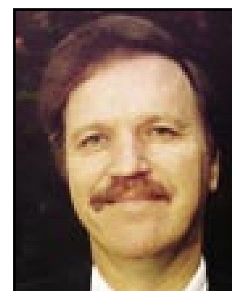
Refugee health

BACKGROUND Refugees and asylum seekers in Australia come from many countries. They present a significant challenge for general practice.

OBJECTIVE This article outlines the unique range of problems presented by refugee patients in general practice and some approaches to dealing with them.

DISCUSSION Refugees and asylum seekers come to Australia with a range of health problems related to their experience both overseas and in Australia. These include the physical and psychological sequelae of torture and trauma such as anxiety, depression or post-traumatic stress disorder, infectious diseases such as tuberculosis, as well as chronic illness. These problems need to be addressed in general practice, as should preventive care, which is often overlooked. While those on permanent or temporary visas will have access to Medicare, those on bridging visas may not.



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Refugees have been arriving in Australia for over 150 years. Since 1945, over a half a million refugees have resettled in Australia.[1] Refugees have made major contributions to all walks of Australian society.

A refugee is defined by the 1951 United Nations Convention as a person who 'owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion is outside of the country of his nationality and is unable or owing to such fear is unwilling to avail himself of the protection of that country'.[2] An asylum seeker is a person whose application for asylum or refugee status is pending in the administrative or legal processes.

The refugee experience overseas

Refugees come from many countries, with the United Nations High Commission for refugees (UNHCR) reporting over 9.7 million worldwide in 2003 with another 4.2 million internally displaced people.[3] In recent years, the majority of refugees coming to Australia have been from Africa (especially Sudan, Ethiopia and Liberia), the Middle East (especially Iraq, Iran and Afghanistan) and eastern Europe (especially the countries of former Yugoslavia)[4] (*Table 1*). However over the past 20 years they have also come from many other countries, eg. South America, eastern Europe, Asia and the Indian subcontinent.

Refugees flee their home countries for many reasons, most commonly war and the experience of political or social persecution.[5] As a result, they may have experienced psychological trauma through the death of, and separation from, friends or family; torture; or abuse while living in the community or during imprisonment.[6] The torture may have involved physical abuse, sexual abuse, and psychological torture, and being forced to be complicit in the arrest or torture of others.[7] The authors have also cared for patients who have reported being starved and deliberately exposed to infectious disease such as tuberculosis.

Many take refuge in neighbouring countries where they are temporarily situated in refugee camps. In these camps they may have experienced overcrowding, violence, poor nutrition and hygiene leading to infectious disease and poor medical care.[6] If they have spent long periods in these camps, they may have developed depression, anxiety or passivity,[8] and their children may have received little or no education

and suffer psychological problems as a result.[9,10]

Australia's humanitarian program comprises offshore resettlement for those overseas, and onshore protection for those who arrived on temporary visas or unauthorised and who claim protection.[11] Offshore entrants through Australia's Refugee and Humanitarian Program are screened abroad (often in refugee camps with the assistance of UNHCR) and then brought to Australia. They may then be offered permanent or temporary visas. Onshore applicants may come on visitors' visas and then either declare asylum or overstay their visas. A small number seek entry via boat or other means. The latter may have experienced severe hazards during their passage to Australia and may have suffered abuse in transit.

Table 1. Humanitarian visa grants to Australia by country of birth 2003–2004[4]

Country of birth	Number of humanitarian visas granted
Sudan	6147
Iraq	1400
Afghanistan	933
Ethiopia	690
Iran	375
Liberia	368
Yugoslavia FR	322
Sierra Leone	287
Congo	226
Somalia	185
Others	789

Case study 1

AB is a refugee from an African country. Both his parents are dead – his father having being killed during the war and his mother soon after. He has lost contact with his sister who is his only sibling. He has hearing loss from exposure to reports from gun shots, present since he was kidnapped by rebels for 9 months. He has a history of being tortured and forced to work for the military carrying arms and acting as a courier. His torture consisted of being repeatedly beaten with sticks on both sides of his body, especially his lower back and pelvis. He was also sexually assaulted. This has left him with significant physical and psychological problems.

Life in Australia

Refugees arriving through the offshore humanitarian program are brought here by the Australian government and assisted to settle in Australia. Refugees with temporary or permanent visas have access to a Medicare card, the Pharmaceutical Benefits Scheme (PBS) and Centrelink benefits.[12] However they may still face difficulties with language, finding a job and long term accommodation. They are likely to be concerned about their families or friends in their home country who may continue to suffer war or persecution. They may also find it difficult to adjust to life in Australia after a prolonged period as a refugee. Those on temporary visas (who may also be 'on shore applicants') face an uncertain future once their visa expires (usually after 3 years).[13]

Asylum seekers on bridging visas living in the community in Australia face a very uncertain future not knowing if they will be successful in attaining refugee status or if they will be deported. This uncertainty may continue for many years as they are assessed by the Immigration Department, Refugee Tribunal, the courts, and the Minister for Immigration. Many will succeed in obtaining permanent residence in the long term.

