AN EVALUATION OF THE PRIMARY HEALTHCARE NEEDS OF REFUGEES IN SOUTH EAST METROPOLITAN MELBOURNE

A report by the Southern Academic Primary Care Research Unit to the Refugee Health Research Consortium, Dandenong

May 2011
ACKNOWLEDGEMENTS

Refugee Health Research Consortium members:
Southern Health
Dandenong Casey General Practice Association
Monash University
AMES Settlement
Foundation House (The Victorian Foundation for Survivors of Torture)
Southern Synergy
Victorian Department of Health
Victorian Department of Human Services
(Funding was provided by the Refugee Health Research Consortium)

Additional thanks to:
Australian Bureau of Statistics
Department of Immigration and Citizenship
Medicare Australia
Translating and Interpreting Service (TIS) National
Victorian Refugee Health Network
Royal Children’s Hospital
City of Greater Dandenong
City of Casey
South Eastern Region Migrant Resource Centre
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ABBREVIATIONS

ABS Australian Bureau of Statistics
AMES Adult Multicultural Education Service
BOS Birthing Outcomes System
CBD Central Business District
CC City of Casey
CCCHS Cardinia Casey Community Health Service
CGD City of Greater Dandenong
DCGPA Dandenong Casey General Practice Association
DDDPG Dandenong District Division of General Practice
DH Department of Health (Victoria)
DHS Department of Human Services (Victoria)
DIAC Department of Immigration and Citizenship
DoHA Department of Health and Ageing
DRG Diagnostic Related Group
ED Emergency Department
ERMHA Eastern Region Mental Health Association
FARREP Family And Reproductive Rights Education Program
FGM Female Genital Mutilation (female circumcision)
FH Foundation House
FYRM Former Yugoslav Republic of Macedonia
GDCHS Greater Dandenong Community Health Service
GP General Practitioner
HSC Humanitarian Source Country
HSS Humanitarian Settlement Strategy
LGA Local Government Area
MBS Medicare Benefits Schedule
MCH Maternal and Child Health
MDC Major Diagnostic Category
PMHT Primary Mental Health Team
RACGP Royal Australian College of General Practitioners
RHN Refugee Health Nurse
RHS Refugee Health Service
SAPCRU Southern Academic Primary Care Research Unit
SCAAB Springvale Community Aid and Advice Bureau
SEADS South East Alcohol and Drug Service
SERMRC South Eastern Region Migrant Resource Centre
SHP Special Humanitarian Program
SWITCH State Wide Information Technology for Community Health
TIS Translating and Interpreter Service
UNHCR United Nations High Commissioner for Refugees
USA United States of America
VAED Victorian Admitted Episodes Database
VEMD Victorian Emergency Management Database
VITS Victorian Interpreting and Translation Service
VFST Victorian Foundation for Survivors of Torture
MAIN MESSAGES

Since 1945 Australia has resettled over 700,000 refugee and humanitarian migrants. In recent years one in every twelve has resettled in Melbourne's south east, in the Cities of Greater Dandenong and Casey.

The south east region’s Refugee Health Research Consortium commissioned this study to examine whether the primary healthcare needs of local residents from refugee backgrounds were met by existing primary care services. The Southern Academic Primary Care Research Unit (SAPCRU) conducted this study between June 2010 and May 2011.

Study methods involved gathering data from a wide range of existing public hospital and community health data sets.

Key findings

The Cities of Greater Dandenong and Casey are the home of nearly 20,000 people from contemporary refugee backgrounds. Most have come from republics of the Former Yugoslavia (45%), Afghanistan (25%) and Sudan (13%). The 1,155 refugees currently arriving each year are mostly from Afghanistan and Sri Lanka. Refugees of different nationalities show distinct but overlapping residential patterns. Nearly half arrive before the age of 18 (44%), and they are more likely to be male than female (ratio 4:3).

Local refugees account for 6% of emergency department presentations and 7% of hospital admissions. They are 23% more likely to present to an emergency department and 47% more likely to be admitted to hospital than other residents. Hospitalised refugees have a significantly higher rate of: mental health conditions (i.e. depression, anxiety and psychosis), obstetric complications (i.e. foetal death in utero and stillbirth) and infectious diseases (i.e. tuberculosis).

Most refugee related primary care is delivered by general practice and refugee health nurses, with support from public emergency services. Torture and trauma counselling is provided by the Victorian Foundation for Survivors of Torture (Foundation House). Several medical specialists provide infectious disease, paediatric and psychiatrist services through the Dandenong Hospital Refugee Health Service.

The data shows increasing utilisation of local primary care services by refugees particularly amongst certain nationalities in specific locations. Despite this, refugees can still face difficulties accessing these services.

We found major gaps in General Practice utilisation data, and there were surprisingly few studies of the refugee client experience of local primary care services.

Recommendations

Health policy makers and health service providers should address the responsiveness of local primary care services to refugees, to ameliorate their higher use of public hospital services. Approaches should be especially mindful of the fast growing Afghani population.

- Urgently review refugee-specific, community-based, mental health service capacity.
- Review the provision of sexual and reproductive health services to refugees.
- Review the effectiveness of tuberculosis screening and management by community-based services.
- Improve the completeness of routine ‘country of birth’ data collection by health services.
- Support research to examine access, utilisation and the refugee experience of general practice, community and hospital services.
EXECUTIVE SUMMARY

Introduction

Since 1945 Australia has resettled over 700,000 refugees and humanitarian migrants. This group has complex health needs related to prior, often traumatic, experiences and the challenges of resettlement in a foreign country. While some of these needs require specific health services, many can be addressed within the general healthcare system.

Approximately one in every twelve refugees recently resettled in Australia come to live in the Cities of Greater Dandenong and Casey. These municipalities in the south east metropolitan region of Melbourne have a combined population of 385,733, with 5% having arrived under contemporary refugee and humanitarian resettlement programs. Over many decades the region has developed numerous specific health, settlement and ancillary services to assist refugees.

This study arose from a desire of the region’s Refugee Health Research Consortium to understand the degree to which the primary healthcare needs of local residents from refugee backgrounds are met by existing healthcare services. The Southern Academic Primary Care Research Unit (SAPCRU) conducted this study between June 2010 and February 2011.

Project objectives were to:
1) describe the demographic characteristics of the refugee population in south east metropolitan Melbourne,
2) describe their health issues,
3) describe the capacity of local primary care services to assist refugees,
4) describe the utilisation of local primary care services by refugees,
5) identify important gaps in evidence, and
6) recommend priorities for research and local primary care service development.

Methods

Study methods followed community needs assessment principles. We used a matrix to compare project questions against data sources and used a comprehensive and collaborative strategy to gather existing data from a wide range of existing data sets. We made extensive use of regional public hospital admission rates to try to understand disease and illness behaviour. Analysis involved descriptive, statistical and thematic qualitative methods.

We used the United Nations High Commission for Refugees definition of a refugee as being a person, who being afraid of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his or her nationality, and is unable or unwilling to avail himself or herself of the protection of that particular country.

In general our evaluation was limited to residents of Greater Dandenong and Casey who had arrived from major refugee source countries. People from countries associated with a historically distant refugee migration to Australia (such as Vietnamese and Cambodians) were not included in the study.
Findings

Demography
In the year to 30th June 2010 the City of Greater Dandenong and the City of Casey resettled approximately 1,155 people from refugee backgrounds. Most of the region’s 19,149 contemporary refugee background residents have come from republics of the Former Yugoslavia (45%), Afghanistan (25%), Sudan (13%), Iraq (4%) and Burma (3%). High levels of ongoing refugee settlement currently involve people from Afghanistan and Sri Lanka.

Newly arriving refugees are younger in age distribution than existing residents of the region. 44% arrive in the region before their 18th birthday and 93% arrive before the age of 45. They are more likely to be male than female (ratio 4:3) and generally have lower levels of English proficiency, secondary education achievement, employment and income than other residents. Once settled, refugees are geographically distributed across the region in a way which varies distinctly according to country of birth.

Disease burden
Local refugees have a distinct epidemiological profile. Simple comparative data suggests that local refugee residents are 23% more likely to present to a public hospital emergency department and 47% more likely to be admitted to hospital than other residents in the region.

Preliminary analysis shows that refugees are more likely than non-refugees to be discharged from regional public hospitals with diagnoses related to: mental health (psychosis, anxiety/somatization and depression), obstetric complications (female genital mutilation or circumcision, foetal death in utero and stillbirths) and infectious diseases (tuberculosis). Notwithstanding this higher disease burden they only account for 6% of emergency department presentations and 7% of hospital admissions.

Primary healthcare services
Across the region, we identified that the bulk of refugee specific primary care is delivered by general practice and refugee health nurses, although it is clear that the Refugee Health Clinic at the Dandenong Hospital and, by default, hospital emergency services also deliver primary care services. Refugee specific torture and trauma counselling is provided by the Victorian Foundation for Survivors of Torture (Foundation House) and there are some programs which overlap with other refugee population health priorities such as the Healthy Mothers Healthy Babies program and the Family And Reproductive Rights Education Program.

Secondary or tertiary care for refugees is mainly the responsibility of general health services, however 2 infectious disease physicians, 2 paediatricians and 1 psychiatrist offer specific refugee related care on referral. All of these services work in partnership with settlement and interpreter services and together provide a number of defined pathways to healthcare.

Refugee utilisation of local primary healthcare services has been increasing particularly for the Refugee Health Nurse Program, Community Health Services, public obstetric services and torture and trauma counselling services. There are referral waiting lists of up to 8 months for some refugee-specific counsellor-advocate, psychologist and psychiatrist services.

Several qualitative studies have investigated refugee experiences of healthcare services in the region. These highlighted some of the difficulties refugees had in accessing primary care services. Some of the identified barriers related to low levels of English language proficiency, the insufficient use of interpreters and difficulties in understanding the Australian healthcare system. Some practical challenges related to competing settlement priorities, conflicting needs of the family or community, transport logistics and affordability. Concerning health service provision, some studies identified problems with the cultural responsiveness of services, the awareness of refugee specific service roles and the efficient exchange of refugee patient health information.
Gaps in data and knowledge

One of the major barriers in our primary care needs assessment related to difficulties in accessing several key data elements. In particular we found a substantial gap in readily available general practice data relating to refugee epidemiology and service utilisation related to an inability to search general practice databases by refugee status or country of birth. Our small study was unable to fully evaluate ambulatory care sensitive conditions within the hospital data sets. Similarly we did not explore the utilisation of allied health services, oral health services, local government services (immunisation and maternal and child health services), disability services and preventive activities. There was surprisingly little literature on the experiences of using local health services from the refugee client perspective.

Implications and recommendations

This healthcare needs assessment has collated and analysed core existing data regarding the primary healthcare needs of refugees in south east metropolitan Melbourne. While it only provides a snapshot of their overall health and wellbeing needs it has revealed several priorities for Refugee Health Research Consortium members to consider.

The following recommendations relate to the need to develop health services, the need to improve health service data collection and the need to perform further research where there are gaps in knowledge.

Health service development

Our findings suggest that health service policy makers need to optimise the responsiveness of local primary healthcare services to people from refugee backgrounds. This need is likely to increase with the evolving demographic profile of the refugee community and their increasing utilisation of services over time. Policies should be especially mindful of the fast growing Afghani population. More specific recommendations are:

1.1 Urgently review the capacity of refugee-specific, community-based, counsellor-advocate, psychologist and psychiatrist services.

1.2 Review the regional provision of sexual and reproductive health services to refugees, including family planning and maternal care.

1.3 Review the regional effectiveness of community-based strategies for the screening and management of tuberculosis.

Routine data collection

Our study came up against barriers associated with difficulties in identifying refugees in healthcare data sets. Better ways need to be developed to identify refugee status at point of contact with healthcare services. In particular, doing this in general practice would allow for better analysis of ethno-specific population, epidemiology and utilisation issues. Expanding this to include all Victorian Department of Health notifiable disease conditions would allow for a greater level of monitoring of infectious diseases amongst local refugee subpopulations.

2.1 Improve the completeness of routine health service ‘country of birth’ data collection to assist in the extraction and analysis of data related to refugee subpopulations.

Further research

The needs assessment has identified some fertile grounds for further research. Despite some of the limitations in data, routinely collected hospital data sets have the potential to reveal much about the epidemiology and health service utilisation of the refugee community. Filling gaps in primary care knowledge would complement the hospital findings and would assist in understanding the relationship between the burden of disease and different service utilisation patterns across regional health services. While little is known about how refugees conceptualise,
seek and access health services in this region, a deeper understanding of the reasons for
refugees choosing between these services would help to inform interventions for appropriate
service delivery.

3.1 Conduct a more comprehensive analysis of Southern Health hospital data on the
comparative utilisation of services by people from refugee source countries.

3.2 Perform a closer examination of primary care performance for refugees by
conducting a more detailed examination of the impact of Ambulatory Care
Sensitive Conditions on local public hospitals.

3.3 Increase the capacity in using routinely collected general practice data to
understand the characteristics of primary care delivered to refugee populations.

3.4 Use qualitative methods to examine the refugee client experience of using
particular local primary healthcare services, including barriers to access and
reasons for utilisation.

3.5 Perform a separate study on the use of interpreters by local primary healthcare
services to establish utilisation patterns, an understanding of the barriers and
enablers to use and an estimation of the required regional capacity of this
essential service.

Conclusions

This collaborative healthcare needs assessment has identified what is known about the primary
healthcare needs of the growing and diverse population of people from refugee backgrounds in
south east metropolitan Melbourne. It recommends next steps in service development, health
service data collection and research to improve the health of the refugees in this region. We
present this report to the members of the Refugee Health Research Consortium for consideration.
REPORT

BACKGROUND

This population level, refugee primary care needs assessment emerged from the need to address the health needs of the large numbers of refugees settling in Melbourne’s south east. People from refugee backgrounds are known to have special health problems which place specific demands on local health services.

Refugees and Humanitarian Entrants in Australia and Melbourne’s south east

As defined by the United Nations High Commissioner for Refugees (UNHCR) a “refugee” is a person, who being afraid of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his or her nationality, and is unable or unwilling to avail himself or herself of the protection of that particular country (1). They are entitled to rights under the Universal Declaration of Human Rights (2).

