



**World Health
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REGIONAL OFFICE FOR **Europe**



Health of refugee and migrant children

Technical guidance



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**Knowledge Hub
on Health and Migration**

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The Migration and Health programme, the first fully fledged programme on migration and health at the WHO Regional Office for Europe, was established to support Member States to strengthen the health sector's capacity to provide evidence-informed responses to the public health challenges of refugee and migrant health. The programme operates under the umbrella of the European health policy framework Health 2020, providing support to Member States under four pillars: technical assistance; health information, research and training; partnership building; and advocacy and communication. The programme promotes a collaborative intercountry approach to migrant health by facilitating cross-country policy dialogue and encouraging homogeneous health interventions along the migration routes to promote the health of refugees and migrants and protect public health in the host community.

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Abstract

Between 2015 and 2017, almost one million asylum-seeking children registered in the European Union, and 200 000 of these arrived unaccompanied by a caregiver. These children faced particular risks, including being exposed to discrimination, marginalization, institutionalization and exclusion. When considering health and health care interventions for migrant children, some areas need specific attention, such as their diverse backgrounds, whether they are unaccompanied and separated from family, whether they have been trafficked and also if they are children who have been left behind. Policy considerations include an intersectoral approach to promote good health and well-being, particularly mental health, in migrant children that target risk factors at the individual, family and community levels. Particular emphasis is placed on how national/local governments have an important role in fostering or hindering living conditions for refugee and migrant children in the areas of housing, health care services and education.

Keywords

CHILD HEALTH, CHILD HEALTH SERVICES, TRANSIENTS AND MIGRANTS, REFUGEES, EUROPE

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Contents

Acknowledgements	iv
Abbreviations	v
Summary	vi
Introduction	1
Objectives.....	2
Methodology	2
Overview	3
Refugee and migrant children in the EU/EEA area.....	3
Key articles in the CRC with regard to migrant children	3
Risk factors for health and well-being during migration	4
Risk and protective factors for health and well-being in migrant children.....	5
Key policies to promote good health and well-being	5
Evidence	6
Risk and protective factors for migrant children.....	6
Health and health care for newly arrived migrant children in Europe.....	8
Mental health and psychological well-being	9
Summary	13
Areas for intervention	14
Psychoeducational interventions	14
Parenting support programmes.....	15
School-based health promotion	16
Policy considerations	20
Health promotion strategies	20
Public health strategies.....	21
References	22
Recommended reading.....	28
Annex 1. Child asylum applicants in the EU/EEA during 2015–2017	29
Annex 2. Resources	31

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Abbreviations

CRC	Convention on the Rights on the Child
EEA	European Economic Area
EU	European Union
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund

Summary

Around one million asylum-seeking children were registered in the European Union (EU) during 2015–2017, of whom 200 000 (one in five) arrived unaccompanied by a caregiver. This technical guidance focuses on the initial response of the health care services to the needs of these and other refugee and migrant children.

All countries in the WHO European Region have signed and ratified the United Nation's Convention on the Rights on the Child (CRC) and have agreed to the obligations contained in this. This technical guidance identifies a number of areas where the health situation for migrant children would be improved if countries adhered more closely to these obligations.

Medical care for chronic disorders and rehabilitation for disabilities are often the most pressing needs of migrant children, with needs for dental care being the most common. In addition, migrant children from low- and middle-income countries have a higher burden of chronic infectious disorders compared with those from high-income countries, and these disorders need to be identified and treated. Lack of access to preventive health care in the countries of origin make vaccination programmes a high priority to prevent outbreaks of measles and other vaccine-preventable disorders.

To address mental health needs, a holistic and family-oriented public health strategy for promoting mental health and psychological well-being is needed. This should include collaboration between many different sectors of society, with education in schools and pre-schools being particularly important. There is some evidence also to support the effectiveness of more specific interventions to promote well-being, for example psychoeducational approaches to cope with psychological trauma, culturally sensitive parent-support programmes and interventions in the school environment.

A general finding in the literature is that differences in health status between children in different migrant groups are greater than the differences between migrant children and local populations in Europe. Country of origin is an important predictor here, but also the social background of the family in the country of origin and the living conditions in the destination country. Consequently, health assessment/screening procedures should be individualized. A comprehensive individualized health assessment by a paediatric nurse or clinician, preferably as soon as possible after the child arrives in the country of destination, can identify health care needs that might otherwise go undetected for prolonged periods of time. It also allows screening for potentially communicable disorders and updating of vaccinations. Such an approach would save costs by coordinating health care use in an informed manner. The provision of medical interpreters and cultural mediators is important to make care provision for migrant children more equitable with that for the host population.

The evidence presented in this technical guidance is primarily based on observational reports and theory, plus individual evaluative studies. This reflects the lack of evaluative research of policy and specific interventions on how to facilitate health, well-being and positive development in migrant children in Europe. There are large knowledge gaps in research regarding pathways to resilience and for assessing the impact of specific interventions that may be likely to be effective in improving outcomes. Long-term follow-up is required to evaluate interventions intended to enhance well-being, educational outcomes, employment and social inclusion. Close collaboration with policy-makers and key service providers is essential to ensure optimal translation of findings into sustainable practice.



Introduction

In 2017, the Office of the United Nations High Commissioner for Refugees (UNHCR) estimated that there were around 30 million children in the world living outside their country of birth, with 13 million being refugees or asylum seekers. The overwhelming majority of these children reside in countries of low or middle incomes that are neighbours to zones of armed conflict (1). In recent years, more of these child refugees have arrived in Europe, with almost one million asylum-seeking children registered in the EU in 2015–2017, of whom 200 000 were unaccompanied by a caregiver (2).

These children arrive after long and difficult journeys with limited or no access to care. Some come from countries with collapsed health care systems, overwhelmed by both victims of conflict and disaster and the consequences of destroyed infrastructure. Many have been exposed to armed conflict in their country of origin before leaving and will face new, unfamiliar and often hostile surroundings in the countries of destination. These circumstances lead not only to accumulated individual health care needs, but also to a need for effective public health strategies to update preventive child health programmes and promote positive psychological well-being (3,4).

Children's right to health care is codified in the CRC, a Convention which has been signed by all Member States of the WHO European Region. Article 24 recognizes "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health" (5). The Standing Committee on the Rights of the Child has clarified that "The enjoyment of rights stipulated in the Convention is not limited to children who are nationals of a State Party and must therefore, if not explicitly stated otherwise in the Convention, also be available to all children – including asylum-seeking, refugee and migrant children – irrespective of their nationality, immigration status or statelessness" (6). The EU Reception Conditions Directive also obliges Member States to ensure medical or other assistance for asylum applicants with special needs, which includes children and minors (7).

