

The world will not
be destroyed by
those who do evil
but by those who
watch them without
doing anything.

Albert Einstein



REFUGEE & ASYLUM SEEKER

HEALTH

— DR. SHARUNA VERGHIS —

ATHYNA.EDUCATION

LEARNING OUTCOMES

By the end of the lecture and tutorial, students should be able to:

- Distinguish the differences between the terms internally displaced, refugees, asylum seekers and climate refugees.
- Identify the health risks faced by refugees and asylum seekers in the different phases of their mobility.
- Describe the impact of detention on the health of asylum seekers and refugees through a trauma-informed lens.
- Recognize the importance of cultural security and safe communication skills in building trust with refugee patients.
- Locate the appropriate clinical resources available in refugee and asylum seeker health in Australia.
- Demonstrate an introductory understanding of the current political environment regarding the entry of refugees and asylum seekers globally and in Australia

This E-Book should be reviewed alongside the lecture videos and the *required reading* materials. This PDF is interactive. Please click on the links to navigate through the E-Book content.

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DEFINITIONS AND CONCEPTS

Types of Forced Migration

Migration categories are mostly significant for administrative purposes. Nonetheless, understanding them is crucial because they inherently define legal status and the length and terms of residence in a host nation. Additionally, they provide significant insight into the migration process, including exposure to health risks and impact on entitlements and access to essential services like healthcare in the settling country (Allotey and Verghis, 2017).

WHO IS A REFUGEE

A refugee is a person,

- Who has a **well-founded fear of persecution** on grounds of race, religion, nationality, membership of a particular social group or political opinion.

- Whose **own State** or government is **unable or unwilling to protect them**.
- Who has **crossed an international boundary**.
- Who is **unable to return durably** to their country of origin.

Art 1(A)(2) of the UN Convention Relating to the Status of Refugees 1951 and Protocol Relating to the Status of Refugees 1967

Watch this short film to know more about refugees:
<https://www.youtube.com/watch?v=GvzZGplGbL8>

WHO IS AN ASYLUM SEEKER

One who is seeking international protection but whose status has not yet been determined. (UNHCR, 2008).

WHO IS AN INTERNALLY DISPLACED PERSON

Internally displaced persons (also known as "IDPs") are "persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, **and who have not crossed an internationally recognized border.**"

United Nations Guiding Principles on Internal Displacement (E/CN.4/1998/53/Add.2), 1998.

WHO IS A CLIMATE REFUGEE

Climate refugees refer to populations displaced due to the adverse impacts of climate change, including natural disasters, droughts, and other weather events.

Climate refugees are not officially recognized under international law, leading to debates and controversies about their status and protection. The 1951 Refugee Convention and its 1967

Protocol do not extend protection to those displaced by climate change because they focus on persecution due to factors like race, religion, or political opinion.

There is a highly complex legal, ethical, and political debate regarding whether current refugee frameworks sufficiently address the distinct challenges confronting climate refugees. Some contend that broadening the refugee definition in the 1951 Refugee Convention and its 1967 Protocol to encompass climate-induced displacement may weaken protection for conventional refugees. Moreover, concerns arise about the potential magnitude of climate-induced migration and its impact on national security, resource distribution, and social harmony.

Although there is growing acknowledgment of the adverse harms of climate-induced displacement and the need for protection for affected populations has been articulated in some recent global documents (the New York Declaration for

Refugees and Migrants of 2016, the Global Compact for Safe, Orderly and Regular Migration, and the Nansen Initiative), these are legally non-binding documents/efforts for States.

Report of the Special Rapporteur on the human rights of migrants (A/77/189), July 2022

UNHCR, Climate change and displacement, UNHCR 2024.

TYPES OF REFUGEES

Camp-Based Refugees and Urban Refugees

CAMP-BASED REFUGEES

Camp-based refugees live in refugee camps, which are meant to serve as temporary facilities to provide immediate assistance and protection to people forced to flee their homes due to various crises.

