

Paediatric Refugee and Asylum Seeker Health

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November 2022

Acknowledgements to the Entire Immigrant Health and Paediatric Surgical Departments

Outline

- Introduction to Refugee Health
 - Who are our Refugee and Asylum Seeker Patients?
- Paediatric Surgical Issues
- Health Screening for Refugee and Asylum Seeker Patients
 - What is the health screening process for refugees and asylum seekers?
 - Catch up Vaccinations
 - Developmental Screening
- Services and Referral Pathways

Who are our Refugee and Asylum Seeker
Patients?

Definitions

Refugee

- Someone who 'owing to a **well founded fear of being persecuted** for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is **outside the country of his nationality**, and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country, or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is **unable** or, owing to such fear, is unwilling **to return** to it'

UNHCR 1951 'Convention Relating to the Status of Refugees' and 1967 'Protocol relating to the status of refugees'

Asylum seeker

- A person who has left their country of origin, **applied for recognition as a refugee in another country, and is awaiting a decision on their application**. They are not given the rights, protection, assistance associated with UNHCR refugee status

Not every asylum seeker is found to be a refugee

But all refugees were initially asylum seekers

Refugee Data Finder

[Key Indicators](#) [Data Finder](#) [Methodology](#) [Data Insights](#)

89.3 MILLION

Forcibly displaced people worldwide

at the end of 2021 as a result of persecution, conflict, violence, human rights violations or events seriously disturbing public order.



53.2 MILLION

are internally displaced people (Source: IDMC)



27.1 MILLION

are refugees



4.6 MILLION

are asylum seekers



• Last updated June 2022

36.5 million are children

An estimated 36.5 million (41%) of the 89.3 million forcibly displaced people are children below 18 years of age.

486,800 refugees returned or were resettled

Some 429,300 refugees returned to their countries of origin during 2021 while 57,500 were resettled (with or without UNHCR's assistance).

4.3 million stateless people

Data on some 4.3 million stateless people residing in 96 countries was reported at end-2021. The true global figure is estimated to be significantly higher.

1.5 million children were born as refugees

Between 2018 and 2021, an average of between 350,000 and 400,000 children were born into a refugee life per year.

83% hosted in low- and middle-income countries

Low- and middle-income countries host 83 per cent of the world's refugees and Venezuelans displaced abroad. The Least Developed Countries provide asylum to 27 per cent of the total.

72% hosted in neighbouring countries

72 per cent of refugees and Venezuelans displaced abroad lived in countries neighbouring their countries of origin.

Refugee applicant

Offshore program



Humanitarian entrant



Onshore arrivals



Asylum seeker



Air arrivals*

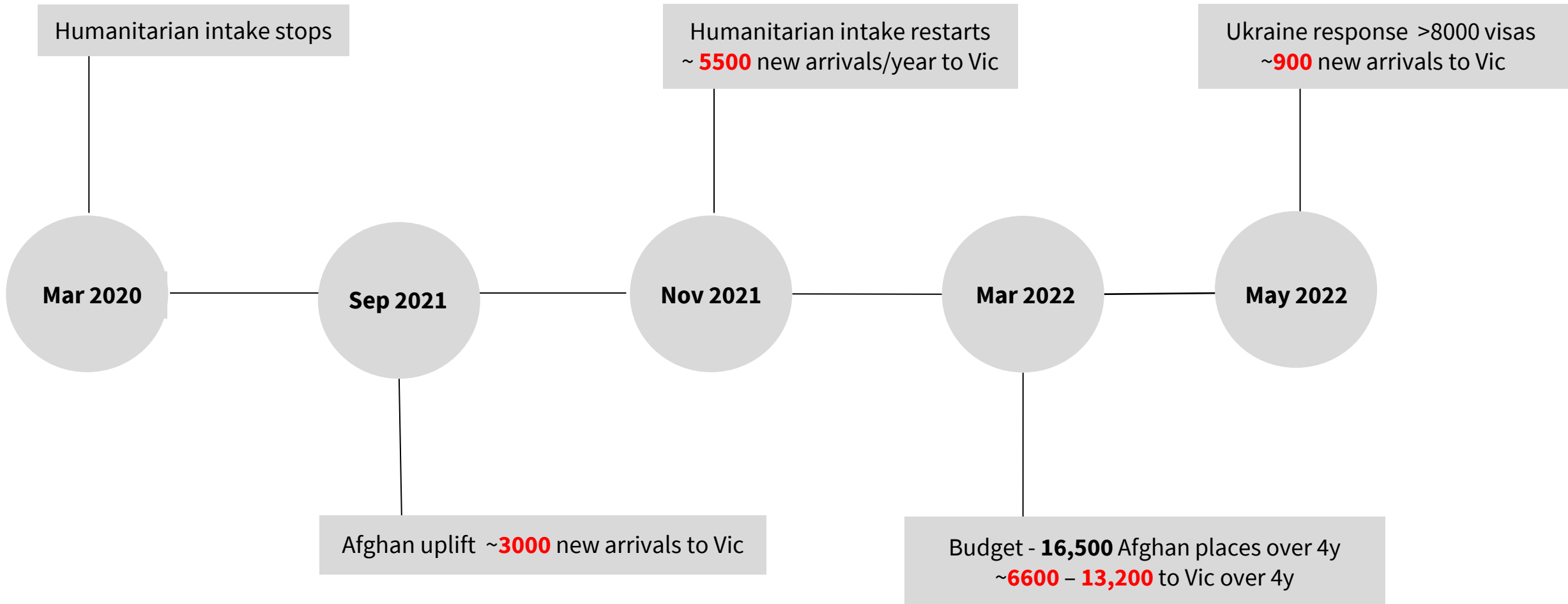


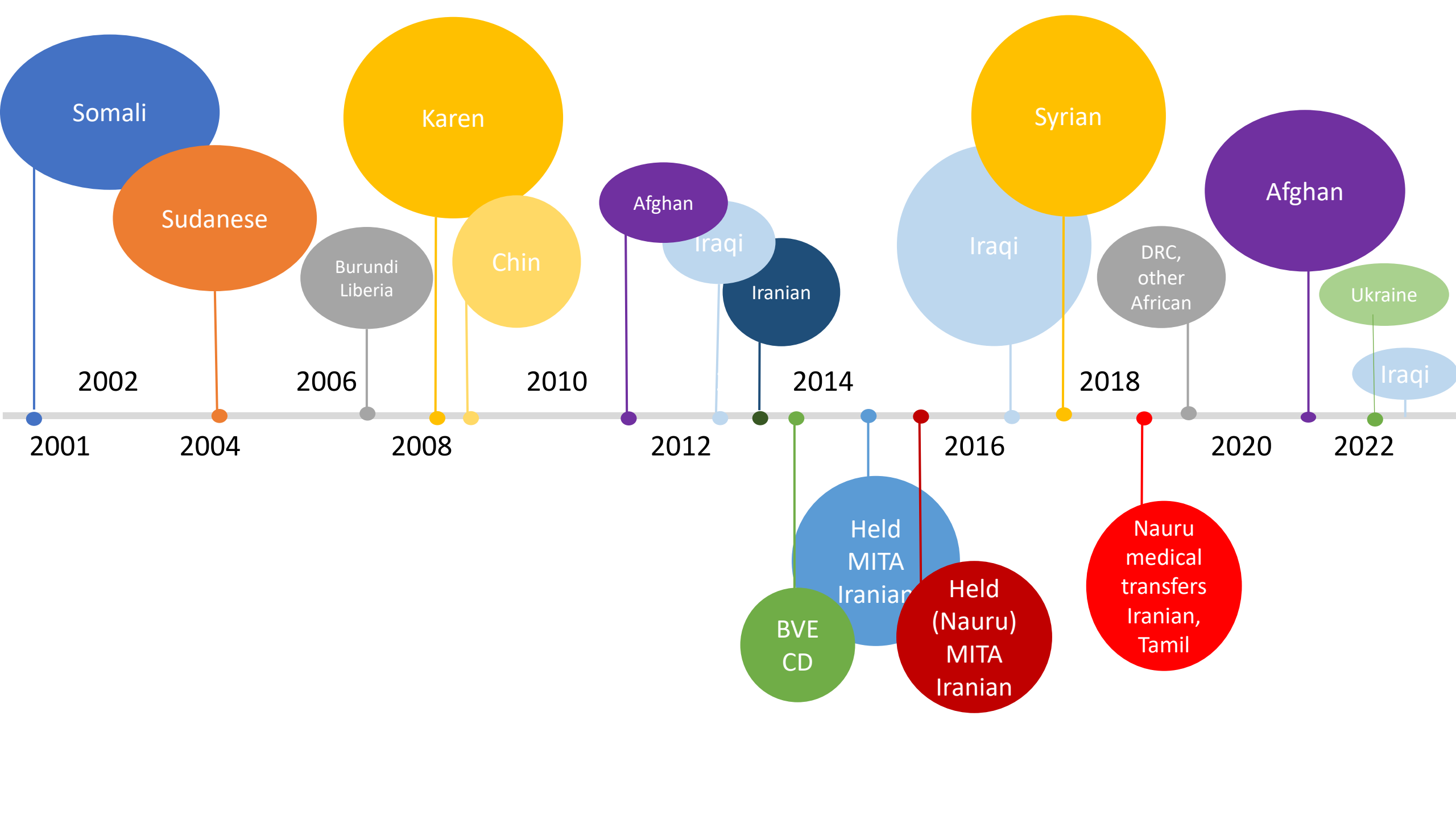
Unauthorised/ Illegal Irregular Maritime Arrivals

