REVIEW

Understanding the healthcare issues of Afghan refugees settling in rural Victoria, Australia

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ABSTRACT

Introduction: Hazaras have experienced prolonged and repetitive marginalisation, stigmatisation, persecution and conflict as a minority ethnic group in Afghanistan for their linguistic, religious and ideological differences. As a marginalised group they are a product of generally poor socioeconomic and health status with resultant ill effects. Hazaras make up the largest group of refugees who have resettled in Victoria, particularly Shepparton. Part of the reason for this is that the region supports the largest food-based manufacturing industries in the country and so there are good work opportunities for those that do not have recognisable skills with limited English.

Aim: To explore the health care issues and challenges of Hazara located in Shepparton, Australia.

Results: The literature review identified that the Hazara community have multiple physical and psychological health needs most likely a result of the trauma and torture when in Afghanistan, plus from the often, dangerous journey to Australia and then from what is usually prolonged periods in immigration detention centres. On top of this are the challenges that occur with their resettlement including language and cultural differences and low health literacy as well as lack of understanding of health services in Australia. All creating barriers to access.

Discussion: The recommendation is to outline the rationale and process for the development of Health Hub (HHH) for the Hazara community within *Community Health @ GV Health*, the major community health centre in Shepparton, Victoria. Through fostering strong relationships between the Hazaras and their primary care team in consultation with the Hazara community will, therefore, ensure the outcomes are tailored to their individual needs and help improve their health outcome.

Key Words: Hazara refugees, Health literacy, Barriers to healthcare, Rural Australia

1. INTRODUCTION

Afghanistan is a land locked country located in the central part of Asia. This is a very mountainous country with a very rugged and challenging terrain that has contributed to invaders not being successful in conquering them.[1] The predominant religion in Afghanistan is Islam which is divided into two denominations of Sunni and Shia; the latter being the smallest of the two. Afghans have a strong sense of family values, beliefs and rules. Afghan culture is based on traditional gender roles of patriarchal with males making decisions to control women's behaviour to preserve male prestige and family honour. Women belong to the family and must be covered from head to foot when in public.[2]

Health care in Afghanistan is very limited with poor infrastructure and security concerns making transport of patients, staff and medical supplies difficult.[3] Consequently,

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Afghanistan's health status is one of the worst in the world and has one of the lowest life expectancies in the world with an overall expectancy of 53.65 years; 52.1 for males and 55.28 years for females.[4] The top three causes of death in Afghanistan in 2019 was reported to include ischaemic heart disease, injury caused by conflict and terror and neonatal disorders.[5]

There are some 14 distinct ethics groups in Afghanistan with Hazaras making up one of the four largest groups. The Hazara people come from Hazarajat/Hazaristan in central Afghanistan.[3,6] The majority of Hazaras are Shiite Muslims, speak Dari and hold more progressive views supporting gender equality and education compared to other Afghans.[3,7] Sunni Muslims as the majority group of Afghans, are in constant conflict with the Shiite's. For more than 25 years, Hazaras have experienced prolonged and repetitive marginalisation, stigmatisation, persecution and conflict as a minority ethnic group in Afghanistan for their linguistic, religious and ideological differences.[7] Hazaras have also been isolated through policy and denied basic services such as health and education, particularly in Taliban controlled areas.[3,7] As a marginalised group they are a product of generally poor socioeconomic and health status and resultant poor health services with resultant ill effects. This has resulted in the Hazar being the most economically deprived group, practicing subsistent farming and have lower status than other groups and forced to live in the barren mountainous area of central Afghanistan.[2]

The country of Afghanistan has suffered decades of invasions and conquests due to its position along the crucial trade route between Middle East and Asia. There is a constant civil war and human rights abuse that has resulted in death and torture of many thousands of people.[3] This civil unrest has resulted in many homes, farms and institutions being ruined leaving millions of Afghans displaced and homeless. Consequently, this has resulted in several challenges including rebuilding the crumbling economy, eliminating the continued opium trafficking, remove terrorist activity, and recovering buried landmines from content wars.[1] This has resulted in several displaced Afghans fleeing the country. It is estimated that some 2.6 million Afghans were hosted as refugees translating to one of largest protracted refugee situation and the third largest displaced population in the world.[8] One of the countries that Afghan refugees have travelled to is Australia.

