Growing up is never easy. For children separated not only from their birth families but from their countries of origin, it can be a long, hard struggle to achieve even the basic levels of good health that are so often taken for granted. Mary Mather and Marko Kerac focus on the health needs of two particular groups of young people: intercountry adoptees and unaccompanied refugee and asylum-seeking children. They discuss the limitations of Department of Health Guidance and identify in some detail the range of health problems which frequently go unrecognised in intercountry adopted children. Although the same problems apply to refugee and asylum-seeking children, these already traumatised young people carry the double burden of the problems they arrive with and the problems that arise once they are in the UK. The authors provide practical suggestions towards easing this burden in the effort to make health care for this group in particular, at once ethical, humane and acceptable. They end with a plea for tolerance and sensitivity, and the need to recognise that health goes way beyond the remit of the National Health Service. The aspiration to and attainment of health is determined by education, politics, the micro-climate of attitudes and the very fabric of our society.

How would refugees like to be treated?
Lots of smiles if possible, it could make a big difference to our health. (Asylum seeker, dispersed to the North West of England, quoted in Burnett and Fassil, 2000)

Introduction
In a perfect world without war, famine and gross inequities in living conditions, population movements would not exist. To leave the place of one’s birth and culture is to undertake an uncertain and hazardous journey which, given a free choice, few would attempt. However, since our world is far from perfect, the mass migrations which have always been a feature of human history will certainly continue.

A child’s journey is a particularly risky and disempowering process. The decision to move is often made for children rather than with them. They move from their country of origin to a country of reception, from the familiar to the different, from fitting in to standing out. Many would point out that the change is often from poverty to relative wealth, but wealth alone cannot guarantee a better life. Children separated from their birth families are especially vulnerable to exploitation and neglect. Growing up is challenging for children from stable backgrounds. For young people carried by the tides of history, politics and policies, it can be a long and difficult struggle to achieve that state of physical, psychological and social well-being otherwise known as good health.

The aim of this article is not to discuss the rights and wrongs of child migration but to highlight the health needs of two groups of children, born abroad but now living in the United Kingdom separated from their birth families: intercountry adoptees and unaccompanied refugee and asylum-seeking children. The emphasis will be on physical health, a relatively neglected area.

Intercountry adoption (ICA)

Demographics
Intercountry adoption involves over 30,000 children per year moving between 100 different countries (Selman, 2000). The USA receives over half of these children (16,396 in 1998) and is the main source of expertise on the health aspects of intercountry adoption. In England and Wales the number of intercountry adopted children arriving each year is relatively small, but the total size of the population is significant and increasing rapidly. The 1998 figure of 258 intercountry adoptees rose to 327 in 2001 (Department of...
Health and Scottish Executive, 2001). In Scotland the 2001 figure was 18. The adoptive parents’ support organisation, OASIS, has 1,000 members, many of whom are prospective adopters (see References for website).

In the UK in 1998 the intercountry adoption rate per 1,000 live births was 0.4 per 1,000, compared to 11.2 in Norway and 4.4 per 1,000 in the USA (Selman, 2000). The main countries of origin for intercountry adoption into England and Wales are China (176), Thailand (29), USA (22), India (19), Guatemala (13), Russia (13), Vietnam (11) and Sri Lanka (7) (Department of Health, 2001). These numbers can fluctuate dramatically for a variety of reasons: internal crisis (Russia), quotas (China), suspensions (Romania) and shifts towards domestic adoptions (India).

Anecdotal evidence suggests that once in the UK, intercountry adopted children mostly end up living within certain, often affluent geographical clusters. Hampshire, Essex, Surrey and Kent have all established intercountry adoption panels and this distribution may reflect the often substantial costs for parents of adopting abroad.

**UK law and policies**

The UK Adoption (Intercountry Aspects) Act 1999 provides the statutory basis for the regulation of intercountry adoption in England, Wales and Scotland. The Act enabled the UK to ratify the Hague Convention on the Protection of Children and Co-operation in respect of Intercountry Adoption 1993. This Convention is based on the principles enshrined in the UN Convention on the Rights of the Child and signatories must act in the best interests of the child, respecting their fundamental rights and setting standards and safeguards to protect their welfare. Towards this goal, the Department of Health published the *Intercountry Adoption Guide – Practice and procedures* in April 2001 detailing the roles and responsibilities during the ICA process, which are outlined below.

