The Royal Australasian College of Physicians

The Royal Australasian College of Physicians

# Policy on Refugee and Asylum Seeker Health

May 2015

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# Definitions

**Asylum seeker** is a person who has left their country and applied for protection as a refugee.[1]

**Bridging visas** are temporary visas that allow people to remain lawfully in Australia while their visa applications are being assessed.

**Community detention** is a form of immigration detention that allows asylum seekers to live in the community while seeking to resolve their immigration status. People in Community detention do not hold a visa; therefore, they do not have the same rights as a person on a visa living in the community.[2]

**Held detention** is the term used for detention in any type of locked immigration detention facility (in Australia this includes immigration detention, immigration transit accommodation, immigration residential housing, or alternative places of detention). This term also applies to offshore immigration detention facilities.

**Humanitarian Programme** is the Australian migration stream supporting resettlement of refugees and people in refugee-like situations.[3] The Humanitarian Programme has two components: 'Offshore Resettlement' – for people outside Australia in need of humanitarian assistance, including 'Refugee' and Special Humanitarian Programme categories, both providing permanent resident status; and 'Onshore Protection' – for people already in Australia who are found to be refugees.[4]

**Refugee** is someone who, "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality, and is unable to, or owing to such fear, is unwilling to avail himself/herself of the protection of that country, or who, not having a nationality and being outside the country of his former habitual residence, as a result of such events, is unable or, owing to such fear, is unwilling to return to it."[5]

**Refugee Family Support Category** is the New Zealand migration stream that assists resettled refugees to sponsor family members who would otherwise not qualify under other New Zealand immigration policies. This program is in addition to the **'Quota refugees'** – New Zealand's formal annual refugee resettlement intake.[6, 7]

**Separated children** are children separated from both parents, or from their previous legal or customary primary caregiver, but not necessarily from other relatives. These may, therefore, include children accompanied by other adult family members.[8]

**Unaccompanied children (also called unaccompanied minors)** are children who have been separated from both parents and other relatives and are not being cared for by an adult who, by law or custom, is responsible for doing so.[9]

In this document, the term **refugee** is used to describe people who have been found to be refugees under the United Nations Refugee Convention, and hold an Australian or New Zealand Humanitarian visa, and also people of 'refugee-like' background who have entered under other migration streams. 'Refugee-like' acknowledges that people may have had refugee experience in their countries of origin, but do not have formal refugee status.

# Abbreviations

AHRC – Australian Human Rights Commission

BVE – Bridging Visa E

CPAC – College Policy and Advocacy Committee

CRC – Convention on the Rights of the Child

CXR – Chest X-Ray

DHC – Departure Health Check

DIBP – Department of Immigration and Border Protection

FBE – Full Blood Examination

HDA – Health Discharge Assessment

HIV – Human Immunodeficiency Virus

IGRA - Interferon Gamma Release Assay

IHMS – International Health and Medical Services

MAW – Mass Arrival Warrant

MRRC – Mangere Refugee Resettlement Centre

PBS – Pharmaceutical Benefits Scheme

PNG – Papua New Guinea

RACP – Royal Australasian College of Physicians

SHEV – Safe Haven Enterprise Visa

SHP – Special Humanitarian Programme

SRSS – Status Resolution Support Services

TB – Tuberculosis

THC – Temporary Humanitarian Concern (visa)

TPV – Temporary Protection Visa

UNHCR – United Nations High Commissioner for Refugees

# Introduction

Refugee and asylum seeker health is an important area of healthcare in the context of (i) increasing numbers of refugees and people seeking asylum globally, (ii) increasing recognition of the unique health and mental health issues faced by this group, and (iii) in Australia, a complex and changing policy environment.

This document provides an overview of the evidence used to develop the Royal Australasian College of Physicians (RACP) position statement addressing four key areas in refugee health: health assessments, access to healthcare, promoting long-term health in the community, and asylum seekers and held detention.

The policy statement and associated position statement update the 2007 RACP policy statement, 'Towards better health for refugee children in Australia and New Zealand', and extend the RACP's position on refugee and asylum seeker health across the lifespan

## Policy and Position Statement development process

The RACP convened a working group in 2014 after an expression of interest process that was approved by the RACP College Policy and Advocacy Committee (CPAC). Members of the working group included Fellows with expertise in paediatrics/refugee health, infectious diseases, public health and adult medicine.

The working group conducted a literature review through systematic searches of the MEDLINE, PsychInfo and ERIC databases (1996–current). An initial draft was prepared for expert comment and provided to RACP members for feedback; revisions were incorporated with consensus from the working group. The revised draft was sent for external consultation, with further revisions based on this second round of feedback (see Appendix 1). Senior members of CPAC reviewed the final manuscript. The statements are intended for physicians, physician trainees, primary care providers, other specialists, medical students, health professionals and policy makers, with the intention of i) broadening the discourse on refugees and asylum seekers, ii) developing an evidence-based summary of health issues relevant to refugees and asylum seekers, and iii) providing an appraisal of the health impacts of refugee and asylum seeker policy.

These statements have a greater focus on the Australian situation due to the complexity of the Australian immigration policy environment and the relative stability of New Zealand refugee intake and policy.

# Background

## Demographics

Australian and New Zealand populations include large numbers of people of refugee background. Over 800,000 refugees have settled in Australia since World War II,[10] with 270,000 Humanitarian entrants in the last 20 years[11] and an ongoing annual Humanitarian Programme intake of 13,750 people.[12, a] This program commenced in 1977 and includes the 'Refugee' and Special Humanitarian Programme (SHP)[b] categories, both providing permanent resident status. The Humanitarian Programme includes a high proportion of children and young people, with half the intake aged less than 25 years; the intake also includes unaccompanied Humanitarian minors. In addition, people arrive from refugee source countries under other migration streams, and there are children born in Australia to refugee-background families. In 2012–13, the most frequent Humanitarian source countries for people entering Australia under the (offshore) Humanitarian Programme were Iraq, Afghanistan, Burma, Bhutan, Democratic Republic of the Congo, Iran, Somalia and Sudan.[3]

In 2012–13, around 8,000 asylum seekers arrived in Australia by plane.[10] Historically, the majority of asylum seekers have arrived in Australia by air with a valid visa, and subsequently claimed asylum;[13, 14] however, over recent years, there has been an increase in the number of asylum seekers arriving by sea. Between 2000 and 2008, 8,904 asylum

a The annual Australian Humanitarian Programme intake was increased to 20,000 places over 2012–2013, then reduced back to 13,750 places from September 2013. In December 2014, the Minister for Immigration and Border Protection announced that the humanitarian intake would increase to 18,750 places by 2018–19 (see www.theguardian.com/australia-news/video/2014/dec/03/scott-morrison-announces-refugee-humanitarian-visa-increase-video).

b The SHP visa is for people outside their home country who have been subjected to substantial discrimination amounting to a gross violation of their human rights in their home country. They are sponsored by a 'proposer' who may be an Australian citizen, permanent resident or organisation, or an eligible New Zealand citizen. The SHP program commenced in 1981.

seekers arrived in Australia by boat, this number increasing to 51,637 between 2009 and 2013, with more than 20,000 arrivals in 2013.[15, c] In 2012–13, the most frequent source countries for asylum seekers arriving in Australia by boat were Sri Lanka, Iran, Afghanistan, 'Stateless'[d] and Pakistan.[10] There have been few boat arrivals since September 2013, after significant shifts in Australian policy (see Appendix 2). People arriving by boat in Australia without a valid visa are subject to mandatory immigration detention, and significant numbers of people have been held in immigration detention on mainland Australia and Christmas Island and in places of offshore processing (Nauru and Manus Island in Papua New Guinea (PNG)).

There are currently (March 2015)[e] 1707 asylum seekers (including 103 children) in immigration detention on Nauru or Manus Island, 1848 asylum seekers (124 children) in detention on Christmas Island and the mainland, more than 2500 asylum seekers (1282 children) in Community detention, and more than 27,000 asylum seekers (2760 children) on bridging visas in the community.[16] More detailed information is provided in Appendix 3. The average length of time in Australian immigration detention facilities reached 413 days in September 2014.[17] This compares to an average length of less than 100 days for most of the period between June 2012 and August 2013, during the peak of asylum seeker boat arrivals to Australia.

