Our Hazara communities: Health and health service experiences

FEBRUARY 2019
Acknowledgements

Murray PHN acknowledges the traditional owners of the lands we work on and would like to pay our respects to their elders past and present and extend that respect to all Aboriginal and Torres Strait Islander people.

This report would not have been possible without the generosity and contributions of those who have been involved. First of all, thanks must go to the Hazara community leaders, volunteers and members in Mildura, Swan Hill, Shepparton and Bendigo for their responses, perspectives, honesty, time and guidance; we could not have done it without them.

Thank you to all the health and community service providers who provided their views, understanding and context about many important issues of refugee health and wellbeing and how local services might respond; these were very valuable insights.

Finally, thank you to Murray PHN colleagues who supported the project throughout its progress and helped transform hypotheses and estimates into evidence, conclusions and recommendations.

The project team has learned a lot through the process of doing this work. It is a sound contribution to our appreciation and understanding of the needs of Hazara refugees from Afghanistan who have settled in northern and north central Victoria.

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Executive Summary

Refugees in Australia often have complex physical and psychological health needs. Murray PHN is home to several different groups of refugees, including Hazara refugees from Afghanistan.

The aim of this project is to explore the health experiences and needs of Hazara people in the Murray PHN catchment, and to consider the barriers and enablers for Hazara residents to access health services.

Undertaking this project adds to our population health knowledge by providing an in-depth understanding of a specific population group within our catchment. The topics explored during the project and the findings also address several of our other strategic health priorities such as mental health, chronic disease, workforce and alcohol and drugs.

In this project, data were collected from community members at meetings and individually, from community leaders and from health service providers (HSPs).

The situation is complex with the impact of migration and the social determinants of health of refugees’ health and wellbeing evident. The main health issues identified were mental health problems and physical health concerns. Related issues were difficulties with health service access due to language and cultural differences, lack of suitable HSPs and low levels of health literacy.

Other concerns which impacted on health and wellbeing related to family, finances, employment and education. Many community members have family in Afghanistan and are worried about their safety. Parents report concerns that their children are losing their Hazaraghi language and customs in Australia; this is a source of conflict within the family. The resettlement process also caused stress and tension within families.

There are a range of primary health organisations across the Murray PHN region which work with refugees as part of wider and also specialised services. These organisations have varying degrees of capacity, skill and experience in working with people from multicultural backgrounds, including Hazara people.

From the findings of this project, our recommendations include:

- improving service access
- improving health literacy
- accessible and appropriate mental health services
- encouraging primary prevention and health promotion including screening
- encouraging further community engagement to build stronger relationships with the Hazara communities and to empower them to positively influence their health and wellbeing.

Findings from this project will inform Murray PHN’s population health planning, and in turn inform the organisation’s other annual planning cycle activities.
Background

Murray PHN

Murray PHN (Primary Health Network) is funded by the Commonwealth Department of Health to help improve primary health outcomes across our region through health systems improvement and the commissioning of efficient and effective primary health services.

With a population of 644,000 people spread over almost 100,000 sq kms, Murray PHN has 55 hospital services, 214 general practices and covers 22 local government areas. Featuring both rural and regional centres, our major towns include Bendigo, Shepparton, Mildura and Albury-Wodonga, where Murray PHN has regional team locations.

Murray PHN has been in operation since 1 July 2015. It operates from Mildura in the North West, to Woodend in the south, across to Seymour and up to Albury - an area of almost 100,000 square kilometres that is home to more than 644,000 people.

As one of the 31 PHNs in Australia, Murray PHN’s role is to hear, understand, and address the health needs of our communities by engaging key partners to deliver targeted actions that:

- increase the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes
- improve the coordination of care to ensure patients receive the right care in the right place at the right time.

Figure 1: Murray PHN catchment
Murray PHN has 10 strategic health priorities which are:

- Alcohol and drugs
- Aboriginal and Torres Strait Islander health
- Aged care
- Child health
- Chronic disease
- Digital health
- Health workforce
- General practice
- Mental health
- Population health.

**Project aim and objectives**

**Aim**

This project aims to explore the health experiences and needs of Hazara people in the Murray PHN catchment, and to consider the barriers and enablers for Hazara residents to access health services.

**Objectives**

The project objectives include:

- design a strategy for evidence-based engagement with the Hazara population
- better understand the health needs of the Hazara population
- understand the barriers and limitations of the Hazara population to access health services
- understand the capacity of the services to respond appropriately to the needs of the Hazara population.

Undertaking this project adds to our population health knowledge by providing an in-depth understanding of a specific population group within our catchment. The topics explored during the project and the findings also address several of our other strategic health priorities including mental health, chronic disease, workforce and alcohol and drugs.

**Refugees in the Murray PHN region**

The Murray PHN region is home to several different groups of refugees. The rate of newly arrived humanitarian settlers, between January 2017 to March 2018, is 0.74 per 1,000 persons across the region. While this is lower than the national rate of 0.83, there are several local government areas within our catchment with rates higher than the national average including Albury (1.55 per 1,000), Alpine (0.81), Greater Bendigo (1.0), Greater Shepparton (2.70), Mildura (0.98), and Wodonga (1.14) (Department of Social Security, 2018).

It is estimated that there are more than 3,000 Hazara people in the Murray PHN region\(^1\). This population is younger than the Victorian population and there is a higher proportion of males. Predominantly, these people are survivors of traumatic migration, detention and resettlement. Generally, population health status and the standard of health service care experienced in Afghanistan (particularly for Hazara people) were lower than in Victoria.

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\(^1\) Population estimates from the 2016 census (ABS 2016) and community leaders are different as noted herein. We have used the higher estimate from the community leaders.
Refugee health

Refugees in Australia frequently have complex physical and psychological health needs (Jackson-Bowers & Zheng, 2010). They may have diseases and conditions which are not common in Australia, nutritional problems, and health conditions and injuries that have been untreated or worsened through lack or treatment and/or poor living conditions. They may also have psychological problems which can be from pre-arrival experiences and experiences when they arrive (Jackson-Bowers & Zheng, 2010).

Common issues that relate to the health and wellbeing of refugees and displaced people internationally and in Australia include (Department of Health & Human Services, 2018a):

- experiences prior to resettlement – life in refugees’ home countries, including trauma and torture, pre-existing health and wellbeing status and health services
- experiences in their new country – health and wellbeing status, impact of change in a new country, culture, language, independence, discrimination, communication and service access and family; the social determinants of health such as employment and accommodation; and concerns related to family who have not been able to leave their home country
- health and wellbeing service sector in the country of settlement.

Afghanistan and Hazaras

Afghanistan is a land-locked country located at the central part of Asia with an estimated population of 36.3 million in 2018 (United Nations Population Division, 2018). It is bordered with Turkmenistan, Uzbekistan and Tajikistan on the North, China on the North-East, Pakistan on the South-East and South and Iran on the West. The capital city is Kabul with the estimated population of 4.6 million. Afghanistan is a mountainous country with highland mostly in the centre and southeast to northeast. The western branches of Himalayas called Hindu Kush mountains enter Afghanistan from the east and reach the central provinces like Bamiyan in Hazarajat called Baba Mountain. The highest peak of Hindu Kush called Tirich Mir is 7,690 metres and the Baba Mountain peak called Foladi reaches to 5,140 metres above sea level.

The political system in Afghanistan is Islamic Republic and the president is elected by the national election for a five-year term. The parliament has 302 seats and members (senators) are elected by the national election for a five-year term.

Hazaras live in Hazarajat/Hazaristan, which is a high and mountainous land located in the centre, from southeast to northwest of Afghanistan. The climate is varied throughout the year with four contrasting seasons starting from rainfall in spring, hot summer, dry cold autumn and a snowy winter.

