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 Kyerematenng 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 n Europe alone, nearly 1/3 of whom were children.[2] Worldwide, there are nearly 100,00 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*[3])

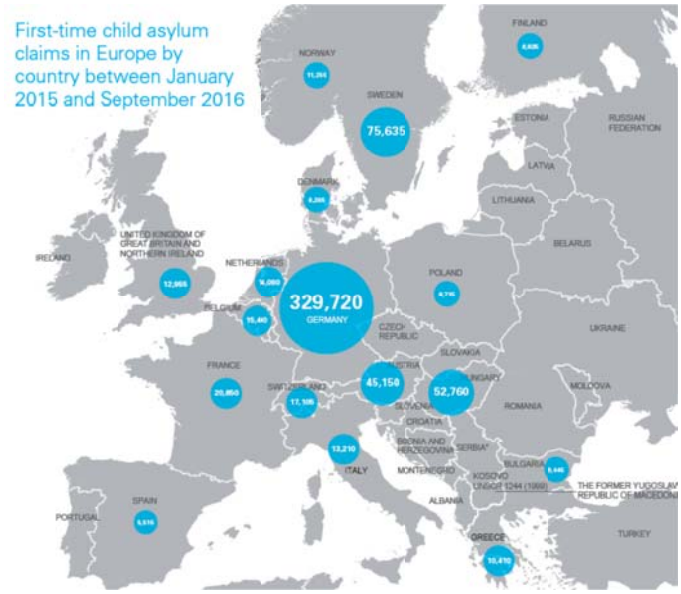

Figure 2. Accompanied and unaccompanied child asylum seekers in, 2015. (*Source: UNICEF*[3])

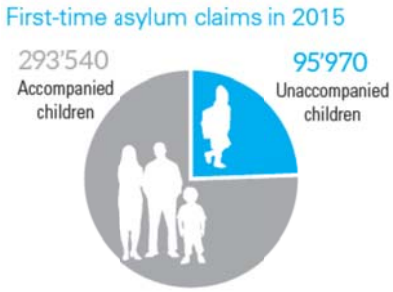

Figure 3. Rights of migrant children in the United Nations Convention on the Rights of the Child

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 for 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 deficiencies[9] and infectious diseases[10] 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 practices[17]. 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 inclusive[53] 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 treatments[58] 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 children[67]
    - 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 practice[68]

A public health intervention to promote migrant child health: Sweden[69]

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 reinstitution 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.

References

1. UNHCR. *Global Trends: Forced displacement in 2015.* UNHCR;2016. http://www.unhcr.org/global-trends-2015.html.
2. UNHCR. *Mediterranean Sea Arrivals in 2015: by Arrival Location, Country, Demographic and Country of Origin breakdown.* UNHCR;2016. http://data.unhcr.org/mediterranean/country.php?id=83.
3. UNICEF. *Child asylum seekrs in Europe: Situation in Figures.* UNICEF; 1 November 2016. https://www.unicef.org/ceecis/Infograph_Child_Relocation_and_Asylum_02_11_16_(002).pdf.
4. Eurostat. Asylum applicants considered to be unaccompanied minors by citizenship, age and sex: Annual data. 2016; http://appsso.eurostat.ec.europa.eu/nui/show.do. Accessed 16 May 2016.
5. UNOCHA. *Myanmar 2016 Humanitarian Needs Overview.* United Nations Office for the Coordination of Humanitarian Affairs; November 2015.
6. United States Border Patrol Southwest Family Unit Subject and Unaccompanied Alien Children Apprehensions Fiscal Year 2016. US Customs and Border Protection. https://www.cbp.gov/newsroom/stats/southwest-border-unaccompanied-children/fy-2016. Accessed 16 May 2016.
7. UNICEF. *Uprooted: The growing crisis for refugee and migrant children.* UNICEF;2016. http://www.unicef.org/emergencies/childrenonthemove/uprooted/.
8. Convention on the Rights of the Child. United Nations; 1989.
9. Gushulak BD, Pottie K, Roberts JH, Torres S, DesMeules M. Migration and health in Canada: health in the global village. *CMAJ : Canadian Medical Association Journal.* 2011;183(12):E952-E958.
10. Semenza JC, Carrillo-Santisteve P, Zeller H, et al. Public health needs of migrants, refugees and asylum seekers in Europe, 2015: Infectious disease aspects. *Eur J Public Health.* 2016;26(3):372-373.
11. Odone A, Tillmann T, Sandgren A, et al. Tuberculosis among migrant populations in the European Union and the European Economic Area. *Eur J Public Health.* Jun 2015;25(3):506-512.
12. Hernando V, Alvarez-del Arco D, Alejos B, et al. HIV Infection in Migrant Populations in the European Union and European Economic Area in 2007-2012: An Epidemic on the Move. *Journal of acquired immune deficiency syndromes (1999).* Oct 1 2015;70(2):204-211.
13. Sonden K, Castro E, Tornnberg L, Stenstrom C, Tegnell A, Farnert A. High incidence of Plasmodium vivax malaria in newly arrived Eritrean refugees in Sweden since May 2014. *Euro surveillance.* Sep 04 2014;19(35):20890.
14. Roggelin L, Tappe D, Noack B, Addo MM, Tannich E, Rothe C. Sharp increase of imported Plasmodium vivax malaria seen in migrants from Eritrea in Hamburg, Germany. *Malar J.* Jun 17 2016;15:325.
15. Garg PK, Perry S, Dorn M, Hardcastle L, Parsonnet J. Risk of intestinal helminth and protozoan infection in a refugee population. *The American journal of tropical medicine and hygiene.* Aug 2005;73(2):386-391.
16. Jaeger FN, Hossain M, Kiss L, Zimmerman C. The health of migrant children in Switzerland. *International journal of public health.* Aug 2012;57(4):659-671.
17. UNICEF. *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change.* Unicef Statistics and Monitoring Section, Division of Policy and Strategy;2013. https://www.unicef.org/media/files/UNICEF_FGM_report_July_2013_Hi_res.pdf.

