

HEALTH SCREENING OF NEWLY ARRIVED REFUGEES

**ADVICE FOR GPs in the SOUTH EASTERN SYDNEY
and ILLAWARRA AREA HEALTH SERVICE**

DECEMBER 2010

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INTRODUCTION

- This version was endorsed by the SESIH Refugee Health Coordination Group in September 2010.
- Version 1 was released as “Unofficial guidelines to GPs in the Illawarra” in May 2007.
- Updated recommendations relate to HIV tests, *Vitamin D* deficiency and mental health.
- The Australasian Society for Infectious Diseases (ASID) published ‘*Diagnosis, management and prevention of infections in recently arrived refugees*’ in 2009. All *advice* given in the document you are currently reading is intended to be consistent with the ASID guidelines.
 - You can download the ASID Guidelines or request a hardcopy at <http://www.asid.net.au/> under “Guidelines and publications”.
- The purpose of this document is to provide GPs working in SESIH area with support and specific advice about what to do with the results of screening tests for newly arriving refugees. *Please note that suggestions for referral/obtaining advice are certainly not meant to supplant existing GP referral patterns or to interfere with GPs existing relationships with specialists.*
- The advice in this guide is generally derived from results produced by South Eastern Area Laboratory Service (SEALS). Laboratory methodologies vary and no account has been made for different assays, or methods of reporting etc. that might be used by other laboratories.

Acknowledgements

- The previous “Unofficial guidelines” were written by Dr Craig Boutlis, Infectious Diseases Physician, Wollongong Hospital.
- These guidelines have only been made possible by the extensive work that has been done previously by a number of committed individuals around the country, including but not limited to Josh Davis and Murray Webber (Newcastle guidelines), Meredith Hansen-Knarhoi and Nathan Zweck (Darwin guidelines), members of ARHIG and ASID, Mitchell Smith (NSW Refugee Health Service), Vicki Wighton (GP reviewer), Karen Zwi (Sydney Children’s Hospital), the Tasmanian and Victorian refugee health groups who have been active in generating publications, forms and guidelines, and all those who have reviewed and contributed to this document prior to its distribution.

ABBREVIATIONS

| | |
|-------|---|
| ARHIG | Australian Refugee Health Information Group |
| ACL | Australian Centre for Languages (current service provider for settlement services in SESIH) |
| ASID | Australasian Society for Infectious Diseases |
| GP | General Practitioner |
| HCIS | Health Care Interpreter Service |
| ID | Infectious Diseases |
| IMACS | Infection Management and Control Service, Wollongong Hospital |
| MHS | Multicultural Health Service |
| SCH | Sydney Children's Hospital, Randwick |
| SEALS | South East Area Laboratory Services |
| SESIH | South Eastern Sydney Illawarra Area Health Service |
| TIS | Translating and Interpreting Service |
| TWH | Wollongong Hospital |

SESIH REFUGEE HEALTH PROGRAM

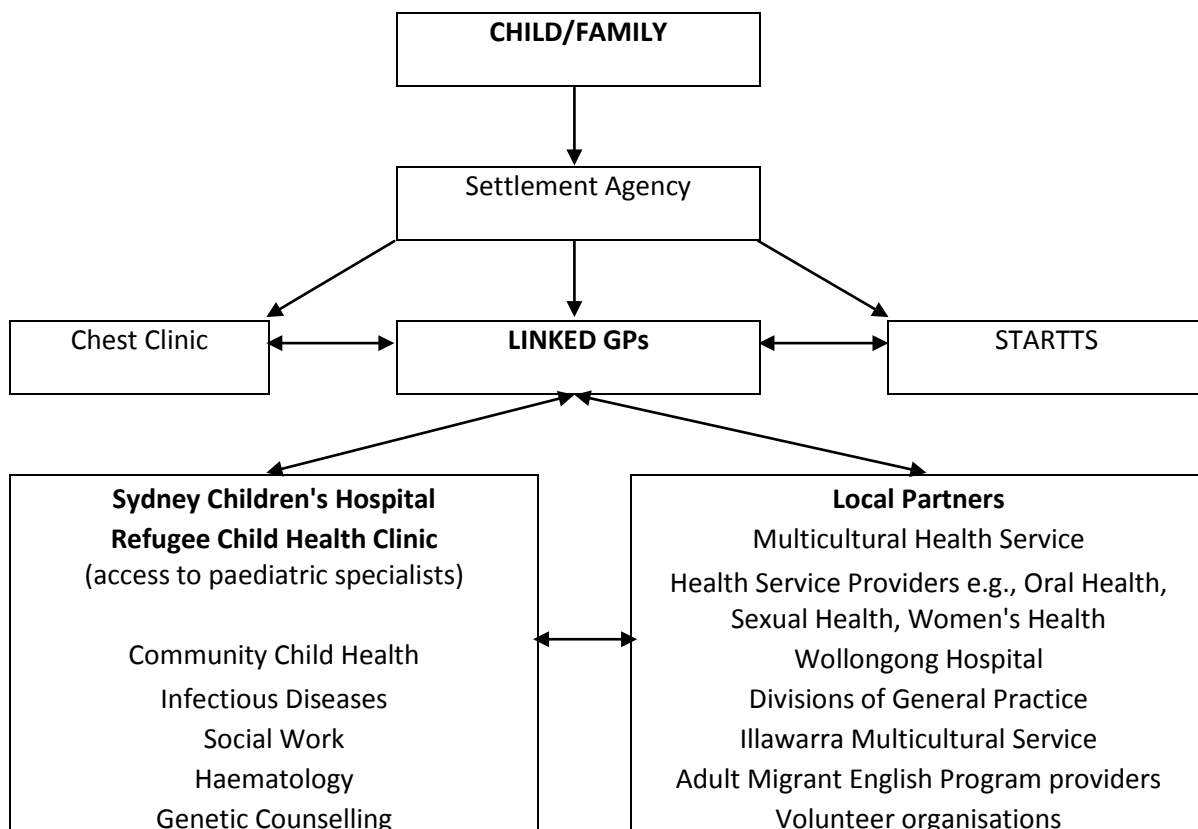
The biggest change since the original version of these GP Guidelines has been the development of a refugee health program in South Eastern Sydney Illawarra Area Health Service (SESIH), coordinated by the Multicultural Health Service (MHS). Multicultural Health Service staff involved in the program are currently:

- Dr Astrid Perry, Director, Multicultural Health Service, phone 9382 3309
- Lisa Woodland, Learning, Research and Workforce Development, phone 9382 3309
- Jenny Lane, Refugee Health Nurse, phone 4221 6700
- Assunta Vellozzi, Refugee Health Nurse, phone 4221 6700

The Refugee Health Nurses support family doctors (GPs) and other health professionals in providing health care to families with a refugee background. They can help individuals understand all aspects of their health care, and coordinate health education and health promotion activities for communities. They are an excellent point of first contact in most instances if guidance or direction is required.

Below is a diagram of the SESIH refugee health program, showing the pivotal role of General Practitioners.

GP CENTRED REFUGEE HEALTH PROGRAM, SESIH



Conditions detected through initial GP screening of refugees in the Illawarra, 2007-2010

Note: Figures obtained from the Refugee Health Database maintained by SESIH Refugee Health Nurses. Percentages based on results from those screened – between 450 and 500 arrivals in the three year period.

| Condition * positive serology, see relevant tables for interpretation | Percentage |
|--|------------|
| Malaria* | 5% |
| Hepatitis B* | 7% |
| Hepatitis C* | 4% |
| Tuberculosis * | 27% |
| Vitamin D deficiency | 23% |
| Low Ferritin | 23% |
| Schistosomiasis* | 33% |
| Strongyloides* | 16% |
| Rubella non-immune | 26% |
| Hepatitis B non-immune | 53% |

HOW DO REFUGEE FAMILIES FIND THEIR WAY TO A GP?

- Agencies throughout Australia assist refugee families to settle in various areas. The current agency in our area is Australian Centre for Languages (ACL).

Contact ACL in the Illawarra on 4228 0063, and in South East Sydney on 9749 3338.

