



Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma
MEM-TP

ADDITIONAL MODULE 1: TARGET GROUPS

Unit 4: VULNERABLE GROUPS

Sub-Unit Children's Health

Guidelines

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**Migrants & Ethnic Minorities
Training Packages**



Escuela Andaluza de Salud Pública
CONSEJERÍA DE IGUALDAD, SALUD Y POLÍTICAS SOCIALES



SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA
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JAGIELLONIAN UNIVERSITY
MEDICAL COLLEGE



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Subunit. Children's Health

1. Objectives and Methods

1.1. Objectives

Objectives of the Presentation:

- To provide an evidence-based update on migrant and ethnic minorities children's health concerns.

1.2. Methods

As part of the local adaptation contents from this subunit are to be integrated in the training as core contents.

Time	Objectives	Activity	Sources
30 min.	Present recent studies on migrant children's health	Presentation (slides 3-11)	Projector, laptop, screen.

2. Presentation

Slide 1 Title

Slide 2 Outline of contents

Slide 3 Children's health

Migrant children and children born into migrant and ethnic minority families are at increased risk of several adverse health outcomes. The stresses of migration and seeking asylum, particularly in communities that have been traumatized or displaced, can result in the early development of mental and psychosocial illnesses. Many adverse health outcomes are related to lack of access to services that promote health and prevent illness, while others result from poverty and exclusion. The most vulnerable are migrant children in an irregular situation and those in single-parent families, particularly single-parent households headed by women or in households with no working adult¹.

In many European countries, children in ethnic minority groups are more likely to live in poverty. Poverty and socioeconomic exclusion strongly affect children's health outcomes. Moreover, poverty begins to exert its harmful effects before children are born. Among EU countries relative

¹ Contents based on Poverty and social exclusion in the WHO European Region: health systems respond. Copenhagen, WHO Regional Office for Europe, 2010.

poverty rates (children living in households with incomes less than 60% of the national median) vary from more than 20% in Greece, Ireland, Italy, Poland, Portugal, Slovakia and the United Kingdom to less than 10% in Denmark, Finland, Norway, Slovenia and Sweden. Poor children are likely to be exposed to a range of risks to their health, including: deprivation of food, water, sanitation, adequate shelter, education, health care and parental care; and increased exposure to environmental pollution and adverse health-related behaviour. Poor children experience increased risks from the obesogenic environment, overcrowded and poor housing conditions and, in the case of migrants and ethnic-minority children, racism and discrimination. “It is widely accepted that minority groups and young people living in conditions of vulnerability and exclusion experience higher risk of drug use”².

As a result of increased exposure to health-related risks, poor children are much more likely to suffer a range of poor health outcomes: increased risk of death throughout childhood, low birth weight and short gestational age, communicable diseases (such as tuberculosis), chronic physical illness, disorders of growth related to poor nutrition (such as stunting, underweight and obesity), mental illness, and accidents and injuries are more common among poorer children.

The unequal distribution of social and environmental risk factors concerns “have increasingly focused on racial minorities and ethnic groups, migrant workers, women and children”³. Among other issues, **blood lead levels in children** reflect this environmental injustice. “Elevated blood lead levels cause severe and chronic adverse health effects, especially in children”^{4,5}. As reported by WHO, “socioeconomic factors are important predictors of exposure to lead”, also, ethnicity and culture “are related to risk factors for exposure to lead”⁶. Researchers from Canary Island reported higher blood lead levels in migrant children than in native children, probably due to lead exposure in their countries of origin⁷. Also, in Mitrovica/ë, region of Kosovo with the largest lead production industry in Europe, Roma, Ashkali and Egyptian displaced children have very high blood lead levels⁸.

Additionally, children born to migrant families from the tropical and low-income regions of the world are at increased risk of travel-associated disease and illnesses when they travel to their

² SRAP Network. Understanding drug addiction in Roma and Sinti communities. Executive Agency for Health and Consumers. January 2012. Available at: <http://srap-project.eu/files/2012/06/SRAP-Action-research-final-report-Long.pdf>

³ Domínguez-Cortinas G, Cifuentes E, Rico E, Díaz-Barriga F. Assessment of Environmental Health Children’s Population Living in Environmental Injustice Scenarios. *J Community Health*, 2012, 37:1199–1207.

