Government of Western Australia
North Metropolitan Health Service
Public Health and Clinical Excellence

Humanitarian Entrant Health Service Annual Report 2025



Contents

Background – the current global situation **3**
Overview of the Humanitarian Entrant Health Service **3**
Demographics **4**
Language **5**
Settlement **6**
Screening outcomes – nutritional deficiencies and infections **7**
Screening – chronic disease and risk factors **8**
Referral data **9**
Achievements and highlights **9**
Maintenance of waiting times 9
Working with partners 9
Education 9
Participation in trauma training 10
Quality improvement activities 10
Membership of committees 10
Focus Areas for 2026 ..... **10**

This document can be made available in alternative formats on request.

© North Metropolitan Health Service 2026

Background – the current global situation

The latest data from the UNHCR Refugee Data Finder reports an ongoing increase in the number of refugees worldwide, with 36.4 million people officially classified as refugees. The number of people internally displaced within their own country is more than double this number at 73.5 million, reflecting the fact that there are ongoing conflicts impacting populations throughout the world. About 71 per cent of refugees are hosted in low- and middle-income countries with 34 per cent hosted in just five countries – Colombia, Germany, Türkiye, Islamic Republic of Iran and Uganda. Australia's Humanitarian Program provided 20,000 humanitarian visas in 2024-2025 with 15999 of these granted offshore.

Social factors continue to impact the health and wellbeing in this population throughout their journey and after settlement in Australia. Humanitarian entrants to Australia have often experienced conflict, malnutrition, poor access to healthcare and exposure to communicable diseases before arriving in the country. Many have undiagnosed or undertreated health conditions, and most are under-immunised by Australian standards. Humanitarian source countries and countries that people transit through have differing epidemiology of acute and chronic diseases, creating a unique health profile in the refugee population.

Refugees continue to experience further trauma in countries of transit due to a variety of factors. These can include a direct result of foreign Government policies such as forced repatriation but are also more broadly from a lack of access to healthcare, education and working opportunities, as well as societal discrimination and vulnerabilities to natural disasters and ongoing conflicts.

Overview of the Humanitarian Entrant Health Service

The Humanitarian Entrant Health Service (HEHS) is located at the Anita Clayton Centre on Wellington Street in Perth. It is a specialist public health program that provides holistic health assessments for all humanitarian entrants (refugees) arriving from overseas who are resettled in Western Australia (WA) under the Commonwealth Government's Humanitarian Program and Special Humanitarian Program. The service also responds to specific humanitarian crises by seeing clients referred by community organisations who have arrived in WA as displaced persons on temporary visas.

Most humanitarian entrants undergo medical screening before arriving in Australia. This includes screening for some infectious and chronic conditions, however, the process does not necessarily identify the broad range of diseases and other health conditions that are present in this population. The medical screening may have been conducted well in advance of travel, and additional health issues could have developed prior to arrival.

A significant number of humanitarian entrant arrivals have chronic mental and physical health conditions or disabilities that require a multidisciplinary, coordinated approach to care. Further health screening and assessment is recommended following arrival to ensure access to early preventive healthcare, access to immunisation and early referral to specialists where required. The post-arrival health assessment at HEHS provides a holistic health screen and aims to detect and treat infectious diseases of public health importance and identify other health issues that may impact on the individual's longer-term health and their settlement experience. Use of face-to-face interpreters is a vital component of the comprehensive assessments provided at HEHS.

Clients at HEHS are seen in family groups, which assists in understanding relationships and trauma experience as well as the clinical and social impact of mental and physical health issues within the family unit. It is also usually more convenient for families to attend together. Care is

taken to ensure that clients are also seen individually, and the service is sensitive to risks such as family and domestic violence, which require privacy for disclosure. It can be logistically challenging to see family groups with seven or more members during the same clinic but this is accommodated where possible by increasing the number of clinicians available.

After an initial assessment with a refugee health nurse, a HEHS General Practitioner (GP) or Nurse Practitioner (NP) reviews the client and develops a management plan that is shared with the client's primary care provider to ensure appropriate follow up of issues identified at the health assessment. Referrals are made to appropriate specialist services including counselling for trauma and torture, child health services, women's health services, chronic disease follow up and other tertiary services. A comprehensive catch-up immunisation program for both adults and children is included in the post-arrival health assessment.