At the beginning of 2010 there were 15.2 million refugees in the world. They mainly originated from: Afghanistan, Iraq, Somalia, the Democratic Republic of the Congo, Sudan and other countries (3). During 2009 112,400 refugees were permanently resettled into countries including Australia, the USA, and Canada (3).

Since 1945 Australia has permanently resettled over 700,000 refugees and humanitarian entrants (4) and today it continues to resettle 13,750 each year through its Refugee and Humanitarian program (5). The majority enter through “off shore” refugee processing programs, while a smaller number enter through the “on shore” processing of claims by asylum seekers. Asylum Seekers are people in Australian territory who have claimed protection as refugees but whose claims are still under review (4). People from refugee backgrounds may also enter through family or skilled migration programs. Their past exposure to persecution makes them different from other migrants.

A significant proportion of these people settle in south east metropolitan region of Melbourne particularly in the City of Greater Dandenong and the City of Casey. The City of Greater Dandenong is an area of high migrant settlement and low socioeconomic status, whereas the City of Casey more closely reflects Melbourne metropolitan averages. In this report the term ‘refugee’ will be used to refer broadly to people from all types of refugee background. This includes people born in notable refugee source countries and people who have entered Australia on refugee or humanitarian visas (Figure 1 and Figure 2).

During the 2009/10 financial year 30% or 1,155 of Victoria’s 3,851 refugee and humanitarian entrants settled in this area (6-9). There were additional settlers from refugee backgrounds arriving under non-refugee and non-humanitarian visa categories and others who initially settled outside of the region and then moved into the area. In recent times many have come from Afghanistan, Sudan, Iraq, Burma and Sri Lanka, adding to an older contingent from the 1990s from the republics of the Former Yugoslavia (4).

In this report the term “refugee” will be used to refer broadly to people from all types of refugee background. This includes people born in notable refugee source countries and people who have entered Australia on refugee or humanitarian visas.
Figure 1 – Municipal profiles

<table>
<thead>
<tr>
<th></th>
<th>City of Greater Dandenong</th>
<th>City of Casey</th>
<th>Metropolitan Melbourne</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population 2010 (projected)</td>
<td>138,838</td>
<td>246,895</td>
<td>4,015,171</td>
</tr>
<tr>
<td>Population 2006</td>
<td>125,520</td>
<td>214,959</td>
<td>3,592,590</td>
</tr>
<tr>
<td>Distance from CBD</td>
<td>24km*</td>
<td>45km**</td>
<td>-</td>
</tr>
<tr>
<td>Born overseas</td>
<td>56% (2006)</td>
<td>32% (2006)</td>
<td>31%</td>
</tr>
<tr>
<td>Speak language other than English</td>
<td>59%</td>
<td>24%</td>
<td>27%</td>
</tr>
<tr>
<td>Limited English fluency</td>
<td>14%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Median income per week</td>
<td>$343</td>
<td>$481</td>
<td>$481</td>
</tr>
<tr>
<td>Unemployment</td>
<td>9.4%</td>
<td>5.3%</td>
<td>5.3%</td>
</tr>
</tbody>
</table>

Sources: City of Greater Dandenong (10, 11); City of Casey (12), 2006

Figure 2 – Map: City of Greater Dandenong and City of Casey

Refugee health problems in Australia

A report prepared for the Victorian Department of Human Services by the Victorian Foundation for Survivors of Torture (Foundation House) found that people with refugee-like experiences “have a relatively high rate of particular physical and mental health problems compared with other migrants and people born in Australia”. This is believed to be caused by “negative influences on their health before, during and following their forced migration”. This can originate from living in areas poor in health resources and the effects of torture, trauma and persecution (13).

In Australia specific health conditions can relate to a number of areas (14). These include infectious diseases such as Malaria, intestinal parasites, skin infections, Schistosomiasis, HIV, Tuberculosis, Syphilis, Hepatitis A, B and C (15, 16), and sexually transmissible infections (17). Demonstrated nutritional problems relate to Vitamin A, Vitamin D, iron and folate deficiencies (15, 17). They may suffer from chronic illnesses including hypertension, heart disease, diabetes and dental caries (16, 18). Children may additionally suffer from problems with growth, development and incomplete immunisation (19). Women may suffer from complications related to poor pregnancy outcomes and gynaecological surgery, female genital circumcision, physical abuse, sexual assault or rape (13, 17). Refugees may have physical injuries, mal-united fractures, musculoskeletal pains, acquired brain injury, sensory impairment or disability (16, 20). They may suffer from psychological symptoms and conditions such as anxiety, depression and post-traumatic stress disorder (16, 21). They may be at higher risk of substance abuse (20). They may have had limited access to preventive health activities such as cervical screening and breast cancer screening (13).
In Australia refugees can encounter difficulties accessing health services on account of: language and cultural differences, a poor understanding of the Australian health system, competing priorities, transport difficulties and cost (14, 22). Health professionals can find it difficult to provide services to refugees because of cultural and language differences, difficulties with using interpreters, difficulties understanding their health needs, the complexity of their inter-related physical, psychological and social problems, and time constraints (22).

In 2004 the Victorian Foundation for Survivors of Torture (Foundation House) found the health needs of refugees were inadequately addressed by the Australian health system (13). Poor health can have a negative impact on the successful resettlement and engagement of refugees in Australian society (14).

Health services for refugees

A priority for Australian health services caring for refugees is the provision of early and comprehensive health assessment, with appropriate treatment and referral (14). In Australia this is provided by primary care, which is the level of the health service system “that provides entry into the system for all new needs and problems”. Primary care provides person-centred care over the continuum of time, assistance for all common conditions, and co-ordinates and integrates care provided by others (23). Primary care includes general practice, community based nursing, allied health services and emergency services (23). Refugees in the community are entitled to at least the same access to these services as other Australian residents (1, 24). At times they are given priority access according to need (20).

In the south east region there are a number of primary care, settlement and ancillary services (including language services) designed to assist refugees. There are pathways to care, partnerships and coordinating networks (25, 26). These exist within the broader context of mainstream health services. They have similarities with international models of refugee primary care service provision (27).

Victorian government policies support this care and include the ‘Refugee health and wellbeing action plan 2008-2010’ and other social, multicultural and human rights policies (20). The National Primary Health Care Strategy supports primary health care reform addressing, particularly relating to equity, accessibility, equity, workforce capacity and cost effectiveness (28).

A primary healthcare needs assessment

The region’s Refugee Health Research Consortium is a formal collaboration of Victorian policy makers, health care providers, community organisations and academics which aims to optimise the health of refugees in south east metropolitan Melbourne. In the light of these issues it commissioned a regional refugee ‘healthcare needs assessment’ to inform the planning of local healthcare services.

A ‘health needs assessment’ is an objective and validated method of gathering information about the health needs of a particular population (29). ‘Health needs’ can be categorised as: normative (measured against expert standards), felt (reflecting the wants of individuals), expressed (related to the demands of individuals) or comparative (determined through the comparison of one population group to another) (30). ‘Unmet’ needs are those which have a potential to benefit from intervention (31).

The Consortium commissioned the Southern Academic Primary Care Research Unit (SAPCRU) to lead this project. SAPCRU provides primary care research expertise through a collaboration of Monash University, Southern Health and the Dandenong Casey General Practice Association.
AIMS & OBJECTIVES

The aims of this healthcare needs assessment are to describe the primary healthcare service needs of refugees in south east metropolitan Melbourne and to make recommendations regarding further research to address these needs. While we acknowledge the influence of the broader socioeconomic determinants in the health of refugee populations, this report focuses on the needs directly related to the delivery of primary care services.

The objectives of this assessment are to:

1) describe the demographic characteristics of the refugee population in the south east metropolitan region of Melbourne (through demography),
2) describe the health problems and needs of this population (through epidemiology),
3) describe the capacity and utilisation of existing primary healthcare services to address these needs (through health service analysis),
4) evaluate the match between healthcare needs and healthcare services, and
5) recommend further research based on gaps in available evidence.

The specific research questions are detailed in Table 1.

Table 1 - Research questions

<table>
<thead>
<tr>
<th>Demographic characteristics:</th>
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<tbody>
<tr>
<td>1) What is the definition of a refugee?</td>
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<tr>
<td>2) How many refugees are there in the region?</td>
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<tr>
<td>3) Where do they live?</td>
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<tr>
<td>4) Which countries do they come from?</td>
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<tr>
<td>5) What are their age and gender distributions?</td>
</tr>
<tr>
<td>6) What are their socio-economic characteristics?</td>
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<tr>
<th>Health problems:</th>
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<tbody>
<tr>
<td>1) What are the incidence and prevalence of physical and mental health conditions?</td>
</tr>
<tr>
<td>2) What are the perspectives of refugees, service providers and policy makers regarding the health needs of this population?</td>
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<table>
<thead>
<tr>
<th>Healthcare services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) What primary healthcare services are available to assist refugees in this region?</td>
</tr>
<tr>
<td>2) What services do they provide?</td>
</tr>
<tr>
<td>3) Where are they located?</td>
</tr>
<tr>
<td>4) What is their capacity?</td>
</tr>
<tr>
<td>5) How much are they used by refugees?</td>
</tr>
<tr>
<td>6) What are the experiences of refugees using these services?</td>
</tr>
<tr>
<td>7) What are the experiences of healthcare workers providing these services?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evaluation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) How well do healthcare needs and healthcare services match?</td>
</tr>
<tr>
<td>2) What are the gaps in information?</td>
</tr>
<tr>
<td>3) What further information is needed?</td>
</tr>
</tbody>
</table>
METHODS

Study design

The design of this primary healthcare needs assessment was based upon the methods described by Wright et al (29), Stevens and Gillam (31), and Wilkinson and Murray (32). It was further informed by the theories of evaluating complex healthcare interventions detailed by Campbell et al (33). Normative needs were assessed where possible.

The final design of this project was formulated with input from Refugee Health Research Consortium partners, service providers and discussions with refugee community representatives.

Study population

For this study refugees were primarily defined as those entering Australia on Refugee or Humanitarian visas. The relevant visa categories are listed in Appendix 2.1.

Where visa category was not obtainable, ‘country of birth’ was used as a proxy measure of refugee status. Countries of interest were defined as those from which over 70 per cent of migrants to Australia entered on refugee or humanitarian visas. Determination against this criterion was made using Department of Immigration and Citizenship (DIAC) Settlement Database data for the period of 2nd January 1991 to 30th June 2010 (Appendix 2.2). The proxy countries of birth used are presented in Appendix 2.3.

We focussed on refugees living in Australia at the time of the Australian Bureau of Statistics Census of 6th August 2006, including new arrivals from that time until 30th June 2010.

The population was geographically limited to residents of the City of Greater Dandenong and the City of Casey. The suburbs and postcodes used are detailed in Appendix 2.4.

Data sources and collection

Multiple data sources were used to answer the research questions (Table 2). These were identified in consultation with Consortium partners. Detail on specific datasets is provided in Appendix 3.

Only pre-existing, de-identified or publically available data was collected.
Table 2 - Data sources

<table>
<thead>
<tr>
<th>Data source</th>
<th>Demography</th>
<th>Epidemiology</th>
<th>Service capacity and utilisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Bureau of Statistics</td>
<td>++</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department of Immigration and Citizenship</td>
<td>++</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMES Settlement</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>South Eastern Region Migrant Resource Centre</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City of Greater Dandenong, Casey, Cardinia</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southern Health</td>
<td>++</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Dandenong Casey General Practice Association</td>
<td>+</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Foundation House</td>
<td>+</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Eastern Region Mental Health Association</td>
<td>+</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Victorian Department of Health</td>
<td>++</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Victorian Department of Human Services</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South East Healthy Communities Partnership</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Translating and Interpreting Service (TIS) National</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Australia</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Literature</td>
<td>++</td>
<td>++</td>
<td></td>
</tr>
</tbody>
</table>

Demography

Demographic data on the size and countries of birth of the refugee population was obtained from public online data from the ABS 2006 Census and the DIAC Settlement Database. This data was limited to the visa categories, countries of birth and local government area postcodes as described.

Resident location mapping by country of birth was obtained from ABS 2006 Census maps of country of birth by postcode.

Age and gender distributions were derived from the DIAC Settlement Database for new arrivals during the period of 1st January 2005 to 30th June 2010 inclusive.

Refugee literacy, education, employment and income data was obtained from the City of Greater Dandenong and City of Casey websites, and the Victorian Department of Human Services ‘Refugee Health and Wellbeing Action Plan 2008-2010’.

Data sources and collection methods were discussed with AMES Settlement to check contextual accuracy.
Epidemiology

Data on public hospital emergency department presentations and admissions were obtained from the Victorian Emergency Department Database and the Victorian Admitted Episodes Database as provided by Southern Health. Data was limited to residents in the region presenting to Monash Medical Centre, Dandenong Hospital and Casey Hospital.

Obstetric complications data was obtained from the Southern Health Birthing Outcome System (BOS). Data was limited to residents in the region giving birth through antenatal services provided by Monash Medical Centre, Dandenong Hospital and Casey Hospital.

Dandenong Hospital Refugee Health Service data on refugee presentations was obtained directly from the head of the service.

Communicable disease notification data was obtained from the Communicable Diseases Section of the Victorian Department of Health.

Health services

Data concerning health service descriptions, capacities and utilisation were obtained from discussions with health service managers, providers, reports, websites and databases. Southern Health organisations included: Community Health Services, Refugee Health Nurse Program, Maternity services and the Refugee Health Service. Other organisations included: the Dandenong Casey General Practice Association, Foundation House, the Eastern Region Mental Health Association, the Victorian Department Health and the Victorian Department of Human Services.

Settlement service descriptions were obtained from managers at AMES Settlement and from the websites of AMES Settlement, the South Eastern Region Migrant Resource Centre and DIAC.

Interpreter service descriptions were obtained from the Department of Human Services Language Services Credit Line website, the Southern Health Interpreting Department at Dandenong Hospital, and from the website and internal data of Translating and Interpreting Service (TIS) National.

Qualitative literature

Existing qualitative reports and literature on local health needs from the perspectives of refugees, service providers, policy makers and others was obtained through discussions with the health and settlement services involved. This was supplemented with literature from an electronic, Ovid Medline database search using the key word stems ‘refugee*’ and ‘asylum seek*’.

Data analysis

Data was analysed using descriptive statistical and qualitative methods. Findings were additionally reviewed by Consortium members, service organisations and academics. Gaps in local data were highlighted.