Two categories of particularly vulnerable migrant children in a social perspective are asylum seekers and children in an irregular situation. They may be accompanied or unaccompanied, but they have the same rights as children with legal residency according to the CRC. Asylum seekers have usually experienced armed conflicts and/or political persecution in the country of origin. While seeking asylum, they live under circumstances characterized by temporality and uncertainty about their situation and future. Children with irregular migrant status are also referred to as "undocumented" or "unregistered" migrants. These children often live "under the radar" in precarious situations with no or limited access to basic social rights and exposed to poverty, exploitation, social exclusion and violence (8).

Objectives

The objective of this technical guidance is to inform national and local health policy regarding health care for newly arrived refugee and migrant children. This grouping encompasses children aged 0–18 years who are asylum seekers, in an irregular situation or in the first two years after obtaining residency in the country of reception. The guidance, therefore, focuses on the initial health care response to the needs of these children.

Methodology

This technical guidance reviewed academic literature on migrant child health in a European context. It built on the WHO Regional Office for Europe's Child and Adolescent Strategy for 2015–2020 by combining a child rights approach with an evidence-based approach (9) to put forward practical policy considerations for improving refugee and migrant child health. The CRC pays specific attention to displaced and unaccompanied children and so provides a useful framework from which to approach health policy for migrant children.

Published peer-reviewed literature in English, for the period 2007–2018 was identified through a comprehensive literature search in EMBASE and PubMed. Search terms included combinations of terms for children (“child”, “youth” and “adolescent”) with terms for migrants (“migrant”, “asylum seeker”, “refugee” and “undocumented migrant”) and terms for countries in the EU/European Economic Area (EEA). The search was limited to publications covering children from birth to 18 years of age. This search was complimented by a search in the grey literature from the EU/EEA, UNHCR, the United Nations Children's Fund (UNICEF) and WHO during 2013–2018. Extensive searches were also made by hand from the reference lists of the articles retrieved.

A scoping review was found to best fit the available evidence and a narrative design was chosen to merge the empirical studies, theory and policy. Policy implications were based on the policy articles retrieved in this search and documents published by the EU, UNICEF and WHO.

Overview

Refugee and migrant children in the EU/EEA area

In 2015–2017, there were 1 037 440 children applying for asylum in the EU/EEA. Of these 200 550 (19.3%) were unaccompanied (Annex 1). Table 1 gives the EU/EEA countries hosting the greatest and least number of unaccompanied children, a grouping with particular health concerns.

Table 1. Countries of the EU/EEA with the highest and lowest percentages of unaccompanied child asylum seekers in 2015–2017

Country	All children 2015–2017	Unaccompanied/ separated children	Unaccompanied/ separated (% total children)
More than 30% of children unaccompanied			
Bulgaria	13 270	5 005	38
Croatia	665	215	32
Denmark	9 905	3 770	38
Italy	33 975	20 095	59
Netherlands	21 080	6 740	32
Norway	12 700	5 235	41
Slovenia	1 020	675	66
Sweden	90 265	37 740	42
United Kingdom	25 445	8 635	34
Less than 5% of children unaccompanied			
Czechia	810	15	2
Estonia	215	0	0
France	50 300	1 385	3
Lithuania	420	5	1
Malta	1 315	55	4
Poland	13 825	405	3
Spain	15 490	75	1

Source: Eurostat, 2017 (2).

Key articles in the CRC with regard to migrant children

Article 2.1. Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

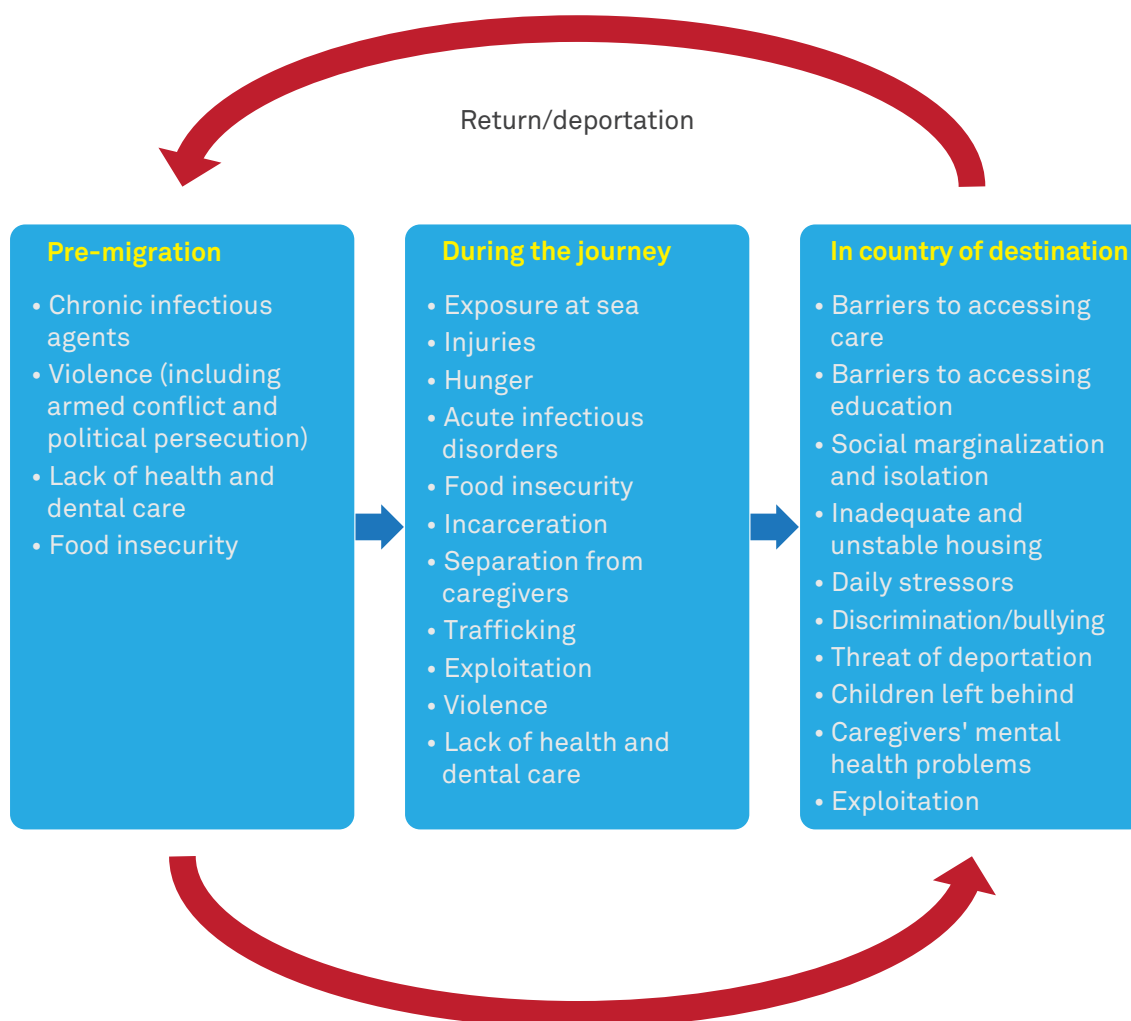
Article 24 1. Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

