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**Author/s:**

Kiang, KM;Elia, S;Paxton, GA

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No jab, no record: Catch-up vaccination of children in immigration detention

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### Abstract

International Health and Medical Services (IHMS) are contracted to provide health services, including catch-up vaccination, for individuals in immigration detention. Our audit of catch-up vaccination in asylum seeker children who spent time in held detention demonstrates inadequate and suboptimal vaccine delivery in this setting, and no evidence that IHMS recorded vaccines on the Australian Childhood Immunisation Register at the time. We also found substantial shortfalls in vaccination for these children after they were released from detention. Immunisation in this cohort falls well below Australian community standards; does not demonstrate assurance in IHMS provision of care; and has implications for similar asylum seeker cohorts nationally, as well as people in held detention.

### Keywords

Child, immunisation, immigration detention, vaccine, asylum seekers

### Key points

Asylum seeker children are likely to be under-vaccinated compared to their Australian-born peers.

Most children in held detention did not have recommended catch-up vaccinations, and their vaccines were not recorded on the Australian Immunisation Register.

There are shortfalls in the provision and recording of catch-up vaccination in asylum seeker children in primary care in Victoria.

### Background

The Australian National Audit Office (ANAO) released their findings on health services in immigration detention in September 2016,<sup>(1)</sup> noting the Department of Immigration and Border Protection (DIBP) had previously identified a need for assurance on provision of care, including *'adequate vaccination rates in line with Australian community standards'*. *'Timely conduct of a vaccination program'* is one of 17 performance measures in the DIBP health service contract, currently held by IHMS. The ANAO found that while IHMS reports on this performance indicator, planned DIBP verifications of this reporting measure had not commenced.

IHMS have previously reported on delivery of catch-up vaccination in detention, specifically that:

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*“IHMS immunises detainees to Australian community standards...Children less than seven years of age vaccinated have their records entered onto the Australian Childhood Immunisation Register (ACIR).”(2)*

In contrast, our clinical experience working with asylum seeker children in the Immigrant Health Service at the Royal Children’s Hospital (RCH) in Melbourne has suggested substantial concerns with catch-up vaccination in detention. Our observation has been that few children were vaccinated as per the National Immunisation Program (NIP) schedule, or had vaccines recorded on the ACIR (now the Australian Immunisation Register - AIR) while they were detained. We have also noted issues with vaccination of asylum seeker children in primary care. After release from held detention, children/families should have been linked with either IHMS-approved primary care (community detention) or mainstream primary care through their Status Resolution Support Service providers (bridging visa holders). The Victorian Refugee Health Program also ran ‘triage’ sessions for large numbers of people on release from detention, assessing their healthcare needs and linking them with primary care providers.(3, 4)

To explore this discrepancy, we undertook an audit of catch-up vaccination in asylum seeker children presenting to our service who had spent time in held detention. We examined RCH records, IHMS records, general practice (GP) records, and any available patient held records to determine vaccination status. We recorded age, current and past detention status, the duration of detention, parent report of whether children had received vaccination in detention or the community, and written records of vaccines administered - comparing this to the recommended NIP schedule for age.(5)

‘Up-to-date’ status was calculated comparing documented vaccinations to Australian catch-up immunisation guidelines,(5, 6) adjusting for length of detention and time in the community. Minimum vaccine dosing intervals mean adolescents/adults can complete catch-up vaccination (3 doses) over 4 months and children less than 10 years can complete catch-up vaccination (4 doses) over 10 months. We allowed a standard (2-month) interval between dose 1 and 2, and dose 2 and 3, and used the 10-month duration for assessing completed vaccination for children less than 10 years.

We reviewed the ACIR/AIR for vaccination records in this cohort, searching by Medicare where possible, and also by name, surname, all possible combinations of name/surname, and also by alternative spellings. Prior to 2016, the (then) ACIR only recorded vaccination information for children less than 7 years of age; therefore analysis of ACIR/AIR records was completed for children aged less than 7 years on arrival in Australia. ACIR registration has

been possible for all asylum seeker children, through Medicare for children on bridging visas in the community, or using name and date of birth for children without Medicare access.