18. Brian T, Laczko F. *Fatal Journeys Volume II: Identification and tracing of dead and missing migrants.* International Organization for Migration Global Migration Data Analysis Centre;2016. https://missingmigrants.iom.int.

19. IOM, UNICEF. *IOM and UNICEF Data Brief: Migration of Children to Europe.* 30 November 2015. http://www.iom.int/sites/default/files/press_release/file/IOM-UNICEF-Data-Brief-Refugee-and-Migrant-Crisis-in-Europe-30.11.15.pdf.

20. European Centre for Disease Prevention and Control. *Assessing the Burden of Key Infectious Diseases Affecting Migrant Populations in the EU/EEA: Technical Report.* 2014. http://ecdc.europa.eu/en/publications/publications/assessing-burden-disease-migrant-populations.pdf.

21. IOM, UNICEF. Data brief: Migration of Children to Europe. 30 November 2015.

22. Hagen-Zanker J, Mallett R. *Journeys to Europe - The role of policy in migrant decision-making.* Overseas Development Institute;2016. https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/10297.pdf.

23. Hjern A, Ringback-Weitoft G, Andersson R. Socio-demographic risk factors for home-type injuries in Swedish infants and toddlers. *Acta paediatrica (Oslo, Norway : 1992).* Jan 2001;90(1):61-68.

24. *Recommendation of the Committee of Ministers to member states on the Council of Europe Action Plan to promote the rights and full participation of people with disabilities in society: improving the quality of life of people with disabilities in Europe 2006-2015.* Council of Europe;2006. https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=0900001680595206.

25. Vaage A. Asylum-seeking children, mental health and child psychiatry services: Reflections from a project in south-western Norway. In: Overland G, Guribye E, Lie B, eds. *Nordic Work with Traumatised Refugees: Do We Really Care*. Newcastle upon Tyne: Cambridge Scholars; 2014:71-87.

26. Métraux J. Les liens familiaux à l'épreuve de la migration. *Paediatrica.* 2016;27(2):19-20.

27. Ratkowska KA, De Leo D. Suicide in immigrants: an Overview. *Open Journal of Medical Psychology.* 2013;2(3):124-133.

28. Kos AM. Psychosocial programmes can also diminish or destroy local human resources. In: Kaloianov EB, Kos AM, eds. *Activating Psychosocial Local Resources in Territories Affected by War and Terrorism.* Vol 57: IOS Press; 2009:139 -156.

