Afghan Community Health and Wellbeing Needs Assessment

July 2016

Final Report

A Qualitative Study

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About the Researcher

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Philip Moran,

CEO, Link Health and Community

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List of Acronyms

AMES	Adult Multicultural Education Services
ANC	Antenatal Care
BVE	Bridging Visa E
CALD	Culturally and linguistically Diverse
FGD	Focus Group Discussion
GP	General Practitioner
IHMS	International Health and Medical Services
IMA	Illegal Maritime Arrivals
LGA	Local Government Area
Link HC	Link Health and Community
PTSD	Post-Traumatic Stress Disorder
SAPCRU	Southern Academic Primary Care Research Unit
SEMPHN	South East Melbourne Primary Health Network
SEMML	South East Melbourne Medicare Local
SEMRASHA	South Eastern Melbourne Refugee and Asylum Seeker Health Alliance
SBA	Skilled Birth Attendant
SRSS	Status Resolution Support Service
WHO	World Health Organization

Executive Summary

Link Health and Community (Link HC) has conducted a study of the health and wellbeing needs of the Afghan community living in the south-east of Melbourne, focusing in particular on Monash, Greater Dandenong and Kingston.

The study is intended to increase awareness and understanding of health and wellbeing needs, identifying specific health needs and barriers to accessing health services, including preventative health and early intervention services. This will help inform ways in which Link HC, together with partner organisations, might better respond to Afghan community needs.

The study was qualitative, involving extensive consultation with community organizations and agencies, a small survey of general practitioners (GPs), and focus group discussions (FGD) on mental health. Research for the study also involved reviewing current literature and research reports on Afghan community needs by community organisations, academic institutions and most importantly, agencies such as South East Melbourne Medicare Local (SEMML) and Southern Academic Primary Care Research Unit (SAPCRU). Consultations took place with around 22 Afghan community organizations and agencies working in the target area. An Afghan Community Advisory Group was also established by Link HC to help guide the project. The main outcomes of the consultation concerned barriers to accessing health services, health needs and other problems.

Barriers to health services were linked to visa status, physical access, socioeconomic status and literacy, cultural and social isolation. These issues are discussed at length in this report.

Preliminary recommendations are set out below. These recommendations will be the subject of discussion with the Afghan Community Advisory Group, other stakeholders and agencies to discuss initiatives, to determine what is feasible and to consider how the community and agencies might work together to achieve better outcomes for the Afghan community.

Recommendations for addressing barriers to accessing health services:

- Advocate for speeding up the processing of applications for protection for asylum seekers with the relevant government bodies to ensure refugees have access to the comprehensive health care they need
- Advocate for a review of asylums seekers health service eligibility, policy and procedures
- Encourage and support Afghan health professionals to work in the health sector as GPs, nurses and bicultural health workers.
- Increase health literacy via community engagement programs including continuation of the Afghan Community Engagement project
- Improve cultural competency among mainstream health workers including receptionists, health service providers and case workers.

- Provide professional development and training for GPs to enhance cultural competencies, as recommended by the National Health and Medical Research Council
- Involve religious leaders, Imams and influential community people in disseminating culturally relevant health information and messages to the Afghan community aimed at increasing their level of understanding and knowledge of health issues
- Support the Afghan Community Advisory Group in order to establish strong links with the community
- Promote and support English learning among Afghans in partnership with community agencies and Afghan community organisations
- Promote and support social cohesion and inclusion programs in the target areas

The study found that the main health needs of Afghans living in the study area were mental health, gender and reproductive health, oral health, problems with immunizations and communicable diseases, chronic conditions and diseases, and problems pertaining to health coordination and networking among multiple Afghan community organizations and associations.

Recommendations for addressing health needs:

- Afghan Community Advisory Group to explore options for community-led initiatives to address mental health needs;
- Promote awareness and understanding of mental health risks for Afghan community members;
- Promote access to community based mental health and counselling services;
- Develop targeted prevention and early intervention strategies for mental wellbeing;
- Improve referral pathways to clinical services for mental health including Headspace;
- Promote access to public dental services and improve oral health literacy;
- Develop effective preventative oral health promotion campaigns to improve understanding of oral health care and impacts on general health status. Links between oral health disease and chronic disease are not well understood;
- Conduct targeted outreach to age groups that miss out on school dental programs (secondary schoolers, teenagers, young adults), including outreach programs to sporting clubs to provide mouth-guards, oral health promotion to Afghan adolescents, teenagers and young adults;
- Mobile dental van to be used for outreach screenings;
- Conduct further research to identify the reproductive health status of the Afghanistan-born women living in Victoria;
- Facilitate the establishment of an umbrella or platform or consortium for Afghan organizations to better represent their community and promote their interests with stakeholders e.g. local, state, and federal agencies;
- Promote prevention and early intervention through access to cancer screening programs in partnership with GPs and Cancer Council Victoria;

- Promote infectious diseases screenings and immunization catch up programs.

Other problems identified during consultations included intergenerational gaps between children and their parents, lack of career pathways for unemployed Afghan community members including Afghan trained doctors and engineers, higher rates of early school leaving, and risky driving behaviours among new arrivals. Additionally, there were also problems with the cultural competency levels of some service providers, lack of awareness among Afghans about government laws and policies, and problematic alcohol and drug use and gambling, particularly among Hazara asylum seekers.

Recommendations for addressing other problems

- Conduct orientation sessions on the current government laws and policies;
- Develop culturally inclusive practice for GPs and Case Workers in collaboration with the relevant partners and the Afghan Community Advisory Group;
- Build on the capacity of Afghan community volunteers through the Afghan Community Advisory Group and the Afghan Community Engagement Project;
- Work in collaboration with the relevant stakeholders in the target area for developing strategies to enable Afghan professionals to be employed;
- Conduct further research in the area of alcohol, substance abuse and gambling among Afghans;
- Develop strategies on how to bridge the generation gap between parents and children as well as parenting support programs for Afghan parents.

The main findings from the survey of GPs concerned lack of comprehensive patient information collected by GPs, the importance of GP knowledge of the lives of Afghan people in Melbourne, and observations by GPs about Afghan health literacy and use of the health system, and suggestions for improving Afghan access to services.

Recommendations based on the Survey of GPs

- Encourage GPs to collect comprehensive information about presenting clients, including place of birth, ethnicity, and refugee status, as part of patient histories;
- Raise awareness of clients on the importance of completing courses of medication and how to make appointments and how to follow and understand the role of the pharmacist;
- Develop a call back system to ensure clients attend appointments;
- Develop or source factsheets about various health issues and programs in Afghan local languages;
- Develop a strategy on how to keep GPs informed about appropriate screening programs;

- Develop relevant health education materials for new mums regarding parenting, pap smears, catch up vaccinations and the importance of not missing follow up appointments with GPs, in Afghan languages;
- Conduct further study among Afghans to identify reasons for the behaviour of frequently changing service providers, and develop appropriate strategies for changing such behaviours;
- Improve the health literacy of Afghans with more emphasis on their English reading capability.

Community Consultation (Focus Group Discussion) on Mental Health

The aim of the FGD was to develop strategies to address mental health problems and stigma and determine awareness of mental health and counselling services among Afghans in the target area of the study. The FGD were conducted among 11 women and 12 men from different localities in the target area. The study found that both Afghan men and women participants generally had poor understanding of mental health and knowledge of existing mental health services. It was also evident that the majority of bridging visa holders who have high rates of unemployment were lacking the knowledge of the concept of mental health. Additionally, the burden of stigma pertaining to mental health problems was huge among Afghans that need different strategies to be addressed.