Afghanistan follows the Solar Calendar which is now 1397 and 621 years behind from the Gregorian Calendar (2018). Its duration is the same as the Gregorian Calendar which is 365 days, divided into 12 months. The first day of the Solar Calendar (New Year’s Day) is concurrent with 21 March and the first day of spring in the northern hemisphere.
The people of Afghanistan have suffered decades of civil war and human rights abuse, with hundreds of thousands of people killed or injured in bombings and thousands more who have experienced forms of trauma and torture as a result of ongoing conflict. Homes, farms and public institutions, such as schools and hospitals, have been ruined leaving millions of Afghans displaced and homeless (Department of Immigration and Citizenship, 2012).

Much of the information available about the Hazara in Afghanistan is controversial or contested – there are acute socio-political sensitivities related to ethnicity (Department of Foreign Affairs and Trade, 2017). Afghanistan is a multi-ethnic country where more than 14 distinct ethnic groups live. Hazaras make up one of the four largest ethnic groups in Afghanistan. The majority are Shia/ Shiite Muslims, the remainder is Sunni or Ismaili Muslims. Most Hazaras live in the central regions of Afghanistan called Hazaristan/ Hazarajat.

Hazaras’ history is culturally rich with traditional dress, music and cuisine. Education is more important and gender equality is more common than elsewhere in Afghanistan, although still a struggle. Hazara children are encouraged to pursue further education where family circumstances allow. Until the late 1970s, the government did not provide education for Hazara children, nor were they allowed to attend university. This improved when the Russians arrived, but gains were reversed when the Taliban came to power in the late 1990s. The literacy of the entire population of Afghanistan over the age of 15 years is 38%; 52% for males and 24% for females (Department of Foreign Affairs and Trade, 2017).

Hazaras living in rural Afghanistan tend to speak Hazaragi, a dialect of Persian that is mutually intelligible with Dari (dialect of Persian in Afghanistan), the more commonly used of Afghanistan’s two official languages (Department of Foreign Affairs and Trade, 2017).

It is unclear exactly when the Hazaras first arrived in Afghanistan, but they have been there for centuries (Department of Foreign Affairs and Trade, 2017). Historically, the Hazaras lived quite independently in Hazarajat as pastoral farmers, active in herding in the central and south-eastern highlands of Afghanistan. More recently they have become more urbanised and involved in business and it is estimated that Hazaras form half the current population of Kabul, the capital city (Department of Foreign Affairs and Trade, 2017).

Hazaras were living across much larger parts of Khurasan/ Afghanistan (Hazaristan) (Sarabi, 2005) until 1747 when Afghans/ Pashtuns came in power. The Pashtuns or Afghans are one of the ethnic groups living on the border of Afghanistan and Pakistan - their heritage is unclear, but it is suggested that they may have Eastern Iranian and Northern Indian origins. In the late 19th century, when the Pashtun Emir Abdur Rahman Khan launched a campaign to bring Hazarajat under his control, he responded to Hazara resistance to his rule by ordering the killing of all Hazaras in central Afghanistan. It is estimated up to 60% of the Hazara population was killed, sold into slavery, or forced into exile from Hazarajat, resulting in a strong and lasting enmity between the Hazara and Pashtun communities. Khurasan was then renamed Afghanistan (Waak, 2005).
Abdur Rahman’s successor granted amnesty to all those exiled by his predecessor in 1901, allowing the Hazaras to return. However, the Hazaras continued to face considerable social, economic and political discrimination through much of the 20th and now the 21st century. They also experience persecution because of their religion as Shia Muslims – not the predominant Sunni Muslims (Department of Foreign Affairs and Trade, 2017).

Hazaras in Afghanistan continue to be discriminated against and stigmatised for ethnic and religious differences. From 1994, the Hazaras were targeted by the Taliban and Al-Qaeda resulting in the death and displacement of thousands of people. In 2001, international forces led by the USA entered Afghanistan to destroy terrorist activity. There was some success, although after 2007, the Taliban regrouped and the Hazara were again pursued. As well as experiencing direct attacks and living in constant fear, the Hazara are denied basic services such as health and education in Taliban controlled areas (Department of Foreign Affairs and Trade, 2017).

Health and the health system in Afghanistan

Although the availability and quality of health care in Afghanistan has improved markedly since 2001, it is still limited, especially outside Kabul. There are few generalists and even fewer specialists. Poor infrastructure and security concerns affect transport of patients, staff and medical supplies (Department of Foreign Affairs and Trade, 2017). There is little data on the health status of Hazara people in Afghanistan specifically. The following data refers to the country’s total population.


Table 1: Key demographic indicators for children 2017 in Afghanistan and Australia (UNICEF, 2019b)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Afghanistan</th>
<th>Australia</th>
<th>International</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal mortality rate (per 1,000 live births)</td>
<td>39</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Infant mortality rate (per 1,000 live births)</td>
<td>52</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Under 5 mortality rate (per 1,000 live births)</td>
<td>68</td>
<td>4</td>
<td>10</td>
</tr>
</tbody>
</table>

Life expectancy is improving in Afghanistan, although it still has one of the lowest life expectancies (also by gender) in the world. Chad at 224 has the lowest (Central Intelligence Agency, 2017).

Ischaemic heart disease, lower respiratory tract infection and stroke were the top-ranking causes of death in adults in 2017. Neonatal death was the second ranked cause of death for the entire population. Neonatal disorders and congenital disorders were the first and third most common causes of premature death in all people; lower respiratory infections, ischaemic heart disease and diarrhoeal disease were ranked second, fourth and fifth respectively.
In 2017, the ranking of health problems causing the most disability in Afghanistan were (Institute for Health Metrics and Evaluation, 2017):

- terror and conflict
- drug use disorders
- headache disorders.

Additionally, communicable (such as malaria, diarrhoeal disease, including cholera, respiratory tract infections including tuberculosis and measles) (Wallace et al., 2002) and non-communicable diseases (such as ischaemic heart disease, diabetes and stroke) are common causes of ill health. The rates of delivery of prevention programs, such as immunisation are much lower in Afghanistan, with correspondingly higher rates of vaccine preventable disease. It is estimated that 65% of all infants received a full course of DTP vaccine and 39% of children received their second dose of measles containing vaccine (UNICEF, 2019a).

### Hazaras in Australia

Hazaras make up one of the major groups of refugees and asylum seekers\(^2\) who have resettled in Victoria. There have been two main waves of Hazara refugee arrivals in Australia with the first wave of refugee and asylum seekers arrived from Afghanistan between 1999 to 2002, and the second wave mostly resettled in Victoria including in the Murray PHN catchment between 2009 to 2013. The majority of these refugees have received permanent residency visa; some are still living with temporary or bridging visas. Also, many Hazaras are entering to Australia via refugee family reunion programs.

The majority of refugees from Afghanistan in the Murray PHN catchment have settled in four major centres – Bendigo, Mildura, Shepparton and Swan Hill. Hazara people make up the overwhelming majority of these settlers from Afghanistan. They have been persecuted in Afghanistan because they belong to Hazara ethnicity and are also the Shi’a Muslim minority, rather than the Sunni majority. It is estimated that there are more than 3,000 Hazara people in the Murray PHN catchment; more men than women, with the majority under 45. Population estimates for Hazara people in the Murray PHN catchment are detailed in Table 3 below.

#### Table 3: Hazara population in the Murray PHN catchment by location, gender and age group and by census data based on country of birth and community leader estimate.

