



Tasmania

DEPARTMENT of
HEALTH and
HUMAN SERVICES

Guide for General Practitioners in Tasmania

Refugee Health Care

May 2005

*This document is available for download at
<https://www.dhhs.tas.gov.au/agency/extranet/index.php>
please check this site regularly for updates to the content of the guide. A modified version
(minus medical information) will be available on the public-access site.*

Acknowledgements

This guide has been developed by Population Health in consultation with Physicians at the Royal Hobart Hospital, external agencies and services such as the Southern Tasmanian Division of General Practice, the Phoenix Centre and the Department of Immigration, Multicultural and Indigenous Affairs. It contains information sourced, with copyright approval, from existing publications which are referenced throughout the document. The time, effort and expertise of all those who contributed to this guide is greatly appreciated.

Updates

This guide will be updated regularly, and amendments will be sent out, and updated versions will be on the DHHS website. If you find any errors, omissions, outdated material, or simply wish to make suggestions for the content of future editions, please submit your comments to the Department on

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Introduction

Tasmania has received refugees and migrants from a wide range of countries over many decades. Recently most refugees have arrived from regions such as Africa, the Middle East, Asia, South America and the former Yugoslavia. Refugees are people who often have a higher proportion of long-term physical and psychological problems than other migrants, due to experiences of long term conflict, persecution, repression, long dangerous journeys, in many cases torture and other severe human rights violations, and will almost all be suffering from separation and displacement issues, as well as trying to adjust to a totally new environment, culture and language.

Due to the amount of time spent displaced and in refugee camps, many will not have had access to comprehensive health care for long periods of time, often several years. There are also health problems inherent to some refugee camps.

This guide, developed by the Department of Health and Human Services (DHHS), in consultation with other agencies and service providers, will provide General Practitioners (GPs) with the information they need to undertake a comprehensive health assessment of a newly arrived refugee patient, as well as to support them in providing ongoing clinical care.

It is recommended that GPs familiarise themselves with the content of the guide and, if possible, attend training sessions offered by the Divisions, prior to seeing their first refugee patient.

There are some sections of the guide that are designed to be used by front office staff, in particular the process for registering with the interpreting service and booking interpreters. This information is provided in step-by-step guides in the appendices.

Section One: Overview

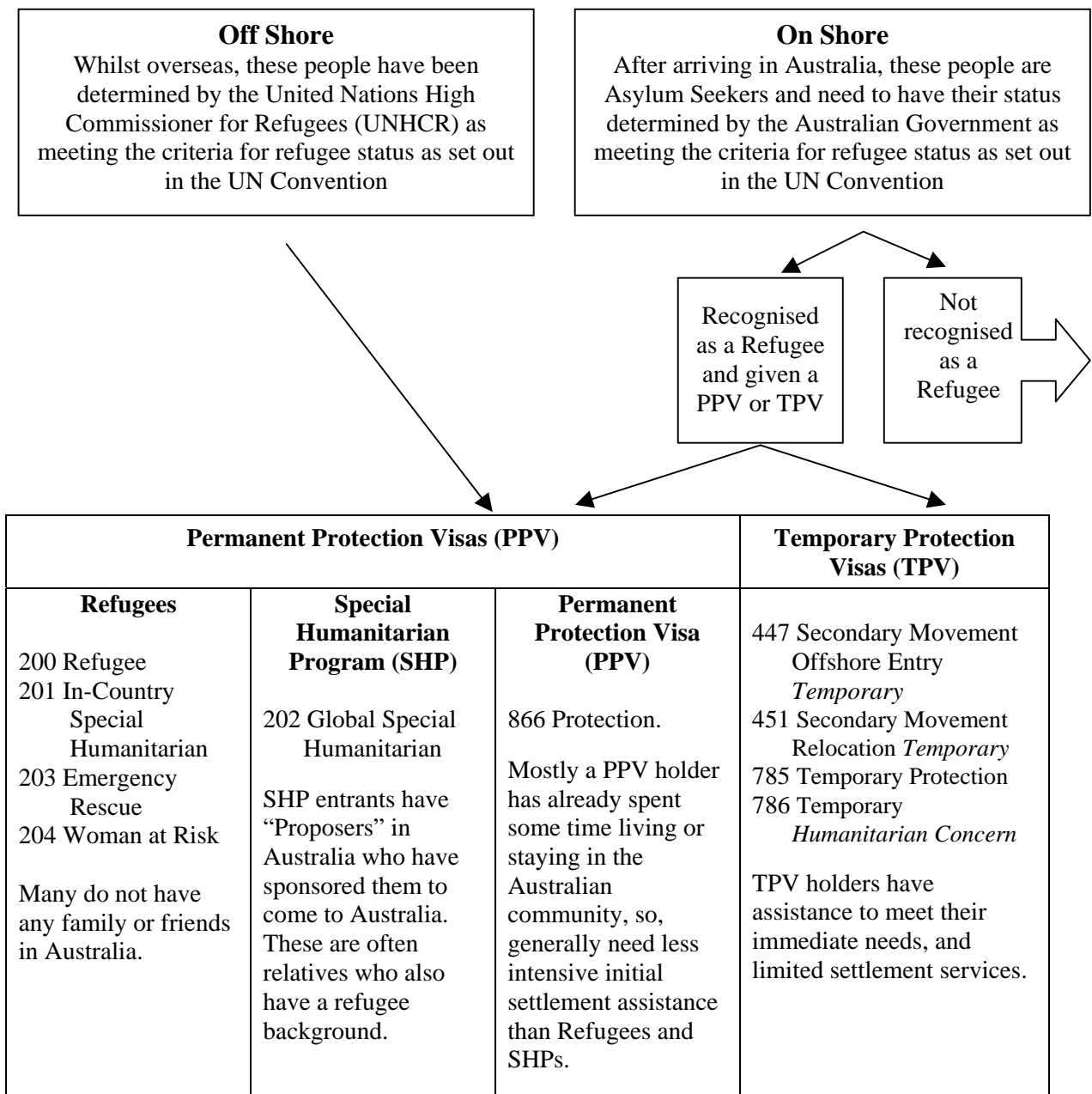
What is a Refugee and What do the Different Visa Types Mean?

The United Nations (UN) Convention relating to the status of refugees defines refugees as:

“People who are outside their country of nationality and unable or unwilling to return because of a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion.”

The term refugee is often used colloquially to refer to people who have been displaced due to natural disaster or similar – this usage is not strictly correct.

The diagram below shows a simplified version of the process refugees take to arrive in Australia and the most common visas granted (for more detail on the criteria of each visa, go to http://www.immi.gov.au/refugee/migrating_refugee.htm):



What Settlement Support Does Each Refugee Get?

On arrival, initial settlement services are provided by the Commonwealth with other services such as GPs and State services being accessible as needed. Eligibility for specific services and entitlements will depend on the type of visa (see the table below).

The Department of Immigration, Multicultural and Indigenous Affairs (DIMIA) provides various services for about six months through a program called the *Integrated Humanitarian Settlement Strategy* (IHSS). The IHSS aims to help humanitarian entrants achieve self-sufficiency as soon as possible by providing them with support for the initial settlement period, which, in most cases is about six months, although this can be extended to 12 months depending on the case. The IHSS contracts service providers to deliver the following services:

Table: IHSS Services and Eligibility depending on Visa

DIMIA Contracts various Agencies to deliver assistance	IHSS SERVICES FOR 6 MONTHS AFTER ARRIVAL (SEE APPENDIX 10 FOR MORE DETAILS)	Refugees	Special Humanitarian Program (SHP)	Permanent Protection Visa (PPV)	Temporary Protection Visa (TPV)
	Initial Information & Orientation	✓	✓	×	×
	Accommodation Support	✓	✓	×	×
	Household Formations Support	✓	✓	×	×
	Proposer Support	na	✓	×	×
	Early Health Assessment and Intervention Program (EHAIP)	✓	✓	✓*	✓*
	Community Support for Refugees (CSR)	✓	✓	✓	×

*Supports from IHSS or EHAIP can be extended to up to 12 months depending on the case

Access to Services Beyond the IHSS:

Commonwealth - Once humanitarian entrants exit the IHSS, they are referred to general, longer term settlement services provided through Migrant Resource Centres and organisations funded under the Community Settlement Services Scheme (see Appendix 10). Other longer term supports are also provided (depending on the visa category), such as Centrelink payments, counselling for torture and trauma, assistance to employment, health and education.

State - The Tasmanian State Government provides a range of services for Tasmanians including newly arrived residents. Services also work closely with Commonwealth-funded and non-Government agencies to assist with settlement.

Refugees in Tasmania

At the time of writing, Australia takes approximately 13,000 refugees and humanitarian entrants each year. In past years the composition has been approximately one third from each of Europe, the Middle East and Africa. Over time these patterns change, and the predictions for 2005/6 are for around 80% from African countries, particularly Sudan, Sierra Leone and Ethiopia, and the remainder from the Middle East, Europe and South Asia. Tasmania receives around 4% of the total number of people resettled through the national IHSS program, and for the next few years, this will mean approximately 500 refugees and humanitarian entrants with permanent visas settling in Tasmania each year.

There is a common misconception that refugees and humanitarian entrants, particularly those from Africa, are of the same cultural background. This is far from the truth. Even within a single country, there are often major differences in cultural practice, clan or tribe, language and dialect, religion, living conditions and experiences of war, persecution and trauma. Professionals need to work with the strengths and issues of each individual person's diversity. Appendix 12 gives some detail about selected countries to assist in understanding these differences, however even with this knowledge it is unwise to make assumptions about what a refugee's experiences will have been.

In Tasmania we receive very few Temporary Protection Visa (TPV) holders or asylum seekers. The majority of refugee/humanitarian entrants are being settled here on a long-term or permanent basis. This is where the General Practitioner has an important role in overseeing the health assessment, long-term management and healthcare for the patient.

Summary Points – Section One

- There are several different classifications of refugees and visa types determined by the Immigration Department (DIMIA), however in Tasmania the vast majority of our refugees are here on permanent visas and are trying to establish a new life here.
- Increasingly refugees arriving here are from African countries and have had less access to health services than those we have received previously from Europe and the Middle East. Education and literacy levels are also often lower.
- Tasmania is receiving approximately 500 refugees per year and they are increasingly being placed in the north and north west of the state. They come from a diverse range of ethnic and tribal groups, with different religions, languages and cultural practices.

Section Two: Refugee Settlement and Health

The Integrated Humanitarian Settlement Strategy (IHSS) funded by the Commonwealth Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) funds a range of services for recently arrived refugees and humanitarian entrants (who are sponsored by a 'proposer', usually a relative already living in Tasmania). Appendix 10 gives detail of these services and may be of use for health professionals to know what sort of Government and community support the patient is eligible to receive.

The flow of events once a refugee or humanitarian entrant arrives in Tasmania is basically as follows:

1. Refugees are met at the airport by representatives from the Integrated Humanitarian Settlement Strategy (IHSS), housed in temporary accommodation provided by DHHS and allocated a Community Support for Refugees (CSR) volunteer group (for six months) wherever possible. Special Humanitarian entrants are met at the airport by their proposer, who is the primary support during resettlement. The proposer is briefed under the Proposer Support Service on what is required and other IHSS support is provided.
2. Both refugees and humanitarian entrants are offered the Early Health Assessment and Intervention Program (EHAIP), which is run by the Phoenix Centre (managed by the Migrant Resource Centre South). An EHAIP worker offers initial assessment process (verbally) to assess the urgency of medical and psycho-emotional conditions (this may take more than one visit in complex cases or in a larger family group) and will then refer on to a general practitioner and/or to other health professionals such as dentists, optometrists, Family Planning, Phoenix Centre etc. The EHAIP program is available for the first 12 months after arrival and has a 98% uptake rate with Refugees, slightly lower with Special Humanitarian entrants. For more information on EHAIP contact the Manager on ph 6234 9330.
3. A CSR group volunteer or the proposer will ring and book the medical appointment, explaining that the patient is a refugee and specifying the language, dialect and gender needed for an interpreter (where required) and the gender preferred for the GP.
4. The CSR volunteer or the proposer will usually accompany the patient to their first appointment. This person can be a valuable resource for the general practitioner to find out what other community support the patient is receiving.

Immigration Processes and Health Assessment Carried out Overseas

In addition to meeting the definition of a refugee, applicants to Australia's refugee/humanitarian resettlement program must also pass medical and character checks. The medical checks overseas are carried out by approved panel doctors for DIMIA.

Medical Examinations include a physical examination, Chest X-Ray (for TB) and an HIV test (for adults), usually a number of months prior to migration, and are generally valid for 12 months (though sometimes less).

The information obtained in this assessment can be available to applicants via the usual Freedom of Information (FOI) guidelines (and as an exception, if urgent medically, to

treating general practitioners if they contact DIMIA Tasmania on 03 6220 4011. DIMIA's Fact Sheet 22. *Health Requirements* is available at:
<http://www.immi.gov.au/facts/22health.htm>

The process of off-shore health assessment and treatment prior to travel is under review. Check with DIMIA for more information.

It is recommended, however, that a thorough health assessment be undertaken in Australia regardless of previous tests.

If a medical condition such as inactive TB, (or stable hepatitis B or C or similar) is found in the overseas assessment and where it will not impact on their acceptance to Australia, they are required to seek follow up for that condition on arrival in Australia, usually through the chest clinic system. A "Health Undertaking" (Form 815) is registered for that person and DIMIA alerts the contracted settlement services provider to ensure the Health Undertaking is followed up. The Health Undertaking Service can be contacted on 1800 811 334.

The health needs of this patient group will change significantly over the course of the first few years of their settlement. In the first few months treatment of immediate clinical illness, vaccination and health assessment will be a priority. Over time, once a trusting relationship has been established with the General Practitioner or other health professional, the patient may begin to relate torture and trauma experiences or may show symptoms consistent with post-traumatic stress. As they gradually adjust to a totally new way of life, they may require advice on nutrition, food safety/hygiene, exercise etc.

Summary Points – Section Two

- Refugees receive support from a range of Commonwealth and State Government agencies, as well as community organizations and volunteers
- Newly arrived refugees and families will usually have a support person accompanying them to their initial medical appointments – this person can be a source of information on what other community supports the refugee has.
- General Practitioners have an important role in overseeing their long term health care needs, and in working with other support agencies statewide.

Section Three: Preparing for the First Visit

Conducting the Initial Consultation – Special Considerations for Refugee Patients

For simplicity sake, the term “refugee” will be used from now on to cover both refugee and humanitarian entrant patients, as the health needs are not significantly distinct for these groups.

Medical consultations may be a source of anxiety for refugee patients, especially those who have experienced significant trauma. Symptoms such as memory loss, confusion, hyper-anxiety and poor concentration may affect their capacity to hear and understand instructions and to provide information to the doctor. Intrusive traumatic memories may be triggered in the course of consultation.

Refugees may have a distrust of authority figures, among them medical professionals. For some this fear may be based on doctors having been actively involved in perpetrating or supervising torture in their country of origin. Others may have uncertainties about their immigration status, fearing deportation if they are found to have a serious health problem. Women who have been raped are usually reluctant to report this at an early stage of their resettlement and may not alert the doctor to the need for pregnancy testing and assessment for sexually transmissible infections (STIs).

Communication difficulties may be further complicated by cultural and religious differences and the patient’s lack of familiarity with the Australian health care system. For this reason it is important to remember not to assume knowledge and to keep in mind the following:

- The refugee patient may request a male or female doctor, due to cultural or religious customs relating to gender. In particular Muslim women must have a female GP. Due to the high rates of rape and sexual assault that refugee women and girls have experienced, it is recommended that all female refugee patients be seen by a female GP wherever possible
- Explain doctor-patient confidentiality (and situations where they are required to report things such as mandatory reporting of child abuse), patient consent, choice and control
- Use plain, simple language and speak slowly and clearly when asking questions, giving information and explaining procedures even if working through an interpreter
- Be aware that education for children and adults is likely to have been disrupted or completely absent and there are high rates of illiteracy in some refugee communities, even in their own language – ensure that instructions are clear and if written instructions are given make sure the patient understands them
- Poor education can also result in very poor understanding of basic anatomy and physiology, and the patient may not understand the basics of how their body works
- Provide opportunities for the patient to ask questions or seek clarification as some will have come from cultures in which this was not encouraged. The patient may also have beliefs about their health related to their religion or spiritual beliefs that may be important for you to know
- Providing an explanation for a line of questioning may be helpful in putting the patient at ease
- Be aware that the surgery and aspects of the consultation may be reminders of past trauma (eg being made to wait, physical touching without warning, medical instruments)

- In cases where the patient does not speak or understand English adequately, it may be necessary to record the name and contact details of the proposer or CSR volunteer who can be contacted for making follow-up appointments etc
- In some cultures there is much less importance placed on time-specific events, and the concept of being on time for a medical appointment may be a new one for some recently arrived refugees.

Planning the Consultations

There can be a range of short and long term health issues that the patient will present with, and a range of things to explain to the patient about the Australian Health Care System. General Practitioners who have experience in seeing refugee patients have developed a visit structure designed to accommodate these many needs. This is contained in the next section.

Using an Interpreter

In some cases the refugee patient may have a family or community member with them who speaks English, and there may be a temptation to use this person as an informal interpreter. This is strongly discouraged for a number of reasons.

A professional interpreter is always recommended for medical appointments as they have been independently assessed as having a high level of technical competence in both English and the patient's language, they are more able to convey complex medical information in an accurate and non-emotive way and are bound by a code of ethics including strict confidentiality. A friend or companion acting as interpreter may prevent the patient from disclosing information fully out of embarrassment or fear of breach of confidentiality.

The Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) runs the Translating and Interpreting Service (TIS), which is the recommended translator service for medical consultations. **The telephone interpreting service is free to any doctor in private practice for a consultation claimable under Medicare. It is the health care provider's role to book an interpreter.**

Registration with TIS can be done by phone or fax, and each GP is issued with a Client Code Number. Appendix 1 contains a guide for practice staff and proformas for registration and bookings with TIS.

Face to face interpreters can be arranged within certain hours if booked two weeks in advance however in Tasmania the number of interpreters and languages is very limited. Telephone interpreters are usually preferred and can be pre-booked.

In cases when an interpreter has not been pre-booked, TIS has a special Doctors Priority Line which operates 24 hours a day 7 days a week. For major languages a translator can usually be found within a few minutes.

The Doctors Priority Line number is 1300 131 450.

For general enquiries, feedback and complaints, the number is 131 450.

Appendix 2 contains guidelines for health professionals in working through an interpreter.

Summary Points – Section Three

- Some refugees may have a distrust of medical professionals and other authority figures due to past experiences, and may be unfamiliar with western medical services
- Be sensitive to religious, cultural and gender needs of the patient
- There can be high rates of illiteracy and poor understanding of anatomy and health
- For non-English speaking patients always use a professional interpreter
- Telephone interpreters provided through TIS are free for any consultation billable under Medicare
- If you refer on to a medical specialist, remember to include the patient's needs for an interpreter

Section Four: Examination and Treatment in the First Few Visits

Suggested Visit Schedule

This schedule is a guide only, and can be adjusted to suit an individual General Practitioner's way of working. Remember to book long consultations for the first few visits. Naturally if a patient needs urgent emergency or specialist treatment, refer on as you would any other patient.