⁴ Brown, M.J., McWeeney, G., Kim, R., Tahirukaj, A., Bulat, P., Sylva, S., Savic, Z., Amitai, Y., Dignam, T. Kaluski, D.N. Lead poisoning among internally displaced Roma, Ashkali and Egyptian children in the United Nations-Administered Province of Kosovo. *European Journal of Public Health*, 2010, Vol. 20, No. 3, 288–292.

⁵ Lidsky TI, Schneider JS. Lead neurotoxicity in children: basic mechanisms and clinical correlates. *Brain*, 2003; 126: 5–19.

⁶ WHO, World Health Organisation. Childhood Lead Poisoning. Geneva: WHO, 2010. Available at: <http://www.who.int/ceh/publications/leadguidance.pdf>

⁷ Basa, P., Luzardo, O.P., Peña-Quintana, L., González, J.E., Peña, J.A., Gracia, J., Zumbado, M. & Boadab, L.D. Determinants of blood lead levels in children: A cross-sectional study in the Canary Islands (Spain). *International Journal of Hygiene and Environmental Health*, 2012, 215: 383–388.

⁸ Brown, M.J., McWeeney, G., Kim, R., Tahirukaj, A., Bulat, P., Sylva, S., Savic, Z., Amitai, Y., Dignam, T. Kaluski, D.N. Lead poisoning among internally displaced Roma, Ashkali and Egyptian children in the United Nations-Administered Province of Kosovo. *European Journal of Public Health*, 2010, Vol. 20, No. 3, 288–292.

place of origin to visit friends and families.

Access to adequate health care for children is essential to support their growth and development. The early identification of the presence of abnormalities is crucially important to ensuring that treatment and interventions are introduced early to mitigate and prevent subsequent adverse effects. Childhood and adolescence are also the time when activities that promote health and prevent illness produce maximum results – when interventions can significantly affect risk taking behaviour, such as smoking, substance abuse and high-risk sexual activity.

“Common problems of migrant families include parental poverty, frequent moves, low health expectations, interrupted schooling, overcrowded living conditions, and poor sanitation facilities. Migrants' children are at increased risk for respiratory and ear infections, bacterial and viral gastroenteritis, intestinal parasites, skin infections, scabies and head lice, pesticide exposure, tuberculosis, poor nutrition, anemia, short stature, undiagnosed congenital anomalies, undiagnosed delayed development, intentional and unintentional injuries, substance use, and teenage pregnancy. Immunizations and dental care are often delayed or absent. Many children have never been screened for chronic disease or vision and hearing impairment. Providing health care services for these children benefits the children, the family, the community, and the country”⁹.

Slide 4 Unaccompanied migrant children

“Unaccompanied migrant children are some of the most vulnerable in Europe, subject to detention and brutality, unable to access their rights to education, health care, or to seek asylum, and left without adequate legal protections in domestic legal systems throughout the continent”¹⁰ Greece, Italy and Spain are the major entrance countries for unaccompanied migrant children¹¹. According to data, in 2013 more than 12,640 unaccompanied migrant children made claims for asylum in EU countries (31% in Sweden, 20% in Germany and 9% in UK), most of them coming from Afghanistan (26%), Somalia (13%) and Syria (8%)¹².

Regarding health care, the European Migration Network (2010) reports on the provision of healthcare to unaccompanied minors, including emergency but also other treatments¹³. For all Member States, an unaccompanied minor receives at least basic medical care, according to their needs, normally provided as part of the provision of accommodation. For some Member States

⁹ Migrant Clinicians Network. Issues in Migrant Health. Children’s Health. Available at: <http://www.migrantclinician.org/issues/childrens-health.html>

¹⁰ HRW. HUMAN RIGHT WATCH. Caught in a net. Unaccompanied migrant children in Europe, 2012. Available at: http://www.hrw.org/sites/default/files/related_material/Caught%20in%20a%20Net-%20Unaccompanied%20Migrant%20Children%20in%20Europe.pdf

¹¹ FRONTEX. Unaccompanied Minors in the Migration Process. Warsaw: FRONTEX, 2010. Available at: http://frontex.europa.eu/assets/Publications/Risk_Analysis/Unaccompanied_Minors_in_Migration_Process.pdf

¹² Eurostat. Eurostat Newsrelease 46/2014-24 March 2014. Luxembourg: Eurostat, 2014.