<table>
<thead>
<tr>
<th>Area</th>
<th>Population from Census 2016(^a)</th>
<th>Population estimate(^b)</th>
<th>Male estimate(^b)</th>
<th>Female estimate(^b)</th>
<th>Age range (%)(^b) (less than 18 years, less than 50 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Shepparton</td>
<td>755</td>
<td>Up to 2,000</td>
<td>60%</td>
<td>40%</td>
<td>&lt;50 - 65% &lt;18 - 25%</td>
</tr>
<tr>
<td>Mildura</td>
<td>260</td>
<td>Over 900</td>
<td>58%</td>
<td>42%</td>
<td>&lt; 50 - 72% &lt;18 - 24%</td>
</tr>
<tr>
<td>Swan Hill</td>
<td>162</td>
<td>Over 270</td>
<td>62%</td>
<td>38%</td>
<td>&lt;50 - 60% &lt;18 - 18%</td>
</tr>
<tr>
<td>Greater Bendigo</td>
<td>90</td>
<td>Up to 200</td>
<td>55%</td>
<td>45%</td>
<td>&lt;50 - 95% &lt;18 - 35%</td>
</tr>
</tbody>
</table>


\(^b\) by local community leaders 2018

\(^2\) ‘Refugee’ is used commonly to refer to people who are forced to leave their homes for many reasons, including conflict and violence (or natural disaster); asylum seekers have sought protection as a refugee, but their claim for refugee status has not yet been assessed or finalised. [https://www.refugeecouncil.org.au/definitions/]
Please note, population estimates presented in Table 3 differ between Census data and community leader estimates. Reasons for these differences may include:
- respondents did not complete the census (technology, language or other access issues)
- there are now Australian born Hazara children in Hazara communities
- there have been many new arrivals in the two years since the census
- some Hazaras may have been born in Pakistan before arriving in Australia.

**The health of Hazaras in Australia**

Many Hazara refugees are suffering from multiple and complex physical and psychological health issues, which may be influenced by both pre-and post-arrival experiences. The experience of trauma and torture in their home country, dangerous journeys to Australia and prolonged periods in immigration detention centres may have direct and indirect impacts on physical and mental health and wellbeing. There is a legacy for members of a marginalised group, of their life in Afghanistan, with its generally poor socioeconomic and health status and health services that has an effect. As a group, coming from Afghanistan via a possibly traumatic migration process, their physical health is poorer than most Australians, with higher age standardised rates of chronic non-communicable diseases and chronic infections (such as tuberculosis and hepatitis B) (Qazi, 2018; Sievert et al., 2018).

Resettlement has its own challenges. As new residents, refugees’ understanding of the Australian health system, health literacy and access to regional health care services, as well as poor fluency in English, are barriers to receiving appropriate understanding, treatment and support for physical and mental health issues. There is the care of children and family members to contend with, dealing with education, housing and social service systems and getting suitable employment, engaging with the Hazara and non-Hazara communities and trying to establish new lives. These are significant life changing events (Department of Health & Human Services, 2018a).

**The services**

Community health service providers focus on refugee communities including Hazara people. Basic health services are provided such as a refugee health check for new arrivals, mental health support and counsellors, dental health, women’s health and maternity support, referral services, youth activities, and Humanitarian Settlement Program services. The TAFE sector commonly provides English language training for refugees.

The same local providers also deliver services for the general population. That is, there are no specific services for Hazara communities. The types of services Hazara communities may access in the regional centres included in this project are detailed below.

**Greater Bendigo**

Bendigo Health (emergency and general departments), Bendigo Community Health Services (BCHS), Bendigo Dental Health and local general practitioners (GPs).

**Greater Shepparton**

Goulburn Valley Health (hospital), Primary Care Connect (PCC), local general practitioners (GPs), Ethnic Council Shepparton and Kildonan Uniting Care.

**Swan Hill**

Swan Hill District Health, Mallee Family Care, local general practitioners (GPs) and Community Issues Group.

**Mildura**

Mildura Base Hospital, Sunraysia Community Health Services (SCHS), local general practitioners (GPs) including a Farsi language speaking GP and Sunraysia Mallee Ethnic Communities Council (SMECC).
Methodology

As detailed herein, the aim of the project was to explore the health and health service experiences of the Hazara population in the Murray PHN region, to describe their health needs, to consider the barriers and enablers of health service delivery and provide recommendations to improve the current situation.

The project officer, who undertook the majority of the project, is a Hazara man who was medically trained in Afghanistan and supported by Murray PHN population health staff throughout the project.

Methods

This project focuses on the Hazara people from Afghanistan who have resettled in the Murray PHN region, and in particular, in the local government areas (LGAs) of Greater Shepparton, Mildura, Swan Hill and Greater Bendigo. These LGAs were selected as ABS Census data indicated that sizeable, identifiable populations of Hazara people have resettled in these locations (Australian Bureau of Statistics, 2016).

Mixed methods were used in the project. The project officer engaged with local HSPs and community leaders and volunteers, community gatherings and individuals. These activities were conducted sequentially (in the order detailed below) to foster relationships with community members and develop their familiarity with the project and process. Questions and hypotheses were developed, and data were collected based on existing literature and information from community leaders and health service providers (HSPs). When engagement activities were undertaken, the project officer wrote responses and notes and checked back with respondents for accuracy. The areas discussed during each engagement activity are listed in the points below. Questions were generally open-ended and used to guide discussions, while still allowing community concerns to emerge.

Local HSP meetings

HSPs were selected from the identified LGAs and if they provided services for refugees in that area. Discussion questions with HSPs included:

- Which health services can Hazara people access?
- Are these services used by the Hazara community?
- How is the health and wellbeing of the Hazara community?
- What access issues have they identified for the Hazara community?
- What other issues are there for Hazara community members?

The project officer also used these meetings to seek information on how to best contact and engage with the local Hazara community.

Community leader and volunteer meetings

Meeting with community leaders and volunteers was exploratory and used to understand the best methods of connecting with community members. Discussion points included:

- The project aims and objectives
- Details of the project’s expected outcomes
- Data collection process
- Health issues including:
  - What health issues exist in the community? What are common issues and concerns?
  - What are the community’s priorities?

3. The majority of refugees from Afghanistan in Northern and Central Victoria are Hazara people. All participants in this project were Hazaras.
Community meetings

Community meetings were then held where the aim and objectives of the project were explained, and then a series of direct and open-ended questions were asked. These discussion points and questions included:

- Understanding of the project aim
- What health issues exist in the community? What are the common health issues?
- What are the concerns around health issues?
- What are the community priorities to address the identified issues?

Community members at these meetings were then invited to participate in the individual interviews/discussions with the project officer with registration forms for these circulated through their community.

Interviews/discussions with individuals

The interviews/discussions with individuals were conducted face-to-face and on the phone. Demographic data, information about general physical and mental health status, and information about service access and other health concerns were collected. Questions were open-ended and frequently led to further discussion.

There were broad questions about general health, mental health and wellbeing including sleep and life enjoyment, physical illnesses, chronic disease, screening tests, alcohol and drugs, children’s health and immunisation, women’s health, family concerns, the impacts of pre and post arrival tortures and traumas on general health and wellbeing, demographic questions and the priorities of community.

We promoted the opportunity to participate to the Hazara communities in the selected locations. The interviews were undertaken in Hazaraghi language by our project officer. This facilitated the approach to, and engagement with the community, and allowed individuals to speak comfortably in their own first language (Hazaraghi).
Results

Overview of communities

The 2016 Australian census\(^4\) estimates there are approximately 1,200 people from Afghanistan living in the region, however local sources suggest that the numbers are much higher (see Table 3 in background section).

Interviews with Health Service Providers

Interviews were held with a selection of Health Service Providers (HSPs) from each of the four sites between February and May 2018. A refugee nurse and refugee health access worker attended from Sunraysia Community Health Service in Mildura. In Swan Hill, service providers from Headspace, Mallee Family Care and the Community Issues Group attended, as well as three Hazara women who were volunteering at Mallee Family Care to support health and recreational activities for the Hazara women’s group and one Hazara man volunteering with the men’s group. In Shepparton, five staff from Kildonan Uniting Care and three staff from Primary Care Connect attended. The manager and a team member of the Cultural Diversity and Relationships team program at Bendigo Community Health Service were interviewed. A summary of responses is presented below.

What does your organisation know about Hazara community in this local region?

There was an understanding of the different waves of arrival in different towns, for example in Mildura and Bendigo refugees were relatively new arrivals, in contrast to Swan Hill where there had been two waves of arrivals; the first in 2001 and the second in 2009-2016. It was noted that the Australian Bureau of Statistics’ estimates of population (ABS 2016) were outdated and that the Hazara population in all centres was much larger in 2018. Cultural differences, such as gender separation and different meeting arrangements, community organisation into subgroups with community boards were described. The importance of children’s education, especially university education, to Hazara parents, was highlighted. It was noted in all towns that men tended to undertake manual and farm labour, or industry in Bendigo, whereas women tended to work caring for children, family and the home.

