

# ADDRESSING REFUGEE CHILDREN'S HEALTH NEEDS: HAVE WE GOT IT RIGHT?

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In this project we collated information from three public clinics. Clinical information gathered was already collected for regular audit purposes, no new information was requested, no personal identifying information was sought. We did not apply for ethics approval.

## **Authors:**

Raman S: conceived project, provided clinical input, main author

Wood N: provided clinical input, data from clinic 1, helped with writing

Webber M: provided clinical input, data from clinic 2, helped with writing

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## **Abstract:**

**Introduction:** Refugee children are known to be at risk of poor health outcomes, poor immunisation status, and limited access to healthcare. Of the 13,000 refugees accepted to settle each year in Australia, 50% are children and youth. Our objectives were to document the health needs of refugee children accessing comprehensive refugee health services in New South Wales (NSW), and match needs with available services.

**Methods:** We gathered clinical data on all children <14 years attending refugee specific clinics in NSW in 2005. We compared these data to the number of refugee children settling in NSW in 2005.

**Results:** NSW received 1557 refugee children (< 14 years) in 2005. Around one in five (n=331) was seen in three refugee specific clinics, most were asymptomatic. Of those tested, 25% had anaemia, 27% were serology positive for schistosomiasis, 16% had evidence of current or recent malaria, 25% were Mantoux positive, 69% were hepatitis B non immune and 20% had low vitamin D levels. Most children needed catch up immunisation. Other problems included chronic health, developmental and behavioural problems. Screening tests varied across sites. Follow up was not possible for most.

**Conclusions:** Refugee children arriving in NSW have significant health needs. Only a small proportion of refugee children have access to comprehensive screening and assessment, and follow up remains poor. Most children are asymptomatic; however there is a high pick up rate for diseases of personal and, at times, public health significance. Most of the identified health issues can be prevented or treated effectively.

## **Introduction**

Children and young people make up a significant proportion of the refugee population and are arguably the most vulnerable. Several national and international studies have documented the physical, social and psychological health problems in refugee children and young people; these include high rates of preventable conditions.<sup>1,2,3</sup> These problems are as the result of and compounded by poverty, civil strife, poor infrastructure and poor access to services. Refugee children's health needs are often complex and unfamiliar to Australian clinicians.

Australia is one of the 71 countries that accept refugees and asylum seekers; in 2004 the annual quota of new places for refugees increased to 13 000.<sup>4</sup> New South Wales (NSW) gets about 40% of the intake, a majority settle in metropolitan Sydney. The regional focus of the humanitarian resettlement program has changed over the last few decades; so that the focus has shifted from South East Asia and Europe in the 1980s and 1990s, to the Middle East and Africa.<sup>5</sup> In 2005, 70% of new refugees came from African countries.

Despite complex health needs in refugee children and young people, service delivery in Australia is fragmented and there are many barriers to providing the most effective health care.<sup>2,6</sup> Refugee specific services have been set up in NSW in the past few years to respond to the specific health needs of refugees. Of these, the NSW Refugee Health Service (RHS) run general practice clinics in greater Western Sydney. The Newcastle Refugee Health Service clinic was set up in 2004 to comprehensively screen and treat refugee families in the Hunter region and a specialised refugee children's clinic based at The Children's Hospital at Westmead called Health Assessment for Refugee Kids (HARK) commenced in May 2005. These services have different models of care, different staffing and resources available.

Our aims were to identify the number of refugee children accessing specific refugee health services through the three main clinics (HARK, RHS and Newcastle) in NSW in 2005. We wanted to determine their health needs when assessed and to compare the number of refugee children who had been comprehensively assessed with the total number of newly arrived refugee children in that year.

## **Methods**

We gathered data on all children under 14 years attending the three refugee clinics specific in NSW in 2005. Information sought was on clinical and treatment outcomes. We compared the number of children seen to the number of recently arrived refugee children in NSW in 2005 (information provided by the Department of Immigration).

## **Results**

In 2005 NSW received 1557 refugee children (< 14 years). Through 2005, a total of 331 children <14 years attended refugee specific clinics. Mean age of the children seen was 7.5 years, 52% were male. Region of origin was 99% from African countries in the Newcastle clinic, 86% from African countries in the

HARK clinic, and from mixed African/middle eastern region in the RHS clinic. Most children seen in these clinics were asymptomatic.

Table 1 shows the percentage of children seen in the three clinics who received routine screening tests. Tests varied across sites. Table 2 shows the percentage of children screened, who had positive test results. None of the children tested were positive for human immunodeficiency virus (HIV) or Syphilis. Mantoux screening was performed only at the HARK clinic, 25% of children tested had a positive result greater than 10mm in diameter. Chest X-rays on all positive Mantoux results revealed five children with tuberculosis all of whom were referred to the chest clinic for observed treatment. Other clinical problems documented included haematological, skin lesions, cutaneous Leishmaniasis, nocturnal enuresis, dental caries, dental abscess, hearing deficit, developmental delay, growth problems, emotional/ behavioural, school and settling issues. Management ranged from therapy for malaria, schistosomiasis, tuberculosis, fungal infections, gastroenterological parasites, iron deficiency, Vitamin D deficiency and providing catch up immunisation. Follow up information was not available for most children.

