



National Children's
Bureau

Delivering the Healthy Child Programme for young refugee and migrant children

Zoë Renton, Emily Hamblin and Keith Clements

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Introduction

Of all children living in England, refugee and migrant children are among the most vulnerable to poor health and development. This is both as a result of the effects of their, or their parents', experiences in their country of origin and during migration, and due to their social and economic circumstances in this country.

In October 2015, local authorities in England took over responsibility for the provision of health promotion and protection services for young children from pregnancy to age 5, delivered through the Healthy Child Programme 0-5. Local authorities are required to spend funds allocated by central government for public health services (the public health grant) with a view to tackling health inequalities.

This report, based on a scoping study undertaken by the National Children's Bureau (NCB) as part of the Health and Care Strategic Partnership Programme¹, explores:

- The barriers and enablers refugee and migrant families experience in promoting the health of their young children (from pregnancy to age 5)
- How local authorities, in shaping their Healthy Child Programme 0-5, are addressing the needs of young refugee and migrant children and their families, and what lessons can be shared across areas
- Recommendations for how national and local government can promote a healthy start for young refugee and migrant children in England.

As part of the scoping study, NCB: conducted a review of the evidence on public health issues affecting young refugee and migrant children aged 0-5 in England²; reviewed the policy framework underpinning public health provision for refugee and migrant families; undertook a desk-based review of local authority public health work targeted at refugee and migrant children; and carried out a focus group with parents of young refugee and migrant children.

The scope of the project

This project took a broad approach when thinking about the individuals that might be described as 'refugee and migrant children'. When reviewing the literature and policy context, we did not seek to filter out evidence by immigration status, but drew upon information relating to refugee and asylum-seeking children, children of economic migrants, and children born within and outside the UK. This approach allowed us to draw upon a broader range of literature, and reflected the fact that many individual sources of evidence include children and families in a range of circumstances in their investigations. As the project focused on provision of public health services by local authorities, we have not aimed to address the needs of children in detention for immigration services, for whom public health services are overseen by NHS England.

Section 1 outlines the policy context relating to public health provision for young refugee and migrant children, and section 2 reviews some of the evidence relating to their health and well-being. Section 3 explores the experiences of refugee and migrant families with young children when accessing health services and the barriers they face, and section 4 assesses how current guidance for local authorities will help them to address those needs and barriers. Finally, the report provides some examples of work already taking place in England to deliver public health services that meet the needs of young refugee and migrant children and their families.

¹ A programme of the Department of Health (DH), NHS England and Public Health England (PHE)

² This project focused on the refugee and migrant children living in England. However, the UK is referred to in relation to specific research findings, policies, immigration status types and with reference to families' arrival in the UK and individuals being born within or outside the UK.

The policy context

The section outlines the policy context relevant to the provision of public health services for young refugee and migrant children living in England.

Children's right to good health

In 2008, the government removed its reservation to the United Nations Convention on the Rights of the Child (UNCRC) with regard to immigration. This means that when making decisions affecting children subject to immigration control, government must have the same regard to the UNCRC as decisions concerning all other children in the UK.

Under Article 24 of the UNCRC, all children have the right to the highest attainable standard of health and healthcare services. In particular, this should include a range of public health measures and outcomes, including: reducing infant and child mortality, combating disease and malnutrition, ensuring appropriate prenatal and postnatal care for mothers, ensuring access to health education and information, promotion of breastfeeding, prevention of accidents, health guidance for parents and family planning services. In April 2013, the UN Committee on the Rights of the Child published a General Comment on the child's right to health, with key messages for government about how to interpret Article 24. In this, the Committee emphasised the importance of signatories to the UNCRC focusing on the underlying determinants of children's health, as well as primary healthcare (UNCRC, 2013).

Local authorities' responsibilities for public health services

The Health and Social Care Act 2012 included a wide range of reforms to health services in England, including transferring responsibility for public health from Primary Care Trusts (which were abolished) to local authorities. From April 2013, local authorities took on responsibility for public services for all adults and for children aged 5 to 19 only. Responsibility for public health provision from pregnancy to age 5 was held by NHS England to ensure central oversight of the government's commitment to increase of the number of health visitors by 50 per cent. In October 2015 the transfer was complete, with responsibility for public health provision for children from pregnancy through birth and up to age five passing to local authorities.

Local authorities deliver their public health services for young children through the Healthy Child Programme 0-5, which covers the child's life from pregnancy up to the age of five. The programme, led by health visitors, is offered to all families with core elements including: health and development reviews, screening, immunisations, promotion of social and emotional development, support for parenting, and effective promotion of health and behaviour change (Department of Health, 2015a). Along with health visiting services and health and development checks, the programme could include activity to reduce childhood obesity, nutrition initiatives, programmes to prevent accidental injury and public mental health³.

The most recent government guidance on the Healthy Child Programme was published by the Labour government in 2009 (Department of Health, 2009), although Public Health England provided local authorities with an up-to-date review of relevant evidence in March 2015 (Public Health England, 2015a). While every local authority now has the ability to shape their Healthy Child Programme to meet local needs, some elements are required by regulations ('mandated'), specifically five health visitor checks: antenatal health promoting visits; new baby review; 6-8 week assessment; 1 year assessment; and a review when the child is aged 2 to 2½ (Department of Health, 2015b). These regulations are only in force until April 2017, and the Department of Health and Public Health England are currently reviewing the arrangements. There are also requirements

³ Some elements of the programme, such as immunisation programmes, are commissioned at the national level by NHS England.

in relation to maternity services starting at the 12th week of pregnancy⁴.

