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Introduction

Health promotion is a vast subject, and an area which deserves more attention. It is a significant part of the work performed by a broad range of people who work in health care and those involved in education and social welfare, along with the concerned and proactive members of the community. This essay intends to explore the primary health problems and needs that may frequently affect children in refugee and asylum seeking groups. Furthermore, there are a number of health promotion strategies available which merit exploration as they could potentially support children, in particular those under the age of 14 –who are considered the most vulnerable population group.

An overview –refugees and asylum seekers in Canada and Australia

The United Nations 1951 Convention defines refugees as people who are "outside their country of nationality or their usual country of residence", and Australia is one of the 146 signatory countries to the UN convention (Australian Government, 2008). Refugees may also be described as people who are either unable or unwilling to return to their country, and are incapable of seeking protection from that particular country. There are various reasons for this, such as a justifiable fear of being prosecuted on the grounds of religion, race, nationality, political views, etc. There may also be extraordinary circumstances for why people seek asylum, for instance; war, famine, or environmental collapse, etc. In majority of cases however, the end result is that refugees are endeavoring to find a better life for themselves and their families. Seeking asylum means that a person is seeking legal and physical protection, and therefore refugees often become 'asylum seekers' at some stage.

Statistics show that Australia and other countries such as Canada, are accepting increasing numbers of refugees and asylum seekers. However, there has been a slight decrease in the number of applicants over the past years, as demonstrated in the table below.

	1997	1998	1999	2000	2001	2002	2003	Total
Australia	9,312	8,156	9,451	13,065	12,366	5,863	4,295	86,162
Canada	22,584	23,838	29,393	34,252	44,038	39,498	31,937	299,738
Denmark	5,092	9,370	12,331	12,200	12,512	6,068	4,593	79,814
France	21,416	22,375	30,907	38,747	54,291	58,971	59,768	350,283
Germany	104,353	98,644	95,113	78,564	88,287	71,127	50,563	958,165
Italy	1,858	11,122	33,364	15,564	9,620	16,015	13,455	105,191
New Zealand	1,495	1,972	1,528	1,551	1,601	997	841	12,403
Sweden	9,662	12,844	11,231	16,303	23,515	33,016	31,348	171,359
United Kingdom	41,500	58,500	91,200	98,900	91,600	103,080	60,047	679,027
United States	52,200	35,903	32,711	40,867	59,432	58,439	43,338	723,662

Figure 1.1: The number of asylum applications submitted in the first instance in Australia and 'Like' Countries, 1997-2003 (Refugee Council of Australia, 2003).

According to NCCA (2008), there has been a significant decline in the number of asylum applications in industrialised or developed countries since 2002, and by the beginning of 2005 they were at "a 17 year low". This proved to reduce the pressure of asylum states, and as a result led to a possibility that it would weaken public campaigns seeking tighter controls on immigration policies. In terms of epidemiology (the study of factors affecting/ influencing the health of populations), the countries listed above (more developed countries) tend to have higher numbers of refugees.

Main health problems and needs common to children in refugee and asylum seeking groups

PudMed (1997) conducted a study (based in the United States) which revealed that refugees often suffer from diseases originating from their country of origin. It also concluded that major health problems in many of the asylum seeking groups include; tuberculosis, nutritional deficiencies (malnutrition), intestinal parasites, chronic hepatitis B infection, lack of immunization, and depression. Also, other infectious diseases, psychological health issues, unresolved or untreated previous injuries, and oral health issues are common. It is unrealistic to try to generalise all refugees and their associated health issues, as there is great variation in the health and psychosocial issues, as well as cultural beliefs, among the refugees. However, it is possible to identify these commonly occurring health issues and consequently identify the holistic health issue/needs that relate. Holistic healthcare considers not only physical health but also the spiritual, social, cultural and mental well-being of the person.

Mental

Many refugees and asylum seekers have survived horrific torture and trauma in their homeland prior to seeking asylum, however many experience an array of mental health issues as a result of being subjected to long-term detention. Common health issues include mental anguish, depression, trauma and psychological damage (Amnesty International Australia, 2007). Detention has proven to have an immense affect on the psychological well-being of asylum seekers, and under current Australian law, even children asylum seekers can be "arbitrarily detained for an indefinite period while their claims for refugee status are being assessed" (Amnesty International Australia, 2007). Detention leads to ongoing stress and tension, as there is usually no end in sight, and are asylum seekers are often distressed by their previous experiences. For instance; many are survivors of torture and prosecution, and have left their family members behind. Dr Choong-Siew Yong (Vice President of the Australian Medical Association, 2006) states:

"Indefinite detention is bad for a child's physical and mental wellbeing. We see severe and chronic post-traumatic stress disorder among asylum seekers during and after detention." (Amnesty International Australia, 2007).

