

MR WAKERMAN: Dr Mitchell Smith's day job is as the Director of the New South Wales Refugee Health Service. He wears a number of other hats, including through his membership of the Royal Australasian College of Physicians Working Party on Refugee Health. Although Dr Smith is based in Sydney, many of his cases with which he is familiar are in regional and rural areas of the State.

(Applause)

The health of refugee children

Dr Mitchell Smith, Member of the Royal Australasian College of Physicians Working Party on Refugee Health

DR SMITH: Thanks, John, for the intro and thanks to the Alliance for inviting me to present. I am here at the moment a bit like default. I am next to be in the next session - I am in the next session - and because I was here anyway my good colleagues in the working group volunteered me to present the policy on refugee children that was prepared by the [College of Physicians](#) and released earlier this year. So that's what I'll be doing first off. I must say, as well as, you know, pleased to be on Aboriginal ground here, I'm also pleased to be in the Australian War Memorial. It's my favourite place in Canberra. I always find it very affirming to come here despite the reasons for its existence and anyone who saw the news last night who saw the Australian Naval Personnel commiserating with the Japanese personnel submarines losses in 1942 in Sydney Harbour will, I guess, have shared some of those sentiments.

So I'm presenting this policy statement. I'm in a public health position. I'm not a part of the paediatrician part of this College but I was on the working group. So I just wanted to let you know. I guess what you can do as I'm talking is think about the relevance to rural and regional areas of the country. Clearly it wasn't designed necessarily with that in mind, but hopefully there is relevance and you can look at it perhaps critically in terms of where it's missed out on addressing those issues.

But I also just want to clarify a couple of things - and following on from Daniel's talk, perhaps, you're aware of how refugees do arrive and the fact that they do undergo the health screening that Daniel referred to and it's in those two stages. Those of you with a medical background might be interested to just know some of the details of that. Daniel affirmed that the health testing that does go on is largely for the public health protection of the community, if you like. It's not necessarily directed at the individual health of refugees, including refugee children.

We are trying to exclude TB and people with HIV perhaps and there are some additional checks that happen just prior to departure, as he mentioned, including Malaria tests. That little picture there is of a finger prick test that's available now for testing for malaria. It's a bit like a pregnancy test. For the first time vaccinations are being given to

people before they come to Australia. That's never happened before. That happened about 18 months ago. So everyone under 30 is getting a measles, mumps and rubella vaccine, which is very positive.

Also, just to focus a little bit on what we are talking about and why the College produced something particularly targeting refugee children, that is because clearly because of the sort of experiences that Dr Sundram referred to in his talk in terms of the refugee experience, clearly within the disadvantaged group that is refugees or people of refugee background, children and young people are perhaps even more disadvantaged subgroup in that larger group. This is a list of just some of the issues that some of you will be familiar with. You'll see some cross-over with Aboriginal health and crossover with other disadvantaged groups that exist in Australia and elsewhere.

Certainly by definition refugees have been through trauma, so mental and emotional health can often be an issue. Children won't have had this sort of access to services like hearing screening and growth monitoring that will have happened for children born here in Australia. Certain issues like vitamin D deficiency are emerging in Australia, particularly amongst dark-skinned populations, and so nutrition is an important one. Infectious diseases, we've heard something about lack of immunisation, has to be considered also. Oral health of refugees has been an issue since the 1970s and probably before that and is particularly bad in people from parts of the Middle East or Yugoslavia countries and not so bad in Africans.

Things like untreated orthopaedic problems, war wounds, things that haven't been fixed, hernias, surgical conditions that haven't been corrected, and so kids could be landing in rural and regional areas with that sort of problem. Past sexual abuse, past child abuse, parenting issues, risk of female genital mutilation or existing female genital mutilation in young girls, can present health problems. Adolescent health is a particular sort of one that has to be remembered and just a slide reminding us of some of the issues that pertain to refugee youth in particular and as well as the normal adolescent health aspects, they are also having to deal with the things that they've been exposed to as young people in refugee situations, which largely speaking are unheard of in this country, things like being forced to be a child soldier and the extreme responsibility they have to be given for young people of that age.

So this is a summary of the policy and it has some underlying principles. Essentially, that if you're an asylum seeker children have rights to healthcare as would any other child and that access should be culturally appropriate and not constrained by finances, and that clearly the health status of children and any other refugees is not just dependent on health services. In fact, we play a very small part in terms of overall health and we know it makes sense to keep children health. So early beginnings are very important. So they are the sort of broad principles, if you like.

The desire of the policy was to advocate for timely and high quality healthcare. It was existing College documents which target things like equity and obviously child health and the target audience is largely - my formatting is a bit bizarre here, but the target audience is principally members of the College, so paediatricians, if you like, but also health services, both local, State level, national level, policymakers at all those levels, and governments both here in New Zealand. It was done as an evidence based document drawing together literature and other information and expertise of local practitioners, including those in rural and regional areas.

There was feedback received from a number of people around the country on the draft of this. So the recommendations come in four areas listed there. I will go through them. They range from interventions that target government leadership and what governments at different levels should do, right down to what individual professionals, particularly paediatricians, should be thinking about. So the first overarching theme is the feeling that health services need to be enhanced because of the complex health needs of refugee kids and young people and their families. So there was some fairly broad statements, motherhood almost, if you like, relating to dignity of refugees, a whole of government approach, goes without saying. We've heard already about the different levels of involvement of governments.

