Closing the gaps for Disadvantaged Children

Dr Karen Zwi
Community Paediatrician
Outline

• Health Inequalities and vulnerable children
• Pathways to improve outcomes
• Refugee children
  – health
  – local programs
  – research
Child mortality (<5 years): Gaps are Becoming Wider

- High income world 6/1000
- Low income world 120/1000
- 99% of deaths in less developed countries
- Gaps becoming wider

Figure 2: Rates of change in under-5 mortality by income groups

Based on data taken from UNICEF¹ and the World Bank.²
Local Health Inequality is not improving

Life expectancy at birth in highest and lowest socioeconomic status quintiles and rest of population by sex, NSW 1996 to 2007

Males

Females

Socioeconomic inequities in child survival thus exist at every step along the path from exposure and resistance to infectious disease, through careseeking, to the probability that the child will receive prompt treatment with effective therapeutic agents. The odds are stacked against the poorest children at every one of these steps. As a result, they are more likely than their better-off peers to die in childhood.
Vulnerable Populations

- Children of substance abusing parents
- COPMI
- Children of parents in jail
- Children of parents with DD
- Children known to FaCS
- Children in OOHC
- Children of parents with chronic medical conditions
- Children in jail
- Aboriginal
- Children with DD
- Children with chronic medical conditions
- CALD/NESB
- Refugee and Asylum Seeker
- Homeless
- Poverty
But....not everyone from a high risk groups is vulnerable
Prioritisation means taking into account the social and economic factors in how you manage patients such that you increase the chance of achieving the same health outcome as in better off peers.

**PRIORITISATION TOOL**

The following optional questions allow us to provide the most appropriate care for your child:

1. Are you a **refugee** or **asylum seeker**?  
   Yes □ No □

1. Does your child or either parent/carer **identify as an Aboriginal** or Torres Strait Islander?  
   Yes □ No □

2. Does your child or either parent/carer **obtain Family Support** from an agency such as brighter futures or Anglicare, from ADHAC, Department of Housing, or DoCS (Community Services)?  
   Yes □ No □

3. Does your child or either parent/carer **hold a Health Care Card** or Pension card?  
   Yes □ No □ If so, for what reason?  
   low income†  disability†  medical condition†  Out of home care †
Strategies to improve health in vulnerable children

- Assessment based on risk status rather than symptoms
- Strengthening access – community workers
- Systematic population screening – Utilising uniform standards and protocols
- Standardised, periodic follow-up
- Using a health case manager
Pathways to improve outcomes

- In utero
- Antenatal
- Parenting programs
- Financial enhancements
- Postnatal care
- Home visiting
- High quality child care
- High quality preschool
- At home
- Baby
- Family
- Community
- Society

K Williams 2008
The effectiveness of domiciliary health visiting: a systematic review of international studies and a selective review of the British literature

R Elkan
D Kendrick
M Hewitt
JJA Robinson
K Tolley
M Blair
M Dewey
D Williams
K Brummell
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<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>?</th>
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<tbody>
<tr>
<td>Improve parenting skills &amp; quality home environment</td>
<td>√</td>
<td></td>
<td></td>
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<tr>
<td>Ameliorate child behaviour problems eg sleep</td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decrease unintentional injury and home hazards</td>
<td>√</td>
<td></td>
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<tr>
<td>Improve detection &amp; management postnatal depression</td>
<td>√</td>
<td></td>
<td></td>
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<tr>
<td>Enhance quality of social support to mothers</td>
<td>√</td>
<td></td>
<td></td>
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<tr>
<td>Improve rates of breastfeeding</td>
<td>√</td>
<td></td>
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<tr>
<td>Increase uptake immunisation/other preventive strategies</td>
<td>√</td>
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<tr>
<td>Reduce emergency medical/hospital admission rates</td>
<td>√</td>
<td></td>
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<tr>
<td>Physical development/child’s diet</td>
<td>√</td>
<td></td>
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<tr>
<td>Mothers’ return to education, participation workforce</td>
<td>√</td>
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Outcomes high quality preschool

