CHILD HEALTH OF REFUGEES IN AUSTRALIA

The treatment of refugees and asylum seekers remains a divisive issue in our nation. The incendiary political debate surrounding this matter diminishes the importance of the wellbeing and worth of each individual refugee. This essay will reflect upon the biblical and historical origins of our identity and how we are called to respond to the specific health needs of refugees in Australia, with a particular focus on child health.

OUR IDENTITY IN CHRIST

The Lord is sovereign and His purposes and plans will prevail (Psalm 33:10-11, Isaiah 14:24-27) [1]. God's heart is for all people, He is compassionate, just and concerned for the vulnerable and impoverished (Psalm 140:12, Psalm 146:9). His desire is for everyone to know the truth and experience of His saving grace (1Timothy 2:3-4).

Throughout the scriptures, conflict and risks of persecution displaced God's people, but the Lord's purposes were worked through the adversity of forced migration. Moses and the Israelites were brought into the promised land, Israel was exiled to Assyria and Judah into Babylon. Godly refugees influenced their host nations, such as Joseph in Egypt, Daniel in Babylon and Esther in Persia. Elijah, Jesus with Mary and Joseph and the scattered early Church were evading danger. Jesus told the disciples they would be hated for their faith and forced to flee from their homes (Matthew 10:22-23), but through this, the gospel reached many nations. Paul's unjust imprisonment in Rome allowed the imperial guards to hear the gospel. John was exiled on Patmos and wrote Revelations. In a world rife with conflict and injustice, we can be assured that God is working out His plans and purposes. He may have brought people to a place to hear the gospel, or to be used for His glory.

The scriptures clearly demonstrate the responsibility of God's people towards foreigners (Deut 10:17-19). Jesus himself was a foreigner with no home (Matthew 8:18-20) and the essence of his ministry was to serve people in refugee like situations (Luke 4:16-21). God expects us to love them, stand up for them and give freely to help them. '*When a foreigner resides among you in your land, do not mistreat them. The foreigner residing among you must be treated just as your native-born .Love them as yourself, for you were foreigners in Egypt. I am the Lord your God*' (Lev 19:33-34).

1 Peter 2 reminds us that as followers of Christ, we are foreigners and strangers in this world, with our citizenship in heaven (Philippians 3:20). We may also consider that all people have a common identity as descendents of 'boat people,' through God's judgement on the world and the covenant God made with Noah. We are biblically refugees from the sin and violence we brought to our world[2].

Until Christ returns, the plight of refugees will always be with us. However, as believers, we must be challenged to reach out to refugees, in obedience to the teaching and example Christ has given us. Our care is an expression of our love and honour for God (Matthew 25:40).

The role and ministry of the church will vary, according to the situation, cultural context and the physical, emotional and spiritual needs of refugees. We can depend on God's provision and guidance as we trust and obey Him (2 Corinthians 9). Foremostly, we can support our brothers and sisters by welcoming them and through prayer for individuals, for organisations working with them and for opportunities and the wisdom to know how to love them. There are opportunities to befriend and support them, or to advocate in seeking more just policies towards asylum seekers[3].

REFUGEES IN AUSTRALIA

Australia is a nation built on migration. The 'contact art' of Indigenous rock paintings in the Kimberleys and Kakadu depict the arrival of the early settlers on this land. Since 1945, over 6.5 million migrants and 700,000 refugees have settled in Australia. The attitudes and insecurities of Australians have seen the harsh enforcement of the White Australia Policy and the prevailing instilment of fear in people, identifying asylum seekers as the threatening 'other'.

The United Nations High Commissioner for Refugees (UNHCR) definition of a refugee is a person who:

> *"owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country… "*
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> Article 1, Convention Relating to the Status of Refugees (1951)

An asylum seeker is a person who has departed their country of origin, and is awaiting a decision on their application for recognition as a refugee in another country[4]. For the purposes of this essay, the term 'refugee' is applied to describe all people of a refugee or refugee-like background.