Accommodating approximately a fifth of the world's refugee population, camps offer basic services such as water, food, shelter, healthcare, and emergency relief items during initial emergencies. As situations become protracted, services

expand to include education and livelihood opportunities to aid in rebuilding lives. Despite these provisions, camps often face challenges like overcrowding, limited access to clean water and sanitation, and the risk of disease outbreaks. Furthermore, the prolonged nature of some camps can lead to dependency on humanitarian aid and reduced livelihood opportunities, especially during crises like the COVID-19 pandemic.



Kutupalong extension refugee camp for Rohingyas, Bangladesh, (World Bank on Flickr)

The health outcomes within refugee camps are contingent upon the nature of the camp, thereby shaping:

- Accessibility to health services, skilled health professionals & medication
- Distance, transportation and referral linkages to secondary/tertiary care
- Hours of operation of services
- Functional laboratory facilities
- Attitudes and behaviors of health workers



Zaatari Refugee Camp, Jordan (UN on Flickr)



IDP camp, Somalia

URBAN REFUGEES

Urban refugees, in contrast, reside outside of camp settings, often among the urban poor in cities. Unlike their camp-based counterparts, urban refugees do not receive systematic assistance from the UNHCR or the international community, making their situation particularly

precarious. They face numerous protection challenges, including legal recognition, access to basic services, and the risk of exploitation. The dispersion of urban refugees within cities complicates the delivery of aid and protection, often leading to increased vulnerability and isolation from support networks.

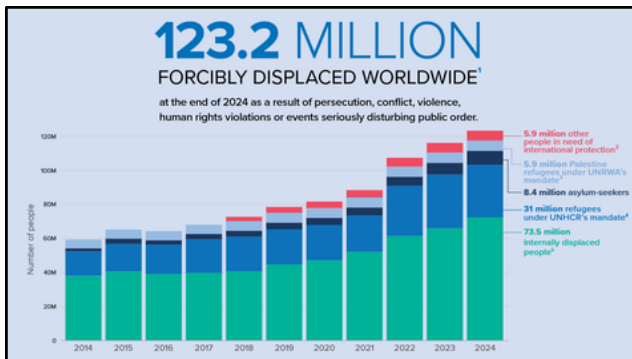
TOP COUNTRIES HOSTING REFUGEES AND ASYLUM SEEKERS IN URBAN AREAS @ Dec 2016				
	Refugees	Asylum Seekers	Total	Estimated Percentage Outside Camps
Lebanon	1,012,969	13,745	1,026,714	100
Germany	669,482	587,346	1,256,828	100
Malaysia	92,054	56,311	148,365	100
Egypt	213,530	49,877	263,407	100
India	197,851	9,219	207,070	100
Iran	979,435	91	979,526	97
Turkey	2,869,421	245,955	3,115,376	90
Jordan	685,197	35,615	720,812	79
Pakistan	1,352,560	4,856	1,357,416	67
Iraq	261,888	11,458	273,346	61***
Kenya	451,099	43,764	494,863	12.5
Thailand	106,447	5,010	111,457	7.5
Uganda	940,835	41,880	982,715	2.2

Verghis S and Balasundaram. Urban refugees: The hidden population. In Allotey P, Reidpath D, editors. The health of refugees. Oxford: Oxford University Press; 2019. p. 128-66. DOI: 10.1093/oso/9780198814733.001.0001



Rohingya refugee school in Malaysia (ODI on Flickr)

UNHCR Global Trends Report 2024



42.7 million refugees at the end of 2024 including 30.8 million refugees under UNHCR's mandate, 5.9 million other people in need of international protection, and 6 million Palestine refugees under UNRWA's mandate.

73% HOSTED IN LOW-AND MIDDLE-INCOME COUNTRIES

Low- and middle-income countries hosted 73 per cent of the world's refugees and other people in need of international protection.⁶ The Least Developed Countries provided asylum to 23 per cent of the total.

34%

hosted in five countries

Colombia, Germany, Türkiye, the Islamic Republic of Iran and Uganda hosted over one-third of the world's refugees and other people in need of international protection.

