Medical and social issues of child refugees in Europe

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ABSTRACT

In mid-2015, there were an estimated 20.2 million refugees in the world; over half of them are children. Globally, this is the highest number of refugees moving across borders in 20 years. The rights of refugee children to access healthcare and be free from arbitrary detention are enshrined in law. Unaccompanied asylum-seeking children have a statutory medical assessment, but refugee children arriving with their families do not. Paediatricians assessing both unaccompanied and accompanied refugee children must be alert to the possibilities of nutritional deficiencies, infectious diseases, dental caries and mental health disorders and be aware of the national and international health guidance available for support.

BACKGROUND

The 2014–2015 European 'migrant crisis' has been widely covered in the news, with harrowing pictures of desperate families at borders and in makeshift camps and reports of children drowned permeating international consciousness. In mid-2015, there were an estimated 20.2 million refugees in the world.[1] Globally, this is the highest number of refugees moving across borders in 20 years.

The term 'refugees of concern' covers refugees outside their country of origin, stateless persons, refugees returning home and those seeking asylum. Last year, there were 4.1 million refugees of concern living in Sub-Saharan Africa, 3.8 million in Asia and the Pacific, 3.5 million in Europe, 3 million in the Middle East and North Africa and 753 000 in the Americas. There were a further 38 million internally displaced persons in 2014: people who have been displaced from their homes by conflict or persecution but remain within the borders of their home state.[2] In 2014, on average, 30 000 people per day were forcibly displaced within their own country. Globally, more than half of those who have been forcibly displaced are children, some of whom have become separated from their families during their flight.[3]

LANGUAGE MATTERS

The terms 'migrant', 'refugee' and 'asylum seeker' are often used interchangeably and incorrectly.

Refugees are persons outside their home country as the result of a 'well-founded fear of being persecuted' or in flight from the threat of armed conflict.

An asylum seeker is a person who has arrived in another country and sought protection but who has not (yet) been recognised as a refugee.

Migrants are people and families who move within or beyond national borders, usually with sociocultural, educational or economic motives, rather than being forcibly uprooted.

United Nations High Commissioner for Refugees (UNHCR) data up to 1 January 2016 show that the overwhelming majority of people reaching Europe by sea were from Syria (43%), Afghanistan (23%) and Iraq (14%)—all countries with well-documented ongoing conflicts.[4] To term the current crisis a 'migrant crisis' rather than a 'refugee crisis' is inaccurate. Data show that incoming population (migrant and refugee) to the European mainland has remained remarkably steady—at around 2.5 million a year since 2008; the proportion of refugees within this has also remained stable and marginally falling between 2008 and 2014.[5]

The distinction between refugee and migrant is, in any case, increasingly blurred—in particular where migrating individuals and groups are fleeing from conditions of poverty so severe that they effectively mimic persecution and violence in the impact they have on basic human rights. What is clear is that international population movement—whether of refugees or migrants—is likely to be the part of the new global normal; and that finding ways to engage humanely with arriving families and children is a challenge for the UK and other high-income countries.

AN OVERVIEW OF THE UK

In 2015, the UK received some 38 878 asylum applications. This compares with 159 000 claims made in Germany, 100 000 in the Russian Federation and 65 400 in Hungary. The UK is ranked 7th among European states received asylum seekers.[6] Meanwhile, between 2014 and 2015, our refusal rate for those seeking asylum protection rose from 54% to 61% of claims.[7]

Only a very small proportion of child refugees reach our shores. In 2015, there were 3043 unaccompanied children seeking asylum (UASC) in the UK. Ninety-three per cent of these were male, with the highest numbers coming from Afghanistan, Eritrea, Albania and Iran. There were an additional 766 age-disputed cases. In 2013, there was a 70% refusal rate once unaccompanied children reached the age of 18. In 2014, there were 7427 children whose applications for asylum were as part of a family unit; 4522 boys and 2905 girls. In 2015, 128 children were placed in detention in the UK solely for immigration reasons, of whom 38 were under the age of 5.[8] While the government announced the aim of ending detention of children in May 2010, families with children can still be held in secure 'pre-departure' accommodation and may also be held in short-term holding facilities at ports. It is notable that the Australian Human Rights Commission described multiple breaches of child human rights in Australia pertaining to the

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implementation of legislation permitting compulsory detention of all asylum seekers.

