MR WAKERMAN: It gives me great pleasure to introduce Dr Sundram Sivamalai, who is the chair of the Regional Committee of the Federation of Ethnic Communities Council of Australia. In this capacity, Sundram has been leading FECCA's monitoring of regional aspects of its work and the Alliance is very pleased to be a member of that regional committee. Sundram is a colleague of mine, an academic from the University of Melbourne, located at Shepparton. It gives me great pleasure to ask Sundram to come and open the seminar. Thanks, Sundram.

(Applause)

Refugees and migrants in rural and remote Australia: numbers, location and health status

Dr Sundram Sivamalai
Regional Chair
Federation of Ethnic Communities Councils of Australia (FECCA)

MR SIVAMALAI: Thank you, John. Certainly first I'd like to acknowledge the elder Ngunnawal and Matilda House who welcomed us to the country and again, I'd like to acknowledge the indigenous owners of this land upon which this seminar is being held. I'd like to thank Professor John Wakerman, Chairperson, and Mr Gordon Gregory, Executive Director, and the staff and other who are part of the National Rural Health Alliance, for organising this seminar on the wellbeing of refugees, the School of Rural Health, Shepparton, where I come from and also to thank all of you for your attendance.

The outline of the session today is I am going to briefly touch on rural remote Australia, some of the common circumstances of migrants, the United Nations High Commission definition of a refugee, some of the common circumstances of refugees, the present scenario of the Rural Health Service and the wellbeing of refugees, and what are the serious issues for refugees in rural and remote Australia, and some of the challenges that is going to be faced by service providers and who is going to be responsible for the health of our refugees.

I'm still learning how to use this microphone and the IT. Firstly, the definition of rural and remote Australia. There are several definitions given for the "rural remote." There is the accessibility remoteness index of Australia, which is commonly known as the "ARIA" definition. This actually tells you the accessing of services and goods; how far is it from the population of the small town. The other one is the Rural and Remote Metropolitan Areas, which is the "RARMA" classification and it tells you where the classification sits in terms of rural remote and metropolitan areas. I'm going to be mainly using the definition of where you talk about "rural remote" mainly refers to towns and populations that exist outside major metropolitan and urban areas.

Looking at the circumstances of migrants - when we talk about refugees, let's put in

perspective where they sit in terms of the migrants and of course, some of the refugees would fit under the classification of "migrants," but there are some very basic differences. The migrants, they have come here to the country, or have moved to the country, where they have a choice. They have made a decision to move. They can prepare themselves for the move; they can prepare the timing of the move. They can prepare themselves with whom they want to move, when they want to move and the list goes on. They know that they can return to their country. They know that their families are together in the journey and they can link up with the families at the time they have planned to move. They have the options to explore all possible avenues for the support that they are going to receive and are expected to receive before, during and after arrival.

So if we look at the United Nations High Commission for Refugees, now coming along to the circumstances of the refugee, the definition of a refugee, as a person who owing to a well-founded fear of being prosecuted for reasons of race, religion and nationality, membership of particular social group or political opinion, is outside the country for his nationality and is unable to, or owing to such fear, is unwilling to avail himself of protection of that country. So that is the United Nations definition. So what is the circumstances of a refugee? I mean the refugees are obviously here or in other countries. They seldom have a choice about the country they are being sent to. They may be forced to leave their country of origin. They usually face the family separation. They do not have control on the timing of the move or any idea of their stay or return. They may spend time, sometimes, in refugee camps or in other places. So the scenarios are quite different, when we talk about migrants and refugees.

Back to Australia. We have the Commonwealth Government that is encouraging migrants and refugees to settle in rural and remote Australia, to reduce the burden on the metropolitan and urban areas. But many of the rural and remote Australia still lacks the infrastructure to support the refugees who come from diverse backgrounds. Again, looking at other present scenarios, that the list goes on. Studies have shown that refugees face several layers of jeopardy. Being poor, from an ethnic minority or being a female, loss of home and aging, are some of the layers of these jeopardies. The jeopardies are compounded, if one can't communicate in English and living in rural and remote Australia.

The lack of reinforcement of the Commonwealth strategy on the charter of public service in a culturally diverse society, again, needs a bit more reinforcement. So the full cooperation, according to the charter - the charter expected to see that there is a cooperation between the Commonwealth, the state and the local government agencies. But there is a poor coordination and collaboration between the layers of this government and the organisations.