What does your organisation know about Hazara community health status in this local region?

The poor health status of the Hazara people was commented on by some of the interviewees. Mental health problems and chronic pain were identified in all towns as major health issues for their Hazara communities.

The other important issues affecting the Hazara people’s health are:

- women’s health issues, in particular pap smear/HPV screening and mammography, and postnatal issues. It was noted that women at home with new babies feel very isolated and miss the support of wider family and community that they would have had in Afghanistan. Low rates of attendance by women for health screens was noted in Mildura
- gastrointestinal problems
- diabetes
- high blood pressure.

What does your organisation know about the local service providers and health services in which Hazara community has access to?

HSPs identified a number of services that the Hazara people can access and it was observed that there are barriers to the Hazara people accessing them. The major problems were language and unfamiliarity with the health system and limited cross-cultural understanding by both HSP and client. Health services are trying to improve service access by broadening what they offer the community.

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**What advice do you have about engaging with the community?**

The advice HSPs gave varied with different communities and included:

- use pre-existing networks such as mothers’ group meetings or men’s welcoming nights to connect
- invite them to the health centre for interviews
- throw a party and present the project there
- work with group leaders to get their support for the project and to spread the message and otherwise assist with communication. This was especially important in the towns with bigger communities
- meet women and men separately
- contact community members directly to explain the project.

**Meetings with community leaders and volunteers**

The meetings with community leaders varied from site to site. In Mildura, two out of the seven community leaders participated in the meeting. In Shepparton, three out of 12 community leaders attended, and the president of the community attended in a separate meeting. However, they could not reach a decision on how to help the project connect with the community members due to the decision requiring the majority of leaders in the meetings. Because of this the role of the community volunteers in Shepparton was important for engagement. In Swan Hill and Bendigo, the communities are managed by volunteers who actively attended the meetings.

Community leaders and volunteers were asked about their understanding of the issues influencing the health and wellbeing of the community. They identified the following main areas:

- mental health was top of the list
- chronic body pain and back pain
- women’s health
- family concerns causing health issues
- health service access (delaying presentations).

**Community meetings**

Community members who attended meetings were provided with information about the project aims and how it would be conducted. They were invited to participate in the individual interviews/discussions at a later stage. Community members were asked about their understanding of the issues having an effect on the health and wellbeing of the community. They identified the following four main areas:

**Poor mental health**

The poor mental health of many members of the Hazara community was identified as the major concern. This was primarily depression, high levels of anxiety and low mood. Various reasons were cited for this, in particular, experiences prior to leaving Afghanistan (with torture and trauma), departure and travel to Australia, detention, concern about visa status, the impact of cultural changes and other transitions, family separation and security. They stated that other factors related to life in Australia impact on mental health, such as the living arrangements of those without families which is reported as less than ideal; they live alone or with housemates, and report reclusiveness and lack of sociability affecting their quality of life. Lack of knowledge about or understanding of mental health problems caused concern and the impact of stigma related to their status in Australia caused tension.

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5. Hazara community is formed from sub-groups/small groups. Each sub-group is led by a leader who is elected by the group members in an election annually or biannually. These are the community leaders who form the community board and lead the community, including managing the community in any events or activities. This system was active in Mildura and Shepparton. Volunteers are the people who help the community for any events or activities. They are not elected by the community members, however, their help and activities within the community are accepted and respected.
Limited knowledge or understanding – disempowerment

Community members identified the adverse impact of not believing they had the knowledge to maintain and improve their health and wellbeing. They felt they did not understand enough about health conditions to know when they should present to a health service, and then to understand and act on advice provided. There was little understanding of the importance of prevention, with the exception of immunisation which was strongly endorsed for children and adults, and the benefits of early presentation. Finally, there was a general lack of understanding about what the Australian health system offers and how to navigate it for one’s best interests; low health literacy was a recurrent theme. Lack of trust in HSPs was also reported.

Service access

Difficulties finding suitable services or service providers was also a recurrent theme. The main concerns were sociocultural – gender and language and communication generally, for people who have not had traditionally a lot of experience with HSPs in Afghanistan – and conversely HSPs who have not had a lot of experience with complex and serious problems that refugees may present with; accessing suitable mental health providers, with an appropriate interpreter, finding women’s health services, and isolation – whether social, language or physical. A spiral of individuals (frequently men without family in Australia) feeling bad, experiencing difficulties finding help, feeling worse and withdrawing from personal or professional supports was described.

“Many in our community are suffering from headache, lack of sleep, behavioural change - mostly because of isolation” - comment about the impact of isolation from family (and possible somatisation of isolation)

Community meeting participant

Family issues

Many concerns were raised relating to family. The first was the worry about the safety and security of family members who are still in Afghanistan. The others related to family in Australia. Parents are particularly concerned that their children are losing their culture. Children are learning English and losing their Hazaraghi language and customs. This causes sadness, and also conflict between parents and children. Of lesser concern, but noted, is the impact of the move from Afghanistan to Australia in search of a safer, better life. Different approaches to life and family can contribute to tension between a husband and wife, and other family members.

Interviews/ discussions with individuals

Interviews/ discussions were conducted with members of the Hazara community in the identified locations. Seventy people responded which included:

- 17 from Swan Hill,
- 12 from Mildura
- 30 from Shepparton
- 11 from Bendigo.

A summary of the main results is presented below.

Demographic features

The respondents ranged in age from 14 to 68 years, the mean age was 46 years. Most participants were over 30 years: 44% (31/70) were aged 50 to 70 years and 39% (27/70) were between 30 and 50 years, 16% were aged 20 to 30 years (10/70); one respondent was 14 years old. Twenty-two (22) women and 47 men participated (ratio ~3:7). Most (85%) were married, two were widowed, one was divorced and the remainder (~10% - 7) were single. However, many male respondents who are married (N=44), do not have their wives and family with them in Australia (24/44, 55%). Most respondents live with their families (64%), 15% live with friends and 19% live alone.
The majority of respondents had children, again not necessarily living in Australia. Family size ranged from 0-11 children, with a mean ~5 children/family. All of those people surveyed were born in Afghanistan. The majority (68%) required an interpreter for general activities, although in Mildura 11/12 (90%) stated that they required an interpreter.

Overall, 32% of respondents are employed. This varied across the different sites: 10/11 (91%) are employed in Bendigo – the rates are lower in Swan Hill (63%), Mildura (17%) and Shepparton (23%). The rate of internet access is 93%.

**Health and wellbeing**
Refugee health checks (MBS items 701, 703, 705 and 707) are health assessments for refugee or other humanitarian settlers. These assessments include the patient’s physical, psychological and social functioning and whether preventive health care and education should be offered to the patient to improve their health. Psychological history should take into account possible long-term effects of torture and other forms of trauma. Clinical investigations vary by country of origin, age, gender and any previous tests (Department of Health, 2018). The majority of respondents had had a refugee health check (91%).

**Self-reported health status**
Respondents were asked to assess their own health using a scale of 1-10, where 1-2 indicated poor health condition; 3-4 fair health; 5-6 good health; 7-8 very good health and 9-10 excellent health. Responses crossed the spectrum and the mean was 6.5. Bendigo and Mildura had the highest assessment values of 7.3 and 6.8 respectively, Swan Hill and Shepparton reported 5.4 and 5.1 respectively. Table 4 shows the distribution of participants responses in comparison with regional Victoria and all of Victoria state (Department of Health & Human Services, 2018b).