Demography

Demographic data was analysed using basic descriptive statistics. Baseline refugee population numbers were determined through the addition of (1) the refugee population as identified by country of birth at the time of the ABS Census on 6th August 2006, and (2) new migrant by country of birth data provided by the DIAC Settlement Database from the time of the Census until 30th June 2010. Comparisons were made with the 2010 populations of the City of Greater Dandenong and the City of Casey as estimated by the respective councils.

Country of birth, age and gender trends were determined for new arrival refugees for the 5 years from 1st January 2005 to 31st December 2009, and for the 6 months of 1st January 2010 to 30th June 2010.
Epidemiology
Public hospital emergency department presentation and admission data were analysed using basic descriptive statistical methods for the period of 1st July 2008 to 30th June 2009. The primary separation diagnosis for each client contact was used (i.e. the main diagnosis ascribed to the client at discharge or transfer from or death in a department or unit). Diagnoses for analysis included those which were thought to be of high prevalence in the refugee population, those which were thought to be of serious individual or public health concern and those which were Ambulatory Care Sensitive Conditions (for which hospitalisation is thought to be avoidable with application of preventive care and early disease management delivered in an ambulatory setting such as primary care) (34). Diagnostic Related Groups (DRG’s) were analysed for emergency department contacts and Major Diagnostic Categories (MDCs) were analysed for inpatient episodes. Data was further stratified according to country of birth and expressed as a rate per 1000 residents. Comparison was made with the local non-refugee population.

Obstetric data was analysed according to the number and type of complications per birth during the antenatal and perinatal periods for the period of 1st January 2005 to 30th June 2010. Data was further stratified by country of birth and comparison made between refugee and non-refugee populations.

Dandenong Hospital Refugee Health Service data was analysed according to the reasons for referral stated on referral letters from General Practitioners in the community. This was for clients seen at the service from 1st January 2007 to 30th June 2010.

Communicable disease notification data was analysed by calculating the proportions of specific disease notifications for people born in refugee source countries compared to overall totals. This was for the period of 1st January 2005 to 30th June 2010.

Stratification was performed by ‘country of birth’. The category ‘humanitarian source country’ was used to group the countries where over 70 per cent of migrants to Australia entered on refugee or humanitarian visas.

Health Services
Descriptions of health services were analysed according to: service type, function, location and staff levels. Service descriptions were checked by the services for accuracy.

Health service utilisation was analysed by: type of service, number of individual clients serviced (different from the number of services provided to individual clients), client country of birth and time period. The proportion to which a service was used by refugees was further compared to proportion of refugees living in the community.

Qualitative literature
Qualitative reports and publications were analysed using thematic analysis centered around healthcare needs.

Data management
Data and metadata were securely stored in password protected files on a computer server accessible only by the research team. Data was organised according to research question and data source. Daily back-up copies were made.

Ethical approval
Ethical approvals were obtained from the Monash University Human Research Ethics Committee and the Southern Health Human Research Ethics Committee in accordance with National Health and Medical Research Council guidelines (35).
FINDINGS

Refugee Demographics

This section describes the size of the current refugee population in the City of Greater Dandenong and City of Casey area and the characteristics of new arrivals. It describes their nationality, place of residence, age, gender, literacy, education, employment and income levels.

Over time, demographic characteristics vary according to changes in humanitarian situations overseas, changes in national immigration policy and changes in settlement patterns in Australia. Local population numbers further vary because of births and deaths of residents, and secondary movements into or out of the area.

Population size and nationalities

A combination of Australian Bureau of Statistics (ABS) 2006 Census data and subsequent Department of Immigration and Citizenship (DIAC) Settlement data shows that on 1st July 2010 there were an estimated 19,149 refugees in the Cities of Greater Dandenong and Casey. This represented 5.0% of the total population (8.7% of Greater Dandenong and 2.9% of Casey). Figure 3 shows analysis by country of birth. Complete data is provided in Appendix 4.

Figure 3 - Number of refugees in the Cities of Greater Dandenong and Casey, 30th June 2010

![Graph showing number of refugees by country of birth]

Sources: ABS 2006 Census (6th August 2006); DIAC Settlement Database (7th August 2006 to 30th June 2010).

The DIAC Settlement Database shows that from 2005 to 2009 the major refugee source countries were Afghanistan, Sudan and Burma (Figure 4). Over the more recent 6 months of 1st January 2010 to 30th June 2010 the major countries have shifted to Afghanistan and Sri Lanka (Figure 5).
Residential location

ABS 2006 Census data shows refugees from the most significant recent arrival countries display a unique residential distribution according to country of birth (Figure 6). Further detail is provided in Appendix 4.2.
Figure 6 – Geographical distribution of residents by country of birth in the Cities of Greater Dandenong and Casey

Afghanistan

Legend

- 8 to 76 people
- 4 to 8 people
- 2 to 4 people
- 0 to 2 people

Sudan

Legend

- 20 to 39 people
- 10 to 20 people
- 5 to 10 people
- 0 to 5 people

Burma

Legend

- 5 to 45 people
- 4 to 5 people
- 1 to 4 people
- 0 to 1 people

Source: ABS Census 2006
Age and gender

The DIAC settlement database for recent arrivals shows that the age at arrival shows a trend toward younger age groups, with 44% of arrivals below the age of 18 years and 93% under the age of 45 years. More males have been arriving than females (57% compared to 43%) (Figure 7).

Figure 7 - Age and gender of refugee arrivals to the Cities of Greater Dandenong and Casey, 1st January 2005 to 30th June 2010

Stratification by country of birth shows younger arriving populations of Afghani (49%) and Sudanese (40%) compared to Burmese (19%). There were more males from Afghanistan (54%) and Sudan (57%), but more females (53%) from Burma (Appendix 4.5).

Literacy, education, employment and income

Government and other reports suggest local refugees struggle with English literacy, educational achievement, unemployment and low income.

Lower English literacy levels have been reported amongst refugees in Victoria, supporting the need for access to English language classes, interpreters and translated materials (13).

Secondary school completion rates amongst refugees in the City of Greater Dandenong were lower than Melbourne metropolitan averages. The City reported that in the 2006 ABS Census nearly half of all local, young people from Sudan, Afghanistan and the former Yugoslav republic of Macedonia left school before year 11, compared to averages of 16% in the Greater Dandenong area and 11% across metropolitan Melbourne.

Higher unemployment rates were experienced by City of Greater Dandenong residents from Sudan (39%), Afghanistan (20%) and Serbia (13%) in comparison to the local average (9%) and the Melbourne metropolitan average (5%) in 2006 (11).

The median weekly gross income reported by the City of Greater Dandenong in 2006 among 35-44 year old residents from Afghanistan was $231 and from Sudan $271. This was well below the local median of $492 for all residents, which itself was the lowest level in metropolitan Melbourne (11). The Victorian Department of Human Services reported in 2008 that upon arrival, refugees struggle with having few financial resources, poverty and sometimes debt (20).
Health Needs

The epidemiology of local refugee residents was particularly reflected in public hospital (Southern Health) data sets relating to: emergency department diagnoses, hospital admission diagnoses, complication rates and the reasons for referral to outpatient clinics. Additional information was gained from Victorian Department of Health communicable disease notifications. Epidemiological information specific to refugees was not readily available from General Practices or Community Health Services.

Public hospital emergency department presentations

The Victorian Emergency Management Database (VEMD) shows local residents from refugee source countries have a 23% higher rate of public hospital emergency department presentation and higher rates of specific conditions, including some Ambulatory Sensitive Conditions (Table 3).

Public hospital admissions

The Victorian Admitted Episodes Database (VAED) shows local residents from refugee source countries are 47% more likely to be admitted to public hospitals than non-refugees and shows higher rates for some Major Diagnostic Categories (Table 4).

Obstetric complications

Southern Health Birthing Outcomes System (BOS) data suggests local residents from humanitarian source countries have higher rates of stillbirths and foetal death in utero. They had higher rates of some obstetric risk factors such as female genital mutilation/circumcision and lower rates of others (Table 5).

Dandenong Hospital Refugee Health Service presentations

The reasons for referral stated on GP referral letters to the Dandenong Hospital Refugee Health Service showed a burden of disease clustered around nutritional deficiencies and infectious diseases (Table 6).

Communicable disease notifications

Victorian Department of Health communicable disease notifications show local residents from refugee source countries have a higher rate of notifications than non-refugees (Table 7). This population accounts for 3.8% of notifications while being only 1.7% of the Southern Metropolitan Region population of 1.2 million (36). There were relatively high rates of Tuberculosis notification among some nationalities (Table 8) and in some suburbs (Table 9).
Table 3 - Emergency Department diagnoses at Monash Medical Centre, Dandenong Hospital and Casey Hospital for residents of Greater Dandenong and Casey, 2008/09

<table>
<thead>
<tr>
<th>Separation Diagnosis</th>
<th>Total</th>
<th>Non Humanitarian source country</th>
<th>Humanitarian Source Countries</th>
<th>Risk Ratio of HSC to non-HSC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rate per 1000 pop (n)</td>
<td>Rate per 1000 pop (n)</td>
<td>Rate per 1000 pop (n)</td>
<td>Rate per 1000 pop (n)</td>
</tr>
<tr>
<td>Obstetric Complications</td>
<td>3.3 (1267)</td>
<td>2.9 (1,071)</td>
<td>2.9 (25)</td>
<td>16.4 (171)</td>
</tr>
<tr>
<td>Cancer</td>
<td>0.6 (249)</td>
<td>0.6 (222)</td>
<td>2.8 (24)</td>
<td>0.3 (3)</td>
</tr>
<tr>
<td>Asthma #</td>
<td>4.8 (1842)</td>
<td>4.5 (1,645)</td>
<td>10.3 (90)</td>
<td>10.3 (107)</td>
</tr>
<tr>
<td>Congestive Cardiac Failure #</td>
<td>4.1 (1593)</td>
<td>4.0 (1,470)</td>
<td>10.0 (87)</td>
<td>3.5 (36)</td>
</tr>
<tr>
<td>Angina #</td>
<td>3.1 (1199)</td>
<td>3.0 (1,110)</td>
<td>8.0 (70)</td>
<td>1.8 (19)</td>
</tr>
<tr>
<td>Musculoskeletal pain</td>
<td>0.3 (108)</td>
<td>0.3 (100)</td>
<td>0.3 (3)</td>
<td>0.5 (5)</td>
</tr>
<tr>
<td>Diabetes complications #</td>
<td>0.8 (307)</td>
<td>0.8 (293)</td>
<td>0.8 (7)</td>
<td>0.7 (7)</td>
</tr>
<tr>
<td>Nutritional deficiencies</td>
<td>0.2 (66)</td>
<td>0.2 (63)</td>
<td>0.2 (2)</td>
<td>0.1 (1)</td>
</tr>
<tr>
<td>COPD #</td>
<td>5.6 (2169)</td>
<td>5.8 (2,108)</td>
<td>3.3 (29)</td>
<td>3.1 (32)</td>
</tr>
<tr>
<td>Infectious and parasitic:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>0.1 (23)</td>
<td>0.0 (12)</td>
<td>0.0 (0)</td>
<td>1.1 (11)</td>
</tr>
<tr>
<td>Pyelonephritis #</td>
<td>0.8 (290)</td>
<td>0.7 (271)</td>
<td>0.9 (8)</td>
<td>1.1 (11)</td>
</tr>
<tr>
<td>Cellulitis #</td>
<td>4.6 (1784)</td>
<td>4.6 (1,695)</td>
<td>5.7 (50)</td>
<td>3.7 (39)</td>
</tr>
<tr>
<td>Influenza &amp; Pneumonia #</td>
<td>6.3 (2435)</td>
<td>6.3 (2,317)</td>
<td>6.2 (54)</td>
<td>6.1 (64)</td>
</tr>
<tr>
<td>Gastroenteritis &amp; dehydration #</td>
<td>4.7 (1806)</td>
<td>4.7 (1,719)</td>
<td>4.5 (39)</td>
<td>4.6 (48)</td>
</tr>
<tr>
<td>ENT infection #</td>
<td>7.0 (2706)</td>
<td>7.0 (2,584)</td>
<td>2.9 (25)</td>
<td>9.3 (97)</td>
</tr>
<tr>
<td>Mental disease/ disorders:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosis</td>
<td>1.3 (486)</td>
<td>1.2 (437)</td>
<td>1.6 (14)</td>
<td>3.4 (35)</td>
</tr>
<tr>
<td>Anxiety/Somatisation*</td>
<td>1.8 (703)</td>
<td>1.7 (635)</td>
<td>4.4 (38)</td>
<td>2.9 (30)</td>
</tr>
<tr>
<td>Depression</td>
<td>1.8 (704)</td>
<td>1.8 (646)</td>
<td>2.4 (21)</td>
<td>3.5 (37)</td>
</tr>
<tr>
<td>Other mental disorder^</td>
<td>2.3 (868)</td>
<td>2.2 (799)</td>
<td>5.0 (44)</td>
<td>2.4 (25)</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>1.3 (500)</td>
<td>1.3 (473)</td>
<td>1.6 (14)</td>
<td>1.2 (13)</td>
</tr>
<tr>
<td>All Presentations</td>
<td>230 (88,910)</td>
<td>228 (83,505)</td>
<td>295 (2,572)</td>
<td>272 (2,833)</td>
</tr>
</tbody>
</table>

Source: Victorian Emergency Management Database (VAED)

# Ambulatory Sensitive Condition
Red = higher than non-humanitarian
Black = similar to non-humanitarian
Green = lower than non-humanitarian
Table 4 - Victorian public hospital admissions for residents of Greater Dandenong and of Casey, 2008/2009

