# Demographics and utilisation of health services by paediatric refugees from East Africa: implications for service planning and provision

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## Abstract

*Little is known of difficulties in accessing health care for recently arrived paediatric refugees in Australia. We reviewed routinely collected data for all 199 East African children attending a hospital Immigrant Health Clinic for the first time over a 16 month period. Although 63% of parents reported medical consultations since arrival, 77% of this group reported outstanding, unaddressed health problems. Availability of interpreters and information on health services were the main factors hindering access to care. These data have informed future service planning at the Clinic. Ongoing data collection is key to maintaining a responsive, targeted service for a continually changing population.*

## Background

The Humanitarian Program in Australia resettles persons deemed 'refugees' by the United Nations High Commissioner for Refugees (UNHCR)[(UNHCR 1996)]. In addition, the program resettles those who have applied and been recognised as asylum seekers in Australia (Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) 2003). Approximately 60% of Humanitarian arrivals are under 19 years of age (DIMIA 2002). In 2001-2002, almost 3,000 people from Africa were granted visas under Australia's Humanitarian Program, accounting for almost one quarter of this category of arrivals for this period (DIMIA 2002). The majority were from East Africa (in particular, Somalia, Sudan, Ethiopia, Eritrea and Kenya).

Pre-departure health screening for entrants under the Humanitarian program is minimal for children under 16 years of age. It consists of a general medical examination, urinalysis for children over five years of age and chest radiography only if there are clinical indications or a history of contact with tuberculosis (DIMIA, 2003). In Victoria post-arrival health checks ceased in 1991, except for tuberculosis screening in high-risk individuals.

Previous studies from outside Australia reveal that recently arrived paediatric refugees often have complex medical and psychological needs including inadequate immunisation, parasitic infections, dental conditions and experiences of trauma (Meropol 1995; Hayes, Talbot *et al.* 1998) and that their families may experience difficulty in accessing appropriate health services (Uba 1992; Refugee Council 1994; Deale 1997). In addition, previous experiences of trauma may result in distrust or anxiety when encountering health professionals in the resettlement country.

No data are available for Australian paediatric refugees. In order to identify the health needs of East African immigrant children, one of the largest cultural groups arriving here in recent years, and to better inform provision of a comprehensive health service for refugee children, an Immigrant Health Clinic (IHC) was established at our hospital in February 2001. IHC offers holistic medical assessment, investigation and treatment of pre-existing or newly acquired conditions, updating of vaccination status, and also links families to other community or hospital based health services. Such services include dental services, mental health and trauma services and local community and migrant groups. The clinic staff include an administrative assistant, paediatrician, paediatric registrar, dental therapist and nursing coordinator.

A questionnaire is administered to parents of first time attendees with their consent. Initially the clinic focussed resources on East African children born outside Australia and who arrived in Australia after January 1998. These criteria have been expanded more recently to include refugee children from all origins. In this paper we present demographic and health service utilisation data for the initial group of children from East Africa.

# Methods

Data were reviewed for consecutive patients attending from February 2001 to May 2002. Children were referred from hospital clinicians, general practitioners, workers employed by the local immigration settlement body and refugee mental health services, and a multilingual East African health worker employed by the clinic. The hospital's Non-English Speaking and Interpreter Service Department made appointments and follow-up reminder calls.

At first appointments, trained interpreters administered a pre-piloted, community-approved 30-minute questionnaire to parents, addressing demographic data, health service utilisation and access issues, and health needs. Questionnaire data addressing issues other than demographics and health service utilisation was not included in this analysis. Parents were informed that they could choose not to answer any question they did not wish to, and therefore denominators reflect the response rates of each question. Data were analysed using Stata 7.0.(Stata Corporation 2001).

# Results

### *Demographics*

There were 199 first time attendees during the study period. Their mean age was 8.8 years (range 0.6 years - 17.8 years). The majority were born in Somalia, Sudan, Kenya and Ethiopia (Table 1).

**Table 1: Country of birth (n=199)**

| Country of birth | No. (%) |
|---|---|
| Somalia | 88 (44) |
| Sudan | 51 (26) |
| Kenya | 24 (12) |
| Ethiopia | 17 (8) |
| Egypt | 8 (4) |
| Eritrea | 5 (2) |
| Djibouti | 3 (1) |
| Other | 2 (1) |
| Missing | 1 (0.5) |

Most families (114/199, 57%) had been in Australia for less than 12 months (median 7.9 months, range 0.4-43.8) and 64 (38%) had spent time in a refugee camp in transit to Australia (median 36 months, range 3 - 172). The mean number of adults per household was two (range 1-6) and the mean number of children was five (range 1-14). Almost one third (62/199, 31%) of children lived in single parent families.

### *Language and Education*

Only two children lived in a home where English was the predominant language spoken (Table 2). The most common first languages spoken were Somali and Arabic.

**Table 2: First language spoken at home (n=199)**

| First language spoken at home | No. (%) |
|---|---|
| Somali | 113 (57) |
| Arabic | 25 (13) |
| Tigrigna | 15 (7) |
| Tigre | 13 (6) |
| Oromo | 5 (2) |
| Other | 28 (14) |

More than one third of parents (35%) reported no understanding of English (Table 3). An interpreter was required in 173 (87%) cases.