29. Métraux J. L'interprète, ce nouvel acteur. *Cahiers psychiatriques.* 2002;29:115-135.

30. Masten AS. Global perspectives on resilience in children and youth. *Child Dev.* 2014;85(1):6-20.

31. Betancourt TS, Khan KT. The mental health of children affected by armed conflict: protective processes and pathways to resilience. *Int Rev Psychiatry.* 2008;20(3):317-328.

32. Fazel M, Reed RV, Panter-Brick C, Stein A. Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *Lancet.* 2012;379(9812):266-282.

33. Aynsley-Green A, Cole TJ, Crawley H, Lessof N, Boag LR, Wallace RM. Medical, statistical, ethical and human rights considerations in the assessment of age in children and young people subject to immigration control. *British medical bulletin.* Jun 2012;102:17-42.

34. Hjern A, Brendler-Lindqvist M, Norredam M. Age assessment of young asylum seekers. *Acta paediatrica (Oslo, Norway : 1992).* Jan 2012;101(1):4-7.

35. Cole TJ. The evidential value of developmental age imaging for assessing age of majority. *Annals of human biology.* 2015;42(4):379-388.

36. Sauer PJ, Nicholson A, Neubauer D. Age determination in asylum seekers: physicians should not be implicated. *European journal of pediatrics.* Mar 2016;175(3):299-303.

37. EUROSTAT. *Almost 90 000 unaccompanied minors among asylum seekers registered in the EU in 2015* Eurostat Press Office; 2 May 2016. http://ec.europa.eu/eurostat/documents/2995521/7244677/3-02052016-AP-EN.pdf/.

38. Townsend M. 10,000 refugee children are missing, says Europol. *The Guardian.* 30 January 2016.

39. European Parliament Press Release: Fate of 10,000 missing refugee children debated in Civil Liberties Committee. 2016; http://www.europarl.europa.eu/pdfs/news/expert/infopress/20160419IPR23951/20160419IPR23951_en.pdf.

40. Reijneveld SA, de Boer JB, Bean T, Korfker DG. Unaccompanied adolescents seeking asylum: poorer mental health under a restrictive reception. *The Journal of nervous and mental disease.* Nov 2005;193(11):759-761.

41. Bean T, Derluyn I, Eurelings-Bontekoe E, Broekaert E, Spinhoven P. Comparing psychological distress, traumatic stress reactions, and experiences of unaccompanied refugee minors with experiences of adolescents accompanied by parents. *The Journal of nervous and mental disease.* Apr 2007;195(4):288-297.

42. Vervliet M, Lammertyn J, Broekaert E, Derluyn I. Longitudinal follow-up of the mental health of unaccompanied refugee minors. *European child & adolescent psychiatry.* May 2014;23(5):337-346.

43. Watters C. *Refugee children. Towards the next horizon.* . London: Routledge; 2008.

44. Eide K, Hjern A. Unaccompanied refugee children--vulnerability and agency. *Acta paediatrica (Oslo, Norway : 1992).* Jul 2013;102(7):666-668.

45. Keygnaert I, Ivanova O, Guieu A, Van Parys AS, Leye E, Roelens K. *What is the Evidence on the Reduction of Inequalities in Accessibility and Quality of Maternal Health Care Delivery for Migrants? A Review of the Existing Evidence in the WHO European Region.* Copenhagen: World Health Organization 2016.; 2016.

46. UNHCR. *Initial Assessment Report: Protection Risks for Women and Girls in the European Refugee and Migrant Crisis - Greece and the former Yugoslav Republic of Macedonia.* 20 January 2016. http://www.unhcr.org/569f8f419.html.

47. Machado MdC, Fernandes A, Padilla B, et al. *Maternal and child healthcare for immigrant populations.* International Organization for Migration;2009. http://www.migrant-health-europe.org/files/FINAL%20DRAFT%20LISBON(3).pdf.

48. WHO. *Situation Update 3: Refugee Crisis* World Health Organization Regional Office for Europe;2016. http://www.euro.who.int/__data/assets/pdf_file/0016/305503/Refugee-Crisis-situation-update-report-n3.pdf.

49. Small R, Roth C, Raval M, et al. Immigrant and non-immigrant women's experiences of maternity care: a systematic and comparative review of studies in five countries. *BMC pregnancy and childbirth.* Apr 29 2014;14:152.