- Each refugee family is linked with a case worker by the settlement agency on arrival in Australia. As much as possible, the case workers will be from the same cultural background as the new arrivals. Case workers are responsible for arranging transport for families to and from GPs, and for helping families navigate pathology labs, pharmacies and specialist health services as required. They assist with making appointments, and ensuring appointments are kept.
- It is helpful in encouraging attendance to book appointments outside the times allocated for AMEP English Language classes where possible.
- The settlement agency supports refugee families through the case workers, for between 6 and 12 months only. Families may then be referred to the local Migrant Resource Centre.
- *Case workers are not accredited interpreters and are not permitted to do health interpreting.*

ACCESS TO INTERPRETERS

- Telephone interpreters can be booked (for free) through the Commonwealth's Translation and Interpreter Service (TIS) doctors' priority line, Ph 1300 131 450.
- A TIS National Client Code is needed when making telephone interpreter bookings. You can request a form for a TIS National Client Code via http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/medical-practitioners.htm .
- GPs with a TIS National Client Code can pre-book a telephone interpreter via http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/telephone-booking.htm .
- If you have difficulties accessing interpreter services please contact the Multicultural Health Service.
- Refugee communities request that same sex interpreters be used wherever available – even when using the telephone interpreter service.
- *When making referrals, please indicate the languages spoken so that an appropriate interpreter can be organised for the patient prior to them being seen in clinic.*

MEDICARE ITEM NUMBERS 701, 703, 705 and 707

- The health assessment for refugees and other humanitarian entrants may be completed under **MBS Items 701 (brief), 703 (standard), 705 (long) or 707 (prolonged)** depending on the length of the consultation which will be determined by the complexity of the patient's presentation. These items replace the previous refugee health assessment items 714 and 716.
- Details relating to the item numbers and GP resources can be obtained at: http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_mbsitem_refugees
- Questions and Answers can be obtained at: http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_mbsitem_refugees_qanda
- Staff from Divisions of General Practice can load a template for refugee screening onto *Medical Director* and related programs.

| | |
|--|-----------|
| Eastern Sydney Division General Practice | 9389 0874 |
| Illawarra Division General Practice | 4220 7600 |
| Shoalhaven Division General Practice | 4423 6441 |
| South Eastern Division General Practice | 9663 5958 |
| St George Division General Practice | 9585 2044 |
| Shire GPs | 9525 4011 |

LIST of RECOMMENDED SCREENING TESTS FOR NEWLY ARRIVED REFUGEES

Serology for infectious diseases

Hepatitis B surface antigen, surface antibody, core antibody

Hepatitis C antibody

Human immunodeficiency virus (HIV)

Measles IgG

Mumps IgG

Rubella IgG

Schistosomiasis IgG

Strongyloides IgG

Syphilis serology screen

Tuberculosis CMI response/Quantiferon Gold

Haematology and biochemistry tests

Full blood examination (FBE)

Malaria parasites (thick and thin film)

ICT malarial antigen

Liver function tests (LFTs)

Urea and electrolytes (U&Es)

Calcium, magnesium and phosphate

Beta-HCG (women only)

25-OH Vit D (Vitamin D)

Urine tests

Neisseria gonorrhoea DNA

Chlamydia trachomatis DNA

SEROLOGY FOR INFECTIOUS DISEASES

Hepatitis B surface antigen, core antibody, and surface antibody

| Test | Interpretation | What to do |
|---|---|---|
| Hepatitis B core antibody (HBcAb) positive | Previous and/or current natural infection. Persists for life after infection, but occasionally wanes & becomes undetectable. Doesn't occur with vaccination. | <ul style="list-style-type: none"> Check HepB surface antigen and surface antibody tests to accurately categorise |
| Hepatitis B surface antigen (HBsAg) positive | Chronic carrier at risk of further liver disease. Laboratory will routinely perform Hepatitis B e antigen and Hepatitis B e antibody tests. | <ul style="list-style-type: none"> Alpha-fetoprotein level Upper abdominal Ultrasound <i>If ≥ 15 years</i> referral to TWH Gastroenterology Clinic, phone 4222 5180, fax 4222 5170, or page Gastroenterology Registrar by calling TWH on 4222 5000 <i>If ≤ 16 years</i> refer to Paediatric Refugee Clinic at SCH, Ph 9382 8472 , fax 9382 1461 (Outreach clinics conducted in Wollongong) Check Hepatitis A IgG and if negative, vaccinate for Hepatitis A Note: The reason to vaccinate for Hepatitis A is not because of increased risk but because of increased severity of disease if they were unlucky enough to get it Vaccinate non-immune family members (order free vaccine from Public Health Unit Ph 4221 6700) |
| Hepatitis B e antigen (HBeAg) positive | Ongoing high levels of virus replication in the blood, and therefore high risk of further liver damage and transmission. ALT often elevated as a marker of liver damage. | <ul style="list-style-type: none"> As advised following referral |
| Hepatitis B e antibody (HBeAb) positive [and negative HBeAg] | Partial self-resolution of infection with much lower levels of viral replication, lower risk of liver damage, and lower risk of transmission. ALT usually normal. | <ul style="list-style-type: none"> As advised following referral |
| Hepatitis B surface antibody (HBsAb) positive i.e., ≥ 10 IU/mL | Immunity due to natural infection (especially if associated with positive HBcAb) or vaccination | <ul style="list-style-type: none"> No further follow up. |
| Hepatitis B surface antibody (HBsAb) negative [with negative HBcAb] | Non-immune | <ul style="list-style-type: none"> Primary course of Hepatitis B vaccination (order free vaccine from Public Health Unit by calling 4221 6700) |
| HBcAb positive and HBsAg negative and HBsAb negative | Usually indicates past infection with robust natural immunity and waning of HBsAb. May also indicate recent acute infection, chronic infection with a mutated virus, or a false positive result. | <ul style="list-style-type: none"> Seek phone advice from a Microbiologist at the laboratory that performed the tests (these patients require further testing that may include a HbeAg and HbeAb, Hb core IgM, and HepB virus DNA). |

Clinical advice about adult patients: Gastroenterologist or advanced trainee at TWH Ph: 4222 5000

Clinical advice about children ≤ 16 yrs: Paediatric Infectious Diseases physician or Gastroenterologist at the Sydney Children's Hospital Ph: 9382 1111

Backup advice: Infectious Diseases physician, TWH

HEPATITIS B PATIENT INFORMATION SHEET

Patient Information Sheets included in English, Arabic, Burmese, French, Kirundi versions on CD

What is Hepatitis B?

- Hepatitis means inflammation (pain and swelling) of the liver.
- Hepatitis can be caused by chemicals, drugs, drinking too much alcohol or viruses.
- Hepatitis B is caused by the hepatitis B virus. It occurs more commonly in southeast Asia and parts of Africa.
- Some people who are infected will clear the virus from their body, and develop life long immunity. These people can no longer pass on hepatitis B to other people.
- Other people stay infected with hepatitis B, and some of these people get liver damage or liver cancer many years later. These people, called 'carriers', can also pass on the virus to other people.

What are the symptoms?

Many people have no symptoms when they first catch hepatitis B. Symptoms may include:

- Jaundice (the skin and whites of the eyes become yellow)
- Dark urine
- Pale faeces
- Tiredness
- Abdominal pain
- Loss of appetite
- Nausea & vomiting
- Joint pain.

How does someone catch Hepatitis B?

The hepatitis B virus is in the blood, liver and body fluids of an infected person.

The virus may spread to the baby of a woman carrier of hepatitis B during pregnancy or birth. In Australia all babies are vaccinated against hepatitis B after birth.

The hepatitis B virus can also be spread by:

- Unclean equipment used for injections, operations, removal of teeth, or tattooing.
- A blood transfusion which contains hepatitis B virus. Blood used for transfusions in Australia is tested for hepatitis B.
- Using personal items like razors and toothbrushes (which may have blood on them) belonging to someone with hepatitis B.
- Sexual activity with an infected person when a condom is not used.

How is hepatitis B diagnosed?

- A blood test can tell if you have been infected with hepatitis B virus in the past.
- A blood test can also tell whether you have cleared the virus from your body. Hepatitis B antibodies (from proteins that fight infection) will still be in your blood even if you have cleared the virus.
- If the test shows that you are still a carrier of hepatitis B, your doctor may do another test and refer you to a specialist doctor or clinic.

HEPATITIS B PATIENT INFORMATION SHEET continued

Patient Information Sheets included in English, Arabic, Burmese, French, Kirundi versions on CD

How is hepatitis B treated?

- Treatment aims to clear hepatitis B from your body. The treatment is usually arranged by special liver clinics.