Colombia	2.8 million
Germany	2.7 million
Türkiye	2.7 million
Islamic Republic of Iran	2.5 million
Uganda	1.9 million

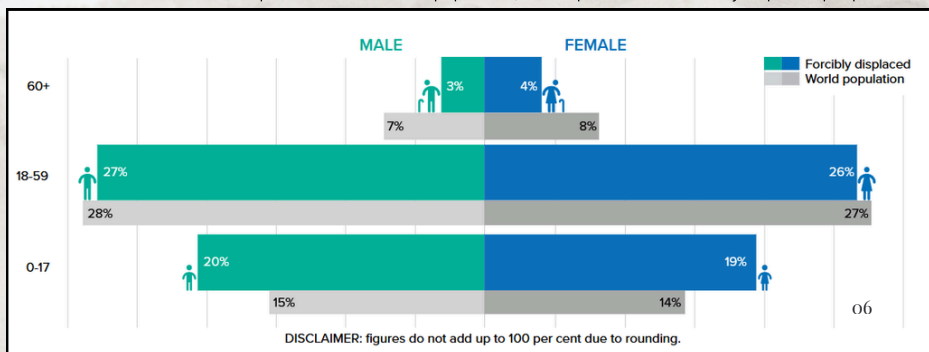
67%

originate from just five countries

Nearly seven in ten of all refugees under UNHCR's mandate and other people in need of international protection come from just five countries.

Venezuela	6.5 million
Syrian Arab Republic	5.5 million
Ukraine	5.3 million
Afghanistan	4.8 million
Sudan	2.5 million

Children account for 29 per cent of the world's population, but 40 per cent of all forcibly displaced people.



HEALTH RISKS

IN PHASES OF THE REFUGEE JOURNEY

COUNTRY OF ORIGIN



- Epidemiological profile of country of origin
- Violence
- Torture and trauma
- (In)Efficiency & (in)effectiveness of the health system
- Under vaccination
- Disaster (un)preparedness

FLIGHT



- Travel conditions
- Traumatic events
- Sexual violence
- Access to basic necessities

ARRIVAL / ASYLUM



Created by Gan Khoo Lay from Icon Project

- Refugee protection policies
- Immigration detention – predictor of psychological trauma
- Legal status as requirement to access services
- Lack of access to health care
- Abuse, exploitation, violence
- Epidemiological profile of country of asylum and related health risks
- Linguistic / cultural barriers
- Discrimination & social exclusion

VOLUNTARY REPATRIATION & REINTEGRATION



Created by Manasiporn from Icon Project

- Wellbeing depends on whether: land, home still exist; what remains of community networks, available livelihood opportunities
- Violence
- (Un)available services
- State of the health system
- Prevalence of disease

RESETTLEMENT



Created by Manasiporn from Icon Project

- Linguistic / cultural barriers
- Discrimination & social exclusion
- Prevalence of disease in country of resettlement
- Stress of adjustment, redefining identity, and rebuilding life

IMMIGRATION DETENTION AND REFUGEE HEALTH

Immigration Detention - Predictor of Psychological Trauma

The escalating numbers of refugees and forcibly displaced individuals worldwide underscore a precarious protection environment, particularly within developing nations that may lack robust legal and administrative frameworks to recognize and safeguard refugee populations adequately. Consequently, these individuals often encounter legal challenges akin to those faced by undocumented migrants, subjected to the same stringent laws and measures designed to manage and deter irregular migration. Among these measures, immigration detention emerges as a prevalent

strategy, notwithstanding its documented detrimental effects on mental health.

A significant body of research, including systematic reviews, highlights the profound mental health ramifications of immigration detention across diverse age groups, including adults, adolescents, and children. Findings consistently demonstrate elevated incidences of anxiety, depression, and post-traumatic stress disorder among detained individuals compared to their non-detained counterparts, underscoring the urgent need for alternative approaches to detention (von Werthern et al., 2018).

In Malaysia, Chuah et al (2018) report the dire conditions in Immigration Detention Centers (IDCs), including poor sanitation, inadequate food and water, and overcrowding, leading to health risks and the spread of infectious diseases like skin infections, TB, infectious diarrhea, leptospirosis, and respiratory illnesses. Limited access to healthcare services due to staffing shortages results in long wait times for medical attention. However, medical assistants stationed at IDCs provide basic care such as first aid and medication prescriptions, though referrals to hospitals may be necessary for more serious cases (Chuah et al, 2018).