Over 2008–2013, 88–100% of asylum seekers arriving by boat to Australia were found to have valid refugee claims, with a final protection grant rate of over 90% in most years for people from Afghanistan, Iran, Iraq and Burma, and people who are 'Stateless'.[14, 18]

New Zealand has also settled refugees since the 1930s, with more than 40,000 refugees arriving since 1976[19] and a formal annual refugee intake quota since 1987.[6] New Zealand maintains a quota of 750 refugee entrants annually ('Quota refugees'), with half this intake from the Asia Pacific region and half from other areas (Africa, Middle East and Americas), and up to 300 places for family reunion within this quota.[6, 20] New Zealand has accepted unaccompanied minors within the Refugee Quota Programme; however, the Immigration Act 2009 does not state explicitly that children or adolescents in this category are accepted as part of this program.[21] In addition, New Zealand accepts up to 300 people under the Refugee Family Support Category,[22, f] and just over 3,000 asylum seekers arrived between 1992 and early 2014.[23] New Zealand currently receives around 300 asylum seekers each year[g], with the majority arriving as students or visitors. New Zealand has not had asylum seekers arrive by boat.[24]

## Global context

The RACP notes that it is important to consider refugee and asylum seeker numbers in the global context. At the end of 2013, there were 51.2 million forcibly displaced people, including 33.3 million internally displaced persons and 16.7 million refugees, with 50% aged less than 18 years.[25] There are currently nearly 4 million refugees from Syria, with 100,000 Syrians registering as refugees each month in 2014,[26] and more than 2.5 million refugees from Afghanistan.[25] Over 86% of refugees are hosted in developing and/or nearby countries; for example, there are over 1.6 million refugees in Pakistan,[25] and over a million refugees in Lebanon.[26] During 2013, there were more than one million applications for asylum worldwide, with more than 100,000 applications to Germany and 50,000–80,000 applications to each of USA, South Africa, France, Sweden and Malaysia.[25] Less than 1% of people who have been forcibly displaced are permanently resettled through humanitarian programs.[25]

## Policy context

Australian government policy related to asylum seekers is complex and controversial, and continues to change. Australia has had a policy of mandatory detention for people arriving by boat without a valid visa since 1992, and indefinite immigration detention is possible under Australian law. Asylum seekers arriving by plane are generally not subject to mandatory detention, although this may apply if their visas are cancelled or expire. The offshore (people arriving from overseas) and onshore (people arriving in Australia and claiming asylum) components of Australia's

c Deaths at sea are documented in the Australian Border Deaths database (available at http://artsonline.monash.edu.au/thebordercrossingobservatory/publications/australian-border-deaths-database/). Using these figures and boat arrival numbers, the mortality risk of boat journeys was 1.6% over the period 2009– 2013 and 7.4% over the period 2000–2008.

d 'Stateless' refers to lacking identity as a national of a country under relevant law.

e Detention statistics are available at www.immi.gov.au/About/Pages/detention/about-immigration-detention.aspx.

f Previously called 'Family Reunification Refugee'.

g Information provided by Dr Martin Reeve, Mangere Refugee Resettlement Centre, November 2014.

Humanitarian Programme have been linked since 1996 – so an increase in onshore claims reduces the number of places for people arriving under the offshore program, with significant effects on sponsored places for people in refugee-like situations[h].

Key dates and implications of recent Australian policy for asylum seekers arriving by boat are shown in Appendix 2. Detailed timelines of policy changes are available elsewhere.[27, 28] The Migration and Maritime Powers Legislation Amendment (Resolving the Asylum Legacy Caseload) Bill 2014[29] passed in December 2014, amending a range of legislation, with the ability to be applied retrospectively. These changes included extending the Minister for Immigration and Border Protection's power to detain and transfer people at sea, the introduction of a new system of 'fast track' processing with restriction, and in some cases exclusion, of rights of review, and reintroduction of temporary protection visas (TPV) and a new class of temporary visa (the Safe Haven Enterprise Visa – SHEV). Multiple agencies, including the United Nations High Commissioner for Refugees (UNHCR),[30] the Refugee Council of Australia,[31] the Law Council of Australia[32] and other legal groups[33, 35] have expressed concern that the proposed amendments within the Bill may compromise Australia's obligations under international refugee law, human rights law and the international law of the sea, and risk breaching the principle of 'non-refoulement', which prohibits states from returning refugees to countries where their life or freedom would be threatened. The Australian Parliamentary Joint Committee on Human Rights found the proposed amendments were incompatible with Australia's obligations of non-refoulement under the International Covenant on Civil and Political Rights and Convention Against Torture.[36]

While New Zealand has had a steady quota of refugees, and fewer policy changes compared to Australia, in 2013 the New Zealand government amended the Immigration Act 2009[21], enabling mandatory detention of asylum seekers, including children, if they are part of a 'mass arrival' by boat, with limitations on family reunion and reassessment of refugee status after three years. A mass arrival is defined as more than 30 people, and a 'Mass Arrival Warrant' (MAW) allows the group to be detained for a maximum of six months, with renewal of the warrant every 28 days thereafter[i]. This legislation therefore has provisions for continuous detention of asylum seekers, in contrast to the New Zealand Bill of Rights Act 1990,[38] which describes the right to be free from arbitrary detention. The possibility of using Australian offshore processing centres for mass arrivals to New Zealand has been raised, noting that New Zealand does not have any dedicated immigration detention centres, and the prison system may be used for long-term detention.[37] In practice, people arriving at the airport and seeking asylum in New Zealand with false or no documentation may be detained in the prison system while their identity is established. Some are then transferred to the Mangere Refugee Resettlement Centre (MRRC) in Auckland, which is officially a detention centre, although people have freedom of movement, there are no guards, and they have a court review every two weeks if they are to be detained. Once their identity is established, they are 'released on condition' while they await the outcome of their case. They may then move to the community if they have support, or continue to stay at the MRRC.

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h The current caseload of asylum seekers who arrived in Australia by boat without a valid visa and who remain on Christmas Island and the mainland (around 30,000 people) will have their claims for refugee status assessed under the new legislation, and will be considered separately from the Humanitarian Programme.

i Children arriving in New Zealand as part of a mass arrival **without** their parents or guardians are not included as part of the MAW. The Act does not specify whether or not unaccompanied minors would be subject to the same conditions of detention as children and young people arriving with their parents and/or guardians. Young people between the ages of 17 and 19 can be detained in youth units by the New Zealand Department of Corrections for the period of the MAW, and children and young people under the age of 17 can be held in a facility operated by Child Youth and Family.37

# Section 1. Health assessments of refugees and asylum seekers

Refugees have, by definition, experienced forced migration, conflict and upheaval, and language and cultural transitions. They may have experienced significant human rights violations or torture, prolonged periods of uncertainty, loss of and separation from family members, physical and/or sexual violence, in addition to poor living conditions and disruption of basic services such as health and education.

Many humanitarian source countries and transit countries have a different profile of acute and chronic diseases to Australia and New Zealand. These factors combine to create a unique profile of health and mental health conditions in people of refugee background. Asylum seekers arriving by boat and spending time in detention frequently have additional trauma related to perilous journeys and their detention experience.[39]

## Offshore screening

All permanent entrants to Australia, including offshore Humanitarian Programme entrants, undergo a visa health assessment approximately six months prior to departure for Australia. This assessment is intended to exclude conditions of public health significance,[40] particularly tuberculosis (TB), and includes a physical examination, chest X-ray (CXR) in those aged 11 years and older[j], human immunodeficiency virus (HIV) screening in unaccompanied minors and those aged 15 years and older, and syphilis screening in those aged 15 years and older. Other screening may be completed at the discretion of the doctor completing the examination.[41] People found to have active TB must complete treatment before travel to Australia. The visa health assessment may generate a health undertaking, which is an agreement for follow-up healthcare after arrival in Australia. In May 2012, there were changes to the health requirement for offshore Humanitarian entrants to Australia,[42] allowing greater equity in migration access for people with disabilities or health conditions, including HIV.

New Zealand has a similar system of medical assessment for permanent residents and for temporary residents staying longer than 12 months.[43] The New Zealand General Medical Certificate[44] includes more comprehensive testing compared to that in the Australian system[k]; however, refugee entrants to New Zealand are only required to have a CXR, screening for TB and HIV,[6] and a limited medical certificate, although other tests may be undertaken if the examining physician considers them clinically necessary.[45] People with active TB must complete treatment prior to travel; HIV does not preclude travel, although there is an annual quota on the number of people with HIV accepted (20 people). New Zealand introduced health selection criteria for refugees in 2013, excluding people with certain medical conditions.[6, l] New Zealand asylum seekers granted refugee status can apply for permanent residence in New Zealand and must complete an abbreviated medical assessment as part of the process, in addition to any onshore screening they may have completed. In general, an asylum seeker cannot be declined refugee status in New Zealand on health grounds[m].

Offshore refugee entrants to Australia may also undergo a voluntary Departure Health Check (DHC) in the week prior to travel, which includes an assessment of ‘fitness to fly’, mumps-measles-rubella vaccine for those aged 9 months to 54 years, anti-helminth treatment (albendazole) for those aged 12 months and older, and malaria screening in endemic areas.[46] In 2014, polio vaccination was added to the DHC process in some source countries.[47] Similarly, some refugees may undergo ‘fitness to fly’ assessments before travel to New Zealand, including measles and polio vaccinations. Other health issues arising in humanitarian source countries, such as Ebola virus disease, may also be addressed through the offshore screening processes.

## Detention health screening

Asylum seekers in held detention in Australia undergo an induction health assessment and detention health screening. Protocols are not publicly available, although the health screening appears similar to the Australian visa

j CXR may also be completed in younger children if the clinical history suggests tuberculosis.

k The NZ General Medical Certificate includes FBE, HbA1C, creatinine, HBsAg, HCV, HIV, and treponemal serology for all entrants 15 and older.

l Medical conditions include a) need for dialysis, b) severe haemophilia and c) physical, intellectual, cognitive or sensory incapacity requiring full-time care.

m Information provided by Dr Martin Reeve, Mangere Refugee Resettlement Centre.

health assessment and includes blood screening (full blood examination (FBE)), ferritin, hepatitis B, hepatitis C, HIV, syphilis and TB screening, with a CXR for those aged 11 years and older. Doctors working in detention health have raised serious concerns about the process and quality of the induction health assessment and health screening[48], and the RACP has spoken publicly about the integrity of such screening and the 48 hour 'rapid transfer' policy introduced in 2013,[49] whereby adolescents and adults in detention undergo health screening and are transferred offshore within 48 hours of arrival in Australia, prior to screening results being available, increasing the risk of missing key health concerns.

