EU-VET CARE LITERATURE REVIEW & COUNTRY PROFILES

EU-VET CARE

STRENGTHENING CAPACITIES
FOR BETTER HEALTH CARE
TO REFUGEE & MIGRANT CHILDREN

June 2019

This report has been developed by the consortium of the "EU-VET CARE Project - Strengthening capacities for better health care to refugee and migrant children".

The EU-VET CARE partnership comprises 6 partners from 5 countries:

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Partners	
Prolepsis Institute	**Greece**
University of Valencia, Polybienestar	**Spain**
ZADIG SRL	**Italy**
Cyprus University of Technology	**Cyprus**
FAROS	**Greece**

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Contents

Summary

The problem

Since 2015 due to the Middle East crisis and poverty in many parts of the world, Europe has experienced increasing migrant and refugee flows. The arrival to Europe of large numbers of displaced people has caused a number of problems in terms of public health and public health access. Of particular concern is the fact that one out of three migrants/refugees reaching European countries is a child. The evidence regarding the provision and access to health care for this group is scarce due to the inadequate understanding of the actual needs of migrant/refugee children to achieve more tailor-made interventions.

Aim

The aim of this report is to provide an overview of evidence on the topic of migrant/refugee children's physical and psychological needs in Europe.

Specifically the aim of the research is to review:

- The epidemiological data regarding migration in the European Union, Mediterranean region as well as the consortium countries, with the focus oriented towards migrant/refugee children
- The health and social care needs of migrant/refugee children according to their country of origin, their journey, as well as the host/destination country
- The available data and evidence regarding the term of intercultural mediation in Europe and specific EU member states
- The knowledge gaps and needs of health professionals who provide health care to migrant/refugee children
- The available validation and accreditation systems in Europe and specific EU member states regarding training applied to health professionals.

Methods

A scoping review was primarily conducted using Medline (PubMed), Scopus and ISI Web of Knowledge (for proceedings and abstracts from congresses). Secondarily, the literature search was expanded to non-scientific databases to reach as many electronic resources as possible. Hence, the websites and online resources of public health and non-governmental organizations were reviewed; World Health Organization (www.who.int), ISSOP (https://www.issop.org), Centre of Disease Control and Prevention (CDC) (www.cdc.gov), International Organization for Migration (https://www.iom.int/), Institute of Medicine (http://www.iom.edu.np/), United Nations High Commissioner for Refugees (http://www.unhcr.org/), UNICEF (https://www.unicef.org/) as well as non-governmental organizations with relevant initiatives in the field of migration and health with national and international activities such as Medecins du Monde (https://www.medecinsdumonde.org/en) and other national organizations from various countries such as Denmark, Germany, Greece, Ireland etc. Literature search was performed from 2010 onwards without any language limits. The search strategy was mainly based on Medical Subject Headings terms, as follows; ("refugees"[MeSH Terms] OR "refugees"[All Fields] OR "refugee" [All Fields]) AND ("child"[MeSH Terms] OR "child"[All Fields] OR "children"[All Fields]) AND ("health services needs and demand"[MeSH Terms] OR ("health"[All Fields] AND "services"[All Fields] AND "needs"[All Fields] AND "demand"[All Fields]) OR "health services needs and demand"[All Fields] OR "needs"[All Fields]) AND ("europe"[MeSH Terms] OR "europe"[All Fields]) as well as: ("refugees"[MeSH Terms] OR "refugees"[All Fields] OR "refugee"[All Fields]) AND ("child"[MeSH Terms] OR "child"[All Fields] OR "children"[All Fields]) AND ("health"[MeSH Terms] OR "health"[All Fields]) AND barriers [All Fields] AND ("europe"[MeSH Terms] OR

"europe"[All Fields]). The reference lists of retrieved articles were also considered when these were relevant to the issue examined yet not allocated in the basic search. The relevance of studies was assessed by using a hierarchical approach based on: title, abstract, and full manuscript. Besides the published scientific articles, scientific or professional reports, national reports, books or book chapters, conference proceedings, and book of abstracts theses, statistics presented were issued by competent authorities.

Results and Conclusions

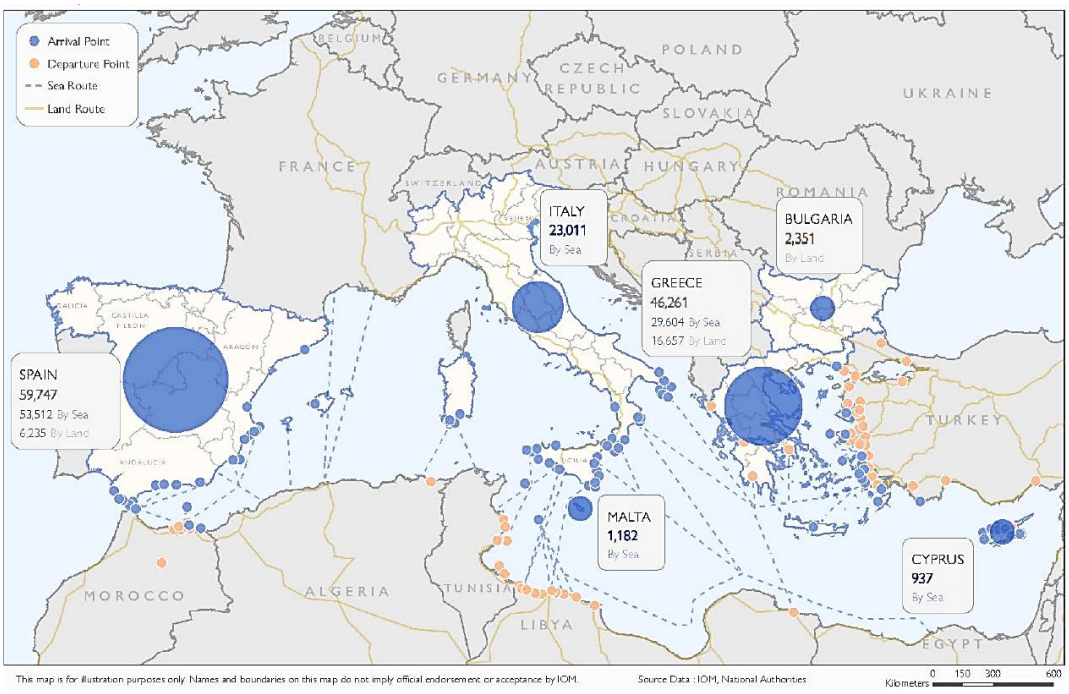
The scoping review performed here highlights that migrant/refugee children have numerous health and social care needs related with physical, psychosocial, and mental disorders. Consideration should be placed on pre-existing problems (caused in children's country of origin), their experience during the migrant/refugee journey, as well as the hosting country. The evidence points to the need for public health initiatives to prevent or manage major disability-related conditions among migrant/refugee children. Paediatricians and other primary care health professionals who provide health care to migrant/refugee pediatric patients can improve the health and well-being of these children. Nevertheless, as several studies and technical reports reveal, the educational background of health professionals is rather insufficient to deal with these special conditions. Major barriers such as language or communication and cultural competence are important limitations to the provision of sufficient health care. Additionally, the availability of health professionals who have attended special education or training to achieve a holistic primary and secondary prevention strategy for this special target group is very low. Health professionals as well as national pediatric societies need to place high in their agenda the appropriate health care provision to migrant/refugee children. Pediatricians and other health professionals can play an important role in advocating for migrant/refugee children in their local community. Thereby, appropriate training of health professionals regarding the health care provision in migration crisis, tailor-made for the pediatric population remains an imminent need.

1. Introduction

Since 2015 Europe has experienced high migrant/refugee and asylum seeker flows due to war and poverty in the Middle East and Africa. National authorities as well as international organizations, such as the United Nations High Commissioner for Refugees (UNHCR) and Eurostat, monitor annual statistics on refugees and asylum seeker arriving to Europe. In many countries, the selection, compilation and presentation of data on refugees is undertaken by the UNHCR on behalf of the country until a specialized –for this task– organization is created (Eurostat, 2018a).

1.1 Migration: existing situation at international and European levels

The current estimated number of migrants worldwide is about 258 million which is almost 48% higher than the respective number in 2000. Focusing on the migration flows to European countries, in 2016 the number of migrants/refugees reached *n*=390,432 with the respective number in 2017 being *n*=186,768. What is more, in 2018 according to available data from national authorities and the International Organization for Migration, a total of *n*=133,489 migrants and refugees arrived in Europe within the period between January and November, which corresponds to a 25% decline compared to the respective period in 2017.



Picture 1 Migration flows in Europe from January to November 2018 (Source: IOM, 2018)

1.2 Migration: existing situation in EU member states

1.2.1 Mediterranean Region

According to the UNHCR the estimated number of refugees who reached countries that border the Mediterranean Sea, i.e. Greece, Italy, Spain, Cyprus, reached *n*=1,015,877 people in 2015. As expected, this migration peak was followed by a progressive decline in refugee arrivals which in 2018 were estimated to be *n*=139,300. The annual migration rates from 2014 until 2018 are summarized in **Table 1**. About 2 out of 10 refugees arriving in Mediterranean countries are children, while the rest are adults with a female:male ratio of about 1:4.

Table 1. Epidemiological data for refugees between 2014 and 2018 reaching **Mediterranean countries**

Year	Arrivals	Dead and missing
2018	139,300	2,275
2017	172,324	3,139
2016	363,425	5,096
2015	1,015,877	3,771
2014	215,690	3,538

Data were obtained from the United Nations High Commissioner for Refugees. Available at: https://data2.unhcr.org/en/situations/mediterranean

Within 2019 (data up to 29th January 2019), *n*=6,727 total arrivals were recorded (*n*=5,685 from sea and *n*=1,042 from land). As regards to refugees' country of origin, the most updated epidemiological data provided by the UNHR are summarized in **Figure 1**.

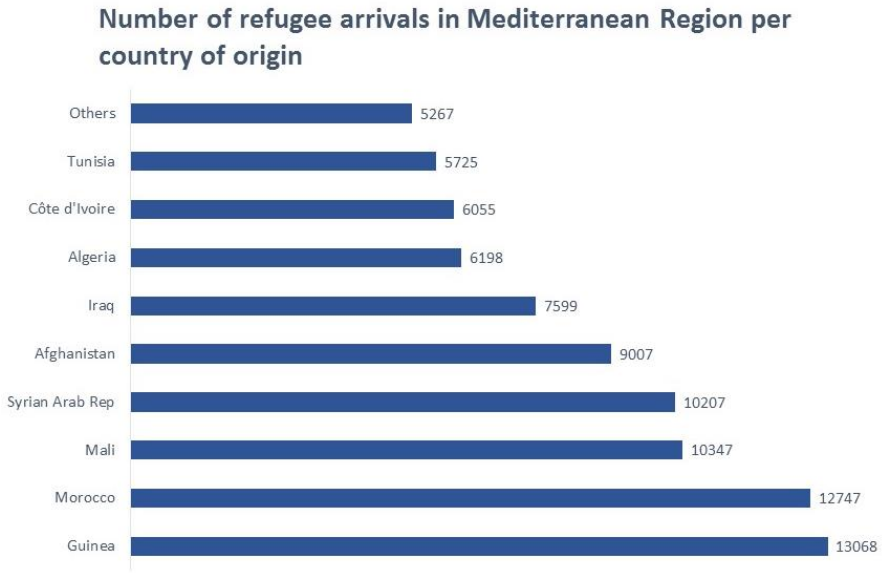


Figure 1 Data were obtained from the United Nations High Commissioner for Refugees, according to the last update in 31st December 2018. Available at: https://data2.unhcr.org/en/situations/mediterranean

As for the country-specific profile of refugee arrivals the UNHCR provides separate epidemiological data for countries bordering the Mediterranean Sea, i.e. Greece, Spain, Italy,

which are represented by the partners in the present consortium. Hence, in the following subunits the aforementioned country-specific data are more analytically presented.

