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# Migrating Children: The Need for Comprehensive Integrated Health Prevention Measures

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## Abstract

**Purpose of the Review** Millions of children have migrated across borders with more than half of these children fleeing violence. The purpose of this review is to highlight the health issues that these children face. While the amount of sheer trauma that these children experience is astounding, there are policies and clinical models that could be developed and implemented to improve the health and well-being of these children.

**Recent Findings** Community-based clinical models that provide culturally sensitive health care with links to mental health, legal services, and language services are one way to mitigate the effects of the health inequities that immigrant children and their families face.

**Summary** A more comprehensive understanding of the effect of resiliency in these children would help to inform interventional programs that could promote resiliency and improve long-term outcomes. As institutional, local, national, and international policy decisions affect the health of migrating children, policies at every level should include provisions for children.

**Keywords** Immigrant children · Migrant children · Refugee · Mental health · Access to care · Global health

## Introduction

A young child lying dead on a beach struck the world momentarily. The story of young Alan Kurdi is unfortunately not unique among children. Children are often the most vulnerable in situations of conflict and strife [1•]. As Dr. Fernando Stein stated in January 2017, "Children do not immigrate, they flee [2]."

It is estimated that over 50 million children have migrated across borders around the world seeking safe haven, and these are believed to be conservative estimates. Over half of the migrating children were fleeing violence [3]. More than 25 million of these children are currently displaced, internally and across borders, as a result of violence, armed conflicts, deprivation, climate change, globalization, and natural disasters [4]. Migration as an issue has captured headlines globally with the photos of suffering, maimed, or dead children burning a hole in our consciousness that cannot be forgotten. These children may be refugees, internally displaced or irregular migrants, but each and every one of them is a child on the move. As migrating children, they are among the most vulnerable on the earth [3]. Various terms to describe migrating children are listed in Table 1.

The reasons for this increasing movement of families and children are multifactorial, including war, violence, extreme poverty, and climate change. Regardless of cause, these families and children are fleeing for their lives.

The United Nations High Commission for Refugees (UNHCR) estimates that nearly 500,000 people annually cross Mexico, the world's largest migration corridor that has received considerable attention [6]. Most of these irregular immigrants originate in one of three Central America countries, Honduras, El Salvador, and Guatemala, which have some of the highest homicide and femicide rates in the world. The conditions and abuses these immigrants suffer in these countries are well-documented in the American Immigration Council special report written by Elizabeth Kennedy, *No Childhood Here: Why Central American Children are*

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**Table 1** Definitions of migrating children adapted from UNICEF (United Nations Children's Fund) [5]

| Name | Definition |
|---|---|
| Migrant | A person who is moving or has moved across an international border or within a home country regardless of whether the move is voluntary or involuntary and regardless of the length of stay |
| Refugee | A person who lives outside his or her country of nationality or habitual residence and is unable to return because of persecution or fear of persecution based on race, religion, nationality, political opinion, or membership in a particular social group. |
| Asylum seeker | A person who seeks refuge in a country to which he or she has fled because of persecution. |
| Internally displaced person | People who fled their homes—but not their countries—because of armed conflict, violence, disaster, or a violation of human rights. |
| Unaccompanied child | A child who has been separated from both parents and is not being cared for by an adult legally responsible to do so |
| Separated child | A child separated from both parents or a previous legal guardian but not necessarily other adult family members. |

*Fleeing Their Homes*, which include organized crime, gangs, violence, and extreme poverty. Leaving their country is often their last resort and the only way to save their lives or the lives of their children [7]. The children and families who flee these countries face continued abuse and violence in Mexico, which is documented in the report by Medicins San Frontieres (Doctors Without Borders) *Forced to Flee Central America's Northern Triangle: A Neglected Humanitarian Crisis* [8].

Children can be subject to physical, sexual, and emotional abuse prior, during, and after migration. A study by Edwards et al. showed that children were more likely to suffer physical trauma in Iraq and Afghanistan when compared to adults [9]. Following exposure to blasts, children were more likely to have a higher injury severity score and have a longer intensive care stay [9]. A recent report by Digidiki and Bhabha for the Harvard School of Public Health highlights the ongoing vulnerability of migrant children after migration [10•]. This article describes the experience of migrant children in Greece which is often a first stop country for many refugees. In this recently emerging setting, children have been forced into prostitution to earn money for those at home and/or enough to make money to support onward migration via smuggling into another country [10•]. This report not only highlights the preponderance of commercial sexual exploitation of children but also the physical and sexual violence that these children face in migrant camps [10•].

