Rockhampton Refugee Health Reference Group

Health Issues Statement

Rockhampton Refugee Health Planning Project

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June 2011
Disclaimer:

This document was produced in June 2011 by:

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Glossary

ACCES – ACCES Services Inc
CALD – Culturally and linguistically diverse
CDGP – Capricornia Division of General Practice
CQPCP – Central Queensland Primary Care Partnership
DIAC – Department of Immigration and Citizenship
DOC – Department of Communities
HIV – Human immunodeficiency virus
HSS – Humanitarian Settlement Services Program
MBS – Medicare Benefits Scheme
MOC – Medical Officer of the Commonwealth
MRC – Migrant Resource Centre
NAATI – The National Association for Accreditation of Translators and Interpreters Ltd
PBS – Pharmaceutical Benefits Scheme
QPASTT – Queensland Program of Assistance to Survivors of Trauma and Torture
QTMHC – Queensland Trans-cultural Mental Health Centre
RHQ – Refugee Health Queensland
RRC – Rockhampton Regional Council
RRHRG – Rockhampton Refugee Health Reference Group
TAFE – Technical and further education
TB - Tuberculosis
TIS – TIS National (Translation and Interpreting Service)
Executive summary

Commencing in April 2011, Justin Power was contracted by Rockhampton Refugee Health Reference Group (RRHRG) to complete a health needs analysis for the refugee, newly arrived migrant, and work visa holder population in Rockhampton. This report represents the results of the first 3 tasks of the project.

1. Undertake background analysis of socio-demographic and health data (where available) for refugees and new migrants, in order to identify and quantify major health issues in these groups,
2. Undertake consultation with stakeholders identified by Rockhampton Refugee Health Reference Group,
3. Document needs and service gaps, and capacity of mental and physical health providers within Rockhampton,

The work completed included an initial search for sources of demographic data for refugee, migrant, and work visa arrivals to Rockhampton, and pertinent information concerning health issues for this population. The demographic data was collated and analysed to develop a description of the population.

A stakeholder consultation program was implemented, based on an initial list of contacts supplied by RRHRG. A total of 55 stakeholders were contacted, with representation from migrants, the health sector, migrant support agencies, local government, and the Department of Immigration and Citizenship (DIAC). Semi-structured individual, group and telephone interviews were conducted with 48 stakeholders, including 11 members of the migrant community. The information obtained from the stakeholder consultation program was collated and analysed to identify key health issues for consideration by RRHRG.

The following issues are suggested for consideration the 4th task of the project – development of the strategic plan for RRHRG:

1. How can information systems be improved to gain timely information about new arrivals in Rockhampton, and ensure that they are linked with the health services they need?
2. What strategies can be developed to increase the use of accredited interpreters in health consultations, and improve the ability of practitioners and clients to share information through them?
3. How can information on the portfolio of health services available in Rockhampton, and the eligibility requirements for access to them, be made available to migrants on arrival here in a form that they can understand?
4. What strategies can be implemented to assist practitioners to gain a better understanding of the cultures and practices of new migrants to Rockhampton, in order to better meet their needs in a health setting?
5. What can RRHRG do to support the development of solutions to other issues which may impact on health or access to services?
1. Introduction

The Rockhampton Refugee Health Reference Group (RRHRG) was formed in 2010 by the Central Queensland Primary Care Partnership. It is a network of health service providers and social service providers with the following objectives:

- Assist the successful settlement of refugees, newly arrived migrants and work visa holders into the Rockhampton community by ensuring that they have access to the mental and physical health services that they require and are entitled to, and
- Support the work of mental and physical health service providers in Rockhampton by identifying service needs and facilitating links and partnerships with these target groups

To assist with achievement of these objectives the RRHRG contracted Justin Power in April 2011 to complete a health needs analysis for the refugee, newly arrived migrant, and work visa holder population in Rockhampton, including the key activities:

4. Undertake background analysis of socio-demographic and health data (where available) for refugees and new migrants, in order to identify and quantify major health issues in these groups,
5. Undertake consultation with stakeholders identified by RRHRG,
6. Document needs and service gaps, and capacity of mental and physical health providers within Rockhampton,
7. Draft a Health Issues Statement based on the stakeholder consultation, and
8. Facilitate the Development of a Strategic Plan to enable RRHRG to act on the identified needs.

This Health Issues Statement represents the results of the background analysis and stakeholder consultation program. Given that the RRHG intends to welcome new stakeholders who feel that they can contribute to its work, it is likely that additional information and perspectives will be provided during the strategic planning and implementation stages. This statement could possibly be used as a living document, and amended to incorporate new contributions as project progresses. The current version will be incorporated into the strategic plan approved by RRHRG.
2. Methodology

The methodology for this stage of the project included an initial search for sources of demographic data for refugee, migrant, and work visa arrivals to Rockhampton, and pertinent information concerning health issues for this population. The demographic data was collated and analysed to develop a description of the population.

A stakeholder consultation program was implemented, based on an initial list of contacts supplied by RRHRG. A total of 55 stakeholders were contacted, with representation from migrants, the health sector, migrant support agencies, local government, and the Department of Immigration and Citizenship (DIAC).

Semi-structured individual, group and telephone interviews were conducted with 48 stakeholders, including 11 members of the migrant community. The structure of the interviews was designed to obtained information about:

- Migrant experience with the health sector,
- Health needs particular to new migrants,
- The health services available to migrants and any identified gaps, and
- Barriers to access.

The information obtained from the stakeholder consultation program was collated and analysed to identify key health issues for consideration by RRHRG.

Given the short timeframe available for completion of the first 3 tasks of the project, it was anticipated that the stakeholder consultation period could take more time than originally planned. This expectation was realised, with a consequent impact on the completion date for this report. The beneficial outcome of this situation was an expansion of the coverage of the stakeholder consultation.
3. The refugee and migrant population in Rockhampton

Entry into Australia

Entry of non-citizens into Australia is regulated by the Australian Government through DIAC. A system of visas is used to classify different classes of entry approval within the 2 categories of residency available; temporary and permanent. Within the categories of residency, entry approval types are grouped into streams; such as the Humanitarian Stream, which provides permanent residency to eligible applicants who are unable to remain in their home country, or return to it, due to dangers to them and their families presented by political, religious or cultural situations there. Streams are further divided into subclasses: such as subclass 457, which allows the approval of temporary entry of overseas workers to meet skill needs in particular industries, or in particular regions.

Each visa subclass carries specific conditions and obligations relating to length of stay, ability to work in Australia, and access to Medicare and social security benefits. For the purposes of this project, we are interested in investigating the health needs of new arrivals comprising refugees, newly arrived migrants, and temporary work visa holders. These could include people in the following visa streams:

- Permanent residents – Humanitarian (refugees), Business (includes Employer Nomination Scheme, Regional Sponsored Migration Scheme, Business owners), and Family (reunification of family members in the previous streams),
- Temporary residents – Employer-sponsored temporary (such as subclass 457 Business (Long stay)), Labour Agreements, Working holiday (subclass 417 & 462).

