Barriers to access to health care for newly resettled sub-Saharan refugees in Australia

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ABSTRACT

Objective: To determine barriers that affect access to health care for refugees from sub-Saharan Africa resettled in Sydney.

Design: Descriptive epidemiological study and survey.

Participants and setting: Parents of newly resettled refugee children seen at a tertiary hospital paediatric clinic between 10 June 2005 and 19 May 2006.

Main outcome measures: Socioeconomic indicators, health seeking behaviour, social barriers, and beliefs about health.

Results: Parents of 34 of a possible 35 families (97%) agreed to participate. Barriers to accessing health care include language barriers, financial handicap, lack of health information, not knowing where to seek help, and poor understanding of how to access health services. Most refugee families established connections with community and religious groups soon after arrival in Australia.

Conclusions: Our findings suggest that most refugee families are not totally isolated in Australia, but form early connections with cultural, social and religious groups of their own ethnic background. These groups provide an opportunity to deliver health education and health information that would improve their access to health services.

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In November 2005, a newly arrived 2-year-old refugee child from Burundi died in an apartment in Sydney of a treatable disease.[1] He entered the country with medical records outlining his medical condition, but when he became ill within days of arrival, his parents did not know how to access medical care or contact emergency services.[1] Another refugee from Sudan, an amputee without legs, was housed in a first-floor apartment, where he had to crawl up the stairs and rely on passers-by to carry his wheelchair.[2] The *Sydney Morning Herald* reported that "he said he made many requests for medical help which resulted in him being referred to a GP, who gave him some tablets. What he really wanted was prosthetic legs and he could not . . . find out how to contact the right health services".[2]

Refugees endure conditions of social disconnection, displacement, isolation, famine, war and overcrowding, and are regarded as being among the most poor and marginalised members of the Australian community.[3] They suffer a high rate of social, physical, emotional and mental health problems, many of which are treatable or preventable. Current migration policy for carrying out health checks on humanitarian entrants before they arrive in Australia requires refugees aged over 15 years to have HIV screening and those aged over 11 years to have a chest x-ray.[4] These requirements may not ensure that social and mental health problems are identified, and if new refugees have difficulties accessing health care, their health problems may worsen with time.[5] Social isolation and disconnection have been shown to contribute to premature death among members of isolated communities.[6]

A study on use of medical services has found that such services are less used by people with lower socioeconomic status.[7,8] However, there are few specific data on the diverse refugee communities in Australia,[3] and refugee health remains a low government priority in this country.[9]

A new clinic for refugee children was established at The Children's Hospital at Westmead, Sydney, in May 2005. Its purpose was to provide screening and treatment for a range of infections, to update vaccinations and to address basic refugee health issues in refugee children.

In this study, we aimed to identify important sociocultural and knowledge issues that may affect access to health care.

METHODS

All families from sub-Saharan Africa who presented to the clinic from 10 June 2005 until 19 May 2006 were approached for the study. Sub-Saharan African families who had lived in Australia for less than 5 years were eligible for the study. Parents were given an information sheet in their relevant language, and written consent was obtained. The clinic was operational for a maximum of 3 hours a week for the period of the study. Stakeholders, including participants, were consulted to help inform the development of the questionnaire we used.

The resulting structured questionnaire was administered by means of face-to-face interviews with consenting parents (one parent per family) visiting the clinic. Parents were asked about their beliefs, knowledge, access to care, and experience with the Australian health care system.

Most questions required yes/no responses, but also allowed a small number of open-ended responses.

The study was approved by the Human Research Ethics Committee at The Children's Hospital at Westmead, Sydney.

Statistical analysis

Descriptive data were analysed with SPSS (SPSS Inc, Chicago, Ill, USA) and Epi Info 6 (Centers for Disease Control, Atlanta, Ga, USA) statistical packages.

RESULTS

Between 10 June 2005 and 19 May 2006, we saw and interviewed 34 of 35 eligible sub-Saharan African refugee families (97% response rate; one parent refused to participate). Their most common countries of origin were Sudan, Burundi, Liberia, Sierra Leone, Ethiopia and Guinea. There were 12 non-African families seen during the same time who were not included in the study, from Afghanistan, Iraq and Nepal. A total of 97 African children were seen during the study period. Box 1 shows the demographic characteristics of participants.

Box 2 shows selected socioeconomic features that may contribute to barriers to health care. All families reported having a Medicare card as well as a Health Care card. Few owned a house or a car, and smoking was uncommon. Two families did not have a telephone at home. Only two parents were currently employed. Despite indicating an average literacy level, most parents did not have functional English language skills and

1 Demographic characteristics of 34 participating sub-Saharan refugee families attending the children's refugee clinic between 10 June 2005 and 19 May 2006

Demographic characteristic	Number of families
Marital status of parents	
Married	27
Widowed	5
Divorced or separated	2
Number of children	97
Mean number of children per family (range)	3 (1–7)
Mean years lived in a refugee camp (range)	7 (1–26)
Sex of parent interviewed	
Female	15
Male	19

2 Socioeconomic indicators of 34 refugee families attending the children's refugee clinic between 10 June 2005 and 19 May 2006

Socioeconomic indicator	Number of families
Have a Health Care card	34
Have a Medicare card	34
Have a home telephone	32
Membership of specific social group (eg, mosque/church, sports group, cultural group)	29
Attend social functions of ethnic community (including congregational prayers)	27
Literate (in own language)	26
Literate (in English)	25
Access to radio at home	28
Aware of ethnic radio station	19
Listen to radio station in ethnic language	1
Completed high school	13
Never formally educated	9
University graduate	2
Currently employed	2
Own a house	1
Own a car	5
Smoker in household	2

used a health care interpreter during the visit to the clinic and at our interview.

