Health services utilisation and barriers for settlers from the Horn of Africa

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Abstract

Objective: To examine health services use and barriers for recently arrived immigrants from the Horn of Africa.

Method: A cross-sectional study conducted in Melbourne, Australia, with a convenience sample of newly arrived immigrants (n=126) from Somalia (n=67), Ethiopia (n=24), Eritrea (n=26) and Sudan (n=6).

Results: GPs were the major health providers for participants, yet 22 (17%) respondents had not yet accessed health services in Australia. Thirty-three (26%) participants reported having had an unmet health concern for which they would have liked to seek advice. The most commonly identified barriers to health care and recommendations for improving services were associated with communication.

Conclusions: This study illustrates unmet health needs among new arrivals and a need for linguistically appropriate information about the use of Australia's health system.

Implications: The findings support increased use of professional interpreting services and support for new arrivals in making initial contact with the health system.

Key words: Africa, eastern; immigrants; refugees; health services accessibility; utilisation.

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Australia's humanitarian program seeks to assist people who have been forced to find a new homeland after fleeing from conflict or persecution. During the 1990s the focus of this program shifted from South-East Asia and Europe to Africa, the Middle East and south-west Asia. In the new millennium, the biggest rate of increase for humanitarian arrivals has been from African countries,[1] with the greatest numbers of people arriving from Somalia, Sudan, Ethiopia and Eritrea.[2]

Most settlers from these countries have fled situations of conflict, political unrest or fear of persecution and are likely to suffer poorer health in comparison with other migrants and their host community because of a range of pre- and post-migration factors.[3]

In response to the increasing numbers of new settlers from Africa and a lack of information about their health needs, a pilot study was undertaken to examine health service use and barriers to accessing health services for recently arrived immigrants from the Horn of Africa.

Methods

Widespread consultation was undertaken prior to the start of the study in July 2000 to gain support from community leaders and health providers. A steering committee was established to guide implementation. Five African support workers and a nurse were employed as part of the research team. The study population consisted of a purposive sample of members of the Somali, Sudanese, Ethiopian and Eritrean communities residing in Victoria. Inclusion criteria were: country of origin being one of the four of interest; aged 16 years or greater; and an arrival date in Australia after 1 January 1997. The target sample was 150 participants of equal gender distribution. Multiple active strategies were used in recruitment, including: distribution

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of flyers and posters in appropriate languages; letters of invitation; community radio; and community information sessions (formal and informal) to raise awareness about the project. Interested persons contacted members of the research team, who explained the research in detail in a language of choice, gained written informed consent, and made an appointment for the participant to complete the questionnaire.

The research tool consisted of a semi-structured questionnaire developed in consultation with community members. Following pilot testing, the questionnaire was administered face-to-face by the Australian-born primary researcher. If desired, translation was provided by a support worker in the participant's language of choice. The questionnaire collected information on demographics, use of health services, factors affecting access to services, and recommendations for improving access to these services. Ethics approval was obtained from the Royal Melbourne Hospital Human Research Ethics Committee.

Univariate analysis was performed in Epi Info (6.0). Relative risk (RRs) with 95% confidence intervals were calculated to examine potential determinants and differences in the use of and access to health services.

Results

The study sample consisted of 126 participants (80 female and 46 male). The majority of participants were Somali (n=67), followed by Eritrean (n=29), Ethiopian (n=24) and Sudanese (n=6). The mean age of participants was 34 years (range 16-75), with no significant age difference between genders. The majority of participants (n=77) had been in Australia for less than 24 months (median 19 months; range 0.7-42.6). Almost half (n=56) had spent time in a refugee camp prior to immigration (median 68 months; range 1-240).

Twenty-two per cent (n=28) of participants reported their command of English, on a five-point scale, as excellent (fluent), while 14% (n=17) rated it as very poor (no understanding at all). Only 23% of participants stated English was one of the first three languages spoken within the home. The median duration of residence for these participants was 27.5 months, in comparison to 16.2 months for those who did not. This did not vary by age group or gender.

Most participants (n=80) nominated a doctor who they were happy to attend regularly, 21% (n=27) did not have a regular doctor and 15% (n=19) were undecided. Females were more likely to have a regular doctor (RR=1.6; 95% CI 1.2-2.3). Median duration of residence in Australia for those with a regular doctor was 25.5 months compared to 9.3 months for those without.

Of the 22 (17%) participants who had not seen a GP since arrival in Australia, 68% (n=15) had been resident in Australia for less than six months. Approximately one-quarter of participants (n=33) reported having had a health concern they would have liked to seek advice for but did not; having a regular doctor significantly reduced the likelihood of this (RR=0.54; 95% CI 0.30-0.97).