Prior to mid-2014, children in held detention had an induction health assessment, but they did not have blood testing or TB screening (aside from CXR for those aged 11 years and older). Screening was introduced in mid-2014, and although protocols are not available, they appear to be similar to the adult protocols. This means children on Nauru did not have blood tests or communicable disease screening prior to being transferred offshore, unless they were found to have risk factors on the induction health assessment.

Detention health screening (but not detention mental health screening) is summarised in a document called 'Health Discharge Assessment' (HDA), which can be accessed for people in held detention. A copy of the HDA is given to people on release from held detention.

In New Zealand, asylum seekers 'in detention' at MRRC all receive comprehensive 'onshore' refugee physical and mental health screening. Community-based asylum seekers may also be seen for initial assessment through the same service.[23, n] Specialist mental health assessment, initial treatment and referral are available to detained asylum seekers, including those held in New Zealand corrections facilities.[50, o]

## Onshore health assessments

Expert consensus, Australian and New Zealand guidelines and the UNHCR suggest all refugees and asylum seekers should be offered a voluntary comprehensive health assessment after arrival.[23, 39, 50–53] This assessment should include identifying any acute or chronic medical conditions (including mental health, oral health, vision, hearing, developmental issues, disability, and women's health/maternity issues where relevant), a full physical examination and measurement of growth/weight/height, screening for nutritional status and infectious diseases (including TB, blood-borne viruses, parasites and sexually transmitted infections), mental health and trauma screening, oral health screening, appropriate women's health screening and provision of catch-up immunisation. The intention of screening is to ensure early preventive healthcare and appropriate immunisation, to assess whether specialist referral is required, and to exclude conditions of individual and public health significance in a population that may have had limited access to health services previously. Available prevalence information is shown in Appendix 4.

## Mental health screening

Many refugees and asylum seekers, including children, have experienced conflict, family separation and significant human rights violations, including torture and physical and sexual violence. Widely variable rates of mental health issues are reported in refugee children[54] and adults.[55–61] A meta-analysis found the population prevalence of reported torture was 21% in refugee adults.[57]

Unaccompanied minors and separated children are recognised as having specific risks and vulnerabilities.[62–66] They have often embarked on dangerous journeys, and many have experienced the death of family members, persecution, conflict, and physical and/or sexual violence. They may have experienced forced military recruitment or forced domestic labour. These experiences occur during critical developmental periods, placing them at risk of long-term developmental and mental health problems.

There is clear evidence that Australian immigration detention, especially long-term detention, is detrimental to health and mental health at all ages, in the short and long term.[56, 67–86] Additionally, Australian temporary protection visas have been shown to be harmful to mental health and associated with worse mental health status when compared to permanent protection visas.[74, 78, 87–90]

Screening for torture, trauma, and mental health conditions is recommended in Australian refugee health assessment guidelines for both refugees and asylum seekers,[39] although the validity of mental health screening

n Mangere staff reported 30% of community-based asylum seekers in NZ have health screening at MRRC.

o Services are provided through the specialist mental health service: Refugees as Survivors.

in refugee groups has been questioned.[91] Existing assessment tools, diagnostic approaches and psychological interventions may have limited applicability to refugees and asylum seekers, and caution is required with mental health diagnoses; however, evidence suggests that therapy is beneficial in these groups.[92–94]

In Australia, mental health screening generally occurs as part of the initial onshore health assessment, and counselling is provided through specialist services for survivors of torture and trauma in each jurisdiction. In New Zealand, specialist mental health assessment is offered to all refugees at MRRC, and is available to community-based asylum seekers who have experienced trauma and/or torture.[50]

## Women's health and maternity screening

Pregnancy and childbirth are significant events in the lives of women and families, and may be times of increased vulnerability, especially for women who are refugees or asylum seekers. Refugee women in Australia have been found to have poorer general health and high levels of social disadvantage during pregnancy[95–97] and increased risk of adverse pregnancy outcomes[54, 95, 98] and caesarean delivery.[95, 98] In addition, refugee women may have experienced sexual violence[99] and may have undergone female genital mutilation.[39, 50, 100] Women's health screening, and consideration of pregnancy and birthing issues, are an essential part of post-arrival health screening for women of child-bearing age, allowing women to be linked with appropriate services as soon as possible.[39, 50]

## Practicalities of assessment

Health assessments for refugees are completed shortly after arrival in New Zealand, and should be completed as soon as possible after arrival in Australia, acknowledging competing priorities in the early settlement period, together with any requirements for follow-up arising from offshore health assessments. Health assessments should also be completed for asylum seekers as soon as possible after their arrival in the community. In Australia, asylum seekers who arrive by boat will have had detention health screening (details page 9); however no data are available on health screening in asylum seekers who arrive by plane. Asylum seekers in New Zealand are encouraged to undergo health screening, although there is no formal requirement for health screening until their refugee status is confirmed and permanent residence is granted.[101] This process can take an extended period of time and asylum seekers may remain unscreened for months or years. A small study from 2004 found only 57% of asylum seekers reported undergoing health screening within six months of arriving in New Zealand.[101]

It is important to explain the concepts of health assessment, screening and disease prevention and to obtain informed consent for testing,[39, 102] making sure there are no contraindications to aspects of screening (e.g. pregnancy in women of childbearing age). It is essential to ensure screening is followed up and issues arising are managed appropriately.

Most patients will require the assistance of an interpreter, and appropriately qualified and accredited interpreters should be engaged where needed.[39, 50, 103] Generally, assessment and catch-up immunisation will occur over several visits. Different models of care (primary care/specialised services/specialist clinics) are used in different jurisdictions in Australia, whereas New Zealand uses a centralised, specialised screening model. Consistent health screening strategies are necessary, ensuring all refugees and asylum seekers receive comprehensive health screening regardless of their visa type (i.e. including SHP entrants in Australia and Refugee Family Support Category migrants in New Zealand), mode of arrival or permanent residency status.

Adequate transfer of accurate and complete health screening information is essential to streamline testing, to reduce duplications and costs to the patient and the health system, and to meet legal and regulatory requirements. In Australia, there are particular challenges with accessing detention health summaries and ensuring transfer of health information when patients move interstate. In New Zealand, the MRRC ensures copies of the refugee health assessments are transferred to the primary care providers. The inclusion of adequate information to identify refugee and/or asylum seeker status in existing administrative datasets is essential to enable monitoring of post-arrival health assessments and long-term outcomes.

## Age assessment of children and young people

Refugee arrivals may have an incorrect birthdate on their visa documentation, which becomes the basis for official documents after settlement. Likewise, asylum seekers may have an unknown or undocumented birthdate. Reasons for an incorrect birthdate are often complex, and may include bureaucratic errors, calendar differences, birth during flight/transit, an unknown birthdate and/or lack of previous paperwork/birth registration, noting that one in three children worldwide are not registered at birth.[104]

Having an incorrect birthdate has implications for school placement, service access, welfare access and legal status and, for asylum seekers, their legal status as minors and age-related detention placement. Age assessment is an issue that is not uncommon in paediatric refugee health. Requests for age assessment may occur years after arrival, but are sometimes an urgent issue for young people seeking asylum. The only Australian study including prevalence data found 5% of refugee children were reported to have an incorrect birthdate on their documentation.[68]

Suggested approaches to age assessment are available.[105, 106] The Committee on the Rights of the Child states:[107]

> *Age assessment … should not only take into account the physical appearance of the individual, but also his or her psychological maturity. Moreover, the assessment must be conducted in a scientific, safe, child and gender-sensitive and fair manner, avoiding any risk of violation of the physical integrity of the child; giving due respect to human dignity; and, in the event of remaining uncertainty, should accord the individual the benefit of the doubt such that if there is a possibility that the individual is a child, she or he should be treated as such.*

The RACP notes it is not possible to determine age, but only to assess age, and that no single test can define age. Neither bone age X-rays nor dental assessment/imaging define age, having been developed to provide measures of skeletal maturity and dental eruption in the setting of known chronological age. Importantly, these tests provide an age estimate within a 3–4 year range, and thus are not adequate to determine whether or not someone is a minor (aged under 18 years).[108–113] Age assessment requires a combination of narrative history, review of any available documentation, physical examination, and review of growth, pubertal status, development, education and peer relationships. Bone age/dental X-rays are not useful in isolation. The RACP suggests that the benefit of the doubt should be given where there is uncertainty about minor status, and that unaccompanied refugee and asylum seeker children and young people who claim to be minors should have an independent advocate present while undergoing age assessment.

### RACP position – Health assessments

- All refugees and asylum seekers should be offered a voluntary assessment of their physical and mental health on arrival in Australia or New Zealand. This should include assessment of acute or chronic medical conditions, developmental issues and disability, screening for nutritional status and infectious diseases (including tuberculosis, blood-borne viruses, parasites and sexually transmitted infections), mental health and trauma screening, oral health screening, and appropriate women's health screening. Consideration of pregnancy and birthing issues is an essential part of post-arrival health screening for women of childbearing age. Asylum seekers should have the same post-arrival assessment as refugees.
- Health assessments and screening should be completed as recommended by expert guidelines, with informed consent and with the assistance of a qualified interpreter as needed, and screening should be followed up with appropriate management and linkage to ongoing primary care. In women of childbearing age, pregnancy should be considered when planning catch-up immunisation or radiological investigations.
- Screening is required to ensure early preventive healthcare and appropriate immunisation, to assess whether specialist referral is required, and to exclude conditions of individual and public health significance.
- Health screening protocols should be publicly available for review and oversight by independent health advisory groups and professional bodies.
- Administrative datasets should include adequate information to identify refugee and asylum seeker patients to enable monitoring of initial health assessments (and long-term outcomes) and to facilitate health service planning.
- Any rapid screening process – such as the 'rapid turnaround' health screening used prior to transfer to offshore immigration detention from Australia – is not appropriate, and will compromise health and safety and health professionals' duty of care to their patients.
- Adequate and timely transfer of accurate and complete health screening information is essential in order to streamline testing and reduce duplications and costs (in terms of time and money) to the patient and the health system. Health screening results and treatment plans should be available to healthcare providers when asylum seekers or refugees move between jurisdictions (or from held detention to the community). Accessible verbal information and written information on health screening results should be provided to patients. All refugee and asylum seeker patients should be provided with a copy of their medical records (and parents provided with their children's records) to assist with primary care follow-up in the community.
- Age assessment requires a combination of narrative history, review of any available documentation, physical examination, and review of growth, pubertal status, development, education and peer relationships completed with informed consent and extreme sensitivity. Bone age/dental X-rays are not useful in isolation.
- Where age assessment is required, and there is uncertainty about a young person's age, the benefit of the doubt should be given to their claim. Unaccompanied refugee or asylum seeker children or young people who claim to be minors should have an independent advocate present while undergoing age assessment.