1.2.2 Greece

Within the last five years, about *n*=1,010,846 refugees have reached Greece of which 4% (*n*=50,511) are related with recorded arrivals in 2018. According to 2019 data about 1 out of three refugees are children while the female:male ratio is 1:2. Arrivals per year to Greece are summarized in **Table 2**.

Table 2. Epidemiological data for refugees from 2014 till 2018 reaching **Greece**.

Year	Sea Arrivals	Land arrivals	Dead and missing
2018	32,497	18,014	174
2017	29,718	6,592	59
2016	173,450	3,784	441
2015	856,723	4,907	799
2014	41,038	2,280	405

Data were obtained from the United Nations High Commissioner for Refugees. Available at: https://data2.unhcr.org/en/situations/mediterranean/location/5179

In 2019 (estimations up to the 27th January 2019), about *n*=2,233 total arrivals were recorded (i.e. *n*=1,637 from sea and *n*=596 from land). As regards to country of origin, the most updated epidemiological data regarding Greece provided by the UNHCR are summarized in **Figure 2**.

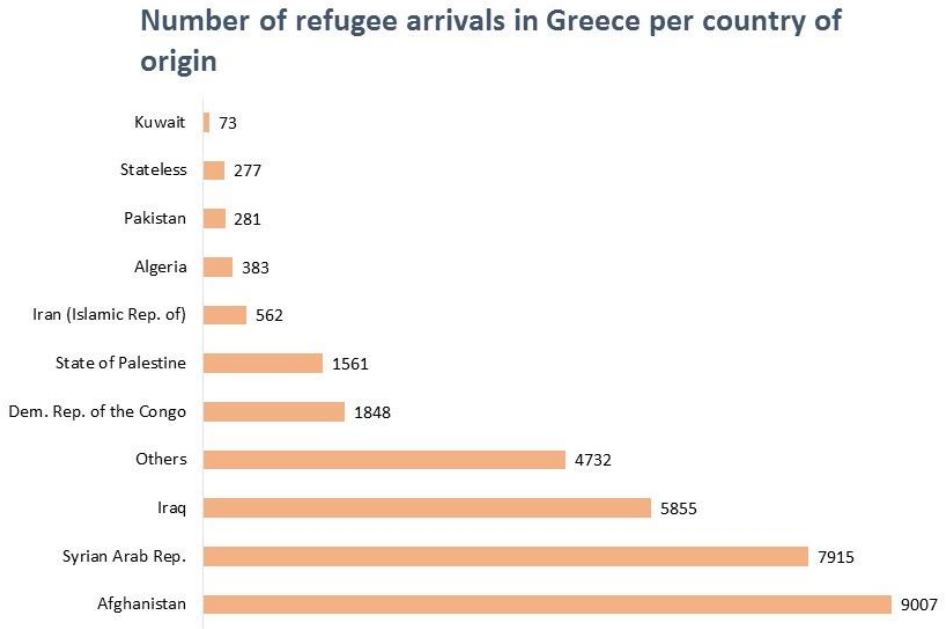


Figure 2 Data were obtained from the United Nations High Commissioner for Refugees, according to the last update in 31st December 2018. Available at: https://data2.unhcr.org/en/situations/mediterranean

1.2.3 Italy

Within the last five years, *n*=648,117 refugees reached Italy or which 4% (*n*=23,370) are related to arrivals in 2018. According to 2019 data, about 2 out of 10 refugees are children

while the female:male ratio of the 2018-related arrivals is close to 1:7. Year-specific arrival data to Italy are summarized in **Table 3**.

Table 3. Epidemiological data for refugees from 2014 till 2018 reaching **Italy**

Year	Arrivals	Dead and missing
2018	23,370	1,311
2017	119,369	2,873
2016	181,436	4,578
2015	153,842	2,913
2014	170,100	3,093

Data were obtained from the United Nations High Commissioner for Refugees. Available at: https://data2.unhcr.org/en/situations/mediterranean/location/5205

In 2019 (data up to 29th January 2019), about *n*=115 arrivals from sea were recorded. As regards to refugees' country of origin, the most updated epidemiological data regarding Italy provided by the UNHCR are summarized in **Figure 3**.

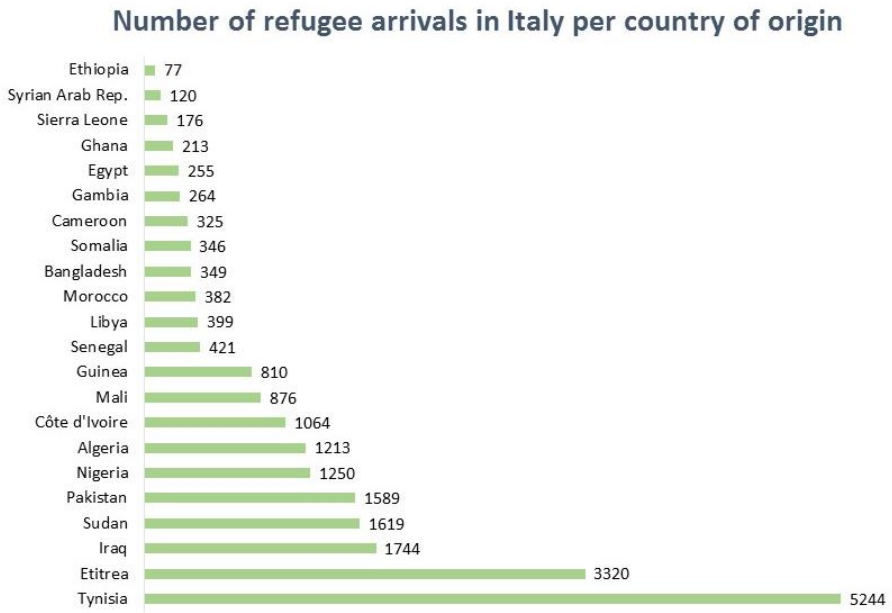


Figure 3 Data were obtained from the United Nations High Commissioner for Refugees, according to the last update in 31st December 2018. Available at: https://data2.unhcr.org/en/situations/mediterranean/location/5205

1.2.4 Spain

Within the last five years, *n*=137,310 refugees reached Spain from which 5% (*n*=65,383) concern recorded arrivals in 2018. According to 2019 data about 2 out of 10 refugees are children while the female: male ratio is 1:4. Year-specific data of refugee arrivals in Spain are summarized in **Table 4**.

Table 4. Epidemiological data for refugees from 2014 till 2018 reaching **Spain**.

Year	Sea Arrivals	Land arrivals	Dead and missing
2018	58,569	6,814	784
2017	22,103	6,246	202
2016	8,162	6,443	77
2015	5,312	11,624	59
2014	4,552	7,485	40

Data were obtained from the United Nations High Commissioner for Refugees. Available at: https://data2.unhcr.org/en/situations/mediterranean/location/5226

In 2019 (data up to 27th January 2019), about *n*=4,254 arrivals (i.e. *n*=3,808 from sea and *n*=446 from land) were recorded. Concerning country of origin, the most updated epidemiological data regarding Spain provided by the UNHCR are summarized in **Figure 4**.

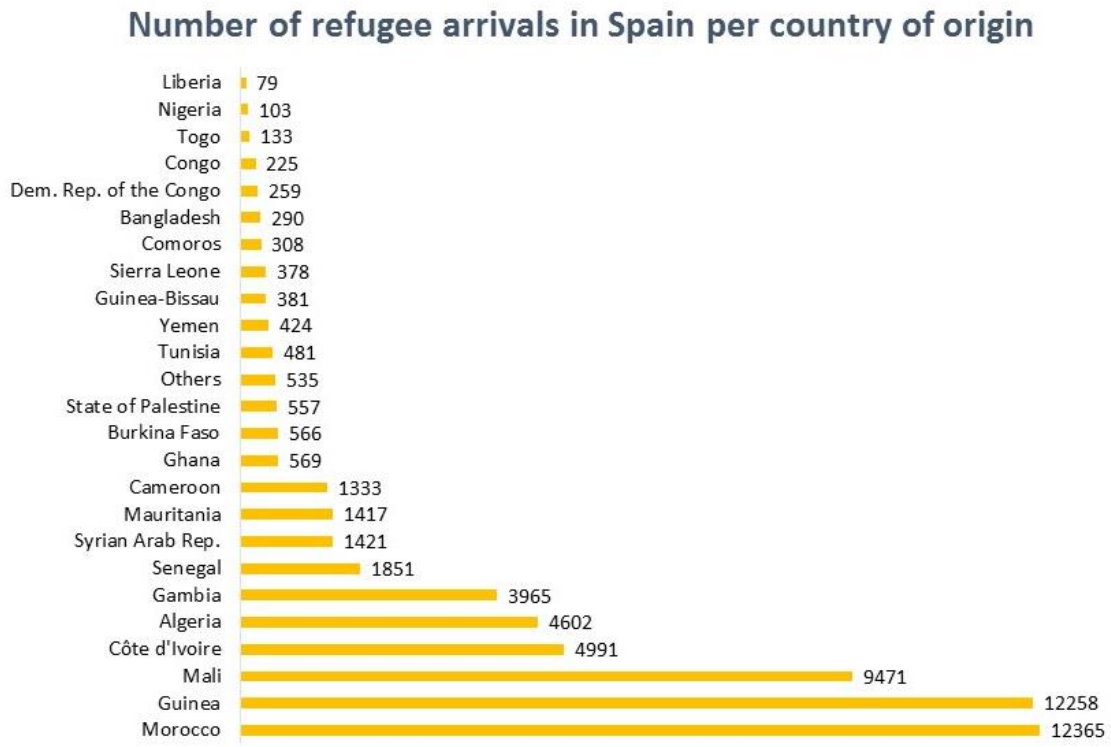


Figure 4 Data were obtained from the United Nations High Commissioner for Refugees, according to the last update in 31st December 2018. Available at: https://data2.unhcr.org/en/situations/mediterranean/location/5226

1.3 Accompanied, separated and unaccompanied migrant/refugee children: the existing situation in Europe and EU member states

For the purposes of the present literature review, the term "migrant/refugee children" had to be better clarified. The term "migrant/refugee children" refers to the definition provided by the International Society for Social Pediatrics & Child Health in a position statement published in 2018. In particular migrant/refugee children are "*children and adolescents less than 18 years of age who are or were on the move and who experience unfavourable conditions. This includes children who are currently travelling, those who have moved from one country or region and settled in another, and those who are born during the journey or in the early period after their mothers have arrived at their destination. The term unfavourable conditions refers*

to conditions such as exposure to war and other forms of violence, hunger, insecure, and/or inadequate housing, food insecurity, social isolation, limited access to healthcare, limited access to education, lack of legal registration or uncertain legal status, and socio-economic deprivation. These examples are only a few among a wide range of adverse conditions that migrant/refugee children may experience and which affect their immediate and long-term health and well-being" (ISSOP, 2018).