Although most of the world's immigrants are living and working under approved and sanctioned regulations, millions of immigrants around the globe are living in "irregular" situations. Irregular migration may include minor infractions, such as overstaying a visa, or more serious infractions, such as using falsified documents to cross borders, or crossing borders without permission at unauthorized sites [11]. Irregular immigration is a major political battleground currently in many countries. It undercuts the authority of regional and local governments, may place unfair pressures on competitive businesses, and most certainly places immigrants at great risk. Irregular immigrants face discrimination and unfair labor practices in informal markets. Others face abuse or are denied rights, but are afraid to seek protection and relief for fear of deportation or prolonged detention without recourse [11]. When these situations affect the lives of children, children's health and well-being will suffer.

Many of these traumas may not leave physical marks, but can result in an indelible mark on the mental psyche. A seminal study by Felitti et al. highlighted how adverse childhood events lead to increased health risks as adults [12]. As defined by the American Academy of Pediatrics (AAP), toxic stress is "strong, frequent, or prolonged activation of the body's stress response systems in the absence of the buffering protection of a supportive, adult relationship [13]." Some of the mental health illnesses that disproportionately affect children fleeing violence include post-traumatic stress disorder, depression, and anxiety disorders, all of which can present as psychosomatic disorders [14•]. The World Health Organization (WHO) European policy brief on mental health for refugees described the mental health risk factors that arise at various stages of migration "pre-migration factors (such as persecution, economic hardship), migration factors (physical danger, separation), and post-migration factors (detention, hostility, uncertainty)" [15].

Up to 2% of the world's population is living outside their country of birth; the impact of immigration on the epidemiology of infectious disease is important to recognize [16]. Old and new data has consistently described an increased risk of infectious disease among migrants after arriving in receiving countries. Recent data on refugees arriving to the USA from 35 countries demonstrated a prevalence of the following: latent tuberculosis infection (LTBI) (8.9%), HIV (0.7%), hepatitis B (2.1%), and parasites (28.1%) [17]. A review article

which looked specifically at Hispanic immigrants who emigrated to the USA showed that latent tuberculosis infection, malaria, helminthes, brucellosis, typhoid fever, and neurocysticercosis were of concern [18]. A recent pediatric study importantly highlighted the challenges of accurately screening refugee children for LTBI. In this Australian study, 61% of refugee children completing both the tuberculin skin test and the Quantiferon Gold-in-tube test had discordant results suggesting that 8–38% of these children may have had LTBI [19•]. Most importantly, Kevin Schwartzman's seminal mathematical modeling work demonstrated that investments made in screening for tuberculosis prior to emigration to the USA were tremendously cost-effective [20]. This evidence informed the 2007 change in the US TB screening policy which enhanced screening practices prior to emigration and has been associated with a dramatic decline in tuberculosis among immigrants after arrival to the USA [21]. Translation of this policy change to other infectious diseases would likely result in a similarly dramatic decline in the incidence and potential spread of other infections.

Despite recognition of these increased risks in receiving countries, many immigrants and refugees are challenged to access care to address these infectious diseases and physical or mental health issues once they arrive in their new country. Gaps, obstacles, and potential solutions to improve access to care are further explored later in this paper.

### Post-migration Health Effects

Moving from a limited resource setting to a high-resource setting can result in improved access to better quality health care, water, and nutrition. Unfortunately, emerging evidence is beginning to demonstrate the negative impact of migration, as well. For example, children who migrated from Guatemala to USA and from Tonga to Australia had increased prevalence of being overweight and obese due to access to energy dense, yet poor quality food [22, 23]. These poor health outcomes are likely further propagated by the poor access to quality health care that many immigrant families struggle to obtain after migration.

Of the countries that resettle refugees, the USA settles the most refugees [24]. This paragraph takes a further look into the process of resettlement for the USA. Resettlement of refugees can take many years and is often a complex process involving clearance from many different departments [25]. Prior to arrival, refugees receive a health screen to check for any major medical conditions and infectious disease [26]. After arrival, they again receive another extensive physical examination and laboratory screening to rule out any infectious diseases [26]. For this population, access to care can vary based upon the state in which the refugee is placed [27]. In general, the US refugees/asylees are provided with short-term medical insurance known as Refugee Medical Assistance (RMA) until 8 months post-arrival [28]. Afterwards, families have to apply for medical insurance through federal government programs such as Medicaid, the Children's Health Insurance Program (CHIP), or the federal Marketplace, which are generally available to lower income individuals and families [27]. The complexity of the health care system compounded with language barriers, transportation barriers, and even understanding the concept of preventative care can make it difficult for refugees to access care.