The government has promised to resettle 20 000 Syrian refugees from camps neighbouring that country into the UK by 2020. These are individuals whose need for protection has already been established by the UNHCR rather than subsequently being assessed upon arrival in the UK and are planned in addition to 'normal' asylum requests over the period. The UK has recently acceded—under substantial duress—to a commitment to accept up to 3000 unaccompanied child refugees from the European mainland (though at the time of writing, the details of the commitment remain to be confirmed).

THE RIGHT TO HEALTH AND SAFEGUARDING

The 1948 Universal Declaration of Human Rights calls for all people, including refugees, to enjoy the right to a standard of living adequate for health and well-being.[9]

The 1951 Geneva Convention Relating to the Status of Refugees: countries are obligated to give protection to individuals who are persecuted and to ensure that asylum seekers are not sent back to a country where their lives may be in danger (*non-refoulement*).[10]

Article 22 of the UN Convention on the Rights of the Child asserts that child refugees should have access to health services equivalent to that of the local population in the new host country.[11]

Article 37 states further that: 'No child shall be deprived of his or her liberty unlawfully or arbitrarily'. The UNHCR guidance on detaining refugees and asylum seekers asserts that children should 'in principle not be detained at all'.

CHILDREN IN CAMPS

Exposures to conflict, organised violence or natural disaster result in immediate losses to children's health and access to healthcare, as local health workers are killed or themselves flee, health facilities cease to function, nutritious food, clean water and shelter become less available and safe spaces diminish. Processes of displacement—often in the midst of violence or under direct threat—are frequently traumatic. Children arrive in refugee camps often in parlous conditions of physical and mental health.

Although healthcare within camps can address some of the health issues of arriving refugees through routine immunisation campaigns, nutrition and micronutrient supplements and basic medical care (following Integrated Management Childhood Illness protocols), children are especially at risk of morbidity and mortality from conditions of crowding and suboptimal sanitation which facilitate exposure to infectious diseases like measles and malaria, to diarrhoeal disease and respiratory tract infections, and to undernutrition. Comprehensive data on child health in refugee camps are generally weak, but UNHCR refugee programmes record an under-5 mortality rate of under 1.5 deaths per 1000 per month; 41% of camps assessed report rates of global acute malnutrition among refugees higher than 10%, and all camps reported childhood anaemia higher than 20%.[12 13]

Control programmes for tuberculosis (TB), as well as for HIV are often disrupted in conflict zones. Data show a high TB burden in refugee camps.[14] Although in 2012, 93% of refugees had access to antiretroviral (ART) medication at the same level as the host population, ensuring adequate provision of ARTs, prioritisation of maternal to child transmission of HIV and efforts to address heightened exposure to sexual violence, particularly for women and girls, should be more strongly prioritised in refugee camp situations.

Poor mental health among refugees is now widely documented, but generally still poorly addressed. A study on the effects of war trauma on Cambodian adolescents in a refugee camp showed 54% of the 182 12-year-olds and 13-year-olds questioned had significant problems with somatic illness, depression, attention problems, social withdrawal and anxiety.[15] The dose–response relationship between exposure to violence and subsequent psychosocial distress was marked. More widely, symptoms associated with post-traumatic stress disorder and depression have been noted in 35–64% of post-conflict surveys in East Timor and Kosovo. The mental health impact of conflict on children is noted as a global public health issue.[16]

HEALTH AND SOCIAL PATHWAYS OF CHILD ASYLUM SEEKER INTO THE UK

Once an unaccompanied asylum-seeking child (UASC) is made known to social care in the UK, an age assessment is carried out and social services of the local authority conduct a preliminary assessment. A medical assessment is subsequently carried out, usually by designated 'looked-after children' teams with variable levels of experience in dealing with the specific health needs of UASC. If under 16, the child is usually placed in foster care. If 16 or 17, they are placed in 'supervised accommodation' with varying levels of support. Independent living is currently reported to be 150% oversubscribed. Some will be granted refugee status when their asylum cases are heard and will have the right to remain in the UK up to age 18. Most children are given UASC 'leave to remain' until 17 and a half years of age and need to reapply for leave to remain at this time, which may not be granted. If rejected, their right to claim welfare support is removed, they forfeit rights of access to basic services, including health and education, and they are returned voluntarily or involuntarily to their country of origin.

