people are likely to have a poor utilisation of primary health care relative to their needs. Most who had seen a GP in Australia required catch up immunisation. Stronger links and increased GP education about the requirements of these young people are needed to improve immunisation status and GP utilisation in this high risk group.

Between 2000 and 2003 Australia's net migration rate was higher than at any time during the previous decade.¹ In 2003 more than one in 10 total settler arrivals were humanitarian settlers.¹ The annual intake of refugee settlers to Australia now exceeds 13 000.²

This raises special challenges for primary health care providers given that people of refugee background face numerous barriers to accessing local health care, including language, cultural and financial constraints, limited awareness of services, and a systemic lack of understanding of the complex issues faced by refugees.³ The health problems faced by refugees in Australia have been described elsewhere.⁴

Young people have specific health needs, and it is likely that young refugees will have similar needs particularly in the areas of immunisation, drug and alcohol issues, family planning and relationship issues.^{5,6} A comprehensive health assessment can assist in providing young people with timely and effective health care and health advocacy.⁷

A very limited formal assessment of young people may have been undertaken before arrival in Australia, however this assessment is principally aimed at identifying conditions that may exclude entry into the country, or which are of public health importance. There is no requirement to

either document immunisation status or for the person to have catch up immunisation before or upon entering Australia. The Australian Federal Government has recently acknowledged the need for a more detailed approach to assessing the health of refugee people by the addition of a new Medicare item for assessment of newly arrived refugees.⁸

Most refugee or new migrant young people attend Intensive English Centre (IEC) high schools for 6–12 months before integration to mainstream high schools. We looked at the relationship between reported health status and the need for immunisation and previous visits to a general practitioner in newly arrived migrant and refugee young people attending an IEC in western Sydney, New South Wales. This was incorporated into a pilot project offering immunisation for measles, mumps and rubella (MMR) and hepatitis B, with the aim of referring students to a GP for completion of their immunisation course.

Method

We surveyed all students attending an IEC high school in western Sydney during June 2003. The survey assessed self reported general health status, presentation to a GP, dentist or hospital following arrival in Australia, and MMR and hepatitis B immunisation status. We asked

Table 1. Country of birth and primary language spoken at home of students attending IEC high school in western Sydney, June 2003

Country of birth	No. (%)
Southeast Asia	54 (32)
Africa	39 (24)
Unknown	29 (18)
Middle East	24 (15)
Europe	7 (4)
Western Pacific	6 (4)
Other	5 (3)
Language group	No. (%)
Southeast Asian	66 (41)
Middle Eastern	42 (26)
African	17 (10)
European	16 (10)
English	9 (5)
Unknown	9 (5)
Other	4 (2)
Western Pacific	2 (1)

students to name their local GP. The survey was translated into six languages: Arabic, Chinese, Dari/Farsi, Filipino, Korean and Turkish. Surveys were completed by either parents, carers, or by the student (if aged over 18 years).

A single dose of MMR and the first and second doses of a three dose schedule of hepatitis B were given to students upon provision of informed consent. Students were provided with a list of local GPs who spoke relevant languages and a generic referral letter to take to a GP for their third hepatitis B vaccination.

Data were analysed using SPSS version 10. Chi-square statistics were used to analyse differences between two proportions.

Formal ethics approval was not sought as the data had been collected as part of a school based health program. Consultation with the Department of Education and Training, NSW Health, the area health service and the school itself suggested that formal consent would not be required.

Results

One hundred and ninety-three students were enrolled in the IEC high school at the time of the survey and immunisation program; 165 (85%) completed questionnaires. There were 96 (58%) males and 65 (39%) females, with four (2%) students for whom gender was not recorded. The average age was 15 years (range 10–23 years). Students were from 32 countries and between them spoke 36 languages (*Table 1*). Fifty-nine (36%) had lived in Australia for less than 6 months, with the average settlement period being 7 months. One hundred and thirty-five (82%) lived with their immediate family (including at least one parent), 11 (7%) lived without a parent but at least one sibling, and 12 (7%) did not live with any immediate family. None of the students lived alone.

Findings for self reported health, immunisation status and presentation to a GP are shown in *Table 2*. The relationship between request for immunisation and GP attendance is shown in *Table 3*. Students who had not seen a doctor in the previous 12 months were significantly more likely to request immunisation with both MMR and hepatitis B vaccines ($p < 0.01$). There was no difference in requests for immunisation between those who could name a local doctor and those who could not. There was no difference between the number of students requesting immunisation for hepatitis B or MMR by length of stay.