Most immigrants coming to the USA are seeking safe haven with family or friends in the USA. The top five destination states include California, Texas, New York, Florida, and New Jersey [29]. Of these top five states, only California and New York allow access to health care to immigrants. Only six states (NY, CA, WA, MA, IL, OR) and the District of Columbia provide public coverage of health care to immigrant children regardless of their immigration status [30]. Thus, most of the immigrants across the USA have little or no access to health care, except through hospital emergency rooms or community health care centers, which are under threat of federal cuts. Moreover, the vast majority of these immigrants receive no education on how to navigate the complicated US health care system.

Once immigrants without refugee status arrive in their destination communities, access to health care is not guaranteed. Further, if available, case management services are often not sensitive to the needs of this vulnerable population of children, which include both physical and mental health care needs. In addition to primary pediatric health care that can assess for disease, migrant children and adolescents benefit from important preventive pediatric health care that includes health promotion, health supervision, and anticipatory guidance. These important services must be integrated with family planning, mental health, and dental services. Access to trauma-informed mental health screening and care is insufficient in many areas, particularly in rural areas with few mental health services at all, and it is a particular problem for children with limited English or other language proficiency. Access to dental services, often needed urgently and/or chronically, is also inadequate.

## The Importance of Primary Care Health Prevention

While it is clear that the consequences of a forced migration can be detrimental, the path to prevent or mitigate these effects is less apparent. This may include coping with or recovering from trauma experienced prior to or during migration or preventing any new mental or physical health concerns after arrival. Indeed, many immigrants may arrive in better health than their local citizen counterparts, known as the "Healthy Immigrant Effect." Unfortunately, over time, post-migration

trauma, poverty, lack of access to care, and other stressors may negate this effect [31, 32]. How to prevent this decline is less apparent. There is very limited outcome-based research evaluating interventions to address existing physical or mental health conditions or prevent the decline in migrants' health. There are, however, many local organizations working tirelessly to meet the needs of the refugee and other immigrant groups in their communities. A thoughtful review of these efforts provides useful insights and guidance for health care providers, advocates, and policy makers.

## Clinical Level

While many immigrants arrive to resettlement countries healthier than the local population, this health advantage appears to diminish over time. While there are many factors that contribute to the deterioration, poor access to quality medical care must play a role. It seems logical that creating public policy, and a public dialog, that improves access to health care will improve the overall health of immigrants over time. Unfortunately, this challenge is hardly unique to any one country, as access to quality health care is an issue for many immigrants throughout the world arriving to high, middle, and low-income countries. In addition to quality preventative, routine care, it is clear that certain sub-groups within the immigrant population have unique health care needs on arrival. This may include treatment for physical problems related to recent or past trauma, unmet medical needs for the treatment of chronic medical conditions, or mental health needs as a result of many forms of emotional or psychological stressors. For these groups in particular, access to quality health care is essential. The following sections describe some clinical models that have sought to address the health of immigrants in their community.

One model program is Terra Firma in New York City. Terra Firma is a collaborative project of Catholic Charities New York, The Children's Health Fund, and The Children's Hospital at Montefiore and is a recognized Medical-Legal Partnership by the National Center for Medical-Legal Partnership. This award-winning model incorporates legal services, along with direct medical care, mental health services, support programs, and advocacy [33]. By incorporating mental health, legal services, and medical services in one setting, immigrant children have access to multi-faceted resources without having to go to multiple locations [33]. In addition, the Terra Firma model has evening clinic hours instead of daytime hours to minimize patients' absence from school [33]. More information about this model can be found on their website (www.terrafirma.nyc/) [33]. Community partnerships are another way to address this need. A clinic in San Francisco called School Based Newcomer Outreach Initiative at La Clinica de La Raza, which treats immigrant patients in the school-based setting has a medical-legal partnership with the East Bay Community Law Center to address their legal needs in the clinical setting [34]. These two clinical models emphasize the importance of community connection, which is highlighted later in this paper. Another excellent resource is the website created by the Immigrant Child Health Committee of the Washington, D.C. Chapter of the American Academy of Pediatrics. This website provides clinical guidelines, community resources, and a model for other academic centers [35].