Detailed recommendations are contained in the accompanying position statement.

# Section 2. Access to healthcare

In New Zealand, Quota refugee arrivals are housed in the MRRC in Auckland for a period of six weeks, where they receive mandatory comprehensive physical and mental health screening before transfer to a community-based setting, with full access to health and welfare services, orientation to life in New Zealand and English language classes.[22] They receive assistance to access housing[p] and to enrol with a family doctor. Copies of their initial assessment are sent on to the primary care provider. Family support entrants receive relatively less settlement support. Asylum seekers who are applying for refugee/protection status and asylum seekers who are appealing against a negative decision on their status are eligible for the full range of publicly funded health and disability services in New Zealand, including subsidised pharmaceuticals. However, they become ineligible for public services if their claim for refugee status is not successful or their appeal fails – meaning there are small numbers of asylum seekers in New Zealand who are not able to access health services.[114] Asylum seekers in New Zealand do not receive assistance to enrol with a family doctor, and barriers to accessing primary care have been identified, including access to language services. Asylum seekers at MRRC receive assistance to find appropriate housing, although this may be limited[q]. New Zealand uses a state-subsidised fee-for-service model for primary care, with a complex system of patient co-payments. All children in New Zealand are eligible for well child services, regardless of their immigration or citizenship status.[115]

In Australia, there are differences in access to Medicare, health services, support and work rights for asylum seekers and refugees, depending on their visa type, visa status, time of arrival and detention status.

- **All permanent residents, including Humanitarian permanent visa holders**, have Medicare access, Pharmaceutical Benefits Scheme (PBS) access and work rights, and are able to access a full range of health and welfare services, including healthcare cards, where eligibility criteria are met. New arrivals with low English proficiency are able to access 510 hours of English language tuition. Settlement support for Humanitarian entrants is provided through different agencies in the different jurisdictions for a period of 6–12 months; refugee arrivals receive a greater level of support compared to SHP arrivals. Settlement services provide assistance to access housing, furniture, healthcare, welfare services and education, as well as orientation to the local community.
- **Asylum seekers who arrived by boat and hold a Bridging Visa E (BVE)** generally had not had work rights prior to 2015[r]. They are entitled to Medicare[s], although this is granted on a temporary basis and is conditional on having a valid BVE, noting that BVE are issued for 12 months. From late 2013 and through 2014, 30–50% of BVE holders had lapsed visas and lost Medicare access, presenting ongoing challenges for health service access. Medicare cards for asylum seekers on a BVE all expired on 31 December 2014, although people with a valid BVE are able to renew their Medicare[t]. Pharmaceutical access is complex and depends on Medicare access and the Status Resolution Support Services (SRSS) provider. Casework and accommodation support is provided through SRSS for a six-week period following release from detention; after this period, limited support may be provided through ongoing programs for people who are particularly vulnerable. People holding a BVE are entitled to a weekly support payment equivalent to 89% of the special benefit or youth allowance (around $230/week or less), they are not provided with ongoing accommodation and they have to sign a code of conduct, which is also required for reissue of a BVE.[116]
- **People on Temporary Protection Visas:- People on a Temporary Humanitarian Concern (THC) visa** (up to 3 years duration) are generally asylum seekers who arrived by boat, although few of these visas have been issued. They have access to Medicare, the PBS and healthcare cards. They receive full special benefit and rental assistance and have work rights; they do not have specific casework support and are

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p Quota refugees receive assistance from Red Cross to access either private rental or Housing New Zealand accommodation.

q Asylum seekers at MRRC have some access to social housing, and may also access emergency housing through the Auckland Refugee Council.

r While the new Temporary Protection Visas carry work rights, it is not clear how long it will take to implement these visas, or for BVE to be amended or reissued with work rights in the interim.

s Asylum seekers on a BVE with Medicare receive a distinctive blue-coloured Medicare card that is different from the standard Australian Medicare card.

t Under the Health Insurance Act, the Health Minister can allow non-citizens to access Medicare through a limited order – the order for the asylum seeker cohort expired 31 December 2014. This order has been renewed for a further 3-year period, allowing people with a valid BVE to renew their Medicare.

not entitled to family reunion or to travel overseas. **TPV** (3 years duration) will be reintroduced and will include work rights, Medicare access and welfare benefits subject to Social Security legislation. They will not include family reunion or the right to travel and re-enter Australia[u]. In addition, **Safe Haven Enterprise Visas (SHEV)** (5 years duration) will be introduced, targeted to 'designated regions' with the same support arrangements and restrictions as TPV. SHEV visa holders who meet specified work requirements will be able to apply for a limited range of other onshore visas.[32] The TPV and SHEV visas are due to commence in mid-2015, when processing of asylum claims recommences, although it is likely to take several years before all asylum seekers on BVE have their claims assessed.

- **Asylum seekers who arrived by plane** have variable access to work rights, Medicare, the PBS and welfare support, depending on the visa they used to enter Australia, the type of bridging visa they hold and the stage of their refugee claim process. Some asylum seekers do not have access to any of these supports.
- **Asylum seekers in Community detention** are provided with housing, but do not have visas, Medicare access or work rights. They are entitled to a weekly support payment equivalent to 60% of the special benefit (around $150 weekly). Their healthcare and pharmaceuticals are provided through a network of specified health providers that have been approved by the detention health service provider. They also access State health services, e.g. through specialist referrals. Casework support is provided through SRSS by settlement agencies under specified contractual agreements, and asylum seekers have to sign a (different) code of conduct.

Available evidence suggests that both refugees[54, 117–124] and asylum seekers[125–128] face significant barriers to accessing health, mental health, pharmacy[129] and dental services[130–135] in Australia. Financial constraints mean they are generally not able to access private services, and depend on public or community-based services. Key barriers to accessing health services include different levels of settlement support, difficulty accessing (or failure to engage with) language services, financial and transport stressors, unfamiliarity of new arrivals with the health system, unfamiliarity of health services with the refugee experience, and perceived discrimination.[54, 103, 117, 118, 125, 129, 136, v] Similar barriers are described for women accessing maternity services and post-natal care.[96, 97, 100, 137–139] General practice co-payments are likely to be a significant barrier to service access for this group (and also for other vulnerable groups), and may have unintended consequences, such as a diversion to higher cost acute care services and/or delayed presentations. In New Zealand, where the predominant model of primary care is a state-subsidised fee for service model with variable patient co-payments, health and disability service access for refugees and asylum seekers has been described as 'limited and inequitable'.[140]

Asylum seekers in Australia without Medicare rights face even greater challenges to accessing healthcare[w]. Lack of Medicare access results in increasing pressure on (and cost to) State-funded health and mental health services, and is likely to result in increased acute service presentations, with some emerging evidence of increased emergency attendances by asylum seekers in Victoria,[141] and high rates of emergency attendance and health service use by people in held detention.[76, 142] Pro-bono clinics established to fill gaps in health service delivery have been overwhelmed by increasing numbers of patients in recent years. Similarly, lack of access to pharmaceuticals may affect treatment adherence.

The RACP suggests that a lack of Medicare and pharmaceutical access for asylum seekers is likely to increase costs to the health, immigration and service systems through increased need for case management, delays in presentations or treatment leading to higher severity illness, cost shifting from (lower cost) primary and preventive care to (higher cost) acute care and specialist services, and considerable administrative inefficiency.

The RACP supports equity of access to healthcare for refugees and asylum seekers; specifically, access to primary care, allied health, specialist care, mental health services, oral health services across the lifespan, and maternity/women's health and torture/trauma services where relevant. Key strategies to enable timely health service access and reduce administrative inefficiencies include: i) casework support for refugee and asylum seeker arrivals in the

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u Routine travel will not be possible; it may be possible to travel to a third country under compassionate circumstances with specific permission.

v Consultations for this statement with FASSTT (Forum of Australian Services for Survivors of Torture and Trauma) providers suggested an additional barrier for asylum seekers accessing mainstream mental health services is a perception that their mental health problems are 'situational'.

w In some jurisdictions, asylum seekers with lapsed BVEs require Department of Immigration and Border Protection pre-approval for non emergency appointments at tertiary hospitals for costs to be covered, and only a limited cost authorization is given. Additional tests/investigations also need pre-approval, which creates a different standard of healthcare access for these patients.

early settlement period, and beyond this time for unaccompanied minors and vulnerable individuals or families, ii) timely processing of bridging visas for asylum seekers to restore Medicare access where applicable, iii) reducing the complexity of healthcare pathways for asylum seekers, and iv) more broadly, enabling culturally responsive care and language service access, and ensuring all healthcare and service delivery is appropriate for all Culturally and Linguistically Diverse (CALD) and refugee-background groups, in line with relevant national policies on multicultural access and equity.[143, 144]

Effective communication with patients is essential for safety and quality in healthcare. Language service support is essential for care of patients with low English proficiency where health providers do not speak the same language as their patients. Patients who are relatively proficient in English may still require interpreting assistance for complex or sensitive discussions. Appropriately qualified and accredited interpreters are required;[39, 50, 103] family members/children should never be asked to interpret. There is considerable medico-legal risk where interpreters are not engaged appropriately.[145] Access to adequate health information is essential, and can only be achieved through good clinical communication, with language support and appropriate translated resources. Picture-based/graphic information may also be useful in clinical care, especially for individuals with low print literacy.