If you have hepatitis B you will feel better if you:

- Avoid drinking alcohol
- Eat a well-balanced, low fat diet
- Do regular exercise
- Rest when you are tired.

It is important to have regular checkups with your family doctor.

How can someone avoid catching hepatitis B?

- Always use condoms with new sexual partners or with people who are not vaccinated against hepatitis B.
- Do not share needles, syringes or injecting drug use equipment.
- Do not share tooth brushes or razors.
- Get vaccinated against hepatitis B if you do not have immunity. People who live with a person with hepatitis B can get free hepatitis B vaccination from their family doctor.
- Babies born to mothers who are carriers, can receive extra protection with an injection of hepatitis B immunoglobulin after birth.

Hepatitis C Antibody

Most laboratories employ two different ELISA tests (i.e., from separate manufacturers) to test for HepC IgG antibodies. Different ELISA tests target slightly different antigenic determinants and this allows possible false positive results from one ELISA to be rejected or confirmed by the other.

| Test results | Interpretation | What to do |
|--|---|---|
| Negative Hepatitis C antibody (both assays are negative) | Usually indicates no HepC. May be seen in first few months following infection in presence of recent risk factors or with acute hepatitis. | <ul style="list-style-type: none"> No further follow-up in absence of signs of acute hepatitis (e.g., elevated bilirubin or ALT, jaundice) |
| Indeterminate Hepatitis C result (when one assay is positive and the other negative) | The likelihood that an indeterminate result represents infection with HepC is heavily influenced by risk factors (e.g., higher likelihood in intravenous drug users, much lower in refugees and general community). | <ul style="list-style-type: none"> Repeat HepC antibody test sent to a different laboratory in one month's time <i>If test is again indeterminate</i> Refer those ≥ 15 years to TWH Gastroenterology Clinic, phone 4222 5180, fax 4222 5170, or page Gastroenterology Registrar on 4222 5000 <i>Refer those ≤ 16 years</i> to Paediatric Refugee Clinic at SCH, phone 9382 8472, fax 9382 1461 (Outreach clinics conducted in Wollongong) |
| Positive result on both Hepatitis C antibody tests | Previous \pm ongoing infection. About 20% of people may clear HepC spontaneously without sequelae. The rest remain infected and are at risk of chronic hepatitis, cirrhosis and hepatocellular carcinoma. | <ul style="list-style-type: none"> Alpha-fetoprotein level Upper abdominal ultrasound looking for hepatocellular carcinoma Seek phone advice if evidence of acute HepC (e.g., jaundice or ALT level > 5 times normal) <i>If ≥ 15 years</i> referral to TWH Gastroenterology Clinic, phone 4222 5180, fax 4222 5170, or page Gastroenterology Registrar on 4222 5000 <i>If ≤ 16 years</i> referral to Paediatric Infectious Diseases Clinic at SCH, Fax referral to 9382 1461 |

Further advice

- Advice regarding interpretation of serology and further testing: Speak with a Microbiologist representing the laboratory that performed the tests.
- Clinical advice about adult patients: Gastroenterologist or advanced trainee at TWH.
- Clinical advice about children ≤ 16 yrs: Paediatric Infectious Diseases physician or Gastroenterologist at the Sydney Children's Hospital Ph: 9382 1111.
- Backup advice: Infectious diseases physician at Wollongong Hospital Ph: 4222 5000.

HEPATITIS C PATIENT INFORMATION SHEET

Patient Information Sheets included in English, Arabic, Burmese, French, Kirundi versions on CD

What is hepatitis C?

- Hepatitis means inflammation (pain and swelling) of the liver.
- Hepatitis can be caused by chemicals, drugs, drinking too much alcohol or viruses.
- Hepatitis C is caused by the hepatitis C virus; there are many different strains of this virus.
- About one quarter of people who are infected will clear the virus from their body in six months.
- The rest will carry the virus for life, and some will get liver damage or liver cancer many years later.

What are the symptoms of hepatitis C?

Symptoms often don't appear until years after infection with the hepatitis C virus. Symptoms include:

- Tiredness
- Loss of appetite
- Nausea and vomiting
- Soreness under the ribs on the right side
- Fever
- Joint pain
- Mood changes and depression.

How is hepatitis C spread?

The hepatitis C virus is in the blood of an infected person. The virus can be spread by:

- Unclean equipment used for injections, operations, removal of teeth, or tattooing
- Infected blood transfusions. Blood used for transfusions in Australia is tested for hepatitis C
- Using personal items like razors and toothbrushes (which may have blood on them) belonging to someone with hepatitis C
- Sometimes the virus may spread to the baby of a woman with hepatitis C during pregnancy or birth. The risk is higher if the mother has been recently infected. Hepatitis C does not seem to be spread through breast milk, unless there is blood in the milk
- Hepatitis C is rarely spread through sexual activity, but is more likely if there is contact with blood.

How is hepatitis C diagnosed?

- A blood test can tell if you have been infected with hepatitis C virus. It may take up to 6 months after infection before the blood test can detect hepatitis C.
- A blood test can also tell whether you have cleared the virus from your body.
- Hepatitis C antibodies (from proteins that fight infection) will still be in your blood even if you have cleared the virus.
- If you have hepatitis C antibodies, and your body has not cleared the virus, your doctor may refer you to a specialist doctor or clinic.

How is hepatitis C treated?

- Treatment aims to clear hepatitis C from your body. The treatment lasts for 6 to 12 months, and is usually arranged by special liver clinics.

If you have hepatitis C you will feel better if you:

- Avoid drinking alcohol
- Eat a well-balanced, low fat diet
- Do regular exercise
- Rest when you are tired.
- Have regular checkups with your family doctor.

Do I have to tell anyone if I have hepatitis C?

Unless you are donating blood, or applying for life insurance, you do not have to tell anyone.

Human Immunodeficiency Virus (HIV)

People over the age of 15 years are tested for HIV as part of the visa application process. Testing may be done up to 6 months prior to travel to Australia, leaving a large window of opportunity for infection after testing. In addition an antibody-only test is often used, rather than the combined antibody/antigen test used in Australia.

The Australasian Society for Infectious Diseases (ASID) recommends that all refugees, including children, be offered screening for HIV. ASID advises that:

- “All screening test should be performed with the knowledge and informed consent of the individual or their legal guardian.
- GPs should explain that the results of screening tests do not have adverse implications for the refugees’ status as Australian residents.
- Testing the mother for HIV infection should not be used *in lieu* of direct testing of the child.
- Refugees with positive serology for HIV should be advised of transmission risk (including vertical transmission of pregnant) and referred urgently to the local HIV management service”.

(Australian Society for Infectious Diseases. 2009. Diagnosis, management and prevention of infections in recently arrived refugees. p 20)

A useful guide for pre-test discussion is attached to the SESIH *HIV Pre-test Discussion and Consent Form*. Contact a Refugee Health Nurse on 4221 6700 for a copy.

Measles, Mumps & Rubella IgG Antibody

| Test results | Interpretation | What to do |
|--------------------------------------|--|---|
| Negative Measles IgG antibody | Not immune | <ul style="list-style-type: none"> Primary vaccination course (see current <i>Australian Immunisation Handbook</i> or contact the Public Health Unit on 4221 6700 for advice). |
| Equivocal Measles IgG antibody | Don't assume immunity SEALS states 'This is most likely due to waning immunity from past measles infection or vaccination' | <ul style="list-style-type: none"> Primary vaccination course |
| Positive Measles IgG antibody | Immune | <ul style="list-style-type: none"> No further follow up |
| Negative Mumps IgG antibody | Not immune | <ul style="list-style-type: none"> Primary vaccination course (see above) |
| Equivocal Mumps IgG antibody | Don't assume immunity | <ul style="list-style-type: none"> Primary vaccination course |
| Positive Mumps IgG antibody | Immune | <ul style="list-style-type: none"> No further follow up |
| Rubella IgG antibody (measures vary) | Not immune | <ul style="list-style-type: none"> Primary vaccination course (see current <i>Australian Immunisation Handbook</i> or contact the Public Health Unit on 4221 6700 for advice) |
| | Doubtful immunity May indicate cross-reactivity or substantially waned immunity | <ul style="list-style-type: none"> Primary vaccination course |
| | Low level of antibody, likely waning immunity Low levels of antibody more likely to be protective if acquired through natural infection rather than vaccination | <ul style="list-style-type: none"> No further follow up |
| | Robust immunity | <ul style="list-style-type: none"> No further follow up |

- MMR is contraindicated during pregnancy and in other immunosuppressive conditions.
- Women should be advised not to become pregnant for 28 days after vaccination.
- Non-immune pregnant women should be vaccinated with MMR after the pregnancy.
- For children aged < 7 yrs, a catch-up calculator conforming to the NSW schedule for all vaccine-preventable diseases can be found at <http://www.health.sa.gov.au/immunisationcalculator/>
- We recommend testing for mumps immunity as we have recognised non-immune refugees previously and a high proportion of refugees choose a future career in health care or aged care.

