Health (and systems) issues in refugee and immigrant children

Georgie Paxton
February 2019
Health examinations

You might be required to undergo health examinations as part of the visa application process. A report containing the results of these examinations will then be assessed to determine if you meet the health requirement.

**Important:** In addition to the standard health examination requirements explained below, additional health examinations can also be requested for applicants in certain countries where considered necessary to address public health and safety risks. For example, to help prevent the spread of Polio or Ebola Virus Disease (EVD) infection. For more information see: Threats to public health.

**Permanent and provisional visa applicants**

All applicants for permanent and provisional visas including the main applicant, spouse and any members of the family unit must be assessed against the health requirement. In addition, in certain circumstances, family members who are not applying for the visa (non-migrating family members) will be assessed against the health requirement.
Pre-departure health screen (offshore)

**Immigration Medical Exam - all**
- Compulsory, 3-12 months prior to travel
  - History/exam
  - Tuberculosis screen 2-10 years
  - CXR ≥ 11 years
  - HIV ≥ 15 years
  - FWTU ≥ 5 years
  - HBsAg (pregnant/URM/health workers)
  - HCV (health workers)
  - Syphilis (humanitarian)

**Outcomes**
- +/- Visa grant (+/- waiver)
- Alert - red/general
- Health undertaking +/- delay travel

**Australia**
- Health undertaking follow-up
- Post arrival health screening **Voluntary**

**Departure health check - refugee/SHP**
- Voluntary – 3 days prior to travel
  - Exam, parasite check
  - Malaria RDT and Rx if positive (location)
  - CXR and HIV if prior TB
  - Albendazole ≥ 1 y
  - MMR 9m – 54y
  - +/- Yellow fever vaccine, Polio vaccine
  - Assess local conditions
  - +/- Repeat IME

**Outcomes**
- Fitness to fly assessment
- Alert – red/general
- +/- Health undertaking

**Character requirement**

**AUSCO**

Australian Panel Member Instructions - Immigration Medical Examinations July 2018
Pre-departure health screen (offshore)

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- MMR 9m – 54y
- +/- Yellow fever vaccine, Polio vaccine
- Assess local conditions
- +/- Repeat IME

**Syrian and Iraqi cohorts (2015)**
Combined IME and DHC
Compulsory, ~1-2m prior to travel
- History/exam
- Tuberculosis screen 2-10 years
  - CXR ≥ 11 years
  - HIV ≥ 15 years
  - HBsAg
  - FWTU ≥ 5 years
  - Albendazole
- Full 1st dose catch-up immunisations
- Mental health screen
- Development screen (<5 years)

**Outcomes**
+/- Visa grant (+/- waiver)
Alert – red/general
Health undertaking +/- delay travel
Australia
Health undertaking follow-up
Post arrival health screening Voluntary

**Outcomes**
+/- Visa grant (+/- waiver)
Alert – red/general
Health undertaking +/- delay travel
Australia committed to refugees most in need

Wednesday, 09 May 2012

The Gillard Government will continue its commitment to providing refuge for the world’s most vulnerable people by again designating 13,750 places under the humanitarian program in 2012–13.

‘Australia resettles the third largest number of refugees of any country, and we resettle more refugees, per capita, than any other nation. Australians should be proud of the part we play in providing protection to refugees,’ Mr Bowen said.

The humanitarian program is for offshore refugees referred by the United Nations High Commissioner for Refugees; people in Australia seeking protection and found to be refugees; and for those in need with links to Australia through the special humanitarian program.

‘Under the 2012–13 program, our main resettlement focus will continue to be on refugees from the three key regions of Africa, Asia and the Middle East,’ Mr Bowen said.

Mr Bowen also announced the streamlining of health waiver provisions for offshore humanitarian applicants in response to a recommendation in the Joint Standing Committee on Migration report, Enabling Australia: Inquiry into the Migration Treatment of Disability.

‘Streamlining the health waiver provision means that offshore humanitarian applicants who do not meet the health requirement on cost grounds are more likely to have a visa granted,’ Mr Bowen said.

‘This change brings requirements for offshore applicants into line with those for applicants under the onshore protection program. However, the change does not alter policies relating to health conditions that are a public health risk, or would require health care or community services that would prejudice the access of Australian residents.’