-
- Visit 1
- Introductions, clarify interpreter suitability
 - Inform patient about the surgery opening times, appointment system, medical records, confidentiality, what to do in cases of emergency
 - Address any obvious acute illness & ask accompanying support worker if they have been told of any "Health Undertaking" for the patient
 - Ask the patient about any health concerns they have and make a list which can be prioritised
 - Explain to the patient that this visit has been an introduction and in the next visit more information will be sought, a physical examination will be done and they may be asked to give blood or other samples for testing.
 - Inform them that you will ask for a full medical history and ask them to think about and write down if possible, all major health events they can remember (illnesses, injuries, immunisations etc) for the whole family if necessary

-
- Visit 2
- Obtain full medical history, asking sensitively about assault and torture issues
 - Conduct a thorough physical examination
 - Ask whether the patient is using any traditional medications or other treatments and what their beliefs are about their illness

**Referral to a specialist clinic such as the RAHAC Clinic (in the south only at this stage) is an option. The clinic can order and perform all necessary tests and treatment for acute and infectious illnesses, and provide a report back to the referring GP. Contact details are provided in Appendix 9 and a referral proforma is provided in Appendix 6.*

- Give three faecal specimen containers for OCP if required, and explain why you need the samples and give instructions on how and when to return
- Take blood samples as required and explain that they will be sent away for tests
- Prioritise the patient's health concerns and explain that acute, painful or infectious conditions will be treated first while long-term health problems will be dealt with in later visits
- Ensure that the patient has a basic understanding of their health problems, and begin any treatment as appropriate

-
- Visit 3 **Functions of this visit would be performed by RAHAC or equivalent clinic if the patient has been referred there.*

-
- Review any test results that have come in and commence treatment or refer to specialist as required
 - Begin “catch-up” vaccinations
 - Begin Vitamin D supplementation if required
 - Referrals to other health professionals or services as required (Phoenix Centre, Dental, Optometry, Audiometry, Physiotherapy etc)
 - Make sure that the patient has understood instructions for taking medication (ask them to repeat the instructions back to you) or that they have literacy skills to read instructions. See Appendix 9 for websites which can provide medical information translated into a range of languages
- Ongoing Visits
- Continue immunisation catch ups as needed
 - Check patient is taking medication and as prescribed (some patients have been known to send their prescription medication to family in their country of origin rather than take it themselves). Check compliance with any health advice
 - Educate patient further as needed on the workings of the health system, especially how to distinguish between serious and routine illness. Some patients, once they realise a good health service is available, will start to present regularly with a range of trivial illnesses which do not require medical attention. They may also benefit from further information about how their body works. One way of doing this is to print out patient handouts in the patient’s language from the internet (see Useful Websites in Appendix 9)
 - In later visits settlement issues may become a higher priority (such as accommodation, adjusting to a western diet, social networking and support) and this may lead to psychosocial issues such as memories of past traumas to cause problems for the patient. Maintain awareness of this and refer to the Phoenix Centre as appropriate (See Appendix 9 for contact details or Appendix 7 for a referral fax proforma).
-

Assessment Details

Initial assessment of newly arrived refugees should be performed by a General Practitioner. The GP can choose to refer to the Refugee and Humanitarian Arrivals Clinic (RAHAC) at the Royal Hobart Hospital, which offers a comprehensive health assessment service with a particular focus on infectious diseases.

In the north of Tasmania respiratory assessment for tuberculosis is available at the Chest Clinic, Launceston General Hospital and in the north west of Tasmania at the Devonport Community Health Service Centre.

History

A suggested checklist for clinical history relevant to the refugee adult and child is included in Appendix 4. This checklist is intended as a prompt for areas relevant for discussion in the clinical history.

Physical Examination

A suggested checklist for clinical examination of the refugee adult and child is also included in Appendix 4. Although the list is not exhaustive, contained within it are key conditions to remember when undertaking physical examination. Preventive screening including Papanicolaou smears, breast cancer screening and dental review should also be performed.

Screening Investigations

As infectious diseases are common in many of the countries of origin of newly arrived refugees, investigations to screen for these infections are recommended. The following is a general list to consider. Further investigations may be required as determined from the history:

- Full blood count
- Serum electrolytes, liver function tests, calcium and phosphate levels
- Vitamin D levels
- Serum iron, transferrin and ferritin levels
- Hepatitis B surface antigen, surface antibody and core antibody testing
- Hepatitis C serology
- Human Immunodeficiency Virus (HIV) serology (after informed consent)
- Syphilis testing (RPR and TPHA)
- Strongyloides and schistosomiasis serology
- Malaria thick and thin films
- Faecal samples for ova, cysts and parasites x 3

Management of common presenting symptoms

Anaemia

In the refugee population anaemia may be caused by any of the three basic mechanisms, blood loss, decreased red cell production and increased destruction (haemolysis), however it is often multifactorial and related to comorbidity with infectious diseases.

Iron deficiency anaemia

Iron deficiency can be diagnosed with iron studies, demonstrating low serum iron, raised plasma transferrin and low transferrin saturation. Although typically low, normal or elevated serum ferritin levels may be found due to the presence of chronic, low grade infection.

Severe iron deficiency may result in anaemia, angular stomatitis, koilonychia and loss of melanin skin pigmentation. In children iron deficiency may lead to impaired motor development and co-ordination, impaired scholastic achievement and behavioural effects. Infant and maternal morbidity and mortality are increased in pregnant women with iron deficiency.

Common causes of iron deficiency anaemia in the tropics are infection with hookworm, trichuris and schistosomiasis and inadequate dietary intake, particularly amongst infants that have had late introduction to solids.

Treatment of iron deficiency requires dietary modification, supplementation and control of helminthic infections. Severe iron deficiency may required parenteral iron therapy.

Anaemia associated with malaria

Children living in areas where malaria is endemic suffer from recurrent attacks, and develop a chronic normochromic, normocytic anaemia with a low reticulocyte count. This anaemia is the result of both hypersplenism and dyserythropoiesis, and will respond to anti-malarial therapy.

Anaemia associated with splenomegaly

Anaemia associated with splenomegaly is a result of red cells pooling in the spleen and shortened red cell lifespan. Whilst malaria is the most common cause of splenomegaly, other causes such as such as visceral leishmaniasis, portal hypertension related to hepatic cirrhosis and schistosomiasis will cause similar haematological disturbances.

Haemoglobinopathies

The thalassaemias occur widely in tropical regions, however the major forms are uncommon. Thalassaemia trait is usually detected on full blood examination, which shows mild anaemia with hypochromic, microcytic red cells. Iron deficiency should be excluded before further diagnostic testing with haemoglobin electrophoresis is undertaken.

Dermatological Presentations

Dermatophyte Infections

Superficial infections by dermatocious fungal can manifest as localized single or multiple coalescing circinate plaques with erythema and scaling. The main clinical presentation are of localized tinea pedis, interigo, onychomycosis and tinea corporis. Scalp infections are manifest as patchy alopecia and boggy inflammation, and are most common in children. Pityriasis versicolor may present with multiple, coalescing hypopigmented lesions.

Common Presentations

<i>Clinical Features</i>	<i>Differential diagnosis</i>
Single ulcerated lesion	Cutaneous leishmaniasis, TB
Ulcerated nodule and lymphangitis	Cutaneous leishmaniasis, sporotrichosis
Itchy papules in clusters	Arthropod bites, molluscom contagiosum

Chronic scarring and sinus tracts	Mycetoma
Itchy serpiginous tract	Cutaneous larva migrans
Patchy alopecia and boggy inflammation	Scalp ringworm
Erythematous crusting lesions	Impetigo
Pruritic vesicles on palms and soles	Pompholyx

Abdominal Pain

Abdominal pain is a very common presenting problem, with a broad differential diagnosis. Helicobacter, gastrointestinal and schistosomal infection should be excluded and possibility of intra-abdominal tuberculosis considered. Chronic lower abdominal pain in women may be a complication of traumatic childbirth. Frequently no cause for the pain is identified, and the clinician should be aware that the symptoms may be a manifestation of post traumatic stress disorder.

Hepatosplenomegaly

Tropical hepatomegaly and splenomegaly may be a result of infections and their complications. Splenomegaly is most often detected in association with malaria, and may persist after leaving a malarious zone. Tuberculosis, HIV and visceral leishmaniasis should be considered as well as complications of chronic infections involving the liver, such as hepatitis B and schistosomiasis, that may lead to portal hypertension may cause splenomegaly. Children with moderate splenomegaly are at risk of rupture and the parents should be counselled. Hepatomegaly has similar aetiologies, however viral hepatitis and schistosomiasis are a more common cause of hepatomegaly.

Arthritis

Children presenting with joint pain should be assessed for signs of rickets and a vitamin D, parathyroid hormone, calcium and alanine phosphatase levels measured. Joint effusions are a rare presentation of Vitamin C deficiency, malaria and sickle cell disease. Bone pain may be a manifestation of sickle cell anaemia and should be urgently assessed and referral to a paediatric or adult physician is recommended.

Tuberculosis

M. tuberculosis infects one third of the world's population, and is the leading cause of death due to an infectious agent. Infection most often presents as pulmonary disease with non-specific constitutional symptoms such as night sweats, chills, anorexia, fatigue and weight loss and a productive cough. Lymphadenitis is the most common form of extra pulmonary infection, however tuberculosis must be considered in the differential diagnosis of any presentation in this population.

Latent tuberculosis infection (LTBI) is the most frequent manifestation of tuberculosis in the refugee population. A positive tuberculin skin test (Mantoux test) with purified protein derivative of *M. Tb* indicates primary infection, and active disease must be excluded. Importantly there is no risk of transmission of latent infection, nor is it a notifiable disease.

Individuals with latent infection may be offered chemoprophylaxis, which consists of six to nine months of Isoniazid. Patients older than 35 years are at increased risk of isoniazid hepatotoxicity and are usually monitored with 1-2 years of radiological surveillance.

Malaria

Malaria infection in the non immune population causes a febrile illness with headache, myalgia, fevers and chills. Individuals from endemic areas however, who have partial immunity to malaria may develop atypical symptoms or have malaria detected on a blood film during an intercurrent illness. Finally a small proportion of individuals have a persistent low grade parasitaemia, and may be entirely asymptomatic or manifest only with splenomegaly or anaemia. All individuals presenting with a febrile illness who have travelled to or who are from a malaria endemic country must have at least one thick and thin blood film performed for microscopy.

Clinical presentations of malaria may be due to relapse of infection with *Plasmodium vivax* or *ovale*, or recrudescence of infection with *Plasmodium falciparum* or *malariae*.

Management of malaria depends upon species of parasite and the severity of the illness. *P. falciparum* is the most serious form, particularly in young children and pregnant women, and is the most frequent form detected in African immigrants. *P. vivax* and *ovale* have liver schizont phases and require an agent with schizont activity, such as primaquine to prevent relapse.

A diagnosis of malaria should prompt investigation of remaining family members for asymptomatic infection. In view of its public health significance, particularly in Northern Australia where conditions are receptive for the re-introduction, malaria is a notifiable infection.

Viral Hepatitis

Viral hepatitis should be detected on routine screening, or included in the investigation of abnormal liver function tests. Past hepatitis B is most often detected, manifest as a positive hepatitis B core or surface antibody test. A positive hepatitis B surface antigen test indicates active, usually chronic infection, and hepatitis "e" antigen test will indicate infectivity. An alpha-fetoprotein should be measured and a liver ultrasound performed in view of the risk of hepatocellular cancer in this group. It is very important to ensure that family members of a patient with chronic hepatitis B be immunised against infection if they have not had previous infection.

Patients in Hobart may be referred to the viral hepatitis clinic at the Royal Hobart Hospital for further management or treatment.

Vitamin D Deficiency

Vitamin D deficiency causes rickets in children and osteomalacia in adults. These diseases are a result of inadequate skeletal mineralisation.

Skin synthesis of vitamin D provides approximately 90% of our vitamin D requirement. Dark skinned adults and children at southern latitudes are particularly at risk of vitamin D deficiency as the skin pigment inhibits synthesis of vitamin D.

There is currently no consensus on the treatment of Vitamin D deficiency in Australia. Newborn infants are generally not exposed to direct sunlight and breast milk is a poor source of Vitamin D. Vitamin D stores, even if normal at birth, may become depleted at eight weeks in infants who are exclusively breastfed. Most African women in Southern Australia are Vitamin D deficient within 6 months of arrival in Australia and thus have breast milk low in Vitamin D. Supplementing breast fed infants with 400IU of Vitamin D per day (0.45 mL of

Pentavite per day) should maintain Vitamin D stores. Calcium supplementation may also be required.

When infants are diagnosed with Vitamin D deficiency Vitamin D levels in their mothers and siblings should also be assessed. All pregnant women with dark skin and/or with limited access to the sun due to veiling or social isolation should have their Vitamin D levels assessed. During pregnancy and lactation these women require 500-700IU of Vitamin D. If there is a demonstrated Vitamin D deficiency, doses from 1000IU to 3000-4000 IU should be given with reassessment every 3-4 months or at each trimester if pregnant.

A detailed fact sheet on vitamin D deficiency is included in Appendix 8 of this manual.

Syphilis

Syphilis infection is usually detected on serological screening. Approximately 5% of adults screened at the RAHAC clinic had positive serology were positive, with all patients having a past infection, manifest by a negative RPR, positive TPPA and FTA-Abs. A positive result mandates careful assessment for evidence of neurosyphilis and cardiovascular disease. If neurosyphilis is suspected a lumbar puncture should be performed, CSF serology undertaken and a two week course of intravenous penicillin commenced. Spouses and children of seropositive mothers should also be tested.

In most circumstances the positive serology indicates late latent infection. As it is often difficult to obtain a history of adequate treatment the patient should be retreated with three doses of Benzathine penicillin (1.8g IM weekly for three weeks).

Intestinal Parasitic Infections

Intestinal parasite infections have been detected in over 60% of patients attending RAHAC, making them the most common infectious diseases. The consequences of infection are well known, including persistent eosinophilia, iron deficiency, anaemia and chronic abdominal pain. More specific complications are listed in Appendix 5 under the individual parasites. Following treatment the stools should be checked for clearance of infection, and the full blood count and iron studies repeated to ensure resolution of eosinophilia and iron deficiency.

Immunologic tests also exist for other parasitic infections such as invasive amebiasis, hydatid disease, filarial infection, Fasciola hepatica, and Toxocara canis. Specialist advice regarding indications and appropriate use of these tests is available from the Department of Microbiology and Infectious Diseases at the RHH.

Schistosomiasis (bilharzia)

If there is a history of Schistosomiasis in either the country of origin or the country of refuge, a workup for Schistosomiasis should be started. The Schistosoma ELISA test is the most sensitive test, but remains positive for many months even after successful treatment. Stool and urine for ova should also be tested as detection of ova allows full identification of the species. Rectal biopsy for ova has greater sensitivity, but is more invasive, so if Schistosomiasis is presumed, but laboratory diagnosis is inconclusive, presumptive treatment with Praziquantel can be offered.

Strongyloidiasis

Strongyloidiasis is of particular importance as infection can persist for decades, and invasive infection can develop if the patient becomes immuno-suppressed. Faecal microscopy is required to identify Strongyloides larvae. At least two specimens should be examined.

Strongyloides serology, performed on a blood sample, can be used to diagnose infection and also monitor the response to anti-helminth therapy.

Eosinophilia

In the refugee population a high eosinophil count almost always indicates helminth infection. If present the patient should be investigated for a gastrointestinal infection and two to three faecal specimens should be collected for microscopy. If these are negative faecal microscopy should be repeated using specimen containers containing a preservative (available from RAHAC), urine microscopy performed and blood collected for schistosomiasis and strongyloides serology. Other rarer infectious causes of eosinophilia include filarial and trematode infection. If an infection cannot be detected other causes of eosinophilia should be considered, including allergic disorders and medications.

Nutritional disorders

Malnutrition may be the result of decreased intake of one or all food groups or to decreased absorption. Metabolic disorders, diarrhoeal illnesses, or the indirect effects of chronic illnesses are common causes of decreased absorption.

Malnutrition has long-term deleterious effects on the person suffering from decreased intake or absorption; or on the foetus or on the children of the person with malnutrition. Loss of intellectual potential, incomplete physical or mental development, and vulnerability to illness are among the long-term effects of malnutrition.

Malnutrition typically presents with growth restriction, low body mass index, vitamin and micronutrient deficiencies. Marasmus (due to inadequate caloric intake) and Kwashiorkor (due to protein-calorie malnutrition) are rare. If suspected, referral to a paediatrician or physician is advised.

Tropical sprue is a malabsorption disorder of unknown etiology (possibly coliform organisms) that affects residents of or visitors to endemic or epidemic areas. Note that the disorder may occur years after leaving the tropics. Common manifestations are anorexia, abdominal distension, weight loss, decreased iron, folate, and B12 and other findings consistent with malabsorption disorders.

Immunisation Recommendations

Immunisation recommendations are from the Australian Immunisation Handbook, 8th Edition, as are suggested catch-up schedules for various vaccines. The handbook can be accessed at: <http://immunise.health.gov.au/handbook.htm>. For other enquiries contact the Public and Environmental Health Service (Tasmania) on ph 1800 671 738.

Vaccination of Immigrants and Refugees to Australia

Immigrants or refugees may be incompletely vaccinated or have unsatisfactory records of vaccination. Immunisation status is not routinely assessed in children and adults entering Australia as refugees or immigrants.

- If an immigrant child has no valid documentation of vaccination, a 'catch-up' schedule should be commenced. For details see Part 1.9 of the *Australian Immunisation Handbook*, 'Catch-up vaccination'.

- If there is a valid record of vaccination, the history of prior doses should be taken into account when planning a catch-up vaccination series.
- Immigrant adults need to be targeted for vaccination against rubella using MMR. This is particularly important for women of child-bearing age.
- ADT vaccine is funded for immigrants and refugees by contacting the Communicable Disease Prevention Unit on ph 1800 671 738.

Adult Immunisations

IPV

- 3 doses, each 1-month apart, are required for all people not previously immunised against poliomyelitis.

ADT and dTpa (Boostrix)

- 3 doses, each a minimum of 1-month apart, are required.
- If an adolescent or adult has failed to receive one or more doses of pertussis vaccine for primary immunisation, or if no reliable history of vaccination is available, a single dose of acellular pertussis vaccine ('Boostrix' – dTpa) is appropriate for protection against pertussis.

MMR

- Adults should also be given MMR, 2 doses at least 4 weeks apart, unless there is a history of past infection or documented evidence of 2 doses of MMR vaccine.
- There are no ill effects from vaccinating those with pre-existing immunity to one or more of the 3 diseases.
- Non-pregnant seronegative women should be advised to avoid becoming pregnant for 28 days after vaccination.

Hepatitis B

- Hepatitis B vaccination is especially important for household and sexual contacts of a person who is hepatitis B positive.
- Hepatitis B surface antigen, surface antibody and core antibody testing are routinely done in the RAHAC clinic

BCG

- Not routinely recommended.

Paediatric Immunisations

Recommendations include but are not limited to the following:

IPV

- 3 doses, each 1-month apart, are required for all people not previously immunised against poliomyelitis.

Hib

- Hib vaccines should not be administered before 6 weeks of age.
- Hib vaccines are not necessary after the 5th birthday.
- For children aged up to 15 months, the catch-up for Hib vaccines depends on the brand of vaccine used. Refer to the Australian Immunisation Handbook, 8th Edition for the correct catch-up schedule for Hib.

- A single dose of Hib vaccine is required if the child is aged between 15 months and 5 years.

DTPa / ADT / dTpa (Boostrix)

- Only use DTPa if the child is < 8 years of age.
- 3 doses, each 1 month apart, to complete the primary series
- A booster dose of DTPa should be given at 4 years of age or 6 months after the 3rd dose, whichever is later.
- ADT is to be used if child is 8 years of age or older.
- If an adolescent has failed to receive one or more doses of pertussis vaccine for primary immunisation, or if no reliable history of vaccination is available, a single dose of acellular pertussis vaccine ('Boostrix' – dTpa) is appropriate for protection against pertussis.

MMR

- There are no ill effects from vaccinating those with pre-existing immunity to one or more of the 3 diseases.
- If no previous documented doses have been given, catch-up for MMR consists of 2 doses at least 4 weeks apart.

Hepatitis B

- Following the birth dose, a total of 3 doses are required to achieve optimum protection in infants and young children.
- Provided that the birth dose was administered, catch-up doses of Hepatitis B vaccine can be given 1 month apart otherwise ensure a minimum interval of 4 weeks between the first and second doses, and 2 months between the second and third doses (see p50 of the *Australian Immunisation Handbook*)
- Hepatitis B vaccination is especially important for household and sexual contacts of a person who is hepatitis B positive.

Conjugated Meningococcal Vaccination (type C)

- A single dose is recommended for children over 12 months of age.

Pneumococcal Vaccination (Prevenar)

- Prevenar is currently available for all children born after 1/1/03 and children under 5 years with specific risk factors.
- All children born between 1/1/03 and 31/12/04 will be eligible for the catch-up program during 2005.

Referrals

Referral of refugee patients may be necessary. The RAHAC clinic in the South of Tasmania is able to undertake comprehensive health assessment of all refugee patients who are referred. The Departments of Microbiology and Infectious Diseases are available to give telephone advice regarding all refugee healthcare enquiries from GPs throughout the State. A proforma for referral to RAHAC is provided in appendix 6.