## **Discussion**

Several studies have documented the significant health needs of refugee children.<sup>1,2,3</sup> Our study, in keeping with national and international studies, confirms that newly arriving refugee children have significant health needs. These include diseases of public health significance such as tuberculosis, malaria, schistosomiasis and under immunisation. Our study is the first to attempt to quantify the number of refugee children comprehensively assessed in a population. Given that NSW received over 1500 refugee children in 2005, about a fifth of this population were comprehensively assessed within existing resources.

The three sites providing refugee specific services in NSW varied widely in the screening procedures; models of assessment and care also varied. Some of the variation is likely to be explained by the population attending these services; those attending HARK and Newcastle clinics were predominantly of African background, while the population attending RHS clinics were mixed Middle Eastern and African background. Other reasons include lack of easy access to services such as Mantoux testing and lack of consensus guidelines for assessment of refugees. Barriers to access to appropriate care for refugee populations have been described and include parents putting a low priority for health in favour of settling children in education, language and cultural difficulties, transport problems, the diversity of options and lack of co-ordination between services.<sup>78</sup> From our study a further barrier to appropriate assessment could be distance from or poor access to, a refugee specific service.

The recently released Royal Australasian College of Physicians policy statement on the health of refugee children and young people strongly advocates for publicly funded comprehensive health assessment for all refugee children arriving in Australia.<sup>9</sup> We know that pre-departure screening of refugees is inconsistent and variable; children under 11 years of age are not screened at all.<sup>3,10</sup> Investing in children's health has been shown to produce sound economic benefits,<sup>11</sup> and there is good evidence that preventive

immunisation represents a cost saving to the health service in Australia.<sup>12</sup> Of the one in five refugee children seen in the refugee specific clinics in NSW in our study, most were asymptomatic. In spite of this, there was significant pick up of diseases of personal and public health significance. Many of the health problems identified were easily treated. Our study adds further weight to the urgent calls for targeted comprehensive health assessment and screening for refugee children and young people.

We limited our collation of clinical data to 2005, as that was the year that African intake peaked in NSW. The HARK Clinic only became fully operational in May 2005, so potentially 30 more children could have been assessed through that clinic. Two other small refugee specific services have since been set up, one in Coffs Harbour, one in Wollongong (personal communication M Smith). Even with these enhancements, the services are well short of being able to provide coverage for the current refugee intake. It is likely that some or many of the refugee children may have been seen by general practitioners (GP), some refugee youth would have had limited screening and immunisation provided through their high schools. A study of refugee young people attending special English classes in western Sydney, found that although 40% had their own GP most needed catch up immunisation suggesting that general practice was not the ideal location for preventive healthcare.<sup>13</sup>

## **Conclusions**

Australia's newly arriving refugee children and young people have significant health needs. Most of the identified health issues can be prevented or treated effectively. There is a major gap in service provision, with current capacity of healthcare inadequate to service needs. There is a strong moral and public health imperative to provide appropriately resourced, culturally competent and comprehensive healthcare to optimise these children's wellbeing.

**Table 1: Percentage of refugee children <14 years seen in Refugee Clinics in NSW who received routine tests in 2005**

<b>Tests</b>	<b>NSW RHS Clinic (N=122)</b>	<b>Newcastle Refugee Clinic (N=103)</b>	<b>HARK Clinic* (N=106)</b>
<b>Full Blood Count</b>	46%	90%	96%
<b>Ferritin Levels</b>	0%	0%	87%
<b>Schistosomiasis IgG</b>	44%	87%	91%
<b>Hepatitis B Screen</b>	49%	86%	95%
<b>Malaria Screen</b>	27%	71%	91%
<b>Measles/Rubella Screen</b>	26%	0%	0%
<b>Vitamin D Levels</b>	34%	0%	93%
<b>Parathyroid Hormone</b>	0%	0%	93%
<b>Mantoux</b>	0%	0%	92%
<b>HIV</b>	0%	59%	91%
<b>Syphilis</b>	4%	13%	81%

\* Data from HARK is only over an 8 month period as the clinic was established in May 2005

**Table 2: Percentage of refugee children screened in 2005 with significant results**

<b>Tests</b>	<b>NSW RHS Clinic %</b>	<b>Newcastle Refugee Clinic %</b>	<b>HARK Clinic* %</b>
<b>FBC (anaemic)</b>	21	28	25
<b>Schistosomiasis pos</b>	22	36	24
<b>Hep B Non Immune</b>	55	70	81
<b>Malaria</b>	15	23	9
<b>Measles/Rubella Non Immune</b>	19	none tested	none tested
<b>Low Vitamin D Levels</b>	10	none tested	30
<b>Mantoux &gt;10mm</b>	none tested	none tested	25
<b>CXR pos TB</b>	none tested	none tested	21
<b>Low Ferritin</b>	none tested	none tested	15

\* Data from HARK is only over an 8 month period as the clinic was established in May 2005

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