

International Society for
Social Pediatrics & Child Health
with the collaboration of the Hungarian Pediatric Association
2017 Annual Meeting

**„Children on the Move:
rights, health and well-being“**



ISSOP
INTERNATIONAL SOCIETY for
SOCIAL PEDIATRICS and CHILD HEALTH



Program and Abstract Book

September 28-30, 2017

Danubius Hotel Flamenco, Budapest, Hungary

www.issop2017.com | www.convention.hu



Dear Conference participants,

I am delighted to welcome you to the 2017 Annual Congress of the International Society of Social Pediatrics and Child Health (ISSOP) in the beautiful city of Budapest. The theme of the meeting is timely given the unprecedented movement of children across the globe in response to humanitarian crises. Given its long-standing commitment to child rights and the health of child populations, it is appropriate for ISSOP to discuss how paediatricians and other child health professionals should respond to crisis facing millions of children and their families. The Congress represents a major opportunity for ISSOP to lead and coordinate a Child Rights-based response to the health and well-being of migrant children and young people with relevant international organisations.

I am confident that the Congress will contribute positively to promoting the rights, health and well-being of displaced children as well as offering an enjoyable social programme.

We are most grateful to Dr Zsuzsanna Kovacs and the Hungarian Paediatric Association for agreeing to be our hosts in Hungary.

Welcome on behalf of ISSOP

Prof. Nick Spencer
ISSOP president

Dear All,

We are delighted that more than 130 participants honour the conference by coming from 26 countries; 4 continents. We are also delighted that so many prestigious speakers representing very important organizations accepted our invitation and are ready to think together on today's crisis.

We hope that the conference will launch a wide-ranging cooperation and both professional and social programs will be memorable for all of us.

Welcome on behalf of Hungarian Paediatric Association

Zsuzsanna Kovács

Organizers

Scientific Committee

Jeffrey Goldhagen (USA)
Ayesha Kadir (Denmark)
Zsuzsanna Kovács (Hungary)

Luis Martin (Spain)
Shanti Raman (Australia)
Barbara Rubio (Spain)

Erika Sievers (Germany)
Nick Spencer (UK)
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Zsófia Mészner
Bea Pászthy

György Velkey

Venue

Danubius Hotel Flamenco

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General information

Venue and Locations

Registration:	lobby area of Danubius Hotel Flamenco (ground level)
Lecture room:	Ravel room (ground level)
Session rooms:	Ravel room (ground level), Buda1 (first floor), Buda2 (first floor)
Posters:	foyer of Ravel room (ground level)
Lunch:	Bolero room (ground level)
Coffee breaks:	foyer (ground level)
Welcome dinner:	Bolero room (ground level)

Social Programs

September 28, Thursday: Welcome dinner

At 19.00 at the event venue, Danubius Hotel Flamenco.

September 29, Friday: Banquet dinner in Domonyvölgy

Bus departs at 18:30 to Domonyvölgy, where the event starts at 19:30.

Please take warm cloth, part of the program is outdoors and at the end of September it might be chilly. Dressing is casual!

September 30, Saturday: Sightseeing tour

Bus departs at 14:00 from the hotel. The trip lasts for approx. 3-3,5 hours and finishes at the hotel. We show you the most important sights, with stopping on Castle Hill, Gellert Hill.

Name Badges

All registered delegates are required to wear a conference name badge when attending sessions and social events.

Certificate of Attendance

Certificates will be available at the registration desk.

Insurance

The organizers do not accept any responsibility for injuries/damages or losses sustained by persons or personal belongings during the conference. Participants are strongly advised to carry appropriate travelling and health insurance.

Registration

Registration area, opening hours: The registration desk is to be found on the ground level of Danubius Hotel Flamenco.

Registration desk opening hours:

Thursday, September 28, 2017	08.30-18.00
Friday, September 29, 2017	08.30-18.00
Saturday, September 30, 2017	08.30-14.00

Registration for participants includes: name badge, congress bag, access to all scientific programs, program book.

Sponsors

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Program at a Glance

Thursday, September 28, 2017

TIME	RAVEL	BUDA 1	BUDA 2	FOYER	BOLERO
09:00-10:00	Registration				
10:00-10:30	Opening ceremony				
10:30-13:00	Plenary 1				
13:00-14:00					Lunch
14:00-15:00	Plenary 2				
15:00-16:30	Workshop 2	Session 2B	Workshop 2C		
16:30-17:00	Coffee break			Poster session No. 1-7.	
17:00-18:30	Plenary 3				
19:00-21:00					Welcome dinner (optional)

Friday, September 29, 2017

TIME	RAVEL	BUDA 1	BUDA 2	FOYER	BOLERO
09:00-10:30	Plenary 4				
10:30-11:00	Coffee break			Poster session No. 8-14.	
11:00-12:00	Plenary 5				
12:00-13:00		Lunchtime trainee workshop	EC+Council meeting		Lunch
13:00-14:30	Plenary 6	Session 3A			
14:30-16:00	Workshop 6A	Session 6B	Session 6C		
16:00-16:30	Coffee break			Poster session No. 1-7.	
16:30-17:00		ISSOP AGM			
18:30	Departure for Domonyvölgy (optional)				

Saturday, September 30, 2017

TIME	RAVEL	BUDA 1	BUDA 2	FOYER	BOLERO
08:30-09:30	Scientific Committee meeting				
09:30-11:30	Plenary 7				
11:30-12:00	Coffee break			Poster session No. 8-14	
12:00-13:00	Plenary 8				
13:00-14:00	Lunch time				
14:00	Departure for sightseeing tour (optional)				



Scientific Program





Thursday | September 28, 2017

09:00-10:00 Registration

10:00-10:30 Opening ceremony

György Velkey, Hungarian Paediatric Society president

Prof. Nick Spencer, ISSOP president

10:30-13:00 Plenary 1: Displaced children: health needs and challenges for an equitable paediatric health care

Moderator: **Prof. Nick Spencer** ISSOP; **Zsófia Mészner** Hungarian Paediatric Society

Prof. Zulfiqar Bhutta (Pakistan) IPA president (recorded video message)

Prof. István Szilárd (Hungary) University of Pécs: Migrant health – new challenges in Europe

Prof. Anders Hjern (Sweden) ISSOP; Stockholm University, Karolinska Institutet: Health care for migrant children in Europe

Karen Zwi (Australia) Univ. New South Wales and Sydney Children's Hospitals Network, Shanti Raman (Australia)) ISSOP, South Western Sydney Local Health District: Health needs of refugee and asylum seeking children in Australia

Angel Carrasco (Spain) ECPCP; EAP: Challenges ahead for paediatric primary paediatric care services

Lenneke Schrier (Netherlands) EAP; Willem Alexander Children's Hospital- via Skype: Providing primary care for migrant children in Europe: a European Academy of Paediatrics Guideline for first contact care

13:00-14:00 Lunch

14:00-15:00 Plenary 2: Role of paediatricians to deal with xenophobia

Moderator: **Prof. Jeffrey Goldhagen** (US) ISSOP

Prof. Shanti Raman (Australia) South Western Sydney Local Health District: Role of paediatricians in tackling racism and xenophobia

Prof. Jeffrey Goldhagen (USA) University of Florida, College of Medicine Jacksonville: Cultural and linguistic competence in health care

15:00-16:30 Parallel sessions

15:00-16:30 Workshop 2A: Cultural and linguistic competence; health communication and promotion

Katarina Carlzén (Sweden) MILSA Project

Ziad Jomaa (Sweden) ISSOP

15:00-16:30 Session 2B: Care for refugees, governmental and nongovernmental involvement, the role of NGO-s

Moderator: **Luis Martin Alvarez** (Spain) ISSOP, **Csaba Bereczki** (Hungary) University of Szeged

Countries' experience session:

Germany – **Erika Sievers** (Academy of Public Health Services)

Hungary – **Zsuzsanna Kovács** (primary care Budapest)

Sweden – **Prof. Anders Hjern** (Stockholm University)

Turkey – **Filiz Simsek Orhon** (Ankara University)

Australia – **Karen Zwi** (University of New South Wales, Sydney)

Lebanon – **Prof. Fouad M. Fouad** (American University of Beirut)

Austria – **Nicole Grois** (Kinderordination Alsergrund - Politische Kindermedizin)

Slovenia – **Martin Bigec** (University Medical Centre Maribor)

15:00-16:30 Workshop 2C: Free papers

Moderator: Olivier Duperrex (Switzerland) ISSOP

1. **Jónína Einarsdóttir** (Iceland; University of Iceland), Hamadou Boiro (Guinea-bissau): Does repatriation succeed to rescue Bissau-Guinean Koran school boys from trafficking?
2. **Shanti Raman** (Australia; South Western Sydney Local Health District): "We came, we didn't know anyone, we didn't know the culture": Triple burden of developmental disability in refugee children in South Western Sydney
3. **Marylyn Emedo** (UK; Guys and St. Thomas' NHS Foundation Trust): Adverse experiences of Unaccompanied Asylum Seeking children (UASC) and the impact on their emotional wellbeing and mental health needs
4. **Helga Guðmundsdóttir** (Iceland; University of Iceland): Invisibility of children of asylum-seeking families in Iceland
5. **Elsa Hrund Jensdóttir** (Iceland; University of Iceland): How prepared are healthcare workers? Reception of refugee families with children in Sweden and Iceland

6. **Raziye Salari** (Sweden; Uppsala University): Teaching Recovery Techniques – A pilot study of a group intervention for unaccompanied refugee minors with PTSD symptoms in Sweden

7. **Damla Mutlu** (Turkey; Koç University Hospital): Remarks of society among refugee children issues and to determine the solution proposals in our country

16:30-17:00 Coffee break and Poster section - No. 1-7.

17:00-18:30 Plenary 3: Infectious diseases challenges for migrant children (Symposium)

Moderator: **Zsófia Mészner** (Hungarian Paediatric Society)

Zsófia Mészner (Hungary, National Institute of Health Development): Risks of infections among migrant children

János Nemes (Hungary, „Ärzte für die dritte Welt“): Tropical medicine

László Szabó (Hungary; Hungarian Continence Society): Easy integration using guidelines (Urinary incontinence)

17:00-18:30 Session 3A: Free papers

Moderator: **Shanti Raman** (Australia) ISSOP

1. **Shanti Raman** (Australia; South Western Sydney Local Health District): Multicultural Expressions of Parenting Love: Promoting positive parenting practices in refugee and migrant families

2. **Karen Zwi** (Australia; Univ. New South Wales and Sydney Children's Hospitals Network): Protective factors for social-emotional well-being of refugee children in the first three years of settlement in Australia

3. **Justin M. Petkus** (Qatar; Hamad Medical Corporation): The Pediatric Patient's Hierarchy of Developmental Needs: An Ecobiodevelopmental Protective Framework for Hospitalized Children

4. **Magdalini Patseadou** (Switzerland ; Geneva University Hospital) Health care needs of young refugees resettling in Geneva: Experience of an adolescent outpatient clinic

5. **Magdalini Patseadou** (Switzerland; Geneva University Hospital): Unaccompanied minors seeking asylum in Switzerland: Migration trend over a 10 year period

6. **Anna Fäldt** (Sweden; Uppsala University): Study protocol - ComAlong Toddler: a randomized control trial of an Early Communication Intervention

7. **Rajeev Seth** (India, BUDS): The Growing Crisis of Internally displaced Migrant Street Children: the challenges for child protection

19:00-21:00 Social program - get together, welcome dinner (optional)

Friday | September 29, 2017

09:00-10:30 Plenary 4: Advocacy for displaced children – child rights approach
(Round table)

Moderator: **Barbara Rubio** (Spain) ISSOP

Prof. Jeffrey Goldhagen (US) University of Florida, College of Medicine Jacksonville:
Implementation of protection, promotion and participation rights of children

Balázs Lehel (Hungary) International Organization for Migration: Child participation in
IOM's "Protecting children in the context of the refugee and migrant crisis in Europe" project

Prof. Ute Thyen (Germany) Universität zu Lübeck: Children's rights in national
constitutions- a way to advocate for children?

Veronique Lerch (Portugal): Rights-based approach to the health of migrant children

10:30-11:00 Coffee break and Poster section - No. 8-14.

11:00-12:00 Plenary 5: Children on the move and stranded in Greece: Needs
assessment, interventions, limitations and good practices

Moderator: **Stella Tsitoura** (Greece) ISSOP

Nicolaos Gkionakis, Babel Day Centre: Mental health interventions for refugee minors
and families in Greece. The experience of Babel Day Centre

Agis Terzidis, Vice President Hellenic Center for Diseases Control and Prevention
(KEELPNO) Ministry of Health: Health care of migrant/refugee children in Greece: Improving
vaccination coverage. "PHILOS" Programme Greece, 2017

Andreas Dimou, PRAKSIS model of Accommodation Centres for Unaccompanied minors

Ira-Iliana Papadopoulou, Working Group on the Management, Coordination and
Monitoring of the Refugee Education, Ministry of Education: Ensuring the right to education
for refugee children in Greece: Challenges and accomplishments of an emergency action
plan for the education of refugee children

Stella Tsitoura, Network for children's rights: Holistic care of children in refugee camp of
Schisto

12:00-13:00 Lunch

12:00-13:00 Lunchtime trainee workshop
Moderator: **Rosina Kyeremateng** (ISSOP; UK)

12:00-13:00 EC+Council meeting

13:00-14:30 Plenary 6: Tackling health care of displaced children with mental, behavioural and developmental problems: A comprehensive and inclusive approach

Moderator: **Luis Martin Alvarez** (Spain) ISSOP; MOCHA Project /AEP Spain Country Agent

Bea Pászthy (Hungary) Semmelweis University: Psychosocial and mental health disorders

Marcia Brophy (Lebanon) Save the children international: Invisible wounds

Maria Herczog (Hungary) EUROCHILD: Access to health care and social protection of displaced children - child rights approach

Charlotte Clous (Netherlands) TOGETHER Dutch national taskforce: Emancipating refugee children through Dutch child health systems: professionals address national challenges TOGETHER

14:30-16:00 Parallel sessions

14:30-16:00 Workshop 6A: Identifying, assessing and intervening for refugee/migrant children exposed to violence, neglect and abuse

Moderator: **Prof. Shanti Raman** (Australia) ISSOP

Ayesha Kadir (Denmark) ISSOP: Violence against Children: existing evidence, advocacy, and lessons learnt

Prof. Shanti Raman and **Rajeev Seth** (India); ISPCAN: Combined position statement on Violence against Children: lessons learnt

14:30-16:00 Session 6B: Free papers

Moderator: **Erika Sievers** (Germany), ISSOP

1. **Francis Rushton** (US) South Carolina Department of Health and Human Services: Using Quality Improvement Technique to Introduce Attention to Social-Behavioral-Environmental Factors in Pediatric Well Child Care

2. **Colleen Kraft** (US) Cincinnati Children's Hospital: Social Investment Fund: Reducing Health Care Cost by Improving Care

3. **Serpil Ugur Baysal** (Turkey) Dokuz Eylul University: Investigation of the exposure of environmental tobacco smoke(secondhand/ passive smoking) in children below five years of age

4. **Manuel Katz** (Israel) Ministry of Health Goshen Foundation: Innovative model for Integrative Community Paediatrics: The Goshen project

5. **Jónína Einarsdóttir** (Iceland) : Children on the move in Iceland: Summer stays on farms

6. **Geir Gunnlaugsson** (Iceland) University of Iceland: Children´s work experience during summer stays on farms in Iceland

7. **Inna Feldman** (Sweden) Uppsala University: Is the Salut Programme an effective and cost-effective universal health promotion intervention for parents and their children? A register-based retrospective observational study

8. **Natalie Durbeej** (Sweden) Uppsala University, Karolinska Institute: Improving school performance among foster children in Sweden: A quasi-experimental study exploring outcomes of the Skolfam model

14:30-16:00 Session 6C: Free papers

Moderator: **Luis Martin Alvarez** (Spain) ISSOP

1. **Hajime Takeuchi** (Japan) Umea University & School of Social Welfare: Income inequality and child living conditions in Japan -Findings based on income per capita

2. **John Eastwood** (Australia) Sydney Health District: Defining the Barriers to Health and Social Care for Vulnerable Clients: An Exploratory Study of Contexts Underlying an Integrated Care Initiative

3. **John Eastwood** (Australia) Sydney Health District: A Qualitative Exploration of Outcomes for Vulnerable Families Enrolled in an Inner City Integrated Care Initiative in Sydney, Australia

4. **John Eastwood** (Australia) Sydney Health District: Designing an Integrated Care Initiative for Vulnerable Families: Operationalization of realist causal and programme theory, Sydney, Australia

5. **Selda Fatma Bulbul** (Turkey) Kirikkale University School of Medicine: A Model of Training for National Training Coordinators in Immunization in Preventive Child Health

6. **Ariani Ariani** (Indonesia) Department of Child Health, Malang: Relationship between gadget and nutritional problems of elementary school children in urban and rural area of Malang, Indonesia

7. **Arzu Arat** (Sweden) Stockholm University, Karolinska Institute: ADHD medication in offspring of immigrants — Does the income level of the country of parental origin matter?

8. **Olivier Duperrex** (Switzerland) CRIPE, AVASAD: A change in national health law for midwives had an impact on health visitors activities in Canton de Vaud

16:00-16:30 Coffee break and Poster section - No. 1-7.

16:30-17:00 ISSOP AGM

18:30-23:00 Social program: Banquet dinner in Domonyvölgy (optional)

Saturday | September 30, 2017

08:30-09:30 Scientific Committee meeting

09:00-11:30 Plenary 7: Policies

Strategic response to improving the current care for displaced children;

Moderators: **Ayesha Kadir** (Denmark) ISSOP, **Jeffrey Goldhagen** (US) ISSOP

Prof. Tony Costello (UK) WHO (via Skype)

Marcia Brophy (Lebanon) Save the Children

Ernő Simon (Hungary) UNHCR Regional Representation for Central Europe

Katalin Tausz (Hungary) UNICEF

Katarina Carlzen (Sweden) MILSA project

Prof. Fouad M. Fouad (Lebanon) American Univ. Beirut Refugees Health Program

Lenneke Schrier (Netherlands) EAP

Geert Tom Heikens (Netherlands) TOGETHER taskforce

09.00-09.15 Welcome and introduction of panellists (**Jeffrey Goldhagen** and **Ayesha Kadir**)

09.15-11.00

Strategic planning. How can paediatricians, paediatric societies and international organizations collaborate to improve the health and health care of migrant children at the programme and policy levels?