Those refugees in detention centres are the most 'visible' group in the Australian media. During detention inmates are subject to uncertainty, isolation and lack of activity. The Human Rights and Equal Opportunity Commission also found 'evidence of violence between detainees, within families, as well as between detainees and custodial officers' and concluded that there was 'considerable tension created by the regime of control necessary to implement the policy of mandatory detention. Evidence suggests that the indeterminacy of detention makes detention considerably more difficult to endure'.[14]

Health problems

Many refugees suffer from psychological symptoms related to their experience of torture and trauma in their own countries.[15] They may feel intense anxiety, have nightmares and poor sleep, or show signs of depression. They may complain of poor concentration, heightened arousal and loss of memory – important signs of post-traumatic stress disorder.[16] Children often suffer prolonged psychological distress after resettlement.[17] In Australia, these psychological problems may be compounded by the effects of detention, discrimination, lack of social support and unemployment.[18]

Some refugees have physical sequelae of torture or trauma which may not have received adequate medical attention in their countries of origin. These sequelae include mal-united fractures, osteomyelitis, epilepsy or deafness from head injuries, or nonspecific musculoskeletal pain or weakness.[19] In rape victims, in addition to the psychological sequelae of rape, there may be a risk of HIV or other sexually transmitted infections.

Infectious and nutritional diseases are common among refugees, although the prevalence varies according to their country of origin.[20] These may include tropical infections such as malaria, parasitic infections (eg. intestinal helminthes, hookworm, ascaris lumbricoides, trichuris trichiura, schistosomiasis, strongyloides, amoebiasis, and giardia), HIV, hepatitis A, B and C, and tuberculosis.[21] People from sub-Saharan Africa have particularly high rates of tropical infections, and guidelines for screening have been published.[22]

Case study 2

CD and EF, and their three children aged 8, 5 and 2 years, are refugees from a camp in Tanzania where they have lived for the past 3 years since fleeing civil war in their native country of Burundi. The children have all had recurrent episodes of fever treated as malaria in the camp. The younger two children are malnourished. No immunisation records are available. Predeparture screening was limited to chest X-ray for those over 11 years, HIV tests for those over 15 years, and hepatitis B and syphilis serology for pregnant women.

Refugee patients may also suffer a wide range of chronic illnesses including hypertension, heart disease and diabetes in proportions similar to the rest of the community.[23] Peptic ulcer disease due to *Helicobacter pylori* infections is common.[24] These conditions may be complicated by their psychological conditions. For asylum seekers it is compounded by their lack of access to primary health care causing delays in access to treatment.

Managing refugees and asylum seekers in general practice

The New South Wales Refugee Health Service developed guidelines for managing survivors of torture and refugee trauma.[25] The guidelines identify six roles for general practice care:

- identification of patients who may have experienced torture and/or traumatic experiences
- understanding of the context in which torture and refugee trauma may have occurred, and the impact on the individual, family and community
- assessment of the physical and mental health problems of torture and refugee trauma survivors
- working with the patient to develop a management plan
- referral to appropriate services, and
- awareness of the impact of these issues on the treating GP.

As the first two suggest, GPs need to be sensitive to these issues, which may not be raised by the patient or associated in their mind with their current problem. This is especially important for older refugees whose experiences may be recalled at times of illness or disability. Patients may be reluctant to talk; it is important not to force the patient to relive their experience unless adequate support is available.

As a result of their experiences overseas and in Australia, refugees may be mistrustful of governments and reluctant to be referred to government services. The patient may need to be reassured about confidentiality. It is important to consider that the patient may have received torture involving surgical or dental procedures such as applying electricity to broken teeth, and that physical examination or surgical or dental procedures may rekindle these experiences and fears.

Use of interpreters is always important, even when patients have some limited English, to ensure there is adequate understanding on both sides. It is especially important where there is a traumatic history or where the situation is emotionally charged. There is risk in involving family or friends to both confidentiality and the accuracy of translation. For patients requiring a full assessment, an onsite interpreter may be arranged through local community health services. However this may be very difficult to arrange. While having an interpreter on site is ideal, a telephone interpreter together with a speakerphone is an invaluable aid. Telephone or onsite interpreting may be accessed through the Translating and Interpreting Service (TIS), a national government service available throughout Australia 24 hours a day 7 days a week (131 450). This service is available free to GPs.