The Rural Health Service and the wellbeing of refugees in rural and remote areas, is the fact that - by the health service availability, accessibility, accommodating to the special needs of refugees and the affordability of health costs. Maintaining confidentiality in rural

areas is another issue. Given fully informed consent to treatment, communicating health needs of refugees.

Before we move on to looking at some of these examples of these services, we will look at what is the definition of the Rural Health Service. People tend to assume the Rural Health Service in the remote and rural Australia is very similar to the services offered in the metropolitan areas. The rural health care relates the provision of health services to areas outside of metropolitan centres, but there is not really access to specialists. So finding specialists is a burden. Intensive and or high technology care or where the resources, both human and material, are often lacking. The service may be within hospitals, within health centres, clinics or independent practice. It is thus provided by a team healthcare workers and is based on the principles of primary healthcare, which then encompasses prevention aspects as well.

So what are the service issues for refugees in rural and remote Australia? Availability of the health service. Does the health service exist? We often assume that there is a health service that exists. The second point is what type of service exists? Particularly if people who have come from abroad who have suffered torture and trauma. Do they have a counselling service? Is there a service that is, you know, specialised in ..... provision? The issue of accessibility; how far is the service? Is there transport available? What are the roads like? Particularly now with the influence of weather changes, sometimes you find that the roads are not usable. How does the refugee get to these services? Then there is the issue of accommodation of their health needs. Will the service accommodate refugee needs? An example of any special foods they may have during illness. Is the service staff culturally sensitive and are aware of the refugee needs? Is the service flexible and acceptable to the refugee needs? If all this can be met, the other question maybe would be to ask the question of affordability. Can the refugee afford the healthcare costs? What are the funding supports available to these refugees?

Particularly in terms of the healthcare, there is the issue of confidentiality. Maintaining confidentiality about refugee health in small towns is difficult. As we all know, when the town is of a small size, people tend to know each other quite well and are very closely connected. So refugees' disclosure of their history to non-relevant people and the repercussions of it. So when they arrive, when they are in a situation of need, they look for people who are sympathetic, who are compassionate about the needs of refugees, they tend to share their information. And there may be some repercussions.

I'll give you an example of what happened in one of the small towns where this mother shared about the situation of her son. While this information was shared, the next minute the son was being isolated in the school grounds because they tend to know what the son is suffering from. All would have been roles for the service providers, sometimes they are the health professionals, who may be close to the family of these refugees or may come

from a similar culture, therefore they find that issues of sensitive nature are very difficult to be discussed.

Informed consent, we know very well that how Australia upholds the informed consent, that the information that you give to the patient or client has to be fully informed. Do the clients understand all of the risks associated with certain treatments or surgery or any care that they're going for? How does one verify their understanding? Are the refugees competent to give a consent to treatment after periods of torture and trauma?

I'd like to briefly touch on the communication of health needs of refugees. Certainly very few available interpreting services exist, sometimes we find the lack of full-time professional interpreters, the lack of skills by the part-time interpreters, the telephone interpreting services is again as an issue. Certainly there is an advantage, because you don't see the person face-to-face. Information dissemination about specialist visits, are very negative sometimes. An example quoted in Fuller and Ballantyne (1999); studies shows that they did go ahead and advertise about a specialist's visit to a small time, but unfortunately the information that was disseminated was in English, therefore they did not have people from non-English speaking backgrounds to turn up for the appointment.

Hospital signs. Very well, the hospital is wanting to be involved in caring for refugees, but some of the information is in English. Anglo-Saxon background staffing sometimes may make the refugees feel a bit uncomfortable, therefore, the health service providers should be aware of it and also the gender issues, you find some of the refugees have come from very - certain cultural background, may not feel comfortable, if they don't have the - the gender that they are looking for to share the health information.

In brief, what are the generic challenges of health services providers? Yes, we have to deal with complex health needs of this first small and diverse strategic groups, limited multicultural ethno-specific organisations to support the diverse needs, cultural competence of staff that really understand health issues, limitations of online services to help information in some areas, lack of flexible interpreting services, more research needs to be done to understand the complexities that exist in terms of caring for the refugee health and wellbeing, education forums for refugees is another area that we should invest our time and effort.