The experience and expression of ill health and expectations of healthcare vary between individuals and groups, and are strongly influenced by culture. The RACP acknowledges the need to consider and integrate culture within the health consultation, access culture-specific expertise, and consider the refugee and asylum seeker experience in delivering healthcare. Alongside the broad need for education in cross-cultural healthcare and cultural competency within the health workforce, there is a case to develop nodes of expertise in refugee and asylum seeker health in areas of high settlement.

## Assessment of immunisation status and catch-up immunisation

Refugees are at risk of inadequate immunisation for multiple reasons. These include differences in country of origin schedules, difficulty accessing (or disrupted) healthcare and immunisation programs, and issues with vaccine quality.

Available studies suggest almost all refugees require catch-up immunisation on arrival to Australia(146–149) and New Zealand,[150] and recent Victorian data showed 44–53% of asylum seekers released from detention still required further catch-up immunisation.[151, 152]

There are considerable barriers to accessing catch-up immunisation after arrival in Australia, including the complexity of catch-up schedules, a lack of written records, challenges in service delivery, missed opportunities by service providers, gaps in vaccine funding, and difficulty in accessing or navigating the Australian health system.[153, 154] Hepatitis B immunisation is of particular concern, given the high prevalence of Hepatitis B infection[146, 149, 155–158] alongside household susceptible individuals, and lack of funded vaccine for older children, adolescents and adults, despite Australian recommendations for catch-up vaccination[159] and the identification of CALD populations in the Australian Hepatitis B strategy.[160]

In comparison, in New Zealand, all children under 18 years are eligible for immunisation schedule vaccines,[115] regardless of immigration status, and providers can claim the immunisation benefit for administering vaccines. All Quota refugees and all detained asylum seekers receive catch-up immunisation through the centralised health screening service at MRRC. Similar challenges with differences in vaccine schedules and a lack of written immunisation records are identified.

All refugees and asylum seekers should be offered catch-up vaccination,[39, 51, 52, 115, 159] so they are immunised equivalent to an Australian-born or New Zealand-born person of the same age. Full catch-up immunisation is required if written records are not available.

Barriers to immunisation service delivery in Australia require local, State and Federal level action to enable funded catch-up vaccines for children, accessible catch-up immunisation service delivery, centralised 'whole of life' immunisation registers, and inclusion of refugee-background communities and asylum seekers in the respective National Immunisation Strategies. In Australia, there are specific gaps in vaccine funding (notably for vaccines against hepatitis B, varicella and Human Papilloma Virus (HPV)) for children aged over 7 years, adolescents and adults. Additionally, the complex Australian system of vaccine notification payments does not capture catch-up vaccinations adequately.[153] Gaps in immunisation funding and service delivery need to be addressed as a matter of urgency, in order to meet the Australian Immunisation Handbook[159] recommendations for catch-up immunisation and to ensure delivery of the National Immunisation Program.

## RACP position – Access to healthcare

- The RACP supports equity of access to healthcare for refugees and asylum seekers, and suggests targeted strategies will be required to ensure equitable access to mainstream primary care, allied health and specialist health services.
- Key strategies to enable timely health service access and reduce administrative inefficiencies include i) casework support for refugee and asylum seeker arrivals in the early settlement period, and beyond this time for unaccompanied minors and vulnerable individuals or families, ii) reducing the complexity of healthcare pathways for asylum seekers, and iii) enabling culturally responsive care and language service access, and providing health, mental health and maternity care and service delivery that is appropriate for all Culturally and Linguistically Diverse (CALD) and refugee groups.
- The experience and expression of ill health, and expectations of healthcare, vary between individuals and groups, and are strongly influenced by culture. The RACP acknowledges the need to consider and integrate culture within the health consultation, access culture-specific expertise, and consider the refugee and asylum seeker experience in delivering healthcare.
- Asylum seekers should have continuous access to healthcare and pharmaceuticals, and asylum seekers in Australia require continuous Medicare cover. A lack of, or lapse in, Medicare access is likely to increase costs to the health, immigration and service systems through increased need for case management to establish pathways to care, delays in presentations leading to higher severity illness, cost shifting from primary and preventive care to acute care and specialist services, and considerable administrative inefficiency. Timely processing of bridging visas to restore Medicare access is essential. The RACP supports New Zealand's policy of providing full access to publicly funded health and disability services once asylum seekers have lodged a claim for refugee status, although notes small numbers of asylum seekers in New Zealand do not have access to public services.
- Refugees and asylum seekers should receive immunisation catch-up equivalent to those received by an Australian or New Zealand-born person of the same age. Catch-up immunisations should be funded and accessible at all ages.
- Barriers to immunisation service delivery in Australia require local, State and Federal level action to enable funded catch-up vaccines across the lifespan, accessible catch-up immunisation service delivery, centralised 'whole of life' immunisation registers, and inclusion of refugee-background populations and asylum seekers in the Australian and New Zealand National Immunisation Strategies. The RACP supports the inclusion of refugees and asylum seekers as named 'at risk' groups for vaccine preventable diseases in the Australian and New Zealand Immunisation Handbooks.
- Effective communication is essential for safety and quality in healthcare. Health professionals should work with professional interpreters in all interactions where patients have low English proficiency (where the provider does not speak the patient's language), and in any interaction where there is an identified need for interpreter assistance.

Detailed recommendations are contained in the accompanying position statement.

# Section 3. Promoting long-term health in the community

The RACP acknowledges the contribution of refugee-background people and communities to Australia and New Zealand, noting these communities bring skills and diversity to our countries. Specifically, the RACP acknowledges the contribution of refugee-background physicians and health providers, and the value placed on health by refugee-background communities.

Evidence suggests Humanitarian entrants make a significant economic, social and civic contribution to Australia[161]. This occurs through the demographic dividend of a younger community with low rates of secondary movement back overseas and a high proportion of children who spend their working lives in Australia, settlement in regional Australia with resultant secondary economic benefits, strong entrepreneurial qualities, economic linkages with their countries of origin, and significant contributions through volunteering and civic engagement. This analysis found workforce participation converges with the workforce participation of Australian-born populations over time, and that workforce participation of the second generation is higher than the Australian population average. Further, two-thirds of adult Humanitarian entrants have completed Year 12 or higher education, representing substantial human capital, contrary to the (incorrect) perception of refugee entrants being unskilled.

Long-term health and wellbeing can be supported through early physical and mental health screening and treatment as needed. Despite the complexity of physical and mental health issues that may be detected on initial screening, available evidence suggests people of refugee background in Australia do not have increased rates of hospital use,[162, 163] although high birth rates[54] result in increased rates of maternity service use.[164] Further, economic analysis suggests the long-term health costs of refugee/Humanitarian entrants are lower than those of family stream permanent migrants, and lower than those of some, but not all, groups of skilled permanent migrants.[165]

Health status is influenced by access to healthcare services, language support, housing, education, family integrity, employment and to a safe environment, free from racism and discrimination.[166–170] These social determinants have significant impact on long-term health and wellbeing and should be addressed throughout the assessment and settlement phase to maximise health and human potential. The New Zealand Refugee Settlement Strategy[171] outlines five goals, in line with these principles: self-sufficiency through employment, participation in community, health and wellbeing, education, including English language support, and safe and secure housing.

In the early stages of settlement, casework support plays an essential role in facilitating access to health, education, housing, welfare and employment services for refugees in Australia and New Zealand, although SHP entrants in Australia and family support entrants in New Zealand receive a lower level of case support compared to that received by refugee arrivals. In the longer term, these functions are generally provided in Australia through Migrant Resource Centres. Similar casework models are utilised for asylum seekers in Australia, although there are significant challenges for health service access as outlined previously, and even greater challenges in mental health, with people affected by uncertainty over their migration status, housing insecurity, differences in education access, and a lack of work rights and family reunion. There is a strong argument for flexible casework support and settlement services that are needs based rather than time limited and for consistency of services across visa types and jurisdictions in both Australia and New Zealand.

Housing insecurity is detrimental to mental and physical health, and limits engagement with the community and services.[53, 172] Access to housing that is warm, dry, clean, safe and a suitable size is a core requirement for health; poor quality housing can adversely affect health.[173] There are broad issues with housing for vulnerable groups in Australia, and housing stress and poverty are identified as pre-eminent issues for refugee-background Australians. The housing and financial stressors for asylum seekers on Australian bridging visas without work rights are extreme and likely to result in pressure on multiple service sectors. Housing is one of the five refugee settlement goals in New Zealand. While Quota refugees receive assistance to access housing, Refugee Family Support Category entrants and asylum seekers in New Zealand may also face housing insecurity.