Australia is divided up into 31 regions, called primary health networks, which are closely aligned with the state and territory local hospital network.[9] A primary health network is an independent organisation that is funded by the Commonwealth Department of Health to coordinate primary health care within the designated area. This occurs by assessing the needs of the population in the area, especially those at risk of poor health outcomes, and setting up health services specifically to address the needs to this group of people aimed to improve the health outcomes.[9] Each PHN community has different health needs which means the health services are tailored to these needs. This results in different PHN having a variety of models to accommodate the various needs of the community.

One of the areas that have welcomes Afghan refugees is Victoria, specifically the Murray region. Victoria is a state in the south-eastern corner of Australia and consists of six Primary Health Networks (PHN). One of these is Murray PHN in the north of the state of Victoria. This region is almost 100,000 square kilometres, and spans from Mildura in the west to Woodend in the south, across to Seymour and up to Albury. Within this region is a population of 650,000 people in both rural and regional centres. Within this region are 55 hospital services, 214 general practitioners and covers 22 local government areas (LGA).[6]

Murray PHN contains four areas of humanitarian refugee settlement; Greater Bendigo, Greater Shepparton, Mildura and Wodonga.[10] The rate of resettlement in this PHN was 0.48 per 1,000 persons between July 2018 and March 2019 and higher than the national rate of 0.32.[6,11] Refugees from various backgrounds have been resettled in the various region, one of these being Hazara from Afghanistan.

Refugees are individuals who cross international border to escape war, violence, conflict, or persecution for reasons of race, religion, nationality or political opinion.[8] It is estimated that some 68.5 million individuals have been displaced globally with 25.4 million seeking refuge internationally.[12] Many of these refugees come to Australia, considered the third resettlement nation in offering protection to refugees, with Afghans one of the top ten groups applying.[12,13] Murray PHN and particularly, Great Shepparton is fast becoming internationally renowned for being a centre that is accepting of many people from diverse backgrounds as either migrants or refugee/asylum seekers.[14] Part of the reason for this is that the region supports the largest food-based manufacturing industries in the country[15] and so there are good work opportunities for those that do not have recognisable skills with limited English.

Hazaras make up the largest group of refugees and asylum seekers who have resettled in Victoria, particularly Murray PHN. The Hazara community is substantial with estimates of 3000 plus people now living within the Murray PHN, the majority being under 45 years of age and predominantly settled in Greater Shepparton.[3] As the largest refugee group in

the Murray PHN this paper will focus its discussion on the health care issues of the Hazara community.

2. SEARCH STRATEGY

A search was undertaken though various databases including CINAH, Medline, Scopus and PubMed using keywords of Hazara refugees, Australia, health needs, health challenges. This extensive search of the literature from 2000 to 2022 resulted in the identification and selection of seven articles relevant to the aim. A thematic analysis was then undertaken of these articles which identified health needs and challenges. These will be discussed in detail in the next section.

3. RESULTS: HEALTH NEEDS

Studies of the Hazara people in Victoria reveal multiple physical and psychological health needs.[3,7,16–18] These are most likely a result of the trauma and torture when in Afghanistan, plus from the often, dangerous journey Australia and then from what is usually prolonged periods in immigration detention centres. This results in poorer health status than most Australians with higher rates of chronic diseases and infections.

There are several specific health issues which have been identified in the Hazara community. This includes headache, reported as the most common physical health condition followed by gastrointestinal concerns, asthma, diabetes and hypertension.[3] Additionally, musculoskeletal pain is commonly reported but only considered mild to disabling, suggesting a tolerance to daily pain exists.[3] Smoking is very uncommon and of course Hazara community do not consume alcohol. For those Afghans who presented to GP and had laboratory tests undertaken, high levels of cholesterol, and vitamin D deficiency were reported as well as increased infections such as giardia.[18]