<table>
<thead>
<tr>
<th>Population</th>
<th>Region</th>
<th>Excellent or very good</th>
<th>Good</th>
<th>Fair/ poor</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hazara population</td>
<td>Swan Hill</td>
<td>41%</td>
<td>35%</td>
<td>23.5%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Mildura</td>
<td>58%</td>
<td>17%</td>
<td>25%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Shepparton</td>
<td>40%</td>
<td>37%</td>
<td>23%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Bendigo</td>
<td>55%</td>
<td>36%</td>
<td>9%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>45.6%</td>
<td>32.9%</td>
<td>21.5%</td>
<td>100%</td>
</tr>
<tr>
<td>Entire population</td>
<td>Regional Victoria</td>
<td>46.7%</td>
<td>35.7%</td>
<td>17.1%</td>
<td></td>
</tr>
<tr>
<td>Entire population</td>
<td>All Victoria</td>
<td>44.1%</td>
<td>36.6%</td>
<td>18.9%</td>
<td></td>
</tr>
</tbody>
</table>

**Results by gender**
The results by gender show 47.7% of women rate their health as excellent or very good, compared with men at 45.8%. More men rated their health as fair to poor (23%) compared to women (19%) (Table 5 below). Younger Hazara people reported much higher rates of good or excellent health.
Table 5: Self-rated general health status of Hazara population 2018, all regional Victoria and all Victoria 2016 (Department of Health & Human Services, 2018b), by gender

<table>
<thead>
<tr>
<th>Population</th>
<th>Gender</th>
<th>Excellent or very good</th>
<th>Good</th>
<th>Fair/ poor</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hazara Population</td>
<td>Male</td>
<td>45.8%</td>
<td>22%</td>
<td>23%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>45.5%</td>
<td>36%</td>
<td>18%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>46%</td>
<td>32%</td>
<td>22%</td>
<td>100%</td>
</tr>
<tr>
<td>All Victoria (over 18 years)</td>
<td>Male</td>
<td>42.3%</td>
<td>38.2%</td>
<td>19.0%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>45.6%</td>
<td>35.3%</td>
<td>18.8%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>44.1%</td>
<td>36.6%</td>
<td>18.9%</td>
<td></td>
</tr>
</tbody>
</table>

**Alcohol, tobacco and other drugs use**
Smoking was very uncommon with this group of respondents (99% were non-smokers) and there was only one self-identified smoker. Twenty-seven per cent of male respondents identified as tobacco chewers (13/48). The frequency of chewing tobacco ranged from 4-45 times per day. No respondents drank alcohol. One respondent smoked marijuana and said he would like to speak to someone about stopping his marijuana use.

**Medical history**
Gastrointestinal problems (48%), diabetes (17%) asthma/ allergy (17%) and high blood pressure (16%) were the four most commonly reported medical conditions. Headache was reported as a health concern by 60% of the group surveyed. Nearly half (48%) of all respondents described body pain, generally back or joint pain, which is higher than joint pain reported across Victoria of 20% (Department of Health & Human Services, 2014). The pain is mild to disabling.

**Mental health**
Mental health problems were reported as one of the most significant concerns by respondents.

> **“Poor condition of mental health is a big concern in our community, particularly, depression and anxiety; but it is very hard to seek help for it.”**
> Community member

> **“The causes are torture and trauma from past experiences in their home country, during journey to Australia, post arrival incidents like long term detention, visa status, cultural diversities, and most importantly isolation from their family for many years. However, many people are not seeking help for it, because of a number of reasons like the severity of stress and anxiety often causes losing their interest of seeking help, the thoughts it may negatively affect their visa status or their family visa application process. Also, a misunderstanding of mental health issues, which have been known as insanity or loss of personality. This causes them to hide their mental health problems.”**
> Community volunteer
It was suggested that mental health issues for Hazara individuals did not show any improvement when receiving mental health support from service providers. Possible reasons for this may be reduced effectiveness of psychological counselling when an interpreter is required in a session, as this may reduce the quality of the counselling. The respondents in the individual interviews claimed that psychological counselling does not work for them at all.

“The psychologists or counsellors always advise us to do exercise, go for a walk, and drink water but it does not work for us.”
Community member at community meeting

Self-assessed mood ranged from 2-10 on a scale of 1-10, the mean for all respondents was 5.9. Sixty-one per cent of women rated their mood as good-excellent; 58% of men rated their mood as good-excellent. There were no corresponding Victorian data using this methodology.

Table 6: Self-rated mood status by gender for the Hazara population*

<table>
<thead>
<tr>
<th>Gender</th>
<th>Excellent or very good</th>
<th>Good</th>
<th>Fair/ Poor</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>35%</td>
<td>23%</td>
<td>42%</td>
<td>100%</td>
</tr>
<tr>
<td>Female</td>
<td>27.3%</td>
<td>36.3%</td>
<td>36.4%</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>33%</td>
<td>27%</td>
<td>40%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*No comparative data were available

Self-reported psychological anxiety/distress levels were rated on using a single point measurement - a scale of 1-10 (mild to very high). The Victoria data are not directly comparable because this area was assessed using the Kessler 10 Psychological Distress Scale which uses 10 questions over a four week period (Department of Health & Human Services, 2018b). They are included as a rough comparison.

Table 7: Self-rated psychological distress levels for Hazara, compared with Victorian population (Department of Health & Human Services, 2018b) by gender

<table>
<thead>
<tr>
<th>Population</th>
<th>Gender</th>
<th>Mild (1-3)</th>
<th>Moderate (4-5)</th>
<th>High (6-7)</th>
<th>Very high (8-10)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hazara population</td>
<td>Male</td>
<td>17%</td>
<td>21%</td>
<td>44%</td>
<td>19%</td>
<td>68.6%</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>18%</td>
<td>27.3%</td>
<td>41%</td>
<td>13.7%</td>
<td>31.4%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>17%</td>
<td>22%</td>
<td>44%</td>
<td>17%</td>
<td>100%</td>
</tr>
<tr>
<td>Victoria</td>
<td>Female</td>
<td>54%</td>
<td>24%</td>
<td>10%</td>
<td>6%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>57%</td>
<td>23%</td>
<td>9%</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>56%</td>
<td>24%</td>
<td>10%</td>
<td>5%</td>
<td></td>
</tr>
</tbody>
</table>

Similarly, self-reported psychological distress/anxiety ranged from 2-9 on a scale of 1-10. The mean was 5.7. These results show that 63% of men and 55% of women report experiencing high to very high levels of psychological stress or anxiety that often affects their daily life, including not being able to maintain their daily activities at all. Although very preliminary, these figures contrast to the state figures which estimate the prevalence of high to very high psychological distress in the community at 15%.
Men who were married, but not living with their family (who were either in Afghanistan or elsewhere), reported the highest levels of psychological distress; 70% report high to very high levels. The rates are considerably lower for the small number of women in the same situation, 12.5%. Fifty per cent of married men and women living with family report high to very high levels of psychological distress.

Most respondents reported sleeping well: 70% experienced very good to excellent sleep, a further 17% had good sleep and 13% experienced fair to poor sleep. Ninety-five per cent of women had good to excellent sleep; this was slightly less in men at 84%. No comparative data for Victoria were found.

Appetite and life enjoyment ranged between 2 and 10 on a scale of 1-10, the mean was 7.5 for appetite and 6.4 for life enjoyment. Life enjoyment was assessed as low at 1-4, medium at 5-6, high at 7-8 and very high at 9-10. The figure of 5-6 indicates that a person only enjoyed 50% of his/her time in the last 12 months. Fifty-two per cent of women reported high or very high levels of enjoyment and 40% of Hazara men reported high or very high levels of enjoyment and 23% low levels of life enjoyment (10% of the time in the last 12 months). For the entire Hazara population, 43% had high or very high levels of enjoyment and 23% experienced low levels of life enjoyment. The Victorian Population Health Survey 2016 (Department of Health & Human Services, 2018b) reported on life satisfaction. This is different from life enjoyment but provides a population-based comparator: across the state 78% of the population reported high or very high levels of life satisfaction; only 6% reported low levels. There was not a significant difference by gender or between regional and metropolitan Victoria. Headache was reported as a health concern in 60% of the respondents.

Of 60 responders, 10 (15%) reported that they had thought about killing themselves; 9% (6/68) had thought of ways of harming themselves. No one considered harming other people. Nationally it is estimated that 2.3% of the Australian population think about committing suicide; 0.6% formulate and plan and 0.4% harm themselves (Suicide Prevention Australia, 2016).