Assessment of both physical and mental health problems is likely to take longer with refugee patients. It is important that there is sufficient time for the consultation, especially if an interpreter is to

be used. This should include assessment for infectious diseases, including where appropriate, screening for hepatitis B and C, and tuberculosis.[26] (Applicants whose tuberculosis has been treated, as well as those with previous but now nonactive tuberculosis, are required to make a formal 'health undertaking' which requires follow up[27]). Initial screening, especially for patients from sub-Saharan Africa, is time consuming and GPs may wish to contact their public health units, refugee or migrant health service (where available) for advice and assistance.

Patients should also be assessed for chronic diseases such as hypertension or diabetes.[23] Sensitivity may be required in relation to the gender of the patient and doctor, especially for physical examination. This may be because of religious or cultural requirements, or previous sexual abuse.

Case study 3

HI is an asylum seeker from the Middle East. She reports having been assaulted by her husband before leaving her country. She has not had contact with her family including her siblings and other children. While in a neighbouring country, she was hit by a motor vehicle, which she thinks was driven by a friend of her husband. She fell and injured her left knee and head. She has persistent symptoms of depression. In managing her depression it is important to consider her fear of being 'found' by her husband and her reluctance to accept referral to other services as a result.

Preventive care is often overlooked – especially immunisation, lifestyle risk factors and screening for cancer and vascular disease.[28] Nutrition, growth and development in children should be reviewed, and immunisation status checked and recorded.[29] Smoking may be a particular problem, especially in men. Dental problems, often as a consequence of poor nutrition and absence of previous dental care, are particularly common among refugees, and private dental care may not be affordable.[30]

Those asylum seekers in Australia who are not on permanent or temporary visas are ineligible to receive medical services through Medicare (including investigations), the PBS, or free access to public hospital care. This may occur if they delayed claiming asylum for more than 45 days after their arrival, or if they have appealed their case to the Refugee Review Tribunal or the courts. In exceptional circumstances, asylum seekers can receive help from the Asylum Seekers Assistance Scheme (ASAS) – a commonwealth government scheme administered by the Red Cross.[31] Primary health services for asylum seekers exist in most states, staffed by volunteer medical staff, which provide some primary health care for asylum seekers. If such patients present to public hospitals, they are likely to be billed and may require a financial guarantor in order to be seen. This increases anxiety and unwillingness to present to hospitals.

Case study 4

A 6 year old asylum seeker from South America sustained a fractured humerus following a fall from a bicycle. His family took him to a hospital emergency department where he was X-rayed and his arm put in a sling. After follow up in the orthopaedics OPD, his family were issued with a bill for $1400. The hospital debt collectors pursed the family by mail and phone, although it was clear the family could not pay. Subsequently the family was afraid to go to hospital when the boy's grandmother had a fall and sustained a fractured wrist. They were very worried about the impact of their debt on their application for residency with the immigration department.

Advocacy

The medical profession, including The Royal Australian College of General Practitioners have played an important role in advocating for the rights of refugees in Australia by participating in the submission to the Human Rights and Equal Opportunity Commission on children in detention and raising.[10] It has also joined the other medical colleges in speaking out about the mental health assessment and care in detention centres, and access of the asylum seekers living in the community to primary health care.

Resources

- Translating and Interpreting Service: 131450. Doctors' priority line: 1300 131 450 www.immi.gov.au/tis/
- RACGP Refugee and Asylum Seeker Resource Centre provides publications, contact details and useful links including support organisations to provide assistance with asylum seekers' health needs: www.racgp.org.au/refugeehealth/
- NSW Refugee Health Service: *Managing survivors*

of torture and tefugee trauma: guidelines for general practitioners
- Desktop guide to caring for refugee patients in general practice: www.racgp.org.au/document.asp?id=6926
- *Guidelines for screening and management of infectious diseases in refuges from sub-Saharan Africa – based on a single initial blood sample after arrival in the Northern Territory*: www.nt.gov.au/health/cdc/bulletin/dec_2004.pdf>
- NSW Refugee health service: www.refugeehealth.org.au
- Refugee Council of Australia: www.refugeecouncil.org.au/
- Australian Department of Immigration and Multicultural and Indigenous Affairs: www.immi.gov.au