Recommendations for addressing mental health problems and stigma

- Improve the level of understanding of both male and female Afghan community members in regard to mental health and mental health services with particular emphasis on bridging visa holders and new arrivals;
- Develop strategies to overcome stigma within the Afghan community towards mental health, including changing the way in which mental health is described or discussed;
- Enhance the Afghan Community Engagement Program as a means of improving community knowledge about mental health and community-based services;
- Develop community-led initiatives that provide opportunities for socially isolated Afghan community members to come together, learn English and provide each other with support;
- Develop strategies to enable more Afghan health professionals to be registered in the health system especially as GPs, nurses, bicultural health workers and counsellors;
- Develop targeted therapeutic group counselling and education programs which focus on key issues impacting on mental health, such as coping with stress, parenting strategies, relationship issues, sleep disorders, anxiety and depression, to help build personal resilience and coping skills, and to encourage peer support among Afghans;
- Consult with the Afghan community about developing effective and culturally appropriate programs for early intervention and prevention for mental health;

- Develop cultural competency among existing health professionals and administration staff in health services, including GPs, community health and private health providers, to improve access and understanding of Afghan community mental health needs;
- Promote wider health sector awareness of the factors that negatively impact on the health and wellbeing of the Afghan community;
- Conduct cultural orientation among overseas born Afghans on the importance of acculturation, and participation in the mainstream culture;
- Develop strategies to build a sense of cooperation and trust among Afghan males and females;
- Look for mechanisms that can increase the number of female interpreters available in local health facilities;
- Provide advocacy on behalf of bridging visa holders with the relevant government body to speed up resolution of their visa status;
- Conduct further research in the area of domestic violence, intimate partner violence, drug and substance abuse;
- Conduct orientation sessions on the mental health and health system in Australia with information comparing the health system in Afghanistan with the health system in Australia, in order to improve knowledge and expectations from the mainstream health system;
- Work in collaboration with other relevant agencies to reduce the level of unemployment and poor English competency among Afghans;
- Organize social cohesion and inclusion programs among Afghans;
- Work with the relevant partners to develop strategies for preventing violence, racism and discrimination which are essentials for maintaining good mental health.

The detailed findings of the Focus Group Discussion (FDG) are set out in a separate report.

Background

Link Health and Community (Link HC) is a community-based health service that provides an extensive range of health services within the City of Monash and surrounding areas. The Link HC Strategic Plan, 2016-2020 has a Vision of 'healthier people participating in their communities' and a Mission, 'to provide integrated health and community services in Melbourne's east and southeast'.

Link HC's programs have been developed to meet the health needs of its local population and to provide accessible and affordable health and social services particularly to those most in need. The programs provided by Link HC are supported by funding from the Victorian and Commonwealth Governments (Link Health and Community, Annual Report, 2013).

The Victorian Government's guidelines for community health services set priorities for key population groups (Department of Health and Human Services, Community Health Integrated Program Guidelines, 2015). This includes people who experience poorer overall health outcomes, have barriers to accessing adequate healthcare, are economically and/or socially disadvantaged, and/or are people with complex care needs. The target prioritized groups are Aboriginal and Torres Strait Islander people, people with an intellectual disability, refugees and people seeking asylum, people experiencing homelessness and people at risk of homelessness, people with a serious mental illness and children in out-of-home care.

In keeping with organizational strategic priorities and the priority populations for community health, Link Health and Community has undertaken a study of the health and wellbeing needs of the growing community of Afghan residents in the Cities of Monash, Greater Dandenong and Kingston. As a refugee community, the Afghan community is considered a high needs group for health care and support (Southern Academic Primary Care Research Unit, 2011).

Introduction

Afghanistan is a war torn country. More than three decades of conflict and instability has led to some of the worst socioeconomic indicators in the world, especially in the health and nutrition sector. Life expectancy at birth is 47 years for men and 45 years for women, slightly more than half that of the wealthiest countries of the world (Afghanistan Health and Nutrition Sector Strategy, 2008-2013). Maternal mortality ratio is 1600/100,000 live births, which is the second highest in the world (Afghanistan Health and Nutrition Sector Strategy, 2008-2013). The most common causes of this high ratio are haemorrhage and obstructed labour. Infant and under five mortality rates are 129 and 191 per 1000 live births respectively and full immunization coverage is only 27% among children under two years of age (Afghanistan Health Survey, 2006). Only 19% of deliveries are conducted by a skilled birth attendant while 32% of pregnant women are seen by a skilled health worker during their antenatal care in the last two years of their most recent pregnancy (AHS, 2006). Current use of at least one modern contraceptive method is 16% by all currently married women (AHS, 2006). Moreover, in 2002,

there was high prevalence of mental health issues: 67.7% depression, 72.2% anxiety and 42% Post Traumatic Stress Disorder (PTSD) (Rintoul, 2010).

Over the last several years of unrest, people of Afghanistan have experienced natural disasters, internal displacement, drought, war and migration to the neighbouring countries of Pakistan and Iran. These circumstances would have contributed to the worsening of the health indicators among Afghans either living inside or outside of Afghanistan and to some extent would affect their health after resettlement in the secure countries such as Australia, European countries and the US.

Afghan Population of Melbourne

From 1 April 2010 to 31 March 2015, the Afghan refugee population in Australia was the second largest population group of immigrants under the humanitarian program after Iraqi refugees, while refugees from Pakistan were the fifth largest group (Australian Government, Department of Social Services, Settlement Reports, Top 25 Countries of Birth by Migration Stream 2015). Refugees from Pakistan will include Afghan refugees displaced to Pakistan. Some of the Afghan refugees living in Australia are Pakistan-born. The Afghan ethnic Hazara and Pashtun peoples were among the top 25 ethnicities by migration stream between the years 2010 to 2015. Hazara is in fact the largest ethnic group in the humanitarian stream (21%) (Australian Government, Department of Social Services, Settlement Reports, Top 25 Ethnicities by Migration Stream, 2015).

In Victoria the number of arrivals of Afghanistan-born people increased from 2,308 (23.2%) in 1991-2000 to 6,019 (60.5%) in 2001-2010 (Victorian Community Profiles, 2011 Census). The age and gender distribution of Afghanistan-born refugees is different to the population structure of Victorians generally. The ratio of males per 100 females is 136. The Afghanistan-born population of Victoria is also younger than the population of Victorians generally, with 59% being between ages 19-44 years (Victorian Community Profiles, 2011). This may indicate that a greater proportion of Afghan refugees in Victoria are economically and socially independent; however, they may also be more likely to be predisposed to reproductive health problems, mental health problems and sexually transmitted diseases.

Greater Dandenong (2nd), Monash (5th) and Kingston (19th) were among the top twenty Local Government Areas (LGA) in Victoria for the number of Afghanistan-born residents in 2011. Greater Dandenong constitutes 25.3% (2,520) of the Afghanistan-born population Victoria; Monash LGA is the residence for 2.3% (232) and Kingston, 0.5% (53). Neighbouring Casey LGA has the largest number of Afghanistan-born residents in Victoria (44.6%, 4,437 people). Almost 35% of all the Afghanistan-born population of Australia live in Victoria (9,944 people), the primary destination state ahead of New South Wales (Victorian Community Profiles, 2011 Census).

Project Rationale

According to the Southern Academic Primary Care Research Unit (SAPCRU, 2011), local refugee residents (in Greater Dandenong and Casey) are 23% more likely to present to a public hospital emergency department and 47% more likely to be admitted to hospital than other residents in the region. Preliminary analysis shows that refugees are more likely than non-refugees to be discharged from regional public hospitals with diagnoses related to: mental health (psychosis, anxiety/somatisation and depression), obstetric complications (female genital mutilation or circumcision, foetal death in utero and stillbirths) and infectious diseases (tuberculosis). Across the region, the bulk of refugee-specific primary care is delivered by general practice and refugee health nurses, including the Refugee Health Clinic at the Dandenong Hospital. By default, hospital emergency services also deliver primary care services.