A dramatic increase has been observed over the last years in the numbers of migrant/refugee children arriving in Europe via the Mediterranean and Balkan routes including those seeking asylum in the EU. In particular, 1 out of 4 children arriving via this route seeks asylum. Of particular importance is the fact that many of these children travel alone. According to the updated Eurostat database, children's applications for asylum between 2014 and 2018 reached 1,100,345. More details for specific EU member states are summarized in **Table 5** (Eurostat, 2018b).

Table 5. Asylum applications for migrant/refugee children

	EU	Greece	Italy	Spain	Germany
2017	201,345	19,670	15,495	7,730	89,710
2016	386,410	19,635	11,080	3,710	261,315
2015	368,040	2,420	7,165	3,715	137,415
2014	144,550	1,300	4,340	1,140	59,910

Data were obtained from the Eurostat 2018. Available at: https://ec.europa.eu/eurostat/web/asylum-and-managed-migration/data/database

The large number of unaccompanied children creates major public health challenges and sets the basis for an emergency situation. In **Table 6**, a presentation regarding the current state from 2015 to 2017 in Europe and specific EU member states is provided, with regards to the number of migrant/refugee children reaching EU countries as well as their age-status.

Table 6. Sex- and age- related distribution of migrant/refugee children in Europe and specific EU members

		Age, years			
Hosting region		**0-4**	**5-9**	**10-14**	**15-19**
Europe					
2017					
	Total	944,542	1,487,378	1,872,731	2,693,360
	Males	487.619	763.196	953.311	1.391.529
	Females	456.923	724.182	919.420	1.301.831
2015					
	Total	901,015	1,437,513	1,846,948	2,696,889
	Males	460.723	735.183	946.462	1.386.057
	Females	440.292	702.330	900.486	1.310.832
Greece					
2017					
	Total	14,637	18,044	21,785	36,401
	Males	7.387	9.222	11.614	18.980
	Females	7.250	8.822	10.171	17.421

2015					
	Total	14,563	14,180	24,243	42,148
	Males	7.437	7.355	12.759	21.849
	Females	7.126	6.825	11.484	20.299
Italy					
2017					
	Total	41,366	101,180	177,319	283,941
	Males	21.374	52.887	93.229	151.513
	Females	19.992	48.293	84.090	132.428
2015					
	Total				
	Males	21.087	52.208	92.078	147.166
	Females	19.565	47.224	82.177	131.867
Spain					
2017					
	Total	39,475	97,387	194,678	316,834
	Males	20.535	49.833	97.239	164.353
	Females	18.940	47.554	97.439	152.481
2015					
	Total	36,957	104,414	212,775	319,296
	Males	19.327	52.591	107.081	165.670
	Females	17.630	51.823	105.694	153.626
Germany					
2017					
	Total	84.577	196.003	207.078	290.261
	Males	37.491	91.349	98.623	136.642
	Females	47.086	104.654	108.455	153.619
2015					
	Total	78.013	158.661	168.161	242.911
	Males	43.094	83.992	87.289	127.441
	Females	34.919	74.669	80.872	115.470

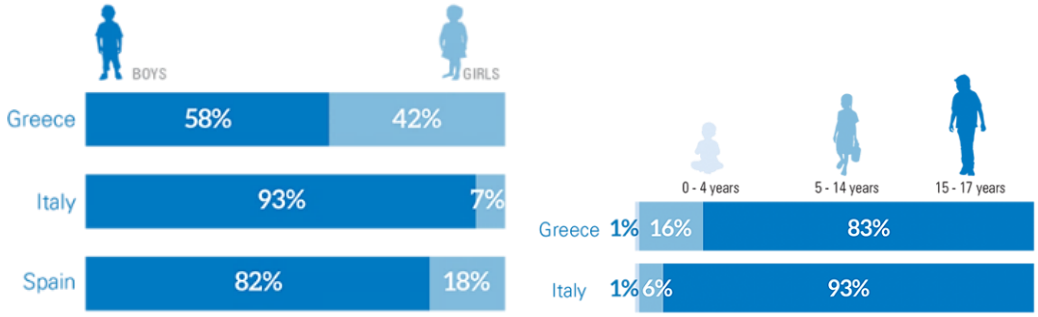
Data were obtained from the United Nations database, 2017. Available at: http://www.un.org/en/development/desa/population/migration/data/estimates2/estimates17.shtml

1.4 Unaccompanied migrant/refugee children

In regard to unaccompanied migrant/refugee children, the available numbers indicate that a potentially difficult situation is emerging. According to the available annual records from the EUROSTAT database, n=96,640 unaccompanied children in 2017 and 2018 were identified (Eurostat, 2018b). However, before discussing each country specific situation it should be outlined that the availability of reliable data concerning the number of unaccompanied migrant/refugee children either arriving to or currently residing in different European countries is often limited. The number of asylum applications may provide an indication without necessarily providing an accurate picture of the exact numbers because of backlogs in national asylum systems, onward irregular movements or not applying for asylum at all.

Additionally, numbers are usually doubted due to the lack of a common set of criteria to define unaccompanied children which along with the discrepancies in national procedures and practices make exact estimations challenging.

According In a recent report by UNICEF, for the period between January and December 2017 updated data were selected by national authorities, e.g. Hellenic Police, EKKA (Greece), Italian Ministry of Interior and Ministry of Labour and Social Policy (Italy), Spanish Ministry of Interior (Spain), to depict the current situation concerning migrant/refugee children arrivals. The data are shown in Picture 2.



Picture 2 Gender and age breakdown of accompanied and unaccompanied and separated children by country of arrival *(Data were obtained from the UNICEF, 2018. Latest statistics and graphics on refugee and migrant children, Available at: https://www.unicef.org/eca/emergencies/latest-statistics-and-graphics-refugee-and-migrant-children)*

As depicted in **Picture 2**, the boys:girls frequency ratio who reached Europe via the Mediterranean route is close to 4:1. The vast majority of unaccompanied or separated children are between 15-17 years. The report also includes more country-specific data (UNICEF, 2018).

1.4.1 Greece

January – September 2017

- In total, *n*=438 unaccompanied children were in Reception and Identification Centers. This corresponds to a twice as high number in relation to the respective metrics in September 2017.
- In total, *n*=54 unaccompanied children in protective custody/detection were identified which is almost half compared with the respective number in September 2017.
- In total, *n*=1,101 unaccompanied and separated children were in special shelters, with an additional *n*=2,290 on waiting lists for a shelter. Due to increased arrivals and limited places, the number of children on waiting lists for shelters increased by 88% during the second half of 2017.

August 2017 – April 2018

According to the most updated report by EKKA (National Center for Social Solidarity), from January 2016 to 30 April 2018, about 12,325 referrals for unaccompanied children were received out of which 10,007 were processed and completed, 2,318 are wait listed for a shelter including 205 separated children. As for the reported place of stay, *n*=2.038 children are in long term or temporary accommodation, *n*=72 are in protective custody, *n*=657 in reception and identification centers, *n*=202 in open temporary accommodation facilities, *n*=570 are reported as homeless, *n*=92 are in informal housing arrangements, *n*=245 have no location reported, *n*=271 are in safe zones, *n*=470 are in hotels, *n*=991 in shelters and *n*=16 are in supported independent living (EKKA, 2018).

Data concerning unaccompanied migrant/refugee children for the period between August 2017 and April 2018 are point-by-point presented, as follows:

- The currently estimated number of unaccompanied migrant/refugee children has reached *n*=3,150 and *n*=205 separated children
- More sex-based data revealed that, in line with the aforementioned data for January to September 2017, about 96% are boys and only 4.3% of the total sample are children below the age of 14 years.

The following country map presents the available safe zones, shelters and hotels for unaccompanied migrant/refugee children up until the 30th April 2018.

Picture 3 Number and places of shelters, safe zones and hotels for unaccompanied migrant/refugee children in Greece, 30 April 2018 (EKKA, 2018). Data available at: https://data2.unhcr.org/en/documents/download/63462

1.4.2 Italy

According to a statistical report published by the Ministry of Labour and Social Policies in Italy (Ministero del lavoro e delle politiche sociali 2018; Ministero del lavoro e delle politiche sociali 2019; Ministero del lavoro e delle politiche sociali 2017) the number of unaccompanied children who reached Italy between 2014 and 2018 are presented as follows:

- **2014:** *0-14 years old:* 979 (9.3% of total migrant/refugee children)
- **2015:** *0-14 years old:* 939 (7.9% of total migrant/refugee children)
- **30 June 2016**: 12,241, *0-14 years old:* 1,326 (7.7% of total migrant/refugee children)
- **30 June 2017**: 17,864, *0-14 years old:* 1,229 (6.7% of total migrant/refugee children)
- **31 December 2017**: 18,303 unaccompanied children were present and listed in Italy (+ 5.3% compared to 2016, n=17,373; in 2012 n=5,821), of which 17,056 boys (93.2%) and 1,247 girls (6.8%). Children living in reception facilities up to 18 years of age: 90.8% were hosted in reception facilities (5,605 children, means the 30.6% in first reception centres and 11,022 children means the 60.2% in second reception centres). Only 3,1% live in private families.
- **30 June 2018**:
- 13,151 (Males: 12,169 - 92.5%, females: 982 - 7.5%), 34.0% in first reception centre (4,476), 54,7% in second reception centre (7,190), 3,9% with private (compatriots, relatives, families; 517) and 7,4% no information (968).
- **30 November 2018**: 11,339 (males: 10,506 - 92.7%, females: 833 - 7.3%)

Unaccompanied children lost - (unaccounted for) (Ministero del lavoro e delle politiche sociali; Save the Children, Rome, 2018)

- **31 December 2017:** 6,561 in 31st December 2016), 5,223 boys (89.6%) and 605 girls (10.4%). Considering only the year 2017, 2,440 children were nowhere to be found.
- **30 June 2018:** 4,677 children.

Table 7 Age- related distribution of unaccompanied migrant/refugee children in Italy

	Total	**Age categories**				
		0-6	***7-14***	***15***	***16***	***17***
30 November 2018	11,339	87	707	922	2,833	6,790
30 June 2018	13,151	104	845	1,172	3,315	7,715
31 December 2017	5,828	12	1,168	1,329	3,021	298
30 June 2017	17,864	92	1,157	1,687	4,227	10,701
30 June 2016	12,241	17	945	1,222	3,414	6,643

Data were obtained from Ministero del lavoro e delle politiche sociali, 2019; Ministero del lavoro e delle politiche sociali, 2018; Ministero del lavoro e delle politiche sociali, 2017

1.4.3 Spain

According to a Save the Children Spain 2018 Report:

- **In 2017** the number of female unaccompanied minors represented 10% of the total number of children under public custody. The number has decreased since 2014, when it was 23%.