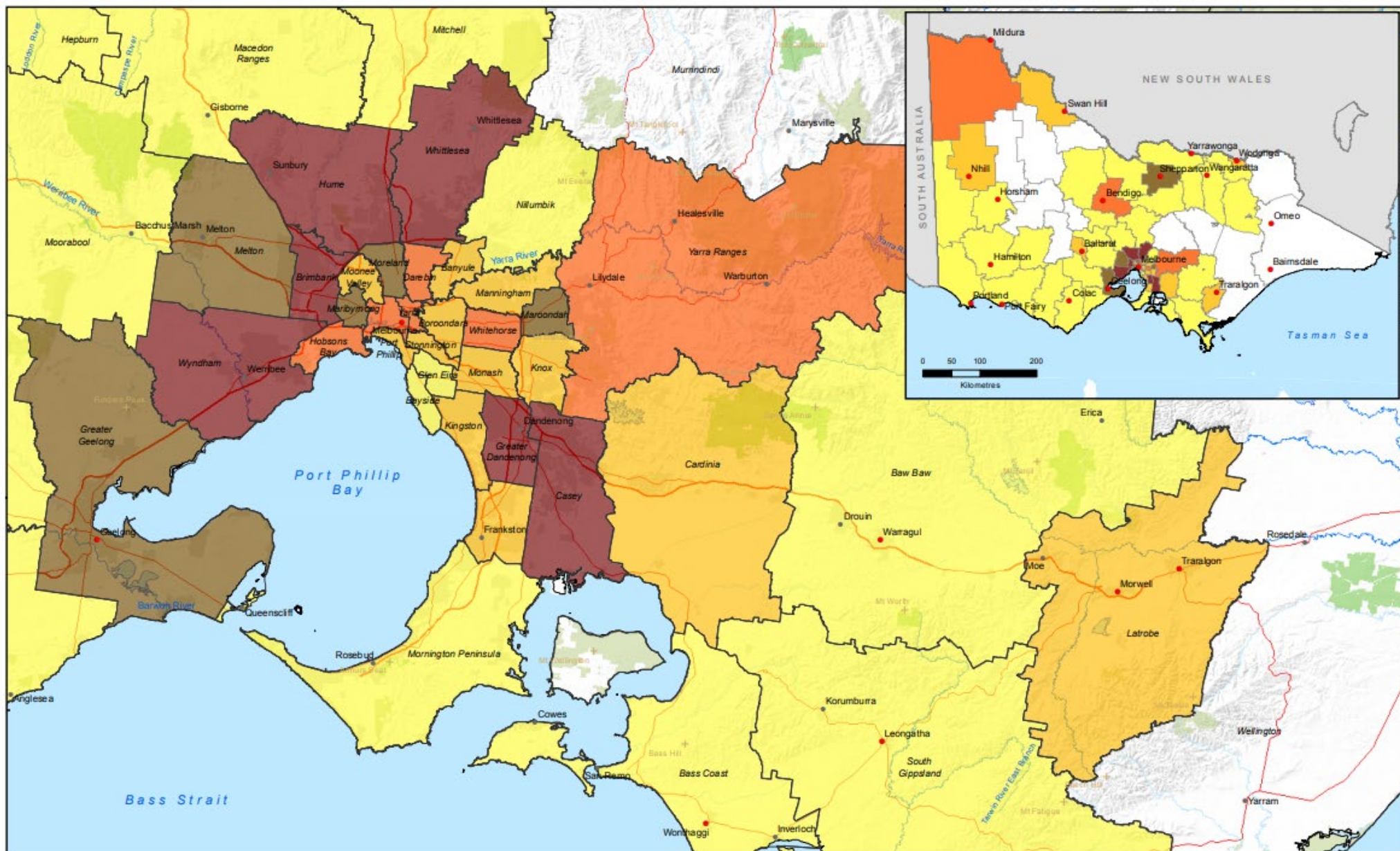
Australian Context

Annual humanitarian intake: 13,750 (↑27,000) | 40% aged <18 y on arrival | 40% settle in Victoria annually

Anticipated (min) 33,500 refugee arrivals to Victoria over the next 4 years







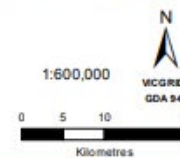
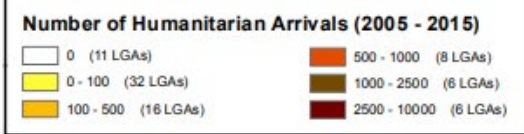
Number of Humanitarian Arrivals (2005-2015) & Asylum seekers who arrived by boat on Bridging Visa E by Local Government Area

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Produced by Department of Premier and Cabinet

September 2015



Access to health care

	Offshore	TPV	BVE	CD	Post-claim
GP	✓	Most	Most	✓	Varies
Refugee health program	Varies	✗	✗	✗	✗
Medicare	✓	✓	✓ If BVE valid	✗	Varies may be short duration
Services	All	All	All	All – funded via IHMS/DHA	State support packages 2018, 2019, 2020
Torture/trauma counselling	✓	✓	✓	✓	✗
NDIS	✓	✗	✗	✗	✗
Early intervention	✓	Non-resident	Non-resident	Non-resident	Non-resident
Medications	HCC	HCC	Medicare - PBS SRSS – HCC (?)	IHMS letter, nominated pharmacy	PBS cost

Community supports and settlement services

	Offshore	TPV	BVE	CD	Post-claim
Visa status	PR	Temporary	Bridging	No visa	No visa
Housing support	✓ To find housing	✗	✗	✓ Full + utilities	✗
Case management	✓ 6-18m	✗	✗ possible if extreme vulnerability	✓	✗
Centrelink	✓	✓	✗	✗	✗
Benefits	All Includes HCC and CA/CP	Most HCC No CA/CP/Austudy	89% Special benefit equivalent	60% Special benefit equivalent	✗
Code conduct	✗	✗	✓	✓	✗
Work Rights	✓	✓	✓ If BVE valid	✗	Varies
Kinder/school	✓	✓	✓	✓ kinder from 2015	✓
Australian tertiary access	✓	✗ International rates apply	✗ International rates apply	✗ International rates apply	✗ International rates apply

Paediatric Surgical Issues

Genito-urinary conditions/ issues

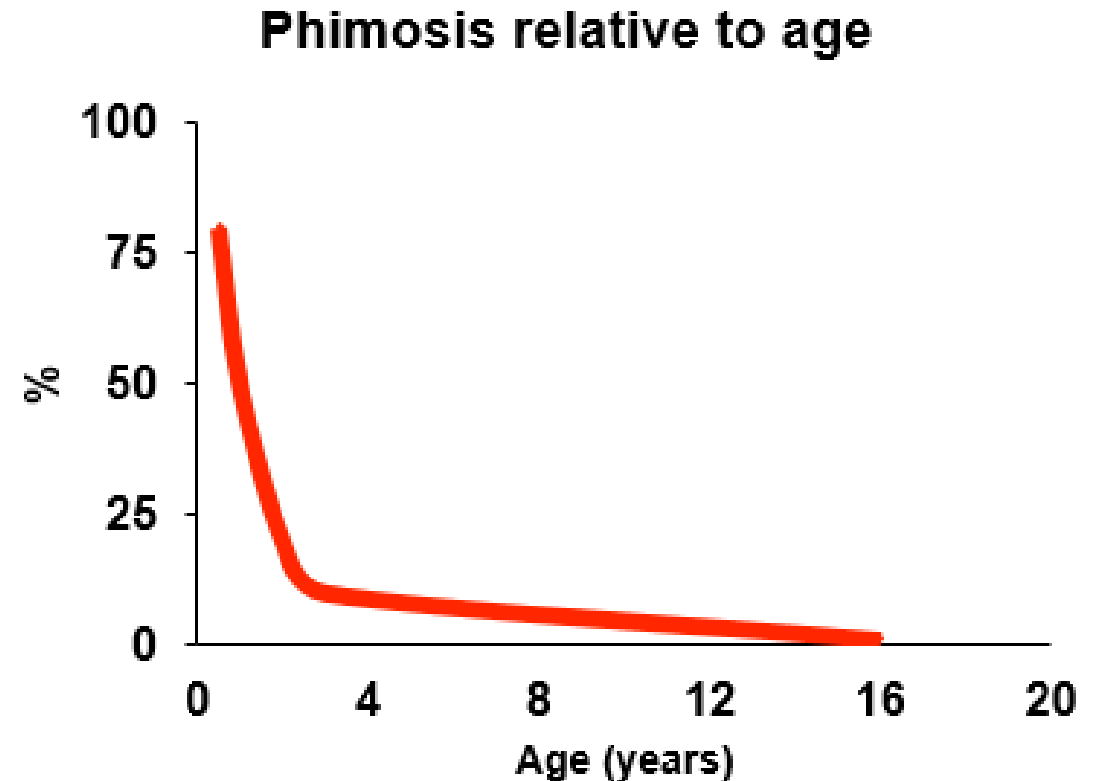
Colin Brook, Urology Fellow, RCH

Overview

- Males
 - Foreskin issues
 - Phimosis – Physiological & Pathological
 - Paraphimosis
 - Zipper injuries
 - Hair tourniquet
 - Smegma
 - Penoscrotal fusion anomalies
 - Circumcision
 - Hypospadias
 - Cryptorchidism/ Undescended testis
- Females
 - Labial adhesions
- Toilet training

Foreskin Issues

- Phimosis is when the foreskin is non-retractile
- It is a normal variant and therefore referred to as *physiological* phimosis
- At birth, the normal foreskin (prepuce) is attached to the glans and has a tight opening (preputial ring) at the distal end
- The foreskin is not retractable in most newborns
- Retractability increases with age, with full retraction possible in:
 - 10% of boys at 1 year
 - 50% of boys at 10 years
 - 99% of boys at 17 years
- Does not need any intervention







