Migration and child health: the Dutch experience

Abstract Nearly one million of the fifteen million inhabitants of the Netherlands are directly descending from migrant parents. Of these inhabitants, 75% come from former colonies (Surinam and the Netherlands Antilles) and Mediterranean countries like Turkey and Morocco. The mortality rate of Turkish and Moroccan children under 15 years of age is two to three times higher compared to Dutch children. Main causes are perinatal death (including congenital malformations), accidents and drowning, infectious diseases and death during holidays in the country of origin. Inequalities in health between the migrant and Dutch children are demonstrated in several surveys conducted at both national and local levels. Apart from socio-economic differences, this can be attributed to three main causes; different pathology due to imported infectious diseases or inherited disorders, different life style and socio-cultural factors. The cumulative factor explains the differences in health, comparable with several other countries in Europe where migrants from Mediterranean countries and former colonies live.

Conclusion Migration has an increasing impact on the daily practice of Dutch paediatricians as well as elsewhere in Europe. Inclusion of intercultural and international aspects of health in the curriculum of the medical paediatric education is paramount.

Key words Migrant children · Child health · Social paediatrics · Intercultural aspects · Tropical medicine

Introduction

Migration has always been inherent to mankind, influenced by economic, social, political or religious differences. All over the world population movements have regularly taken place and resulted in settlement and often integration of the newcomers. In most European countries between 4% and 10% of the population come from a foreign country. In the United Kingdom immigrants mainly come from former colonial countries like India, Pakistan, East Africa and the Caribbean. In Spain, Portugal and Italy too, migrants are mainly from former colonial countries and from other north African countries. France, Belgium and the Netherlands have a mixture of former colonial citizens and migrant labourers from the Mediterranean area. In Germany and the Scandinavian countries they are mainly migrant labourers from Mediterranean countries. It is estimated that there are over 15 million immigrant workers in western Europe. During the last 5 years eastern European citizens seek asylum all over western Europe, creating a new and unforeseen problem. Their number exceeds 1 million persons. As one third of the migrant population consists of children, extra attention of European governments goes to this section of the migrant population. In the Netherlands this has resulted in many studies, conferences and projects. Different approaches have had varying success as the problem is com-
plex and changes in the course of time. This article presents an overview of the Dutch situation, which is comparable with several other countries in western Europe.

**Migration**

The Netherlands, with its 15 million inhabitants, has always been an immigration country, well known for its hospitality and founded democratic principles. During the last three centuries major migrations have taken place from France, Belgium and eastern Europe. Population statistics of Amsterdam indicate that between the 17th and 19th century 20%–30% of the newly married came from outside the Netherlands [9]. In the 20th century many people settled in the Netherlands during World War I, when the Netherlands remained neutral. After World War II over 280,000 people immigrated from the former colony Indonesia, the first major population movement from outside Europe. Since the early 1970s migrant labourers from Morocco and Turkey have been encouraged to come to the country, soon followed by their families and relatives. When Surinam became independent in 1975 nearly half the population decided to move to the homeland of their former colonial ruler. At present over 6% of the Dutch population, nearly 1 million people, directly descend from migrant parents. Of them, 75% are from Surinam (240,000), Turkey (210,000), Morocco (170,000) and the Netherlands Antilles (80,000). Nearly half of them live in the four major cities, where 15% of the population and 40%–50% of the children are of foreign descent. Between 1986 and 1990 the Turkish people in the Netherlands increased by 22% while the Moroccan group grew by 27%. This is partly due to a birth rate that is twice that of the original Dutch population [17].

Apart from migrant labourers and ex-colonial movements, an increasing number of refugees and asylum seekers are entering the Netherlands. In 1994 over 50,000 persons asked for asylum in the Netherlands, many of whom will remain as accepted refugees. One quarter of them are children under 16 years of age [11].

**Inequalities in health**

During the last 15 years much research has been conducted on differences in health and disease between migrant children and Dutch children. Socio-economic factors are the main cause for the recorded inequalities in health, but even after correction for these, there are still differences [2]. Most research has been done among Turkish and Moroccan children. Differences were found in respiratory tract infections, (traffic) accidents, perinatal problems, congenital malformations, dental caries and nocturnal enuresis [2, 19]. Hospital admissions and making use of specialist medical care are more frequent. A nationwide survey among the Turkish population showed hardly any difference in the use made of general practitioner’s care. Preventive services, such as child welfare clinics and school health services, were equally used by over 90% of all children. Other preventive activities such as regular dental checks, use of maternity home care and home care for chronic diseases were significantly less used by the Turkish population [2, 20].

Mortality among migrant children appears to be two to three times higher than among Dutch children. Data from the Central Bureau of Statistics in the Netherlands (Fig. 1) are in accordance with smaller studies performed in Amsterdam and The Hague [3].

Analysis of these data shows that the main causes of death are perinatal death (including congenital malformations), accidents and drowning, infectious diseases (mainly of the respiratory tract) and a major group of unidentified causes, partly registered under sudden infant death syndrome and partly having occurred during holidays in the home country [6].

**Important pathology and exotic medical problems**

Specific knowledge of import pathology and exotic (inherited) disorders is needed more and more in paediatric

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**Fig. 1 Relative risk on mortality of Turkish and Moroccan inhabitants in the Netherlands compared with the total population over the period 1979–1988 [6]**