Schistosomiasis IgG EIA Ratio

| Test results | Interpretation | What to do |
|--|--|---|
| Negative Schistosomiasis IgG EIA ratio | Not infected with Schistosomiasis NB: Negative results may be found during acute Schistosomiasis (in the first 12 weeks following exposure) | <ul style="list-style-type: none"> If asymptomatic no further follow up Seek phone advice from Infectious Diseases physician at TWH, Ph 4222 5000 if evidence of acute infection (very rare in endemic populations; a hypersensitivity syndrome of fever, myalgia, arthralgia, diarrhoea, cough, headache, lymphadenopathy, hepatosplenomegaly and eosinophilia) |
| Equivocal Schistosomiasis IgG EIA ratio | May indicate low level infection, waning of previously positive test, or cross-reactions with other helminths (i.e., false positive) | Equivocal results are treated as positive |
| Positive Schistosomiasis IgG EIA ratio | Infection with Schistosomiasis at some time in the past but does not differentiate acute, chronic or resolved infection | <ul style="list-style-type: none"> Seek phone advice if patient has evidence of acute infection (see above) Request a single faeces specimen for 'OCP, permanent stain and concentrate' Request a single TERMINAL stream urine (to be taken at lunchtime) for 'microscopy [looking for haematuria], OCP, and concentrate' Treat with Praziquantel as per protocol below. Praziquantel has been added to the PBS as an authority-required (streamlined) benefit. |
| With positive faeces or urine microscopy | High worm burden | <ul style="list-style-type: none"> Repeat urine or faeces microscopy 2 months after treatment |
| With haematuria or genitourinary symptoms | | <ul style="list-style-type: none"> Renal U/Sound Referral to ID physician |
| With history or evidence of liver disease | | <ul style="list-style-type: none"> Liver U/Sound Referral to ID physician |
| <ul style="list-style-type: none"> If patient had eosinophilia repeat the FBE 8-12 weeks after treatment. If eosinophilia persists, check a faeces test for strongyloides or other parasites, and call Infectious Diseases physician at TWH for advice Ph: 4222 5000. | | |

Praziquantel regime

- Praziquantel (Biltricide, 600mg tablets) has been listed as an authority-required (streamlined) benefit on the Pharmaceutical Benefits Scheme as of 1 August 2009. Praziquantel is listed for the treatment of schistosomiasis (bilharzia) in people with positive serology.
- Praziquantel is prescribed in two doses of 20mg/kg, taken four apart, with a fatty meal.
- Praziquantel tablets are scored and can be broken into either 2 x 300mg halves or 4 x 150mg quarters as necessary (see MIMS for more details)
- Praziquantel is category B1 and is probably best avoided in the first trimester, but can be offered later in pregnancy and during breastfeeding, especially if follow up will be difficult or in the case of heavy worm burdens (ova present in feces or urine). If follow up can be assured and there are no ova, then treatment can be withheld until after pregnancy.
- Follow the link for further information:
<http://www.asid.net.au/downloads/RefugeeGuidelines.pdf>

SCHISTOSOMIASIS PATIENT INFORMATION SHEET

Patient Information Sheets included in English, Arabic, Burmese, French, Kirundi versions on CD

What is Schistosomiasis?

- Schistosomiasis, also known as bilharzia, is a disease caused by tiny worms that live in fresh water.
- Infection occurs when your skin comes into contact with young worms.
- The worms can burrow through the skin and travel to the lungs and liver, where they grow into adult worms and start making eggs.
- The worms can live in the blood vessels, bladder or the gut for many years.
- If not treated, the worms and their eggs can cause damage to the liver, intestines, and bladder. Rarely, they can cause problems such as seizures (fits).

Who is at risk?

- If you have lived in, or travelled to areas where schistosomiasis worms live in fresh water (e.g., in some African countries, the Caribbean, southern China, southeast Asia and the Middle East), you may have been infected in the past.
- People become infected during activities like collecting water, farming or fishing in freshwater canals, streams or lakes.

What are the symptoms?

- Within days of being infected some people notice a rash or itchy skin.
- Over the next few weeks, fever, headache, cough and muscle aches can occur.
- Most people will not have any symptoms, even with worms living in their body and making eggs.

How is it diagnosed?

- A blood test will show if you have ever had schistosomiasis.
- If the test is positive, you may be asked to give samples of your urine and faeces to see if there are any eggs.
- If eggs are found, further tests (e.g., x-rays) may be needed.

How is the infection treated?

- Safe and effective drugs are available for treating schistosomiasis.
- Most people with a positive blood test will be offered tablets.
- If eggs are found in your urine or faeces, a second course of treatment might be needed.

Strongyloides antibody IgG EIA ratio

| Test results | Interpretation | What to do |
|--|--|---|
| <p>Equivocal Strongyloides IgG EIA ratio</p> <p>Positive Strongyloides IgG EIA ratio</p> | <p>May indicate low level infection, waning of previously positive test, or cross-reactions with other helminths (i.e., false positive)</p> <p>Infection with Strongyloides at some time in the past, does not differentiate between acute (uncommon), chronic or resolved infection</p> | <p>Equivocal results are treated as positive</p> <ul style="list-style-type: none"> Well patients with Strongyloides can be treated by GPs as per protocol below <i>In patients with immunosuppression, or evidence of complicated or disseminated infection (e.g., fever, anorexia, abdominal and/or respiratory symptoms), seek advice from Infectious Diseases physician at TWH (4222 5000)</i> <i>For pregnant women delay treatment until after pregnancy.</i> |

Treatment protocol for Strongyloides

| Patient age/profile | Treatment/dose | Follow up |
|--|---|---|
| Children < 5 years | Refer to Paediatric Infectious Diseases Clinic at SCH, Fax referral to 9382 1461 | <ul style="list-style-type: none"> Treatment must be repeated after 2 weeks to eliminate any migrating parasites |
| Adults and children > 5 years | <p>Ivermectin 200 micrograms/kg stat – rounded off to nearest 3 mg (3000 mcg) tablet</p> <p>To be taken orally with fatty food</p> <p>Ivermectin is compatible with breastfeeding</p> | <ul style="list-style-type: none"> Repeat the dose after 2 weeks to eliminate any migrating parasites |
| <p><i>If patient had eosinophilia repeat the FBE 8-12 weeks after treatment. If eosinophilia persists, check a faeces test for strongyloides or other parasites, and call Infectious Diseases physician at TWH for advice Ph: 4222 5000.</i></p> | | |

STRONGYLOIDIASIS PATIENT INFORMATION SHEET

Patient Information Sheets included in English, Arabic, Burmese, French, Kirundi versions on CD

What is strongyloidiasis?

- Strongyloidiasis is an infection with a tiny roundworm called *Strongyloides stercoralis*, which occurs in many tropical countries.
- People become infected when the worms burrow through the skin and travel to the intestines.

Who is at risk?

- Anyone who comes in contact with infected soil or faeces is at risk of being infected with this worm. Over 30 million people in 70 countries have strongyloidiasis.
- The worms can live outside the body for up to 3 weeks, and infection is more common when hygiene and sanitation is poor.
- Where there is good sanitation and good hand washing practices, there is little risk of transmitting *Strongyloides* to other people.

What are the symptoms?

Most people with Strongyloidiasis have no symptoms.

Sometimes an infected person may have some or all of the following symptoms:

- Diarrhoea and abdominal pain.
- Itchy rash on the buttocks or waist.
- Chest symptoms e.g., cough.
- Sometimes, if a person becomes sick for other reasons, the worms can spread to other parts of the body and cause serious health problems.
- People who are infected with *Strongyloides* worms may have symptoms over years or even decades, if they are not treated.