Article 39. Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

Risk factors for health and well-being during migration

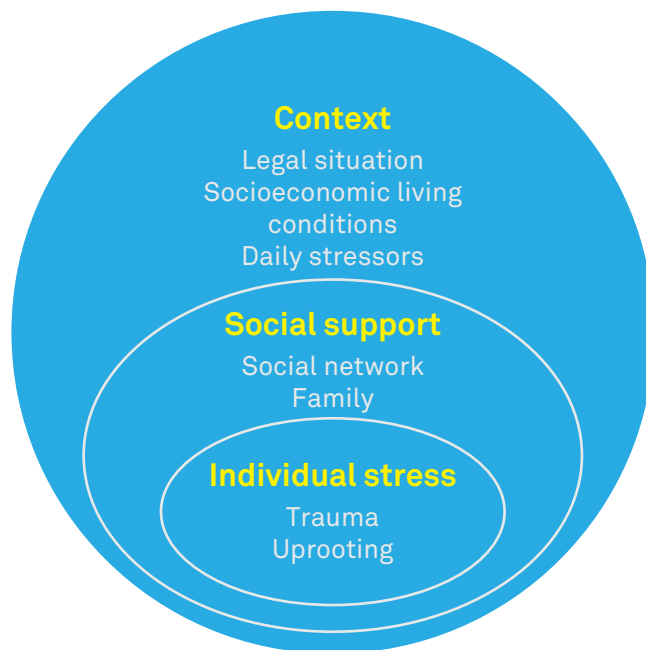
Figs. 1-3 outline risk and protective factors for health and well-being in child migrants.

Fig. 1. Risk factors for health problems and poor well-being during the different phases of migration



Risk and protective factors for health and well-being in migrant children

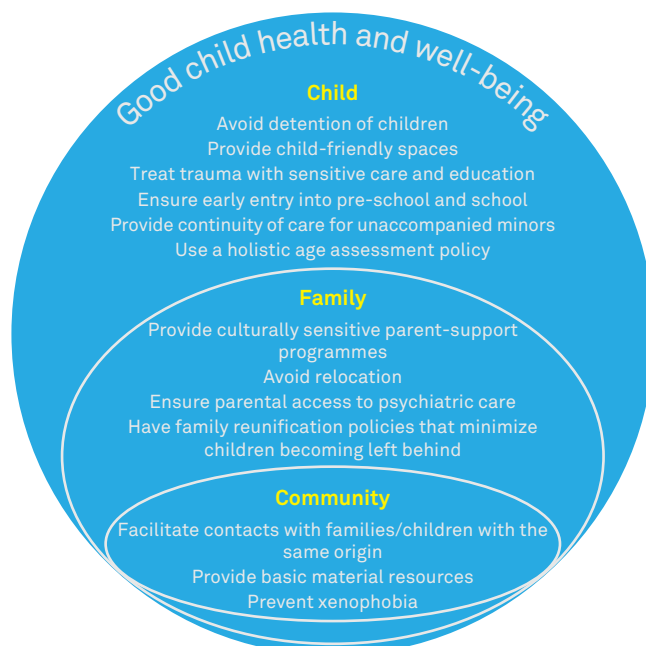
Fig. 2. An ecological model of risk and protective factors to be targeted in a public health strategy for promoting well-being in migrant children



Source: Hjern & Jeppson, 2005 (10).

Key policies to promote good health and well-being

Fig. 3. Key policies to promote child health and well-being



Evidence

Risk and protective factors for migrant children

The health of migrant children is related to both their state of health before their journey and the risks they face at all phases of their journey and settlement in the country of destination; it is also linked to the health of their caregivers (Fig. 1). Consequently, risks for a child will vary according to the child's particular experiences in the home country, during travel and after arrival at the destination country (3, 11).

Health risks associated with the country of origin

There may be multiple underlying reasons for children's departure from the 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. In conflict zones, health care is often disrupted and has other priorities than prevention; therefore, children may have been without access to health care for prolonged periods of time (12) and may be vulnerable to vaccine-preventable diseases (13). They may also have increased rates of dental caries because of inadequate dental care (14). Nutritional deficiencies, chronic infections and noncommunicable diseases may also affect migrant children, although the epidemiology varies by social background, exposures and experience in the country of origin (13).

Health risks during the journey

Depending on the route, and the method and length of travel, the journey presents the migrant child with different challenges. During the crossing of the Aegean Sea between Turkey and Greece and the Mediterranean Sea between Libya and southern Europe, many children have drowned when overcrowded boats have capsized (15). Infants born during the journey are at increased risk of severe and life-threatening illnesses, including hypothermia, septicaemia, meningitis and pneumonia (16). These infants may also suffer from poor nutrition, particularly as breastfeeding is a challenge for mothers during their journey. A recent survey of rescue ships found that dehydration and dermatological conditions associated with poor hygiene and crowded conditions were common, as well as new and old traumatic injuries from both violence and accidents (17). There has been a dramatic increase in recent years in the number of children migrating to southern Europe who have been subjected to incarceration, sexual violence and kidnapping during their journey, increasing the risk of both mental and physical health problems (4, 15). Another common risk is the separation of children from their caregiver during the journey.

Children may spend time in overcrowded accommodation with inadequate hygiene and sanitation facilities, which places them at risk for diarrhoeal diseases, respiratory infections, skin infections and other communicable diseases (16). This is particularly

the case for children who are trapped for long periods of time in transit accommodation, without being able to reach their final destination.

Risks in the country of destination

After reaching the country of destination, asylum seekers have a prolonged period of uncertainty while their application for asylum is being processed. The living conditions of children and families during this period is often stressful, including frequent housing relocations, lack of toys or spaces to play, limited access to school, social isolation from peers, and caregivers under pressure. A recent survey of children living in refugee camps in Germany also pointed to the risk of injuries in the newly settled children, for example falls while playing and burns (18).