**Family history**

There was no family history of cancer in this group. Approximately 27% reported a family history of chronic disease – cardiovascular disease, diabetes or asthma/allergy.

**Diet and exercise**

Forty-one per cent (28/70) of respondents reported that they exercise regularly. The majority exercise at least five days per week. Walking was the most popular form of exercise (59%); other activities included running, cycling and going to the gym.

Most respondents were happy with their body weight. A greater proportion wanted to gain, rather than lose weight. Less than half of respondents said they knew about healthy and unhealthy foods (41%).

**Screening tests**

Bowel (Cancer Council, 2019a) and breast cancer (Cancer Council, 2019b) screening are recommended in Australia, with free testing available from 50 years of age. Of the 32 people in the sample aged 50 years and over (and therefore eligible for screening), four (12.5%) people knew they had participated in bowel cancer screening (faecal occult blood test). Corresponding figures for the Victorian population are 60% of the population returned and completed the bowel cancer screening (Department of Health & Human Services, 2014).

Of the six women aged 50 years and over, one (17%) had a mammogram. In comparison, 90% of eligible women in Victoria have had a mammogram, ever, and 73% had had one in the last two years (Department of Health & Human Services, 2014).

There were 18 women aged between 25 and 74 years who were therefore eligible for cervical cancer screening (Department of Health, 2019) and eight of this group (36.5%) had been tested. In comparison, 83% of Victorian women have had a pap smear, ever, and 73% have been screened in the last two years (Department of Health & Human Services, 2014).
An attendee (at the community meeting) who needed urgent health review was referred to a refugee health nurse and she referred him to hospital. He could not speak English at the time of his appointment and an interpreter was not available. He could not tell his problems to the doctor while he was examined and got the prescription of a course of antibiotics. He did not understand what the doctor said. He did not commence taking the medication because he was not sure if the doctor diagnosed his problem correctly.

This kind of incidence has happened in the past and was spoken about in the community. Therefore, most of the time they are not sure if they would receive help at a health service centre, where to seek help or they use their friends as interpreters for whom they need to wait until they are available.

Community member

There are misunderstandings about health services. Many in our community believe that the health providers do not understand their health issues, and the treatment does not work. This is mostly because of the language barrier, and lack of explanation of health issues...

From the community meeting

Lack of understanding, acknowledgment and response to the cultural differences between the Hazara people and local HSPs has an impact on health service attendance. The major example is for women who find it very difficult and uncomfortable to see male health service providers.

There is a low level of knowledge about health conditions and how they are managed in Australia. There are many issues affecting our health and we need to know more about them.

Community member
We cannot get access to the health services at the right time, until our health condition gets worse to the advanced stage…It is a long wait to see a doctor. When we get sick, when trying to make an appointment to see the doctor, the appointment is given within days or weeks. During this time, we handle severe pain till the pain gets relieved by itself or even worse.

The doctor always says to exercise, go for walk, and or gives us sleeping tablets, but these are not working...

Thank you very much for providing this health assessment program. I have never had an opportunity like this to speak about my health condition to someone who could understand my language. I am feeling relieved of a big concern that I have had for a long time about joint pain.

I just say if you were not here I would never know where to go to seek help for my health problems. I have emotional stress and depression, because of family separation for quite a while. I have been handling severe pain for a long time but did not know what to do. Thank you for referring me to Primary Care Connect. I have a GP but I could not tell her about my mens health problems. In addition, I have never had this opportunity to speak about my health issues this much.

Community members

Family concerns and other matters
Approximately half of all respondents reported being worried about the security and wellbeing of family members who aren’t in Australia. Concerns about the (lack of or decreasing) attachment of children to traditional Hazara cultural practices was also raised. Different approaches to managing life in Australia is reported to lead to sadness and conflict between parents and children. Other worries for the group include finances, employment and children’s education.
Discussion

The findings from this project about Hazara refugees who have resettled in regional Victoria reinforce those presented in other Australian, Victorian and international reports and literature. Members of the Hazara community in northern Victoria have experienced great life stressors which have been previously outlined. In Afghanistan, their health and wellbeing status was low and difficult to improve and now, every day in Australia, they strive to overcome the challenges of a socially, culturally and linguistically foreign society for themselves and their families.

There is a range of primary health and wellbeing services across the Murray PHN region. These services have varying degrees of capacity, skills and experience in working with people from multicultural backgrounds, including Hazara people. Priority areas of need identified are service access, health literacy, and communication.

Service access

Difficulty in accessing all types of health and wellbeing services is an extremely common, recurrent and serious theme when refugees are discussing issues that affect their health status. Difficulties relate to the actual existence of suitable services, their capacity and culture, as well as to the understanding of Hazara community members about their own (ill) health, their ability to locate, contact, arrive at and communicate with services, so that they will leave a consultation with a clear understanding of what is wrong with them and the management plan, what that involves and what actions they must take to make a change. The barriers that affect equity and access to services for Hazara migrants have been previously summarised as (Brazier, 2015):

- low health literacy
- delayed patterns in health seeking behaviour (seeking assistance only when conditions are advanced)
- low levels of English proficiency
- low socio-economic status
- varying levels of cultural responsiveness of health services and staff
- differences in the way the Australian health system functions compared to their country of origin.

Our findings aligned with these barriers.

Health literacy

“Individual health literacy is about a person’s ability to access, understand and apply health information; for example, to complete health care forms or navigate the health care system … It can influence decisions people make, such as how often to take medication, when to access health care services, and which services to access” (Australian Institute of Health and Welfare, 2018).

Not surprisingly, low health literacy is affected by the social determinants of health, for example health, education, income, accommodation and employment are a strong predictor of health outcomes (Centre for Culture, 2015). Higher rates of hospitalisation and emergency care use… premature death among older people, lower participation in preventative programs, and poor medication adherence are examples of adverse effects of low health literacy (Australian Institute of Health and Welfare, 2018).

Low health literacy was identified by respondents as a major concern. They had limited understanding or misunderstood how to use health and community services. Additionally, they had little understanding about their bodies, common health problems and the management of common health problems. This relates again to social determinants of health, particularly education and all that influences that. It appears that there are few easily accessible supports services to assist in the navigation of health services; this is reported in other studies with refugees in Victoria (Russell et al., 2013). A 2015 project in Melbourne reported that a peer group model, using community volunteers, which developed and delivered key health messages to the diverse Afghani refugee communities was successful (Brazier, 2015).
Communication

Communication, verbal and non-verbal, was identified as another difficulty in accessing the right services at the right time; as with health literacy, this is a common problem for refugees with low English literacy skills (Russell et al., 2013).

Lack of fluency in spoken and written English reportedly prevented community members from seeking health care in a timely way, or understanding the advice provided in the consultation – and acting on it. Cultural practices such as seeing health practitioners who were the same gender were identified as very important in many situations, especially consultations of a private or intimate nature, such as sexual and reproductive health and mental health. Although it was not specifically mentioned in our project, low literacy in Farsi has been identified in migrants to Australia. If this is the case with our cohort, providing printed material in Farsi may not be a complete or effective response.

Equally, there are very few Farsi speaking health providers or health providers with an understanding of Hazara culture and practices surrounding illness, wellbeing and health seeking behaviour in northern Victoria. The two Farsi speaking workers in HSPs have limited availability and presumably geographical reach.

The knowledge and use of interpreter services appears to be variable, by community members and HSPs alike. It also seems that interpreters are not routinely booked when appointments are made. Community members have concerns about the accessibility and quality (e.g. speaking a different dialect of Farsi resulting in miscommunication) of the interpreter service, including the Telephone Interpreter Service (TIS). Concern that confidentiality will not be respected when using interpreters was expressed by community members; adults frequently use their children to translate for them – again, this may not be appropriate especially if discussing private matters, and also family members who may be fluent in the activities of daily living, school etc, might not have a sufficiently sophisticated understanding of medical or health concepts in English.