¹³ EMN. Policies on Reception, Return and Integration arrangements for, and numbers of, Unaccompanied Minors –an EU comparative study, 2010. Available at: http://ec.europa.eu/dgs/home-affairs/what-we-do/networks/european_migration_network/reports/docs/emn-studies/unaccompanied-minors/0_emn_synthesis_report_unaccompanied_minors_publication_sept10_en.pdf

physiological assessments and care also form an important part of the healthcare provided.

According to FRA *“children had mixed experiences of healthcare. Most were satisfied with the medical treatment and the behavior of medical staff. However, problems identified included lack of medical screening upon arrival, insufficient attention to health complaints, and, in one case, denial of specialist medical treatment. A need for better interpretation was also identified, in particular concerning psychological support. Some girls noted that their preference for female doctors was not always accommodated. Interpretation and intercultural mediation often only relied on the support provided by social workers, foster parents and other persons of trust. Children had rarely asked for psychological support. Many children claimed that they were not aware of its availability and adults noted the need for better psychological support.”*¹⁴ Access to health care is also affected by administrative procedures related to identification and age determining.

Slide 5 Migrant children and bullying

Bullying is considered an international public health problem. Children frequently involved in bullying share a risk of suffering health problems such as anxiety, backaches, depression, headaches, irritability, sleeping difficulties, suicidal attempts, etc.¹⁵. As concludes some meta-analysis, there is an “association between being bullied and psychosomatic problems”¹⁶.

“Data on racial bullying is less consistently available than the data on bullying in general”¹⁷. Conforming to Italian Health Behavior in School-Aged Children (HBSC) study, “immigrant students seem to be more victimized by bullying behavior” than natives¹⁸. Similar results have been found in Spain¹⁹. “In Finnish research children with immigrant background are reported to be in higher risk of being isolated and thus being alone in difficult situations such as bullying as well”²⁰. An investigation in Ireland (2010) concludes that 28% of teachers were aware of “racist incidents in their school or college during the previous month. Black children were identified as particularly vulnerable to such incidents”²¹. According to Kane (2008), in countries as Spain, Germany and Latvia “when young people of migrant background are involved in school violence, it is often assumed that cultural identity is the cause of the conflict. Because the young people concerned have often experienced exclusion and discrimination, they expect and so emphasise

¹⁴FRA. European Union Agency for Fundamental Rights. Separated, asylum-seeking children in European Union Member States. Comparative report. Luxembourg: Publications Office of the European Union, 2010. Available at: http://fra.europa.eu/sites/default/files/fra_uploads/1692-SEPAC-comparative-report_EN.pdf

¹⁵Children’s National Health System. The Clinic for Health Problems Related to Bullying. Available at: <http://childrensnational.org/departments/bullying-related-health-risks>

¹⁶Gini G, & Pozzoli T. Bullied Children and Psychosomatic Problems: A Meta-analysis. *Pediatrics*, 2013; 132: 720–729.

¹⁷Pihkala, S. (Compiled). Report on Inter-Ethnic Relations, School Bullying and Adolescent Violence. Arbox General Report 9/2012. Lifelong Learning. Available at: http://www.schoolbullying.eu/doc/ARBAX_Report.pdf

¹⁸Vieno, A., Santinello, M., Lenzi, M., Baldassari, D. & Mirandola, M. Health Status in Immigrants and Native Early Adolescents in Italy. *Journal of Community Health*, June 2009, Volume 34, Issue 3: 181-187. Available at: <http://link.springer.com/article/10.1007%2Fs10900-008-9144-2>

¹⁹Pantzer, K., Rajmil, L., Tebé, C., Codina, F., Serra-Sutton, V., Ferrer, M., Ravens-Sieberer, U., Simeoni, M-C. & Alonso, J. Health related quality of life in immigrants and native school aged adolescents in Spain. *J Epidemiol Community Health* 2006; 60(8): 694–698. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2588083/>

²⁰Pihkala, S. (Compiled). Report on Inter-Ethnic Relations, School Bullying and Adolescent Violence. Arbox General Report 9/2012. Lifelong Learning. Available at: http://www.schoolbullying.eu/doc/ARBAX_Report.pdf

²¹Pihkala, S. 2012. op cit.

cultural differences and attribute the conflict to them. In reality, the analysis found that the reasons for conflict among adolescents in school do not markedly differ when the protagonists include migrant children”²².

