Chapter 27 HFAC5:

Travellers, migrants and refugee children

Summary

This chapter is concerned with children in special circumstances due to migration or refugee status, or being of Gypsy, Roma or Traveller ethnicity. It identifies the reasons why children from these groups require focused health promotion, summarises their health needs, describes interventions to improve their physical and mental health through the Healthy Child Programme (HCP) and discusses factors that influence their ability to access preventive services.

Introduction

Migrant, refugee and Traveller children belong to diverse ethnic and social groups, but share characteristics which increase their need for targeted health promotion. All groups are small subsections of the population who have poor self-reported health and poor access to health services. The median age of migrants and Travellers is younger than the majority population and they more likely to have dependent children. It is well recognised that all groups experience high levels of discrimination and social exclusion which adversely impacts upon their health. There is overlap between groups, for example refugees are migrants who have left their country of origin to avoid persecution, and Roma are migrants who are of Gypsy ethnicity. Specialist services may be commissioned for these groups, and occasionally there are combined specialist services, such as the Walsall specialist health visiting service for Asylum Seekers, Refugees, Migrants, Travellers and No Recourse to Public Funds families (see Renton *et al*, 2016).

There is a lack of data about the health status and needs of all Travellers and migrants. A significant barrier to accessing information about the health of migrants and refugees is that

routinely collected data may record ethnic group, but not migration variables such as country of birth, length of residence, or immigration status (Jayaweera, 2014).Similarly there is a lack of data on the health status of Travellers and their children due to the 2011 census categories not being routinely used in health records (Welsh Government, 2015).

Who are Travellers?

The umbrella phrase Travellers covers a range of groups including English, Welsh and Scottish Gypsies, Irish Travellers, New Age Travellers, Boat People and Show People, as well as Roma people from a variety of European counties (van Cleemput, 2010). Of these the Equality Act 2010 defines just Romany Gypsies and Irish Travellers as ethnic groups, who are therefore legally protected against race discrimination. Gypsies and Irish Travellers were included as an ethnic group for the first time in the 2011 Census, and 58,000 people (0.1 per cent of the usual resident population of England and Wales) identified themselves as belonging to the ethnic category 'Gypsy or Irish Traveller'. Numbers responding were limited by factors such as data collection not including all Traveller sites, low literacy among respondents and reluctance to self-identity as a Gypsy or Traveller due to fear of prejudice and discrimination (Welsh Government, 2015).

Gypsies and Irish Travellers are more likely to be under 20 years (39 %, compared to 24 % of the England and Wales population), and almost half of census respondents had dependent children (ONS, 2014). Numbers with no qualifications was almost three times higher than for England and Wales as a whole, and fewer people were economically active (47% compared to 63 % for England and Wales). Only a quarter of Gypsies and Travellers lived in a caravan or other mobile/temporary structure, with the rest living in 'bricks and mortar'. In Scotland's 2011 census 0.1 per cent of the population self-identified as 'White: Gypsy/Traveller', and in Ireland 0.6% of the population self-identified as Irish Traveller.

Roma people are also known as Gypsies, Travellers, Manouches, Ashkali, Sinti and Boyash and it is estimated that 10-12 million live in Europe (European Commission, 2017). They are the largest ethnic minority in the EU and experience social exclusion, discrimination and unequal access to employment, education and health (FRA, 2014; European Commission, 2017). Prior to migrating to the UK Roma people are likely to have lived in highly deprived circumstances; for instance, in Romania 78% of Roma are at risk of poverty, rising to almost 100% in Italy, France and Portugal (FRA, 2014). Numbers of Roma people in the UK have been estimated at 200,000 but are extremely difficult to identify and count (Brown *et al*, 2014).

Who are migrants?

A migrant is a person born abroad who intends to stay in the country of settlement for at least one year (United Nations Statistical Commission, 1998). Migration to the UK has increased since the accession of new member states to the European Union in 2004 and 2007. In 2015 just over 13% of the UK population were foreign-born (Migration Observatory, 2017). Currently about a third of UK migrants were born in other EU member states with a fifth from South Asia (India, Pakistan, Bangladesh and Sri Lanka), and the remainder from elsewhere (Rutter, 2015). In 2015 India was the most common non-UK country of birth and Polish the most common non-British nationality (ONS, 2016a).