## Mental Health

Immigrants are commonly exposed to significant adverse emotional and physical stress including physical violence, trauma, and family separation that may result from natural disasters and/or manmade conflict. Despite the potential negative impact that these exposures may have, many immigrants do quite well. Certain characteristics of immigrant communities may have protective benefits. For example, while immigrant children are more likely to live in poverty, they are more likely to have a two-parent household, have an involved extended family, and be a member of a local community with similar language, cultural, and religious practices [36, 37]. It has been further shown that leaving an environment of instability and insecurity, and resettling to another location with significantly more constancy and safety, may be beneficial to one's sense of well-being [38]. Nevertheless, there are subpopulations of refugees or other immigrant groups who experience much higher rates of depression, posttraumatic stress disorder (PTSD), or other mental health conditions that require additional support and treatment [31].

Immigrants benefit from mainstream community-based mental health resources; however, special consideration should be paid to "non-traditional" resources that some may seek in lieu of more "traditional" services. Immigrants and refugees likely receive a mental health benefit from living in a community with others that share a common background [36]. Hence, efforts to foster this connectedness may provide some mental health advantages. In addition, immigrants seek and receive care from alternative sources such as traditional healers, religious leaders, or other culturally specific resources. For those that do access care from mental health facilities within our mainstream medical system, it is important that linguistically and culturally sensitive care is provided, while recognizing the heterogeneity and diverse needs of the local immigrant populations. For example, it has been demonstrated that Vietnamese immigrants may be more comfortable seeking care in community mental health facilities, whereas Mexican immigrants may be more likely to seek mental health care from their primary care physician. Further, individuals from different cultural backgrounds may differ in how they manifest or describe their mental health symptoms [39]. Given the rich heterogeneity of immigrant populations, it is likely that community-based services have

the best insight to meet the unique mental health needs of their community members.

School-based programs afford a unique, community-based opportunity to meet the mental health needs of immigrant children. Studies have found high rates of exposure to trauma and resultant PTSD in schools serving predominantly poor immigrant children. In these settings, school-based mental health services cannot only overcome access and financial barriers, but can effectively meet the needs of their students [39, 40]. Services focusing on the family unit have also been shown to be effective. Forced migration often disrupts and places unique stressors on the family structure. Efforts supporting family resettlement, acculturation, and general well-being are likely to improve the mental health of affected children. As the mental health of the parent clearly affects their children, child health care providers should be cognizant of mental health within the entire family unit and well-versed on available local resources that will benefit the entire family. Improving access to mental health services for all community members will lead to the improved mental health of children in the community [38].

## Improving Care Through Improved Language Services

Improving our ability to overcome language barriers is an attainable goal and can improve the health of immigrant patients. Although this poses a growing challenge for medical systems, provision of language services to support effective and high-quality care is a legal and ethical requirement. Under Title VI of the Civil Rights Act of 1964, the Office for Civil Rights of the US Department of Health and Human Services requires that medical care not be delayed or denied based on language and that all Medicare or Medicaid recipients provide adequate language services [41]. The WHO has passed multiple resolutions to ensure that its material is available in multiple languages and cites the importance of having material in different languages [42]. The AAP recommends "the delivery of care within the context of appropriate physician knowledge, understanding, and appreciation of cultural distinctions leading to optimal health outcomes." In the AAP policy statement, culture is defined to include "the full spectrum of values, behaviors, customs, language, race, ethnicity, gender, sexual orientation, religious beliefs, socioeconomic status, and other distinct attributes of population groups" [43]. Language barriers have a negative impact on patient outcomes. Studies performed in the emergency department setting have demonstrated that language barriers can result in decreased adherence to patient instructions and increased resource utilization, cost, length of stay, and admission rates [41, 44, 45]. Interpreter or language concordant provider use has also been associated with decreased adverse events, improved communication, more willingness to ask sensitive questions, and better perception of medical care received [46, 47]. By utilizing a language and culturally concordant provider or interpreter, physicians can better elicit and respond to patient concerns and improve their explanation or treatment recommendations [48]. Despite this evidence, medical providers consistently underutilize translational services. In 2010, 57% of US pediatricians reported using a family member to translate during a patient encounter [49]. In the USA, Latino parents report language as their largest barrier to accessing health care [46]. While the quality of health care received by racial and ethnic groups is certainly influenced by numerous factors, language barrier is an important and modifiable obstacle that providers and families can overcome.