In addition to RAHAC, referrals to other services may be appropriate, such as; Phoenix Centre (counselling for torture and trauma), Oral Health Service, Family and Child Health Nurses, paediatrics, audiometry, optometry and so on. A list of contact phone numbers is provided in Appendix 9.

Section Five: Longer-Term Health and Wellbeing Issues

Nutrition

Nutrition Status on Arrival

The nutritional status of refugees on arrival into Australia can be poor due to periods of food deprivation and/or limited range of foods and availability of clean water.

In some cases families have been living in refugee camps for up to 10 years, and children who have been born in these camps are particularly at risk of nutritional deficiencies. In some camps the food is limited to grains, legumes and oil. In other camps there is an opportunity to grow food or opportunities for work and to buy extra food. Single women and their children in refugee camps are often particularly vulnerable due to customs in some communities of men eating first and women eating only if food is left over.

Nutritional deficiency problems may include: Vitamin D deficiency in dark skinned people (especially veiled women), iron deficiency anaemia, poor appetite (due to depression and stress, anaemia, intestinal parasites or other causes) and poor oral health (particularly gum infections, missing teeth).

Adjusting to a Western Diet and Food Supply

The refugees who arrive in Australia come from a diverse range of backgrounds. Some will have lived in urban centres where they are used to buying food from retail outlets, a good food supply, access to cooking equipment and storage facilities (eg refrigerators) whereas others may be from rural backgrounds where food is grown, killed or bartered. For some, everything about living in a western, urban environment may be new to them, including handling money, shopping and using electrical equipment such as stoves and refrigerators.

There may be little or no access to traditional foods and unfamiliarity with new foods (eg which vegetables need to be cooked and which can be eaten raw). Packing lunches for children to take to school can also be an unfamiliar practice, as in many communities the school provides lunch or children return home to eat, or meals may be eaten at different times. Drinks such as caffeine, alcohol and sugar-laden cordials may be new to the diet also, and as these can exacerbate anxiety states it is wise to advise against excess consumption of these drinks.

After settlement in Tasmania, food insecurity (not being able to afford or access an adequate supply of food) may be a problem for refugees. Contributing factors may include: a lack of knowledge of how to store, cook, prepare and eat unfamiliar foods, lack of experience with shopping and handling money, leading to running out of money to buy food, language and literacy problems, or simply a fear of venturing out to attempt to obtain food. Shame and fear of stigma may prevent individuals from raising this issue, so it is advisable to ask (in later consultations) if the family is getting enough to eat. Concerns can be directed to the support services such as the IHSS workers or CSR volunteers who assist refugees to adjust to Australian life.

The Community Nutrition Unit, part of the Department of Health and Human Services, may be able to provide advice and referrals, and are listed in the contacts section (Appendix 9).

Physical Activity

Due to the major disruptions and changes to living conditions, the level and type of physical activity may have varied enormously over recent years for refugees and adjusting to a western culture may mean that a sedentary lifestyle is adopted.

Some may also have transport and cost barriers for sporting participation, and some may feel unsafe venturing out in public places such as walking tracks, parks etc.

Encourage individuals and family groups to engage in leisure time physical activity, preferably in groups, to enhance social and mental health as well as physical health.

Mental Health

This is largely covered in Section Nine – Psychosocial Considerations.

Participation in Community Activities

Over time, refugees will feel more comfortable accessing mainstream services and forming friendships and networks, particularly younger, school age people. A range of services for refugees and migrants are offered in the community, check Appendix 9 for contacts and websites for recommendations.

Alcohol and Drugs

Recently arrived refugees may have access to a range of tobacco, alcohol and other drug products that they are not used to. Some may abuse alcohol and/or drugs in an attempt to dull emotional pain related to past trauma. Education and information on safe and unsafe use of drugs and alcohol may be necessary.

Summary Points – Section Five

- There may be nutritional deficiencies in refugee patients, particularly Vitamin D deficiency in dark skinned patients and veiled women
- Newly arrived refugees may be unfamiliar with western foods and may not be eating properly as a result
- There may be many other areas where adjusting to a new way of life presents health problems such as access to drugs and alcohol and a sedentary society

Section Six: Women's Health

Sexual Violence and Trauma

Rape of women and girls is often used as a weapon of war, and even in refugee camps, the incidence rate for rape can be up to 90%, including repeated assaults and gang rape. This is done to women and girls of all ages and backgrounds and can be a severely traumatising experience. It can bring shame to the victim and her family and is unlikely to be readily disclosed.

Some female refugees have had little or no access to education and lack of knowledge about the functioning of their own bodies and this may mean that a woman who has been raped may not recognise the signs of pregnancy, so it is advisable to do a pregnancy test as well as assessment for sexually transmissible infections. Needless to say, it is particularly important to have informed consent and tell the patient what you are going to do as they may be particularly anxious about gynaecological examinations due to past abuse.

Section 9 of this guide on psychosocial considerations when treating a refugee patient has more information regarding management strategies for patients suffering the effects of severe trauma.

Family Violence

Many refugees have lived for long periods in very violent times, often fighting for their lives for extended periods. This can lead to a skewed vision of what constitutes 'violence' and what is 'normal'.

In some cultures, particularly many traditional African societies, the role of men in family and social structures is quite different than in western societies. In most cases men (particularly the oldest man in the family) are the 'head of the family', and they can struggle with new expectations of them and new freedoms for their wives and children (especially daughters) when they arrive in Australia. While there is little reliable data, anecdotally service providers report high levels of family violence among refugee communities.

For refugee women and girls suffering violence at the hands of family members, their vulnerability can be compounded by their language barrier, cultural expectations, lack of understanding of Australian laws and support services.

Reproductive Health Concerns

Female patients may not feel comfortable talking about sexual and reproductive health issues if any other family member or support worker is in the room. This can be a problem in cases where a male relative insists on accompanying the patient. An interpreter on a normal phone handset where the phone is passed from patient to doctor, without the third person being able to hear the conversation is one way around this.

Unplanned pregnancies can be a cause of great distress among newly arrived refugee women, and while they may seek to terminate the pregnancy, this may be very distressing for them and they may not want other family members to know about the pregnancy. For this reason it is advisable to not discuss pregnancy testing while anyone else is in the room.

Referral to Family Planning Tasmania, the Sexual Health Service (DHHS) or the Gynaecology Clinic at the RHH are options for ongoing sexual and reproductive health needs. See the contacts list in Appendix 9.

Female Genital Mutilation (FGM)

Definition and Classification of FGM

Female genital mutilation constitutes all procedures which involve partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or any other non-therapeutic reasons.

- **Type I** Excision of the prepuce with or without excision of part or all of the clitoris
- **Type II** Excision of the prepuce and clitoris together with partial or total excision of the labia minora
- **Type III** Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)
- **Type IV** Unclassified: includes pricking, piercing or incision of clitoris and/or labia; stretching of clitoris and/or labia; cauterization by burning of clitoris and surrounding tissues; scraping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina; introduction of corrosive substances into the vagina to cause bleeding or herbs into the vagina with the aim of tightening or narrowing the vagina; any other procedure which falls under the definition of FGM given above.

Prevalence and Cultural Context

The prevalence of FGM in African countries ranges from 10% - 90%. In Indonesia, Malaysia, India, Oman, United Arab Emirates and Yemen the practice has been reported but no data are available. It is impossible to be certain of the prevalence rate or severity among refugee women in Tasmania, however, a conservative estimate based on the 2004-5 intake of 500 refugees per annum might be that about 140 additional women or girls may be settling across Tasmania every year who may be affected by FGM.

In communities where it is widely practiced it is an ingrained cultural tradition and can be seen as normal among parts of the community. Many women who suffer gynaecological and urinary problems see these as normal and do not realise they are a result of the practice. Women who have had the procedure performed are often traumatised by the experience and ongoing problems it causes, and may find it very difficult to talk about it. At the same time, they may not regard it as a human rights violation as westerners might, but rather as a cultural rite of passage. As always, it is best to make no assumptions and to approach the issue very gently. It is recommended that health professionals try to use terminology used by the woman as the term 'female genital mutilation' can be offensive to some. Phrases such as *traditional or ritual female cutting* may be used by some women.

Legal Status

Australia has a two part strategy to prevent the practice of FGM: a national education program and legislation against the practice. There is specific legislation against the practice of FGM in Tasmania and in all states of Australia, except Western Australia and Queensland where legislation against FGM is covered under sections of the Criminal Codes related to assault.

In Tasmania, legislation was passed on 1 December 1999, making both the performing of FGM on a female of any age or the removal of a child under the age of 18 years with the intention of having FGM performed, a criminal activity. For both these charges there is a significant, maximum penalty of seven years imprisonment.

Section 14 of the *Children, Young Persons and Their Families Act 1997*, stipulates that it is mandatory for certain persons, including registered medical practitioners, to report any child who has been subjected to FGM or who they believe is at risk of this practice to the Department of Health and Human Services. There is protection in place under Section 15 of the same Act for people who provide this information.

If you perceive a risk of FGM being performed, please promptly call either: *Child Protection Advice and Referral Service (CPARS)* ph1300 737 639 24 hours/7 days a week or *Tasmania Police Victims of Crime Unit* ph6230-2614 during working hours or contact your local police station.

Both of these services work together with the FGM program to sensitively explain the law and assist families to reach the best outcomes for their daughters.

Health Consequences

Women subjected to the more severe forms of FGM are particularly likely to suffer from health complications requiring medical attention throughout their lives. Some complications such as severe bleeding and infections may occur immediately or shortly after the practice is performed; other complications may occur years after the event. It is difficult to assess the frequency with which the various complications of FGM occur, as too few surveys have been undertaken to establish the incidence of health consequences. It is however apparent that the physical, psycho-sexual and psychological complications of FGM are sizeable and constitute in some countries a serious public health problem which endangers the life and health of women and children.

Long Term Complications Associated with FGM:

Complications often arise at the time of mutilation, and in some cases longer term complications can occur, such as:

- Urinary - urinary retention, urinary frequency, urinary incontinence and recurrent urinary tract infection
- Chronic pelvic infection
- Infertility
- Vulval abscesses
- Keloid formation
- Dermoid cysts
- Neurinoma where the dorsal nerve of the clitoris is cut
- Calculus formation due to menstrual debris or urinary deposits in the vagina or in the space behind the bridge of skin created when infibulation is performed
- Vesico-vaginal or recto-vaginal fistulae
- Sexual dysfunction
- Menstrual abnormalities – haematocolpos and dysmenorrhoea
- Complications in pregnancy and childbirth – foetal retention after miscarriage, obstructed labour due to prevention of dilation by scar tissue
- HIV transmission may be increased as scar tissue is prone to bleeding and the small vaginal opening prone to laceration during sexual intercourse or as a result of anal intercourse due to inability to penetrate the vagina.

Pelvic Examinations and Pap Smears

For women from some backgrounds, pelvic examinations and pap smears may seem strange and intrusive. A thorough explanation of the need for such examinations may be required, and informed consent must be gained before undertaking such an examination. The management of other gynaecological conditions will not usually deviate from usual practice,

unless severe FGM has occurred, in which case restriction, scarring, tenderness and repeat infections may need to be addressed first.

Reversal of FGM procedures

This procedure is also called 'de-infibulation' and reverses some forms of FGM. It can be considered or requested by a patient, perhaps during pregnancy or prior to marriage. De-infibulation can alleviate and manage ongoing health problems as well as minimise FGM-associated risks to both mother and baby at the time of delivery. It is recommended antenatally (after 20 weeks) to ensure a period of healing

It is a recognised lifesaving medical procedure, so is covered by Medicare. It is done with local or general anaesthetic (discuss this with your patient). Current best practice aims for reconstruction to a 'two-finger opening'. It is important that GPs discuss issues with both the woman and her partner and ensure counselling about the procedure and the physical and mental implications of the changes.

Contact the Gynaecology Clinics at State hospitals for further details on what the procedures may involve.

Psychosexual, Psychological and Social Consequences

Almost all types of female genital mutilation involve the removal of part or the whole of the clitoris. Sexual dysfunction in both partners may be the result of painful intercourse and reduced sexual sensitivity following clitoridectomy and narrowing of the vaginal opening. The more severe types of FGM, like infibulation, remove larger parts of the genitals, and close off the vagina, leaving areas of tough scar tissue in place of sensitive genitals, thus creating permanent damage and dysfunction.

In some cases, FGM may leave a lasting mark on the life and mind of the woman who has undergone it. The psychological complications of FGM may be submerged deeply in her mind as a child, and they may trigger the onset of behavioural disturbances in later life. The possible loss of trust and confidence in those that are the care-givers has been reported as another serious effect. In the longer term, women may suffer feelings of incompleteness, anxiety, depression, chronic irritability, frigidity, marital conflicts, conversion reactions, or even psychosis. Many women traumatized by their FGM may have no acceptable means of expressing their feelings and fears, and suffer in silence. For others, their FGM may have been celebrated within their community as a rite of passage, the physical damage less severe, and the psychological trauma less acute.

There is also the consideration that FGM is part of the broader socialisation of women to behave in gender-defined ways, including being docile and compliant with the wishes of male relatives and husbands. There may be a strong message that women are expected to suppress their thoughts and feelings.

Putting FGM in context

Some female refugees arriving in Australia will have experienced years, perhaps a whole lifetime of war, violence and famine. They may have been victims of torture and may have witnessed family members being killed, they have been displaced from their home and uncertain of their future. In addition they are likely to be struggling with relocation, adjustment to a new culture and environment, isolation and possibly experiences of racism. In this context, for some women FGM may well be low on the list of factors leading to physical and psychological health problems.

Key Messages for Women and Communities affected by FGM

- The practice is harmful to a person's health and wellbeing

- The practice is illegal in Tasmania and other parts of Australia. Many other countries have similar laws
- Tasmania wants to assist people and communities already affected, and to prevent the practice occurring again
- When settling in a new country, some traditions can go on, but harmful ones must stop. By slightly changing a ritual, you can celebrate your culture and still ensure women and children are healthy and benefit from all the education and employment opportunities
- Women and girls arriving in Tasmania may have special health problems due to the practice. There are services or male and female workers to provide sensitive and confidential support.

For more information

For information on training for clinicians and other education strategies in Tasmania, contact the FGM program officers (see contacts page in Appendix 9).

Much of the information in this section has been taken from the World Health Organization August 1996: More information can be obtained from: http://www.who.int/docstore/frh-whd/FGM/infopack/English/fgm_infopack.htm .

The publication: *Female Genital Mutilation: Information for Australian Health Professions*, published by the College of Obstetricians and Gynaecologists, is available at <http://www.ranzcog.edu.au> under the publications section.

Responding to Cultural Diversity in Women's Health A Resource for Health Professionals, by the Royal Women's Hospital, Melbourne
http://www.rwh.org.au/cultural_diversity/Cultural_Diversity_RWH.pdf

Summary Points – Section Six

- Rape is a common event in war and torture, and there is a high rate among refugee women
- Due to trauma and shame, many women will not volunteer this information, particularly if other family members are present
- Pregnancy testing and STI screening are recommended
- Female Genital Mutilation (FGM) is a common cultural practice in some African, Middle Eastern and Asian countries – rates vary from place to place
- Women who have been subjected to FGM vary in their attitude toward it. De-infibulation is available through gynaecological units at State Hospitals
- Unplanned pregnancy and terminations can be a source of great distress for many refugee women and confidentiality is extremely important

Section Seven: Men's Health

Social Role of Men

In some cultures, particularly many traditional African societies, the role of men in family and social structures is quite different than in western societies. Men who come from backgrounds where they are the 'head of the family', make all the decisions, earn and receive all family income, educate their children etc struggle with new expectations on them and new freedoms to their wives and children (especially daughters) when they arrive in Australia. For some men the impact of this on their self-esteem (particularly in relation to lack of employment) and sense of self can lead to stress-induced aggression (in public and private arenas), abuse of drugs and alcohol, somatising stress and risk taking behaviours.

Aggression and Violence

Many refugees have lived for long periods in very violent times, often fighting for their lives for extended periods. This can lead to a skewed vision of what constitutes 'violence' and what is 'normal'. While there is little reliable data, anecdotally service providers report high levels of domestic violence among refugee communities. Sexual abuse can occur to male children.

Approaches to Health Care and Counselling

Many men, particularly from a range of African cultures, can show a reluctance to admit they are not coping, or acknowledge that post-traumatic stress may be the cause of their anxiety or their depressive or somatic symptoms. There can be strong reluctance to participate in counselling among refugee men, due to stigma associated with mental health problems, so care is needed in explaining a referral for counselling or assessment. Group approaches that are activity based and get men talking to each other in a non-threatening environment can sometimes be a way of reducing barriers to talking about problems they are facing in adjusting to western life. For some, religious/spiritual guidance or rituals such as prayer may be beneficial.

Sexual Health and Sexual Behaviour

Male circumcision is widely practiced in some African countries and is often seen as a rite of passage. Often men would prefer to see a male GP if there are any sexual problems or concerns.

Some communities and religions have traditionally had a lack of access to, and stigma with using condoms, yet teenage and adult men, particularly in African communities can be very sexually active, and may need regular advice on safer sex practices as well as screening for STIs.

In some cultures the age of consent is different than in Australia, thus it may be advisable to discuss with new arrivals, Australian practices and laws concerning sexual relations including age of consent. Family Planning Tasmania provide education services throughout schools, and may have suitable resources available (see contacts in Appendix 9).

Summary Points – Section Seven

- The roles and power relations between men and women in western society can be quite different from the upbringing of refugee patients, and men may have difficulty adjusting to the freedoms women and girls experience here
- Violence toward women and children is believed to be common in refugee families in Tasmania
- Advice on safer sex, particularly condom use, is important for sexually active men and boys

Section Eight: Infant and Child Health

Material from previous sections of this guide also relates to children in most cases.

Children are particularly vulnerable refugees as the upheaval and deprivations experienced by their families is occurring at a time important for physical and psychological development.

Growth and Development

Impaired physical growth - many children's growth parameters are less than would be predicted by mid parental centiles. Mapping of catch up growth is important.

As children may have been raised in deprived or traumatic circumstances, their risk of developmental problems is greater than that of the general community.

Developmental assessment is advised with early referral to intervention services as appropriate. Parents will often not mention any developmental concerns as they are seen as low priority compared to other medical concerns.

Nutritional Deficiency

Iron deficiency - growing children have a higher requirement for iron. Iron deficiency is associated with poorer developmental outcomes.

Vitamin D deficiency and Rickets - as previously stated Vitamin D deficiency is very common in dark skinned people living in southern Australia. Children who are vitamin D deficient may present with macrocephaly, delayed milestones (especially motor) and bony changes. All dark skinned children need vitamin D supplementation over winter. See the nutrition information in Section 5 of this guide for more detail.

Infectious Diseases

Children are at risk of the same infectious illnesses as their parents (please see infectious diseases information in section 4 of this guide). It is important to check carefully for splenomegaly and to conduct a thorough examination of the skin and hair. Scars on the body may indicate an area of traditional medicine and give clues to previous health concerns.

Emotional and Behavioural Problems

The early experiences of refugee children predispose to a higher risk of behavioural issues. Some children have lost primary caregivers and arrive in family groups based around grandparents, older siblings or aunts and uncles. Families often view emotional and behavioural issues as 'bad behaviour' and are unaware that help is available through mental health services. Referral to the Phoenix Centre is recommended for initial assessment (referral proforma in Appendix 7).

Oral Health

Most refugee children have not seen a dentist. A check by the school dental service is advisable for those aged 0-18 years. Adults can access the public dental service for emergencies and a private dentist for non-urgent problems and maintenance. Phone numbers for bookings are listed in Appendix 9.

Summary Points – Section Eight

- Impaired development may be due to nutritional deficiency as well as lack of education and experiences of trauma
- A thorough health and developmental assessment is recommended
- Infants and children are exposed to much the same range of infectious illnesses as adults

Section Nine: Psychosocial Considerations

Psychological, psychosomatic and social problems can all arise from traumatic experiences including experiences of torture.

It can help to know a little about the background and current political and security situation in the country from which your patient is from, however as always there is great variation in experience so it is best to avoid making assumptions. Appendix 12 gives an overview of the background to major countries from which we receive refugees.

Figure 2 (below) gives an overview of the experiences that give rise to common psychological and emotional conditions experienced by refugees.