- The number of minors estimated to be immigrating to Spain represents 14% of the total number of immigrants. Moreover, **during 2017** a total of 2.177 children arrived alone on a dinghy to Spain, increasing four times the number since 2016.
- **In 2016**, a total of 825 unaccompanied minors abandoned voluntarily the protection system and their current status is unknown.
- **31 December 2016:** The prosecutor authority reported 3.997 children under the custody of the corresponding autonomic community (527 females and 3.470 males). The number of children increased 19.63% since 2015. In this regard, the trend has followed an increase in the number of children under custody in 2017 with a total of 6.414. This represented an increase of 60%.

1.4.4 Germany

Data retrieved from the Federal Office for Migration and Refugees, in Germany regarding the percentage of unaccompanied migrant/refugee children from 2014 to 2017 are summarized in **Table 8** (Federal Office for Migration and Refugees, 2018; Federal Office for Migration and Refugees, 2014).

Table 8 Number of unaccompanied migrant/refugee children in Germany.

	2014	**2015**	**2016**	**2017**
Total	42,123	48,059	77,645	84,230
Unaccompanied children	6,854	11,642	42,309	44,935
Age				
14 years	5,73%	6,21%	8,05%	7,03%
≥14 years	94,27%	93,79%	91,95%	92,97%
Sex				
Boys	74,8%	84,2%	89,6%	91,8%
Girls	25,2%	15,08%	10,4%	8,3%
Country of origin	Afghanistan Somalia Syria Eritrea Vietnam	Syria Afghanistan Guinea Eritrea Vietnam	Syria Afghanistan Somalia Eritrea Vietnam	Afghanistan Eritrea Somalia Guinea Vietnam

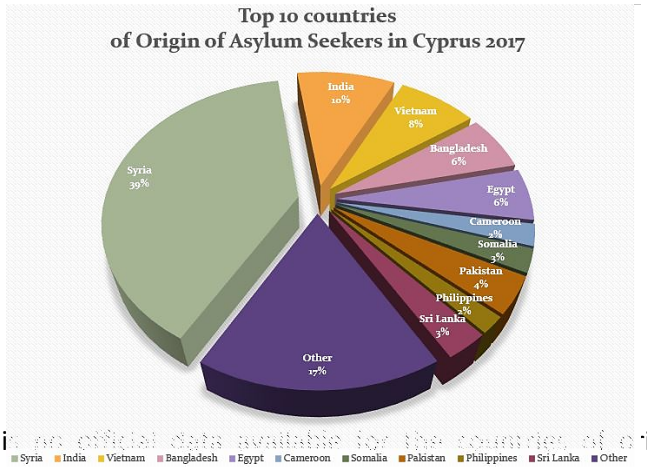
Data were obtained from the Federal Office for Migration and Refugees, 2014 and Federal Office for Migration and Refugees, 2018.

1.4.5 Cyprus

The Statistical Service of the Republic of Cyprus publishes data about migration in their Demographic reports (AIDA, 2017; Statistical Service of Republic of Cyprus, 2017). Asylum Service, a department of the Ministry of Interior, is the agency responsible for asylum-related data, including that of children, in Cyprus, and, in addition, the Civil Registry and Migration department is responsible for statistics regarding migrants. However, limited data are available for children and unaccompanied children by the Asylum Service or the Statistical Service of the Republic of Cyprus and, furthermore, there is no specific data regarding the category of refugee children/ unaccompanied children.

The data from the Asylum Service is based on the direct assistance provided to asylum seekers and beneficiaries of international protection and it also includes information received for advocacy interventions and studies/assessments as well as information obtained directly from the authorities. Data on detention is based on weekly visits to the Menogia Detention Centre and information from the Kofinou Reception Centre based on biweekly visits (AIDA, 2017).

Based on the latest data from 2017, the country of origin of most asylum seekers in Cyprus was Syria (39%). The countries of origin of asylum seekers are shown in the pie chart below:



There is no official data available for the countries of origin specifically for children or unaccompanied children that apply for asylum in Cyprus. In an interview on November 25, 2018 in the *Cyprus Mail*, Ms. Christina Markou, the child protection coordinator from the non-governmental organization *Hope for Children*, said that the unaccompanied children are mainly from Somalia, and from other African countries, such as Cameroon, Congo, Nigeria, and the Ivory Coast (Crysostomou, 2018). Unfortunately, there is no data in regards to the number of children applicants for 2017, based on the Asylum Information Database. However, it is noted that the unaccompanied children were 221, which was 4.8% of the total number of applicants (AIDA, 2017).

Gender/age breakdown of the total number of applicants: 2017

	Number	Percentage
Total number of applicants	4,582	-
Men	:	:
Women	:	:
Children	:	:
Unaccompanied children	221	4.8%

Source: Asylum Service

Based on the data from 2016, the number of unaccompanied children was again 221, which was 7.2% of the total number of applicants for that year (Table 2) (AIDA, 2017).

Gender/age breakdown of the total number of applicants: 2016

	Number	Percentage
Total number of applicants	3,055	
Men	:	
Women	:	
Children	:	
Unaccompanied children	221	

Source: Asylum Service, Refugee Reviewing Authority.

Data from 2014 indicates that the number of unaccompanied children who applied for asylum in Cyprus was only 52, which was 3.52% of the total number of asylum seekers in that year (AIDA, 2013).

Gender/age breakdown of the total numbers of applicants in 2014

	Number	Percentage
Total number of applicants (A)*	1479	
Men (B)	914	61.80
Women (C)	565	38.20
Unaccompanied children (D)	52	3.52

Source: Asylum Service
The above table does not include subsequent applications.

In general, these numbers have been rising over the last few years. In an interview with Ms. Emilia Strovolidou from the *United Nations High Commission for Refugees* (UNHCR) on November 25, 2018 in the *Cyprus Mail*, it was stated that "in 2018 the numbers so far were at 280 unaccompanied and separated children whose asylum-applications are pending examination. They are teenagers around 15 to 17 years of age" (Chrysostomou, 2018). Based on the most recent Demographic Report of the Statistical Service of the Republic of Cyprus, the long-term immigrants in 2017 in Cyprus were in total 21,306 (see table below). The children (under 19 years old) were 2,846, from which 1,177 were boys and 1,669 were girls. Furthermore, regarding the children's citizenship, most (2,043) were from the European Union, whereas 623 were outside the European Union, and 180 had Cypriot citizenship (Statistical Service of Republic of Cyprus, 2017).

2. Health and social care needs of migrant/refugee children: a scoping review of the current situation

An increasing number of political, social, economic and environmental risks have been brought to attention in the current migration crisis around the European countries. These risks affect migrant/refugee children during their journey to and through Europe in search of safety and security creating challenges related to the provision of health, social and education services (ISSOP, 2018; WHO, 2018a; WHO, 2018b). Being aware of the actual health and social needs of migrant/refugee children remains a top priority in particular concerning the ability of national public health services to effectively deal with this emergency. Migrant/refugee children's health is related with their health status before their journey and during their stay

in their country of origin, as well as the health risks related with the migrant/refugee journey and after their arrival at the destination country (Gushulak, 2018).

2.1 Health and social care needs at arrival: "on the move" problems or problems created in origin country

On arrival the most common health problems among migrants and refugees recorded at the points of entry are related to problems originating in the country of origin related possibly to war or political instability as well as problems caused by the migrant journey, or "on the move" health complications. Various reasons like war and conflict, human right abuses e.g. torture or sexual violence, extreme poverty are among the reasons that hinder these children's health. In addition, refugees, including those in childhood and adolescence are particularly vulnerable to contagious infectious diseases during their travel, considering destroyed health care systems at country of origin which may mean inadequate vaccination services, inadequate water networks and housing, overcrowded conditions with suboptimal hygiene standards during travel, malnutrition and lack of access to health care services (WHO, 2016).

Documents concerning recommendations and guidelines for migrant children's health outline the importance of knowing the local health system organization and health conditions in the country of origin. Although necessary, it's often not easy, or sometimes impossible, to find relevant information for different patients. Moreover, it's not possible to describe specific needs related to the conditions for so many countries of origin.

In 2016 WHO, with UNHCR and IOM, published a global document focused on assessment of health system capacity in case of large influxes of migrants and health risk (WHO, 2016). Global health risks to be taken in account in the evaluation of migrant health and social needs are: pre-departure health risk, journey-related health risk by sea and by land, health risk during SAR (search and rescue) and after arrival. Considering the country of origin, general health risks (not only for children) are related to level of immunization coverage, strength of surveillance and outbreak control systems, presence of communicable disease epidemics, maternal health services and risk of pregnancy-related illnesses and birth complications, accessibility of essential medicines and absence of or interruption in treatment of chronic diseases, potential postponement of elective surgical procedures, food insecurity, malnutrition, gender-based violence, conflict-related trauma and torture. In addition, a general lack of health and dental care should be considered (WHO, 2018a).

The following information related with the most frequently reported country of origin have been generated by the Save the Children foundation (2018) and presented as follows:

Morocco

Morocco, during the few years has seen the aggravation of social tensions caused by a fragile economy, few opportunities for the population and repressions of freedom expression in 2017. The fragile economy has been a consequence of a strong drought that has affected to their production, who has shown to be dependent on the agriculture sector and the climate. Also, the rural population is the most affected in this situation, which is reflected by their intern migration to the big urban areas. In Morocco about 6'3 million people live in poverty conditions. This hard situation drove people from different areas of the country to protests and confrontations during 2017. Particularly in the Rif region, where the demonstrations have

been violently repressed, with many activists and journalists arrested and mistreated. There is also a lack of labour opportunities and a lack of access to professional formation, causing high rates of unemployment in the young population. Morocco has tried through several legislative reforms make some social and human rights changes but has failed in the application of these in all their regions, being violence in childhood and abandonment still socially acceptable and practiced in some communities. Another fight is the strong discrimination that people from the LGTBI community suffer, being homosexuality still a crime according to Moroccan law.

Algeria

Although the economic situation of Algeria has grown in recent years, thanks to its production of hydrocarbons; the global drop in oil prices and the bad harvests have affected their economic situation. The recent contraction in its GDP has had negative effects on the welfare of families, young people and their high rates of unemployment and inactivity. The cuts in subsidies and in social programs, as well as the increase in taxes, has also increased social tensions. Other problems that face Algeria is the lack of improvement in freedom of speech, assembly and religion; women's situation (being still discriminated in aspects such as marriage, divorce, inheritance or custody of minors by the current Family Code); and the discrimination to the LGTBI collective.