Australia’s Humanitarian Program has 2 components, onshore and offshore. The onshore component allows people within Australia who are refugees to apply for protection, and the offshore covers people who are living in their home country or another country.

The offshore component has Refugee and Special Humanitarian Program categories, with the latter including provision for the immediate family of persons granted protection in Australia. Our consultations with stakeholders indicate that some of the male humanitarian migrants currently working in Rockhampton are sending their income overseas to finance the migration of their families to Australia.
Migrants in Rockhampton

Table 1 provides a summary of trends in the overseas-born population of Rockhampton over the census periods from 1996 to 2006. It indicates that this population grew over this decade, whilst remaining stable as a proportion of the total population.

Table 1: Overseas-born population by sex, Rockhampton Regional Council

<table>
<thead>
<tr>
<th></th>
<th>1996</th>
<th>2001</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>4,195</td>
<td>3,928</td>
<td>4,483</td>
</tr>
<tr>
<td>Female</td>
<td>4,177</td>
<td>4,070</td>
<td>4,495</td>
</tr>
<tr>
<td>Total</td>
<td>8,372</td>
<td>7,998</td>
<td>8,978</td>
</tr>
<tr>
<td>Population % born overseas</td>
<td>9</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

Table 2 provides some indication of change in the composition of the overseas-born population during the decade to 2006. It excludes people born in New Zealand, the highest population group, as well as United States, Canada and Ireland. Of interest is the growth in the cohorts born in the Philippines and South Africa.

Table 2: Overseas-born population, top 5 countries, Rockhampton Regional Council

(excludes New Zealand, United Kingdom, United States, Canada & Ireland)

<table>
<thead>
<tr>
<th>Country</th>
<th>1996</th>
<th>2001</th>
<th>2006</th>
<th>Growth %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germany</td>
<td>296</td>
<td>281</td>
<td>326</td>
<td>10</td>
</tr>
<tr>
<td>Philippines</td>
<td>219</td>
<td>248</td>
<td>319</td>
<td>46</td>
</tr>
<tr>
<td>Netherlands</td>
<td>280</td>
<td>270</td>
<td>280</td>
<td>0</td>
</tr>
<tr>
<td>South Africa</td>
<td>35</td>
<td>148</td>
<td>254</td>
<td>626</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>268</td>
<td>148</td>
<td>138</td>
<td>-49</td>
</tr>
</tbody>
</table>

The on-ground experience of agencies represented on the RRHRG, and information obtained from DIAC suggests that change in the size and composition of the overseas born population of Rockhampton has continued since the 2006 census. The employment opportunities available within Rockhampton and its’ hinterland have attracted migrants with permanent residency, refugees granted permanent residency on humanitarian grounds, and temporary work visa holders. Many of these originate from countries where English is not a first or commonly spoken language. RRHRG is interested in describing this population, assessing its’ health needs, and ensuring that services are available in Rockhampton to meet these needs.

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Permanent Residents

The available information sources do not enable us to capture all of the new overseas-born arrivals to Rockhampton since the 2006 census, particularly those for whom Rockhampton was not their initial Australian residence. We have been able to source information on permanent resident arrivals nominating Rockhampton as their destination, using the resources of the DIAC Settlement Reporting facility. This facility provides data, available at a local government area scale, covering humanitarian, skilled, and family migration streams. Information on recent secondary migrant arrivals, captured by DIAC from settlement support agencies and other contacts, is contained in a separate section below.

Table 3 summarises arrivals in these categories from selected regions comprising non-European/Western countries. Their selection was based on:

- Information from stakeholders interviewed and information in the public arena noting increased levels of arrivals in Rockhampton from these regions, and
- The cultural and language backgrounds of migrants from them may provide more settlement challenges for them, relative to those from European/Western backgrounds.

The Africa category comprises all countries within Africa other than in North Africa. North Africa and the Middle East includes Algeria, Egypt, Libya, Morocco, Sudan, Tunisia and Western Sahara, as well as the countries of the Middle East. North East Asia comprises Japan and North and South Korea. South East Asia includes Cambodia, Laos, Burma, Thailand, Vietnam, Malaysia, Brunei, East Timor, Indonesia, the Philippines and Singapore. South Asia comprises India, Pakistan, Bangladesh, Bhutan, Nepal, Maldives, Afghanistan and Sri Lanka.

Table 3: Permanent Resident arrivals by migration stream, selected regions
September 2006- April 2011

<table>
<thead>
<tr>
<th>Migration Stream</th>
<th>Africa</th>
<th>Nth Africa &amp; Middle East</th>
<th>NE Asia</th>
<th>SE Asia</th>
<th>S Asia</th>
<th>Sth &amp; Central America, Caribbean</th>
<th>Melanesia, Micronesia, Oceania, Polynesia</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humanitarian</td>
<td>41</td>
<td>16</td>
<td>0</td>
<td>0</td>
<td>83</td>
<td>1</td>
<td>0</td>
<td>141</td>
</tr>
<tr>
<td>Skilled</td>
<td>220</td>
<td>14</td>
<td>20</td>
<td>100</td>
<td>202</td>
<td>5</td>
<td>17</td>
<td>578</td>
</tr>
<tr>
<td>Family</td>
<td>13</td>
<td>4</td>
<td>42</td>
<td>118</td>
<td>34</td>
<td>10</td>
<td>18</td>
<td>239</td>
</tr>
<tr>
<td>TOTAL</td>
<td>274</td>
<td>34</td>
<td>62</td>
<td>218</td>
<td>319</td>
<td>16</td>
<td>35</td>
<td>958</td>
</tr>
</tbody>
</table>

Skilled visa arrivals are the largest stream in the selected population, followed by the family stream. The African and South Asia regions represent the largest contributors to the skilled stream. The Settlement Reporting data indicates that 74% of the 220 skilled migrants from Africa originated from Southern and East Africa, and that 54% of those from South Asia originated from India.

South East Asia provided the largest cohort of family arrivals, with 45% of them originating from the Philippines, and 36% from Thailand.

The highest proportion of humanitarian entrants originated in South Asia, with 72% of them arriving from Afghanistan. Of the African entrants, 59% originated from the Democratic Republic of Congo.

**Age characteristics**
Table 4 summarises the age distribution of new arrivals since the 2006 Census by selected geographical regions. The total selected population is characterised by a predominance of arrivals of working age between 18 and 64, with 53% of the population aged between the prime working years of 25-44. The South and Central America cohort had working age arrivals comprising 69% of its total.

This data is consistent with information obtained from stakeholders interviewed, indicating that most new arrivals locate in Rockhampton for work opportunities, and that men often arrive in Rockhampton (and also in Australia) in advance of their families.