Support for accompanied asylum-seeking children is equally problematic, their families having to negotiate the complexities of the UK immigration system. Where a family's asylum claim is rejected, the trauma of forced deportation is prefaced by the gruelling challenge of feeding and clothing their children with no access to welfare benefits compounded by ineligibility to work. Children arriving with family seeking asylum should, ideally, have access to a general practitioner who can carry out a holistic medical assessment or refer to a paediatrician where necessary. Unlike the unaccompanied child asylum seeker, no pathway for such statutory medical assessment is currently in place.

Even where paediatricians assessing the needs of accompanied asylum-seeking children consider them to be 'children in need', there is no statutory recourse to social care support. It is only when such children can be classed as 'at risk of significant harm' that the social care system recognises responsibility.

WHAT DO WE KNOW ABOUT REFUGEE CHILD HEALTH IN HIGH-INCOME SETTINGS?

Children arriving in high-income countries like the UK are liable to present with a combination of physical and psychological issues originating in trauma, exposure and inadequate access to basic rights, including care in their home country and through often long and arduous journeys before reaching us.

Mental health and emotional well-being are key. Increased levels of depression, anxiety disorders and post-traumatic stress

in refugee children are well described in the literature.[17–19] In one study of 101 refugee children in Oxford, more than a quarter of refugee children had significant psychological disturbance; three times the national average.[20] Emotional difficulties were particularly noted. A Swedish study of Iranian child refugees showed that war and violence were the main risk factors for post-traumatic stress disorder but that maternal emotional well-being was significantly protective of children's well-being.[21] An Australian study described a lack of healthcare workers' understanding of the complex health needs of child refugees combined with cultural, financial and language barriers limiting access to healthcare.[22] In the UK, in a cohort of 75 UASC presenting to a single paediatric clinic in Kent, mental health was of concern to the clinician in 92% of cases. Dental decay was evident in 65% and abnormal physical findings in 76% of children. In all cases, immunisation was deemed incomplete; it was not always clear whether this was due to a lack of immunisation, a lack of documentation or (most likely) a combination of the two.[23] A systematic review of 34 studies showed that native born and refugee young people had comparable secondary school outcomes.[24]

Much of the data on the health of resettled refugee children come from Western Australia. A study of 1026 children described 90% referral rates to a multidisciplinary refugee child health service following initial post-settlement health assessments.[25] The median age of this cohort was 7.8 years; 39% had vitamin D deficiency, 22% had iron deficiency, 21% had positive *Helicobacter pylori* serology, 18% had poor appetite, 17% had schistosomiasis, 29% had tinea corporis or capitis and 22% had dental problems. Another survey of 332 refugee children demonstrated a significant association between a history of compulsory detention and familial separation with post-traumatic stress disorder.[26] A dental study described caries in 65 of the 105 refugee children assessed.[27] Many papers describe resilience in refugee children and families,[28] often linked to close and supportive family relationships. These studies demonstrate a range of medical, dental and psychological issues in refugee children and thus show the need for holistic and sensitive healthcare provision.

CASE HISTORY

A 14-year-old boy was seen in clinic 4 months after arrival in the UK. He had been brought to the emergency department by his foster carer who was concerned about a 4-week history of cough, anorexia and weight loss. He was seen by his general practitioner (GP) and sent straight into the hospital for paediatric evaluation. His chest examination was abnormal and his radiograph showed left hilar consolidation. A tuberculin skin test was strongly positive at 28 mm (the threshold for positivity at the time of presentation was 15 mm, now 5 mm—National Institute for Health and Care Excellence (NICE) guidance). His sputum was smear negative but culture positive for fully sensitive *Mycobacterium tuberculosis*.

