

# Victorian refugee health and wellbeing action plan

## Consultation summary

### Introduction

Every year, over 4,000 people from refugee backgrounds settle in Victoria, including a significant number in rural and regional areas. The health and wellbeing needs of people from refugee backgrounds and asylum seekers<sup>1</sup> exist in a complex environment in which pre and post arrival experiences can have profound impacts on health outcomes. Prolonged periods in refugee camps, experiences of war, effects of torture and trauma, loss of or separation from family members, dangerous journeys to Australia, deprivation and lack of access to food, safe drinking water, basic health care and shelter are highly traumatic experiences that differentiate refugees from most other migrants to Australia and impact greatly on their health and wellbeing.

Most health problems, however, can be addressed through health care and support in the early periods of settlement. Timely and expert health care is critical, as successful settlement, including active participation in family, schooling, working and community life, is more likely once good physical and mental health is restored.

The long-term planning and development priorities for Victoria's health system are articulated in the *Victorian Health Priorities Framework 2012–2022* and associated *Metropolitan Health Plan 2012-2022* and *Rural and Regional Health Plan 2012-2022*. In conjunction with the *Victorian Public Health and Wellbeing Plan 2011-2015*, these policies have a particular emphasis on responding to the needs of those who are disadvantaged and at risk of poorer health outcomes compared to the wider community, including people from refugee backgrounds. The development of a *Victorian Refugee Health and Wellbeing Action Plan* is described in the *Framework* as a way to address these health disparities between refugees and the broader Victorian community.

The action plan will define the Government's strategic vision for how the health system in Victoria can better meet the needs of people from refugee backgrounds and asylum seekers. It will set priorities for our efforts to help ensure that refugees and asylum seekers achieve health outcomes comparable to the broader population.

The consultation findings summarised in this paper will assist the development of the action plan.

### Who did we consult?

This paper provides an overview of the outcomes of consultations attended by a wide range of stakeholder organisations, conducted between October 2011 and January 2012. Consultations were held across a number of health and community sectors in rural and metropolitan areas, including: community groups from refugee and asylum seeker backgrounds, the Victorian Refugee Health Network, peak culturally and linguistically diverse (CALD) and refugee support agencies, asylum seeker support agencies, settlement services, primary care, acute and specialist services, mental health and drug services, child and maternal health, youth services, school nursing, sexual and reproductive health services, refugee health research groups, local and state government departments. See **Appendix A** for a list of groups involved in the consultations.

Stakeholder engagement primarily occurred through targeted meetings and forums. Other opportunities for gathering information, such as participating in refugee health conferences and forums, were also maximised.

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<sup>1</sup> The term 'people from refugee backgrounds' used in this document describes people who have come to Australia as refugees under the Humanitarian Program, as well as other migrants arriving from refugee source countries through the Family and Skilled Migration Streams, who are likely to have experienced the same persecution and violence. The term 'asylum seeker' refers to people who enter Australia by plane or boat and subsequently seek to be recognised as a refugee by applying for a protection visa to remain in Australia.

In total 35 targeted meetings and nine forums were conducted with over 100 agencies including 38 in metropolitan Melbourne and six in rural and regional Victoria, to inform development of the action plan. Targeted rural and regional consultations took place in the two largest areas of refugee settlement in Victoria; Shepparton and Geelong.

Eight community group consultations with over 90 community members were undertaken including meetings with Community Advisory Groups linked to the Victorian Foundation for Survivors of Torture (Foundation House) in metropolitan Melbourne, community groups in rural and regional areas, AMES Settlement Community Guides<sup>2</sup> and Foundation House Community Liaison Workers.

## Who are our consultation partners?

The Victorian Refugee Health Network has been the department's key consultation partner, facilitating a number of key forums and meetings for the purpose of directly informing this document. The Network brings together government departments and health and community service providers to facilitate greater coordination and collaboration to provide more accessible and responsive health services for people from refugee backgrounds and asylum seekers.

An expert Advisory Committee, comprised of members of the Network, has guided the consultation process, including assisting in identifying the range of groups to consult as well as the broad areas for consultation discussion. Members of the Advisory Committee have been drawn from across the health and partner sectors, including specialist care (paediatrics and communicable diseases), refugee health research, settlement services, asylum seeker support agencies, general practice, refugee health nursing, mental health and rural refugee health care.

The Network and Advisory Committee will continue to play critical roles in the development of the action plan.

## What did we ask?

Discussion with consultation participants was guided by findings from a preliminary literature review and early consultation with the Victorian Refugee Health Network and the Advisory Committee. This paper presents an overview of issues and themes identified through the consultation process based on five broad areas of consultation discussion:

1. What affects the health and wellbeing of people from refugee backgrounds in Victoria?
2. What factors enable quality refugee health care?
3. What health issues concern people from refugee backgrounds?
4. What issues are of particular concern in rural and regional Victoria?
5. What are the special needs of people within the refugee population?

## What did participants say?

### 1. Broader factors affecting the health of people from refugee backgrounds

Consultations highlighted the importance of responding to the needs of people from refugee backgrounds and asylum seekers within a framework that recognises the broader determinants of health and social outcomes. Some of the many factors that can impact on the ability of people from refugee backgrounds and asylum seekers to achieve good physical and mental health and wellbeing include:

- housing insecurity or affordability
- no or under employment and poor working conditions; financial hardship, debt and poverty due to low or no income or supporting family members still overseas
- levels of education and literacy
- changed social status and adapting to a new culture and environment

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<sup>2</sup> Community Guides are former refugees who provide settlement support in preferred language during the first six months of resettlement.

- the effects of gender, stigma and discrimination
- lack of family or other social support networks, ongoing or prolonged family separation, and changes in family dynamics
- the ability to access and use health services.

People's health status may be further impacted by prioritising other settlement needs, such as settling children into school and earning an income, ahead of their own health needs, which can lead to the onset or exacerbation of health problems. The action plan will aim to address the health and wellbeing of people from refugee backgrounds and asylum seekers within the broader context of these interacting factors.

## **2. Enablers of quality refugee health care**

Consultations identified a number of enablers that are essential to the delivery of quality health care for people from refugee backgrounds and asylum seekers across all health sectors. Issues around these enablers of quality refugee health care will also be identified more specifically in each health issues section:

### **Communication**

Effective communication, including the appropriate use of language services at key points, is essential to the delivery of quality and safe health care for people from refugee backgrounds and asylum seekers.

Communication issues were the main theme of the consultations, which highlighted the need for further work around:

- the need for better access to interpreting services across state-funded health sectors
- better access to Commonwealth-funded interpreting services for Commonwealth-funded allied health and mental health programs and services
- understanding by services of how to access and work with interpreters appropriately and effectively
- better awareness of a patient's need and right to access an interpreter, and the inappropriate use of family members and friends as interpreters
- the basic infrastructure to support interpreter use in hospitals and community health services, including the availability of speaker phones to use for telephone interpreting
- limited numbers of professional interpreters in smaller, new and emerging languages, and accredited interpreters specialising in health terminology and concepts
- the lack of translated information in new and emerging languages.