How is *Strongyloides* detected?

- A blood test will show if you have ever been infected with *Strongyloides* worms.
- If the blood test is positive, the doctor may ask you to collect one or more samples of your faeces to check if the worms are still active.

How is the infection treated?

- Your doctor may prescribe a single course of tablets.
- The tablets are safe for children and adults who are well.
- People who are very sick with Strongyloidiasis may be referred to a specialist doctor.

Syphilis serology screen

| Test results | Interpretation | What to do |
|---|--|---|
| <i>Treponema pallidum</i> antibody (TP EIA test) positive | Patient is currently, or has previously been, infected with syphilis False positives may occur Laboratory will routinely perform a TPPA and FTA-Abs, and a VDRL or RPR | Unless GPs are very comfortable with the management of syphilis it is recommended that ALL patients with positive serology be referred for assessment, counseling, and treatment. |
| TPPA and/or FTA-Abs positive | Infection with syphilis (or another pathogenic treponemal infection such as yaws) at some time in the patient's life Tests usually remain positive for life despite adequate treatment | <ul style="list-style-type: none"> • Notifiable disease, call Public Health Unit (Wollongong 4221 6700 or Randwick 9382 833) or complete notification form at www.health.nsw.gov.au/public-health/forms/pdf/illawarra/index.html • HIV test • Examine for signs of tertiary syphilis |
| VDRL and/or RPR positive (a reasonable test of current activity) | Early/active syphilis (primary syphilis with chancre), secondary syphilis (with rash or condylomata lata), or latent syphilis (asymptomatic < 2 years duration) <i>OR</i> Late syphilis (i.e., late latent syphilis [asymptomatic > 2 years duration] or tertiary syphilis [neurological or cardiovascular disease]). | <ul style="list-style-type: none"> • Referral recommended • Examine patient for signs of primary & secondary syphilis. If asymptomatic, it is most likely the patient will have latent or tertiary syphilis |
| TPPA and/or FTA-Abs positive and VDRL negative | If asymptomatic but with no history of specific treatment for syphilis assume latent syphilis If asymptomatic and an accurate history of specific treatment for syphilis, no further follow up | <ul style="list-style-type: none"> • Referral recommended • No treatment required |
| <p>Referral pathways/further advice</p> <p><i>Age ≤ 16 years</i>, refer to Infectious Diseases clinic at Sydney Children's Hospital, ph 9382 1111 For advice regarding child protection contact the Child Wellbeing Area Coordinator on 4224 2900</p> <p><i>Age ≥ 14 years</i>, refer to Illawarra Sexual Health Service, Port Kembla Ph 4223 8457, fax 4276 2521 For clinical advice phone Sexual Health physician at the Illawarra Sexual Health Service 4223 8457</p> <p><i>Refer to Service for Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) as appropriate, Ph: 9794 1900</i></p> | | |

Tuberculosis CMI response/Quantiferon Gold

- People coming to the Illawarra on 200 Visas (Refugee visa) are referred to The Wollongong Hospital Chest Clinic by the settlement agency on arrival. The case worker will ensure the family attends the Chest Clinic appointment. A GP referral will confirm the name of the family doctor and provide information regarding health conditions, pregnancy, vaccinations and medications that may affect the Chest Clinic screening.
- People sponsoring others to settle through 202 Visas (Global Special Humanitarian visas) are responsible for taking their family/friends to the Chest Clinic. The sponsored family will need to be referred to TWH Chest Clinic by the GP.
- Catch-up testing is available for refugees who may have missed out on TB screening in the past. Refer these people to the Chest Clinic at TWH.

Note: NSW Health TB factsheets have been translated into Arabic, Burmese, French, and Kirundi languages; these are available on the enclosed CD.

Interpreting TB CMI/Quantiferon Gold blood test

- A positive test indicates likely infection with *M. tuberculosis* but does not differentiate latent (asymptomatic) infection from active TB. Most refugees will have been screened for active TB prior to departure with a chest X-ray and therefore positive results usually indicate latent infection.
- Measures a person's cellular immune response to tuberculous proteins, giving similar information to the traditional Mantoux skin test. It is probably more specific for TB than a Mantoux test and is less likely to be affected by BCG vaccination. *In general, the TB CMI and Mantoux provide complementary information and are best interpreted together by staff at the Chest Clinic (see above).*
- The TB CMI assay measures gamma interferon production (international units [IU]/mL) by T cells and there are two components:
 - Non-specific mitogen gamma interferon – tests to see if the patient's T cells are working properly, everyone should produce gamma interferon in response to stimulation by the mitogen (i.e., a positive control).
 - TB-specific antigen gamma interferon – tests to see if the patient's T cells recognise TB-specific proteins (indicating prior TB exposure resulting in latent "asymptomatic" infection or active disease).
- A TB CMI test is only interpretable if the response to mitogen is positive; if the response to mitogen is negative, then the result will be reported as "indeterminate".

When there are symptoms or signs of possible active TB

- If you detect symptoms or signs of possible active TB in any refugee through routine clinical assessment (e.g., fever, persistent cough > 2 weeks, unexplained localised lymphadenopathy or other organ specific pathology) regardless of their TB CMI test, then *please seek urgent phone assistance through the Chest Clinic at TWH, Ph: 4253 4138*. After hours, send the patient to the Emergency department for isolation and assessment.

HAEMATOLOGY AND BIOCHEMISTRY TESTS

25-OH Vit D (Vitamin D) adults & children > 16 years

| Adult results | Interpretation | What to do |
|---------------|--------------------------------------|--|
| > 75 nmol/L | Normal Vitamin D | |
| 50-75 nmol/L | Relative Vitamin D insufficiency | <ul style="list-style-type: none"> Vitamin D₂ (Ergocalciferol) or D₃ (Cholecalciferol) 400-1000 IU/day Check Vitamin D level 3 and 12 months after treatment |
| < 50 nmol/L | Deficiency of Vitamin D | <ul style="list-style-type: none"> If clinical evidence of rickets (e.g., muscle pain and weakness is common), refer to public Endocrine Clinic at TWH, Ph4253 4136 Vitamin D₂ (Ergocalciferol) or D₃ (Cholecalciferol) 400-1000 IU/day [do not use preparations containing Vitamin A during pregnancy] Dietary advice to ensure adequate calcium intake Check Vitamin D level 3 & 12 months after treatment |
| <25 nmol/L | Moderate-severe Vitamin D deficiency | <ul style="list-style-type: none"> Refer to public Endocrine Clinic at TWH, as requires high dose therapy (phone 4222 4136) |

25-OH Vit D (Vitamin D) children < 16 years

| Children results | Interpretation | What to do |
|------------------|----------------------------------|--|
| > 50 nmol/L | Normal Vitamin D | Annual testing after winter is recommended for children at risk (e.g., those born to Vitamin D deficient mothers, or having IBD & cystic fibrosis) |
| 25-50 nmol/L | Relative Vitamin D insufficiency | <ul style="list-style-type: none"> If not referring, test for Ca/Mg/PO₄, ALP, PTH, Albumin & concurrent Fe deficiency Measure & treat low Ca levels See treatment course & monitoring guide below |
| <25 nmol/L | Deficiency of Vitamin D | <ul style="list-style-type: none"> X-Ray knee or wrist to assess for rickets; repeat after 6 months therapy if rickets evident If clinical evidence of rickets (e.g., delayed walking, leg bowing, seizures, failure to thrive) refer to Paediatric Refugee Clinic at SCH, Ph Dr Karen Zwi on 9382 8472 or 9382 1111. <i>NB: there is the option for a single high dose of Vitamin D (STOSS therapy) via SCH & Outreach Clinics in Wollongong</i> If not referring, , test for Ca/Mg/PO₄, ALP, PTH, Albumin & concurrent Fe deficiency Measure & treat low Ca levels See treatment course & monitoring guide below |

Vitamin D treatment course and monitoring for children

| CHILD AGE | VITAMIN D INSUFFICIENCY 25-50 NMOL/L | | VITAMIN D DEFICIENCY < 25 NMOL/L | |
|--------------------|---|---|--|---|
| | Treatment | Follow up | Treatment | Follow up |
| Neonate < 1 month | 10 µg/day (400 IU) of Vitamin D for 3 months | <i>Maintenance</i> dose of 10 µg/day (400 IU) of Vitamin D <i>Recheck</i> Ca/Mg/PO ₄ ; ALP; PTH; Vitamin D levels at 1, 3 & 12 months after treatment | 25 µg/day (1000 IU) of Vitamin D for 3 months | <i>Maintenance</i> dose of 10 µg/day (400 IU) of Vitamin D <i>Recheck</i> Ca/Mg/PO ₄ ; ALP; PTH; Vitamin D levels at 1, 3 & 12 months after treatment |
| Infant 1-12 months | 25 µg/day (1000 IU) of Vitamin D for 3 months | | 75 µg/day (3000 IU) of Vitamin D for 3 months | |
| Child > 12 months | 25-50 µg/day (1000 – 2000 IU) of Vitamin D for 3 months | | 125 µg/day (5000 IU) of Vitamin D for 3 months | |

VITAMIN D DEFICIENCY PATIENT INFORMATION SHEET

Patient Information Sheets included in English, Arabic, Burmese, French, Kirundi versions on CD

Why do we need Vitamin D ?

