COMPANION HOUSE

Medical Service

CLINICAL GUIDELINES

These Clinical Guidelines were developed by the Companion House Medical Service by Dr Christine Phillips, with contributions from Dr Siobhan Reddell and Dr Shanti Narayanaswamy. We are grateful for the comments provided by Dr Lucy Ong and Dr Clare Willington.

Updated December 2010.

Table of Contents

Chapter

1

Companion House

How the medical service fits into Companion House, staffing and governance structure.

Companion House Medical Service is a transitional general practice integrated into a refugee support service. The service aims to provide a transitional general practice for the first twelve months after resettlement. This service has almost complete ascertainment of newly arrived refugees in the ACT. Patients of this service are:

(1) All newly-arrived refugees. Visa status is immaterial, but most will have access to Medicare and health care cards. The service aims to see them for the first twelve months after settlement in Australia or the ACT.

(2) Asylum seekers.

(3) Refugees who have been here for a longer period, and have complex care needs that require ongoing support from Companion House.

(4) Refugees that are referred in by community general practitioners for complex care or who need specific clinical services available at Companion House Medical Services.

ICON KEY

- Medical Program
- Community Development
- Training and Awareness
- Counselling

Structure of Companion House

Companion House has four programs:

Counselling. The Counselling program includes workers with specific foci on Early Intervention (EI - who focus on newly arrived refugees), longer term refugees, and a children's program. All of these counselors may at times refer patients into the medical service, or collaborate on their treatment. Newly-arrived patients are often seen with the counselor and doctor working in tandem. Early Intervention counselors will enter their assessments onto Genie, the practice software.

Community Development. The Community Development (CD) program includes a diverse set of workers who have specific community development programs for newly arrived communities. The types of work done in the CD stream vary from year to year, as needs evolve. CD workers occasionally attend with patients or provide outreach support or advocacy. The Medical Service also provides input to the CD team about evolving health needs, including health promotion projects.

Training and Awareness. This program is oriented to the outside community and provides education to services (government and community organizations) who are in contact with refugees on refugee experiences, needs and short and long term sequelae of torture and trauma. The Medical Service contributes to ongoing education to medical students and GP registrars as part of this program. The training program at Companion House also manages the Immigration Advice and Application Assistance Service, which may be able to provide migration advice, particularly for asylum seekers.

Medical Service. Companion House's Medical Service began in 1995. It is the second oldest refugee health service in the country. The service has had increased demands placed upon it over the last five years as a result of the critical health workforce shortage in the ACT. The Medical Service is funded through the Child and Women's Program, ACT Community Health, and through Medicare income.

Companion House Governance

Companion House is a community-based organization mandated to work with survivors of torture and trauma. It is the ACT member of a national network of similar services called the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT). Companion House is an incorporated association, governed by a Board, who make final decisions on the direction of Companion House and managed by the Director. Each of the four programs has a team leader, who takes responsibility for day to day oversighting of their programs. The Medical Service also has a Medical Director, who is responsible for clinical oversight of the service.

Medical Service

The Medical Service provides four to five clinics a week. These are intended to last for a session, though sometimes the sessions are extended because of the tendency of newly arrived refugees to drop in, or to arrive late.

The service has four to five sessional doctors, one practice nurse (four to five days per week), who is also the Team Leader of the Medical Service, and one service coordinator (half time). The service coordinator is a critical component of the service, since it is their job to ensure that patients know when their appointment is, know how to get there, and are reminded in time to attend.

A special skills GP registrar training position at Companion House is generally held on a rotating basis.

Interpreters

Where possible, the Medical Service pre-books interpreters with the Translating and Interpreting Service (TIS), so that there is no delay accessing interpreters. This means that Companion House has to carry the cost if the patient does not attend for the appointment. If there is no interpreter pre-arranged, or if you realize that you need an interpreter at short notice because the patient does not understand you, an interpreter can be readily accessed by telephoning the Translating and Interpreting Service on their Doctor's Priority Line on 131450. They will generally arrange an interpreter within five minutes.

There are various grades of interpreters, and not all TIS interpreters are fully accredited. This is particularly the case for languages of newly arrived cultural groups, such as Chin, Mon and Krio. If the interpreter is unsatisfactory for some reason, you are entitled to let that interpreter go and ring back and ask TIS for another interpreter.

The Medical Service keeps a list of interpreters who are used regularly for some languages, and these will be requested when pre-booking.

Some diaspora languages (eg Hindi, Arabic) and some languages still spoken in former colonies (French and Spanish) differ quite significantly from the language spoken in the language's home region. South American Spanish speakers will generally be happier with an interpreter from their continent than one from Spain. Patients from West Africa who speak French often understand the French of their region or the South Pacific more easily than French speakers from France. The same principle of asking for region-specific speakers of the language also applies to Arabic.

Verbal communication in English

Australian English is spoken rapidly without much mouth movement or emphasis on consonants. Many newly arrived refugees who come with English have difficulty comprehending this unemphatic, rapid version of English. Some of our verbal tics can also be misinterpreted. For example, "It's all right", in response to a question seeking consent in African English means "Yes, I am happy to do this", whereas in Australian English it could also be interpreted as "I am happy not to do this".

Health information in other languages

The best sources of health information in other languages are the NSW Multicultural Health Communication website: http://www.mhcs.health.nsw.gov.au and the Victorian Department of Human Service's Health Translation Directory: www.healthtranslations.vic.gov.au These are searchable by language or condition. You can print out health information in language on any printer.

Documents in other languages

These can be formally translated by TIS for free. This is particularly useful for immunization documents. Interpreters can generally read them to you, although Level 1 and 2 interpreters may not have expertise in medical language. Not all refugee-source countries use the Gregorian calendar. Other calendars include:

- Islamic calendar: uses lunar months and commences on Friday, 16 July 622 CE, the date of Mohammed's flight to Mecca.
- Persian calendar (Iran, Afghanistan). Adopted in 1925; very accurate solar calendar
- Indian civil calendar. Starts from 79 CE. Apart from the year number, synchronises with the Gregorian calendar.
- Bahai calendar. Synchronises with the Gregorian calendar, but has cycles of 19 days.
- Hebrew calendar (either Hebrew or Gregorian dates are legal for official documents in Israel). Dates from Monday, October 7, 3761 B.C.E.

To convert dates to Gregorian calendar dates, go to:
http://www.fourmilab.ch/documents/calendar/

Chapter

2

Screening Guidelines

Screening processes for the Medical Service

The purpose of the first consultation(s) with a refugee is:

- to ascertain what they are concerned about in relation to their health. This will generally be headaches, dental concerns, or backache. Many will also tell you of their concerns about treatment they have previously received and its consequences
- to perform a physical examination
- to assess their mental health at this point and with the EI counselor to assess the overall resilience of the family at this point
- to assess the need for catch-up primary health care (immunizations, screening)
- to undertake screening for diseases of public health importance, nutritional disorders or infectious diseases that are of relevance to the patient.

Although there are some differences between countries of origin in types of screening, these are generally fairly minimal.

Clinical history

The EI counselor will generally have met the patient and may have conducted a psychological state and functioning. If not, the counselor will ask you to undertake a **mental health screen** – checking on mood, sleep, appetite, and feelings about settling in Australia. Very few refugees want to recount their trauma history at the first consultation (and in fact many never do to the doctor). One of the reasons why refugees like going to the doctor at Companion House is that it is a fairly narrow service, which is not overwhelming and responds to their immediate needs. This seems to build confidence overall with the service, and is particularly useful for patients who come from cultures with no tradition of counseling or psychotherapy.

Ensure that you cover in your history:

Immunisation history: We have information on standard schedules around the world. (Note that all refugee camps use the schedule of the host country). Those least likely to have been immunized are those from countries where the primary health care sector functioned poorly:

- people from Afghanistan, especially women, under the age of 45
- people from south Sudan over the age of 18, who have often spent their early years out of country
- people from Sierra Leone under the age of 40
- young children from Zimbabwe
- older people from Burma (younger children will have been well immunized in Thai refugee camps and should have records).

Reproductive health history: This is often undertaken in the examination room if a patient attends with her family. Many women have never had the opportunity to discuss reproductive health with a clinician and will be very grateful for the opportunity. If you do not cover it in the first consultation, ensure that in subsequent consultations you address cervical screening. Some of the refugee-source countries have the highest incidences of cervical cancer in the world.

Clinical examination

Key aspects of the clinical examination are:

- Height and weight - take these at baseline and monitor them. Some common medications are dose-dependent. Many children are undersized and go through such a marked growth spurt that is very heartening for the parents, so we need a baseline.
- Visual acuity – this is often done poorly in the pre-arrival medicals.
- Dental check – dental referrals can be prioritized if there is a dental issue; otherwise the wait is approximately three months.
- Ears – looking for chronic perforations particularly.
- Be aware that the one body system that is never examined in pre-departure medicals is the genitalia, and sometimes the most significant abnormalities are

found in this region. However, it's generally not appropriate to do this early on unless the patient requests you to.

The rest of the clinical examination follows standard systems-based processes, focusing particularly on what the patient is concerned about. Take the opportunity of being in the small consulting room away from family members to ask about reproductive health issues, especially menorrhagia or amenorrhoea.

Pathology

Our standard screening schedule consists of:

- Full blood count
- Ferritin
- UEC and LFTs
- Schistosomiasis serology (essential for East and West Africans, good idea for those from SE Asia)
- Hepatitis B SAb and Sag. Antibody levels are to determine who should be immunized.
- Hepatitis C serology
- HIV
- VDRL
- Helicobacter stool serology if they meet screening guidelines
- Strongyloides screen
- Vitamin D levels. Even patients with lightly pigmented skin become vitamin D deficient over winter in Canberra. Anyone who wears hijab should have Vitamin D and PTH levels measured.
- Malaria screen (Pf and Pv antigen) + thick and thin film. Especially if children, and from malarious zone. However, if they have had pre-departure screening, they will have been given some anti-malarials before getting on the plane.
- Urine. If done at midday, and the patient is from a high risk country, also check for schistosomes on this. Dipstick urine looking for renal impairment.