### **Expertise in refugee health**

Expertise in refugee health requires knowledge and skills around: the refugee and asylum seeker experience and determination process; refugee health issues; social determinants of health; special needs groups; referral pathways; refugee and asylum seeker entitlements and the support services available; and high quality comprehensive assessment using national protocols and best practice. While consultations acknowledged there have been some remarkable achievements in Victoria over the past five years around building the capacity of service providers in refugee health and initial assessment, they highlighted the need for further work around:

- developing and implementing national coordinated protocols and best practice for comprehensive refugee health assessment
- increasing health practitioners' knowledge and skills in refugee health, including appropriate identification and referral, and responsiveness to changing migration waves and the different health needs of new arrivals
- the need for health professionals to be better supported by professional development resources that can be accessed across the state
- improving knowledge and application of policies on refugee and asylum seeker priority of access and eligibility for services.

### **Culturally responsive services**

Culturally responsive service delivery addresses cultural diversity across all levels of service design and delivery and includes working with individual culturally and linguistically diverse (CALD) communities to identify

the best models for engaging and retaining people from CALD backgrounds in services. Consultations highlighted the need for further work around:

- developing consistent approaches to meeting the needs of CALD and refugee background communities such as the development of effective cultural diversity policies
- improving the cultural competence of health services, including awareness of and respect for different cultural perceptions and practices and help-seeking behaviours
- increasing consultation with communities around health needs, service design and delivery, and evaluation of services.

### **Health literacy**

Health literacy is defined as the degree to which people have the capacity to obtain, process, and understand and interpret basic health information and apply it to a particular situation in order to make appropriate decisions about their health and follow instructions for treatment.<sup>3</sup> Health literacy includes understanding the health system and its processes, as well as understanding how to prevent, treat and manage particular health issues, where to find services, and when and how to access them. People from refugee backgrounds and asylum seekers are more likely to have low health literacy, and therefore poorer health outcomes, due to language and literacy barriers, combined with unfamiliarity with the Australian health system and health terminology, and different cultural perceptions around illness and health care. Consultations highlighted the need for further work around:

- service provider support for clients to obtain and understand basic health information, particularly around medication management and navigating the health system
- understanding by service providers of people's differing levels of health literacy and perceptions of health and illness and how this impacts on behaviours and the ability to manage their own health
- increasing community engagement and consultation to ensure health promotion strategies are responsive to the people's varying needs
- support for refugee background clients to obtain and understand basic health information so they are better able to consent to and make decisions about their health.

### **Accessibility**

Accessible and equitable service provision recognises that some client groups, including people from refugee backgrounds and asylum seekers, may have reduced access to services due to a number of factors, such as affordability, eligibility, timeliness and capacity of services, and geographic distance from services. While a lot of work has been done to improve access to services for refugees and asylum seekers, particularly around affordability and eligibility, consultations highlighted the need for further work around:

- the prohibitive cost of some services, medicines and aids
- the need to be able to better identify refugee and asylum seeker clients for priority of access
- the capacity of nurses, GPs and specialists to provide comprehensive health screening and treatment for all new arrivals to Victoria, regardless of where they live
- the availability of bulk-billing GPs in any given geographic area
- long waiting lists to receive some types of necessary health care during the first six to 12 months
- the geographic distance of clients from services, combined with a lack of access to affordable transport.

### **Service coordination**

Effective service coordination contributes to improved health outcomes for clients by improving timely access to appropriate services. It is particularly important for people from refugee backgrounds and asylum seekers, who often have complex and multiple needs and require services across a number of sectors, agencies and levels of government. Consultations highlighted the need for further work around:

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<sup>3</sup> Department of Health (2011). Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan, Department of Health.

- the consistent transfer of client information between Department of Immigration and Citizenship (DIAC) and detention centres to settlement services and Victorian health services, and between schools, primary care and specialist services, to improve confidentiality and continuity of care and reduce the occurrence of duplicated or inadequate vaccination and testing
- the need for a broad framework for overall Victorian settlement planning and better information sharing to occur across local, state and Commonwealth governments
- clear referral pathways and improved consistency and communication between settlement services and health care providers across different regions, including between metropolitan and rural areas
- strengthening relationships between service providers and local and statewide refugee health networks to ensure better communication and sharing of innovative practice and resources.

### **Flexibility of service models**

Flexible service models are required in order to respond to the needs of people from refugee backgrounds and asylum seekers in an appropriate and timely way. Consultations highlighted the need for further work around:

- designing service responses around the needs of families, rather than only focussing on the individual
- the development of more flexible service models and settings such as outreach, group health education and drop-in services to better meet the needs of people who find it difficult to engage with clinic or appointment-based systems
- the need to better support health services to be able to respond in a timely way to changes in settlement patterns, including the changing demographic profile of new arrivals
- the nature of the current Medicare funding model for GPs and allied specialists, which results in inadequate flexibility in the length of consultations, and impacts the ability of service providers to use interpreters and undertake comprehensive assessments.

### **Evidence-based service planning and provision**

Evidence-based service planning and provision to inform quality development of service and health promotion interventions for people from refugee backgrounds and asylum seekers includes the use of routine standardised data collection, and culturally appropriate research and service evaluation. Consultations highlighted the need for further work to increase the evidence base for quality refugee health service provision, in particular:

- the need for longitudinal monitoring of refugee health outcomes, with a focus on preventative health and long term management of chronic disease
- understanding the key protective factors for people from refugee backgrounds, such as what promotes resilience and successful adaptation
- improved understanding of the special needs of particular groups of refugees and how to better engage people from refugee backgrounds and asylum seekers in services
- better quality and consistency in collecting and sharing of service utilisation data by health services and government which identifies refugee and asylum seeker background service users
- improved planning to respond to changing Commonwealth immigration policies, including asylum seeker policy, settlement patterns and the demographic profile of new arrivals.

## **3. Health issues for people from refugee backgrounds**

Consultations identified the specific health issues of greatest concern for people from refugee backgrounds and asylum seekers as follows:

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| • Oral health                                 | • Social connection and independent living |
| • Diet and nutrition                          | • Mental health                            |
| • Chronic disease                             | • Alcohol, drugs and smoking               |
| • Infectious and vaccine preventable diseases | • Vitamin D                                |
| • Sexual and reproductive health              | • Vision and hearing                       |
| • Maternal health                             |  |

Participants provided detailed feedback on these health issues, including how each issue impacts people from refugee backgrounds and asylum seekers, and how we could better respond to, or prevent, these particular health issues. The following sections also include a description of the impacts of pre-arrival and settlement experiences on each health issue, as well as a brief description of the programs and initiatives underway in Victoria that will provide potential mechanisms for addressing the issues raised throughout the consultations.

### 3.1 Oral health

*'Other problems can wait but physical pain from dental needs urgent care otherwise you cannot eat or have a life.'* Community member

There is a range of factors that contribute to the often poor oral health of recently arrived refugees, including lack of or disrupted dental care in countries of origin, inadequate nutrition and ill health due to extended periods of living in poverty and deprivation, direct injury to teeth and gums in the course of torture, cultural beliefs and practices and living for extended periods with oral pain and untreated problems such as abscesses or other dental infections. On arrival, changes in diet and a general lack of awareness about the negative effects of Western foods such as processed and highly sugared foods can impact oral health.

People from refugee backgrounds and asylum seekers are exempt from fees for public dental services. Since 2008, both groups have been identified as having priority access for general, specialist and denture care. Priority access to dental services recognises the need to provide dental health care upon arrival to treat existing oral health issues, relieve pain and prevent the escalation of any oral health problems.