Box 3 shows health care use and access by these families. The main sources of health information were health care professionals and educational institutions. General practitioners were the most used health care service. Several families reported difficulties with access to care.

Box 4 describes select attitudes to vaccination and infections. Many parents had misconceptions about tuberculosis (TB), and did not realise that measles was a serious disease.

Respondents were asked unstructured questions about some of their past experiences with the health care systems in their countries of origin that may affect their attitudes to health care providers generally (see Box 5). Despite their need for health services, many had problems attending clinic appointments. Often, this related to resettlement issues including other coinciding appointments such as housing, social security or language schools interviews, or even the cost of travel to the clinic. Some who were interviewed indicated cultural "bereavement", hopelessness and "homesickness". We also found that many children with potentially serious illness detected on screening appeared otherwise well, and their diseases would not have been detected on appearance or clinical suspicion alone.

3 Factors identified in interviews with parents from 34 refugee families that may inhibit access to health care by recently arrived refugees

Health care use and access	Number of families
Satisfied with Australian health care facilities	32
Prefer Western medical practitioners	27
On average, have been to general practitioner at least once a month	23
Used interpreter at clinic	22
Never or rarely had access to all information needed to make decisions about health care for their children in Australia	20
Had restricted access to health care facilities in country of origin	19
Do not have the money to pay for health services in Australia	18
Do not know where to go to seek health care in Australia	15
Did not get help when someone in the family was ill (in Australia)	13
Have ever used a traditional health care facility	13
Have never or have rarely been able to access or use health care facilities in Australia when needed	7
Are afraid of seeking help from an Australian doctor	4
Prefer a medical practitioner of a specific sex	4
Have had a bad experience with Australia's health care system once	2

DISCUSSION

Despite high levels of satisfaction with Australia's health care facilities, several of the families we interviewed had difficulties in accessing health care, including at times when a family member was sick. These families were disadvantaged by language barriers, low levels of education and literacy, lack of transport, and poor understanding of the risk of illness (as shown by misconceptions about measles and TB), all of which may have contributed to problems with access. Although many refugees had been to a GP at least once, we observed (unpublished data) that serious disease was not detected until they attended the clinic. Further, our study showed that many had had negative experiences of health care overseas, a factor which may also affect access to care in Australia. It has been previously reported that refugees may anticipate negative social

4 Select attitudes and beliefs of parents of 34 families attending the children's refugee clinic about vaccination and infections

Attitude/belief	Number of families
I prefer my child to be vaccinated rather than develop natural immunity by exposure to disease	21
Measles is a serious disease	15
Tuberculosis (TB) is a serious disease	34
TB is a poor man's illness	19
People die of TB	28
TB is curable by taking pills regularly	28
Germs can cause TB	16
Sins can cause TB	9
I would be ashamed if someone in the family had TB	8

consequences as a result of having infectious diseases (such as fear of job loss, loss of rights as an immigrant, negative reactions from family), and this may cause some to become secretive about suspected illness.[10,11] Clearly, the importance of education and health promotion cannot be underestimated.

We found that refugees spent an average of 7 years (range, 1–26 years) in refugee camps. This means that many would have spent crucial years of their childhood or young adulthood in camps, thus missing out on opportunities for education, resulting in low literacy and reduced potential to contribute to society. Researchers at the Australian Bureau of Statistics have suggested that parents' participation in school affairs contributes to their children's education.[12] Children of refugee parents who are illiterate may therefore be further handicapped.

Unemployment and poverty may affect health access for refugees. Studies show that people with little or no income have poor housing, poor nutrition, depression, poor hygiene and poor access to services.[13] Improvement in mental health is seen following re-employment,[14] and research confirms that gains in income translate to gains in health status for low wage earners.[13,15,16]

Our study had some limitations. Although the participating families represented almost complete capture of the clinic population, the number of families in the study was small and all were African. The results may therefore not be generalisable to refugees from other regions. As our questionnaire focused on participants' connection with their own ethnic communities rather than mainstream communities, further research is needed to explore issues of social isolation encountered by those resettled away from their ethnic groups. While our study touched on issues of transport difficulties, it did not explore whether participants knew how to use public transport to reach health care facilities. Research is also required to ascertain whether using public transport affects health care accessibility. Further research is also required to explore the social capital of areas where newly arrived refugees are being resettled. Such social capital includes specialist services within areas of reach, access to public transport and to health education, and English language education programs.

Various nations have faced the challenges of providing responsive and well planned health care to refugees with unique backgrounds and diverse health needs.[17] We have identified lack of language skills, poor access to health information, misconceptions about infectious diseases, lack of transport, and unemployment as potential barriers to health care use. It is important that refugee support agencies give priority to addressing literacy and transport issues.

Our data suggest that most refugee families are not isolated and do form early connections with cultural, social and religious groups in the community. These groups provide an important opportunity to deliver health information and promotion messages. We also identified that most refugee families have access to radio, but that many are not aware of radio broadcasts in their native languages. Raising awareness of the availability of ethnic radio to these groups, and using radio as a medium to reach them may also facilitate communication. Finally, most of the families in our study had already seen a GP, making general practice the most important first point of contact with the health care system. The role of GPs in understanding the specific health and social issues of refugees is crucial.

5 Refugees' experience with health care services overseas

Comments from respondents about health care received overseas:

- Corruption and bribery . . . no money, no treatment
- Denied medical support by government
- Not enough medical facilities
- They don't care about people
- They don't give proper treatment
- Health care was costly and only minor help was given
- Health care workers asked for sexual favours from patients ◆

COMPETING INTERESTS

None identified.

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