Vanstone (2012) has identified the following factors that can support the use of interpreters for HSPs, organisations and clients:

- health practitioner
  - awareness of interpreter services
  - training in working with interpreters
- organisational
  - ensuring staff are aware of and trained to access and use interpreters
  - employment of in-house interpreters
  - use of interpreter equipment technologies
- service planning and data collection
  - efficient interpreter booking systems
  - block booking interpreters
  - clear and supportive policy and procedures
- client
  - increasing clients’ awareness of interpreter services
  - supporting their skills to access interpreter services.

There are Australian examples where failure to use interpreters has resulted in patient death (Bird, 2010). Wider research indicates that over two thirds of Australian general practices had never used professional telephone interpreters and only 61% of the practices were aware of the free TIS; with misconceptions about the accessibility of interpreter services and assumptions that patients always preferred to use family members to interpret for them (Atkin, 2008). The importance of engaging non-medical practice staff has been highlighted: ‘the attitudes and leadership of non-medical staff about the need for interpreters may be key factors in promoting the use of interpreters in the general practice setting (Huang & Phillips, 2009).
Expectations about health and community services

Unfulfilled or unrealistic expectations of general health services by community members are observed to result in frustration, non-attendance and lack of trust in the system and organisations and individual HSPs in particular. This is caused by limited health literacy, experience or health practices from Afghanistan and opportunism. Problems with the appointment system such as non-attendance or late arrival, unexpectedly long consultations, presentation of unscheduled patients, especially in group consultations, were identified as causing frustration to both HSPs and clients alike. Community members observed the lack of continuity of care by HSPs; consequently, a lack of trust resulted from this added to other factors previously mentioned, translated to reduced service access and poorer health outcomes. The cost of services was not identified as a major issue by our respondents.

HSPs noted that the appointment system did not always work as efficiently as it could. The literature also points out that because consultations become longer than average and that refugee patients frequently have complex health problems, there are concerns about the costs of providing these services to organisations and individual practitioners. This was not found in this project, although GPs were not interviewed and may present a different perspective.

HSPs may have quite different expectations of providing services to the Hazara community and this could be a source of frustration for them, if expectations do not align with those of their patients. In particular, length of consultation, their cross-cultural experience, confidence and expertise in communicating through an interpreter are important areas for success of the consultation and relationship development.

The literature emphasises the significance of service coordination to achieve positive health outcomes. Reasons for this were client complexity, higher risks of being lost in the system, risks of service duplication and possibly mobility (Cheng, Russell, Bailes, & Block, 2011). This was not identified in this project which may reflect on the number of services available or interviewed.

Other research has suggested that because some refugees report experiences with doctors in their home countries as being treated poorly in consultations and that the home medical system is an hierarchical environment (Sievert et al., 2018). This may mean our respondents could be hesitant to critiquing their experiences with health services in Australia.

Physical and mental health

Mental health issues were the highest priority health and wellbeing concern identified by community members and HSPs. The literature also reports on the importance of “understanding of the effects of cultural dislocation, persecution and trauma, and role and identity changes, and the challenges associated with re-starting life in an entirely different cultural, social and political context. Importantly, history taking, physical examination and procedures may trigger traumatic memories in refugee patients who are survivors of torture and trauma. A sensitive and gentle physical examination with explanation of investigations, empathy and interest expressed by the GP and adequate consultation time are important to accommodate a traumatised refugee patient” (Milosevic, Cheng, & Smith, 2012). Milosevic et al (2012) also note that psychological symptoms may masquerade as physical symptoms, especially headache, chest pain and upper gastrointestinal discomfort.

This is consistent with a Melbourne study (Rintoul, 2010) which showed a higher than expected proportion of Afghan refugees use the emergency department of the local hospital. “The most common primary diagnostic categories were unspecified abdominal pain, unspecified chest pain, syncope and collapse, gastrointestinal symptoms and dizziness and giddiness. Less than 0.5% were referred to a mental health clinician”. Although the higher rates of mental ill health in this group was known, referral to and use of mental health services was low. The understanding of and stigma attached to mental illness in this community is different from the mainstream community – where it is still not great. It is also noted that women experience greater isolation, with consequent anxiety and depression in antenatal and postnatal periods. Support of family is the norm in Afghanistan; in Australia if there are fewer family members, women rely on their husbands during this time; which is a cultural shift, and the husbands may not be available if they are working; or women are left to manage on their own; this may not be satisfactory for them or their family’s health and wellbeing. In contrast to the picture of low referral to and attendance at mental health services in Melbourne, a
contrasting view of services being unable to meet the demand for clients with mental health needs was also presented (Cheng, Russell, Bailes, & Block, 2011). Further information about the availability of models of cross-cultural mental health service delivery in Northern Victoria is required.

**Chronic pain**

Chronic pain was the next most commonly reported symptom, which included headache and other body pains – muscular and joint. Survey respondents were older than the average Hazara population and predominantly male. This may have biased the results; care should be taken in generalising to the entire population; however, for this sample chronic pain was obviously a significant, present and not well managed part of their lives. It is unclear to what extent this pain is physical or a result of poor mental health. Further work to clarify the aetiology and appropriate management pathways is desirable.

**Women’s health issues**

HSPs and community members reported that providing for women’s health needs was another priority. Again, this is reflected in the literature (Rintoul, 2010). The need for support in antenatal and postnatal periods was identified. It is also reported that there is limited understanding of contraception and termination options and sexual and reproductive health in women from Afghanistan (Cheng I-H et al., 2011). In this Melbourne-based study, problems of teenage pregnancy, contraception and antenatal care were identified as priorities – these areas were not defined in our study. Our data showed that very few eligible women participated in screening for breast or cervical cancer. Women’s health matters require further investigation; these issues could be addressed more effectively through women’s groups, peer group educators and developing relationships with HSPs.

**Gastrointestinal issues**

Gastrointestinal symptoms were a high prevalence complaint in the group who responded to the survey, this was seen in the literature. High levels of helicobacter pylori infection have been identified in refugee groups, which may explain the high level of gastrointestinal symptoms in our group. Alternatively, the symptoms may relate to high levels of stress and anxiety. Further information about the epidemiology (older people responded to our survey), diagnosis and treatment of these symptoms would assist the understanding of the condition and ways to better manage affected clients.

**Chronic disease**

From our survey, chronic diseases were reported as a health issue. There was no further information about the associated issues (management, complications, prevention, adherence to treatment). At a population level, consequences of chronic disease are common, and many are preventable at primary, secondary and tertiary levels. Potentially it could be beneficial at an individual and community level to consider the applicability of health promotion programs to this population.

**Other issues**

Four distinct issues were strongly identified by community leaders at the community meetings, by individuals and by the HSPs; these were:

- concern for the safety and future of relatives who are overseas e.g. Afghanistan or in transit/ in detention
- concern about intergenerational change and conflict with children losing their culture
- concern for their own future with respect to employment, education and finances
- social and cultural isolation.

These issues affect the psychological, social and physical health and wellbeing of the community on the background of trauma, migration and resettlement.

An understanding of these issues, and how they may be addressed by HSPs as part of client centred care is important. This may require education and training for HSPs and their entire organisation. Support and information for affected community members to become more resilient when facing problems they can’t control (such as family overseas) and dealing with difficult areas (such as family conflict), where they do have control, could improve their situations.
**Primary prevention**

Low rates of screening were identified in this project. As such a priority area should include early detection and screening activities.

Close to 30% of the men interviewed chewed tobacco with a need to consider tobacco cessation interventions for these men.

Although health promotion was not specifically explored in the project, it is clear that there is a need for health promotion to improve the health and wellbeing of this community. This is made more challenging in the cross-cultural context. Health promotion as we experience it in Australia, is not a familiar concept in Afghanistan. Health promotion activities could address physical exercise and healthy eating, women’s health, understanding mental health and social inclusion supported by programs to improve health literacy, English classes and communication (with HSPs etc and family – intergenerational).