- Stool MCS/COP especially for children. There is no need to do more than one sample as the chance of having a positive yield on a second or third sample when the first sample was negative is of the order of 1:100.

These tests are listed on Genie as a "refugee screening set".

It can be useful to do the blood collection yourself at Companion House, as otherwise it can become logistically difficult for the patient and the volunteer provide transport to arrange testing at a community pathology laboratory. However, especially for children, you may choose to get the pathology agency to collect the blood.

Other things to be considered in the initial assessment, depending on where they come from:

- TSH for patients from SE Asia – due to low iodine levels there, subclinical hypothyroidism with goiter is quite common.

- Thalassaemia screen. Do this as part of the routine screen ONLY in women of reproductive age. Iron deficiency will result in a false negative and if the film is microcytic and hypochromic, tests for haemoglobinopathy may need to be carried out later.

Other screening services

Tuberculosis:
Screening is currently performed at the Chest Clinic at the Canberra Hospital for **everyone under the age of 35 years who is asymptomatic**. Volunteers providing transport through the Settlement Support program generally take all family members at one appointment. There is significant attrition of patients going to TCH. Mantoux testing cannot be performed within a month of a live vaccine, eg MMR. People with Health Undertakings for CXR abnormalities, or those who have a history of treated TB should also be referred to the Chest Clinic.

Dental:
The ACT Dental Service provides free assessment and treatment for newly arrived refugees within the first 12 months of settlement.

Hearing:
ACT Community Health will provide screening for patients if you deem it necessary.

Pre-departure screening

Refugees assessed offshore have received the following assessment as part of the medical examination:

- Medical examination
- HIV test
- Chest Xray if over 11 years
- Hepatitis B test if pregnant

Refugees assessed at Christmas Island Immigration Detention Centre (IDC) receive a medical examination and hepatitis B serology. HIV testing is NOT performed on Christmas Island (as of December 2010). Results of Chest Xray screening at Christmas Island are often not available prior to the patient's departure from the IDC.

The medical examination for the visa for offshore refugees may be conducted over a year before departure. Since 2006, refugees from most refugee-source countries also receive a pre-departure assessment and treatment conducted within 72 hours of departure. This screening and treatment consists of:

- Malaria screen and treatment
- MMR vaccination
- Fungicidal scalp treatment
- Medical examination

Notification of patients who require medical assessment in Australia within 72 hours or 2 weeks will be provided to the medical service, usually via the Settlement Support provider.

Chapter

3

What to do about….

Age, indeterminant

Patients' ages can be misestimated on their visa documents. This can result in adults having to return to school, and not being able to access adult privileges (eg driving). Sometimes patients cannot undertake proposer-supported visa applications because their "visa" age is incompatible with being the parents of the children they are trying to sponsor out. The Medical Service guidelines include a recent document on age estimation for refugees, including the role of xrays of the forearm and the central importance of clinical assessment. You may need to fill out a statutory declaration about the age of the patient to support them having their formal documents amended.

See Appendix 1 for history dates for Sudan, Sierra Leone, Tibet, Burma, Afghanistan, Iran, Iraq, and Palestine that might help to correlate when a patient was born.

Anaemia or other blood abnormalities

Microcytosis – This may be due to thalassaemia or iron deficiency. If iron deficient, defer testing for thalassaemia until the patient has a normal iron count.

Neutopenia – This may be benign neutropenia of ethnic origin, which is frequent in Africans, and probably reflects different normal ranges in different ethnic groups. Patients who are otherwise well should not have further investigation of neutropenia.

Thrombocytopenia – This may be due to hypersplenism, the most common causes of which are repeated episodes of malaria or schistosomiasis. It may also reflect acute malaria.

Iron deficiency – Treat this with Ferro-liquid in children, and check for hookworm.

Eosinophilia – If the cause is not apparent, consider filariasis or strongyloides as causes.

Child protection issues

All doctors are required to report any concerns as mandated professionals. Further information is available in the Companion House Policies and Procedures manual. Be prepared to advocate to the courts sensibly and in conjunction with counseling staff at Companion House.

Circumcision (male)

It is not unusual for adult men to ask for circumcision, if it was a culturally valued procedure that was not performed in their childhood because of war and displacement. Circumcision cannot be performed in the ACT or NSW public hospital systems for non-medical reasons. This also applies for male children, though there are a number of private GPs who do it in their rooms when the baby is a neonate.

Currently neonatal circumcision for babies who are under 6-weeks old are performed in Canberra by Dr Tim O'Neill at Majura Medical Centre in Dickson.

Phone : (02) 6247 5833 Fax : (02) 6247 6286

Address: 3/151 Cowper St, Dickson, ACT 2906

Email : timon@majuramedical.com.au, admin@majuramedical.com.au

Contraception

Some cultures strongly disapprove of contraception, and women may therefore seek modes such as depo-provera or IUDs which are not immediately apparent. SHFPACT will insert IUDs upon request.

Vasectomies are performed at Marie Stopes Centre in Civic, and by Dr Ian Pryor in Tuggeranong.

The NSW Multicultural Health Communication has some excellent factsheets on the webpage on the topic of contraception for both men and women, which have been translated into a number of languages. They are:

- "*Contraception: Condoms and Diaphragms*", in Chinese, Croatian, English, Italian, Khmer, Macedonian, Russian, Serbian, Somali, Spanish, Turkish, Vietnamese

- "*Safe Sex. No Regrets. Anyone can get condoms*" in Arabic, Chinese, English, Indonesian, Khmer, Korean, Macedonian, Portuguese, Serbian, Spanish, Thai, Turkish, Vietnamese

The factsheets can be found at:
http://www.mhcs.health.nsw.gov.au/mhcs/topics/Womens_Health.html

Cysticercosis

This is due to *Taenia solium* tapeworm infection, from regions where pork is consumed (eg Papua New Guinea, South America). *Taenia solium* infection is often relatively unsymptomatic apart from passage of proglottids in stool. The main risk is the development of cysticercosis, the most common parasitic infection of the neurological system worldwide. The larvae of the tapeworm can spread via the blood stream to many organs where they form tissue cysts (cysticerci). These might evince themselves clinically as nodules in muscles, or abnormal heart rhythm if in cardiac muscle, or in neurological symptoms suggesting nodules in the brain (convulsions, headache, long tract signs indicating spinal cord compression etc). Diagnosis is by stool tests which will be positive three months after infection, or on biopsy of the infected area. The treatment is praziquantel or albendazole, and advice should be sought from the Infectious Diseases team at The Canberra Hospital. Only Albendazole is approved for treatment of the infection. This infection is rare among refugees from Muslim countries, for obvious reasons.

Dental problem

If the problem is acute the patient will need to be referred to ACT Health's Emergency Dentist. The medical service has written material with detailed instructions of how to access emergency dental services in Canberra, which can be given to patients.

Ear, nose and throat assessments

There is no public otolaryngology clinic at The Canberra Hospital. The private ENT surgeons operate in the public sector. Appointments should be made with the private ENT surgeon.

Female genital mutilation

The ACT is not a resettlement area for cultural groups which have practised FGM. Women who have had this procedure require specific support in childbirth and should deliver at The Canberra Hospital. Gynaecological referral may be required for cervical screening.

Guinea worm (dracunculiasis)

This rare condition remains endemic in six African countries, one of which is southern Sudan. The patient will report a fiery sense in the region where the worm is erupting from the skin. Seek advice from the ID clinic at The Canberra Hospital. Treatment involves slowly winding the worm around a piece of wood, which can take up to a

month, and is painful. Give adequate analgesia, watch out for secondary infection and ensure they are protected against tetanus.

Hearing

Australian Hearing will do hearing assessments and support, including subsidized hearing aids for children under 18, and pensioners. Accessing hearing aids for patients outside this age-group is very difficult.

Macquarie University and 'Self Help for Hard of Hearing' (SHHH) a not-for-profit organization provide cheap second hand or reconditioned hearing aids for the unemployed. However they are willing to make concessions for people who don't fall exactly into this group, such as refugees. Membership with SHH is $37 and all the appointments for hearing testing etc cost $100. Once this has been done individuals are sent over to Macquarie University to get an appropriate hearing aid for free. SHHH can be contacted on: (02) 9144 7586. Persevere with this number as SHHH is run by volunteers and sometimes the office is not staffed. Alternatively, they can be contacted via email: shhh@netspace.net.au

Helicobacter seropositivity/dyspepsia

See Appendix 5 and 6 for algorithm on treatment of *H. pylori* in patients with or without dyspeptic symptoms.

Hepatitis B chronic infection

All refugees in the ACT are entitled to free hepatitis B vaccination. We use the following monitoring guidelines (Reference: Australia and New Zealand Chronic Hepatitis B Recommendations, 2008).

	Tests	**Actions**
At diagnosis	Hepatitis BeAg, anti-Hepatitis e Ag, HBV DNA; AFP; HAV antibodies; Liver ultrasound; Hepatitis D antibody and antigen; INR	Refer to Liver Clinic if any abnormalities. Vaccinate against Hepatitis A if not immune.
Monitoring in persons with HBV <2000 levels and normal ALT at diagnosis	HBV DNA and LFTs every 12 months	Add on annual screening for HCC if at high risk (co-infection with hepatitis C, alcohol drinker, over 40 years, family history of HCC)

Hepatitis C seropositivy

Check viral load and genotype, AFP and arrange liver ultrasound. Most genotypes in refugees are amenable to treatment. (Reference: RACGP Guidelines 2003)

	Tests	Actions
At diagnosis	Hepatitis C viral load and genotype, LFTs, FBC, INR, Liver ultrasound	Refer to Liver Clinic if any abnormalities. Vaccinate against Hepatitis A if not immune.
Monitoring in persons with AST and ALT within the normal range	LFTs, platelets every 6-12 months	Consider referring for liver biopsy in older persons, or people from Egypt, even with normal liver function tests

Hydatid disease

This is not uncommonly found in refugees from Tibet. The treatment is both surgical and medical, using Albendazole (available on authority prescription for this purpose). They should have an ultrasound or CT and echincococcus serology testing. Refer for further advice to the Infectious Diseases clinic at The Canberra Hospital.