Discussion of collaboration, with the concrete proposal of a multicentre international collaborative intervention using existing models to improve care in three specific areas:

- Health communication
- Education of clinicians in cultural competence and the care of migrant children
- Improving the coordination of care for migrant children and families

11.00-11.30

Outline proposal for ISSOP-led collaborative work programme

Includes consideration of time and funding required, and seeking agreement on contribution of time and personnel from collaborating institutions

11:30-12:00 Coffee break and Poster section - No. 8-14.

12:00-13:00 Plenary 8: Closing

12.00-12.20

CHIFA: Social pediatrics discussion platform

Moderator: **Tony Waterston** (UK) ISSOP EC

Speaker: **Prof. Gonca Yilmaz** (Turkey) ISSOP EC

- 12.20-13.00 Closing
Prof. Nick Spencer, Ayesha Kadir: Conclusions
Prof. Nick Spencer: Farewell
- 13:00-14:00 Lunch
- 14:00-17:00 Social program: Budapest sightseeing (optional)

Posters

1. **Kljaic Bukvic Blazenka** (Croatia) General Hospital Dr Josip Bencevic: Providing medical care for migrant children from Southwest and Central Asia
2. **Geir Gunnlaugsson** (Iceland) University of Iceland: Prevalence of neglect in childhood in Iceland and experience of physical and emotional abuse
3. **Zuhail Gündoğdu** (Turkey) Kocaeli University Medical Faculty: Parental attitudes and Human Papillomavirus Vaccine (HPV) in Kocaeli, Turkey
4. **Camilla Nystrand** (Sweden) Public Health and Caring Science: Cost-offset analysis of parenting interventions to prevent externalizing behavior problems
5. **Katalin Berend** (Hungary) Budapest primary care: Pediatric Care at Refugee Centre Bicske, Hungary
6. **Elisabet Fält** (Sweden) Uppsala University: Agreement between parent and teacher SDQ ratings in Swedish preschool-aged children
7. **Helena Fabian** (Sweden) Uppsala University: Is mental health associated with academic failure in Swedish adolescents?
8. **John Eastwood** (Australia) Sydney Health District: Building Realist Program Theory for Interventions for Vulnerable Children and Families in Sydney, Australia
9. **Laleh Nayeb** (Sweden) Uppsala University: A step toward equitable language development monitoring for bilingual children at age 2.5-3 in Swedish child health care
10. **Anton Dahlberg** (Sweden) Uppsala University: Validity of the Strengths and Difficulties Questionnaire for non-native parents in Sweden
11. **Nanda Juwita** (Indonesia) Brawijaya University: The Impact of Gadget in Children Living in Urban and Rural Areas on Their Behavior
12. **Valbona Zheqj** (Albania) Medical Faculty of Prishtina , College Universi): Health education regarding infants and child nutrition at the Pediatric Clinic at University Clinical Hospital Center of Kosovo
13. **Gonca Keskindemirci** (Turkey) Kanuni Sultan Süleyman Training and Research Hospital: ZAP70 mutation in Syrian Girl Patinet
14. **Alexandra Kruse** (Denmark) Copenhagen University Hospital: Assessing trauma and mental health in refugee children and youth. A systematic review of validated screening and measurement tools

Abstracts





Migrant health – new challenges in Europe

Prof. István Szilárd

University of Pécs Medical School, Chair of Migration Health, Pécs, Hungary

The number of people forced to leave their place of residence is growing continuously worldwide. Office of the United Nations High Commissioner for Refugees (UNHCR) assumes it by 2014 as high as nearly 60 million.

During the past years, member states of the European Union (EU) were exposed to a high, rapidly growing influx of migrants, refugees and asylum seekers with a peak of over one million in 2015 and even in 2016 more than 216 000 request for refugee status were submitted in Germany only. Today one out of twelve residents of the WHO European Regions' Member States has already migratory background.

As a consequence of the bloody war in Syria, Turkey hosts the highest number of refugees (more than three millions). Not surprisingly Syrians are making up the majority of migrants arriving to the EU (41 %) followed by Afghanises (26 %) and those from Iraq (16%). (UNHCR) Among the migrants and refugees entered the EU during the past years, the number of children is unexpectedly high, more than 30 %. Many of them are unaccompanied minors.

Reflecting the conditions ('push factors') forcing migrants to come to the decision taking the risky wandering routs and/ or crossing the Mediterranean See, throughout only in 2015, more than 3700 refugees and migrants are known to have died or gone missing at sea and unfortunately these figures are still continuously growing.

Already during the bloody civil war in the former Yugoslavia, Europe has experienced a rapid movement of migrants, refuges and internally displaced people. In the Former Yugoslavian Republic of Macedonia alone more than 300 000 Kosovar Albanian were living in refugee camps in the years of 1999 -2000. The need for their health assistance has stretched the humanitarian health assistance preparedness of Europe, highlighting its limits. At the beginning of the Millennium, the rapidly growing tension in the countries of Northern Africa and Near East have already forecasted a new, significant wave of refugees and migrants heading to the EU.

Migration health as a new challenging issue has been set first as a priority topic during the program of the Portuguese Presidency in 2007, concluding to the conference on "Health and migration in the European Union – Better health for all in an inclusive society. Resolution of the World Health Assembly (2008) entitled "Health of migrants", was calling for the creation of Migrant Sensitive Health System in order to filling gaps in the health service delivery and train health workforce on migrant health issues. It has been repeated in the final document of WHO High Level Meeting in Rome (2015) and is the core element of the WHO Migration Health Strategy and Action Plan in Europe, adopted by the Regional Committee in November 2016.

Addressing migrant health goes beyond issues of differing morbidity profiles and vaccination status linked to country of origin or potential for spreading diseases. Assistance tailored to migrants' needs is an essential prerequisite of their smooth and successful integration. Its success has clear economic impact and benefits, and increases the public health safety of the host countries. Although this rapidly increasing need for specially trained professionals capable coping with this complex, multidisciplinary task - where health, human rights

and intercultural aspects are equally represented - is more and more recognised, at present there is significant shortage of formal higher education programs in Europe aiming to build the human resource capacity that will address this new challenge. Health assistance of the most vulnerable groups of migrants and refugees (children, women, elderly, and victims of trafficking) needs eminent attention where not only additional training is required for the service providers, but the legal and institutional background has to be tailored to addressing their special needs.

On the field of human resource capacity building University of Pécs Medical School – as coordinator of the consortium of six EU universities – will launch by February 2018 an accredited ‘Specialist on Migration Health’ full time four-semester training program.



Health care for migrant children in Europe

Prof. Anders Hjern

ISSOP; Stockholm University, Karolinska Institutet, Sweden

Research has shown that asylum-seeking and newly-settled refugee children have high rates of stress-related mental health problems during the first years after resettlement, with unaccompanied minors having the highest rates of symptoms. Infectious diseases and poor dental health are more common in these children than in settled European populations and many have an accumulated need of preventive and basic health. Thus, access to health care is a major concern for migrant children. All countries in the world, with the exception of the USA, has signed the UN Convention on the Rights of the Child, which grants migrant children, irrespective of legal status or citizenship equal right to health care to the resident population, "without discrimination of any kind".

Despite these obligations only five EU countries (France, Italy, Norway, Portugal, and Spain) explicitly entitle all migrant children, irrespective of legal status, to receive equal care to that of nationals, with Germany and Slovakia standing out as the EU countries with the most restrictive health care policies. Health care policies in the EU/EEA frequently do not address the rights of migrants with citizenship from other EU countries, including many Roma children, who have overstayed the three-month period of free mobility; or who lack identification. These migrants fall outside the defined categories of a migrant in many national as well as European policies.

In all but four countries in the EU/EEA there are systematic health examinations of newly settled migrants of some kind. In most eastern European countries and Germany this health examination is mandatory; while in the rest of western and northern Europe it is voluntary. All countries that have a policy of health examination aim to identify communicable diseases, so as to protect the host population. Almost all countries with a voluntary policy also aim to identify a child's individual health care needs, but this is rarely the case in countries that have a mandatory policy.

Action is needed to improve entitlements to primary health care for migrant children in Europe on the national as well as on the European level in accordance with the UN Convention of the Child. Health examinations should be designed to identify the health care needs of the individual child.

Challenges ahead for paediatric primary care services

Angel Carrasco

Primary Care paediatrician, Madrid, Spain
Advocacy for children Working Group EAP
Vice president ECPCP

Advocacy for Children (AdvCh) is an European Academy of Paediatrics (EAP) Working Group (WG), whose aim is to advocate for children's rights, influencing policies and actions of governments, international institutions and the private sector, building alliances and lobbying regional decision-makers, in order to achieve positive changes in children's lives. AdvCh WG maintains an active collaboration with ISSOP (International Society for Social Paediatrics and Child Health) and ECPCP (European Confederation of Primary Care Paediatricians).

In the last several years there has been a high migratory flow to many European countries, and European Primary Care paediatricians have been on the front line of medical care for migrant children.

Care of migrant children and families can be compounded by the presence of barriers that generate inequalities. To research this issue, AdvCh WG proposed the online survey "Child Health Inequalities among Migrant Children in the European Region", that was carried through the EAP Research in Ambulatory Setting EAPRASnet. The survey comprised 22 questions and was launched in September 2015.

Almost 500 paediatricians, from 17 countries of the European region answered the questionnaire, most of them working in Primary Care. Of those paediatricians that responded, one-third have more than 10 % of migrant children among the children they take care of, and 10% have more than 30 % of migrant children in their practices.

Compared to non-migrant families half of the paediatricians think that migrant children have more frequent health problems, particularly chronic and communicable diseases, neurodevelopmental and mental health problems and accidental injuries. Two-thirds of paediatricians think that the general health of migrant children is worse than that of non-migrants.

Regarding health needs, two-thirds of paediatricians believe that migrant children have different health needs compared to non-migrants, particularly catch-up immunisations, nutritional and accident prevention advice, oral health, socio-emotional development and attachment and screening for visual and hearing defects and for illnesses associated with poverty. 85% of paediatricians think that vaccination coverage is lower in migrant children on arrival, but gets better one year after arrival in two-thirds of cases.

Only 40 % of the paediatricians acknowledge specific child care/welfare policies for migrant children and families in their countries.

Migrant children are entitled to the same health services coverage than non-migrants in most cases, less so if their families are irregular or undocumented.

One-third of the paediatricians think that migrant families and children find barriers to access child health services produced by bureaucracy, family economic status, religion, cultural and linguistic barriers, nationality or

undocumented status. Barriers are present in Primary Care, care for chronic disease and disability and mental health care.

Although paediatricians report significant difficulties communicating with migrant families because of language, interpreters and cultural mediators are not readily available in two-thirds of the practices.

Two-thirds of the paediatricians say updated guidelines for care of migrant children and families are lacking in their countries, and 80% of them have not received training on migrant health care problems, needs and peculiarities.

These results should draw attention to the health problems and needs of the migrant children in the European region, and to the barriers that migrant families find for the care of their children.



Providing primary care for migrant children in Europe: a European Academy of Paediatrics Guideline for first contact care

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BACKGROUND: In 2015, more than 300 000 children seeking asylum were registered in EU countries, including almost 90 000 unaccompanied minors. Access to high-quality health care is important for migrant and children as they may have specific health risks and needs. Unrestricted entitlement is defined by United Nations Convention in the Rights of the Child ratified by all EU/EEA countries but specific rights and access to health services are very variable. The aim of the study is to collect and compare current recommendations across Europe and define a consensus minimal standard of care.

METHOD: Data was collected using an e-mail survey conducted among representatives from national paediatric societies from 30 EU/EEA countries. In addition, guidelines from Australia, Canada, and the United States were also reviewed.

RESULTS: Responses from 25 countries were received (response rate, 83%). National representatives from seven countries (Germany, Switzerland, Austria, Italy, Spain, United Kingdom, Finland, and the Netherlands) reported to have a national recommendation. National representatives from 17 European countries reported that there was no recommendation available or that they were not aware of any existing guideline. In current guidelines vaccine-preventable infections (including Hepatitis B and C), malaria, tuberculosis, HIV, schistosomiasis, helminth or protozoan infection, syphilis, anemia, vision impairment, hearing impairment, dental problems and obesity/malnutrition were mentioned in at least 7 out of 11 guidelines and therefore selected for further evaluation.

DISCUSSION: Underlying evidence for all these recommendation is currently being evaluated and will form the bases for the minima standard recommendations.

Role of paediatricians in tackling racism and xenophobia

Prof. Shanti Raman

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Waves of migration and movement from the latter half of the 20th century onwards have changed the cultural and ethnic mix of major regions of the world. A major part of this movement of populations, is people fleeing violence and persecution as refugees. Globally, there are approximately 65 million people around the world currently displaced, half of whom are children under 18 years of age. In the western world we have the added complexity of highly disadvantaged Indigenous minorities, with many other non-western minorities who are culturally and linguistically very distinct. Over the past decade, paralleling the rise in the movement of people, there has been a rise in racism and xenophobia; mostly targeting specific identifiable minority groups. Regretably, some of the outpourings of racism and xenophobia have been politically sanctioned and even encouraged in many parts of the world.

Racism and xenophobia are dangerous threats to public health. Racism and perceived discrimination can be particularly harmful to children and young people, in their growing years of identity formation and consolidation. Hate, fear, intolerance, and racism are entirely inconsistent with good public health and undermine any attempt to create strong and cohesive communities.

Paediatricians have long been at the forefront of advocacy on a range of issues pertinent to children's rights and wellbeing. In this session, I will explore the role that paediatricians and their allies can play in combating racism and xenophobia, both in their day to day clinical or academic lives and in the public policy sphere.



Care for refugees, governmental and nongovernmental involvement - Germany

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BACKGROUND: In 2015, 310 171 children - equivalent to the number of 42% of all newborns in Germany immigrated to Germany.

During the last decade the application for asylum in Germany raised from 28 018 to 745.545 in 2016. In 2017, 44,3% of the applicants were children (26,1% < 6 years of age, 18,2% 6-18years), another 31,4% adults aged 18-<30 years, parents to be.

These developments challenge targeted support for young families, especially in medical care in pregnancy, childhood and youth.

METHOD: The responsibilities for health care in Germany are in general partly on the federal level, especially for public health services important tasks are organized in the Bundesländer, counties or municipal level. The Office for Migration and Refugees, however, as well as the Youth Welfare Office and the Youth Migration Service are federal organisations. In addition, tasks may be delegated to the central associations of free welfare work in Germany. All of these sectors, as well as NGO's focussing on care for refugees, have to be taken into account to describe increased their activities significantly in the last years, as will be described in an overview.

RESULTS: Despite the diversity of the population in Germany, previous approaches to health care for migrant families and respective structures were insufficient. Due to the influx of refugees 2015, especially care for refugee children improved significantly, however a special challenge remains in institutional offers in preschool institutions and schools.

DISCUSSION: Social pediatric care for refugee children in Germany still has to be improved.

Against the wind – The migration crisis in Hungary

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BACKGROUND: Due to the geographical position migration has always been present in Hungary. Recently the country had become a transit to the West. Before the crisis 12 centers were available for asylum seekers with the capacity of 2000 people. In 2015 some 400 000 asylum seekers have crossed the Hungarian border; most of them left the country towards the West. The official politics is subordinated to political considerations. By now some 3000 refugee has legal status. Since 2015 September a fence was erected along the border and now most of asylum seekers are either expelled from Hungary to Serbia as a safe country or kept in detention facilities. 5 person /day can apply for refugee status staying in the transit zone. The civil society gave humanitarian help weeks before the official care would have been started. Pediatricians were the first providing medical care.

Access to health care is provided by law only for recognized refugees and for those who are staying in the transit zone. Psycho-social care is not available.

METHOD: In the second part of the presentation we demonstrate the activities of pediatricians

RESULTS:

- at a railway station in Budapest
- at the transit zone
- with a case history

DISCUSSION: Now the NGO-s including voluntary pediatricians, are balancing on the boundaries of legality and illegality.

Care for refugees in Turkey, governmental and nongovernmental involvement, the role of nongovernmental organizations

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Turkey is deemed not only a country of immigration, but also a transit centre for asylum-seekers and refugees. The official number of refugees in Turkey has reached over 3.2 million in April 2017, and more than half of them are children. As a governmental organization, Directorate General of Migration Management, which implements migration policies and strategies, is the sole institution officially responsible for asylum seekers and refugees. In legal terms, Syrian refugees in Turkey are currently under “temporary protection status”, which grants them access to health, education, as well as social and legal assistance through a provisional identity card with a registration procedure. Recently, while about 90% of Syrian refugees in Turkey remain outside of camp settings, others are hosted in 26 camps run by the Disaster and Emergency Management Presidency of Turkey, where refugees have access to shelter, food, health, education and social activities. Nongovernmental organizations in Turkey carry out the works related to refugees and their children, including humanitarian aid, provision of healthcare, psychosocial and educational support, child protection, legal and social assistance, as well as advice and occupational retraining of the refugees. Due to various reasons such as accelerated migration movements, depleted resources, and relatively limited access to public services, refugees’ children may be exposed to problems related to healthcare, shelter, education, nutrition, protection and adaptation in Turkey. An appropriate collaboration with governmental and nongovernmental organizations in Turkey is required for solving the problems of displaced children and implementing social policies and strategies.

Medical Care for Refugee Children in Austria ISSOP

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BACKGROUND: In 2016, 42.070 refugees applied for asylum in Austria, 4.551 were unaccompanied minors. The total number of children under 18 is not listed in the asylum statistics of the Ministry of Internal Affairs.

METHOD: Arriving refugees undergo a mandatory medical entry exam performed by authorities. No pediatric expertise is available at these exams. The health data are entered into a database of the ministry of internal affairs but are not available for follow-up treatments in the public health care system. Upon submission of the asylum application all refugees are issued an ID card and receive basic public services including housing, clothing, education, food and health care. With the „e-card“ every asylum seeker can visit hospitals and physicians with public insurance contracts and is entitled to free vaccinations according to the public vaccination program.

RESULTS: There is no systematic transfer of health data and information between different providers. Complete pediatric entry assessment is not prescribed. There is no organized process for refugee children to see a practising pediatrician. Also, public pediatric offices lack support of interpreters, migrant expertise and often time to ensure responsible care. Accordingly, children seek medical help often only in case of emergency or acute illness. Less overt conditions remain undiagnosed and often untreated. Catch up vaccinations are often missed. Access to free functional therapies is rare. Medical care for migrant children without insurance is provided by voluntary services only and insufficient.

DISCUSSION: Overall, medical care for refugees provided by the Austrian government is uncoordinated and lacks prospective planning.



Treatment of Children of Immigrants and Refugees at the Division of Pediatrics University Medical Centre Maribor, Slovenia

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Treatment of children at the Division of Paediatrics of University Medical Centre Maribor

At the Division of Paediatrics Maribor, located 17 km south of Šentilj and Austrian border, from September 2015 to February 2016, we treated 32 ill children, which is only a small portion of acute, possibly also seriously ill children.