Guinea Conakry

During 2016, the economic has grown thanks to an increase in the production of bauxite and gold and to the resilience shown by its agricultural sector. However, general improvements in the economics have not yet resulted in greater welfare of the population, with 73.8% suffering from multidimensional poverty. Also, the outbreak of the Ebola has caused a crisis not only in health but also humanitarian, social, economic and security crisis. Guinea is in the 7th global position on infant mortality. Also, children face difficulties to see their right to education fulfilled. In 2016, half of the children from 5 to 14 years of age did not attend school, and the 28% of them worked. Girls are frequently employed in the domestic sector, sent by their families from rural areas to live in the city. They are also more vulnerable to female genital mutilation, which affects the 96.9% of women older than 15 years, or early marriages. Human rights, freedom of speech, manifestation and association remain a task pending for the country, being also compromised in 2017.

As already briefly mentioned before, during journey, children are exposed to risks of violence, exploitation, abuse and trafficking for slavery, forced job, prostitution, pornography and mendicancy, with consequences on mental and physical health. Risks of trafficking is greater in case of unaccompanied children (Caritas, Rome, 2018). The previously cited publication of WHO with UNHCR and IOM, on assessment of health system capacity in case of large influxes of migrants and health risk (WHO, 2016), reported some of the possible risks of the journey (for all migrants, not only for children) to be considered in the evaluation of needs, as physical and psychological trauma, dehydration, nutritional disorders, hypothermia, communicable diseases, burns, heat-related illness, cardiovascular emergencies, birth-related illness, drowning, gender-based violence, violence and torture, untreated chronic diseases. A study pointed out that infants born during the journey are at an increased risk of severe and life-threatening illnesses, including meningitis and pneumonia (ECDC, 2014). In addition, these

newborns may experience malnutrition, predominantly as breastfeeding is not an easy procedure for mothers during their journey. In addition, in transit countries migrants could be accommodated in precarious, overcrowded settlements with poor hygienic conditions and limited or no access to health services.

2.1.1 Communicable diseases and vaccinations

According to a recent report from the American Academy of Pediatrics, the most prevalent infectious diseases in migrant/refugee children are summarized in the following figure (American Academy of Pediatrics 2015).

M tuberculosis	Typhoid fever *(Salmonella Typhi)* among recently arrived febrile patients
M Bovis	Geographically specific infections: • Schistosoma spp. (trematode) • *Opisthorchis* species • Chagas Disease—(Trypanosoma cruzi) • Coccidioidomycosis • Histoplasmosis • Lymphatic filariasis • *Loa loa* • Leishmaniasis • Chikungunya virus
HIV 1, 2	Sexually Transmitted Infections • *Gonococcus* • *Chlamydia* • Syphilis
Viral hepatitis • Hepatitis A • Hepatitis B • Hepatitis C (overseas surgery, transfusion, female genital mutilation, traditional cutting, tattoos, sexual abuse)[12] • Hepatitis D (chronic carriers of Hepatitis B)	Skin infections • Scabies • Lice • Impetigo • cutaneous larva migrans
Parasitic infections • Soil-transmitted helminths – Roundworm *(Ascaris lumbricoides)* – Whipworm *(Trichuris trichura)* – Hookworm *(Necator americanus, Ancylostoma duodenale)* • *Strongyloides stercoralis* (nematode) • *Entamoeba histolytica* • *Giardia intestinalis* • Cryptosporidium • Taenia solium (cysticercosis, pork tapeworm) • *Toxocara canis and visceral larva migrans*	
Malaria	*Helicobacter pylori*

Figure 5. Infectious diseases to consider in immigrant children. Data available at American Academy of Pediatrics 2015

Refugees' countries of origin present a high incidence rate of infectious diseases e.g. tuberculosis, hepatitis B, HIV, malaria. For instance, data from France and Germany have shown that between 2011 and 2013, unaccompanied refugee minors from Africa, Asia and Eastern Europe, were diagnosed most frequently with digestive parasitoses (50%), schistosomiasis (7%), filariasis (6%) ,and hepatitis B (chronic 6%, seroprevalence 28%) (Gushulak et al, 2011; Semenza et al, 2016; Odone et al, 2015; Hernando et al, 2016; Roggelin et al, 2016; Cai et al, 2011; Sonden et al, 2014). Respiratory infections and gastrointestinal illnesses are on the short list of complications related with migrants' and refugees' health status (Pavli et al, 2018). Children are more prone to respiratory infections and gastrointestinal illnesses because of poor living conditions, suboptimal hygiene and deprivation during migration, and they require access to proper health care. In addition to this, physical and mental stress deprivation due to lack of housing, food and clean water undoubtedly contribute to increase migrant/refugee children's likelihood to suffer from respiratory infections (WHO, 2016). Influenza can have major health complications in children especially those aged <5 years. Poor hygienic conditions can also lead to skin infections especially among children (WHO, 2016).

Vaccination constitutes one of the most important problems related with refugees, in general and specifically with migrant/refuge children (de la Fuente IG et al, 2013; Williams GA, 2016; Jablonka A et al, 2016). Indeed, the most prevalent health-related need that services in destination countries have to mostly deal with when it comes to children and adolescents is related with unvaccinated or partially vaccinated children (Pavli et al 2017). Hence, vaccine-preventable diseases are the principle consideration of health professionals. **Table 8** summarizes the results from a very recent meta-analysis regarding the level of coverage of common vaccinations for six of the most frequent countries of origin of migrants arriving in Europe since 2012 (Syria, Afghanistan, Iraq, Albania, Pakistan, and Eritrea).

Table 7. Coverage of vaccinations in 2014, %

Vaccine	Code	Syria	Iraq	Afghanistan	Albania	Pakistan	Eritrea
Bacille de Calmette-Guerin	BCG	81	95	86	99	85	97
Diphtheriate-tanus-pertussis 1st dose	DTP1	65	77	82	99	79	97
Diphtheriate-tanus-pertussis 3rd dose	DTP3	43	64	75	98	72	94
HBV 3rd dose	HepB3	71	62	75	98	72	94
HBV birth dose	HepB_ BD	78	43	4	99	_	_
Haemophilusinfluentiae 3rd	Hib3	43	64	75	98	72	94
Measles Containing Vaccine 1st dose	MCV1	54	57	66	98	61	96
MeaslesContainingVaccine 2nd dose	MCV2	49	57	39	98	52	_
Maternalimmunization with ≥2 doses of tetanustoxoid	PAB	92	72	70	92	75	94
PneumococcalConjugate Vaccine	PCV3	_	_	40	99	72	_
Polio vaccine 3rd dose	Pol3	52	67	75	98	72	94
Rotavirus	RotaC	_	29	_	_	_	25

Data were obtained from Mipatrini et al 2018.

The availability of data regarding vaccination in migrant/refugee children is limited to some non-consistent references. For instance, as regards, the Hepatitis B virus (HBV), migrant/refugee children in Germany presented higher prevalence of HBV infection compared to the native population (Cai et al, 2011), yet no HBV cases were found among a sample of unaccompanied minor refugees from Syria in Berlin (Mockenhaupt et al, 2016). Other research indicated that less than 15% of Syrian children refugees in Germany had vaccination coverage for Sabin-like polioviruses (Böttcher et al, 2015). Moreover, in Switzerland, among 92 newly arrived migrant children, antibodies against diphtheria–tetanus–pertussis consistent with previous vaccination were detected in only one out of three migrants (de la Fuente et al, 2013). Additionally, in a cohort of 2,126 asylum-seeking children in Denmark, 30% were considered not to be immunised in accordance with the Danish schedule, with under immunisation being particularly high in adolescent migrants aged 10–17 years (Nakken et al, 2018). The lowest uptake was found for immunisation against diphtheria, tetanus, pertussis and polio. Migrant/refugee children appear to be more commonly unvaccinated for measles as revealed by a study in Germany (Jablonka et al, 2016). A similar condition has been

observed in Spain and Italy as well with coverage rates being higher among native populations than among foreign-born children (Williams et al, 2016; Pavli et al, 2017).

Screening for multi-drug resistant (MDR) bacterial carriage and infections, and MDR-tuberculosis (TB) in migrant/refugee children from 2010, revealed high MDR carriage rates, attributed to high pre-civil war MDR rates, war-damaged infrastructure and healthcare systems and poor hygiene conditions (Maltezou et al, 2017). In Germany 2015 multidrug-resistant Enterobacteriaceae were reported in stool samples of unaccompanied refugee minors arriving in Frankfurt am Main (Heudorf et al, 2015).

The circumstances under which refugees and migrants travel can accurately exacerbate or cause a life-threatening health condition related with non-communicable diseases. In brief, acute traumatic injuries, loss of access to medication and other health care services, degradation of living conditions (i.e. loss of shelter, shortages of water and regular food supplies), interruption of health care due to destruction of health infrastructure, disruption of medical supplies and the absence of health care providers who have been killed, injured or are unable to return to work have aggravating effects on the health of migrants/refugees who are on the move (Pavli et al 2017). Children are among the most vulnerable groups of this situation. According to the travelling route, migrant/refugee child's health is challenged for various reasons. In this context, increased risk of hypothermia, septicaemia, meningitis and pneumonia is observed in infants born "on the move" (European Centre for Disease Prevention and Control, 2014). Additionally, considering that breastfeeding remains a challenge for refugee/migrant mothers, infants present a high likelihood to suffer from inadequate and poor nutrition which along with the overcrowded accommodation and substandard hygiene and sanitation facilities set infants as well as children in general at increased risk for communicable diseases like diarrhoeal diseases and skin infections (European Centre for Disease Prevention and Control, 2014).

2.1.2 Nutrition-related disorders

In general, migrant/refugee children are very likely to present with malnutrition, including wasting and stunting while despite this, the prevalence of overweight and obesity status among migrant/refugee children is quite high. Additionally, refugees' countries of origin present a high incidence rate of nutritional deficiencies. From the standpoint of nutrient deficiencies, iron deficiency comes on the top of the rank. For instance, unaccompanied minors from Africa, Asia and Eastern Europe reaching France and Germany (2011-2013), were diagnosed most frequently with iron deficiency (26%) or anaemia (4%) (Gushulak et al, 2011; Semenza et al, 2016; Odone et al, 2015; Hernando et al, 2016; Roggelin et al, 2016; Cai et al, 2011; Sonden et al, 2014). Among migrant/refugee children with anemia the undiagnosed haemoglobinopathies is a rather important challenge, mainly for children in African, Southeast Asian, East Asian, Hipsanic or Mediterranean ethnicities. Vitamin D deficiency is another common nutrition-related disorder particularly in children with growth delay, poor dietary intake as well as limited sun exposure. Vitamin A, zinc, cobalamin, niacin, tryptophan, iodine, thiamine and vitamin C are additional nutrient deficiencies identified in migrant/refugee children.

2.1.3 Non-communicable diseases

Apart from the communicable diseases related with migrants/refugees, it should be outlined that the non-communicable disease profile of their country of origin is of high importance regarding the appropriate prevention measures that have to be taken by the public health policy makers of the hosting countries. For instance, there are cases of chronic diseases that

are more frequent in migrant populations like diabetes, hypertension, cerebrovascular disease, coronary heart disease and stroke. What is more, iron deficiency or anemia is diagnosed more often in case of migrant/refugee children compared with the local-born child populations (Economopoulou et al 2017; European Observatory on Health Systems and Policies 2011).