<table>
<thead>
<tr>
<th>Major Diagnostic Category</th>
<th>Total Rate per 1000 pop (n)</th>
<th>Non Humanitarian Source Country Rate per 1000 pop (n)</th>
<th>Humanitarian Source Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Former Yugoslavia Rate per 1000 pop (n)</td>
<td>Africa, Middle East, Asia Rate per 1000 pop (n)</td>
</tr>
<tr>
<td>Pregnancy, Childbirth &amp; the Puerperium</td>
<td>19.8 (7648)</td>
<td>21.9 (191)</td>
<td>78.8 (821)</td>
</tr>
<tr>
<td>Circulatory System</td>
<td>18.7 (7209)</td>
<td>18.0 (6592)</td>
<td>49.5 (432)</td>
</tr>
<tr>
<td>Injuries, Poisonings and Toxic Effects of Drugs</td>
<td>7.3 (2852)</td>
<td>7.2 (2624)</td>
<td>11.5 (100)</td>
</tr>
<tr>
<td>Infectious and Parasitic Diseases</td>
<td>3.0 (1142)</td>
<td>2.9 (1051)</td>
<td>4.1 (36)</td>
</tr>
<tr>
<td>Mental Disease &amp; Disorders</td>
<td>6.1 (2337)</td>
<td>6.4 (56)</td>
<td>10.2 (106)</td>
</tr>
<tr>
<td>Musculoskeletal System and Connective Tissue</td>
<td>15.2 (5859)</td>
<td>14.9 (5479)</td>
<td>26.5 (231)</td>
</tr>
<tr>
<td>Neoplastic (Haematology &amp; Solid Neoplasm)</td>
<td>15.9 (6118)</td>
<td>15.7 (5744)</td>
<td>33.8 (295)</td>
</tr>
<tr>
<td>Alcohol and Drug Use</td>
<td>1.0 (391)</td>
<td>1.4 (12)</td>
<td>1.1 (11)</td>
</tr>
<tr>
<td>All admissions</td>
<td><strong>262</strong> (101,378)</td>
<td><strong>508</strong> (4431)</td>
<td><strong>272</strong> (2835)</td>
</tr>
</tbody>
</table>

Source: Victorian Admitted Episodes Database (VAED)

**Red** = higher than non-humanitarian
**Black** = similar to non-humanitarian
**Green** = lower than non-humanitarian
Table 5 - Obstetric complications and birth outcomes at Monash Medical Centre, Dandenong Hospital and Casey Hospital, for residents of Greater Dandenong of Casey, 1st January 2005 to 30th June 2010

<table>
<thead>
<tr>
<th>Complication or birth outcome</th>
<th>Total</th>
<th>Non Humanitarian Source Country</th>
<th>Humanitarian Source Countries</th>
<th>Risk Ratio HSC to non-HSC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>number</td>
<td>rate per 1000 births</td>
<td>number</td>
<td>rate per 1000 births</td>
</tr>
<tr>
<td>Total births</td>
<td>23525</td>
<td>20476</td>
<td>3049</td>
<td></td>
</tr>
<tr>
<td>Female Genital Mutilation</td>
<td>77</td>
<td>3.3</td>
<td>2</td>
<td>0.1</td>
</tr>
<tr>
<td>Stillbirths</td>
<td>177</td>
<td>7.5</td>
<td>127</td>
<td>6.2</td>
</tr>
<tr>
<td>Foetal Death inutero</td>
<td>107</td>
<td>4.5</td>
<td>82</td>
<td>4.0</td>
</tr>
<tr>
<td>Birth Before Arrival</td>
<td>210</td>
<td>8.9</td>
<td>169</td>
<td>8.3</td>
</tr>
<tr>
<td>Poor Obstetric History</td>
<td>325</td>
<td>13.8</td>
<td>264</td>
<td>12.9</td>
</tr>
<tr>
<td>Poor Antenatal Attendance</td>
<td>496</td>
<td>21.1</td>
<td>423</td>
<td>20.7</td>
</tr>
<tr>
<td>Twins</td>
<td>337</td>
<td>14.3</td>
<td>296</td>
<td>14.5</td>
</tr>
<tr>
<td>Foetal Abnormality</td>
<td>254</td>
<td>10.8</td>
<td>227</td>
<td>11.1</td>
</tr>
<tr>
<td>No Antenatal Attendance</td>
<td>75</td>
<td>3.2</td>
<td>69</td>
<td>3.4</td>
</tr>
</tbody>
</table>

Source: Southern Health, Birthing Outcomes System (BOS)

- **Red** = Risk ratio higher than non-humanitarian
- **Black** = Risk ratio similar to non-humanitarian
- **Green** = Risk ratio lower than non-humanitarian

---

Table 6 - Dandenong Hospital Refugee Health Clinic, reasons for GP referral, 1st March 2007 to 31st October 2010

![Graph showing reasons for GP referral](Image)

Source: Southern Health, Dandenong Hospital Refugee Health Service
Table 7 - Communicable disease notifications, Southern Metropolitan Region, 1st January 2005 to 30th June 2010

<table>
<thead>
<tr>
<th>Disease</th>
<th>Humanitarian Source Country</th>
<th>Non Humanitarian Source Country</th>
<th>Unknown Source Country</th>
<th>Total</th>
<th>Percentage of notifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis</td>
<td>79</td>
<td>435</td>
<td>0</td>
<td>514</td>
<td>15.3</td>
</tr>
<tr>
<td>Gonococcal infection</td>
<td>16</td>
<td>916</td>
<td>671</td>
<td>1603</td>
<td>0.9</td>
</tr>
<tr>
<td>Syphilis (infectious)</td>
<td>6</td>
<td>318</td>
<td>8</td>
<td>332</td>
<td>1.8</td>
</tr>
<tr>
<td>Shigella</td>
<td>2</td>
<td>61</td>
<td>18</td>
<td>81</td>
<td>2.4</td>
</tr>
<tr>
<td>Measles</td>
<td>1</td>
<td>22</td>
<td>0</td>
<td>23</td>
<td>4.3</td>
</tr>
<tr>
<td>Meningitis</td>
<td>1</td>
<td>71</td>
<td>4</td>
<td>76</td>
<td>1.3</td>
</tr>
<tr>
<td>Typhoid</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>1</td>
<td>62</td>
<td>15</td>
<td>78</td>
<td>1.2</td>
</tr>
<tr>
<td>Mumps</td>
<td>0</td>
<td>16</td>
<td>3</td>
<td>19</td>
<td>0</td>
</tr>
<tr>
<td>Rubella</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Malaria</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Haemophilius influenzae type b</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Leprosy</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>HIV</td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>Total</td>
<td>107</td>
<td>1919</td>
<td>724</td>
<td>2750</td>
<td>3.8</td>
</tr>
</tbody>
</table>

Source: Victorian Department of Health, Communicable Diseases Section

* Country of birth data not available
** Withheld for confidentiality reasons

Table 8 - Tuberculosis notifications by country of birth, Southern Metropolitan Region, 1st January 2005 to 30th June 2010

<table>
<thead>
<tr>
<th>Country of birth</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudan</td>
<td>26</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>26</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>79</td>
</tr>
</tbody>
</table>

Source: Victorian Department of Health, Communicable Diseases Section

Table 9 - Tuberculosis notifications by postcode, Southern Metropolitan Region, 1st January 2005 to 30th June 2010

<table>
<thead>
<tr>
<th>Postcode</th>
<th>Suburb</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>3175</td>
<td>Dandenong</td>
<td>20</td>
</tr>
<tr>
<td>3174</td>
<td>Noble Park</td>
<td>13</td>
</tr>
<tr>
<td>3976</td>
<td>Hampton Park</td>
<td>8</td>
</tr>
<tr>
<td>3802</td>
<td>Endeavour Hills</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>31</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>79</td>
</tr>
</tbody>
</table>

Source: Victorian Department of Health, Communicable Diseases Section
Service Capacity

Services overview
The region has a number of health, settlement and language organisations assisting refugees and other humanitarian entrants. The roles and capacities of key services and programs are summarised in Table 10, Table 11 and Table 12. Further detail is provided in Appendix 5.1.

The functional interrelationships between these services and programs were mapped by the South East Healthy Communities Partnership and the Dandenong Casey General Practice Association (Appendix 1). They exist in the setting of other mainstream services and programs.

Table 10 - Refugee specific health services and programs

<table>
<thead>
<tr>
<th>Health Service/ Program</th>
<th>Role</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GENERAL PRACTICE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private GP clinics throughout Greater Dandenong and Casey.</td>
<td>Primary care screening, health assessment, diagnosis, management, referral.</td>
<td>16 private General Practitioners providing refugee specific services.</td>
</tr>
<tr>
<td><strong>COMMUNITY HEALTH SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southern Health, Greater Dandenong Community Health Service, Southern Health, Cardinia Casey Community Health Service.</td>
<td>Community health and wellbeing, allied health, oral health.</td>
<td>5 Bicultural community health workers, Midwives, 4 Family And Reproductive Rights Education (FARREP) workers, 4 Dental chairs.</td>
</tr>
<tr>
<td><strong>REFUGEE HEALTH NURSE PROGRAM</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southern Health, Greater Dandenong Community Health Service, Southern Health, Cardinia Casey Community Health Service.</td>
<td>Assessment, management, MCH, Immunisation, MY Health Clinic, education, case coordination, outreach, referral.</td>
<td>3 Refugee Health Nurses.</td>
</tr>
<tr>
<td><strong>REFUGEE HEALTH CLINIC</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southern Health, Dandenong Hospital Refugee Health Service.</td>
<td>Specialist medical care.</td>
<td>2 Infectious diseases physicians, 2 Paediatricians, 1 GP, 1 Dietitian, 1 Bicultural community health worker (with participation of RHNs).</td>
</tr>
<tr>
<td><strong>MENTAL HEALTH SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foundation House, Eastern Region Mental Health Association.</td>
<td>Assessment, counselling, complementary therapy, support, advocacy, facilitating access and referral.</td>
<td>11 Counselor-advocates, 3 Community Liaison Workers, 2 Natural therapists, 1 Psychiatrist, 4 Community mental health workers (ERMHA).</td>
</tr>
</tbody>
</table>
Table 11 - Language services and programs

<table>
<thead>
<tr>
<th>Language Services</th>
<th>Role</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTERPRETERS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Translating and Interpreting (TIS)</td>
<td>Language interpreting and translating.</td>
<td>Publically funded services and additional private services.</td>
</tr>
<tr>
<td>National,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department of Human Services and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department of Health Language Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services Credit Line,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southern Health interpreter department,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private interpreting services.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 12 - Settlement services and programs

<table>
<thead>
<tr>
<th>Settlement Services</th>
<th>Role</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SETTLEMENT SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Humanitarian Settlement Strategy</td>
<td>Settlement assistance.</td>
<td>Numerous managers, case coordinators, support workers,</td>
</tr>
<tr>
<td>Consortium (led by AMES Settlement),</td>
<td></td>
<td>community guides, volunteers.</td>
</tr>
<tr>
<td>South Eastern Region Migrant Resource</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centre,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refugee Minor Program,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complex Case Support.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

General Practice

General Practice provides primary continuing comprehensive whole-patient medical care to refugee individuals, families and their communities. It provides the first point of contact for the majority of people seeking health care and takes action on any medical problem the patient presents with including undifferentiated illness (37). Refugee specific activities include: orientation to the Australian Health system, comprehensive health assessments, referral to appropriate health care professionals or services and the use of interpreters (38). There is significant variation in individual clinical practice relating to the needs of different local population groups, geographical considerations, the interests of practitioners, the special skills of practice staff (37).

The Dandenong Casey General Practice Association's (DCGPA) Refugee Health Program supports 255 local GPs in 94 clinics (39, 40). It helps refugees to access General Practice services and assists General Practice staff to provide quality care to refugees including providing support in performing comprehensive health assessments for refugees.

DCGPA data outlines the capacity of General Practice to assist refugees. Medicare Australia data collected by DCGPA shows there were up to 16 GPs performing MBS rebatable comprehensive Refugee Health Assessments for refugees during the 2009/10 year. In 2010 a postal survey showed 20 GPs (26% of respondents) saw refugees in their clinics (39). The Refugee Health Program Coordinator notes 55 individual GPs in the region had indicated an interest in refugee health during the period of 2007 to 2010 inclusive.
These specialised GP services to refugees are provided within the wider setting of general GP services. They are supported by settlement, refugee health nurse, community health, hospital and interpreter services.

**Southern Health, Community Health Services**

Public Community Health Services include the Greater Dandenong Community Health Service (GDCHS) and the Cardinia Casey Community Health Service (CCCHS) as managed by Southern Health. These services seek to improve the health and wellbeing of community members. In this study region GDCHS has two sites in Dandenong and one in Springvale (41). Similarly in this region CCCHS has three sites across Doveton, Cranbourne and Berwick (42).

Services and programs provide direct healthcare to individuals and groups, as well as early intervention, health information, general wellness, health promotion, preventative health, support groups and work with communities and organisations. Direct services and programs include: allied health, oral care, counselling, immunisation, youth health, family support, early intervention for children, child psychology, family planning, women’s health, a Family And Reproductive Rights Education Program (FARREP – see Appendix 5.2), community midwifery (including a Healthy Mothers Health Babies Program (see Appendix 5.3), community nursing, refugee health nurses, drug and alcohol services, disability services, aged service and financial assistance. Some services are limited to certain sites.

There is a particular focus on ensuring access for those with or at risk of the poorest health status. Refugees receive priority access to all services under the Department of Health Primary Health demand management framework (20). Individuals either self-refer or are referred by General Practitioners, settlement or other organisations.

A Sudanese community worker works across GDCHS and CCCHS sites. CCCHS has additional bicultural community health workers of Oromo (Ethiopian) and Afghan nationality, and a bicultural youth worker of Afghan nationality. Free interpreter services are available. A General Practitioner at GDCHS provides BCG vaccination and Mantoux tests for the prevention and diagnosis of Tuberculosis. Three Refugee Health Nurses are based across these services.

**Southern Health, Refugee Health Nurse Program**

The Refugee Health Nurse Program is a Victorian Government initiative which aims to increase refugee access to primary health services, improve the response of health services to refugees’ needs and to enable refugee individuals, families and communities to improve their health and wellbeing (43).

The GDCHS in Springvale has two full-time refugee health nurses (RHN’s) and the CCCHS in Doveton has one part-time RHN.

RHN’s receive referrals particularly if clients have significant health issues from: settlement workers, General Practitioners, language schools (including the Noble Park English language school and AMES Education) and other services. Refugees can self-refer.

RHN’s work with each family’s settlement case coordinator to perform initial assessments at the community health centre or at the refugee’s home. Referrals are then made to link them into other services within Community Health Services, Foundation House and General Practitioners in the area. They provide assistance with accessing health services and liaise between all services. They have access to Southern Health medical records and diagnostic pathology data which assists in the sharing of health information between clinicians.

