Refugee health nursing

The United Nations was formed, and the UN Declaration of Human Rights was signed in 1948, following the Second World War, which saw displacement of refugees, persecution and genocide on a scale never previously witnessed. Enshrined in this document are the rights of every person to life, health, freedom from persecution and torture, and the right to a nationality (United Nations, 1948). The signing of the United Nations Convention Relating to the Status of Refugees in 1951 (Assembly, 1951) further preserved the right to seek safety from persecution in international law. Since then, there has been a huge increase in the numbers of people displaced by conflict worldwide, with the number of people forcibly displaced now standing at 80 million people (1% of the global population or the same as the whole population of France), over 26 million of whom are recognised as refugees (UNHCR, 2020). While countries neighbouring those experiencing conflict accommodate the majority of the world’s refugees, well-resourced countries such as Australia and USA have programmes to resettle a small proportion of the global total, in addition to those who seek asylum in these countries. For this reason, refugee health is relevant not only to nurses working in areas directly affected by conflict but also those working in healthcare across the globe: nurses everywhere are likely to have contact with people of refugee-like background (Amnesty International Australia, 2017).

Despite the focus on current events, conflicts around the world continue to displace people and traumatised those within diaspora populations. People of refugee background are already vulnerable and marginalised, and whether living in refugee camps or in high-income countries of resettlement, they are affected by structural inequities through inequitable access to healthcare, including access to necessary care in relation to the COVID-19 pandemic, such as access to testing and vaccination programmes (Alemi 2020).

Understanding the legal and systemic difference between an individual seeking asylum for fear of persecution and someone who has been granted refugee status and offered humanitarian protection is an important distinction for healthcare workers. While healthcare entitlements between these groups remain inconsistent, the principle of access to equitable healthcare as a fundamental human right must be upheld.

Against the backdrop of global unrest and mass population movements, the global COVID-19 pandemic and the Black Lives Matter movement have thrown existing health and social inequities into sharp focus, highlighting the systemic discrimination and racism within health systems. This is manifested in the way that inequity is coded into the policies and design of healthcare systems, unevenly distributing health resources and privileging dominant groups, while further disadvantaging and marginalising others.

The vast majority (80%) of refugees live in resource-poor countries which have weak health-care systems, scarce protective equipment, and poor testing and treatment capacity (UNHCR, 2020). The global humanitarian protection system is built around people’s ability to leave their country of origin and seek asylum elsewhere: a person cannot be recognised as a refugee until they have crossed an international border. The UN declarations clearly articulate that health is a human right and no human being is illegal (United Nations, 1948), yet COVID-19 affects asylum seekers at the most fundamental level: their ability to seek protection in another country. Border closures have forced many refugees to return to situations of violence and instability, while loss of safety and well-being through food and employment insecurity, and the decimation of informal economies have pushed vulnerable communities of displaced people further into destitution.

The need for financial aid and development is enormous. At a time when most host governments focus on the COVID-19 pandemic and vaccine roll out for their citizens, refugee aid and resettlement are being deprioritised. For example, prior to March 2020, Australia’s humanitarian programme was on track to reach its annual settlement target of around 18,700 people. This was reduced and capped to 13,750 in the 2020 Federal budget (Refugee Council of Australia 2020). According to the United Nations High Commissioner for Refugees (UNHCR 2020) only 22,770 out of 26 million legally recognised refugees were resettled globally in 2020—the lowest number of refugees in nearly two decades, despite record levels of forced displacement. On 17 March 2020, UNHCR and the International Organization for Migration (IOM) announced that they would temporarily suspend resettlement travel for refugees for ‘as long as it remains essential’ (UNHCR 2020). Many international borders remain officially closed for people without travel exemptions and arrivals are capped on a state by state basis. In 2021, the pandemic will increase global inequality and the threat of famine looms large for many countries in the Global South such as Yemen, South Sudan and Northern Nigeria.

Vaccine nationalism, defined as the efforts by wealthy countries to use their greater resources to secure vaccines for their own populations at the expense of a more equitable approach to global vaccine distribution, has significant potential to limit the vaccines available for poorly resourced countries. ‘COVID passports’ have been proposed by several governments and airlines, as a digital document that will allow the documentation of COVID-19
vaccine or immune status of an individual traveller. For those fleeing across international borders to seek safety from persecution, a ‘COVID passport’ may prove a difficult document to attain. Displaced people seeking asylum who may already have difficulty accessing identity documents are likely to experience the greatest barriers in being able to access vaccines, and the prospect of a ‘COVID passport’ arguably threatens the long-term viability of the humanitarian settlement programme.

