MEDICAL PRACTICE

Child Health in Ethnic Minorities

The difficulties of living in Britain

JOHN BLACK

This series of articles will consider the medical and sociomedical problems of children belonging to the main ethnic minorities in Britain. The first two articles deal with general aspects, and later articles are concerned with the diseases of children of families originating from India, Pakistan, Bangladesh, including Asians from east Africa; the West Indies and Africa; the Mediterranean and Aegean; and China and Vietnam.

An ethnic minority is a group of individuals who consider themselves separate from the general population, and are seen by the population at large to be distinct because of one or more of the following: common geographical or racial origin, skin colour, language, religious beliefs and practices, or dietary customs. Generally such minority groups live in fairly well defined areas in our cities and large towns. The term Asian is used to describe people from the Indian subcontinent and also those who, though originally from India, entered Britain from east Africa. The South East Asian minorities considered here are the Chinese and Vietnamese. In working with families of the various ethnic minorities in Britain doctors and others should avoid "stereotyping" and appreciate that each individual's responses and adaptations to Britain are unique.

Why the children are important

Britain has a long history of acceptance, with varying degrees of tolerance, of peaceful immigration from different parts of Europe, and Italian, Greek, and Cypriot communities have been established in Britain for many generations. Immigration from outside Europe on a large scale is something new and has brought with it problems that were previously unfamiliar to the health services. Even now there is still inadequate instruction about the needs and diseases of minority groups in our medical and nursing schools. The medical and nursing professions have little knowledge of their cultures, religion, and dietary customs, though these often have a direct bearing on medical conditions in the children, and there is a poor appreciation of the difficulties that many families face in adapting to life in Britain.

It is often through its children that a family first comes into contact with the medical services, and the family's subsequent attitude to medical care may be determined by the amount of tolerance and understanding which it receives over its children from doctors, nurses, and non-medical staff. Members of the groups that are the subject of these articles have a high incidence of conditions which do not occur, or are rare, in the general population of the United Kingdom. Most of these conditions, particularly those of genetic or nutritional origin, become apparent in infancy and childhood. Tuberculosis and the tropical and subtropical infections and infestations are often acquired in childhood. Finally, emotional and behaviour disorders in the children are often a symptom of difficulties in adjustment which the whole family is experiencing.

Types of disease

GENETICALLY DETERMINED DISEASE

In some groups genetically determined disease occurs with sufficient frequency and severity to constitute an important health problem—for example, sickle cell anaemia in the West Indian community occurs in about 1 in every 400 children born. β Thalassaemia in the Greek, Cypriot, and Italian communities is now much less common than it was a few years ago, due to screening in antenatal clinics and fetal diagnosis of the homozygous state. Similarly, glucose-6-phosphate dehydrogenase deficiency occurs in the West Indian, African, Mediterranean, Chinese, and Vietnamese communities but rarely causes serious problems in the United Kingdom except when neonatal jaundice occurs. However, if properly treated these conditions do not cause the same amount of distress and disability as does cystic fibrosis, which is the commonest genetically determined recessive condition in European

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populations. Both cystic fibrosis (1 in 1250-2500 live births) and phenylketonuria (1 in 7000-10 000 live births) are very rare in the Asian, African, and Chinese communities.

In communities where marriages between first or second cousins are common, as in Moslems from Asia, other recessively determined disorders occur with a much greater frequency than in a population where such marriages are rare. Most of these conditions are metabolic disorders, which become apparent in the neonatal period or early infancy, though there also appears to be an increased incidence of multiple congenital malformations, which are probably of genetic origin. Homozygous β thalassaemia (major) is relatively common in Moslems from Pakistan.

ACQUIRED DISEASES

Among people of Asian origin nutritional disorders such as iron deficiency anaemia and rickets manifest themselves in infancy or childhood, and tuberculosis is relatively common in both adults and children. Diseases of the tropics and subtropics, such as malaria and worm and intestinal infections, are all seen in Asian children who have lived in or visited the Indian subcontinent. Established rheumatic heart disease may be found in the older children of any of the immigrant groups.