• increases children’s IQ
• beneficial effects on behavioural development and school achievement.
• Long-term follow up demonstrates increased employment, lower teenage pregnancy rates, higher socio-economic status and decreased criminal behaviour.
• There are positive effects on mothers’ education, employment and interaction with children. Effects on fathers have not been examined.
Education & Child Mortality

Deaths of children < 2 years (per 1000) by education of mother in Latin America

Child Well-being is Better in More Equal Rich Countries

Refugee program in Australia

- Highly controlled refugee intake of 13,750 per year
- 40% aged under 20 years
- 30% from Africa
  - Sudan, Congo, Ethiopia, Somalia
- 30% from SE Asia
  - Burma mainly
- >30% from Middle East
  - Afghanistan, Iraq, Iran
Support systems in Australia once granted refugee status

- Housing, public school enrolment, benefits, federally funded GP access, case management, English lessons

- Health care available but not systematically offered
  - 1 in 5 children in NSW screened
  - 80% in Victoria
## Humanitarian Entrants to SESLHD

1 July 2006 to 30 June 2011

*DIAC Settlement reporting facility, downloaded 20/10/11*

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<thead>
<tr>
<th>Main Countries of Birth</th>
<th>Number</th>
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<td>CHINA PEOPLES REP</td>
<td>177</td>
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<tr>
<td>IRAN</td>
<td>101</td>
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<tr>
<td>IRAQ</td>
<td>75</td>
</tr>
<tr>
<td>EGYPT ARAB REP OF</td>
<td>64</td>
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<tr>
<td>BANGLADESH</td>
<td>58</td>
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<tr>
<td>NEPAL</td>
<td>30</td>
</tr>
<tr>
<td>INDONESIA</td>
<td>18</td>
</tr>
<tr>
<td>MONGOLIA</td>
<td>18</td>
</tr>
<tr>
<td>ZIMBABWE</td>
<td>16</td>
</tr>
<tr>
<td>TURKEY</td>
<td>14</td>
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<tr>
<td>SEIRRA LEONE</td>
<td>12</td>
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<tr>
<td>ZIMBABWE</td>
<td>16</td>
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<tr>
<td>SRI LANKA</td>
<td>11</td>
</tr>
<tr>
<td>LIBERIA</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>782</strong></td>
</tr>
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</table>
Collaborative Care Model for refugee children and their families

- Comprehensive health assessment on arrival
- Referral to specialist services
- Catch up immunisation
- Ongoing care

- Register GPs
- Host training sessions

- Information re. health system
- Screening & management guidelines
- Communication and liaison with GPs
- Support for coordination care
- Case management
- Access to consultation
- Clinical referral pathways
- Maintain database/track health status
- Education and training forums
Multicultural Health Worker Role

• Meet refugees while in temporary accommodation & explain the Australian health system

• Conduct a needs assessment

• Link newly arrived refugees to health and welfare services

• Support community development activities in conjunction with other agencies & NGOs
Strengths of the program

• Health outcomes
• Focus on continuity of care across community, private practice and hospital
• Team work across settings
• Building capacity
  – Partnerships
  – Education and training
  – Resources
  – Organisational support
FM 9 yr old born refugee camp Tanzania

“since moving to this beautiful country we have experienced so much more than we could ever have hoped for in a lifetime in Africa”

- **Diagnosis:** lower limb phocomelia
- Vit D deficient
- Learning issues - Yr 5

- **Interventions:**
  - New wheelchair
  - Limb prosthetics
  - OT & Physio, home and school assessment for support
Common health issues in Refugee Children and Youth (Australian studies)

- Growth and development issues
- Nutrition: Anaemia (10-30%), Vit D deficiency (up to 90%)
- Under-immunisation (100%)
- Infectious diseases
  - Latent Tuberculosis (37-55%) Schisto (30%) Malaria (5-10% pre 2005)
  - Hep B infection (3-16%)
  - Intestinal parasites
- Undetected chronic disease
- Poor dental health

Refugee Status Report Victorian Government 2011

Photo courtesy M Harmey BHIEC
Refugee Status Report 2011: Mental health issues

- most children experienced threat of harm to families and have undergone a dangerous flight
  - 40% separated from their family at some point
  - >33% witnessed violence
  - 25% under combat fire
  - 25% disappearance of family members

