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Child Health Outcomes Among Excluded Groups

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In response to Editor's Commentary, 'Setting the Standards for Early Childhood Health and Wellbeing'. Published *Irish Medical Journal*, March 2024; Vol. 117, No. 3:
https://imj.ie/setting-the-standards-for-early-childhood-health-and-wellbeing/

Dear Editor,

Your Editorial this month highlights the importance of early childhood outcomes for health and development. You make note of the challenge facing high-income societies such as ours, of how to achieve further improvements to our already-low infant mortality rate (IMR), of 3.2 per 1,000 live births[1]. Needless to say, this is a 'good' problem to have.

In epidemiological terms, most key public health interventions listed in your editorial apply to children on a whole-population basis, like universal newborn screening, vaccines, and the sugar tax. I suspect our greatest potential for further improving the health of Ireland's children is likely to be found by complementing these measures with a 'high-risk population' approach – that is, by focusing on where the need is greatest.

For example, outcomes for children from marginalised groups like the Traveller and Roma communities are unacceptably poor, and these are masked by whole-society statistics.

The All-Ireland Traveller Health Study (AITHS) in 2007 calculated the IMR of Traveller babies to be 14.1 per 1,000 live births[2]. In other words, Traveller babies die at a rate about four times higher than the rest of Irish society. This is worse than many middle-income nations with far lesser means than ours, such as Uzbekistan (13 per 1,000), Moldova (12) and Nicaragua (11)[3].

As stated in your editorial, all development builds on early development. Traveller health disparities begin at birth and widen thereafter. For example, the AITHS reported the life expectancy of Traveller men as 61.7 years, shorter than men in low-income countries, such as Haiti (62.8), Burkina Faso (62.1) or Afghanistan (64.5)[3]. This not acceptable.

Discrimination against Travellers pervades the employment, health and education sectors, with roots going back centuries. In 1522, King Edward passed the 'Acte for Tynkers and Pedlars'[4]. In the 1960s, a governmental commission examined Ireland's 'itinerant problem'; Charles Haughey declared that "there could be no 'final solution' until itinerant families were absorbed into the

general community"[4]. Today, large sums of money earmarked for improvements in Traveller housing go unspent, every year.

Similarly, the Roma community in Ireland is deeply excluded and marginalised. I know of no large-scale research project, analogous to the AITHS, examining their needs in an Irish context. Nonetheless, children born into Roma families clearly face great obstacles, like poverty, poor housing, discrimination and language barriers. From my clinical experience, Roma children appear more likely to be unvaccinated, to have missed antenatal and perinatal care, and to die prematurely. Large-scale research is needed to quantify the level of need. In tandem, excellent initiatives such as the Lynn Clinic, led by Dr Aoibhinn Walsh in Temple Street, must be supported and replicated.

While Ireland's child health outcomes are strong overall, deep disparities come into focus when we look closer. The historical and political context of social exclusion helps explain this. To break that cycle of exclusion, paediatricians and policymakers must be guided foremost by the equal dignity and value of every child.

Declarations of Conflicts of Interest:
None declared.

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