People from refugee backgrounds have been identified as a 'population group at greatest risk' in the 2011 departmental publication *Evidence-based oral health promotion resource*. The document describes a number of interventions that have been used with people from refugee and CALD backgrounds. These initiatives, in conjunction with a refugee oral health project by the Victorian Refugee Health Network and the recent development of regional oral health action plans will assist in addressing oral health issues identified in the consultations.

#### What did participants say?

- Some dental service providers are having difficulty identifying who is a refugee or an asylum seeker, resulting in reduced ability to consistently identify people for priority of access.
- Fee waivers for general and specialist dental care and dentures has greatly increased access to dental care, but there remain some gaps in awareness by service providers and the community about these government policies. This results in sometimes long waiting periods for an initial check-up, and if fees are incorrectly applied, the cost of attending multiple appointments becomes an obstacle to completing treatment.
- Some services, particularly in newer settlement areas, have more limited knowledge of how to work with interpreters effectively.
- There is a need for improved access to interpreting services by dental service providers. Failure to book or work with an appropriate interpreter may lead to clients are not providing informed consent for procedures or poor diagnosis
- More work is needed to assist some dental services to obtain the necessary knowledge and skills and implement systems to work effectively with people from refugee backgrounds and asylum seekers, including understanding that oral health care can sometimes elicit memories of past sexual assault and experiences of torture and trauma.
- Base-line data is needed to better understand the oral health needs and service usage patterns of changing refugee background population cohorts over time.
- There is a need to build an evidence base around the efficacy of various approaches to oral health promotion interventions with new arrival communities.
- Service models need to be sufficiently flexible to enable successful engagement and access to services for people who need more time, support and orientation.
- New arrivals can lack confidence in and be unfamiliar with available oral health care services and waiting list protocols, resulting in some people not accessing necessary services until a crisis point is reached.

- Oral health promotion projects are beginning to address identified issues such as people having limited knowledge of how to prevent dental caries, the role of fluoridation, how to brush teeth correctly and the importance of introducing oral health practices early in a child's life.
- Many conventional oral health promotion strategies are not taking into account different cultural practices such as the continuation of traditional oral health practices after arrival, which may only sometimes be combined with tooth brushing.
- Early detection and screening for oral health issues by GPs and settlement services are not routinely occurring on arrival, resulting in reduced referrals for dental health checks and some dental problems not being identified in a timely way.

### 3.2 Diet and nutrition

*'No one would like to become sick from food.'* Community Guide

Nutritional deficiencies and dietary problems are very common in people from refugee backgrounds and asylum seekers and can greatly impact their long term health status. Pre-arrival factors that may continue to influence diet and nutrition during settlement include prolonged deprivation, malnutrition, contaminated water, untreated or undiagnosed illnesses such as parasitic infections and chronic diarrhoea, and dental problems that may cause difficulties eating.

Resettlement factors that may contribute to depleted nutritional status and onset of chronic disease include: changes in diet, lifestyle and exercise; unfamiliarity with Western foods and cultural differences in food preparation, safety and handling - particularly combined with family separation; lack of nutritional education and reduced local access to affordable food. This is especially the case in outer metropolitan and rural and regional areas. Further the poor financial situation and multiple psychosocial stressors many people from refugee backgrounds and asylum seekers face during settlement greatly diminishes their ability to make healthy food choices.

There are a number of departmental initiatives to improve diet and nutrition, including: dietetic services provided through the community health program; the Healthy Eating Advisory Service for early childhood services, schools, hospitals and workplaces; and a range of healthy lifestyle programs, which include healthy eating and food skills, that are proposed as part of the Prevention Community Model within 12 local areas across Victoria.

#### What did participants say?

- There is a lack of access to local affordable food or traditional ingredients, particularly for refugees living in outer metropolitan and rural and regional areas.
- Although some community health services have dieticians on staff, their availability is inconsistent and this results in some refugees not having access to affordable public dietetics.
- Dieticians, as allied health practitioners using Commonwealth funded MBS items, do not have free access to Commonwealth-funded interpreting services, reducing access to people who speak little or no English
- There is a lack of culturally appropriate dietary and health assessments, and awareness about the impact of culture and tradition on dietary practices.
- There is insufficient data on the dietary habits of refugees after settlement, particularly children and young people, and the long term impacts this has on chronic disease prevalence in refugee communities.
- Initial health assessments do not consistently identify nutritional deficiencies or take into consideration the impacts of malnutrition and untreated conditions, such as parasites, on nutritional status.
- Health professionals often lack understanding of the specific needs of some refugees, such as single young men or men separated from their families, who are particularly at risk of unhealthy dietary practices due to lack of experience with food preparation and competing financial priorities, such as the need to send money back home.
- Many projects undertaken on diet and nutrition are time limited and are therefore unable to systematically address issues over the longer term or with each new group of arrivals.
- A more systematic approach to the development and implementation of health promotion strategies regarding diet and nutrition for refugee communities is required, developed in consultation with the

community. This information should be provided early in settlement before diet and weight-related health conditions emerge.

- People from refugee backgrounds generally lack familiarity with Western foods and can have difficulty assessing the nutritional value of food. Newly arrived communities need more information and education about how to make informed choices about food, such as what is healthy and how to substitute available foods for a healthy but traditional diet.
- People from refugee backgrounds may be unfamiliar with the concept of preventative care and often do not recognise the long term impacts that unhealthy eating, physical inactivity and not drinking water has on their health and wellbeing, which can lead to rapid weight gain, overweight and obesity, and result in onset of chronic conditions.

### **3.3 Chronic disease**

The most common chronic diseases for people from refugee backgrounds and asylum seekers in both established and newly arrived communities include diabetes (particularly type 2 diabetes), cardiovascular disease, arthritis, osteoporosis, cancer, asthma and chronic infections such as hepatitis B. Psychosomatic illness and chronic pain are also very common in people from refugee backgrounds. The prevalence of chronic disease is reported to be particularly high for older people from refugee backgrounds and those who have spent extended periods in refugee camps. This is due to prolonged deprivation and malnutrition and lack of access to preventative health care and treatment.

Resettlement factors that may contribute to the development of chronic disease include: changes in diet, lifestyle and exercise stemming from factors such as unfamiliarity with Australian foods or food preparation; lack of culturally appropriate health promotion opportunities; and limited access to culturally appropriate sport and recreational activities, particularly in outer metropolitan and rural and regional areas. The lower income status of people from refugee backgrounds and asylum seekers, combined with other settlement stressors also affects their ability to prevent or manage chronic disease.

Prevention, detection and intervention early on in settlement, including while asylum seekers are waiting for their application for refugee status to be processed, will ensure that people can achieve optimal health outcomes rather than compounding existing health issues. The department supports a number of initiatives aimed at preventing chronic disease and reducing its burden. These include health promotion initiatives that support physical activity, healthy eating and smoking cessation, such as Life!, Quit, and other lifestyle modification programs as well as the Early Intervention in Chronic Disease initiative.