Children experiencing these conditions may enter a kind of survival mode, making it difficult for them to envisage their futures (19). At the same time, daily stressors related to the struggle to make ends meet with minimal allowances and the possible encounters with xenophobia from local populations and peer groups also take their toll (20,21).

Migrant families may struggle to access education. This challenge places children at risk for delayed learning and also serves as a barrier to integration into age-appropriate schooling (3). Migrant children with chronic health problem and disabilities are at particularly high risk for exclusion from education and may have lower levels of participation in society than other disabled children (22).

Language barriers, cultural differences and the new and unfamiliar environment in the country of reception may lead to delayed presentation for health care or the inappropriate use of health services. Populations at particularly high risk include migrants in an irregular situation, who may fear being reported to migration authorities, and unaccompanied minors, who lack information about their health rights and guidance in seeking health care (22).

Migrant children in detention

Systematic detention of asylum seekers, often in temporarily constructed structures, at entry points and/or when they are waiting for deportation is a reality. The material conditions in detention centres can vary from appalling in some countries to comparatively better standards in others (23,24). Children can be detained both in transit countries and in countries that they or their parents see as the ultimate destination. Immigration detention has negative consequences for the well-being of all those detained, but studies have found that it is most detrimental to children (23).

The United Nations Committee on the Rights of the Child has commented on children in detention: “the leading principles for the use of deprivation of liberty are: (a) the arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time; and (b) no child shall be deprived of his/her liberty unlawfully or arbitrarily” (25). The

Committee also stated that every child in detention has a right to education and health care, something that is lacking in many countries in Europe (25). In 2014, the Council of Europe passed a resolution that strongly opposed the detention of migrant children (26), a call that has been supported also by Caritas, UNHCR and UNICEF.

Health and health care for newly arrived migrant children in Europe

Migrant children have diverse backgrounds, coming from countries with different socioeconomic living conditions and from different social strata in these countries. Accordingly, the health status within the population of refugee and migrant children varies greatly. Nonetheless, their situation and exposure to the risk factors described above make them vulnerable to the development of health problems. Infectious diseases have been investigated most frequently in published studies, perhaps because of fears of transmission of these diseases to others in the population.

Assessment of health care needs

A comprehensive individualized health assessment by a paediatric nurse or physician, preferably as soon as possible after the child arrives in the country of destination, can identify health care needs that might otherwise go undetected for prolonged periods of time. Untreated health problems and unidentified disabilities can have long-term consequences for well-being, learning and integration into the new country (27). Health assessments made within a clear structure, with the participation of qualified medical interpreters and with the collaboration of a network of relevant specialists, can increase the likelihood of detection of significant health conditions, link newly arrived migrant children and their families with primary health care and reduce costs by coordinating care across primary care and specialist services (28).

A survey in 2016 found that in all but four countries in the EU/EEA there were systematic health examinations of some kind for newly arrived migrants (29). This health examination was mandatory in most eastern European countries and Germany, while it was voluntary in the rest of western and northern Europe. All countries that have a policy of health examination aimed to identify communicable diseases in order to protect the host population. Almost all countries with a voluntary policy also aimed to identify a child's individual health care needs, but this was rarely the case in countries with a mandatory policy, where the focus was strictly on communicable disorders (29).

Communicable diseases

Increased incidence of infectious diseases has been identified in refugee and migrant children in the EU in a range of settings. Infections identified include minor infections as well as more significant diseases requiring hospital admission (30). Inadequate, overcrowded accommodation and substandard hygiene and sanitation facilities place children at risk for communicable diseases such as diarrhoeal diseases and skin infections (16). The prevalence of many chronic infections, such as tuberculosis,

hepatitis B and C, malaria and intestinal parasites, is more common in middle-income and, particularly, low-income countries than in the EU/EEA, and this is reflected in a higher prevalence of these disorders in migrant children (30,31). The European Centre for Disease Prevention and Control provides information about infectious disorders in migrant populations (31), as well as guidance for screening and treatment.

Refugee and migrant children arriving in Germany unaccompanied have been found to have higher rates of colonization with multidrug-resistant bacteria (32). These children are potentially at risk of morbidity and mortality from contracting clinically important infections, which would be more difficult to treat and need specialized hospital care.

Outbreaks of measles, a potentially vaccine-preventable disorder, have been reported in asylum-seeking children. A literature review in 2016 covering publications from 2012 onwards found that outbreaks of measles were linked to lack of protective vaccine-related antibodies for measles and other main vaccines in a significant proportion of migrant children in Europe (33). This underlines the importance of establishing public health routines for vaccination of young migrants entering Europe.

Noncommunicable diseases

Compared with their Swiss peers, migrant children had more dental cavities, twice the odds of being obese and migrant adolescents seemed more frequently affected by psychological problems (14). Children of migrants may have distinct health needs and paediatric care and health promotion activities should be aware of these.

Nutrition

The first years in the country of destination may put newly settled children at risk for the development of obesity; this is linked to issues such as stress and the potential for replacement of dietary habits in the country of origin with food less suitable for children, including new breastfeeding patterns (34). The lack of sunshine during the winter also puts children with dark skin at particular risk for the development of vitamin D deficiency if this is not supplemented (35,36).

Mental health and psychological well-being

There is abundant evidence showing that newly arrived migrant children are at high risk for mental and psychosocial problems (37–39), predominately internalizing disorders – post-traumatic stress disorder, depression and anxiety – associated with exposure to organized violence and migration stress (40). Externalizing symptoms, however, appear to be no more common in migrant children than in children in the host majority population (39). Longitudinal studies of refugee children in Scandinavia during the 1990s showed that the high rate of internalizing symptoms on arrival in the destination country tended to fade slowly over time, with post-traumatic stress disorder being rare six or seven years after arrival (41). Risk factors associated with life in the country of

destination, such as socioeconomic deprivation, parental divorce and bullying, were identified as important determinants of mental health at follow-up (41).

Migrant children often have to cope with parents who themselves are suffering from stress-related psychological disorders after traumatic experiences and migration stress. Caregivers with psychiatric disorders may struggle to provide their children with a sense of security and psychological support (42), as has been shown in studies of families of Holocaust survivors (43). In combination with socioeconomic deprivation, these parenting difficulties also increase the risk for child abuse (44).