We need Vitamin D so that our bodies can use the calcium in food. Calcium helps to:

- build strong and healthy bones, teeth and muscles
- prevent rickets (soft and weakened bones) in children
- prevent bone fractures in the elderly.

Where is Vitamin D found ?

- Most of the Vitamin D needed by the body is made by cells in the skin when sunlight shines on the skin.
- There are only small amounts of Vitamin D in foods like saltwater fish (e.g., tuna, salmon, mackerel, sardines) eggs, margarine, oils and milk.
- It is hard to get enough Vitamin D just from food; some sunlight is needed.

Who is at risk of Vitamin D deficiency?

- Children as their bones are growing
- People with dark skin
- People who haven't been exposed to enough sunlight
- People who cover most of their body
- Frail, elderly people
- People with medical conditions like some bowel diseases.

How is it diagnosed ?

- A blood test can check to see if you have low Vitamin D.
- Your doctor may refer children with Vitamin D deficiency to a specialist to check their bone development.

How is Vitamin D deficiency treated?

- Your family doctor may prescribe Vitamin D tablets, which usually have to be taken every day for several months.
- In Australia, being in the sun for 5 to 15 minutes several times a week will give you enough sunlight to make Vitamin D. People with darker skins need 15 to 45 minutes in the sun.
- Remember to use sunscreen if you are in the sun between 11am and 3pm during the summer months. Always avoid sunburn.
- Ensure you have a well balanced diet, including foods containing calcium. Some foods which contain calcium are dairy products (like milk, cheese, butter, yoghurt), soy bean products, green vegetables (like spinach & broccoli), boiled eggs, oranges and dried apricots.

Full blood examination (FBE) interpreting results in refugee patients

| Test results | Interpretation/comments | What to do |
|--------------------------------------|---|--|
| Microcytic anaemia (no eosinophilia) | Commonest cause is iron deficiency due to GI bleeding from hookworm infection If documented Albendazole pre-departure | <ul style="list-style-type: none"> • Single dose of Albendazole (at doses below) • Recheck FBE 8-12 weeks later • No treatment, but repeat FBE in 8-12 weeks to check for resolution |
| Mild neutropaenia | Very common in refugees from African countries and is not pathological | <ul style="list-style-type: none"> • In absence of history of recurrent infections, can generally be ignored |
| Thrombocytopenia | Common feature of malaria | <ul style="list-style-type: none"> • Exclude acute malaria (fever etc.) • Ensure that a thick and thin film and ICT malaria antigen were done |
| Haemoglobin level <90 g/L | | <ul style="list-style-type: none"> • Commence on oral iron |
| Significant lymphocytopenia | May reflect intercurrent illness or malnutrition | <ul style="list-style-type: none"> • Review risk factors for HIV and check HIV serology if not done |
| Eosinophilia | <p>Commonest cause in refugees is helminth infections e.g., hookworm, ascariasis, schistosomiasis, strongyloides, trichuris / whipworm</p> <p>May persist for up to a month after successful treatment of helminth infection</p> <p>(Rare causes of eosinophilia include lymphoma, vasculitis, drug hypersensitivity, and eosinophilic pulmonary disease)</p> | <ul style="list-style-type: none"> • Manage schistosomiasis & strongyloides as appropriate • If possible (and certainly if gastrointestinal symptoms are present) send a single faeces sample for 'OCP, concentrate & permanent stain'. Seek advice from Infectious Diseases physician (Ph4222 5000) • Treat asymptomatic patients with Albendazole, unless pre-departure Albendazole is documented (check with Refugee Health Nurse). • <i>Albendazole is not suitable for pregnant women or children < 6 months old. Seek phone advice</i> • Repeat FBE 8-12 weeks after treatment |

Albendazole therapy protocol for eosinophilia

| Patient age/profile | Treatment/dose | Follow up |
|--|----------------------------|--|
| Children ≤ 10kg | 200 mg stat | <ul style="list-style-type: none"> • Repeat FBE 8-12 weeks following treatment. • <i>If eosinophilia persists send three consecutive faeces specimens for 'OCP, concentrate & permanent stain' and refer to ID physician</i> |
| Adults and children > 10 kg | 400 mg stat | |
| If hookworm or ascaris identified, or if a pathogen hasn't been identified | Only 1 dose is required | |
| For <i>Trichuris</i> (whipworm) | 3 daily doses are required | |

Pregnancy

A positive Beta-HCG test on arrival may indicate an unplanned pregnancy, particularly in a single or widowed woman. Rape, forced prostitution and sexual slavery are common repercussions of war, and sexual violence may persist even after women have escaped the conflict area. Refugee women and girls are vulnerable to sexual violence in refugee camps or while in transit to another country.

In addition, many women have experienced years of deprivation, under-nutrition and lack of access to quality health care, with a high rate of unassisted births and high infant mortality rates. Finally, women often lack knowledge of birthing and childcare practices in the Australian context, and may be fearful of pregnancy outcomes.

Female Genital Mutilation

Significant numbers of refugee women migrate to Australia from regions where female genital mutilation (FGM) is practised, such as the Horn of Africa, the Middle East and parts of South East Asia. FGM is a practice that is usually performed without anaesthetic and in unsanitary conditions. Apart from the immediate risk to girls of haemorrhage, infection, pain and fear, many women experience long-term complications including recurrent urinary tract infections, incontinence, obstructed menstrual flow, sexual difficulties and obstetric problems. For more information on FGM contact

| | |
|--------------------------------------|-----------|
| NSW Education Program on FGM | 9840 4101 |
| Auburn Hospital Maternity Unit (FGM) | 9563 9500 |
| Education Centre Against Violence | 9840 3737 |

Ferritin and iron deficiency in children

| Test results | Interpretation/comments | What to do |
|--|-------------------------|--|
| Low ferritin < 20 µg/L and MCV < 75 fL if < 13 years MCV < 80 fL if > 13 years and Haemoglobin < 100 g/L | Iron deficiency anaemia | <ul style="list-style-type: none"> • Fe supplementation, Hb 80-100 g/L Fe Supplementation at 3 mg elemental iron/kg/day in one or two doses daily between meals for 4 weeks • Fe supplementation, Hb < 80 g/L Fe Supplementation at 4-6 mg elemental iron/kg/day in one or two doses daily between meals for 4 weeks • Encourage iron-rich foods such as meat, poultry, fish, wholegrain cereals, raisins, almonds and peanuts, leafy green vegetables, dried beans • Vitamin C-rich foods improve absorption of Fe • The following foods reduce absorption: certain cereals (bran, oats, rye), soy protein, tea, coffee, eggs, calcium rich foods • Retest FBC 4 weeks after commencing therapy when the child is clinically well • If Hb has increased by 1g/L or reached normal range for age, continue Fe supplementation and retest FBC every 2-3 months until normal Hb is reached • Continue treatment for 2 months after normal Hb is reached • If not responding to treatment Reassess treatment plan and diet Check compliance Check stool for occult blood Haemoglobin Electrophoresis (HbEPG) to exclude Thalassaemia & haemoglobinopathies Consider other causes of anaemia eg chronic disease |
| NOTES <ul style="list-style-type: none"> • Parenteral Fe therapy is reserved for patients who have severe persistent anaemia with proven intolerance to oral Fe, malabsorption or poor compliance • Transfusion is only considered for Hb of below 4-5 g/when the patient is in distress (HR>160b/min, Respiratory rate >30/min, lethargy, poor feeding) • FERRO LIQUID 5ml = 30 mg elemental iron • FERRO-GRADUMET 1 tablet = 105 mg elemental iron | | |