Giving local authorities responsibility for planning and commissioning local public health services has the potential to bring benefits for young children, and particularly those living in challenging social and economic circumstances, like many young refugee and migrant children. It means there is the potential for local authorities to bring a range of policies and services together to promote good health and well-being, looking at young children's health through the lens of other local authority services, such as housing and planning, parks and play provision, early childhood services and support for schools.

However, this change in public health provision is taking place at a challenging time for local authorities. The public health grant, allocated to local authorities by central government in light of their new duties, saw an in-year reduction of £200 million in 2015-16 (Department of Health, 2015c), and the Spending Review 2015 announced that it would reduce by a further 3.9 per cent every year until 2019-20 (HM Treasury, 2015). At the same time, local authorities have seen significant reductions to the funds available for early intervention services that help them to promote children's health and well-being, with more to come. It is estimated that central government funding for early intervention services, such as children's centres and family support, will fall by 71 per cent in real terms between 2010 and 2020. Overall, local authorities in England reduced their spending on children's centres, a key route to providing health advice and support to families of young children, by 48 per cent in real terms between 2010 and 2016 (NCB and others, 2016).

Tackling health inequalities

There is a clear expectation that local authorities will use their new role in delivering public health services to tackle health inequalities. In spending its public health grant, a local authority must "have regard to the need to reduce inequalities between the people in its area" (Department of Health, 2016). In addition, the Healthy Child Programme is based on a model of progressive universalism, with the expectation of more intensive or extensive work with families who are vulnerable to poor health outcomes or who have additional needs. The 2009 guidance on the Healthy Child Programme recommends that local needs assessments identify sub-populations in the community, including refugees and migrants, and set out action required to address their specific needs. It also states that one of the key outcomes that commissioners should seek to achieve through the programme is better short- and long-term outcomes for children who are at risk of social exclusion.

Charging for health services

Individuals who are 'ordinarily resident' are entitled to access free NHS secondary healthcare. The definition of 'ordinarily resident' was recently narrowed, under the Immigration Act 2014, to include only those who have indefinite leave to remain – although there are exemptions including refugees and asylum seekers. This means that some undocumented migrants are charged for most secondary healthcare. In addition, the government has consulted on proposals to extend charging to a range of primary care services, including GP services, primary dental care and prescriptions (Department of Health, 2015d). Although the same exemptions will apply, in terms of a migrant's status and in relation to specific services (e.g. GP and nurse consultations), these charges are likely to have implications for refugee and migrant children's access to public health services and for local authorities seeking to promote good health and well-being among their population of young children.

Research indicates that charging for secondary care poses a barrier to accessing healthcare even among those who may be entitled to it, due to confusion about entitlement among refugee and

⁴ For more details about the arrangements for local authority delivery of public health provision from pregnancy to age 5, see NCB (2016) Local authorities' role in public health: briefing for the children and young people's voluntary sector

http://www.ncb.org.uk/media/1242459/160218_local_authorities_role_in_public_health.pdf

migrant families and service providers and fear of unaffordable charges (Doctors of the World, 2016a; Maternity Action and others, 2013). Experts argue that this 'detrant effect' will only worsen with the introduction of primary care charging, whatever exemptions are in place (Dorling, 2013; Doctors of the World, 2016a).

Primary care is acknowledged as an important route to public health and preventative services; the Department of Health itself has recognised that children are heavily reliant on primary care for prevention services – such as immunisations and health checks through GP surgeries and links between GPs, health visiting and other services (Department of Health, 2013). So, there are concerns that the extension of charging to primary healthcare will undermine efforts to promote good health among all children – a requirement under the UNCRC – and the government's own immunisation programmes.

The health needs of young refugee and migrant children

Based on a review of available literature on the health needs of refugee and migrant families, this section outlines some of the issues local authorities will need to take into account when planning public health provision for young refugee and migrant children aged 0-5.

The available literature on the health of refugee and migrant children and pregnant women tends to focus on barriers to accessing primary and secondary healthcare, such as GP services and antenatal and maternity care. There is less of a focus on refugee and migrant families' access to the full range of services that can form part of a local authority's Healthy Child Programme, or the ways in which such services can be promoted successfully to these families. Nevertheless, the available material does provide some insight as to the public health needs of refugee and migrant families and the challenges they may face when accessing public health services.

Although much of what follows focuses on the prevalence of poor health outcomes among refugee and migrant adults and children, it is important to note that overall many migrants have *better* health than the 'native' population when they arrive in the UK. However, health can deteriorate after they settle in the UK, and there are variations between different groups of refugees and migrants, with researchers pointing to differing migration histories and socio-economic circumstances. In addition, much of the research depends upon qualitative studies or data that describe outcomes by ethnicity, as health data generally does not take account of individuals' country of birth or immigration status (Jayaweera, 2014).

Mental health

By far the most dominant issue highlighted in the literature is poor mental health. Anxiety, depression, phobias and post-traumatic stress disorder (PTSD) are some of the most frequently reported health problems among refugee and asylum seekers (Aspinal, 2011; Maternity Action and others, 2013; Jayaweera, 2014). These have been linked to individuals' experiences before and during migration, but also their circumstances when they arrive in the UK, including the immigration process itself and experiences of discrimination. For example, research has linked the immigration process and discrimination to greater PTSD scores, and uncertainty regarding one's asylum status or having a failed claim has been shown to have an effect on levels of depression (The Children's Society, 2012).