Foreskin Issues

- Pathological phimosis is when the failure to retract is because of some underlying cause, mostly scarring
- May involve:
 - Ballooning of foreskin
 - Infection of foreskin (posthitis) or glans (balanitis)
 - Urinary retention
 - Abnormal scarring (BXO – Balanitis Xerotica Obliterans)
 - Very rare <8yo
- The foreskin should never be forcibly retracted for cleaning
- Will need to be referred
- Surgical interventions may be necessary

Foreskin Issues

Posthitis, Balanitis, Balanoposthitis



Posthitis - foreskin

Balanitis - glans

Balanoposthitis - both

Cellulitis - shaft and
abdominal wall

Treatment:

Barrier Ointment

Antibiotic Ointment

Oral antibiotics

IV Antibiotics

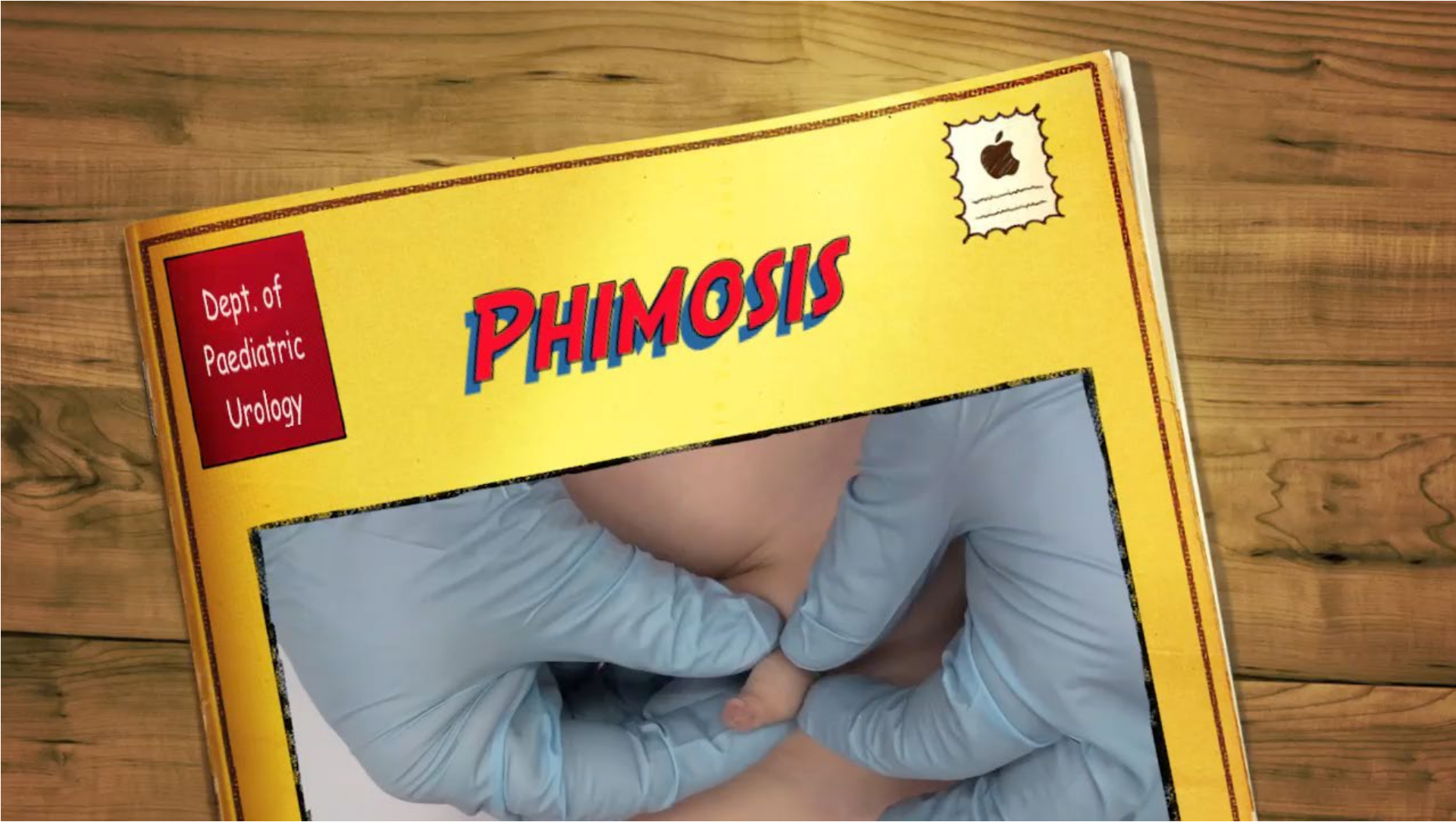
Foreskin Issues

BXO



Balanitis Xerotica Obliterans

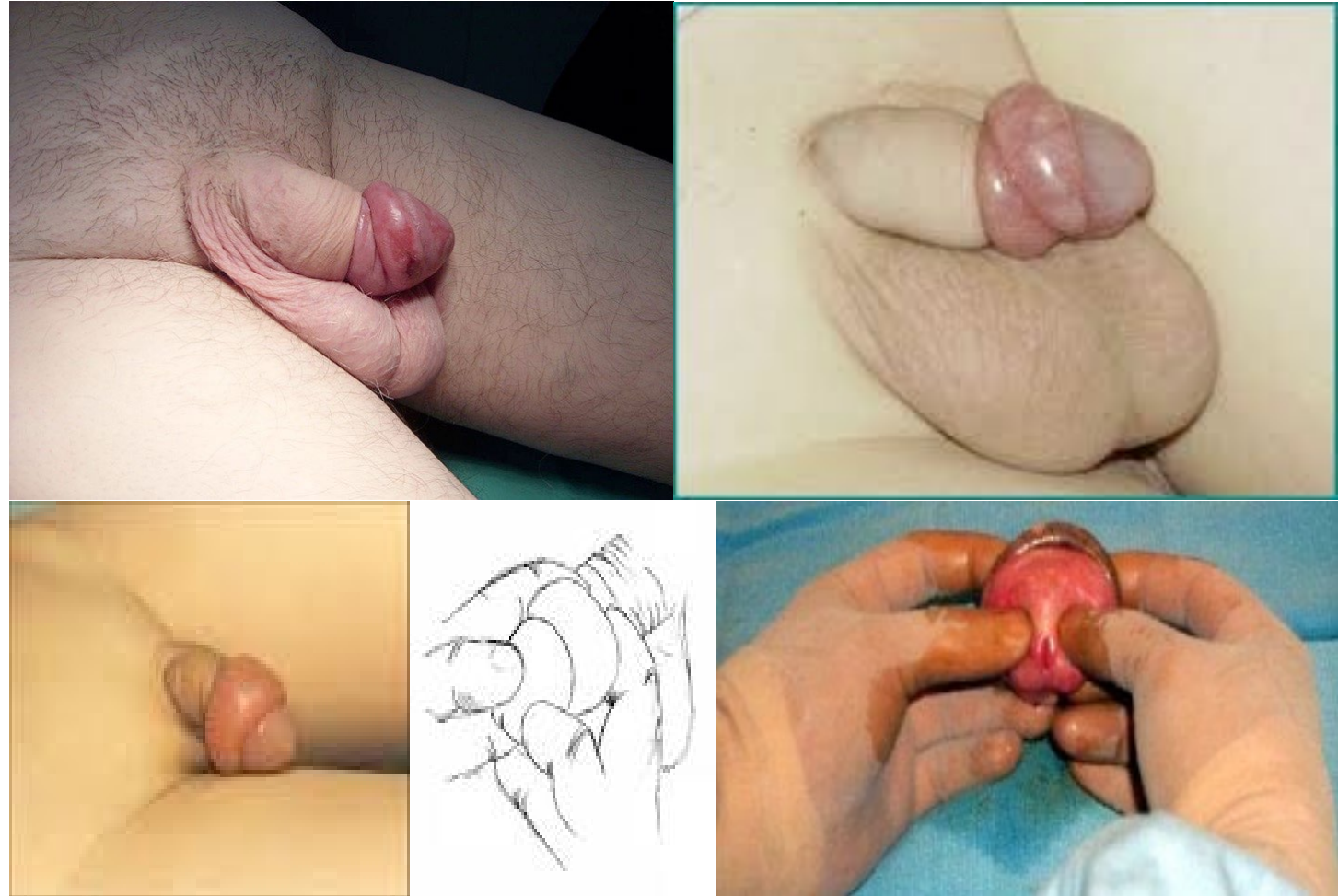
- 0.5% Betamethasone for 6- 8 weeks (very mild form) and repeat if improving
- Treatment – Circumcision +/- steroid cream
- Ongoing scarring, meatal stenosis, urethral stricture



Foreskin Issues

Paraphimosis

1. Paraphimosis occurs when the foreskin is left in the retracted position i.e. is retracted and can not be pulled back over the glans
 - a. It becomes oedematous which makes it difficult to reduce
 - b. It is a urological emergency – they will need to present to the Emergency Department



Foreskin Issues

- Zipper injuries
 - The foreskin or scrotum may become entrapped within the zipper
 - If the skin is caught between the teeth then cut the zipper above or below and pull apart
 - If it is stuck in the sliding mechanism, you must either release the median bar or use a screwdriver to break the sliding mechanism
- Hair tourniquet
 - In infants, hair or clothing fibres can wind around the penile shaft forming a tourniquet
 - Presents as redness and swelling of the distal part of the penis with a demarcation line
 - Treatment: divide fibre or hair ring and check skin for integrity. Discuss with a senior doctor if unsure