**Identifying and managing health issues**

Identifying and then addressing health issues are the key to securing a child’s well-being and protecting their future health. Unfortunately the Department of Health Guide places the entire responsibility for obtaining medical information on the prospective adoptive parents. Acknowledging that in many cases this information is unavailable, the Guide advises parents to identify any possible health risks by ‘establishing which medical conditions are endemic in the child’s country of origin’ (p 33). The prospective parents, who usually have had little or no medical training, are then recommended to ‘consider these risks and understand the implications’ (p 34).

For parents who have obtained some medical information, the situation is not much better. The Department of Health is in ‘no position to verify the quality of medical information contained in any medical report received from abroad’ (p 34) and recommends that a child’s health information is discussed with an adopter’s own general practitioner (GP), who can arrange immunisations and consult if necessary with communicable disease specialists.

**Limitations of the Department of Health guidelines**

It is doubtful whether the advice in the current Department of Health guidelines is sufficient to secure a child’s right to health. Given the small number of children involved, a British GP or even a non-specialist paediatrician will often not be in a position to provide the necessary advice and care.

Even medical advisers to adoption panels, who are experienced in the health needs of children presented to domestic adoption, do not routinely see intercountry adopted children. Intercountry adoptions are categorised into designated and non-designated country of origin. Only children from non-designated countries, whose adopters have to finalise the adoption process in the UK, are subject to a local authority monitoring process and this may not include a comprehensive health assessment. Children from a designated country are considered
legally adopted on arrival in the UK, so they are not subject to formal British adoption checks.

**Range of health problems in ICA children**

The few research studies that have been done suggest that intercountry adopted children have a number of significant, and more importantly, unrecognised health problems.

Jenista and Chapman (1987) reviewed 128 children, ranging in age from one month to ten years, adopted into the United States from Asia and Latin America. The problems identified included incomplete immunisations (37 per cent), intestinal parasites (29 per cent), emotional or behavioural problems (22 per cent), skin diseases (16 per cent), estimated age only (12 per cent), scabies and/or lice (10 per cent) and congenital anomalies (10 per cent). Twenty-one other classes of problems were identified, including developmental delay, lactose intolerance, vision and hearing deficits and chronic hepatitis B carrier status. Not only did a high proportion of children arrive in the USA with an undiagnosed medical condition, but many were vulnerable to new illnesses. Within one month of arrival, 49 per cent had developed acute infectious diseases, including upper respiratory tract infections, otitis media, rubella, chicken pox and mumps. Some 19 per cent required surgical procedures, including circumcision and cleft palate repair, and 14 per cent were hospitalised at least once in the 20-month period of follow-up, with five per cent of admissions to hospital occurring within the first month.

Miller (2000) examined 452 Chinese children (of whom 443 were girls) adopted into the USA. Eighteen per cent had unsuspected significant medical diagnoses including hearing loss, orthopaedic problems and congenital abnormalities. Seventy-five per cent had significant developmental delay. Anaemia was found in 13 per cent, abnormal thyroid function in ten per cent, previous hepatitis B infection in 28 per cent, intestinal parasites in 9 per cent and positive skin tests for tuberculosis in 3.5 per cent. Thirty-nine per cent had short stature, with the loss of one month of height age for every 2.8 months spent in an orphanage. This pattern of unrecognised medical problems was similar to other groups of internationally adopted children, apart from elevated blood lead levels which was found in 14 per cent of the Chinese children.

It is especially interesting to look at those children where pre-adoptive written health information was actually available. Albers et al (1997) followed up 56 children from Eastern Europe and the former Soviet Union adopted into the USA and reviewed at a US international adoption clinic. The children’s health records were generally of poor quality. Diagnoses were rarely dated or supported by documented physical or laboratory findings. The US clinicians could not confirm some of the original diagnoses, notably those that suggested severe neurological impairment. Substantial growth and developmental delays were identified, but adopters were given little specific information about the severity of the delay and the areas of development which were impaired.