Education is an essential aspect of settlement. There is increasing recognition that education and schools support the health and wellbeing of refugee children,[174-177] and English language tuition is valuable for new arrivals with low English proficiency.[53] More broadly, the motivation and potential demonstrated by many children and people of refugee background "provides a compelling argument for developing more innovative and flexible strategies for participation in education."[174] Specific support is required to ensure students of refugee background reach their full educational and social potential,[178] and both Australia and New Zealand have multiple strategies in place to support refugee school students. Both countries provide access to tertiary education for refugee entrants and people granted permanent protection.

Refugee-background children and adolescents face significant educational disadvantage due to their refugee experience, migration and language transitions.[178, 179] A recent Western Australian study of education experience in refugee children[68] found previous schooling was limited: two-thirds of children had interrupted education, and only half the group had experienced schooling in their first language, reflecting the complexity of their migration pathways. For many years, paediatricians have noted the interrupted education of refugee children entering under the offshore program; more recently, they report children have missed months of school during their time in Australian immigration detention. The June 2014 announcement of education for children on Christmas Island[180] raises serious questions as to the lack of education for these children previously, given they are children in Australia, where compulsory schooling ages apply, and recognising education is a core child right.[181]

Refugees and asylum seekers should have equitable access to education at all life stages, with acknowledgement of prior interruption or limited access to education, and support to reach their potential.

While Humanitarian entrants bring skills to Australia and New Zealand, low English proficiency is a significant barrier to workforce participation,[161] study and service access.[54] In Australia, refugee arrivals with low English proficiency are entitled to English language tuition to support settlement and entry into work or study, whereas English language tuition for asylum seeker adults is extremely limited. In New Zealand, Quota refugees have access to English language teaching at the MRRC and a variety of initiatives are available in the community; however, asylum seekers also face barriers to English tuition. The RACP recognises that asylum seekers also bring skills and human capital to Australia and New Zealand, and that there are likely to be advantages in equitable access to English language tuition and education while their claims are assessed.

Employment and work are important protective factors in maintaining health and wellbeing, and long-term work absence or unemployment has a negative impact on health and wellbeing.[53, 182] A meta-analysis of risk factors for poor mental health outcomes in resettled refugees found restricted economic opportunity after settlement and higher education level (linked with downward occupational mobility) were associated with worse outcomes.[79] A more recent study of asylum seekers in Australia found unemployment was a predictor of worse mental health symptoms.[183] Refugees and asylum seekers should be provided with opportunities to utilise pre-existing skills and experience, and to train for and access meaningful employment in Australia. Restricting work rights for asylum seekers is contrary to maintaining health, and is likely to lead to increased costs for the health system and increasing burden on other services, including housing services, due to the resulting demoralisation, poverty and social disadvantage. Access to work, employment training and opportunities to utilise pre-existing skills will promote independence, improve health, and maximise people's skills and contribution to Australia and New Zealand.

Racism and race-based discrimination adversely affect physical and mental health in children and adults,[166, 167, 169] with negative social and economic consequences for individuals and communities.[184] The RACP does not tolerate racism or race-based discrimination, and recognises the associated health impact.

Family separation affects health and wellbeing. Separation has a profound psychological impact on families, with the loss of primary support networks causing grief, fear and uncertainty, and deterioration in the mental health of both children and parents. Re-establishment of the family and extended family unit (where possible) is an important factor in recovery and wellbeing.[185] The RACP supports the right to family integrity, and does not support restrictions on family reunion for refugees or for asylum seekers.

Asylum seekers in Australia face uncertainty due to the current policy settings, understanding there are more than 27,000 asylum seekers on bridging visas and over 3,000 asylum seekers in Community detention. In addition to the physical and mental health issues arising from their journey or time in detention, they face uncertainty around their asylum claims and status in Australia, and it is likely to be years before the asylum claims of this group are assessed. They also experience poverty, housing stress, barriers to service access, a lack of work rights, and no prospect of family reunion. All of these factors act individually, and synergistically, to undermine health and wellbeing.

Temporary Protection Visas are also associated with uncertainty and worse physical and mental health outcomes when compared to permanent protection visas,[74, 78, 87–90] although the RACP also acknowledges the urgent need to release people from held detention in Australia and places of offshore processing. Temporary protection visas do not provide durable protection outcomes and are associated with a significant administrative burden. The RACP considers that it is essential to expedite the processing of refugee claims, with legislative and policy responses to irregular migration that are clear and accessible, fair, and subject to appropriate oversight and review.[186] Although not all asylum seekers arriving by boat are found to have a valid claim for refugee status[18] there is an urgent need to assess people's claims for protection in order to address uncertainty and allow them to start rebuilding their lives. The RACP supports pathways to permanent protection.

### RACP position – Promoting long-term health in the community

- The RACP acknowledges the contribution of refugee-background communities to Australia and New Zealand, noting these communities bring skills and diversity to our countries. Specifically, the RACP acknowledges the contribution of refugee-background physicians and health providers, and the value placed on health by refugee-background communities.
- Evidence suggests Humanitarian entrants make a significant economic, social and civic contribution to Australia, and refugee-background communities do not represent a greater cost to or burden on health systems over the long term.
- Health status is influenced by access to healthcare services, language support, housing, education, family integrity, employment and a safe environment, free from racism and discrimination.
- In the early stages of settlement, casework support plays an essential role in facilitating access to health, education, housing, welfare and employment services for refugees in Australia and New Zealand, although there is a lower level of support for Special Humanitarian Programme entrants in Australia and Refugee Family Support Category refugees in New Zealand. Asylum seekers face specific challenges. Longer term, there is a strong argument for flexible casework support and settlement services that are needs based rather than time limited, and for consistency of services across visa types and jurisdictions in both Australia and New Zealand.
- Education is an essential component of settlement and supports health and wellbeing. Refugees and asylum seekers should have equitable access to education at all life stages, with acknowledgement of prior interruption or limited access to education.
- The RACP supports equitable education access for adults, and considers that there are likely to be advantages in equitable access to English language tuition for asylum seekers while their claims are assessed.
- Employment and work are important protective factors for health. Refugees and asylum seekers should be provided with opportunities to work and to train for meaningful employment in order to protect their health and wellbeing.
- The RACP supports the right to family integrity and does not support restrictions on family reunion for people of refugee background or for asylum seekers.
- The RACP does not support the use of temporary protection visas, based on the evidence that temporary protection visas are associated with worse physical and mental health outcomes and because temporary protection visas do not provide durable protection outcomes. The RACP supports pathways to permanent protection.
- There is an urgent need to process the refugee status claims of asylum seekers in Australia, to reduce uncertainty, costs to physical and mental health, and the impact on individual and family function. Refugee status determination requires legislative and policy responses to irregular migration that are clear and accessible, fair, and subject to appropriate oversight and review.

Detailed recommendations are contained in the accompanying position statement.

# Section 4. Asylum seekers and held detention – the Australian situation

Australia (and New Zealand) is a signatory to the Refugee Convention and Protocol,[5] the International Covenant on Civil and Political Rights,[187] the International Covenant on Economic, Social and Cultural Rights,[188] and the Convention on the Rights of the Child (CRC).[181] These major international instruments provide for rights to be applied without discrimination, and include rights to liberty, to not be detained arbitrarily, rights to health, education, and protection from abuse and degradation, and rights to self-determination. Special provisions are made for families and children. These include the principle that the best interests of the child shall be a primary consideration in all actions concerning children,[181] and that children have rights to health, education, play and participation in decisions affecting their lives, as well as rights to protection from physical and mental violence, injury, abuse, neglect and maltreatment.

The RACP is concerned that detention of people seeking asylum contravenes Australia's obligations under these international instruments, in particular, the right to health.

As of March 2015, there are more than 3,500 people in detention on the Australian mainland, Nauru, Manus Island and Christmas Island, including 227 children.[16] The average time in detention is longer than one year, with limited decisions on refugee status for the group in offshore detention, notably on Manus Island.

The financial costs of detention are enormous. The National Commission of Audit found the cost of immigration detention and processing asylum seekers arriving by boat was A$3.3 billion over 2013–2014, with projected costs of A$10 billion over the forward estimates.[189] The estimated costs of immigration detention (per person per year) were over A$430,000 for offshore detention and over A$230,000 for onshore detention, compared to less than A$100,000 for Community detention and less than A$30,000 for a bridging visa.[189] A more recent analysis of the contracts for immigration detention noted multiple contracts worth billions of dollars, and estimated the total cost of offshore detention at over A$859,000 per person per year.[190]

The arguments put forward in favour of mandatory immigration detention in Australia warrant inspection. These are generally framed around four themes: i) border protection in the face of increasing arrivals and projected costs, ii) deaths at sea, iii) asylum seekers not following the 'legal' pathway, and iv) security concerns. At the peak of boat arrivals in 2013, there were 25,000 asylum claims within a year, which is less than the number of claims in other developed countries, and a low number in the global context of forced migration.[25] The cost of immigration detention is so high that it is difficult to consider it as a 'cost-saving' measure; and avoiding the negative impact of detention is likely to reduce future costs to individuals, and to the health system. While there are deaths at sea, it is arguable that, for an individual, the risk of death at sea is lower than the risk of death from staying in a situation of conflict. The concept of legal and 'illegal' pathways is false, with less than 1% of the world's refugee population achieving permanent resettlement in a third country, therefore accessibility to formal resettlement pathways is extremely limited. In recent years, 88–100% of asylum seekers arriving in Australia by sea have been found to have valid refugee claims.[14, 18] Finally, policies of detention have been applied by date, gender and age, and only rarely due to security concerns, with the majority of asylum seekers situated in the community after initial security checks, as occurs in other countries, including New Zealand.