The majority of migrants come to the UK to work, with smaller numbers arriving to study or as family migrants (ONS, 2016b). Migrants differ from UK-born workers in being more highly educated, less likely to be unemployed and younger; in 2015 over a third of migrants were aged 25-35 years old compared with less than a quarter of UK-born (Rienzo, 2017). Migrants often live in precarious social and financial circumstances due to low pay, paired with high housing and living costs (Netto *et al*, 2011; Pemberton *et al*, 2014). Children of

migrants are a growing sector of the population, with over a quarter (27.5%) of live births in 2015 being to mothers born outside the UK (ONS, 2016c).

Who are refugees and asylum seekers?

A refugee has left their homeland 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion' (1951 Convention relating to the Status of Refugees and its 1967 Protocol) and has received a positive decision from the authorities on his or her asylum claim. In order to become an asylum applicant and be legally recognised as a refugee in Britain, migrants need to be on UK territory. As a result of this, many migrants fleeing from war and persecution have resorted to 'illegal' means to get to Europe, leading to large numbers of migrants risking injury and death while attempting to reach safety.

In mid-2016 there were over 117,000 refugees and over 34,000 pending asylum cases, making up around 0.24% of the UK population. Around 10% of applications were from unaccompanied asylum seeking children (UASC), with most from Afghanistan (740 children), Albania (407) and Eritrea (405) (Refugee Council, 2017a). A UASC is defined as an individual who is under 18, has arrived in the UK without a responsible adult, is not being cared for by an adult who by law or custom has responsibility to do so, is separated from both parents and has applied for asylum in the United Kingdom in his or her own right. Local authorities are funded by the Home Office to support UASC; the transfer flow chart for children arriving in the UK is shown in figure 1. In 2016 only 8% of UASC were less than 14 years old, with most aged 16 – 17 years (65%). The majority of child asylum seekers are dependants rather than having an application in their own name, and most of these are aged under 5 years. In 2015 2,681 children aged under 5 years were included in asylum applications as dependants (Refugee Council, 2017a).

In 2016 29% of UK asylum seekers were granted asylum, compared with 40% in Germany and Belgium. If the claim for asylum is allowed under the 1951 Geneva Convention the applicant is granted refugee status which lasts for five years; however, the case can be reviewed at any time, adding to uncertainty for individuals and families. Of the decisions made on unaccompanied children's claims in 2016, 31% were refugee status (Refugee Council, 2017a). If after five years it remains unsafe to return to the country of origin, refugees can apply for Indefinite Leave to Remain (ILR) in the UK.

The health of Gypsy, Roma and Traveller children

Gypsies and Travellers in the UK have poorer health status and a higher risk of mortality than other socio-economically matched comparison groups (van Cleemput & Parry, 2001; Parry *et al*, 2007). Levels of anxiety and depression are higher than other ethnic groups (Peters et al 2009) and rates of stillbirth and premature death of offspring are also disproportionately higher (Parry *et al*, 2007). Despite high health needs, there is traditionally a low uptake of health services (Peters *et al*, 2009). On occasion, reluctance by some GP practices to register transient Travellers, reduces access to healthcare (van Cleemput, 2010).

Preventive healthcare is underused by Gypsies and Travellers (Parry *et al*, 2007; Aspinall, 2014) which has been attributed to low health expectations, fear about potential diagnoses, and structural constraints such as a lack of stopping places or sites being located far from services (van Cleemput *et al*, 2007; Dion, 2008). There is a low or variable uptake of childhood immunisation, and outbreaks of measles and whooping cough in Traveller communities have been reported (Cohuet *et al*, 2007; Dar *et al*, 2013; Walsh *et al*, 2015). Gypsies and Travellers in England are less likely to visit a dentist, chiropodist or practice nurse, to contact NHS Direct or to be registered with a general practitioner (Peters *et al*,

2009). Lifestyle factors which merit health promotion are a high prevalence of smoking and below average consumption of fruit and vegetables (Abdalla *et al*, 2010), and low incidence of breastfeeding (Pinkney, 2012).

Roma people have a higher prevalence of communicable and non-communicable disease, linked to significantly shorter life expectancies than national averages (Parekh & Rose, 2011). Roma children are at high risk of malnutrition across Eastern Europe (UNCF, 2007; Janevic *et al*, 2010), and have greater prevalence of health risk factors, such as low birth weight, lower vaccination coverage and environmental risks (Cook *et al*, 2013). Mothers lack access to maternity care and can experience discriminatory mistreatment on the basis of their ethnicity, economic status, place of residence or language (Watson & Downe, 2017). Fésüs *et al* (2012) conclude that in order to reduce health inequalities for the Roma in Europe, not only health policy, but also education, economic, labour market, housing and territorial polices must be addressed.