Smegma

- Smegma is a collection of desquamated epithelial cells and sebaceous matter that collects between the glans penis and the foreskin
- Before the foreskin becomes separate and retractable, it is common for smegma to collect in small yellow/white lumps which may be visible or palpable through the foreskin
- These are normal, and need no intervention
- Discharge of smegma from the foreskin opening is sometimes mistaken for pus
- Smegma often causes anxiety amongst parents because the lump may appear quite large or irregular





Penoscrotal fusion anomalies



Congenital Megaprepuce

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MEGA- PREPUCE



Circumcision

1. Circumcision is an operation to remove the foreskin and expose the glans
2. The Paediatrics and Child Health Division of the Royal Australasian College of Physicians, the Canadian Paediatric Society and the American Academy of Paediatrics do not support routine neonatal circumcision
3. In 2003, the infant circumcision rate in Australia was 13% (down from 40-50% in the 1970s)
4. As of 1 September 2007, Victorian public hospitals only provide circumcision of males for medical reasons:
 - a. Phimosis, congenital megaprepuce
 - b. Recurrent balanoposthitis/ BXO
 - c. Paraphimosis
 - d. Recurrent UTI
 - e. Hypospadias correction

Circumcision

1. Non-medical requests for circumcision include:
 - a. Religio-Cultural
 - b. Hygiene and appearance (similar to siblings/ parent)
 - c. The potential health benefits (decreased UTI, decreased risk of HIV and other STI transmission, decreased risk of penile cancer)
2. Non-medically indicated circumcisions are mostly performed by private practitioners
3. Parents need to make an informed decision after carefully looking at all the facts about the benefits and risks for their child
4. Circumcision should be done in a safe, child-friendly environment by properly trained and qualified staff who are available to manage any post-operative complications
5. The child should receive appropriate analgesia

Circumcision

- ***Contraindications:***

- Hypospadias
- Chordee
- Buried Penis
- Penoscrotal fusion
- Ambiguous genitalia
- H/o Bleeding disorder

- ***Complications*** (in controlled environments):

- Bleeding - 0.5-3%
- Post-operative infection - 0.5%
- Injury to glans/ urethra (incidence unknown)
- Removal of too much skin
- Trapped penis
- Meatal stenosis - 7%

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GROIN PATHOLOGY



Hypospadias

Ventral opening of urethra

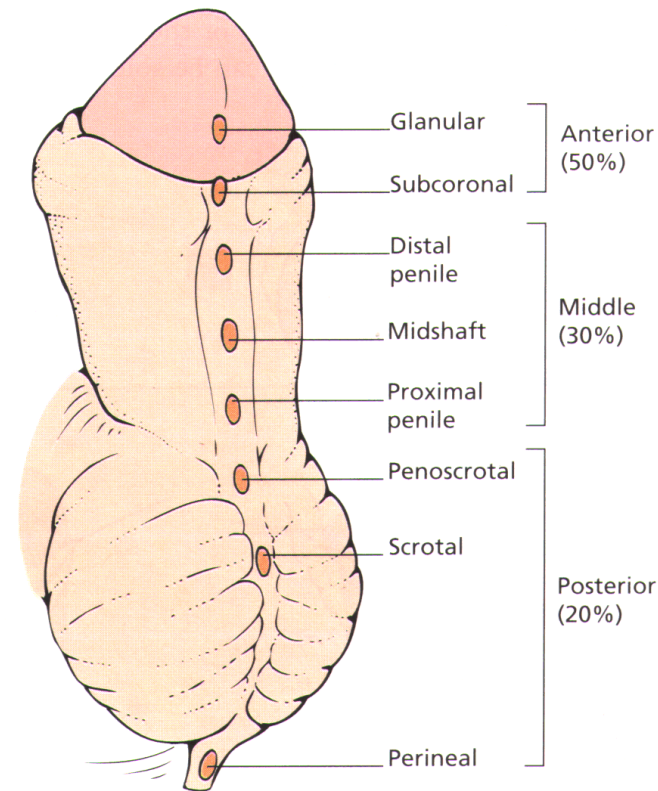
Chordee

Hooded Foreskin

Treatment:

Surgical correction

Do not advise circumcision if noted



Anterior 50%

Middle 30%

Posterior 20%

Inguinal Hernia



2% of boys

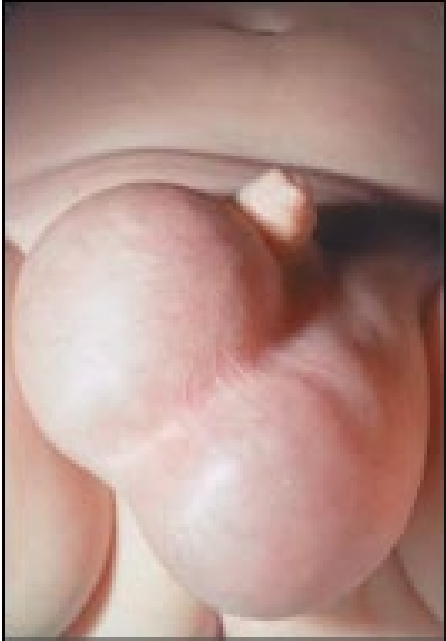
10% of Premmies

10% contralateral in neonates

60% on right side

25% left, 15% bilateral

Hydrocele



Appear within first few months of life
Disappear by age 2yo.

Surgery for persistent, recurrent,
symptomatic, large or secondary





Cryptorchidism/ UDT

	Incidence		
	Birth Weight (gms)	At Birth	At 3/12
	<2000	45.4%	7.7%
	2000-2499	13.4%	2.5%
	>2500	3.8%	1.4%
	Total	4.9%	1.55%

Arch. Dis. Child. 1992; 67: 892-9

1. Risk (Predisposing) Factors

Other Cong. Malformations

Low birth weight

Prematurity

Twins

Birth Order

Pre-eclampsia

Previous Stillbirth

Cyptorchidism/ UDT

Undescended

Abdominal, Canalicular, Emergent

Maldescended or Ectopic

Superficial Inguinal Pouch, Femoral,
Perineal, Pre-penile, Transverse

Testicular Ectopia

Retractile

Ascending

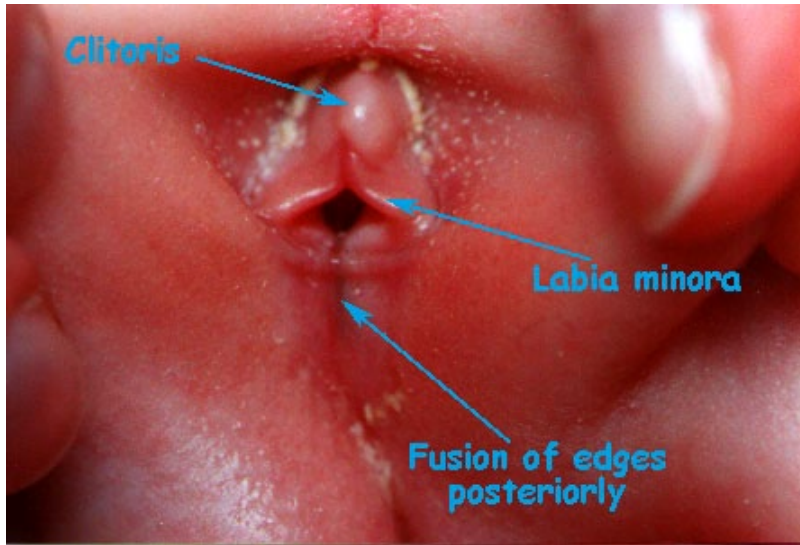
Iatrogenic

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UNDESCENDED TESTIS



Labial adhesions



1. Sometimes the medial edges of the labia minor become adherent
2. This is probably due to a combination of thin vaginal mucosa (the normal prepubescent state) and minor irritation
3. This is a normal variant and will resolve spontaneously in late childhood
4. If voiding easily, no treatment is needed other than reassurance
5. Treatment options (manual separation or oestrogen creams) can be distressing for the child and/ or followed by a high risk of recurrence
 - a. These options are not recommended
6. Refer if having issues with UTI, vulvovaginitis or incontinence/ toilet training

Toilet training

1. Urinary incontinence is defined as day wetting in a child over 5 years of age that occurs more than once per month for ≥ 3 months
2. Daytime urinary continence is usually achieved by 4 years of age
3. Day wetting occurs in around 10% of 5-6 year olds, decreasing with age
4. Night-time bladder control typically takes longer and is not expected until a child is 5–7 years old
 - a. At 4yo approx. 1 in 3 children wets the bed
 - b. By 6yo this falls to about 1 in 10

Toilet training

1. Functional causes of incontinence in children include:
 - a. *Over active bladder (OAB)*- urgency being the most important feature
 - b. Voiding postponement- habitually delayed urination, with overfilling and leakage
 - c. *Underactive bladder*- infrequent urination and overfilling leading to overflow incontinence. A large post-void residual is common
 - d. *Dysfunctional voiding* - an inability to relax the urethral sphincter and/or pelvic floor musculature during voiding, resulting in an interrupted urinary flow and prolonged voiding time

Toilet training

1. Daytime urinary incontinence in school aged children is distressing and requires timely assessment and management
2. The goal of evaluation of daytime incontinence is to distinguish neurological and anatomical causes from functional causes of bladder dysfunction
3. A thorough history of voiding symptoms and a Bladder diary are essential components to assessment, directing targeted investigation and treatment
4. The most common treatment for urinary incontinence is behaviour modification



What is the health screening process for refugees and asylum seekers?

