Current Paediatrics (2005) **15**, 339–346

Current
PAEDIATRICS

www.elsevier.com/locate/cupe

The needs of children newly arrived from abroad

Elspeth Webb[a,b,*], Amanda D. Ryan[c], Bernadette A.M. O'Hare[d,e]

[a]*Department of Child Health, Cardiff University, Cardiff, UK*
[b]*Department of Child Health, Cardiff and Vale NHS Trust, Children's Centre, St. David's Hospital, Cowbridge Road, Canton, Cardiff CF11 9XB, UK*
[c]*Cardiff Health Access Team, Lansdowne Hospital, Canton, Cardiff CF11 8PL, UK*
[d]*Department of Child Health, University Hospital of Wales, Cardiff, UK*
[e]*Child Advocacy International, 29 Grove Place, Penarth, Vale of Glamorgan, CF64 2LB, UK*

KEYWORDS
Children;
Migrants;
Health care;
Infections;
Accidents;
Trafficking

Summary The population of children newly arrived from abroad is highly heterogeneous; their health-care needs reflect this heterogeneity, requiring broad and flexible responses from paediatricians and their colleagues. This review will explore the factors leading to children arriving in the UK as new migrants, including pull and push migration. Specific health issues as they relate to migrant children in general are discussed. These are: immunisation and child surveillance, the screening and treatment of infections and infectious diseases, child protection and accident prevention. The review also considers the risks facing certain vulnerable groups of children who make up a part of the larger migrant community, describes their needs and explores how these needs might be met. These groups are: the children of asylum seekers and refugees, trafficked or smuggled children, children with disabilities, Roma children from Eastern Europe and internationally adopted children.

Introduction

The population of children newly arrived from abroad is a highly heterogeneous one in terms of ethnic group, social and educational status, languages spoken, factors prompting migration, previous health status and health-care needs following migration. Not surprisingly, therefore, the responses of institutions and individuals charged to provide health care to these children must be equally diverse and flexible.

In this review, as well as describing the factors that result in migration, we will:

(1) Explore specific health issues as they relate to migrant children in general, including:
- Immunisation and child surveillance
- Screening for infections and infectious diseases
- Child protection
- Accident prevention

*Corresponding author. Department of Child Health, University of Wales College of Medicine, Heath Park, Cardiff CF144XN, UK. Tel.: +029 20536795.
E-mail address: webbev@cf.ac.uk (E. Webb).

0957-5839/$ - see front matter © 2005 Elsevier Ltd. All rights reserved.
doi:10.1016/j.cupe.2005.04.005

(2) Discuss the needs of certain vulnerable groups of children. These are:
- The children of asylum seekers and refugees
- Trafficked children
- Children with disabilities
- Children from Roma families fleeing persecution in Eastern Europe
- Internationally adopted children.

Reasons for migration

People move between countries because they are pushed, pulled, or both—the so-called 'push' and 'pull' factors in migration.[1]

Pull Factors: In Britain pull factors such as shortages in the labour market, positive recruitment in consequence of these and chain migrations due to kin-networks have been important in migration, mainly from the New Commonwealth, but latterly including many other areas such as the Philippines and parts of former Eastern Europe and the USSR. Such migrants are attracted by the possibility of a more prosperous life style and the perception of better opportunities, education and welfare services for their children.

Push Factors: Pushed migration results when people arrive following evacuation from their country of origin. The main factors in this pattern of migration are armed conflict, political persecution and forced expulsion. War has consequences that themselves become push factors, for example, famine, loss of infrastructure with coincident loss of medical services and extreme poverty. Unfair trading rules and large debts have contributed to this poverty.[2]

Push and pull factors can occur together. The civil war in Somalia forced many to flee their country. Within these refugee groups were people with extended family in Liverpool and Cardiff, members of long-standing communities, legacies of the maritime role of these cities. Thus 'pull' chain migrations of Somali fleeing armed conflict occurred to both cities.

The reasons for migration (pull and/or push) together with the patterns of migration have important implications for service needs. Different groups may have specific and unique health needs; even where needs are similar the response strategies for meeting them may differ markedly from group to group.

Access to services

Children arriving from abroad are usually members of minority ethnic communities. These communities, even when well established, do not have equality of access to health services in this country; the reasons for this have been explored in a recent review[3] and will not be further discussed here. Access difficulties are compounded when families newly arriving have no knowledge or understanding of how health and welfare systems operate or what their entitlements to services are. Given this, providers cannot wait for families to present with problems, but need to have systems designed to seek out those children who are in need.

Specific health issues as they relate to migrant children

Immunisation and child surveillance

Immunisation and child surveillance programmes vary from country to country. Children may arrive with incomplete immunisation schedules, an unknown immunisation history, or with no immunisations or screening having previously occurred; the latter situation is more likely in children arriving from countries with either no or very little health infrastructure as a consequence of extreme poverty, war, or both. Catch-up immunisation is recommended by the Department of Health and a schedule advising how to do this is provided by the UK Health Protection Agency.[4]

Health for All Children[5] provides evidence-based recommendations on child health surveillance and health promotion. It would seem reasonable to ensure that children arriving from countries without a comprehensive surveillance programme should have access to a catch-up health review that allows screening for common developmental problems, congenital abnormalities and parental access to age appropriate health promotion advice. The Royal College of Paediatrics and Child Health (RCPCH) advises this for all newly arrived refugees,[6] but children arriving not as refugees but from resource-poor countries have similar immunisation and surveillance needs. Screening for genetic disorders, such as the haemoglobinopathies or G6PD deficiency, must be considered in high-risk populations.

Rarely, children may have been exposed to environmental toxins in their country of origin, or to cultural practices that inadvertently cause harm to children, e.g. the application of lead-containing kohl, a mascara preparation. Clinicians need to be alert to these possibilities and respond appropriately.

Without a system in place to identify newly arrived children, children in need of catch-up immunisation and surveillance will be missed, with consequences for public health and for their own health, welfare and education. All Primary Care Trusts or their equivalents should implement procedures to identify such children. Health visitors, school nurses and schools are key players in this.