Unaccompanied/separated children

Around 20% of the asylum-seeking children in the EU during recent years have arrived unaccompanied by an adult caregiver, most of them boys aged 15–17 years on arrival (4). Unaccompanied or separated children are at high risk for exploitation and trafficking as they lack the protection and support of a caregiver. Consequently, they are also particularly vulnerable for the development of poor mental health and well-being. Large epidemiological studies of unaccompanied teenage asylum seekers in Belgium and the Netherlands have confirmed this vulnerability, demonstrating high rates of depression and post-traumatic stress disorder during the first years after resettlement (21,45,46). At the same time, there are also indications that unaccompanied children often are resourceful and arrive with a clear vision of a positive future in the new country despite the suffering they may have endured (47). Education and continuity in care so that relations can be maintained with substitute caregivers during the first years after resettlement have been identified as key determinants of long-term adjustment of unaccompanied children (47).

Having an assumed chronological age above or below 18 years determines the support provided for young asylum seekers in most European countries, despite the fact that many, particularly unaccompanied children, lack documents with an exact birth date (48). This has led to the use of many different methods to assess age. The majority of EU Member States rely on medical examinations, primarily in the form of radiograph of the hand/wrist, collarbone and/or teeth (49); more recently magnetic resonance imaging has been utilized (50). Factors such as individual variation in age-specific maturity in later teenagers, and unknown variations between children from high- and low-income countries, make these methods unreliable for correct assessment of whether a young person is below or above 18 years of age (51,52).

The imprecision of these methods to assess age raises serious ethical and human rights concerns and is often experienced as unfair and stressful by the young asylum seekers themselves. The European Academy of Paediatrics and several national medical associations have, therefore, recommended their members not to participate in medical age-assessment procedures for asylum applicants on behalf of the state. European paediatric associations instead advocate for a holistic age assessment to allow for the benefit of the doubt that these imprecise methods demand (53).

Child trafficking

Refugee and migrant children are at increased risk of being trafficked for sexual exploitation, labour exploitation, forced criminal activities, illegal adoption and street begging (54). At particularly high risk are children who become separated from family, children travelling unaccompanied and children who are left behind (55). Traffickers exploit young age and the challenges that young migrants face such as unfamiliarity with new surroundings, separation from family and friends, language barriers and social isolation (56). In a survey of migrants in Bulgaria, Greece, Hungary, Italy, Romania and countries of the former Yugoslavia by the International Organization for Migration in 2017, 88% of children surveyed reported having experienced exploitation in labour, being locked up and/or being approached with an offer of arranged marriage (57). Even after arrival at their destination, children continue to be at risk. An estimated 10 000 unaccompanied minors went missing in Europe in 2015, many while in state care (56). Factors that protect migrant children from trafficking include living in a supportive and stable family environment, the existence of well-functioning child protection and social support systems, access to education, access to information on safety and child rights, access to health care and the existence of intervention strategies aimed at preventing trafficking (55).

Children left behind

Many adult migrants arrive in a country of destination without their children or partners. Parents are the main sources of social and physical support for children and separation from them can be detrimental to a child's health and well-being, particularly mental health (58). The CRC is very clear on the right of children to be united with their parents. It requires states to protect children against separation from their parents against their will (Article 9), and to ensure that applications of a child or his or her parents for the child to leave a country for the purpose of family reunification are dealt with "in a positive, humane and expeditious manner" (Article 10, paragraph 1) (5). Migration policy in many European countries today violates this obligation by creating obstacles for family reunification (59), leaving the children left behind in dire circumstances without protection of their caregiver.

Promoting mental health and well-being in migrant children

A public health strategy to promote well-being and mental health in migrant children should have a holistic framework, targeting risk factors for the individual, their family and the community using a mixture of policy-based and more specific interventions (Fig. 2) (10).

Risk factors at the individual level are primarily targeted by the more specific interventions described below. Parents are the most important psychological support children have provided that they are not separated from them. Access to adequate psychological support for parents suffering from psychiatric disorders is, therefore, an important part of support for children. Additionally, schools and child care centres

provide a sense of security and help children to develop social support systems. A beneficial effect has been shown even with only a few hours of school each day (60).

On the level of context, government policy defines many aspects of the socioeconomic living conditions for asylum seekers, such as material resources and housing. These are important social determinants of health in general, applying equally to migrant children (10). The stress associated with the asylum process is profound and has been shown to increase with time of waiting (61,62); this makes effective administrative procedures during the asylum process particularly important for children.

The second paragraph of the CRC non-discrimination legislation implies that nations should provide care on the same terms for both migrant and resident children. However, a survey in 2016 found that entitlements to care for migrant children varied considerably between countries in the EU/EEA (28). Migrant children legally categorized as asylum seekers were more likely to be entitled to health care on equal terms with resident children than were other migrant children without permanent residency. Only 11 EU Member States provided similar care arrangements for irregular migrant children from non-EU/EEA countries.

The system used to fund health care differs considerably across Europe. Some countries have a tax-based system while others are funded by insurance. Although the insurance-based system is more administratively complicated in terms of funding health care for migrant children, the effective working solutions to this challenge in insurance-funded countries such as France and the Netherlands show that these obstacles can be overcome.

Health care provided in a primary care setting is, in most societies, the most cost-effective way of providing psychological support, which is the most pressing health care need for migrant children, particularly for victimized children who have a specific right to rehabilitation (CRC Article 39). European governments also have to consider how health care can be delivered in a context that allows children in an irregular situation to access care without fear of deportation (63).

Newly settled migrants face numerous barriers for accessing care: unfamiliarity with rights, entitlements and the overall health system; gaps in health literacy; social exclusion; and direct and indirect discrimination (3,64). Outreach strategies with access to services and closely connected with asylum centres and refugee-dense neighbourhoods are important to overcome these barriers (27). Cultural and language barriers can also influence the quality of the care received. The use of professional medical interpreters improves the quality of communication, and studies have found that using professional interpreters also reduces the cost of care and helps to avoid unnecessary diagnostic evaluations and treatments. Cultural mediators facilitate the care process by explaining health concepts and health behaviours, and by helping to ensure that investigations and treatments take into account culturally specific needs.

Before migrant families find a more permanent home in the country of destination, they often pass through less than satisfactory transitory housing facilities, including detention centres. To promote child well-being in these situations, child-friendly

spaces have been developed. These are spaces that are designed to promote a sense of safety and normality in children whose lives have been disrupted (65). They are used to promote resilience and well-being in children and are, therefore, adapted to meet their needs, often with colourful decorations, child-sized furniture, simple toys and structured activities. Child-friendly spaces can be set up virtually anywhere that is safe, including in asylum centres, government offices that carry out asylum procedures, health facilities, schools, community settings and even in detention centres. Child-friendly spaces have been used successfully in psychosocial and educational interventions to promote child mental health both during and after armed conflict (65).