He had travelled alone from Afghanistan, having fled after his father was killed by the Taliban. He reported walking from Afghanistan, through Iran and Turkey into Europe. The journey took 4 months. He denied any known TB contacts and stated he had not been subject to violence or imprisonment himself. He had been diagnosed with hepatitis in Afghanistan 3 weeks prior to departure and was started on tablet medication but was unsure which. He stopped the medication upon fleeing Afghanistan. His hepatitis B viral load at presentation at hospital was 200 million copies per mL of blood, and he was profoundly vitamin D deficient.

At the time of writing, he continued to improve clinically with good adherence to antituberculous treatment. His hepatitis B viral load has remained high and his vitamin D levels have improved following treatment. The whole household has been vaccinated against hepatitis B. His foster brother was screened for TB and was tuberculin skin test positive but asymptomatic and has since been treated for latent TB infection. He has settled well with his foster carer, is learning English rapidly and is doing well at school. He plans to study medicine.

This young man has responded well to hospital medical treatment and being in a highly supportive foster care environment. He had a looked-after child medical assessment by community paediatric services but the need for TB screening had not been considered. The GP had been proactive in arranging for catch-up vaccinations. Had he been referred early for TB screening instead of reactively when he became unwell, he could have been proactively treated for latent TB infection, saving him from becoming unwell, possibly having inadvertently infecting his foster brother and necessitating a longer and more complex course of treatment. This case also illustrates ethical problems around consent and information sharing for UASC. As in this case, many are Gillick competent to consent to screening for TB and bloodborne viruses. Social care institutions have parental responsibility and thus should be informed about test results. It is important to minimise information sharing around stigmatising infectious diseases, but there is a clear need for foster carers to be sensitively made aware of the health problems of the young people in their care.

GUIDANCE FOR CLINICIANS

Any clinician undertaking an initial assessment of a refugee child should undertake a holistic, sensitive history and examination. Guidance is provided by the Royal College of Paediatrics and Child Health as well as other evidence-based international screening guidelines.[29–32] Given the evidence presented above, the examination should pay particular attention to nutritional status, dental health, signs of vitamin deficiency, scabies, fungal skin and lice infestations. Injuries should be carefully documented on a body map. A full sexual health review should be undertaken where appropriate, bearing in mind that some asylum-seeking children will have been subject to sexual violence and forms of torture either before, during or after their flight. Sensitive inquiry about female genital mutilation should be undertaken, bearing in mind mandatory reporting requirements.

Any assessment of age undertaken by a paediatrician should only be after full consent has been given by the young person. There is a wide margin of error for age assessments of children. Dental assessments are considered to have a 2-year margin of error and the British Dental Association has issued a clear warning to state it does not support dental radiographs being taken for the sole purpose of age assessments. Wrist radiographs for bone age should only be used if there is clinical need. There is a need for a multidisciplinary, multiagency approach to age assessments.

Given the high prevalence of TB and bloodborne viruses in certain countries, appropriate referral should be made to an infectious diseases paediatrician. It should be noted that given the high prevalence of TB in their countries of origin, all children and young people from Afghanistan and Eritrea should be referred for screening. In the absence of a reliable vaccine history, children should be assumed to be unimmunised and a full immunisation course should be undertaken in the shortest possible time frame. Mental health and emotional difficulties may be screened for through use of the 'strengths and

difficulties' tool. Follow-up for these children will vary according to problems found on assessment.

CONCLUSION

The political debate around migrants and refugees—and the UK's appropriate response and role—will likely continue to rage. In the meantime, asylum-seeking children, in refugee camps, in transit across harsh regions, on the European mainland and here in the UK, are exposed to unacceptable levels of physical and psychological harm.

The rights of refugee and asylum-seeking children are enshrined in law. Clinicians have a dual role—in providing care for these children and advocating for adequate care to be made mandatory. Clinicians assessing refugee children should be alert in particular to the high rates of emotional difficulties, inadequate immunisation, exposure to infectious diseases in this population as well as being aware of potential language, cultural and systemic barriers that may prevent children and their families from accessing care. Paediatricians should act as vocal advocates for this vulnerable group: children are children, not aliens nor criminals, and their best interests should *always* be paramount.

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