ICT malarial antigen and malaria parasite (thick and thin film)

About the tests

- Screening samples sent to the TWH laboratory will be processed for a standard thick and thin film to look for malaria parasites, as well as an antigen test. Blood films are reviewed at the TWH laboratory, and then sent to a reference laboratory for a final check before issuing a negative result.
- The thick film is a drop of blood that concentrates parasites, which makes detection easier but precise identification a little more difficult. Thin films are a smear of blood 1 cell layer thick, which makes detection of low level malaria parasitaemia very difficult, but enables precise identification of the malaria species.
- The immuno-chromatographic malaria antigen test (ICT) uses a piece of filter paper impregnated with antibodies to both a general malaria antigen (common to all four species affecting humans) and a specific *Plasmodium falciparum* antigen. It has about the same sensitivity and specificity as a thick and thin smear (done in expert hands) but does not replace the need to review the smear.
- ICT results may fall into a number of categories: Negative; Falciparum; Falciparum/mixed; Plasmodium species; Invalid. Each category is accompanied by a detailed explanation.
- As the ICT measures live and dead parasites, it may remain reactive for up to 4 weeks after successful treatment.
- Note: negative results on arrival do not exclude this diagnosis if the patient becomes symptomatic within one year of arrival

What to do with the results

- ***Malaria infection is a medical emergency*** and therefore a Microbiologist at TWH is always contacted immediately in the event of a positive result. All children and most adults require admission to hospital.
- Many newly arriving refugees will have been given pre-departure treatment for malaria; however, this is sometimes not taken or is ineffective.
- In most instances, a Microbiologist or Infectious Diseases physician will directly contact GPs, the patient, and case workers to organise urgent expert review and admission to hospital for treatment of malaria.
- Treatment for adults and children will be coordinated through TWH.
- For advice at any time, call an Infectious Diseases physician at TWH Ph: 4222 5000.

URINE TESTS

Neisseria gonorrhoea and *Chlamydia trachomatis* PCRs

- These tests detect DNA and are both highly sensitive and specific for asymptomatic or symptomatic infection.
- It should be remembered that false positives may occur with any test, given the implications of positive results occurring in monogamous relationships and in children.
- False positive tests are more common for *Neisseria gonorrhoea* than for *Chlamydia trachomatis*.

| Test results | What to do |
|---|--|
| Positive PCR for <i>N. gonorrhoea</i> | <ul style="list-style-type: none"> • Follow up with culture as there is an increasing risk of resistance to therapy, even with Ceftriaxone • Treat immediately after taking the culture with IM Ceftriaxone 500 mg. <i>Do not treat with penicillin, doxycycline or quinolones as there is up to 60% resistance with these drugs.</i> • Contact tracing • Partner therapy immediately after testing • Advise patients to avoid sexual contact for at least seven days |
| Positive PCR for <i>C. trachomatis</i> | <ul style="list-style-type: none"> • Azithromycin 1 gm orally stat (can be used in pregnancy) OR • Doxycycline 100 mg bd for 7-10 days (<i>contraindicated in pregnancy</i>) • Contact tracing • Partner therapy immediately after testing • Advise patients to avoid sexual contact for at least seven days |
| <ul style="list-style-type: none"> • Refugees with sexually transmitted infections often have psychological issues related to previous sexual abuse • Sexual Health services offer counselling and contact tracing in relation to positive results for sexually transmitted infections • Children with confirmed sexually transmitted infections require referral to Child Wellbeing Area Coordinator on 4224 2900 | |

CATCH-UP VACCINATION

- Children and adults should be assessed for age appropriate commencement/catch up vaccinations. The Refugee Health Nurses can assist you with planning a catch-up program, or you can contact the Public Health Unit on 4221 6700 for advice from the SESIH Immunisation Coordinator.
- Currently NSW Health supplies the following vaccines free of charge to refugee families. Contact the Public Health Unit on 4221 6700 (Wollongong) or 9382 8333 (Randwick) to order these vaccines:

ADT booster
Boostrix
H-B-Vax 11 (adult & paediatric formulations)
IPOL

- An excellent catch-up calculator for children up to the age of 7 is available at <http://www.health.sa.gov.au/immunisationcalculator/>
- Comprehensive information on catch-up vaccination is given in section 1.3.5 of the Australian Immunisation Handbook 9th edition, which is available on line at <http://www9.health.gov.au/immhandbook/>
- Remember to notify the Australian Childhood Immunisation Register of all catch up immunisation in children <7 years as they occur. It is helpful to send an initial letter indicating the child is a new arrival and is undergoing a catch up program.

ORAL HEALTH

- A high proportion of adults and children have oral health problems. All families, other than those sponsored by family already living in Australia, are registered with the Oral Health Service (by the settlement agency) on arrival.
- The Refugee Health Nurses will ensure sponsored families that are known to them are registered with the Oral Health Service.
- Refugee families are triaged by the Oral Health Service intake officer at a higher level than the general population, especially if they are experiencing pain and/or swelling. Contact the Oral Health Service on 1300 369 651 making sure to advise the service of your patient's refugee status, and of any symptoms.

MENTAL HEALTH

Many people from a refugee-like background may be survivors of torture and/or trauma experiences. These experiences can be compounded by stressors associated with resettlement such as learning a new language, poverty, and survivor guilt.

Enquiries about the patient's history should be handled sensitively, keeping in mind that it is not always beneficial or appropriate for people to discuss their experiences, and that many refugee families come from communities which stigmatise mental illness. Denial and lack of insight into the mind-body connection is common. Post traumatic stress and other mental illnesses may therefore present in a variety of ways including multiple physical complaints that prove difficult to resolve, complex and/or psychosomatic problems, and persistent psychological distress.

The following are among the common problems associated with persistent psychological distress in refugees: sleep disturbances/nightmares, high anxiety, panic attacks, irritability/aggressiveness, depression, concentration/memory problems, eating disorders, psychosexual problems, domestic violence, and substance misuse. Children may present with recurrent abdominal pain, nightmares, eating and sleep disorders, separation anxiety and difficult behaviours.

Newly arrived refugees, other than those sponsored by family already living in Australia, are referred to the NSW Service for Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) by the settlement agency on arrival. Approximately half of all adults attend at least one counseling session at STARTTS under the Early Intervention Program. Interpreters are always used by STARTTS counsellors.

Contact STARTTS Early Intervention Program (EIP), Intake officer 9646 6666

Acute mental health problems

If the patient is experiencing acute mental health problems, presenting a current risk of harm to themselves or others and/or requiring an urgent response, contact the Emergency 24 hours Mental Health Service:

| | | | |
|-----------|--------------|--------|--------------|
| Illawarra | 1300 552 289 | Sydney | 1300 300 180 |
|-----------|--------------|--------|--------------|

Local mental health service acute care teams:

- St George Acute Community Care Team 9113 1111
- Sutherland Acute Community Treatment Team 9540 7831
- St Vincent's Mental Health Services Crisis and Intake Service 8382 1911
- Eastern Suburbs Crisis and Intake Service 9382 2489
- Northern (Illawarra) Community Mental Health Service 4254 1500
- Lake Illawarra Community Health Service 4223 8001
- Shoalhaven Community Mental Health Service 4422 6066

Non-acute mental health problems

In the first six months of settlement

The most helpful interventions at this stage relate to:

- Providing a safe and supportive environment in which to address physical health problems
- Normalising the patient's experience by 1) explaining how their symptoms may relate to their past – and current – stressful experiences, and are part of a very common response to torture and trauma, and 2) helping the patient to understand the link between physical and psychological effects.
- Linking people with settlement and/or community support services

Referral options for settlement difficulties

Reducing settlement difficulties (e.g., housing, education, employment) or the social consequences of the migration process are also important ways to support refugees.

- In the first six to twelve months following arrival, referral to the settlement agency is the most appropriate way to handle these issues.
- Refugees who are no longer being supported by the settlement agency can be referred to the local Migrant Resource Centre.
- For refugees that have been sponsored by family members, or those that no longer have the support of the settlement agency, contact the Refugee Health Nurses on 4221 6700.