A British study (Harnott and Robertson, 1999) involved 35 children between five weeks and 16 years, adopted into Hampshire from Romania (15), India (3), Paraguay (3), the Far East, Central America and Eastern Europe. Medical forms were available for only 22 children (63 per cent). The majority were poorly filled in with little information about family medical or social history, pregnancy, birth history or feeding. Twenty-four (69 per cent) of the children were known to have had medical treatment in their countries of origin for conditions including respiratory infections, asthma, gastro-intestinal infections, failure to thrive, anaemia, rickets, recurrent ear infections, threadworms, measles, chicken pox and scabies. One child had severe untreated hemiplegia diagnosed as ‘problem with one leg’. Three (9 per cent) had been in hospital for between nine and 11 months and were abandoned there. Screening tests carried out in the UK found one child had hepatitis B, another had abnormal haemoglobin and another was a chronic salmonella carrier.
Implications of health problems in ICA children

All potential intercountry adoptive parents are aware that their future child is likely to have been exposed to the effects of deprivation, neglect or abuse. Inter-country adopters need to become more aware that their children may have had their future health further jeopardised by problems that are rare or unknown in the developed world. These include the potentially damaging effects of infections, malnutrition, toxic substances and severe institutionalisation. The most important message from disease prevalence studies, which are not currently adequately addressed by UK practice guidelines, is that these conditions can remain undetected by routine questioning or after physical examination.

Specific medical conditions

A full description of the range and complexity of the health problems affecting ICA adopted children is beyond the scope of this article. Some are easily identified and are common British paediatric problems, such as physical deformity, hearing loss and developmental delay. Clear routes of treatment and referral already exist for these problems and children can be referred into the existing health infrastructure. We focus therefore on an overview of the main physical problems that will not be immediately obvious to parents or even doctors but which need to be identified and properly managed.

Infections

Infection represents a massive global disease burden, especially in the developing countries. In one study of 293 intercountry adopted children, infectious diseases made up 73 per cent of the conditions diagnosed (Hostetter, 1991). The most important to recognise are the silent, asymptomatic, often treatable infections which can cause long-term damage.

Many infections, including rubella, syphilis, cytomegalovirus, HIV and hepatitis B and C, can be transmitted from mother to baby during pregnancy, at birth or during breast-feeding. This transmission of congenital infections from mother to baby can be greatly reduced by early detection and treatment but needs resources and sophisticated drugs which many countries do not have. Once transmitted, infection can be easily missed, even by routine laboratory testing. The mothers and their babies may be well and often completely asymptomatic and the interpretation of tests carried out abroad is notoriously difficult.

HIV

According to UNICEF (2001), in 1999 1.3 million children under the age of 15 were affected with the HIV virus and since the AIDS epidemic began more than ten million children have been born with HIV infection. The number of children infected continues to increase remorselessly. In intercountry adoption HIV infection was not recognised as a problem until the situation in Romanian orphanages heightened awareness. One study showed a 20 per cent prevalence in Romanian orphanages and worryingly indicated that the cause of infection was neither contaminated blood transfusion nor mother-to-child transmission, but therapeutic injections with contaminated needles and syringes (Hersh et al., 1993).

HIV infection is now specifically highlighted in the Department of Health guidelines, which state that testing for HIV in a country of origin may expose children to risk because the safety of procedures, which involve the use of needles, cannot be guaranteed. Laboratory diagnosis is a particular concern as false positive and false negative test results have occurred from laboratories in some countries. Both are equally catastrophic (Jenista, 2001). Even in gold-standard laboratories, the diagnosis can be missed because of the long latent phase of the HIV virus and positive blood tests may not occur until three months after the initial infection.

Hepatitis B and C

These are the commonest of a group of viral illnesses that affect the liver and can lead to chronic liver disease. They are spread in a similar way to HIV, via blood products, intrauterine transmission or sexual contact, but are far more infectious. Officially many countries now screen blood transfu-
sion products, though it is questionable how comprehensive and reliable this process is in resource-poor economies. The risk of contacting infection from a contaminated needle is 6–30 per cent for hepatitis B, 1.8 per cent for hepatitis C, and 0.3 per cent for HIV (Beltrami et al, 2000). In a Manitoba adoption clinic, 27 per cent of 22 adopted Romanian children were hepatitis B carriers (Benoit, 1996). Hepatitis C is less common (Johansson et al, 1990).