2.1.4 Psychological problems

Apart from the aforementioned physical health problems, mental and psychological health merits particular attention in migrant/refugee populations. Stressful experiences may be related with conditions in the country of origin, during transit or upon arrival to the hosting country (American Academy of Pediatrics). For instance, incarceration during journey or traumatic events like separation from family, death of family members, sexual violence, kidnapping or extortion are associated with long-lasting psychological health complications on the migrant/refugee child including depression and post-traumatic stress disorder (ISSOP, 2018). Leaving post-traumatic stress disorder untreated has a risk of chronification. To this issue, interviews given between June 2016 and May 2017 by adolescents (14-17 years old) and young people (18-24 years old) arriving in Italy via the Central Mediterranean route, showed risk of abuse, trafficking and exploitation (forced labour, sexual exploitation, violence and abuse, child marriage, captivity), as well as discrimination with xenophobia and racism. Children travelling alone, with low level of education, with a longer journey and from sub-Saharan Africa are more vulnerable. The analysis of the survey showed that the Central Mediterranean route to Italy is singularly dangerous (UNICEF, IOM, New York, 2017). At the beginning of the 2018, a focus group organised in Italy, unaccompanied female minors mainly from Nigeria, reported similar characteristics in the migratory history and of exploitation, almost totality in order to sexual exploitation (Ministero del lavoro e delle politiche sociali, 2018 June).

2.1.5 Other health-related problems

Oral health is another crucial part of migrant/refugee children's status for which little knowledge has been obtained. According to recent work for migrant/refugee children in Greece, it was found that about one out of five children present dental problems (Linden et al, 2013; Pavlopoulou et al, 2017). Dental problems, including dental caries or more serious dental diseases, are pervasive in immigrant children, given scant, if any access to dental preventive care and treatment in their countries of origin. Poor oral health is highly associated with suboptimal quality of life while it possesses aggravating effects on various chronic diseases. As for the infants reaching EU countries, those may have been born without skilled postnatal care e.g. screening for congenital disorders and/or they could have received inappropriate or delayed medical treatment (ISSOP, 2018). Other medical issues, such as thyroid disease and congenital defects may be present, demanding subspecialty care while increased weight status is another crucial matter related with high risk of hypertension, hypercholesterolemia and diabetes mellitus. Moreover, considering the impoverished living conditions in their country of origin, toxin exposure is highly common in migrant/refugee children. Lead exposure is the most widespread toxin exposure within this population; exposures prior to the country of origin may include leaded gasoline, contaminated home remedies or traditional cosmetics, leaded ceramic glazes, leaded cookware or air pollution. History of female genital cutting and parents' beliefs regarding this practice particularly for child from Africa is of high importance to be inquired. Undiagnosed vision and hearing are also problems which may be present.

2.2 Health and social care needs related with the hosting reception centres

The early settlement of migrant/refugee children at points of care is usually accompanied by a large number of health problems which have to be taken into account by the care providers. In particular, it has been demonstrated that the aforementioned communicable diseases cause flare-ups in reception and holding centers with outbreaks being generally more severe in refugee camps. Sharing dormitories, lack of accessible toilet facilities, poor hygiene conditions, undernourishment and limited access to medical care are usually reported as the principle contributors to disease susceptibility. Children are undoubtedly particularly vulnerable. In addition, overcrowding in holding/detention centers or refugee camps may contribute to the rapid spread of communicable diseases, such as influenza, varicella, tuberculosis, measles, and meningococcal disease (Kotsiou et al 2018).

Malnutrition is another major issue which is highly presented in migrant/refugee children usually related with their local dietary habits as well as the poor nutrition presented as a common "on the move" problem. For instance, in July 2018 multiple surveys assessed malnutrition prevalence among migrant/refugee children living in reception areas in northern Greece; in particular, more than one out of ten migrant/refugee children had at least one form of malnutrition, reported stunting or had a body weight below the normal range. Interestingly, girls were more likely to be malnourished compared with their boys counterparts while as expected children <5 years old were more vulnerable (Grammatikopoulou et al, 2018; Walpole et al, 2018). In the field related with nutrition-related disorders of migrant/refugee children, mostly related with local dietary habits, it should be underscored that one of the most relevant childhood diseases in this target group is the nutritional rickets. This disease is characterized by softening of the growing bones of children, resulting in bone pain, delayed motor development, muscle weakness, and bending of the bones. Deficiency in vitamin D and calcium are the principle nutritional factors that are related with this nutrition-dependent disease (Thacher et al, 2016).

Policy making regarding the integration of migrant/refugee populations in European countries mostly focuses on legal aspects, facilitation of language acquisition, schooling, employment, mental health problems, radicalization, security and safety issues and the special needs of particular vulnerable subgroups including minors (WHO, 2018a). The new and unfamiliar environment in the hosting country accompanied by language, cultural and educational barriers set newly settled children at risk for delayed presentation and inadequate or inappropriate use of health and social care services. This is even more important in case of unaccompanied minors who need being guided on their right to care and assistance in seeking care for health maintenance and disease prevention. Accommodation circumstances for migrant/refugee children are very likely to be inadequate or unsafe. Inappropriate living conditions set them at increased risk for injuries and accidents at home or within the immediate surrounding environment. What is more, migrant/refugee families usually struggle to access education which results in delayed learning and challenges for integration into age-appropriate schooling for numerous children. As for the child subgroups with chronic health problems and/or disabilities major concerns are arisen. To this issue, these children present a higher risk for social exclusion and may present lower participation in society compared with other disabled children from the local country (ISSOP, 2018).

Apart from the aforementioned problems from which migrant/refugee children are to suffer when reaching their hosting country, mental-health related problems remain on the top of the rank. More specifically, abundance of evidence shows that both accompanied and unaccompanied children either travelling to Europe of even born in the destination country

are at high risk of health and psychological problems. Apart from the psychological traumas experienced in their country of origin or during their journey (previously reported), the worsening living condition in the destination countries, xenophobia and social marginalization increase this psychological risk. For instance, unaccompanied minors in France, Belgium and Norway have reported various forms of psychological disorders including anxiety, depression, suicidal thoughts and post-traumatic stress disorder, throughout their first years after resettlement (Monpierre et al, 2016). As already mentioned, unaccompanied children are at very high risk for exploitation and trafficking; of the nearly 90,000 unaccompanied minors that have applied for asylum in 2015 about 10,000 subjects have gone missing (Monpierre et al, 2016). Additionally, mental health of migrant/refugee children is challenged by the mental health of their care givers, the inadequate living conditions, the marginalization, the lack of trauma-informed services and the lack of cultural competency among professionals who are in contact with them. Such conditions may result in migrant/refugee children with poor self-esteem. Accompanied migrant/refugee children are also very likely to live with parents who suffer themselves from psychological disorders mostly due to the feeling of insecurity during the asylum-related process (Vaage et al, 2014). The damaging effects of this on children may be further compounded by child professionals who fail to acknowledge cultural differences in child care and who may consider the parent as unfit or lacking parenting skills. Furthermore, the living conditions of migrant/refugee children including housing, continuous moving, lack of toys, limited access to school, lack of communication and social interaction with peers are additional parameters which influence their psychological health. Simultaneously, xenophobia from other children and most importantly the professionals who are in contact with them may progressively result in a child who devaluates its origins. This can easily lead to a double marginalization of migrant/refugee children from both the society of their origin and their host country. Double marginalization consequences are evident in the cases of violence, delinquency, addiction, suicide and radicalisation (Ratkowska et al, 2013). What is more, migrant/refugee children may be susceptible to psychological disorders that are highly prevalent in the country of origin e.g. depression, anxiety, posttraumatic stress disorder, somatization, sleep disturbance, and substance abuse. To this issue, sleep disorders have also been mentioned in case of unaccompanied asylum-seeking adolescents resulting in various functional problems in memory, concentration, attention, motor performance, academic performance and behavior (Bronstein et al, 2013). Lastly, in a very recent systematic review of the elements (as presented by children themselves) which are mostly related with migrant/refugee children's mental health, these could be summarized as follows (Van Os et al, 2016):

- Pre-existing vulnerability
- Extreme poverty
- Being unaccompanied
- Exposure to violence
- Witnessing to violence
- Having stayed in refugee camps
- Poor parental support
- Experience of discrimination
- Lack of opportunities to play
- Drastic changes in family
- Loses of close relatives

- Separations
- High annual relocation rate

Additionally, in a participatory needs assessment done in some reception facilities by the Autorità garante per l'infanzia e l'adolescenza (Authority guaranteeing for infancy and adolescence) and the UNHCR, listening to/interviewing 134 minors (mean age 17 years; 84% males), from 21 different countries in Italy (AGA, 2018), the following barriers and needs were mostly reported:

- a too long stay in first reception facilities (more than 30 days as allowed by law), in most cases until the age of majority, without access to second reception facilities and integration projects; less availability than necessary of SPRAR (system of protection for asylum seekers and refugees) projects for unaccompanied children;
- not defined and homogeneous procedures for the relocation and the family rejoining, with difficulty and distress for children, living and waiting in uncertainty;
- limitations to the right to be listened (delay in the nominations of the legal tutor) and difficulty in communications with tutors;
- need of child friendly information concerning their doubts and questions;
- need to be listened by the operators of the receptive facilities and adult of reference;
- considering the high number of applications for asylum, need to guarantee the protection of children and the correct evaluation of their condition;
- need to guarantee integration and individual projects tailored on specific needs and resources and competences of the minor;
- lack of socialization with the local community, especially Italian minors (and feeling of insecurity because of episodes of intolerance and racism also reported);
- lack of possibility to participate to sport activity because of lack of authorization by parents.

In Germany, social disadvantages derived from the migration background in children have been identified. This refers to the role of culture, and how children assume the role of mediators between their parents and society, such as assuming adults' functions since their early childhood (Marquardt et al, 2016). For example a study shows an exposure of migrant/refugee children to diseases and less frequent use of prevention examinations, evident in the partial willingness to vaccinate. Following the work of Carballo and Nerukar, during the process of migration, risk conditions for children were found. Among them were a series of events that can affect immigrant children psychologically, due to the inherent migration risk in the field of (Carballo et al, 2011):

- Separation from family and traditional values;
- Relocation in new cultural and social situations;
- Languages difficulties;
- Presence of culturally defined behavior that could reinforce stereotypes and prejudices.

Sexual and reproductive health is another important aspect which is high among migrant/refugee children. To this issue, adolescent girls are an overlooked group within the migrant/refugee population whose sexual and reproductive health remains unmet. The neglect of these needs make undoubtedly this target group largely vulnerable to unwanted pregnancies, HIV and other sexually transmitted infections maternal death as well as sexual violence. Indeed, in humanitarian settings girls in adolescence are usually exposed to early and forced marriage, early childbearing, sexual exploitation and trafficking. In a very recent systematic review regarding this issue several remarks of high concern have been highlighted;

revealing negative sexual and reproductive health experiences and practices as well as the limitations in sexual and reproductive health knowledge and the access to relevant health services, commodities and information sources (Ivanova et al, 2018).