Immunisations (catch-up)

If facilities for imunisation exist, refugee children will have been immunized according to the schedule of the country they have been living in. National schedules are in a folder in the medical room. Catch-up immunization is complex; consult Appendix 4 for catch-up schedules using the vaccines provided by ACT Health. All refugees are entitled to free hepatitis B vaccination.

Most international schedules are monovalent measles, and do not confer protection against mumps and rubella. Predeparture screening have protection against mumps and rubella.

Malaria

Many people from malarious areas assume that their immunity will protect them when they return home, and do not take prophylaxis. There is an increasing incidence of malaria in returned travelers from Africa.

Because the vector for malaria is not native to the ACT, patients with vivax, ovale or malariae may be treated as outpatients. Some adult patients with falciparum malaria and mild disease may also be treated as an outpatient.

Urgent hospital treatment of severe malaria is essential if the patient has any of the following:

- **any degree of altered consciousness**, jaundice, oliguria, severe anaemia or hypoglycaemia.
- a parasite count above 100 000/mm3 **(>2% of red blood cells parasitised)**
- the patient is **vomiting or clinically acidotic**
- the **patient is pregnant**

For *falciparum* malaria:

- if the patient is clinically well, has a parasitaemia count < 2%, and is afebrile then they are suitable in Canberra for outpatient treatment with Atovaquone with proguanil (available as an authority script on the PBS) for "Treatment of suspected or confirmed *Plasmodium falciparum* malaria in a patient aged 3 years or older where quinine containing regimens are inappropriate". The dose of atovaquone+proguanil (250/100mg) is:
    - **adult:** 4 tablets orally with fatty food, daily for 3 days
    - **child 11 to 20 kg**: 1 tablet orally with fatty food, daily for 3 days
    - **child 21 to 30 kg**: 2 tablets orally with fatty food, daily for 3 days
    - **child 31 to 40 kg:** 3 tablets orally with fatty food, daily for 3 days
- if there is any doubt, refer to hospital. Patients with falciparum malaria can deteriorate quickly
- If falciparum malaria is treated as an outpatient, follow-up thick and thin films are required at 28 days

For *vivax, malariae* and *ovale*:

- chloroquine 620 mg base (= 4 tablets) (child: 10 mg base/kg up to 620 mg base) orally, initially, then 310 mg (= 2 tablets) (child: 5 mg base/kg up to 310 mg base) 6 hours later and on days 2 and 3, making a total adult dose of 10 tablets.
    - Chloroquine is currently available only through the Special Access Scheme.

To eliminate liver forms of *P. vivax* infections, add or follow within a few days with:

- primaquine 30 mg (child: 0.5 mg/kg up to 30 mg) orally, daily with food, or if nausea occurs 15 mg (child: 0.25 mg/kg up to 15 mg) orally, 12-hourly with food for 14 days.

To eliminate liver forms of *P. ovale* infections, add or follow within a few days with:

- primaquine 15 mg (child: 0.25 mg/kg up to 15 mg) orally, daily with food for 14 days.

Exclude G6PD **deficiency** prior to the use of primaquine, as **severe haemolysis may occur in these patients**.

If the patient relapses after the primaquine treatment, seek expert advice.

If the patient is unable to tolerate oral therapy, best taken with food, treat as severe malaria as above and consult a specialist.

Reports of chloroquine-resistant *P. vivax* have come from areas in Papua New Guinea, Indonesia and South-East Asia and this should be considered if a patient with *P. vivax* fails to respond to standard doses of chloroquine.

Neonatal or early childhood difficulties

Managing the first six months of a baby's life can be very difficult and isolating for women who do not have their mothers and other female relatives to provide support. The pathways into the Queen Elizabeth II Centre have been expedited for refugees. Telephone the service to ask for admission.

"OV fly", onchocerciasis (river blindness)

Onchocerciaisis is often referred to by patients as "OV fly", after the black fly *Onchocerca volvulus* whose bite can transmit the nematode which causes onchocerciasis. Onchocerciasis is the second most common treatable cause of blindness in the world, with the blindness being due to the body's immune response to the microfilaraie across the cornea. As the adult worm can live within the body for 15 years, an infected person (diagnosed on serology and symptoms) will need ongoing six to twelve monthly treatment with Ivermectin for an extended period. They may have a pronounced Herxheimer reaction to Ivermectin, which to the patient may be indistinguishable from the subcutaneous migration of the microfilariae. The most marked clinical findings will be skin changes such as skin atrophy, "leopard skin" due to patchy depigmentation, and lichenified dermatitis. Discuss management with the ID department.

Pain

A hitherto underestimated cause of lower back and neck pain is vitamin D deficiency. If this is not the cause, and treatment is ineffective, refer to The Canberra Hospital's Pain Clinic.

Pregnancy and childbirth

Arrange the referral to the relevant antenatal clinic. For high risk patients, the medical service will provide outreach support through the pregnancy. Encourage iron and vitamin D supplementation when necessary.

Many Dinka patients are very concerned about caesarian sections as there are prevalent cultural beliefs that hysterectomy is routinely performed with a LUSCS, and therefore a woman who has had a caesarian is rendered infertile. If there is a possibility that she may require an elective LUSCS, raise this possibility and reassure her that she will be able to have children in future. Emergency LUSCS among Dinka patients can be highly charged emotional affairs where mothers have refused permission and the hospitals have threatened legal action.

Psychosis

❋ Counselling ✚ Medical Service

Acute psychosis is an emergency. There are olanzepine wafers in the drug cupboard in the doctor's room, if necessary. Place the patient in a quiet room and alert other staff members at Companion House. While awaiting the arrival of the CAT team, ensure the patient is safe and observed. Generally one or two staff members will wait with the affected persons.

Subacute psychosis is not uncommon in traumatized patients. Assess them formally and encourage them to be cared for in combination with the mental health team. If they are not a risk to themselves or others, and decline mental health referral, ensure that family members are aware of the CAT team crisis number, and in concert with a counselor, begin medical management with frequent review.

Remanded patients

Patients in remand are likely to be very distressed. Liaise with doctors at the Alexander Maconochie Centre (eg Michael Levy, the Director of the Prison Health Service, or Liz Fraser at Interchange General Practice 62475742) if you are concerns about the patient's health.

Rickets

Those at risk are children who have not been exposed to sunlight (for example, dark-skinned refugees who have lived in flight in towns where it was not safe to go out during the day), or babies born to and breastfeeding from a vitamin D deficient mother. Suspect biochemical rickets if an infant after six months has musculoskeletal weakness, and seek this at the 6 and 12 month immunisation consultations. Tests include wrist Xray and Ca, PO4, ALP, Vitamin D and PTH. Treatment schedules should be worked out in collaboration with the pediatrics clinic (see Vitamin D schedules to start with). Babies will need admission to hospital to ensure that tetany is not triggered by Vitamin D replacement.

Schistosomiasis

A raised titre on serology is consistent with latent schistosomiasis. These patients have almost certainly not been treated in their home country. If they have been treated, they should be retreated as the failure rate of treatment is around 10%. These patients should also have a liver ultrasound assessing portal blood flow. Praziquantel is available on authority for schistosomiasis.

Dosage instructions:

Praziquantel 20 mg/kg/dose orally, for 2 doses after food, 4 hours apart.

Each tablet is 600mg. The dosage for people infected ***outside*** **South-East Asia** is as follows:

Weight (kg)	**Size of Individual Dose (in tablets)**
20-25	¾ tablet

26-33	1 tablet
34-41	1¼ tablet
42-48	1½ tablet
49-56	1¾ tablet
57-63	2 tablets
64-70	2¼ tablets
71-78	2½ tablets
79-86	2¾ tablets

For people *infected* **in south-east Asia** (note, they don't have to be from south-east Asia) a higher dose is required: The dose is praziquantel **30 mg/kg, for 2 doses after food, 4 hours apart** .

Weight (kg)	**Size of Individual Dose (in tablets)**
20-25	1 tablet
26-33	1½ tablet
34-41	2 tablets
42-48	2¼ tablets
49-56	2 ½ tablets
57-63	3 tablets
64-70	3¼ tablets
71-78	3¾ tablets
79-86	4 tablets

Each dose should be taken after food. The tablets can be broken into four pieces to ensure accurate dosing but should not be chewed because of their bitter taste.

** Some patients have a Herxheimer reaction to praziquantel treatment but it is generally well tolerated. Transient adverse effects include gastrointestinal upset, headache, dizziness and drowsiness.

School performance

❋ Counselling. The Children's counselors will provide ongoing support for the child when at school.

Some extra resources may be available at the school, for instance if the child is diagnosed with certain medical health conditions. Consult with the Children's Counsellors at Companion House about support they can provide and/or can facilitate.

Sexual performance

Erectile dysfunction in the post-settlement period is very common.

There are two excellent factsheets on the NSW Multicultural Health Communication Service webpage on the topic of Men's Sexual Health which have been translated into a number of languages. They are:

- "*A User's Guide. What every man needs to know about how his reproductive system works*" (Includes information about prostate health, male infertility, testosterone deficiency, testicular cancer and erection problems.) in Arabic, Bosnian, Chinese, Dari, English, Farsi, Greek, Italian, Khmer, Korean, Serbian, Turkish, Vietnamese.

- "*Successful treatment for impotence*" in Arabic, Chinese, Croatian, English, Italian, Khmer, Korean, Lao, Macedonian, Portuguese, Russian, Spanish, Thai, Turkish, Vietnamese

The factsheets can be found at:
http://www.mhcs.health.nsw.gov.au/mhcs/topics/Mens_Health.html#7650

Skin problem – undiagnosed

Many Africans have marked xerosis which is a significant cause of disability and discomfort for them. The first level of treatment is emulsifying ointment, which can be readily purchased in any supermarket. For advice about skin problems, refer patients to Dr Andrew Miller's public dermatology clinic at The Canberra Hospital. Bookings are made by ringing his private rooms.