Variances are evident in the characteristics of populations originating from the different regions. Africa, Middle East, and the Pacific populations have significantly higher proportions in the 0-5 age group, and the African cohort has 24% in the school age years 6-17, compared to 15% in the overall population of new arrivals.

**Table 4 Permanent resident arrivals by age, selected regions**
September 2006-April 2011

<table>
<thead>
<tr>
<th>%</th>
<th>Africa</th>
<th>Nth Africa &amp; Middle East</th>
<th>NE Asia</th>
<th>SE Asia</th>
<th>S Asia</th>
<th>Sth &amp; Central America, Caribbean</th>
<th>Melanesia, Micronesia, Oceania, Polynesia</th>
<th>Selected population</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>15</td>
<td>15</td>
<td>6</td>
<td>8</td>
<td>8</td>
<td>0</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>6 - 11</td>
<td>13</td>
<td>6</td>
<td>5</td>
<td>9</td>
<td>5</td>
<td>6</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>12 - 15</td>
<td>9</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>16 - 17</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>18 - 24</td>
<td>8</td>
<td>15</td>
<td>13</td>
<td>15</td>
<td>18</td>
<td>6</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>25 - 34</td>
<td>18</td>
<td>35</td>
<td>35</td>
<td>30</td>
<td>44</td>
<td>56</td>
<td>34</td>
<td>32</td>
</tr>
<tr>
<td>35 - 44</td>
<td>28</td>
<td>21</td>
<td>26</td>
<td>22</td>
<td>14</td>
<td>25</td>
<td>9</td>
<td>21</td>
</tr>
<tr>
<td>45 - 54</td>
<td>7</td>
<td>0</td>
<td>6</td>
<td>7</td>
<td>4</td>
<td>0</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>55 - 64</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>65 +</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

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4 DIAC 2011.
Gender Characteristics

Table 5 illustrates the variance in gender characteristics within populations arriving from the selected regions. Both the North East Asia and South East Asia cohorts had high proportions of female arrivals, whilst North Africa and the Middle East, South Asia and the Melanesia/Micronesia/Oceania/Polynesia cohorts had higher proportions of male arrivals. On initial consideration this data would seem to be inconsistent with the proposition of advance male arrival mentioned above; however examination of the visa stream information indicates that 68% of the arrivals in the North East Asia cohort were from the family stream, as were 54% of the South East Asia arrivals.

Table 5: Permanent Resident arrivals by gender, selected regions September 2006-April 2011

<table>
<thead>
<tr>
<th>%</th>
<th>Africa</th>
<th>N th Africa &amp; Middle East</th>
<th>NE Asia</th>
<th>SE Asia</th>
<th>S Asia</th>
<th>S th &amp; Central America, Caribbean</th>
<th>Melanesia, Micronesia, Oceania, Polynesia</th>
<th>Selected population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>51</td>
<td>29</td>
<td>61</td>
<td>64</td>
<td>41</td>
<td>50</td>
<td>43</td>
<td>50</td>
</tr>
<tr>
<td>Male</td>
<td>49</td>
<td>71</td>
<td>39</td>
<td>36</td>
<td>59</td>
<td>50</td>
<td>57</td>
<td>50</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

DIAC migration update

DIAC was requested to provide an update on recent migration data for refugee and humanitarian clients. An email from Caroline Ruiz-Archipala, Acting Settlement Planning Coordinator, on 1st June 2011 advises that, based on information obtained from various service providers in the region, the actual number of humanitarian entrants settled in the region at the end of 2010 was between 350 and 400.

The Department has also estimated the extent of recent secondary migration of refugees and humanitarian entrants to Rockhampton. It advises that a large cohort of Afghan Hazara men moved to Rockhampton with a number of Sri Lankan Tamil men in 2010 to take up employment. By October 2010 approximately 155 Afghan and Sri Lankan men had arrived, with the majority moving from Brisbane.

In April 2011 the family of a Sri Lankan Tamil worker, comprising wife and 4 children, were the first to arrive in Rockhampton. DIAC envisages that approximately 30% of the men working in Rockhampton will bring their families here on a long term basis.

DIAC advises that approximately 60 Sudanese people have moved to Rockhampton for employment and educational opportunities since 2003. In January 2010 a Liberian family also moved here.

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5 DIAC 2011.
Temporary Residents

DIAC does not have an equivalent to the Settlement Reporting facility for temporary arrivals that can provide publically available information at a Local Government Area level. An email from Julie Garrett, Queensland Industry and Union Outreach Officer, DIAC, on 13th June 2011 advised that on 31st March 2011 there were 434 primary subclass 457 visa holders with their nominated position being Rockhampton, compared to 417 at the same date in 2010. Of the current population 88% are male. Brazil (24%) and Vietnam (23%) make up the largest groups, followed by the Philippines (9%) and India (9%).

These workers were employed by 36 active subclass 457 sponsors (employers) in Rockhampton.

We were advised by the DIAC representative that these primary visa holder figures do not take into account any other visa grants to family members included in the main visa application – known as “secondary visa holders”.

Discussions have been held with representatives of known employers of large numbers of overseas workers, Teys Brothers and JB Swift, who operate meatworks in Rockhampton. Teys Brothers has declined to assist with information on the structure of its overseas worker complement; however we are advised by stakeholders who have visited the site that temporary workers from Vietnam and Korea are employed there. JB Swift is currently collating data to respond to our request; however we are advised by stakeholders that their workforce includes Brazilian and Korean workers. Some of the Vietnamese and Brazilian workers have brought their families to Rockhampton.

AWX, a recruitment agency contracted to Teys Brothers, advises that they currently have 55 subclass 457 Visa holders contracted there, with most originating from Korea and Taiwan on holiday work visas.

Conclusions

The published and internal information sourced regarding migration to Rockhampton since the last census in 2006 indicates that at least 1000 permanent migrants have arrived in Rockhampton from the regions of Africa, Asia, Island countries of the Pacific, the Middle East, and Central and South America. The largest cohorts originated from South Asia, Africa, and South East Asia. Most migrants were of working age and, whilst there were significant variations by region of origin, the overall population had equal numbers of males and females. Recent secondary migrant arrivals, however, have been predominately male.

Migrants in the skilled entry category formed the largest group of arrivals for whom Rockhampton was the nominated destination. Over the past 12 months, however, the population of humanitarian (refugee) migrants has been increased significantly by the arrival of secondary migrants from their initial settlement points. DIAC estimates that the refugee and humanitarian migrant population at the end of 2010 was 350-400, and included up to 60 people originally from Sudan, and approximately 155 men of Afghan and Sri Lankan origin. DIAC believes that up to 30% of the latter group will bring their families to Rockhampton on a long term basis.
As at 31st March there are currently 434 temporary migrants working in Rockhampton on subclass 457 visas, and our enquiries indicate that a significant proportion of these have originated from Brazil, Vietnam, the Philippines, India, Korea, and Taiwan. Some Brazilian and Vietnamese families have moved to Rockhampton with these workers.