**Community engagement**

In our work, we found that outcomes of efforts to engage with the community were varied. Our experience emphasises that each community must be viewed separately – that one approach does not suit all, and that time and flexibility are required to make progress. It is also clear that in the time allowed for this project, no deep, effective and transformative community engagement/participation could occur, rather this was the beginning of a process that could be built on to improve health and wellbeing of the community, by changes in the HSP organisations and community members themselves.

When referring to the International Association for Public Participation. IAP2’s Public Participation Spectrum (International Association for Public Participation, 2014) our results suggest that the project was able to inform and consult with a proportion of community members. The additional stages along the spectrum: involvement, collaboration and empowerment, understandably were some way off. Despite this, the initial work completed was a solid basis for more work with all stakeholders. This process is important because it starts from the community’s defined priorities and needs (Moore, McDonald, McHugh-Dillon, & West, 2016) – there is trust involved in speaking out – revealing individual and social vulnerabilities and concerns that cannot be ignored or set aside. This suggests the importance of continuing to build on the work that has been started by this project.

In Swan Hill, there was an established and positive relationship between the Hazara community and the Community Issues Group (CIG), key community members and service providers. This CIG supported the project and facilitated the participation of community members in the meetings.

In Bendigo, the project was well supported by HSPs. The project team relied on the men’s only group to encourage all the community to become involved. This was insufficient to get buy-in from the women.

In Shepparton and Mildura, expectations and lack of availability (due to work and other commitments) of the community leaders resulted in limited interest. Similarly, in Mildura, the project team struggled to develop an effective relationship with local services; again availability and lack of remuneration were factors. In Shepparton, community volunteers from the men’s and women’s groups proved very helpful in connecting the project team with community members for meetings and recruitment into the surveys. In Mildura, the project team contacted community members directly with some success.

The difficulties that were identified in this project are common in community development/engagement. They relate to timing and availability, personality (including leadership), relationships (within community, between HSPs and project team), expectations, cultural beliefs and practices, reciprocity and individual and community benefit - ‘what’s in it for me’ (WIIFM).
**Recommendations**

From the findings the key recommendations are detailed below.

- **Service access**
  - Support organisations and staff to respond appropriately to the needs of the Hazara community, which may include organisational training programs
  - Promote the use of interpreter services

- **Health literacy**
  - Support strategies to improve health literacy in each community, which might include encouraging HSPs to consider:
    i. Peer educator models (support the development of Hazara health workforce, e.g. peer health worker, mental health worker)
    ii. The guest speakers from health services attend men’s and women’s meetings (with interpreters)
    iii. Explore the range of interpreter services that are available in regional Victoria
    iv. Address community’s lack of trust and other concerns about integrity/quality of interpreter services
    v. Work with organisations, health practitioners and clients to educate and inform them about the importance of interpreters and to ensure they are used at consultations

- **Services for mental health**
  - Review the mental health services available for these communities
  - Consider approaches that address the social determinants of mental health affecting this community, and also address the potential history of trauma and torture. Consider leveraging the expertise of Foundation House and the Victorian Refugee Health Network (Refugee Council of Australia) to address these issues
  - Support the development of Hazara health workforce (e.g. peer mental health workers)

- **Primary prevention and health promotion**
  - Promote early detection and screening
  - Promote tobacco chewing cessation
  - Develop strategies to educate the Hazara community about priority areas of health and illness
  - Develop strategies to assist HSPs to respond to Hazara people’s priority health concerns
  - Support health promotion programs in the priority areas of mental health, women’s health, physical exercise and healthy eating, which also address the long process of resettlement in a new country, including drawing upon resources in Farsi and/or Hazaraghi

- **Community engagement and education**
  - Build on work engagement that has already been undertaken with community volunteers and leaders
  - Support the local community members to develop a cultural awareness and Hazara language training for Hazara children
  - Assist community members to understand and respond to the impact of resettlement on the entire family
  - Promote participation in English language education for Hazara local community members (e.g. bilingual teachers for primary level of English classes)
Strengths and limitations

A key strength of this project was that the project officer was Hazara, and so he could engage and talk with the Hazara community members in their first language, which provided a greater level of trust and engagement that is likely to not have existed if a non-Hazara person had been leading the project activities.

Another strength of the project was the process of community engagement. Over 250 people attended the project orientation gatherings in four major areas of northern Victoria: Shepparton, Swan Hill, Mildura and Bendigo. Seventy people participated in the individual health and wellbeing assessment interviews/ discussions; either face-to-face or over the phone. Respondents were given time to talk and discuss their concerns in their first preferred language (Hazaraghi). During the course of the project, the project team developed strong partnerships and cooperative relationships with a range of service providers, community leaders, advisors and volunteers in the region.

Although despite these various forms of participation, connecting with local Hazara communities was a challenge. The difficulties varied across different sites. The main challenges were related to the community or the individual. These are summarised in Table 8 and Table 9 below:

Table 8: Community related barriers to engagement

<table>
<thead>
<tr>
<th>Community structure</th>
<th>The Hazara community is organised into sub-groups (Chanta), usually based on location and family connections</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• Each Chanta is led by a group leader</td>
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<tr>
<td></td>
<td>• The leaders represent the community on the community board</td>
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<tr>
<td></td>
<td>• It is the role and responsibility of the community board to determine community activities and priorities and to feed that back to the community</td>
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<td></td>
<td>• The community board meetings occur at pre-arranged times</td>
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<td></td>
<td>• Occasionally special board meetings may occur to address special matters</td>
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<td></td>
<td>• This can cause delays</td>
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<tr>
<th>Community leadership and expectations</th>
<th>Community leaders have many commitments and may not be available for meetings</th>
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<tbody>
<tr>
<td></td>
<td>Leaders had expectations that participation in the project would result in direct and speedy clinical assistance. This was not the purpose of these early consultations with the project leader</td>
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<tr>
<th>Culture</th>
<th>In the Hazara community, men and women meet separately</th>
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<tbody>
<tr>
<td></td>
<td>They have a general preference to speak with people of the same gender for personal/ intimate matters</td>
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</table>
Table 9: Personal barriers to engagement

| Impact of poor mental health on engagement | Some community members who acknowledged that they are experiencing depression or anxiety admitted that their motivation to be involved in community activities and to care for their health and wellbeing was adversely affected, so they were less inclined to engage in this project. Some attended the community gathering but didn’t attend the interviews. |
| Lack of trust in the health system | Poor experiences, often based on inadequate or incomplete understanding of the health service system, resulted in a lack of trust of health-related projects such as this one and unwillingness to participate. |
| Lack of access/availability | Many community members were not available for interview during standard work hours. |

We acknowledge other limitations in this project. As the first work Murray PHN has undertaken with this community, the project did not investigate the health needs of children, young people and women in detail. There are also a number of specific health issues that were not explored, including oral health, Hepatitis B and Vitamin D deficiency (especially for women).

Also, participants were more likely to be older people who did not have jobs. Although efforts were made to address this limitation by conducting some interviews and meetings after working hours and on the weekends.

There was no exploration of disability, its impact and options for services. The project officer was male; we do not know what impact this may have had on community participation and the project findings.

Also, through the project activities we discovered the Hazara communities were much larger than expected; as such our sample is a smaller proportion of the community than originally expected.
Conclusion

Refugees commonly have complex physical and psychological health needs. This project has investigated a discrete group of refugees in the Murray PHN catchment – the Hazara people. This project adds to our population health and organisational knowledge by providing an in-depth understanding of a Hazara communities within our catchment. The topics explored within, and findings from the project, address several of our other strategic priorities, including population health, mental health, chronic disease, primary care, health workforce and alcohol and drugs.

The project has achieved its objectives to understand the health needs of the Hazara population, understand the barriers and limitations of the Hazara population to access health services, and to understand the capacity of the services to respond appropriately to the needs of the Hazara population.

The findings from the project have highlighted key issues including: the need for improved service access and health literacy, accessible and appropriate mental health services, improved primary prevention and health promotion, including screening, and the need for health services to be informed and responsive to their Hazara clients and communities.

The findings of this project will assist Murray PHN in developing responses to support the efficiency and effectiveness of health services to support Hazara clients and to support the provision of the right care in the right place at the right time.
References