In alignment with global health perspectives, the World Health Organization advocates prioritizing non-detention alternatives, citing the enduring negative impacts of detention practices. The WHO firmly recommends that detention should only be considered as an extreme measure, with a categorical stance against the detention of children under any circumstances.

Furthermore, legal discourse often categorizes the lack of documentation among refugees as an administrative, rather than a criminal, infraction. This distinction calls into question the ethical and legal justification for the criminalization of refugees lacking official documents, urging a re-evaluation of policies that conflate administrative infractions with criminal acts.

Chuah, F., Tan, S.T., Yeo, J. et al. The health needs and access barriers among refugees and asylum-seekers in Malaysia: a qualitative study. *Int J Equity Health* 17, 120 (2018).
<https://doi.org/10.1186/s12939-018-0833-x>

von Werthern, M., Robjant, K., Chui, Z. et al. The impact of immigration detention on mental health: a systematic review. *BMC Psychiatry* 18, 382 (2018).

World Health Organization. Immigration detention is harmful to health – alternatives to detention should be used 2022 [Available from: [https://www.who.int/europe/news/item/04-05-2022-immigration-detention-is-harmful-to-health---alternatives-to-detention-should-be-used.](https://www.who.int/europe/news/item/04-05-2022-immigration-detention-is-harmful-to-health---alternatives-to-detention-should-be-used)]

REFUGEE PROTECTION

Malaysia and Australia

Refugee protection currently faces significant challenges due to various global factors. This situation is compounded by ongoing conflicts, political instability, and the need to reaffirm human rights norms constantly. The global response to refugee protection is hindered by limited pathways to permanent safety; necessitating increased international cooperation.

MALAYSIA

As of end February 2025, there are some 192,800 refugees and asylum-seekers registered with UNHCR in Malaysia.

Some 171,450 are from Myanmar, comprising some 112,320 Rohingyas, 28,070 Chins, and 31,050 other ethnic groups from conflict-affected areas or fleeing persecution in Myanmar.

The remaining individuals are some 21,500 refugees and asylum-seekers from 50 countries fleeing war and persecution, including some 5,670 Pakistanis, 3,060 Yemenis, 2,800 Afghans, 2,780 Somalis, 2,580 Syrians, 1,050 Sri Lankans, 520 Palestinians, 460 Iraqis, and others.

Some 65% of refugees and asylum-seekers are men, while 35% are women. There are some 54,870 children below the age of 18.

([UNHCR Malaysia](#)).

Protection Environment

In Malaysia, the legal framework does not distinguish between refugees and undocumented migrants, treating both as "undocumented" under the Immigration Act (Act 1959/1063). This lack of a

distinct legal status for refugees means they are deprived of formal rights to work, their children are unable to attend mainstream schools, and they are at risk of arrest and detention. The absence of a legislative or administrative framework for refugee protection exacerbates these challenges, placing refugees in a precarious position within the country.

Health Care Policy Related to Refugees and Asylum Seekers In Malaysia

Cost of Health Care

Refugees and asylum seekers in Malaysia face significant barriers in accessing healthcare services. While the healthcare system in Malaysia is of high quality, the costs for non-citizens, including refugees and asylum seekers, are unsubsidized and higher compared to those for citizens in public hospitals. Although refugees and asylum seekers are eligible for a 50% discount on the foreigner rates at public healthcare facilities, the costs can still be prohibitive due to their precarious economic situation and lack

of formal work authorization.

Check out this [link](#) for information on the difference in fees for citizens and foreigners in public healthcare facilities.

Medication

With regard to non-citizens, prescriptions are restricted to a five-day supply from government hospital pharmacies in public hospitals. This policy for medication dispensation poses additional challenges, particularly for those with chronic conditions. Although refugees are nominally exempt from the policy that restricts non-citizens to a five-day supply of medication from government hospital pharmacies, the enforcement of this directive is inconsistent. This inconsistency can limit access to necessary long-term medication for both refugees and asylum seekers.