Other conditions to consider are onchocerciasis causing lichenification (ask for a history of being bitten by the black fly vector for the disease and check serology for

microfilaraie). If the main problem is patchy pigmentation especially on palms and soles of feet consider and test for secondary syphilis.

Substance abuse

Counselling Medical Community Development.

Alcohol and marijuana currently seem to be the most used drugs among our clientele, though injecting drug use is frequent in the camps in SE Asia. Both alcohol and THC are often used as a means of managing trauma. Collaborative work with the counselor is important. It is important that standard management be put into place for patients abusing drugs (for example, they may need to transfer to Drug and Alcohol clinic or to Interchange General Practice), and that Companion House is aware early and can respond to the social consequences of substance abuse.

Suicidality

Counselling. Medical Service

Suicidality is a Companion House emergency. All counselors will be familiar with the suicide protocol. If suicidality has been reported to another staff member, they will have filled in a suicide risk assessment form. A copy of this will be placed on Genie. Notify the CAT team. Notify the practice nurse and the senior counselor as this person will need a support system. If the person is psychotic, there are olanzepine wafers in the drug cupboard.

Syphilis

If the patient has a positive VDRL, the laboratory will undertake further testing, which should assist in assessing whether the patient has primary, or latent syphilis. Most patients diagnosed through screening have latent syphilis. This is treated with **3 x 1.8 g intramuscular injections of benzathine penicillin** over three or six weeks. If you are concerned about primary or secondary syphilis, ask advice from the Sexual Health Unit, TCH. You are obliged to ask about contacts!

Tallness

Very tall Dinka people often get musculoskeletal pain because the chairs, beds and working equipment they have is unergonomic. This is a particular problem for school children or for people working in the cleaning industry, as the equipment is often designed for people who are several feet shorter than they are.

Thyroid disease

Patients with euthyroid goitres will probably become hyperthyroid in Australia as they will be exposed to more iodine. Seek further advice and assessment from Dr Fred Lomas (NCDI).

Tinea capitis

This will not respond to topic treatment. The patient will need griseofulvin. The dose adjusted for children is **20 mg/kg/day** for six-eight weeks. The duration needed to treat tinea capitis with oral terbinafine is only 4 weeks, but this medication is not authorized by the PBS for children. There is a Woods lamp in the treatment room.

Visual impairment

If problem is refractive error, OPSM will assess patient's vision, bulkbilling them. The ACT Spectacle Subsidy Scheme will offset some of the cost of spectacles. The public ophthalmology service at The Canberra Hospital does not assess and treat cataracts (as of December 2010). For cataract surgery, refer to The Canberra Eye Hospital.

Vitamin D deficiency

Vitamin D deficiency is defined as a serum level of 25-hydroxyvitamin D less than 20 ng/mL or 50 nmol/L1. One international unit (IU) equals 25ng. Most people with significant vitamin D deficiency on arrival will need supplementation over winter.

The medical service has a supply of megadose vitamin D (100,000 IU/1.0mL) which may need to be given repeatedly to patients with very low levels of vitamin D. Children with rickets should be referred to a pediatric endocrinologist.

Persons with dark skin will need supplementation over winter with daily Ostelin, or a megadose of 100 000 IU in autumn. Pregnant African women or women wearing hijab probably need Ostelin supplements. See Appendix 2 and 3 for Vitamin D Protocols for adults and children respectively.

Chapter 4

Essential medicines

Essential medicines for refugees and asylum seekers, and how to keep our stocks up

Refugee medicine requires a pharmaceutical profile that is a little idiosyncratic. Some of the most-used medications are not part of the regular pharmacopoeia of general practices. Keeping stocks up requires strategic stocking from samples, donations from supportive organizations and occasional investment ourselves.

Gastro-intestinal drugs

- Proton-pump inhibitors

Psychotropic medications

- Antidepressants (SSRIs and Avanza). A few TCAs would be useful.
- Efexor (wafers) for acute psychosis

Vitamins and minerals

- Vitamin D + calcium
- Iron and folate combination

Topical medications

- Hydrocortisone
- Miconazole
- Canestan PV
- Capsaicin

- Tubs of emulsifying ointment

Allergies/dry eyes

- Antihistamines (non-sedating)
- Artificial tears

Analgesics

- Paracetamol, Panadeine forte

Asthma medication

- Puffers with spacers.

APPENDIX ONE

KEY DATES IN HISTORY OF REFUGEE-SOURCE COUNTRIES

Sudan Timeline

Military regimes favoring Islamic-oriented governments have dominated national politics since independence from the UK in 1956. Sudan was embroiled in two prolonged civil wars during most of the remainder of the 20th century. These conflicts were rooted in northern economic, political, and social domination of largely non-Muslim, non-Arab southern Sudanese. The first civil war ended in 1972 but broke out again in 1983. The second war and famine-related effects resulted in more than four million people displaced and, according to rebel estimates, more than two million deaths over a period of two decades.

Peace talks gained momentum in 2002-04 with the signing of several accords. The final North/South Comprehensive Peace Agreement (CPA), signed in January 2005, granted the southern rebels autonomy for six years. The referendum for independence scheduled for January 2011 (agreed as part of the CPA) is likely to move South Sudan towards becoming its own country. A separate conflict, which broke out in the western region of Darfur in 2003, has displaced nearly two million people and caused an estimated 200,000 to 400,000 deaths. The UN took command of the Darfur peacekeeping operation from the African Union on 31 December 2007. Armed conflict, poor transport infrastructure, and lack of government support have chronically obstructed the provision of humanitarian assistance to affected populations.

Until the second half of 2008, Sudan's economy boomed on the back of increases in oil production, high oil prices, and large inflows of foreign direct investment. GDP growth registered more than 10% per year in 2006 and 2007. From 1997 to date, Sudan has been working with the IMF to implement macroeconomic reforms, including a managed float of the exchange rate. Sudan began exporting crude oil in the last quarter of 1999. Agricultural production remains important, because it employs 80% of the work force and contributes a third of GDP. The Darfur conflict, the aftermath of two decades of civil war in the south, the lack of basic infrastructure in large areas, and a reliance by much of the population on subsistence agriculture ensure much of the population will remain at or below the poverty line for years despite rapid rises in average per capita income.

Ethnic groups: black 52%, Arab 39%, Beja 6%, foreigners 2%, other 1%

Religions: Sunni Muslim 70% (in north), Christian 5% (mostly in south and Khartoum), indigenous beliefs 25%

<u>Modern time Sudan</u>
1820: Sudan is conquered by Turkey and Egypt.

1881: Rebellion against the Turkish-Egyptian administration.

1882: The British invade Sudan.

1885: An Islamic state is founded in Sudan.

1899: Sudan is governed by British-Egyptian rule.

1955: Revolt and start of the civil war.

Independence
1956: Sudan gains independence.

1958: General Abbud leads military coup against the civilian government elected earlier in the year. The civilian government is removed.

1962: The civil war breaks out in the southern (mainly Christian/African) parts of Sudan, led by the Anya Nya movement.

October 1964: People of Sudan rebels. The military junta falls after a communist general strike. A national government is formed. The "October Revolution" overthrows Abbud and a national government is established

May 1969: the 'May Revolution' military coup places Jaafar Numeiri (also Gaafar an-Nimeiry) in power with the support of communist and socialist leaders.

1971: Leaders of the Sudanese Communist Party are executed for attempting a coup against Numeiri.

Mohammed Wardi, Nubian-Sudanese singer known as the Golden Throat, began a 2 year prison term under the authoritarian regime of Gen. Jaafar Nimeiri, who ruled Sudan from 1969-1985.[1]

1972 March 27: A peace agreement is signed in Addis Ababa ending fighting between the north and south Sudan. The southern Sudan achieves partial self-governance. Under the Addis Ababa peace agreement between the government and the Anya Nya the south becomes a self-governing region.

1973 Sep: Gen. Jaafar Nimeiri, Sudan's military ruler, introduces Islamic Sharia law.

Ingredients for war: Oil and Sharia
1978: Large findings of oil are made in Bentiu, southern Sudan by Chevron. The oil becomes an important factor in the strife between North and South.

1983: Sudan's Pres. Gaafar Numeiri brought in Sharia law as the basis for criminal law causing much grievance in the non-Muslim south. Numieri introduces the Islamic Sharia law to Sudan leading to a new breakout of the civil war in the Christian south. In the south the forces are led by the Sudan People's Liberation Movement (SPLM) under command by John Garang.

[1] http://timelinesdb.com/listevents.php?subjid=185&dayinhist=&date1=-99999999999&date2=99999999999&words=&title=Sudan&fromrec=0

1985 Jan 18 Mahmud Mohammed Taha (b.1909) was hanged for refusing to recant his unorthodox views on Islam. Sudanese president Jaafar Nimeiri, on the advice of Islamist leader Hassan al-Turabi, ordered the execution.

1985 April 4: President Numieri is removed from power in a military coup and replaced by Gen. Dahab. After widespread popular unrest Numayri is deposed by a group of officers and a Transitional Military Council is set up to rule the country.

1986: A civilian government is made in an effort to restore peace after general elections. Coalition government formed after general elections, with Sadiq al-Mahdi as prime minister.

1988: Famine in Bahr El Ghazal, southwestern Sudan, kills an estimated 250,000 people[2]

1989: The elected coalition government of Sadiq al-Mahdi is overthrown in a military coup. Omar Hassan al-Bashir and Sheik Hassan al-Turabi, brother-in-law of Sadiq el-Mahdi, seize power. They imposed an Iranian style theocracy along with the strict Muslim Shariah law on the country including the Christian southern Sudan. The National Islamic Front (NIF) overthrew a democratic government under prime minister Sadiq el-Mahdi and have ruled ever since. The Umma Party and the Democratic Union party established bases in Cairo and Eritrea and later allied with rebel groups that included the Southern People's Liberation Party. Al-Bashir and his Islamic Front (NIC) takes power in a military coup. National Salvation Revolution takes over in military coup.

1991 August 28: Bor-Dinka massacre or more than 2000 people in the southern city of Bor. Neur people massacred Dinka because of a split in the SPLA along tribal lines; Dinka fighters supporting John Garang and Neur fighters supporting Riek Machar.[3]

1992 In Kenya the Kakuma camp is founded for some 30,000 refugees from Sudan.

1993 - Revolution Command Council dissolved after Omar al-Bashir is appointed president.