Slide 6 Migrant Children Vaccination

According to PROMOVAX project, **most of the non-immunized belong to hard-to-reach groups that lack access to vaccines and balanced information about the importance of immunization.** These pockets of marginalized, non-immunized groups in the WHO European Region pose a threat for outbreaks of contagious diseases, making it a national as well as international issue. **Immunization of migrants is a high priority issue for the EU health program** within the context of encompassing hard to reach populations.

In order to promote more immunizations among child migrant populations in Europe, it's important to take account of different cultures and attitudes towards immunizations, and the vaccination coverage in countries of migrant origin²³.

In many cases, documentation of previous immunizations may be lacking or suspect, and most developing countries follow the World Health Organization's Expanded Programme²⁴ on Immunization Plus, which varies significantly from most vaccine schedules in developed countries in its use of bacille Calmette-Guérin, oral poliovirus and yellow fever vaccines. In addition, the Expanded Programme on Immunization Plus does not include the newer vaccines, such as the conjugate meningococcal, pneumococcal and *Haemophilus influenzae* type b vaccines, as well as the varicella vaccine and the acellular pertussis vaccine. Country-specific vaccine-preventable disease statistics and immunization schedules can be found on the World Health Organization's Web site²⁵.

Generally speaking, vaccination documents provided by migrant families are accepted as valid when the dosages and intervals coincide with those employed in the receiving countries' vaccination programs. Therefore, the vaccination calendar for migrant children can be completed accordingly in the receiving country,

The Canadian guideline is to start the appropriate immunization schedule without antibody determination for those children without reliable vaccine records because most of the currently used vaccines have few adverse effects following repeat doses²⁶. When no documentation can be provided regarding vaccinations previously received by migrant children, an accelerated vaccination calendar deemed valid by the receiving country is initiated.

²² Kane J. Violence and School. Daphne Booklets. Brussels: European Commission, DG Justice, Freedom and Security, Daphne Programme, 2008. Available at:

http://ec.europa.eu/justice_home/daphnetoolkit/files/others/booklets/08_daphne_booklet_8_en.pdf

²³ Karnaki, P. PROMOVAX: Promote vaccinations among migrant populations in Europe. In: Childhood Immunization, Progress, challenges & priorities for further action Luxembourg, 16 & 17 October 2012. Available at: http://ec.europa.eu/health/vaccination/events/ev_20121016_en.htm

²⁴ Crockett M. New faces from faraway places: Immigrant child health in Canada. Paediatr Child Health. 2005 May; 10(5): 277-81.

²⁵ WHO Vaccine Preventable Diseases Monitoring System. 2004 Global Summary. Available at: www.who.int/vaccines/globalsummary/immunization/countryprofilesselect.cfm

²⁶ Vacunación de niños inmigrantes y adoptados. Comité Asesor de Vacunas de la Asociación Española de Pediatría. Available at: <http://vacunasaep.org/documentos/manual/cap-12>

To ensure that they are correctly vaccinated in accordance with the receiving country's vaccination calendar, it is also important to be aware of issues that arise when this population travels back to countries of origin. For example, it might be necessary to move ahead certain vaccination dates prior to beginning the trip. It is also important not to overlook the fact that migrants may be returning home to developing countries, where certain vaccinations are recommended. These, however, are not always included in the receiving country's own vaccination calendar vaccine (for example, hepatitis A, yellow fever, typhoid fever, etc., depending on the country involved).

Slide 7 Specific risk due to circular migration or trips back home

Due to the nature of their trip, young migrant travellers returning home to visit friends or relatives (VFR travellers) are at greater risk of acquiring travel-related illnesses than would be the case with children who travel as tourists. Generally speaking their stays are longer, often in remote rural areas, and in proximity to unique living conditions. Such factors increase the risk of VFR travellers' exposure to disease at levels similar to those encountered by the developing country's own local population.

In addition, VFR travellers are less likely to seek travel-related medical care and adhere to recommended medications and travel precautions. Many studies associate this behaviour with their low perception of personal risk for disease. Multiple factors are involved here, including access to care; language barriers; distrust of western medicine; lack of awareness of pre-travel services; fear of authorities from the immigration services; and a perception that they are relatively immune to or not at risk of acquiring specific illnesses. Sometimes the problem is that information regarding travel is not provided in time to ensure the implementation of necessary preventive measures.