Reporting Undocumented Persons

Furthermore, a 2001 directive requires hospital personnel to report undocumented

individuals seeking health services (2001 Bil (1)dlm.KKM/62/BPKK(AM)/PeI -22-Garispuanduan melaporkan pndatang tanpa izin yang mendapatkan perkhidmatan kesihatan di hospital dan klinik kesihatan), which contributes to a climate of fear among refugees and asylum seekers, deterring them from accessing healthcare services. This situation is further complicated by concerns within the medical community regarding the potential conflict between their duty to provide care and the directive to report undocumented individuals (Dual Loyalty), highlighting the need for a more inclusive approach that considers public health imperatives. Such approaches include a 'Don't ask Don't Tell Approach' and 'Firewalls' in healthcare settings.

Chuah, F. L. H., Tan, S. T., Yeo, J., & Legido-Quigley, H. (2019). Health system responses to the health needs of refugees and asylum-seekers in Malaysia: A qualitative study [Article]. *International Journal of Environmental Research and Public Health*, 16(9), Article 1584. <https://doi.org/10.3390/ijerph16091584>

Chuah, F. L. H., Tan, S. T., Yeo, J., & Legido-Quigley, H. (2018). The health needs and access barriers among refugees and asylum-seekers in Malaysia: A qualitative study [Article]. *International Journal for Equity in Health*, 17(1), Article 120. <https://doi.org/10.1186/s12939-018-0833-x>.

AUSTRALIA

Australia's approach to the Global Compact on Refugees and its commitment to refugee protection have been critiqued. While Australia has pledged support at international forums, critiques point to the modest and inadequate nature of these commitments, particularly in light of the country's capabilities and the scale of global refugee crises.

Australia's refugee protection framework, including the visa system, has been a subject of significant debate and calls for reform. Key concerns include the need for a permanent cessation of offshore processing, improvement in the fairness of the asylum claim process, and reform of the

immigration detention system. Additionally, there is a push for a more comprehensive and responsive Refugee and Humanitarian Program, alongside better regional engagement in Asia for refugee protection.

The government has made efforts to address the backlog in visa processing by investing in the decision-making capacity within the Department of Home Affairs and improving the legal assistance available to asylum seekers. This aims to facilitate faster and more equitable decisions on protection visa applications.

Central to the discourse on Australia's asylum policies is the issue of temporary protection visas (TPVs), which offer limited rights and uncertain futures for holders, contrasting with the permanent protection visas that provide a clearer pathway to resettlement and

integration. The TPV system has been criticized for not offering a durable solution to refugees, essentially leaving them in limbo without the ability to plan for their future or reunite with their families. The ongoing debate underscores the complexity of refugee protection in Australia. It highlights the need for policies that respect international human rights standards, offering refugees and asylum seekers a fair chance at safety and integration.

RCOA. (2023). Refugee Council welcomes investment in protection visa reform Refugee Council of Australia. Retrieved 22 Feb 2024 from <https://www.refugeecouncil.org.au/refugee-council-welcomes-investment-in-protection-visa-reform/>.

RCOA. (2022). Three refugee issues requiring urgent change in 2022. Refugee Council of Australia. Retrieved 22 Feb 2024 from <https://www.refugeecouncil.org.au/three-refugee-issues-requiring-urgent-change-in-2022/>



ETHICAL CONCEPTS IN HEALTHCARE

NAVIGATING COMPLEXITIES IN MEDICAL PRACTICE

In many countries that lack a legal and administrative framework to recognize refugees, they are counted among the undocumented. Given the resistance against undocumented migrants and the growing use of healthcare policy as a deterrent to irregular migration, it is important to consider ethical debates in healthcare concerning these populations.

THE ETHICAL DILEMMA OF DUAL LOYALTY

Dual loyalty is the potential conflict between clinicians' duties of 'first consideration of the health of the patient'... and ...'full technical and moral independence' (World Medical Association, International Code of Medical Ethics) and their obligations to their employers, particularly governments. It arises when healthcare professionals face conflicting obligations because of directives of employers or authorities. This is particularly relevant in contexts involving refugees and undocumented migrants, where healthcare providers may be required by law to report individuals without legal status, potentially putting patients at risk of detention or deportation. This conflict can compromise the healthcare provider's primary commitment to patient well-being and confidentiality.