Outpatient treatment of children

We examined 11 children at an outpatient clinic where we performed the most urgent diagnostics and therapy. The parents of all treated children refused hospitalization, although it was in some cases strictly indicated. The average age was 2 years and 26 days, the youngest was 2 months and 5 days, the oldest 5 years and 4 months.

The diagnoses for which they were treated: Virosis, Emesis, Gastroenterocolitis, Vicium cordis congenita, Anemia sideropenia, Scabies, Lymphadenitis mesent., Bronchitis acuta.

Children treated at the hospital

We hospitalized 21 children, 14 boys and 7 girls. Their age on admission was on average 1 year and 17 days, the youngest had 22 days, the oldest 16 years, 11 children were younger than one year and 4 younger than 2 years old.

Diagnoses for which children were hospitalized: Gastroenterocolitis acuta, Dehydratio, Hypokaliemia, Acidosis metab. Anemia, Bronchitis acuta, Convulsiones, Infectio tract resp. Supp, Virosis, Protein-energy malnutrition of moderate and mild degree, Vitium cordis cong, Marasmus.

6 children were dismissed on the same day, 7 children were hospitalized for 1 day, 6 children for 2 days, one child for 3.4 days and one child for 5 days.

During the hospitalization, we had major problems with the cooperation of the parents. The other major problem was establishing communication.

Conclusion

We are satisfied that we were able to ease the suffering of many children for at least a short period, while they were hospitalized at our institution. We experienced an indescribable anguish of mothers who were worried about their lives and lives of their children.

Does repatriation succeed to rescue Bissau-Guinean Koran school boys from trafficking?

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BACKGROUND: International laws and declarations aim to protect children from abuse, exploitation and trafficking. Consequently, many states have ratified laws and taken legal action or policy measures in their respective countries to persecute traffickers and prevent child trafficking. Despite huge funds, anti-trafficking measures are fraught with problems. Koran school teachers in Senegal (marabouts) are accused of trafficking Bissau-Guinean boys attending their schools and begging on their behalf. For more than a decade, NGOs have developed action plans, established transit centers and organized repatriation of the boys to Guinea-Bissau. The aim of the study is to explore the effectiveness of using repatriation to counteract the alleged trafficking of Bissau-Guinean boys to Senegal.

METHOD: Anthropological fieldwork and qualitative interviews with villagers and repatriated boys in Guinea-Bissau.

RESULTS: The NGOs need trafficked victims to repatriate to justify the funding of their transit centers and activities. The boys decide to become repatriated to prepare the fields in their village, for which the parents need their labor. Thereafter many return to their marabouts in Senegal, survive as beggars on the streets of Dakar together with younger village boys who followed them to Senegal, or head for clandestine migration to Europe. Although the parents get the boys home, they oppose repatriation and criticize the NGOs for breaking promises to support the sons as rescued trafficked victims.

DISCUSSION: Repatriation of Bissau-Guinean boys from Senegal allows all involved to keep on with their business as the boys, NGOs, parents and marabouts alike appear to have adjusted to the measure.

“We came, we didn’t know anyone, we didn’t know the culture”: Triple burden of developmental disability in refugee children in South Western Sydney

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BACKGROUND: The significant health needs of resettled refugee children and youth have been well documented. The population of refugee children with disability is growing in South Western Sydney (SWS); little is known about access to healthcare and support services in this group. Our aims were to identify the health and service needs of refugee children presenting with disability in SWS, to explore barriers to access to relevant services, and formulate recommendations for improvement.

METHOD: Clinical data from children attending refugee specific clinics in SWS between 2010 and 2015 were analysed with a focus on disability. Using purposeful sampling, in-depth interviews were conducted with parents of these children and relevant health and welfare providers. Thematic analysis was used to identify key issues for access to health and support.

RESULTS: A total of 159 children were seen in paediatric refugee clinics in SWS in the period, majority were of Middle-Eastern origin. The proportion of children with disability steadily increased from 12% in 2010, to 41% in 2015; more children had severe disability with co-morbid conditions in 2014-15. Identified barriers to access included the need for complex case-management, inadequate respite services, lack of education support, poor experiences with healthcare and cultural attitudes towards disability; a key enabler was good access to interpreter services.

DISCUSSION: Disability and co-morbid chronic health conditions are significant burdens in newly arrived refugee families, who are already dealing with trauma and displacement. Addressing identified barriers and promoting enablers to care and support can help shape culturally appropriate interventions for this vulnerable group.

Adverse experiences of Unaccompanied Asylum Seeking children (UASC) and the impact on their emotional wellbeing and mental health needs

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BACKGROUND: All UASC entering English local authority care must have a holistic health assessment. Within our local authority this includes history and physical examination using a standardised proforma and Strengths and Difficulties Questionnaire (SDQ).

METHOD: Retrospective review of records from Jan – August 2016. Recording SDQ scores, experiences of abuse and mental health difficulties.

RESULTS: 99 UASC; median age 16 (range 12 – 17)years, 96% male. Ten nationalities, mostly Afghani 39% or Eritrean 35 %.

High levels of negative life experiences; 46% had experienced the death of a close family member; 75% not in contact with any family.

In addition to adversity prior to departure, 51% experienced trauma en route to the UK. 32% reported detention, 27% physical assault and 12% were tortured. Libya was most commonly named, however European countries such as Belgium, Hungary and Bulgaria were also identified as locations of abuse.

SDQ scores outside the normal range for emotional distress in 37%, peer relationships in 17% and overall stress in 13%.

There was a statistically significant association (Fisher's exact test; $P = 0.0003$) between high SDQ score for emotional distress and adverse experiences during transit to the UK.

43(43%) identified as needing referral to mental health services.

DISCUSSION: Data from our cohort demonstrates a high burden of distress, with large numbers of UASC experiencing abuse in transit to the UK. This is significantly associated with high levels of emotional distress in our cohort. The predictable need in this population should be accounted for in planning for and increasing access to mental health services.

Invisibility of children of asylum-seeking families in Iceland

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BACKGROUND: The number of refugees seeking asylum in Europe has rapidly increased, including Iceland despite its location in the North-Atlantic Sea. In 2016, the number of asylum seeking families with children tripled compared to 2015. According to the Convention on the Rights of the Child (CRC), adopted into Icelandic legislation in 2013, children who seek asylum should be given the same rights as other children in Iceland. The aim of the research is to describe and analyse how children's rights and their needs are taken into consideration during the asylum-seeking process of their families in Iceland.

METHOD: Semi-structured interviews were taken with 12 children and 10 parents who had sought asylum in Iceland. To facilitate discussion, children's own photographs and drawings were used. The participants were chosen through purposeful sampling, and included families who were waiting for the outcome of their application, had already gained refugee status, or had been granted humanitarian residence permit.

RESULTS: The asylum process in Iceland is adultist in practice. Children were seldom given the opportunity to express their opinions on issues of importance for them, and housing arrangements and facilities of service providers were most often not child-friendly. The children often had to wait for weeks or months to start school, and little or no attention was given to their psychosocial well-being.

DISCUSSION: The asylum-seeking process for families in Iceland needs revision so that the best interests of children are taken into consideration in accordance with the CRC, now part of Icelandic legislation.



How prepared are healthcare workers? Reception of refugee families with children in Sweden and Iceland

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BACKGROUND: Reception and treatment of refugees in healthcare systems is a continuous challenge. A large group of individuals sought asylum in Sweden and Iceland in 2015, a group with particular needs that bring new and challenging demands. The aim is to shed light on and identify factors with potential for improvement in the reception and treatment of refugee children and their families in Iceland and Sweden.

METHOD: Qualitative study based on 12 semi-structured interviews with Swedish and Icelandic pediatric healthcare professionals was conducted in 2016. The data were analyzed using grounded theory, and grouped into five distinct themes: organization, communication, cultural competence, culture, and empathy, prejudice and racism.

RESULTS: There is a lack of written guidelines in the healthcare systems in both countries and insufficient knowledge of refugee children and other immigrants. Language and communicational obstacles are present, cultural differences and lack of cultural competence are apparent, and organizational barriers and failures are common. From the interviewees' stand-point there is a strong will and desire for improvement and a clear wish for healthcare administrators to revise their policies and guidelines, with the aim to improve healthcare services for refugees with children.

DISCUSSION: The healthcare systems in Iceland and Sweden need to scrutinize and revise their systems to improve the reception of asylum-seeking families with children, material intended for their use needs to become readily available in different languages, and healthcare professionals should be offered training linked to their place of work, in order to make all levels of health care culturally competent.

Teaching Recovery Techniques – A pilot study of a group intervention for unaccompanied refugee minors with PTSD symptoms in Sweden

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BACKGROUND: In 2015, a total of 35369 unaccompanied refugee minors (URMs) sought asylum in Sweden. In a previous study of 208 URMs, we found that 76% screened positive for PTSD. This study aimed to (1) pilot the indicated prevention program Teaching Recovery Techniques (TRT) in a community setting and evaluate the program's effects on symptoms of PTSD and depression in URMs; and (2) examine participants' experiences of the program.

METHOD: The pilot study included 10 groups. Methods for evaluation included Children's Revised Impact of Event Scale (CRIES-8) and the Montgomery-Åsberg Depression Rating Scale self-report (MADRS-S) at baseline and at post-intervention. Qualitative interviews were conducted with 22 participating URMs to describe their experiences.

RESULTS: Baseline measures were available for 55 participants of which 84% reported moderate or severe depression and 45% suicidal ideation or plans. Pre- and post-measures were available for 46 participants (84%). Although more than half (62%) of the participants reported negative life events during the study period, PTSD (CRIES-8) and depression (MADRS-S) symptoms decreased significantly, ($p=0.017$, 95% CI -5.55; -0.58) and ($p<0.001$, 95% CI -8.94; -2.88), respectively.

The interview analysis resulted in six overall categories: social support, normalisation, valuable tools, comprehensibility, manageability, and meaningfulness when the youth described their experiences of the program, well reflecting TRT's program theory.

DISCUSSION: Overall, results indicate that TRT, delivered by staff without previous therapeutic experience, is a promising indicated preventive intervention for URMs with PTSD symptoms. This successful pilot should be followed up with a controlled study.

Remarks of society among refugee children issues and to determine the solution proposals in our country

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BACKGROUND: The attitude against refugees in Turkey sets the world an example. Turkey has the largest number of refugees in the world which is above 3 million and 70% of those are women and children. The purpose of this study is collecting remarks of society among refugee children issues and to determine the solution proposals.

METHOD: Data was collected via a survey filled by volunteers whom were selected among 305 parents admitted to different hospitals in İstanbul during May-June 2017 period. . It was asked what the most important issues were for refugees and what would be the possible solutions for the future of the refugee children.

RESULTS: Problems were grouped under six titles according to statements of 248 parents who participated in the survey. 1.Uneducated parents, inconvenient conditions for children (58.4%) 2. Language related problems (14.5%) 3. Large family pattern, insufficient family planning (4.8%) 4. culture difference (%3.6) 5. Unknown previous health conditions (2%) 6. Psychological problems, war trauma (2.8%) 7.Other (13.7%).

Parents also reported solutions to those problems in the survey such as psychological support, reintegration to the society, making them involved in the employment/production process, family and children education including family planning, solutions to the problems of their country, being able to go back to their country and if not, capt under record in Turkey.

DISCUSSION: Children need to have competent parents and good social environment in order to become healthy adults. Therefore, programmed education of parents and psychological support to minimize war trauma are crucial steps in providing a healthy environment.

„Ärzte für die dritte Welt“ Tropical Medicine

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The author shares his experiences as a voluntary doctor doing basic medicine for the German organisation „Ärzte für die Dritte Welt“. He used to work for poor people in different countries on three continents - Asia, Africa, South America. We did our work in outpatient clinics in big cities, in few small hospitals run by the German organisation and in so called “Rolling Clinics”. 80% of the patients were children. Most of them suffered from relatively banal infectious diseases but generally in more severe forms. There were some specific health problems as well typical for poor tropical countries like malnutrition, malaria, AIDS, etc. This lecture is not intended to be a scientific presentation but a photo gallery to give general overview.



Easy integration using guidelines (Urinary incontinence)

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BACKGROUND: The integration will be easier if there are clear guidelines. The people feel better themselves if they received good information in a migration situation. I explain the usefulness of it through incontinence care.

METHOD: Survey of the incontinence care in Hungary.

RESULTS: There were many „hiding” patients, because the problem is shame and taboo topic, and the general practitioner has no interest in mentioning urine complaints. They do not recommend further substantive investigation, and help. Further problem there is no pelvic floor training and it is not financed. Diaper, as a symptomatic treatment is not enabled in primary care. Modern drugs are not supported, so there are expensive, that's why not given. Not modern drugs are supported, but the treatment outcome is not so good. Modern surgical procedure is less known and less applied now, and non-modern process known, applied, but the results are not very good. Rehabilitation is partial support, and partial results.

DISCUSSION: The primary goal of continence care is the full social reintegration of the patient, which requires the immediate and complete symptomatic stabilization, medication and/or instrumental intervention to ensure and the causative treatment as soon as possible commencing. Guideline was written for healthcare professionals who deal with the prevention, investigation, treatment, rehabilitation, care and nursing patients. The guideline is the cornerstone for everything from prevention to gradual, postgradual training through support technology.

Multicultural Expressions of Parenting Love: Promoting positive parenting practices in refugee and migrant families

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BACKGROUND: Refugee families' experiences of parenting in a new land may be coloured by past experiences of trauma, loss and displacement. Research from other western countries has identified that ethnic minority populations are at increased risk of child maltreatment notifications. We wanted to explore positive parenting stories—in particular cultural expressions of parenting love from refugee and migrant families from Western Sydney, in order to promote child safety and wellbeing.

METHOD: In this documentary film which arose from community development work with participating communities in Western Sydney, we captured stories of parenting from newly arriving refugee and migrant families.

RESULTS: We showcase how refugee families, in spite of displacement and loss of agency, carry forward cultural child rearing and child nurturing practices to strengthen their bonds with their children. Themes explored in the film include celebration of the mother and child, ceremonies and rituals in the first years of the child's life marking important transition periods, selected cross cultural child rearing practices, the changing role of fathers, respect for elders and inter-generational tensions in parenting. The film documents the anxieties of parents in transitional refugee situations, balanced by the use of music bringing a sense of normality for families post migration.

DISCUSSION: Using excerpts from the film we will demonstrate how it can be used by refugee and migrant communities to share and learn about positive parenting practices. Service providers and community agencies can use the film to learn about cross-cultural child rearing practices of migrant communities, to help promote culturally safe positive parenting practices.

Protective factors for social-emotional well-being of refugee children in the first three years of settlement in Australia

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BACKGROUND: We conducted a longitudinal study to investigate the protective factors for social-emotional well-being in newly arrived refugee children in Australia.

METHOD: Newly arrived refugee children aged 4-17 years were recruited between 2009 and 2013 and assessments conducted 2-3 years post arrival. Social-emotional well-being was assessed using the Strengths and Difficulties Questionnaire (SDQ). Protective factors were assessed by structured interview and the Social Readjustment Rating Scale (SRRS); scores <150 reflect fewer stressful life events in the previous year.

RESULTS: Forty-three eligible refugee children were recruited to the study. The SDQ was completed by parents in 90% and protective factor data in 80% at years 2 and 3 of follow-up. Protective factors for normal SDQ scores were: originating from Africa ($p=0.01$), father present on arrival ($p=0.019$) and family SRRS scores <150 at year 2 ($p=0.045$). The median number of protective factors was 4 (range 1-8). Better SDQ scores were associated with ≥ 4 protective factors ($p<0.006$). Furthermore more protective factors increased the child's likelihood of a stable or improved SDQ score over time ($p<0.04$). Modifiable protective factors likely to promote social-emotional well-being include stability in the child's school and residence, parental employment, financial and marital stability, proximity to one's own ethnic community and external community support.

DISCUSSION: Cumulative protective factors, some of which are potentially modifiable, can predict social-emotional well-being in newly arrived refugee children. Children with four or more protective factors are at low risk of poor social-emotional well-being. Identification of children with fewer protective factors allows proactive follow-up to improve settlement outcomes.

The Pediatric Patient's Hierarchy of Developmental Needs: An Ecobiodevelopmental Protective Framework for Hospitalized Children

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Across the developmental lifespan, a relationship exists between coping management and ecological outcomes for children and families, such as: physical, developmental, mental, risk behavior, academic success, and social outcomes. The intersection of the relationship between health as a predictor of healthy children, strong families, and thriving communities, requires preventative measures be taken. The ecobiodevelopmental framework is an emerging science for understanding the evolution of human health and disease across the lifespan. The framework converges and demonstrates the strong association between physiological adaptations and disruptions (biology), the social and physical environment (ecology), and learning, behavior, and physical and mental well-being (health and development) on the developmental outcomes and life course trajectories of children.

The authors propose a Pediatric Patient's Hierarchy of Developmental Needs (PPHDN) as a means for global application when treating children in hospital. Drawing upon Maslow's hierarchy of needs, and the ecobiodevelopmental framework, the PPHDN adds the component of child development to guide best practice intervention strategies. The strategies correspond with, and are guided by child development through 5 hierarchical needs of: 1. physiological, 2. environmental, 3. cognitive, 4. social, and 5. participatory, all of which contribute to the child's ability to cope with hospitalization, leading to the outcome of "developmental well-being."

Therefore, it is proposed that a pediatric patient's ability to reach a state of developmental well-being progresses through sequential hierarchical domains. The child's ability to reach a state of developmental well-being is dependent upon protective factors in each domain that boost their overall coping status

Health care needs of young refugees resettling in Geneva: Experience of an adolescent outpatient clinic

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BACKGROUND: Since 2015 there has been an important increase in the number of young refugees resettling in the European region, mainly unaccompanied minors (UM). The aim of the study was to assess the frequent medical problems identified throughout a systematic post-arrival health screening of all UM resettled at the canton of Geneva in 2015.

METHOD: Medical records of all UM registered at the Geneva adolescent outpatient clinic in 2015 were retrospectively investigated. The follow-up duration of all patients was at least 12 months. All medical diagnoses based on ICD-10 system were classified into 5 major types of health diseases.

RESULTS: A total of 141 adolescent asylum seekers (90 % males; median age: 16 years) was identified. Only 14 % of them were free from illness and received preventive primary care (growth and development follow-up, risk prevention, vaccinations), whereas the majority of them were generally high users of health care services because of acute or chronic complaints. Almost four out of ten were diagnosed with an infectious disease, primarily parasitosis or scabies. One third of youth had a non-communicable disease (chronic illness 10.6 %) and about a quarter of them presented a nutritional deficiency. The percentage of mental health disorders reported was great (34.8 %), mainly emotional troubles and post-traumatic stress disorder (PTSD). Miscellaneous medical complaints were mentioned by half of UM.