**Table 3: Competence in English (self report) (n=197)**

| Competence in English | No. (%) |
|---|---|
| No understanding | 69 (35) |
| Understand English reasonably well but don't speak English | 40 (20) |
| Understand and speak some English but don't read or write | 26 (13) |
| Understand, speak and read/write some English | 23 (12) |
| Able to speak, read and write English well | 39 (20) |

The level of parental education was most commonly reported as secondary school (88/197, 44%), followed by primary school (52/197, 26%) and tertiary level education (52/197, 17%). Twelve percent (24/197) of parents had no formal education.

### *Source of Referral*

Data on referral source were available for 118 children. A multilingual health worker who disseminated information about the clinic among the East African community was responsible for 75 (64%) referrals. The majority of remaining referrals came from within the Royal Children's Hospital (37/118, 31%) with six (5%) coming from other sources within the community. General practitioners referred two children.

### *Health Service Utilisation since Arrival*

Almost two thirds of children (124/198, 63%) had seen a general practitioner (GP) since arrival in Australia. The median number of visits was three (range: 1 - 20). One third (66/192, 34%) of children were reported to have an outstanding health problem about which their parents wished to seek advice. The majority of these children (51/66, 77%) had already seen a GP. A small number of children had seen a Maternal and Child Health Nurse (15/199, 7%) and 81 (43%) had attended a hospital. Parents of 112 (57%) attendees had not yet identified a doctor or nurse to whom they were happy to regularly take their child.

### *Accessing Health Care*

Parents identified the following factors which would make it easier to obtain health care for their children: availability of interpreters (53/198, 26%), information on where to find health services (47/198, 23%), availability of health services closer to their home (37/198, 19%), better understanding by health providers of their cultural needs (35/198, 18%), more health providers who spoke their own language (27/198, 14%) and availability of more written information in their own language (24/198, 12%).

## Discussion

Parents of children from East Africa frequently reported unmet child health needs. This review of demographic and health service utilisation data has influenced planning for future health service delivery, by identifying key areas of need among this community. This is always of particular importance in a setting where there are few published data to inform clinical practice and health service organisation. As a result of these data, effort has been put into better linking families attending the clinic to community services with interpreters or health providers who speak East African languages, and which are in reasonable geographic proximity to clients' homes. We are also improving mechanisms for sharing information about client-specified needs with other health providers working with refugees, via a regional refugee health network and the development of a patient held record for immigrant and refugee clients.

Our data confirm anecdotal evidence from IHC staff regarding large family size and composition. At present, families attending the IHC travel to our hospital for initial assessment and usually for at least one follow up visit, with the ultimate aim of linking them back to community health providers. The costs and difficulties of using public transport with large families are considerable. As a result, we are planning to establish an outreach clinic at a local community health centre. In the meantime, we endeavour to keep review appointments to a minimum and to link families to appropriate local services wherever possible.

As attendees commonly did not identify a regular primary health care provider, we have specifically assisted with the compilation of a list of GPs willing to provide comprehensive health care for refugees and who have experience working with refugee families and/or specific language skills. We now link each family with a GP on discharge from the clinic, facilitating a two way referral base of GPs with expertise in refugee health. Our long-term hope is that services for refugee children will be provided entirely by community-based primary care practitioners, with specialist support from our institution when needed. However, until settlement agencies responsible for integration of newly-arrived families with community services have better resources, we expect to continue to need to provide similar services through our clinic.

In a setting where one third of attendees have no understanding of English, adequate access to interpreter services is critical. This has been shown to be an important component of a successful interaction with health providers (Jones 1998). At the IHC, medical and nursing staff work closely with the interpreting service in appointment planning and consultations. Although it is unrealistic to expect ready availability of interpreters in all clinical settings, further development of telephone interpreting services and improved usage and awareness of existing services would assist with this process.

We provide written information in languages other than English, as requested by attendees. With translated health and health system information freely available on the Internet, provision of such information should be similarly possible in other clinical settings. The use of written information must nonetheless be considered in a context where some parents have no schooling and are likely to have poor literacy skills.

Our data have highlighted a number of risk factors for mental health problems among participant families. Almost one third of children had spent time in a refugee camp, in transit to Australia, many for a prolonged period. While few studies have been published on the specific problems in children related to residence in refugee camps, they do indicate that refugee camp experiences are significant predictors of psychological distress in children (Chung and Kagawa-Singer 1993; Montgomery 1998). Many children also lived in single parent families, a factor also known to affect children's psychological health (Montgomery 1998). Montgomery et al found that arrival in the country of asylum in the company of both parents was the most important anxiety-modifying factor and that the loss of the father contributed significantly to the development of anxiety. (Montgomery 1998) Although our initial questionnaire did not include specific questions about mental health concerns, mental health screening questions have now been added and we have streamlined our procedures for referring clients to the departments of psychiatry and social work.

Finally, it has been acknowledged that health consultation may be a source of anxiety for some immigrants as a consequence of previous experiences in their country of origin (Victorian Foundation for the Survivors of Torture and Trauma 2001). The clinic's multilingual health worker was critical to the establishment of trust with communities, allaying this anxiety, as well as disseminating information about the clinic. The importance of allowing skilled and experienced bilingual workers to work in partnership with existing health care providers has been highlighted previously (Webb 1998). Currently, as we expand our service to include refugee children from all origins, we continue to involve bilingual health workers in all steps of the planning process.

Although data from this survey cannot be considered representative of all African immigrants living in Victoria, we believe it provides a valuable addition to the previously limited knowledge of health service utilisation among paediatric refugees in Australia. We plan an iterative approach to ongoing data collection to enable future reviews to examine differences in health needs and use of services in what is a continually changing paediatric refugee population. This is vital to maintain a responsive, appropriately targeted service.

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