Slide 8 High-risk illnesses in VFR travellers include childhood vaccine-preventable illnesses; hepatitis A and B; tuberculosis; malaria; typhoid fever; traveller's diarrhea; animal bites and rabies; and injuries. This is why it is so important for immigrant families to be advised on the need for them to provide timely notifications of their travel plans.

Recommendations will be made in accordance with the destination involved and the characteristics of the trip (length of stay, rural/non-rural setting, housing, etc.). Numerous electronic addresses are available to assist in limiting many of the most important travel risks involved depending on the destination and where recommended preventive measures are proposed.

Such measures include:

- Verify the vaccination status included under the originating country's vaccination calendar.
- Administer required and recommended vaccinations depending on the country of destination involved.

- Evaluate the need for malaria prophylaxis and insist on the need to administer it correctly.
- Avoid contact with insects.
- Make preventive recommendations regarding safety in the area, including water quality, incidents that might involve contact with blood, or other specific risks in any given destination (bathing in lakes, traffic accidents).
- Provide recommendations and treatment for situations most likely to arise in such settings (travellers' diarrhea, fever, insect bites, wounds...).
- Take advantage of the occasion to identify girls at risk of female genital mutilation (FGM) and take actions in accordance with the legal framework and protocols applicable in the country where they live.

Slide 9 Physical activity and healthy diet –local and imported behaviours

“Children from migrant origin are at higher risk for overweight and obesity. As limited physical activity is a key factor in this overweight and obesity risk”²⁷. Children of North African origin in Europe “have higher levels of overweight and obesity than the native ones, especially girls. However, this trend can also be detected in urban areas of North African countries”²⁸. The “westernization of eating habits, the level of physical activity and body image perception” are important factors in order to explain childhood overweight and obesity among children immigrants. Some factors are “linked to acculturation in the host society and others are maintained from the country of origin”²⁹. “Apparently, migrant children display an even more sedentary way of life or adverse dietary patterns, as compared with native children. To what degree these differences can be explained by socioeconomic and cultural factors remains to be investigated”³⁰.

Slide 10 Substance misuse (tobacco, alcohol, drugs)

According to Svensson & Hagquist (2009), immigrant adolescents from Nordic countries were more likely to use alcohol than Swedish adolescents. Immigrants from non-European countries were less likely to use alcohol, mainly because of relatively low use by girls from non-European countries. All immigrant groups were more likely to use illicit drugs, especially Nordic immigrants and non-European immigrants³¹. In Spain, Marsiglia et al. (2008) conclude that “Latin American

²⁷ Labree W, Lötters F, van de Mheen D, Rutten F, Rivera Cavaía A, Neve M, Rodenburg G, Machielsen H, Koopmans G & Foets M. Physical activity differences between children from migrant and native origin. BMC Public Health 2014, 14: 819. Available at: <http://www.biomedcentral.com/1471-2458/14/819>

²⁸ Gualdi-Russo E, Zaccagni L, Manzon VS, Masotti S, Rinaldo N, & Khyatti M. Obesity and physical activity in children of immigrants. European Journal of Public Health 2014, Vol. 24, Supplement 1, 40–46. Available at: http://eurpub.oxfordjournals.org/content/eurpub/24/suppl_1/40.full.pdf

²⁹ Gualdi-Russo E, Zaccagni L, Manzon VS, Masotti S, Rinaldo N, & Khyatti M. Obesity and physical activity in children of immigrants. European Journal of Public Health 2014, Vol. 24, Supplement 1, 40–46. Available at: http://eurpub.oxfordjournals.org/content/eurpub/24/suppl_1/40.full.pdf

³⁰ Labree L JW, van de Mheen H, Rutten FFH, and Foets M. Differences in overweight and obesity among children from migrant and native origin: a systematic review of the European literature. International Association for the Study of Obesity 2011, 12, e535–e547.

³¹ Svensson M & Hagquist C. Adolescent Alcohol- and Illicit Drug-Use in First and Second Generation Immigrants in

immigrant youth were less at risk than native youth on their intentions to use substances and on their reported actual substance use” than native-born youth³². The OIM analysis of HBSC study (2006) found that “foreign-born children in Greece were more likely to report a history of drunkenness” than natives, however in Denmark or Wales immigrant children were less likely to report a history of drunkenness³³.