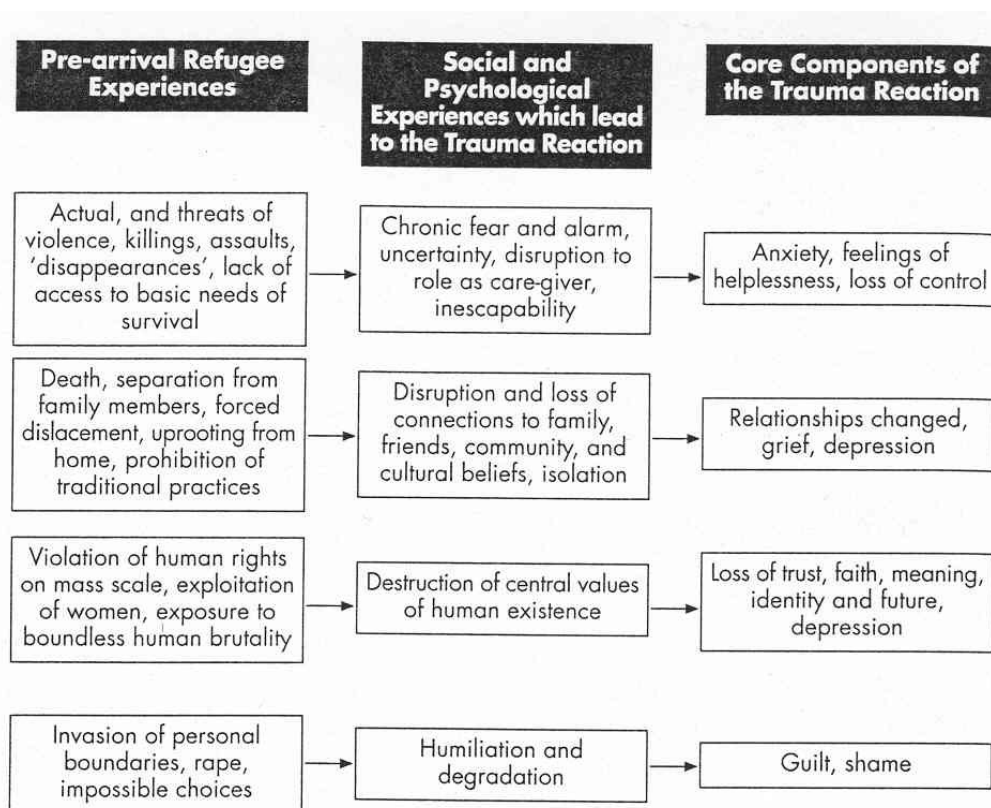


Figure 2: Summary of the psychosocial changes experienced by refugees (Kaplan and Webster, in Allotey ed. 2003)

Cultural and Spiritual Beliefs and Practices Relating to Health

Refugees have many different religious and spiritual backgrounds. Some religious or spiritual beliefs may impact on the patient's understanding of health and on consent to health treatment, especially invasive procedures. This can range from Muslim women not making eye contact or consenting to an examination from a male doctor, through to someone from a traditional culture believing that someone exhibiting psychiatric symptoms may be cursed. Understanding the beliefs that shape a person's approach to health and illness can assist in managing health care for that person.

One way to ascertain whether religious / spiritual beliefs are part of the patient's beliefs about their health may be to ask something like "what do you think is causing this?"

Refugees of Islamic faith usually observe the holy month of Ramadan, during which they abstain from eating and drinking during daylight hours. They may or may not make exceptions for medication that needs to be taken during the day, so it is always best to ask the individual. The month is determined by a lunar calendar, and usually runs from around mid-October to mid-November.

Seeking Information

For newly arrived refugees, the resettlement process is overwhelming and it may be wise to wait until later consultations before investigating trauma experiences and current psychological adjustments.

When asking a patient if they have experienced torture or other trauma be as sensitive as possible, perhaps phrasing the question something like: *“I understand that terrible things have happened to people who have been forced to leave their countries. Have you had any experiences that may be affecting you now that you would like to talk about?”* If the patient does not wish to discuss such things at the time the question is asked, it is advisable to reassure them that they can bring up any issues in any future consultation, when they are ready.

Responding to Disclosure

The way in which a health professional responds to a disclosure can determine whether the patient will feel comfortable in disclosing further information.

- Validate the patient’s reaction by acknowledging their experience and its associated pain
- Remind them that their reaction is a characteristic response to their circumstances. This is important because survivors often blame themselves – seeing their reactions as abnormal or weak
- The person who has disclosed a painful event may be unwilling to talk about it in subsequent consultations. Rather than pushing them to do so, talk about other things that may be troubling them in the here and now.

Traditional Medicines

Some patients may combine indigenous/traditional and biomedical forms of treatment simultaneously. If there is some suspicion that indigenous/traditional medication may be interfering with prescribed treatment, sensitively ask the person, or the family member in charge of decision-making for the sick person, what other forms of treatment are being concurrently given. Try to avoid expressing value judgments about the efficacy of the other treatments, as this may result in information not being given in the future.

Somatic Complaints

It is not uncommon for refugee patients to somatise stress. Consider the following approaches:

- Take complaints seriously and conduct appropriate examinations as this can serve to reassure patients when nothing is physically wrong. This is particularly relevant for patients reporting rapid heart beat

- Help the patient to make connections between the body and mind. Explaining the body's physiological response to extreme danger can be helpful in making this link (eg "fight, flight or freeze" response)
- Avoid dismissing somatic complaints or giving reassurances that they will 'go away with time'
- If somatic symptoms persist, consider a referral for counselling and support. The Phoenix Centre uses a holistic treatment model which may include natural therapies such as massage for somatic problems.

Torture

The main aim of torture and trauma is to destroy trust in others and in humanity and to create fear in the society. This may take place for the following reasons: to instill fear, to set an example to others, to enforce submission (break the spirit), punishment for political or religious opinions different from that of the government, punishment of family members for the actions of a single member of the family, deserting the army or refusing an order, refusing to conform, pay back to others, material gain, personal vendetta, to extract information, because the person is from a different ethnic or cultural background to the dominant group.

As well as the impact on the individual and their family, such events also affect the whole society through increasing social polarisation and isolation, destroying trust, and weakening personal autonomy and self-confidence. This continues to affect people's perceptions of the world around them even when living in Australia, and it may take years before they begin to develop a sense of trust again.

The effects of torture and trauma on the individual are often very complex, as the experiences affect the physical, mental and social health of the survivor. The magnitude of the impact of sexual violence, for example, is often difficult to assess as women are often reluctant to disclose due to the stigma and shame associated with rape.

Physical, psychological and social signs of possible experience of torture and trauma should be considered. Possible signs and symptoms of torture experiences include:

- Musculoskeletal - eg malunited bone, deformed or missing body parts - fingers, toes, tendon rupture, fibrosis of muscles or fasciae, abnormal gait, chronic pain
Skin - eg scars, burns
- Dental -eg broken or missing teeth, poor dental health due to malnutrition
- Ears/Nose/Throat/Eyes - eg perforated ear drums, visual impairment
- Genito-urinary - eg anal fissures and fistulae, anogenital scars/vaginal constriction
- Neurological - eg. confusion/disorientation, peripheral nerve damage
- Psychological – eg Post Traumatic Stress Disorder (PTSD), hyper-arousal, sleep disturbances, panic attacks, anxiety, depression, grief, tension reduction behaviour (eg alcohol abuse, violent outbursts)

In some cases there may be little or no physical evidence of previous torture. However, this does not mean that if other symptoms are present, torture and/or refugee trauma should not be considered.

Settlement Issues

As explained in Section Two of this guide, there are Commonwealth funded and volunteer programs which provide support for refugees in the early phase of their settlement. Contact details for these services in each region are provided in Appendix 9.

There are many issues that can emerge as refugees slowly become more and more exposed to the Australian community. Housing insecurity can become a major source of stress and GPs may be asked to fill out forms assessing eligibility for public housing. Other issues can include language barriers, fear and distrust of authority figures, cultural clashes related to the rights of women and children, and religious practices.

Referrals

The Phoenix Centre is the recommended service provider for referral of refugee patients for torture or trauma issues. The Centre is funded by the Commonwealth Departments of Health and Ageing and Immigration, Multicultural and Indigenous Affairs, and is supported by the Tasmanian Department of Health and Human Services to provide torture and trauma counselling and associated services to refugees in Tasmania.

The Phoenix Centre:

- Runs the Early Health Assessment and Intervention Program (EHAIP)
- Provides a counselling service, enabling clients to work through traumatic experiences in a safe and private environment in their own language, and at their own pace
- Offers a Natural Therapies Program which provides individual and group sessions to improve clients' health and wellbeing in a less confronting way than counselling
- Offers community education and training to other professionals in torture and trauma awareness.

The centre works cooperatively with other health professionals to meet clients' needs.

It is important to be aware that in some communities, seeing a counsellor has great stigma attached and can be interpreted as the client being seen as "crazy". It may be helpful to normalise "talking about your experience in a confidential setting" as something that all new arrivals do, and avoid the term "counselling". Some cultures and languages do not even have a word for "counselling".

To refer a client to the Phoenix Centre, simply fax the referral proforma in Appendix 7, and the Phoenix Centre will contact the client within a week to make an appointment. The referring doctor will be informed if there is a waiting list for counselling services.

Case Studies

Mr W., a 45 year old man from Liberia, was referred to a GP shortly after his arrival in Tasmania. He presented with headaches, disturbance in sleep pattern, nightmares, difficulties with concentration and rapid heart beat, which was triggered by loud noises. During the war, his parents were shot in his presence.

He was told by the GP that he would benefit from the help of a mental health professional. Mr W. immediately declined such a referral and did not respond to further questioning. He instead asked for medication to help him sleep. A prescription was given to Mr W to alleviate his symptoms. The GP also invited Mr W to see him again in case he would like to be referred to a mental health professional.

One week later, the GP was informed by a priest that Mr W had started to see him for spiritual counselling and that he seems to be doing fine. Mr W had explained to the priest that he is a devoted Christian who believes that all tragedies, including the war in his country are due to the sinful act of human beings. Therefore he would only be able to overcome his suffering and the memories of his traumatic experiences with the help of prayers.

Ms F. is a 34-year-old woman from Ethiopia. She was complaining of neck and back pain and headaches. She was also unable to sleep without the help of sleeping pills.

On further investigation she revealed that she had been suffering pain from the neck and headaches for 5 years. This started when she had to flee her home country for a refugee camp. She had been taking large doses of strong pain tablets for this amount of time as well as sleeping pills. The pills were bought in a regular chemist in Africa, without prescription. She felt that the sleeping pills were no longer effective and wanted something stronger. Ms F. was afraid she might have a brain tumour.

Later she revealed that she had been seeing a counsellor for torture/trauma issues in Africa for 2 years. When offered counselling she declined until she could get her pain under control.

The GP changed her medication and arranged for neck x-ray and head scan. It was also recommended that she see a natural therapist for massage and relaxation. With counselling suggested as a long-term option.

Summary Points – Section Nine

- Trauma, displacement, loss, fear, violence and a range of human rights violations are almost universal experiences for refugees
- The process of settling in a new country can be overwhelming, and issues related to this may be apparent in the first instance, with evidence of past trauma emerging as time progresses
- The Phoenix Centre specialises in torture and trauma counselling, and is recommended for referrals

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Appendices

- Appendix 1 Booking Interpreters – A Guide for Practice Staff
- Appendix 2 Working with Interpreters – A Guide for GPs
- Appendix 3 Availability and Cost of Medications
- Appendix 4 Suggested History and Examination Protocol
- Appendix 5 Immunisation Recommendations
- Appendix 6 Referral to the Refugee and Humanitarian Arrival Clinic (RAHAC)
- Appendix 7 Referral Letter to Phoenix Centre
- Appendix 8 Fact Sheet on Vitamin D Deficiency
- Appendix 9 Contacts & Useful Websites
- Appendix 10 Integrated Humanitarian Settlement Strategy (IHSS)
- Appendix 11 Acronyms
- Appendix 12 Specific Country Information

Appendix 1 Booking Interpreters – A Guide for Practice Staff

Many newly arrived refugees will not speak English or their proficiency in English will not be good enough to speak about and understand health issues in a medical consultation, and they will need a professional interpreter .

It is the service provider's responsibility to provide an interpreter if one is needed.

When the appointment is made

When refugees arrive in Tasmania they are offered assistance from Community Support for Refugees (CSR) volunteers.

Normally it will be one of these workers who will ring to make an appointment, and they will accompany the patient to the appointment. It is important to record their name and contact details as well as the patients, in case you need to ring someone eg to change the appointment time.

They will inform you if an interpreter is required, and if so, of the language and dialect required and whether a female or male interpreter would be preferable.

The patient may also have a little business sized card ("I need an interpreter" cards) with their name and language and the interpreter service phone number. These are produced by state government and distributed to new arrivals as part of their settlement program.

Please note that if a telephone interpreter is required, check with the doctor as to whether a hands-free speaker phone will be required in the doctor's consulting room and how much time will be needed for the appointment.

It is often better to make appointments toward the end of the day as English lessons for refugees are run in the mornings and if the consultation includes children, try to make the appointment outside of school hours. It may also be advisable to make the appointment at the end of the doctor's session for that day as there can be a high rate of failure to attend appointments among new arrivals.

Registering with the Interpreting Service

The Department of Immigration and Multicultural Affairs (DIMIA) runs the Translating and Interpreting Service (TIS), which is the recommended interpreter service for medical consultations. Telephone interpreting (not on-site) is provided as a free service for any consultation billable under Medicare.

Before your medical practice can access TIS services, you need to register each medical practitioner with TIS so they can be allocated a Client Code Number.

This can be done over the phone or by fax (see proforma). Ring 1300 131 450 and have the following information ready:

- Doctor's name
- Phone and fax numbers for the doctor
- Name, phone and fax numbers for the person requesting the client code (ie receptionist)

- Postal and street addresses of the medical practice
- Whether the doctor is a GP or specialist
- Medicare provider number or medical registration number

For GPs who work in more than one practice, they will have one code that they can use regardless of which practice they are in.

Record on the patient's file if they need an interpreter, including the language, dialect, gender and other cultural/political requirements.

Options for Interpreters

There are two options for interpreters, face-to-face and telephone.

Face to face interpreters can be arranged within certain hours if booked two weeks in advance although in Tasmania the range of languages is very limited. The form "request for on-site interpreter" needs to be faxed to TIS to arrange a booking. There is a fee for on-site interpreters that must be paid for by the service provider (not the patient).

Telephone interpreters from TIS can also be pre-booked and are provided as a free service for any consultation billable under Medicare.

To pre-book an interpreter, fill out the "request for pre-booked telephone interpreter" form and fax to TIS. This can be done a minimum of 2 weeks in advance, and up to 3 months in advance.

For Emergencies or Short Notice

TIS also runs the Doctors Priority Line which operates 24 hours a day 7 days a week. For major languages a translator will be available within a few minutes. The TIS Doctors Priority Line phone number is **1300 131 450**.

When ringing for an interpreter on the Doctors Priority Line, you will be asked to provide the following details:

- The Doctor's client code number
- Your patient's name and gender (and perhaps religion)
- Language or dialect requirements
- Estimated length of time needed (remember that everything needs to be said twice, so consultations take longer than usual)
- Time and venue of medical consultation

For general enquiries of TIS or for feedback or complaints phone **131 450**.

Translating and Interpreting Service

Medical Practitioner Registration Form / Application for Client Code Number

TIS may use a range of means to communicate with you. However, electronic means such as fax or e-mail will only be used if you indicate your agreement to receiving communication that way. Electronic communications, unless adequately encrypted, are not secure and may be viewed by others or interfered with. If you agree to TIS communicating electronically with you, the details you provide will only be used by TIS or its contractors, for the purpose for which you have provided them.

I authorise TIS to communicate with me via:

Fax Email

(email address)

Application Details:

Date:/...../.....

Doctor's full name

Doctor's phone number

Doctor's fax number

Type of practitioner
(eg GP or Specialist)

Medicare provider number or
medical registration number

Name of person requesting the code
(eg receptionist or practice manager)

Phone number of person requesting code

Fax number of person requesting code

Name of Practice

Postal Address

Suburb & Postcode

Street Address

Suburb & Postcode

Fax to: 1300 654 151

Email: tis@immi.gov.au

Translating and Interpreting Service Request for Pre-Booked Telephone Interpreter

TIS may use a range of means to communicate with you. However, electronic means such as facsimile or e-mail will only be used if you indicate your agreement to receiving communication that way. Electronic communications, unless adequately encrypted, are not secure and may be viewed by others or interfered with. If you agree to TIS communicating electronically with you, the details you provide will only be used by TIS or its contractors, for the purpose for which you have provided them.

I authorise TIS to communicate with me via e-mail facsimile

Your e-mail address _____

Information you provide will be disclosed to independent contractor(s) related to their undertaking the requested interpreting assignment(s). Each TIS contractor is obliged contractually to protect personal information revealed in the course of interpreting.

Your State: NSW/ACT NT QLD SA TAS VIC WA

Your TIS Client code

C

Language

Your Agency* Name

Special Language Needs

If applicable include dialect

Booking Contact

Full name with family name in BLOCK letters

Non-English Speaker

Your Agency Phone and Fax No

Phone

Fax

Phone

Fax

Non-English Speaker's Phone No



date ____/____/____

start time _____ AM/PM

finish time _____ AM/PM

A. Is your client a Temporary Protection Visa (TPV) holder? Y N

B. Is the consultation related to compensation or litigation claims? Y N

If YES to Question B, a letter from the relevant insurance company quoting the claim number and accepting TIS charges must be attached to this request.

Office use only

Job Number

Contractor

How to make a pre-booked telephone interpreter booking



When completed, please fax or e-mail this form to:

Fax 1300 654 151

tis@immi.gov.au



TIS will allocate an interpreter and send a confirmation to you with a JOB NUMBER



On the day of the job, just prior to the start time of the pre-booked job:

- Telephone TIS on **131 450**
- Inform the TIS operator that you are calling about a pre-booked call
- Quote the pre-booked job number and TIS will connect you with the interpreter.

* Please notify TIS of any change in Billing Address

Bookings will only be taken for appointments up to 3 months in advance from the date of request. Cancellations must be made in writing providing valid reasons for the cancellation at least 24 hours prior to the appointment or the client will be charged. The cancellation fee is for the period of the phone booking.

TAS

Translating and Interpreting Service Request for On-Site Interpreting

TIS may use a range of means to communicate with you. However, electronic means such as facsimile or e-mail will only be used if you indicate your agreement to receiving communication that way. Electronic communications, unless adequately encrypted, are not secure and may be viewed by others or interfered with. If you agree to TIS communicating electronically with you, the details you provide will only be used by TIS or its contractors, for the purpose for which you have provided them.

I authorise TIS to communicate with me via e-mail facsimile _____
Your e-mail address

Information you provide will be disclosed to independent contractor(s) related to their undertaking the requested on-site interpreting assignment(s). Each TIS contractor is obliged contractually to protect personal information revealed in the course of interpreting.

Your TIS Client code	C	Language	
Your Agency * Name		Special Language Needs	If applicable include dialect
Site Contact & Phone	Full name with family name in BLOCK letters	Non-English Speaker	Full name with Family name in BLOCK letters
Site Address		Your Agency Phone and Fax no.	Phone
Booking Contact			Fax

Client Reference/ Requirements or Nature of appointment

Option 1 date ____/____/____ start time ____ AM/PM finish time ____ AM/PM

Option 2 date ____/____/____ start time ____ AM/PM finish time ____ AM/PM

Options will assist where interpreters are not available for your first appointment option

A. Is your client a Temporary Protection Visa (TPV) holder? Y N

B. Is the consultation related to compensation or litigation claims? Y N

If **YES** to **Question B**, a letter from the relevant insurance company quoting the claim number and accepting TIS charges must be attached to this request.

Office use only	Job Number	Contractor
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When completed, please fax or e-mail this form to:

Fax 1300 654 151

tis@immi.gov.au

Please notify TIS of any change in Billing Address

Bookings will not be taken earlier than 3 months prior to the assignment date (4 weeks prior to the assignment date for fee free requests). Cancellations must be Cancellations must be made in writing providing valid reasons for the cancellation at least 24 hours prior to the appointment or the client will be charged. The minimum cancellation fee is 1.5 hours unless the booking was for a specifically longer period. A booking for multiple day interpreting with less than 24 hours cancellation notice will attract a cancellation fee equivalent to a full day's work including interpreter travel time and costs.