‘In the coming months, we will be seeking input from peak refugee bodies, non-government organisations and other relevant community stakeholders on the feasibility of such a program.’
Frequently Asked Questions: Health Assessment Portal (HAP) for Refugee Clinics and General Practitioners (GPs)

Background

What is HAPlite?
HAPlite is a reduced version of the Department of Home Affairs (Home Affairs) health processing system called the Health Assessment Portal (HAP) that is accessible via the internet.

What is the Health Assessment Portal (HAP)?
The HAP is a system used by Home Affairs and its migration medical service provider, Bupa Medical Visa Services, to process immigration health examinations and assessments.

What will Refugee Clinics or GPs use HAPlite for?
Refugee clinics or GPs will have access to HAPlite to view client information, view and download health records including reports and x-ray image files.

Which client cohorts are included in these arrangements?
These arrangements are for clients who are referred to you by Humanitarian Settlement Program (HSP) Service Providers who deliver settlement services on behalf of the Department of Social Services (DSS). The full health records for these clients will be available in HAPlite for you to access (except where residual paper health examination reports exist).

Getting ready for HAPlite implementation

What are the minimum technical requirements for HAPlite?
A computer that is connected to the internet with a current browser (i.e. Internet explorer 11, Chrome, Firefox or Safari).
Diagnosis, management and prevention of infections in recently arrived refugees

Australasian Society for Infectious Diseases

https://www.asid.net.au/documents/item/1225
### Baseline
- FBE and film
- Ferritin
- Hepatitis B - HBsAg, HBsAb, HBcAb
- Strongyloides serology
- Tuberculosis screening (TST ≤5 years, TST/IGRA older children)
- Faecal OCP (ideally fixed) varies pre-arrival albendazole

### Risk-based
- Vitamin B12
- Vitamin D, Ca, PO4, ALP
- Varicella
- Rubella
- STI screen – syphilis, gonorrhea, chlamydia
- HIV
- Helicobacter pylori
- (Other)

### Country-based
- Schistosoma
- Malaria
- Hepatitis C

<table>
<thead>
<tr>
<th>All</th>
<th>FBE</th>
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<tbody>
<tr>
<td></td>
<td>HBsAg, HBsAb, HBcAb. Write: ‘Query chronic hepatitis B?’</td>
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<tr>
<td></td>
<td>Strongyloides serology</td>
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<tr>
<td></td>
<td>HIV serology (≥15 years or unaccompanied minor)</td>
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<tr>
<td></td>
<td>TST or IGRA (depends on risk factors and local jurisdiction, check Medicare for IGRA rebates, TST preferred for children &lt;5 years)</td>
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<tr>
<td></td>
<td>Varicella serology (≥14 years if no known history of disease)</td>
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<td></td>
<td>Visual acuity and review for glaucoma in Africans ≥40 years and others ≥50 years</td>
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<td></td>
<td>Dental review</td>
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<td></td>
<td>Hearing review</td>
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<td></td>
<td>Social and emotional wellbeing/mental health</td>
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<td>Disability</td>
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<td></td>
<td>Developmental delay or learning concerns (children and adolescents)</td>
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<td></td>
<td>Preventive health as per RACGP, consider screening earlier for NCDs</td>
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<tr>
<td></td>
<td>Catch-up immunisations</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Risk-based</th>
<th>Rubella serology (women childbearing age)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ferritin (women and children, men where risk factors present)</td>
</tr>
<tr>
<td></td>
<td>Vitamin D (write risk factors e.g. dark skin, lack of sun exposure). Also check Ca, PO4, and ALP in children.</td>
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<tr>
<td></td>
<td>Vitamin B12 (arrival ≤6 months, food insecurity, vegan, from: Bhutan, Afghanistan, Iran, Horn of Africa)</td>
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<tr>
<td></td>
<td>NAAT first pass urine or self-obtained low vaginal swabs for gonorrhoea or chlamydia (risk of STIs)</td>
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<tr>
<td></td>
<td>Syphilis serology (risk of STIs, unaccompanied minor)</td>
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<td></td>
<td>Helicobacter pylori stool antigen or breath test (gastric cancer family history, upper GI symptoms)</td>
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<td></td>
<td>Stool microscopy (OCP) (no pre-departure albendazole or persisting eosinophilia after albendazole treatment)</td>
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<table>
<thead>
<tr>
<th>Country-based</th>
<th>Schistosoma</th>
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<tbody>
<tr>
<td></td>
<td>Malaria thick and thin films and RDT</td>
</tr>
<tr>
<td></td>
<td>Hepatitis C Ab (also screen if risk factors)</td>
</tr>
</tbody>
</table>
Table 1.4: Top 20 countries of origin for refugees and asylum seekers\textsuperscript{22,26}, and country-specific recommendations for malaria, schistosomiasis and hepatitis C screening\textsuperscript{a}