Health screening

Refugee applicant

Offshore program



Humanitarian entrant

- 1) Immigration medical examination offshore (mandated)
- 2) Pre departure health checks (voluntary)
- 3) Post-arrival (voluntary)

Afghan Uplift
Ukrainian Arrivals

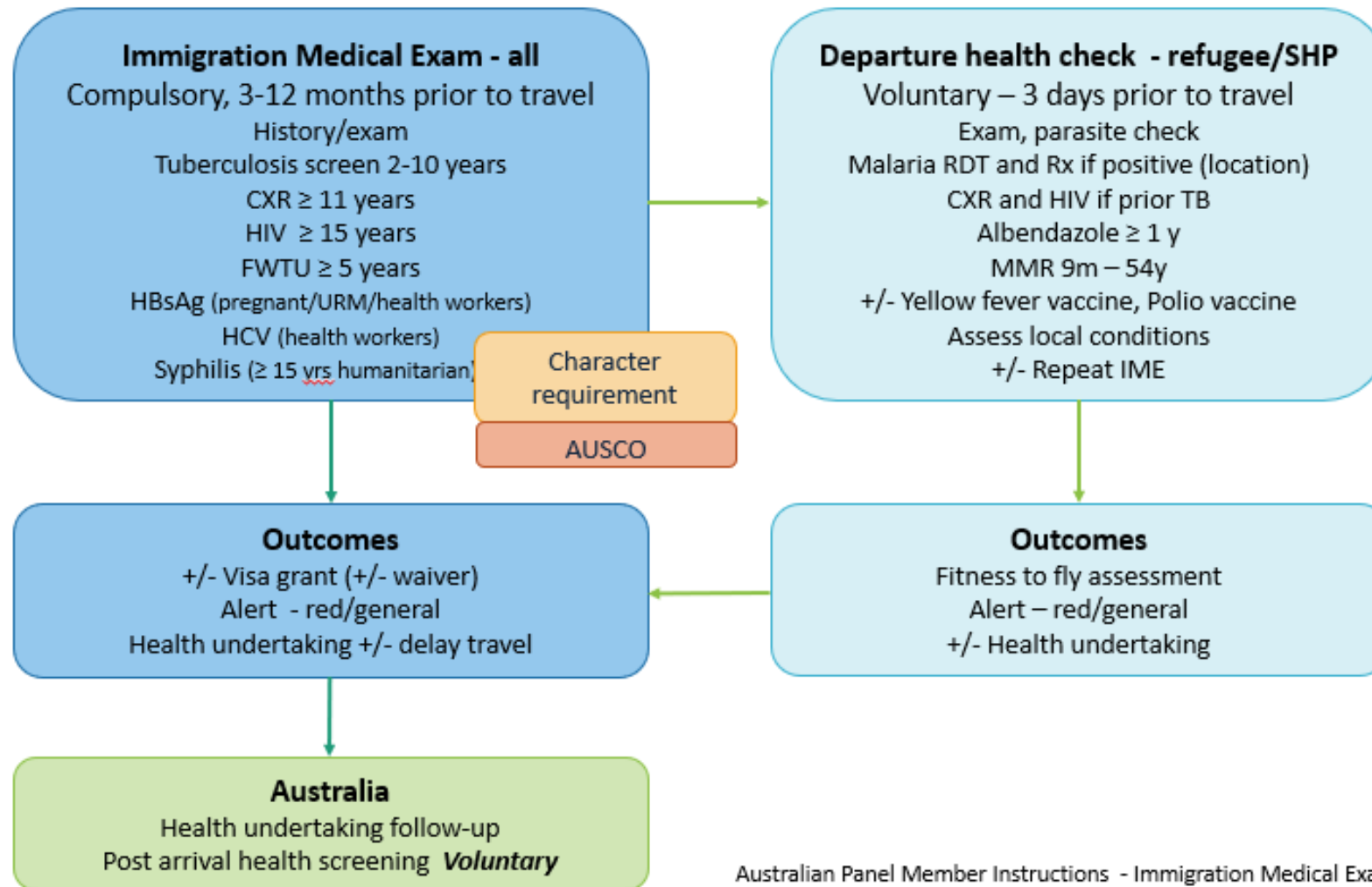
Onshore arrival



Asylum seeker

- 1) No offshore
- 2) Detention health
- 3) Post-release (voluntary)
- 4) IME at visa grant

Pre-departure health screen (offshore)



Post arrival health assessment

All	FBE	
	HBsAg, HBsAb, HBcAb. Write: 'Query chronic hepatitis B?'	
	Strongyloides serology	
	HIV serology (≥15 years or unaccompanied minor)	
	TST or IGRA (depends on risk factors and local jurisdiction, check Medicare for IGRA rebates, TST preferred for children <5 years)	
	Varicella serology (≥14 years if no known history of disease)	
	Visual acuity and review for glaucoma in Africans >40 years and others >50 years	
	Dental review	
	Hearing review	
	Social and emotional wellbeing/mental health	
	Disability	
	Developmental delay or learning concerns (children and adolescents)	
	Preventive health as per RACGP, consider screening earlier for NCDs	
	Catch-up immunisations	
Risk-based	Rubella serology (women childbearing age)	
	Ferritin (women and children, men where risk factors present)	
	Vitamin D (write risk factors e.g. dark skin, lack of sun exposure). Also check Ca, PO ₄ and ALP in children.	
	Vitamin B12 (arrival <6 months, food insecurity, vegan, from: Bhutan, Afghanistan, Iran, Horn of Africa)	
	NAAT first pass urine or self-obtained low vaginal swabs for gonorrhoea or chlamydia) (risk of STIs)	
	Syphilis serology (risk of STIs, unaccompanied minor)	
	Helicobacter pylori stool antigen or breath test (gastric cancer family history, upper GI symptoms)	
	Stool microscopy (OCP) (no pre-departure albendazole or persisting eosinophilia after albendazole treatment)	
Country-based	Schistosoma serology	
	Malaria thick and thin films and RDT	
	Hepatitis C Ab (also screen if risk factors)	

Baseline

- FBE and film
- Ferritin
- Hepatitis B - HBsAg, HBsAb, HBcAb
- Strongyloides serology
- Tuberculosis screening
- Faecal OCP

Risk-based

- Vitamin B12
- Vitamin D, Ca, PO₄, ALP
- Varicella
- Rubella
- STI screen – syphilis, gonorrhoea, chlamydia
- HIV
- Helicobacter pylori
- *(Other)*

Country-based

- Schistosoma
- Malaria
- Hepatitis C

Special note on Screening: B12 Deficiency

- Widespread B12 Deficiency in the Afghan cohort 2021-2022
- Medical emergency in infants – can cause irreversible neurological damage
- Screen all Afghan arrivals, infants, those with poor nutrition, neurological defects, disability
- If delay in screening, commence 3m oral B12 supplements (100 mcg oral daily, all ages), or give 1000 mcg intramuscular injection if possible.
- Provide appropriate dietary advice.
- In breastfeeding infants with low B12 - seek specialist advice, and ensure their mothers also have screening for B12 and treatment if deficiency identified.



Special Note on Screening: Vitamin D Deficiency

- Sunlight is the most important source of Vitamin D (90%). It is also found in some dietary sources.
- Refugee-background communities may have multiple risk factors for low vitamin D - e.g. dark skin, covering clothing and limited time outside.
- Note: Breastmilk contains almost no vitamin D.
- Breastfed babies with at least one other risk factor for low vitamin D should be given 400 IU daily for at least the first 12 months of life.
- Children/young people with ongoing risk factors for low vitamin D need to understand this is a long-term issue.



In this section

About us

COVID-19 Immigrant health

Clinical

Other

Research

Translated

Talks

Contact us

Catch-up immunisation in refugees

Covid vaccination

- See talking points for health providers and Covid vaccination resources on our [Covid-19 page](#) - updated weekly

Background

Vaccine preventable diseases are endemic and/or epidemic in countries of origin of refugee families, and disruptions to health care may affect vaccine quality and access to vaccination. Information on vaccination coverage and disease status in country of origin is available from the [World Health Organization \(WHO\)](#), including [immunisation schedules by country](#). See the [Australian Immunisation Handbook](#)¹ for specific information on [catch-up vaccination](#), [vaccine preventable diseases \(VPD\)](#), the [Australian National Immunisation Program \(NIP\) Schedule](#), and guidance on catch-up for [<10 years](#) and [10 years and older](#).

Please also see the [Victorian Immunisation Schedule](#).

Additional note: COVID-19 – Annual influenza vaccine is recommended for all people 6 months and older, and is especially important with COVID-19 - see [fact sheet](#). Flu and other vaccines should be separated from Covid vaccines by 14 days. Guidelines for managing LGA immunisation in the setting of COVID-19 are [available](#).