A recent UK study revealed low mental well-being, high levels of stress and unhealthy lifestyles (high rates of smoking and alcohol use, suboptimal intake of fruit and vegetables) as prevalent in Roma communities (Warwick-Booth *et al*, 2017), all of which impact upon the health of babies and children. While breastfeeding is practised commonly in countries of origin, duration of breastfeeding can decline once resident in the UK (Dar *et al*, 2012; Condon & Salmon, 2015).

The health of the children of migrants

Health outcomes vary according to migration histories and experience but current evidence suggests poorer health outcomes for all non-UK born individuals (Jayaweera & Quigley, 2010; Jayaweera, 2014). While the health of migrants is frequently good at the time of migration, there is often a decline in health status in the country of residence (Rechel *et al*,

2013). Hazardous working conditions and inadequate safety practices in some industries employing migrants contribute to ill-health (McKay *et al*, 2006), as does poor quality, badly-managed housing (Perry 2012). Behaviour changes such as increasing smoking and alcohol use, increase in fat in diet and lack of exercise also impact upon the health of children (Jayaweera, 2010). The Millennium Cohort Study showed that for every additional five years spent in the UK the likelihood of mothers smoking during pregnancy increased by 31% and they were 5% less likely to breastfeed for at least four months (Hawkins *et al*, 2008). These behaviour changes have been attributed to acculturation (where incomers progressively adopt the prevalent health behaviours of the host population) but are increasingly linked to structural factors, such as housing, and other wider determinants of health (Jayaweera, 2010; Condon & McClean, 2016). Obesity is increasing among migrant populations in high income countries (Delavari *et al*, 2013), and migrant children, especially non-Europeans, are at higher risk for overweight and obesity than other European children (Labree *et al*, 2011).

The health of refugee and asylum seeker children

Refugee and asylum seeker children may travel to the UK independently or accompanying family members. These vulnerable migrants are at high risk of poverty in the UK. An asylum seeker entering the UK must immediately make an asylum application or they may be denied welfare support and accommodation (Asylum Aid, 2017). Dispersal under the Immigration and Asylum Act 1999 means that some refugees are now finding themselves in areas unfamiliar with the provision of specialist services and where health service staff may have had little or no advance warning of their arrival. In 2016 92% of those supported in dispersed accommodation were located outside London (Home Office, 2017). Almost all asylum seekers are not allowed to work, are not entitled to council housing and live on state support which can be as little as £5 per day (Refugee Council 2017b; UN Refugee Agency, 2017). Many asylum seeker families cannot pay for basics such as clothing or nappies (The

Children's Society, 2012). Those who have been refused asylum are not entitled to any form of financial support and can become homeless (Refugee Council, 2017b). Where there is no recourse to public funds, local authorities have a duty to provide support for a child in need (Home Office, 2016) but provision by the local authority is likely to be very limited.

Although refugee women are at higher risk of adverse outcomes in pregnancy and birth (Maternity Action, 2013), maternity care in the NHS is chargeable for most women who do not have indefinite leave to remain in the UK. Maternity care must be offered regardless of a woman's ability to pay, but in practice many pregnant women are deterred from accessing maternity care, and late booking and missed appointments are common (Feldman, 2016). Frequent moves associated with asylum claims and lack of interpretation and translation also create barriers to accessing healthcare care (Reynolds & White, 2010, Renton *et al,* 2016). Many refugees migrate from countries with high rates of HIV. Despite this, formula milk is not universally provided to HIV-positive refugee mothers, reducing the likelihood of infant feeding guidelines being followed (National Aids Trust, 2017). Refugee and asylum feeding women can find breastfeeding difficult to sustain in the UK due to multifaceted personal challenges, and exposure to a culture where bottle-feeding is the norm (Hufton & Raven, 2016).

Refugee children are vulnerable to mental health problems such as anxiety and depression, sleep disorders, self-harm and post-traumatic stress disorder (Brownlees *et al,* 2010; Aspinall, 2011; The Children's Society, 2012). Tuberculosis is prevalent in some migrant populations (Maternity Action, 2013; Public Health England, 2016) but there is lower uptake of immunisations and screening in non-UK born populations (Jayaweera, 2014; Aspinall, 2011). Dental problems are common among refugee and asylum-seeking populations, which can lead to problems with sleeping, eating and speech (Renton *et al,* 2016). The UK government

has the power to detain people seeking refuge, and in the 12 months prior to March 2017, 51 children were locked up in immigrant detention, despite a promise in 2010 to end this practice (Refugee Council, 2017c).

Effectiveness of interventions to improve health through the delivery of the healthy child programme.