Appendix 2 Working With Interpreters – A Guide for GPs

Working with Interpreters during the consultation

Telephone interpreting can be done via a hand-free speakerphone or dual handset. If using a single handset telephone, inform the interpreter and allow conversation to be guided by the interpreter. When connected to the telephone interpreter, introduce yourself and your patient and tell the interpreter clearly and briefly about what it is you will be doing during the session.

In situations where a family member insists on accompanying the patient and you feel you cannot have a confidential discussion with the patient, a single handset may be better, as the family member will not be able to hear or participate in the conversation between you and the patient (for example a woman's husband may not allow dialogue about contraception, abortion or reversal of female genital mutilation but the woman may wish to talk to you about these things).

The effectiveness of using interpreters is optimised when you place yourself face to face with the patient (without barriers such as desks and equipment), and the interpreter (or phone) is located off-side but at equal distance between yourself and the patient (to form a triangle).

It is important to brief the interpreter

- Explain to the interpreter the reason for the consultation, or give a brief overview of what you want to achieve
- If needed, make them aware of circumstances relating to the patient that is likely to impact on the interview
- Establish a style of interpreting: you say a few sentences, and pause to allow the interpreter to translate etc
- Ask the interpreter for feedback – ask them to tell you if they do not understand the terms you use, or if the terms are not easily translated. Ask them to tell you if the patient is expressing a culturally related idea or concept that they think you may not understand
- Ask the interpreter if they have any concerns they want to share with you before ending the consultation

During the session

- Introduce yourself, then the interpreter to the patient
- Explain your role and that of the interpreter, and that you are both bound by Codes of Ethics and Confidentiality. You may need to explain what you mean by confidential
- Explain the purpose of the consultation. Do not presume the patient knows
- Explain how the consultation will proceed
- Set ground rules:
 - Make sure only one person speaks at a time
 - Ask everyone to try to avoid speaking too long, as the interpreter has to remember all the details of what has been said
 - Repeat information if the patient appears confused
 - Encourage patients to ask questions or raise concerns
- Explain the role of all participants to the patient
- Welcome any support person who may have accompanied the patient (with the patient's consent), but discourage that person's involvement in interpreting, especially without consent procedures.

Some Helpful Tips

- Speak and attend directly to the patient and always use first person (“how are you?” instead of “Ask the patient how she is”)
- Speak clearly and more slowly than usual
- Use short concise sentences in plain English where possible
- Pause to allow time for translation
- Watch the body language of both yourself and your patient, respond accordingly
- Clarify cultural aspects directly with your patient through the interpreter
- Summarise regularly if information is complex
- Give specific instructions for each action throughout the consultation
- If using an on-site interpreter, don’t look at the interpreter unless speaking directly to him/her
- Don’t try to save time by asking the interpreter to summarise
- Do not use jargon or slang, and don’t make jokes as humour is hard to interpret and may damage rapport

At the End of the Session

- Summarise the main issues discussed in the consultation, as well as follow-up requirements
- Check and ensure the patient has properly understood them
- Ask the patient if they have any more questions or concerns
- Arrange further appointments and referrals if necessary and provide date, time, location and name of person they are required to see to the patient in writing
- Thank both the patient and the interpreter and say a formal goodbye

Debrief with the Interpreter in Necessary

- It is your responsibility to debrief the interpreter, particularly if the information has been distressing
- Clarify information about the patients socio-cultural or religious background or language variety
- Determine whether or not there was a language difficulty that needs to be addressed prior to the patients next appointment

Complaints

- If you wish to give feedback are not satisfied with the interpreter service provided, report the complaint to the TIS team leader on 131 450.

Appendix 3 Availability and Cost of Medications*

Drug	Indication	Access	Cost
Anthelminths			
Metronidazole	Giardiasis, Dientamoeba	PBS	
Praziquantel	Schistosomiasis, Hymenolopsis	Unrestricted	\$52.54 x 8 tabs
Albendazole	Hookworm, Whip-worm, Hydatids	PBS/RPBS	\$26.68 / 6 x 200mg tabs
Ivermectin	Strongyloidiasis	PBS/RPBS	\$29.31 x 4 tabs
Paramomycin	E.histolytica cyst carriage	SAS Catagory B	N/A
Antibiotics			
Isoniazid	RHH only		
Benzathine penicillin	Latent syphillis	RPBS	\$42.76 per dose
Antifungals			
Itraconazole syrup	Dermatophyte infections		Private \$237.57 x 150ml
Terbinafine	Dermatophyte infections		Private \$262.96 x 42 tabs
Supplements			
Oral			
	Iron deficiency	Unrestricted	
Fergon	Iron deficiency	Unrestricted	\$9.42 x 100mls
Ergocalciferol capsules	Vitamin D deficiency	Unrestricted	\$14.25 x 60 tabs
Ergocalciferol syrup	Vitamin D deficiency	Unavailable	N/A
Penta-vite drops	Vitamin D deficiency	Unrestricted	\$17.10 / 50ml
Penta-vite tablets	Vitamin D deficiency	Unrestricted	\$19.79 x 90 tabs

**current as at May 2005 but subject to change*

Appendix 4 Suggested History and Examination Protocol

Adult Health History

Date _____

Adult History

Last Name _____ First _____ MI _____

DOB _____ Age _____

Address _____

Female History

1. Para _____ Gravida _____

2. LMP _____

Health History

1. Hospitalisation
2. Surgery
3. Major illnesses
4. Allergies
5. Drug allergies
6. Accidents
7. Recent medications/remedies
8. Immunisations (attach record)
9. Smoking
10. Alcohol use

Review of Systems Norm Abnorm/Comments

1. General (malnutrition, weight loss, fever)
2. Skin (rash, scars, wounds)
3. Neuro (seizures, headache, vision, hearing)
4. ENT (throat, masses, caries, discharge)
5. Respiratory (SOB, cough, haemoptysis)
6. CVS (BP, chest pain, SOA, palpitations)
7. GIT (N&V, constipation, bloody stool)
8. GU (discharge, hernia, urinary problems)
9. GYN (pregnancy, discharge, bleeding, female circumcision)
10. Musculo-skeletal (limp, pain, swelling, back pain)
10. Pysch (depression, anxiety, nightmares, suicidal ideation)

Paediatric Health History

Date _____

Paediatric History

Last Name _____ First _____ MI _____

DOB _____ Age _____

Address _____

Social history.

Country of origin, country of transit, ethnicity

Language group (essential for interpreters, cultural information)

Family dynamics

Religious group

Education child and parent- are the parents literate?

Birth History

1. Problems in pregnancy including nutrition status
2. Problems in birth
3. Maternal medications
4. Developmental milestones (walking, talking, socialising)

Health History

1. Hospitalisation
2. Surgery
3. Major illnesses
4. Allergies
5. Drug allergies
6. Injuries
7. Recent medications/remedies
8. Immunisations
9. Nutrition

Review of Systems

1. General (malnutrition, weight loss, fever)
2. Skin (rash, scars, wounds, hair)
3. Neuro (seizures, headache, vision, hearing)
4. ENT (throat, masses, caries, discharge)
5. Respiratory (SOB, cough)
6. CVS (murmurs, pain)
7. GIT (N&V, constipation, bloody stool)
8. GU (discharge, hernia, urinary problems)
9. Musculo-skeletal (limp, pain, swelling, back pain)
10. Psych (depression, anxiety, nightmares, suicidal ideation, behaviour problems)
11. Developmental concerns

Physical Examination

Height _____ Wt _____ head circumference BP _____ Temp _____ Pulse _____
Resp: _____

General appearance: Nutritional status, rickets wasting (HIV infection, TB, visceral leishmaniasis, other chronic illness). Screen developmental status

Skin: Ulcers (leishmaniasis, tuberculosis), lesions or rashes (lice, scabies, fungal infections, molluscum contagiosum, yaws, pinta, cutaneous larva migrans, filarial infections, mycetoma), rash (viral exanthems). Scars from traditional medicine

Head and neck: Observe facies, assess hearing, perform otoscopy, examine mouth and teeth, and inspect nasal passages. (Otitis media or externa, perforated tympanic membrane, oral thrush, dental infections)

Eyes: Test visual acuity, perform fundoscopy and assess conjunctiva. (Trachoma, filarial infections, bacterial conjunctivitis, vitamin A deficiency pterygia).

Adenopathy: Examine for peripheral lymphadenopathy, examine liver and spleen (TB, HIV infection, human T-cell lymphotropic virus type I (HTLV-I), Epstein-Barr virus, Hansen's disease, melioidosis, chancroid, lymphogranuloma venereum, plague, and many others).

Respiratory system, with observation of cough and sputum production: (Asthma, bronchitis, pneumonia, pleural effusion, TB, , malignancy).

Cardiovascular system: (Congenital heart disease, rheumatic heart disease, endocarditis, dilated cardiomyopathy, murmurs).

Abdomen: Tenderness, masses, hepatosplenomegaly (malaria, viral hepatitis, schistosomiasis, visceral leishmaniasis, tropical splenomegaly), ascites (advanced liver disease, tuberculous or bacterial peritonitis, malignancy), focal tenderness (bacterial or amoebic liver abscess,).

Pelvis: Genital ulcers (syphilis, chancroid, herpes), cervicitis (gonorrhoea, chlamydia), pelvic inflammatory disease, sequelae of female genital mutilation, endometritis (if recent delivery or abortion). Problems post circumcision.

Extremities: Lymphoedema (filariasis), loss of distal digits (Hansen's disease), generalized oedema (cardiac or liver disease or postmalarial nephrotic syndrome), deformities due to uncorrected congenital abnormalities, trauma and rickets.

Central and peripheral neurological disease: Chronic dementing disease (HIV infection, African trypanosomiasis, others), anaesthetic lesions (Hansen's disease), focal findings (cerebral cysticercosis, tuberculoma, toxoplasmosis, hydatid disease), spastic paraparesis (HTLV-I), asymmetric leg weakness (prior polio).

Appendix 5 Infectious Diseases & Their Treatments

The following is more detailed information regarding infectious diseases sometimes found in refugee patients. These diseases are rarely found in the general community. Listings are alphabetical.

Ascariasis

Primary Distribution	Worldwide. With an estimated one billion infected persons worldwide, ascariasis is the most common human helminthic infection.
Agents and Vectors	<i>Ascaris lumbricoides</i> (nematode or roundworm) eggs are ingested via water, food, or hands contaminated with human faeces. Eggs or larvae of the ascarids of dogs or cats (<i>Toxocara</i> spp.) may be ingested by children or the larvae may pass through the skin. After passage in stool, eggs mature and become infective in 5-10 days; and may remain so for up to two years.
Incubation	1-6 months
Signs and Symptoms	Transient respiratory symptoms of pneumonitis with productive coughing (sometimes slight hemoptysis), wheezing, pulmonary infiltrates, and fever occur after the eggs hatch in the small intestine and the larvae travel to the respiratory system. Gastrointestinal symptoms include most commonly vague and/or colicky abdominal pain; and also nausea and vomiting, with vomitus sometimes bile-stained and sometimes containing worms. Steatorrhea and diminished vitamin A absorption also may occur. The adult worms may be more than 20 cm. in length, hence are easily seen in the stool. Worms may also emerge from the nose or mouth as a result of coughing or vomiting.
Complications	Children are more likely than adults to have complications, which, with heavy worm burdens, may include hiatal hernia, duodenal ulcer, bowel obstruction, perforation, appendicitis, pancreatitis, cholecystitis, cholangitis, obstructive jaundice, diverticulitis, invasion of other organ systems, malnutrition, and stunted growth.
Laboratory Findings	Eosinophils (30-50%) are elevated during the pulmonary phase, but not in the intestinal phase.
Diagnosis	Visualization and description of the worms establishes diagnosis. Microscopic exam of direct faecal smear shows eggs or ova. Diagnosis of pulmonary ascariasis is primarily on the basis of clinical data. Chest radiographs may show patchy, ill-defined transitory asymmetric infiltrations (Loeffler's syndrome). With bowel obstruction, abdominal radiographic examination (with or without barium) shows worms, especially in large air-filled bowel loops.
Differential	Pulmonary: asthma, pneumonia, aspergillosis, strongyloidiasis,

Diagnosis	hookworm, or other parasitic infections. The intestinal phase may resemble a variety of gastrointestinal problems (also see complications above). Postprandial dyspepsia may appear as duodenal ulcer, hiatal hernia, pancreatic or gall bladder disease.
Treatment	Albendazole 400 mg (200 mg for children < 10 kg) PO as single dose.

Filariasis:

Primary Distribution	Numerous areas of the world, with variants and locations noted below under vectors and agents.
Agents and Vectors	<p>The filarial parasites are tissue-dwelling nematodes (roundworms) whose microfilaria (mf) larvae are transmitted by several species of mosquitos or flies as follows:</p> <ul style="list-style-type: none"> ▪ Bancroftian filariasis is caused by the nematode <i>Wuchereria bancrofti</i>, transmitted by <i>Anopheline</i> mosquitos, and occurs in much of the tropical and subtropical world (except western South America and Northern Australia) between the Tropics of Cancer and Capricorn ▪ Malayan filariasis is caused by the nematode <i>Brugia malayi</i>, transmitted by <i>Mansonia</i> or <i>Anopheline</i> mosquitos, and occurs primarily in Malaysia, Indonesia, and some nearby pacific Islands, as well as scattered areas of India, Bangladesh, Vietnam, and China. <i>Brugia timori</i> infections are similar, confined to Timor and nearby islands, and transmitted by <i>Anopheles barbinotris</i> - which also carries malaria ▪ Loiasis (loa loa) is caused by the nematode <i>Loa loa</i> (African eye worm), transmitted by <i>Chrysops</i> (red) flies, and occurs in tropical Africa ▪ Onchocerciasis (river blindness) is caused by the nematode <i>Onchocerca volvulus</i>, transmitted by <i>Simulium</i> blackflies, and occurs primarily in equatorial Africa (and also in South America and the Middle East). The vectors breed only in swiftly moving water, hence endemic areas are confined to such locales ▪ Other filarial parasites exist but are of less public health significance ▪ Incubation: Variable according to species. Symptoms may begin six months or longer after infection.

Bancroftian filariasis or Wuchereria bancrofti and Brugia malayi infection

Clinical Findings	(Note: <i>Wuchereria bancrofti</i> and <i>Brugia malayi</i> infections are similar, except that <i>B. malayi</i> is less widely distributed (see above) and the clinical features of <i>B. malayi</i> tend to be less severe.)
Signs and Symptoms	Adult worms live in lymph vessels and nodes, while the mf are found primarily in the blood. Symptoms begin four to twelve months (usually > six) after infection, and not all infected persons

are symptomatic. Symptoms usually begin with localized inflammation in genitalia or extremities. Lymphadenitis and lymphangitis begin at a single site and spread regionally within hours. Acute onset recurrent bouts of fever, chills, headache, and malaise also occur. Lymphedema may begin accumulating in the first 24 hours. Acute symptoms of mild attacks resolve within a few days; with lymphedema taking several weeks to resolve. Hydrocele, orchitis, epididymitis, and/or funiculitis are common in males. Filarial abscesses are usually found in the groin or axillae; but among patients from the Pacific Islands, may also occur in deep fascial spaces of muscles. Chronic disease may lead to chronic obstruction of lymph and serous fluid resulting in chronic and permanent (and disabling) elephantiasis of the lower extremities or testes; and to a lesser extent, arms, breasts, labia, and penis. Chyluria (galacturia) results from chyle (lymph and triglyceride in an emulsion) in the urine caused by obstruction between intestinal lymphatics and thoracic duct leading to rupture of renal lymphatics into renal tubules.

Complications	Chronic lymphedema leads to elephantiasis, which includes hyperplasia of skin and subcutaneous tissue - all of which predispose to ulceration and secondary infection. The size and weight of the affected parts lead to disability.
Laboratory Findings	Moderate eosinophilia, elevation of serum concentrations of IgE and antifilarial antibody.
Diagnosis	Note that the life cycle of the mf varies according to species and area in which the disease is contracted and mf concentrations vary according to the time of day (diurnal periodicity) and that depending on these factors, peripheral blood of infected persons may or may not have mfs. Microfilariae are detectable primarily in blood and hydrocele fluid. Giemsa-stained thick blood film is a commonly used test. Polymerase chain reaction-based assays are available for the presence of <i>W. bancrofti</i> and <i>B. malayi</i> in blood and sputum. Ultrasound of the scrotum detects adult worms, nodules, or lymphatic dilatation in 80% of affected men. ELISA, CFT, and IFAT tests for serum are also available and are highly accurate.
Differential Diagnosis	Acute bacterial lymphangitis, thrombophlebitis (although lymphatic filariasis may feature thrombophlebitis), lymphogranuloma inguinale and other infections; other causes of recurrent fever such as tuberculosis or urinary tract infection; other causes of orchitis and related disorders such as gonorrhoea, tubercular epididymitis, hernia, trauma, etc. Persons from Ethiopian highlands may present with African "bigfoot" disease, which does not include hydrocele.
Treatment	Treatment is undertaken by an Infectious Diseases Physician. Ivermectin in a single oral dose of 100-400 mcg/kg; sometimes combined with albendazole may be used. Alternative treatment (first-line in some references) is diethylcarbamazine (DEC).

Loiasis

Signs and Symptoms	Loiasis is often asymptomatic among indigenous people of endemic areas, but more problematic among non-indigenous persons who are infected. The worms live in subcutaneous tissues and cause intermittent development of localized areas (> 10 cm) of erythema and angioedema (Calabar swellings), usually on the extremities. Moving worms are sometimes visible in the eye between the bulbar conjunctiva and sclera.
Complications	Rarely seen complications are nephropathy, encephalopathy, and cardiomyopathy.
Laboratory Findings	Eosinophilia, increased antifilarial antibodies, hypergammaglobulinemia, increased IgE, and increased leukocyte and eosinophil counts.
Diagnosis	See <i>Wuchereria bancrofti</i> and <i>Brugia malayi</i> infections above; the presence of a worm in the eye is diagnostic.
Treatment	Treatment is undertaken by an Infectious Diseases Physician. The following is for your information only. Diethylcarbamazine (DEC) given in graduated doses as follows: Day 1: 50 mg po; day 2: 50 mg po tid; day 3: 100 mg po tid; days 4-21: 9 mg/kg/d po in 3 divided doses. Alternative treatment is ivermectin in a single oral dose of 100-400 mcg/kg; sometimes combined with lower doses DEC (0.5-1.0 mg/kg/d in combination with corticosteroids. Multiple courses of treatment with DEC are required in about 50% of patients.

Onchocerciasis

Signs and Symptoms	Unlike other filarial infections, the problems of onchocerciasis are caused by mf rather than adult worms. Very severe pruritus, with or without papular rash is caused by mf in subcutaneous tissue. Subcutaneous nodules (onchocercomata) contain adult worms. The skin may eventually lose its elasticity and become atrophied and fibrous, and in some cases, hypo or hyper-pigmentation occurs. Eczema and secondary infections may result from scratching. Skin involvement among patients in Africa tends to be greatest on the lower extremities, while in Central America, the head is more commonly involved. Involvement of the eyes usually is manifested first by conjunctivitis and photophobia. Neovascularization, keratitis, and corneal scarring occur in a small percentage of patients and lead to blindness. Uveitis, chorioretinitis, and optic atrophy also occur; as may secondary glaucoma. Lymphadenopathy in the femoral and inguinal areas may lead to "hanging groin."
Complications	Cachexia may occur with heavy infestation.
Laboratory Findings	Eosinophilia.
Diagnosis	Skin biopsy (snips) is incubated in tissue culture medium or saline and within 2-24 hours, mf can be visualized in a low power

microscope.

Differential Diagnosis	Other causes of pruritis, eczema, nodules, conjunctivitis, and eye infection.
Treatment	Treatment is usually undertaken by and Infectious Diseases Physician. The following is for your information only. Ivermectin in a single oral dose of 150 mcg/kg, repeated every 3-12 months kills mf, but not adult worms. Because of proximity to eyes, nodules on the head are sometimes removed.