## Building on Resiliency

While the trauma of migration can significantly impact the health of a child, there are recognized factors that can promote resiliency in children. These factors include the value of education and work within the immigrant family context and the importance of family connection [50]. For example, immigrant children who "saw that their parents wanted them to do better than they had" shared that "their parents' low paying jobs served as motivation to do better" [50]. Recognized factors that promote resiliency should be fostered as they support immigrant and refugee children to overcome adversity and reach their full potential. Nevertheless, more research is needed to improve our understanding of resiliency and identify additional modifiable factors that promote resiliency in immigrant children.

## Current Policies Impacting Immigrants Post-migration

In the USA and UK, it has been noted that immigrants may not access health care due to fear of deportation. These fears are unfortunately not irrational. In the first 11 months of 2016, the National Health Service (NHS) shared over 8000 patients information to the UK home office that resulted in nearly 6000 people being traced by immigration enforcement [51].

Once resettled in the USA, it is clear that immigrants' access to care is a significant barrier to obtaining appropriate health care and preventing the deterioration of the "Healthy Immigrant." Even without taking immigration status into account, Latinos are the most uninsured racial or ethnic group in the USA [52]. Children with non-citizen parents are significantly less likely to have insurance, to have access to preventative care, and to have a regular source of medical care. Despite popular beliefs, citizen children with non-citizen parents, or non-citizen adults/children, had fewer Emergency Department visits than their citizen counterparts [52]. This diminished access to care is multifactorial. It involves socioeconomic status, as immigrants often have less access to

employment-based health insurance, have lower education, and higher rates of poverty. Additional barriers may include limited English proficiency, issues with immigration status, fear or marginalization, or the effects of public policy [53].

The US landscape provides an example of how immigrant access to care is limited by misunderstanding of policy, and fear created through public and political discourse. In 1996, policy was reformed with the exception of emergency services, and immigrants were not eligible for government supported Medicaid benefits until they have been in the country for greater than 5 years. Although refugees and other specific groups may be excluded from the 5-year waiting period, undocumented immigrants are permanently prohibited from Medicaid benefits. Individual states may provide certain additional safety net coverage, and some states may further restrict access to care even beyond the 5-year waiting period. This very complex system, especially for immigrants with limited English ability, education, literacy, and familiarity with the public health system, likely discourages some from signing up for medical benefits, even when they are otherwise eligible.

### Needed Policy Changes

At the January 2018 launch of the United Nations' report "Making Migration Work For All", the United Nations (UN) Secretary General, António Guterres, stated "Migration is a positive global phenomenon. It powers economic growth, reduces inequalities, connects diverse societies, and helps us ride the demographic waves of population growth and decline [54]". The report outlines global policies that could protect migrating populations by restoring orderly migration. The policies support [54]:

a) the provision of health, education, and other services, regardless of immigration status;
b) an increase in the number of temporary stay permits, instead of denying existing temporary stay permits; and
c) permanent pathways to citizenship based on work, family ties, and humanitarian considerations.

The International Society of Social Pediatrics and Child Health issued a 2017 policy statement on migration entitled "The Budapest declaration for children and youth on the move" [55•]. This Declaration outlines a global response to promote the health and well-being of migrating children and young people and requires that health care providers and organizations be:

(i) aware of the global movement of children;
(ii) cognizant of the perverse effects of displacement on the health and well-being of these children;
(iii) familiar with the vulnerabilities of these children;
(iv) conscious that systems of care for these children are fragmented, and
(v) committed to the WHO definition of health.

It further establishes guidelines based on the UN Convention on the Rights of the Child requiring that nations ensure children's entitlement to:

(i) optimal survival and development (Article 6),
(ii) opportunity to participate in decisions that affect them (Article 12),
(iii) optimal health and health care (Article 24) specifically stipulating that children on the move receive the same comprehensive health-care services as those available to residents.

The Budapest Declaration specifically calls for primary care with referral services to local support agencies, psychosocial, and developmental care while maintaining a focus on urgent and chronic problems and risks—including the mental health of caregivers [55•].

## Conclusion

The vulnerability of children, especially in situations of strife and violence, cannot be overstated. Comprehensive, culturally sensitive primary health care must be provided to migrant children through a universal health care plan. Health care providers and organizations must inform themselves regarding the risks faced by migrant children. Further, child health providers must advocate within their own institutions and externally with national and international policy makers to promote policies that will ensure not only the health of migrating children but also protection of their inherent rights. National policies which include global universal health care for all migrating children should be adopted by nations to ensure that the health, development, and well-being of all children are protected.

### Compliance with Ethical Standards

**Conflict of Interest** The authors declare that they have no conflict of interest.

**Human and Animal Rights and Informed Consent** This article does not contain any studies with human or animal subjects performed by any of the authors.

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