Summary

The evidence presented in this technical guidance is primarily based on observational reports and theory, and on individual evaluative studies, reflecting the lack of rigorous evaluative research of policies and specific interventions on facilitating health, well-being and positive development for migrant children in Europe (66). There are large knowledge gaps in research on understanding pathways to resilience and in assessing the impact of specific interventions that evidence suggests may be effective in improving outcomes. Long-term follow-up is required to evaluate interventions that enhance well-being, educational outcomes, employment and social inclusion. Close collaboration between policy-makers and key service providers is also essential to ensure optimal translation of findings into sustainable practice (21).

Areas for intervention

The burden of poor mental health and psychological well-being in refugee and migrant children has been addressed by interventions specifically developed to target newly settled refugee and migrant children and families. Three different strategies are illustrated with case studies: psychoeducation, parenting support and school-based programmes.

Psychoeducational interventions

Psychological trauma, often associated with conflict and persecution in the country of origin or events during the migration journey, is an important risk factor for poor mental health and well-being in newly arrived migrant children. Interventions based on psychoeducational principles have been developed to help migrant children to cope with their symptoms (Case study 1) (67).

Case study 1. Teaching Recovery Techniques (Sweden, the United Kingdom)

Teaching Recovery Techniques is a psychosocial intervention for children who have experienced traumatic events. It was initially developed for children who had experienced war or disasters, including refugees and asylum-seeking children, but the programme has since been used for groups of children who have experienced other kinds of trauma. Children take part in group sessions aimed at enhancing emotional regulation, coping skills and problem-solving techniques, and in helping the children to express themselves. A parent component has two parallel sessions that provide information on the intervention and education on techniques to support their children.

The Teaching Recovery Techniques approach has been used in numerous contexts since its first development in 1999 and has been shown to reduce children's distress and post-traumatic symptoms and to improve peer and sibling relations (67,68). Recently, it was also adapted to the context of unaccompanied children, with positive effects on symptom levels (69). A manual for the programme is now available in 10 languages (70).

Duration: five sessions, 1.5 hours per session.

Cost: training programme for trainers £300 per person in the United Kingdom.

Parenting support programmes

Caregivers are the main source of support for all children and this is particularly true for migrant children during the journey and the first phase of resettlement when other sources of social support are often non-existent. Finding ways of strengthening parents as a source of support for their children is, therefore, vital (Case studies 2 and 3) (67).

Case study 2. Ladnaan: a culturally sensitive parent-support programme for Somali-born parents (Sweden)

Ladnaan is a 12-week culturally adapted parenting support programme combined with civic orientation for Somali-born parents living in Sweden. The programme builds on the well-established parent-support programme Connec, but was modified by qualitative interviews with Somali parents in Sweden about the parenting challenges they experience in the new society (71).

The programme was provided in weekly group-based sessions lasting 1–2 hours each, facilitated by a trained community educator of Somali origin. In addition to societal information, parents received educational lectures and participated in workshops and discussions on the parent–child relationship, attachment, child development and challenged interactions.

The effect of the programme was studied in a randomized controlled trial of 57 parents of children aged 11–16 years with self-reported stress related to parenting practices, compared with a control group of 52 parents on the waiting list for Ladnaan. Children's behaviour was examined by parent reporting, using the Child Behaviour Checklist. Parents participating in Ladnaan reported higher efficacy and parent satisfaction after having participated in the programme, and significant improvement in behavioural problems in their children two months after completing the programme (72).

Duration: 12 weeks.

Cost: €120 per parent/family included in the programme in Sweden.

Case study 3. Mind-Spring (Belgium, Denmark, the Netherlands)

Mind-Spring is a mental health prevention programme in Belgium, Denmark and the Netherlands that provides psychoeducation plus psychosocial and parenting support for asylum-seeking parents in a culturally sensitive manner and in their own language (73).

Training sessions for parents are carried out by a trainer with a refugee background and a mental health professional and cover topics such as stress, trauma, depression, identity, acculturation and mental health care. The programme is designed to facilitate the sharing of experiences and to empower parents with knowledge about mental health and the ability to recognize signs of trauma and mental illness in themselves. It also gives information about where to seek help. Additionally, parents receive training and support in parenting practices and how to navigate cross-cultural parenting issues. Participants in the programme report improved understanding of the effect of migration and trauma on their reactions and behaviour, improved understanding of mental health and an increased sense of control.

Duration: eight sessions, 2 hours per session.

Cost: €1375 for eight group sessions in Belgium.

School-based health promotion

A growing body of evidence and experience has shown that schools play a critical role in protecting and promoting the health of refugee and migrant children. Successful school-based mental health prevention requires professionals trained in cultural competence, who understand the mental health needs and risks of refugee and migrant children, and who are able to adapt the learning programme to the needs of the individual child and family. The literature on school-based programmes is large and includes programmes that focus on promoting a healthy adaptation to the host society in a holistic manner (Case studies 4 and 5), plus ones that focus on specific child mental health issues and that use particular treatment modalities to promote child mental health (67,74).

Case study 4. Hearing All Voices (United Kingdom)

Hearing All Voices was a pilot project undertaken by Child to Child in London, United Kingdom, in 2013–2016, aimed at enhancing social inclusion, engagement in educational activities and social participation among vulnerable youth, with a particular focus on refugee, migrant and asylum-seeking youth (75). The project used a child rights participatory approach, whereby the students, aged 16–18 years, identified a social problem that they wished to address, investigated the issue, designed an intervention, implemented it, evaluated the results and identified future steps and needs. In order to equip the students for their projects, they were given training in the English language and in activities designed to enhance agency, communication and teamwork. Additionally, teachers and teaching assistants were trained in methods of supporting the participation of young people in the classroom while being non-directive.

Over the three years, the groups developed projects on a wide range of issues, including street safety, knife crime, homelessness, bullying in schools and the care of Ebola orphans. At the end of the project, students reported improved self-confidence and a sense of self-worth, an increased sense of control over their lives and improved ability to initiate conversations with adults. The projects created a space for the young people to speak about their lives and experiences, and teachers reported that this helped them to better understand the needs of their students.

Teachers noted substantial improvement in the students' communication, ability to work in groups and increased solidarity and mutual support, with these effects apparent from early stages of the project and increasing throughout the project. Hearing All Voices demonstrates the potential for educational interventions to promote the social and psychological well-being of youth on the move, and enhance their language and life skills. The project is also an example of a successful way to train professionals working with youth on the move to understand and respond to their needs.