In addition, many members of the Hazara community have been identified as having poor mental health, not surprisingly being considered a major concern. Major depression, anxiety, loneliness and low mood are major concerns likely associated with pre-arrival experiences of torture, trauma, displacement and dangerous living circumstances with post traumatic stress disorder being common.[3,12,16,17,19] Afghans coming to Australia have lost everything, including in many cases, family members who have been killed or left behind.[12] These concerns can be perpetuated by post-arrival experiences including detention, visa status concerns, and family separation.[3,17] In addition, anxiety due to family members left in Afghanistan was also reported.[18] Much of the mental health issues are hidden, however, due to misunderstanding and stigma associated with having mental health issues as well as fear that this may affect their visa status. In other words, poor mental health literacy.[12] The other issue here is that providing psychological support through a necessary interpreter often makes this ineffective and a perception that this is not working, further impeding access to psychological support.[3] There is also a reported lack of mental health services available in rural areas of Australia which further compounds issues of access.[18] There is a need for more research into this area of mental health and help seeking behaviour to understand how best to improve mental health in Afghan refugees.[12]

Hazara oral health is also generally poor, with most new arrivals having had extractions.[7] Toothpaste and toothbrushes are not widely available outside of cities in Afghanistan, and most use salt to clean their teeth and gums.[7] Many describe a tolerance to living with persistent oral pain over time and described having had little to no access to dentists in Afghanistan.[7] Oral health is worsened by smokeless tobacco chewing, which is common among Hazaras and a risk factor for oral disease.[3,7] Oral health was considered a low priority for the Hazara community which continued when they arrived in Australia.

Many of the adolescent Hazaras living in Australia were born in Afghanistan during Taliban rule and subject to extreme Islamic practices with devastating health and educational consequences, particularly for women.[16] Hazara females report difficulty in knowing how to dress "safely," experiencing criticism at home for not adhering to cultural dress and bullying within the community when wearing headscarves.[16] This contributes to them experiencing discomfort in the school environment and not "fitting in" as they are seen as different and subject to discrimination potentially resulting in mental health issues. Additionally young Hazara women report that their parents are not supportive of them engaging in sporting activities, sex education or school camps as it is incongruent with Afghan culture and leads to perceived isolation from their peers and family conflict.[16]

Challenges

Not surprisingly considering the circumstances from which these Hazara refugees have come from, there are a number of challenges that occur with their resettlement in Australia. This includes language and cultural differences and low health literacy as well as lack of understanding of health services in Australia. All creating barriers to access.

Generally, Hazaras report lower levels of health literacy and a lack of knowledge for how to improve and maintain their own health and wellbeing.[3,18] Specifically, Hazaras believe they do not know enough about physical signs and symptoms of disease that would indicate when they need to present to

a health service. Additionally, there is little understanding of health prevention and how the Australian Health Care System works which compounds this.[3]

One the other major issues Hazaras reported is communication barriers. These are a major source of worry and results in Hazaras being less likely to attend any service if an interpreter was not available.[3] There is also reported to be a distrust of interpreters generally due to a perceived lack of confidentiality and resultant preference for using family members, particularly when the interpreter uses a different dialect so miscommunication is common.[3] Furthermore, the Telephone Interpreter Service was considered unsatisfactory due to its impersonal nature.[3] Effective communication is considered central to an effective patient clinical therapeutic relationship and is associated with positive health outcomes.[20,21] In a health system where English is the primary language, lack of English proficiency in clients and lack of trained multilingual staff is associated with lower quality care and perpetuation and exacerbation of health inequalities.[20,22] Additionally, hospitalisations, invasive management, medical errors and drug complications become more frequent.[21,22]

As previously mentioned, Hazara community distrust the interpreters they had used for fear of confidentiality breaches and felt that Telephone Interpreter Service was undesirable due to being impersonal.[3] A preference for using family members to translate information was common among the community. Studies have confirmed, however, that using untrained people for interpretation results in doubling of communication errors, yields degraded information and can result in misdiagnosis and unnecessary interventions.[20] Furthermore, it is important to use interpreters with the same dialect as the client for accurate interpretation. Studies have shown that using an interpreter in a client's first language results in longer replies with greater disclosure and improved clinician examination by reducing the risk to ask closed response questions.[22]