The most frequently identified needs for women assessed by Walsall's Specialist Health Visiting service are anxiety and depression requiring referral to mental health services.

See case study on page 18

Refugee and migrant children are particularly vulnerable to mental health problems. Unaccompanied asylum-seeking children and other separated migrant children, the majority of whom arrive in the UK alone, are especially vulnerable to experiencing post-traumatic stress disorder, low level and severe depression, anxiety, sleep disorders, self-harming behaviour, and loneliness (Brownlees and others, 2010; Aspinal, 2011; The Children's Society, 2012). Public health experts advise that the mental health needs of children seeking asylum are underestimated and neglected (Faculty of Public Health, 2008).

Refugee and migrant children are at a higher risk of mental health problems, when compared to their peers. However, young refugee and migrant children may also be indirectly affected through the impact of their parents' or carers' mental health problems on their care and the development of parent/carer-child relationships. For example, research has identified this indirect impact specifically in relation to women who have been victims of trafficking, with the mental health effects of trafficking having a negative impact on the relationship and interaction between mother and child (Anti-Trafficking Monitoring Group, 2016).

Pregnancy and birth

Access to good antenatal care is key to the promotion of good health among young children (Templeton, 2015). It prevents transmission of infectious diseases, reduces the risk of complications in pregnancy, improves health outcomes for later in life and provides opportunities for parents to access health advice for pregnancy and early childhood. Refugee and migrant women are more likely to be affected by poor outcomes in pregnancy and birth. For example, there are higher rates of maternal death among women from some Black and Minority Ethnic (BME) backgrounds and born outside the UK, compared to white women born in the UK (Jayaweera, 2014; Doctors of the World, 2014). Similarly, rates of stillbirth and neonatal death in the UK are higher for black mothers and those born in Pakistan, parts of Africa and the Caribbean (Maternity Action and others, 2013). Key risk factors associated with poor pregnancy outcomes include a lack of antenatal care or late booking, which is found to be particularly associated with mothers' African-Caribbean and Pakistani ethnicity, limited or no English language fluency, inadequate interpretation services within maternity services, a lack of social support and female genital mutilation. There is evidence of a higher prevalence of low birthweight among certain ethnic groups. Low birthweight is associated with later health issues in childhood such as obesity (Public Health England, 2014) – although data is not available by immigration status.

93% of the 80 pregnant women who used Doctors of the World's Family Clinic in 2015 had not accessed antenatal care prior to attending DOTW and 91% did not have a GP.

Data from Doctors of the World (2016b); see also Family Clinic case study on page 15

Infectious diseases

Available data indicates that certain infectious diseases, such as tuberculosis (TB) and HIV, are more prevalent in certain migrant populations or minority ethnic groups, compared to the broader UK population. For example, in 2014, the TB incidence rate in England's non-UK born population was fifteen times higher than in the UK born population, and people born outside of the UK accounted for 72% of reported TB cases (Public Health England, 2015b). In the UK, HIV is significantly more prevalent among people of black African ethnicity than any other ethnic group⁵. While higher prevalence of some infectious diseases in specific populations has been linked to poor or non-existent immunisation programmes in countries of origin (Faculty of Public Health, 2008), researchers also emphasise the importance of the context in the receiving country. For example, low income and poor housing conditions – such as overcrowding, poor ventilation and mould – contribute to the higher incidence of TB among refugees and migrants, and more broadly among ethnic minority communities, in the UK (Patel and others, 2012; Jayaweera, 2014).

Immunisation and screening

Immunisation and screening make up a key pillar of the Healthy Child Programme 0-5. There is evidence of lower uptake and immunisations and screening by non-UK born populations compared to those who are UK-born, though ethnicity and socio-economic status are also important factors (Jayaweera, 2014). Low rates of vaccination for children are reported in a number of studies in dispersal areas (Aspinal, 2011).

⁵ Data on HIV prevalence is available categorised by ethnicity but not region of birth; however, data on the region of birth for individuals diagnosed with HIV is available. Of 6,151 new HIV diagnoses in the UK in 2014, one in five were in people born in Africa. See Public Health England. *National HIV surveillance data tables to end December 2014. Tables No. 1:2015.*

Long-term and other health conditions

Reviews of the research also highlight that refugee and migrant populations in the UK may be affected by the impact of having undiagnosed or poorly managed long-term conditions – such as diabetes (Faculty of Public Health, 2008). The Faculty of Public Health advises public health leaders that dental problems are 'commonly reported' among refugee and asylum-seeking populations. This is a significant area of concern among young children in general; poor oral health in early childhood has been linked to problems with sleeping, eating and speech, resulting in potentially long-term impact on a child's development.

The importance of social determinants

When considering the health outcomes of refugee and migrant families and their implications for public health provision of young children, it is also important to consider the wider circumstances in which children are living and growing up. A review of the available literature identifies specific social, economic and policy factors that clearly have an impact on young refugee and migrant children's health (as well as the ability of their families to access services, the subject of further discussion below).

Poverty and destitution

The link between growing up in poverty and poor health in childhood has been widely acknowledged and was a central feature of Professor Michael Marmot's review into health inequalities in the UK (The Marmot Review, 2010). The research indicates that many refugee and migrant children are living in poverty and destitution – often as a result of immigration policies (see below) – impeding their health and development. For example, The Children's Society estimated that "many thousands" of migrant children are living without access to any mainstream support and without any formal means of obtaining an income (through their parents working for example). Such circumstances limit families' access to food, clothing, medicine and housing (Pinter, 2012) – all fundamental to a child's early health and development. Other research points to the relatively poor quality of local services in areas of deprivation, in which refugee and migrant families are more likely to live, as a key factor in the prevalence of poor health outcomes (Jayaweera, 2014). Child dependants of asylum-seeking adults experiencing disadvantage are at particular risk of poor health (Aspinal, 2011).