Syphilis This is a sexually transmitted disease, which has re-emerged in Eastern Europe with the collapse of communism. Russia has seen a 43-fold increase over 1989 levels (Borisenko et al, 1999). The main issue for intercountry adoption is congenital syphilis as 60 per cent of infected babies have no symptoms at birth and can remain asymptomatic for months or years, although symptoms normally appear in the first two years of life. Congenital syphilis can lead to multiple problems including blindness, skin problems, destruction of bones and teeth and developmental delay. Screening programmes for pregnant women, in use in most of the developed world, are relatively simple, but need resources that are not available in many areas of the world. Two per cent of 129 intercountry adopted children screened in Boston had congenital syphilis (Albers et al, 1997). Even at this late stage, treatment with penicillin is possible, though damage may already be done.

Parasites They include scabies, mites, body lice, head lice and gut organisms such as Giardia lamblia, which is transmitted by infested water. These can all be easily transmitted to the child’s new adoptive family in the UK. Intestinal infestations are most important since they can exacerbate or even directly cause malnutrition even without obvious gastrointestinal symptoms to give clues to their presence.

Tuberculosis Compared to adults, children carry a higher risk of contracting tuberculosis after contact with an infected person. They are also more at risk of the infection becoming widespread in the body rather than infecting just the lungs. The symptoms – fever, weight loss and cough – can be subtle and can mimic other conditions, and the diagnosis is more difficult to make than in adults. Unless there is a high index of suspicion the diagnosis will be missed, with potentially disastrous consequences, both for the individual and for the new adoptive family who are also at risk. The children most likely to become infected are babies, young toddlers, the malnourished, children living in institutions or those with a coincident infection such as HIV. One US study showed prevalence in intercountry adopted children up to 50 times greater than in other US children of the same ages (Lange et al, 1989).

Malnutrition It is estimated that 35 to 45 per cent of children in the developing world suffer from moderate malnutrition at some time during the first two years of life and that ten per cent suffer severe malnutrition during this critical period (UNICEF, 2001). In the short term, malnutrition leads to an increased susceptibility to infection and poor growth. These initial effects can be reversible with subsequent good nutrition. In the long term, however, there is now substantial and increasing evidence to suggest a direct relationship between under-nutrition in early life and developmental and learning problems in late childhood, which may not be reversible. For intercountry adopters therefore, these persisting, subtle, long-term effects on health and the developing brain become the important ones. The seminal work of Dr Janina Galler (Galler and Ramsey, 1984; Galler et al, 1990) followed a cohort of 185 malnourished infants for 30 years. She showed that ‘in spite of subsequent rehabilitation and good nutrition’, 60 to 70 per cent of children demonstrated symptoms of attention deficit, poor memory, easy distractibility and poor overall educational performance.

Malnutrition can relate to micronutrients (vitamins and minerals) as well as carbohydrate, protein and fats (macronutrients). These too can have long-term
effects. Anaemia due to diets poor in iron is widespread in developing countries and more than 30 per cent of pregnant women in developing countries have iron deficiency anaemia (Lozoff, 2000). This can directly affect the health of the newborn. In one long-term study of Costa Rican infants problems with behaviour and development were demonstrated more than ten years after treatment for iron deficiency (Lozoff et al, 2000). Rickets, a disease of bones and muscles, is found in children from orphanages due to the lack of vitamin D and exposure to sunlight (Jenista, 1997).

Iodine deficiency Iodine is an essential component of thyroid hormones, which are vital to brain development. In the developed world early identification and treatment with the screening of all newborn babies for iodine deficiency has virtually eliminated congenital thyroid disease as a preventable cause of mental retardation in children. Where iodised salt is part of the diet, as in most parts of the developed world, children are doubly protected. Children adopted from some areas of the world may not have had these benefits. Even if the deficiency is identified and corrected later in life, the mental impairment is permanent and irreversible. Areas of the world with endemic iodine deficiency include large areas of China, particularly Mongolia and Tibet, Africa and South America.

Drugs and toxins Exposure to certain drugs and toxins can be harmful long after the original substance has been removed. Damage to children can occur at any age and include exposure during pregnancy. Developed countries have health and safety legislation to limit such exposures but this protection often does not exist or is not well enforced in poorer areas.

Lead poisoning, for example, can cause learning disabilities and behaviour problems, and at very high levels can cause seizures and coma. It is prevalent in areas that are heavily polluted by petrol, coal burning or smelting factories, or where lead-based paints are still used. Children from China are particularly affected (Miller and Hendrie, 2000). Mobile, exploring toddlers who put contaminated objects into their mouths during play are most likely to be affected.

