REFUGEE HEALTH MATTERS

A newsletter brought to you by the Refugee Health Fellows **April 2016**

Refugee Health Assessment 2016

All people of refugee/asylum seeker background should have an initial refugee health assessment (RHA) after arrival to Australia, **ideally within one month of arrival**. (http://www.asid.net.au/documents/item/1225)

The previous (2009) RHA recommendations have now been updated and new guidelines include asylum seekers as well as refugees, a broader range of source countries, infectious and non-infectious conditions, and include more input from primary care, nursing, and public health experts. (http://www.asid.net.au/products/refugee-guidelines-2016)
The RHA follows a **protocol**, and is **detailed** and **structured.** Offering **person-centred** care, using an **interpreter**, and taking a **full history** and **physical examination** will allow a more **tailored approach** to investigations.

All	FBE	**Bloods**
	HBsAg, HBsAb, HBcAb. Write: "Query chronic hepatitis B?"	
	Strongyloides serology	
	HIV (≥15 years or unaccompanied minor)	
	Varicella serology (≥14 years old if no known history of disease)	
	Mantoux test or Quantiferon (depends on risk factors and local jurisdiction)	**TB Screen**
	Visual acuity and review for glaucoma in Africans >40 years	**History and referral**
	Dental review	
	Hearing review	
	Social and emotional well-being/mental health	
	Disability	
	Developmental delay or learning concerns (children and adolescents)	
	Preventive health as per RACGP, consider screening earlier for NCDs	
	Catch-up immunisations	**Vaccination**
Risk-based	Rubella IgG (women of child-bearing age)	**Bloods**
	Ferritin (women and children, men where risk factors present)	
	Vitamin D (risk factors such as dark skin, lack of sun exposure)	
	Vitamin B12 (arrival <6 months, food insecurity, vegan, from: Bhutan, Afghanistan, Iran, Horn of Africa)	
	Syphilis serology (risk of STIs, unaccompanied minor)	
	NAAT first pass urine or self-obtained low vaginal swabs for gonorrhoea or chlamydia (risk of STIs)	
	Helicobacter pylori stool or breath test (gastric cancer family history or symptomatic)	**Stool**
	Faeces microscopy - cysts, ova, parasites (no pre-departure albendazole)	
Country-based	Schistosomiasis	**Bloods**
	Malaria thick and thin films and RDT	
	Hepatitis C Ab OR if risk factors	

Additional info on specific screening tests:

FBE (and **ferritin** in all women and children) to look for anaemia **and** eosinophilia. If eosinophilia, do faecal OCP and consider empiric albendazole. Consider THALASSAEMIA as well as iron deficiency as a cause of microcytic hypochromic anaemia.

Latent TB - TST (Mantoux) for all age groups or Quantiferon for those ≥5 years of age. Refer ALL children <5 years for a TST (e.g., Royal Children's Hospital Immigrant Health Clinic or TB Clinic). Mantoux/Quantiferon do not differentiate between latent and active TB – if positive (see VIC TB guidelines for TST cut-offs), take a detailed history and do a physical exam and chest xray (to exclude active TB), then refer to TB services. If you request a Quantiferon, make sure there is an arrangement for the fee – it is

currently only Medicare-rebatable if there is a history of exposure to active TB or the patient is immunosuppressed. Clearly write this indication and 'please bulk-bill' on pathology requests otherwise patients will incur a $60-$80 out of pocket fee. If there is concern about exposure and a problem with screening, refer to a local ID clinic for screening.

Hepatitis B - SPECIFICALLY ask for HepB core Ab, HepB surface Ag and HepB surface Ab (**all three**) to look for current or past infection and/or vaccination status (see www.hepbhelp.org.au). Write "Query chronic hepatitis B", NOT "hep B serology").

Schistosomiasis - if positive, send stool for ova. Perform midday urinary dipstick - if positive for blood, also send urine for microscopy looking for ova.

Vitamin D - write the specific indication/risk factors on the path form ("darkly pigmented skin"/"lack of sun exposure due to cultural reasons") or the patient will be billed. Repeat again one year later (post-winter period).

Other Important Points for the Refugee Health Assessment

1. RHA must be completed within 12 months of arrival to be Medicare-billable. Complete the RHA over 2-3 appointments, and bill for the assessment when results have been reviewed and discussed with the patient (usually the 2nd or 3rd visit).

2. Explain the concepts of health assessment, screening and disease prevention, confidentiality and informed consent. Explain that screening helps to ensure good health and identify conditions that may be asymptomatic but harmful to health and wellbeing. Explain that lots of information will be recorded on computer, but that this information is accessible only by GPs in the clinic and not by anyone else including other GP clinics, hospitals, **government**, **police**, etc. without consent. If health conditions are uncovered during the RHA, these will **not** cause the patient to be sent back to their country of origin.

3. Record date of arrival, country of birth, migration route (transit countries and dates), ethnicity, language(s) spoken, need for an interpreter. Also record caseworker and refugee health nurse (RHN) details if available. Knowing country of birth and migration route will flag potential health risks. Ethnicity, language(s) spoken and need for interpreter prepares you for the consultation (e.g. booking appropriate interpreters). RHNs and caseworkers can be your best friend in helping to ensure that appointments are attended and health needs are followed-up.

4. Manage patient expectations and be aware of low health literacy as this may be the patient's first full health check. Experiences of medical care overseas may also impact patient expectations (e.g., after this visit I shall receive medications that will cure my illness, otherwise the GP is not treating me properly).

5. MENTAL health issues can take **years** to identify, but if a clear torture/trauma history is disclosed, expedite referral to specialty organisations such as Foundation House. Discussion around mental health should be patient-led and performed sensitively to avoid re-traumatisation. Useful questions include "Has anything happened to you in the past that you think is causing your problem today?" Or "I know many people from (country of origin) have had a difficult time. Is there anything about your situation or experiences there that is still worrying you?"

6. Consider offering a pregnancy test – it is important to consider pregnancy since poor health outcomes are more common in pregnant women of refugee background. Offer a pregnancy test and/or contraception if appropriate. Be aware of cultural sensitivities around family planning; sexual health may be best covered in 2nd or 3rd visit.

7. Be aware of family violence and services available to support victims. Social isolation, lack of language skills and/or employment, prior trauma, and cultural norms all contribute to higher vulnerability amongst those of refugee background.

8. When offering investigations, say 'we offer tests' rather than 'we need to do tests'. Ensure informed consent. Inform patients that results will not impact their visa status and are confidential, RHA covers a lot of tests (i.e., a large number of tubes will be taken, but not enough to cause harm), and that the blood will not be sold! If there is no onsite pathology, offer a printed map of path services and check with provider about use of interpreters.

9. Arrange Follow-up - schedule a follow-up visit in 2-3 weeks to review all results. Inform the patient that he/she will be notified immediately if anything urgent is identified.

Please email the Refugee Health Fellows at: Refugee.Fellow@rch.org.au for any paediatric refugee health enquiries Refugee.fellow@mh.org.au or mark.timlin@monashhealth.org for any adult refugee health enquiries.