Overall, when treating a migrant/refugee child (accompanied or not) the first visit must be especially empathetic and requires, in many cases, a mediator or, at least, a translator. In many cases refugees answering questions could be considered dangerous for their wellbeing. Therefor health professionals must be trained in terms of sensibility to certain topics and behaviors. The health professionals will have in mind the following questions: country and place of origin (rural or urban area), studies and profession of parents, the time and reason for emigration, the migration route and its vicissitudes, background of the pregnancy and childbirth, personal pathological history, diseases, surgical interventions, possible parenteral treatments (transfusions), allergies, medications taken, symptoms of possible imported diseases (fever, skin lesions or rashes, diarrhea, abdominal pain, pruritus, respiratory signs , weight loss), dietary habits, administered vaccines, family pathological background, consanguinity of the parents and religion. Especially in the case of refugees, irregular or unaccompanied migrants it is important to know the family/social network that can protect the child and the possible exposure to violence, traumas or abuse. There must be, during Primary Care, a physical exploration. This exploration must be as exhaustive as possible and made by health professionals. In cases of refugees or traumatic emigration, a psychological assessment is essential and must be made by the Primary Care Pediatricians. Health professionals must be alert about states that indicate post-traumatic stress, depression, apathy, exaggerated irritability, etc (Council on Community Pediatrics, 2013).
Some preventive activities should be also made in migrant children:

- Vaccination
- Prophylaxis of iron deficiency
- Prophylaxis of rickets
- Prophylaxis of female genital mutilation (FGM)
- Prophylaxis of nutritional deficits
- Mental health examination: Health professionals must be sensitive to what can be represented by the “migratory grief” of children and adolescents and their parents, and the adaptation to/of the family, especially of adolescents who have been separated from their parents for years (Council on Community Pediatrics, 2013).

3. Intercultural mediation across Europe

During the last years plenty of interventions have been carried out in the EU region enhancing cohesive synergy within multicultural communities. One of the core measures taken to strengthen migrant integration is the education of intercultural mediators. The book entitled “*Intercultural Mediation in Healthcare: From the Professional Medical Interpreters' Perspective*” (Souza, 2016) presented several international standards regarding intercultural mediation in health care released from the International Medical Interpreters Association (IMIA) and the International Organization for Standardization (ISO). According to the IMIA Guide on Medical Interpreter Ethical Conduct, the standards for health-related intercultural mediators were presented as follows (IMIA 2010):

- Confidentiality
- Accuracy
- Professionalism (refraining from accepting assignments beyond professional skills, language fluency or level of training nor gaining favors from clients)

- Impartiality (engaging in client advocacy and cultural interface roles only when appropriate and necessary for communication purposes)
- Professional development

Most recently, the ISO has applied a worldwide set of standards for community interpreting, released in 2014 (ISO, 2014). In this publication, the skills and competences of community interpreters – not specific to healthcare interpreting, but as an answer to the international call for milestones of integration of linguistic, cultural and ethnic diversity – were presented as follows:

- Understanding and conveying cultural nuances
- Interrupting to point out the existence of a cultural barrier when it can result in misunderstanding (cultural custom, health belief or practice, for example refusing surgery on the basis of religious beliefs)
- Being careful not to provide explanations but to identify clearly the misunderstanding so that the end users can explore and clarify It with each other

Country specific information concerning terms and standards of intercultural mediation were presented by various countries in Europe in order to define the occupational profile of an intercultural mediator. Such standards have been summarized in the technical report of Intellectual Output 1 retrieved from the TIME project in 2016 and are summarized in the following sections. However, no precise picture exists so far of the current European situation of intercultural mediation for immigrants, minors included, nor does communication of practices exist between the partnership countries (Aspioti et al, 2016). At European level, each country applies different standards for intercultural mediators. However, certain countries present an occupational profile for intercultural mediator.

3.1 Terms of intercultural mediation across Europe

There is a variety of terms used for intercultural mediation. This use of different terms reflects the different situation in each country and the different roles that need to be undertaken. However, it should be outlined that two elements are of major importance concerning intercultural mediators; firstly, the practice of interpretation (shown in the frequency of the term “interpreter” employed in the terminology) and secondly the importance attributed to the cultural context (shown in terms such as community, intercultural, sociocultural etc). The table below presents some of the terms used across several European countries:

Table 8. Country-specific terms of intercultural mediators

Country	Terms
Greece	Interpreter - Intercultural mediator
Germany	Mediation and Arbitration- alternative dispute resolution (ADR) and mediation; Linguistic and integration mediation, community interpreter, Integration facilitator
Italy1	Cultural Mediator (Friuli Venezia Giulia, Abruzzo, Campania); intercultural Mediator (Autonomous Province of Bolzano, Liguria, Valle d’Aosta, Lazio, Emilia Romagna, Piedmont); qualified Technician in Cultural Mediation and Linguistics for Immigrants (Tuscany); intercultural operator (Autonomous Province of Bolzano); social worker (Liguria, Friuli Venezia Giulia, Valle d’Aosta); operator

	able to perform the function of linguistic mediation and above all of cultural orientation (Campania); technician working in the health and social care sector (Tuscany); technician of intercultural communication (Abruzzo)
Spain	Intercultural mediator
Austria	Cultural Interpreter; community Interpreter
Belgium	Intercultural mediator; family supporters; social Interpreting
France	Interpreter in the social sector; social and cultural mediators; femmes relais mediatrices
Netherlands	Interpreter; ethnic minority health care counsellor
Portugal	Sociocultural mediator; community mediator; intercultural mediator
Switzerland	Intercultural interpreter; intercultural mediator

Data were obtained from Aspioti et al, 2016.
1 For Italy data were also retrieved from the following link from Ministero del Lavoro 2009.

3.1.1 Greece

In Greece intercultural mediator is usually applied in the fields of health (interpretation in hospitals), law (in courts or police stations or any other state structures used for migrants' hosting or penitentiary purposes), housing and social affairs (public offices where migrants come to complete various bureaucratic procedures regarding their stay documents etc), where migrants need to be treated and served. Intercultural mediation in the field of education is another part which is highly discussed since an increasing number of migrant/refugee children attend Greek schools. Concerning the political and legal framework, the concept of "intercultural mediator" has not been officially introduced in the Greek Law. Despite that, the Law 3386/2005 refers to the integration of Third Country nationals into Greek society, without specifying the measures for such integration processes or referring to cultural mediation. The sole indirect referral of the Greek state to cultural mediation is the official definition of integration as a process where migrants/refugees adapt to the host country and at the same time the host country adapts to the newcomers. Moreover, the 2013 National Strategy for the Integration of Third Country Nationals includes cultural mediation and defines it as a measure for supporting the integration process (General Secretariat for Population and Social Cohesion Ministry of the Interior, 2013). Despite these claims, a professional profile regarding the intercultural mediator has not been demonstrated yet.

3.1.2 Germany

Germany is considered as one of the most developed countries in improving attitudes towards immigrants. According to the European Union (2016), Germany accounts for an integration rate of 83%, lifting the country into the top 10 on integration policies. Due to extremely high immigrant flows to Germany, there is a specialization level in services in the immigrant integration sector. At the national level, there are two types of mediators: a) integration facilitators or linguistic and integration mediators (Integrationslotsen / Sprach und Integrationsmittler) and b) intercultural mediators. The first group is usually composed of persons with migration background, they assist immigrants in the integration process and offer practical support. The second group includes professional intercultural mediators,

commonly non migrants, who are specialized in conflict resolution in an intercultural context. The German legislation includes the terms: a) mediation and arbitration- alternative dispute resolution (ADR) and b) mediation or linguistic and integration mediation, community interpreter, integration facilitator. In Germany, the Mediation Act (21 of July 2012) Mediationsgesetz, defines and regulates the tasks of mediators. Paragraphs 1 and 2 of § 1 indicate: *"(1) Mediation is a confidential and structured process in which the parties strive, on a voluntary basis and autonomously, to achieve an amicable resolution of their conflict with the assistance of one or more mediators. (2) A mediator is an independent and impartial person without any decision-making power who guides the parties through the mediation" (Mediation Act, p. 1, 2012). Likewise, § 5 express "initial and further training of the mediator; certified mediator" under the next parameters: (1) The mediator himself shall be responsible for ensuring that, by virtue of appropriate initial training and regular further training, he possesses the theoretical knowledge and practical experience to enable him to guide the parties through mediation in a competent manner. Suitable initial training shall impart the following in particular: 1. knowledge about the fundamentals of mediation as well as the process and framework conditions therefore, 2. negotiation and communication techniques, 3. conflict competence, 4. knowledge about the law governing mediation and the role of the law in mediation, and 5. include practical exercises, role play and supervision. (2) A person shall be permitted to call himself a certified mediator if he has completed initial training as a mediator in fulfilment of the requirements of the statutory instrument pursuant to section 6. (3) Certified mediators shall undergo further training in accordance with the requirements of the statutory instrument pursuant to section 6"*. In Germany, there are university degrees in mediation. Trainings can be advance or basic. The Mediation Act indicates 120 hours as the minimum training for a certified mediator. Trainings are imparted by educational institutions; the number of hours vary from 120 to 450. There is a post-secondary level, on it, intercultural trainings are conducted by mediators with university degree. Within the framework of mediation or linguistic and integration mediation, community interpreter, integration facilitator, training programs are frequently available to non – professionals. Courses typically have a duration from 40 to 100 hours. Graduates become "ambassadors" of intercultural dialogue and function as multipliers.