Australian immigration detention is detrimental to the physical and mental health of people of all ages in the short and long term.[56, 67–86] People face profound uncertainty, hopelessness and fear for their future, which, in combination with the environment and lack of meaningful activity, contribute to high rates of mental health problems, self-harm and attempted suicide.[69, 75, 76, 142, 191]

There are limited current data on mental health screening of adult asylum seekers in held detention. A 2013 report of over 12,000 people in onshore held detention over July–September 2013 showed 24.6% of adults required care for psychological problems (increasing to 44% in the final month of reporting). There were over 2,300 disclosures of torture and trauma, and over 30% of adults detained less than 3 months had moderate to extremely severe depression, anxiety and stress on mental health screening, with deterioration over time in detention. At the time of this report, 84% of people were in held detention for less than three months. Self-harm and suicide are issues of concern – the 2013 Commonwealth Ombudsman report[69] found 11 deaths in immigration detention over the period 2010–2013, including at least 4 suicides, and a rapid increase in self-harm in 2011 correlated with increasing time in detention. There are no comparable publicly available data for people in offshore detention, or for the current cohort of asylum seekers who have been detained for extremely prolonged periods.

Immigration detention facilities are prison-like environments due to the heavy security presence, restriction of liberty, locked environment, use of identification numbers and institutional living conditions. There are clear concerns about the remote location of most detention centres, poor living conditions,[192, 193] lack of education access, the standard of healthcare provided,[48, 142] lack of realistic prospects for settlement, secrecy, lack of clarity on professional indemnity and standards, and the lack of transparent independent oversight. The risks of held detention are amplified in offshore detention facilities on Nauru and Manus Island, and also Christmas Island, due to environmental and infrastructure challenges, limited access to specialist health services, ongoing risk of destabilisation, and uncertainty around the future and settlement options.[194]

Held detention presents an extreme and unacceptable risk to children's health, development and mental health,[56, 73, 81, 195] and adversely affects families and parenting,[80, 81] compounding this risk. These risks arise primarily as a result of the detention environment. Children in detention are at high risk of mental health problems including post-traumatic stress disorder, distress, anxiety and depression, sleep and behavioural disturbances, bedwetting, suicidal ideation, and attempted and actual self-harm.[67–70, 80, 81] There are no current published data on mental health or developmental screening of children in Australian held detention, although the AHRC National Inquiry into Children in Detention (2014)[67] provides parent-reported information and figures on self-harm in children. Over 85% of parents and children reported negative effects on their mental health while in detention, 60% of parents were concerned about their child's development, 30% of children were described as 'always sad', and 25% as 'always worried'. The Inquiry found between January 2013 and March 2014 there were 233 assaults involving children and 128 incidents of self-harm in children. Clinicians report high rates of developmental delay/regression, disability, mental health issues and trauma-related behaviours in children and adults who have experienced detention. These risks appear to be particularly high for infants and toddlers and women in the pregnancy or post-partum period.

Families may be separated across the detention system, with impacts on family functioning and support. Family integrity is critical for parents' and children's health and should be maintained at all times, including during pregnancy and post-partum periods. Children should not be separated from their parents or family at any time, including during medical transfers or transfers for maternity care.

Family life is eroded in held detention – a restricted environment that is monotonous and fosters dependency. There is a lack of living space for family members to interact in privacy and engage in daily activities such as cooking or eating together. Family members sleep in close proximity to one another and to other families, resulting in minimal privacy and a limited ability to prevent children from vicarious trauma exposure. Many children missed months of schooling while in held detention on Christmas Island, and there are limited play spaces or ability to separate children from adults for any period of time. These conditions undermine parents' capacity to care for their children and protect them from the stress of the detention environment. Children's restriction of liberty and lack of access to equitable health, education and recreational opportunities are in contravention of Australia's international obligations as a signatory to the CRC. Article 37b of the CRC states:[181]

> *No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time.*

In held detention, children are exposed to, and cannot be protected from, physical and mental violence in adults, including their parents. They are also exposed to adults with mental illness. The AHRC Inquiry noted 30% of detained adults had moderate to severe mental health problems, and 38% met criteria for post-traumatic stress disorder.[67] Children are likely to be at significant risk of physical and sexual abuse and maltreatment, including neglect, with significant concerns raised about child protection issues on Nauru[196, 197] and in immigration detention on Christmas Island and the mainland.[67] Despite the fact that children and adults are held together in a closed environment, there is no clear or consistent child protection framework governing child safety in immigration detention.[72, 198]

The RACP expresses extreme concern about unaccompanied minors and separated children in held detention, recognising their risk and vulnerability prior to, and within, the detention setting. The 2014 AHRC Inquiry interviewed 49 unaccompanied minors in detention and found nearly half reported feeling depressed or hopeless 'all of the time' and a high proportion had engaged in self-harm.[67]

The guardianship of unaccompanied minors is a further area of concern. On arrival to Australia, unaccompanied Humanitarian minors and unaccompanied children seeking asylum are placed under the guardianship of the Minister for Immigration and Border Protection. This duty is currently delegated to an officer of the Department of Immigration and Border Protection in each centre. The Minister is thus responsible for protecting the

child and their best interests, and also for placing asylum seeker children in immigration detention. Given immigration detention is not in the best interests of any child, there is a conflict of interest between these dual responsibilities.[199, 200] The RACP supports the recommendations of the Australian 2012 Joint Select Committee that the then Minister for Immigration and Citizenship be replaced as the guardian of unaccompanied children in detention.[72]

There are significant ethical issues related to providing care in the detention setting,[201–205] balanced against risk and harm when care is not provided. Doctors and health professionals working within held detention are exposed to significant stress and trauma, and resources are required to ensure appropriate support, supervision and self-care.[206]

While the Australian government has stated that asylum seekers, including those in offshore facilities, are provided with a standard of care 'broadly comparable with health services within the Australian community',[207] there are multiple constraints to providing healthcare in held detention, and people in detention are highly likely to have physical and mental health issues that require additional and specialised services. Further, health providers cannot address health issues caused by held detention while people remain in held detention. The RACP supports all doctors and health professionals in their duty of care to their patients, including the need to maintain professional standards and to speak out to support best practice and ethical care.

Finally, the RACP considers there is an urgent need to establish independent oversight of health service provision to asylum seekers, and notes the findings of the 2005 Palmer Inquiry:[208]

> *The question of service quality and standards extends beyond the detention services contract. The Inquiry concluded the delivery of adequate and appropriate health care for immigration detainees, and their welfare in general, need to be safeguarded by continuous oversight by an independent, external review body to complement the operations of the Health Advisory Panel. At the highest level of oversight, it should be able to initiate reviews and audits of health care standards and the welfare of immigration detainees…A primary consideration is that it must be overtly independent and be staffed by people of integrity. It should also have statutory powers to protect its independence and should not be involved in commercial undertakings…it would need to be adequately resourced to sustain effective professional operations and win credibility. The overwhelming conclusion reached by the Inquiry is that, in the light of the many health care difficulties and deficiencies that were raised, there is an urgent need to carry out an independent assessment of the structure of health care arrangements at immigration detention facilities and of the adequacy and quality of the health care services provided.*

The RACP endorses these principles, and suggests an independent health advisory body should include expertise across the health disciplines, with transparency on governance and terms of reference, agreement to consult with relevant Colleges and peak bodies, access to longitudinal data to monitor health outcomes, and agreed timelines for the Department of Immigration and Border Protection to consider and respond to recommendations.

### RACP position – Asylum seekers and held detention

- The RACP does not condone held immigration detention in any form. Australian held detention is harmful to physical and mental health at all ages, and represents a significant breach of human rights. There is an urgent need to release people seeking asylum from held detention in Australia and places of offshore processing, and to process their refugee status claims, understanding that the average duration of detention has been over 400 days since late 2014 and the extreme harm being caused by the current detention arrangements.
- The risks of held detention are amplified in offshore detention facilities on Nauru, Manus Island and Christmas Island. The RACP expresses extreme concern at the use of offshore detention and considers that asylum seekers seeking protection from Australia should not be transferred to, or detained or resettled in, regional processing countries, including Nauru, Papua New Guinea and Cambodia.
- Held detention presents an extreme and unacceptable risk to children's health, development and mental health. These risks are particularly high for infants and toddlers in held detention and for women in the pregnancy or post-partum period. Children should not be separated from their parents or family at any time.
- Unaccompanied children and separated children have specific risks and vulnerability, and the RACP expresses extreme concern about unaccompanied children and separated children in held detention.
- There is a need for an integrated national policy framework for the guardianship of unaccompanied refugee and asylum seeker children, and for legislative reform to enable an independent guardian, who does not hold responsibility for their migration status, to be appointed for each unaccompanied child.
- An independent health advisory body is required to oversee health service provision for asylum seekers, including those in onshore and offshore detention, with expertise in (at minimum) general practice, child mental health, adult mental health, torture/trauma, paediatrics, public health, infectious diseases, obstetrics, midwifery, nursing (including early childhood nursing), oral health and allied health. Such an advisory board requires i) transparency in the governance arrangements and terms of reference, ii) agreement to consult with the relevant Colleges and peak bodies across the medical, nursing and allied health disciplines, iii) access to data to monitor service delivery and outcomes, and iv) agreed timelines for the Department of Immigration and Border Protection to consider and respond to recommendations.
- The RACP supports all doctors and health professionals in their duty of care to their patients, including the need to maintain professional standards and to speak out to support best practice and ethical care.

Detailed recommendations are contained in the accompanying position statement.