Who is responsible for the health of refugees? The individuals themselves? Their families, friends and neighbours? There has been ownership on the refugees themselves, they have to let their friends, the people they feel are sympathetic, know what are some of the needs or the problems they are facing. The local ethnic community council in small towns, the regional councils, they have to understand the health needs of the refugee, so the coordination or the settlement service strategies, given that public forums - they should be able to bring information to the public, at community functions as well, are examples where they can understand the refugee health needs. And again, the local ethnic community council

should update the peak state ethnic community council, local governments and state governments, where appropriate, on the refugee health need challenges.

Again, the local government has got a role here. According to the Local Government Charter, the role of Local Council includes:

- acting as a representative government by taking into a representative government by taking into account the diverse needs of the local account the diverse needs of the local community in decision making community in decision making;

- advocating the advocating the interests of the local community to other interests of the local community to other communities and governments communities and governments; and

- acting as a acting as a responsible partner in government by taking into responsible partner in government by taking into account the needs of other

The local government is expected, by the community, that it will have dialogue with the local ethnic community council, to explore the health needs of the refugees; assist in health planning and decision making with consumers and community representatives from rural and regional ethnic community councils for refugees, act as a conduit for the health services between refugee health needs and local health service providers. The local government, again, can bring local refugee health issues, where appropriate, to table these issues at the State and the national levels.

The State Government should be able to plan and support the health needs of all, through the appropriate resources. They should ensure that the health service providers are executing the cultural diversity plans. There is a role for the Federal Government. The Federal Government should plan with the State and the local government about the health of the refugees so that there is a whole of government approach to address the health needs of refugees. There should be a national focus, such as these. It should be happening more often and where appropriate, in different places, on the health of refugees from diverse cultural and linguistic backgrounds in rural and remote Australia.

My concluding remarks would be the health service to the refugees should be planned, coordinated and evaluated regularly. A planned service should also be flexible and adaptable, according to the health needs of the refugees. The service should be in partnership with consumers, service providers and all government bodies. Investment in the wellbeing of our refugees is investment in of future health of all Australians. Thank you all to show compassion in listening and to respond with respect to our refugees.

(Applause)

MR WAKERMAN: Thank you very much, Sundram. We do have a few minutes for questions and comments.

UNIDENTIFIED FEMALE: Doctor Sundram, can I just affirm, I guess, your remarks. I come from a town called Tamworth in northern New South Wales that some people may be aware of that has recently confronted some of the issues around refugee settlement in regional areas. If I look at why there have been so many issues around that, I think it very much comes down to the issues as you raised them; the lack of consultation, perhaps, with the refugees, some issues around local government and local government's capacity, but more and more an issue around the lack of planning and the lack of insight into the fact that the community as a whole lacks some very basic access to services.

I think the community's really felt that many of the refugees who would have significant needs of services would not have access to those services either. I think it just illustrates why this is such an important thing to be talking about, because from where I sit and from the community that I live in, there is a genuine commitment to want to engage and provide supportive services for refugees, but sometimes we don't have the way forward.

MR WAKERMAN: Thank you.

UNIDENTIFIED MALE: Hi, Doctor Sundram. Doctor Sundram, thanks very much for your presentation. I was just wondering, it is a while since I've been involved in this sphere and I was wondering, the funding and the infrastructural status of support that is available for local Ethnic Community Councils these days?

MR SIVAMALAI: Sorry, you're wanting to know the support?

UNIDENTIFIED MALE: Yes, and what kind of level of funding they get from State and Federal Governments?

MR SIVAMALAI: Yes. Certainly the Federal Government is one of the main funding bodies, DIAC, for the Federation of the Ethnic Communities Councils of Australia and through the main office, which is located in Canberra, we do get support through the regionals and again, there are some funding from the State Governments, such as the - if I use the example of the Victoria one, in the Victoria Multicultural Commission, which is part of the Department of Communities and that is the sort of the support we get. Certainly we needed more support. If you're really wanting to look at these issues in the whole of, you know, support approach, we needed more support. I can't emphasise that. Certainly, we depend a lot on volunteers. Many of the members who belong to the Ethnic Community Councils are working on voluntary capacities. I think I can't emphasise any more, besides volunteers I think the support of the refugees we have would be absolutely zilch.

UNIDENTIFIED MALE: ..... potentially has some recommendations that have come from .....?

MR SIVAMALAI: Certainly, I think there is a session, yes.