In 2010, an estimated 43.7million people were forcibly displaced worldwide [4]. As a signatory to the *Convention relating to the Status of Refugees* (1951) and its 1967 *Protocol* (the Refugee Convention), Australia acknowledges its responsibility for providing sanctuary to refugees and resolving refugee situations[5,6]. Australia's Immigration Program has two components, the Migration Program for skilled and family migrants and the Humanitarian Program (HP) for refugees and those in refugee-like situations. The proportion of migrants with HP visas has decreased from 10.5% in 2004-2005 to below 6%. In 2010-11, Of the 13 799 HP visas, 8971 entrants arrived via the offshore program, which resettles refugees applying for protection from overseas. The onshore component processed 4284 Refugee or Special Humanitarian visas to those seeking protection following arrival in Australia[7]. Over the past decade, most entered from Sudan, Iraq, Afghanistan, Yugoslavia, Bosnia Herzegovina, Croatia, Ethiopia, Somalia, Burma (Myanmar) and Iran[5]. 1 in 8 of the 32,000 accepted through the Family Migration Program were from these countries with refugee-like backgrounds'[8].

Children and young people aged up to 19 years, including unaccompanied humanitarian minors, make over 40% of the Humanitarian Program entrants. This represents a much higher proportion of children and young people than in the Australian population as a whole (25%). Most live in metropolitan areas, with fewer than 10% of Humanitarian entrants settling in rural areas.

CHILD HEALTH

Childhood and adolescence are imperative foundational years, in which health potential and future patterns of health are established. Interactions between prenatal and childhood development, biological, environmental and social determinants of health ultimately shape ones' propensity for health and wellbeing. Following harrowing experiences of deprivation and persecution as a refugee, a child's opportunity for health advances immensely with resettlement in Australia. However, assisting them in achieving their full health potential remains a challenge, with shortfalls in the accessibility and responsiveness of healthcare services. The majority of Australian health professionals may be unfamiliar with the range of conditions and unique health needs specific to refugees with diverse backgrounds, which are continually evolving. In less resourced areas where refugees have settled, there are minimal paediatric services with little experience or training in refugee health[8]. The following discussion reviews the current recommendations for common pathologies within this population.

Predeparture health care

The *Department of Immigration and Citizenship* requires completion of pre departure health assessments and "fitness-to-fly" assessment prior to processing of visas. Mandatory components include HIV infection screening for those aged over 15 years, chest radiography for active tuberculosis infection in those over 11 years and hepatitis B serology in unaccompanied minors. In certain regions, malaria testing, empirical treatment for intestinal parasites and administration of the MMR vaccine is provided for children[9]. Despite screening, acute and chronic diseases may be undiagnosed or untreated at the time of arrival in Australia[10]. There is no consensus postarrival assessment nationwide, but timely screening and follow up is essential to ensure the health of each refugee and the broader Australian community.

Infectious diseases

The *Australasian Society for Infectious Diseases* has developed comprehensive guidelines for the screening, management and prevention of infection in newly arrived refugees[10]. Data detailing probable infections by country of origin is not easily extrapolated considering circumstances in refugee camps or transition through various countries[8]. Within one month of arrival, comprehensive assessment should include screening and treatment of tuberculosis, malaria, blood-borne viral infections, schistosomiasis, helminth infection, sexually transmitted infections, as indicated by clinical assessment[10].

The tuberculosis disease rate in overseas born children under 15 years is 18 per 100 000, compared to 0.7 per 100 000 in Australian born children. The lifetime risk of TB reactivation for immigrant children below 5 years of age is approximately 17%, and 100% in the presence of HIV infection[11]. Younger children are at greatest risk of developing TB, particularly in the 12-18 months following exposure. Risks of developing extra-pulmonary TB and TB meningitis are also higher[12]. Post-arrival screening and latent TB infection (LTBI) treatment in refugees is a cost-effective measure, considering the prevention of TB transmission in the community and the aversion of cases and mortality. All newly arrived refugee children should be assessed for LTBI through a Mantoux test or Inteferon gamma release assay[10].

Screening for malaria is pertinent as it is life threatening for children with underdeveloped immunity. HBV screening is recommended, since Hepatitis B infections are increased within this population and children are particular susceptible following exposure to chronic carriers. Schistosomiasis serology should be offered to African and South East Asian refugees. Schistosomiasis was detected in 41% of newly arrived Africans in NSW[10].