Other toxin damage can result from social factors. Fetal Alcohol Syndrome entails a combination of permanent physical and mental birth defects, which can develop in children whose mothers consumed large amounts of alcohol during pregnancy. The worldwide prevalence is 1.9 per 1,000 births (Abel and Sokol, 1987). In Russia and Eastern Europe alcohol consumption is on the increase and implicated as a major factor in a national rising death rate and a falling life expectancy (Ryan, 1995).

The need for national UK standards for intercountry adopted children The doctor seeing a clean and well-dressed child remote from the country of origin and with his or her middle-class adoptive parents may find it difficult to be persuaded of the need for any routine testing. The children may have absolutely no symptoms, no cough for TB, no jaundice for parasites, no jaundice for hepatitis B, no obvious developmental concerns specific to lead poisoning, and no growth failure for thyroid dysfunction. Yet a careful health assessment is vital.

In the USA, where specialised intercountry adoption clinics have existed for over a decade, there is a nationally recommended schedule of screening tests for all adopted children whatever their country of origin. Hostetter et al’s 1991 paper gave this position its most dramatic justification when she found that 81 per cent of the medical problems found in ICA children were only detected by a screening test and were not evident from the medical history or physical examination.

The schedule includes screening for medical disease, nutritional status, psychological problems, special needs, and even if necessary, proof of age. The aim is not to carry out unnecessary tests, nor to create a vulnerable child. Most intercountry adopted children are healthy, despite high-risk backgrounds. Instead, the purpose is to ‘define any risks so that problems may be anticipated and dealt
USA screening tests suggested for intercountry adopted children (American Academy of Pediatrics, 1991; Borchers, 2000) include blood tests for hepatitis B, hepatitis C, HIV and syphilis, a skin test for tuberculosis and a urine test and stool examination for parasites. Blood is also checked for anaemia and other inherited conditions like sickle cell or thalassaemia, when the child is from an at-risk racial group. Lead levels, thyroid function and tests for rickets are also recommended. Six months after their arrival in the USA there is repeat testing for hepatitis B and C, HIV and tuberculosis. In addition it is recommended that all children should have a full audiological test, a full vision screen, a full developmental assessment and a review of their immunisation status.

Although most children will have received some routine childhood immunisations prior to arrival in the country, in the USA it is recommended that all immunisations given to children in orphanages be repeated on arrival. All live vaccines are given again, once the HIV test has been shown to be negative. This is because there is concern about the proper storage and administration of vaccines in some Third World countries and real doubt about the accuracy of medical records. When in doubt, it is much better to repeat a vaccination that carries virtually no risk to a child rather than leave the child unprotected against a serious infectious disease.1

This comprehensive medical screening of intercountry adopted children rarely occurs in the UK and clear, specific guidance for adopters is urgently required. The present Department of Health advice, which places all the responsibility for health onto adoptive parents, is totally inadequate. It leaves parents uninformed and children at risk and isolated.

The vast majority of health problems that affect intercountry adopted children are correctable and even though they come from deprived backgrounds most are, or will be, physically healthy. All adopters need to be advised honestly and clearly of those problems that can be detected, anticipated and above all treated both now and in the future. It is not the paediatrician’s role to judge the suitability of a placement or to take a politically biased view of the process of intercountry adoption. Intercountry adopters deserve better support and guidance than being left to fend for themselves while agencies abrogate themselves of any responsibility for the health of a group of very vulnerable children.

Refugee and asylum-seeking children

Background
There are approximately 6,000 unaccompanied asylum-seeking and refugee children in the UK, mostly looked after or supported by local authorities. The majority are in London and the South East of England (Kidane, 2001). They are a diverse group with wide-ranging health, social and educational needs. Intercountry adopted children are normally babies or young children with the advantage of being cared for by motivated articulate parents who will ensure that their health is given priority and, where possible, any previous disadvantage is reversed. Asylum-seeking children, who are often older children or adolescents, do not have this security and within the immigration or care system it is rare that an equivalent parental responsibility is undertaken by anyone.

Health issues
Any of the health problems discussed in the first section of this article can apply to refugee and asylum-seeking children. There are, however, specific difficulties that can cause additional problems. Clinical problems that are unfamiliar to the health professional are even more difficult to manage in children who are separated from both their families and their culture. Training on the health needs of minority ethnic groups remains woefully inadequate in the UK.