#### **What did participants say?**

- The complexity of chronic health issues can lead to multiple referrals and appointments across multiple service settings, which can be difficult to access financially and geographically, particularly for people settling in outer metropolitan or rural areas. This issue is exacerbated by the inconsistent transfer of health information between GPs and specialists, and between schools and primary care services, which can result in inadequate or duplicated testing and treatment.
- Medicare ineligible asylum seekers do not have access to affordable medications or chronic disease management programs such as the Commonwealth's National Diabetes Service Scheme. This group also has poorer access to GPs and specialist services, which further reduces their ability to receive appropriate treatment for and management of chronic disease.
- Commonwealth chronic disease initiatives such as Early Intervention in Chronic Disease and allied health services such as physiotherapists and podiatrists using Commonwealth funded MBS items do not have free access to Commonwealth-funded interpreting services, reducing access to allied health support for people who speak little or no English.
- There is lack of information on people's health following settlement, particularly chronic disease and its risk factors, and data on disease rates, co-morbidity and longitudinal health outcomes.
- Initial health assessments do not consistently prioritise assessment for chronic disease or identify risk factors and behaviours related to chronic disease, such as unhealthy eating practices.
- In order to tailor interventions appropriately, service providers need to better understand how people's differing levels of health literacy and perceptions of disease and treatment impacts service usage.

- Essential health information is currently not routinely available to GPs from DIAC, pre-departure screening off-shore or detention settings on-shore. This impacts the ability of health care providers to develop or sustain chronic disease management strategies and can increase duplication in testing and treatment.

### **3.4 Infectious and vaccine preventable disease**

A significant number of people from refugee backgrounds and asylum seekers arrive in Victoria with complex medical conditions that require timely and comprehensive assessment and sometimes multiple investigations and referral for specialist care. These include conditions that may be unfamiliar in the typical general practice environment including parasitic infections such as schistosomiasis, strongyloides and helicobacter pylori; hepatitis B and C; HIV; tuberculosis (usually latent); and malaria. Delayed or interrupted treatment can have long term health impacts.

The department supports a number of initiatives that have significantly improved the timely and comprehensive identification and management of infectious and vaccine preventable diseases in many areas of the state. These include local GPs, nurses and specialists working in collaboration with the Victorian Refugee Health Network, the Refugee Health Nurse program, the Refugee Health Fellows program and refugee and immigrant health clinics. Vaccination initiatives targeted to people from refugee backgrounds, and the national blood borne viruses (BBV) and sexually transmissible infections (STI) strategies, to which Victoria is a signatory, will guide the development of more targeted culturally appropriate initiatives to ensure earlier identification and management of chronic infections and vaccine preventable diseases for people from CALD and refugee backgrounds.

#### **What did participants say?**

- Many chronic illnesses are manageable, however late presentation and the deferral of therapy for conditions such as HIV is a significant factor affecting early diagnosis and intervention.
- Some refugee children and young people are missing out on age-related catch up vaccinations, such as HPV and meningococcal C vaccines, due to their age of arrival in Australia. Further, some GPs and nurses may not understand or be familiar with the catch-up immunisation schedule or the range of immunisation factsheets available in community languages.
- The affordability of some vaccines, such as the hepatitis B vaccine, or diagnostic tests, such as for Helicobacter pylori, can be an obstacle for some people from refugee backgrounds.
- There is a need to better understand mobility patterns among both established and newly arrived refugees who inject drugs or have unsafe sex and travel to and from countries of high HIV and infectious disease prevalence in order to enable more timely and appropriate health promotion and preventative responses.
- Regular visiting infectious disease specialists facilitate better access to services and expertise in rural and regional areas, however these arrangements are only in place in some areas of the state.
- Many health professionals, particularly in rural areas, do not have adequate knowledge of how to effectively diagnose and treat specific infectious diseases, particularly tropical diseases and HIV, which result in delayed or inappropriate service responses.
- Refugees often have difficulty travelling long distances to attend the statewide tuberculosis service when they have a tuberculosis health undertaking, reducing their ability to access an initial assessment in a timely way.
- Poor health literacy, cultural myths and misunderstandings about transmission and treatment are leading to late presentations, delayed or irregular testing and delayed treatment of infectious and vaccine preventable diseases.
- Stigma associated with chronic infections such as HIV and hepatitis B in some refugee background communities impacts their help seeking behaviour and their levels of family and community support.
- Health professionals providing screening and pre and post-test counselling for diseases such as HIV need to better support their clients regarding the implications of a positive diagnosis and the importance of sustained chronic disease management in order to prevent complications such as liver cancer.
- The inconsistent transfer of client health information between DIAC and health services, and between GPs and specialists, is potentially delaying or interrupting essential treatment and support, and leading to duplicated or inadequate testing and treatment, including immunisations.

### 3.5 Sexual and reproductive health

Women, men, children and young people from refugee backgrounds are all vulnerable to poor sexual and reproductive health outcomes due to lower health literacy, limited preventative health care prior to migration, and some practices and events that may impact on sexual and reproductive health and increase the risk of contracting BBV and STI. These include gender and sexual based violence, such as rape and sexual slavery, women and girls marrying and having sex at a very young age, and undergoing female genital mutilation (FGM).

Different cultural norms around relationships and sexual behaviour, and changing family dynamics, social expectations and gender roles following arrival can lead to family and intergenerational conflict and impact the sexual and reproductive health of people from refugee backgrounds, creating heightened risk for unplanned pregnancies, difficulties negotiating sexual relationships and family planning and exposure to BBV and STI. There may be community stigma associated with seeking sexual and reproductive health care and information, and reticence by practitioners to discuss what are considered to be sensitive topics. Gay, lesbian, bisexual, transgender or intersex young people from refugee backgrounds are at particularly increased risk of poor sexual and reproductive health outcomes.

The department has identified a number of prevention, early intervention and treatment initiatives that are assisting in addressing the sexual and reproductive health related issues identified in the consultations. Opportunities include improving young people's sexual health literacy through quality school-based sexuality education and improving access to sexual and reproductive health services across Victoria. These services include: family planning support; initiatives through women's health agencies; the Family and Reproductive Rights and Education Program, which addresses FGM; community and maternal and child health nursing support; GP care and education; Family Planning Victoria; and programs for newly arrived communities, which explain Australian practices, laws and services around sexual and reproductive health. Further, the department is collaborating with relevant agencies to work toward reducing, over time, the number of unplanned pregnancies and incidence of BBV and STI.

#### What did participants say?

- People need to know early in settlement about Australian practices, laws and services concerning sexual health, such as the age of consent, laws prohibiting FGM, and family planning options, which may be unfamiliar to new arrivals. However timely access to sexual and reproductive health care and information is inconsistent.
- Poor or no access to income or subsidised pharmaceuticals directly reduces access to contraception and medications to treat conditions such as STI. This is particularly an issue for Medicare-ineligible asylum seekers.
- Health practitioners need to better understand that people's experiences and cultural practices vary widely, such as negotiating contraception and sexual relationships, and respond appropriately.
- People from refugee backgrounds can find it difficult to disclose or discuss sexual and reproductive health issues such as FGM, safer sex and STIs due to the shame and stigma that may be associated with sex.
- There is limited research available on the sexual and reproductive health of refugees to inform service development.
- There is a need to build an evidence base around the efficacy of various approaches to sexual and reproductive health promotion interventions with new arrival communities across various population cohorts including young people, men and women.
- Many people are inadequately informed about support services and sexual and reproductive health issues which can lead to poor sexual health outcomes, such as unplanned pregnancies and associated breakdown in family relationships, difficulties negotiating sexual relationships and being exposed to BBVs and STIs.
- People from refugee backgrounds often miss out on sexual health information and education, especially if they are older than school age or are not engaged with services. Some women, men and unaccompanied minors, and refugees who are gay, lesbian, bisexual, transgender, or intersex can be quite isolated and disconnected from services and their own communities, which reduces their ability to receive information and appropriate support.