Table 1. Catch-up vaccination guidelines

Vaccine type	Age, Number of doses	Route and dose	Minimum dosing interval (months)	Notes
Diphtheria Tetanus Pertussis (DTP, dTp)	<4 years 4 or 5 doses DTPa	IM 0.5 ml	1,1*,6**	3 doses for primary series then **4th dose at 18 months of age or 6 months after primary course. If 4 doses of DTP given before age 18 months, give a 5th dose at 4 years, reflecting the NIP which includes dose 4 at 18 months and dose 5 at 4 years. If the 4th dose is given after the child is 3.5 years the 5th dose is not required, and in this case the next dose is the early adolescent booster dose. A hexavalent vaccine is available in all jurisdictions, (combining DTPa with IPV/Hib/HepB). *If using the hexavalent vaccine combined with hepatitis B, the dosing interval changes (2 months between doses 2 and 3 and 4 months between dose 1 and 3).
	4-9 years 4 doses DTPa	IM 0.5 ml	1,1*,6**	3 doses for primary series then **4th dose 6 months after primary course. Hexavalent vaccine as above.
	10 years and older 3 doses (dTpa)	IM 0.5 ml	1,1	Up to 3 doses of dTpa may now be used (previously dTpa, dT, dT), then 10-year and 20-year booster dTpa. dTpa is now available combined with IPV (dTpa-IPV). <i>dTpa is also recommended for pregnant women between 20-32 weeks gestation in every pregnancy (can be given any time up to delivery); partners of women who are at least 28 weeks gestation if no booster for 10 years, and parents of children <6 months if no booster for 10 years.</i>
Measles Mumps Rubella (MMR) (LAV)	<10 years 2 doses	IM or SC* 0.5 ml	1	2 nd dose due at 3.5–4 years if <3.5 years at first dose. MMR (*given IM) is now available combined with Varicella Vaccine (VV) as MMR-V (*given SC) – although MMR-V is not recommended as the first dose of MMR containing vaccine in children <4 years, due to increased risk of fever/febrile

Barriers to accessing health services

- Health systems understanding of patients
- Patient knowledge of health systems
- Case worker knowledge of health systems
- Competing priorities – settlement and beyond

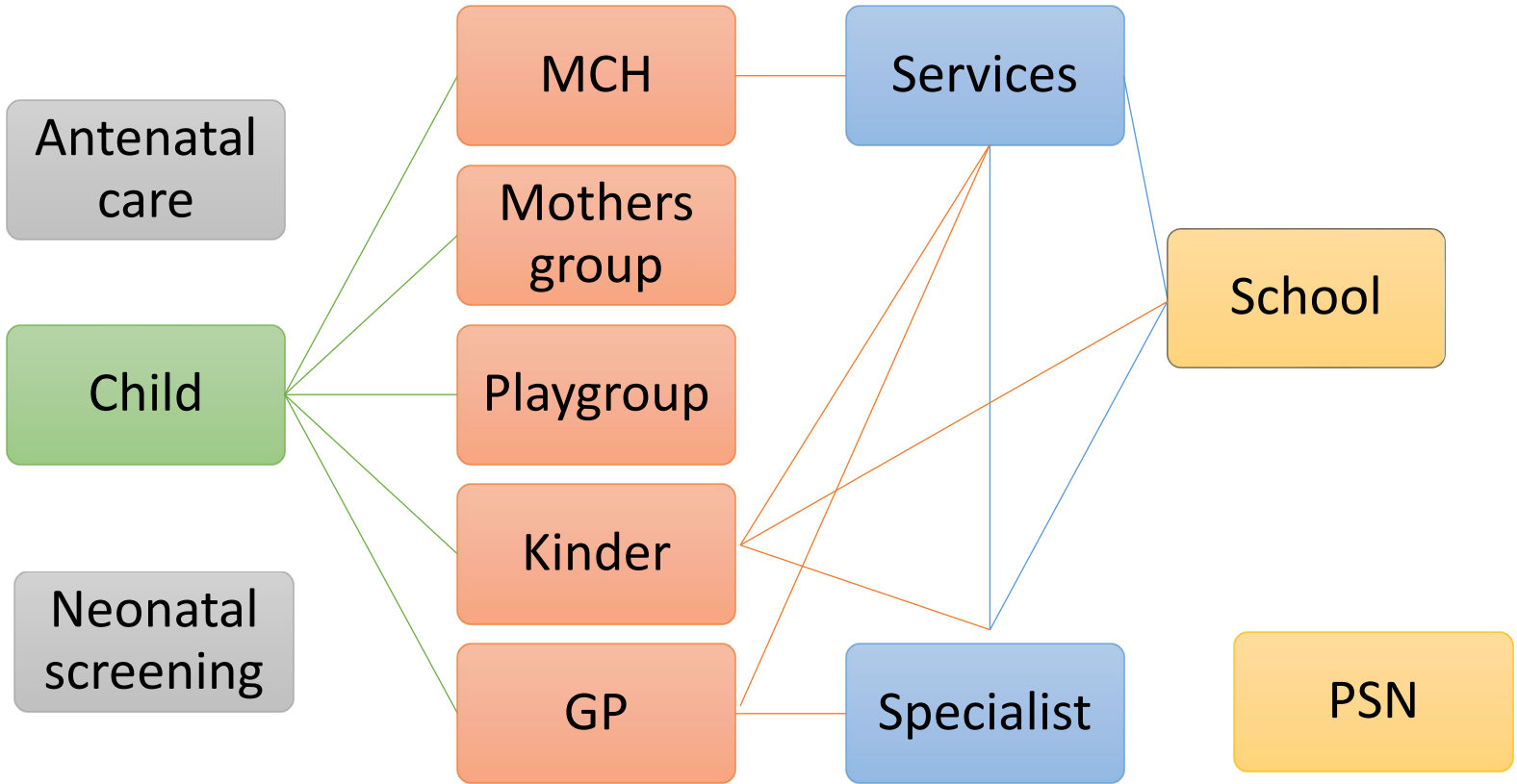
- Language
- Language service access
- Transport
- Mobile populations – continuity of care
- Move from short term accommodation to long term accommodation

- Cost – private system, public system, pharmaceuticals
- Medicare access

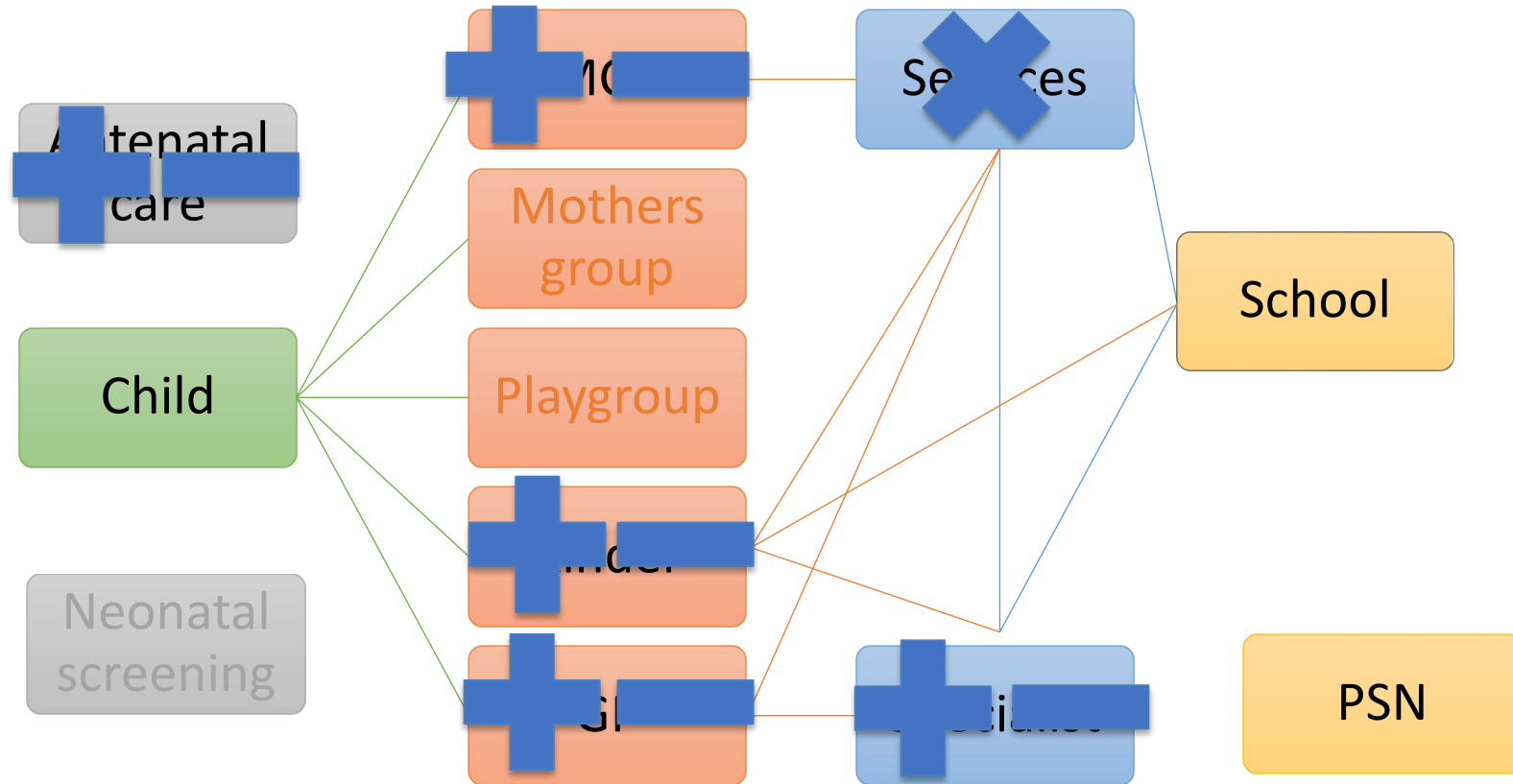
- Confusing service systems, service entry/exclusion criteria (Dx, age, postcode, school status, residency, housing permanency)
- Assess and refer models
- Cultural elements – expectations, values, beliefs

