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The Secretary  
Joint Standing Committee on Migration  
Parliament House  
Canberra ACT

Submission No 104

Dear Madam

I am writing to make a submission to the Committee, on behalf of the Deafness Foundation (Victoria), to the current enquiry into the Immigration Treatment of Disability. Senator Boyce suggested I do this at the public hearings into the Enquiry into Hearing Health in Melbourne. I apologise for the delay in submitting this.

I enclose a copy of the submission to that enquiry and list the main points below.

1. Rubella infection when contracted during the early months of pregnancy carries a substantial risk of damage to the fetus – deafness, blindness and intellectual handicap.
2. Infection can be prevented in almost all cases by vaccination before pregnancy.
3. Government vaccination programmes are very efficient at eradicating the condition but are only well developed (if present at all) in Western (industrialised) countries.
4. Migrants from Asia and Africa have a high susceptibility to rubella infection (up to 25% compared with Australian born women of 3-5%)
5. A more proactive approach at the occasion of the immigration medical examination (counselling the prospective migrants about the value of vaccination and encouraging them to seek vaccination), would be most valuable in increasing the proportion of migrants who are protected against rubella and other vaccine preventable diseases.
6. It is our experience that the issue is not refusal to be vaccinated but lack of knowledge of the diseases and the availability of vaccines to protect against them. Almost all women to whom we have offered vaccination have accepted it.
7. Our position is very similar to the views expressed by Mr Philip Ruddock (in the context of Hepatitis B) at the hearings of the Joint Standing Committee on Migration Regulations

“...where the incidence is known to be significant... a more comprehensive medical screening process is undertaken .... and perhaps those people should be allowed migrant entry on a conditional basis if they submit to inoculation or something of that nature.”<sup>1</sup>

And the Committee itself recommended (Recommendation 12)

“...testing for Hepatitis B in particular .... be introduced for groups which in the relevant medical literature are recognised as being at high risk. On entry persons from these groups or countries of origin should be required to produce a certificate of vaccination....”<sup>2</sup>

However, as stated above, the Foundation does not believe that compulsory vaccination is required and this approach should be extended to all age-appropriate vaccine preventable diseases.

I would be most willing to expand upon this submission if the Committee requested it.

Yours sincerely

Adrian K Thomas

1. Subcommittee on Conditional Migrant Entry) Wednesday 11 March 1992 (Official Hansard Report; pages 307-308).

2. Joint Standing Committee on Migration Regulations: Conditional Migrant Entry: *the health rules*. December 1992; paras 4.65 – 4.72).

## Congenital Rubella and Hearing Health

Infection of the baby in utero in the first four months of pregnancy carries with it a significant risk of causing congenital deafness in the newborn. As well as this other major effects can occur – blindness, heart defects and intellectual disability. The earlier the infection occurs the greater the likelihood of infection in the baby and the greater are the effects on the baby such that infection in the first 2-3 months of pregnancy has an 80-90% chance of the baby being significantly affected. Australia has a link with the connection between rubella infection and fetal abnormalities as it was Sir Norman Gregg in Sydney in 1941, who first proposed the link between the two. The Deafness Foundation has had since its inception, a special interest in rubella prevention. (Downie 2006)

The significance of this condition as a cause of hearing impairment is not so much its numerical frequency but its major effects on the family of the child so affected and the cost to the community of the support for such children and adults. The condition is also readily preventable by the mother being vaccinated against the disease.

1. The incidence of Congenital Rubella Syndrome (CRS) in Australia in recent years has ranged from zero to 5 per annum (While this may seem a relatively small number it takes no account of any terminations of pregnancy for this condition and, regardless of the actual numbers, the potential impact of even one child born with CRS is huge).
2. The lifetime direct costs of a child born with CRS was calculated to be approximately \$250,000 in 1982-83 (Owens et al 1983). This takes no account of the indirect costs (institutional care, special schooling etc) nor of the emotional cost of caring for such a child). In 2009 the equivalent cost would be of the order of \$1,000,000.
3. Vaccination programs have been calculated as having a benefit/cost ratio of 12.85:1 (Owens et al 1983).
3. In recent years migrant and refugee communities especially from Asia and sub Saharan Africa have been identified as having a much greater susceptibility to rubella infection than those born in Australia or the developed world. (Francis et al 2003)
4. Communities from these countries are largely unaware of the significance of rubella infection in pregnancy. Because they tend not to engage with the local communities and because of a lack of understanding of the benefits of vaccination in general, it is very difficult to conduct public health programs directed towards these communities.
5. We believe that a more proactive approach to vaccination for prospective migrants and refugees would be very cost effective. It is our experience that these communities generally accept vaccination once the benefits are explained to them. We believe that prospective migrants/refugees to Australia, should be given, as part of the premigration medical assessment information about relevant vaccine preventable diseases, offered vaccination and be required to either (1) undergo blood testing to ascertain their immunity to the diseases or (2) formally decline to be vaccinated without prior testing. We are not suggesting that vaccination be a condition of entry, merely that they be fully informed about the benefits of vaccination and be

required to formally address the issue and make a decision as they feel appropriate. This is effectively the same situation as applies to local residents.

More can be done and should be done to help protect these communities and the Australian community at large. As noted above these programs are highly cost effective.

6. Ongoing surveillance is required to ensure that the community remains protected against rubella as immunity levels can decline with age especially when the immunity occurs as a result of vaccination.

7. Research is also required as to why some people do not respond to rubella vaccination, the effects of rubella reinfection and the risk to the fetus of reinfection in the mother during pregnancy.

#### References

1. Downie E ed. Hearing the Need: The Deafness Foundation 1974 to 2006. Deafness Foundation (Victoria) Nunawading, Victoria.
2. Australian Government. National Notifiable Disease Surveillance System 2009.
3. Owens H, Burrows C and Brown K. 1983. Prevention of congenital Rubella Syndrome. A Cost-Benefit Analysis. Economics and Health: 1984. Proceedings of the 6<sup>th</sup> Australian Conference of Health Economists.
4. Francis BH, Thomas AK, McCarty CA. The impact of rubella immunisation on the serological status of women of child bearing age: A retrospective longitudinal study in Melbourne Australia. American Journal of Public Health. 93 (8) 2003 1274-6