ALTERNATIVE OR "INDIGENOUS" MEDICINES AND TRADITIONAL PRACTICES

Obscure or puzzling symptoms may be due to the effect of medicines sold over the counter or prescribed by unqualified practitioners in the community. Physical methods of treatment, such as "coin rubbing" or cauterisation produce lesions that may be attributed to child abuse, while in Asian children the application round the eyes of cosmetics which contain lead may expose the child to the risk of lead poisoning.

DISEASES RELATED TO POOR SOCIOECONOMIC CONDITIONS

Low wages, long working hours, and night shift working are common in families from Asia and the Caribbean, and overcrowding and bad housing result in a high incidence of respiratory and gastrointestinal infections. If both parents are working the children may become emotionally and socially deprived if left with a baby minder.

Problems of adaptation and their effect on the children

Cultural shock may develop after a family arrives in Britain, with a severity which is related to the amount of change experienced, and may be initiated by unsympathetic or degrading immigration procedures and exacerbated by difficulties in obtaining accommodation or employment. Adult members of the family may develop a confusional state, paranoid attitudes or behaviour, or depression, causing the children to become anxious and insecure because of the altered behaviour of their parents. Cultural shock may be succeeded by more permanent states of mind, such as suspiciousness, feelings of insecurity, fear of persecution or physical violence. Fortunately, in most groups there is usually considerable support available from the rest of their own community or from family members already established in the United Kingdom. At the moment few children are arriving as immigrants, apart from those, mainly from Pakistan and Bangladesh, who are joining their fathers already established in Britain. The Vietnamese "Boat People," without any established community to help them, suffered severely when they settled in Britain.

Insecurity—Insecurity in the parents may manifest itself by a constant anxiety about the health of their children, requiring repeated reassurance, numerous hospital referrals, and requests for investigations and second opinions. There is often a tendency to magnify the child's symptoms. Anxiety about poor weight gain or small stature may indicate a desire that the child, especially a boy, should become as tall and strong as possible to cope with a physically hostile environment. Other signs of parental insecurity include an undue concern about recurrent upper respiratory infections in their children, though this is sometimes simply due to a failure to appreciate that such infections are as inevitable in Britain as are gastrointestinal infections in Asia or Africa.

Reasons for coming to Britain—It is helpful to have some idea of the reason (which is usually the same in each group) why the family came to Britain, since this may influence their readiness to adapt to life in this country. Groups who maintain strong links with their home by frequent visits and live in a closely knit community with its own shops and organisations may not need to alter their way of life very much. Those who have been forced to leave their country because of political, racial, or religious persecution are more likely to have to accept the reality of permanent residence here because they may have little prospect of returning. In most cases families have come to Britain from areas with a depressed or declining economy and few opportunities to improve their standards of living. At the time when most recent immigration occurred, between 1950 and 1970, Britain offered such opportunities, but with the present high level of unemployment many families from Asia and the Caribbean have the worst housing and poor prospects of employment for their children.

Divided families—Marital difficulties and emotional upsets in the children may arise when families are split up, often for years, while the father establishes himself in a job or in business in Britain, or there is a delay in obtaining an entry permit. Children born to a couple in their 40s or 50s who have been separated for some years may suffer from the rigidity of outlook which often occurs in older than average parents.

Concept of illness and disease—The idea of follow up appointments and long term treatment does not come easily to families from countries where disease is treated episode by episode or only when a crisis occurs. Attendance at follow up appointments is poor in many Asian families, partly for these reasons and partly because the mother may be unwilling or unable to bring the child on her own, while the father may not want to risk losing his job by repeatedly taking time off work. Particularly when discussing genetically determined disease or mental retardation, and in giving advice, the help of someone with the same cultural and religious background as the family may be required.

The child's problems

Pressure to succeed—Parental pressure to succeed is often considerable, particularly in those groups which came to Britain with high financial expectations or where, as in the Asians from east Africa, the father has been unable to obtain a job of the status equivalent to that which he left. The child may respond by school refusal or by difficult behaviour at home or at school, particularly when he or she is unable to live up to the parents' hopes or expectations.