Families with children are referred to the Child and Adolescent Health Service (CAHS) Refugee Health Team. For adults not linked with this team, nurses working at HEHS provide follow up in the months following the second visit via the HEHS City Program to ensure that clients are appropriately linked with primary care and other health services. Clients can also elect to complete catch-up immunisations at HEHS.

The governance of HEHS is overseen by the WA Refugee Health Advisory Committee (WARHAC), which meets quarterly. HEHS is part of the Public Health Unit, which sits within the Public Health and Clinical Excellence (PHCE) directorate.

Demographics

In 2025, HEHS provided care to a total of 856 people from 26 countries of origin. This represents an 18 per cent increase from 2024. Clients with countries of origin listed as Afghanistan, Syria and Myanmar accounted for 69 per cent of the clients seen in 2025. The number of arrivals from South and Central America remained relatively low when compared to 2023. There was a significant increase in arrivals from Eritrea. The 10 most frequent countries or territories of origin are illustrated in Table 1 below. Clients displaced as a result of the Israeli Palestinian conflict and referred to HEHS from community agencies are included in these numbers.

Table 1. The 10 most frequent countries of origin for HEHS clients in 2025

Country of Origin	Number of Clients
Afghanistan	248
Syria	191
Myanmar	150
Eritrea	53
Ethiopia	33
Occupied Palestinian Territory	27
Iran	18
Venezuela	16
Israel	14
Democratic Republic of Congo	13

The gender distribution remained similar to previous years with the number of people identifying as female (53.5 per cent) slightly higher than the number identifying as male (46.5 per cent).

The age distribution of clients seen in HEHS reflects the population age distributions in countries of origin, with a high number of children and young adults. Those aged between 0 and 19 years make up 40.4 per cent of the total and there is a smaller proportion of older adults when compared to the age distribution of the general Australian population.

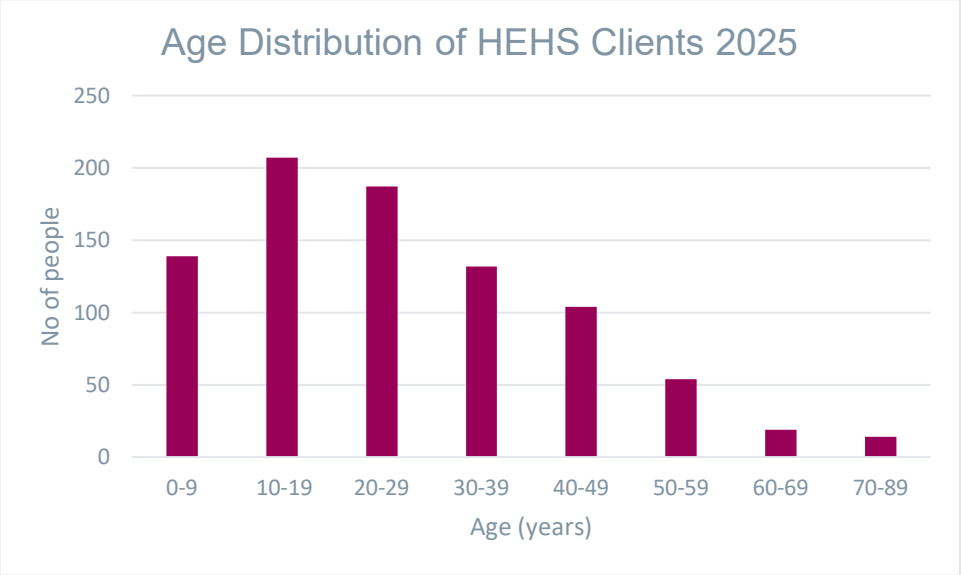


Figure 1. Age of Humanitarian Entrants seen at HEHS 2025

Language

Clients seen at HEHS in 2025 spoke a total of 31 different languages with 16 of these languages being spoken by at least 10 people. The 10 most frequently spoken languages are listed below.