It is stated that social determinants are critical to the health of a community and comprise the conditions in which people are born, grow, live, work and age (Department of Health and Human Services, Community Health Integrated Program Guidelines, 2015). Therefore, the health issues of the target population on arrival and post arrival might be influenced by factors such as mental and emotional health, oral health, reproductive health and infectious disease, as well as barriers to employment and education, stress associated with a new country and culture, housing and financial insecurity, racism and social stigma, limited connection with family and community and social isolation in connection with limited English language (Department of Health and Human Services, Refugee and Asylum Seeker Health Services, Guidelines for the Community Health Program, 2015).

Given the high burden of diseases among Afghans in their home country and the large number of Afghan refugees in the Cities of Greater Dandenong, Monash and Kingston and the high likelihood of mental health problem, reproductive health, and infectious diseases in the mentioned areas, the Afghan community constitutes a high needs group for community health agencies. Hence, **this study aims to Increase awareness and understanding of the health and wellbeing needs of the Afghan community in the Cities of Greater Dandenong, Monash and Kingston**.

Objectives

- Identify barriers to accessing health services, including preventative health and early intervention services;
- Identify specific health needs of the community;
- Examine ways in which Link Health and Community might better respond to the health and wellbeing needs of the Afghan community.

Project Strengths and Enablers

The project was enhanced by establishing connections with refugee community organizations and other agencies. Refugee community organizations are a structure or association that is developed by refugees and asylum seekers to benefit their own community (Refugee Council of Australia, 2014). The Association of Hazara in Victoria is one such organization that was established in 2002 when the population of both refugee and asylum seekers Hazara increased significantly in Melbourne. The aim of the committee was to assist Afghan refugees with their settlement problems and promote their active participation in Australian society. This association constitutes Afghans living in Greater Dandenong and Casey and is managed by a volunteer committee (Refugee Council of Australia, 2014).

The Afghan Hazara Students Group in Dandenong was helpful in providing input in regard to Afghan health needs during implementation of the project.

An Afghan Community Advisory Group established by Link Health and Community has contributed significantly during the planning and implementation of the project. The group aimed to assist the project in identifying emerging health issues, barriers to accessing health services, sharing experience of Afghan community and family, exploring of knowledge of Afghan community and mobilizing the Afghan community during the study.

Afghan Community Advisory Group, 2016

Left to right: Weda Mohseni, Khalilur Hamid, Sayed Wahidi, Jaweed Ali Mohammadi, Ahsanullah Noori and B Ghezal Zara

A Dialogue with Afghan Communities, part of the Social Cohesion initiative facilitated by the City of Greater Dandenong, was another strength for the project. The Dialogue with Afghan Communities was conducted over three days from October 2015 to March 2016, and was very

helpful in identifying some of the health issues in the Afghan community as well as further building networks among the Afghan community.

Consultation with both Afghan male and female community researchers also added more value to the process of our study design, planning and data collection. Two researchers with extensive background of work with Refugee and Afghan communities in Afghanistan and Australia provided continuing support to the project.

An Afghan Health and Wellbeing Project Reference Group was established from representatives across Link Health and Community. This together with the Research Sub-Committee of the Link HC Quality Improvement Committee (QIC) supported the project and ensured inputs from staff in the process of project development, implementation and report writing.

The following organizations were consulted for this project: Catholic Care, Foundation House, Monash Health Southern Academic Primary Care Research Unit, Eastern Melbourne Primary Health Network, Communities' Council On Ethnic Issues Eastern Region, Migrant Settlement Committee (Eastern Region), Refugee Council of Australia, Eastern Health, AMES, South Eastern Melbourne Primary Health Network, Monash Council, Monash Health Refugee Health and Wellbeing, Clarinda-Clayton Multicultural Forum, Monash Multicultural and Settlement Services Network Working Group, Asylum Seeker Resource Centre, enliven, and Department of Health and Human Services. The researcher also attended the East Melbourne Refugee Health Forum, Women's Health East Sexual and Reproductive Health Planning Forum and a refugee health assessment workshop at the Victorian Refugee Health Network.

The aforementioned strengths and enablers in the target areas played very important roles in the successful planning and implementation of the project.

Methods

Review of Research Evidence Base

Research literature from a variety of sources was reviewed during planning for the project. Recent studies relating to the Afghan community in Australia were also examined, to avoid duplication and to allow the project to add to the knowledge base. The review of the evidence-base included both academic and grey literature. Current government policies and frameworks were also reviewed.

Qualitative Research

Qualitative research methods were used to collect data and information on the health and wellbeing needs of Afghan community in the target areas. Interviews and focus group

discussions (FGD) were conducted to gather data among General Practitioners (GPs), community organizations, community members and agencies.

Consultation with Community Organizations and Agencies

The following community organizations were consulted: the Association of Hazara in Victoria, Afghan Women's Community Kitchen, Australian Hazara Students Group, Afghan Community Advisory Group, and Afghan community researchers. Agencies consulted included Catholic Care, Foundation House, Southern Academic Primary Care Research Unit, Eastern Melbourne Primary Health Network, Communities' Council on Ethnic Issues Eastern Region Migrant Settlement Committee, Refugee Council of Australia, Eastern Health, AMES, South Eastern Melbourne Primary Health Network, Monash Council, Monash Health Refugee Health and Wellbeing, Clarinda-Clayton Multicultural Forum, Monash Multicultural and Settlement Services Network Working Group, Asylum Seeker Resource Centre, enliven, Victorian Department of Health and Human Services.

Consultations with GPs

Around 10 GPs from each LGA were proposed to be interviewed individually. Unfortunately because of lack of interest and unavailability of GPs, the number was reduced to five GPs in the whole of the study area. Moreover, the unavailability of GPs compelled the researcher to replace interviews with GPs to a survey of GPs. Nevertheless, the survey provided important insights.

Community Consultations (Focus Group Discussion)

While it was intended to provide a broad overview of Afghan community health and wellbeing needs in the catchment area, for practical purposes, the project adopted a case study approach focusing on specific health issues identified in the survey of GPs, consultation with Afghan community organizations, discussions with Afghan researchers, consultation with agencies and the Afghan Community Advisory Group. Focus Group Discussions (FGD) on mental health and community awareness of mental health and counselling services among Afghans were conducted, with the following aim and objectives.

Aim: to develop strategies to address mental health (problems) and mental health stigma and determine awareness of mental health and counselling services among Afghans in the target area for the study.

Objectives:

- Identify perceptions and understandings of mental health by Afghan community members and the prevalence of stigma related to mental health problems;

- Determine Afghan community perception, and experience of mental health and counselling services, and GP/primary health care system;
- Discuss different ways services might engage with Afghan community members to better identify and address individual and family mental health issues and stigma pertaining to it, including ways of describing mental health, use of different settings for consultations and effective coping strategies.

Link HC worked in partnership with the South East Melbourne Primary Health Network (SEMPHN) to design and conduct two focus group discussions on mental health for the Afghan community. Common themes had emerged in recent community consultations undertaken by each of the organizations and working together ensured that we avoided duplication and could build on the excellent work already undertaken as part of the South East Melbourne Medicare Local (SEMML) Afghan Community Engagement Project.