Refugee health nursing is a growing nursing specialty grounded in a human rights approach, which uses a trauma informed framework and considers the social determinants of health. At an individual and systems level, this means we must critically examine the context of our own practice and challenge structures and practices which promote systematic racism and inequity, where we find them. The term ‘cultural competence’ implies a willingness to acknowledge one’s own cultural worldview, a knowledge of different cultural practices and the real-life use of cross-cultural skills. This can be as simple as using picture dominant health education material for those with poor literacy skills or knowing how to engage a professional healthcare interpreter (and knowing which language is required) to accepting the parenting practices of the family in your care.

The role of nurses in refugee health varies from country to country, region to region. Nurses may be employed in the large non-government sector, including well known entities such as Medecins Sans Frontieres, Save the Children, The International Red Cross and Red Crescent Movement or indeed in the front lines of their own countries caught up in conflict and war. Alternatively, they may be working in countries of resettlement. The clinical work of refugee health nurses may vary, but our underlying goal of promoting the right to accessible and equitable healthcare to those affected/displaced by conflict remains a constant. Key roles of the refugee health nurse are providing primary care that is culturally responsive, promoting health literacy and empowering and advocating for our patients within healthcare systems. Refugee nursing offers care across the life span and includes comprehensive physical assessment, mental health assessment, immunisation history and catch-up, family planning, oral health, nutrition, torture and trauma sequelae, infectious, parasitic, and vaccine preventable disease and chronic disease recognition and management.

Despite many refugee nurses practising at an advanced level, there is a dearth of research about the impact of the specialist care they provide. Much of the published research is in the domain of mental health and post-traumatic stress syndromes, and hence, the voices of refugee nurses are yet to be heard. There is an urgent need to develop nurse-sensitive indicators in refugee health and the authors call on Nurse Academics and Nurse Researchers to consider this emerging topic.

For refugee health nurses, there are many challenges in providing care in a pandemic and post pandemic environment. Many of our clients have experienced enormous distress, concern and anxiety for family at home. Sponsorship programmes through which resettled refugees can bring family members to join them have been derailed. Lockdowns have significant financial and social impact on those living in financially insecure and socially marginalised situations, and there is a great need for up to date, accurate and accessible information about public health measures (Australian Red Cross 2020).

A key part of the health advocacy work done by refugee health nurses is for those with precarious visa status (often described as asylum seekers or undocumented workers). This population is also growing globally, and the reluctance of governments and systems to treat individuals with equity and compassion leads to significantly poorer health outcomes. People seeking asylum in many countries are often on short-term bridging visas which decrease their chances of securing and maintaining employment. Visa insecurity has been driving this cohort into destitution and placed many individuals at increasing risk of exploitation at work at a time when globally the number of people enslaved is at its highest ever: Amnesty International estimates up to 45.8 million individuals are in modern slavery worldwide. These vulnerabilities combined with the perpetual limbo people seeking asylum find themselves having significant and long-term negative impacts on people’s physical and mental health.

In Australia and elsewhere, refugee health nurses play a significant role in addressing the effects of the global pandemic by ensuring that people of refugee background are not left behind. Refugee health nurses provide key input to policy makers to ensure that the needs of marginalised communities are considered in vaccine roll-out and key health information is communicated to those with language/health literacy barriers. The recent shift to digital health services, information and activities during COVID-19 lockdowns highlighted the digital exclusion of many newly arrived migrants and refugees due to limited host country language proficiency and accessibility of devices. The health impacts of digital exclusion are not confined to refugee and migrant groups but also other vulnerable groups such as older people and those living with disabilities. Refugee health nurses provide care to those who may be excluded from mainstream services, for example, by advocating for care for those whose visa status causes access barriers to public health services.

Promoting equity in healthcare requires an awareness and understanding of the structural and social barriers that people of refugee background face. If we make our health systems accessible for the hardiest to reach, we enable better outcomes for all. We believe that nurses are uniquely positioned and trained to do this, and nurses in all clinical settings must step forward and advocate at local, regional and national levels to improve the health status of all refugees regardless of their country of origin, their religion, their age or other parameters that may impede their ability to seek and receive healthcare. We all have a duty of care to our patients to decolonise health systems, advocate and provide truly person-centred care.

It is often said that successful resettlement is largely dependent on the attitudes of the host country. If refugees are met with indifference, suspicion or disdain, their ability to settle into their new environment is made more difficult. This is certainly true of healthcare environments, and it is in this domain that all nurses can make the difference in the health of refugees. It is about showing leadership within the healthcare team to ensure that healthcare is delivered based on the individual’s needs and not visa status.
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