You may read more about Dual Loyalty and Human Rights in Health Professional Practice [here](#).

SANCTUARY CITIES / SAFE CITIES

Sanctuary cities in North America encompass a broad range of jurisdictions including counties, states, universities, hospitals, and school districts. These entities adopt policies that effectively limit their cooperation with federal immigration enforcement efforts, particularly concerning the detention and deportation of undocumented immigrants. The underlying principle of sanctuary cities is to foster a safe and inclusive environment for all residents, regardless of their immigration status, ensuring equitable access to essential services and protections. This approach is rooted in the belief that such inclusivity enhances public safety and community well-being by encouraging cooperation with local law enforcement and reducing fear among immigrant communities.

A short film on safe cities [here](#):

FIREWALLS

Firewalls are about creating safe spaces to reduce inequalities in access to healthcare. They delink health services from immigration enforcement by clearly separating immigration enforcement from access to essential services like healthcare. By establishing 'firewalls,' healthcare facilities become safe zones where immigration status is not disclosed or used against individuals seeking care, thus ensuring that public health priorities, particularly the control of disease transmission, are not compromised by immigration control measures.

They create safe zones by erecting information barriers through a Don't Ask Don't Tell policy, whereby healthcare personnel would not be required to ask or report an undocumented person to immigration authorities. The 'Don't Ask, Don't Tell' approach is suggested as a policy solution to address these ethical dilemmas by allowing healthcare providers to deliver care without inquiring about a patient's legal status. The rationale of this policy is predicated on the importance of building trust in the health system and disease control requiring the active participation of all sections of society..

To know how a firewall works in a healthcare setting, check out this [infographic](#) by PICUM.



NO HUMAN BEING IS ILLEGAL

What is wrong with the term “illegal” or “illegals”?

- It is linguistically incorrect because ‘illegal’ is not a noun.
- Linguistic experts such as Prof. Otto Santa Ana from UCLA argue that it is neither “accurate nor neutral” because other lawbreakers, such as those who might be caught jaywalking, are not referred to as “illegal pedestrians.” According to him and other experts, it makes immigrants an ‘outlier in the naming system’.
- It defines a person by their behavior by labeling them instead of focusing on their behavior.
- It is legally incorrect because, in most countries, living in another country without authorization is an administrative infraction, not a criminal offense.
- The act of crossing a border without authorization is illegal, not the person.
- The United Nations and major international press agencies have dropped the use of the word ‘illegal’ for ‘undocumented person’ or ‘person residing without authorization’. The Associated Press states that calling a person illegal because they lack documents is like calling a person diagnosed with Schizophrenia a schizophrenic, the latter being pejorative.

Read more [here](#).



COMMUNICATING WITH REFUGEE PATIENTS

CULTURAL SECURITY AND SAFE COMMUNICATION



From Cultural Safety to Cultural Security

In your Indigenous Health unit, you studied the cultural safety continuum, where safety is defined by the person receiving care and depends on both interpersonal communication and the structural and institutional power

shaping clinical encounters (Papps & Ramsden, 1996; Williams, 1999). This section extends those principles to cultural security in refugee and asylum seeker care.

The Australian Human Rights Commission (2011) defines cultural security as the responsibility on services, governments, and organizations to create environments where people feel safe and can draw strength from their identity, culture, and community (Australian Human Rights Commission, 2011). Cultural safety is the outcome; cultural security is the obligation on institutions and clinicians to create the conditions for that outcome. The Royal Australian and New Zealand College of Psychiatrists emphasizes that culturally safe and secure care requires confronting power structures in health systems and embedding change at service and system levels, not relying on individual goodwill alone (RANZCP, 2021).