The recent arrival of significant numbers of refugee and humanitarian migrants, the existing population of temporary workers also from non-English speaking backgrounds, and the potential arrival of many refugee and humanitarian migrant families, will provide challenges for health sector providers to engage with them and respond to their health needs.
4. Health issues for refugees and migrants

Whilst all migrants have their own individual health profile, research indicates that in general migrants’ health is comparable to, or better than, that of other Australians. This ‘healthy migrant effect’ may be explained by selection procedures for entry into Australia, which prioritise good health and, in several categories, socioeconomic status. Particular migrant groups, such as refugees, may not share this effect due to exposure to living conditions with high health risk levels and traumatic life experiences prior to arrival in Australia.

Whilst the wider migrant population exhibits good health data, the literature identifies risk factors and conditions which are more common to migrants from particular countries or regions. The risk factors and conditions that may be relevant to known groups of recent arrivals to Rockhampton, or those likely to arrive in the short term, are discussed in the sections below.

Health requirements for entry to Australia

Australia’s health requirements for entry are motivated by public health, economic, and resourcing concerns. DIAC’s documentation summarises these:

- “minimise public health and safety risks to the Australian community;
- contain public expenditure on health and community services, including Australian social security benefits, allowances and pensions; and
- Maintain access of Australian residents to health and community services.”

The Australian migration regulations require that all applicants for a permanent visa must be assessed against the health requirement. This includes a spouse and dependants of an applicant who may not themselves be applicants. This assessment normally includes a medical examination, a chest x-ray if 11 or more years of age, and a HIV/AIDS test if 15 or more years of age.

Whilst tuberculosis (TB) is the only condition mentioned in the migration legislation as precluding the issue of a visa, other conditions may be considered by the Medical Officer of the Commonwealth (MOC) under the 3 concerns mentioned above when determining if an applicant meets the requirement.

Offshore humanitarian visas, most family visa subclasses, and some skilled visa subclasses provide for a health waiver where a DIAC delegate is “satisfied that the costs to the community and the prejudice to Australian citizens and permanent residents accessing health care and community services would not be undue.” State health authorities provide input on the likely costs to the

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8 DIAC 2007, p2.

community during consideration of waivers for skilled visas. It is health providers at the community level who will, however, bear the impact of care for migrants approved for entry by waiver.

Temporary visa applicants may be required to undergo a medical examination or other tests, depending on considerations including the length of proposed stay, intended activities (e.g. working as a doctor, nurse or paramedic) and the risk level for TB of their country of origin.

Normally if active TB is identified in a medical examination, a visa cannot be granted until the person has undergone treatment, and been declared free of the active disease. If evidence of previous, but now inactive, or latent TB is found, the visa applicant could be asked to sign an undertaking to report for follow-up monitoring on arrival in Australia. Health undertakings can also be a condition of visa approval where other diseases, such as hepatitis are identified.

Health examinations conducted outside Australia are normally arranged with a panel doctor and/or panel radiology clinic nominated by the Australian Government. Health examination results are generally valid for 12 months. Examinations within Australia are arranged through Medibank Health Solutions.

Health risks/conditions

We have noted earlier that the “healthy migrant effect” is attributed to the health requirements of Australia’s migration regulations and the requirements for business stream visas, which support the selection of migrants with the life experience and socio-economic status that has enabled them to maintain good health. This is not the case with many migrants who enter Australia on visas approved under its humanitarian stream. Their health experience in Australia could be influenced by:

- Physical health and limited prior access to health care,
- Trauma and torture,
- The impacts of resettlement on health, and
- Difficulties with access to health care, (e.g. negotiating the system, language barriers, prioritising health, and anxiety re health consultation).

The Australian Government arranges for pre-departure screening for humanitarian entrants from offshore. This can include screening for TB, malaria, and HIV. Where required, treatment for malaria and intestinal parasites is administered. Stakeholders working with new arrivals advised that this screening and treatment is not always of a high standard and the records are often poor. It is mainly designed to ensure that migrants are ‘fit to fly’.

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Upon arrival in Australia humanitarian migrants are provided with settlement assistance by agencies funded under DIAC’s Humanitarian Settlement Services (HSS program). In Queensland this program is delivered at designated settlement centres, which include Brisbane, Toowoomba, Townsville and Cairns. The program provides case-managed settlement and orientation assistance for the first 6-12 months of residency. This includes assistance with introduction to health services to obtain a health assessment and deal with any issues identified. The Settlement Grants Program provides support after the expiry of HSS assistance.

The Multicultural Development Association has coverage of Brisbane and Central Coast Region, which includes Rockhampton, for the HSS Program. ACCES Services Inc has coverage of South East Queensland, which has been the origination point for many of the secondary migrants who arrived in Rockhampton recently. Both organisations work with Refugee Health Queensland (RHQ) and specialist organisations such as Queensland Program of Assistance to Survivors of Trauma and Torture (QPASST) and Queensland Transcultural Mental Health Centre (QTMHC).

ACCES currently has a Settlement Grants Program officer located in Rockhampton. MDA is currently advertising a position for the HSS program.

Our discussions with these stakeholders indicated that the medical records of most humanitarian migrants are incomplete or non-existent. They also advised that a large number of asylum seekers are processed through the Christmas Island detention centre, which is operated by private contractors. The processing includes health screening; however stakeholders representing ACCES Services and Refugee Health Queensland advised that the contractor will not provide the results of health screens completed there to 3rd party organisations. This issue has been raised with the Senior Medical Officer at DIAC, and is currently under review.

The current situation is that a comprehensive health check should be completed for all successful humanitarian applicants to assess their individual health needs as soon as possible after they enter the community. RHQ and the settlement agencies are working to ensure this occurs. Given that all humanitarian entrants are initially settled at designated communities, this means that they should have updated medical records if they subsequently chose to move to Rockhampton.

Physical health

The references and stakeholder discussions identify a number of conditions of public or personal health concern which may be presented by some migrants, some of which may not have been commonly encountered within Rockhampton’s health sector. They include:

- Infectious diseases such as TB, hepatitis B and C, malaria,
- Under immunisation,
- Nutritional deficiencies
- Gastrointestinal infections such as H. Pylori,
- Oral health problems,
- Behaviour and development issues in children
- Musculoskeletal problems,
- Upper respiratory infections, and
• Skin infections.

Some of these conditions are prevalent in countries located in Africa, the Middle East and Asia, which have been the source of the majority of Australia’s intake under the humanitarian stream intake during the last decade. Migrants from these regions also represent the majority of the population of new arrivals to Rockhampton discussed in Section 3.