We hoped to come up with a process for actions on outcomes from the focus groups, aimed at helping to change the conversation within the Afghan community around mental health and to encourage help seeking across the spectrum of psychological distress and life stressors, as well as acute mental illness.

Link HC has worked with SEMPHN to come up with recommendations for action. Possible outcomes could include recommendations for the provision of resources for GPs, community health worker roles, and community-led initiatives that encourage people to speak to others about their stresses, worries, family issues etc., that impact adversely on their daily lives and their capacity to live well within the community.

We also tried to identify different ways of describing 'mental health' to reduce stigma and barriers to help seeking. This also has relevance to other refugee and newly emerging migrant communities in the target area.

The FGDs included 12 men and 11 women aged 18 years old and over, with different ethnicities, dates of arrival in Australia, visa status and socioeconomic background. FGD for women was facilitated by an Afghan female facilitator and an Afghan male facilitator was engaged for the men's group. Both female and male FGDs were observed by a female and male member from the research team. FGD participants were given a $50 supermarket gift card as a token of appreciation for their participation. Given the level of fluency of the study participants in Dari language, FGD was conducted in Dari. The study questionnaire and consent paper were designed after discussions with the Afghan Health and Wellbeing Needs Assessment Project Reference Group, the Afghan Community Advisory Group and the project researchers. Data were safely stored daily in Microsoft Word program and the analysis was descriptive and qualitative.

A separate report has been prepared on the FGD.

Ethical Considerations

The study was deemed low risk given the focus on general health and wellbeing, and the nature of the discussions on mental health issues and problems of access in the FGD. Safeguards were put in place to protect confidentiality and to ensure that participants in the FDGs were supported. The research was conducted in a manner consistent with the principles of the ethical conduct of human research.

Project Risks and Limitations

There were some risks that had the potential to impact on successful implementation of the project. For instance, risk of delayed participation and lack of interest by the study participants; Afghan cultural sensitivities (for example, some women might not talk to a male researcher in regards to their reproductive health or any other issues); and low level of interest and cooperation from some agencies, community organizations and GPs because of their time constraints.

Delayed participation and lack of interest were addressed by discussing the project well in advance with the community and community representatives and explaining the possible good outcomes of the project for their community. For the focus group discussions, incentives were provided (each of the participants was provided with a $50 supermarket gift card as a token of appreciation for their participation in the project). Additionally, a female facilitator was assigned to help conduct the FGD among women.

Potential risks for low level of participation by various agencies, GPs and community organizations were addressed by flexibility in arranging meetings by allowing alternative time slots and locations. Explanation of the project proposal and describing its goals and objectives raised the stakeholder's interest and enhanced their level of cooperation. Unavailability of GPs and their time constraints compelled the researcher to replace interviews with GPs to a limited survey of GPs.

It should be noted that initially it was planned to also conduct a quantitative analysis of the most contemporary available data regarding the demography and burden of diseases for the Afghan community from information sources such as Monash Health. Accessing data from the database of Monash Health required a Memorandum of Understanding (MOU) to be signed between Link HC and Monash Health. This was not possible during the study period.

Study Findings

The main purpose of the study was to increase awareness and understanding of the health and wellbeing needs of the Afghan community in the target areas and to identify barriers to accessing health services, including preventative health and early intervention services. It was also intended to examine ways in which Link HC might better respond to the health and wellbeing needs of the Afghan community.

In order to achieve the aforementioned goal and objectives, the following activities were carried out:

Consultation with Afghan community organizations and agencies

Survey of GPs

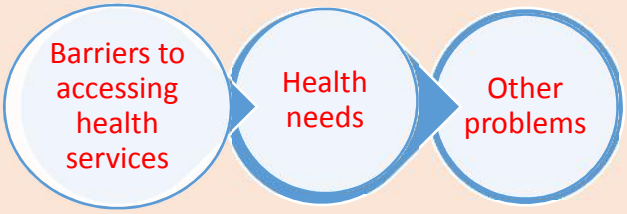
Community consultations (focus group discussion)

Findings of Consultations with Afghan Community Organizations and Agencies

Consultations took place with around 22 Afghan community organizations and agencies working in the target area. All of the consultations were face to face discussions, including meetings, forums, and dialogues and working groups.

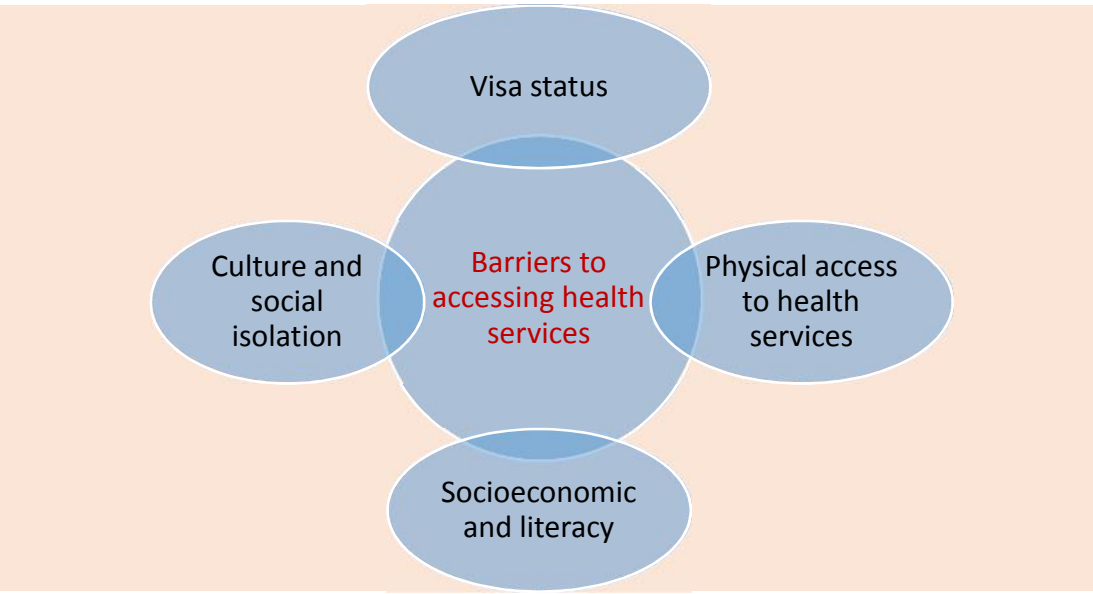
Consultations also took place with seven members of Afghan Community Advisory Group established by Link HC during the process of planning and implementation of the project. The advisory group comprised representatives of the Afghan community in Dandenong, Narre Warren, Hallam, Cranbourne, Noble Park, Rowville and Clarinda.

The main consultation questions focused on barriers to accessing health services and health needs. Findings were classified under three main headings:



I. Barriers to Accessing Health Services

The following barriers to health services were found during consultations and categorized according to visa status, physical access to health services, socioeconomic and literacy, culture and social isolation.



Visa Status

Some population groups were identified as being at particular risk of poor health linked to their visa status. Visa type can pose barriers to accessing health care and community services. Asylum seekers living in the community are on Bridging Visa E. Out of 10,902 Bridging Visa E holders in Victoria, 1,885 are Afghan (Illegal Maritime Arrival Bridging Visa E holders by Suburb and Citizenship, June 2015). Afghan Hazara is the largest ethnic group in the humanitarian stream (21%) (Australian Government, Department of Social Services, Settlement Reports, Top 25 Ethnicities by Migration Stream, 2015). Therefore, it is most likely the majority of Afghans on BVE are Hazara who are awaiting for their visa status to be resolved.

Asylum seekers living in the community on Bridging Visa E have access to Medicare. It was noted that there are two types of Medicare cards- blue and green. Blue Medicare card holders (asylum seekers on bridging visas) have no concessional access for English courses, kindergarten services, child care services and other education.