Poor quality and unstable accommodation

Experts point to the poor quality and instability of housing as a significant factor in the health of refugee and migrant families in the UK. Overcrowding, dilapidation, cold and damp, and housing insecurity have been linked to a range of health-related outcomes among children including: respiratory problems like asthma and bronchitis, accidental injury, poor mental health and household relationships and poor early childhood development (Harker, 2006; Fauth and others, 2010; Cutts, 2011; The Marmot Review Team, 2011; Ormandy, 2013). One study describes housing conditions for pregnant women and new mothers seeking asylum, with unhygienic facilities, insufficient baby equipment and inappropriate facilities for sterilising babies' bottles, with implications for early health and development (Maternity Action and others, 2013). The instability of accommodation for some refugees and migrants – including undocumented migrants or asylum seeking families being relocated across the country – can reduce access to support networks and increase social isolation, with implications for mental health and family relationships. Unstable accommodation also creates barriers to registering with GPs in order to access timely healthcare (Dorling, 2013). Undocumented migrant children are particularly vulnerable to living in poor quality or unstable housing (ibid.).

Of the 51 children accessing Doctors of the World's Family Clinic in 2015, half were living in temporary or unstable housing. Parents of 39 children were asked about family income; 97% reported living below the poverty line.

Data on children aged under 18 from Doctors of the World (2016b); see also Family Clinic case study on page 15

Immigration policies not related to health

Evidence shows that immigration policies not related to healthcare – such as levels of asylum support, dispersal, and cashless support – have an impact on families' health and well-being, by pushing families into poverty and destitution, limiting access to services and placing families in poor accommodation. Levels of asylum support – provided to destitute asylum-seekers and their dependants – have been frozen since 2011, representing a 7.5 per cent cut in real terms, and, if a child is born after an asylum claim has been refused, the family is only eligible for short-term cashless (voucher based) support (Children's Rights Alliance for England, 2015). The following examples illustrate how immigration policies can impact on young children's health:

- Maternity Action and Refugee Council (2013) have described the experiences of pregnant women being moved to other parts of the country days before giving birth, sometimes against medical advice and breaking social networks, being placed in poor quality accommodation and unable to use public transport with only cashless support. This will have clear implications for the outcome of these women's pregnancies but also the early health and development of the children.
- Research among victims of trafficking found that poor and slow decision-making within the National Referral Mechanism⁶ meant that victims were denied healthcare or saw their access delayed (Anti-Trafficking Monitoring Group, 2016).
- Written evidence submitted by the National AIDS Trust (NAT) to the Immigration Bill Public Bill Committee in 2015 raised concerns about proposals within the Bill to remove section 95 support⁷ from asylum seeker families whose appeal rights are exhausted (Immigration Bill Public Bill Committee, 2015). NAT argued that parents use their s95 support 'to directly prevent vertical (mother-to-child) transmission of HIV through the use of infant formula milk'. While UK national HIV guidelines recommend exclusive formula-feeding of infants born to mothers who are HIV positive in order to prevent transmission to the infant through breast-feeding, there is no NHS entitlement to free formula feed. NAT argued that removing s95 support would remove the support mothers rely upon to safeguard their infant's health.

Overall, the research indicates that there are specific health issues affecting refugee and migrant families which will have implications for the health and development of children in their early years. These health issues can be the result of experiences prior to or during migration, but have also been linked to immigration policies and families' living conditions, which can undermine parents' ability to promote a healthy start for their child. These issues will need to be taken into account by local authorities as they plan and develop their Healthy Child Programme 0-5, taking into account the specific needs of their local population.

⁶ A framework for identifying, and securing support for, victims of human trafficking or modern slavery. See <http://www.nationalcrimeagency.gov.uk/about-us/what-we-do/specialist-capabilities/uk-human-trafficking-centre/national-referral-mechanism>

⁷ Support that asylum seekers can apply for whilst awaiting decisions on their asylum applications and any subsequent appeals, provided under Section 95 of the Immigration and Asylum Act 1999.

Refugee and migrant families' experiences of using services

The following discussion of refugee and migrants families' experiences of public health services combines findings from a focus group run by NCB (see text box) and from the available literature.

Focus group with refugee and migrant parents of young children

In early 2016, NCB held a focus group with eight parents of children under the age of five at The Children's Society's [Family Voice](#) Project in London. The session aimed to gather the views of some refugee and migrant parents on what is important in keeping young children healthy, what services help and what makes it easier or harder. It was conducted in English.

Information on the immigration status of focus group participants was not gathered. However, most of the families known to the Family Voice Project have No Recourse to Public Funds and are awaiting the outcome of applications to extend their leave to remain or regularise their stay. A few have leave to remain but have a No Recourse to Public Funds condition attached to their leave. Many rely on accommodation and financial assistance provided to destitute families by the local authority under section 17 Children Act 1989. They have often moved around a lot and tend to be accommodated outside the boroughs in which they had previously lived.