<table>
<thead>
<tr>
<th>Country of birth</th>
<th>Malaria\textsuperscript{27}</th>
<th>Schistosomiasis\textsuperscript{28}</th>
<th>Hepatitis C\textsuperscript{29}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Bangladesh</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Bhutan</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Burma</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>China</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Congo</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Egypt</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Eritrea</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>India</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Iran</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Iraq</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Lebanon</td>
<td>No</td>
<td>No</td>
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<td>Pakistan</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Somalia</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Sri Lanka</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Stateless*</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Sudan</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Syria</td>
<td>No</td>
<td>Yes</td>
<td>Consider</td>
</tr>
<tr>
<td>Vietnam</td>
<td>No</td>
<td>No</td>
<td>No</td>
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\textsuperscript{a} There are regional variations in the prevalence of these conditions within some countries. We have taken the conservative approach of recommending screening for all people from an endemic country rather than basing the recommendation on exact place of residence.

\textsuperscript{*} 'Stateless' in this table refers to people of Rohingya origin.

Malaria link: http://www.who.int/ith/en/
and: http://apps.who.int/neglected_diseases/ntddata/sch/sch.html


https://www.asid.net.au/documents/item/1225
Prevalence (Australian data)

Anaemia
Iron deficiency
Low Vitamin D
Low Vitamin A
Low Vitamin B12
Hepatitis B
Hepatitis C
HIV
Schistosoma
Strongyloides
Malaria
Faecal parasites
Mantoux test +
STIs
Syphilis
Helicobacter pylori
Inadequate immunisation

- 7 – 30% all groups, 23 – 39% < 5 years
- 13 – 30%
- 60 - 90% African, 33 - 37% Karen
- 20 - 40% African children, occasional Syrian/Iraqi
- 16 – 18% Afghan, Iran, Bhutan
- sAg 0 – 21%, sAb 26 – 60% *(changed with vaccination source countries)*
- 1 - 4%
- < 1%
- 5 – 38% African and South Asian
- 0 – 21% higher South Asian
- 4 – 10% African - prior to DHC, still get cases
- 11 – 42% all groups, higher children
- 10 – 53%
- 0% gonorrhoea, 0 – 6% chlamydia
- 0 – 8% adults, 0% children
- 82% African children
- 100%

https://www.asid.net.au/documents/item/1225
Initial assessment

Health issues

Refugee or asylum seeker children and adolescents will have typical paediatric health problems, and may also have health issues specific to their background or forced migration experience. Common paediatric problems, e.g. iron deficiency anaemia, may have a more complicated aetiology in refugee children. All refugees and asylum seekers should have a full health assessment after arrival in Australia, ideally within one month of arrival.

Assessment of newly arrived refugee or asylum seeker children and adolescents should focus on:

- Parent (or self-identified) concerns
- Excluding acute illness
- Immunisation status and catch-up immunisation
- Tuberculosis screening
- Other infections, including hepatitis, parasites and malaria (depending on areas of origin and transit)
- Nutritional status and growth (including micronutrient and vitamin deficiencies)
- Oral health issues
- Concerns about development, disability, vision, or hearing, previous educational experience
- Mental health issues and trauma exposure
- Previous severe/chronic childhood illness or physical trauma
- Confirming the child’s reported birthdate
- Issues arising after arrival in Australia.
Refugee Health Program

Key messages

- The Refugee Health Program (formerly the Refugee Health Nurse Program) operates in 17 local government areas of Victoria.
- Community health services in other local government areas also provide care for refugee communities.
- The program responds to the poor health and complex health issues of arriving refugees in Victoria.
- Service coordination is important for the community health services that run the program or otherwise provide refugee health care.