**Infectious diseases**

A number of countries in Africa, Asia and Central and South America have high rates of infectious disease relative to Australia. A 2006 study of data for all refugee and humanitarian entrants presenting to Western Australia’s Migrant Health Unit in 2003 and 2004 noted a high prevalence of infectious diseases of public health significance, including TB, Hepatitis B and Malaria in people who had last resided in sub-Saharan Africa prior to arrival in Australia. People originating from North Africa and South East Asia also had a high prevalence of Hepatitis B carrier state. The study found that “*giardia intestinalis* was common in refugees from all areas, while other pathogenic gut parasites were found mostly in people from Africa.”

TB is a world-wide health issue and, whilst it has low rates of prevalence in Australia due to successful national and state programs, the potential for it to be carried by arrivals from overseas remains a public health concern. The highest prevalence regions of origin are Vietnam, India, Philippines and Africa.

Our discussions with stakeholders in Queensland Health’s Public Health Unit and Rockhampton TB Control Unit indicate that TB testing has been carried out on newly arrived individuals and groups with humanitarian stream visa referred by Queensland Health. Several positive tests for latent TB have been returned, and treatment programs commenced. Both units liaise with Queensland Health’s administration and with agencies assisting the settlement of humanitarian entrants to preserve public health and support the settlement process for the individual.

Whilst Australia is malaria free the disease is prevalent countries within Africa, Asia, South East Asia and South America. Migrants arriving in Rockhampton may have pre-existing conditions contracted in their country of origin or transit.

Some instances of positive tests for Hepatitis C have been recorded by Rockhampton health sector stakeholders.

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15 Victorian Foundation for Survivors of Torture Inc 2007, p 111.
**Immunisation**

The immunisation status of many migrants, particularly those arriving under humanitarian programs, is unknown or poorly recorded. Many countries of origin do not have comprehensive immunisation programs, and children born in refugee camps often do not receive immunisation prior to departure to Australia. This increases the risk of contracting preventable diseases; however catch-up programs are effective when the issue is identified.

**Nutritional deficiencies**

Many migrants originate from regions where food is scarce and/or lacking in nutritional elements. They may have lived for long periods in transit locations where diseases such as parasitic infection and chronic diarrhoea are prevalent. Some people may also have dental problems which cause difficulties with eating.

Other issues that may be experienced following settlement could contribute to nutritional deficiencies, including unfamiliarity with Australia food types and the storage of food. Low levels of English literacy would also make it difficult to read food labels and instructions. In Rockhampton recent arrivals have comprised large numbers of unaccompanied men, who may have little experience in buying food and cooking in their cultures, and who also work shifts during normal shopping hours. These factors may lead to poor nutritional choices.

**Oral health**

Many migrants may originate from countries with limited access to oral health care. They may also have oral health conditions resulting from disease or injury sustained in conflict. On arrival in Australia oral health may be a low priority relative to other settlement issues, and access to oral health services may be subject to lengthy waiting times or limited by cost in the private sector.

**Mental Health**

Some of the migrants arriving in Australia under the humanitarian programs have been subjected to conflict, the loss of or separation from family members, torture or sexual assault in their countries of origin, or in transit locations. These experiences can initiate mental health conditions, such as post-traumatic stress, which require intervention to assist the victim to settle successfully in Australia. Refugees also experience the psychological problems that would be noted in any population.

In Queensland, QPASTT and QTMHC work with migrants from non-English speaking backgrounds who present with mental health conditions. Stakeholders interviewed from both organisations mentioned that most of their clients initially present with post-migration issues, rather than issues related to the pre-migration period of their lives.

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16 Victorian Foundation for Survivors of Torture Inc 2007, p 90.

17 Victorian Foundation for Survivors of Torture Inc 2007, p 49.
Several factors were noted as contributors to post-migration issues:

- Ambiguous loss – client has no closure because their family remains overseas,
- Loss of employment,
- Lack of English language skills,
- Loss of respect/value within family or community.

It was observed by the stakeholders that if the current problems are not addressed pre-migration problems can often surface, in some cases with acute consequences.
5. Health services in Rockhampton

As a significant regional population centre and a major service centre for Central and western Queensland, Rockhampton supports a significant portfolio of health services, including:

- primary health care services such as those provided by Community Health workers, general practitioners, nurses, dentists,
- secondary care services provided by public and privately operated hospitals, such as emergency treatment, maternity services, surgery,
- tertiary services such as those supplied by locally-based and visiting specialists,
- Allied health services, such as clinical psychologists, physiotherapists, dieticians.

The city does not currently offer health services targeted specifically at migrants, possibly because the historical inflow of migrants from a non-English speaking background has been relatively small. The recent secondary migration of large groups of humanitarian stream migrants from settlement centres such as Brisbane and Sydney to take up employment opportunities has been unplanned; with the result that services have had to respond to demand using the resources currently available to them. Our stakeholder consultation activity has revealed that a number of services work cooperatively with settlement agencies, employers and migrant-specific health services in other locations to refer clients, access information, and to source training to assist them to meet migrant health needs.

Physical Health

For most migrants, their initial engagement with the health sector in Australia would be via an appointment with a general practitioner. The Australian Government provides free telephone interpreting services through TIS National (TIS) to non-English speaking Australian citizens and permanent residents to communicate with “private medical practitioners providing Medicare-rebateable services and their reception staff to arrange appointments and obtain the results of medical tests.” Practitioners are required to register for this service, and interpreters must be booked in advance. A number of practitioners in Rockhampton are registered, and practices that stakeholders indicated were used by migrants include Mandalay Medical Centre, North Rockhampton Medical Centre, and Mount Archer Medical Centre.

A Doctors Priority Line, offering a 24 hour 7 days a week free telephone interpreting service, is available to general practitioners and specialists when providing services to non-English speakers, who are Australian Citizens or permanent residents, that are claimable under Medicare and delivered in private practices.

Temporary visa holders would not be eligible for these services, and would have to pay the normal fee charged by an interpreting service.

Pharmacies dispensing Pharmaceutical Benefits Scheme (PBS) medications are also able to register for free interpreting services through TIS, and 10 Rockhampton pharmacies are currently listed on the DIAC register.

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Allied health professionals in the following categories who are registered with the Medicare Benefits Scheme (MBS) can also bulk bill some approved services:

- Audiologist,
- Chiropractor,
- Clinical Psychologist and Psychologist,
- Diabetes Educator,
- Dietician
- Exercise Physiologist
- Mental Health Nurse
- Occupational Therapist
- Osteopath
- Physiotherapist
- Podiatrist
- Social Worker
- Speech Pathologist

Most of the MBS-approved allied health services require a referral from a general practitioner.

Facilities operated by Queensland Health, such as hospitals and community health centres, have access to a government interpreting service, using TIS or an interpreter accredited by the National Accreditation Authority for Translators and Interpreters (NAATI) which is available for the use of its' staff when working with non-English speaking clients. Government policy requires Queensland Government Agencies to provide and pay for this service. Temporary residents, who are required to have their own health insurance, would be invoiced for the cost of any health services provided.