Participants were asked to help build a visual overview of all the factors that keep young children healthy, and of the services and resources that can help. Parents' own ideas were used as the starting point, and supplemented with images representing different concepts relevant to, and aspects of, the Healthy Child Programme. This made it possible to gauge parents' awareness and experience of various elements of the Healthy Child Programme initially, then to ensure all relevant aspects were covered through the discussions.

Participants were then invited to categorise different services/resources as having been helpful to them, not helpful or accessible, or not known about. This exercise provided a basis for discussion about barriers to keeping children healthy and accessing services.

Parents' perspectives on what can help to keep their young children healthy

Participants in NCB's focus group demonstrated awareness of current health promotion messages relevant to young children, for example using toothpaste with fluoride, eating whole fruits and avoiding giving children too much juice.

When discussing the question 'How are children kept healthy?' the group recognised the role of all key factors addressed by the Healthy Child Programme. The Healthy Child Programme guidance, framed in terms of services targeting needs, mentions 'family support', though members of the group emphasised that families themselves are the primary enablers of children's health, by highlighting family time together and positive role modelling as important factors.

Participants were aware of a wide range of services, professionals and community initiatives and resources that can help to keep children healthy. These included key services involved in the Healthy Child Programme, as well as Accident & Emergency, NHS walk-in centres, the non-emergency telephone service (NHS 111), leisure facilities, play schemes, school trips and faith groups. Families had accessed community-based services, such as Sure Start centres.

Experiences of accessing services and resources

During the NCB focus group discussion, there were individual reports of excellent care and high satisfaction with NHS services and children's provision. When asked to categorise a range of services by helpfulness, participants gave the most positive responses to health visitors, pregnancy care, GPs and community organisations. Focus group participants mentioned faith groups as a source of support, both in terms of providing practical help and informing a child's attitudes and beliefs.

However, these positive experiences were counterbalanced by other negative experiences of trying to access health services, even to the extent of parents feeling discriminated against by healthcare professionals (one mother reported having been asked "Are you black or white?" by a 999 call operator when calling an ambulance for her baby).

Barriers to accessing services

Members of the focus group identified a number of barriers to accessing services that help them promote the health of their young children. This echoes the existing evidence about barriers to healthcare for refugees and migrants, which highlights the impact of: inadequate information, confusion around entitlement, and lack of knowledge and cultural insensitivity among staff. The literature also highlights some barriers that did not feature in the focus group discussion, including insufficient Interpretation and translation support, lack of reliable transport, living in areas of deprivation with poorer services, and a general fear of authorities (particularly among undocumented migrants who may worry about being reported to immigration authorities by other public agencies) (Dorling, 2013; Maternity Action and others, 2013; Jayaweera, 2014; Anti-Trafficking Monitoring Group, 2016).

In the focus group, navigating inconsistencies in provision was mentioned as a barrier to keeping young children healthy, for example, a 'programme for children' – possibly the minor ailments scheme – not being available at all pharmacies. One participant reported having been inaccurately advised by a health visitor that her family was not eligible for another service.

Several participants expressed that the upheaval of moving around created a barrier to accessing healthcare (as well as education) for their children. In particular, families had experienced administrative hassles and unwanted changes of GP due to moving out of practice catchment areas.

Social isolation was another reported obstacle to keeping children healthy; one mother said her child had become aggressive around other children because "we don't go out, we don't do anything". Some healthy activities, for example at leisure centres, were felt to be inaccessible due to cost. Waiting times, particularly at walk-in centres, were also mentioned as an issue.

General Practice

GP services play a central role in ensuring children access key elements of the Healthy Child Programme, from immunisations to antenatal care and health visitor checks. However, evidence suggests that refugee and migrant families face barriers to accessing General Practice.

Research into the experiences of undocumented migrant children describes confusion among GP staff, as well as the Primary Care Trusts of the time, relating to GPs' responsibilities for treating migrants who do not have leave to remain in the UK – with varied experiences across different surgeries (Dorling, 2013). This confusion can also affect access to support and services among families from the EU (Children's Rights Alliance for England, 2015).

Difficulties registering with GPs are also a concern in relation to pregnancy. One young undocumented migrant, Lilian (not her real name), sought help from Doctors of the World's (DOTW) Family Clinic when she was 10 weeks pregnant (Doctors of the World, 2015). DOTW volunteers phoned three GP practices before finding one that agreed to register Lilian. However, when she went into the practice to register she was turned away because she did not have a passport. By the time Lilian was accepted by a GP practice and started accessing antenatal care she was 15

weeks pregnant.

In November 2015, NHS England published guidance for GP practices and commissioners of primary care, clarifying that 'when applying to become a patient there is no regulatory requirement to prove identity, address, immigration status or the provision of an NHS number in order to register' (NHS England, 2015). GP practices have limited discretion to refuse patients, and must not discriminate on the grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition.

When participants at NCB's focus group were asked about experiences of GP registration processes, only a few reported experiencing problems, namely being asked to show passports (though details of these interactions and their outcomes are not known). One mother reported that her GP surgery has "done everything they can to help me in every way possible".

When asked which service they would turn to first if concerned about their child's health, the group agreed that they would first go to their GP, unless the service was unavailable or taking too long. However, staff at the Family Voice project mentioned that they encourage families to make use of GPs, as many go to A&E instead. It is not possible to tell if the answers of those parents who engaged with a focus group are representative of the service's broader client group, or if their use of health services is influenced by accessing the Family Voice Project.