Leishmaniasis: Visceral (Kala-Azar), Cutaneous, and Mucocutaneous Leishmaniasis (Espundia)

Primary Distribution	East and North Africa, Middle East, Southern Europe, Central, South, and East Asia, South America, West Mexico.
Agents and Vectors	<p>The protozoal parasite species <i>Leishmania</i> is transmitted through the bite of female sandflies (phlebotomine) as follows:</p> <ul style="list-style-type: none">• Visceral leishmaniasis or kala-azar is caused primarily by <i>L. donovani</i>, <i>L. chagasi</i>, or <i>L. infantum</i>. Dogs (feral or domesticated) are a reservoir for <i>L. chagasi</i>.• Cutaneous leishmaniasis usually divided into (1) Old World leishmaniasis caused primarily by <i>L. tropica</i>, <i>L. major</i>, <i>L. aethiopica</i>, and (2) New World leishmaniasis caused primarily by <i>L. Mexicana</i> or <i>L. braziliensis</i>. Diffuse cutaneous leishmaniasis is caused primarily by <i>L. aethiopica</i> or <i>L. mexicana</i>.• Mucocutaneous leishmaniasis (espundia) is caused primarily by <i>L. (viannia) braziliensis</i>. Altogether, there are about 21 leishmanial species that are transmitted by about 30 species of sandflies.
Incubation	Usually 2-6 months or longer. Relapse may occur as many as 10 years after first episode. Local trauma sometimes activates latent infection in cutaneous leishmaniasis.

Visceral Leishmaniasis (Kala-Azar)

Signs and Symptoms	Cardinal signs of visceral leishmaniasis (VL) are prolonged fever, splenomegaly, anaemia, leukopenia, or hypergammaglobulinemia. A cutaneous nodule may or may not appear at the site of the bite within several days of inoculation. If present, the nodule remains, but in most cases, no other symptoms are present for at least several months. Systemic symptoms include gradual onset fever that often rises and falls twice/day, fatigue, weight loss, dizziness, cough, and diarrhoea. Visceral manifestations include pronounced splenomegaly (hard, non-tender) and to a lesser extent hepatomegaly. Other manifestations may include generalized lymphadenopathy; hyperpigmented skin of the forehead, abdomen, hands, and feet in light-skinned persons; skin lesions in dark-
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skinned persons; signs of bleeding (petechiae, epistaxis, bleeding gums); jaundice and ascites; and progressive wasting. Onset may also be acute, with the above manifestations appearing a few weeks after infection.

Complications	Progressive wasting or intercurrent infections (e.g., pneumonia, tuberculosis, diarrhoea) may lead to death. Post kala-azar cutaneous leishmaniasis may occur as many as 10 years after the first episode. Lesions may resemble Hansen's disease and include hypopigmented macules, nodules, and erythematous patches. Leshmaniasis may occur as an opportunistic infection in immunocompromised persons. The disease may also be passed from an asymptomatic mother to her child.
Laboratory Findings	Leukopenia, hypergammaglobulinemia, hypoalbuminemia; thrombocytopenia with hemorrhagic fever.
Diagnosis	Presence of cardinal signs noted above, in addition to living in or visiting endemic area lead to suspicion of leishmaniasis. The organism is present in bone marrow or splenic aspirate (most sensitive), blood, and nasopharyngeal secretions. If parasites are present in sufficient concentration, light microscopy of giemsa-stained slides reveals amastigotes, the tissue form of the parasite. Direct agglutination and ELISA are positive early and the leishmanin skin test is positive only after active disease.
Differential Diagnosis	Brucellosis, leprosy, schistosomiasis, trypanosomiasis (African), leukemia, lymphoma, malaria, typhoid, liver diseases, other entities.
Treatment	Treatment is undertaken by and Infectious Diseases Physician.

Cutaneous Leishmaniasis

Signs and Symptoms Cutaneous leishmaniasis (CL) is characterized by single or multiple lesions that typically progress from papules to nodules to non-ulcerated dry plaques or ulcers (with raised indurated border and central depression) that usually are painless unless secondarily infected. The appearance of lesions depends largely on the host's immune response. Lesions are sometimes described as wet or dry. Distribution may be a single primary lesion, multiple primary lesions, and/or satellite lesions. Low-grade fever, regional lymphadenopathy and/or lymphangitis, and lesion pruritis or pain may be present. Most new world cutaneous lesions are ulcers as are some old world cutaneous lesions. In many cases, healing is spontaneous within months or years of onset. In other cases, however, the disease is progressive with visceral manifestations or



spreading skin lesions.

Complications	Mucosal leishmaniasis may occur as a sequela of new world cutaneous leishmaniasis (see below). Diffuse cutaneous leishmaniasis (DCL) is characterized by non-ulcerating nodules over the entire body, resembling lepromatous leprosy and is usually associated with <i>L. mexicana</i> or <i>L. aethiopica</i> infection. Diffuse cutaneous leishmaniasis (DCL) tends to be refractory to treatment. Leishmaniasis recidivans is recurrent leishmaniasis that is resistant to treatment. Cutaneous leishmaniasis may occur as an opportunistic infection in immunocompromised persons.
Laboratory Findings	There are no specific laboratory findings characteristic of primary CL.
Diagnosis	Presence of cardinal signs noted above and geographic risk lead to suspicion of leishmaniasis. The organism is present in histopathologic studies of slit skin smears or in cultures - though neither is highly reliable. Leishmanin skin test is positive only after active disease.
Differential Diagnosis	Numerous primary and secondary skin diseases/conditions such as other tropical ulcers, impetigo, infected insect bites, leprosy, lupus vulgaris, tertiary syphilis, yaws, blastomycosis, skin cancer, and others.
Treatment	CL generally heals spontaneously in 5-12 months in non-immunocompromised patients. Treatment depends on whether the patient is immunocompromised and/or at risk for mucosal leishmaniasis (in which case, treatment is provided) and on site and severity of lesions, with metastatic lesions treated and unobtrusive lesions not always treated. Treatment is undertaken by and Infectious Diseases Physician.

Mucocutaneous Leishmaniasis (Espundia)

Signs and Symptoms	Mucocutaneous leishmaniasis (MCL) is a sequela of new world cutaneous leishmaniasis and results from direct extension or hematogenous or lymphatic metastasis to the nasal or oral mucosa. In most cases, naso-oropharyngeal symptoms appear several years after resolution of the primary lesion(s), but may also appear while the primary lesions are still present or decades later. Manifestations of mucocutaneous leishmaniasis include chronic nasal symptoms, especially of the anterior nasal septum (leading to development of the characteristic "tapir nose") and progressing to extensive naso-oropharyngeal destruction. Secondary bacterial (or fungal) infections and associated problems are common.
Complications	Mucosal leishmaniasis is, itself, a complication. Secondary infections and associated problems are common.
Laboratory	There are no specific laboratory findings characteristic of MCL.

Findings	
Diagnosis	Presence of cardinal signs, positive history, and geographic risk lead to suspicion of mucocutaneous leishmaniasis. Diagnosis is difficult because amastigotes are scarce in the usual sources (scrapings, tissue aspirates, biopsy). Culture and serologic tests are usually necessary.
Differential Diagnosis	Paracoccidioidomycosis, polymorphic reticulosis, Wegener's granulomatosis, lymphoma, histoplasmosis, yaws, gummatous syphilis, tuberculosis, nasopharyngeal carcinoma, other destructive lesions.
Treatment	Treatment is difficult and cure rates decrease with advanced disease. Treatment is as for cutaneous leishmaniasis.

Malaria

Primary Distribution	Tropical Africa, Asia, South and Central Americas, East China, Middle East. Approximately 2.7 million people die each year from malaria and there are 300-500 million new cases per year.
Agents and Vectors	The obligate intracellular protozoa <i>Plasmodium falciparum</i> , <i>P. vivax</i> , <i>P. ovale</i> , and <i>P. malariae</i> are transmitted by female <i>Anopheles</i> mosquitos.
Incubation	Usually one to four weeks, but sometimes more than a year. Relapse may occur as many as 10 years after first episode. <i>P. vivax</i> and <i>P. ovale</i> may remain dormant in the liver and cause relapses. <i>P. falciparum</i> , the most virulent form, does not lie dormant, nor does <i>P. malariae</i> .
Signs and Symptoms	Malaria is usually characterized by sudden onset of high fever, sweating, chills, uncontrollable shaking, headache, and splenomegaly. Fever tends to wax and wane in 48-72 hour cycles, though cycles may be irregular, especially with infection by <i>P. falciparum</i> . Onset may also be insidious, with less dramatic symptoms such as fever, headache, dyspnea, abdominal pain, nausea, diarrhoea, myalgias, and splenomegaly. <i>P. falciparum</i> may cause parasitemia resulting in a life-threatening condition characterized by hemolysis, jaundice, anaemia, acute renal failure, and hemoglobinuria. Cerebral malaria, also life threatening, is characterized by gradual onset of severe headache, drowsiness, delerium, and coma. Seizures may also occur and are most common in children.
Complications	Cerebral malaria primarily affects children and nonimmune patients. Other complications include splenic rupture, hypoglycemia, renal failure, anaemia, pulmonary failure, and/or algid malaria (cold skin, profuse diarrhoea, and profound weakness).

Laboratory Findings	Anaemia, leukopenia, and thrombocytopenia are common. Hyponatremia and hypoglycemia may be found in patients with <i>P. falciparum</i> infection.
Diagnosis	Fever + geographic exposure lead to suspicion of malaria. Microscopic examination of Giemsa stained thick (detection of organisms) and thin (identification of species) blood smears is the standard for diagnosis. However, this technique requires specific expertise, and other commercially available techniques may yield more accurate (albeit more expensive) tests in areas with inexperienced labs, especially areas where malaria is imported. Sensitive alternatives to microscopy of Giemsa-stained films include Dipstick antigen detection of HRP2 and pLDH (Parasight-F, ICT Malaria Pf, OptiMAL)
Differential Diagnosis	Influenza, visceral leishmaniasis, leptospirosis, relapsing fever, typhoid fever, dengue fever, brucellosis, trypanosomiasis, gastroenteritis, urinary tract infection, amebic liver abscess, hepatitis, tuberculosis; and other causes of fever, splenomegaly, hepatomegaly, and anaemia.
Treatment	<p>A variety of antimalarial drugs are in use, including the traditional quinine given orally or parenterally. Treatment depends on the organism and severity of the attack. Treatment should be undertaken by an Infectious Diseases Physician..</p> <p>For all <i>P. vivax</i> and <i>P. ovale</i> cases, a full course of primaquine is required to eradicate the hepatic hypnozoite stage. For <i>P. vivax</i> acquired in certain areas (Papua New Guinea, Solomon Islands, Vanuatu, Thailand and Indonesia), a higher dose of primaquine is required to achieve this. G6PD levels should be assessed prior to treatment.</p>

Gastrointestinal Parasites

Parasite	Common Name	Treatment
Ancylostoma spp and Necator spp	Hookworm	Albendazole 400 mg (200 mg for children < 10 kg) PO as single dose.
Ascaris lumbricoides		Albendazole 400 mg (200 mg for children < 10 kg) PO as single dose.
Blastocystis hominis		Generally non-pathogenic
Chilomastix mesnili		Generally non-pathogenic
Endolimax nana		Generally non-pathogenic
Entamoeba coli		Generally non-pathogenic
Entamoeba histolytica	Ameobic dysentery	Flagyl 15 mg / kg up to 600 mg tds for 5 to 10 days, together with paromomycin (these drugs are only available through hospital special access – contact the Infectious Diseases Physician at the Royal Hobart Hospital for further advice)
Enterobius vermicularis	Pinworm	Mebendazole (Vermox) 100 mg x1, chew tablet and repeat dose in one week
Giardia lamblia		Flagyl 30 mg / kg up to 2 g orally daily for 3 days, or tinidazole 50 mg / kg up to 2 g orally as a single dose. Syrup is available for children.
Hymenolepis diminuta or nana	Dwarf tape worm (rat, human)	Praziquantel 25 mg/kg PO as a single dose
Iodamoeba butschlii		Generally non-pathogenic
Strongyloides stercoralis		See section below
Taenia saginata or solium	Beef or pork tapeworm	Praziquantel 10 mg/kg PO as a single dose
Trichostrongylus		Albendazole 400 mg PO x 1
Trichuris trichiura	Whipworm	Albendazole 400 mg (200 mg for child < 10 kg) PO daily for 3 days

Strongyloides

Primary Distribution	Strongyloidiasis occurs throughout most of the tropical world.
Agents and Vectors	Strongyloidiasis is a nematode (roundworm) infection by <i>Strongyloides stercoralis</i> following larval penetration of the skin.
Signs and Symptoms	<p>Infected persons may be asymptomatic. Cutaneous manifestations may occur at the site of penetration (often feet), and include inflammation, serpiginous or urticarial tracts, and pruritis. Intestinal manifestations follow cutaneous, and include abdominal pain, nausea, flatulence, and diarrhoea.</p> <p>Larval migration to lungs results in a variety of pulmonary symptoms, ranging from cough to pneumonia, pleural effusion, and miliary abscesses.</p>
Complications	Hyperinfection syndrome causes life-threatening CNS, cardiac, and wide-ranging gastrointestinal problems.
Laboratory Findings & Diagnosis	<ul style="list-style-type: none">• There are a number of methods for diagnosing strongyloidiasis. Microscopic identification of larvae (rhabditiform and occasionally filariform) in the stool or duodenal fluid is one method however examination of serial samples may be necessary, and is not always sufficient, because stool examination is relatively insensitive.• Alternatively, larvae may be detected in sputum from patients with disseminated strongyloidiasis.• Lastly, blood tests may be used. Serologic monitoring may be useful in the follow-up of immunocompetent treated patients: antibody levels decrease markedly within 6 months after successful chemotherapy.
Treatment	Treatment is with ivermectin 200 mcg/kg as a single dose for adults and children > 5 years old OR albendazole 400 mg (200 mg for children < 10 kg) daily for 3 days.

Tissue Parasites

Dracunculiasis	(Guinea worm disease) (Primarily West Africa [Nigeria] and Sudan; other areas of tropical Asia and Africa, Middle East, South America): Dracunculiasis is a tissue nematode infection with <i>Dracunculus medinensis</i> , the largest (up to one meter in length) filarial worm affecting humans. Infection occurs when small <i>Cyclops</i> (crustaceans) that contain larvae are ingested in contaminated fresh water such as that from large open wells. Infected persons are asymptomatic for approximately one year. Then, as the female worm reaches maturity, a papule, or in some cases, a sepiginous elevation of the skin develops - usually on a lower extremity. The papule progresses to a painful and pruritic blister, then an ulcer, and then the prolapsed uterus of the worm
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becomes visible and on contact with water releases larvae in a milky fluid. After repeated emptying, the worm dies and can then be slowly pulled forth and wound around a stick over a period of several weeks. Metronidazole 250 mg po tid for 10 days is used as an adjunct to mechanical removal. In most cases one to two worms emerge/year. Most people with dracunculiasis are incapacitated for about a month. Secondary bacterial infections are the most common complication.

Schistosomiasis (Bilharzia)

Primary Distribution	Scattered areas of sub-Saharan, tropical, South, and North Africa; Middle East; West India; Central and Eastern China; Philippine Islands and nearby islands; numerous areas of the world, with variants and locations noted below under vectors and agents.
Agents and Vectors	<p>Schistosomes (<i>Schistosoma sp.</i>) are flatworms or blood flukes (trematodes) carried by freshwater snails (the intermediate host). Humans pass eggs via stool or urine into the water where the parasites grow inside the snails. The parasite then leaves the snail in the form of cercaria and directly penetrates the skin of persons working (e.g., planting rice), bathing, or swimming in the water. The worms then grow inside vessels, bladder, or intestines, resulting in symptoms (from the worms and retained eggs) as well as means of repeating the life cycle. Important species of <i>Schistosoma</i> are:</p> <ul style="list-style-type: none"> • <i>S. japonica</i> is found in Central and Eastern China, and the Philippines and nearby islands; and primarily affects the liver and intestines. • <i>S. mansoni</i> is found in Africa, the Eastern Mediterranean, the Caribbean, and South America and primarily affects the liver and intestines. • <i>S. haematobium</i> is found in Africa, the Middle East, and Eastern Mediterranean and primarily affects the urinary tract. • <i>S. mekongi</i> is found in Southeast Asia and primarily affects the liver and intestines. <p>Other species also exist, but are of lesser public health importance.</p>
Signs and Symptoms	<p>Symptoms of acute schistosomiasis begin about a month after infection. There are several syndromes, not all of which are evident in all infected persons. The last (chronic) stage varies according to species, i.e., <i>S. japonica</i>, <i>S. mansoni</i>, and <i>S. mekongi</i> primarily affect liver and intestines, while <i>S. haematobium</i> primarily affects the urinary tract.</p> <p>In general, patients with chronic schistosomiasis tend to present in developed countries with lethargy, colicky abdominal pain, mucoid/bloody diarrhoea, or dysuria and hematuria.</p> <p>Initial symptoms may be a pruritic, papular rash that may be caused</p>

by schistosome species noted above or by other non-pathogenic parasites. This rash is most likely to occur in persons who do not live in endemic areas.

Acute schistosomiasis (Katayama fever - named after an area of Japan in which schistosomiasis no longer occurs) occurs in primary infection 1-2 months after exposure to heavy cercariae loads. Acute schistosomiasis is common in *S. japonicum* and *S. mansoni* infection. Symptoms may include fever of several weeks duration (especially with *S. japonicum*/Asian), headache, urticaria, cough, hepatosplenomegaly, lymphadenopathy, diarrhoea, and eosinophilia.

Haematuria and dysuria are common in *S. haematobium*. These symptoms tend to gradually diminish over several months, but may intensify as more eggs are deposited.

Chronic hepatosplenic schistosomiasis is a consequence of eggs retained in tissue and prolonged infection - usually of >10 years duration. The eggs provoke a delayed hypersensitive granulomatous reaction with the granuloma occupying >200 times the volume of the egg. The liver may be large or small and firm with nodularity. Fibrosis may cause portal hypertension, splenomegaly, or esophageal or gastric varices. Haematemesis and splenomegaly are common presenting symptoms, with normal liver function. In endemic areas, periportal fibrosis is common and is usually not detectable on physical exam. Periportal fibrosis and portal hypertension is associated with glomerulonephritis (proteinuria, renal failure) and pulmonary hypertension (cor pulmonale). Granulomatous tissue in the bowel results in bloody diarrhoea.

Chronic genitourinary schistosomiasis is associated with chronic *S. haematobium* infection. Granulomas in the bladder mucosa result from repeated masses of eggs laid by female worms residing in the bladder. Haematuria and dysuria are common from the acute through chronic stages. Obstructive uropathy develops from granulomas blocking ureteral orifices and ureteral dilation may also occur with the end results of hydronephrosis and uremia. Bladder cancer rates are increased in endemic areas.

Complications	Progression of liver, kidney, or other dysfunction may occur for many years after transmission has been interrupted - especially with heavy infection and re-exposure. Central nervous system lesions occur, but rarely.
Laboratory Findings	Eosinophilia, leukocytosis, mild anaemia, hypoalbuminemia are common. Increased immune complexes, IgM, IgE, and IgG are also found. Patients with <i>S. haematobium</i> commonly exhibit albuminuria and red cells.
Diagnosis	Note that periportal fibrosis, glomerulonephritis, and other manifestations and complications are diagnosed separately. Diagnosis of <i>S. japonicum</i> and <i>S. mansoni</i> is by the presence of ova

in faeces or tissue. Diagnosis of *S. haematobium* is by the presence of ova in urine or tissue. Serology is highly sensitive but will not differentiate species.

Differential
Diagnosis

Any prolonged febrile illness; typhoid fever, strongyloidosis, trichuriasis; other causes of hepatic, renal, GI, or urinary tract dysfunction - including carcinoma.

Treatment

Treatment is undertaken by an Infectious Diseases Physician. The following is for your information only. For *S. haematobium* and *S. mansoni*, praziquantel 20/kg po for two doses, four hours apart; for *S. japonica* and *S. mekongi*, praziquantel 20/kg po for 3 doses, 4 hours apart are the treatments of choice.

African Trypanosomiasis (African Sleeping Sickness) (Tropical Africa)

Trypanosomiasis is caused by protozoal parasites, *Trypanosoma brucei rhodesiense* or *T b gambiense*, transmitted by bite of the tsetse fly. *T b rhodesiense* infections are more virulent than *T b gambiense*; and in the former, patients experience three stages of illness (trypanosomal chancre, hemolymphatic, and meningoencephalitic) as opposed to two stages in the latter (trypanosomal chancre and meningoencephalitic) with significantly milder symptoms. The painful trypanosomal chancre (3-10 cm) appears about two days after the bite and lasts 2-4 weeks. The hemolymphatic stage is characterized by high fevers lasting several days, with symptom-free periods of days to weeks. Less common manifestations of this stage are severe headache, malaise, arthralgia, lymphadenopathy, circinate rash, pruritis, and hepatosplenomegaly. Weight loss and debilitation also occur, and myocarditis may develop. The meningoencephalitic stage is characterized by progressive apathy, night time insomnia and daytime somnolence, anorexia, retarded speech, extrapyramidal signs (tremors, fasciculations, choreiform movements, and Parkinsonian-like appearance), and finally, coma and death.