Queensland Health services in Rockhampton can also access information and assistance from Refugee Health Queensland, based in Brisbane. RHQ also provides information and some education opportunities to general practitioners via Divisions of General Practice.

Stakeholders from Queensland Health reported that eligible non-English speaking migrants currently access:

- Antenatal clinics and classes, birthing services, and postnatal clinics at Rockhampton Base Hospital
- Outpatients at Rockhampton Base Hospital
- Phillips St Medical Centre for child health and immunisation services and education, and
- Oral health services for children at schools throughout the city

The management stakeholder at Community Health has reported minimal experience with migrants in the services under his supervision, which include: Community and Oral Health Services, Child Protection Team, Family Health Team, Chronic Disease program, Alcohol Tobacco and Other Drugs Service, and Population Health. Some migrants have accessed child and family development services to assist them with children experiencing developmental delays.

The Women’s Health Centre Manager advised that they have not had contact with migrant clients to date, however engagement with the culturally and Linguistically Diverse (CALD) community was a priority in their current business planning process.

We are advised by stakeholders that non-English speaking migrants also access services such as antenatal clinics and birthing services at the Mater private hospital.

Carers Queensland operates a support service to culturally and linguistically diverse (CALD) clients with HACC eligibility to support them to continue to live in their own homes.

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Rockhampton has a variety of resident medical specialists, based at public and private health facilities. Other specialists also service patients via a visiting program from their metropolitan bases.

Private hospitals, practitioners and specialists providing services not claimable under Medicare, and private allied health practitioners working with non-English speaking migrants would need to access interpreters at commercial rates if required, and would implement individual cost recovery policies.

**Mental Health**

Mental health services available in Rockhampton include

- Mental health consultations and plans through general practitioners,
- Psychologists and Clinical Psychologists in private practice, GP Clinics and Queensland Health,
- Counselling services, supplied by human services agencies such as Centacare, Lifeline, and Ozcare, and
- Acute mental health services at Rockhampton District Mental Health Service, and
- Support services provided by not for profit organisations.

Some mental health services delivered by eligible general practitioners and Psychologists are able to be bulk billed. Under the Better Access to Mental Health Care initiative the MBS can cover up to 12 individual services with a registered psychologist, who is also an approved Medicare provider, in a calendar year for eligible patients. Patients must be referred by a general practitioner, Psychiatrist or Paediatrician. The general practitioner completes a detailed mental health assessment and a Mental Health Care Plan prior to referral.  

Of the general practice clinics used by significant numbers of migrants, Mandalay Medical Centre has an in-house psychologist, and North Rockhampton Medical Centre has a weekly visiting Psychologist service. Both medical centres advised that absence of a Medicare rebate for the use of interpreters by Psychologists does restrict the access of some migrant clients to this service.

Counselling services would normally be provided on a fee for service basis, however agencies are contracted to deliver concessional services to discrete groups via a variety of Australian and Queensland Government programs.

QPASST visits Rockhampton monthly to provide services to referred clients. This organisation has also secured funding for the placement of a part time counsellor in Rockhampton, and is currently recruiting for the position. QPASST also works with other organisations and professionals to improve awareness about mental health issues associated with trauma and torture.

QTMHC provides information, referral, resources and a clinical consultation service to District Mental Health Services throughout Queensland to assist them in working with clients for non-English speaking backgrounds. The centre has a team of over 170 casual employees from 60 ethnic backgrounds, who are used to separate psychological and cultural issues in dealings with clients.

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6. Issues impacting on access to health services

Members of the RRHRG provided introductions to members of the Sudanese, Afghan and Sri Lankan refugee communities, who were interviewed to discuss their experience of accessing health services in Rockhampton. Representatives of settlement agencies, the Central Queensland Multicultural Association, medical services attended by migrants, and the Rockhampton Regional Council Multicultural Community Relations Officer were also interviewed to gain information on the migrant experience as encountered in their work.

The length of residency of the migrants interviewed varied from 2 months to 2 years. They indicated overall satisfaction with their experience of the health system in Rockhampton to date. The key issues identified by them and the other stakeholders interviewed as impacting on their access to health services were:

- Language difficulties,
- Access to information,
- Eligibility for services,
- Cultural awareness, and
- Other contributing issues

Language and communication difficulties

Most of the migrants interviewed indicated that difficulties with understanding and speaking English, including Australian colloquialisms, inhibited their access to services on arrival in Australia. A Sudanese community member who is new to Rockhampton commented that “a lack of interpreters that speak our (Dinka) language was the biggest challenge for us on arrival” He advised that the minority Dinka-speaking population originate from Southern Sudan, whilst the majority of the population speaks Arabic. It is rare to find an interpreter service that employs a Dinka speaker.

Effective communication is most important when discussing health issues with a health professional. The need for an interpreter adds a layer of complexity to the consultation which could lead to misinterpretation of the message of either party. It is for this reason that health professional practices recommend the use of an accredited interpreter with some understanding of medical terminology. Unfortunately the everyday practice situation is not always ideal. Rockhampton has few accredited interpreters; we were advised by two stakeholders that a Vietnamese couple, who were their only locally available interpreters, have recently withdrawn their services due to other commitments.
A search of the NAATI website\textsuperscript{21} identified that accredited translators or interpreters for the following languages are resident within the Rockhampton Regional Council area:

- Chinese (translator),
- Hindi (translator),
- Punjabi (translator), and
- Vietnamese (translator/interpreter).

Several of the stakeholders interviewed, who experience difficulty with speaking and/or understanding English, reported that they attended medical and other appointments accompanied by a friend or relative. GP stakeholders also reported this as commonplace, advising that the clients felt more comfortable with their friend interpreting for them. On some occasions a multilingual staff member from the workplace has accompanied a client.

Bookings for free interpreters through TIS are normally required 2 weeks in advance, with waiver of this requirement possible on medical grounds subject to the availability of a suitable interpreter. Health workers and general practitioners sector stakeholders advised that the use of telephone interpreter could double the duration of a consultation.

Ozcare is currently attempting to establish a volunteer program to support migrants to practise conversational English. Rockhampton TAFE also provides English courses, however some migrants are unable to attend due to their irregular work hours. The settlement of migrants will be enhanced by the acquisition of English language skills. The challenge of communication also provides an opportunity to consider strategies that may increase health practitioner skills and confidence in using accredited interpreters, with potentially improved health outcomes for patients.

**Access to information**

Most stakeholders reported initial difficulty in accessing information about the services available to them in Rockhampton. Their limited experience of Australian culture, the language, and the structure of the health system presented obstacles in the first weeks after arrival. Their main sources of information were:

- Co-workers with longer residency in Rockhampton,
- Settlement service agency staff located in Rockhampton,
- Human resource staff at their workplace, or
- Staff members of the recruitment company that relocated them to Rockhampton.