A literature review of studies undertaken in the UK to improve the health of Traveller, migrant and refugee children's health through prevention, screening, surveillance and health promotion identified very limited evidence. Where found, it related specifically to interventions to promote mother-child bonding or positive parenting. This highlights a focus on individual factors rather than the wider determinants of health in current literature. While this review of the evidence base has focused on Travellers, refugees, asylum seekers and migrants, the principles of good practice identified and the recommendations made as a result of the review are likely to apply to children from other vulnerable groups, such as homeless families.

Gypsies, Travellers and Roma: No UK-based studies of evaluated interventions to improve access or uptake of preventive healthcare, screening or health promotion for Gypsies, Travellers or Roma parents and children were identified. NICE has produced guidance for local authorities on best practice in providing services for communities who do not normally access health and social care services (NICE, 2014). NICE recommend understanding the characteristics and needs of the local community, and using that information to develop, commission and deliver local services that meet those needs. Success is more likely if these activities are undertaken in partnership with the community and if led by local health

champions. An example of how such services are received by Traveller communities is illustrated by the value placed upon Specialist Health Visitors for Travellers as trusted sources of advice for immunisations (Jackson *et al*, 2016). The Institute for Health Visiting Good Practice Guidance recommends that understanding Traveller culture and values is essential for building a trusting relationship between families and practitioners. Information and advice given orally with no medical jargon is valued and key areas for health promotion include immunisation and injury prevention (http://ihv.org.uk/wp-content/uploads/2015/09/02-MG_Traveller-Families.pdf).

Refugees and Asylum Seekers: One case study and one participatory action research study evaluated culturally sensitive community-based services to support the mental health of women from specific countries or ethnic groups; Afghanistan (Hughes, 2014) and West Africa (O'Shaunessey *et al*, 2012). Both studies identified the strengths and resources from the mothers' cultural and religious backgrounds which, within a safe setting and supported by a trusted link worker, were built upon to enable mothers to address the needs of their children. The study designs mean it is not possible to determine that an intervention will have a specific clinically relevant effect, but these two studies have indicated an area for further research. (Quality of evidence – needs further research, Strength of evidence – moderate).

Migrants: One quasi-experimental intervention study to improve mother-infant bonding in Chinese migrant mothers living in social isolation in Northern Ireland was identified (Yuan & Freeman, 2011). Mothers were non-randomly allocated to a social support programme delivered in the guise of an infant oral health education programme, or a no-treatment comparison group. Using questionnaires at baseline and follow up to 12 months, mothers in

the intervention arm had better bonding scores than those in the comparison arm. Oral health outcomes were not assessed. [Quality of evidence: moderate, Strength of evidence; low (single study)]. The Institute for Health Visiting Good Practice Guidance recommends; engaging families in health promotion through discussion of usual health behaviours in their country of origin, encouraging continuation of healthy behaviours, and sign posting to services and information (http://ihv.org.uk/wp-content/uploads/2016/11/GPP_Migrant_Familes_V1_2.pdf).

Facilitators and Barriers to accessing the Healthy Child Programme

A literature review of studies exploring the barriers and facilitators to services such as those delivered through the Healthy Child Programme provides insights into the factors influencing access to services.

Gypsies, Roma and Travellers: Qualitative studies exploring facilitators and barriers to parents and children accessing preventive health services in the UK were identified across three health HCP topics; infant feeding (Condon & Salmon, 2015), pre-school children's health (Dion, 2008) and immunisation uptake (Jackson *et al*, 2016, Jackson *et al*, 2017). Barriers to accessing HCP topics that were reported across more than one study included, (i) a sense of fatalism and not feeling enabled to influence your own health outcomes, (ii) a tendency to low literacy (especially in older generations) not recognised by health practitioners who provide written information, (iii) low levels of spoken and written English for Roma families newly arrived in the UK, (iv) a cultural tradition of living in the present and not arranging appointments in the future, and (v) the fact that managing poor housing conditions, low income and discrimination are likely to take priority over actions to improve

health or prevent ill health. Factors that facilitate access to HCP topics across more than one study included; (i) health professionals who understood the cultural sensitivity of some issues (e.g. breastfeeding in front of other people, that cervical cancer can be prevented by a vaccination given to children before they are sexually active), (ii) valuing health information delivered orally, especially through trusted health professionals with whom a relationship had been developed over time, and (iii) younger generations being more likely to read, write and be internet literate; additionally as they travel less they are more likely to have a location where they return to and can receive post. Quality of evidence: high, Strength of evidence: high.