Asylum seekers who are in community detention are not eligible for Medicare and they only get medical support through International Health and Medical Services (IHMS). Additionally, groups consulted believed that bridging visa holders have only Foundation House for mental health counselling services. In fact, asylum seekers also have priority access to community health counselling under Victorian Government guidelines.

Teenagers either on bridging visas or living in community detention centres are not eligible for a health care card and as such were identified as having difficulties accessing health care. There is restricted access to oral health care for asylum seekers living in the community detention centres.

There is a need to improve access for the Afghan community, especially for new arrivals on bridging visas, to child care and kindergarten services. Access problems include lack of private transport (unable to drive), cultural barriers and low levels of literacy.

Women at Risk visa holders were identified as a specific group at risk for oral health care, because of high cost, personal vulnerability and long waiting times especially for dental fillings and root canal treatment. Women at Risk visa holders also face additional life stresses due to their experience of trauma, lack of family supports and social isolation.

Furthermore, asylum seekers are trained by some reputable institutions but they are not provided with certificates unless their visa status has cleared and they have the right to work. They are not eligible for concessions for education.

Note:
For further details about the type of visas and their eligibility for health and welfare services, refer to Appendix 1.

Physical Access to Health Services

Lack of Afghan GPs: this was identified as a significant problem by community groups. Currently there is only one Afghan male GP in Dandenong and there is a long waiting list for patients. There is no Afghan female GP in all of Dandenong or surrounding areas (Monash and Kingston). **Access to interpreters** was also found to be another problem, particularly for females. Afghan women would prefer a female interpreter for contacts with the health sector.

Afghanistan is a religious country and more than 99% of the people are Muslims. Religion plays a very important role in most Afghans' lives. Most women in Afghanistan in rural areas and even in the major cities, cover their hair and body with a cloth called Chadari (Hijab) and most women are not allowed to speak to strangers, according to cultural protocols. Boys and girls at schools are separated. These norms have affected Afghan women health seeking behaviour. The majority of women even in the capital city do not consent to being examined by male medical service providers. They do not disclose their background information and past history either medical or non-medical to males. Considering these cultural issues, which are still practiced among Afghan women in Australia, access to a female health practitioner, female translator, female case worker and even female receptionists are important to Afghan

women and can be considered part of a culturally responsive strategy for improving physical access of Afghan women to health services.

Long waiting times for GPs may be in part attributed to a lack of culturally competent receptionists. It appears that some receptionists are not well oriented with Afghan culture and traditions. For instance, Afghan women generally prefer to be seen by a female doctor or have translations by a female interpreter, as outlined above. This preference is not always understood by mainstream health providers. Moreover, in Afghanistan most patients are used to being seen on the same day without waiting and making appointments for another time. They also expect prescriptions for multiple medications from doctors. Unfortunately poly-pharmacy was common among health care providers in Afghanistan. These experiences of the health system in Afghanistan shape expectations of the health system in Australia. It means that Afghan patients expect urgent and immediate appointments when they go to a GP or other health provider. They may also expect the doctor to give them a prescription for medication regardless of whether this is warranted by the diagnosis of the presenting condition. These attitudes might end up causing many appointment cancellations and long waiting times.

Such problems are also visible in large hospitals as well: long waiting times to see specialists, problems in categorizing patients based on whether they are very urgent, less urgent or not urgent.

A separate report has been prepared on the issue of doctor shopping and poly-pharmacy in the Afghan community so that these behaviours can be more readily understood.

It was evident that Women at Risk visa holders are suffering specific problems with access to physical health care: primarily because of their inability to communicate in English, their lack of driving licences and many are also lacking friends and family members to assist them. Therefore, they are considered a high risk group and the physical barriers to accessing health services are more prominent among this group.

It was suggested that bicultural Afghan community health workers might play a crucial role in improving access to health services for the Afghan community. Bicultural health workers are now part of the Victorian refugee health workforce, although there is considerable variation in what these roles may comprise. One strategy would be the replication of the Aboriginal health practitioner model into the refugee health workforce, in this instance, with Afghan community health practitioner roles. This would give recognition to prior learning and build career pathways in the health sector, for the benefit of the Afghan community. A separate paper has been prepared which sets out the rationale for such an approach.

Socioeconomic Status and Literacy

Low levels of income, limited education, poor health literacy, and lack of awareness about government laws and policies might contribute to poor access to health services.

Many in the Afghan community reportedly have a low level of knowledge about the health services they are eligible for via the Medicare Benefits Schedule (MBS) and their eligibility for community health services, Centrelink and other welfare services given their visa status. Some asylum seeker case workers may also need support on how to appropriately refer asylum seekers to the right service provider based on their actual needs.

The literacy levels of a person are predictive of their health outcomes. An individual's health literacy levels are linked to many social determinants of health. For example, 59% of Australians have low health literacy, of whom 75% are born overseas. As a result, health literacy is becoming a strong predictor of a person's health status. When we start to see low health literacy as an indicator of poor health, it allows us to get to the core of the problem and plan appropriate health services and interventions (Centre for Culture, Ethnicity & Health).

Improving health literacy has been a key goal of the Afghan Community Engagement Project undertaken by SEMML. As reported elsewhere, the health literacy of Afghans needs to be further improved in various areas such as finding medical help after hours, using an ambulance in cases of an emergency, going to the hospital emergency department, going to a GP, using community health services and purchasing medicine (Brazier, 2015).

Our stakeholder consultations reiterated the importance of improving general health literacy in the Afghan community. It was suggested that raising awareness about health problems and disseminating health information via Mosques, schools, local sport clubs, and Afghan gatherings could be an effective strategy. It was also noted that the communication techniques including peer workers and community leaders as 'health champions' adopted by the Afghan Community Engagement Project were effective and need to be ongoing.

Culture and Social Isolation

The cultural and linguistic diversity of Australia is well documented. The term cultural responsiveness refers to health care services that are respectful of, and relevant to, the health beliefs, health practices, culture and linguistic needs of diverse consumer/patient populations and communities. That is, communities whose members identify as having particular cultural or linguistic affiliations by virtue of their place of birth, ancestry or ethnic origin, religion, preferred language or language spoken at home. Cultural responsiveness describes the capacity to respond to the healthcare issues of diverse communities. It thus requires knowledge and capacity at different levels of intervention: systemic, organisational,

professional and individual (Department of Health Victoria, 2009). Given the importance of cultural responsiveness, the following suggestions in the study might contribute to improved health outcomes for Afghan communities.

Raising awareness and sharing information regarding various Afghan traditions, habits and cultures among GPs and other service providers might be helpful to increasing cultural competency among health organizations at different levels such as at corporate governance, clinical governance and service delivery.

GPs and other health professionals who do not know about the reality of the lives of people in the Afghan community and their socioeconomic issues may inadvertently place barriers in the way of people accessing health care. Unfortunately some stakeholders reported that discrimination is common in health service delivery. It was pointed out that some GPs seem to be reluctant to accept refugees, especially asylum seekers, as patients because of the complications of organizing interpreters and communicating with them.

Additionally, some GPs are reportedly not taking accurate and complete patient histories and are not always taking the time to consider broader issues and risks while examining patients; not asking the right questions; or not making enquiries beyond presenting issues. Some may prescribe medicine without referring to their patients' background information such as family history and drug history. Afghans suffer from both pre-migration and post migration trauma and have very poor health indicators back in their home country that might significantly affect their health status here in Australia. Therefore, having a complete past history might indicate possible risk and allow for more accurate and complete diagnosis and in some circumstances, allow for early medical intervention. For instance, given Afghans' poor mental health status, a good and complete background on family history might help health service providers to diagnose psychological distress, stress and anxiety at the early stage with the application of early interventions that might be more effective, easy and cheap compared to the treatment at the later stage of the problems.