This word-of-of-mouth recommendation of particular health services, such as a general practitioner, was usually sufficient to meet the immediate needs of the migrant stakeholders interviewed. The majority of these were males, originally from Sudan, Afghanistan, and Sri Lanka. The 2 women who provided comment were from Sudan and Sri Lanka. The stakeholder from Sudan recently gave birth to a child in Rockhampton Base Hospital, and indicated she was referred there by her GP.

Representatives of general practices interviewed reported that their clients generally adapted well to the services available, which the practitioners partly attributed to the Australian services being a significant improvement on the patient’s health care experience prior to arrival here.

Some stakeholders commented that migrants can be unfamiliar with some of the characteristics of health care in Australia, such as illness prevention programs, because they had no experience of similar services in their home country. Breast and cervical preventative screening were mentioned as examples of this. This could be indicative of a broader ignorance of the primary health care services, particularly those targeted at women and families in Rockhampton, leading to passive barriers to access. Further engagement with female migrants and mothers to examine their awareness of the services available to them could be a strategic opportunity for the RRHRG.

Migrant stakeholders and a settlement services worker suggested that new arrivals would find it easier to use the health system if they had a single point of access to information about the full portfolio of health services available in Rockhampton. This central information point may include a nominated person to assist migrants to navigate the health system and to meet follow-up appointments. The justification for this was that many migrants do not understand the necessity of attending the full course of treatment for a condition. Some also come from cultures with a more casual attitude to punctuality than would be considered the norm in Australia, and do not understand that other appointments will replace theirs if they do not present on time. It was suggested that health service providers could agree to a protocol allowing the client-directed release of appointment information to a nominated coordinator who would ensure that the client continued to attend follow up appointments for treatment.

Eligibility for services

The eligibility of migrants to access a particular health service is determined by their visa type, and any means test that may apply to the service. Most permanent residents are eligible to access the Medicare Benefit Scheme (MBS), which covers the cost of approved health services delivered by registered providers including general practitioners and some allied health professionals. If they are registered with Centrelink and have been issued with a health care card, permanent residents of Queensland, and their children under 4, are eligible to access the Queensland Health Oral Health Service. All children who are permanent residents of Queensland are able to access the School Dental Service from age 4 to year 10.

We were advised by stakeholders that income of many migrants with permanent residency makes them ineligible to access means tested services such as public oral health. If they are males who are working to send money overseas to facilitate the migration of their family, they cannot afford to access private dental and other services not covered by the Medicare rebate.

Temporary visa holders, such as subclass 457 approved after September 2009, are required to arrange private health cover prior to arrival in Australia. Prior to 2009 the sponsoring employer was required to provide evidence of appropriate health cover for the employee. Should a temporary visa holder present at a Queensland health service, they will be invoiced for the cost of the treatment.

Some stakeholders indicated that many migrants were unsure of their eligibility for particular health services. This may be due to a lack of information regarding their entitlements or a lack of
appreciation of the scope of the Australian health system. One settlement services agency representative mentioned that his agency provides health system information to all clients on arrival in Australia. Given that some time can elapse between receipt of the information and the emergence of a need for health services it may be mislaid, or difficult to recall, when an individual needs to use it. The individual may choose to endure a health condition, thinking that they cannot afford to access an appropriate service.

Cultural issues/awareness

The cultural background and the life experience of migrants can have an impact on their ability to access to health services and their interaction with health providers. Some examples of relevant issues mentioned by stakeholders include:

- Gender roles – difficulties may arise for women if a female doctor is not available, or for men in situations where their traditional role as a decision maker for the family may be threatened,
- People may have not had regular contact with health providers in their country of origin, or their previous experience with emergency services and the health profession may have been traumatic,
- Stigma attached to certain diseases in particular societies, such as TB and HIV or mental illness, may discourage people from presenting for testing or treatment,
- Cultural traditions may conflict with western treatment methods for certain conditions
- Religious practices may prohibit certain procedures or medications,
- Some societies do not have a descriptive word or phrase for certain conditions, such as depression, which can make it difficult to communicate symptoms accurately.

The small selection of migrants interviewed during the stakeholder consultation advised that they had experienced limited contact with the health system in Rockhampton beyond their general practitioner. Most had been in Rockhampton for only a short period.

Information obtained from stakeholders within the health sector indicated that whilst, some services are being well utilised by migrants, others have had limited or no contact. Whether this is due to some of the issues noted above, or a lack of information, is impossible to conclude within the limited reach of this project. The information gathered to date does, however, indicate that more migrants and refugees, particularly families, will be arriving in Rockhampton in the future. It is likely that this expanded population will need to access the full range of health services over their lives.

Whilst a health professional cannot be expected to be familiar with all of the cultures of presenting patients, there are resources available to improve cultural awareness and to assist with information gathering techniques which can yield information in a sensitive manner. The sharing of useful information and experiences between professionals and provider organisations can also assist engagement with clients and individual cultural communities.
Other issues

The stakeholders interviewed in the consultation process identified some additional issues which impact on health and access to health services for refugees and migrants.

- Access to affordable housing
- Access to transport
- Hours of work

Refugee stakeholders, all of whom are currently housed, told of their initial difficulty in obtaining rental housing on arrival in Rockhampton. Most rental agencies require references from previous tenancy contracts, which refugees are usually not able to produce. For other migrants, any references would need to be sourced overseas. Stakeholders also reported problems with the cost of housing in Rockhampton, which is also an issue for others in the community. Many of the unaccompanied male refugees are sharing accommodation with several others.

Access to reliable transport is an issue for refugees in particular, who have arrived in Australia with minimal resources. One stakeholder advised that accommodation for many of the refugees working at local meatworks has been arranged conveniently to the worksite by their recruitment agency. This location is, however, a significant distance from general practices and shopping facilities. It lacks regular public transport, particularly on the weekends, making it difficult to attend appointments.

Many of the recent refugee arrivals work at one of the 2 meatworks in Rockhampton, on shifts. These shifts make it difficult to arrange appointments for health services without taking time off work. Many of the employees are also casual workers, and do not have access to the same sick leave entitlements as permanent employees.
7. Summary

The investigations completed for this report confirm the existence of a significant population of newly arrived refugees, migrants, and work visa holders. Many of the recent arrivals with permanent residency status have been unaccompanied males, and DIAC expects that up to 30% of these will bring their families to Rockhampton at a later date. The countries of origin represented by most of the new arrivals include Afghanistan, Sri Lanka, Korea, Sudan, Taiwan and Vietnam.

From a health perspective, the new arrivals may present a number of issues for Rockhampton’s providers, including:

- Particular physical and mental health issues originating from living conditions or conflict in their country of origin or transit,
- Incomplete medical records
- Language and communication issues, and
- Cultural issues which may impact on access to health services.