Charging for NHS services

Evidence indicates that there is confusion about the government's current policy of charging for secondary care services and that this poses a barrier to vulnerable individuals, such as pregnant women and children, accessing healthcare. There is evidence of people from exempt groups (for example refugees and asylum seekers) receiving bills for NHS care, being denied care due to professionals' misunderstanding charging arrangements, and being deterred from seeking care due to fears about incurring charges from which they are exempt (Maternity Action and others, 2013; Doctors of the World, 2016a).

The case study below describes one pregnant woman's experiences. This woman was supported by Doctors of the World's Family Clinic, described in more detail on page 15.

Accessing care during pregnancy

Lucy (not her real name) is a 22 year old from China who speaks very limited English. Lucy overstayed her student visa.

Lucy was 3 months pregnant when she first came to Doctors of the World's Family Clinic. She didn't have a GP and had not received any antenatal care for fear of being *turned away or charged high fees*. She presented at the clinic with severe abdominal pain, and was weak and unresponsive.

After sending Lucy directly to A&E, where a scan showed that neither she nor her baby were in any immediate danger, DOTW helped Lucy to register with a GP practice and access antenatal care. During her first antenatal appointment, the hospital told Lucy about the fees she would incur during her pregnancy. Afraid that she would not be able to cover these costs, she was referred by DOTW to the Mary Ward Legal Centre for advice.

Lucy went on to receive regular antenatal care. She has not received a bill, but this is a great stress for her. She also finds GP appointments difficult because her GP does not use translation services "as [she] does not pay for GP services". Lucy also worries about how she and her partner will manage after she gives birth: "I don't have many friends or other people to support me. My partner works part-time so he is able to help me pay for our rent and buy us food, but I worry about how we are going to pay for things when the baby is born".

Case study provided by Doctors of the World

Doctors of the World's Family Clinic

Doctors of the World's (DOTW) Family Clinic helps some of the most marginalised individuals in society, including vulnerable migrants, to access healthcare. It provides specialist care for pregnant women and families with children under the age of 18.

The clinic (recently increased to twice a month) offers a specialist service including obstetric checks; child health assessments, assistance with antenatal referrals; GP registration; information on rights and entitlements; and referrals to advice services, support organisations, and food banks. In addition to this clinic, volunteers work on maternal and child health issues within the week-day clinic and follow-up complex cases.

Mental health and psychosocial support is integrated into the Family Clinic with social considerations, basic services and security forming the backbone of support. The Family Clinic also plays a role in identifying potential past or current trafficking, domestic violence and other safeguarding concerns. It makes referrals to Children's Services when needed, and supports access to services included in the Healthy Child Programme that have a strong safeguarding function. The clinic team also work with partner organisations to promote health and wellbeing by addressing the wider social and environmental determinants of health.

In 2015 the Family Clinic worked with 175 individuals, including 120 undocumented migrants, 11 refused asylum seekers, 25 refugees or asylum seekers, and five people with another form of leave to remain in the UK.

Pregnant women

In 2015, the Family Clinic worked with 80 pregnant women. It is recommended that all pregnant women receive antenatal care by 10 weeks; however, over half of these women were presenting with no access to antenatal care after 10 weeks, while 23% were presenting after 20 weeks gestation. Reasons for not accessing antenatal care included not having registered with a GP, fear of being reported and healthcare costs being prohibitive. The Family Clinic facilitated self-referral to antenatal care for 52 pregnant women and nine women required an additional urgent referral to hospital for immediate medical attention. Alarmingly, three women stopped attending antenatal care after receiving bills through fear of debt and being reported to the Home Office.

Children

In 2015, the Family Clinic helped 51 children under the age of 18, taking a child-centred and holistic approach to meeting the needs of families. Of the 51 children, 27 were under school age. Thirty were born in the UK, including 15 children who were considered undocumented; seven UK citizens; two asylum seeker dependants; two refused asylum seeker dependants; two children with leave to remain; one EEA national; and one refugee dependant.

Thirty children (59%) did not have a GP, despite half of their parents having attempted to register with a practice. Commonly cited barriers included administrative problems and issues with documentation such as no proof of address (21%) and lack of understanding or knowledge of the system and rights (28%).

The families of six children reported being denied healthcare. Over a third of children had no health cover at all or were considered fully chargeable for care.

Case study drawn from Doctors of the World UK Family Clinic: Annual Review 2015

See: https://www.doctorsoftheworld.org.uk/files/Family_Clinic_Report_20157.pdf

How does current public health guidance for local authorities address the needs of refugee and migrant children?

The evidence outlined above indicates that young refugee and migrant children have public health needs specific to their particular circumstances – although often linked to poverty, poor housing as well as immigration status and process. This should be taken into account by local authorities when developing their Healthy Child Programme 0-5. However, to what degree do current official guidelines on public health services provide local authorities with direction and support on the needs of these children?

There is limited official guidance to inform the work of local authorities in shaping their Healthy Child Programme 0-5 so that it meets the specific needs of refugee and migrant children. The Department of Health's 2009 guidance advises the targeting of immunisation programmes. In addition, more recent evidence-based advice, published by Public Health England (2015a) to help authorities with their new public health role, states that migrant families may be concerned about triggering child protection investigations when seeking care if their child is injured.