DISCUSSION: UM represent a vulnerable population group with particular health care needs. Priority should be given for equitable access to appropriate health care resources.

Unaccompanied minors seeking asylum in Switzerland: Migration trend over a 10 year period

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BACKGROUND: Unaccompanied minors (UM) represent a vulnerable population group with particular social, educational, medical and psychological needs. The aim of the study was to estimate the number and the socio-demographic characteristics of UM resettled in Switzerland during the last 10 years.

METHOD: The national registry database was obtained from the State Secretariat for Migration of Switzerland. All data concerning youth asylum seekers under the age of 18 and who were not in the care of a parent were examined.

RESULTS: Between 2007 and 2016, 2,198 UM arrived in Switzerland, equal to the 4% of the total asylum seekers' population resettled in the whole country. The top five countries of origin were: Eritrea (35%), Afghanistan (19.7%), Somalia (7.4%), Syria (4.7%) and Guinea (4.4%). Boys were significantly more likely (higher than 8 out of 10) to leave their country without their family compared to girls. The number of UM grew rapidly over the last three years (2014-2016), an increase corresponding proportionally to the international migration crisis. The majority of these youth arrived in the summer or autumn. About 5% of all young people received in Switzerland were resettled in the canton of Geneva. Almost 65% of them were older than 15 years, one third were 13 to 15 years, and 4% younger than 13 years.

DISCUSSION: The development of an appropriate social care system that fulfills children's rights and gives them the opportunity to realize their full potential has emerged as a challenge for Swiss public services as a result of the significant increase of UM.

Study protocol - ComAlong Toddler: a randomized control trial of an Early Communication Intervention

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BACKGROUND: Communication provides an indicator of the child's development. Evidence points to the importance of early detection and intervention to improve young children's communicative abilities and decrease developmental delay.

METHOD: This is a three-step study consisting of 1) communication screening at the 18-month child health visit, 2) assessment and consultation during a home visit and 3) a randomized trial comparing (a) telephone consultation with (b) ComAlong Toddler parental course. The study uses a prospective cohort design. Children are consecutively recruited during 2015–2017.

The ComAlong Toddler parental course is tailored to the needs of parents of children younger than three years with communication delay. It comprises five sessions combined with a follow-up home visit. The main focus of the intervention is responsive communication and augmentative and alternative communication

Outcomes measures will be child communication and language skills, use of augmentative and alternative communication and parental communication style with the child. Parents' perceptions of the in-home visit and ComAlong parental course will be studied through semi-structured focus group interviews.

RESULTS: Study progress

To date, 650 children have been screened in the CHS, of which 43 children have been identified with communication delay. Twenty of these children were found to have a major communication delay and have been randomized to the two interventions. Child health care nurses' experiences of communication screening at 18-month has been collected through semi-structured focus groups interviews. Data collection ends in September 2017.

DISCUSSION: The study will give us information about the ComAlong toddler intervention and how ITC can serve as a screening tool in Sweden.

The Growing Crisis of Internally displaced Migrant Street Children: the challenges for child protection

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BACKGROUND: Internally displaced persons (IDPs) are people who have fled their homes, but have not crossed an international frontier. 65.3 million People are forcibly internally displaced around the globe, 1/3rd are children. In India's metropolitan cities, it is estimated that there are almost 18 million runaway migrant streets children; who are subjected to extreme forms of violence, abuse, deprivation, poverty and deprivation of their basic child rights.

BUDS (www.buds.in), a not for profit organisation, is working in two different urban slum locations in National Capital region of Delhi, India since 2003. BUDS aims to reduce the vulnerability of migrant street children, through a continuum of services including education, health, physical, psychological, life skills and vocational development.

METHOD: BUDS strategic public health rehabilitation strategies for street children include: Mobile health services, prompt treatment and preventive immunization drives, Day care facility and mid-day meals at drop-in-centres (DIC), Home repatriation for runaway children through Government Child Welfare Committee (CWC), Non formal and formal education programs, Vocational development to improve livelihood opportunities, cultural & recreational activities.

RESULTS: BUDS DIC have served more than 25000 street children, Home Repatriation: 1193, Referrals to CWC: 971, Vocational skill development: 7441 & Job placement: 2262. There are several success stories, and high achievers among these vulnerable children.

DISCUSSION: There is an urgent need to keep the spotlight of our attention and compassion on the plight of internally displaced migrating street children, alongside refugees. Government & Societies of multidisciplinary professionals should develop guidelines and standard operating procedures to address their basic child right and protection.

Implementation of Protection, Promotion and Participation Rights

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Achieving sustainable progress toward equity in the health and well-being of “children on the move” requires a human (child) rights-based approach (CRBA). This approach utilizes the Convention on the Rights of the Child (CRC) as a foundation, and the principles, standards and norms of child rights as a framework to analyze and respond to the challenges these children confront in every step of their journey.

Using this approach, the Physical; Social, Economic and Cultural; and Intellectual Psychological and Emotional needs of children are translated into rights—with the inherent responsibilities of duty-bearers to fulfill them, and the legal requirement of States to ensure they are fulfilled. The four basic child rights principles of non-discrimination, best interests, optimal survival and development, and giving children a voice anchor this approach in the substance of the CRC.

The human-rights principle of interdependence and indivisibility requires stakeholders in children’s health and well-being to address all rights without priority—individually and in collaboration with public and private sector organizations.

A CRBA provides child health professionals and organizations with the strategies and tools required to vertically integrate clinical practice, community systems and public policy into a holistic strategy to address the needs and rights of children on the move.



Child participation in IOM's "Protecting children in the context of the refugee and migrant crisis in Europe" project

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BACKGROUND: The International Organization for Migration (IOM) assesses that the lack of reliable, systematized data on migrant children, shared among EU member states is a clear obstacle to provide effective protection of this vulnerable group. The EU-funded „Protecting children in the context of the refugee and migrant crisis in Europe” project is implemented by IOM to prevent violence against children and promote respect for their rights along the migration route in Member States.

METHOD: IOM seeks to forge a coherent protection response complementing and reinforcing existing activities to protect children and to develop new or strengthen existing protection responses. The countries for intervention include the main entry/transit and destination countries such as: Italy, Greece, Bulgaria, Slovenia, Croatia, Hungary and Austria. The activities are done during a period of 15 months (October 2016 – January 2018).

RESULTS: Within the framework of the project, children were involved in the development of a child-specific data collection module with the focus on their subjective well-being and in the development of child-friendly information materials with the aim of informing children of their rights, accessible services and available legal options. IOM also provides counselling directly to children in facilities on a weekly basis. Furthermore, IOM is in the process of developing standard operating procedures/guidelines and facilitates capacity-building among frontline workers to ensure standards.

DISCUSSION: In order to better facilitate child participation it is essential to identify their vulnerability and carry-out a proper age-assessment of unaccompanied minors which issues are also in the focus of IOM Budapest's child protection guideline.

Children 's rights in national constitutions - a way to advocate for children?

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BACKGROUND: Germany signed the UN Convention of the Rights of the Child in 1992 but did not comply to the recommendation to include a special article on children's rights in the national constitution. However, little progress has been made to challenge the social injustices for children and the wide gap in opportunities for children of varying social and cultural backgrounds. Critiques have argued that strengthening of children's rights will alienate children and parents, diminish parental rights and increase state interference in family affairs.

METHOD: We analyzed data describing the participation of children in Germany and the distribution of societal wealth.

RESULTS: Analyses of the effects of social inequality even in rich countries such as Germany found that children are among the most disadvantaged citizens of society. However, they have very limited potential to participate in societal decision making and to voice their preferences as well as their complaints. Comparisons among member states of the European Union have shown that access to resources and health services for refugee and migrant children in Germany are more restricted compared to other states.

DISCUSSION: The explicit statement of children's rights in the national constitution is necessary to support the notion of children as subjects of rights as opposed to the object of parental duties. In addition this can help parents to advocate for the rights of their children related to access to education, prevention health care and inclusion.



Mental health interventions for refugee minors and families in Greece. The experience of Babel Day Centre

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BACKGROUND: A large number (30-40%) of migrants and refugees arrived in Greece since January 2015 is under 18 years old. A consistent number are unaccompanied minors. Refugee children are at high risk for suffering from mental health problems and they also tend to have higher levels of behavioural or emotional problems, including aggression and other affective disorders.

METHOD: Through a EU fund managed by UNICEF, Babel Day Centre (mental health unit for migrants and refugees operating in Athens since 2007) is implementing a 12-month project (September 2016-August 2017) concerning the delivery of (a) specialized mental health care and psychosocial support to minors and families as well as (b) support (through supervision, consultation, mentoring and training) to professionals and volunteers working with migrants and refugees who live in Attika region.

RESULTS: 294 children were taken in charge coming from 18 different countries (mostly Syria and Afghanistan) and different interventions were implemented (such as psychosocial assessment, child psychiatric treatment, psychotherapy, special therapies (speech, occupational therapy, special education), counselling and family therapy.

DISCUSSION: Bad living conditions at the host country as well as the lack of perspective may be responsible for the aggravation of pre-existing behavioural problems or the creation of new ones. A comprehensive and complex cluster of interventions is needed to address needs related to such a reality and may influence in a negative way the mental health of a whole family and threaten her cohesion.



Health care of migrant/refugee children in Greece: Improving vaccination coverage. “PHILOS” Programme Greece, 2017

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BACKGROUND: Crisis in Middle-East has led to a migration influx of families and children to Greece with more than 62,000 refugees hosted at the moment in the country. Children entering the EU/EEA are a vulnerable population with low vaccination coverage.

METHOD: The program “PHILOS – Emergency health response to refugee crisis” funded by EU’s DG Migration and Home Affairs foresees vaccination needs assessment of children hosted at camps and interventions for the enhancement of vaccination coverage. The National Immunisation Advisory Committee recommended MMR (Measles, Mumps, and Rubella), PCV (Pneumococcal conjugate vaccine) and HEXA (diphtheria, tetanus, pertussis, polio, hepatitis B, Haemophilus influenzae type b) as priority vaccines.

RESULTS: Recording was completed at all 30 camps (May - August 2017); 4187 children (0-18 years) were recorded. The median number of children hosted at each camp was 107 (range: 5-553). For 68% of the children the WHO vaccination booklet was available. 24%, 25% and 53% of the children were vaccinated with at least one dose of PCV, HEXA and MMR, respectively. The proportion of vaccinated children is significantly lower for the remaining doses. There is no differentiation of vaccination coverage among different ethnicities. Catch up vaccination was performed at seven camps and 1,490 vaccinations were performed (698 MMR, 386 PCV, 406 HEXA).

DISCUSSION: Vaccination campaigns can increase vaccination coverage of the childhood population living at camps and prevent the occurrence of outbreaks of infectious diseases.

Ensuring the right to education for refugee children in Greece: Challenges and accomplishments of an emergency action plan for the education of refugee children

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To deal with a sudden and unprecedented number of arrivals of displaced children in the country, the Greek Ministry of Education, Research and Religious Affairs established in March 2016 a “Scientific Committee for the Support of Refugee Children”. Based on the Committee’s reports and recommendations and with the support of the newly-founded task force called “Working Group on the Management, Coordination and Monitoring of the Refugee Education”, the Ministry initiated and implemented for the school year 2016-2017 an emergency action plan for the education of refugee children. Through this education plan, the main objective of the Ministry was to ensure the psychosocial support and the integration of refugee children in the Greek educational system following a preparatory, transitional period.

The plan was tailored according to the age groups of children. Based on the Committee’s reports, and taking into consideration the fact that a considerable number of refugees and migrants are in transit, as well as the number and the sites of Refugee Accommodation Centers are not stable, the Ministry created the “Reception School Annexes for Refugee Education” (R.S.A.R.E). These were established in school districts around Refugee Accommodation Centers in Public Primary Schools for children aged 6 to 12 years, and Public Secondary Schools for children aged 12 to 15 years old.

About 110 Reception School Annexes for Refugee Education were established for 34 Accommodation Centers around Greece covering areas from Attica and Peloponnese to Epirus and Macedonia providing education to thousands of refugee children.

The operation of Reception School Annexes for Refugee Education offered children the opportunity to attend classes outside the environment of the Refugee Centers and experience the school normality through a daily schedule, while at the same time it provided them with the required time to get adjusted to the Greek education system without experiencing excessive pressure.

The Emergency Action Plan for the Education of the Refugee Children in Greece wouldn’t have been possible to implement without a great number of synergies and collaborations with Ministries, International Organizations and NGOs. Among other limitations and challenges the Ministry had to deal with: the intense mobility of the refugee population and the frequent reallocation to various Refugee Accommodation Centers, the difficulty of mapping and covering all children housed in flats and hotels under various housing programs and, the significant delay of kindergartens operation due to technical difficulties.

Holistic care of children in refugee camp of Schisto

Stella Tsitoura

Network for children's rights

Network for Children's rights

Schisto camp is an open accommodation center, vast fenced, for asylum seekers coming from Afghanistan. It is far from the urban hub with difficult access to city center.

The Network for Children's Rights is a non-profit organization founded in 2004 with the aim of drawing awareness to and intervening in problems relating to the rights of the child. Since 2016 Network is working in Schisto camp on a daily basis.

Needs assessment

Official reports have pointed out substantial inadequacies, deficiencies and even large gaps in the protection, security, dignity and quality of living conditions of asylum seekers. Their rights to information and inclusion in decision-making for urgent vital issues were also completely ignored. Shortage of interpreters put at risk the correct provision of health services to the refugees. The rights of the largest vulnerable group namely children to life, health, security, education, proper food, recreation were heavily flouted. And also the best interest of children was not given priority.

Interventions

The Network for Children's Rights since April 2016 with cooperation of Save the Children, support and funding by UNHCR and ECHO implemented the following programs:

a) Mother – Baby Area (MBA)

In a especially decorated container pregnant women, women in puerperium, mothers of babies up to 2nd year of age under the supervision of midwife and breastfeeding advisors learn how to offer care to their babies and breastfeed in warm, supportive female environment. There is also provision of plenty and quality food (fruits and vegetables).

b) Child Friendly Space (CFS)

Children 3 – 6 years with the help of animators and teachers have creative occupation and learn basics of the Greek language.

c) Child Protection Unit (CPU)

Manned by two social workers, psychologist and lawyer offer psychosocial support, information about referral procedures and the available services, legal advices concerning asylum and reunification, registration of children in schools, deals with cases of child abuse and neglect, information for children's safeguarding policy, communication as well as company to doctors and hospitals.

All the above units collaborate closely with interpreters and cultural mediators.

d) Contact Points

The program consists of:

- Enhancement of dialogue inside the community and preparation of communication with outside world
- Information of adolescences about the social and cultural European and Greek way of life
- Their socialization and free expression through participation in meetings, talks and visits of a social, cultural and artistic nature with participation of Greeks
- The start of integration processes through communication and acquaintance with their Greek peers and mutual interest groups, recreational activities, language courses, newspaper publishing, web radio and making films etc.

Good Practices:

The movement of mainly vulnerable groups to other forms of housing, apartments, hotels, buildings within urban fabric as well as hospitality by families. This form of accommodation fosters social integration and encouragement of everyone's participation in social cultural and economic activities – for the duration of accommodation, whether it is short or long.

The establishment of adolescence Network in a square of Athens with the aim to be a space of meeting, association, development of skills and expression.

Access to health care and social protection for displaced children – a child rights approach

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EUROCHILD, Hungary

BACKGROUND: There are special provisions in the United Nations' Convention on the Rights of the Child focusing on children in especially vulnerable situations, like children on the move, including misplaced, refugee, unaccompanied, migrant children.

There are other human rights treaties also referring to these needs and the state obligations in this regard.

DISCUSSION: Governments should ensure that children survive and develop healthily – regardless of their status, and should have access to all services needed, including health care, education and social support. The children have a right to special care and must be looked after properly, by people who respect their ethnic group, religion, culture and language and take into consideration their special needs. All governments have an obligation to provide family, community type provisions for children avoiding their detention, institutionalization and further traumatisation by providing rehabilitation and integration in an inclusive manner.

“Individual children’s best interests should be based on their physical, emotional, social and educational needs, age, sex, relationship with parents and caregivers, and their family and social background, and after having heard their views according to article 12 of the Convention”



Emancipating refugee children through Dutch child health systems: professionals address national challenges TOGETHER

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BACKGROUND: In 2015/16 the influx of poorly documented refugees took place in environments where ad-hoc governmental policies and civic compassion conflicted with xenophobia. Reception of refugees was mono-sectoral organised by the Ministry of Security&Justice consisted of screening, housing in RCs before granting asylum and settling in municipalities. Professionals facing this influx, concerned about effectiveness, reconsidered practices and called for contingencies.

METHOD: A Dutch/global health paediatrician, medical anthropologist and Syrian paediatrician analysed, through participant observation, determinants, children's symptoms and medical care in RCs. Results, contextualized in prevailing literature, led to the establishment of TOGETHER: the Dutch national interdisciplinary taskforce for (health-) care of refugee-children. Latter brings together national professional organisations and stakeholders.

RESULTS: Cultural sensitivity and -mediators appear critically lacking in determining psycho/somatic-pathology and facilitating improvements in quality- and continuum of care of refugees: i.e. prevalent mental health problems were neither well-recognised nor addressed. Equally challenging is moving professionals beyond their clinical/medical to a more global/public health outlook to enable solutions for observed problems in both health system and care of children

DISCUSSION: TOGETHER stimulates/facilitates interdisciplinary guideline development, culture competence and use of cultural mediators, continuing education, advocacy and research as means to improve the care, and herewith the emancipation, of refugee-children. Its success will be measured by the development of migrant-friendly/informed services, national/local capacity building, and being invited at the highest political tables to provide evidence that good care for refugee children results in well-integrated communities where equities, respect and safety will increase.

Violence against Children: existing evidence, advocacy, and lessons learnt

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ISSOP, Denmark

Violence in all its forms is a global public health problem. Violence against children (VAC) is both a human-rights violation and a public-health problem, and incurs huge costs for both individuals and society. Yet VAC as a public health, clinical and social concern has not had the prominence it deserves. The spectrum of kinds of violence wrought upon children is extraordinarily broad, ranging from societal level armed conflict to violence within the home. VAC occurs in all parts of the globe and has long-lasting consequences through childhood, into adulthood, inter-generationally and for society.. The VAC working group, a partnership of global agencies, has developed an action oriented position statement on VAC, which:

- Establishes a broad definition of violence to include inter-personal, institutional, structural, and societal violence, thus including children affected by armed conflict, harmful traditional practices and gender-based violence.
- Gathers the best available global evidence for the burden and consequences of VAC.
- Puts forth recommendations for concrete actions that can be taken in the domains of clinical care and programs serving children, systems development, and public policy to: a) define the epidemiology and metrics of violence, b) identify and prevent violence against individual and populations of children, and c) mitigate and rehabilitate the effects of violence upon children.