Table 2. The 10 most commonly spoken languages for HEHS clients in 2025

Language	No of Clients
Arabic	220
Dari	172
Hazaragi	58
Tigrinya	48
Burmese	44
Chin Haka	42
Karen	40
Spanish	37
Farsi	35
Kurdish	21

Whilst every effort is made to find an interpreter who can provide face-to-face interpretation at HEHS, it can at times be challenging to engage both in-person and telephone interpreters. Compared to 2024, there was a 127 per cent increase in the number of Arabic speaking clients. There were 11 languages spoken by five or fewer clients. Some of these languages, such as some Chin dialects spoken by clients originating from Myanmar, can be impacted by interpreter availability.

HEHS has the benefit of having long established relationships with multiple agencies to source interpreters. Unfortunately, feedback from clients consistently suggests that in the broader health system both availability of interpreters and willingness of health practitioners to use them continues to be a barrier to accessing healthcare. Frequently, clients may have some knowledge of a second more frequently spoken language, however with the complexities of health conversations it is far preferable and safer for them to be able to communicate in their primary preferred language.

As an organisation, HEHS is also mindful that vicarious trauma is a real risk for professional interpreters. Time is given to brief and debrief interpreters when difficult conversations are expected or have occurred. A benefit of the model of care at HEHS is that relationships established between staff and interpreters can support this process.

Settlement

Availability of rental accommodation continues to impact newly arrived humanitarian entrants in WA. Families are moving to accommodation in suburbs distant from central Perth and away from traditional settlement areas that host many refugees and culturally and linguistically diverse (CaLD) specific services. This can be particularly difficult for families requiring access to tertiary paediatric care on an ongoing basis at Perth Children's Hospital (PCH) or adults requiring specialist services found only in major tertiary adult hospitals.

Families are also expressing that distance from schooling is a major concern and stressor, especially for those attending secondary school who rely on public transport. Additionally, families are reporting difficulties relating to living long distances from communities and extended family who may be settled around more established hubs, such as Mirrabooka.

Excluding those who moved interstate after visits to HEHS, about 68.5 per cent lived within the East Metropolitan Health Service (EMHS) catchment area, 25.6 per cent had a North Metropolitan Health Service (NMHS) catchment area address and 5.9 per cent had a South Metropolitan Health Service (SMHS) catchment area address. When compared to 2023 and 2024 data, there has been a reversal in the trend for increasing numbers of clients to settle in the NMHS and SMHS catchments.

Only 31 clients were living in the 6000 Central Perth postcode at the time of their HEHS visits, reflecting the ongoing efforts of the local Humanitarian Settlement Program Provider to find permanent accommodation for clients prior to arrival, rather than making use of temporary short-stay accommodation. Many of the families living in the EMHS catchment are settling in the south-east corridor in suburbs such as Thornlie, Maddington, Gosnells, Kelmscott, Armadale, and Byford rather than in more central areas. The opening of Ishar Multicultural Women's Health Service in Cannington in 2023 has been a valuable addition to services available for families settling close to this area.

Screening outcomes – nutritional deficiencies and infections

Screening outcomes at HEHS (table 3) reflect the prevalence of health conditions in source and transit countries. In 2024, it was noted that there was an increase in positive *QuantiFERON* Tuberculosis screening tests to 16.8 per cent from a long-term average of about 10 per cent. In 2025, the rate was 9.6 per cent and it is likely that the previous increase was because of a larger number of arrivals from higher prevalence countries during 2024.

Nutritional deficiencies such as B12 and iron deficiency often occur as a result of inadequate nutrition. Clients can access appropriate supplementation at their screening appointments and basic education is provided on diet and nutrition. Clinicians are always mindful that these abnormalities may sometimes indicate underlying disease, and further testing and follow up is undertaken when risks are identified.

Anaemia was identified in 7.8 per cent of HEHS clients, with children and female clients being at highest risk. Anaemia reduction has been identified as a global health priority by the World Health Organisation (WHO), which estimates that anaemia affects half a billion women worldwide. Anaemia leads to fatigue, reduced physical capacity and maternal and newborn health risks. In children, anaemia may lead to problems with growth, development and learning. Ongoing food insecurity after arrival in Australia may prolong the duration of anaemia or contribute to a recurrence after initial treatment.