According to SRAP Network findings in Bulgaria, Italy, Spain, Slovenia, Romania, Bulgaria and France (2012), worrying trends identified in the patterns of consumption of Roma adolescents are the early onset of tobacco consumption (11-12 years old), exposure to consumption of alcohol by adults, underestimation of the consequences of many drugs (especially cannabis), and presence of injecting drug use of heroin in specific contexts³⁴.

“The role of the peer group in the processes linked to drug consumption remains crucial for young Roma, as for adolescents in general, an indication that supports the idea of developing peer education prevention programs”³⁵.

Slide 11 Sexual health promotion

According to Keygnaert et al. (2014) “migrants’ sexual and reproductive health interventions should stem from a holistic and positive approach and also address sexual health promotion in adolescents”³⁶. “Evidence about unintended teenage pregnancy in migrant young women is scarce. An analysis of national surveillance data in the Netherlands suggests high teenage pregnancy and abortion rates among female asylum seekers, especially among adolescent girls of African, Central and South-eastern Asian origin³⁷, when compared to the native population. Although this result indicates that teenage pregnancy and abortion may be an issue for adolescent migrants, it cannot be generalised to all migrants”³⁸. In poorer neighbourhoods, “compared with Portuguese adolescents, African migrant teens reported initial sexual intercourse at earlier ages, less frequent condom use, and less frequent and less comfortable communications with parents about sexual issues”³⁹.

Sweden. Working Paper 2009, No. 8. Örebro University, Swedish Business School. Available at: http://www.oru.se/PageFiles/16759/WP_2009_8-1.pdf

³² Marsiglia F, Kulis S, Luengo MA, Nieri T & Villar P. Immigrant advantage? Substance use among Latin American immigrant and native-born youth in Spain. *Ethn Health* 2008, 13(2): 149–170. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3038204/pdf/nihms269204.pdf>

³³ IOM, International Organization for Migration. Foreign-born children in Europe: an Overview from the Health Behaviour in School-Aged Children (HBSC) Study. Background paper. Brussels: IOM, 2006. Available at: http://www.nuigalway.ie/hbsc/documents/foreign_born_children_iom.pdf

³⁴ SRAP Network. Understanding drug addiction in Roma and Sinti communities. Executive Agency for Health and Consumers. January 2012. Available at: <http://srap-project.eu/files/2012/06/SRAP-Action-research-final-report-Long.pdf>

³⁵ SRAP Network. 2012.

³⁶ Keygnaert I, Guieu A, Ooms G, Vettenburg N, Temmerman M, Roelens K. Sexual and reproductive health of migrants: Does the EU care? *Health Policy*, 2014, 114: 215–225. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/24268324>

³⁷ Goosen S, Uitenbroek D, Wijzen C, Stronks K. Induced abortions and teenage births among asylum seekers in The Netherlands: analysis of national surveillance data. *J Epidemiol Community Health* 2009; 63(7): 528-33.

³⁸ Pfarrwaller E, & Suris J-C. Determinants of health in recently arrived young migrants and refugees: a review of the literature. *Italian Journal of Public Health*, 2012, 9, 3, e7529-1 – e7529-16. Available at: <http://ijphjournal.it/article/viewFile/7529/6788>

³⁹ Gaspar de Matos M, Gaspar T, Simons-Morton B, Reis M, and Ramiro L. Communication and Information About “Safer Sex:” Intervention Issues Within Communities of African Migrants Living in Poorer Neighbourhoods in Portugal.

Slide 12 Descendants of migrants⁴⁰

The “second generation,” or migrant offspring, tends to be invisible in statistics on health: either by excluding them from studies of migrants, or by lumping together migrants and their offspring born in the host country.