In the first part of this session, we review the evidence on the effects of armed conflict on child health and explore how this affects our understanding of both armed conflict and of VAC. In the second part, we describe the development of the position paper and the challenges of: bringing international focus on VAC as an issue for urgent action; identifying the typologies of violence that are most pertinent for children given the diversity of children's lives; identifying the right partners and collaborators for advocacy and action.

Using Quality Improvement Technique to Introduce Attention to Social-Behavioral-Environmental Factors in Pediatric Well Child Care

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BACKGROUND: Incorporating attention to social-environmental factors in pediatric outpatient facilities is both important and daunting within the structure of current care.

METHOD: Between 2010 and 2015 the South Carolina Department of Health and Human Services focused on improving care related to behavioral health and social-environmental factors among other issues using quality improvement technique. 18 pediatric outpatient facilities were recruited to participate in a quality improvement learning collaborative. Learning sessions were held in a central site with outside experts and sessions designed to create sharing among the participating offices. Twice a year technical assistance visits were provided to each office to encourage engagement. Academic content for the learning collaborative was overseen by the South Carolina Chapter of the American Academy of Pediatrics.

RESULTS: Practices encountered barriers to incorporation of behavioral and social-environmental factors in five different areas.

1. Effective screening routines upon which to identify those patients with substantial risk of poor developmental outcomes related to behavioral and social environmental factors
2. Inadequate knowledge and awareness of other agencies impacting child health and development
3. Financial incentives to address social-behavioral-environmental determinants of health
4. Inadequate clinic-based systems for the determination and treatment of social-behavioral-environmental factors
5. Point-of-care support for providers who had questions when needs were identified

All of these factors were jointly addressed with the participating offices resulting in substantial improvement in outpatient office capability

DISCUSSION: Regional quality improvement collaboratives are an effective strategy in developing improved techniques to address social-behavioral-environmental factors in pediatric offices. Local opportunities for innovation and sharing were a critical component of this effort.

Social Investment Fund: Reducing Health Care Cost by Improving Care

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BACKGROUND: Social determinants of health are a significant driver of health care costs, particularly in an underserved population. Poor transportation, housing insecurity, and inability to pay bills play a key role in influencing both the utilization of and cost of delivering health care. The Cincinnati Children's Health Network's Social Investment Fund (SIF) is designed as an intervention to decrease emergency health care utilization and medical costs by using health insurance dollars to provide "non-medical" items to address social determinants of health. Hypothesis is that funding resources for housing, food, or electricity will improve needed care and reduce the total cost of care for these children.

METHOD: This retrospective quantitative study was conducted for Network members who received SIF from January 2016 and February 2017 and remained eligible 3-month pre-/post-SIF (n=22). Data was obtained from Medicaid claims and CCHMC electronic medical records. Individual cost and PMPM claims expense was evaluated. Wilcoxon Signed-Rank Test was used to assess changes in the metrics.

RESULTS: Admissions, ED visits, and no-show rates were measured for three months pre-/post SIF intervention. Annualized ER visits/1,000 members decreased by 60% (p=0.14). No show rates for planned care decreased by 3% (p=0.28). Annualized claims expense/1,000 members decreased by 6%

DISCUSSION: Evaluation of the initial cohort of 22 members receiving SIF support revealed decreased ED visits and total cost of care, with improved compliance for planned care visits. Use of Medicaid funds to address social determinants may prove a promising intervention for children and families living in poverty.

Investigation of the exposure of environmental tobacco smoke (secondhand/ passive smoking) in children below five years of age

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BACKGROUND: Children are commonly affected by environmental tobacco smoke. The aim of this study was to investigate the secondhand tobacco smoke in children and to determine the adverse effects of passive smoking on child health.

METHOD: Children under five years of age, regularly monitored at the Child Health Surveillance Outpatient Clinic, were included following informed consent by their parents and the questionnaire method was applied. Demographic variables related to family and children, respiratory tract infections, recurrent infections were asked. The levels of cotinine and creatinine were measured and the cotinine / creatinine ratios were calculated in urine specimens taken from children. Using demographic data, cotinine / creatinine ratios in urine, the effects of secondhand tobacco smoke on children, growth status and infection frequency were determined. Chi square test for non-numerical data and Student's t test for numerical values were utilized.

RESULTS: The ratio of household smokers was 70.3% and the ratio of non-smokers was 29.7%. Fifty percent of the mothers of children were smokers. The presence of a smoker at home and the increase in the number of cigarettes smoked during the day increased the incidence of infection ($p = 0.047$). Urinary cotinine / creatinine ratios were found to be significantly higher in children of smokers compared to children of non-smokers ($p = 0.011$).

DISCUSSION: In this regularly monitored preschool children, we found frequent exposure to cigarette smoke. This study contributes to national data and will aid in increasing the awareness in families to the deleterious effects of secondhand smoking on child health.

Innovative model for Integrative Community Paediatrics: The Goshen Project

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BACKGROUND: Child Health Services and training of pediatricians in Israel have been focused in hospital settings. A new community-based paradigm for child health services has been developed, involving a series of changes involving the pediatric community, the pediatric leadership, health service managers, politicians, and fundraisers.

METHODS: A series of processes have been initiated in community pediatrics, including CME activities for pediatricians in the community, initiating changes in residency training to ensure community pediatrics training and the establishment of a fellowship program. An NGO was established as the administrative framework, and stakeholders were recruited at the community and national level.

RESULTS: The NGO is now funded and established, and three pediatricians have been recruited for fellowship training in Melbourne. A CME program in developmental-behavioral pediatrics has trained 115 pediatricians to date. Professional links have been established with representatives of education and welfare. A leading advocate for children in the Israel parliament has committed to an ongoing partnership.

IMPLICATIONS: The establishment of an NGO with a goal of improving child health represents a major shift in child health policy in Israel, and has the potential to transform the health of children and their families. The process has involved changes in undergraduate and post-graduate pediatric education together changes in the delivery of services, and need for political activity at all levels. The Goshen experience in Israel should provide a model for other countries wishing to strengthen community pediatrics.

Children on the move in Iceland: Summer stays on farms

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BACKGROUND: Ideas on the advantage of sending Icelandic children from 'dirty' towns and 'morally corrupting' lifestyles to stay at farms during the summer months first appeared in journal articles in 1892. Later, summer stays became a popular custom, and is still practiced. The aim of the study is to describe and analyze the arguments for this custom, estimate its prevalence and opinions on its merits.

METHOD: Retrieval and analysis of information on the custom from the database 'timarit.is' that includes journals, magazines, newspapers, and other publications. Prevalence data is based on a stratified random sample of 2.000 adults taken from Registers Iceland, and interviewed in telephone in December 2015.

RESULTS: Arguments for children's summer stays on farms included the importance to enjoy the clean and healthy air, nature, good food and normal family life, and an opportunity to learn to work. Out of 1295 (65%) respondents, after weighting 475 (37%) had the experience; 56% were boys and 44% girls. The custom was considered good or very good by 88% of them, compared to 73% of respondents who did not have the experience.

DISCUSSION: Icelanders tend to look favorably on the 20th century common practice to send young children to stay on farms during the summer, and there are little changes in arguments for the custom throughout time. However, rapid urbanization, alternative summer activities for urban children and change in agricultural work resulted in gradual decrease in prevalence of the custom since the 1970s.



Children ´s work experience during summer stays on farms in Iceland

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BACKGROUND: In 20th century Iceland, it was customary to send young urban children to stay on farms for 2-4 months during school leave. This was considered to be an opportunity to learn to work rather than hanging around in the urban landscape. The aim is to analyze work experience among Icelandic adults who stayed in the summers on farms as children.

METHOD: A stratified random sample of 2.000 adults (18 years and older) was taken from Registers Iceland. In December 2015, telephone interview was conducted with 1295 (65%) and they answered questions about their experience of summer stays on farms.

RESULTS: In a weighted total, 475 (37%) had stayed on farms. One third had worked a lot or rather much, and mastered their tasks always (64%) or almost always (29%). With gender differences, they did a myriad of tasks, for example attending cows and horses, collected hay for the winter, and house-work. In total, 244 (49%) had driven a tractor, for the first time at the average age of 11.4 years (range 6-17 years), and 9% reported an accident or incident in that work. Just less than half of the group had seldom or never received salaries. Most (88%) said the experience had changed their life in a positive way.

DISCUSSION: During summer stays on farms, children ´s were exposed to diverse work experience, claimed to be appropriate for age despite some tasks entailed risk to their lives. The experience was considered a life-changing event for most.

Is the Salut Programme an effective and cost-effective universal health promotion intervention for parents and their children? A register-based retrospective observational study

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BACKGROUND: This study investigates the effectiveness and cost-effectiveness of the Salut Programme, a universal health promotion intervention, compared to care-as-usual, over the periods of pregnancy, delivery and the child's first two years of life.

METHOD: We adopted a register-based retrospective observational design using existing data sources with respect to both exposures and outcomes. Health outcomes and costs were compared between geographical areas that received care-as-usual, and areas where the Programme was implemented. We included mothers and their children from both areas if: i) the child was born 2002-2004 (premeasure period) or ii) the child was born 2006-2008 (postmeasure period). The effectiveness study adopted two strategies: i) a matched difference-in-difference analysis; and ii) a longitudinal analysis restricted to mothers who had given birth twice, in the pre- and postmeasure periods. The economic evaluation was performed from a health care and a limited societal perspective. Outcomes were clustered during pregnancy, delivery and birth, and the child's first two years.

RESULTS: Difference-in-difference analyses did not yield any significant effect on the outcomes. Longitudinal analyses resulted in significant positive improvement in Apgar scores, reflecting the newborn's physical condition, with more children having a normal Apgar score (1 minute +3%, 5 minutes +1%). The cost of the Programme was INT\$ 308/child. From both costing perspectives, the Programme yielded higher effects and lower costs than care-as-usual, being thus cost-saving (probability of around 50%).

DISCUSSION: Our findings suggest that the Programme is an effective universal intervention to improve maternal and child health, and may be good value for money.

Improving school performance among foster children in Sweden: A quasi-experimental study exploring outcomes of the Skolfam model

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BACKGROUND: The educational underachievement of foster children has long been known and interventions aiming to improve school achievements in this population are highly warranted. The Skolfam model is a preventive intervention focused on structured individualized support, which has been implemented by some of the municipalities in Sweden. Its primary goal is to improve school performance among foster children. This study aimed to explore the effects of Skolfam in comparison with the effects of ordinary support from the local community among foster children in Sweden.

METHOD: The study used a quasi-experimental pre-post design with one intervention group and one comparison group, including both psychological and pedagogical outcome measures. In total, 91 foster children were included, of which 54 participated in the intervention group (Skolfam) and 37 participated in the comparison group. Participants were followed for approximately two years.

RESULTS: Children who had been given support in accordance with the Skolfam model showed improvements ($p < 0.05$) with small effects (Cohen's $d = 0.22-0.28$) on perceptual reasoning, general cognitive ability and literacy skills relative to the comparison group. These improvements were found regardless of gender, native language, signs of intellectual deficiency or having been replaced in a new foster home and/or in other societal care during follow-up.

DISCUSSION: For foster children in Sweden, the Skolfam model could be considered promising in improving school performance and may serve as a protective factor against adverse outcomes. Given the limited sample size, further research on this topic should be conducted before firm conclusions are drawn.

Income inequality and child living conditions in Japan -Findings based on income per capita

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BACKGROUND: In Japan, child poverty has increased over time, from 11% in 1985 to 16% in 2012. Our aim was to increase knowledge about families with children growing up in poverty.

METHOD: During 2014-2015 we performed surveys across Japan in three different clinical populations: 1) new-borns (five hospitals); 2) hospitalized children (eleven hospitals), and 3) children in outpatient care (54 clinics). The parental responded questionnaire covered: family structure, welfare support, mother's smoking habits, subjective socioeconomic status and household income. The latter was divided into strata based on annual income per capita with the following cut-offs: 1.5 million yen per year (\approx EU standard of relative poverty) and 2.5 (\approx the median income per capita).

RESULTS: The sample was 1,911 children, including 607 new-borns, 647 inpatients (Age: 2.9 ± 3.2) and 657 outpatients (Age: 10.7 ± 2.6). 61% of the annual income of single parent was below the poverty level. Notably, 90% of families living under poverty level were not receiving welfare. Still, 38% of lowest income families recognized their socioeconomic status as fair or even good. We have also performed some regression analysis that showed the odds of smoking mothers, poor self-rated status and living in less than three rooms. These in low income were high compared to high income families.

DISCUSSION: Child poverty is an increasing health threat in Japan, especially those in single-parent-households. Despite all socioeconomic improvement in Japan, still income inequalities present among children. Eliminating inequalities may provide children with a good start.

Defining the Barriers to Health and Social Care for Vulnerable Clients: An Exploratory Study of Contexts Underlying an Integrated Care Initiative

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BACKGROUND: The Healthy Homes and Neighbourhoods Integrated Care Initiative (HHAN) seeks to improve the care of families with complex needs and/or inter-generational trauma by providing care coordination and undertaking activities that promote inter- and intra-agency integration

METHOD: Six HHAN clients, four HHAN staff and 9 stakeholders (2 from governmental organisations, 4 health workers and 3 from collaborating NGOs) participated in semi-structured interviews to determine the underlying issues facing vulnerable families. Thematic analysis was undertaken

RESULTS: Three themes emerged:

1. Services misaligned with clients' needs: Issues included child protection concerns/previous let-downs by services impacting on trust/engagement, lack of uniform trauma-informed care training by organisations and unrealistic care plans given the client's social circumstances.
2. Service access barriers: All groups described user-hostile referral systems, rigid criteria (precluding access) and long waiting times. Other issues included costly specialist referrals, inequity of service access geographically and inconsistent community consultation. Providers acknowledged service navigation for clients sometimes being too time-consuming or difficult to perform.
3. Communication difficulties at provider-client, intra- and inter-agency levels. Clients and stakeholders were often unclear of the role (and even existence) of one another. Some interviews depicted hostility between services. Other issues included confidentiality concerns impeding communication and rapid turnover of workers (damaging intra-service relationships and creating instability for clients).

DISCUSSION: Families with complex needs face multiple barriers to care. The study's findings highlight the necessity for integrated care initiatives such as HHAN, which encourage reorientation to address social determinants of health and create enabling systems for integration/communication between professionals.

A Qualitative Exploration of Outcomes for Vulnerable Families Enrolled in an Inner City Integrated Care Initiative in Sydney, Australia

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BACKGROUND: Healthy Homes and Neighbourhoods (HHAN) is an integrated care initiative that aims to meet the needs of the most vulnerable families in inner city Sydney, Australia. The principle component is care coordination for vulnerable families, for which a mixed-methods evaluation is ongoing. We report on the early findings of the qualitative evaluation component.

METHOD: Semi-structured interviews were undertaken with 12 clients enrolled in the initiative and 21 professionals (from the core HHAN team or stakeholder organisations). Two investigators utilised NVivo v11 to develop and modify the coding frame used to analyse transcripts. Using a critical realist approach, the contexts affecting clients, interventions used, underlying mechanisms and outcomes were explored.

RESULTS: Enrolled families were affected by a range of adverse social and health indicators, with trauma and disadvantage affecting families both horizontally and vertically. A variety of support interventions were utilised. Several underlying mechanisms were identified. Multiple positive outcomes were reported by both clients and professionals, in addition to some limitations/challenges. Interviews with professionals underlined the importance of “back end” projects that focused on relationship building and enhancing confidence of stakeholders.

DISCUSSION: Our results to date suggest that the HHAN initiative is producing favourable outcomes for vulnerable clients and overall has been well received by professionals. A long-term, non-judgemental relationship with a care coordinator is a prerequisite to engagement. Clients appreciated empathy but responded most favourably to genuine outcomes (often related to finances or housing) that improved their social situation.

Designing an Integrated Care Initiative for Vulnerable Families: Operationalization of realist causal and programme theory, Sydney, Australia

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BACKGROUND: In July 2015 Sydney Local Health District (SLHD) implemented an integrated care initiative for vulnerable families in the inner West region of Sydney, Australia. That initiative was designed as a cross-agency care coordination network that would ensure that vulnerable families: had their complex health and social needs met; kept themselves and their children safe; and were connected to society. We will describe the development of the integrated care design that drew on earlier realist causal and program theoretical work

METHOD: Realist causal and program theory were used to inform the collaborative design of initiatives for vulnerable families. The collaborative design process included: identification of desirable and undesirable outcomes and contextual factors, consultation forums, interagency planning, and development of a service proposal.

RESULTS: The Design Elements included: identification of vulnerable families; care coordination; evidence-informed intervention(s); general Practice engagement and support; family health improvement; placed-based neighbourhood initiatives; interagency system change and planning; monitoring of individual and family outcomes; and evaluation.

DISCUSSION: The study advances our earlier empirical and programme design studies toward the implementation of an integrated health and social care initiative. The design seeks to ensure that vulnerable families have their complex health and social needs met; kept themselves and their children safe; and were connected to society. In so doing we aim to break intergenerational cycles of poverty, violence and crime, poor education and employment opportunities, psychopathology, and poor lifestyle and health behaviours, through strengthening family resiliency, improving access to services, and addressing the social determinants of health and well-being.

A Model of Training for National Training Coordinators in Immunization in Preventive Child Health

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BACKGROUND: Childhood vaccination is a major factor affecting the public health status of nations. In 1974, the World Health Organization (WHO) established the Expanded Programme on Immunization (EPI) to ensure all children had access to vaccines. Then after, strengthening routine immunization services, especially in countries with the greatest number of under vaccinated children, had been a global priority for the governments. Thus, it is necessary to build a strong awareness among government, public and at international level. Moreover, a strong collaboration between the MoH, academia, vaccine industry, media, and public needs to be maintained.

METHOD: As a Collaborating Center of WHO, International Children's Center (ICC) aims to expand this approach in Eastern Europe, Balkans, and South Caucasus and in Commonwealth of Independent States by providing skill-based training on program management to mid-level managers (MLM). A total of 152 MLM (25 countries) were trained in Ankara through 6 rounds of workshops and ten in-country trainings (Uzbekistan, Ukraine, Moldova, Azerbaijan) between 2009-2016 were conducted.