- There needs to be greater flexibility of services to be able to respond to changing settlement patterns, demographics and emerging health issues in order to meet the sexual and reproductive health needs of particular groups across a range of scenarios. Examples include support for young men being released from detention, or who are otherwise newly arrived, potentially engaging in unsafe sex.
- It is important to adopt a family centred approach to sexual health promotion, and support the role that parents and the extended family play in providing sexual and reproductive health advice to their children or young relatives.
- Poor understanding of the benefits of early intervention, preventive sexual health behaviours and awareness of how to access sexual health information and services can create a barrier to good sexual and reproductive health.
- There is a need to improve the documenting and sharing of sexual and reproductive health promotion information that is appropriate for people from refugee backgrounds, including evaluations of good practice, which is needed to inform partnerships to further develop service models for different population cohorts.

### 3.6 Maternal health

*'Maternal services are some of the best services in Australia.'* Community Guide

*'There is no-one to link all the silos or facilitate women through the maternity experience.'* Maternity Services Manager

Women from refugee backgrounds have often had experiences that impact their ability to achieve good maternal health and can lead to obstetric and gynaecological complications. These include chronic stress, malnutrition, homelessness, infection and injuries, and experiences of violence such as female genital mutilation (FGM), rape, sexual slavery and forced marriage. Previous maternity experiences such as unattended births, traumatic and unsafe abortions, forced pregnancies, the use of unsterilized equipment, poor sanitation, infant mortality and child removal can also impact maternal health outcomes for refugee women. These experiences can also lead to increased anxiety and complications when receiving maternity care in Australia.

Post arrival experiences affecting maternal health include fewer family and social supports, social isolation and limited transport options. Women from refugee backgrounds may have had minimal or no previous exposure to formal maternity services and be unfamiliar with the range of antenatal and birthing options available in Victoria, such as shared maternity care and birthing centres, reducing knowledge of, and participation in, these services.

Public maternal health services are funded through GP referred antenatal classes and hospital maternity services. A number of Victorian Government programs that complement maternity services are also targeted at meeting the needs of vulnerable women, including women from refugee backgrounds. These include the Department of Health funded Healthy Mothers, Healthy Babies program, which supports disadvantaged or vulnerable pregnant women, and the Family and Reproductive Rights and Education Program (FARREP), which responds to specific maternal health risks related to FGM. Other Victorian Government programs include Maternal and Child Health (MCH) and Enhanced Maternal and Child Health Services and the Cradle to Kinder program.

#### What did participants say?

- Some women are presenting late to maternity services because they are not connected with a GP or programs such as the Healthy Mothers, Healthy Babies program. These factors are further exacerbated for Medicare ineligible asylum seekers who have poor access to GPs, pharmaceuticals and vitamins, so often miss out on quality maternity care.
- Although some initiatives to improve access to maternity services have been introduced, the lack of transport options in outer metropolitan and rural and regional areas continues to impact participation in services and antenatal classes. This is compounded by the multiple appointments required for quality maternity care.
- People from refugee backgrounds who had children born in Melbourne have good initial access to, and experience of, using Maternal and Child Health (MCH) services, due to processes which facilitate access. However, significant barriers remain particularly in terms of supporting continued use, such as language and cultural barriers, lack of formalised links and relationships between settlement services and MCH services.

- Inconsistent use of interpreters for antenatal care in a range of settings is contributing to lower participation rates and miscommunication between providers and their clients. Women sometimes cannot give informed consent, make informed decisions or communicate their needs and choices during labour and following birth due to insufficient use of interpreters.
- Cultural beliefs and practices around pregnancy, childbirth and child rearing can be different from those advocated by maternity care services and may not be accommodated, contributing to lower service participation by women from refugee backgrounds.
- Programs like FARREP are helping to reduce risks of complications during pregnancy by assisting health professionals to communicate sensitively with women affected by FGM and provide adequate care, including support for de-infibulation in a health setting, however FARREP is not available statewide.
- There are some small innovative antenatal programs in Victoria, but classes can be inaccessible due to cost, a perceived lack of cultural responsiveness, and low use of language services.
- There are limited data on birthing and breastfeeding rates of women from refugee backgrounds, infant mortality and Sudden Infant Death Syndrome, and research on ways to increase low participation in services.
- Women who arrive in Victoria with young infants can miss out on referral to Maternal and Child Health services and associated child development checks that infants born in Australia receive.
- The Healthy Mothers, Healthy Babies program supports vulnerable pregnant women and their families to access services and enhance their health behaviours throughout the perinatal period, however is not available in all areas of the state including parts of metropolitan Melbourne and rural and regional Victoria.
- Women from refugee backgrounds need better awareness of and access to more flexible birthing options such as publicly funded midwife-led home birthing, which can be more suitable to meeting their needs, particularly during periods of confinement.
- Maternity services generally attracted positive comment for their service coordination between GPs and hospitals, and between primary care and Maternal and Child Health services.

### 3.7 Social connection and independent living

*'For people with a disability and who are not connected with the mainstream community, loneliness and isolation is a problem across all ages.'* Community member

Some groups of refugees are at increased risk of social isolation due to frailty or disability and require additional support for independent living. This particularly includes younger people with a disability, older refugees who have recently arrived, and people from refugee backgrounds who came in previous migration waves and have grown old in Australia. The health of many older people from refugee backgrounds is diminished from living in harsh conditions for long periods of time, particularly those who have lived for extended periods in refugee camps. Some refugees arrive in Australia with disabilities including intellectual disabilities and acquired brain injuries, clinical psychiatric disabilities including psychosis; and physical disabilities such as hearing and vision impairment, and those stemming from amputations, shrapnel injuries or untreated injuries such as poorly mended broken bones. Newly arrived older refugees or refugees with a disability often have fewer family and social connections and transport options, but need support to live independently and attend multiple appointments and services.

The department's Home and Community Care (HACC) program supports people whose capacity for independent living is limited or who are at risk of premature or inappropriate admission to long-term residential care. A number of successful initiatives have been implemented to improve access to HACC services for people from CALD backgrounds in Victoria. The recently introduced HACC Diversity Planning and Practice policy will provide a mechanism to respond to issues identified through consultation by increasing the responsiveness of local HACC services for people with special needs, including those from new and emerging and CALD communities. In addition, the Department of Human Services funds Disability Support Services which offer a range of specialist disability supports to people with a disability and their families to help the person participate actively in the community and reach their full potential.