At GDCHS the Refugee Health Nurses lead refugee community health clinics two mornings each week. There is a flexible appointment system and ‘drop-ins’ are accepted. They offer: nursing assessment, catch-up immunisation, sexual and reproductive health assistance, health education, management and referral. Community health nurses and midwives are also involved. A Burmese interpreter is present at the clinics allowing Burmese clients to freely discuss issues
which usually revolve around mental health, women’s health and settlement problems. There is specific funding for each RHN position for additional interpreting.

Both GDCHS RHNs attend the weekly Refugee Health Clinic at Dandenong Hospital. They also act as resource staff for the wider Southern Health network and provide professional development for other healthcare providers and capacity building for healthcare organisations. The capacity and roles of the RHNs are continually reviewed to respond to changing refugee health needs and settlement patterns (44). A regional submission to the National Primary Health Care Strategy reform process identified a need to increase capacity in 2009 (45). A review of the GDCHS program by the La Trobe University Refugee Health Research Centre recommended a need for providing increased support in mental health issues (46).

**Southern Health, Refugee Health Service**

The Refugee Health Service runs a weekly specialist, outpatient, Refugee Health Clinic at Dandenong Hospital for both refugees and asylum seekers. General Practitioners refer patients to the clinic. Patients have usually already had pre-migration health screening overseas and additional health screening by a local general practitioner.

Health problems addressed by the Refugee Health Clinic include: infectious diseases, such as TB, hepatitis B and C, malaria, parasitic infections (including schistosomiasis and strongyloides), syphilis, HIV, nutritional deficiencies, general medical health problems, chronic complex medical problems, and paediatric conditions, including Vitamin D deficiency, failure to thrive, under-nutrition, and developmental problems.

Core medical staff include: two infectious disease physicians, two Paediatricians and one GP who assists Asylum Seekers. The Refugee Health Nurses attend and there is one dietitian. A bicultural community development worker assists in liaising with patients including the coordination of telephone reminders for appointments. Hospital radiology, pathology and pharmacy services are available and on-site hospital interpreters assist with consultations when needed. Liaison with and referral to other outpatient specialists are carried out as required.

Mental health problems are not specifically addressed by the clinic although there are plans to do so in conjunction with the Cardinia Casey Community Health Service and to work more closely with community based refugee mental health services.

Currently there is a 3 to 4 weeks waiting list for new patients.

**Foundation House**

The Dandenong site of Foundation House (The Victorian Foundation For Survivors of Torture) assists refugees and asylum seekers who have mental health problems related to previous experiences of torture and other traumatic events. Clients typically present with a range of mental health issues including grief and loss, depression, anxiety and post-traumatic stress disorder. Priority is given to particularly vulnerable clients such as unaccompanied minors, children and young people, asylum seekers and single parent families. All clients from a refugee-type background are eligible for services regardless of amount of time in Australia.

Referrals are received and prioritised via an intake service. Referrals are received from a multiplicity of services including settlement services, General Practitioners, Refugee Health Nurses, schools, Centrelink and refugees themselves.

Initial assessment is performed by a counsellor advocate with a background in psychology, social work or other relevant counselling discipline. Assessment includes the client’s background, pre-arrival experiences and current psychosocial concerns. Goals are formulated in consultation with clients.

Services include case management and counselling for individuals, couples or families, with therapeutic groups as an additional modality. Outreach services are provided to the more
vulnerable groups such as women and children. Natural therapies are available. If mental health concerns are contributing to broader problems in psychosocial functioning advocacy and linkage to other organisations is provided. Interpreters are used.

A Refugee Mental Health clinic provides clinical mental health support for Foundation House clients. Staffed with psychiatrists and psychologists the service is available three days per week. Due to high demand, referrals for this clinic cannot be accepted from external providers at present.

The therapeutic relationship may be brief or longer term. Clients may re-present with the emergence of mental health problems over time for counselling and advocacy.

Foundation House is also engaged in family strengthening projects and community development work in collaboration with other services. The current family strengthening program is in partnership with key local family support agencies and Afghan community advisors. Foundation House furthermore provides professional development sessions and secondary consultation to health, education and community services working with refugees.

The wait for counsellor-advocate services for new clients within the first twelve months of their arrival in Australia is minimal, while the wait for new clients who have been in Australia for more than 12 months is about 8 months (as of July 2010). The wait for Psychiatrist services is similar and external referrals for this cannot be accepted at the time of writing because of limitations in capacity. These waiting lists suggest demand for counsellor-advocate and Psychiatrist services is greater than capacity.

**Eastern Region Mental Health Association**

The Eastern Region Mental Health Association (ERMHA) provides practical support to adults with signs of psychiatric illness living in the City of Greater Dandenong. This is provided through group support with other people with mental illness, individual support in ‘Home Based Outreach’ and weaving webs of support with other organisations that have skills relevant to clients’ needs including: health, employment, education, legal issues, housing and counselling. Some programs provide intensive support for clients with a severe mental illness and/or complex needs while other programs are less intensive.

Within ERMHA the Origins program supports people from culturally and linguistically diverse backgrounds. Over 80% of Origins program clients are of refugee or asylum seeker background. The program assists people with a mental illness, builds pathways to culturally appropriate mainstream mental health services and facilitates access to community support options. The program includes community development.

The Origins program team consists of multidisciplinary, community mental health workers. Interpreters are accessed as required. Referrals are made to other organisations as needed.

**Interpreter services**

Interpreting services are provided to the local healthcare sector by four main groups of organisations.

**Translating and Interpreting Service (TIS) National**

The Australian Government provides free interpreting services to non-English speaking Australian citizens and permanent residents communicating with health professionals in the private sector through TIS National. Eligible services include GPs and Specialists providing Medicare-rebatable services, their reception staff and pharmacies for the purpose of dispensing medications under the Pharmaceutical Benefits Scheme (PBS) (47). TIS National services are available 24 hours a day, seven days a week. TIS National also provides translation services for essential documents.
The DHS and DH Language Services Credit Line provides interpreter services for DHS and DH funded services which do not already receive direct funding for language services from the Victorian Government. These are provided through OnCall Interpreters and Translators. High service users may be given a further direct allocation. Services are provided for specific programs including: community health services, children and youth, families, aged care, disability, optometry, mental health, alcohol and other drugs, palliative care, housing, quality and safety (48). Training is provided. In 2005, DHS produced a language services policy to help identify when a professional interpreter was necessary and to inform the use of interpreter services for department staff and agencies (20).

Southern Health Interpreter services

Southern Health offers interpreter services to their clients in over 100 different languages across all sites. A number of language service agencies are used. At intake or admission a preferred language is identified and appropriate interpreters are booked for appointments. The services are furthermore involved in building effective working relationships with ethno specific agencies and CALD communities, participating in various community events, establishing partnerships with government agencies, conducting cultural awareness training for staff, and providing translated information on health (49).

Private interpreting services

Apart from government funded interpreter services, private services are additionally available by direct arrangement through organisations such as VITS (the Victorian Interpreting and Translation Service), TIS National and OnCall. These organisations assist multiple service sectors.

Settlement services

A number of services assist with the specific settlement needs of refugees in the region.

AMES Humanitarian Settlement Strategy (HSS) Consortium

The Humanitarian Settlement Strategy (HSS) Consortium led by AMES Settlement provides intensive settlement support to Refugees and Special Humanitarian Program (SHP) entrants and to refugee proposers. The Consortium provides on-arrival reception and assistance, information, accommodation services, case coordination and referral.

AMES Settlement is responsible for the overall management of the program in south east metropolitan Melbourne. It provides coordination from an office in Noble Park. Other consortium partners include the Springvale Community Aid and Advice Bureau (SCAAB) which provides coordination from Springvale, New Hope from offices based in Frankston, Redback Settlement Services and the Brotherhood of St. Laurence (50).

Each refugee or SHP entrant is assigned to a case coordinator for 6 to 12 months. The case coordinator makes a comprehensive assessment of their needs and develops and implements a tailored case plan. Community guides with a similar language and cultural background to the client provide practical assistance. Additional volunteers are utilised when required (50).

With regard to on arrival health needs the case coordinator notes any health alerts from the Department of Immigration, carries out a basic health assessment (to determine if there are any emergency issues) and arranges appropriate referrals to health professionals. Referrals include to General Practitioners for comprehensive health assessment, Refugee Health Nurses, Maternal and Child Health Nurses for children under 6 years of age, council immunisation programs, specialist migrant or refugee health services, Foundation House for torture and trauma counselling, dental services and optometrists. Assistance is also given to clients to understand how to make appointments and with attending appointments (51).
**South Eastern Region Migrant Resource Centre**

The South Eastern Region Migrant Resource Centre (SERMRC) aims to assist and empower refugees and migrants in Melbourne's south east to establish themselves and achieve their aspirations in the community (52).

SERMRC provides settlement services to new arrival migrants during their first 5 years in Australia. The service includes: information sessions, individual case work, groups for men and women, recreation activities and capacity building for new and emerging communities. Referrals and links are made to health services, housing organisations, education providers, employment, financial assistance, local council services, and other agencies. The centre is also involved in community development projects and in assisting mainstream agencies to work with culturally and linguistically diverse communities (52). Their offices are based in Dandenong and Narre Warren.

**Refugee Minor Program**

The Refugee Minor Program assists ‘unaccompanied’ young people and children up to the age of 18 years to settle into life in Australia through a casework-based approach. Clients are referred directly by DIAC. The Department of Human Services provides services to clients (and their relatives or carers) to develop key settlement competencies while establishing and maintaining relationships with other key agencies in the community (20).

Partners include: the AMES Humanitarian Settlement Strategy consortium, Foundation House, youth justice and child protection areas of the department, Centre for Multicultural Youth, Department of Education and Early Childhood Development, local migrant resource centres, multicultural policy and tertiary learning institutions such as La Trobe, Monash and Melbourne universities.

**Complex Case Support**

Funded by the Department of Immigration and Citizenship, Complex Case Support (CCS) delivers specialised and intensive case management services to humanitarian entrants with exceptional needs. It provides tailored and localised responses to meet the individual needs of each case, working in partnership with settlement and mainstream services, and going beyond the scope of core settlement services (53).

Clients are eligible for services for up to five years after arrival in Australia. Flexibility may be exercised in this timeframe in exceptional circumstances. Referrals can be accepted from anyone including health services.

Exceptional needs may relate to: physical health, mental health, family relationship counselling, family violence intervention, personal and grief counselling, and special services for children and youth.
Service Utilisation

Local data generally shows increasing utilisation of primary healthcare services by refugees over time. Furthermore there are variations in service use according to country of birth, particularly with Afghani, Sudanese and Burmese refugees using different types of services at different rates.

General Practice

DCGPA Refugee Health Program data shows an increasing utilisation of Medicare-funded, GP health assessment services by refugees over time. Absolute numbers vary per quarter according to the number of refugees arriving in the region. A large proportion of refugees attend for these assessments (Figure 8).

Figure 8 – General Practice Comprehensive Refugee Health Assessments provided to refugees

Source: DCGPA, Refugee Health Program
Southern Health, Community Health Services

SWITCH data shows that an increasing number and proportion of clients of Southern Health Community Health Services for Greater Dandenong and Casey Cardinia are born in humanitarian source countries (Figure 9). Stratification shows different levels of utilisation according to country of birth (Figure 10). A further comparison of utilisation data (SWITCH) with demographic data (ABS 2006 Census and DIAC Settlement Database) shows that in 2010 the Burmese comprised 2.4% of clients at GDCHS while being 0.4% of the catchment population and the Afghans comprised 1.9% of clients at CCCHS while being 0.9% of the catchment population.

Figure 9 - Community Health Service utilisation by humanitarian source country status

![Figure 9](source)

Source: Southern Health, SWITCH

Figure 10 - Community Health Service utilisation by country of birth

![Figure 10](source)

Source: Southern Health, SWITCH
Southern Health, Refugee Health Nurse Program

SWITCH data shows increasing client utilisation of the Southern Health Greater Dandenong Community Health Service, Refugee Health Nurse Program since commencement in 2006. There was a particular increase in utilisation from 2009 when a second nurse was appointed (Figure 11). Analysis by country of birth shows increasing use by Afghans and declining use by Sudanese over time (Figure 12).

Figure 11 - Greater Dandenong Community Health Service, Refugee Health Nurse Program utilisation

![Bar chart showing client utilisation over time](#)

Source: Southern Health, SWITCH

Figure 12 - Greater Dandenong Community Health Service, Refugee Health Nurse Program utilisation by country of birth

![Bar chart showing utilisation by country over time](#)

Source: Southern Health, SWITCH
Southern Health, Dandenong Hospital Refugee Health Service

Dandenong Hospital Refugee Health Clinic data shows a steady number of refugees using the service over the period that it has been operating (Figure 13). Major nationalities represented include especially the Sudanese, Afghani and Burmese (Figure 14). The relatively high representation of Sudanese (39% of patients seen in the clinic compared with being 12.6% of total refugee catchment population in 2010) may reflect higher specialised health service needs in the Sudanese.

Figure 13 - Dandenong Hospital Refugee Health Clinic utilisation

![Bar chart showing utilisation of the clinic from 2007 to 2010.](source)

Figure 14 - Dandenong Hospital Refugee Health Clinic utilisation by country of birth

![Bar chart showing utilisation by country of birth from 2007 to 2010.](source)
Southern Health, Maternity Services

Southern Health BOS data shows that an increasing number and proportion of obstetric services are provided to local refugees through Dandenong Hospital, Casey Hospital and Monash Medical Centre Clayton (Figure 15). (Women with high risk pregnancies are re-referred to Monash Medical Centre Clayton for obstetric care). Furthermore, refugees account for a relatively larger proportion of births compared to their population size (14% of projected births in 2010 compared to being 5% of the resident population).

Analysis by country of birth shows that the Afghani mothers make up the largest group followed by Sudanese and those from the republics of the Former Yugoslavia (Figure 15). There is a relatively high representation of Afghans (6.5% of mothers seen compared with being 1.3% of the resident population) and Sudanese (2.8% of mothers seen compared with being 0.6% of the resident population in 2010).

Figure 15 - Public obstetric service utilisation by humanitarian source country status

![Figure 15](image1)

Source: Southern Health, BOS

Figure 16 - Public obstetric service utilisation by country of birth

![Figure 16](image2)

Source: Southern Health, BOS
Foundation House

Foundation House data shows utilisation by individuals increasing over time (Figure 17).

