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Challenges in immunisation service delivery for refugees in Australia: A health system perspective

A. Mahimbo [a,*], H. Seale [a], M. Smith [b], A. Heywood [a]

[a] School of Public Health and Community Medicine, UNSW Medicine, University of New South Wales, New South Wales, Australia
[b] NSW Refugee Health Service, Liverpool, NSW 2170, Australia

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ABSTRACT

Background: Refugees are at risk of being under-immunised in their countries of origin, in transit and post-resettlement in Australia. Whilst studies have focused on identifying barriers to accessibility of health services among refugees, few focus on providers' perspectives on immunisation service delivery to this group. Health service providers are well placed to provide insights into the pragmatic challenges associated with refugee health service delivery, which can be useful in identifying strategies aimed at improving immunisation coverage among this group.

Methods: A qualitative study involving 30 semi-structured interviews was undertaken with key stakeholders in immunisation service delivery across all States and Territories in Australia between December 2014 and December 2015. Thematic analysis was undertaken.

Results: Variability in accessing program funding and vaccines, lack of a national policy for catch-up vaccination, unclear roles and responsibilities for catch-up, a lack of a central immunisation register and insufficient training among general practitioners were seen as the main challenges impacting on immunisation service delivery for refugees.

Conclusions: This study provides insight into the challenges that impact on effective immunisation service delivery for refugees. Deliberate strategies such as national funding for relevant vaccines, improved data collection nationally and increased guidance for general practitioners on catch-up immunisation for refugees would help to ensure equitable access across all age groups.

1. Background

Australia resettles around 14,000 people of refugee background each year, and this is on the increase [1–4]. Refugees often originate from countries with limited or disrupted access to health services and may present with a multitude of complex health issues upon resettlement [5,6]. They face several barriers that impede their accessibility to primary health care in Australia including language, cultural, financial and logistical barriers as well as a lack of familiarity with the health care system [7–10].

Australia has a very comprehensive National Immunisation Program (NIP); however its strength is compromised by fragmented immunisation coverage, particularly among adolescents and adults [11]. Refugees are at high risk of being under-immunised, and to date there has been no national strategy aimed at improving immunisation uptake among this group. Whilst data on immunisation coverage for refugees in Australia is not known [12], small cohort studies of newly arrived refugees have indicated that the majority are under-immunised [13–16]. A complete assessment of an individual refugee's immunisation needs and implementation of an appropriate catch-up schedule is recommended as part of a comprehensive health assessment within the first six months' post-resettlement [17]. However, there is variability in how these assessments are undertaken and how complete they are both within and between States/Territories [18,19].

Currently, the models of care for refugee health services vary across the States and Territories. In most jurisdictions, initial refugee health assessments are mainly conducted by refugee-specific services offering a range of professional (chronic disease management e.g. diabetes or community nutrition services, sexual health andsexual assault and violence related services) and organisational development services (education and support to GPs and other health care staff) via community-based services and paediatric/-family screening clinics [20–22]. Ongoing care on the other hand is mainly provided by mainstream services via General

* Corresponding author at: School of Public Health & Community Medicine, Level 2, Samuels Building, Faculty of Medicine, University of New South Wales, Sydney 2052, Australia.
E-mail address: a.mahimbo@unsw.edu.au (A. Mahimbo).

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Practitioners (GPs) in private practice [22]. It has been argued that specialised services are better positioned in offering initial health care to refugees due to having the necessary infrastructure (including a range of health/non-health services) and organisational capacity (multidisciplinary) to cater for their needs [22,23]. However, existing literature shows gaps in service delivery including poor uptake of comprehensive health screening services and follow-up including catch-up immunisation [19]. GPs are likely to be the first point of contact for initial health care including immunisation for refugee populations resettled in rural and regional areas [24] and those geographically dispersed in larger states like New South Wales (NSW) and Victoria [19,25].

Previous studies have identified a number of barriers that impede the delivery of immunisation services to refugees from the perspective of the GP, including difficulties in implementing complex catch-up plans, inexperience in providing catch-up [26,27] and provision of catch-up immunisation for school children enrolling in school after their designated age-appropriate catch-up point [28]. Other factors limiting service provision to this group are not clearly understood. Missed opportunities for immunisation may result in pockets of under-immunised populations thereby risking outbreaks of vaccine-preventable diseases within the communities. Furthermore, pockets of under-immunised populations within the community pose a threat to the success of the National Immunisation Program (NIP) [11].