Refugees and Asylum Seekers: Four qualitative studies explored facilitators and barriers to parents and children accessing preventive health services in the UK across three health topics; infant feeding (Hufton & Raven, 2016), safeguarding (Burchill, 2011) and maternity care (Bridle, 2012, Lepherd & Haith-Cooper, 2016). Barriers for refugees and asylum seekers reported across more than one study included; (i) lack of knowledge of the health system, including entitlement to services and where services were free to access, (ii) not being registered with a general practitioner or difficulty registering with a GP, (iii) not speaking English or being able to read English, ~~and~~ (iv) a fear of deportation arising from engagement with health services, and (v) disruption to the delivery of health services due to dispersal. Factors facilitating access to HCP services for refugees and asylum seekers reported across more than one study included; (i) awareness by staff of religious or cultural traditions and practices (for example, the practice of female genital mutilation, or stigma associated with a diagnosis of HIV), (ii) having trusted health professionals, and (iii) the use of non-written information to deliver healthcare messages (for example, orally, or through pictures or DVDs). Quality of evidence: moderate, Strength of evidence: high.

Migrants: Five qualitative and one mixed methods study explored facilitators and barriers to parents and children accessing preventive health services in the UK across four health topics; preschool children's general health (Abbott & Riga, 2007), maternity care (Balaam *et al,* 2013; Phillimore, 2016), infant feeding (Choudhry & Wallace, 2012) and supporting children with disabilities (Croot *et al,* 2012). These included a range of ethnic groups; Bangladeshi (Abbott & Riga, 2007), South Asian (Choudhry & Wallace, 2012), Pakistani (Croot *et al,* 2012), European country migrants (Balaam *et al,* 2013, Richards *et al,* 2014) and one study explored any migrant to the UK in the last 5 years (Philimore, 2016). Barriers to accessing HCP services reported in more than one study included; (i) limited English combined with lack of interpreting, advocacy or translating services, risks mis-communication and a subsequent mistrust of health practitioners, (ii) not understanding what services are available or how to use them, (iii) not being registered with a general practitioner, (iv) economic reasons for not being able to engage with health services (such as inability to afford travel costs or childcare for other children in the family), (v) a sense of fatalism or lack of ability to influence your own health outcomes, and (vi) religious or cultural traditions (such as fasting) that are prioritised over individual health needs. Factors that facilitated use of services delivering HCP services included (i) practitioner sensitivity and understanding of both the cultural traditions of that community and how that community understand specific health conditions, (ii) having good advocacy, interpreting and translation services available, (iii) being able to develop trusted relationships with community members often facilitated through continuity of care, and (iv) the ability to deliver individualised information. Quality of evidence moderate to high, Strength of evidence moderate.

Good practice in child health promotion

Many local areas develop their own resources to ensure that the children of Travellers, migrants and refugees have access to the HCP. As an example, Figure 1 is a flowchart devised by the Health Visitor Champion for Gypsy, Traveller and Migrant families in Redruth, Cornwall. In addition to a usually resident population of Gypsies and Travellers, many others visit Cornwall over the summer. This flowchart provides guidance for health visiting and school nursing teams on delivering the HCP.

Flowchart attached- here is the key to acronyms to go with it

Acronyms:

NBV - New Birth Visit

TF in- Transfer in visit

LA; Local authority

SN- School Nurse

HV-Health visitor

TAC- Team around the child

CAF-Common Assessment framework

FFT-Friends, Families and Travellers (local organisation)

Recommendations

Little evidence of effective interventions results in recommendations that seek to address the barriers to health identified in the literature, are supported by good practice guidance, and which require future formal evaluation. The following interventions are recommended:

1) Providing cultural competence training for health professionals and support staff, including an understanding of how cultural beliefs inform health behaviours, and how these evolve with subsequent generations.
2) Ensuring provision of effective communication with communities; for example, through link workers, advocates or interpreting services, such that there is no dependence on family members for translation, and that non-written forms of information and advice are available.
3) Developing trusted relationships between communities and health professionals built through mutual respect, active listening and continuity of care; statutory and specialist health visiting services are often well placed to develop these relationships
4) Recognising that factors such as poor housing, poverty and discrimination impede families' ability to engage with health promotion and health services in the manner expected of families not experiencing these difficulties.
5) Asking families their ethnic group and whether they have migrated when they access services, thereby enabling them to disclose their migrant, Traveller, refugee or asylum seeker status and access the support they need.
6) Ensuring that health records include service users' migrant, Traveller, refugee or asylum seeker status for monitoring purposes and to aid optimal access to child health promotion services

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