Provide publicly funded healthcare to all refugees. Now, at a national level, the torture and trauma services are well funded. The federal Health Department does not do a lot in terms of - I shouldn't say this. In terms of direct service provision for physical and public health it doesn't do a lot. It certainly fund Medicare and some of you will be aware there is a new Medicare item number for refugee health assessments. So certainly Federal Government is doing that. So it's up to the State Governments and Territory Governments to put in money for the health services.

Now, all States at the State level and sometimes at the local regional level, put in money at various levels for refugee health. To my knowledge, the Northern Territory and the ACT do not. Somebody from the ACT Government might correct me there, but to my knowledge those two Health Departments do not put in money at the territory level for refugee health. The last recommendation there was about accessible and affordable health care, a sort of generic statement, if you like.

This is the second slide about health service enhancements and those recommendations to governments and health services. The College felt that it was legitimate particularly for children to recommend comprehensive health assessments on arrival. This goes back to the slide I showed at the very start about the health checks that happen overseas and the concept that whilst that happens, it doesn't detect everything that needs to be detected and that there is good evidence, it would appear from what we've seen from checking the children once they've arrived in the Australia, for further health assessments to happen here

on shore and for linking people into the health services that exist here in Australia. That pertains both to physical and of course psycho-social health needs.

Recommendations about, of course, ideally having appropriately trained staff, which you want across the board, don't you, but including regarding refugee health, and using refugee workers yourself where you can and bilingual workers where they're available. Interpreter access we've already heard mention of and there will be more about that later in the day I'm sure. The recommendation relating to differential access to health services based on visa category pertains largely, I guess, to temporary humanitarian visas or temporary protection visas. An example of that would be a child on a temporary protection visa, say, having come out of a detention centre, when they were in detention centres, would not be eligible for a hearing aid because that is a Commonwealth funded service and temporary protection visa holders are not eligible for things like rehabilitation and hearing aid services which are directly Commonwealth funded.

Lastly there, the college, the AMA and a number of bodies, including some of those represented in the Alliance, were instrumental in advocating for children to be released from detention centres. That has happened. However, the legislation still exists such that that could be repealed. So there is ongoing advocacy on that issue.

So that related to beefing up health services. The second broad area relates to research and data collection and some fairly self-evidence recommendations in terms of further research, which is better coordinate at a national level that leads to an evidence base, and data that is collated and so informing policy makers, government and service providers about what they should be doing and indeed about what interventions are working and those that aren't. I think it could be said that some of the services that are funded at both federal, State and local levels are not sufficiently evaluated at this time. I looked at Daniel when I said that.

There was a recommendation encouraging participation of refugees in research. That's always said, isn't it, that we should involve those on whom we are carrying out research on who's behalf, if you like. Of course, it could be seen as controversial to mention children in that. There are clearly ethical issues in terms of involving children in research, but I guess it is a matter of making sure they're not forgotten. Maybe that was the thrust of that recommendation.

Third, in terms of training, some recommendations which relates to what should be happening with professional bodies. This is where the College itself, I think, can have a particularly strong role in ensuring that there are members of the College, i.e. paediatricians, their trainees, and those affiliated with other parts of the College, are essentially skilled enough to deal with the complex issues that happen in refugees and other migrants indeed. "Cultural competency" isn't a term I really like. I think you can be competent at looking at

x-ray. I don't know that you be competent in dealing with a culture. I think it is about having sensitivity and respect and listening and maybe that's all it needs, but you have to at least do that. We don't have to be cultural experts. That's just not possible.

You will see again a human rights based approach. Human rights is mentioned a couple of times in this, and the importance of advocacy. People who are on the ground dealing with refugees are often well placed or best placed to advocate on their behalf both at local and higher levels.

Lastly, professional practice was the fore fare. This relates to specific individual paediatricians, if you like, called "fellows" and really, again, it's just a matter of them being aware, being compassionate and sensitive, and I hope they're like that for all their child patients, but including those from different cultural backgrounds and particularly those who are from a refugee background. And that they as individual doctors advocate for quality care for their children that they are seeing and for the families of those refugee children that they are seeing.

So from here the College is, I guess, able to provide leadership in advocating for the implementation of this policy, but also for the health of refugee children and their families in general. It can support special interest groups and other healthcare providers to look at change, to look at what's working and what's not. We're going to update the policy every two years, so it's said, depending on what emerges from research and other evidence and disseminate widely. You can access this on the website for the college. The web address is there. Just I think in the last fortnight there's been a brief paper published in one of the paediatric journals and there's also a one page physician statement summary that's around and is available.

Possibly the most important thing I'm going to say, and everyone will wake up and listen now, is that you can use this document as an advocacy tool. It's a very important policy document that now exists and whichever organisation your represent or whatever level you're working with refugees around the country, you know, you now know that you've got something that you can bring out and wave under the noses of interested parties and say, "Well, this is what the College of Paediatrics says," you know. So I think you can use that. I guess, similarly, you can advocate towards the college and say, "Well, why isn't this being implemented where I'm working?"

So I think it can be a very useful tool and that's probably its greatest benefit. This is the working group, or most of it. A couple of the policy officers have been chopped off it from the bottom, but these are my colleagues; mostly paediatricians, mostly New South Wales, but, as I said, the information was gained from all over the country. Thank you very much.