1995: The Sudanese government are accused of being part of an attempt on the life of Egyptian prime minister Mubarak. UN decides on sanctions against Sudan.

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[2] Human Rights Watch http://www.hrw.org/legacy/reports/1999/sudan/SUDAWEB2.htm#P374_19682

New York Times http://www.nytimes.com/1990/02/04/weekinreview/the-world-for-the-sudan-famine-is-almost-as-certain-as-civil-war.html

[3] Sudan Tribune http://www.sudantribune.com/spip.php?article23513, BBC Journalist Personal Reflection http://83.137.212.42/siteArchive/catalystmagazine/Default.aspx.LocID-0hgnew0hu.RefLocID-0hg01b00100600g004.Lang-EN.htm, 'The lost boys of Sudan: an American story of the refugee experience', Mark Bixler p129

1998: Famine: the worst affected area was Bahr El Ghazal in southwestern Sudan. In this region over 70,000 people died during the famine.

1998: USA launches a missile attack on a chemical plant in Khartoum assumed to develop chemical weapons possibly in coorporation with the Al'Qaeeda terror network. Civilians are killed in the attack. The Sudanese government denies any link to terror and chemical weapons.

1998: A new constitution in Sudan endorsed by 96% of voters in a referendum.

1999: President Bashir dissolves the National Assembly and declares a state of emergency following a power struggle with parliamentary speaker, Hassan al-Turabi..

1999 September: Flood in Northern State Capital of Dongola[4]

1999: Sudan start an export of oil assisted by China, Canada, Sweden and other countries.

2001: An internal struggle in the government, leads to the arrest of an ideological leader who were making peace attempts with the Sudan People's Liberation Army (SPLA)

March 2001: Hunger and famine in Sudan affects 3 million people.

May 2001: A Danish pilot flying for the International Red Cross is attacked and killed when delivering aid in southern Sudan. All flights in the area are temporarily stopped.

June 2001: Peace negotiations breaks down in Nairobi, Kenya.

August 2001: The Nile river floods leaving thousands homeless in Sudan.

September 2001: the UN lifts on sanctions against Sudan to support ongoing peace negotiations.

October 2001: Following the New York terror attacks, USA puts new sanctions on Sudan due to accusations of Sudan's involvment with international terrorism.

During 2001: More than 14,550 slaves are freed after pressure from human rights groups.

<u>New hope for peace?</u>
January 2002: A ceasefire between government forces and the SPLM are finally agreed upon.

July 20th 2002: the government and SPLA signs a protocol to end the civil war.

July 27th 2002: President al-Bashir meets for the first time with SPLA leader John Garang. Ugandan president Yoweri Museveni has arranged the meeting. The war in Sudan is also having huge impact on the northen Uganda.

[4] BBC http://news.bbc.co.uk/2/hi/africa/445191.stm

July 31st 2002: Government attacks SPLA again.

October 2002: The ceasefire is confirmed again, but remains very uncertain. Pecae negations still continues during the next years.

February 2003: The 2 rebelgroups representing the African population in Darfur starts a rebellion against the government as protest against neglection and suppression.

December 2003: Progress is made in the peace negotiations. The negotiations are mainly focused on sharing the important oil-ressources.

Ethnic killings in Darfur

January 2004: Government army strikes down on uprising in Darfur region in the Western Sudan. More than 100,000 people seeks refuge in Chad.

March 2004: UN officers reports that systematic killings on villagers are taking place in Darfur. UN names Darfur as the worst humanitarian disaster currently, but nothing happens. UN fails to take action as Western countries and media has close to no focus on the problems in Sudan. But even the African leaders refuse to take action on the problem.

May 26th 2004: A historic peace agreement is signed, but the situation in Darfur remains unchanged and extremely critical.

January 9th 2005 : In Nairobi the government and rebels signs the last parts of the peace treaty for Southern Sudan. All fighting in Africa's longest civil war is expected to end in January 2005, but the peace agreement still doesn't cover the Darfur region. More than 1.5 million people lost their homes since the conflict in Darfur broke out early 2003.

March 15th 2005: United Nations Security Council agrees to send 10,000 peace keeping soldiers to Southern Sudan. Again the descision does not cover the Darfur region.

2005 July 31: Death of John Garang in a helicopter accident at age 60, while holding the post of vice-president of Sudan.

2006 May - Khartoum government and the main rebel faction in Darfur, the Sudan Liberation Movement, sign a peace accord. Two smaller rebel groups reject the deal. Fighting continues.

2006 August - Sudan rejects a UN resolution calling for a UN peacekeeping force in Darfur, saying it would compromise sovereignty.

2006 October - Jan Pronk, the UN's top official in Sudan, is expelled.

2006 November - African Union extends mandate of its peacekeeping force in Darfur for six months.

Hundreds are thought to have died in the heaviest fighting between northern Sudanese forces and their former southern rebel foes since they signed a peace deal last year. Fighting is centred on the southern town of Malakal.

2007: Violence and killings continues in the Darfur region. The conflict is in reality a genocide and is still considered the worst huminitarian disaster in the world. But not much is done about it. China has large oil interests in Africa and Sudan in particular. UN sanctions and security forces are needed, but China blocks any real decisions in the UN security council. The rest of the world is not applying the necessary political pressure on the governments in Sudan and China.

2007 May - International Criminal Court issues arrest warrants for a minister and a janjaweed militia leader suspected of Darfur war crimes.

US President George W Bush announces fresh sanctions against Sudan.

2007 July - UN Security Council approves a resolution authorising a 26,000-strong force for Darfur. Sudan says it will co-operate with the United Nations-African Union Mission in Darfur (Unamid).

2007 July and August: Flooding in south Sudan (worst in the states of Kassala, Khartoum, Northern Kordofan, Unity State, Lakes, Jonglei and Upper Nile)[5]

2007 October - SPLM temporarily suspends participation in national unity government, accusing Khartoum of failing to honour the 2005 peace deal.

2007 December - SPLM resumes participation in national unity government.

2008 January - UN takes over Darfur peace force.

Within days Sudan apologises after its troops fire on a convoy of Unamid, the UN-African Union hybrid mission.

Government planes bomb rebel positions in West Darfur, turning some areas into no-go zones for aid workers.

2008 February - Commander of the UN-African Union peacekeepers in Darfur, Balla Keita, says more troops needed urgently in west Darfur.

2008 March - Russia says it's prepared to provide some of the helicopters urgently needed by UN-African Union peacekeepers.

Tensions rise over clashes between an Arab militia and SPLM in Abyei area on north-south divide - a key sticking point in 2005 peace accord.

[5] Press release by the UN http://www.reliefweb.int/rw/rwb.nsf/db900sid/LSGZ-75TGFJ?OpenDocument

Presidents of Sudan and Chad sign accord aimed at halting five years of hostilities between their countries.

2008 April - Counting begins in national census which is seen as a vital step towards holding democratic elections after the landmark 2005 north-south peace deal.

UN humanitarian chief John Holmes says 300,000 people may have died in the five-year Darfur conflict.

2008 May - Southern defence minister Dominic Dim Deng is killed in a plane crash in the south.

Tension increases between Sudan and Chad after Darfur rebel group mounts raid on Omdurman, Khartoum's twin city across the Nile. Sudan accuses Chad of involvement and breaks off diplomatic relations.

Intense fighting breaks out between northern and southern forces in disputed oil-rich town of Abyei.

2008 June - President Bashir and southern leader Salva Kiir agree to seek international arbitration to resolve dispute over Abyei.

2008 July - The International Criminal Court's top prosecutor calls for the arrest of President Bashir for genocide, crimes against humanity and war crimes in Darfur; the appeal is the first ever request to the ICC for the arrest of a sitting head of state. Sudan rejects the indictment.

2008 September - Darfur rebels accuse government forces backed by militias of launching air and ground attacks on two towns in the region.

2008 October - Allegations that Ukrainian tanks hijacked off the coast of Somalia were bound for southern Sudan spark fears of an arms race between the North and former rebels in the South.

2008 November - President Bashir announces an immediate ceasefire in Darfur, but the region's two main rebel groups reject the move, saying they will fight on until the government agrees to share power and wealth in the region.

2008 December - The Sudanese army says it has sent more troops to the sensitive oil-rich South Kordofan state, claiming that a Darfur rebel group plans to attack the area.

2009 January - Sudanese Islamist leader Hassan al-Turabi is arrested after saying President Bashir should hand himself in to The Hague to face war crimes charges for the Darfur war.

2009 March - The International Criminal Court in The Hague issues an arrest warrant for President Omar al-Bashir on charges of war crimes and crimes against humanity in Darfur.

2009 May - An estimated 250 people in central Sudan are killed during a week of clashes between nomadic groups fighting over grazing land and cattle in the semi-arid region of Southern Kordofan. Conflict raises concern about further insecurity ahead of national elections due in 2010.

2009 June - The leader of South Sudan and vice-president of the country, Salva Kiir, warns his armed forces are being re-organised so they are prepared for any return to war with the north. His remarks follow claims, denied by the Khartoum government, that it is supplying arms to ethnic groups in the south to destabilise the region.

Sudan's presidential election, due to take place in February 2010, is postponed by two months after former rebels in the south disputed new census results.

2009 July - Arbitration court in The Hague rules on disputed Abyei region, shrinking it and placing the major Heglig oil field in the north. North and south Sudan say they accept the decision.

President Al-Bashir cancelled plans to travel to Uganda following speculation he could be arrested, according to Ugandan officials.

The trial of a Sudanese woman charged with wearing "indecent" clothing has been adjourned, but will continue after she decided to waive her immunity. A Khartoum judge told Lubna Ahmed Hussein she could have immunity because she works for the UN.