Evaluations of this project showed improved peer relations and life skills among the students plus enhanced engagement with the wider school and community (75).

Duration: 19 weeks.

Cost: £120 per student for the 18-session programme in the United Kingdom.

Case study 5. The Pharos Schools Programme (the Netherlands)

The Pharos Schools Programme provides classroom programmes in the Netherlands focused on nurturing social participation among migrant children with host society children and adults while also providing individualized attention according to the needs of the child (76). The Programme is offered in special primary and secondary schools for refugee and asylum-seeking children. Teachers are trained in teaching techniques for children at each developmental level. The techniques include verbal and nonverbal activities, with attention to past and present life, identity, feelings of trust and safety, and the development of agency in the children. In a version of the programme in the United Kingdom, services from refugee community organizations are also included (77).

Duration: primary school programme 8 weeks; secondary school programme 21 lessons.

Cost: not available; guidance materials are available for teachers and students which cost €20–34.95 for teachers and €5 for students.

Case study 6. Health assessment in a school setting (Sweden)

In the Swedish city of Malmö, a central unit in the school system screens all children who have recently arrived with an origin outside Sweden. Screening for infectious disorders is not included as this occurs at a separate county council unit.

The school nurse meets all children and their caregivers for a health assessment to broadly define and address each child's health care needs. An interpreter is used if needed. For children without their original caregiver, the city provides a substitute caregiver for the assessment.

There is a structured interview and a superficial examination of the body, including dentition, eyesight and hearing, and the child's height and weight are recorded. Structured questions are posed regarding acute symptoms (e.g. diarrhoea, jaundice, cough, fever, skin problems, fatigue, pallor or nightly sweat) and an immediate referral is made to a physician in a primary care clinic if any are identified.

Questions are also posed about long-standing health problems (e.g. stunted growth or disabilities) and medications. Mental health problems are explored using open questions that explicitly ask about symptoms associated with traumatic events or sleeping disturbances. These are only recorded if the symptoms are severe enough to impair the well-being of the child. Vaccination history is taken from documents if these are available and if not through the use of structured questions.

Case study 6. (contd)

Identified health care needs that are not urgent are addressed initially by the school health team of nurses, physicians, psychologists and social workers. Children with milder forms of mental health problems are provided with psychoeducational advice and followed up. Referrals are made if more specialized services are needed.

The results of the interview and the examination are documented in a structured patient record and statistics are regularly produced based on these records. During the autumn semester of 2015, 639 children aged 6–18 years who were either asylum seekers or children in refugee families were screened. Immediate referral to a physician was needed for 1% of accompanied children and 5% of unaccompanied children; 20% of accompanied children and 39% of unaccompanied children needed support from the school health team. Mental health issues were twice as likely in the unaccompanied children (e.g. 33% with sleep problems and 22% with post-traumatic stress, compared with 15% and 6%, respectively, in accompanied children). Almost 50% of children in both groups had untreated caries.

Source: Stefan Kling and Anders Hjarn, unpublished information.

Policy considerations

National governments have an important role in the creation of living conditions for refugee and migrant children. Most newly settled refugee families rely on government support for housing and living expenses, and governments define the rights of children to access health care services and education. Local government has an important role in adjusting services to the special needs of refugee and migrant children. The following policies considerations are suggested as methods to promote health and well-being, particularly mental health, which is a major issue, in these circumstances. (Annex 2 lists some resources to support decisions on service provision.)

Health promotion strategies

Access to equitable care and education for all categories of migrant children

Article 2 of the CRC implies that nations should provide care to all categories of migrant children on equal terms with resident children. Access to education, including pre-school, is another fundamental right in the CRC that is particularly important for refugee and migrant children. The provision of medical interpreters and cultural mediators is important to ensure that care provision for migrant children is more equitable with that for the majority population. The use of professional interpreters with medical knowledge improves the quality of translation, and studies have found that using professional interpreters reduces the cost of care and helps to avoid unnecessary diagnostic evaluations and treatments.

Provision of psychological support is the most pressing health care need for migrant children and in most societies the primary health care setting is the most cost-effective way of providing this. This is particularly important for victimized children (CRC outlines specific rights to rehabilitation in Article 39).

Individualized health assessment

Most European countries today provide some kind of health screening for newly arrived migrants but in many this only covers communicable disorders. A comprehensive individualized health assessment by a paediatric nurse or clinician, preferably as soon as possible after the child arrives in the country of destination, can identify health care requirements that might otherwise go undetected for prolonged periods of time. It can also link newly arrived migrant children and their families with primary health care and coordination of care across primary health and specialist services, thus reducing costs.

Public health strategies

Intersectoral collaboration for promotion of health and well-being

A public health strategy to promote well-being and health in migrant children should have a holistic framework, targeting risk factors on individual, family and community levels. Moving children between multiple locations hinders the creation of peer networks and educational continuity. For unaccompanied children, minimizing relocation is particularly important to allow them to build good sustainable relations with substitute caregivers. Before migrant families find a more permanent home in the country of destination, they often pass through less than satisfactory transitory housing facilities, sometimes including detention centres. To promote child well-being in these situations, child-friendly spaces can be developed that are designed to promote a sense of safety and normality in children whose lives have been disrupted.

A public health strategy to promote mental health and psychological well-being in migrant children should target the support systems for the children as well as identifying and treating specific issues. The most important psychological support for children is their parents. Consequently, early/expedited family reunion, as outlined in the CRC, is essential for the well-being of refugee and migrant children. Other important aspects are early access to education for children in pre-school and access for parents to psychiatric care, trauma-informed care and education.

Avoidance of detention of migrant children

Children are more vulnerable than adults to the negative consequences of detention on health, particularly their mental health. Consequently, detention should not be used as a means for control or deportation of migrant children. If such use is unavoidable, the facilities should include child-friendly areas and access to health care and education.

Holistic age assessment

Many unaccompanied young people lack documents to prove their age. Since children have additional rights over adults, an assessment of their age is often deemed necessary. Current evidence indicates that medical methods cannot determine age accurately in those in their upper teens with the precision needed for this critical determination. Therefore, a holistic assessment that provides fair benefit of the doubt is highly preferable.