Schistosomiasis is a parasitic disease that can cause chronic infection resulting in significant morbidity and disability. Positive schistosomiasis serology was identified in 16.6 per cent of all clients. Screening is only performed when clients have lived in an endemic country so the rate of positive tests in those screened is higher than this figure. Some clients now receive presumptive treatment for schistosomiasis at the overseas point of departure, however, many of those screening positive at HEHS have not received this treatment. During 2025, access to the drug praziquantel, which is used to treat schistosomiasis, continued to be complicated as a result of the Therapeutic Goods Administration (TGA) approved brand becoming unavailable in Australia. Fortunately, through a collaboration with the Pharmacy Department at Sir Charles Gardiner Hospital, HEHS secured supply of an alternative overseas brand that could be prescribed through the TGA Special Access Scheme (SAS). This avoided an interruption in the supply to clients. Translated medication information sheets assist with the process of consent to treatment.

Screening for Hepatitis B is included in overseas health screening and most clients diagnosed with Hepatitis B had screened positive overseas. However, many have no or little understanding of the condition and the need for lifelong follow up to ensure the risk of complications can be minimised. Management at HEHS combines a thorough medical assessment with education and shared decision-making regarding the best options for longer-term follow up for the client. HEHS clinicians also ensure that family members are adequately protected with Hepatitis B immunisations.

Table 3. HEHS screening outcomes

Condition	% of Clients
Vitamin D Deficiency	58
Iron deficiency	20.7
B2 deficiency	17.2

Schistosomiasis	16.6
Positive QuantiFERON	9.6
Strongyloides	8.2
Anaemia	7.8
Hypocalcaemia (% of children under 19 yr)	2.6
Hepatitis B	2.5

HEHS screening also includes screening for malaria and other blood borne viruses. The number of positive results is small and therefore not included in the table above. HEHS facilitates appropriate treatment and referral when positive results are identified.

Screening – chronic disease and risk factors

HEHS continues to offer screening for chronic disease, targeting those at highest risk due to age and other risk factors (table 4).

Table 4. HEHS screening outcomes chronic disease

Condition / test result	**% of clients (note only those >35 or with risk factors screened)**
Elevated ACR or decreased eGFR	4.2
Elevated HbA1C 6-6.4%	2.7
Diabetes, HbA1C >6.5%	3.9
Dyslipidaemia	14.3

In adult clients over the age of 18, Body Mass Index (BMI) measurement found that just over half of adults had a BMI classified as overweight or obese. This is lower than in the general Australian population where around two-thirds of adults are considered overweight or obese Overweight and obesity, Summary - Australian Institute of Health and Welfare. However, anecdotally, clients often report having gained weight since arriving in Australia due to more sedentary lifestyles and potentially easier access to a greater range of food choices that may include less healthy but relatively cheap 'fast-food' options.

As dietary and lifestyle habits established after arrival in Australia are likely to determine long-term health outcomes, there is great potential for interventions to promote healthy lifestyles during the settlement period. However, when families are experiencing stresses relating to their basic needs, they may experience barriers to making healthy choices and lifestyle changes. It is important that all services engaging with refugees consider healthy lifestyles and health promotion when designing programs and resources to make healthy choices an easier option for individuals and families when possible. Access to opportunities for exercise and sports are also likely to promote engagement with the local community and positive mental health effects as well as promoting physical health.

Referral data

All individuals seen at HEHS are given a comprehensive discharge letter. If they have already engaged with a regular GP, a copy is directly sent to the GP, with their consent. All families with school-aged children are referred to the CAHS Community Refugee Health Team and most clients are referred to public and school dental services. Excluding these referrals, in 2025, 1258 other onward referrals were made for the 856 clients seen at HEHS, and 98 onward referrals were made to the Association for Services to Torture and Trauma Survivors. There were 206 referrals made to ISHAR and 89 to the Western Australian Tuberculosis Control Program. Other referrals totalled 868 and the majority of these were to the PCH Department of Global and Refugee Health, as well other tertiary services and Lions Eye Institute Refugee Service.