- Anxiety, depression and PTSD 3-96%
  difficult to measure but low level of dysfunction and low service use
Education

- Disruption to education
- Language barriers
- Sense of belonging
Development – literacy and numeracy

Figure 4.5: Percentage of years 3, 5, 7 and 9 students at or above the national minimum standard, Victoria, NAPLAN 2009

Refugee Status report 2011:
Some health parameters are better

- Very low rates of allergic disease
- Low rates overweight on arrival
- "healthy migrant effect"
  - Fewer pre-term births (6.7% vs 7.9%)
  - Fewer low birth weight (5.7% vs 6.4%)
  - Lower proportion of births to younger and older mothers (Maternal and perinatal mortality Vic 1999-2006)
## Demography – 2006 Census Population and Housing

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Refugee-like</th>
<th>Victoria overall</th>
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<tbody>
<tr>
<td>Single parent family</td>
<td>21%</td>
<td>17.8%</td>
</tr>
<tr>
<td>Household – single family</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>Flat/apartment</td>
<td>17.5%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Private rental</td>
<td>47%</td>
<td>18.7%</td>
</tr>
<tr>
<td>Poverty</td>
<td>50.1%</td>
<td>14.3%</td>
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<tr>
<td>No car</td>
<td>17%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Internet</td>
<td>48.3%</td>
<td>76.9%</td>
</tr>
<tr>
<td>Yr 12/higher (18 yrs +)</td>
<td>54.8%</td>
<td>56.8%</td>
</tr>
<tr>
<td>No education (18 yrs +)</td>
<td>7.8%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Current tertiary</td>
<td>17.4%</td>
<td>7.8%</td>
</tr>
<tr>
<td>4 yr olds/preschool</td>
<td>655/536</td>
<td>60,618/76,489</td>
</tr>
</tbody>
</table>
Development - ongoing education

Figure 4.6: Current reported tertiary study by age

Challenges in health care delivery

- Almost no predeparture screening
- Access poor in NSW
- Pre-existing conditions unfamiliar
  - hard to get a Mantoux test!
- No national consensus on testing & treatment for latent tuberculosis
- No predeparture Hep B immunisation
- Limited health care interpreters
Access issues for refugees

- don’t know where to go for help
- lack of knowledge of how the health system works
- Present late (health knowledge, priorities)
- language & cultural barriers
- financial
- lack of confidence/fear/distrust in approaching health services
Towards better health for refugee children and young people in Australia and New Zealand

Key recommendation: timely and high quality health care for every refugee child and young person living in Australia and New Zealand

Launched Melbourne
May 2007
Practice points in working with refugee families

- Interpreter, interpreter, interpreter: communication is the biggest hurdle
  - Patience, time
- Culturally congruent and competent care
- Flexibility
- You may be the first health professional they have seen for years
- Role as case manager
What type of conditions will you see?

• Medical conditions in common with other ethnic minorities
• Specific health conditions from their country of origin
• Effects of the refugee experience
  – psychological
  – conditions and care in the camp
• Behaviour attributed to socio-cultural factors:
  – eating and drinking habits
  – child-rearing practices
  – family structure and interaction, family stressors
Pedagogic vs child-centred model
<table>
<thead>
<tr>
<th>Pedagogic versus Child-Centred</th>
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<tbody>
<tr>
<td><strong>lack of co-sleeping</strong></td>
</tr>
<tr>
<td><strong>relatively tolerant of other separations</strong></td>
</tr>
<tr>
<td>↑ emphasis on verbal interaction</td>
</tr>
<tr>
<td>↓ emphasis on physical contact</td>
</tr>
<tr>
<td>co-sleeping and breastfeeding on demand</td>
</tr>
<tr>
<td>respond rapidly to crying</td>
</tr>
<tr>
<td>↑ physical contact</td>
</tr>
<tr>
<td>↓ verbal interaction</td>
</tr>
</tbody>
</table>
Cultural Differences in child rearing impacts on skills and behaviour

- Motor development
- Verbal Skills
- Crying
- Toilet training
- Independence
- Obedience
- Learning
- Sleeping