Data were recorded in Microsoft Excel, and analysed using Statistical Package for Social Sciences (SPSS®) software. The RCH Human Research Ethics Committee approved the audit [HREC 35219A].

## Results

Over March 2012 - April 2016, the Immigrant Health Service saw 149 asylum seeker children (79/149 (53.0%) male) who had been in held detention; 140/149 (94.0%) had arrived in Australia by boat, 9/149 (6.0%) were infants born in held detention. No child had been referred for review of immunisation status or catch-up vaccination, and 96/149 (64.4%) were aged less than 7 years on arrival in Australia (and thus could have had information recorded on ACIR at the time). At the time of the first clinic visit, 39/149 (26.2%) were in held detention, 56/149 (37.6%) were in community detention, 52/149 (34.9%) were on a bridging visa in the community and 2/149 (1.3%) children had been granted protection visas. The mean duration of held detention was 5.9 months (range 2 to 18 months) for those arriving before July 2013, and 17.4 months (range 1 to 33 months) for those who had been sent to Nauru or arrived after July 2013 (excluding infants born in detention in Australia). Sixty-nine (69/149, 46.3%) children had been in held detention for 10 months or longer, meaning catch-up vaccination could have been completed during the period of held detention.

At the time of the first clinic visit, 118/149 (79.2%) children were reported to have had vaccinations from IHMS while they were in held detention. IHMS vaccination records were available for 94/149 (63.1%) at the first visit, although these records had been requested for all children prior to initial review. IHMS vaccine records were subsequently clarified for 29/149 (19.4%) children; we were not able to obtain IHMS records despite direct requests for 26/149 (17.4%) children (including 8 in held detention and 9 in community detention at the first visit).

Table 1 provides detail on completion of appropriate catch-up vaccination in detention; results are presented for the entire cohort, children in held detention at the first visit, and children who experienced prolonged detention where completing catch-up vaccination should have been possible. Where inappropriate vaccination is recorded, details on missing and extra vaccine administration (compared to the recommended NIP schedule) suggest both over and under-administration of vaccines by IHMS. Overall, only 24/149 (16.1%) children had appropriate vaccination while they were in held detention, with similar

proportions in the children who were in held detention at the time of the first visit (7/39, 17.9%), and those who had experienced prolonged held detention 12/69, 17.4%).

Cohort	Appropriate and complete catch-up vaccines while in held detention confirmed by IHMS written record*	Incomplete/inappropriate vaccines while in held detention (confirmed by IHMS written records)	No vaccinations in held detention	No IHMS records available	ACIR/AIR entry at time of vaccine administration in held detention
All children (149)	24 (16.1%)	86 (57.7%) Extra vaccines** 5 Missed vaccine doses 34 Missed set of vaccines 41 Missed and extra vaccines 6	12 (8.1%)*	26 (17.4%)	0 (0%)
In held detention at the first visit (39)	7 (17.9%)	24 (61.5%) Extra vaccines** 2 Missed vaccines 6 Missed set of vaccines 14 Missed and extra vaccines 2	0	8 (20.5%)	0 (0%)
In held detention longer than 10 months duration (69)	12 (17.4%)	44 (63.8%) Extra vaccines** 3 Missed vaccine 19 Missed set of vaccines 19 Missed and extra vaccines 3	0	13 (18.8%)	0 (0%)
In community at the first visit (either CD or BVE) (110)	17 (15.5%)	62 (56.4%) Extra vaccines** 3 Missed vaccine doses 28 Missed set of vaccines 27 Missed and extra vaccines 4	12 (10.9%)*	18 (16.4%)	0 (0%)

\*Adjusted for age, and duration in detention using Australian NIP schedule requirements and a standard (2-month) interval between dose 1 and 2, and dose 2 and 3. Using a minimum-dosing interval (which is recommended in catch-up immunisation) would have resulted in even fewer children achieving vaccination targets. The bottom row of the table (children in the community at the first visit) refers to vaccines administered by IHMS while these children were in held detention.

\*\*'Extra vaccines' were defined as additional doses (above the recommended number of doses) of vaccines included in the NIP schedule (and not additional vaccinations given in detention, such as influenza, typhoid or hepatitis A).