In addition to Department of Health and Public Health England guidance and evidence, local authority public health commissioners would be expected to draw upon public health guidelines published by the National Institute for Health and Care Excellence (NICE). A number of these do highlight the specific needs of young refugee and migrant children and their families. For example:

- Guidelines on depression in children (2005) advise that professionals in community settings be trained to detect symptoms and depression in children and young people and to understand factors associated with poor mental health, including refugee status (NICE, 2005, updated 2015).
- Guidelines on pregnancies in women affected by complex social factors provides healthcare professionals and commissioners with a model of provision and advice around antenatal care for women who are recent migrants, asylum seekers or refugees or who have difficulty reading/speaking English. Recommendations include additional training for healthcare professionals, working with local agencies to maintain correct contact details, flexibility to support the use of interpreters and provision of information in appropriate formats (NICE, 2010).
- Guidelines on immunisation (2009) identify children whose families are seeking asylum as a group vulnerable to not receiving their advised immunisations and recommend tailored information, advice and support for parents along with home visits (NICE, 2009a).
- Guidelines on physical activity for children and young people states that children of asylum seekers and refugees are in need of special consideration as many will have limited access to regular leisure, support and play activities. However, it states that there is little evidence about what might work to encourage more physical activity among these children and families (NICE, 2009b).

In conclusion, guidance on the Healthy Child Programme 0-5 recommends that local areas assess the needs of sub-populations, such as refugee and migrant children, and put in place appropriate services. There are some more specific references to the needs of refugee and migrant young children in guidelines to which local authorities may turn when planning their services. However, these documents tend to be at least five years old and limited in their scope and level of detail.

What action are local authorities already taking?

In addition to speaking to families, we wanted to gain a picture of what some local authorities are already doing as part of their Healthy Child Programme 0-5 to support refugee and migrant parents to promote the health of their young children. We reviewed the joint strategic needs assessments (JSNAs) and other publically available information⁸ for 16 local authority areas with significant proportions of residents born outside the UK. In addition we collected case studies from a local authority and Doctors of the World in order to share examples of practice in targeting public health services to young refugee and migrant children.

From the 16 areas we reviewed, we identified four specific examples of public health activity targeted at refugee and migrant children, including:

- **Sandwell** delivering health advice alongside immigration support and English language courses
- **Harrow** collocating services for migrant parents with child health promotion and development interventions within children's centres – including access to English language courses, food banks, Citizens Advice and oral health and child safety programmes
- **Walsall's** specialist health visiting service for asylum seekers, refugees, migrants and travelling families
- **Liverpool** undertook a health needs assessment of local asylum-seeking population, but concluded that a 'one size fits all' approach would not work because of the diverse backgrounds and experiences of this population.

While across the 16 areas the information we reviewed did not generally refer explicitly to refugee and migrant children, there was normally some consideration of the diverse needs of the population in a way that may benefit this group, such as addressing the needs of people from particular ethnic groups and of those newly arrived in the area.

⁸ For example other published strategies for refugees and migrants, children and young people and specific public health issues, and information available online about specific services.

Walsall's Specialist Health Visiting service

The service

Walsall is one of the areas in the West Midlands into which asylum seekers are placed whilst waiting for asylum claims to be processed. In Walsall, a Specialist Health Visiting Service for Asylum Seekers, Refugees, Migrants, Travellers and No Recourse to Public Funds Families has been developed. The needs of families using the Specialist Health Visiting service are diverse and complex. They often relate to experiences such as persecution, trafficking, sexual abuse, domestic violence and female genital mutilation (FGM).

The Specialist Health Visiting service provided to pregnant women and families with children aged 0-5 in this client group is supported by a robust system of interpreting and includes:

- an initial home visit after arriving in Walsall, which includes offering skills support and English for Speakers of Other Languages provision
- tailored initial health assessments (each woman and child is assessed and a care plan is formulated for each identified need)
- support to register with and access GP and dental services, local Sure Start children's centre provision, schools and other services
- an integrated multi-agency health approach
- responding to safeguarding concerns.

The Specialist Health Visitor also trains local health and social care professionals to improve access to and uptake of appropriate services for migrant families. The service strengthens partnership working between agencies, hosting monthly meetings that include the police; fire service; Walsall Council's Equality, Safety and Wellbeing service; Walsall Council's Crisis Support Team; Walsall Housing Group; Victim Support; the UK Border Agency; Citizens Advice; local charities and other relevant services.

The Specialist Health Visitor receives referrals from Birmingham Children's Services; Sandwell housing in which families newly dispersed to the area are accommodated whilst awaiting the outcomes of asylum applications; and a local hotel where families live whilst awaiting rehousing, attempting to regularise their immigration status (e.g. after overstaying visas), or appealing against refusals of asylum claims. The service also accepts referrals from outside the borough, and from families themselves.

Between January and April 2016, Walsall has accommodated 298 service users. Sixty-three families have required Universal Plus or Universal Partnership Plus health visiting service provision*.

Feedback indicates that clients are happy with the Specialist Health Visiting service, scoring it 10/10 in a questionnaire. Most respondents stated that the service helped them with behaviour, diet, education, GP appointments, referrals to other services, breast feeding and GP registration; and communicated on their behalf with social services, teachers and the Home Office.

* With Universal Plus support, families can access timely, expert advice from a health visitor when they need it on specific issues. With Universal Partnership Plus support, families with continuing complex needs receive ongoing support from health visitors, who play a key role in bringing together relevant local services.

Case study continued over the page.

One family's story

A young woman and her child supported by Walsall's Specialist Health Visiting service

A pregnant young woman from Nigeria was referred to Walsall's Specialist Health Visiting service by a local sexual health service. The young woman, aged 19, had been trafficked and coerced into sex work in the UK. She had undergone female genital mutilation (FGM) in Nigeria. Her partner had no recourse to public funds.