# Conclusion

Refugee health is an evolving area of healthcare, with large refugee-background populations in Australia and New Zealand, significant numbers of asylum seekers in Australia and increasing forced migration globally. The RACP supports the right to health, understanding that health is socially determined and depends on individual, family and community circumstances, and also that health is linked to housing, education, work, freedom from discrimination and opportunities to contribute to society.

People of refugee background and people seeking asylum have a unique profile of physical and mental health needs related to their refugee and asylum seeker experience and forced migration; however, they also bring skills and hope to their countries of settlement. The RACP supports a targeted physical and mental health assessment after arrival, facilitated and equitable access to healthcare, and support for long-term health through education and employment.

The RACP does not support held detention for people seeking asylum, and considers that Australian immigration detention is detrimental to physical and mental health across the lifespan. The RACP supports all doctors and health professionals in their duty of care to their patients, and will continue to speak out to support best practice and ethical care. The RACP advocates a rights-based and humane approach to fulfilling our obligations under the Refugee Convention.

# Appendix 1: External consultations

We are grateful to the following organisations for their review and suggestions.

- Australasian Society of Infectious Diseases (ASID)
- Australian Medical Students Association (AMSA)
- Australian Psychological Society (APS)
- College of Nurses Aotearoa
- Forum of Australian Services for Survivors for Torture and Trauma (FASSTT)
- Melbourne Children's Campus
- New Zealand College of Midwives
- New Zealand College of Public Health Medicine (NZCPHM)
- New Zealand Medical Association (NZMA)
- Public Health Association of Australia (PHAA)
- Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- Royal Australian College of General Practitioners (RACGP)
- Royal New Zealand College of General Practitioners (RNZCGP)
- Sydney Children's Hospital Network
- The Andrew and Renata Kaldor Centre for International Refugee Law
- The Australian Association of Social Workers
- Women's Healthcare Australasia

We are indebted to Dr Martin Reeve and Dr Helen Saunders of the Mangere Refugee Resettlement Centre who have provided expert content advice on refugees and asylum seekers in New Zealand.

# Appendix 2: Timeline of recent Australian asylum seeker policy

| Key dates | Implications for asylum seekers arriving by boat |
|---|---|
| 13 August 2012 – Report from the Expert Panel on Asylum Seekers[209] recommended:<br>• An increase in Australia's Humanitarian intake (to 20,000 places)<br>• Additional family places and changes to family sponsorship<br>• Reintroduction of offshore processing<br>• The application of a 'no advantage' principle (i.e. refugees arriving by boat should not receive an 'advantage' over refugees awaiting resettlement overseas), which was extended to a lack of work and education rights for bridging visa holders.[210] | **Arrival before 13 August 2012**<br>Work rights for BVE holders. Pathway generally held detention, then released on a permanent protection visa if status granted. BVE does not allow family reunion or sponsorship. |
| December 2012 – mid-2013 Large numbers of boat arrivals, peaking at over 3000/month in mid-2013, with the majority of people released on Bridging Visa E (BVE) into the community without work rights.<br>January 2013 – Introduction of Medicare to valid BVE holders, facilitating access to healthcare.<br>19 July 2013 – Announcement of no resettlement in Australia for people arriving by boat without a valid visa.<br>September 2013 – Operation Sovereign Borders commences (a military-led border security operation to prevent asylum seeker boat arrivals from reaching Australia), Humanitarian Programme intake reduced back to 13,750 places (predominantly offshore resettlement program), releases from held detention ceased, increased transfers of people to offshore detention, large numbers of BVEs (and associated Medicare) lapse, reduced legal support. | **Arrival 13 August 2012 – 19 July 2013**<br>Subject to offshore processing, no guarantee of settlement in Australia.<br>People on BVE – no work rights, no family sponsorship rights.<br>Pathway generally held detention to either Community Detention (CD) or BVE, or CD then BVE. |
| December 2013 – attempted reintroduction of Temporary Protection visas (TPVs), subsequently blocked by the Senate.<br>February 2014 – Use of Temporary Humanitarian Concern (THC) visas announced.<br>March 2014 – Removal of funding for legal assistance for asylum seekers who arrived without valid visas.<br>August 2014 – Announcement that children aged < 10 years and their families arriving before 19 July 2013 and in mainland detention (not Christmas island) will be released from held and from Community detention.[211]<br>September 2014 – High Court decision that grant of a Temporary Humanitarian Concern (THC) visa to an individual assessed as being in need of protection was invalid.[212]<br>November 2014 – Announcement that Nauru regional processing centre will transition to an open-centre model.[213]<br>December 2014 – Migration and Maritime Powers Legislation Amendment (Resolving the Asylum Legacy Caseload) Bill 2014[29] passed with key amendments (to a range of legislation) including:[32]<br>• Removing most references to the Refugee Convention in the Migration Act.<br>• Extending the Minister for Immigration and Border Protection's powers to detain and transfer people intercepted at sea.<br>• Introducing 'fast track processing for the "legacy caseload"' and restricting or excluding rights of review; also introducing a new 'Immigration Assessment Authority'.<br>• Clarifying children born in Australia to non-citizen parents will have the same immigration status as their parents.<br>• Allowing the Minister for Immigration and Border Protection to cap the number of protection visas issued.<br>• Reintroducing 3 year TPVs and introducing 5 year Safe Haven Enterprise Visas (also applicable to people in detention on mainland Australia and Christmas Island arriving after 19 July 2013)[214] with work rights associated with these temporary visas.<br>Announcement of increased Humanitarian Programme intake to 18,750 places by 2018–19, work rights for Bridging Visa holders, and release of children and families from Christmas Island.[215] | **Arrival after 19 July 2013**<br>Subject to offshore processing, and no resettlement in Australia.<br>Prolonged held immigration detention, processing of asylum claims effectively suspended. People who arrived after this date who remained in held detention on Christmas Island or mainland Australia (i.e. were not sent for offshore processing) were subsequently included in the 'Legacy caseload'.[216] |

# Appendix 3: Numbers of people in Australian immigration detention

The numbers of people and duration of time in Australian immigration detention are shown in Table 1.

### Table 1: Numbers of people and duration of time in Australian immigration detention.

| | July 2013[217] | January 2014[218] | July 2014[219] | January 2015[16] |
|---|---|---|---|---|
| **Immigration detention Nauru** | 543[220] | 1,012<br>(132 children) | 1,146<br>(183 children) | 802<br>(119 children) |
| **Immigration detention Manus Island** | 302[221, x]<br>200 single men<br>102 (families)<br>(26 children) | 1,353 men | 1,127 men | 1,023 men |
| **Immigration detention Christmas Island/ mainland** | 10,201<br>(1,992 children) | 5,867<br>(1,006 children) | 3,702<br>(712 children) | 2,298<br>(211 children) |
| **Community detention** | 2,773<br>(1,363 children) | 3,391<br>(1,631 children) | 3,028<br>(1,547 children) | 3,014<br>(1,551 children) |
| **Bridging visa E (BVE) in the community** | ~15,000(222)<br>(456 children) | 22,670<br>(1,751 children) | 24,724<br>(2,008 children) | 26,168<br>(2,423 children) |
| **Duration of detention** | 72 days | 226 days | 226 days | 442 days |

# Appendix 4: Prevalence information from post-arrival health screening

Evidence from paediatric and mixed child/adult refugee cohorts from African, Asian and Middle Eastern source countries in Australia and New Zealand suggests the following prevalence figures for health conditions detected on post-arrival refugee health screening.

- Anaemia in 7–20%,[146, 155–157, 223, 224] with higher prevalence in young children (23–39%)[155, 223]
- Iron deficiency in 11–34%,[149, 150, 155–157, 223] with higher prevalence in young children[150, 155, 223]
- Low vitamin D in 27–87% of people from African source countries[146, 149, 156, 157, 223, 225, 226] (with variation by latitude), 20–33% of people from Asian source countries in Australia[146, 155] and 15% of a paediatric cohort in New Zealand[150]
- Low vitamin B12 in 16.5%, with higher prevalence in groups from Iran, Bhutan and Afghanistan[227]
- Latent tuberculosis infection[z] in 17–55%, [146, 150, 155, 156, 158, 224, 228]
- Active TB disease in 0–3.3%[146, 150, 155, 156, 224, 225]
- Hepatitis B infection in 1–21%[146, 149, 150, 155–158, 224]
- Hepatitis C in 0.6–3.5%[146, 149, 150, 155, 157, 224, 228–230]
- HIV in 0%[146, 150, 155, 229, 231] and < 1%(158, 230, 232) in Australia, and 2% in New Zealand[224]
- Syphilis in 1–5%[146, 149, 157, 158, 224, 229, 232] (although it was 0% in three cohorts of children[150, 156, 229] and a large cohort of Karen refugees[155])
- Gonorrhoea in 0%[155, 229, 233–235]
- Chlamydia in 0–0.8%[155, 233–235]
- Schistosoma infection in 4–24%[146, 149, 150, 155–158, 224, 228] in both African and South Asian cohorts, with higher prevalence in some African cohorts
- Strongyloides infection in 2–21%[146, 155, 158, 228, 236], with higher prevalence in South Asian cohorts
- Malaria in 4–10%[149, 158, 228, 237, 238] predominantly in African cohorts.
- Pathogenic faecal parasites in 11–42%[149, 150, 155, 157, 158, 224, 236, 238]
- Helicobacter pylori in 82% of African refugee children[239]

z Latent tuberculosis infection is evidence of tuberculosis infection (i.e. a positive screening test) without evidence of active disease based on history, examination and CXR.

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