\*\*\*For one additional infant this was appropriate - aged 1 month on release from detention (i.e. 13 children with no vaccinations in held detention). For 8 of the 12 children we had written IHMS records with a section specifically for immunisation that showed no vaccines given. In the remaining 4 children, this was based on

parent report, where records were available for at least one child in the sibling group confirming the report of no vaccination.

At the time of the first visit, 110/149 (73.8%) children were living in the community (in community detention (n=56), on bridging visas (n=52), or with a permanent protection visa (n=2)). Overall, 38/110 (34.6%) of asylum seeker children in the community at the first visit were up-to-date with catch-up vaccinations (confirmed through analysis of GP records, IHMS records, patient held records or ACIR/AIR), 36/110 (32.7%) were not up-to-date and for 36/110 (32.7%) children, vaccination status could not be clarified.

In April 2016, we examined ACIR/AIR data for the 96 asylum seeker children who had arrived in Australia aged less than 7 years; 24/96 (25.0%) children were up to date with vaccinations, 29/96 (30.2%) had vaccines that were overdue, 26/96 (27.1%) children were registered with ACIR/AIR but had no vaccines recorded, and there was no ACIR/AIR record for 17/96 (17.7%) children. ACIR/AIR records vaccine administration prospectively, prior vaccines can be recorded as being administered by 'historical providers'. No child had vaccinations recorded in ACIR/AIR at the time of administration while they were in held detention; all the ACIR/AIR records had been recorded as being administered by 'historical providers', *after* children had been released into the community.

### **Conclusions**

This audit raises concern about incomplete and suboptimal vaccination delivery and reporting in held detention, despite prolonged detention, and a 'closed system' where complete catch-up immunisation should have been achievable. These Melbourne findings are likely to be representative of the situation for asylum seeker children in other states. The implications of this audit require consideration (and appropriate resourcing) to ensure complete vaccination and adequate documentation on AIR for asylum seeker children, especially given interstate movement. Although there have been no children in prolonged held detention since April 2016, current legislation does not preclude this situation in the future, and inadequate vaccination and reporting are likely to be ongoing issues for adults remaining in held detention.

Furthermore, given the large proportion of asylum seeker children in the community who were inadequately vaccinated at the time of their first clinic visit and/or lacked ACIR/AIR records, there are also substantial concerns about delivery and registration of catch-up vaccinations in primary care in Victoria, despite triage sessions intended to link asylum seekers with primary care providers and substantial investment in refugee health in recent years.

*At the time of writing (March 2017), 5/149 children (3.4%) were not up to date, 3/149 (2.0%) children had not had immunisation addressed and we were unable to clarify status for 22/149 (14.8%) children, despite multiple requests to both IHMS and primary care providers at the time of their attendance at our service. In some cases this situation has occurred due to children moving or being transferred, discharged, or lost to follow-up before their vaccinations were completed or immunisation status clarified.*

#### DISCLOSURE

Dr Paxton has provided advice to Department of Immigration and Border Protection through the Minister's Council for Asylum Seekers and Detention (from 2015), the Independent Health Advisor's Panel (from 2014) and the Health Subcommittee of the Joint Advisory Committee for Regional Processing arrangements (from 2013 - 2016), and chairs a working group on Immunisation in refugee and asylum seeker populations for the Victorian Department of Health and Human Services (from 2015). The RCH Immigrant Health Service is funded by the Victorian Department of Health and Human Services.

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Name of authors:

Dr Karen M Kiang

*Corresponding Author*

Immigrant Health Service

Department of General Medicine

The Royal Children's Hospital Melbourne

50 Flemington Road

Parkville, VIC 3052 AUSTRALIA

Phone: 03 9435 6846 or 0402 533 965 or 03 9482 1128

Email: karen.kiang@rch.org.au

Sonja Elia

Immunisation Service

The Royal Children's Hospital Melbourne

Parkville, VIC AUSTRALIA

Dr Georgia A Paxton

Immigrant Health Service

Department of General Medicine

The Royal Children's Hospital Melbourne

Parkville, VIC AUSTRALIA

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