1A useful World Health Organisation website (http://www.who.int/vaccinesurveillance/WHOUNICEF_coverage_review/) gives the current vaccine uptake rates in most countries of the world.
Asylum-seeking children carry the double health burden of the problems they arrive with and problems that occur once they are in the UK. At home many will have suffered emotional, sexual or physical abuse. Interrupted or damaged attachments in early life place them at significant risk of later emotional and behavioural difficulties. Some children will have witnessed war, violence, murder and family destruction, causing complex psychological problems. In addition, one survey revealed that more than 50 per cent of asylum-seeking children believed their health had deteriorated since arriving in this country. In the UK, the factors identified by the young people themselves as adversely affecting their health included poverty, poor housing, bullying at school, separation from family members, language barriers, a lack of interpreters, worrying about their families and loneliness (Community Health South London, 2000).

Resources for helping at-risk children
A recently published resource pack deals with the health needs of adult refugees and asylum seekers in general (Burnett and Fassil, 2000) and the King’s Fund together with the Royal College of Paediatrics and Child Health (Levenson and Sharma, 1999) has issued detailed and specific guidance on children’s needs. Overall, however, systematic health research and well-defined policy are still very limited.

Entitled to health?
When the British government signed up to the UN Convention on the Rights of the Child they made an exception: refugee children. Recent immigration legislation has excluded them even more. There is no longer an obligation under the Children Act 1989 for local authorities to ensure that asylum-seeking children have an adequate standard of living. Asylum-seeking adults are no longer automatically entitled to income support, which also means no entitlement to free prescriptions, glasses, dental care, welfare foods and vitamins for their babies. Charges do not apply to asylum-seeking children under 16 who are entitled to routine child health surveillance, health promotion, health screening, dental care and free school meals. The welfare provision for 16–18-year-olds is unclear.

Children are entitled to routine immunisations but need first to be permanently registered with a general practitioner or appointments will not be sent. Sadly, some general practitioners continue to offer only temporary registration, assuming that asylum seekers are likely to move on and will not complete the course of immunisation. This reputation for high mobility has been exaggerated (Carey Wood et al, 1995).

Anecdotally there is an impression that children with disabilities and learning difficulties are over represented in the asylum-seeking population. Asylum seekers are not entitled to claim disability living allowance for themselves or their children.

Making health care ethical, humane and acceptable
Doctors, nurses, social workers and others can do much to ensure that a child’s initial contact with the health service is one of tolerance and understanding. Several practical things are easy to achieve and can make an enormous difference to a child.

Having your name mispronounced, misspelt or written in the wrong order not only creates a very bad initial impression but also involves a loss of personal dignity. Doctors (and their receptionists) can ensure that they try to pronounce names correctly. The child’s ethnic group and religion should be recorded in every case. The religious beliefs of parents and children must be respected and any religious dietary restrictions observed for the child in care.

Lack of English can be a major barrier to accessing health. Instruction leaflets in a child’s own language can make the difference between a child taking medication or not complying. Interpreting services are under-resourced and in short supply but may be essential for some children. It is very regrettable that in many areas the health budget for interpreters has been progressively reduced. It is better to defer a medical assessment until an interpreter is present, than to complete
it inadequately and inappropriately merely because the paperwork is needed for a review.

In the case of unaccompanied refugee children, care must be taken to ensure that valid consent has been obtained for any health assessment, particularly for any invasive procedure. No child should ever be forced to have a medical examination purely for bureaucratic or administrative reasons. It is the responsibility of the doctor to ensure that the child is fully consenting to any examination and not to proceed where there is any doubt. If the child is considered too young to be able to give valid consent, the assistance of the social services department or appropriate legal proceedings is required. Interpreters should be used to ensure that truly valid consent is obtained. Consent may be waived if a young child is seriously ill or requires urgent medical treatment.

Like all National Health Service (NHS) patients, refugee children have the right to be treated in a confidential manner. Refugee children may incorrectly assume that undergoing a medical examination, after which the doctor divulges the outcome to social services or the immigration authority, is an essential part of the asylum-seeking process. This should never be the case. Doctors are under no obligation to divulge the contents of a consultation to other agencies unless it is in the best interests of the child or if the child is at risk of harm.