The Refugee Health Program (RHP) began in 2005, with the aim of responding to the poor health and complex health issues of arriving refugees in Victoria. The program aims to:

- increase refugee access to primary health services
- improve how health services respond to refugees’ needs
- coordinate a response to newly arrived refugees
- help individuals, families and refugee communities improve their health and wellbeing.

The program is delivered by community health services (CHSs), and employs community health nurses, allied health professionals and assistants, and bicultural workers. The nurses and other health professionals have expertise in working with culturally and linguistically diverse and marginalised communities.
Coverage – 2017 intake, model, health screening

- 50 visas: Central 200 (95%), Dispersed 202 (unknown)
- 2100 visas: Mixed - public health, community health colocation (95%)
- 750 visas: Central 200 (95%)
- 1100 visas: Central 2/3 (95%), Dispersed 1/3 (unknown)
- 500 visas: Central tiered (95%)
- 5400 visas: Dispersed (unknown)
- 6500 visas: Central 200 High (95%)
- 200 visas: Central tiered (90%)

200 visas = refugee visas
202 visas = special humanitarian program visas
‘I think we’ve had a health screen’

- New cohorts
- New offshore screening (11/2015)
- New refugee health guidelines (4/2016)
- Est’d primary care screening model (2005)
- New settlement health coordinators (11/2016)

Aim: To examine the outcomes and implementation of post-arrival health assessments in new arrival Syrian and Iraqi children
Post-arrival – health services

• 113/121 (93%) linked with regular GP
  • 104/113 (92%) language congruent GP
  • Likely through settlement/links

• 21/89 (24%) contact with refugee health nurses
• 75/90 (83%) had met their caseworker

• Arrival Australia to referral RCH 10.4w
• Offshore paperwork, 23/91 (25%)
Post-arrival – screening quality

2/113 (1.8%) children with GP had completed recommended health assessment

- 68 incomplete Ix
- 32 no screening Ix
- 11 – unable to ascertain
- None of the children linked with RHP had RHA
- 70 extra tests (average $91/child)

- 34 referred for initial screening
  - 22 had already had some blood tests
- Core tests – 7-10%
  - Tuberculosis, schistosomiasis, strongyloides, hepatitis B
But screening still important

- Low vitamin D 63/99 (64%)
- LTBI 11/93 (12%)
- Strongyloides 3/94 (3%)
- Anaemia 6/116 (5%)
- Iron deficiency 5/108 (5%)

- No schistosoma, hepatitis B, faecal parasites

- Quality of vaccination post-arrival
  - 43/78 (55%) appropriate catch-up
Complex cohort

- Of 128 children
  - 31 (24.2%) nutrition/growth issues
  - 21 (16.4%) neurologic/metabolic conditions
  - 20 (15.6%) learning/behaviour concerns
  - 16 (12.5%) PTSD/other mental health conditions
  - 13 (10.2%) developmental delay
  - 10 (7.8%) presentation c/w intellectual disability
  - 16 (12.5%) required surgery

- 6 life threatening illness on arrival
  - Only 1 had an alert
  - 133 hospital admission days, 20 PICU days, 1 airlift
Victorian immunisation projects – May 2018

Up to date on referral (2017 – 18)

- Language school children – recently arrived
  - 19/695 = 2.7%
- Asylum Seeker Resource Centre adults – variable arrival (years)
  - 0/609 = 0%
- Hume and Whittlesea LGA – 12m post arrival
  - 232/1215 = 19%

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number Up to Date</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-10 years</td>
<td>150</td>
<td>246</td>
</tr>
<tr>
<td>11-19 years</td>
<td>76</td>
<td>209</td>
</tr>
<tr>
<td>Adults</td>
<td>6</td>
<td>760</td>
</tr>
</tbody>
</table>

61% 0-10 years
36% 11-19 years
0.8% adults
Summary

• Changes to offshore health screening
• More sophisticated offshore records
  • Possible, but impractical pathway to retrieve offshore information
• Changes to onshore health screening
  • More complex screening guidelines
  • More complex health issues (in addition to screening)
• Dispersed post-arrival screening model
  • Low coverage
  • Incomplete screening - challenges with core tests
  • ?Loss familiarity with infections
Summary

• Work to link offshore and onshore systems
• Case for nodes of expertise – specialized services
• Post arrival screening far broader than infections
• Complex medicine

• But malaria is still fun
• And forgive me if you notify the cases faster than I do – there is a lot going on