RESULTS: Training modules developed by the WHO and the curriculum was developed by the ICC. The objective of the 6 days training was to enable immunization managers at all levels to acquire skills in planning, management, monitoring and evaluation of NIP as well as ensuring vaccine safety and measurement of the performance of all components of the immunization system.

DISCUSSION: This article emphasizes the importance of the continuous informing of the managers, as "Vaccination programme managers" have critical importance to protect and strengthen the capacity.

Relationship between gadget and nutritional problems of elementary school children in urban and rural area of Malang, Indonesia

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BACKGROUND: According to recent global overview child malnutrition by WHO, the prevalence of overweight or obese children under five tend to increased and the stunting prevalence tend to decreased. Sedentary lifestyle especially due to physical inactivity is identified as one of the risk factors of childhood malnutrition. This study aimed to investigate body mass index (BMI) and characteristic of playing gadget of elementary school children in urban and rural area.

METHODS: Information regarding characteristic of playing gadget was collected via a self-administered questionnaire of 355 children attending elementary school (categorized according to urban or rural areas in Malang, Indonesia). Height and weight of subjects were measured using a SECA stadiometer.

RESULTS: The mean (\pm SD) of BMI was $16,84369 \pm 3,700627$ kg/m². Overall, 18.8% were underweight, 3.7% were overweight/obese, and the rest have normal BMI. All of subjects reported to be using gadgets. In addition, 13.5% of the subjects reported >2 hours/day of total gadgets usage duration and 3.7% of the subject start using gadget under 2 years old, exceeding the international recommendation of <2 hours/day of screen time.

DISCUSSION: The statistically data (logistic multinomial regression) show that underweight children or overweight children have possibility back to normoweight more than 2 times if they use gadget less than 1 hour/day. Generally there were no significant differences of BMI and playing gadget durations between urban and rural areas. This suggests that, the trend of sedentary lifestyle (particularly playing gadget) which may contribute to obesity, is found to be prevalent across different geographical areas.

ADHD medication in offspring of immigrants - Does the income level of the country of parental origin matter?

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BACKGROUND: Child psychiatric treatment facilities vary greatly worldwide and are virtually non-existent in many low-income countries. Clinical studies have shown that children from immigrant families living in Sweden received less psychiatric care than those of native-born parents. However, previous studies have shown a similar prevalence of ADHD in minority and majority children in Sweden and the UK. We tested the hypothesis that the consumption of child psychiatric care in immigrant families would be determined by the availability of such treatment in the parents' country of origin. Patterns of medication for attention-deficit hyperactivity disorder (ADHD) were studied as a proxy for child psychiatric care.

METHOD: This was a register study of dispensed stimulant medication during 2013-2014 in Swedish national birth cohorts from 1995-2009, 1.4 million. The children were divided by national income of the parental country of origin. Logistic regression was used to calculate the odds ratios of having been dispensed at least one ADHD drug during 2013, with adjustments for gender, family status, household income and area of residence.

RESULTS: Having parents born in low-income (OR [95% confidence interval] 0.27 [0.24-0.29]) or middle-income (European: OR 0.23 [0.20-0.26], non-European: OR 0.39 [0.34-0.41]) countries was associated with lower ADHD treatment levels than having parents born in high-income countries (European: OR 0.60 [0.54-0.66], non-European: OR 0.68 [0.59-0.79]), when compared to children of parents born in Sweden.

DISCUSSION: The use of child psychiatric care by immigrant families in Sweden was largely associated with the income level of the country of origin.

A change in national health law for midwives had an impact on health visitors activities in Canton de Vaud

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BACKGROUND: In Switzerland, midwives work either in hospitals or as independent private practitioners. Some cantons like Vaud, the public health department finances the activity of health visitors.

After several years of lobbying at national level, private midwives obtained a substantial change in the national health law in March 2014, with a federal ordinance implementing it in July 2015. The post-partum interventions reimbursed without needing a medical prescription increased from 3 to 16 in case of a first child, caesarean, multiple births or a disabled child. The period also increased from 10 days to 56 days.

The health visitors complained that these changes seemed to have an impact on their activity.

METHOD: Using a series of before-after comparisons with linear regressions and smoothed glm, we analysed the impact of these changes on the number of children seen by health visitors and the volume of interventions they provided. We also explored if there was a change in the age at which a child had its first intervention by a health visitor.

RESULTS: The changes showed an negative impact (changes in slope and step changes) on the trends of proportion of children seen by health visitors and on the volume of interventions, that was variable in intensity and transient for some. The median age changed from 4 to 6 weeks.

DISCUSSION: We will show that change in a federal law for one group of professionals supporting parents of young children had a variable impact on the activities of another group. A better coordination might have limited this negative impact.



Posters





No. 1

Providing medical care for migrant children from Southwest and Central Asia

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BACKGROUND: Due to geopolitical turmoil in Southwest Asia and civil war in Syria, there has been a massive migrant wave towards Germany, where migrants were seeking asylum. From September 2015 to April 2016, Croatia became part of the so called 'Balkan Route' towards West Europe, and provided accommodation in refugee camp Opatovac. In December 2015, winter transit and reception centre was opened in Slavonski Brod. Its aim was to register and receive migrants which were sent from Šid, Republic of Serbia.

METHOD: report

RESULTS: About 350 000 people passed through the centre, one third of which were under 18 years old. After registration, medical care was provided to those in need. If patients needed further care and treatment, they were sent to 'Dr. Josip Benčević' General Hospital in Slavonski Brod. More than 80 children were examined and the most common reasons were febrile state, acute respiration infection and acute gastroenterocolitis. Children were accompanied by parents, Red Cross workers, interpreters and police officers. 22 children, together with their mothers, were admitted to the hospital. Children were mostly hospitalized due to respiratory infections and worsening of chronic diseases with fully developed clinical features caused by incorrect treatment (thalassemia, congenital heart defect, insulin-dependent diabetes, congenital metabolism disorders).

DISCUSSION: The biggest difficulties in working with migrants were caused by language barrier, cultural differences and parents' desire to leave the hospital, and the camp, as soon as possible. Despite the political turmoil that we didn't have an influence on, we did our best to provide maximum health care.

No. 2

Prevalence of neglect in childhood in Iceland and experience of physical and emotional abuse

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BACKGROUND: Child abuse takes various forms with well-known impact on child development and later adult health. The aim of the study is to estimate the prevalence of neglect in childhood in Iceland and explore how it relates to experience of physical and emotional abuse.

METHOD: 1500 adults, 18 years and older, were randomly selected from Registers Iceland. In total, 966 (64%) answered questions in a telephone interview on felt neglect in childhood and answered questions on their experience of four forms of physical abuse and six forms of emotional abuse.

RESULTS: 105/966 (11%) respondents felt they had been neglected in childhood, five answered “do not know” and six denied to answer. Experience of neglect was diverse but gave evidence to difficult family situation and be given great responsibility as children. Those who felt that they had been neglected as children were significantly more likely to report experience of all ten forms of child abuse studied compared to those who did not report neglect in childhood ($p=0.0001$).

DISCUSSION: About one in ten Icelandic adults consider themselves to have been neglected in childhood, and report significantly more exposure to ten different forms of physical and emotional abuse as children compared to those who were not neglected. Parents need appropriate support and information to foster positive upbringing practices for their children to benefit in terms of improved short- and long-term health and wellbeing.

No. 3

Parental attitudes and Human Papillomavirus Vaccine (HPV) in Kocaeli, Turkey

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BACKGROUND: To explore what factors influence parents' decision whether to have their children HPV immunised or not and compare them with other internationally published studies and to spread vaccination with HPV.

METHOD: Data from 302 parents were gathered via a survey completed by the parents during their pediatrics polyclinic visit between August 2015 and May 2016 in Kocaeli, Turkey. The survey content was based on CHIAS (Carolina HPV Immunization Attitudes and Beliefs Scale), each question being based on a 5-point Likert scale together with additional 14 questions in order to discover other demographic factors.

It was also questioned about the level of knowledge about HPV and where it was obtained. At the end of the questionnaire, once the parents were briefed on the HPV by the doctor, questions about immunization of HPV on their children were again redirected.

RESULTS: In the low income group, it was observed that high HPV fee was not a deterrent. Parents' believe that HPV was protect more cervical cancer than genital warts.

The less number of parents who thought that HPV could encourage their children to engage in sexual intercourse and to be combined with other vaccines. HPV immunization ages were accepted from mostly parents. Another major finding is the positive influence of parents being informed .

DISCUSSION: The acceptance of HPV depends on a complex interaction of factors but parents' perceptions may change dramatically by being well informed as well as having financial support from the government.

No. 4

Cost-offset analysis of parenting interventions to prevent externalizing behavior problems

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BACKGROUND: Externalizing behavior problems are common among children, and place a high disease and financial burden on individuals and society. Parenting programs are commonly used to prevent such problems, but little is known about their potential longer-term costs and savings. This study estimates the costs and savings of four parenting programs: Comet, Connect, Incredible Years and COPE, along with bibliotherapy, compared to a waitlist control, for the prevention of externalizing behavior problems.

METHOD: A trial-based Markov model was developed to estimate the costs and savings of the interventions achieved by a reduction of clinical cases of attention-deficit/hyperactivity disorder (ADHD), Conduct disorder (CD) and comorbid ADHD/CD. Epidemiological and effectiveness data (post-test) were sourced from a previous RCT. A limited societal perspective was adopted, including healthcare and education sector costs. Intervention costs were based on intervention descriptions. The study sample consisted of 961 children aged 5-12 years who were followed through to the age of 18 years. Multivariate probabilistic and univariate sensitivity analyses were conducted to test model assumptions.

RESULTS: Preliminary results suggest that intervention costs ranged between 20 000 (bibliotherapy) and 1 300 000 SEK (Comet), and total cost-offsets over the modeling period were estimated between 330 000 (bibliotherapy) and 1 000 000 SEK (COPE). Only COPE and bibliotherapy yielded positive net savings of approximately 300 000 SEK each.

DISCUSSION: Results suggest that COPE and bibliotherapy are likely to yield cost-savings to society over the long-term. Further research is needed to investigate cost-savings accruing to other sectors of the society.

No. 5

Pediatric Care at Refugee Centre Bicske, Hungary

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BACKGROUND: Bicske is a small town near Budapest where a refugee center operated since 1986 till the end of 2016. The medical care was organized by the immigration Office, the pediatric care was organized by a NGO - SOS Children's Villages Hungary. 4 hours/week one pediatrician and one nurse did the job with the help of interpreters and some specialists.

METHOD: During a 10 months period (02/2016-11/2016) the staff has given primary pediatric care for more than 300 patients.

RESULTS: Most patients needed basic primary care (vaccination, average health care). There were two critical cases:

- 5 year old girl tibia-fracture, required corrective surgery
- 17 year old boy suffering from Thalassaemia, Hepatitis C, Diabetes type II and Haemochromatosis. He needed very expensive medication and regular transfusions.

DISCUSSION:

Successes:

- The team managed to create a peaceful, good tempered ambiance during office hours.
- The compliance, considering the situation, was good.
- The team had opportunities to consult psychologists, psychiatrist, social workers employed by other NGO-s.

Problems:

- lack of personal documents
- fluctuation of refugees
- limited access to specialists and hospital wards
- determination of the age of minors without parents

Conclusion:

This is a team-work. The inclusion of well-trained and helpful interpreters is a must.

No. 6

Agreement between parent and teacher SDQ ratings in Swedish preschool-aged children

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BACKGROUND: Increasing numbers of displaced families challenge many host societies in assessing children's mental health and in equitably providing adequate care. Identification of mental health problems requires valid and reliable assessment tools, and a multi-informant approach is valuable when assessing behavioural and emotional problems in young children. The Strengths and Difficulties Questionnaire (SDQ) is a valid instrument for measuring children's mental health, available in parent- and teacher versions. Previous research has established informant discrepancies in SDQ reports; however, inter-parent agreement has not been fully investigated.

METHOD: This paper examines agreement between parents' and teachers' SDQ reports, in a community sample of 4,469 Swedish 3–5-year-old children. Mothers, fathers and preschool teachers completed the SDQ as part of the routine health check-ups at Child Health Centres.

RESULTS: Pearson and Intraclass correlation (ICC) analyses between parents and teachers showed poor/fair agreement between parent and teacher ratings (ICC 0.25 – 0.54) and good/excellent agreement between parent ratings (ICC 0.66 – 0.76). The highest level of agreement between parents and teachers were found for the hyperactivity and peer problem subscales, whereas the strongest agreement between parents were found for the hyperactivity and conduct subscales.

DISCUSSION: The low inter-rater agreement between parent and teacher ratings suggests that information from both parents and teachers is important when using the SDQ as a method to identify mental health problems in preschool-aged children. Although mothers and fathers each provide important information about their child good inter-parent agreement indicate that a single parent informant could be used to facilitate data collection.

No. 7

Is mental health associated with academic failure in Swedish adolescents?

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BACKGROUND: This study contributes with knowledge about youth mental health problems and the association with school performance in Sweden. We examined the relation between self-reported mental health problems, school behaviour and home environment with the risk for academic failure among students.

METHOD: 5830 adolescents (age range: 12-19 years) in school years seven, nine, and eleven in Uppsala county in Sweden participated in a web-based survey in 2015. The outcome variable was failure in school subjects, and the exposure variable was mental health problems, measured using the Strength and Difficulties Questionnaire (SDQ). Linear mixed effects regression analysis was used, controlling for possible confounders at the individual level including gender, socio-economic factors, parental rules regarding school work, truancy, and reading and writing difficulties (dyslexia) and one confounder at the school level namely location of the school (urban or rural school).

RESULTS: Preliminary analysis shows that poor mental health was associated with failure in school subjects, even after controlling for all confounders (OR 1.88, CI: 1.66-2.09). These associations were similar in all age groups and in girls and boys. In addition, male gender, low socio-economic status, low parental engagement in school work, truancy, and having reading and writing difficulties as well as going to a school in rural areas were all significantly and independently associated with school failure.

DISCUSSION: Associations were found between school failure and poor mental health in all age groups. Given the relation between mental health problems and school failure, observing challenges in one of them should trigger an inquiry into the other.

No. 8

Building Realist Program Theory for Interventions for Vulnerable Children and Families in Sydney, Australia

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BACKGROUND: We undertook a mixed method study that sought to explain neighbourhood context, stress, depression and the developmental origins of health and disease. We will describe a middle range program theory that draws on that study and other extant works.

METHOD: Realist causal propositions are translated to program theory . Published literature and abstract thinking (i.e. abduction, retroduction) was used to propose program mechanisms which if applied may improve outcomes. Based on this analysis, intervention activity and design elements are proposed. The programme design propositions and hypotheses will be expressed, in realist terms, as context-intervention-mechanisms and outcome (CIMO) conjectures, which will thus render the full constituents of the programme theory.

RESULTS: Causal mechanisms analysed included: expectations, loss, being alone, lifetime trauma, discrimination, mastery, sense of control, mattering, trust, isolation, access to services, information literacy, social capital, social exclusion.

Preliminary realist program mechanisms were identified that have the potential to improve outcomes for vulnerable families in metropolitan Sydney. Program mechanisms identified included: family-peer trust, family-provider trust, willingness to share power, co-operation, Information, building self-help skills.

DISCUSSION: We used critical realist meta-theory to assist in the translation of previously reported empirical explanatory theory to theory driven interventions. We situate those interventions in the socially disadvantaged regions of Sydney where the local child and family inter-agencies are collaborating to design and implement new programme interventions based on earlier studies of perinatal, child, youth and family outcomes. The analysis described here seeks to bridge the translational research gap from theory building to program design and subsequent theory testing.

No. 9

A step toward equitable language development monitoring for bilingual children at age 2.5-3 in Swedish child health care

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BACKGROUND: The increased number of migrants has placed high demands on the child healthcare (CHC) to identify bilingual children who do not develop as expected. However, the current method for language screening at age 2.5-3 years has not been evaluated for bilingual children. In our first study, a majority of nurses believed that bilingual children had a slower pace of language development and this led to simplified screening and delayed referrals. Thus, there is a need to validate measures for and increase knowledge about language development in bilingual children.

METHOD: 93 bilingual children were recruited from CHCs in an area with high proportion of low SES families. The children were screened at age 30-33 months. All of them were assessed by a speech and language pathologist (SLP) after the screening, and some of them were also followed up by the same assessment at age 36-38 months. All assessments were performed both in Swedish and in the child's mother tongue. The child could respond in any language.

RESULTS: Our preliminary results show almost 3 times more positive outcomes compared to monolingual children, of which 84% were true positive. Of 17 children with true positive results 47% still showed severe, and 23% moderate communication difficulties at 3 years of age.

DISCUSSION: Our data collection has not been completed yet, but the preliminary results point to the need of adjusting the approach and cut-off for language screening for bilingual children. There is also a need to differentiate effects of bilingualism and low SES on the results.

No. 10

Validity of the Strengths and Difficulties Questionnaire for non-native parents in Sweden

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BACKGROUND: To offer timely interventions to children from immigrant families, we need validated tools to easily identify children at risk for negative outcomes. One such tool can be the Strengths and Difficulties Questionnaire (SDQ); an instrument measuring behaviour and emotional problems in children, widely used in clinical and research settings. Support for construct validity exists, but studies are lacking on non-native parents. Furthermore, it is essential to assess whether the same clinical cut-off scores can be used for non-native parents.

METHOD: A confirmatory factor analysis (CFA) was carried out to assess goodness of fit for SDQ answered by parents born outside of Sweden. Additionally, differences in SDQ total scores between native ($n=10\ 325$) and non-native parents ($n=1\ 675$) were measured using one-way ANOVA.

RESULTS: CFA's indicated acceptable fit for both mothers (CFI = .888, TLI = .873, RMSEA = .051) and fathers (CFI = .874, TLI = .857, RMSEA = .051). Non-native mothers and fathers scored significantly higher on the total scores ($F(1, 6447) = 42.421, p < .05$ and $F(1, 5641) = 11.666, p < .05$, respectively). However, the actual mean differences were not large (6.79 vs 5.80 for mothers and 6.93 vs 6.36 for fathers).

DISCUSSION: The results indicate that the factor structure holds for non-native parents. Although significant differences were found between native and non-native parents, the actual differences are not considered clinically significant. We conclude that the SDQ is a valid and useful instrument for non-native parents, and that the same clinical cut-off scores are applicable for use on this sub-population.

No. 11

The Impact of Gadget in Children Living in Urban and Rural Areas on Their Behavior

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BACKGROUND: Technology is inseparable from daily activities. In this current time children are very familiar to using technology, from televisions, computers to sophisticated gadgets equipped with internet access. With the increasing accessibility of children gaining technological ease, this research aims to find out the impact of gadgets on children's behavior who are living in both urban and rural areas.