Doctors need to be particularly aware that teenage girls may be pregnant and that their pregnancies can be the result of abuse or even rape. These young women should be referred for confidential counselling, sexually transmitted diseases screening, pregnancy termination or antenatal care and screening. Asylum-seeking young women may not realise that they are entitled to free antenatal care within the NHS.

The medical screening offered to unaccompanied asylum-seeking children, like the screening that is offered to inter-country adopted children, should be comprehensive. It should concentrate on health, development, immunisation catch-up, diet and sexual health, and incorporate routine testing for any infectious disease endemic in the child’s country of origin that may not be apparent on clinical examination.

The assessment of age
A frequently made and very controversial request is that doctors are asked to give an opinion on whether a young refugee is a child under the age of 18. The child’s legal representative often initiates the process, as children below 18 are not normally held in detention. In practice, the determination of a child’s age is extremely difficult to do with certainty and the margin of error can be as much as five years on either side.

In 1999, the Royal College of Paediatrics and Child Health published guidelines for paediatricians about the assessment of age (Levenson and Sharma, 1999). If an immigration officer requests an x-ray to obtain a child’s chronological age, the College would regard this request as unjustified. The guidance clearly states that ionising radiation should only be used in cases of clinical need. The guidance also argues that the accuracy of the estimation of age, based on x-rays, has not been studied in detail in different ethnic groups.

The dental age of the human from birth to 18 can also be judged by looking at the emergence of primary and secondary teeth. There is, however, no absolute correlation between the dental and physical age of a child. Estimates of a child’s physical age based on his or her dental development are only accurate to within two years in either direction. In older children the margin of uncertainty is even greater.

Mental health problems
Up to 40–50 per cent of asylum-seeking children may have significant mental health problems. This compares to 7–25 per cent for local non-refugee London children (Hodes, 1998). Existing disorders may be amplified by the trauma of the social earthquakes that lead to children becoming asylum seekers in the first place or new disorders can arise. Mental health problems are understandable but not inevitable.

There are protective factors that amelio-
orate mental burdens and risk factors that exacerbate them. Good understanding, education and social support are likely to be protective whereas racism and other forms of discrimination will have a negative impact. The experience of encountering racism in a place that had previously been seen as a safe haven can be emotionally devastating for those who experience it. Other factors such as poverty, poor housing and loss of status may also undermine a sense of emotional well-being in both adults and children. Young people between 16 and 18 may not be recognised as children in need and instead they may be placed in bed and breakfast accommodation. Unable to work and often denied the opportunity of full-time education, they find sustaining a positive outlook on life becomes a major challenge.

Doctors need to be aware that some refugee children will be from cultures where mental illness and psychological distress are taboo subjects, and physical symptoms such as headaches, insomnia and stomach-ache may be the way in which emotional distress is communicated. It is important to recognise this fact, as the doctor faced with an obviously well child may not take these symptoms seriously enough. The end result of this misunderstanding can be upsetting for the child and lead to the underlying emotional distress remaining unresolved.

Conclusions
Providing quality health care for children coming to the UK from overseas may seem like ‘a burden too many’ on the already overstretched NHS. This is to ignore the long-term view that children are life’s most precious investment. A child separated from culture, home and family may have great difficulty reconciling the behaviour and culture learned at home with that experienced in school or in the care system. However, the expectations and attitudes of children arriving from abroad are often very similar to those of their British peers. All children have an innate resilience, a capacity for growth, change, learning and social development and the potential to be productive citizens. Yet too frequently their health and developmental problems are missed and they find themselves obstructed or frustrated by the barriers of prejudice and intolerance.

Social workers, doctors, teachers and other professionals should be very sensitive to the needs of these children and must ensure that areas of need are identified and addressed early and appropriately. However, even caring professionals can find their work made more difficult by social and political agendas which stigmatise, isolate and exaggerate the inherent difficulties of inter-agency co-operation.

Health is the complex interplay and relationship between the physical, the psychological, the social and the spiritual. In order to promote health for all children, it is vital to realise that health goes way beyond the remit of the NHS. The aspiration to and attainment of health is determined by education, politics, the micro-climate of attitudes and the very fabric of our society.

This paper has focused on the health issues of a small, select group of children. However, unless all those working for children continue to advocate for the goals of ‘health for all’ there can never be true health for any.

References


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