Developmental Screening and Challenges

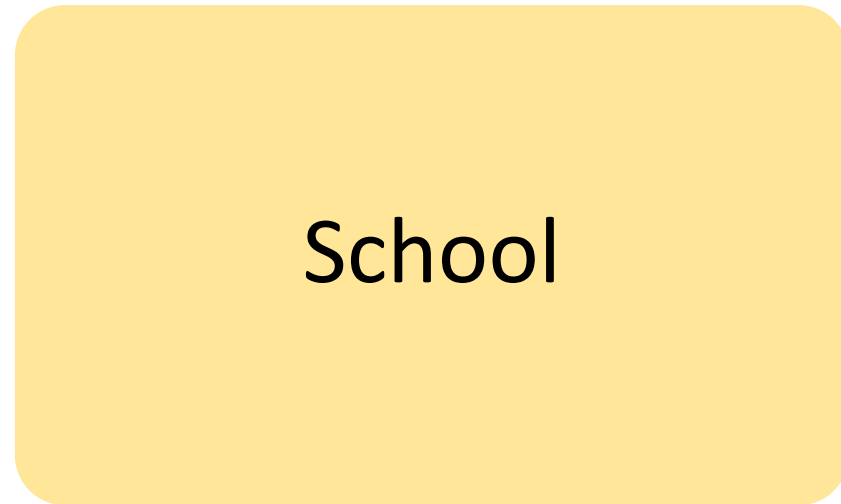
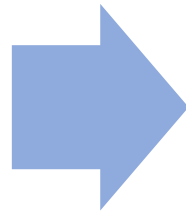
Australian born



Refugee background



Put simply



Development: refugee children & adolescents

Multiple risk factors developmental issues

- Family/community disruption
- Migration/language transitions
- Physical health/nutrition
- Undiagnosed developmental/physical disability
- Antenatal and perinatal complications
- Education access, quality, continuity
- Trauma (including specific to asylum seekers)
- Mental health/attachment
- Adolescent specific
- Parental factors
- Settlement and family function

Same principles...

- Background development
- Family history
- Other factors
 - Medical
 - Hearing
 - Vision
 - Mental health
 - Social
- Education history & progress + Assess and refer for early childhood services
 - Sleep, screentime, parent and family dynamics
- Current function
- Formal assessment

Early Education

Refugee and Asylum Seeker Children Eligible Programs:

Kindergarten Fee Subsidy:

- This subsidy gives eligible children 15 hours a week at a funded kindergarten program for free or at low cost.
- To be eligible, children must be aged at least four years by 30 April, or three years by 30 April if they are in a local government funded three-year-old kindergarten

Early Start Kinder:

- This grant gives eligible three-year-old children 15 hours a week at a funded kindergarten program free of charge or at minimal cost.
- To be eligible, children must be three years old by 30 April in the year they start kindergarten.

Children in community detention can also access 3 and 4-year-old kindergarten.

Early Childhood Services

For children <6 years of age with delays in more than 1 area of development:

- **Non- resident children and adults with disability including asylum seekers and people (refugees) on temporary protection visas (TPV) cannot access the national disability insurance scheme (NDIS).** Alternative pathways are available in Victoria as follows:
- **Age 0-6 years** (non-resident) -
 - early childhood intervention is available through the Department of Education and Training (DET) Early Childhood Intervention Services - Continuity of Support (ECIS-CoS) Program.
 - The process for non-resident children is to
 - i) apply for NDIS through their local early childhood partner
 - ii) confirm they **not** eligible for NDIS (through application to NDIS and then formal rejection)
 - iii) progress the ECIS-CoS with Early childhood partner assistance.

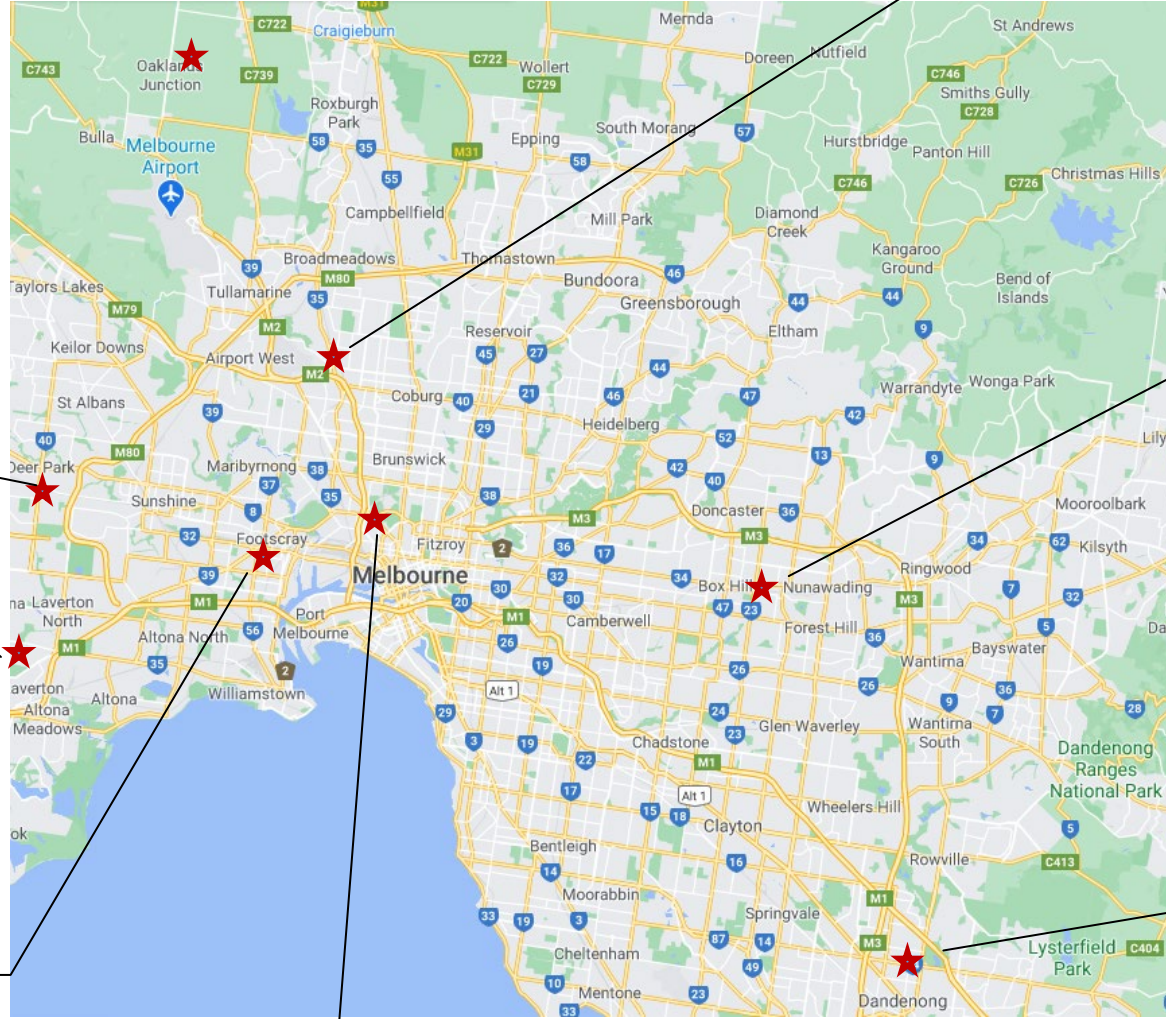
What are some services that are available for Refugees and Asylum seekers?

Craigieburn Health Service,
Paediatric Refugee Health Clinic (Dr Czarina Calderon)
274-304 Craigieburn Rd, Craigieburn,
3064, phone 8338 3081
GP referrals to Intake coordinator:
Teresa Umpherston, Fax 84058616

IPC Health Deer Park
Dr Yoko Asakawa
General Paediatrician
Provider number: 420753DB
Paediatric refugee health clinic
(Monthly on a Wednesday morning)
IPC Health – Deer Park Campus
106 Station Road, Deer Park
Referrals to fax 9363 7110, email
yoko.asakawa2@wh.org.au and
melanie.pearmine@ipchealth.com.au

Utopia Refugee and Asylum Seeker Health
Dr Dan Mason (Paediatrician) and Dr Lester Mascarenhas (GP) and Dr Marian Tokhi (GP)
5 Alexandra Avenue, Hoppers Crossing 3029
Phone 80013049, Referrals to fax 8804 5848
and info@utopiarefugeehealth.com

CoHealth paediatric immigrant health clinic (Footscray).
Dr Jane Standish/Dr Alicia Quach/RCH
paediatric fellow
Paisley St, Footscray, 3011, Phone: 9448
5502, Referrals to Fax: 7000 1818.
GP referrals required.



Darebin (Preston) - Your Community Health
300 Bell Street, Preston, 3072, phone
8470 1111, Referrals to fax 8458 6710.
GP referrals required.
3rd Thursday of every month.