METHOD: The subject of this research were 200 children living in urban area and 200 living in rural area at Malang, East Java, Indonesia, all of whom were in the 4th and 5th grade of primary school, using questionnaire in February 2017.

RESULTS: From all children using gadget, it was found that 65.1% was likely to behave negatively in comparison with those who did not use gadget, making up only 34.9%. For children gaining education in cities, there was 90.7% which was likely to behave negatively. Those studying in rural areas, it was only 9.3% having negatively behavior. Correlation value between gadget and negative behavior is 0.71 with $p < 0.05$ (significant). Gadget use and urban or rural environment on negative behavior has correlation value of 0.73 and $p < 0.05$ (significant).

DISCUSSION: The use of gadget on children has an impact on shaping negative behavior. Children living in urban areas are more likely to shape negative behavior in comparison with those living in rural areas. The environment and the way of using of gadget have a negative impact on children behavior.

No. 12

Health education regarding infants and child nutrition at the Pediatric Clinic at University Clinical Hospital Center of Kosovo

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BACKGROUND: Infant mortality is one of the most important indicators that present the health culture, the level of development, the living standard and the overall health system of a country. Infant mortality in Kosovo is considered a problem compared to the region. Health education of mothers regarding nutrition of infants and young children is important for the welfare and health of this vulnerable category.

The aim of this paper is to present mother's health education on Pediatric Clinic regarding infant and small children feeding.

METHOD: Transversal, cross-sectional, descriptive method was used. The Anonymous questionnaire consisted of 15 questions, was used. The subjects included in the research are consecutively selected, in Pediatric clinic among mothers of hospitalized children.

RESULTS: Knowledge of mothers is satisfactory for breastfeeding, from 60 mothers 73.3% said they were informed while for complementary feeding 48.3%, for the method of preparing food for young children only 41.7%.

About satisfaction of mothers regarding health education in the clinic 61.7% were moderately satisfied, 18.3% were very satisfied, 41.7% of mothers identified the lack of concretization tools, plan for health education 30% of mothers, also lack the motivation of health workers, have declared 10% of mothers.

DISCUSSION: Breastfeeding has a significant positive impact on infant health while health workers play a significant role in promoting breastfeeding (13) and improving breastfeeding rates (Andaya et al., 2012) Provision of the plan, adequate physical and human resources for health education is a prerequisite for the well-being of infants and young children.

No. 13

ZAP70 mutation in Syrian Girl Patient

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ZAP70 related severe combined immunodeficiency (SCID) is one of the several, inherited disorders of SCID. Here we report a Syrian patient in whom ZAP70 mutations was found.

CASE: Eight months old Syrian girl patient was applied to our pediatric clinic because of the non itching skin lesions, growth retardation and recurrent pneumonia. There was no similar history in family and her parents were 1st degree cousin. In the physical examination: her weight and height was under 3rd percentiles. In the laboratory evaluations; Total eosinophil count: 960 /mm³ IgG: 2990mg/dl (463-1006) IgA: 224 mg/dl (17-69) IgM: 462 mg/dl (46-159) IgE: 1668- 1056 KU/L Anti HBs (-) Anti CMV IgM (-), IgG: (+) CMV PCR: 1844869 copy was detected. Lymphocyte subgroup examination was revealed a low level of CD3 (%48 N:% 58-82). IVIG and antiviral treatment was started for CMV infection and immun deficiency. Detailed examination for immun deficiency was done with blood samples which was sent to USA and was showed ZAP70 homozygous mutation. Family education was done for her good care by the help of translator. Bone marrow transplantation was planned but she was died because of the severe pneumonia. In her follow-up period it is learned that her mother was pregnant. Family counseling was done for the risk of disease in other children.

No. 14

Assessing trauma and mental health in refugee children and youth. A systematic review of validated screening and measurement tools

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BACKGROUND: The estimated number of refugee children and youth is increasing globally. Due to the obvious risk of both direct and indirect exposure to traumatic events for this group, validated tools to assess mental health in this age group is important.

The aim of the study was to conduct a systematic review of validated trauma and mental health tools for refugee children and youth.

METHOD: We systematically searched the databases PubMed, PsycINFO and PILOTS, yielding 913 articles, of which 97 fulfilled our first criteria for further investigation. Applying the PRISMA guidelines 23 full text articles were assessed, 9 of these met our final eligibility criteria.

RESULTS: Only 9 studies included validated trauma and mental health tools for refugee children and youth. Particularly a lack of tools to evaluate children less than 6 years was identified.

DISCUSSION: Overall, the evidence is weak with few validation studies in this population and great variation in practices and standards of the screening and measurement tools. Our study does not provide best practice, but is a step towards gathering adequate knowledge of validated tools in a diverse context. Four main issues are discussed; assessment compared to adults, cross-cultural validity, difference between individual and population based screening and implication of using non-validated tools.

In conclusion; validated trauma and mental health tools are scarce, especially for refugee children less than 6 years. Diagnoses and management of mental health among refugee children and youth should be a priority, both in clinical practice and in the scientific community in order to assist this vulnerable group.



ISSOP

INTERNATIONAL SOCIETY for
SOCIAL PEDIATRICS and CHILD HEALTH

ISSOP Position Statement on Migrant Child Health

ISSOP Migration Working Group on behalf of ISSOP

ISSOP Migration Working Group members: **Anna Battersby, Helga Guðmundsdóttir, Yvon Heller, Anders Hjern, Fabienne Jäger, Elsa Hrund Jensdottir, Ayesha Kadir, Zsuzsanna Kovács, Rosina Kyeremateng Luis Martin, Jean-Claude Métraux, Barbara Rubio, Erika Sievers, Stella Tsitoura, Liv Lyngå von Folsach**

ISSOP wishes to express our appreciation toward the countries, communities, organizations, and volunteers who provide humanitarian assistance to migrants. We find it disturbing that some countries refuse to protect the basic human rights of migrants.

Executive Summary

Greater numbers of children are on the move than ever before. In 2015, the number of forcibly displaced people across the globe reached 65.3 million. Of the more than one million migrants, asylum seekers and refugees who arrived in Europe in 2015, nearly one third were children and 90,000 of these children were unaccompanied.

Child migrants are among the most vulnerable, even after arriving at their destination. The health of migrant children is related to their health status before their journey, the conditions during their journey and at their destination, and the physical and mental health of their caregivers. These children may have experienced numerous forms of trauma including war, violence, separation from family, and exploitation. They may suffer from malnutrition and communicable diseases including vaccine-preventable diseases. Pregnant women, newborns, and unaccompanied minors are particularly vulnerable groups. Social isolation is a major risk factor for all migrant children that compounds other health risks even after settlement in their new home. Lack of health information, language and cultural differences serve as major barriers to adequate, timely and appropriate health care. In spite the challenges they face, migrant children demonstrate remarkable resilience that can be nurtured to promote good mental and physical health.

Migrant children, irrespective of their legal status, are entitled to health care of the same standard provided to children in the resident population, as stated in the UN Convention on the Rights of the Child. It is imperative that the health sector includes informed health workers who are able to identify the health risks and needs of these children and provide culturally competent care. In order to achieve this and promote the rights of migrant children to optimal health and wellbeing, ISSOP recommends that:

- Programmes and activities designed to promote and protect migrant child health and wellbeing must be designed in collaboration with all sectors involved, including the education and social sectors among others, and should always include the voices of migrant children and their families.
- Health services should be readily available and easily accessible for preventive, maintenance and curative care regardless of the child's legal status. Care should be of the same standard as care provided to the local population.
- Health information should be provided that is culturally sensitive and readily available in a language that migrant children and families can understand.
- Medical interpreters and cultural mediators should be available during health care encounters, and personnel working with migrants should receive training in cultural competence.
- Health professionals should not participate in age determination until methods with acceptable scientific and ethical standards have been developed.
- Professionals working with migrant children and families should have access to emotional support services.
- Evidence-based best practices in the care of migrant children should be identified and made widely available to health workers.

- An observatory should be established to study the factors leading to poor psychosocial and mental health in migrant children and youth
- Paediatricians and paediatric societies should work to improve the sensitivity of their respective populations towards migrants, asylum-seekers and refugees.

Introduction

Today, greater numbers of children are on the move than ever before. The number of forcibly displaced people across the globe reached 65.3 million in 2015.¹ In the same year, over one million migrants, asylum seekers and refugees arrived in Europe alone, nearly 1/3 of whom were children.² Worldwide, there are nearly 100,000 children who are known to be unaccompanied or separated from their families.¹

Background

In recent years, there has been an evolution in the pattern of migration throughout the world. This is perhaps most widely publicised in Europe, where since 2011, increasing numbers of people have been arriving (Figure 1)³. Nearly 96,000 asylum applications were submitted by unaccompanied minors in Europe in 2015 (Figure 2).^{3,4} Similar phenomena are occurring in other areas. An estimated 240,000 Rohingya people, including children and families, remain internally displaced due to inter-communal violence during 2011-2013 and a further 94,000 Rohingya people have fled by sea to other parts of Southeast Asia and Australia.⁵ In 2015, nearly 40,000 unaccompanied minors sought to cross into the United States at its southern border with Mexico.⁶

The reasons children leave their homes, with or without their families, are diverse. Some are seeking safety, others are rejoining family that have migrated, and yet others are searching for better life opportunities. Forced displacement is a major driving factor, with children accounting for one fourth of the 65 million forcibly displaced people worldwide.¹ Persecution, armed conflict, generalized violence, climate change, manmade disasters, and human rights violations are the main reasons for forced displacement.¹ While children make up 13% of migrants across the globe, fully one half of refugees and 40% of internally displaced people are children.⁷

The health risks migrant children face are affected by their modes of travel, the distance and duration of their journey and the health, social and political situations in their countries of origin, transit and destination. Children are among the most vulnerable, and the risks they face have immediate and long-term impacts on their health, safety, wellbeing and their ability to reach their full potential. This, in turn, has an impact on local, regional and global societies, both socially and economically. As the physical and mental health of migrant children are interdependent, all references to health in this statement refer to both physical and mental health, unless specified otherwise.

Migrant children, irrespective of their legal status, have the right to health care of the same standard provided to children in the resident population. The United Nations Convention on the Rights of the Child (CRC) devotes

specific attention to displaced and unaccompanied children and provides a useful framework from which to approach migrant children’s health risks and health needs (Figure 3).

Figure 1. Map of first time child asylum claims in Europe Jan 2015 – Sept 2016 (Source: UNICEF)

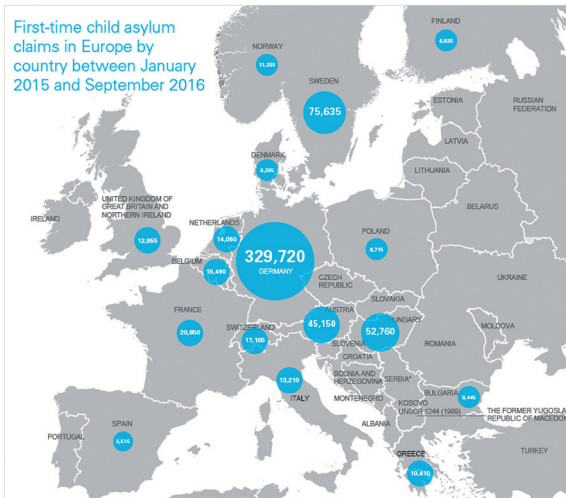


Figure 2. Accompanied and unaccompanied child asylum seekers in, 2015 (Source: UNICEF)

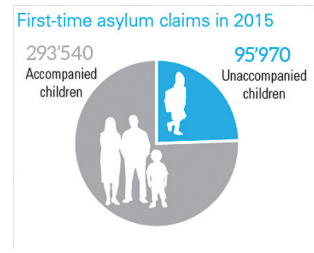


Figure 3. Rights of migrant children in the United Nations Convention on the Rights of the Child

The United Nations Convention on the Rights of the Child (CRC), ratified by all countries except the United States, articulates 40 substantive rights for all children, regardless of their nationality, legal status, gender, religion, or any other characteristic.⁸ These rights are both indivisible and interdependent. As such, in order to fulfil one right, a policy must also promote the other 39 rights that are articulated in the CRC.

The CRC is particularly helpful when considering children, as it acknowledges and addresses the interdependence of different sectors and different aspects of life on the health and wellbeing of the individual child. It grants all children the right to education, health and welfare services, and gives specific attention to refugee children and unaccompanied minors.

CRC articles pertaining to migrant children include:

- Articles 9, 20 and 22: Rights of separated, displaced and refugee children, explicit attention given to the protection of unaccompanied minors
- Article 30: Responsibilities of transit countries
- Article 39: Rights of children affected by armed conflict
- Articles 24, 26, 27 and 28: Rights of all children to educational, health and welfare services

Who are migrant children?

For the purpose of this position statement, the term “migrant children” refers to children and adolescents less than 18 years of age who are or were on the move and who experience unfavourable conditions. This includes children who are currently travelling, those who have moved from one country or region and settled in another, and those who are born during the journey or in the early period after their mothers have arrived at their destination. The term unfavourable conditions refers to conditions such as exposure to war and other forms of violence, hunger, insecure and/or inadequate housing, food insecurity, social isolation, limited access to health care, limited access to education, lack of legal registration or uncertain legal status, and socioeconomic deprivation. These examples are only a few amongst a wide range of adverse conditions that migrant children may experience, and which affect their immediate and long term health and wellbeing.

Why is this important?

The current migration crisis in Europe brings to attention a number of political, social, economic, and environmental risks, which affect children and their families as they travel to and through Europe in search of safety and security. The plight of these children also creates challenges for health, social and education services and policy makers. Rising xenophobia and nationalism in Europe has led to closing of borders and limiting the access these children have to basic needs, and preventing them from realising their human rights. This position paper seeks to use the knowledge gained from the European crisis to highlight key issues in migrant child health that are relevant worldwide. We acknowledge that the health needs and risks of migrant children and any response to mitigate these risks and promote health are dependent on the local and regional context.

Objectives of this Position Statement:

1. **Raise awareness** of the magnitude of specific health and social problems affecting migrant children and the inherent right of every child to be helped and protected.
2. **Advocate for** the right of every child to be provided equal access to the best health and social care available regardless of their legal status.
3. **Call for action** for societies to honour their duty to help every migrant child to achieve their potential to live a happy and healthy life, by preventing disease, providing appropriate medical treatment and supporting social rehabilitation.

Health risks and needs of migrant children

The health of migrant children is related to their state of health before their journey as well as the health of their caregivers. The risks these children face differ according to setting, from their country of origin, throughout their journey, and after arrival at the destination country.⁹ Migrant children are at high risk of psychological trauma

from their experiences in each of these settings, with consequences for their long term physical and mental health. Groups that are particularly vulnerable to ill health and trauma include unaccompanied minors, pregnant women, and infants.

Health risks in the country of origin

There may be multiple underlying reasons for a child's departure from their country of origin. They may be escaping war and conflict, have suffered human rights abuses such as torture or sexual violence, or have been living in extreme poverty. Many migrant children come from countries with a high incidence of nutritional deficiencies⁹ and infectious diseases¹⁰ including tuberculosis,¹¹ hepatitis B,¹⁰ HIV,¹² malaria,^{13,14} and intestinal parasitic infections.¹⁵ They may have spent prolonged periods without access to adequate preventive and curative health care. As such, migrant children may be unvaccinated or partially vaccinated, and therefore vulnerable to vaccine-preventable diseases. They may also have increased rates of dental caries due to inadequate dental care.¹⁶ Infants may have been born without skilled postnatal care such as newborn screening for congenital disorders, and they may have been treated with potentially harmful traditional practices¹⁷. All of these factors can have a detrimental impact on their health due to delayed diagnosis and inappropriate or delayed treatment.

Health risks during the journey

Depending on their route of travel, the journey presents the migrant child with different challenges. During the crossing of the Aegean Sea between Turkey and Greece, many children have drowned when overcrowded boats have capsized.^{18,19} Infants born during the journey are at increased risk of hypothermia, septicaemia, meningitis and pneumonia.²⁰ Infants may also suffer with poor nutrition, particularly as breastfeeding is a challenge for mothers during their journey.²¹ Inadequate, overcrowded accommodation and substandard hygiene and sanitation facilities place children at risk for communicable diseases such as diarrhoeal diseases and skin infections.²⁰ Some children may have been subject to incarceration during their journey, increasing the risk of both mental and physical health problems.²² Traumatic events such as separation from family, death of family members, sexual violence, kidnapping or extortion may have long-lasting physical and psychological effects on the child including depression and post-traumatic stress disorder.²¹

Health risks in the destination country

The new and unfamiliar environment in the country of reception combined with language, cultural and educational barriers places newly settled children at risk for delayed presentation or inadequate use of health services. This is particularly important for undocumented migrants who may fear that health services will report them to civil authorities, and for unaccompanied minors who need information and guidance on their right to care and assistance in seeking care for health maintenance, health promotion and illness prevention. Migrant children's accommodation may be inadequate or unsafe, thus placing them at increased risk of accidents and injuries in the home and within the immediate surrounding environment.²³ Families may struggle to access education, resulting in delayed learning and significant challenges for integration into age-appropriate schooling for many children. Specific concerns arise for migrant children with chronic health problem and disabilities. These children have a higher risk of exclusion and may have lower levels of participation in society than other disabled children.²⁴

Psychosocial and mental health

There is an abundance of evidence that shows migrant children are at high risk for mental and psychosocial problems, including both accompanied and unaccompanied children and even children born in the country of destination. For children travelling to Europe, these risks are increasing due to compounded traumas experienced during their journey, including the closing of borders, the worsening of living conditions, xenophobia, and social marginalisation.

All migrant children and youth experience loss and many of them experience other kinds of trauma that may affect their mental health. The main threats to their mental and psychosocial health are related to the mental health of their caregivers, inadequate living conditions, marginalisation, lack of trauma-informed services, and lack of cultural competency among professionals who work with children. These factors may lead to poor self esteem and struggles with identity.

Migrant children often live with parents who are themselves suffering from psychological disorders after trauma, including from insecurity during the asylum process.²⁵ Caregivers who have experienced trauma may struggle to provide their children with a sense of security and psychological support.²⁶ The damaging effects of this on children may be further compounded by child professionals who fail to acknowledge cultural differences in child care, and who may consider the parent as unfit or lacking parenting skills. Such judgements may be directed towards individuals or even entire cultures. As a result, caregivers may become socially marginalised and may feel that their parental rights have been diminished, which further increases their suffering, and in turn, the suffering of their children.