Another one of the challenges identified in the Afghan refugees was a lack of trust of health professionals.[18] Hazaras have a general distrust of doctors which comes from unrealistic or unfulfilled expectations of health services in Australia as well as their previous experiences of healthcare services in Afghanistan.[3,23] Additionally, a lack of female doctors, particularly in rural areas is a major barrier for female Hazaras who are uncomfortable seeing male doctors.[3,16,17]

4. DISCUSSION

From the literature a number of health care issues were identified. This includes headache, hypertension, musculoskeletal pain, gastrointestinal problems, diabetes, asthma, high cholesterol, low vitamin D and oral health.[3,7] In addition, poor mental health remains a significant concern, including depression and anxiety.[3,16,17] From the literature it can be determined that the key service issues facing Hazaras in the Murray PHN include a need for improved relationship and communication with primary health physicians and health care professionals as distrust of doctors and interpreters are a major barrier to accessing health services. Relationship quality is also worsened by unrealistic and unfulfilled expectations of health services in Australia due to poor health literacy and heath literacy of the Australian Health care system.[3,23] Success of engagement with health care services is contingent on the Hazaras having trust for, and positive relationships with Australian health care system which starts with the primary health care team. Building relationships between Hazaras and the GP and primary health care team will help to renew faith and prioritisation of health care, as well as allow for the provision of health education.

There is a need, therefore, to engage with the Hazara community, stakeholders, planning and funding bodies to better understand and plan for the health and service needs of the community.[24] Consultation should occur with local Hazara community leaders, health service professionals (HSPs) and provide opportunity for input that reach the individual level, such as through community gatherings.[3] It is important that community consultation respect the cultural needs of the Hazaras including ensuring that consultations are not held at key religious times.[24] The National Health and Medical Research Council[25] provide ethical guidelines, the six core values, to provide safe, responsible, respectful, high quality and beneficial care to First Nations people and communities. These values can also be applied to other ethnic groups such as Hazaras. The six core values are reflected in Figure 1. These values are an appropriate and ethical framework that can be used to guide consultation with the Hazara community as they outline spirit and integrity as the central value and demonstration of all other values ensures this is met.[25]

The Hazaras are the most widely studied group in the PHN, despite a very limited number of studies being available that overtly examined their issues. From what is discussed earlier, the most salient issues identified were communication, trust, mental and primary health and oral care. In terms of *Maslow's Hierarchy of Needs*, these needs fall into the three lowest order needs; physiological, safety and belonging.[26] Until these needs are met, the higher order growth needs of esteem and self-actualisation can never be met.[26]

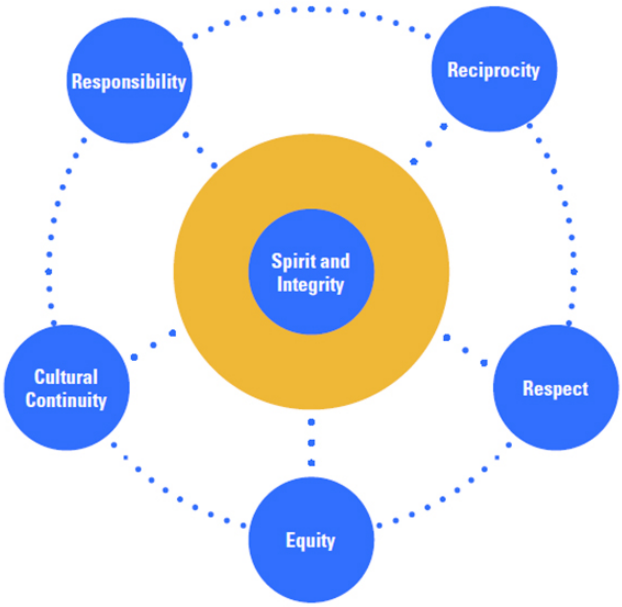

Figure 1. Six core values for ethical research with aboriginal and torres strait islander peoples

5. Recommendations

From the discussion of the literature several recommendations can be made. There is a need to build a relationship between the health care services and the Hazara community. The plan and approach to foster strong relationships between the Hazaras and their primary care team should be done in consultation with the Hazara community to ensure the outcomes are tailored to their individual needs. Consultation should occur with local Hazara community leaders, health service professionals (HSPs) and provide opportunity for input that reaches the individual level, such as through community gatherings.[3] The cultural needs of the Hazaras should be respected during community consultation, including ensuring that consultations are not held at key religious times.[24] In addition to this, a team could be established to direct and oversee all parts of the development process for a community hub for Hazara. It is essential that members of the Hazara community are part of this team.