Intestinal parasite infections are a major burden in developing countries and are readily treatable. Health services in Melbourne (2005) documented findings of one or more pathogenic organisms in the faeces of 30 of 193 (16%) of recently arrived African refugees[13].Faecal microscopy or full blood count may detect *strongyloides* or *ascariasis* (roundworm) infection which is common in children in tropical and subtropical regions of Asia, Africa and Latin America. Children aged 5-15 years are also most susceptible to *Trichuris trichuria* (whipworm) infection.

Active H. pylori infection is common in refugee children, affecting 70-80% of African children[14]. Its association with gastrointestinal symptoms in childhood is unclear and therefore, routine screening of all children is not justified or recommended[15]. H. pylori infection should be considered in a child with persistent iron deficiency[16], and has been suggested as a contributing factor in growth retardation[17]. ELISA monoclonal faecal antigen testing using is the current diagnostic method of choice in children[10].

Serologic testing for *treponemal* infection (syphilis) is recommended for all children. Children are vulnerable to sexual violence in conditions in which poverty, powerlessness, social instability and lack of protection facilitate transmission of STIs in the refugee population[18]. A UK study found over one-third of refugee children under 17 years of age had been raped[19], including boys and young men, and unaccompanied minors were at particular risk.

Immunisation

Fragile primary health care infrastructure and variable coverage of vaccinations in their country of origin eventuates in suboptimal immunisation from preventable diseases[8]. In 2005, approximately 75% of refugee arrivals came from countries with coverage rates below 50%[20]. All refugee children are eligible for vaccinations on the Australian Standard Vaccination Schedule at no cost, so a catch up schedule should be implemented. Age determination may be an issue, with no available birth record or possible separation from their. Reassessment of a birth date will ensure a correct schedule of vaccinations is given. Details on global immunisation schedules is available through the WHO[21], and an online calculator for catch up immunisation for children under 7 years is available through SA Health[22].

Nutrition

Micronutrient deficiencies are common, particularly anaemia due to iron deficiency, B12 deficiency (17% prevalence), parasitic disease, haemoglobinopathies and thalassaemia. Vitamin A deficiency is prevalent among preschool children. Considering growth charts adjusted for race, growth retardation is common but among younger age groups, and catch up growth is generally experienced within a year of resettlement. Two centile discrepancy between height and weight charts or serial measurements demonstrating no weight or height gain necessitate further nutritional assessment. A culturally familiar diet and nutritional education reduces the risk of poor nutrition. Obesity, increases with time following resettlement and precocious puberty may arise for girls[8].

Dental

Poor nutrition prior to arrival and during resettlement increases the preponderance of dental caries and periodontal disease. Functional malocclusion and dentofacial trauma may be present in children. Access is poor as standard dental care is not included for most new arrivals through Medicare[8,23].

Childhood Development

Childhood developmental progress is disrupted by biological factors and changes to social and environmental factors. Chronic malnutrition or infection and physical or emotional trauma affects motor and cognitive development. Separation, uncertainty and survival situations impede family interactions, rendering the parental role as impotent. The psychological impacts are far reaching, undermining the parental role in providing adequately for their child's physical and emotional needs. Parental input and the opportunity to play and learn is lost as parents become physically or emotionally disabled, or focussed on basic survival and protection from physical danger[24].

This is augmented by inadequate physical surroundings such as overcrowding and homelessness. Assessment of developmental progress may identify areas requiring specific services such as speech therapy or language classes, which is of particularly important with associated language barriers and transcultural issues.

Mental health

The rehabilitation of refugee children is shaped by the individual child's response to the extremes of their experiences, resilience factors and the environment into which they are

resettled. Internalising spectrum disorders are common, arising acutely or over time, and include anxiety, depression, post traumatic stress disorder and enuresis. A study of newly arrived refugee children diagnosed 50% with PTSD and 48% with depression[25]. Externalising spectrum disorders include oppositional defiant or conduct disorder[8,26]. State based referral services are accessible for management of psychological distress in refugees.

CHILDREN IN DETENTION

The Public Health Association of Australia recommends an immediate end to the detention of refugee children and their families, as the current mandatory detention policy regime breaches the fundamental principle of the *rights of the child* (*Convention on the Rights of the Child*, 1989), which is that each child should be able to develop to their full potential[6]. The policy also violates the *right to health* as established by international law (*International Convention on Economic, Social and Cultural Rights,* 1966).