Achievements and highlights

Maintenance of waiting times

During 2025, there was an 18 per cent increase in clients assessed when compared to 2024. This included an increase in clients referred from agencies working with asylum seekers and displaced persons. There were 62 clients, or 7.2 per cent, seen in 2025 who held visas that were not classed as permanent humanitarian visas. Often these clients have had extremely limited access to healthcare and have not had the usual health checks that permanent humanitarian entrants have had access to overseas. Referral pathways outside of WA health service providers for these clients can also be limited by lack of access to Medicare, adding to complexity in management.

Despite the increase in referrals, HEHS was able to offer appointments within four weeks to more than half of all clients and 97 per cent of clients were seen within eight weeks of referral. Towards the end of the calendar year, when arrivals would usually decrease, referral numbers remained high, and the team increased the number of clinics to accommodate families before the holiday period. This helped to avoid an increase in waiting times and allowed appointments for those with complex health issues to be expedited. The Australian Red Cross settlement team in Perth formally acknowledged the HEHS team's diligent efforts during this period, particularly their contribution to the effective coordination of care for clients with complex needs.

Working with partners

The team at HEHS continues to collaborate closely with stakeholders to ensure the best possible outcomes for clients. Regular meetings between HEHS, CAHS Department of Global and Refugee Health Service, CAHS Community Refugee Health team and the Australian Red Cross are coordinated and chaired by HEHS. These have now been formalised as the WA Refugee Health Clinical Service Meeting, which meets every three months. A communique is provided from this meeting to the WA Refugee Health Advisory Council. The meeting remains an invaluable opportunity to improve coordination of the services and improve patient experience.

Education

The service aims to provide quality education relating to refugee health to other health providers and community services. HEHS has hosted clinic visits for junior medical staff from the PCH Department of Global and Refugee Health, as well as medical students undertaking placements at the Anita Clayton Centre. For medical students, observing experienced clinicians working with interpreters is particularly valuable, with many reporting this as a new and impactful learning experience.

HEHS aims to provide education and advocacy in other forums. During 2025, an educational presentation on refugee health was provided to case managers from Australian Red Cross and an overview of issues in refugee health was presented to the Humanitarian Entrants Interagency Network meeting. In addition, a short presentation on current issues in refugee health was delivered to the WA Interagency Settlement Group.

A proposal for a series of six webinars on refugee health tailored for primary care and hosted by the WA Primary Health Alliance has also been accepted and will be delivered during 2026.

Participation in trauma training

In December 2025, the HEHS clinical team was given the opportunity to take part in additional training to manage trauma, provided by the Sexual Assault Resource Centre. This was a valuable experience for staff, who were surrounded by a supportive team and those who attended found the training extremely useful and relevant.

Quality improvement activities

A University of Notre Dame student was supported to undertake a re-audit of chronic disease screening at HEHS following implementation of service improvements identified during a previous audit in 2023.

Development of a guideline and introduction of nicotine replacement therapy within HEHS clinics to assist clients wishing to stop smoking was completed.

Membership of committees

- Refugee Health Network of Australia – two senior clinicians from HEHS represent WA in this national network of health practitioners with expertise in refugee health.
- CaLD and Disability Interagency Network Meeting
- Refugee Nurses Australia – clinical nurse manager is currently the co-chair
- Metropolitan Syphilis Outbreak Response Team
- Multicultural Stakeholders Reference Group
- WA FGM/C Interagency Network
- NDIS CaLD Roundtable Discussion Group
- WAPHA Multicultural Stakeholder Reference Group
- WA Interagency Settlement Group

Focus Areas for 2026

During 2026, HEHS will deliver a series of six webinars in collaboration with WA Primary Health Care Alliance, tailored for primary healthcare staff working with refugees.

Work will continue into recording complexity and collaborating with partners to develop referral pathways for clients with complex needs.

This document can be made available in alternative formats on request for a person with a disability.

© North Metropolitan Health Service 2026