The recommendation is to outline the rationale and process for the development of Health Hub (HHH) for the Hazara community within *Community Health @ GV Health*, the major community health centre in Shepparton, Victoria. As part of community consultation, the Hazara community would be encouraged to choose a name for the facility (possibly in Dari) that best represents the goals of the service to provide respectful, culturally informed health care that is designed by and for Hazaras. The suggestion is for a purpose-built hub that services the primary health care needs of the Hazara community through the provision of full-time specialist trained GPs and in-house interpreters as well as multi-lingual nursing and administration staff. A priority of the hub will be to provide continuity of primary health care for Hazara clients through the provision of the same GP and same interpreter to facilitate relationship building and build trust. Through trust and relationships, the health literacy of the Hazara community would increase and provide a foundation for engagement with extended services such as mental and oral health services which are unlikely to be prioritised when a distrust for the medical community exists.

Future service development for the Hazara community should focus on addressing mistrust and improving communication. This will likely reap the largest gains by providing the foundation for extended service engagement. A specialised hub as an adjunct to a community health service employing in-house interpreters and doctors to build relationships and provide continuity of care is recommended. This hub could deliver educational and social programs aimed at improving health literacy and social connectedness as well as offer visiting services such as public dental care. In addition, within the Hub there could be some sort of group gathering social activities that increases community networks, walking groups or some other activity. Once people attend the Hub, then provide some education about health promotion and services, mental health, and heath conditions.[12] Interpreter training for existing suitable Hazara community members could be included to capitalise on existing community relationships, provide access to people with a range of dialects and provide employment and career opportunities to the community. Additionally, appropriate training could also be funded and provided to community members who are suitable qualified nurses, health professionals and administrative staff. This would foster the sense that the Hub has been developed for and by the Hazara community which will improve engagement and trust.

Cultural competency training for GPs will be a priority and policy of the HHH to prevent avoidable relationship breakdown. Studies examining interpreter's perceptions of the effectiveness of interpreter services for refugees identified that a lack of GP cultural understanding and competency was a major concern.[27] As an example, interpreters describe scenarios such as when a GP requests the patient to provide a stool sample in a way that is not culturally appropriate and despite clear interpretation, the patient declined to engage in treatment or interventions.[26] Through fostering strong relationships between the Hazaras and their primary care team in consultation with the Hazara community will, therefore, ensure the outcomes are tailored to their individual needs.

6. Conclusion

Hazaras have been isolated through policy and denied basic services such as health and education, particularly in Taliban controlled areas of Afghanistan.[3,7] As a marginalised group they are product of generally poor socioeconomic and health status and resultant poor health services with resultant ill effects. Hazaras make up the largest group of refugees and asylum seekers who have resettled in Victoria, particularly Murray PHN. This group of people have been found to have multiple physical and psychological health needs.[3,7,16–18] These are most likely a result of the trauma and torture when in Afghanistan, plus from the often, dangerous journey to Australia and then from what is usually prolonged periods in immigration detention centres. This results in poorer health status than most Australians with higher rates of chronic diseases and infections. On top of this are the challenges that occur with their resettlement including language and cultural differences and low health literacy as well as lack of understanding of health services in Australia. All creating barriers to access. There is a need to build a relationship between the health care services and the Hazara community. The recommendation is to outline the rationale and process for the development of Health Hub (HHH) for the Hazara community within *Community Health @ GV Health*, the major community health centre in Shepparton, Victoria. Through fostering strong relationships between the Hazaras and their primary care team in consultation with the Hazara community will, therefore, ensure the outcomes are tailored to their individual needs and help improve their health outcomes and a sense of community.

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Authors contributions

KK was responsible for collecting the literature and writing the paper originally as an assessment piece in Masters course. LJ then revised and formatted this paper into an article. All authors read and approved final manuscript.

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Data sharing statement

No additional data are available.

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