There is a paucity of Australian research into refugee children's morbidity and psychological health in detention. However, international health research establishes that indefinite or prolonged detention of refugee children is significantly harmful to all stages in their development[6]. The deprivation of detention and the ensuing social isolation is a probable risk of harm to their health in their immediate situation and their future.

An estimated 60-85% of detained children and youth have PTSD and depression, with progressive deterioration related to the length of stay[27]. Paranoia and psychotic symptoms increase proportionately with age. The degree of abuse is reflected in the rise in self harm and suicidal behaviour, with prepubertal suicide attempts in children as young as 8 years old[28]. Child psychiatrists have observed children's drawings, bearing witness to the trauma and struggle through common themes of razor wire, fallen children, violence and often beetles (children's pets in detention)[28,29].

ACCESS AND UTILISATION OF SERVICES

On arrival, refugee youth are challenged with negotiating a future in an unfamiliar language and environment while seeking to establish their individuality and identity as part of growing up[23]. Health needs may be given less priority in the face of considerable stress with other resettlement concerns.

Suboptimal utilisation of services may be attributed to unfamiliarity with the Australian health system and the services available to them[8]. A fear and distrust of authority figures or the

medical profession, based on previous experiences in their home country, may prevent timely access to services. Financial constraints particularly affect dental care, utilisation of essential specialist services and long term compliance with treatment. Alternative beliefs about health care such as traditional beliefs or lack of understanding and knowledge for healthcare should also be addressed.

Isolation through lack of communication and language skills can be addressed through the use of interpreters. In some respect, issues with compliance and a lack of understanding of the importance of ongoing management may reflect the quality of communication and rapport of health professionals.

CONCLUSION & FUTURE DIRECTION

A disproportionate burden of health is one of many extraordinary challenges faced by refugee children and youth resettling in Australia. Provision of effective health care demands increasingly supportive government policies and practices, equal access to welfare and entitlements and services informed and guided by specific health needs.

The establishment of a life course and age appropriate model for health care will provide the best opportunities for health for children recovering from the refugee experience. A comprehensive catch up of primary health care needs within the first year optimises their care and identifies possible ongoing issues. Healthcare should extend to childhood care and development programs, with appropriate infant stimulation, education and cultural support environments. For adolescents, social integration, ongoing mental health services and education assistance should be emphasised. Strengthening Commonwealth funded Refugee Health infrastructure will address the current fragmentation caused by shifting responsibilities between state and federal government and government and non government organisations.

Culturally appropriate research and long term data collection of refugee subgroups is further indicated to guide policy development and enable ongoing monitoring of outcomes for refugee children. This process will identify emerging trends and issues in this ever evolving area of work. The recently formed Refugee Health Network of Australia facilitates collaboration between over 140 providers of refugee health care nationally[30]. They aim to inform and support holistic care for refugees, advise state and national policy makers and to disseminate research findings.

Training and awareness of refugee health needs, cross cultural communication and human rights are pivotal in improving delivery of quality care. Medical education curriculum is integrating teaching and opportunities in these areas. Exposure and informed teaching

encourages compassionate and respectful attitudes and approaches to refugee children and their families.

Without the hindrance of political agenda, health practitioners are in a position to advocate and promote the best care for refugees. There is significant capacity to influence the community's perception of refugees, the attitudes and role of other health practitioners, community leaders and policy makers.

PERSONAL IMPACT

Personally, the extremity of refugee children and adolescent experiences encountered through psychiatry services has been a confronting reality. Considering the implications of a refugee child being denied equal access to life saving dialysis based on visa status was a challenge to comprehend. The uncompassionate views of some health practitioners involved underscored the divisive nature of this issue. Looking further into the health status of child refugees has been beneficial in understanding their complex health needs, and how we called to respond. The resonating importance has been on reflecting on walking as Jesus did, loving our neighbour being obedient to God's word. Micah gives a vision of hope: *nations looking to the Lord for his truth and justice, resulting in freedom from fear, every person safe in his own home and land.*

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