Refugees and asylum seekers arrive at health services carrying the cumulative effects of persecution, violence, displacement, and, for many, immigration detention. These experiences do not disappear when a person walks into a clinic; they shape how authority is perceived, how questioning is interpreted, and whether it feels safe to disclose information at all. Legal precarity, trauma, language barriers, and exclusion from health and social protection systems further structure these risks, with refugee status functioning as a legal–sociopolitical classification rather than a unified cultural identity; cultural security must therefore respond to these structural conditions, not to generic assumptions about “culture” (Koutsouradi et al., 2025; Lau & Rodgers, 2021). Legal status is not merely administrative but a determinant of whether services feel safe to use: many refugees and undocumented migrants avoid or delay care, even when formally eligible, because of fear that contact with health services could jeopardize their immigration case or lead to deportation (Pilato et al., 2023; Castañeda et al., 2015). In Malaysia, financial barriers, restrictive medication policies, and the 2001 directive requiring hospital personnel to report

undocumented persons have together created a climate of institutional fear that deters refugees and asylum seekers from seeking care when unwell (Chuah et al., 2018; Chuah et al., 2019). In this context, cultural security involves not only respectful communication but also making visible whatever protections exist and recognizing that patients may not know, or trust, that those protections are real (Chuah et al., 2018).

Trauma-Informed Care as the Clinical Foundation

A trauma-informed approach is the practical expression of cultural security in the consultation. It does not require taking a full trauma history; it assumes that trauma is likely present and that routine clinical practices—rapid, detailed questioning, repeated probing about past events, or examinations without careful explanation and consent—can inadvertently re-traumatize a person who has experienced persecution, violence, sexual assault, or detention (Miller et al., 2019). Trauma-informed care uses a universal-precautions approach: each refugee or asylum seeker is treated as potentially carrying significant trauma, regardless of disclosure, and the encounter is structured accordingly (Miller et al., 2019). Qualitative research with refugee-serving professionals shows that culturally responsive and trauma-informed practice are inseparable: communication that is respectful across cultural difference is also communication that minimizes the risk of re-traumatization (Im & Swan, 2021).

Building Trust: The Opening of the Consultation

The opening minutes of a consultation carry disproportionate weight. The Australian Refugee Health Guide recommends conveying warmth, taking time before structured history-taking, and clearly explaining who you are and what the consultation will involve before asking questions (Refugee Health Guide, 2024). For someone who has been interrogated by border, detention, or immigration authorities, being treated as a person rather than a “case” and being told what to expect before being asked to comply is itself a clinical act. Doctor–patient confidentiality must be explained

clearly, simply, and early. Refugee and asylum seeker patients cannot be assumed to know what protections apply in a given health system, especially if their prior experience has been in settings with no confidentiality protections (Chuah et al., 2018). Explaining that information will not be reported to authorities, that the patient has the right to consent to or decline parts of the encounter, and that they control what they share directly addresses key trust barriers (Chuah et al., 2018; Pilato et al., 2023). Where trauma is present, simple appointment reminders and consistent follow-up communication also support engagement, as memory, concentration, and attendance can be affected by ongoing symptoms (Miller et al., 2019).

During the Consultation

Before entering sensitive areas such as past violence, sexual assault, detention, or mental health, explain why you are asking and give explicit permission to decline or pause. Showing awareness of difficulty without pressing for details is central to avoiding re-traumatization (Miller et al., 2019). Provide opportunities to ask questions at multiple points, not just at the end; for those using a second or third language or with limited prior access to care, information often needs to be introduced gradually and re-explained. Do not dismiss somatic complaints. Common presentations such as chronic pain, fatigue, headaches, and gastrointestinal symptoms are frequently linked to prolonged stress and trauma and should not be attributed to “psychological” causes without proper investigation (Miller et al., 2019). A biopsychosocial history that situates symptoms within mental health, social circumstances, housing, and legal status is more likely to identify the full scope of need. Explain procedures in plain language, repeat key points, and never assume that silence or a nod indicates understanding.