Some of the main findings from available research^{41,42, 43, 44} are as follows:

- Blood pressure rose faster over time for ethnic minority children (UK).
- Adolescent boys from ethnic minorities tended to report better mental health despite coming from poorer families and neighbourhoods. Positive factors identified were caring parents, doing things together as a family and having friends from different ethnic groups (UK).
- Experiences of racism had a negative effect on mental health in all ethnicities (UK).
- Second generation of non-Western migrants are more diagnosed as “psychotic” than the majority population (Netherlands)
- Rates of risky behaviour in the second generation do not always converge towards the rates found in the majority population. This is the case in alcohol consumption.
- In relation to smoking in men and overweight and physical inactivity in women rates of risky behaviour have converged. Male descendants who reported to be daily smokers were slightly higher than migrants overall, and significantly higher compared to the majority population. In adolescence, girls from some ethnic groups were more likely to be overweight than participants from other ethnic groups. Contributory factors included skipping breakfast, drinking too many carbonated soft drinks and not eating enough fruit and vegetables (UK, Netherlands, Denmark).

Slide 13 Controlling FGM before they occur in girls

Female genital mutilation or cutting (FGM) is perhaps the most well-known example of a practice that negatively affects health and is linked to traditional cultures. FGM procedures include the partial or total removal of the external genital organs for cultural or other non-therapeutic reasons. The practice has severe short- and long-term physical and psychological consequences for the victims⁴⁵. Over 140 million women are affected by this practice, both in the countries where these practices originate (countries in Africa and the Middle East), and also in migration destinations. Due to under-reporting and the lack of reliable comparable data, no exact figures exist on the prevalence of FGM in Europe. However, it is safe to say that thousands

J Poverty. 2008; 12(3): 333–350. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2600452/>

⁴⁰ Mock-Muñoz de Luna C, Ingleby D, Graval E, Krasnik A. Synthesis Report. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen, 2015.

⁴¹ Dash. Available at: <http://dash.sphsu.mrc.ac.uk>

⁴² Veling, W., Selten, J. P., Veen, N., Laan, W., Blom, J. D. & Hoek, H. W. Incidence of schizophrenia among ethnic minorities in the Netherlands: a four-year first-contact study. *Schizophr. Res*, 2006, 86: 189-193.

⁴³ Selten, J. P., Laan, W., Kupka, R., Smeets, H. & van Os, J. Meer kans op depressie en psychose bij allochtonen. *Ned Tijdschr Geneesk*, 2011, 155.

⁴⁴ Singhammer, J. *et al.* Etniske minoriteteters sundhed. Partnerskabet for undersøgelse av etniske minoriteteters sundhed, Center for Folkesundhed, 2008.

⁴⁵ As defined by the World Health Organisation, 1998.

of women and girls in Europe live with the effects of FGM or face the risk of undergoing the procedure in a European country or in Africa or the Middle East.⁴⁶ The largest groups of women and girls originating from countries in which the practice of FGM is widespread live in the following EU countries: Austria, Belgium, Denmark, Germany, Spain, Finland, France, Ireland, Italy, the Netherlands, Portugal, Sweden and the United Kingdom.⁴⁷ The health impacts of FGM are well documented. Research has linked FGM with an increased risk in complications during childbirth, e.g. prolonged labour, obstetric lacerations, obstetric haemorrhage, and difficult delivery.⁴⁸ Midwives especially should be trained in how to prepare for potential delivery complications associated with FGM.

“Policies used when dealing with girls at risk of FGM usually contain procedures for risk assessments and outlines on how to respond to cases of potential or earlier FGM in accordance with national laws. It is important for professionals to become familiar with these policies in order to deal effectively with cases of FGM: knowing who to contact,; how to determine risk factors; and a familiarity with legislative and protective mechanisms that are in place at the country or regional level”⁴⁹. “The main role for the protection of girls at risk lies with statutory agencies and staff such as police, social workers, child protection officers and healthcare workers. School teachers also have a crucial role to play in protecting girls at risk”⁵⁰.

Health services providers may be unfamiliar with certain medical procedures which may be needed by a small group, for example defibulation for women who have undergone female genital mutilation (FGM) or cutting. Defibulation is a routine procedure in countries where FGM is widespread: women are often defibulated (or ‘opened up’) when they get married and/or are pregnant. After migrating to countries where FGM is not practiced, women with FGM may not have access to this procedure for a variety of reasons, and consequently, may encounter problems during childbirth.⁵¹

Slide 14 Thank you and questions

Slides 15 References

3. Reading

Recommended reading:

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⁴⁹ EIGE, European Institute for Gender Equality. Female genital mutilation in the European Union and Croatia. Germany: European Union, 2013. Available at: <http://www.endfgm.eu/content/assets/EIGE-Report-FGM-in-the-EU-and-Croatia.pdf>

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