The young woman was supported by a range of services. Midwifery were involved when she was 28 weeks pregnant. She was placed at a safe house provided by the Home Office, but had to be relocated to another area. As a victim of trafficking, she was supported by the police and Victim Support. The young woman had fled from the perpetrators, who continued to threaten her and her family members in Nigeria. The unborn baby required a child protection plan because she was female and the mother's family in Nigeria were pressurising her to have FGM undertaken in this country.

After the young woman gave birth, she and her daughter were unable to visit the mother's partner, as he lived in the same area as those who had trafficked and sexually exploited her. The mother and her daughter had no family support in the UK. The health visiting service referred them to Sure Start for family support, and to the Breast Feeding Team.

The family stayed on a child protection plan for less than a year before being de-registered. They were able to transition to accessing universal health visiting services. The mother was given five years leave to remain and secured a property locally. Her traffickers were arrested and taken to court. The mother now attends college and attends Stay and Play sessions with her daughter at a local Sure Start Children's Centre.

By responding to the particular needs of this young mother and her child, Walsall's Specialist Health Visiting service was able to arrange and provide support that improved the short-term health outcomes of both mother and child, whilst also having potentially significant long-term benefit.

Case study provided by Dionne Frazer, Walsall Healthcare NHS Trust

Conclusion and recommendations

As local authorities develop their role in delivering public health services for young children from birth to age five, it is vital that they take action to tackle health inequalities affecting this age group and their families. The review of the evidence, undertaken for this report, indicates that there are specific health issues affecting refugee and migrant families which will have implications for the health and development of children in their early years. These will need to be taken into account by local authorities as they plan and develop their Healthy Child Programme 0-5, taking into account the specific needs of their local population.

Evidence shows that refugee and migrant children are particularly vulnerable to poor mental health, as a result of experiences before and during migration (if they were born outside the UK) but also due to the impact of immigration processes, discrimination and poverty. In addition, the mental health of parents and carers, and its impact on the provision of parental care and the formation of parent-child relationships, will affect young children's well-being and development. **Therefore, promoting good mental health among young refugee and migrant children, and also identifying where a parent or carer's mental health is having an impact on the child's health and development, will be an important consideration when local authorities are designing and developing their health visiting and other public health services.**

The research indicates that refugee and migrant women are less likely to access antenatal care and more likely to experience poor outcomes in pregnancy and birth. Immigration processes, particularly charging for healthcare services and dispersal, have been shown to impede the ability of parents to access good care or provide a safe environment after birth. **Refugee and migrant mothers' access to and experiences of antenatal care will have implications for the health and development of their child in infancy and the early years, so local authorities should work with health commissioners to tailor antenatal care to meet the needs of these families, drawing upon NICE guidelines.**

At the same time, the evidence indicates that social factors underlying health inequalities affecting *other* groups of children – such as poverty and poor housing – have a part to play in the relatively poor health outcomes of some refugee and migrant children. **Local authorities will want to include targeted activity among refugee and migrant young families in their broader strategies to tackle health inequalities and promote good health and development among all young children living in their area.**

A review of relevant policy and guidelines that will provide direction to local authorities in relation to their public health responsibilities for young children revealed that there is limited information on shaping the Healthy Child Programme 0-5 so that it meets the specific needs of refugee and migrant children. In addition, while there has been a more recent evidence review, government guidance providing a clear and detailed steer to local authorities on their responsibilities, particularly in tackling health inequalities, dates back to 2009. **It is recommended that the Department of Health and Public Health England review and refresh guidance on the Healthy Child Programme 0-5, ensuring that this contains a strong focus on reducing health inequalities, including those affecting vulnerable refugee and migrant children.**

During the focus group, parents of young refugee and migrant children shared positive experiences of public health services in their area, including the support they received from health visitors, maternity services, GPs and community organisations. Nevertheless, the group did identify barriers to accessing care, which echoed findings from the literature about the experiences of accessing healthcare among refugee and migrant families. **When planning their public health provision, local authorities will wish to consider how to overcome these barriers, including: providing adequate and accessible information and interpretation and translation services, ensuring clarity around entitlement and good practice among staff and managers and promoting knowledge and understanding of the specific health needs of refugee and migrant families among the range of services engaged in the Healthy Child Programme.**

Registration with a GP is key to a families' access to the Healthy Child Programme 0-5, providing a route to immunisation, antenatal care, health checks and other health visiting services. However, research indicates that refugee and migrant families face barriers to accessing GP services, including confusion around entitlement and registration requirements among families and GP staff.

As part of their public health responsibilities, local authorities should take action to address these issues, ensuring GP staff understand their responsibilities and making sure all families in their area are registered with a local GP.

Experts have argued that charging for secondary healthcare poses a barrier to vulnerable refugees and migrants accessing care, even for those who are entitled to free care or who will not be charged before receiving care. In particular, research with refugee and migrant women who are pregnant indicates that fear of large bills, or requirements around the provision of documentation, act as a deterrent to accessing antenatal care, with implications for the mother's health and the child's early health and development. Proposals to extend charging to primary care – a key route through which children access public health services – will only aggravate this issue, undermining the government's intention to provide a universal Healthy Child Programme and its ability to fulfil obligations under the UN Convention on the Rights of Child. **The government should introduce a blanket exemption from charges for primary and secondary healthcare for all children and pregnant women.**

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National Children's Bureau
8 Wakley Street
London, EC1V 7QE
T: +44 (0)20 7843 6000
F: +44 (0)20 7278 9512
www.ncb.org.uk



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