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- Politiken, April 24th 2004. Sudan articles by Peter Wulff Kåri, Jesper Strudsholm and Anders Jerichow
- BBC: Sudan timeline http://news.bbc.co.uk/2/hi/middle_east/country_profiles/827425.stm
- CIA Factbook https://www.cia.gov/library/publications/the-world-factbook/geos/su.html
- http://crawfurd.dk/africa/sudan_timeline.htm

Hazara Timeline[6]

1933-1973 Reign of Zahir Shah that represented a time of modernisation for the Hazaras. Many Hazaras migrated from rural areas to Kabul and other urban areas.

Late 1960s: The emergence of the two new political parties among Hazaras. 1) The Socialist group: The Sholai Javid (New-Democratic Party Moist group) and the People Democratic Party of Afghanistan PDPA (Khaq-o Parcham) and 2) the Sazman-e Nasr (Victory group).

Although these parties were not specific to Hazaras, the Sholai Javid (Maoist group) became a Hazara specific party among most of the less educated people because one of the founders, Akram Yari, was a Hazara from Jaghori and the leader of the party.

1978: Mohammad Daoud Khan arrives to a warm welcome in July.

1978 April: Coup installs Noor Mohammad Taraki

1978 April – 1979 September: Noor Mohammad Taraki regime

1979 April: Hazara people from Hazarajat (central highlands area) revolt against the Kabul government and shatter strategic points across Ghor, Bamyan and Urozgan

1979 late: the different groups in Hazarajat gather in Panjaw, Banyan and establish the 'Shura-i-Inqilab Itifaq Islami Afghanistan' under the leadership of Sayed Ali Behishti

1979 Autumn: the Melliat (nationality) policy program of PDPA decided to offer education in different languages such as Pashto, Farsi, Uzbaki, Trukman and Baluchi, but not Hazara.

1979 September – 1979 December: Hafizullah Amin Regime

1979 December – May 1986: Babrak Karmal Regime
Sultan Ali Keshtmand was freed from prison and appointed as the Minister of Plan, then appointed Prime Minister in 1981.

1979 Formation of the Shura-e-Itifaq Hazara political party, considered a government for the whole Hazarajat.

1980 February: the insurrection of Se-e-Hoot. Hazaras in Kabul defied the Kabul regime and demonstrated their opposition by organizing an uprising originiating from districts including Qala-e-Shada, Dasht-e-Barchi, and Afshar. The demonstrators marched toward the Soviet embassy and attacked the house of former president Hafizullah Amin and several police stations, seizing arms and

[6] Sarabi, Humayun, 'Politics and Modern History of Hazara: Sectarian Politics in Afghanistan' Masters Thesis 2005, http://fletcher.tufts.edu/research/2006/Sarabi.pdf

ammunition. As a result Azai Gard Inqilab (Members of Revolutionary Guards) arrested and shot Hazaras with approximately 1,500 Hazara fatalities.

1981 January: Conflict between Hazaras and the common Russian-Afghan troops in Bamyan

1981 The Shura-e-Itifaq drive the Russain-Afghan forces out of Hazarajat (central highlands) territory.

1982: Civil war between opposing Hazara political groups (the Sazman-e Nasr and Sepah-e Pasdaran were allied in one side and Shura and Harakat on the other side.) results in the deaths and migration to other countries of many Hazaras.

1983 late: fighting between Hazara political groups result in the deaths of approximately 1000 Hazaras.

1984 The Shura-e-Itifaq is demolished by the other Hazara groups and all its followers joint mostly the Sazman-e-Nasr and Sepah-e-Pasdaran

1986 May – 1992 Dr. Najibullah Regime

1989 February: Soviets Union withdraws troops from Afghanistan

Sunni groups set up an interim government in Rawalpindi however there is not Shi'ia involvement in the new government.

Formation of Hezb-e Wahdat brings all the Hazara Shi'ia parties (except Harakat-e Islami) united into one group.

1992: The Kabul government fail and Mujahideen take control of the country.

1992-1996: Civil war. Fighting starts between Ittihad forces (a Sunni-Pashtun party led by Abdul Rabb al Sayyaf) and the Hezb-e Wahdat forces (Abdul Ali Mazari) in west Kabul.

1993: Fighting between tribal factions leaves some 10,000 civilians dead.[7]

1993: Massacre of Afshar (district in west Kabul). Approximately 700 Hazaras massacred and many women raped under the command of President Rabbani and his defense minister Ahmad Shah Masood.

1995 March: Death of Hazara leader Abdul Ali Mazari resulting in an exodus of Hazaras from Kabul.[8]

1996: Taliban take over Kabul and the Northern Alliance are driven out leaving at least 50,000 dead.

[7] http://www.worldpress.org/specials/pp/taliban_timeline.htm

[8] http://www.afghanhindu.info/gen_art4.htm

1997 May: killings of the Taliban in Mazar-e Sharif were initiated by the Hazaras and then the population of Mazar-e-Sharif

Taliban leaving Mazar-e-Sharif killed hundreds of Hazaras in retaliation in the village of Qizil Abad, in the south of Mazar-e Sharif.

1998 February: Earthquake in the Afghanistan-Tajikistan Border Region. 2,323 people killed, 818 injured, 8,094 houses destroyed, 6,725 livestock killed and landslides in the Rostaq area.[9]

1998 May: Earthquake in the Afghanistan-Tajikistan Border Region. At least 4,000 people killed, many thousands injured and homeless in Badakhshan and Takhar Provinces.[10]

1998 June: Taliban recapture Mazar-e-Sharif massacring some 2000 Hazaras.

1998 September: Taliban capture Bamyan with few Hazara casualties.

1999 April: Hezb-e Wahdat (Northern Alliance) recapture the Bamyan.

1999 May: Taliban recapture Bamyan killing hundreds of Hazaras.

2000 May: Massacre of Hazaras at Robatak Pass (between the towns of Tashkurgan and Pul-i Khumri) by Taliban[11]

2001 January: Taliban forces recapture the Yakaolang district resulting in the deaths of around 300 Hazaras.

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[9] U.S. Geological Survey website, National Earthquake Information Center
http://earthquake.usgs.gov/regional/world/historical_country.php#afghanistan

[10] U.S. Geological Survey website, National Earthquake Information Center
http://earthquake.usgs.gov/regional/world/historical_country.php#afghanistan

[11] http://www.hrw.org/legacy/reports/2001/afghanistan/afghan101-04.htm#P176_25561

Burma History Key Dates

1852 - Britain annexes lower Burma, including Rangoon, following the second Anglo-Burmese war.

1885-86 - Britain captures Mandalay after a brief battle; Burma becomes a province of British India.

1937 - Britain separates Burma from India and makes it a crown colony.

Japanese occupation

1942 - Japan invades and occupies Burma with some help from the Japanese-trained Burma Independence Army, which later transforms itself into the Anti-Fascist People's Freedom League (AFPFL) and resists Japanese rule.

1945 - Britain liberates Burma from Japanese occupation with help from the AFPFL, led by Aung San.

1947 - Aung San and six members of his interim government assassinated by political opponents led by U Saw, a nationalist rival of Aung San's. U Nu, foreign minister in Ba Maw's government, which ruled Burma during the Japanese occupation, asked to head the AFPFL and the government.

1948 - Burma becomes independent with U Nu as prime minister.

1958-60 - Caretaker government, led by army Chief of Staff General Ne Win, formed following a split in the ruling AFPFL party.

1960 - U Nu's party faction wins decisive victory in elections, but his promotion of Buddhism as the state religion and his tolerance of separatism angers the military.

1962 - U Nu's faction ousted in military coup led by Gen Ne Win, who abolishes the federal system and inaugurates "the Burmese Way to Socialism" - nationalising the economy, forming a single-party state with the Socialist Programme Party as the sole political party, and banning independent newspapers.

1974 - New constitution comes into effect, transferring power from the armed forces to a People's Assembly headed by Ne Win and other former military leaders; body of former United Nations secretary-general U Thant returned to Burma for burial.

1975 - Opposition National Democratic Front formed by regionally-based minority groups, who mounted guerrilla insurgencies.

1981 - Ne Win relinquishes the presidency to San Yu, a retired general, but continues as chairman of the ruling Socialist Programme Party.

1982 - Law designating people of non-indigenous background as "associate citizens" in effect bars such people from public office.

1987 - Currency devaluation wipes out many people's savings and triggers anti-government riots.

1988 - Thousands of people are killed in anti-government riots. The State Law and Order Restoration Council (Slorc) is formed.

1989 - Slorc declares martial law, arrests thousands of people, including advocates of democracy and human rights, renames Burma Myanmar, with the capital, Rangoon, becoming Yangon. NLD leader Aung San Suu Kyi, the daughter of Aung San, is put under house arrest.

Thwarted elections

1990 - Opposition National League for Democracy (NLD) wins landslide victory in general election, but the result is ignored by the military.

1991 - Aung San Suu Kyi awarded Nobel Peace Prize for her commitment to peaceful change.

1992 - Than Shwe replaces Saw Maung as Slorc chairman, prime minister and defence minister. Several political prisoners freed in bid to improve Burma's international image.

1995 - Aung San Suu Kyi is released from house arrest after six years.

1996 - Aung San Suu Kyi attends first NLD congress since her release; Slorc arrests more than 200 delegates on their way to party congress.

1997 - Burma admitted to Association of South East Asian Nations (Asean); Slorc renamed State Peace and Development Council (SPDC).

1998 - 300 NLD members released from prison; ruling council refuses to comply with NLD deadline for convening of parliament; student demonstrations broken up.

1999 - Aung San Suu Kyi rejects ruling council conditions to visit her British husband, Michael Aris, who dies of cancer in UK.

2000 September - Ruling council lifts restrictions on movements of Aung San Suu Kyi and senior NLD members.

2000 October - Aung San Suu Kyi begins secret talks with ruling council.

2008: Cyclone Nargis kills around 130,000.

Karen Timeline

The Karen are the largest of the ethnic minority groups living in the mountain ranges of eastern Burma and northwestern Thailand. There are over six million Karen in Burma, and over 400,000 in Thailand, most of whom are divided into two subgroups - the Skaw (or Pgaganyaw) and the Pwo (or Plong). Karen-speaking people are spread over a large area, mainly on the Burma frontier with Thailand.[12]

1942: the Japanese invaded Burma with the help of the Burma Independence Army (BIA), who led them into the country.