Useful Addresses

Ethnic Minorities Group, Greater London Council, County Hall, London SE1 7PB	01 633 1277/8
Joint Council for the Welfare of Immigrants, 44 Theobalds Road, London WC1	01 405 5527
Community Health Group for Ethnic Minorities, 28 Churchfield Road, London W3 6EB	01 993 6119

Poor school progress may be due to lingustic difficulties at school entry and may be an acute problem in an older child who has recently come to Britain. In families who run restaurants the children may be expected to help behind the scenes instead of doing their homework.

Transcultural problems—Older children, particularly teenagers, often have difficulty in reconciling the patterns of behaviour which they learn at school with those required of them at home. Asian girls may be expected to stay at home in the evenings and not to go out to discos. The prospect of an arranged marriage can be deeply disturbing to a girl brought up in the United Kingdom. Children who can be instantly categorised as being "non-European" because of skin colour or facial appearance may have great difficulty in establishing their true identity and gaining acceptance in the community as a whole.

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Further reading

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Needs and Opportunities in Rehabilitation

Rehabilitation of patients with cardiac conditions

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In the gymnasium of a district general hospital a man of 65 told me how he could again walk in the Welsh hills without breathlessness. He had joined the cardiac rehabilitation programme in despair after a severe myocardial infarction. But how much of his success was due to a conditioning effect of the set exercises and how much to the support and counselling that went with them, and consequent changes in his life? This question sums up many of the features of cardiac rehabilitation, in which it may be difficult to pinpoint the physical effect, if any, of modest exercise programmes but easy to sense a gain in general wellbeing. The services I discuss apply chiefly to myocardial infarction but also to heart surgery.

In 1970 a tiny minority of hospitals offered rehabilitation facilities after myocardial infarction.[1] Five years later a joint working party on the subject believed that things had not greatly improved.[2] Since then there has been a steady growth of both general rehabilitation services and exercise training; in Birmingham, for example, about half the hospitals have formal exercise programmes. In one sense the need for these has become less acute, with early mobilisation and discharge preventing the severe deconditioning and invalidism that used to be the rule.[3] But there is more interest in the possibility of speeding full recovery and achieving considerable fitness, if not lessening future risk, with exercise programmes,[2-5] sometimes as part of a broader rehabilitation programme.[6]

Nature of rehabilitation services

After leaving hospital someone who has had a myocardial infarction may be left to take pot luck as regards rehabilitation. On the other hand, serious attempts may be made to change his goals and life style[7]—or something in between may be offered. Aftercare ranges from occasional outpatient visits to (rarely) residential courses, and structured programmes are arranged both in groups and for the individual to follow at home. Printed schedules for graduated walking and other activities may be used with or without a formal exercise course.

In Britain formal rehabilitation typically consists of exercise sessions with counselling on such matters as diet, smoking, and life style. Classes usually last half an hour to an hour, two or three times a week; they start about a month (or even less) after the infarction and generally go on for a month or two—but sometimes much longer. Pointing out that optimal conditioning of such patients may take one or two years, a report by the American Medical Association advocates supervised training for the first three to six months (more if necessary) and thereafter a programme without medical supervision.[4]

A typical class consists of circuits of exercises; apart from graduated exertion (possibly intermittent at first[3]), the aim should be to use the types of muscular work of daily life, directed at muscle relaxation as well as strength.[9] Games are usually included for the essential element of fun. At one class I watched the sense of enjoyment was obvious, and the patients could chat informally about any problems to the sister from the coronary care unit who ran the programme.

The level of exercise varies widely. At Northwick Park Hospital, Harrow, for example, the course starts as little as 17 days after infarction and is therefore very mild, the aim being to create confidence and show the patient what he can do rather than increase fitness. At the other extreme is vigorous exercise that needs monitoring and resuscitation facilities and depends on formal exercise testing; this kind of programme is less usual in Britain. In a Toronto programme a few have graduated to serious running and even marathons.[10] Levels that have been recommended are 70%[5] and 75-85%[2,9] of the maximum heart rate and 50-75% of the maximal oxygen uptake[4] (a slightly lower range). Exercise testing is strongly recommended by the British joint working party[2] and the American Medical Association[4] as pro-

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