Working with Interpreters

Using a trained interpreter is a core clinical skill. Interpreters should be used in preference to family members; children should never interpret for consultations involving trauma,

sexual or reproductive health, mental health, or other sensitive issues, because this burdens the child, risks harm, and distorts clinical communication (Miller et al., 2019). Any family member interpreter may inhibit disclosure, particularly when discussing matters that affect family dynamics or community standing. Before the consultation, confirm confidentiality with the interpreter and consider whether their gender, ethnicity, and religion are appropriate. A patient may not feel safe disclosing sexual or domestic violence through someone embedded in their community. During the consultation, maintain eye contact with the patient, speak in short, clear sentences with pauses, and direct all questions and responses to the patient, with the interpreter facilitating but not mediating the relationship (Miller et al., 2019; Refugee Health Guide, 2024).

Referrals and Advocacy

When making social or legal referrals, never direct a refugee or asylum seeker to the embassy or consulate of their country of origin, since that state is often the source of persecution and contact may place them at risk. Referrals should be made to organizations that specifically support refugees and asylum seekers – UNHCR, legal aid providers, and NGOs with recognized mandates. Knowing which services are safe and accessible for people without legal status, and directing patients accordingly, is itself part of culturally secure practice (Chuah et al., 2019).

- Australian Human Rights Commission. (2011). Social justice report 2011: Chapter 4 – Cultural safety and security: Tools to address lateral violence. Australian Human Rights Commission. <https://humanrights.gov.au/our-work/projects/chapter-4-cultural-safety-and-security-tools-address-lateral-violence-social>
- Castañeda, H., Holmes, S. M., Madrigal, D. S., Young, M. E. D., Beyeler, N., & Quesada, J. (2015). Immigration as a social determinant of health. *Annual Review of Public Health*, 36, 375–392. <https://doi.org/10.1146/annurev-publhealth-032013-182419>
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- Im, H., & Swan, L. E. T. (2021). Working towards culturally responsive trauma-informed care in the refugee resettlement process: Qualitative inquiry with refugee-serving professionals in the United States. *Behavioural Sciences*, 11(11), 155. <https://doi.org/10.3390/bs1110155>
- Koutsouradi, G., Kavvadas, D., Chatzidimitriou, M., & Kavvada, A. (2025). Cultural competence in refugee healthcare: Exploring the experiences, training needs, challenges and strategies of healthcare professionals in Greece. *Health Education Research*, 40(5), cyaf037. <https://doi.org/10.1093/her/cyaf037>
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CLINICAL RESOURCES

IN REFUGEE AND ASYLUM SEEKER HEALTH IN AUSTRALIA

The Australasian Society of Infectious Diseases (ASID) published guidelines ([Recommendations for Comprehensive Post-Arrival Health Assessment for People from Refugee-Like Backgrounds](#)) on the post-arrival health assessment of recently arrived refugees in 2016 (2nd ed).

The guidelines emphasize thorough history-taking, focusing on the refugee's journey, previous screenings, and any past exposure to diseases or trauma. The recommendations cover both infectious and non-infectious diseases and emphasize the importance of screenings for conditions like tuberculosis, hepatitis B, and mental health issues. The document also stresses the need for culturally sensitive healthcare approaches and the use of interpreters to ensure effective communication and care for individuals from refugee-like backgrounds. They advocate for a coordinated, multisectoral follow-up to address the complex needs of refugees, integrating healthcare with other support services to ensure comprehensive care and support for resettlement and integration into the community.

Familiarity with the ASID framework is essential for both public health professionals and clinical workers in Australia.

MUST KNOW

1. Concepts and definitions - types of forced migrants, including the definition of refugees per the 1951 Refugee Convention.
2. Key statistics related to refugees and asylum seekers globally.
3. Health risks of refugees and asylum seekers.
4. Refugee protection in Australia.
5. Cultural security and safe communication with refugee patients.
6. Key areas covered by the Australian Society for Infectious Diseases (ASID) Guidelines.

The world will not
be destroyed by
those who do evil
but by those who
watch them without
doing anything.

Albert Einstein



REFUGEE & ASYLUM SEEKER HEALTH

ATHYNA.EDUCATION

DR. SHARUNA VERGHIS

THEME II: POPULATION, SOCIETY HEALTH AND ILLNESS
Med1100/1200 Semester 1