Country of birth analysis shows a predominance of Afghani and Burmese clients (Figure 18). The Burmese currently use these services relatively more than other refugee groups (comprising 25% of clients while being only 3% of the local refugee population in 2010).

Figure 17 – Foundation House utilisation

![Foundation House utilisation chart](source)

Source: Foundation House

Figure 18 – Foundation House utilisation by country of birth

![Foundation House utilisation by country of birth chart](source)

Source: Foundation House
Eastern Region Mental Health Association

ERMHA Origins program data shows increasing utilisation by adult refugees over time (Figure 19).

Country of birth analysis shows the largest refugee groups attending were Burmese and Afghani (Figure 20). Population comparison suggests Burmese refugees utilise these services significantly more than other refugee groups in the community (being 29% of clients while being only 3% of the local refugee population in 2010). This finding is similar to that of Foundation House.

Figure 19 – Eastern Region Mental Health Association, Origins program utilisation

![Graph showing utilisation by month](image)

Source: ERHMA, Origins program

Figure 20 - Eastern Region Mental Health Association, Origins program utilisation by country of birth

![Graph showing utilisation by country](image)

Source: ERHMA, Origins program
Qualitative literature

Our review of literature indicated there was little, existing, documented evidence outlining the healthcare needs of refugees specific to this region. The literature that was identified included: published research, community organisation reports, government reports and government policy submissions. Only one study had been published in a peer-reviewed journal.

Many of the papers were based on the expert opinions of health and settlement service providers. Only a few were based on the direct perspectives and experiences of refugee clients.

Health themes articulated in the local literature focussed on women and children, mental health and nutrition. Papers describing health services discussed problems with access, cultural responsiveness and coordination. These themes will be discussed in more detail.

Health issues

Women’s Health

Women’s health was primarily discussed with respect to local problems with family planning, teenage pregnancies and antenatal care.

A number of health workers commented on low levels of family planning education among some Afghani women, including little understanding of sexual and reproductive health and a lack of awareness about contraception and termination options (54).

Greater Dandenong Community Health Service providers expressed concerns about high levels of teenage pregnancies in the refugee population (46). These concerns are supported by City of Greater Dandenong statistics which showed that the region had the third highest rate of teenage pregnancies in metropolitan Melbourne at twice the average. Social concerns, such as youth ‘boredom’, have been cited as reasons for this (55). Birth rates among 20–24 year old women in the region were also relatively high (CGD Council 2007 (55, 56). The Victorian Equal Opportunity and Human Rights Commission recommended more attention be given to youth pregnancy amongst local Sudanese refugees (56).

Providers of the Midwives in Partnerships program at the Dandenong hospital believe the antenatal service is well utilised by Afghan women. The program “provides 3-4 antenatal screening visits with a midwife prior to the birth and, where there are no complications, a ‘natural’ birth with midwives.” One provider reported this program to be agreeable to Afghani clients. Nevertheless providers reported difficulties where some Afghan women did not understand the value of antenatal screening appointments, which itself may have been compounded by their reported preference for home births (54). A further limitation included their “strong preference for female-only carers” (54).

Afghani men reported a need for their pregnant wives to be better informed about the antenatal services available to them. Other barriers included problems with access to after-hours interpreters for antenatal classes at Dandenong Hospital given that many Afghan parents “are unable to attend during business hours due to their husbands work commitments” (54).

The Greater Dandenong Refugee Health Nurse Program has raised concerns about the treatment of sexually transmissible infections in pregnant refugee women and a need for sexual health services for refugees (46).

Child health

We found two documents specifically related to the physical healthcare needs of local refugee children. An evaluation of the Greater Dandenong Refugee Health Nurse Program by LaTrobe University identified that incomplete immunisation was seen by the Refugee Health Nurse as a problem in the region (46). A regional submission to the National Primary Health Care Strategy outlined a need for more services for refugee children with developmental disability (45).
Mental health

Local refugee mental health literature illuminated a diverse range of topics related to the health of local refugees including stressors, diagnoses, access to services and community attitudes to mental illness.

Refugees encounter serious mental health issues from both pre-migration experiences as well as post-migrations difficulties. The South East Healthy Communities Partnership found that local service providers identified high levels of family breakdown in some of the newer communities such as the Sudanese. Difficulties were identified with maintaining social networks in the Afghan community resulting in social isolation, especially of women (25).

Local Afghani focus groups revealed high levels of depression and anxiety amongst Afghan women in the region (54). Asylum seekers using local services were found to have a significant burden of psychological issues (57).

These identified stressors and difficulties facing the refugee population are compounded by problems related to access to services. Refugee mental wellbeing counselling services such as Foundation House pointed out that the demand for mental health services working with refugees was greater than the resources available for service provision, resulting in long waiting lists that frustrated both the staff providers and clients (25, 54). Similarly a regional submission of health and settlement services to the National Primary Health Care Strategy development process in 2009 articulated a shortfall of specialised medical mental health services for refugees and the need for innovative service model development to address the gaps (45).

The cost of private mental health services was also identified as a problem. While some private counselling services were available, some clients were unable to access them because they could not afford the cost (25). Furthermore service providers articulated that the cost of private psychologist and psychiatrist services for Afghan women was prohibitive (54).

Other access problems were related to the broader community beliefs and the stigma associated with mental health problems. That is, there is a lack of readiness to acknowledge mental health issues and therefore a lack of ability to plan for suitable access to services providing mental health assistance. There is anecdotal evidence to suggest that without adequate community supports some refugees resort to alcohol use as a coping strategy (25).

Nutritional deficiencies

Apart from a local nutritional health needs assessment in 2009 recommending the need to address key nutritional priorities within refugee ethnic groups (58), no other documentary evidence was found relating to nutritional deficiencies in the local refugee population. The nutritional health needs assessment surmised that barriers to good nutritional intake were linked to contextual concerns such as mental illness, language and literacy issues, cultural values and beliefs and unemployment.

Access to services

Literature indicated that refugees experienced a number of difficulties accessing local health services.

Availability

While there were many health services available to assist refugees, broad provider consultation through the South East Healthy Communities Partnership suggested there were not enough qualified staff available in the region to fully service their needs (25). The Partnership and a regional submission to the National Primary Health Care Strategy both recommended supporting additional growth in capacity in health services to refugees (25, 45). A regional submission to the National Primary Health Care Strategy reform process in 2009 recommended extending the availability of settlement services for refugees beyond the first 6 months of arrival in order to assist with their ongoing health needs (45).
Furthermore a lack of refugee knowledge about what local health services were available and a limited understanding of the Australian health system were identified as barriers (25, 54, 56, 59).

**Accommodation**

When aware of what health services were available some local refugees were unfamiliar with how to make appointments correctly (22, 59) and some would fail to give advance notice of missing appointments (25).

Literature from beyond this region has highlighted a conflict between the day to day needs of refugee families and the potentially rigid systems of intake, assessment and care (60). Even with inclusive approaches to access, healthcare service seeking can conflict with other settlement priorities such as the search for suitable housing, attending school and finding employment (20, 22). Local literature has also highlighted the ‘gatekeeper’ role of some Afghan husbands concerning their wives’ access to maternity care (54).

**Accessibility**

Providers outlined difficulties refugees have with transport to and from services. This was a particular problem when refugees had to attend multiple appointments at different locations. Literature from beyond the region suggested a significant proportion of refugees lacked their own private transport and were dependent on public transport and the assistance of other people (22, 25).

**Affordability**

Some refugees found the cost of specialist doctor, allied health, private counselling, psychologist and psychiatrist services too expensive to access (25, 45, 54, 59). Because of this barrier some relied on hospital emergency department services to receive free medical attention (45).

The Victorian Government provides free and low cost services to Asylum Seekers using local public hospitals including: emergency ambulance transport, emergency department services, in-patient care, immunisation, pathology tests, diagnostic radiology and pharmaceuticals. This subsidy also extends to community health services, dental services, aides and equipment for people with permanent disability and emergency ambulance services (61).

**Cultural responsiveness of services**

In some cases, local health services were seen by providers and clients as being culturally insensitive or inappropriate to refugee needs (45, 54, 56, 59). Some local agencies felt inadequately prepared to work with or unable to provide specialised services for refugees and their needs (25, 56). Service providers identified a need for increasing the number of local providers with refugee health specific knowledge and skills (45), consistent with a similarly identified needs across Victoria (13, 22, 44).

**Use of interpreters**

Some local refugees felt that local doctors used interpreters inadequately or inappropriately at times (54, 56). Furthermore they raised concerns about the confidentiality of interpreter services (20, 25, 56).

Some local providers described slow response times in engaging interpreters. They felt the increased time needed to use an interpreter upset appointment schedules resulting in delays in for other patients (25, 59). GPs expressed concerns about the low quality of some interpreters, poor access to conference telephone facilities and a lack of financial incentive for culturally and linguistically sensitive GP practice (59). Providers noted occasional interpreter service unavailability particularly for languages relating to small or newly emerging communities (25). Providers expressed that their frustration with interpreter services would at times lead to professional interpreters not being used or being used only as a last resort (20, 59).
Translating health education materials

There appeared to be local difficulties in obtaining translated printed health information and educational materials, particularly for languages of newly established or smaller communities (45, 59). This was consistent with state-wide experiences (20).

Coordination of services

A number of service providers identified that problems with service coordination had led to providers losing track of refugees after referring them through the health system and to the duplication of service provision at times (25, 45).

A regional Primary Care Partnership consultative service coordination report produced by the South East Health Communities Partnership in 2010 identified the need for a more coordinated approach to the care of refugee clients. The report recommended improved intra and inter-agency information exchange through shared protocols. This was to address gaps in refugee client information transfer and to increase the awareness of and the clarity in understanding of agency roles (25).

Broader literature suggests a general need for community workers, bicultural workers, advocates and volunteers to assist refugees to negotiate through health systems (20, 22, 60).
DISCUSSION

Australia is an important site for the permanent resettlement of refugees. The south east metropolitan region of Melbourne, especially around the Cities of Greater Dandenong and Casey, resettles up to 8% of Australia’s 13,750 refugee and humanitarian migrants each year.

While other evaluations of refugee health needs have been conducted around the world, this is the first population level healthcare needs assessment with a focus on primary care. Other assessments have generally been limited to single ethnic groups (62), the analysis of attendees at specific health services (63), or the needs related to specific health conditions (18). Through reviewing regional demography, epidemiology and health service utilisation our investigation has revealed specific patterns of need and highlights important issues for service planning.

Refugees comprise 5% of the total population of the Greater Dandenong and Casey region. They represent many distinct ethnic subpopulations, are relatively young, and are more likely to be male than female. They present more frequently at and are more likely to be admitted to public hospitals than non-refugees. They have greater mental health and obstetric needs. Despite this hospital services do not appear numerically overwhelmed by this population.

There are a number of specialised and mainstream primary care services available for refugees in this region and some clearly defined pathways to care. While service utilisation is increasing, at times refugees experience difficulties accessing these services. It was also difficult to characterise the impact of the refugee population on general practice.

Distinct refugee subpopulations

Our study concentrated on refugees from the major source countries of the last 20 years. The large numbers of refugee arrivals in the last 5 years have reflected the conflicts in Afghanistan, Iraq, Sudan and Burma. In recent years large numbers of people from Sri Lanka have sought asylum in Australia. Other established refugee populations in the region reflect historical areas of conflict such as the republics of the Former Yugoslavia. The combination of international migration trends and local patterns of resettlement have resulted in the existence of unique, ethnic resident subpopulations in the region.

The Afghani population of 4,843 people is our largest, fastest growing, and most geographically dispersed group of refugees, requiring health services across the entire region to be responsive to their relatively young age and rapid numerical growth. Their relatively high use of public obstetric services across the region is likely to continue.

Refugee migration contributing to the growth of the Sudanese population of 2,412 people clustered around the City of Greater Dandenong has slowed dramatically, suggesting a reduced need for immediate, on-arrival health services for this population. Nevertheless their ongoing and relatively high use of specialist paediatric and adult physician services at the Dandenong Hospital Refugee Health Clinic suggests continuing specialised health needs. Their higher proportion of males (4 males to every 3 females) suggests consideration needs to be given to appropriate health services for Sudanese men.

The Burmese population of 600 people clustered around the northwest corner of Greater Dandenong (particularly in Springvale) continues to grow steadily, suggesting an ongoing and increasing need for health services for Burmese in that region. Their strikingly high use of community-based mental health services suggests a high need for mental health service provision to Burmese refugees.

Refugee and humanitarian migration from the republics of the Former Yugoslavia has almost ceased, suggesting the general health service needs of these 8,724 people may now be tending toward that of the Australian-born population. Nevertheless their higher rates of local public hospital presentation and admission for a number of conditions such as circulatory disease and cancer suggest they have some higher chronic disease needs compared to other refugee or Australian-born residents.
Furthermore there are many smaller and unique ethnic groups of refugees from countries such as Somalia, Ethiopia, Sierra Leone, Bhutan and others, each with their own special health service needs.

**Particular healthcare service needs**

Our study showed local refugees had higher public hospital needs and discrete patterns of greater morbidity, particularly concerning mental health conditions, obstetric complications and tuberculosis.

Our finding that the local refugee population was more likely to attend public emergency departments and be admitted to hospital than non-refugees differed from those of Correa-Velez et al (64). Their examination of the same data source from 1998 to 2004 found no significant difference in hospital admissions on the Victorian state level, though did suggest an increasing trend. International migrant literature cited by Correa-Velez et al suggested no increase in migrant hospital admission rates apart from those from the Middle East, West Africa and Central Africa during their first year in Canada. The increased rate of hospitalisation in our study may reflect our analysis of a more focussed refugee population. The increased use of emergency departments might relate to low familiarity with or difficulties accessing other types of primary care services such as general practice clinics.

The higher prevalence of serious mental health conditions seen in hospital (admission rate ratio 1.4) is consistent with wider literature describing this population’s past exposure to torture, trauma and resettlement stresses (14). The higher prevalence of psychosis, anxiety (including somatisation) and depression (emergency presentation risk ratios 2.1, 2.0 and 1.7) is also consistent with a cluster of symptoms recognised with post-traumatic stress disorder which has been associated with refugee populations (14). While specialised refugee health mental health services such as Foundation House address these issues, their waiting lists and the apparent lack of refugee-specialised psychologist and psychiatrist services beyond Foundation House raises concerns about the region’s capacity to fully address their mental health needs.