Ringwood - Eastern Access Community Health (EACH)
Dr Shidan Tosif/Dr Dan Mason
Warrandyte Rd, Ringwood, 3134, phone
9871 1800.
Intake via Royal Children's Hospital
Immigrant Health Service - phone 9345
5522 pager 5985, fax 9345 4751 or email
lil.ingram@rch.org.au. Attn: Immigrant
Health – Lil Ingram (Intake coordinator).
And "Linda.Pratt@each.com.au"
GP referrals required.
Bi-monthly clinic on Thursdays

Royal Childrens Hospital
Dr Georgie Paxton, Dr Andrea Smith, Dr Shidan
Tosif, Dr Hamish Grey, RCH Immigrant Health
Fellow
50 Flemington Road, Parkville 3031. Phone
93455522.
GP referrals required to lil.ingram@rch.org.au or
fax 9345 5034 . Clinics on Monday PM

Monash Refugee Health and Wellbeing (Dandenong)
Dr Saniya Kazi, community paediatrics
fellow
122 Thomas St, Dandenong, phone 9792
8100, referrals to fax 9792 7765 or email
to central email intake
rhn@monashhealth.org. Attention it
to refugee health nurse on triage

Bendigo Community Health Services

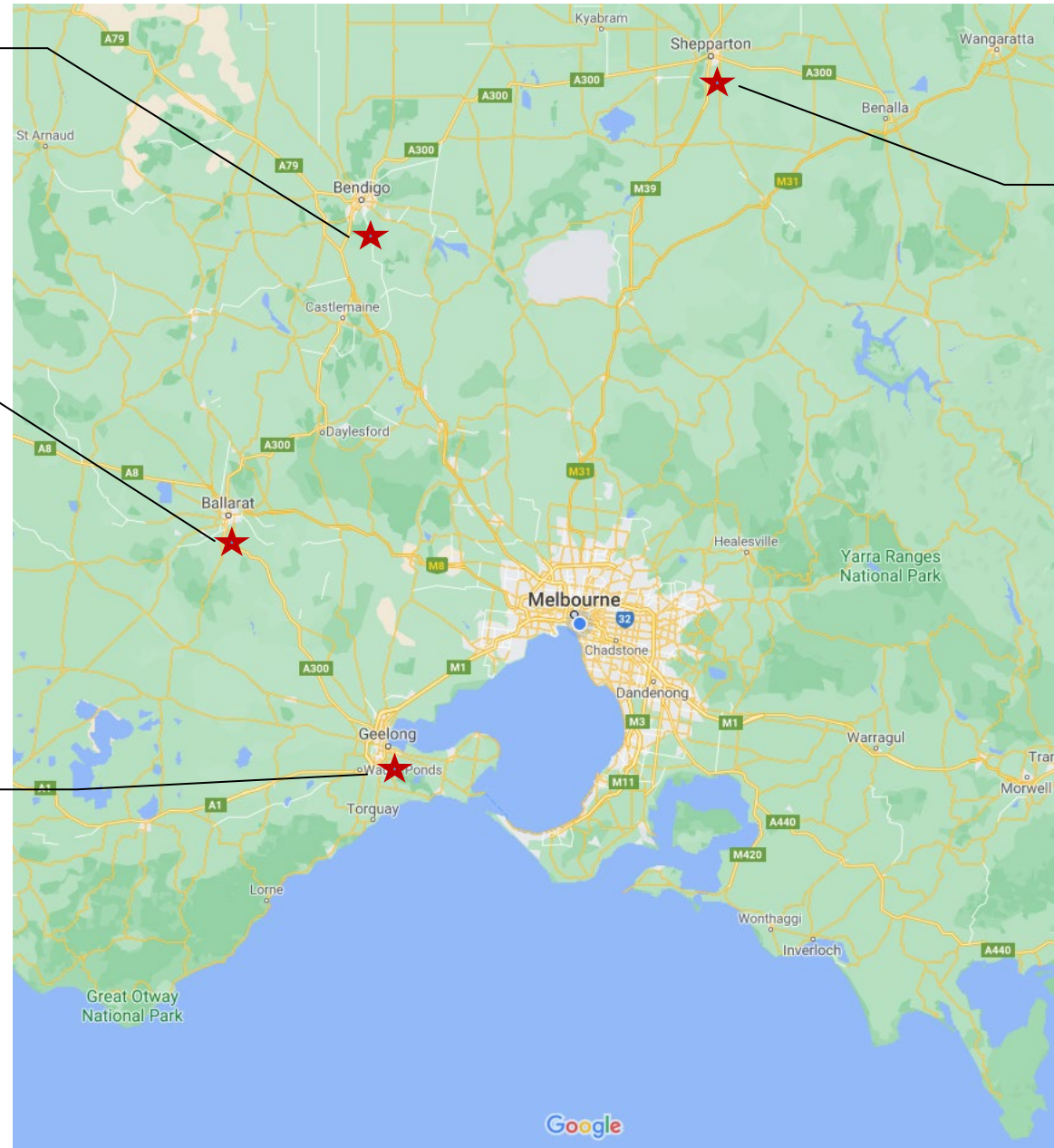
General Paediatrics
19 Helm St, Kangaroo Flat VIC 3555. Phone 5430 0500.
Fax 03 5441 4200
GP referrals required.

Ballarat Community Health Centre

Dr David Tickell
12 Lilburne St, Lucas 3350, phone 5338 4500. Fax
5336 1613. GP referrals required.
Thursday weekly

Geelong (Barwon Health)

Refugee Health Clinic
Dr Jane Standish/Dr Kate McCloskey. Clinic co-
ordinator Jude Butwilowsky
Geelong Hospital Outpatient Annexe, 66 Bellarine St,
Geelong, 3220. phone 4215 1396, fax 4215 1383.
jude.butwilowsky@barwonhealth.org.au
Every Tuesday morning 9:30 - 12:00



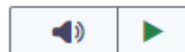
Shepparton - Primary Care Connect-

Wyndham St, Shepparton, 3630, phone 5823
3200
Referrals online via
https://msteams.formmachines.com/dist/renderer?fmMode=new_open_template_submission&fmOpenFormDirParams=eyJmbVRlbmFudEd1aWQiOiI0ZWNmZGUwZi05ODU5LTQ1NjAtOWI5Ny1jNzYyM2RiYTJkNTkiLCJmbVRlbXBsYXRISUQjOiI1dzFCSEVzZyIsImZtVGVtcGxhdGVQYXJlbnRUYWJLZXkiOiI1MDQ2endGQyIsImZtVGVtcGxhdGVQYXJlbnRUZWFtQXp1cmVJZCI6IjE5OjM1MjY2ZGlyM2RmOTQ1ZDg4MDYzMTI4NjVkdjYkODJkYTZhQRocmVhZC50YWN2MjI5bmVsQXp1cmVJZCI6IjE5OjM1MjY2ZGlyM2RmOTQ1ZDg4MDYzMTI4NjVkdjYkODJkYTZhQRocmVhZC50YWN2MjI5

Refugee Health Program

The program aims to:

- increase refugee access to primary health services
- improve how health services respond to refugees' needs
- coordinate a response to newly arrived refugees
- help individuals, families and refugee communities improve their health and wellbeing.



Key messages

- The Refugee Health Program (formerly the Refugee Health Nurse Program) operates in 17 local government areas of Victoria.
- Community health services in other local government areas also provide care for refugee communities.
- The program responds to the poor health and complex health issues of arriving refugees in Victoria.
- Service coordination is important for the community health services that run the program or otherwise provide refugee health care.

What can you do?

- **Migration history**
 - Ask – and consider in clinical presentation
 - Medicare?/Centrelink?/NDIS?
 - Link with case worker
- **Refer for Screening to GP/Refugee health nurse service**
 - Bloods, TB screening, other
- **Catch-up vaccinations + covid/flu vaccinations**
 - Think of it, make a plan, refer if needed
- **Vitamin D + B12 deficiency**
 - Educate, send for testing/screening, Treat
- **Utilise supports available**
 - Access to services, Refugee Health Program, Mental Health services, GP
- **Interpreters**
 - Inform yourself and work with interpreters
- **Advocate**
 - Support letters; referrals to services

Referral Pathways

- If a paediatric team assessment would be helpful – GP referral to local paediatric/refugee health service or RCH requesting immigrant health service.
- A lot of helpful information/services available on our website - www.rch.org.au/immigranthealth/
- Very happy to discuss if required – refugee.fellow@rch.org.au

Thank you!



[Immigrant Health Service : About the Immigrant Health Service \(rch.org.au\)](http://www.rch.org.au)
www.rch.org.au/immigranthealth/

References

- [Immigrant Health Service : About the Immigrant Health Service \(rch.org.au\)](http://rch.org.au)
- [Kindergarten - DFFH Services: https://services.dffh.vic.gov.au/kindergarten](https://services.dffh.vic.gov.au/kindergarten)
- <https://www.unrefugees.org.au/>
- [Early Years | Foundation House: https://foundationhouse.org.au/specialised-programs/early-years/](https://foundationhouse.org.au/specialised-programs/early-years/)
- [Refugee Health Guide Victoria: https://refugeehealthguide.org.au/referrals/victoria/](https://refugeehealthguide.org.au/referrals/victoria/)

References for Urology Segment

- [https://www.rch.org.au/clinicalguide/guideline_index/The penis and foreskin/](https://www.rch.org.au/clinicalguide/guideline_index/The_penis_and_foreskin/)
- <https://www.health.vic.gov.au/publications/guidelines-for-male-circumcision-in-the-victorian-public-hospital-system-information-0>
- <https://content.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/c/circumcision-guidelines-healthprof---pdf.pdf>
- <https://www.racp.edu.au/docs/default-source/advocacy-library/circumcision-brochure.pdf>
- <https://ranzcog.edu.au/wp-content/uploads/2022/05/Circumcision-of-Infant-Males.pdf>
- [https://www.rch.org.au/clinicalguide/guideline_index/Prepubescent Gynaecology/](https://www.rch.org.au/clinicalguide/guideline_index/Prepubescent_Gynaecology/)
- [https://www.rch.org.au/clinicalguide/guideline_index/Urinary Incontinence - Daytime wetting/](https://www.rch.org.au/clinicalguide/guideline_index/Urinary_Incontinence_-_Daytime_wetting/)
- [https://www.rch.org.au/kidsinfo/fact_sheets/bedwetting - videos/](https://www.rch.org.au/kidsinfo/fact_sheets/bedwetting_-_videos/)
- <https://www.continence.org.au/who-it-affects/children/daytime-wetting>