Conflict of interest: none

References

1. Refugee Council of Australia. Available at: www.refugee council.org.au. Accessed 21 July 2005.
2. The United Nations Conference of Plenipotentiaries on the Status of Refugees and Stateless Persons, 28 July 1951. Convened under General Assembly Resolution 429 (V) of 14 December 1950 entry into force 22 April 1954, in accordance with article 43.
3. United Nations High Commission for Refugees. Statistical yearbook, 2003.
4. Australian Department of Immigration and Multicultural and Indigenous Affairs. Fact sheet 60, 2005.
5. United Nationals High Commission on Refugees. The state of the world's refugees 2000: Fifty years of humanitarian action. Oxford: UNHCR, 2000.
6. NSW Refugee Health Service. Fact sheet 1: An overview, November 2002. Available at: www.swsahs.nsw.gov.au/areaser/refugeehs/main.asp.
7. Victorian Foundation for Survivors of Torture and Trauma and Western Melbourne Division of General Practice. Desktop guide to caring for refugee patients in general practice, 2000.
8. Silove D, Steel Z, editors. The mental health and wellbeing of on-shore asylum seekers in Australia. NSW: UNSW Psychiatry Research and Teaching Unit 1998;23–7.
9. Loff B, Snell B, Creati M, Mohan M. 'Inside' Australia's Woomera detention centre. Lancet 2002;359:683.
10. Alliance of Professionals Concerned about the Health of Asylum Seekers and their Children. Submission to Human Rights and Equal Opportunity Commission Inquiry into Children in Immigration Detention, 2002.
11. Australian Department of Immigration and Multicultural and Indigenous Affairs. Fact sheet 65: New humanitarian visa system, 2005.
12. Australian Department of Immigration and Multicultural and Indigenous Affairs. Available at: www.immi.gov.au/refugee/tpv_thv/rpv/2.htm. Accessed 22 July 2005.
13. Refugee Council of Australia. Position paper. Use of temporary protection visas for convention refugees, September 2003.
14. Human Rights and Equal Opportunity Commission. Those who've come across the seas. Report of the Commission's Inquiry Into the Detention of Unauthorised Arrivals. Canberra: Commonwealth of Australia, 1998.
15. Sinnerbrink I, Silove DM, Manicavasagar VL, Steel Z, Field A. Asylum seekers: general health status and problems with access to health care. Med J Aust 1996;165:634–7.
16. Silove D, Sinnerbrink I, Field A, Manicavasagar V, Steel Z. Anxiety, depression and PTSD in asylum seekers: associations with pre-migration trauma and post-migration stressors. Br J Psychiatry 1997;170:351–7.
17. Hjern A, Angel B, Jeppson O. Political Violence, family stress and mental health of refugee children in exile. Scand J Soc Med 1998;26:18–25.
18. Pernice R, Brook J. Refugees' and immigrants mental health: association of demographic and post-immigration factors. J Soc Psychol 1996;136:511–20.
19. Burnett A, Peel M. The health of survivors of torture and organised violence. BMJ 2001;322:606–9.
20. Jones D, Gill, Paramjit S. Refugees and primary care: tackling the inequalities. BMJ 1998;317:1444–6.
21. Burnett A, Peel M. Asylum seekers and refugees in Britain. BMJ 2001;322:544–7.
22. Zweck N Spencer E, Anstey N, Currie B. Guidelines for screening and management of infectious diseases in refuges from sub-Saharan Africa - based on a single initial blood sample after arrival in the Northern Territory. The Northern Territory Disease Control Bulletin 2004;11:13–7.
23. Harris MF, Telfer BL. The health needs of asylum seekers living in the community. Med J Aust 2001;175:589–92.
24. Walker PF, Jaranson J. Refugee and immigrant health care. Med Clin North Am 1999;83:1103–20.
25. NSW Refugee Health Service. Managing survivors of torture and refugee trauma: guidelines for general practitioners. October 2000.
26. NSW Refugee Health Service. Fact sheet 2: Infectious diseases. Available at: www.swsahs.nsw.gov.au/areaser/refugeehs/resources_factsheets.asp. Accessed 22 July 2005.
27. Australian Department of Immigration and Multicultural and Indigenous Affairs. Fact sheet 22, 2004.
28. Victorian Foundation for Survivors of Torture on behalf of the Western Melbourne Division of General Practice. Caring for refugee patients in general practice, 2000.
29. Gracey M. Caring for the health and medical and emotional needs of children of migrants and asylum seekers. Acta Paediatrica 2004;93:1423–6.
30. Davidson N, Skull S, Chaney G, et al. Comprehensive health assessment for newly arrived refugee children in Australia. J Paediatr Child Health 2004;40:562–8.
31. Australian Red Cross. Asylum Seeker Assistance Scheme. Available at: www.redcross.org.au/whatWeDo/asas.html. Accessed October 2001.

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