We were surprised by the higher rates of some obstetric-related complications, in particular foetal death in utero and stillbirths (risk ratios 2.0 and 2.0). This preliminary finding requires further statistical analysis adjusting for age and parity. In comparison, a study done at the Mater Mother’s Hospital in South Brisbane did not find any significant relationship between refugee status and adverse pregnancy outcomes (63). Further to this their relatively young age (93% arriving in Australia under the age of 45) and higher prevalence of female genital mutilation/circumcision (rate ratio 251) suggest specific service needs for refugee women in this region, including family planning and antenatal care.

The higher prevalence of active tuberculosis amongst refugees (emergency department presentation risk ratio 17.5) is not surprising given the known higher prevalence in refugee source countries and the very low overall prevalence in the Australian population (65). While specialist services such as the infectious diseases physicians at the Dandenong Hospital Refugee Health Clinic address this issue, the absolute number of cases diagnosed in the region is relatively low (79 cases over 5 ½ years). This data does however raise questions about the region’s ability to follow up refugees on a ‘Health Undertaking’ (those who have been diagnosed with Tuberculosis prior to arrival in Australia), and to screen for and manage latent (inactive) tuberculosis in the community.

While these health issues are of epidemiological concern in the local refugee population, the absolute numbers of refugees using local public hospital services (6% of emergency department presentations, 7% of hospital admissions and 13% of obstetric services) did not appear to overwhelm them purely from a numerical perspective.
Specialised and mainstream primary care services

Local health care services for refugees can be classified as: ‘specialised’ services established to meet the needs of refugees and ‘mainstream’ services available to all residents.

Refugee ‘specialised’ clinical primary care is delivered by three community-based refugee health nurses and by two infectious disease physicians and two paediatricians at the Dandenong Hospital Refugee Health Clinic, whose services overlap with the primary care domain. Mental health counselling and advocacy is provided by the Victorian Foundation for Survivors of Torture (Foundation House). This includes one psychiatrist whose work supports primary care.

‘Mainstream’ primary care is delivered to refugees predominantly by General Practitioners, Community Health Services and public emergency departments. Within these services a degree of specialisation has occurred, for example with sixteen General Practitioners providing refugee-specialised services within their general clinics. While there are a number of ‘specialised’ services it is clear these ‘mainstream’ services still have to service a large proportion of the refugee residents in the region.

Between these services a number of defined pathways to healthcare for refugees have developed. These are supported by settlement services particularly during the first 6 months of arrival and by a number of interpreter services. These pathways to healthcare have similarities to models in the United Kingdom (27). Full integration between ‘specialised’ and ‘mainstream’ services appears partly limited by a lack of knowledge of some mainstream services regarding some specialised services.

From this study it is unclear if the total primary care workforce is sufficient to service the specific health needs of the existing refugee population (19,149 people) and the additional settlers each year (1,155 per annum). Nevertheless the demonstrated increasing utilisation of General Practice, Community Health Service, community-based mental health and obstetric services by refugees shows a need to continually consider increasing the refugee responsiveness of primary care services in the region.

Difficulties with service access

While there are a number of refugee specific health, settlement and language services provided to refugees we identified a number of local studies which highlighted some problems with service access. These included poor health literacy, language, problems with using interpreters, variable cultural responsiveness of health services, conflicting family priorities, logistical difficulties attending appointments and affordability. With this limited information we found it difficult to determine the level to which each of these factors was a problem in each of the individual services. With access to primary care being a key factor in population health planning, further research into the reasons why refugees attend or do not attend particular health services in this region would be valuable.

Research measurement

While this study has revealed important insights into the primary healthcare needs of refugees and the need to adjust services to assist them, it was clear there still were many gaps in available data. Specifically there were difficulties collecting epidemiological and service utilisation data from General Practice clinics because they did not routinely collect information on the refugee status or country of birth of patients, with which to identify refugees.

Because of these gaps this description of the healthcare needs of refugees only represents one part of the larger, emerging picture. In particular the relationship between their higher hospital needs and their use of primary care services is presently unclear.
Research limitations

While our study has provided important insights into the health needs of refugees in the region, our methods had clear limitations.

As we initially chose to define a refugee as an individual who entered Australia on a refugee or other humanitarian visa, this excluded people from refugee backgrounds who had settled under different visa categories. Furthermore as we used client country of birth as a proxy where data sets did not record refugee visa status (in a similar way other studies (64)) our analysis included some people born in refugee source countries who themselves were not of refugee background, and it excluded some people of refugee background who were not born in recognised refugee source countries. Nevertheless we believe our study population was largely representative of the local refugee population because we were able to demonstrate that the countries of birth used correlated well with the Australian refugee and humanitarian visa categories.

Furthermore we acknowledge the existence of differing views regarding how long a refugee should be in Australia for before they ceased to be referred to as a refugee. While we concentrated on people from the main refugee source countries of the last 5 years this excluded some much older communities of refugees such as the Cambodians and the Vietnamese who might have ongoing health needs related to their past experiences.

At this time we have been unable to perform an extensive, secondary analysis of the hospital epidemiological and utilisation findings. Further statistical analysis would be useful particularly in determining the influence of age, gender and parity on presentation, admission, diagnosis and complication rates. Notwithstanding this we believe the true burden of hospital epidemiology is actually likely to be higher than demonstrated because the data analysed represents only the primary ‘separation’ diagnoses and does not include any secondary or additional diagnoses given to patients.

While focussing on primary care, we were limited in analysing the utilisation of broader services such as: oral health, private allied health, pharmacies, council immunisation, and maternal and child health services. Limitations also meant we could not analyse the use of language services including interpreters and the provision of translated health information. We were unable to assess broader influences on health such as: health literacy, health risk behaviour and social determinants of health.
RECOMMENDATIONS

This healthcare needs assessment has collated and analysed core existing data regarding the primary healthcare needs of refugees in south east metropolitan Melbourne. While it only provides a snapshot of their overall health and wellbeing needs it has revealed several priorities for Refugee Health Research Consortium members to consider.

The following recommendations relate to the need to develop health services, the need to improve health service data collection and the need to perform further research where there are gaps in knowledge.

Health service development

Our findings suggest that health service policy makers need to optimise the responsiveness of local primary healthcare services to people from refugee backgrounds. This need is likely to increase with the evolving demographic profile of the refugee community and their increasing utilisation of services over time. Policies should be especially mindful of the fast growing Afghani population. More specific recommendations are:

1.1 Urgently review the capacity of refugee-specific, community-based, counsellor-advocate, psychologist and psychiatrist services.
1.2 Review the regional provision of sexual and reproductive health services to refugees, including family planning and maternal care.
1.3 Review the regional effectiveness of community-based strategies for the screening and management of tuberculosis.

Routine data collection

Our study came up against barriers associated with difficulties in identifying refugees in healthcare data sets. Better ways need to be developed to identify refugee status at point of contact with healthcare services. In particular, doing this in general practice would allow for better analysis of ethno-specific population, epidemiology and utilisation issues. Expanding this to include all Victorian Department of Health notifiable disease conditions would allow for a greater level of monitoring of infectious diseases amongst local refugee subpopulations.

2.1 Improve the completeness of routine health service ‘country of birth’ data collection to assist in the extraction and analysis of data related to refugee subpopulations.

Research

The needs assessment has identified some fertile grounds for further research. Despite some of the limitations in data, routinely collected hospital data sets have the potential to reveal much about the epidemiology and health service utilisation of the refugee community. Filling gaps in primary care knowledge would complement the hospital findings and would assist in understanding the relationship between the burden of disease and different service utilisation patterns across regional health services. While little is known about how refugees conceptualise, seek and access health services in this region, a deeper understanding of the reasons for refugees choosing between these services would help to inform interventions for appropriate service delivery.

3.1 Conduct a more comprehensive analysis of Southern Health hospital data on the comparative utilisation of services by people from refugee source countries.
3.2 Perform a closer examination of primary care performance for refugees by conducting a more detailed examination of the impact of Ambulatory Care Sensitive Conditions on local public hospitals.

3.3 Increase the capacity in using routinely collected general practice data to understand the characteristics of primary care delivered to refugee populations.

3.4 Use qualitative methods to examine the refugee client experience of using particular local primary healthcare services, including barriers to access and reasons for utilisation.

3.5 Perform a separate study on the use of interpreters by local primary healthcare services to establish utilisation patterns, an understanding of the barriers and enablers to use and an estimation of the required regional capacity of this essential service.
Source: South East Healthy Communities Partnership: Refugee Health Service Coordination Project (25)

SEHCP is a primary care partnership made up of 30 health and community services operating within City of Greater Dandenong, City of Casey and Shire of Cardinia
Appendix 1.2 – Collaborations in refugee health

Source: DCGPA (66)
Appendix 2  Study population

Appendix 2.1 – Refugee and Humanitarian visa categories of interest

<table>
<thead>
<tr>
<th>Visa number</th>
<th>Visa Category</th>
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<td>Refugee</td>
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<tr>
<td>201</td>
<td>In country granting of refugee status (by Minister only)</td>
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<tr>
<td>202</td>
<td>Special Humanitarian Program (SHP)</td>
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<tr>
<td>203</td>
<td>Emergency rescue</td>
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<tr>
<td>204</td>
<td>Women at risk program</td>
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<tr>
<td>866</td>
<td>Asylum seekers who are subsequently found to be eligible for refugee status</td>
</tr>
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</table>

Source: DIAC

Appendix 2.2 – Proportion of Refugee and Humanitarian visa entrants by country of birth
(2nd January 1991 to 30th June 2010)

Source: DIAC Settlement Database

Appendix 2.3 - Countries of birth of interest

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<td>Europe (Former Yugoslavia)</td>
<td>Bosnia and Herzegovina, Croatia, Former Yugoslav Republic of Macedonia, Montenegro, Serbia (including Kosovo), Slovenia</td>
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<td>Burma</td>
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### Appendix 2.4 - Local Government Areas of interest

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Sources: City of Greater Dandenong; City of Casey
## Appendix 3 Datasets

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<td>Regional Manager AMES Settlement 60 Douglas St, Noble Park 3174 <a href="http://www.ames.net.au/settlement">www.ames.net.au/settlement</a></td>
</tr>
<tr>
<td>City of Greater Dandenong</td>
<td>City of Greater Dandenong</td>
<td>Demography</td>
<td>PO Box 200 Dandenong 3175 <a href="http://www.greaterdandenong.com">http://www.greaterdandenong.com</a></td>
</tr>
<tr>
<td>Victorian Government, Department of Health</td>
<td>Victorian Admitted Episodes Database</td>
<td>Public hospital admissions</td>
<td>Manager Integrated Care The Hub Arcade-Business Centre Level 2, 26 McCrae Street Dandenong 3175 Also available from: Manager Clinical Information Management Southern Health 246 Clayton Rd, Clayton</td>
</tr>
<tr>
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<td>Public hospital emergency department presentations</td>
<td>Also available from: Manager Clinical Information Management Southern Health 246 Clayton Rd, Clayton</td>
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<td></td>
<td>Communicable Disease Prevention and Control Unit</td>
<td>Communicable disease notifications</td>
<td>Communicable Disease Prevention and Control Unit Department of Health GPO Box 4057 Melbourne Victoria 3000</td>
</tr>
<tr>
<td>Service Provider</td>
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<td>Access Details</td>
<td>Manager</td>
</tr>
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<td>-------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Victorian Department of Human Services</td>
<td>Access to specialist services report</td>
<td>Access</td>
<td>Manager Strategic Projects Social and Community Strategy Unit 122 Thomas St, Dandenong 3175</td>
</tr>
<tr>
<td>Refugee Minor Program</td>
<td>Refugee Minor Program</td>
<td>Access</td>
<td>Manager Strategic Projects Social and Community Strategy Unit 122 Thomas St, Dandenong 3175</td>
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<tr>
<td>Southern Health</td>
<td>Ambulatory Care Services</td>
<td>Access</td>
<td>Director 239 Clayton Rd Clayton</td>
</tr>
<tr>
<td>Birth Outcomes Systems</td>
<td>Maternity services data</td>
<td>Access</td>
<td>Head Maternity Services Women’s Health IT Manager</td>
</tr>
<tr>
<td>SWITCH</td>
<td>Greater Dandenong Community Health Services</td>
<td>Access</td>
<td>Information Systems Coordinator Greater Dandenong CHS 55 Buckingham Avenue Springvale 3171</td>
</tr>
<tr>
<td></td>
<td>Cardinia Casey Community Health Services</td>
<td>Access</td>
<td>Information Systems Coordinator Cardinia-Casey Community Health Service Locked Bag 2500 Cranbourne VIC 3977</td>
</tr>
<tr>
<td></td>
<td>Refugee Health Nurse Program</td>
<td>Access</td>
<td>Refugee Health Nurse Greater Dandenong CHC 55 Buckingham Avenue Springvale 3171</td>
</tr>
<tr>
<td>Refugee Health Service</td>
<td>Refugee Health Clinic</td>
<td>Access</td>
<td>Head Refugee Health Service Dandenong Hospital</td>
</tr>
<tr>
<td>Clinical Information Management</td>
<td>Hospital outpatient data</td>
<td>Access</td>
<td>Director Ambulatory Care Services 239 Clayton Rd Clayton 3168</td>
</tr>
<tr>
<td>Citrix</td>
<td>Oral Health</td>
<td>Access</td>
<td>Manager Oral Health</td>
</tr>
<tr>
<td>Primary Mental Health Service</td>
<td>Primary Mental Health Services</td>
<td>Access</td>
<td>Manager Primary Mental Health Team</td>
</tr>
<tr>
<td>South East Alcohol and Drug Services</td>
<td>South East Alcohol and Drug Services</td>
<td>Access</td>
<td>Director Community Access Partnerships (SEADS &amp; PMH) 229 Thomas St Dandenong</td>
</tr>
<tr>
<td>Southern Health interpreting department</td>
<td>Interpreters</td>
<td>Access</td>
<td>Dandenong Hospital David Street Dandenong 3175</td>
</tr>
<tr>
<td>Organization</td>
<td>Program/Division</td>
<td>Data Type</td>
<td>Contact Information</td>
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<td>------------------------------------------------------------------------------</td>
<td>-----------------------------------------</td>
<td>--------------------</td>
<td>-------------------------------------------------------------------------------------</td>
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</tbody>
</table>
| Dandenong Casey General Practice Association                                 | Refugee Health Program                  | GP Data            | Refugee Health Program Coordinator  
314B Thomas Street  
Dandenong 3175  
http://www.dcgpa.com.au                                                   |
| Victorian Foundation for the Survivors of Torture and Trauma (Foundation House) | Foundation House                        | Foundation House data | Research and Policy Manager  
Foundation House Brunswick  
6 Gardiner St, Brunswick 3056  
Manager  
Foundation House Dandenong  
155 Foster St  
Dandenong 3175  
http://www.foundationhouse.org.au                                    |
| Eastern Region Mental Health Association                                     | Origins Program                         | Origins Program    | 67 Robinson Street  
Dandenong 3175  
http://www.ermha.org/                                                     |
| South East Health Communities Partnership                                    | Refugee Health Coordination Project Report | Service coordination | Executive Officer  
Level 2/15 Scott Street  
Dandenong 3175                                                        |