Our investigations indicate that Rockhampton has a portfolio of physical and mental health services which can meet the health needs of the current and expected refugee and newly arrived migrant population, with the support of the Brisbane-based specialist organisations targeted at refugee health (RHQ, QPASST, and QTMHC). There are, however, issues which may be limiting the access of migrants to the health services they need.

As a multi-disciplinary network, RRHRG has an important role to play in addressing access issues within the Rockhampton health sector, and in advocating for the migrant population with regard to health determinant issues which may fall outside it. Success in meeting this challenge will, however, require cooperation across the health sector, and engagement with the migrant community.

In the next stage of this project RRHRG may wish to consider strategies to address the following questions:

1. How can information systems be improved to gain timely information about new arrivals in Rockhampton, and ensure that they are linked with the health services they need?

2. What strategies can be developed to increase the use of accredited interpreters in health consultations, and improve the ability of practitioners and clients to share information through them?

3. How can information on the portfolio of health services available in Rockhampton, and the eligibility requirements for access to them, be made available to migrants on arrival here in a form that they can understand?

4. What strategies can be implemented to assist practitioners to gain a better understanding of the cultures and practices of new migrants to Rockhampton, in order to better meet their needs in a health setting?

5. What can RRHRG do to support the development of solutions to other issues which may impact on health or access to services?
The next stage in this project is to develop a strategic plan to enable RRHRG to address the issues raised in this report, and to set up structures to implement the plan over the coming months and years. Given the breadth of experience and organisations represented within RRHRG, and the commitment of the members, the issues can be resolved with positive benefits for the migrant community and for the broader Rockhampton community.

Justin Power
5th June 2011
### Appendix 1 – List of stakeholders contacted

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>James Smith</td>
<td>Public Health Physician</td>
<td>Queensland Health</td>
<td>27/04/2011</td>
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<tr>
<td>Dianne Krenske</td>
<td>Immunisation Coordinator</td>
<td>Queensland Health</td>
<td>27/04/2011</td>
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<tr>
<td>Camille Royal</td>
<td>CALD program officer</td>
<td>Carers Queensland</td>
<td>28/04/2011</td>
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<tr>
<td>Paul Bilal</td>
<td>Senior Nutritionist, Central Regional Services, Division of Chief Health Officer</td>
<td>Queensland Health</td>
<td>5/05/2011</td>
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<tr>
<td>Mark Griffiths</td>
<td>Counsellor</td>
<td>QPASTT</td>
<td>6/05/2011</td>
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<tr>
<td>Rhonda Noyes</td>
<td>Manager, Community Services</td>
<td>Rockhampton Regional Council</td>
<td>6/05/2011</td>
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<tr>
<td>Julie Mc'Innes</td>
<td>Coordinator, Community Programs</td>
<td>Rockhampton Regional Council</td>
<td>6/05/2011</td>
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<tr>
<td>Cameron Venables</td>
<td>President</td>
<td>Sanctuary Central Qld</td>
<td>9/05/2011</td>
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<tr>
<td>Shelly Craig</td>
<td>Integrated care Coordinator</td>
<td>Capricornia Division of General Practice</td>
<td>9/05/2011</td>
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<tr>
<td>Amunal Faraizi</td>
<td>Senior Lecturer, School of Health &amp; Human Services</td>
<td>CQ University</td>
<td>9/05/2011</td>
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<tr>
<td>Harry Platts</td>
<td>Counsellor</td>
<td>Ozcare</td>
<td>10/05/2011</td>
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<tr>
<td>Roslyn Blackman</td>
<td>Mental Health Programs Coordinator</td>
<td>Ozcare</td>
<td>10/05/2011</td>
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<td>Ataus Samad</td>
<td>SGP Officer</td>
<td>ACCES Services Inc</td>
<td>10/05/2011</td>
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<tr>
<td>Greg Turner</td>
<td>Statewide Liaison &amp; Policy Coordinator, Transcultural Mental Health</td>
<td>Queensland Health</td>
<td>11/05/2011</td>
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<tr>
<td>Margaret O'Mara</td>
<td>A/Manager, Oral Health Services</td>
<td>Queensland Health</td>
<td>12/05/2011</td>
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<tr>
<td>Leanne Adams</td>
<td>Oral Health Services</td>
<td>Queensland Health</td>
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<tr>
<td>Paul Tyler</td>
<td>Senior Social Worker, Rockhampton Mental Health Service</td>
<td>Queensland Health</td>
<td>13/05/2011</td>
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<tr>
<td>Rev William Michael</td>
<td>Pastor</td>
<td>Sudanese Dinka community</td>
<td>15/05/2011</td>
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<tr>
<td>Ajak Atem</td>
<td>Community member</td>
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<td>William Manyok</td>
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<td>Michael Ajak</td>
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<td>Jabanesh Japakumar</td>
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<td>Masud Khan</td>
<td>President</td>
<td>Central Queensland Multicultural Association</td>
<td>16/05/2011</td>
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<tr>
<td>Dawn Hay</td>
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<tr>
<td>Rod Hutcheon</td>
<td>A/ Director, Community &amp; Oral Health Services Central Queensland</td>
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<tr>
<td>Diane Jones</td>
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<tr>
<td>Dr Mahmood</td>
<td>General practitioner</td>
<td>North Rockhampton Medical Centre, Vallis St North Rockhampton</td>
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<tr>
<td>Dr Bontula Bhavada</td>
<td>General practitioner</td>
<td>North Rockhampton Medical Centre, Vallis St North Rockhampton</td>
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<tr>
<td>Mr Rudy Vander Hoeven</td>
<td>Psychologist</td>
<td>Cognition Psychology, 55 Painswick St Beserker</td>
<td>19/05/2011</td>
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<tr>
<td>Ewaz Hussain</td>
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<td>Jamila Trad-Padhee</td>
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<td>Tracy McKenna</td>
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<td>Kellie Hill</td>
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<td>Meredith Lovegrove</td>
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<td>Michael John</td>
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<td>Maria Rickertt</td>
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<tr>
<td>Shari Jackson</td>
<td>Team Leader, FRS Counselling &amp; Education Services</td>
<td>Centacare, Catholic Diocese of Rockhampton</td>
<td>27/05/2011</td>
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<tr>
<td>Vivian Rybarczyk</td>
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<td>Gail Parkes</td>
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<tr>
<td>Amanda McMaster</td>
<td>Director of Nursing, Mater Hospitals</td>
<td>Mercy health &amp; Aged Care Central Queensland</td>
<td>27/05/2011</td>
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<tr>
<td>Caroline Ruiz-Archila</td>
<td>A/g Settlement Planning Coordinator</td>
<td>Department of Immigration and Citizenship</td>
<td>30/05/2011</td>
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<tr>
<td>Julie Garrett</td>
<td>QLD Industry &amp; Outreach Officer</td>
<td>Department of Immigration and Citizenship</td>
<td>30/05/2011</td>
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</table>
Appendix 2 – Bibliography


