Fact Sheet 8:

Refugee Children

In 2007-2008, The Federal Government granted 10,332 visas to refugees under the Humanitarian Program. Children and young people under 20 were 50% of this yearly intake.

Children and the refugee experience

Children are especially vulnerable in times of war and conflict because of their dependency on others and their inability to fully understand many of the situations they are forced to confront.

Refugee children are frequently exposed to war and violence. Many would have experienced dislocation or lived in exile, and may have witnessed family members and others being physically or sexually assaulted, or even killed. In war torn countries, many children are regularly exposed to bombings. Children as young as seven may have been forced into being child soldiers (Toole et al 2001).

In most refugee situations, children face an increased risk of sexual abuse and violence. Forced displacement and relocation present risks to the safety and security of children, as does the situation in many refugee camps.

They are also faced with interruption to family life, schooling, routines and rituals, the loss of their home, and for some the death of parents, family and friends.

Refugee children can present with severe caries and gum disease due to substandard dental care and hygiene, and poor nutrition. Refugee families may lack information about the relationship between diet and dental caries. Advice about healthy eating, on the advantages of breastfeeding over bottle feeding, and about oral hygiene is important.

School dental screening is no longer routine in NSW, generally targeting only high needs schools. Early referral to a public clinic for dental assessment is highly recommended.

Malnutrition and micronutrient diseases

The effects of under-nutrition and vitamin deficiencies can be seen in some children following settlement here. Those from Africa and the Middle East are at risk of vitamin D deficiency, with some children suffering from the bone deforming disease rickets. Risk factors include exclusive breast feeding, lack of oral supplementation, poor dietary intake, dark skin and reduced sun exposure.

Other nutritional deficiencies, including thiamine, iodine, vitamin C and vitamin A, may occur in refugees spending long periods in camps (Mason 2002).

Iron deficiency is the most common cause of anaemia in refugee children and women. In the children this can be due to iron deficiency in the mother, exclusive breast feeding, low iron intake, impaired absorption due to chronic diarrhoea, and parasitic infections.

Delays in physical growth and development may occur due to inadequate nutrition, illness such as chronic infections, the emotional environment and other factors. Where developmental delay is suspected, undiagnosed congenital or birth disorders would need to be considered, as well as more unusual causes such as tuberculosis or parasitic infections. Exotic cerebral infections should also be considered in a child with convulsions.

Pre-migration health checks for child refugees consist of a physical examination and
- urinalysis if 5 years & above
- chest x-ray if 11 years & above
- HIV test if 15 years and above, an international adoptee, or an unaccompanied minor

Other impacts on health

Mass population movements, the destruction of health services, water systems and sanitation, malnutrition, and overcrowding in refugee camps encourage the spread of disease. In countries where children are already vulnerable to diseases, the onset of armed conflict may dramatically increase death rates, with those under 5 years at particular risk.

The experiences of violence, war and dislocation can have a profound impact on the psychological and emotional health of refugee children.

Parents may need information on caring for their children’s oral health (and their own), and on how to access public dental clinics.
Developmental delay without any underlying abnormality may of course be seen in a child who has had recurrent illnesses and endured traumatic life experiences.

Pre-schoolers and school-aged refugee children will have missed out on formal hearing and vision screening. Assessment of these faculties should be arranged through community nurses or other health professionals.

Infectious and parasitic diseases
The profile of refugees arriving in Australia has changed in the last two years; places have been allocated evenly between Africa, the Middle East (including South West Asia) and Asia. Children coming from certain regions are at risk from infectious diseases due to their refugee experience and to the high incidence of communicable diseases in these regions. The types of organism would vary with the geographic origin of refugee. A recent study in Victoria found the most common intestinal pathogens among African refugees to be *Giardia lamblia*, *Trichuris trichiura* (whipworm) and *Entamoeba histolytica* (Biggs, Skull & Ngeow, 2000).

Since refugees in NSW do not undergo routine post-arrival health assessment, the existence of infectious and parasitic diseases may go undetected among children. In 2007 the Royal Australasian College of Physicians published a policy statement recommending comprehensive health assessments for all refugee children. Ring NSW Refugee Health service on 8778 0770 to find out about Refugee Paediatric Clinics.

Consider the following baseline investigations, especially if symptomatic: faecal examination (cysts, ova parasites including schistosomiasis and strongyloides), FBE (anaemia, eosinophilia) and serology (schistosomiasis, strongyloides).

Lack of immunisation
Many refugee children may have incomplete immunisation. In particular, arrivals under five years will not have had HIB vaccination. Lack of immunity to measles was found in a third of refugee youth in one NSW study. Information about immunisation schedules in different countries (WHO National Immunisation Schedules) can be found at www.nt.who.int/vaccines-surveillance/.

Offer the standard immunisation schedule if there is no satisfactory history of immunisation. Guidelines for catch-up vaccination are available in the Australian Immunisation Handbook.

Untreated and under-treated injuries
Children who came from conflict-ridden situations may have sustained war-related injuries (e.g. injuries from beatings, landmines, shrapnel, etc) that require assessment or further management.

Psychological health issues
Traumatised refugee children may show a range of behaviours including poor school performance, behavioural problems, withdrawal from parents and other children, lack of confidence and trust, anxiety, depression, post traumatic stress disorder (PTSD), sleeping and eating disorders, bed wetting, sleep walking, speech problems and psychosomatic symptoms.

A child's psychological health is closely linked to the health and security of his/her parents or primary caregiver. Parents who are traumatised and are not coping well may have a diminished ability to support their children physically and emotionally.

In therapeutic interventions with refugee children it is important to gain understanding of the relationship between the social, physical and psychological worlds of the child. Advice about management can be sought from STARTTS: 9794 1900.

Child protection issues
Child protection issues need to be addressed sensitively. Issues that may give cause for concern include the degree of physical discipline, apparent neglect, domestic violence, and female genital mutilation (FGM).

There are girls and women affected by FGM currently who are living in Australia. However the practice of FGM is banned by law in NSW. It is also illegal to take a girl out of the country to seek FGM. For more information contact the NSW Education Program on FGM: 9840 4101.

Resilience
Refugee children are, like their parents, survivors. Although some will have health issues as highlighted above, the majority are healthy and keen to start a new life. Previous generations of refugee children and young people have shown how much they have to offer to their new country.

References