An evaluation of the primary healthcare needs of refugees in south east metropolitan Melbourne
## Appendix 4  Local refugee population

### Appendix 4.1 – Estimated refugee population, Cities of Greater Dandenong and Casey

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CGD</td>
<td>CC</td>
<td>CGD</td>
</tr>
<tr>
<td>Republics of the Former Yugoslavia:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bosnia and Herzegovina</td>
<td>2046</td>
<td>951</td>
<td>10</td>
</tr>
<tr>
<td>Croatia</td>
<td>1275</td>
<td>1285</td>
<td>3</td>
</tr>
<tr>
<td>Macedonia (FYRM)</td>
<td>1047</td>
<td>381</td>
<td>19</td>
</tr>
<tr>
<td>Serbia</td>
<td>847</td>
<td>650</td>
<td>1</td>
</tr>
<tr>
<td>Slovenia</td>
<td>85</td>
<td>91</td>
<td>0</td>
</tr>
<tr>
<td>Montenegro</td>
<td>24</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Kosovo</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Subtotal</td>
<td>5324</td>
<td>3358</td>
<td>42</td>
</tr>
<tr>
<td>Other (non-Former Yugoslavia):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Afghanistan</td>
<td>1681</td>
<td>1711</td>
<td>855</td>
</tr>
<tr>
<td>Sudan</td>
<td>1656</td>
<td>439</td>
<td>256</td>
</tr>
<tr>
<td>Other Africa</td>
<td>785</td>
<td>327</td>
<td>281</td>
</tr>
<tr>
<td>Iraq</td>
<td>238</td>
<td>272</td>
<td>186</td>
</tr>
<tr>
<td>Burma</td>
<td>193</td>
<td>54</td>
<td>343</td>
</tr>
<tr>
<td>Iran</td>
<td>145</td>
<td>142</td>
<td>74</td>
</tr>
<tr>
<td>Subtotal</td>
<td>4698</td>
<td>2945</td>
<td>1995</td>
</tr>
<tr>
<td>Total refugee and humanitarian</td>
<td>10022</td>
<td>6303</td>
<td>2037</td>
</tr>
</tbody>
</table>

CGD = City of Greater Dandenong  
CC = City of Casey
Appendix 4.2 – Residential distribution by country of birth

Residents Born in Afghanistan
Residents born in Afghanistan as a percentage of all Residents (Source: Census, 2006)
Residents Born in Sudan
Residents born in Sudan as a percentage of all Residents (Source: Census, 2006)
An evaluation of the primary healthcare needs of refugees in south east metropolitan Melbourne
Appendix 4.5 - Age and gender of refugee arrivals to the Cities of Greater Dandenong and Casey by country of birth (1st January 2005 to 30th June 2010)

Afghani

Source: DIAC Settlement Database

Sudanese

Source: DIAC Settlement Database

Burmese

Source: DIAC Settlement Database
### Appendix 5  Local services and programs

#### Appendix 5.1 – Services and programs by type

**Health Services and Programs**

<table>
<thead>
<tr>
<th>Service/ Program</th>
<th>Organisation</th>
<th>Role</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practice</td>
<td>General Practice clinics</td>
<td>Primary continuing comprehensive whole-patient assessment, medical care and referral.</td>
<td>255 GPs. 16 GPs with demonstrated, comprehensive refugee health assessment skills.</td>
</tr>
<tr>
<td>Refugee Health Program</td>
<td>Dandenong Casey General Practice Association</td>
<td>Facilitates refugee access to GP services and assists General Practice to provide quality care to refugees</td>
<td>1 coordinator (0.2 EFT)</td>
</tr>
<tr>
<td>Refugee Health Nurse Program</td>
<td>Greater Dandenong Community Health Services, Southern Health</td>
<td>Nursing assessment, health education, management and referral. Social model of health, Maternal and Child Health, Immunisation, MY Health Clinic, case coordination, outreach.</td>
<td>2 nurses (2.0 EFT)</td>
</tr>
<tr>
<td></td>
<td>Cardinia Casey Community Health Service, Southern Health</td>
<td>Health screening, case coordination, referral.</td>
<td>1 nurse (0.5 EFT)</td>
</tr>
<tr>
<td>Dandenong Hospital Refugee Health Service</td>
<td>Dandenong Hospital, Southern Health</td>
<td>Specialist assessment, management, referral for refugees; General Practice services for Asylum Seekers</td>
<td>2 Infectious Disease Physicians, 2 Paediatricians, 1 GPs (0.1 EFT), 1 Dietitian, 1 Community support worker, Refugee Health Nurses involved. Weekly clinic.</td>
</tr>
</tbody>
</table>

**Mental Health Services and Programs**

<table>
<thead>
<tr>
<th>Service/ Program</th>
<th>Organisation</th>
<th>Role</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundation House</td>
<td>Southeast region offices in Dandenong and Ringwood. Early intervention program and Generalist program</td>
<td>Assist with mental health problems related to torture or war trauma through: counselling, psychiatric assessment, medication reviews, complementary</td>
<td>11 Counsellor-advocates, 2 natural therapists (1.2 EFT), 1 Psychiatrist (1d/month), 2 Afghan and 1 Chin (Burmese) community liaison workers (2.6</td>
</tr>
</tbody>
</table>
An evaluation of the primary healthcare needs of refugees in south east metropolitan Melbourne

<table>
<thead>
<tr>
<th>Program</th>
<th>Organisation</th>
<th>Role</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Origins Program</td>
<td>Eastern Region Mental Health Association (Dandenong)</td>
<td>Individual and group support for CALD clients with psychiatric illness, liaising with mainstream mental health services.</td>
<td>4 community mental health workers</td>
</tr>
<tr>
<td>Southern Health</td>
<td>Primary Mental Health Services</td>
<td>Secondary mental health consultation (Appendix 5.4).</td>
<td>2 psychiatrists, 3 psychologists, 1 nurse.</td>
</tr>
</tbody>
</table>

**Women’s and children’s health services and Programs**

<table>
<thead>
<tr>
<th>Service/ Program</th>
<th>Organisation</th>
<th>Role</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refugee Minor Program</td>
<td>Victorian Department of Human Services (Southern Metropolitan region, Dandenong office)</td>
<td>Assists unaccompanied children and youth up to 18 years of age to settle in Australia</td>
<td>Case-workers</td>
</tr>
<tr>
<td>Family And Reproductive Rights Education Program (FARREP)</td>
<td>Greater Dandenong Community Health Service (Springvale and Dandenong), Southern Health; Victorian Department of Human Services</td>
<td>Works with communities that practice female genital mutilation (FGM) to prevent its occurrence, increases access to sexual and reproductive health services, and builds the capacity of health services to deal with FGM.</td>
<td>4 workers (1.6 EFT)</td>
</tr>
<tr>
<td>Maternal and Child Health Nurse and Expanded Maternal and Child Health Nurse programs</td>
<td>City of Greater Dandenong, City of Casey</td>
<td>Maternal wellbeing, child development, immunisation</td>
<td>Maternal and Child Health Nurses</td>
</tr>
<tr>
<td>Council immunisation</td>
<td>City of Greater Dandenong, City of Casey</td>
<td>Immunisation</td>
<td>Nurse immunisers</td>
</tr>
<tr>
<td>Healthy Mothers, Healthy Babies Program</td>
<td>Greater Dandenong Community Health Service, Cardinia Casey Community Health Service; Southern Health</td>
<td>Assists with improving access and attendance at antenatal, post-natal and related support services for women requiring additional support. Delivers health promotion messages.</td>
<td>Program workers</td>
</tr>
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</table>
### Dental services and Programs

<table>
<thead>
<tr>
<th>Service/ Program</th>
<th>Organisation</th>
<th>Role</th>
<th>Capacity</th>
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</thead>
<tbody>
<tr>
<td>Refugee Dental Program</td>
<td>Oral Health Services, Southern Health (Springvale, Dandenong, Cranbourne, Doveton, Berwick)</td>
<td>Emergency and priority general dental care for newly arrived refugees.</td>
<td>Refugee priority dental care 2 mornings per week at Dandenong site.</td>
</tr>
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</table>

### Settlement services and Programs

<table>
<thead>
<tr>
<th>Service/ Program</th>
<th>Organisation</th>
<th>Role</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humanitarian Settlement Strategy</td>
<td>Department of Immigration and Citizenship. Consortium of AMES Settlement (based in Noble Park), SCAAB, Redback settlement services, Foundation House.</td>
<td>Settlement coordination. Referral to health services</td>
<td>Case Coordinators (11 EFT), up to 60 casual bi-lingual community guides, 1 volunteer coordinator, 30 volunteers.</td>
</tr>
<tr>
<td>South Eastern Region Migrant Resource Centre (SERMRC)</td>
<td>Dandenong and Narre Warren offices</td>
<td>Settlement services to refugees within 5 years of arrival. Developing capacity of mainstream agencies.</td>
<td>Managers, team leaders, staff, volunteers.</td>
</tr>
<tr>
<td>Refugee Minor Program</td>
<td>Department of Human Services</td>
<td>Intensive case management services to humanitarian entrants with exceptional needs</td>
<td>2 managers, 4 team leaders and 17 case management staff for Victoria.</td>
</tr>
<tr>
<td>Complex Case Support</td>
<td>Administered by DIAC and provided by local organisations</td>
<td>Intensive case management services to humanitarian entrants with exceptional needs</td>
<td>Variable according to need</td>
</tr>
</tbody>
</table>

### Interpreting services

<table>
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<tr>
<th>Service/ Program</th>
<th>Organisation</th>
<th>Role</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Translating and Interpreting (TIS) National</td>
<td>Department of Immigration and Citizenship</td>
<td>Telephone and on-site interpreting services for private medical practitioners and pharmacies.</td>
<td>Over 1750 interpreters for more than 170 languages and dialects.</td>
</tr>
<tr>
<td>Southern Health Interpreter Department</td>
<td>Southern Health</td>
<td>Telephone and on-site interpreting services for Southern Health services</td>
<td>38,385 occasions of service in 2008/09.</td>
</tr>
<tr>
<td>Department of Human Services and Department of Health Language Services Credit Line</td>
<td>Victorian Department of Human Services and Department of Health contracting ONCALL</td>
<td>Telephone and on-site interpreting services for Departments of Health and Human Services funded services</td>
<td>Over 5500 interpreters and translators in all languages</td>
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</table>
### Research

<table>
<thead>
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<th>Service/ Program</th>
<th>Organisation</th>
<th>Role</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refugee Health Research Consortium</td>
<td>Consortium of Monash University, Southern Health, Southern Synergy, Dandenong Casey General Practice Association, Foundation House, AMES Settlement, Victorian Department of Health, Victorian Department of Human Services. Research expertise provided by the Southern Academic Primary Care Research Unit (SAPCRU)</td>
<td>Improve the health of refugees in southeast metropolitan Melbourne through research, knowledge transfer and exchange.</td>
<td>Organisational capacities</td>
</tr>
</tbody>
</table>

### Appendix 5.2 - Family And Reproductive Rights Education Program (FARREP)

FARREP aims to work with communities that are affected by the traditional cultural practice of FGM (female genital mutilation or circumcision). Communities that are affected by FGM are groups from a number of African countries (including Sudan) and certain ethnic groups from Asia and the Arabian peninsula.

There are four part-time FARREP workers at the Greater Dandenong Community Health Service; two at Dandenong and two at Springvale. Total EFT is 1.6. Family Planning Victoria is developing a State-wide plan to develop health promotion through this program.

### Appendix 5.3 - Healthy Mothers, Healthy Babies Program

The Healthy Mothers, Healthy Babies Program improves access to appropriate services, provides support during pregnancy and delivers key health promotion messages for pregnant women in greatest need. It complements existing services by: linking women into clinical services earlier, providing additional community based support that is beyond the capacity of current services, and promoting a continuum of care for the woman through strong collaboration with Maternity and Maternal and Child Health Services. While it supports women who are pregnant it does not manage the pregnancy.

The Program targets women who are not able to access antenatal care services or require additional support because of their socioeconomic status, culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander descent, age or residential distance to services. Many of these women will have complex health, welfare, and social needs.

Women can access the program through outreach from community health services or referral from General Practitioners, maternity services, Child Protection Services, Maternal and Child Health Nurses and other local services, such as Drug and Alcohol Services, Mental Health Services. Language services are utilised (67).
Appendix 5.4 - Primary Mental Health Service - Southern Health

The Primary Mental Health Team (PMHT) is a consultation liaison team with offices in Dandenong. Referrals are received from a number of sources including general practitioners, community health workers, youth workers, personal helpers and mentors. The role of the team is to provide secondary assessment for patients with mental health problems. Following the referral, a staff member from the team meets with the patient at the general practice, community health centre or other venue where the patient is normally seen. The referring practitioner may be present during the assessment and interpreters are available if required. The PMHT then advises the referring practitioner on treatment options. On occasion short term direct care is given by the PMHT. The team is also available for secondary consultations if a clinician wishes to discuss his or her patient’s condition by telephone. The PMHT’s role is also to build mental health skills and capacity and to this end education and training is carried out for both health workers and patients/clients.
REFERENCES

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