Treatment is complex and toxic, and depends on the infecting organism and stage of illness. Among the medications currently in use are suramin, melarsoprol, pentamidine, eflornithine, and corticosteroids.

Appendix 7 Referral Letter to Phoenix Centre



PHOENIX CENTRE
Support for Survivors of
Torture & Trauma

To: _____ Date of Referral: _____

From: Name: _____

Organisation / Practice Address: _____

Phone: _____ Fax: _____

E-mail: _____

Patient Details:

Patient's Surname: _____

Given name: _____

Address: _____

Phone: _____

Date of Birth: ___/___/___ Single: _____ Couple: _____ No. of Dependents: _____

Country of Birth: _____ Ethnicity: _____

Date of Arrival in Australia: ___/___/___ Male: Female:

Interpreter Needed: Yes / No

If Yes, what language/dialect? _____

Service Requested:

Counselling Early Health Assessment & Intervention Program (EHAIP)

Reason for Referral:

.....
.....
.....

I give permission for the above information to be disclosed to the Phoenix Centre

Signature of Client: _____

Phoenix South: 49 Molle St, Hobart 7000, Ph. 6234 9138 or 6234 9330,
Fax 6231 1264

Phoenix North: 95-99 Cameron St, Launceston 7250, Ph 6332 2226 or 6332 2225,
Fax 6334 2660

Appendix 8 Fact Sheet on Vitamin D Deficiency

(Adapted from info sheet from the WA Assn for Services to Torture and Trauma Survivors)

Vitamin D is the essential for the production of the hormone required for calcium absorption, bone development and growth. Deficiency can result in rickets in children and in osteomalacia and/or osteoporosis in adults. Those most at risk of Vitamin D deficiency include: women and children with dark skin, veiled women and their children, those living in institutions where access to sunlight is restricted.

Vitamin D deficiency has been noted in immigrants from the Mediterranean, Middle East, southern Asia and Africa since the 1960s. However, the recent influx of refugees from Africa and the Middle East has seen a resurgence of Vitamin D deficiency as a potentially significant issue. Those most at risk appear to be women who are dark-skinned and/or veiled and their children (Grover et al. 2001; Nozza and Rodda 2001).

The predominant cause of Vitamin D deficiency in Australia is caused by inadequate exposure to sunlight. This coupled with long term poor access to foods with adequate Vitamin D mean that many refugees are particularly vulnerable.

Ninety per cent of Vitamin D is produced in the skin from the action of sunlight, specifically UV B, with the remaining ten per cent coming from dietary sources. The amount of UV B radiation able to penetrate the skin depends on a number of factors including, latitude, season, smog levels, the actual amount of direct exposure which is further modified by clothing, the use of sun screens and the amount of melanin produced by the skin. Women who are veiled and/or have dark skin are susceptible to Vitamin D deficiency as most clothing effectively absorbs UV B radiation and increased melanin production (ie dark skin) reduces the production of Vitamin D in the skin. This form of Vitamin D made in the skin must undergo conversion to biologically active forms in the liver and then again in the kidney.

Exposure to sunlight

People who are born with naturally dark skin require significant amounts of sun exposure to obtain Vitamin D in an amount equivalent to 1000 IU. This exposure needs to occur in peak ultraviolet periods, 4 times per week between 20 and 30 mins in the warmer months and up to 75 minutes in winter months. Times will vary in different parts of Australia. Sun protection should be used if exposure is likely to be longer than the recommended times but for people who are truly dark skinned there should be no danger of sunburn. Sunscreen use does inhibit the production of Vitamin D and is probably not necessary for the periods of exposure outlined above.

Dietary sources

Ensure adequate access to foods that contain Vitamin D. Vitamin D is found in small quantities in oily fish, eggs, butter and margarine. Unlike countries in the northern hemisphere Australia does not fortify foods with Vitamin D.

It is still unclear as to whether low calcium intakes contribute to the problem of rickets and osteomalacia/osteoporosis caused by Vitamin D deficiency. Certainly in parts of Africa where there is extensive exposure to UV-B radiation, reduced calcium intakes have been implicated in the presentation of rickets in children. Therefore, adequate quantities of calcium rich foods should also be consumed.

Supplementation

There is currently no consensus on the treatment of Vitamin D deficiency in Australia. Newborn infants are generally not exposed to direct sunlight and breastmilk is a poor source of Vitamin D. Vitamin D stores, even if normal at birth, may become depleted at eight weeks in infants who are exclusively breast fed. Supplementing breast fed infants with 400IU of Vitamin D per day (0.45 mL of Pentavite per day) should maintain Vitamin D stores.

When infants are diagnosed with Vitamin D deficiency Vitamin D levels in their mothers and siblings (whether they are symptomatic or not) should also be assessed. All pregnant women with dark skin and/or with limited access to the sun due to veiling or social isolation should have their Vitamin D levels assessed. During pregnancy and lactation these women require 500-700IU of Vitamin D. If there is a demonstrated Vitamin D deficiency, doses from 1000IU to 3000-4000 IU should be given with reassessment every 3-4 months or at each trimester if pregnant.

References

- Nozza, J.M., Rodda, C.P. 2001, Vitamin D Deficiency in mothers and infants with rickets. *Med J Aust* 175:253-255.
- Grover, S.R., Morley, R. 2001, Vitamin D Deficiency in veiled or dark-skinned pregnant women. *Med J Aust* 175: 251-252.
- Mason, R. S., Diamond, T. 201, Vitamin D Deficiency and multicultural Australia. *Med J Aust* 175: 236-237.
- Diamond, T. H., Levy, S., Smith, A., Day, P., 2002, High bone turnover in Muslim women with Vitamin D deficiency. *Med J Aust* 177: 139-141.
- Johnson, G.H., Willis, F. 2003, Seizures as the presenting feature of rickets in an infant. *Med J Aust* 178 (9): 467 [Letters].
- Cowell, C.T. 2003, Comment: Seizures as the presenting feature of rickets in an infant. *Med J Aust* 178 (9) 467-468 [Letters].
- Glendinning, P. 2002. Vitamin D deficiency and multicultural Australia. *Med J Aust* 176: 242 [Letters].

Appendix 9 Contacts & Useful Websites

BreastScreen Tasmania	Statewide	13 20 50
Child Protection Advice and Referral Service (CPARS)	Statewide	1300 737 639
Community Nutrition Unit	Statewide	6222 7222
Community Support for Refugees (volunteer group)	Statewide	6223 7277
Department of Health and Human Services (DHHS) Multicultural Health and Wellbeing Policy	Statewide	6222 7656
Department of Immigration and Multicultural and Indigenous Affairs (DIMIA)	Hobart	6220 4011
Dental - (Oral Health Services – DHHS)	Hobart Launceston Burnie Devonport	6214 5411 6336 4100 6430 3704 6421 7729
Early Health Assessment and Intervention Program (EHAIP) Management	Statewide	6234 9330
Family Planning Tasmania	Hobart Launceston Burnie	6228 5422 6343 6766 6431 6743
Female Genital Mutilation (FGM) Education Program	Statewide	1800-675-028
Migrant Resource Centres (MRCs) and Integrated Humanitarian Settlement Support (IHSS)	Hobart Launceston Devonport Burnie	6234 9411 6331 2300 6423 5598 6431 9476
Multicultural Council of Tasmania	Statewide	6231 5062
Multicultural Health and Wellbeing – Policy Officer (DHHS)	Statewide	6222 7656
Multicultural Tasmania (Department of Premier and Cabinet)	Statewide	6233 3439 1800 066 782
Optometry (Spectacle Assistance Program)	South North North West	6222 7294 6336 4177 6434 6266
Phoenix Centre: (specialist support service for survivors of torture and trauma)	South North	6234 9138 or 6234 9411 6331 6076

Public and Environmental Health Service	Statewide	6222 7724 1800 671 738
Red Cross Asylum Seeker Assistance Scheme (ASAS)		6235-6077
Royal Hobart Hospital		
Refugee and Humanitarian Arrivals Clinic (RAHAC)		6222 8636
To page on call Infectious Diseases Physician		6222 8308
Gynaecology Clinic		6222 8686
Sexual Health Service	Statewide Hobart Launceston Devonport Burnie	1800 765 859 6233 3557 6336 2216 6421 7759 6434 6315
Translating and Interpreting Service (DIMIA) TIS Doctors Priority Line	National	131 450 1300 131 450
Tuberculosis Screening (public hospitals)	South North Devonport	6222 7293 6228 4855 6348 7202 6421 7700

Useful Websites

Health Translations Online Directory – the most useful and commonly used site
The Health Translations Online Directory enables health practitioners and those working with culturally and linguistically diverse communities to easily find reliable translated health information. Health information is available in 55 languages.
www.healthtranslations.vic.gov.au

Government and International Sites

Department of Immigration, Multicultural and Indigenous Affairs
<http://www.immi.gov.au/>

United Nations High Commissioner for Refugees
<http://www.unhcr.ch>

United Nations Development Fund for Women
<http://www.unifem.org/>

World Health Organisation
<http://www.who.int/en/>

Multicultural Tasmania (an office in the Department of Premier and Cabinet)
<http://www.dpac.tas.gov.au/divisions/multitas/>

Department of Education Health and Wellbeing Services Guide for Refugee Students
<http://www.education.tas.gov.au/equitystandards/esl/healthwellbeing/default.htm>

Multicultural demographic information in Australia, State by State.
<http://www.fecca.org.au/Resources/census/index.html>

Multicultural Health - Queensland (policy, guidelines, resources etc)
<http://www.health.qld.gov.au/multicultural/>

NSW Multicultural Health Communication Service
<http://www.mhcs.health.nsw.gov.au/>

Tasmanians for Refugees
<http://www.anglicare-tas.org.au/refugees/>

Refugee Council of Australia
<http://www.refugeecouncil.org.au/html/resources/advocateskit.html>

Resources for Health Professionals

Multicultural Mental Health Database
<http://www.mmha.org.au>

New Zealand Ministry of Health handbook for refugee health care
<http://www.moh.govt.nz/moh.nsf/ea6005dc347e7bd44c2566a40079ae6f/d85ce7cd090faaa4cc256b050007d7cb?OpenDocument>

Queensland Government Cultural Diversity - A Guide for Health Professionals
<http://www.health.qld.gov.au/multicultural/default.asp>

Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Booklet on Female Genital Mutilation
<http://www.ranzcog.edu.au/publications/womenshealth.shtml>

Patient Information in Multiple Languages

Alzheimer's Australia
Alzheimer's Australia has developed a number of fact sheets about Alzheimer's in Arabic, Chinese, Greek, Italian, Polish and Vietnamese.
<http://www.alzheimers.org.au/content.cfm?categoryid=14>

Centre for Culture Ethnicity and Health
A range of health resources available in languages that may include Cambodian, Chinese, Khmer, Korean, Oromo, Russian, Somali, Spanish, Tagalog, Tigrinya, and Vietnamese
<http://www.ceh.org.au/>

Diabetes Australia

Diabetes Australia has diabetes information brochures available in Chinese, Arabic, Hindi, Greek, Thai, Italian, Vietnamese and Turkish. Brochures will soon be translated in Serbian, Ukrainian, Croatian, Spanish and Indonesian speakers. Check the site for up-dated information.

www.diabetesaustralia.com.au/multilingualdiabetes/index.htm

Health Education Net (Canadian Site)

Health topics, including domestic violence, are available in Chinese, Darshan, French, Farsi, Hindi, Italian, Japanese, Korean, Punjabi, Somali, Spanish, Swahili, Tagalog, and Vietnamese

www.multilingual-health-education.net/search.asp?searchkeywords=&searchlanguage=6

University of UTAH Health Sciences Library

Various health brochures are available in Arabic, Armenian, Cambodian, Chinese, Croatia, Farsi, French, German, Haitian Creole, Hmong, Japanese, Korean, Laotian, Portuguese, Romanian, Russian, Samoan, Serbo-Croatian, Somali, Spanish, Tagalog, Thai, Tongan and Vietnamese.

<http://medlib.med.utah.edu/library/refdesk/24lang.html>

HIV/AIDS and Hep. C Services leaflet on HIV/AIDS in a range of languages.

<http://www.multiculturalhivhepc.net/>

Immunisation - Victorian Government

Fact sheets detailing information about various immunisations in Australia is available in Arabic, Bosnian, Cambodian, Chinese, Croatian, Greek, Indonesian, Italian, Khmer, Macedonian, Maltese, Polish, Russian, Serbian, Singhalese, Somali, Spanish, Turkish, and Vietnamese.

www.health.vic.gov.au/immunisation/language.htm

Incontinence – Multilingual Fact Sheets

Continenence information is available in Arabic, Chinese, Croatia, Dutch, English, German, Greek, Italian, Macedonian, Maltese, Polish, Serbian, Spanish, Turkish, and Vietnamese.

www.continence.health.gov.au/

How to Use Medication

The US Food and Drug Administration have produced a fact sheet detailing how to use medication properly. The sheets are available in Cambodian, Chinese, Hmong, Japanese, Korean, Laotian, Polish, Samoan, Tagalog, Thai, and Vietnamese.

www.fda.gov/womens/taketimetocare/mymeds.html

Multicultural Communications provides a comprehensive selection of health resources available in 47 languages. You can search by health subject

www.mhcs.health.nsw.gov.au/ or language www.health.nsw.gov.au/health-public-affairs/mhcs/publications/langindex.html

Multicultural Mental Health Australia provides national leadership in mental health and suicide prevention for Australians from culturally and linguistically diverse backgrounds. Mental health resources are available in 48 languages.

www.mmha.org.au/TranslatedInformation/

Reproductive Health Online

Reproductive Health Online has family planning and maternal and neonatal health information in English, Spanish, French, Portuguese and Russian. It is sponsored by Johns Hopkins University.

<http://www.reproline.jhu.edu/>

The Western Melbourne Division of General Practice

The Western Melbourne Division of General Practice has developed an excellent on-line resource for service providers with bi-lingual clients. Health includes fact sheets on HIV/Hep C; Mental Health; Broader Public Health Publications; Asthma; School Immunisation; Pap Smears; Smoking; and STD's (amongst others). Languages available include Arabic, Chinese, Greek, Italian, Serbian, Macedonian, Spanish and Vietnamese.

www.westerngp.com.au/multi_ling_br.htm#4

Transcultural Mental Health Centre – NSW

The Centre recognises people's cultural and linguistic differences in their understanding of mental illness. It seeks to support mental health policies, programs and services that ensure access and equity of service, while respecting cultural traditions and sensitivities. The Centre has produced mental health resources in Arabic, Bosnian, Croatian, Farsi, Greek, Hindi, Italian, Korean, Macedonian, Serbian, Spanish, Tagalog, Turkish and Vietnamese.

www.tmhc.nsw.gov.au

Palliative Care

The Palliative Care Council of South Australia created have care guides addressing in Arabic, Bosnian, Chinese, Croatian, Greek, Hindi, Italian, Japanese, Khmer, Korean, Macedonian, Maltese, Persian, Polish, Portuguese, Russian, Serbian, Spanish, Turkish and Vietnamese.

www.pallcare.asn.au/mc/mccontents.html

Youth Issues

The Centre of Multicultural Youth Issues aims to strengthen and build innovative partnerships between young people, support services and the community to enhance life opportunities for young people from culturally and linguistically diverse backgrounds. Various resources to assist working with young people are available in various languages including Amharic, Arabic, Assyrian, Bosnian, Cambodian, Chinese, Dari, Pashtu, Samoan, Serbian, Somali, Tigrinya, Turkish and Vietnamese

www.cmyi.net.au/publications/index.html

Appendix 10 Integrated Humanitarian Settlement Strategy (IHSS)

Source: Department of Immigration and Multicultural and Indigenous Affairs, *Australia's Support for Humanitarian Entrants*, Nov 2003 (Copyright Commonwealth of Australia reproduced by permission). check http://www.immi.gov.au/search_for/publications.htm for updates.

The Integrated Humanitarian Settlement Strategy (IHSS)

The IHSS provides intensive initial settlement support to newly-arrived humanitarian entrants with the aim of ensuring that all of these entrants have access to the information, personal tools, services and basic material requirements that they need to rebuild their lives in Australia.

IHSS services are delivered through a network of contractors with assistance from volunteers registered under the Community Support for Refugees (CSR) service, in the case of refugees, or by the proposer in the case of humanitarian (visa 202) entrants.

IHSS support is normally provided for around six months, although this period may be extended for particularly vulnerable clients with special needs. The IHSS focuses strongly on equipping entrants to gain access to mainstream services.

The suite of services provided under the IHSS includes Initial Information and Orientation Assistance (IIOA), Accommodation Support (AS), Household Formation Support (HFS), Early Health Assessment and Intervention (EHAI), Proposer Support (PS), Community Support for Refugees (CSR) volunteers and Service Support. During this period also, entrants will be linked to the Adult Migrant English Program (or the English as a Second Language (ESL) program in schools where applicable), made aware of translation and interpreting services (TIS), and mainstream services for which they are eligible as permanent residents of Australia. Some entrants may require further assistance after their IHSS support period (see Longer-term Settlement Services, below).

Initial Information and Orientation Assistance (IIOA)

IIOA links entrants to the services they need in the initial stages of settlement. This includes meeting entrants at the airport, taking them to register for Centrelink benefits and health support such as Medicare. IIOA also has a role in coordinating with other IHSS services

Accommodation Support (AS)

AS ensures that entrants have accommodation on arrival and have assistance to secure long-term accommodation as soon as possible

Household Formation Support (HFS)

HFS provides entrants with some material goods necessary to start establishing a household in Australia

Early Health Assessment and Intervention Assistance Program (EHAIP)

The EHAIP offers entrants information on health services available to them, a physical health assessment and psychological/psychosocial assessment, and referral to other health services including torture and trauma counselling where required

Proposer Support (PS)

PS provides information and a post-arrival 'help' service to assist proposers of SHP entrants to meet their responsibilities to entrants

Community Support for Refugees (CSR)

Under the CSR service, registered volunteer community groups provide friendship and social support to humanitarian entrants and may choose to assist with the provision of IHSS services.

Service Support

Service Support Providers (SSP) deliver support and training to IHSS service providers to assist them to meet the service needs of entrants and their obligations as contractors. SSP is also responsible for the recruitment, coordination and registration of CSR groups and for providing them with support and training.

Longer-term Settlement Services

Humanitarian entrants and PPV holders are eligible to access a number of mainstream settlement services designed for both humanitarian and non-humanitarian migrants. These include the Adult Migrant English Program (AMEP), the Translating and Interpreting Service (TIS), Migrant Resource Centres (MRCs), and organisations funded under the Community Settlement Services Scheme.

Adult English Migrant Program (AMEP)

The AMEP has two core functions:

- to assist new arrivals to develop English language skills; and
- to provide general orientation to new arrivals to help them participate in wider Australian society and access available services.

The AMEP currently provides up to 510 hours of English tuition to help migrants participate in and settle into Australian society. A range of learning options is available for clients to choose from: classroom or community based tuition (full time or part time), distance learning, or 'one on one' tuition with the help of a volunteer home tutor. Free childcare is also available. Up to an additional 100 hours is also available to some humanitarian entrants who qualify for special assistance under the Special Preparatory Program. As well as learning basic English skills, AMEP students learn about Australian society, culture and customs and are linked with other services and agencies which are vital for their successful settlement. AMEP classes also provide a place in which friendships develop between people from all over the world, affirming respect for differences in an encouraging and non-threatening environment. In this way, the AMEP facilitates participation in the Australian community.

Translating and Interpreting Services (TIS)

TIS provides telephone and on-site interpreting and translations and is an important safety net for people facing language barriers to successful participation in the community. TIS is an important tool which assists government agencies and government-funded organisations (including IHSS contractors) to provide their services to non-English speaking members of the community. TIS interpreting services are available on a userpays or fee-free basis, depending on circumstances.

Migrant Resource Centres (MRCs)

MRCs provide settlement assistance to migrants and humanitarian entrants through the:

- provision of settlement information and referral services to individuals;
- facilitation of community capacity building; and

- promotion of client needs to mainstream service providers.