After the initial 6 month settlement period

Consider the following:

- Planning a long consultation time to identify any persistent mental health problems
- Implementing a management plan jointly with the patient
- Using empathic questioning to explore the patients previous experiences and current difficulties
- Using screening tools such as the K10 and Prime-MD
- Providing psychoeducation
- Referral to specialist service providers.

Referral options for persistent psychological distress

- | | |
|---|---------------------------|
| • Central Network Intake and Assessment team | 9553 2500 |
| • St Vincent's Mental Health Services Crisis and Intake Service | 8382 1911 |
| • Eastern Suburbs Crisis and Intake Service | 9382 2489 |
| • Northern Community Mental Health Service | 4254 1500 |
| • Lake Illawarra Community Health Service | 4223 8001 |
| • Wollongong Community Mental Health Service | 4254 1500 |
| • Shoalhaven Community Mental Health Service | 4422 6066 |
| • Transcultural Mental Health Service | 1800 648 911 or 9840 3800 |

Mental health interventions for children

Interventions for children may focus on supporting the parents and providing them with parenting education and/or offer a family based approach. School counsellors are also well placed to support children.

- Child and Adolescent Mental Health Team, Illawarra 4295 2361
- University of Wollongong Northfields Psychology Clinic 4221 3747
- Intensive English Centre, Warrawong High School 4274 4346
- Sutherland and St George 9540 7474
- Eastern suburbs
 - Children (0 – Year 6) 9382 8213
 - Adolescents/ High school students 9382 4347

CHILD DEVELOPMENT AND LEARNING DIFFICULTIES

Refugee children are at increased risk of developmental delay and language delay due to their environmental circumstances, nutritional status and family stressors. They have also generally not had access to routine newborn screening, such as neonatal hearing screening, phenylketonuria and thyroid screening and may therefore have conditions rarely seen in Australian-born children. School-aged children may struggle to cope with the Australian syllabus due to poor prior educational experiences.

- SCH Refugee Clinic 9382 8472
- Allied Health Department, Wollongong Hospital 4253 4500
- Tumbatin Clinic (Eastern Suburbs) 9382 8189
- Kogarah Diagnostic and Assessment Team (St George) 9587 2444

USEFUL CONTACTS

Australian Centre for Languages (ACL) settlement agency, phone 4228 0063

ACL is currently contracted to manage the settlement process for refugee families in the Illawarra. This includes organising permanent housing, enrolling families in school and/or English language classes, registering families with Centrelink and Medicare, and supporting access to on-arrival health screening.

Chest Clinic, Wollongong Hospital, phone 4253 4138, fax 4253 4141

- The chest clinic is located on the first floor in C block, next to the peri-operative clinics. Hours are 9.30 am to 12.00 pm Monday, and 9.30 am to 4.30 pm Tuesday and Wednesday (to allow reading of Mantoux tests).
- Newly arriving refugees will be automatically referred by the settlement agency. GP referral is advised.
- Refugee families who arrived prior to 2007 may not have had a chest clinic review, and should be referred for one. Please arrange for a TB CMI test and chest X-Ray which can both be brought in by patient on the day of the chest clinic review.

Child Wellbeing Area Coordinator, phone 4224 2900

Endocrinology clinic, Wollongong Hospital, phone 4253 4136, fax 4253 4159

- Endocrinology clinic is held on Tuesday afternoons in the perioperative area on level 1, block C
- Attention referrals to the “specialist endocrinologist”.

Gastroenterology/liver clinics, Wollongong Hospital, phone 4222 5180, fax 4222 5170

- The gastroenterology clinics are located on the 3rd floor, B block, and run most days of the week.
- Attention referral letters to a specific gastroenterologist or the “Doctor in Attendance, Gastroenterology Clinic”
- Referrals must be hand delivered or posted before an appointment time is given (no faxed referrals or phone requests will be accepted)
- It is important to specify at the time of booking whether the patient has HepB or HepC.
- All patients with HepC will be asked to see the Clinical Nurse Consultant (free) prior to the gastroenterologist appointment to ensure that appropriate investigations are available.
- Patients with HepB may be booked to see a gastroenterologist directly.

Health Care Interpreter Service (HCIS)

- Illawarra, Phone 4274 4211, Fax 4276 2487
- South Eastern Sydney, Phone 9828 6088, Fax 9828 6090

Illawarra Sexual Health Service, phone 4223 8457

- Co-located beside the Port Kembla Hospital on Cowper St, Port Kembla. Hours are 9.00 am to 5.00 pm, Monday – Friday (nursing and counseling staff); doctors' clinic hours are 9.00 am to 1.00 pm, on Monday, Wednesday or Friday.
- Urgent referrals may be able to be seen outside clinic hours – seek phone advice from a sexual health physician or the clinic in these instances.
- Attention referral letters to the “sexual health physician” and send along with patient.

Infectious Diseases Clinics, Wollongong Hospital, phone 4222 5898, fax 4222 5367

- Infectious diseases clinics are held at the Infection Management and Control Service (IMACS) offices in Lawson House at Wollongong Hospital, near the Emergency Department entrance.
- Usual clinic days Tuesday mornings (ID specialist and the Infectious Diseases registrar), Tuesday afternoons (ID specialist) and Friday mornings (ID specialist).
 - Occasionally, refugee patients can be booked on other days also.
 - After hours, contact an ID physician or microbiologist through Wollongong Hospital switchboard on 4222 5000
- Attention referrals to “Infectious Diseases clinic” and fax to 4222 5367. Please specify the relevant language so that an interpreter can be booked.
- Referrals will be assessed, prioritised, and allocated to one of these doctors.
- Patients will be contacted with booking times through either the settlement agency, or the Refugee Health Nurses.

Outpatient SEALS pathology collection centres

- Wollongong Hospital, 7th floor, C block. Hours are 8.00 am to 4.30pm, Monday – Friday.
Ph: 4253 4009
- Shellharbour hospital, next door to Emergency Department entrance on the ground floor. Hours are 7.30 am to 5.00 pm, Monday – Friday. Ph: 4295 2487

Paediatric Infectious Diseases & Liver clinic, Sydney Children's Hospital, phone 9382 1508

- ID Clinics are held on Mondays at the Outpatient Department, High St, Randwick. The ID clinic will coordinate joint appointments with Paediatric Gastroenterologists as required.

- Referrals of refugee children to this clinic and other sub-speciality clinics will be coordinated by the Community Paediatrician/Community Child Health Department Ph: 9382 8189.
- Referral letters should be addressed to the “Infectious Diseases Specialist” and then faxed to 9382 1580 marked “ATTN: Infectious Diseases Specialist”. A copy should accompany the patient.

Paediatric Refugee clinic, Sydney Children’s Hospital, phone 9382 8189, fax 9382 8188

- Clinics are located at the Community Child Health Centre, corner of Avoca and Barker Streets, Randwick.
- Outreach clinics are held regularly at The Wollongong Hospital.
- Referrals should first be discussed with Dr Karen Zwi, Community Paediatrician, **or** the Refugee Fellow/Paediatric Registrar, phone 9382 8189, or SCH on 9382 1111.
E-mail: karen.zwi@sesiahs.health.nsw.gov.au
- Referral letters should be addressed to the “Community Paediatrician, Community Child Health Centre” and then faxed to 9382 8188. A copy should accompany the patient.
- Referrals to the SCH Paediatric Infectious Diseases & Liver Clinic and other sub-speciality clinics will be coordinated through the Community Paediatrician/Community Child Health Department. Patients will be contacted via the settlement agency or the Refugee Health Nurses to make arrangements for appointment time, interpreter and transport.

SESIH Infectious Diseases specialists and registrars

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| • Prince of Wales Hospital | 9382 4444 |
| • St George Hospital | 9113 1111 |
| • Sydney Children’s Hospital | 9832 1111 |
| • Wollongong Hospital | 4222 5000 |

SEALS Microbiologists, phone 1800 073 257

SESIH Immunisation Coordinator, Wollongong, phone 4221 6700; Randwick, phone 9382 8333

SESIH Refugee Health Nurses, Multicultural Health Service, phone 4221 6700, fax 4221 6722

SESIH Sexual Health Service, Port Kembla, ph 4223 8457; Sydney Sexual Health Clinic, ph 9382 7440

Translating and Interpreting Service (TIS), Doctors Priority Line, phone 1300 131 450, fax 1300 654 151.

- E-mail: tis@immi.gov.au