## What did participants say?

- Waiting times for assessment for services to support people who are aged or have a disability have a particular impact on new refugee arrivals due to their lack of formal support services and often little or no family support. Refugees also arrive with no aids or equipment and long waiting times can lead to difficulties arranging appropriate care within the initial settlement period and therefore the ability to live independently.
- There continues to be a high demand for interpreting services to support HACC services. Interpreter use is inconsistent and can lead to inaccurate assessment of needs.
- There is significant variability across local government areas in the availability of culturally appropriate support services, such as the use of bilingual workers and provision of appropriate activities and food.
- Language barriers reduce the ability of workers to pick up emerging issues and provide opportunistic social support to their clients in their homes
- Established communities from earlier waves of refugee migration require more particular aged care service responses, especially for those with dementia, including survivors of the Holocaust and other experiences of torture and trauma, such as people from Vietnam and Cambodia.
- Multicultural social support groups are often not suitable for older people or people with dementia, who are more likely to successfully participate in activities with people from their cultural and language background
- Initial health assessments do not consistently identify developmental delay, intellectual disability and acquired brain injury associated with the refugee experience, such as the effects of head injury or malnutrition.
- Culturally held attitudes and misconceptions resulting in shame and stigma associated with having a disability or caring for a family member with a disability can lead to discrimination, loss of support and increased social isolation from people's own family as well as the broader community.
- Older refugees and refugees with disabilities, as well as their children and carers, often lack knowledge of the support services available to assist independent living.
- Recording of disability status on health manifest paperwork from DIAC, pre-departure screening offshore or detention settings onshore does not occur consistently, resulting in the needs of people from refugee backgrounds with diagnosed or suspected disabilities and injuries not being communicated to GPs.
- Information about health care needs, such as mental health issues or injuries, is sometimes unavailable or not communicated by health care and settlement services to HACC assessment officers for consideration.

### 3.8 Mental health

*'Mental health needs to come out to the communities so that it can be normalised instead of stigmatised. We should let people know there are services they can get help from.'* Community members

People from refugee backgrounds and asylum seekers almost universally have a history of exposure to highly traumatic events that impact mental health, including war, loss of loved ones, and human rights abuses, along with periods of deprivation and separation from family. Prolonged periods in refugee camps, detention centres and on dangerous boat journeys can also diminish mental health. The most common disorders experienced by refugees include depression, anxiety and post-traumatic stress disorder (PTSD).

The many challenges of resettlement can further impact people's mental health including: the refugee determination process; bereavement; ongoing anxiety about the safety of, and separation from, family members and friends left behind; cultural dislocation and family tension; financial disadvantage; social isolation and lack of family support; and sometimes discrimination and racism.

People from refugee backgrounds are recognised as requiring priority attention in the Victorian Government's *Because mental health matters: Victorian mental health reform strategy 2009–2019*. As part of this action plan, the Victorian government supports a number of initiatives to improve mental health outcomes for people from refugee backgrounds and their families. These include specialist mental health services, community-based Psychiatric Disability Rehabilitation and Support Services (PDRSS); community health counselling, mental health promotion initiatives and specialised medium to long-term counselling for survivors of torture and trauma. The department also funds professional development to increase the expertise and cultural responsiveness of clinical and community-based mental health services statewide.

The Migrant Mental Health Taskforce of the Victorian Mental Health Reform Council has established a formal network - Mental Health in Multicultural Victoria, to foster partnerships, leverage resources, initiate actions to increase understanding of mental health issues in CALD and refugee background communities and build positive relationships with and between services.

### **What did participants say?**

- Lack of understanding of help seeking behaviour is leading to some people only making contact with health services when their mental health problems have become severe and complicated by a range of unaddressed physical health and social problems
- Demand for specialised torture and trauma counselling and support is high and waiting long periods for a service impacts on people's ability to settle successfully. This is particularly critical for vulnerable young people and people in rural and regional areas.
- There is generally poor use of interpreter services by state-funded specialist mental health services and a lack of professional interpreters specialising in mental health terminology and concepts.
- Affordability of some mental health services is an issue as there are very few private psychiatrists who bulk bill and are willing to use interpreters and there is no access to Commonwealth-funded interpreting services for psychologists, social workers and occupational therapists providing MBS-funded mental health services.
- Specialist mental health services lack trauma informed approaches to care that would enable them to respond more appropriately to the needs of people from refugee backgrounds. Service providers need to be aware that some environments may exacerbate psychiatric symptoms for clients who have experienced trauma and torture at the hands of the police or military prior to their arrival in Australia or those who have spent long periods in detention.
- There is generally a lack of acknowledgment and accommodation of different cultural perceptions of mental health including stigma, non-Western clinical approaches and understanding of what good and poor mental health means for individual communities, what kind of support is needed, pathways and barriers to care.
- Issues associated with mental health co-morbidity with substance use need particular consideration, due to the risk factors associated with the continuing effects of torture and trauma.
- There needs to be a better understanding by service providers of the interaction between mental health and physical health issues, particularly the health impacts of chronic mental illness in refugees and the manifestation of mental health issues as bodily symptoms (somatisation), such as pain and numbness.
- There is a need for greater expertise in refugee mental health care and culturally responsive service delivery in general, including appropriate assessment and referral to generalist counselling, torture and trauma counselling and specialist mental health services.
- Clinic-based services are often not appropriate for newly arrived refugees, especially young people.
- Children and young people from refugee backgrounds have significantly lower service utilisation rates for Child and Adolescent Mental Health Services than the population overall.
- There is stigma around mental health in refugee communities, which means that many people will only seek help when their mental health problems have become severe or complicated by a range of unaddressed physical health and social problems.
- Health promotion messages are not resonating with communities due to a lack of community consultation in the development of health promotion interventions, and limited understanding of different cultural perceptions of mental health, forms of help seeking behaviour, what kind of support is needed, pathways and barriers to care.
- The link between the mental health of refugees and their physical health needs requires better understanding and attention by health providers, such as a person's ability to comply with prescribed medication, attend appointments and be able to live healthy lifestyles.
- There is a lack of systematic reviews and longitudinal monitoring of the prevalence of mental health conditions and use of mental health services needed to design successful mental health promotion and early intervention strategies for refugees. This includes gaps in knowledge of key risk and protective factors, such as what promotes resilience and successful settlement in people from refugee backgrounds.

- The emerging or unaddressed mental health needs of established communities from earlier waves of refugee migration require particular mental health service responses including survivors of the Holocaust and other experiences of torture and trauma such as people from Vietnam and Cambodia.

### **3.9 Alcohol, smoking and other drugs**

Some of the experiences of being a refugee or an asylum seeker may be associated with increased use of alcohol, drugs and smoking, including: family separation; grief; torture and trauma; financial stress; prolonged periods in detention centres; and mental health issues such as depression and post traumatic stress disorder. These stressors are experienced in a culture where alcohol, some drugs and tobacco are more easily accessible and can be associated with adult freedoms and socialising. Alcohol and drug issues typically emerge later during settlement.

The Government is developing a Whole of Government Victorian Alcohol and Drug Strategy, which will improve the responsiveness of services for people from CALD and refugee backgrounds. Work is already being undertaken with more established communities from CALD and refugee backgrounds including: the use of bilingual workers and translated health promotion resources in the alcohol and other drugs sector; and smoking prevention and cessation support services and anti-smoking social marketing campaigns, which incorporate use of translated resources and interpreting services through Quit Victoria. The department will work with services to address some of the issues identified in the consultations related to low participation rates in smoking, alcohol and drug services and programs by people from refugee backgrounds, and to deliver better community prevention programs that assist these communities.