It is not intended that MRCs should duplicate the services provided under the IHSS. Nonetheless they may provide complementary services to humanitarian entrants concurrent with IHSS assistance.

Appendix 11 Acronyms

Acronym	Meaning
AMES	Adult Migrant English Service
CSR	Community Support for Refugees (volunteer program of DIMIA and linked to the IHSS)
CSSS	Community Settlement Support Scheme (DIMIA project grants mainly to MRC's)
DHHS	Department of Health and Human Services
DIMIA	Department of Immigration and Multicultural and Indigenous Affairs (Commonwealth)
DPAC	Department of Premier and Cabinet
EHAIP	Early Health Assessment and Intervention Program (Pheonix Centre)
FGM	Female Genital Mutilation
LGH	Launceston General Hospital
IHSS	Integrated Humanitarian Settlement Scheme (DIMIA) to settle Humanitarian Refugees and support the sponsors of Special Humanitarian Refugees
MT	Multicultural Tasmania (part of DPAC)
MRC	Migrant Resource Centre
RAHAC	Refugee and Humanitarian Arrival Clinic
RHH	Royal Hobart Hospital
NAATI	National Accreditation Authority for Translators and Interpreters
NESB	Non English Speaking Background
NWRH	North West Regional Hospital
PEHS	Public and Environmental Health Service (DHHS)
Phoenix Centre	Runs the EHAIP and T&T counselling and advocacy program
PPV	Permanent Protection Visa
PICC	Partners in Culturally Appropriate Care (with aged care facilities)
PICCAC	PICC Advisory Committee (Dept. of Health and Ageing)
RAHAC	Refugee and Humanitarian Arrival Clinic, Royal Hobart Hospital
RHH	Royal Hobart Hospital
STI	Sexually Transmissible Infection
TACMA	Tasmanian Advisory Council on Multicultural Affairs (MT)
TIS	Translating and Interpreting Services (a national DIMIA service)
TISC	Tasmanian Immigration and Settlement Committee (DIMIA)
TPV	Temporary Protection Visa
UNHCR	United Nations High Commissioner for Refugees

Appendix 12 Specific Country Information

Please note this information is accurate to the best of our knowledge at time of compilation (mid 2004), however situations change very quickly – useful websites for up to date information are provided in the References Section.

Language, Religion and Ethnic Composition in Eritrea, Ethiopia, Liberia, Sierra Leone, Somalia, and Sudan

Country	Language	Religion	Ethnic Groups
Eritrea	Tigrinya, Afar, Arabic, Saho, Kunama	Muslim, Coptic Christian, Roman Catholic, Protestant	Ethnic Tigrinya 50%, Tigre and Kunama 40%, Afar 4%, Saho (Red Sea coast dwellers) 3%, other 3%
Ethiopia	Amharic, Oromigna, Tigrina, Somali, Guaragigna, Arabic	Muslim 45%-50%, Ethiopian Orthodox 35%-40%, animist 12%, other 3%-8%	Oromo 40%, Amhara and Tigre 32%, Sidamo 9%, Shankella 6%, Somali 6%, Afar 4%, Gurage 2%, other 1%
Liberia	Pidgin English, Kpelle, Bassa, Mano, Dan	Indigenous beliefs 40%, Christian 40%, Muslim 20%	Indigenous African tribes 95% (including Kpelle, Bassa, Gio, Kru, Grebo, Mano, Krahn, Gola, Gbandi, Loma, Kissi, Vai, Dei, Bella, Mandingo, and Mende), Americo-Liberians 2.5% (descendants of immigrants from the US who had been slaves), Congo People 2.5% (descendants of immigrants from the Caribbean who had been slaves)
Sierra Leone	Mende, Themne, Creole, Limba, Kuranko	Muslim 60%, indigenous beliefs 30%, Christian 10%	20 native African tribes 90% (Temne 30%, Mende 30%, other 30%), Creole (Krio) 10% (descendants of freed Jamaican slaves who were settled in the Freetown area in the late-18th century), refugees from Liberia's recent civil war, small numbers of Europeans, Lebanese, Pakistanis, and Indians
Somalia	Somale, Maay, Gabre, Swahili, Jiddu	Sunni Muslim	Includes the Dir, Issaq, Hawiye, Digil, Rahawayn, Darood
Sudan	Arabic, Dinka, Bedawi, Nuer, Fur Note: there are 140 languages spoken in Sudan	Sunni Muslim 70% (in north), indigenous beliefs 25%, Christian 5% (mostly in south and Khartoum)	North: Mainly Arabs, including Nubian, Jamla, Beja South: Nilotic Africans, including Dinka, Nuer and Shilluk

Statistical Sources: United Nations Education Scientific and Cultural Organisation, *World Cultures Report 2000*, *Refugee Health Care: A Handbook for Health Professionals* NZ publication; CIA *World Factbook 2003* <http://www.cia.gov/cia/publications/factbook>

Key Health Indicators – Horn of Africa

Country	Life expectancy at birth			Under 5 mortality rate (deaths of children under five/1000 live births)		Adult mortality rate (number of adults, per 1,000 adults, not expected to survive to age 60)	
	Male	Female	Total	Male	Female	Male	Female
Eritrea	52.3	55.0	53.6	123	107	440	383
Ethiopia	46.8	49.2	48.0	185	170	484	420
Liberia	44.6	48.0	47.3	203	185	517	425
Sierra Leone	32.7	35.9	34.3	328	298	673	564
Somalia	41.0	45.4	43.2	219	198	592	471
Sudan	54.1	57.9	56.0	124	117	378	291
Australia	77.4	82.6	80.0	7	5	94	54

Statistical Sources: Country specific web pages on the *World Health Organisation* web site (2004)
<http://www.who.int/country/en/>

Ethiopia

The Federal Democratic Republic of Ethiopia has a population of 66 million divided into over 80 ethnic groups. Ethiopia is divided into 9 ethnically based states and 2 self-governing administrations, and is landlocked, sharing borders with Eritrea, Sudan, Kenya, Djibouti and Somalia. The population of Ethiopia has a literacy rate for persons aged 15 and over of 42.7% (male: 50.3% female: 35.1%) (*CIA The World Fact book*, 2003).



Over the past thirty years, millions of refugees and asylum seeker have fled Ethiopia into neighbouring countries, and some have sought refugee status in the West. The most common reasons for seeking refugee status in other countries include drought and famine (1970s), civil war (1980s) and most recently human rights abuses. Those who flee to the West are largely educated people from urban centres fleeing from political and human rights atrocities.

Aside from Italian occupation between 1936-41, the ancient Ethiopian monarchy maintained its freedom from colonial rule (the only country in Africa to do so). Between 1974 and 1991, Ethiopia was ruled by a military Stalinist system of government (commonly known as the Derg regime). The number of Ethiopians seeking refugee status during this period increased substantially. In 1991 the Ethiopian People's Revolutionary Democratic Front (EPRDF) overthrew the Stalinist system, dividing the newly established Federal Democratic Republic of Ethiopia into nine federal states, however the number of Ethiopian refugees fleeing the country did not decrease. The new political system created ethnic divisions among Ethiopian people and civil war ensued. Numerous human rights abuses followed civil war, whereby many Ethiopians suspected of supporting opposition groups were arbitrarily

arrested and detained without trial, and subsequently beaten, killed or forced to join allegiance with the ruling political group.

Eritrea



Eritrea is one of Africa's newest countries, and shares its borders with the Red Sea, Sudan, Ethiopia, and Djibouti. The State of Eritrea has a population of four million, and a literacy rate of 58.6% for person 15 years and over (male: 69.9% female: 47.6%). Asmara is the Capital. Eritrea's population is made up of nine ethnic groups, many of whom speak Semitic or Cushitic languages. The Tigrinya and Tigre ethnic groups make up around 80% of the population and speak a version of the Semitic language. Christians generally live in the highlands, and Muslims and those with other beliefs live in the lowlands.

Eritrean refugees have historically fled their country due to armed conflict with Ethiopia. Between 1998 and 2000, war raged between Eritrea and Ethiopia over the 620-mile (1,000 km) frontier between the two countries, displacing hundreds of thousands of citizens from both nations. In June 2000, after Ethiopia launched a military offensive into Eritrea and achieved a clear military advantage, the governments of Eritrea and Ethiopia signed a cease-fire agreement. The peace agreement remained in effect during 2001, creating conditions that enabled thousands of refugees and internally displaced Eritreans to return home. However tens of thousands could not return to their areas of origin near the border because of lingering danger, including the presence of an estimated 1 million landmines. The absence of basic health care and education services also hindered their return. Those who did return and resettle were subjected to severe drought and harsh living conditions. By the end of 2002, nearly 300,000 Eritreans were refugees. About 280,000 Eritreans were in Sudan and the remaining 20,000 in Ethiopia and Yemen. Approximately 75,000 Eritreans were internally displaced.

Note: The health beliefs of Eritreans are similar to that of Ethiopians, in that health is defined as a state of equilibrium among physiological, spiritual, cosmological, ecological and social forces surrounding humans. Health and well-being is secured through a peaceful relationship with the supernatural world. Eritreans, like Ethiopians, do not offer personal information readily especially during a first encounter. It is exceedingly important for General Practitioners to reassure patient confidentiality to clients of these nationalities.

Liberia

The Republic of Liberia has a population of 3.5 million, and borders Sierra Leone, Guinea and Cote D'Ivoire. Border instabilities remain due to continued conflict between rebels and refugees. The population of Liberia has a literacy rate for persons aged 15 and over of 57.5% (male: 73.3% female: 41.6%) (*CIA The World Fact book*, 2003).



In 1980, a military coup overthrew the Liberian government. In 1989 the National Patriotic Front of Liberia (NPFL) instigated a rebellion. Despite opposition from a peacekeeping force sent by the Economic Community of West African States (ECOWAS), unrest grew. Violence began to spread out of control. Armed bands claiming allegiance to the NPFL began to engage in ethnic violence against anyone suspected of being Krahn or Mandingo.

By 1991, so many civilians were armed (the UN estimates 60,000) that the militia leaders were unable to exercise complete control, nor were they able to pay their forces regularly. The simultaneous break-up of the Soviet Union ensured a cheap and steady supply of automatic weapons.

In 1993 600 displaced persons, mostly women and children residing at "Harbel" camp on the Firestone Rubber Plantation, were massacred. Over an 8-year period of conflict, well over 150,000 people died, equating to one out of every 17 Liberians. Liberia was the country with the largest percentage of refugees and internally displaced people in the world.

Sierra Leone



The Republic of Sierra Leone has a population of 4.6 Million, and borders Liberia, Guinea and the Atlantic Ocean. Freetown is the country's capital. The population of Sierra Leone has a literacy rate for persons aged 15 and over of 31.4% (male: 45.4% female: 18.2%) (1995 estimate *CIA The World Fact book*, 2003).

Sierra Leone has suffered a brutal civil war since 1991. Although a peace deal was signed in 1999, the fighting continued. Human rights violations include the deliberate amputations of limbs of thousands of people. Over three million people were displaced, mostly within the country. Many have fled to neighbouring countries including Guinea and Ghana, where they continue to live in dangerous conditions.

While formal armed conflicts in Sierra Leone have ceased, the country still faces destabilizing factors. The intensification of civil war in neighbouring Liberia has created a large refugee population in Sierra Leone resulting in instability in the border areas, and drew in hundreds of Sierra Leonean former combatants to fight for both the Liberian government and rebel forces.

The United Nations High Commissioner for Refugees (UNHCR) registered more than 37,500 Liberian refugees in Sierra Leone camps in October 2002. Liberian government troops and rebels of the Liberians United for Reconciliation and Democracy (LURD) often crossed into Sierra Leone to loot, buy provisions, escape fighting, or abduct people who are then forced to work for them as porters. On June 17, 2003 a cease-fire pact was signed in Ghana between the embattled government of Liberian President Charles Taylor and rebel groups.

Sudan

The Republic of Sudan is the largest country in Africa and one of the poorest in the world. Sudan has a population of 35 million, comprised of 50 ethnic groups speaking over 140 languages. Sudan borders with the Red Sea and nine countries namely Egypt, Libya, Chad, Central African Republic, Democratic Republic of Congo, Uganda, Kenya, Ethiopia, and Eritrea.

Northern Sudan is home to the majority of Arab or mixed Arabs (mainly Muslim), while African peoples (mainly Nilotics of Christian or traditional religions) live in Southern Sudan. There is tremendous cultural diversity not only between the Sunni Moslem north and the animist (traditional) and Christian south, but within the southern region itself. Tribal affinity among the "Nilotic" groups is the norm, with infrequent intermarriage. Many ethnic languages are not mutually intelligible, although English, and to a lesser extent, Arabic, are the most widespread languages. Sudan's literacy level is estimated at 61.1% aged 15 and over (male: 71.8% female: 50.5%) (*CIA World Fact Book*, 2003.)



The people of Sudan have endured great persecution and strife for generations. Major disruptions to the country include political and religious oppression, famine, floods, locusts, and warfare. Civil war has raged in Sudan nearly continuously since independence from Britain in 1956. The religious war between the Islamic fundamentalists in the north and the diverse African ethnic groups, many of whom are Christian, in the south, has devastated the country and its people.

The government in Khartoum frequently used starvation as a warfare or political tactic. In 1988 alone, more than 250,000 Sudanese died of starvation. The corruption of the country's leaders prevented aid from such organizations as the United Nations and UNICEF from reaching the rebel-held areas. Thousands of refugees were forced to flee into the neighboring countries of Ethiopia, Uganda, Kenya, and Egypt. In 1993, it was estimated that 4,750,000 Sudanese found refuge in other countries, excluding the greater than 1,300,000 who died in the flight.

Somalia



Somalia shares its borders with the Kenya, Ethiopia, Djibouti and the Indian Ocean. In the mid 1800s France controlled the north, now known as Djibouti, Britain and Italy colonised areas further south, and other regions were under the rule of neighboring Kenya and Ethiopia. In 1960, the Italian and British areas were united into an independent Somalia, and in 1977 Djibouti became a separate nation after receiving independence from France. The regions of Kenya and Ethiopia, which contain large numbers of ethnic Somalis, continue to source many border disputes. Mogadishu, in the South of Somalia, is the country's Capital. Somalia has a population of 10 million, and a literacy rate of 37.8% for person 15 years and over (male: 49.7% female: 25.8%) (2001 estimate *CIA World Fact Book*, 2003.).

Somalia has had an ongoing history of minimal political stability, with border conflicts with Ethiopia and continued internal conflicts and tribal warfare.

In 1988, a full-scale civil war broke out in Somalia. However, up to the present, the clans have continued the bloody war amongst themselves, with no government being established. Around 45% of Somalia's total population has been either internally or externally displaced because of the conflict. The continuous internal warfare together with border clashes has brought the Somali economy to near collapse.

Further to ongoing internal and border conflict, Somalia sustained dreadful starvation and refugee conditions as a result of a severe drought in the early 1990s. At least 400,000 people died between 1991 and 1992. Renewed inter-clan violence and the looming threat of famine has led many Somali's to continue to seek refugee status.

Language, Religion and Ethnic Composition in Afghanistan, Iran and Iraq

Country	Language	Religion	Ethnic Groups
Afghanistan	Dari (50%), Pashto (35%) Turkic languages - Uzbek and Turkmen (11%), Baluchi, Pashai, Nuristani. Bilingualism is very common	Sunni Muslim (84 %), Shi'a Muslim (15 %), other (1 %)	Pashtun, Tajik, Hazara, Uzbek , Aimak, Turkmen, Baloch and others
Iran	Farsi - Persian and Persian dialects (58%), Turkic and Turkic dialects (26%), Kurdish (9%), Luri (2%), Balochi (1%), Arabic (1%), Turkish (1%), other (2%)	Shi'a Muslim (89 %), Sunni Muslim (10 %), Zoroastrian, Jewish, Christian, and Baha'i (1 %)	Persian (51 %), Azeri (24 %), Gilaki and Mazandarani (8 %), Kurd (7 %), Arab (3 %), other (7 %)
Iraq	Arabic, Kurdish, Azeri, Farsi, Turkmen	Sunni Muslim (45%), Shi'ite Muslim (50%), Druze and Christian minorities	Arab (75%), Kurds (15 to 20%) Turkmens, Jews, Armenians, Assyrians and other (5%)

Key Health Indicators – Afghanistan, Iran and Iraq

Country	Life expectancy at birth			Under 5 mortality rate (deaths of children under five/1000 live births)		Adult Mortality Rate (number of adults, per 1,000 adults, not expected to survive to age 60)	
	Male	Female	Total	Male	Female	Male	Female
Afghanistan	41.1	43.7	42.4	252	249	527	418
Iran	66.4	71.1	68.7	45	39	209	137
Iraq	58.7	62.9	60.8	122	111	258	180
Australia	77.4	82.6	80.0	7	5	94	54

Statistical Sources: Country specific web pages on the *World Health Organisation* web site (2004)

Afghanistan

The Transitional Islamic State of Afghanistan has a population of 27.7 million, with an estimated 4 million in neighbouring Pakistan and Iran. Adult literacy rates stand at 51% for males, and 21% for females.

A large proportion of the Afghani population are internally or externally displaced as a direct result of civil war and conflict that has spanned more than 20 years.

A mountainous and landlocked country, Afghanistan has long been fought over because of its strategic location between the Middle East, Central Asia and the Indian subcontinent. The former Soviet Union invaded Afghanistan in 1979 and occupied the country for a decade before withdrawing under pressure by Mujahidin forces. During the Soviet occupation, one-third of the population fled Afghanistan. Fighting has continued among Afghan factions, most recently between the Taliban and Northern Alliance forces.



Together with the widespread suffering caused by the civil war, Afghanistan has faced the worst drought that the Country has seen in over 30 years. Afghanistan's infrastructure has been nearly destroyed, its human resource base severely depleted and its social capital eroded. The United Nations estimates that 7 million people are vulnerable to famine. Pakistan and Iran provided refuge for a combined peak of more than six million refugees, and although the Taliban regime has since been defeated, it remains to be one of the world's leading source of refugees. Afghanistan is the most heavily mined country in the world. An estimated four million people are refugees in neighbouring Pakistan and Iran. Together with the Iranian and Pakistani governments, the UNHCR began its largest voluntary repatriation operation.

Iraq



The Republic of Iraq has a population of 26 Million, of whom 40.4% aged 15 and over can read and write (male: 55.9% female: 24.4%) (2003 est.)

Iraqi refugees consist of two main groups, Iraqi dissidents and deserters from Saddam Hussein's national army, and Shiite Moslems, the so-called "Marsh Arabs," from southern Iraq. A portion of this minority group is of Iranian descent (there is also a third, smaller group of Iraqi "Turkomens" or Iraqis of Turkish descent). Many Iraqis fear retribution against their families still in Iraq; contact with kin in Iraq is guarded and limited, and return visits virtually impossible at this time.

Islam and related cultural practices are important influences on health beliefs and practices. Both women and men are modest and either may resist or refuse examination or treatment by a person of the opposite gender. Dietary proscriptions and fasting requirements also influence health. During Ramadan, for example, more conservative Muslims may refuse medications or medically-indicated foods during daylight hours.

The people of Iraq have a long tradition of complementary and alternative medical practices, although there is much variation between tribes and across geographical areas. Among the most conservative Iraqi Muslims, typically the elderly, Western preventive health concepts may conflict with the belief that God has determined one's lifespan from birth which cannot (and should not) be altered by human intervention.

Iran

The Islamic Republic of Iran has a population of 66.5 million. Iran hosts about 1.5 million refugees from Afghanistan, 387,000 from Iraq and 26,000 from other countries. About 24,000 Iranian refugees are living in Iraq. Iran's Capital is Tehran. Iran has an adult literacy rate of 78.4 % for men and 65.8 for women (UN)



Iran hosts more refugees than any other country in the world. Most are from Afghanistan and are dispersed throughout the country employed as manual labourers. Less than five percent of refugees in Iran live in camps. Iran feared a huge influx of Afghan refugees when the US-led strikes against the Taliban began and said it would help provide humanitarian aid to Afghans across the border. The exodus to Iran did not materialize. About 24,000 Iranians have sought refuge in neighboring Iraq. Tens of thousands of others have left the country for a combination of political and economic reasons. In August 2001 Northern Iran was subjected to the worst floods witnessed by the country in 200 years.