Mental health problems are seemingly on the rise in Australia in particularly, due to the mandatory detention centres. It has been accused of traumatising asylum seekers "to the point where they could be beyond medical help" (Refugee Action Committee, 2005). Traumatised refugee children may show mental problems via behavioural problems, lack of confidence or trust, post-traumatic stress disorder, depression, anxiety, or withdrawal from other children and their parents, for instance (NSW Refugee Health Service, 2003). Psychological health issues may also be exposed through eating and sleeping disorders, bed-wetting, sleep walking, and speech problems. Statistics reveal that 45.6% of refugees are aged under 18, out of the total 6.1 million refugees worldwide (MJA, 2002). This brings to attention the need to address the issue of mental health problems, as a number of refugee children suffer from this type of illness, yet MJA (2002) confirms that research data on this subject is "scarce" so far.

Physical

Physical health relates to how the body functions. The physical health problems of refugees/ asylum seekers are often caused by either the effects war or torture. The main issues include; poor dental/ oral health, headaches, chronic pain, hypertension (high blood pressure), deafness, diabetes, and tremors along with weakness, sweating, fainting and diarrhoea. Other physical problems are delayed development and growth in children refugees, and injuries/ disabilities; including fractures, burns and scars (Friends of Startts, 2006).

Poor oral health is a major problem in refugee children, due to the fact that poor nutrition combined with substandard dental care and hygiene can often lead to children presenting with gum disease and severe caries (NSW Refugee Health Service, 2003). Refugee families also lack education regarding healthy eating and the relationship between dental caries and diet, and therefore many refugee children are also suffering from malnutrition and vitamin deficiencies. The NSW Health Service (2003) claims that children originating from the Middle East and Africa and are at risk of developing a vitamin D deficiency (as predisposing factors include dark skin, reduced sun exposure, lack of oral supplementation, etc), which can in turn lead to the bone deforming disease known as rickets. Nutritional deficiencies is a major health factor affecting children, as it can result in delays in physical development and growth as well as a susceptibility to acquiring illnesses such as chronic infection.

Furthermore, many refugee children may have "incomplete immunisation", and thus it is important to consider certain diseases in the differential diagnosis process, in particular HIB (hepatitis B) and measles (NSW Health

Services, 2003). Other common illnesses among refugees include malaria, skin infestations, intestinal parasites, HIV infection, and exotic skin infections, along with untreated or unresolved injuries –evident in refugee children from conflict-ridden countries (e.g. injuries from landmines or shrapnel for instance).

Cultural

Stein (1980) comments that refugees are people "...caught between danger at home and a loss of identity in a strange land". This basically summarises in a concise way, the cultural aspect affecting refugees and asylum seekers. Refugees often arrive in foreign countries where they tend to feel different and somewhat isolated, however due to the diversity of refugees, specific refugee situations are treated as unique whereas it may be more beneficial to observe the overall pattern –such as identical patterns of behaviour.

Refugees may experience 'culture shock', which is defined as the feelings a person can endure when taken from a familiar environment and forced into a completely different environment (Exodus, 1982). In a new environment, refugees (of all ages) encounter people with an altered way of thinking and dissimilar behaviour. Cultural shock may result in the refugee encompassing a feeling of rejection towards the environment surrounding them. Exodus (1982) suggests that this feeling of regression may mean that the home country of the refugee becomes important, and they tend to only focus on and remember the good experiences/ memories there. In addition, individuals undergoing cultural shock may be subjected to several symptoms or indicators including; a concern for pains /skin eruptions, feelings of anger (or frustration, unhappiness, anxiety, loneliness, etc), a longing to be home among understanding people, a helplessness (as a form of dependence on similar people), a particular concern for cleanliness, fear (e.g. of being injured, robbed, cheated, etc), more irritation shown when things go wrong, and a delay or refusal to learn the language of the new country (Exodus, 1982).