#### **What did participants say?**

- People from refugee backgrounds are generally under-represented at smoking, alcohol and drug treatment services and programs due to cultural, behavioural and language barriers.
- Low use of interpreting services and bilingual counsellors by alcohol and drug agencies, including residential rehabilitation, can limit the quality of service provision and reduce access to services.
- There is an ad hoc approach to cultural diversity by service providers, including little development and implementation of agency-level cultural diversity and language services policies.
- Community consultation in program development and planning is minimal, particularly around culturally appropriate treatment options, early intervention and prevention.
- The cultural competence of service providers is inconsistent, including understanding of the different cultural perceptions of alcohol and drug use.
- Little is known about the extent of substance use within newly arrived refugee communities, and about their smoking, alcohol and drug service usage, including referral pathways, gaps and successful service models.
- There is a lack of understanding by service providers about the link between the refugee experience and potential risk factors for, and patterns of, smoking, drug and alcohol use, along with their impact on particular groups, such as men and young people.
- Services have limited capacity to adopt more flexible approaches such as outreach counselling services, drop-in models or family-centred practices, which may be more appropriate for people from refugee backgrounds, to connect with people who are not accessing services and assist parents to better communicate with their children about unfamiliar practices such as alcohol use.
- There is stigma associated with openly discussing alcohol and drug use in refugee communities and a need to frame education and support in a way that reduces stigmatisation and maximises community engagement.
- There is lack of awareness in refugee communities about the risk and harms associated with alcohol misuse and the health impacts of smoking, especially during pregnancy.
- People from refugee communities do not have a good understanding of services provided by alcohol and drug services or how to access them.
- Health promotion messages from general smoking, alcohol and drug campaigns are not resonating with refugee communities. Many health promoting materials, approaches and campaigns are in English and do not represent the diversity of the population.

### **3.10 Vitamin D**

Very low vitamin D causes bone and muscle pain and poor bone health. Moderate to severe deficiency requires supplementation to prevent bone thinning and fractures. Vitamin D also plays an important role in the immune system, and deficiency has been linked to multiple sclerosis, diabetes (type 1 and type 2), various types of cancers and heart disease. Victorians identified as being at increased risk of low vitamin D include, among others: people with naturally very dark skin; people with little or no sun exposure (such as people who wear concealing clothing for religious or cultural purposes, and people whose occupations are predominantly indoors or who work night-shifts); babies with naturally very dark skin; and babies breast-fed by mothers with low vitamin D. Many of these risk factors for vitamin D deficiency apply to people from refugee backgrounds and asylum seekers settling in Victoria.

Victoria has introduced a number of initiatives to address vitamin D deficiency, including: increasing access to affordable vitamin D supplements; improving knowledge of the causes of vitamin D deficiency; enhancing diagnosis, treatment and health promotion messaging by health care providers; and introducing guidelines to assist Victorian planners, architects and policy makers in local and state government to create safe and private spaces for sun exposure around the home and in the community. A departmental website to inform consumers, pharmacists and medical practitioners about vitamin D deficiency has also been established.

#### **What did participants say?**

- There are no high dose vitamin D products available through routine prescription or over the counter sales in Australia. The products are only available in some parts of the state through a special arrangement to treat patients with an imported high dose vitamin D product, resulting in inconsistent and inequitable access to this treatment option, particularly in rural and regional areas.
- People requiring supplementation who do not have access to high-dose vitamin D must take a more costly lower dose of vitamin D daily, which is not financially sustainable or practical for long term treatment, particularly for large families and people with little or no income such as asylum seekers.
- Further research is required to better understand how the health system can best respond to the needs of people from refugee backgrounds in relation to vitamin D deficiency and musculoskeletal health.
- Knowledge of vitamin D deficiency, diagnosis and recommended treatment for various at-risk groups, such as pregnant women and people with naturally very dark skin, is variable among GPs and specialists and is therefore inhibiting consistent treatment and health messaging.
- Vitamin D clinics have been established in a small number of locations in Victoria which have improved access to supplementation and health promotion about vitamin D deficiency, however there is currently only very limited coverage of this type of service, particularly in rural and regional areas.
- There is little understanding in some communities about what to do to prevent or manage vitamin D deficiency and the importance of vitamin D to good health.

### **3.11 Vision and hearing**

Common eye problems that refugees and asylum seekers present with upon arrival may be caused by refractive errors, infective causes including trachoma and parasites, inflammation or allergy, chronic disease and vitamin A deficiency. Potential causes of deafness and hearing impairment, which may have remained undiagnosed or untreated for long periods, include head injury or exposure to noises such as gunfire or explosions.

Poor hearing and vision or undiagnosed eye conditions can have a significant impact on a person's ability to successfully settle in their new community and can delay people's ability to make social connections, study English, read, work, drive and undertake other activities of daily living. Timely access to affordable vision and hearing services and aids is therefore critical.

The department funds the Australian College of Optometry to deliver low cost eyecare and visual aids to disadvantaged Victorians through the Victorian Eyecare Service (VES). Services are provided throughout Victoria including satellite clinics at a number of community health centres, which have significantly increased access to services for vulnerable groups. There are special arrangements to ensure access for refugees and asylum seekers. Ear, nose and throat specialists at the Royal Victorian Eye and Ear Hospital in Melbourne

provide public specialist services for vision and hearing concerns. Hearing Australia, through the Australian Government Hearing Services Program, provides a range of hearing rehabilitation services, free of charge, to any Australian permanent resident aged up to 25 (inclusive) who has, or is at risk of, permanent or long term hearing loss. Hearing Australia services are also delivered through a voucher system to adults who have a Pensioner Concession Card.

#### **What did participants say?**

- Vision and hearing checks are not consistently undertaken on arrival as part of initial health assessments, resulting in problems not being detected in a timely way.
- There is a general lack of knowledge by service providers of the experiences and underlying health issues that may cause hearing, vision and eye health problems in people from refugee backgrounds, such as explosions, head injuries and nutrient deficiencies.
- Vision and hearing screening is generally bulk-billed, however the aids and operations needed as a result of screening, such as cataract eye surgery, hearing aids and battery replacements, are not always affordable.
- Lack of access to interpreting services is the most commonly identified barrier to vision services, particularly for appointments with private optometrists and at the low cost eyecare service. Clients who require an interpreter are currently being asked to wait several months for a service.
- Knowledge of exemption for refugees and asylum seekers from meeting eligibility requirements for low cost eyecare services is inconsistent among service providers, resulting in reduced access to these services.
- Service providers can find it difficult to assess vision acuity due to lack of awareness of available assessment tools for people who speak little or no English or who are not literate in their first language.

#### **4. Refugee health in rural and regional Victoria**

While the majority of refugees settle in metropolitan areas, the proportion of refugees settling in rural and regional Victoria on arrival has risen in recent years. There has also been an increasing trend towards secondary migration of people from refugee or asylum seeker backgrounds to regional Victoria after initially settling in metropolitan Melbourne. Further, the profile of rural and regional refugee settlement has changed recently from predominantly refugee families to single men leaving detention.