Although many studies have identified barriers to accessibility of health services in general, including from the refugees' perspective, few studies have focused on the perspective of providers and coordinators of immunisation services for people of refugee background. Health service providers are well placed to provide insights into the pragmatic challenges associated with refugee health service delivery [23]. This study aimed to explore the challenges in the provision of immunisation services to newly arrived refugees among key stakeholders to inform effective strategies to improve vaccine coverage among this group.

2. Methods

2.1. Study design

In-depth interviews were undertaken with stakeholders with key roles in immunisation service delivery across all the States and Territories in Australia. Ethics approval was obtained from the Human Research Ethics Advisory (HREA) Panel at the University of New South Wales (Ref: 2014-7-63) and the South Western Sydney Local Health District (SWSLHD) Research and Ethics Office (HREC Ref: LNR/14/LPOOL/542).

2.2. Recruitment and study participants

Stakeholders representing a range of service delivery levels including policy development, co-ordination and delivery of programs including State-funded refugee health services, community-based health services offering services to refugee clients, including GPs and representatives from State and Territory government health departments were purposefully recruited into the study. The following inclusion criteria were used: had at least one-year experience of involvement in immunisation service delivery for refugees either directly or indirectly, or government administrators with at least one year's experience in planning, coordination or management of immunisation services for refugees.

Recruitment involved the following three approaches. Firstly, refugee health network websites were searched to identify potential participants and an invitation letter was sent via email. Secondly, flyers and advertisements were broadcast through the NSW Refugee Health Service electronic network and via the Refugee Health Network of Australia (RHeaNA) to identify potential participants who were interested in participating in the study. Lastly, a snowball technique was used in which participants were asked to directly recommend any colleagues who they thought would fit the selection criteria and letters of invitation were sent via email. Potential participants were followed up three times within three months before being excluded from the study.

2.3. Data collection

Semi-structured telephone interviews were undertaken between December 2014 to December 2015 with key stakeholders representing all Australian States and Territories. The interviews averaged 40 min in length (range 20–60 min). Due to the largest proportion (32%) [1,29–31] of refugees being resettled in New South Wales, at least one representative from among the four specialised refugee services (NSW Refugee Health Service, Coffs Harbour Refugee Health Clinic, Illawarra Shoalhaven Local Health District Refugee Health Services and New England Refugee Health Clinic) was included to obtain a broader perspective on the pertinent issues impacting service delivery within this state.

An interview guide was developed based on available literature to ensure all issues were explored and that a rich description of context specific immunisation service delivery was obtained. The interview guide included the topics of: current models of care for refugee health services; awareness of immunisation policies or guidelines; current barriers and facilitators in the provision of immunisation; and existing and potential strategies to improve vaccination uptake among refugees. Prompts were included to ensure that all of the relevant aspects pertaining to the research questions were exhausted. AM conducted all the interviews via telephone and debriefed the other researchers on the important issues arising from the interviews throughout the process. All participants voluntarily participated in the interviews and individual written informed consent was sought prior to conducting the interviews. All interviews were digitally recorded and transcribed verbatim. To protect the identity of the certain participants, information regarding their location was omitted from the quotes. For confidentiality purposes, the categories of work for general practitioners, paediatricians, clinical nurse consultants and refugee health nurses were classified as 'clinical practice'; immunisation managers/coordinators and policy advisors as 'policy and planning' and health managers as 'management of health services'.

2.4. Data analysis

Data were analysed using a six step process of inductive thematic analysis [32]. AM read and re-read the first quarter of the transcripts during the transcription process and documented emerging ideas. AM and HS then independently coded the data and collated them to potential themes using the interview guide. After an independent analysis of the first quarter of the transcripts, the two researchers then jointly developed a list of themes using an agreed framework. The framework was then applied to another subsample of transcripts and modified further to suit the specifics of each identified theme. Using this final framework, all of the transcripts were analysed and coded. Text was organised within the identified themes of the developed framework with the use of NVIVO 10 software.

3. Results

Forty-nine stakeholders were initially invited to participate in the study. Of these, thirteen did not respond to the invitations,

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