Spiritual

All refugees should have the right to a type of assistance during their time of asylum, which ensures their spiritual needs (among other needs) are met throughout the process of integration in the host country (Pontifical Council, 2008). Spiritual needs are important, as they can enable the refugee to find comfort during their severe trial, which is especially essential to children who may not be able to depend on their parents or family alone for support during this difficult time. As reflected by NSW Health Service (2003), a child's health is closely related to the health and security of his/ her parents (or primary caregiver) particularly when it comes to psychological health, in which spiritual needs are associated. A large percentage of the refugee population is comprised of children, and they tend to be more affected by trauma and consequently their spiritual balance may be jeopardised (Pontifical Council, 2008).

One refugee expressed to Refugees International that they are "...grateful to the government for financial assistance, but we have spiritual problems. We can't live one without the other" (Refugees International, 2008). This further demonstrates the need to incorporate spiritual assistance in the healthcare programs of refugees and asylum seekers.

Social

Being a refugee can be considered a condition of intense stress, predominantly because it is associated with various traumatic experiences. This often leads to a severe impact on the social health aspects of refugees. Behavioural and social problems may be detected in adolescence, and there are several main categories. Theses include; withdrawal, attention problems, somatic complaints, social problems, thinking problems, anxiety-depression, aggressive behaviour, and delinquent behaviour (Priory, 1999). There are many reasons for why social and adaption problems occur amongst refugees, for instance perceived discrimination, along with mental problems, etc (Oxford Journals, 2007).

Health promotion strategies

As WHO (2008) describes, strategies in regards to health promotion "...are not limited to a specific health problem, nor to a specific set of behaviours". In other words, the principles of health promotion apply to variety of aspects, such as risk factors, diseases (in diverse settings), and a range of population groups. Health promotion is defined as a "central strategy", which is designed to encourage and further advance a healthier society (Naidoo et al., 2000). It relates to education, community development, policy, legislation and regulation. Health promotion may be appropriate for the prevention of communicable diseases, injury, violence, and mental problems (as they are for the prevention of non-communicable diseases).

There are general principles and strategies relating to health promotion that are important to consider, in particular; strategies of enabling, mediation, and advocacy. These are health promotion approaches which prove useful to professional healthcare facilities/ environments, along with the overall community. In brief, 'advocacy' refers to supporting or promoting good health and quality of life in all aspects –whether it is economic, social, cultural, environmental, etc. The aim of health promotion is to construct favourable conditions via advocacy for health (Talbot & Verrinder, 2005, p.248-249). To 'enable' health promotion simply means to facilitate and focus on achieving justice in health. Health promotion therefore strives to ensure there are equal opportunities and resources made available to people, in order for them to achieve their maximum health potential. In terms of 'mediation', this can be described as arbitrating health promotion demands, and this may be accomplished through governments, local authorities, volunteer organisations, the media, etc (Talbot & Verrinder, 2005, p.249).

Health promotion strategies and programmes can be embraced by all

individuals in the community, and there are many avenues to explore when considering this subject. For instance, there are organisations such as STARTTS which is set up to help refugees who have suffered from trauma or torture. On a similar note, refugee advocate organisations such as UNHCR (United Nations agency) are mandated to care for refugees worldwide. On the other hand, healthcare professionals and other concerned members of the community are invited to participate in volunteer organisations and there are many opportunities for us to become involved. One example is 'World Refugee Day', which is celebrated on June 20 to "celebrate the extraordinary courage and contributions of refugees, past and present" –as articulated by Kofi Annan (United National Secretary General). Information on how to become actively involved is available at 'Australians for UNHCR'. There are immense resources accessible on the ways in which individuals can assist with health promotion, whether it is on a global, national, or local scale, and the resources are ever-expanding.

Summary

The aim of health promotion is to achieve a healthier society in a variety of respects –environmentally, economically, spiritually, emotionally, and physically, to name a few. In order to attain these values, support is needed in a global sense as well as on a national and local scale. As previously established, there is a diversity of health problems and needs regarding refugees and asylum seekers across the world, and children make up the vast majority of this population of people. Through the guidance of resources such as the 'Ottawa Charter for Health Promotion' (WHO, 1986), we can all create a positive difference to the well-being of refugee children, and thus enhance their life in their new host country.

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