One-third of participants (n=42) had visited an out-patient hospital clinic since immigrating to Australia; this was more common in females (RR=2.9, 95% CI 1.4-5.9). Nineteen per cent (n=24) of participants had been an in-patient at a hospital since arrival; more likely in females (RR=13.2, 95% CI 1.9- 94.7). Sixteen per cent of participants (n=20) had been to a hospital emergency department, again more likely in females (RR=10.9, 95% CI 1.5- 79.0).

Fifty per cent of participants identified difficulties accessing health services (n=63). Table 1 lists the descriptive findings in relation to barriers affecting access to health care. Of those who experienced difficulties, challenges with communication were most frequently reported. Participants older than 40 years were more likely to have had problems accessing health services (RR=1.6, 95% CI 1.1- 2.2).

Participants' suggestions for improved health services delivery are shown in Table 2.

Table 1: Barriers affecting access to health services (126 respondents).

Barrier[a]	Total (%)
None	63 (50)
Difficulties understanding English	29 (23)
Lack of availability of interpreters	26 (21)
Lack of health staff who speak my language	16 (13)
Lack of information in my own language	13 (10)
Lack of information about where to find health services	9 (7)
Lack of understanding of my cultural needs	9 (7)
Health services too far away	5 (4)
Doctors always in a rush	4 (3)
Long waiting lists for hospital appointments	2 (2)
Lack of understanding of Medicare system	2 (2)
Lack of availability of female doctors	1 (1)

Note:
(a) Respondents could nominate more than one factor.

Table 2: Suggestions for improving access to health services (126 respondents).

Suggestion[a]	Total (%)
None	71 (56)
Increase availability of interpreters	24 (19)
Improve command of English	12 (10)
More health staff who speak my language	11 (9)
More information about where to find health services	9 (7)
More information in my own language	5 (4)
Closer health services	5 (4)
More understanding of my cultural needs	3 (2)
Shorter waiting lists for hospital appointments	1 (1)
Longer doctor appointments	1 (1)

Note:
(a) Respondents could nominate more than one factor.

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Discussion

This study of health service use among new arrivals from Somalia, Eritrea, Ethiopia and Sudan has highlighted the importance of GPs as primary health providers for these communities. Difficulties with language, including the availability of interpreters, were identified as the main barriers to accessing appropriate health services. Participants recommended that more interpreters and health staff that spoke their language would improve use of and satisfaction with health services.

Language barriers to accessing optimal health care have been reported for parents of African refugee children who have recently settled in Australia,[4] and previously for other immigrant groups.[5-7] In our study, overall proficiency and use of English in the home increased with a longer period of residency in Australia. However, the ability to communicate effectively with health professionals is also influenced by other factors such as knowledge of the 'language of healthcare' and cultural perceptions of illness.[5]

GPs are both important gateways and ongoing providers of health services for recent immigrants from Africa and it is important that GPs are supported through the provision of appropriate information and education and through readily available professional interpreting services. The latter has been shown to improve reporting of symptoms and appropriate referrals[8] for what may be complex health needs unfamiliar to the GP.[9] The introduction of a specific Medical Benefits Schedule number for initial health assessments for refugee clients in Australia in May 2006 should assist in meeting some of these needs.[10]

The large number of participants who had not seen a GP since arriving in Australia (17%), and/or who had health problems for which they had not sought advice (26%), is of concern. Significantly, of those who had not seen a GP, more than half were resident in Australia for less than six months, highlighting a failure to ensure that new arrivals receive appropriate information and support to ensure initial contact with the health system. It is recommended that clear, culturally and linguistically appropriate information about both Australia's health system and services (including allied health and access to pharmaceuticals) is widely available and that services assisting the settlement process include provision of support to make initial contact with health providers and to undertake early health assessment.[11,12]

In using a non-random sample, the results cannot be considered fully representative of immigrants or refugees from these African countries. In comparison to the total number of immigrants from these countries in the time period studied,[2] women and members of the Eritrean community are significantly over-represented and Sudanese are under-represented. In addition, as recruitment was largely undertaken through community meetings, those who were socially isolated may be under-represented because of selection bias. The findings from this study must therefore be seen in the light of these limitations and it must be acknowledged that in a truly representative sample reported factors influencing the use and barriers to accessing health services may be dissimilar. Nevertheless, as limited research has been conducted in this area for immigrants from these countries, this approach does provide valuable baseline information and a basis for future research.

The strong perception of language and communication as the main barrier to health care and the participants' recommendations for improving services highlights the importance of new arrivals receiving appropriate information, in their own language, about what is a new and complex health system. It illustrates the importance of supporting immigrants who are not fluent in English to make initial contact with health care providers and highlights the need for strengthened GP clinics to optimise care for this disadvantaged population.

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