It is evident that most Afghans especially women and elderly are suffering from social isolation and lack of opportunity to participate in the community. There are also inadequate opportunities for Afghan women to participate in sports given their cultural and traditional limitations in accessing public sport facilities. It is important to understand barriers to community and social participation for Afghan women.

Being socially isolated is harmful for physical and mental health. A recent study explored the extent to which social disconnectedness or isolation (e.g. small social network, infrequent participation in social activities) and perceived isolation (e.g. loneliness, perceived lack of social support) have distinct associations with physical and mental health among older adults especially among members of CALD communities. Indeed, the influence of social

disconnectedness and poor social relationships on the risk of death was found to be comparable with well-established risk factors such as smoking and alcohol consumption, and to exceed the influence of risk factors such as physical inactivity and obesity (Pate, 2014).

Therefore, improving access to social settings and public sporting facilities especially for women, and establishing neighbourhood cohesion and social inclusion programs that promote a sense of belonging to society, building trust and safety, might be helpful strategies for addressing social isolation among Afghans, particularly in the ability to cope with daily troubles and stresses of life.

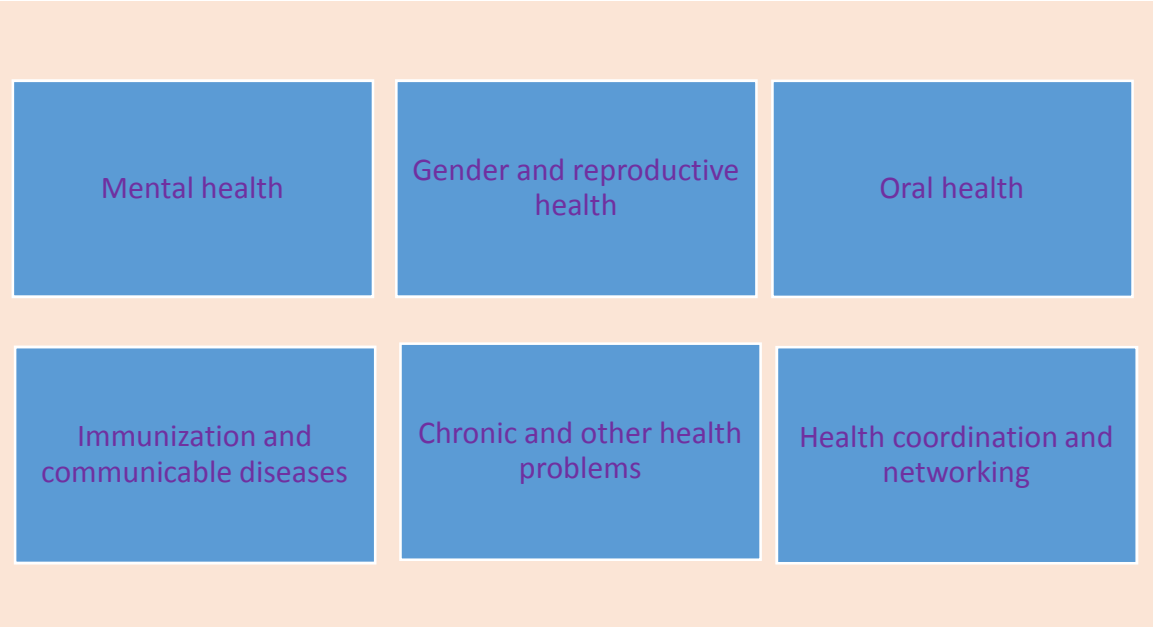
Recommendations for addressing barriers to accessing health services:

- Advocate for speeding up the processing of applications for protection for asylum seekers with the relevant government bodies to ensure refugees have access to the comprehensive health care they need;
- Advocate for a review of asylums seekers health service eligibility, policy and procedures;
- Encourage and support Afghan health professionals to work in the health sector as GPs, nurses and bicultural health workers;
- Increase health literacy via community engagement programs including continuation of the Afghan Community Engagement project;
- Improve cultural competency among mainstream health workers including receptionists, health service providers and case workers;
- Provide professional development and training for GPs to enhance cultural competencies, as recommended by the National Health and Medical Research Council;
- Involve religious leaders, Imams and influential community people in disseminating culturally relevant health information and messages to the Afghan community aimed at increasing their level of understanding and knowledge of health issues;
- Support the Afghan Community Advisory Group in order to establish stronger link with the community;
- Promote and support English learning among Afghans in partnership with community agencies and Afghan community organisations;
- Promote and support social participation, social cohesion and inclusion programs in the target areas, through initiatives such as community-based social groups and better access to public sporting facilities for women.

II. Health Needs

It appears that the main health needs of Afghans living in the study area according to our consultations were mental health, gender and reproductive health, oral health, problems

with immunizations and communicable diseases, chronic and other health problems and issues with health coordination and networking.



Mental Health

There is a high prevalence of psychological distress, trauma, depression, and anxiety among Afghan men and women, which seem to be more prominent among women, according to our consultations and the established research. Pre-arrival experiences of trauma continue to impact on the lives of individuals, families and the community. Furthermore, trauma as a result of time spent in immigration detention, psychological distress among asylum seekers dealing with uncertain residency status, indefinite separation from family, grief and loss of homeland, social isolation, lack of hope (particularly for Hazara unaccompanied minors and asylum seekers on bridging visas), and stigma associated with mental health are among the main mental health issues.

It was also mentioned that life stressors include unemployment, limited career pathways, study stress, family stress, acculturation stress, impacts on mental health of family violence, relationship breakdown and aggressive behaviour among children might also be considered part of mental health needs. Taking care of elderly relatives at home, racism and internalization of racism would contribute to anxiety and stress among some Afghan families. Violence at home and outside the home and even risks of violent extremism have also been identified as undermining mental health and sense of wellbeing.

Finally, it was noted that lack of family reunion and uncertainty of visa status might contribute to use of cigarettes, and risky behaviours such as alcohol and marijuana use and gambling, among unaccompanied minors and across all age groups.

It was suggested that there is need for improved mental health literacy level of Afghans. In order to achieve this, the Afghan Community Advisory Group recommended that at least 15-20 Afghan community volunteers from the different Afghan ethnic groups should be trained in mental health and the mental health system in Victoria to work at community level in order to increase Afghans' understanding and awareness of mental health and mental health services. It was also suggested that all Afghans whose cases are submitted to court for investigation, should be first assessed for their mental health and trauma. Information should be disseminated and shared with relevant government bodies regarding the prevalence of poor mental health among Afghans. It was also mentioned that raising awareness about mental health issues might be possible and more effective through religious people such as Mullah and Imam.

Gender and Reproductive Health Problems

Family violence, forced marriages, gender inequality, miscarriage among women, low knowledge about family planning, and poor knowledge about sexual health and gender identity have emerged as key issues. Gender dynamics within families may determine who speaks for the family and what information is disclosed in consultations with health professionals.

Pregnancy-related deaths are a leading cause of death for women in their childbearing years in Afghanistan. It was found that under current conditions approximately 1 in every 50 women in Afghanistan will die from a pregnancy-related cause during her lifetime. Haemorrhage is by far the leading cause of maternal deaths, Eclampsia is associated with one-fifth of maternal deaths and prolonged or obstructed labour with 11 percent of maternal deaths. Only 60 percent of women received ante natal care (ANC) from skilled birth attendants (SBA), that is, a doctor or nurse/midwife, for their most recent birth, while thirty-seven percent of women received no ANC at all. Eighty-five percent of urban mothers receive ANC from an SBA, compared with only 54 percent of rural mothers. Only 60% of mothers were protected against neonatal tetanus and only 28 percent of women received postnatal care for their last birth (Afghanistan Mortality Survey, 2010).

