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.

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 by default. I am presenting 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 being 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 submarine personnel losses in 1942 in Sydney Harbour will, I guess, have shared some of those sentiments.

I'm a public health physician - I'm not a part of the paediatrician part of this College but I was on the working group for this policy statement. 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 critically in terms of where it's missed out on addressing those issues.

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

We are trying to exclude TB and detect people with HIV, and there are some additional checks that happen just prior to departure, as he mentioned, including malaria tests. The picture shown 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 commenced about 18 months ago. Everyone under 30 is getting a measles, mumps and rubella vaccine, which is very positive.

Just to focus a little bit on why the College produced something particularly targeting refugee children, that is 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 an even more disadvantaged subgroup. Here is a list of 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 the 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 about lack of immunisation - have 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 former Yugoslavian countries, yet not so bad in Africans.

Things like untreated orthopaedic problems, war injuries that haven't been fixed, hernias and other surgical conditions that haven't been corrected - 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 issue that has to be remembered, and here is a slide reminding us of some of the issues that pertain to refugee youth in particular. As well as normal adolescent health aspects, they are also having to deal with the things they've been exposed to as young people in refugee situations, which, largely speaking, are unheard of in this country, like being forced to be a child soldier and the extreme level of responsibility they may have been given for young people of that age.

Here is a summary of the policy and it's underlying principles - essentially, asylum seeker children have rights to healthcare as would any other child; access should be culturally appropriate and not constrained by finances; and the health status of children and 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 healthy, so early beginnings are very important. So they are the broad principles, if you like.

The desire of the policy was to advocate for timely and high quality healthcare. It complements existing College documents which target issues such as equity and obviously child health. The target audience is principally members of the College (paediatricians) but also health services (local, State, national levels), policymakers at all those levels, and governments both here in New Zealand. It was written as an evidence-based document drawing together literature and information and expertise from local practitioners, including those in rural and regional areas. There was feedback received from a number of people around the country on the draft version.

The recommendations come in four areas as listed. 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. 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. There are some fairly broad statements relating to dignity of refugees, and a whole of government approach - we've heard already about the different levels of involvement of governments.

Provide publicly funded healthcare to all refugees - at a national level, the torture and trauma services are well funded, however the federal Health Department does not do a lot in terms of direct service provision for physical and public health. It certainly funds Medicare and some of you will be aware there is a new Medicare item number for

refugee health assessments. So certainly the Federal Government is doing that. So it's up to the State Governments and Territory Governments to put in money for health services. All States at the State level and sometimes at the local regional level, put in money at various levels for refugee health, apart from the Northern Territory.
The last recommendation here was about accessible and affordable health care.
This is the second slide about health service enhancements and 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 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 from what we've seen checking the children once they've arrived in the Australia, for further health assessments to happen here, and for linking people into health services. That pertains both to physical and psycho-social health needs. Other recommendations refer to having appropriately trained staff, and using refugee workers 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 to Temporary Humanitarian Visas or Temporary Protection Visas. An example of that would be a child on a Temporary Protection Visa, 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 TPV holders are not eligible for programs like rehabilitation and hearing aid services which are directly Commonwealth funded.
Lastly, the College, the AMA and a number of other 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.
The second broad area of recommendations relates to research and data collection and some fairly self-evident recommendations in terms of further research, better coordinated at a national level that leads to an evidence base, and data that are collated and so informing policy makers, government and service providers about what they should be doing and about what interventions are working and those that aren't. 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.
There was a recommendation encouraging participation of refugees in research. That's always said, that we should involve those on whom we are carrying out research. This could be seen as controversial to mention children in that context. 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..
Thirdly, in terms of training, are some recommendations which relate to what should be happening with professional bodies. This is where the College itself 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 skilled enough to deal with the complex issues that arise in refugees and indeed other migrants. "Cultural competency" however isn't a term I really like. I think you can be competent at looking at an 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 note a human rights based approach. Human rights is mentioned a couple of times, and the importance of advocacy. People on the ground dealing with refugees are often best placed to advocate on their behalf both at local and higher levels.
Lastly, professional practice was the fourth area. This relates to specific individual paediatricians, called "Fellows" and again it's a matter of them being aware, being compassionate and sensitive (I hope they're like that for all their child patients), but including towards 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 the children that they are seeing, and for the families of those refugee children.
So from here the College is 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, depending on what emerges from research and other evidence, and disseminate it widely. You can access this on the College website. The web address is here. In the last fortnight there's been a brief summary paper published in one of the paediatric journals, and there's a one page position statement that's 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 an important policy document that now exists and whichever organisation you represent or whatever level at which you're working with refugees around the country, 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". 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, mostly paediatricians, mostly New South Wales, but, as I said, the information was gained from all over the country.
Thank you very much.