ARE “CULTURAL PRACTICES” HARMFUL, NEUTRAL OR HELPFUL?
Good local programs in many jurisdictions

- Screen newly arrived refugees in Intensive English Centres
- Refuge nurse facilitates GP access for whole family

Program focuses on health of young migrants

BY EVA TEJSZERSKI

The St George and Sutherland Shire Leader

NAB Schools First Seed Award Winner 2010
NAB Schools First Impact Award Winner 2011
Sydney Children’s Hospital Health Award 2011
Sydney Children’s Hospitals Network Finalist
Health Awards 2011
Outcomes: Partnership

Baseline Network Analysis: May 2010
Strength and Number of relationships between services supporting refugee and other vulnerable new arrival students.

Current Network Analysis: June 2011
Strength and Number of relationships between services supporting refugee and other vulnerable new arrival students.

Abbreviations:

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<td>SES MHS</td>
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<td>Beverly Hills English Enrichment Centre</td>
</tr>
<tr>
<td>SGH</td>
<td>Sydney Children's Hospital</td>
</tr>
<tr>
<td>Menai HS</td>
<td>Menai High School</td>
</tr>
<tr>
<td>STG DGP</td>
<td>St. George Division of General Practice</td>
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<tr>
<td>UZ YHS</td>
<td>Up Zone Youth Health Service</td>
</tr>
<tr>
<td>BYRC</td>
<td>Between Youth Resource Centre</td>
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<tr>
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<tr>
<td>STG MRC</td>
<td>St. George Multi-Cultural Health Service</td>
</tr>
<tr>
<td>TCH Dental</td>
<td>Canterbury Hospital Dental Clinic</td>
</tr>
<tr>
<td>CYHYS</td>
<td>Connect Youth Health Service</td>
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Framework for improving access, equity and quality of care for newly arrived refugee children

The elements include:
1. routine comprehensive health assessment
2. co-ordination of initial and ongoing health care
3. integration of physical, developmental and psychological health care
4. consumer participation
5. culturally and linguistically appropriate service provision
6. inter-sectoral collaboration
7. accessible and affordable services and treatments
8. data collection and evaluation
9. capacity building and sustainability
10. advocacy

Longitudinal study

- Follow up of children for 3 years after arrival
- Physical, development and mental health status
- Do patterns emerge that can guide screening and service provision?
- What factors contribute to favourable health outcomes?
Longitudinal study

• Formal measures at yearly intervals
• 2 children per family
• Physical (BMI) & Development: ADST, PEDS
• Psychological: Strengths and Difficulties
• Post-arrival factors:
  – Social Readjustment Rating Scale (life events)
  – Settlement issues: access to health services
    • Socio-economic resources (employment, grants, education)
    • Community supports and discrimination
Research Findings

- MMR
  Suboptimal seroconversion unless documented vaccination (despite routine predeparture vaccination)  P Joshua

- TB
  Sens and Spec of Quantiferon Gold TB Antibody test being evaluated by analysis of Chest Clinic Data  P Joshua

- 40% of parents/guardians had high risk of developing a stress-related disorder in the next twelve months  M Sissons

Photo courtesy M Harmey BHIEC
Longitudinal study early results
K Zwi, J Paprckova, M Sissons, M Mateos, L Woodland

- community support is provided locally by the respondents’ own ethnic community
- families are accessing their GP more than any other health service provider, with 96% of children seen in last 12 months
- Strengths and Difficulties Questionnaires suggest about a quarter have abnormal results
- Standardised child development measures may not be appropriate
If you arrive by boat the policy in Australia is Mandatory detention.
Refugee children: Rights and wrongs
Children in detention

- Rapid rise since Jan 2009
- Children (<18yrs) in immigration detention
  - currently 1079
  - 133 on Christmas Island
  - 528 locked facilities (APODs) can be very restrictive
    - no longer held in high security detention centres but laws remain & facilities highly restrictive
- community detention for just over half at present 51%
- Average processing time 2011: 364 days for children; 334 days for UAMs

DIAC Jan 31st 2012
Good things are happening

- Increasing use of community detention for families
- Increasing use of Bridging visas for long term detainees
- NSW Refugee plan will require LHD KPIs (access, cultural competency, data collection, research)