It is likely some overseas- born Afghan women may continue to have poor reproductive health because of their prior experiences in their home country. Afghan women who have given birth without a SBA in Afghanistan or in refugee camps may experience health problems with age. These issues and symptoms are highly sensitive and will not be disclosed to a male doctor. A separate report has been written to highlight these issues.

Some stakeholders also mentioned problems with gender relations between young people, particularly involving new arrivals not knowing social protocols and behaviours in conducting respectful relationships. It is evident that some young males are not clear about their

boundaries and appropriate behaviours in their social relationships and interactions with others, particularly young females, so sometimes they cross boundaries and cause social problems (including violence and abusive relationships, and causing rifts within community). This is partly a problem caused by lack of family support, growing up without clear adult guidance, and also misunderstandings about Australian culture and community expectations.

Oral Health

Lack of regular dental check-ups and monitoring, and seeking help only when pain emerges and becomes unbearable may contribute to oral health disease; this impacts adversely on general health and wellbeing and creates risks of chronic disease. Emergency presentations for dental treatment also add to the burden of avoidable hospital admissions. Oral health literacy and promoting access to routine dental checks are key preventative strategies.

Immunization and Communicable Diseases

An evaluation of the Primary Health Care Needs of Refugees in South East Melbourne found that refugees are more likely than non-refugees to be discharged from regional public hospitals with diagnoses related to mental health (psychosis, anxiety/somatisation and depression), obstetric complications (female genital mutilation or circumcision, foetal death in utero and stillbirths) and infectious diseases (tuberculosis) (SAPCRU, 2011). Moreover, the prevalence of TB is 340 per 100,000 population in Afghanistan, which is a major health problem (WHO, 2014) and full immunization coverage was only 27% among children under two years of age (Afghanistan Health Survey, 2006).

During consultations it was also evident that poor immunization status either from their home country or missing out on the catch-up immunizations here in Australia is problematic for both the individuals at risk and for public health herd immunity. It was also noted that there is a high prevalence of TB and Hepatitis B among the Afghan community. This might suggest the probability of a link between poor immunization coverage and high prevalence of TB in Afghanistan and the current immunization and communicable diseases burden in Australia.

Chronic and other health problems

Breast, stomach and bowel cancers, Vitamin D deficiency among women and men, high incidence and prevalence of Diabetes Mellitus (Type 2) and gestational diabetes, disability especially among elderly, acquired brain injury, Downs Syndrome and Autism Spectrum Disorders, were identified as specific concerns during the consultations.

There is a need for more information about screening rates and prevalence of disease in the Afghan community. Targeted strategies should be developed to improve early detection of

risk and access to treatment. Improved health literacy around specific health conditions would promote self- management and help reduce risk.

There is also a need for community education about disability including neurological conditions such as Autism Spectrum Disorders, which are often characterised by challenging behaviours. Wider understanding of these conditions within the Afghan community would help to reduce stigma and social isolation. It may also encourage families to seek help from early childhood intervention services and disability agencies.

Health Coordination and Networking

There is a need for strengthening connections between health service providers across local government boundaries to ensure Afghan community health and wellbeing needs are more widely understood. Within the south-east there are strong links between agencies through networks such as the Refugee Health Network, the South Eastern Melbourne Refugee and Asylum Seeker Health Alliance and the South East Melbourne Primary Health Network. Link HC can add to the capacity to meet Afghan community needs through strengthening links and referral pathways to other service providers in the south-east. It would also be helpful to establish a presence in Dandenong by providing a venue for ongoing Afghan Community Advisory Group meetings, community gatherings, as well as for service coordination and delivery.

There are multiple Afghan community organizations and associations in the area, which need to be coordinated under one umbrella. This was a clear outcome from the Afghan Dialogue conducted by Greater Dandenong Council.

Recommendations for addressing health needs:

- Afghan Community Advisory Group to explore options for community-led initiatives to address mental health needs;
- Promote awareness and understanding of mental health risks for Afghan community members;
- Promote access to community based mental health and counselling services;
- Develop targeted prevention and early intervention strategies for mental wellbeing;
- Improve referral pathways to clinical services for mental health including Headspace;
- Promote access to public dental services and improve oral health literacy;
- Develop effective preventative oral health promotion campaigns to improve understanding of oral health care and impacts on general health status. Links between oral health disease and chronic disease are not well understood;

- Conduct targeted outreach to age groups that miss out on school dental programs (secondary schoolers, teenagers, young adults), including outreach programs to sporting clubs to provide mouth-guards, oral health promotion to Afghan adolescents, teenagers and young adults;
- Mobile dental van to be used for outreach screenings;
- Conduct further research to identify the reproductive health status of the Afghanistan-born women living in Victoria;
- Facilitate the establishment of an umbrella or platform or consortium for Afghan organizations to better represent their community and promote their interest with stakeholders e.g. local, state, and federal agencies;
- Promote prevention and early intervention through access to cancer screening programs in partnership with GPs and Cancer Council Victoria;
- Promote infectious diseases screenings and immunization catch up programs.

III. Other problems

Intergenerational gaps are evident in the Afghan community, between the way of thinking of children and their parents, about acculturation, identity, cultural and behavioural norms. There are also differences in career aspirations, with some Afghan families wanting their children to follow particular career paths such as medicine or engineering, contrary to what their children may want. Such attitudes might originate from stigma. For instance they may be thinking their children are underachieving compared to some of their relatives' children who have just become doctors and engineers. These attitudes and their consequences for family conflict and stress need to be further explored among the community.

There is also a need for support for unemployed Afghan community members including Afghan trained doctors and engineers who need strategies and pathways into the workforce, to allow them to contribute to the community.

Other issues of concern raised in the consultations included higher rates of early school leaving and risky driving behaviours among new arrivals.

Some stakeholders also mentioned problems with the competency, training and attitudes of some case workers who are looking after new arrivals, specifically people on bridging visas. It was considered that some case workers do not have the knowledge to recognize their clients' poor mental status, which in many instances may be linked to the experience of trauma. In some circumstances, this may lead to harsh interactions ultimately causing a case worker to report a mentally ill patient to the court. Such kinds of actions have finally ended up with lots of stress, anxiety and even suicide among Afghan bridging visa holders.

Lack of awareness about government laws and policies was also consistently raised as a problem, causing stress and hardship for people in the Afghan community.

Problematic alcohol and drug use and gambling were also mentioned as problems particularly among Hazara asylum seekers.

Recommendations for addressing other problems

- Conduct orientation sessions on the current government laws and policies;
- Develop culturally inclusive practice for GPs and Case Workers in collaboration with the relevant partners and Afghan Community Advisory Group;
- Build on the capacity of Afghan community volunteers through the Afghan Community Advisory Group and the Afghan Community Engagement Project;
- Work in collaboration with the relevant stakeholders in the target area for developing strategies to enable Afghan professionals to be employed;
- Further research in the area of alcohol, substance abuse and gambling among Afghans;
- Develop strategies on how to bridge the generation gap between the ways of thinking of parents and children as well as good parenting programs for Afghan parents.