Discussion

This study is the first to report self reported health status and immunisation requests of refugee young people attending IEC high schools in Australia. This limited survey suggests that young people from refugee and migrant backgrounds report similar levels of health and wellbeing as young people in the general

Table 2. Self reported health status, previous immunisation and primary care utilisation of students attending IEC high school in western Sydney, 2003

Reported health descriptor	No. (%)
Description of health as poor	0 (0)
Description of health as good	143 (87)
Current health problem	14 (8.5)
Access to Medicare	146 (89)
Previous MMR immunisation (self reported)	49 (30)
Previous hepatitis B immunisation (self reported)	29 (18)
Visit to GP in past 12 months*	66 (40)
Visit to dentist in past 12 months	55 (33)
Visit to hospital in past 12 months**	21 (13)
Named local doctor	68 (41)

* Reasons for visitation to doctor included upper respiratory tract infection, headache, allergy, malaria, muscle strain, immunisation and general check up

** Reasons for visit to hospital included tonsillectomy, laceration, measles, malaria and general check up

Table 3. Relationship between immunisation request and primary health care attendance in students attending IEC high school in western Sydney, June 2003

	Reported own GP	Reported no GP	χ^2 (p value)	Saw GP in past year	Did not see GP	χ^2 (p value)
MMR requested	67%*	76%	1.66 (0.2)	54%	85%	19.45 (<0.01)
Hepatitis B requested	75%	78%	0.27 (0.6)	54%	93%	32.66 (<0.01)

* One student with own GP was immunised for MMR and hepatitis B prompted by the school immunisation program

Australian population,⁹ yet they also report low immunisation rates for MMR and hepatitis B. These rates are well below the target given in the New South Wales Immunisation Strategy 2003–2006 for near universal coverage of children under 17 years of age.¹⁰

There are few studies that document the health seeking behaviours of adolescents from refugee and migrant backgrounds in Australia. This study reports that 40% of these young people had seen a GP after arriving in Australia, and 41% were able to name their own local GP. It is likely that some students who had not seen a GP were naming a GP seen by others in their household.

These proportions are slightly lower than those reported by Booth et al¹¹ who suggest that approximately half of all young people do seek health care from someone. As students who had not seen a GP since arrival in Australia were more likely to request immunisation against both MMR and hepatitis B, seeing a local GP may have presented a window of opportunity for immunisation. Nevertheless, over 50% of these young people who had seen a GP still requested immunisation.

Having a named GP did not mean these young people confidently reported better immunisation status. These findings are similar to a previous report by Yusef et al¹² which found that more than 70% of all adolescents report having had contact with a physician in the previous year, but only a few receive indicated vaccinations. There still remains significant scope – at least among the group of young people surveyed here – for offering opportunistic immunisation in general practice for people of refugee background in accordance with the Australian Immunisation Schedule.¹³

Despite the self reported good health of respondents to this survey, it is likely that a significant proportion of refugee young people will have a range of physical and psychological health problems.^{3,7,14,15} A recent study from the United States documenting the health of unaccompanied refugee minors suggests that the majority of these young people do well if they are well supported by good access to services, especially primary health care.¹⁵ Therefore there is an urgent need to link new arrivals to primary health care providers to enhance the process of detection, prevention

and treatment of both physical and mental health conditions.

Linking young people from refugee backgrounds to GPs and medical services may be difficult for a number of reasons beyond the usual access issues for youth. These include: mistrust of authority figures including medical staff; medical consultations and procedures causing significant anxiety especially where torture has occurred in the past; language difficulties and a lack of awareness of how to access interpreters; and incomplete knowledge of local health services and how the Australian health system is structured.¹⁶

The new Medicare item supporting an extended GP consultation for recently arrived refugees provides an initial step in improving access to effective GP care. However it will need to be supported by substantial education and support for GPs, including the use and accessibility of suitable interpreting services*, and the importance of catch up immunisation in this group. Suitable marketing in refugee communities, plus close links with immigration settlement services, will also be important.

* A list of resources has been provided in a previous article on refugee health in this journal⁴

Implications for general practice

- Many refugee and migrant young people are likely to have more complex health needs than local young people.
- There will be barriers to accessing GP services beyond those usually faced by local young people, including previous torture and trauma.
- A new Medicare initiative allows for an extended consultation to address complicated health issues in refugee people.
- General practitioners have a role in providing opportunistic vaccination to refugee and migrant young people according to the Australian Standard Vaccination Schedule.

Conflict of interest: none declared.

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