1946 August: The Karen sent a Goodwill Mission to England to make the Karen case known to the British Government requesting a Karen State.

1948 January 4: Burma got its independence from the British.

1948 February 11: a peaceful demonstration by 4000,000 Karens all over the country was staged

1948 December: Karen leaders arrested in many parts of the country. General Smith Dun, General Officer Commanding (GOC) of the Burma Army (a Karen), was forced to resign. Many Karen villages were attacked and many villagers were shot, women raped, properties looted and homes burnt.

1949 January 30: Burmese Government declares the KNDO (Karen National Defence Organisation) unlawful.

1960s/1970s: A policy of "Four Cuts" was implemented to cut off supplies of foods, funds, recruits, and intelligence from opposition groups.[13]

1988 August: 8888 Popular Uprising. The uprising began with students in Rangoon on August 8, 1988. Student protests spread throughout the country resulting in hundreds of thousands of people demonstrating against the military regime. The uprising ended on September 18, after a bloody military coup by the State Law and Order Restoration Council (SLORC). Thousands of deaths have been attributed to the military during this uprising.

1994: the KNA headquarters in Manerplaw, near the Thai border, falls to the tatmadaw (Burmese Army).
A group of Buddhist soldiers in the KNLA (now known as the Democratic Karen Buddhist Army, or DKBA) went over to the side of the Burmese regime, alleging among other things Christian domination and anti-Buddhist discrimination in the KNU

[12] http://karenpeople.org/

[13] http://www.partnersworld.org.au/karen.html

Mon Key Dates

1948: The Mon National Defence Organization (MNDO) is formed as a response to what was seen as the growing threat of a Burman-dominated state established without any consideration of the rights or claims of the Mon.[14]

1974: To address some of the Mon demands a theoretically autonomous Mon State is established under the 1974 Constitution.

References

- Minorities at Risk Project, Chronology for Mons in Burma, 2004, available at: http://www.unhcr.org/refworld/docid/469f38711d.html [accessed 6 September 2009] (post-1990)
- Minorities at Risk Project, Chronology for Karens in Burma, 2004, available at: http://www.unhcr.org/refworld/docid/469f3871b.html [accessed 6 September 2009] (post-1990)

[14] http://www.unhcr.org/cgi-bin/texis/vtx/refworld/rwmain?page=search&docid=49749cdc6e&skip=0&query=mon

Sierra Leone Timeline[15]

1808 - Freetown settlement becomes crown colony.

1896 - Britain sets up a protectorate over the Freetown hinterland.

1954 - Sir Milton Margai, leader of the Sierra Leone People's Party, appointed chief minister.

1961 - Sierra Leone becomes independent on April 27.

Queen Elizabeth visits the country in November

1967 - Military coup deposes Premier Siaka Stevens' government.

1968 - Siaka Stevens returns to power at the head of a civilian government following another military coup.

1971 - Sierra Leone declared a republic, Stevens becomes executive president.

1978 - New constitution proclaims Sierra Leone a one-party state with the All People's Congress as the sole legal party.

1985 - Major-General Joseph Saidu Momoh becomes president following Stevens's retirement.

1987 - Momoh declares state of economic emergency.

1991 - Start of civil war. Former army corporal Foday Sankoh and his Revolutionary United Front (RUF) begin campaign against President Momoh, capturing towns on border with Liberia.

1991 September - New constitution providing for a multiparty system adopted.

1992 - President Joseph Momoh ousted in military coup led by Captain Valentine Strasser, apparently frustrated by failure to deal with rebels. Under international pressure, Strasser announces plans for the first multi-party elections since 1967.

1996: Flood affects 200,000.[16]

1996 January - Strasser ousted in military coup led by his defence minister, Brigadier Julius Maada Bio.

1996 - Ahmad Tejan Kabbah elected president in February, signs peace accord with Sankoh's rebels in November.

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[15] http://news.bbc.co.uk/2/hi/africa/country_profiles/1065898.stm

[16] http://www.preventionweb.net/english/countries/statistics/?cid=154

1997 - Peace deal unravels. President Kabbah deposed by army in May. Major Johnny Paul Koroma, in prison awaiting the outcome of a treason trial, leads the military junta - the Armed Forces Revolutionary Council (AFRC). Koroma suspends the constitution, bans demonstrations and abolishes political parties.

Kabbah flees to Guinea to mobilise international support.

1997 July - The Commonwealth suspends Sierra Leone.

1997 October - The UN Security Council imposes sanctions against Sierra Leone, barring the supply of arms and petroleum products. A British company, Sandline, nonetheless supplies "logistical support", including rifles, to Kabbah allies.

1998 February - Nigerian-led West African intervention force Ecomog storms Freetown and drives rebels out.

1998 March - Kabbah makes a triumphant return to Freetown amid scenes of public rejoicing.

1999 January - Rebels backing Revolutionary United Front leader Foday Sankoh seize parts of Freetown from Ecomog. After weeks of bitter fighting they are driven out, leaving behind 5,000 dead and a devastated city.

1999 May - A ceasefire is greeted with cautious optimism in Freetown amid hopes that eight years of civil war may soon be over.

1999 July - Six weeks of talks in the Togolese capital, Lome, result in a peace agreement, under which the rebels receive posts in government and assurances they will not be prosecuted for war crimes.

1999 November/December - UN troops arrive to police the peace agreement - but one rebel leader, Sam Bokari, says they are not welcome. Meanwhile, Ecomog troops are attacked outside Freetown.

2000 April/May - UN forces come under attack in the east of the country, but far worse is in store when first 50, then several hundred UN troops are abducted.

2000 May - Rebels close in on Freetown; 800 British paratroopers sent to Freetown to evacuate British citizens and to help secure the airport for UN peacekeepers

Rebel leader Foday Sankoh captured.

2000 August - Eleven British soldiers taken hostage by a renegade militia group called the West Side Boys.

2000 September - British forces mount operation to rescue remaining UK hostages.

APPENDIX TWO

MANAGEMENT OF VITAMIN D DEFICIENCY IN CHILDREN

Age	Acute	Maintenance	Monitoring
< 1 month	Vitamin D: 1000 IU (25 µg) daily for 3 months	Vitamin D: 400 IU (10 µg) daily OR 150,000 IU (3750 µg) at the start of autumn†	**1 month:** Serum calcium and alkaline phosphatase. **3 months:** Serum calcium, magnesium, phosphate, alkaline phosphatase, 25-hydroxyvitamin , parathyroid hormone. Wrist x-ray to assess healing of rickets. **Annual:** 25-hydroxyvitamin D
1-12 months	Vitamin D: 3000 IU (75 µg) daily for 3 months OR 300,000 IU (7500 µg) over 1-7 days		
>12 months	Vitamin D: 5000 IU (125 µg) daily for 3 months OR 500,000 IU (15,000 µg) over 1–7 days		

Reference: modified from Consensus Statement MJA 2006; 185 (5): 268-272
† Ergocalciferol (vitamin D2) or cholecalciferol (vitamin D3). ‡ This is high-dose vitamin D therapy (stoss therapy), and hypercalcaemia and nephrocalcinosis have been reported with such therapy in well nourished children.

APPENDIX THREE
MANAGEMENT OF VITAMIN D DEFICIENCY IN ADULTS

<table>
<tr><th>Population Group</th><th>Acute</th><th>Maintenance</th><th>Monitoring</th></tr>
<tr><td colspan="4">Initial Treatment to Normalise Levels in Vitamin D Deficiency</td></tr>
<tr><td>Non-Pregnant Adults: Severe Deficiency
(Vitamin D level = <12.5nmol/L)</td><td>100,000 IU (2500 µg) (1mL in olive oil)</td><td>Repeat treatment in 2 - 4 weeks</td><td rowspan="2">1 month: Serum calcium and alkaline phosphatase.

3 months: Serum calcium, magnesium, phosphate, alkaline phosphatase, calcidiol, parathyroid hormone. Wrist x-ray to assess healing of rickets.

Annual: Calcidiol

Levels for vitamin D normalise slowly, and shouldn't be rechecked within 3 months of dosing.</td></tr>
<tr><td>Non-Pregnant Adults: Moderate Deficiency
(Vitamin D level = 12.5 – 50 nmol/L)</td><td>100,000 IU (2500 µg) (1mL in olive oil)</td><td>Repeat dose not required</td></tr>
<tr><td>Pregnant Women: Moderate to Severe Deficiency</td><td>3000 - 5000 IU (75 – 125 µg) daily</td><td rowspan="2">See maintenance treatment protocol below</td><td rowspan="2">Stop treatment when serum 25-OHD concentration is over 50 nmol/L

Ensure regular vitamin supplementation mother is taking (ie. Elevit) doesn't contain Vitamin D, which may lead to foetal toxicity</td></tr>
<tr><td>Pregnant Women: Mild Deficiency</td><td>1000 IU (25 µg) daily</td></tr>
<tr><td colspan="4">Maintenance Treatment for Patients with Normalised Vitamin D Levels in High Risk Groups</td></tr>
<tr><td>Hijabi Women with Normalised Levels</td><td>Little sun exposure: 1000 IU (25 µg) daily

Normal sun exposure: 400 IU daily</td><td rowspan="2"></td><td rowspan="2">Levels for vitamin D normalise slowly, and shouldn't be rechecked within 3 months of dosing</td></tr>
<tr><td>Patients with Dark Skin</td><td>Winter Supplementation: 1000 (25 µg) IU daily

PLUS

Single Autumnal dose if required: 50 000 IU (1250 µg) (0.5mL in olive oil)</td></tr>
</table>

APPENDIX FOUR

CATCH UP IMMUNISATION

Adapted from Victorian Department of Human Services, "Quick Guide: Catch-up immunisation for people with no documentation of previous immunizations" *November 2010* *http://www.health.vic.gov.au/__data/assets/pdf_file/0010/240868/Quick-Guide-Nov-2010.pdf*