Survey of GPs

A total of five GPs were surveyed in Dandenong and Springvale. A questions guide was developed (Appendix II). The following are the main findings from the GP survey:

Information on Afghan Clients

There was an identified lack of information on the number of Afghan clients either born in Australia or overseas. It appeared such information is not available in GPs' patient databases. Information was also lacking on Afghan patients' age breakdown, gender and ethnicity, and

information about their refugee status and type of visa in the GPs database. Such barriers in accessing key data in general practice database was also found during a Primary Healthcare Assessment of refugee conducted in the South East of Melbourne in 2011 (Sothern Academic Primary Care Research Unit, 2011).

Observations of GPs on the lives of Afghans in Melbourne:

- Many Afghan patients seem to attend for recall, however, they may not complete courses of prescribed medication;
- Doctors are stressed when the client does not appreciate the appointment system and expects 2 or 3 family members to be seen without an appointment. Afghan clients need good education around making appointments and understanding the role of the pharmacist, as distinct from the role of the GP;
- It was noted that Afghans meet different doctors at the same time without informing their original GP. Problems arise with Medicare rejection because a patient has seen another doctor a few days previously. Such types of behaviour might have various reasons that might need further research;
- New mums parenting stress and problems were among the primary presentations among Afghans;
- It was also noted that sometimes it is difficult to get Afghan women to do a Pap smear;
- Men are not wanting to present for psychological problems or get counselling;
- As reported by GPs most of Afghan patients miss their appointments or catch up vaccination appointments.

Suggestions for improving access

- It was suggested that audio visual servicing may be useful for some Afghan clients and it was also urged that there is a need for some illustrations or visual materials on medical conditions, treatments and warning signs;
- For improving access to services for Afghan community members it was recommended that information is more readily available in the Dari language for clients, such as health information fact sheets;
- In terms of general observations about how to improve support for Afghan clients and families, GPs suggested that doctors need to be kept up to speed about appropriate screenings for refugees and that they would like to attend annual refresher sessions.

Recommendations based on the Surveys of GPs

- Encourage GPs to collect comprehensive information about presenting clients, including place of birth, ethnicity, and refugee status, as part of patient histories;
- Raise awareness of clients on the importance of completing medication courses and how to make appointments and follow and understand the role of the pharmacist;
- Develop a call back system to ensure clients attend appointments;
- Make factsheets about various health issues and programs in Afghan local languages;
- Develop a strategy on how to keep GPs up to speed with appropriate screening programs;
- Develop relevant health education materials for new mums parenting, pap smears, catch up vaccinations and the importance of not missing follow up appointments with GPs in Afghan languages;
- Conduct further study among Afghans to identify reasons on the behaviour of frequently changing service providers and develop appropriate strategies for changing such behaviours;
- Improve the health literacy of Afghans with more emphasis on their English reading capability.

Community Consultations (Focus Group Discussion)

Link HC worked together with the South East Melbourne Primary Health Network to design and conduct focus group discussions on mental health for the Afghan community. Common themes have emerged in the recent community consultations undertaken by each of the organisations and working together ensured that we avoid duplication and can build on the excellent work already undertaken as part of the SEMML Afghan Community Engagement Project.

The FGD was conducted among 11 female and 12 male from different localities in the target area. The target age group was 18 years old and above with varied level of education, outcome, employment status, visa status and ethnicity. The FGD was facilitated by male and female Afghan experienced researchers in Afghan local language and it was observed by two Afghan staffs from SEMPHN and Link HC throughout the sessions.

The findings of the FDG are set out in a separate report.

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Appendices

Appendix 1

Five categories of **offshore humanitarian visas** offered by Australia:

- **Refugee (subclass 200) visa** this visa is for people who are subject to persecution in their home country and are in need of resettlement.
- **In-Country Special Humanitarian Program (subclass 201) visa** this visa offers resettlement to people who have suffered persecution in their country of nationality or usual residence and who have not been able to leave that country to seek refuge elsewhere.
- **Global Special Humanitarian Program (subclass 202) visa** this visa is for people who, while not being refugees, are subject to substantial discrimination and human rights abuses in their home country.
- **Emergency Rescue (subclass 203) visa** this visa offers an accelerated processing arrangement for people whose lives or freedom depend on urgent resettlement.
- **Woman at Risk (subclass 204) visa** This visa is for women and their dependants who are subject to persecution or are of concern to UNHCR, are living outside their home country without the protection of a male relative and are in danger of victimisation, harassment or serious abuse because of their gender.

For many women, their first experience of loss is often the loss of their home as they flee their villages, towns or cities. They may also lose their children, husbands, fathers, brothers and other family members. Without the effective protection of a male family member, they often struggle to access food and shelter. While this is a common experience for many refugees, these women often have the added challenge of caring for small children and elderly relatives without support (Department of Social Services, 2013).

Women at risk may have come from urban areas and been educated and employed. Women are often the first to experience serious threats when civil disturbances affect the area where they live, as they may have no traditional sources of protection and often lack the means to relocate on their own. Others may have lived in refugee camps for many years waiting for resettlement and are likely to have experienced or witnessed significant trauma and disturbances to their lives (Department of Social Services, 2013).

Onshore humanitarian visas offered by Australia (Department of Immigration and Border Protection):

- **Protection Visa (subclass 866):** allows holders to live and work in Australia as permanent residents. Protection visa are granted to people found to engage Australia's protection obligations as a refugee or as a family member of a person found to engage Australia's protection obligations.
- **Temporary Protection Visa (subclass 785):** allows holders to stay in Australia for up to three years, work and study, having engaged Australia's protection obligations. Holders can access Medicare, social security benefits (Centrelink), job matching and short term counselling for torture and trauma where required. Adult visa holders will have access to the Adult Migrant English Program and children are able to go to school. Approval is required to travel to another country if granted a TPV or after 16 December 2014, and will be given only after demonstrating compassionate or compelling circumstances that justify the travel.
- **Safe Haven Enterprise visa (subclass 790):** holders are allowed to stay in Australia for five years, work, study and apply for certain substantive visas if both the SHEV pathway and the substantive visa application requirements are met. SHEV is a temporary type of protection visa aimed at encouraging people to work and study in regional Australia. Holders can access Medicare, social security benefits (Centrelink), job matching and short-term counselling for torture and trauma where required.

Bridging visas for maritime arrivals (Department of Immigration and Border Protection):
Since November 2011, eligible "illegal maritime arrivals" (IMAs) have been released from immigration detention on a Bridging visa E (BVE). A Bridging visa E is a temporary visa that lets the holder remain in the community lawfully while they await resolution of their immigration status. BVE holders have access to Medicare.

Source: Australia's humanitarian visas Department of Social Services, 2013; Department of Immigration and Border Protection

Appendix II

Questions Guiding GP Survey

Background Information about GP Practice	
Name:	
Organization:	
Address:	Local Government Area (LGA):
Length of time in role:	
Gender:	Date:

The areas for investigation during interviews with GPs include:

Experience of working with the Afghan community

Pattern of service utilization by the Afghan community in the past three years:

Primary presentations/diagnoses:

Referrals to other health services:

Continuity of care provided: e.g. recall for health checks, screenings, and care coordination with other health professionals:

Practices developed to respond to the needs of Afghan clients and families

Identifying needs for interpreter:

Access to interpreters and translated services for Afghans:

Other practice approaches:

Observations about what is happening in the lives of Afghan clients in the local community

Current uptake, any issues:

Unmet needs:

Afghan clients' understanding of health issues/health literacy:

Recommendations for Improving access to services for Afghan community members

Other information/resources required:

Support for health care professionals (best practice approaches):

Support for Afghan community to access /engage with services:

Coordination with other agencies:

General observations about how to improve support for Afghan clients and families:

(Yelland et al, 2014)