

51. Legionnaires disease outbreak. *Commun Dis Intell* 1998;22:155

52. Meningococcal infection. Communicable Diseases Surveillance Highlights. *Commun Dis Intell* 1998;22:255.

53. Meningococcal infection. Communicable Diseases Surveillance Highlights. *Commun Dis Intell* 1999;23:194.

Preparing for refugee crises in Australia: Kosovar health surveillance

Catherine Bennett,^{1,2} Jacki Mein,¹ Mary Beers,¹ Kerry Chant,³ Subramanyam Vemulpad³

Australia provided a temporary safe haven for nearly 4,000 Kosovar refugees in response to a request for assistance from the United Nations High Commission for Refugees (UNHCR). From May 7, 1999, eleven groups of between 50 and 450 refugees arrived in Australia at 2 to 7 day intervals. The refugees were initially received at East Hills Reception Centre in Sydney for health checks and immigration formalities, then transferred to 'safe havens' across five States. By the ninth flight, 3,397 refugees had arrived. Most (59%) were between 16 and 65 years of age; specifically 62 (2%) were less than 1 year of age, 1,342 (40%) were between 1 and 15 years and 45 (1%) were older than 65 years of age. All refugees completed a questionnaire on health symptoms to identify communicable disease risks and the need for urgent medical care. Of the 3,397 people on flights 1 to 9, 97 reported a cough of more than 2 weeks duration, 68 a productive cough, 9 blood in phlegm, 26 fever, 83 night sweats, 27 diarrhoea, and 30 a rash of less than 4 days duration. A total of 543 (16%) reported an urgent need to see a doctor. Presentations at the acute care clinic were mainly for upper respiratory infections (15%),

gastrointestinal illness (13%) or ear-related problems (10%). There were no disease outbreaks in the period at East Hills.

A health surveillance system was established during Operation Safe Haven to plan health care, monitor for potential outbreaks, record health status and service use, and to meet international surveillance requirements. The system provided the necessary infrastructure to link, analyse and disseminate health data as well as other benefits, both at an operational level within health clinics and in communication among the many local, national and international collaborating agencies. However, there were delays in establishing, and difficulties in maintaining, a co-ordinated surveillance system. Health surveillance needs to be an integral part of Australian responses to refugee emergencies in line with international practice. A further intake of refugees into Australia from East Timor more recently reinforced our need for preparedness. Before the knowledge accumulated from these recent experiences is lost, guidelines should be prepared for responding to future refugee crises.

1. Master of Applied Epidemiology Program, National Centre for Epidemiology and Population Health, Australian National University, Canberra, Australian Capital Territory.
2. Hunter Public Health Unit, Wallsend, New South Wales.
3. South Western Sydney Public Health Unit, Liverpool, New South Wales.

Correction

The author list for the article 'Unusual cluster of mild invasive serogroup C meningococcal infection in a university college' published in Volume 23;10:261, should also include the following authors:

Guilietta Pontivivo and Keira Morgan, from South Eastern Sydney Public Health Unit, Zetland, New South Wales.