Under 2 years

Age at 1st visit	Doses due	INFANRIX -IPV®	HBVAX II	7vPCV Prevenar®	MMR Priorix®	Men C NeisVacC®	Hibtitre	VZV Varilrix®
12 - 14 months	Today	✓	✓	✓	✓	✓ Recommended at 12 months of age Funded if born from 1 January 2002	✓	
	1 month	✓						
	1 month	✓	✓	✓				
	2 months		✓					
	Continue vaccine schedule at 18 months of age							
15 - 17 months	Today	✓	✓	✓	✓		✓	✓ Recommended at 18 months of age
	1 month	✓	✓					
	1 month	✓		✓				
	1 month		✓					
	Continue vaccine schedule at 4 years of age							
18 - 23 months	Today	✓	✓	✓	✓			✓ Recommended at 18 months of age Funded if born from 1 May 2004
	1 month	✓	✓				✓	
	1 month	✓						
	1 month		✓					
	Continue vaccine schedule at 4 years of age							

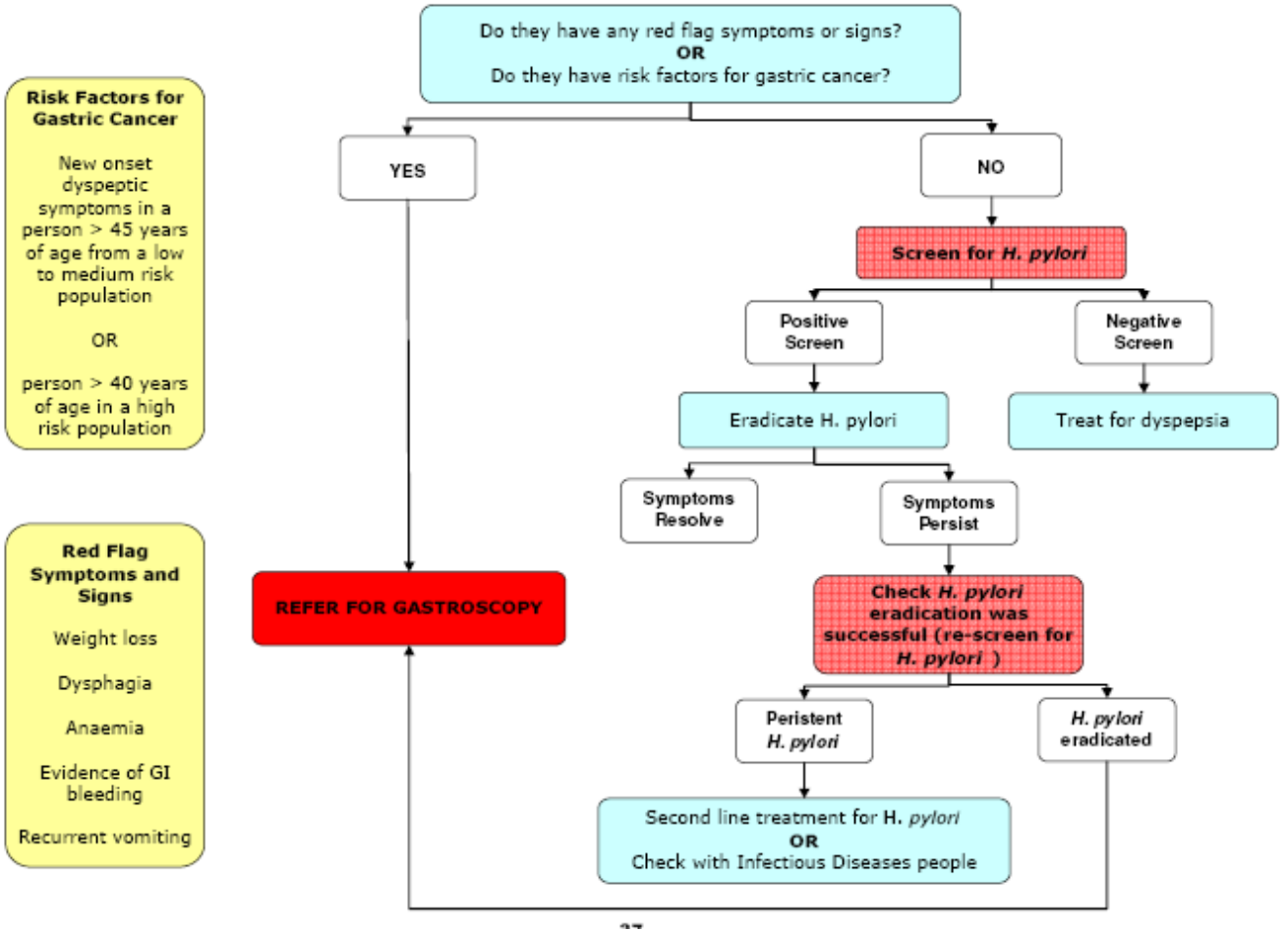
Two to Seven Years

Age at 1st visit	Doses due	INFANRIX IPV	Hiberix	MMR Priorix®	HB VAX-II	Men C NeisVacC®	VZV Varilrix®
2-3 years	Today	✓	✓	✓	✓		
	1 month	✓			✓		
	1 month	✓					
	1 month				✓		
	Continue vaccine schedule at 4 years of age						
4 years	Today	✓	✓	✓	✓		
	1 month	✓		✓	✓		
	1 month	✓					
	1 month				✓		
	5 months	✓				✓ Recommended at 12 months of age	✓ Recommended at 18 months of age
	Continue vaccine schedule at secondary school						
5 - 7 years	Today	✓		✓	✓		
	1 month	✓		✓	✓		
	1 month	✓					
	1 month				✓		
	4 month	✓					

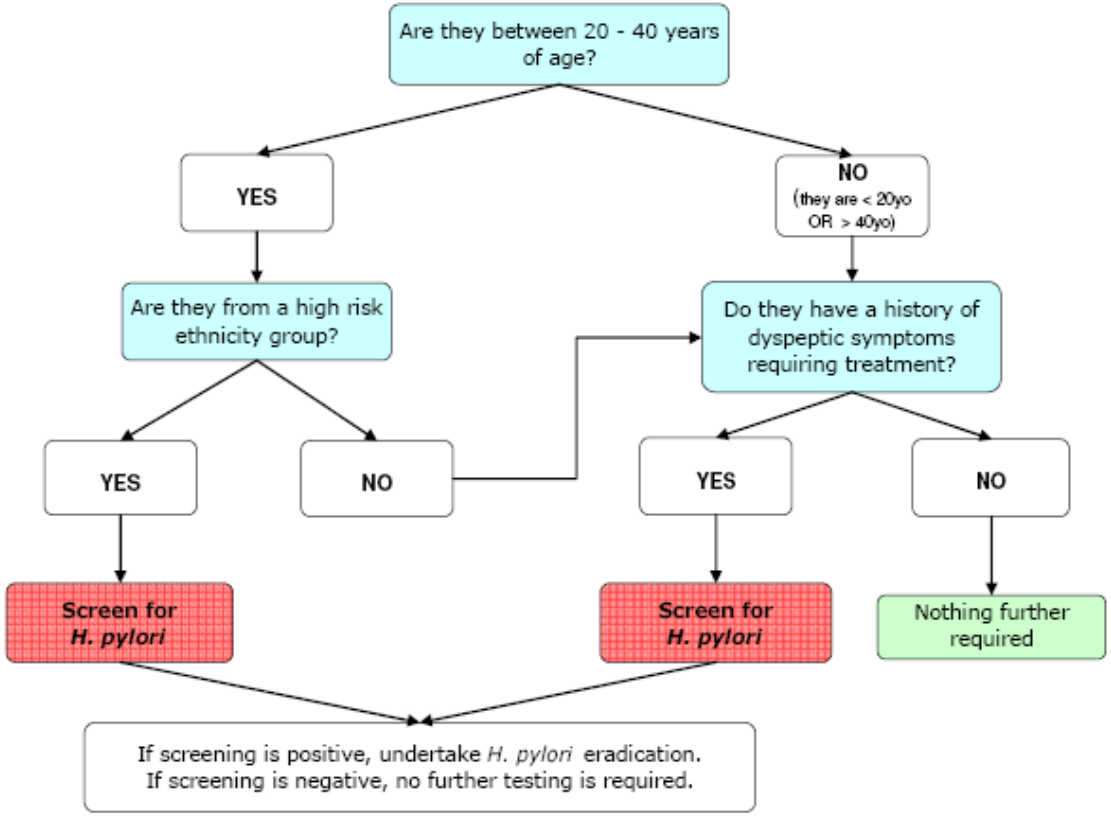
OVER EIGHT YEARS

Age at 1st visit	Doses due	MMR Priorix®	VZV Varilrix®	Hepatitis B HB VaxII®	dT ADT Booster®	dTpa Boostrix®	Polio IPOL®	Men C NeisVacC®	HPV Gardasil®
8 – 14 years	Today	✓	✓ Recommended in Year 7 of secondary school if non-immune	✓ Recommended course in Year 7 of secondary school	✓		✓	✓*	✓ 3 dose course (0,2 & 6 month) Offered to females in Year 7 of secondary school.
	1 month	✓			✓		✓		
	1 month				✓		✓		
	Continue vaccine schedule at secondary school								
15 - 18 years Vaccines funded if attending secondary school	Today	✓	✓* Confirm immunity by serology	✓ See immunisation handbook for doses		✓ Recommended in Year 10 of secondary school	✓		
	1 month	✓	✓*		✓		✓		
	1 month				✓ See immunisation handbook for further booster doses		✓		
19 years & older Vaccines recommended but not funded	Today	✓	✓* Confirm immunity by serology	✓*		✓*	✓*		
	1 month	✓	✓*	✓*	✓*		✓*		
	1 month				✓*		✓*		
	2-5 months			✓*	See immunisation handbook for further booster doses				

APPENDIX FIVE: TREATMENT OF H. PYLORI IN PATIENTS WITH CURRENT DYSPEPTIC SYMPTOMS



APPENDIX SIX: TREATMENT OF H. PYLORI IN PATIENTS WITHOUT CURRENT DYSPEPTIC SYMPTOMS



Developed by Dr Siobhan Reddell