50. Jaeger FN, Kiss L, Hossain M, Zimmerman C. Migrant-friendly hospitals: a paediatric perspective--improving hospital care for migrant children. *BMC health services research.* 2013;13:389.

51. Berlin A. *Cultural competence in primary health care services - interaction between primary health care nurses, parents of foreign origin and their children*. Stockholm, Karolinska Institutet; 2010.

52. P S. *Diversity and equality of opportunity.* . Bern: Bern Federal Office of Public Health; 2007.

53. Maclachlan M, Khasnabis C, Mannan H. Inclusive health. *Tropical medicine & international health : TM & IH.* Jan 2012;17(1):139-141.

54. Festini F, Focardi S, Bisogni S, Mannini C, Neri S. Providing transcultural to children and parents: an exploratory study from Italy. *Journal of nursing scholarship : an official publication of Sigma Theta Tau International Honor Society of Nursing / Sigma Theta Tau.* 2009;41(2):220-227.

55. Bischoff A. *Caring for migrant and minority patients in European hospitals: A review of effective interventions.* Neuchâtel: Swiss Forum for Migration and Population Studies;2006.

56. Hadziabdic E. *The use of interpreter in healthcare perspectives of individuals, healthcare staff and families*. Växjö, Kalmar: Faculty of Health, Social Work and Behavioural Sciences, School of Health and Caring Sciences, Linnaeus University; 2011.

57. Flores G, Laws MB, Mayo SJ, et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics.* Jan 2003;111(1):6-14.

58. Hampers LC, McNulty JE. Professional interpreters and bilingual physicians in a pediatric emergency department: effect on resource utilization. *Archives of pediatrics & adolescent medicine.* Nov 2002;156(11):1108-1113.

59. Garcia EA, Roy LC, Okada PJ, Perkins SD, Wiebe RA. A comparison of the influence of hospital-trained, ad hoc, and telephone interpreters on perceived satisfaction of limited English-proficient parents presenting to a pediatric emergency department. *Pediatric emergency care.* Jun 2004;20(6):373-378.

60. Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports.* Jul-Aug 2003;118(4):293-302.

61. Betancourt JR, Green AR, Carrillo JE, Park ER. Cultural competence and health care disparities: key perspectives and trends. *Health affairs (Project Hope).* Mar-Apr 2005;24(2):499-505.

62. Minhas RS. The double disability of refugee children. *Academic pediatrics.* Jan-Feb 2014;14(1):8-9.

63. Kurth E, Jaeger FN, Zemp E, Tschudin S, Bischoff A. Reproductive health care for asylum-seeking women - a challenge for health professionals. *BMC public health.* 2010;10:659.

64. Betancourt JR, Green AR, Carrillo JE. *Cultural competence in health care: Emerging frameworks and practical approaches.* Commonwealth Fund;2002. http://www.azdhs.gov/bhs/pdf/culturalComp/cchc.pdf.

65. Evidence Based Clinical Guidelines for Immigration and Refugee Health. Canadian Collaboration for Immigrant and Refugee Health. http://ccirhken.ca/ccirh_main/sample-page/page1-2/ Accessed 6 December 2016.

66. Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. *Canadian Medical Association Journal.* 2011;183(12):E824-E925.

67. e-Clinical Checklist for New Immigrants and Refugees. Centre for e-Learning, Teaching and Learning Support Service, University of Ottowa. . http://ccirhken.ca/ccirh_main/sample-page/page3-2/

68. Refugees and Global Health e-Learning Program & Certification. Canadian Collaboration for Immigrant and Refugee Health. http://ccirhken.ca/ccirh_main/sample-page/page2-2/.

69. *MILSA Support platform for migration and health: Laying the foundation.* Malmö: Malmö University;2015. http://www.lansstyrelsen.se/skane/En/manniska-och-samhalle/integration/partnership-skane/PublishingImages/Pages/default/Anthology%20MILSA%20%E2%80%93%20Support%20Platform%20for%20Migration%20and%20health%20-%20Laying%20the%20foundation.pdf.

70. Gehri M, Jäger F, Wagner N, Gehri M. Primary care for the migrant populationin Switzerland: a paediatric focus Paediatrica vol 27 Special issue 2016: migrants – w ww.swiss-paediatrics.org. *Paediatrica.* 2016;27(Special):9-15.