The living conditions of migrant children, including their housing, frequent changing of location, lack of toys, limited access to school, and lack of interaction with peers also places the children in a kind of survival mode, making it difficult for them to envision their futures. At the same time, xenophobia from the local population, including from child professionals, may progressively lead the children to devalue their origins and even break their links with them. Under such conditions, the risk of a progressive “double marginalisation” of migrant children and youth - from their society of origin and from their host society - becomes very high. The consequences of double marginalisation are seen in violence, delinquency, addiction, suicide, and radicalisation.²⁷

A significant reduction in the psychosocial and mental health risks for migrant children may only be achieved by a radical change in the way these children are welcomed into their new society. However, there are some protective factors which have been shown to mitigate the negative impacts of armed conflict, economic deprivation, and social and political marginalisation. Schools and child care centres help children to develop social support systems and provide a sense of security. Even a few hours of school each day have been shown to have a protective effect.²⁸ Training child professionals in cultural competence and the use of cultural mediators have also been shown to have a protective effect on the mental health of children and families.²⁹

Resilience

In spite of the trauma they endure and the challenges they face, migrant children are often able to adapt and maintain a positive outlook and high level of functioning. This resilience is not an inherent or personal trait, but rather, it is a dynamic process that allows the individual child to positively adapt when faced with threats or adversity.³⁰ Studies in refugee children and children affected by armed conflict have found that social inclusion, a supportive family environment, good mental health of caregivers, and positive school experiences enhance resilience in these children.^{31,32} Conversely, prolonged asylum processes, multiple relocations and lack of access to education are risk factors for poor mental health outcomes in forcibly displaced children.³² These findings reinforce the importance of creating immigration policy and practice that pairs the clinical care of traumatised children with health promotion. Policies that support the stable settlement of migrant children and families, quickly resolve asylum claims, provide access to positive school environments, and promote access to health care can enhance resilience in migrant children and promote good health and positive integration trajectories.

High risk groups: Unaccompanied minors, pregnant women, and newborns

Unaccompanied minors

Age has important consequences for young asylum seekers. The UN Convention on the Rights of the Child (CRC) applies to individuals under the age of 18.^{33,34} Unaccompanied children, accordingly, are defined as individuals under the age of 18, who are separated from both parents and who are not in the care of an adult who, by law or custom, is responsible to do so.³³ International and national policies for asylum seekers and refugees often grant young people under the age of 18 years greater protection and support than they do to those above 18 years of age.^{33,34} However, many refugee children lack official documents with a date of birth. This has led to requests to health professionals in many countries to assist migration authorities in determining whether a young asylum seeker is a child or an adult.^{33,34}

Different X-ray methods are currently employed in Europe for age determination, but no available method has been demonstrated to have the accuracy needed to be of real use in this decision.^{33,35} Unclear guidelines and arbitrary practices lead to shortcomings in the protection of this group of children and adolescents in Europe.³⁴ Medical participation, as well as non-participation, in decisions based on these dubious methods raises a number of important ethical questions.³⁶ Furthermore, given the nature of the health and safety risks of this group, it is questionable whether physical age is the best way to define the needs of this vulnerable population.

Unaccompanied or separated children are at high risk for exploitation and trafficking. Of the nearly 90,000 unaccompanied minors who applied for asylum in 2015,³⁷ more than 10,000 have gone missing.^{38,39} These children suffer multiple forms of physical and psychological trauma, and demonstrate high rates of depression and PTSD during the first years after resettlement.⁴⁰⁻⁴² However there are indications that unaccompanied children are often resourceful and arrive with a clear vision of a positive future in the new country.⁴³ Education and the care received during the first years after resettlement are key determinants of long term adjustment.^{43,44}

Pregnant women and newborns

Sexual and reproductive health risks of migrant women and adolescent girls have an important impact on maternal, newborn and child health. Although the CRC has established the right to pre- and post-natal health care and to breastfeeding (Article 24),⁸ migrant women face challenges at all phases of their journey regarding the choice to become pregnant, safe pregnancy and birth, and access to contraception.⁴⁵ They are also at increased risk of trafficking, sexual persuasion, rape, and prostitution.⁴⁶ Women on the move may be in the situation of an unwanted pregnancy with neither access to adequate health care nor informed choice about termination of pregnancy.⁴⁷

Pregnancy- and delivery-related complications are among the most frequent health problems of migrant women.⁴⁸ Barriers in access to health care in their country of origin, during the journey, and after arrival in the destination country have detrimental effects on their nutritional status, immunisation status, and general health. These factors, compounded by barriers in access to pre-, peri- and postnatal health care, high levels of psychological stress, poor hygienic conditions, and lack of access to sanitary products lead to higher risk pregnancies and deliveries.^{45,47,49} Furthermore, pregnant migrants may have lived for periods with inadequate nutrition and may lack support for breastfeeding.

In order to provide adequate care, and thereby realise the human rights of both mother and infant, pregnant women require timely provision of tailored health information and health care, respecting cultural and religious practices, and with the use of interpreters or cultural mediators as needed. Effective access to full pre-, peri- and postnatal care equivalent to the normal standards of care in the respective country is essential. Serious unmet needs among migrant women may result in elevated morbidity and mortality in the mother and infants.

The role of health services: care, prevention, and promotion

The health risks and needs reviewed above illustrate how migrant children and families require a skilled and tailored approach to their health care. Article 24 of the CRC provides every child with the right to “the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.” For some children, the period of migration may last their entire childhood. In order to provide appropriate and effective care, health systems must bridge language and cultural barriers and ensure that health workers are skilled in providing culturally competent, trauma-informed care. Awareness and knowledge of the different needs of all involved, from the individual to the institutional level, on common challenges, such as linguistic and intercultural differences or financial constraints, may help form health services that are not only effective from a paediatric perspective but are also migrant-friendly.⁵⁰

Developing migrant-friendly services

Examination of existing health services with the help of migrant children and families’ perspectives can help to set criteria and standards for “migrant-friendly care” that improves both the quality of care they receive as well as their experience of this care.⁵⁰ Health systems should engage with migrant populations and incorporate their feedback for how to improve the health system more responsive to their needs. Migrant children and

families may express specific needs such as a welcoming and child-friendly environment, creation of safe spaces, assistance with communication, confidentiality, and attention to religious needs such as the provision of a space for prayer or for food that respects religious practices.^{50,51} They may also express a need for privacy, for example when breast feeding or when having to undress for examination.⁵⁰ Adapted signposts (e.g. pictograms and colour codes) may be helpful in paediatric hospitals,⁵⁰ as well as translated health information materials, adequate time allocated for interpreters, and including the entire family when providing health information or education.^{50,52}

While a certain degree of adaptation may be expected from migrant families especially with increased length of stay, health services must ensure that the way they deliver care enables all involved to contribute to best possible health and healthcare for all, including migrant children. This may require adaptations at the policy level to ensure that providers have the necessary tools and resources to provide the care required. Examining health services to become more aware of needs of all members of a community are a step towards inclusive⁵³ and equitable healthcare for all, independent of origin. In particular, newly arrived migrants may need guidance in order to receive the preventive and curative care that will contribute to the child becoming a healthy adult.

Language and cultural mediators

Good communication between migrant children and families and the health staff that work with them is critical for appropriate and effective care.^{50,54,55} Healthcare systems often lack services that meet the needs of minority populations, such as interpretive services and appropriate education materials which cater to culturally and linguistically diverse groups.⁵⁶ Without interpretive services, proper medical care is not possible in language incongruent encounters.⁵⁵ The use of professional interpreters has shown to help improve quality of translations,⁵⁷ reduce cost, unnecessary diagnostics and treatments⁵⁸ and increase satisfaction with physician performance in parents.^{55,59} Hearing a person speak one's own language can be reassuring for all who do not have the linguistic skills required for adequate expression and understanding in the healthcare setting. Cultural mediators can help identify and explain different health concepts and cultural needs relevant for wellbeing, diagnosis and care.^{60,61}

Cultural competence

Healthcare professionals' demeanour and approach during encounters with migrant children and families is crucial for both the delivery and experience of care. Providers who care for migrant children and families should receive training in cultural competence and in managing health conditions that they are not accustomed to encountering.⁵¹ Some healthcare providers may feel insecure on how to best address families from different ethnic or cultural backgrounds, who to address when speaking, and how to work with different cultural beliefs and understandings of health.⁵⁰ Furthermore, caregivers may be anxious about receiving differential care due to their origin,⁵¹ and negative encounters may result in caregivers being reluctant to bring their child back for further care.⁵¹ Training health workers in cultural competence can help to ensure an open, welcoming and respectful approach, reduce uncertainty for all involved, and avoid stigmatization.

Providing culturally competent care to paediatric patients requires consideration of the triangular relationship between the child, caregivers, and provider, attention to family structure, different levels of acculturation within the family, and the care of ill siblings.⁵⁰ Identifying appropriate networks to take care of children with chronic conditions or special needs is important. Migrant families may face difficulties in organising, accessing and

financing the care their special needs children require.⁶² Furthermore, health professionals and interpreters may need support when dealing with emotionally difficult cases, such as when treating patients with a history of violence.⁶³ Providers may also be uncertain about the medical care of conditions encountered in migrants which are less common in the local population. Identifying existing guidelines, practices, and colleagues experienced in the care of migrants can help in these situations (Figure 4).

The diverse backgrounds of healthcare staff can be an asset when caring for migrant children.⁵² Staff with cultural and linguistic knowledge can ideally be matched to care for patients with specific language or religious needs. Studies have shown that when patients and health workers share the same racial or ethnic background, self-rated quality of care and patient satisfaction are higher.⁶⁴

**Figure 4. Putting policy into practice using a rights-based approach:
Case studies in clinical care and public health**

Guidance for clinical care of migrant children: Canada

1. Guidelines for the care of migrant and refugee children^{65,66}
 - Evidence-based national guidelines
 - Case studies for in-depth examples of relevant health issues
2. Clinical checklist for the care of migrant and refugee children⁶⁷
 - What to ask, when to investigate, timeline for care, topics for health promotion
 - Guidance based on the country of origin of the child
3. E-learning tool for clinicians who provide care to help them improve their knowledge and practice⁶⁸

A public health intervention to promote migrant child health: Sweden⁶⁹

1. Study of health status and health literacy among newly arrived migrant and refugee families in Sweden
2. Identification of relevant policy and programming needs
3. Development of health communicator network to address health literacy needs of specific migrant communities in the region – thereby improving access to health information and to appropriate health care
4. Development of health promotion interventions in collaboration with newly arrived migrant and refugee families

Health information

Migrant populations require health information on a variety of topics. These include information about conditions that are specific to their origin (e.g., diet, traditions, diseases), the journey (e.g., trauma, experience of violence), and the situation in the host country (e.g., socio-economic situation, housing, diaspora community). Migrants also require information about the health services in the host country and how to access services, how

to maintain a healthy diet with the available food, age-specific information on the prevention of accidents, and other information such as sexual health and substance abuse. The information provided should be adapted and made relevant to the needs of the different migrant groups. Various programmes have had success in reinforcing the health messages given by health providers using a variety of other media, including leaflets, social media, the internet, community events, and community classes.^{69,70} Schools can also play an important role in helping to foster good health for all children, independent of their origin.

Policy implications

All levels of health providers should follow their local and national guidelines, whilst ensuring that they uphold the rights of the child and family. On the policy level, efforts should be made to enable migrant-friendly care according to the means of the country. First and foremost, this means access to health services should be provided to all children, regardless of their nationality or legal status. Furthermore, services should provide care at the same standard as the care given to the local population. This may imply reducing financial constraints to the use of professional interpreters, ensure that remuneration practices do not punish providers who take the extra time needed in case of language incongruent consultations, set up an enabling infrastructure.⁵⁰

Recommendations

Recommendation 1: In order to meaningfully realise the promotion, protection and participation rights of migrant children, migrant child health programmes and activities must be inter-sectoral in their development and implementation.

As such, they must include migrant children and families, governments (ministries of health, social welfare, education, interior, labour, defence and civil protection authorities), paediatric societies, nongovernmental organisations and civil society organisations. Priority policies include family reunification, the reinstatement of school education, and community-building activities. The right to participation is perhaps the most important and yet the most often neglected right – migrant children and families are experts in their own experiences, and they should be provided the opportunity to participate in their care and in the development and implementation of programmes that are directed at them.

Recommendation 2: Health services should provide inclusive preventive and curative care to migrant children and pregnant women regardless of their legal status.

This includes routine paediatric care, perinatal care, the care of medical conditions related to migration, and health education. Timely and appropriate health care should be given to all pregnant women. The standard of care for migrants should be the same as people from the local population.

Recommendation 3: Migrant children and families should have access to health information in a language which they can understand which is provided in culturally appropriate manner.

Recommendation 4: Migrant children and families and the health professionals who work with them should have access to interpretation and cultural mediation services.

Interpreters and cultural mediators facilitate the use of practices that are sensitive and appropriate to the cultural, spiritual, and religious background of the patient. The financial and availability constraints to these services often present barriers to their use as well as lack of systematic knowledge on the cultural mediation needs of the population. Health systems should collect data on the prevalence of ethnicities and languages spoken amongst their migrant groups in order to effectively deliver interpreter services.^{60,61}

Recommendation 5: Professionals and volunteers working with migrant children and families should undergo training in cultural competence.

Training in cultural competence should be made a standard part of medical and allied health worker training. Furthermore, all institutions working with migrant children and families should require and provide cultural competency training to employees.

Recommendation 6: Health professionals should not participate in age determination until methods with acceptable scientific and ethical standards have been developed.

Recommendation 7: Professionals working with migrant children and families should have access to services for emotional support. This may be best served by a peer group of resource persons experienced in the care of migrants.

Recommendation 8: Best practices in the care of migrant children should be identified, expanded, and made available to health workers.

An example is the improvement in access to school for migrant children, the development of “migrant-friendly schools” and the training of teachers in cultural competence. This will help to improve the psychosocial and mental health of migrant children and prevent double marginalisation.

Recommendation 9: An observatory should be developed to catalogue and study the factors leading to poor psychosocial and mental health in migrant children and youth.

This observatory can be used to identify social, policy and clinical practices to mitigate the harmful effects of migrant children and families, and ultimately, on the society as a whole.

Recommendation 10: Paediatricians and paediatric societies should work to improve tolerance and acceptance of migrants, asylum-seekers and refugees in the general population.

As professionals who work with this population, paediatricians have firsthand knowledge and a deeper understanding of the traumas and injustices this vulnerable population endure as well as the risks and challenges they face in transit and destination countries. In light of recent evidence for secondary trauma experienced in destination countries and subsequent destructive mental and psychosocial health effects of this, it is imperative that paediatricians advocate and become a force for a tolerant and welcoming society.

Conclusion

Migrant children face a broad range of risks in all aspects of their lives, which in turn affect their health and wellbeing. These risks differ based on their country of origin, the means and length of the journey, and the country of destination. Unaccompanied minors, pregnant women, and infants are particularly vulnerable populations. In spite of the traumatic experiences which many migrant children endure, they also demonstrate remarkable resilience. The factors which affect migrant children's health extend beyond the confines of the health care system to include the social and structural determinants of health. Marginalisation and social isolation serve as major barriers to migrant children in realising their health rights. A rise of xenophobia and nationalism presents a particular challenge for health, social and education services and policy makers, in this regard. Furthermore, the political nature of migration has left the burden of responsibility on low- and middle-income countries. In order to meaningfully realise the rights of migrant children, health systems should ensure full access to culturally competent care by informed health providers with the same standard as in the local population. Programmes and activities designed to promote and protect migrant child health must include migrant children and families.

ISSOP-Congress Bonn 2018

The next annual meeting in 2018 will be held at Bonn from September, 27th - 29th. The German Society of Social Pediatrics and Child and Youth Health (DGSPJ) is pleased to cooperate with the University Hospital of Bonn, Department of Pediatrics, the local host of the conference. DGSPJ will partner with the National Center for Early Intervention NZFH and the European Union for School and University Health and Medicine EUSUHM to provide a wide range of timely and relevant topics:

- Early intervention for the prevention of developmental retardation and child neglect,
- Child health at school,
- Chronically sick children, their development and adaption to necessities of daily life
- Developing systems of care for immigrant patients
- The system of social pediatric care in Germany.

Bonn, former capital of Germany and birthtown of L. v. Beethoven, is located on the river Rhine. There are many opportunities to explore one of the oldest cultural regions in Germany in a wonderful landscape, with numerous local museums, and fascinating buildings nearby.

We are looking forward to welcoming you to Bonn in 2018!

Ute THYEN
President DGSPJ

Thorsten LANGER
Scientific Program

Helmut HOLLMANN and Johannes BREUER
Local Organisation

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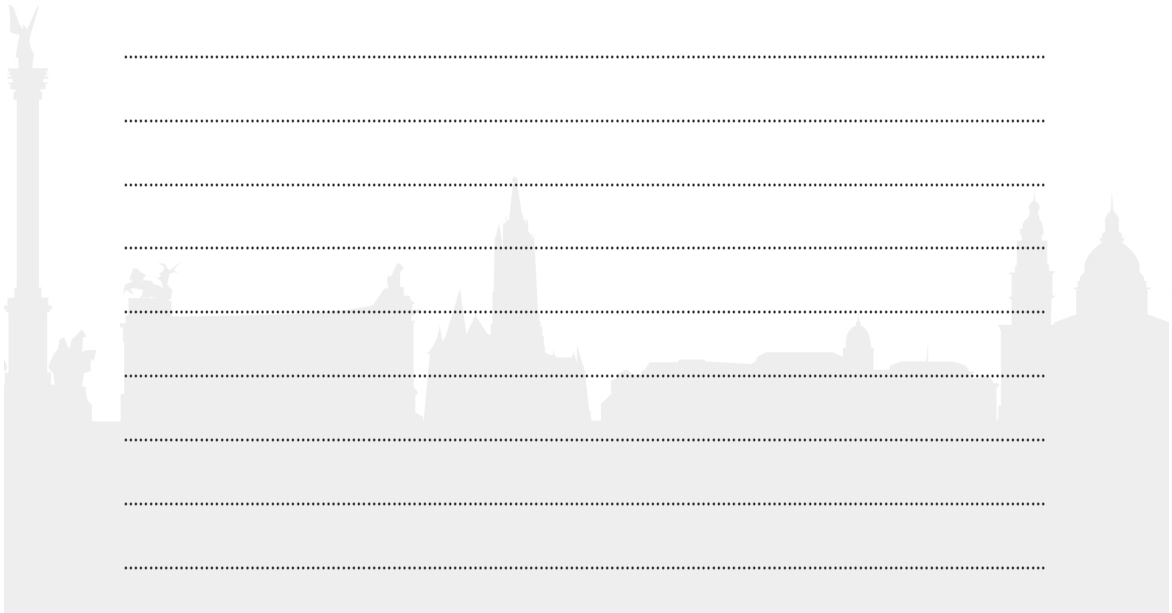
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