The general challenges of the settlement process can be more pronounced in some rural and regional areas, particularly in areas where refugee settlement is more recent. Factors such as access to health and community services, affordable housing, public transport, locally available and affordable food, and employment and educational opportunities may be exacerbated for people settling in some rural and regional areas, and can impact on the health status of people from refugee backgrounds. By contrast however, the sense of community and strength of networks and volunteer groups, along with employment opportunities and the prospect of more affordable housing, can enhance settlement experiences in rural and regional areas. In turn, there is much that refugee settlement offers rural and regional Victoria, including boosting declining populations, addressing labour and skills shortages, and increasing diversity and community networks.

There are a number of services in place in rural areas that help meet the health care needs of people from refugee backgrounds, including services required on arrival such as: refugee health nursing; Commonwealth-funded settlement services; torture and trauma counselling (provided in partnership with Foundation House); GPs and specialist services (including infectious diseases and paediatrics) provided by local specialists, immigrant health clinics in regional centres or outreaching specialists from Melbourne hospitals, including through the Refugee Health Fellows program. In a number of regional locations, these services are supported by refugee health sub-committees and the Victorian Refugee Health Network, which assist sector development through needs identification and documentation, collaboration and resource development.

The *Victorian Rural and Region Health Plan 2012-2022* will help ensure that the health system is responsive to the health needs of vulnerable groups, including people from refugee backgrounds, in rural and regional Victoria.

## What did participants say?

- Specialist services, such as paediatrics, infectious diseases diagnosis and treatment, and specialised torture and trauma counselling, are more limited in rural and regional areas but are often required on arrival.
- Distance and lack of transport options can limit access to services, particularly for the many refugees who do not have a driver's licence or car and face much greater isolation and difficulty in accessing services.
- Staff in some rural and regional areas may have had less experience in providing culturally responsive services and accessing and using interpreters effectively.
- There is difficulty in accessing accredited onsite interpreters in rural and regional areas, especially for new, emerging and smaller communities. Further, issues with gender, confidentiality and privacy in smaller communities are heightened in rural and regional areas.
- While there are pockets of expertise in refugee health in some rural regions, practitioners have difficulty gaining up-to-date knowledge and skills in refugee health, particularly where there are small numbers of arrivals or large gaps in time between arrivals. There are fewer opportunities for capacity building and training, and practitioners often work in isolation without the support of a local network of multi-disciplinary providers. This impacts capacity to provide integrated care for refugees with multiple and complex clinical needs.
- There is a need to further develop formal links between the Victorian Refugee Health Network and regional sub-committees. This will ensure better communication, more accessible information about innovative practice, and resources tailored for use in rural and regional settings.
- Visiting refugee specialists and agencies providing professional development opportunities and outreach services need to coordinate better with local service providers to ensure effective and efficient use of resources.
- Local level planning and service coordination is important for successful rural and regional refugee settlement where information on expected arrivals is required in order to make decisions about whether local health providers have the capacity to meet individual needs. However the level of collaboration across agencies, local, state and Commonwealth government in rural and regional areas is variable.

## 5. Special needs of people within the refugee population

Participants stressed the importance of recognising that in addition to the many shared experiences and health issues of people from refugee backgrounds, the health and wellbeing of groups of people within the broader refugee population may be impacted in different ways. People's age, gender, sexual orientation and gender identity, visa status and eligibility for services and support can be linked to people's settlement and health care experiences, and ultimately to their health outcomes. Groups with special needs identified through the consultations were:

- asylum seekers, including those who have been in long term detention, in the Community Detention Program and those living in the community on arrival or on a Bridging Visa post-detention
- children and young people, including unaccompanied minors
- older people, including newly arrived and those who have grown old in Australia
- people from refugee source countries but not on a Humanitarian Program visa
- women
- men
- gay, lesbian, bisexual, transgender and intersex refugees and asylum seekers

Priorities identified in the action plan will be developed with particular consideration of the specific needs of these groups.

## Where to now?

The government is working in close partnership with the Victorian Refugee Health Network and the Advisory Committee to develop the *Victorian Refugee Health and Wellbeing Action Plan*. The valuable information and advice provided by consultation participants across sectors and metropolitan and rural and regional Victoria is informing the preparation of the action plan. In addition to the consultation findings outlined in this document, the action plan is being shaped by national and international research and policy and practice innovation.

Check the Department of Health's website for updates and further information on the action plan, along with more information on refugee and asylum seeker health and wellbeing:

[www.health.vic.gov.au/diversity/refugee](http://www.health.vic.gov.au/diversity/refugee)

## Appendix A: Consultations participants

Consultations were held across a large number of health and community sectors in rural and metropolitan areas of Victoria including: community groups from refugee backgrounds, specialist and primary health services, Commonwealth funded settlement services and local and state government departments. Stakeholder engagement primarily occurred through targeted meetings and forums to inform the development of the action plan. Some groups were consulted on multiple occasions throughout the consultation process. Other opportunities for gathering information, such as participating in refugee health conferences and forums, were also maximised. The Advisory Committee for the action plan was also a key source for consultation.

### Targeted meetings and forums:

- AMES settlement case coordinators: Inner West
- Local settlement planning committee: Geelong health sub-committee
- AMES settlement case coordinators: North and Outer East
- Local settlement planning committee: Shepparton health sub-committee
- AMES settlement case coordinators: South East
- Network of Asylum Seeker Agencies – Victoria
- AMES settlement community guides
- Asylum Seeker Resource Centre
- Centre for Culture, Ethnicity and Health
- Mental Health in Multicultural Victoria Roundtable
- Centre for Multicultural Youth
- Multicultural Centre for Women's Health
- Community Advisory Group: Afghan (Dandenong)
- Municipal Association of Victoria
- Community Advisory Group: Karen (Wyndham)
- Rural settlement: AMES Statewide case co-ordinator
- Community Advisory Group: Sudanese (Inner north)
- Rural settlement case co-ordinator – Bendigo
- Community groups in rural areas: Geelong Afghan Men's group
- Southern Health: Healthy Mothers Healthy Babies program
- Community groups in rural areas: Geelong Congolese group
- Statewide maternity managers forum
- Community groups in rural areas: Geelong Karen/Karenni group
- Statewide refugee health nurses forum
- Dandenong Refugee Health Research Consortium
- Victorian Refugee Health Network: Oral Health Project Working Group
- Department of Health: Refugee Health Working Group
- Victorian Refugee Health Network: Reference Group
- Department of Health: Regions and program areas
- Victorian Refugee Health Network: GP Working Group
- Ethnic Communities Council of Victoria: Aged Care Committee
- Victorian Refugee Health Network: Specialist Care Working Group
- Ethnic Communities Council of Victoria: Health Policy Committee
- Victorian Refugee Health Network: Sexual and reproductive health forum
- Victorian Foundation for Survivors of Torture (Foundation House)
- Victorian Refugee Health Network: Rural health roundtable
- Foundation House: Community liaison workers
- Victorian Whole of Government Alcohol and Drug Strategy: CALD and Refugee Consultation Forum
- HealthWest Partnership
- Women's Health West

### Forums that informed the findings:

- Primary Care Partnerships: Refugee health service coordination forum (July 2011)
- Eastern region refugee health service providers forum (September 2011)
- Foundation House: How refugee children and young people are faring forum (October 2011)
- A Long Way from Home: The rural and regional resettlement experiences of visible migrants and refugees international conference (February 2012)