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Recommended reading

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Annex 1. Child asylum applicants in the EU/EEA during 2015–2017

Country	2015	2016	2017	All children 2015–2017 (% of total applicants)	Unaccompanied and separated children (% of total in country)
Austria	32 225	17 865	12 020	62 110 (6.0)	13 525 (21.8)
Belgium	13 630	5 690	5 535	24 855 (2.4)	4 300 (17.3)
Bulgaria	5 495	6 575	1 200	13 270 (1.3)	5 005 (37.7)
Croatia	20	465	180	665 (0.1)	215 (32.3)
Cyprus	530	685	690	1 905 (0.2)	545 (28.6)
Czechia	270	275	265	810 (0.1)	15 (1.9)
Denmark	6 320	2 410	1 175	9 905 (1.0)	3 770 (38.1)
Estonia	70	65	80	215 (0.0)	0 (–)
Finland	7 625	1 740	1 350	10 715 (1.0)	3 080 (28.7)
France	14 020	15 285	20 995	50 300 (4.8)	1 385 (2.8)
Germany	148 170	268 195	96 585	512 950 (49.4)	67 275 (13.1)
Greece	2 500	19 720	19 785	42 005 (4.0)	5 225 (12.4)
Hungary	45 895	8 550	1 595	56 040 (5.4)	10 255 (18.3)
Iceland	90	275	175	540 (0.1)	35 (6.5)
Ireland	385	580	840	1 805 (0.2)	100 (5.5)
Italy	7 295	11 170	15 510	33 975 (3.3)	20 095 (59.1)
Latvia	85	125	135	345 (0.0)	25 (7.2)
Liechtenstein	40	15	50	105 (0.0)	10 (9.5)
Lithuania	70	165	185	420 (0.0)	5 (1.2)
Luxembourg	780	625	630	2 035 (0.2)	205 (10.1)
Malta	395	455	465	1 315 (0.1)	55 (4.2)
Netherlands	10 580	6 220	4 280	21 080 (2.0)	6 740 (32.0)
Norway	10 370	1 250	1 080	12 700 (1.2)	5 235 (41.2)
Poland	5 570	5 920	2 335	13 825 (1.3)	405 (2.9)
Portugal	145	360	560	1 065 (0.1)	115 (10.8)
Romania	295	530	1 595	2 420 (0.2)	365 (15.1)
Slovakia	105	35	35	175 (0.0)	15 (8.6)
Slovenia	85	425	510	1 020 (0.1)	675 (66.2)
Spain	3 720	3 740	8 030	15 490 (1.5)	75 (0.5)
Sweden	70 385	10 875	9 005	90 265 (8.7)	37 740 (41.8)

Country	2015	2016	2017	All children 2015–2017 (% of total applicants)	Unaccompanied and separated children (% of total in country)
Switzerland	11 425	9 245	6 990	27 660 (2.7)	5 420 (19.6)
United Kingdom	8 280	9 505	7 660	25 445 (2.5)	8 635 (33.9)
Total	406 870	409 045	221 525	1 037 440 (100)	200 550 (19.3)

Source: Eurostat, 2017 (2).

Annex 2. Resources

Clinical care

Caring for Kids New to Canada

The Canadian Paediatric Society through its website Caring for Kids New to Canada provides guidance to help health professionals providing care to refugee and migrant children, youth and families.

The website provides information on when and how to use cultural mediators and language interpreters in the care of migrant children. This includes guidance on the role of the interpreter and on how to work with interpreters during a medical encounter. It also provides guidance on the needed skills of the interpreter, risks and pitfalls of using untrained interpreters and further literature on using language and culture-incongruent health encounters.

Paediatric-focused guidance on medical assessment as well as information on migration patterns to Canada and relevant health risks and needs for migrant children is also provided.

Canadian Paediatric Society (2018). Caring for Kids New to Canada [website]. Ottawa: Canadian Paediatric Society (<https://www.kidsnewtocanada.ca/>, accessed 25 September 2018).

The Migrant-friendly Hospitals initiative

The EU Migrant-friendly Hospitals initiative was developed to enhance health service needs for migrant populations. A study was conducted in Switzerland to examine how such initiatives might address specific needs during hospital-based care of migrant children. This study identified a need for the development of migrant-sensitive approaches suitable for children. Specific areas of focus include support and training of staff, the availability of interpreters, and allotting adequate time for consultation.

Hudelson P, Dao MD, Perneger T, Durieux-Paillard S (2014). A “migrant friendly hospital” initiative in Geneva, Switzerland: evaluation of the effects on staff knowledge and practices. *PLoS One*. 9(9):e106758.

Jaeger FN, Kiss L, Hossain M, Zimmerman C (2013). Migrant-friendly hospitals: a paediatric perspective: improving hospital care for migrant children. *BMC Health Serv Res*. 13:389.

Krajic K, Stramayr C, Karl-Trummer U, Novak-Zezula S, Pelikan JM (2005). Improving ethnocultural competence of hospital staff by training: experiences from the European “Migrant-friendly Hospitals” project. *Diversity Health Social Care*. 2(4):279–90.

Child and adolescent health promotion

Becoming Adult

The Becoming Adult project that explores the transitions of unaccompanied young migrants, including the perspective of transitions from youth to adulthood as well as the social processes of migration and resettlement in a new country. The study involves young people from Afghanistan, Albania, Eritrea and Vietnam and involves three distinct work packages: Young people's conceptions of futures and wellbeing, Cultural conceptions of futures and wellbeing and Policy conceptions of futures and wellbeing.

The Becoming Adult Project (2018). *Becoming adult: conceptions of futures and wellbeing among migrant young people in the UK* (<https://becomingadult.net/about-becoming-adult/>, accessed 25 September 2018).

Classroom programme of creative expression workshops for refugee and migrant children

Numerous governmental and nongovernmental programmes have incorporated artistic expression in programmes for forcibly displaced children and for children who have experienced adverse events. In spite of its broad use, there are few studies that evaluate the effectiveness of this approach. A study from Montreal, Canada, found that migrant children who participated in a 12-week creative expression programme reported fewer internalizing and externalizing symptoms, independent of gender, age, or fluency in the mainstream language. Additionally, students participating in the programme reported higher self-esteem, with a particularly strong effect for boys.

Rousseau C, Drapeau A, Lacroix L, Bagilishya D, Heusch N (2005). Evaluation of a classroom program of creative expression workshops for refugee and immigrant children. *J Child Psychol Psychiatry*. 46(2):180–5.

Resources on migrant health policy

Investing in children: the European child and adolescent health strategy 2015–2020

This report highlights the importance of early child development and access to health services for migrant children. The report calls for evidence-informed policies for migrant child health.

WHO Regional Office for Europe (2014). *Investing in children: the European child and adolescent health strategy 2015–2020*. Copenhagen: WHO Regional Office for Europe (http://www.euro.who.int/__data/assets/pdf_file/0010/253729/64wd12e_InvestCAHstrategy_140440.pdf?ua=1, accessed 25 September 2018).

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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