3.1.3 Italy

In Italy, the role of intercultural mediators is within regional jurisdiction. A national law established a repertoire of professions in order to harmonize the different professional qualifications (Legislative Decree 276/2003). Intercultural mediation, as a tool to promote the integration of foreigners on the territory and the enhancement of diversity, is born with the Legislative Decree 286/1998. Moreover, the importance of intercultural mediation in integration processes is reiterated by the 2010 Integration Plan in Security. The Integration Plan highlights the need to include intercultural mediation within the social-healthcare services offered, "also through the recruitment of migrants already integrated in Italy" (Portale Integrazione Migranti, 2010). The theme of intercultural mediation is also included in specific legislative areas, where the presence of intercultural mediators is conceived as a useful tool to guarantee the efficiency and effectiveness of the provisions. The presence of intercultural mediators is foreseen, firstly, in the educational field, as a tool to support the educational role of school (Dipartimento per l'Istruzione, 2006). Provisions regarding the role of intercultural

mediator are also found in the health legislation, where they concern both the training of specialized mediators, and the presence of the same in hospital facilities in order to facilitate the removal of socio-cultural barriers and access health care (Law No. 7/2006 and the Ministry of Health Decree of December 17, 2007). Likewise it happens in the norms concerning the theme of the labour insertion of foreign populations and the policies aimed at the integration of foreign minors and second generations. Despite the references contained in the legislation on immigration and integration of migrants, at national level there is no organic legislation defining the profession of intercultural mediator. In order to fill this gap, an inter-institutional working group coordinated by the Ministry of the Interior was set up. At the end of the works, in December 2009, this working group identified the Guidelines for the recognition of the professional figure of the mediator intercultural (Ministero dell'Interno, 2009). This document offers a synthesis of the institutional legislative framework and of the experiences taking place in Italy. In April 2009, Regions and Autonomous Provinces approved the document 09/030/CR/C9 that provides a definition of intercultural mediator, establishing common guidelines in reference to areas of activity, skills and role. In this context, the document of CNEL Mediation and cultural mediators is brought to the attention operational indications proposing, for the basic training of intercultural mediator, a total number of hours of at least 600 hours, which should relate to communication, regulation and organization of services (Consiglio Nazionale dell'Economia e del Lavoro, 2009). The document also underlines the need to contemplate an articulation of disciplinary modules by sectors, according to the areas of employment. According to the document "Riconoscimento della figura professionale del mediatore interculturale"(Conferenza delle Regioni e delle Province Autonome, 2009) the cultural mediator is "*a social worker who facilitates communication between individuals, families and communities carries out mediation and information activities between immigrant citizens and the host society, promoting the removal of cultural and linguistic barriers, the enhancement of the culture of belonging, promoting the culture of reception, socio-economic integration and use of rights and compliance with the duties of citizenship*". The intercultural mediator is presented as an intercultural communication technician in Abruzzo ("*tecnico della comunicazione interculturale"*), an intercultural operator in the Autonomous Province of Bolzano ("*operatore interculturale*"), an operator in Campania ("*operatore*"), a social worker in Marche and Valle d'Aosta ("*operatore sociale*"), or a qualified social operator in Liguria ("*operatore sociale qualificato*"). Some Regions, as Puglia and Valle d'Aosta, also specify that the intercultural mediator is almost always non-Italian, or with an experience of a bicultural life, or preferably an immigrant (Ministero del Lavoro, 2009).

3.1.4 Spain

Sanchez-Perez in 2009 described intercultural mediation in Spain as a concept that appeared in the last decades as a necessity aiming at an optimal interaction between the indigenous population and those coming from technologically underdeveloped countries (Sanchez-Perez, 2009). It started from non-governmental organizations, universities, professional organizations, local and municipal authorities (social actors) and afterwards ended up in the administrative and academic field (García Castaño et al, 2004). The term of intercultural mediator in Spain appeared almost at the same time as immigration (as opposed to other countries with longer history of immigration) and became more systematic, mostly emphasizing on a professional profile with the appropriate training which has provided them

with the skills to acknowledge the cultural and social needs of different cultures and contribute to overcome situations of ignorance, conflicts of values or interests or the existence of inequalities that may appear among the distinct parts population (Richarte Vidal et al, 2008). In Spain although there is no single definition of the term "intercultural mediator", it is usually referred (Agrela, 2002; Urruela et al, 2012) as "a mode of intervention of third parties, in and about social situations with multicultural significance, oriented towards the achievement of the recognition of the Other and the approach of the parts, the communication and mutual understanding, the learning and development of coexistence, the regulation of conflicts and the institutional adequacy, between the social actors or institutions with ethno-cultural differences" provided by Gimenez et al 1997. Concerning the political and legal framework In Spain the Ministry of Interior recognized the "intercultural mediator" as a profession (Royal Decree 638/2000). The Royal Decree 1368/2007 released the National Catalogue of Professional Qualifications where six professional qualifications are established among the socio-cultural services, including community mediation. In the Catalogue, the general competence for Community Mediation is described as "*managing alternatives for resolving conflicts between people at community level, applying strategies and mediation procedures, facilitating and generating actions that facilitate the prevention of them*". Concerning the professional profile, it is mentioned that "*it operates in the planning and organization, and implementation of prevention and attention for collectives, groups and individuals for Alternative Conflict Management, preventing its occurrence and, once they exist, agreeing satisfactory arrangements for the parties involved through a mediation process*". The professional profile of intercultural mediator was recognized by the Information System of the Public Employment Service in Spain in February 2008. The latest legislative steps towards this issue was taken through the Organic Law 5/2012 for the mediation in civil and commercial matters as well as the Royal Decree 980/2013. This law regulates the general characteristics, basic principles and minimum standards of the mediation process (Aspioti et al, 2016)

In the framework of the "Training of Cultural Mediators utilizing new Social Networking Software – SONETOR" project, an "intercultural mediator" profile was generated after extensive research in various European countries including Greece, Poland, Ireland, Spain, and Austria (Aspioti et al, 2016). **Table 9** summarizes the knowledge, skills and competences of intercultural mediators' profiles in specific countries.

Table 9. Country-specific information regarding the knowledge base, skills and competences of cultural mediators.

IM PROFILE	AUSTRIA	BELGIUM	GERMANY	ITALY	POLAND	GREECE	PORTUGAL
KNOWLEDGE							
Professional specialization (medical law, education etc)		✓				✓	
Good knowledge of working language	✓	✓		✓	✓	✓	
Well informed on law						✓	
Knowledge of own boundaries			✓			✓	✓
Well informed about different languages that surround him	✓			✓		✓	✓
Good general knowledge						✓	

Understanding of administrative procedures and bureaucratic issues					✓	✓	
Work experience in the field/Aptitude	✓	✓	✓	✓	✓	✓	✓
Terminology/knowledge of the context	✓			✓		✓	✓
Conflict resolution	✓	✓		✓		✓	✓
Translation/Interpretation techniques		✓				✓	
Deontological rules	✓	✓	✓	✓	✓	✓	
SKILLS							
Good linguistic	✓	✓		✓	✓	✓	
Communicative-interpersonal	✓	✓			✓		✓
Capable of handling situations							✓
Pass the message	✓	✓					
Understanding of position of all parties involved			✓		✓		
Balancing between rights and duties							
Explain choices		✓					
Accuracy in body language use		✓			✓		
Follow deontological rules		✓					
Good note-taking skills		✓					
Staying "invisible"		✓					
COMPETENCES							
Objectivity	✓	✓	✓	✓	✓	✓	✓
Not get emotionally involved/Neutrality/Impartiality	✓	✓		✓	✓	✓	
Multipartiality			✓	✓	✓		
Sociocultural/religious/political sensitivities/awareness	✓	✓	✓				
Empathy	✓	✓	✓			✓	✓
Politeness					✓	✓	✓
Respectful				✓		✓	✓
Good listener	✓	✓			✓	✓	
Friendly personality					✓	✓	
Patience/no tensions/calmness/ability to deal with insults					✓	✓	
Make feel/secure relaxed					✓	✓	
Show sincerity						✓	
Show consistency/punctuality	✓					✓	
Sensitivity to injustice							✓
Not too distant/not too friendly						✓	
Reflect/Transfer emotions of patient	✓					✓	
Flexibility	✓					✓	
Low profile, quiet						✓	

Eager to help	✓	✓				✓	
Confidentiality/Data privacy		✓		✓		✓	✓
Ethical behavior				✓	✓	✓	
Foster in right decision		✓				✓	
Not a racist						✓	✓
No civil-servant mentality						✓	
Eagerness to learn constantly						✓	
Adapts language to the understanding level of the patient		✓					
Professionalism/Seriousness		✓				✓	
Efficiency		✓					

No tick means lack of adequate reference or information regarding this characteristics. Data were obtained from Aspioti et al, 2016.

4. Communication between health professionals and migrant/refugee children: identified knowledge gaps and needs

Comprehensive, coordinated, culturally and linguistically effective health care is highly demanded as regards to health provision to migrants/refugees. To this issue, migrant/refugee populations need to be provided with health information concerning many health-related issues. In this context, conditions that are specific to their origin country (i.e. dietary habits, traditions related to their culture, country-specific pattern of diseases), the journey (i.e. trauma, violence experience) and challenges in the hosting country (i.e. socioeconomic situation, housing, xenophobia) have to be considered with cautiousness by professionals who are in contact with this target group. In particular, successful integration of migrants/refugees to a European society is related with the access to appropriate and effective provision of health care services. This need is amplified in case of children since they are one of the most vulnerable subgroups within the migrant population. Hence, health and other relevant professionals must be provided with adequate knowledge and skills to achieve successful communication and health as well as social care services provision to migrant/refugee children taking into account the specialties from which this group is characterized (ISSOP, 2018). This need for training has been emphasised in the last report from the World Health Organization regarding the challenge to provide suitable health services to migrant/refugee populations, as follows (McGarry et al, pg 21, 2018);

- Provide training for health-care staff in working effectively with cultural mediators and interpreters in cross-cultural consultations with refugees and migrants;
- Ensure the use of professionals who have been trained and accredited for mediating and interpreting roles in health-care settings;
- Establish incident reporting systems in health-care settings where strategies to address communication barriers are being implemented;
- Encourage development of a combination of strategies, such as specific clinics and support services within a centre to support both health-care professionals and refugees and migrants in provision of effective health care

4.1 Frequently reported barriers by health care providers of migrant/refugee children

Several investigators around the globe have made attempts to identify the gaps and needs of health professionals, namely pediatricians, in relation to the appropriate and adequate health

care provision to migrant/refugee children. In a very recent publication regarding the health care system in the Netherlands, the main impediments reported by the pediatricians are presented as follows (Baauw et al 2018):

- Frequent relocations of migrant/refugee children: Relocation of migrant/refugee children to other asylum seekers centers has been linked with major problems to health care delivery mainly due to the limited continuity of information. This is largely attributed to missing of scheduled appointments as well as the lack of appropriately designed medical history which result in low compliance with life-saving treatments.
- Unknown medical history: The phenomenon for migrants/refugees to reach a country without any medical records from their country of origin is very common. This is considered as a significant barrier for health professionals who are usually based on oral information from children's families. This barrier is much higher when it comes to unaccompanied minors.
- Poor handoffs of medical records: Considering that the use as well as access of electronic patient databases is very limited to most health professionals, many children's medical records is lost.
- Poor health literacy: The communication between health professionals and patients is usually characterized by inadequate and poor understanding of the prescribed medicines and diagnosis by children and their families accompanied by the health professionals' medical errors attributed to language barriers, related with unidentified allergies, chronic diseases etc.
- Cultural differences: Culture-related background comes on the top of the rank as regards the determinants regarding the health care delivery to migrants/refugees, challenging medical communication. The inadequate knowledge base of health professionals regarding culture-dependent symptomatology or physical complaints result in lack of correspondence between the perceived health needs by pediatricians and children.

In line with the findings, another survey recently implemented in Germany, revealed that cultural/linguistic factors have been reported as the most frequent barrier to access health care; nevertheless, only four out of ten health care providers mentioned that they have access to professional interpreters and cultural mediators. What should be outlined here is that only two out of ten professionals reported that they had attended training on migrant/refugee children (Carrasco-Sanz et al, 2018).

Additionally, according to the American Academy of Pediatrics, health professionals and especially pediatricians that provide care to migrant/refugee children have to be adequately trained towards the following issues (Council on Community Pediatrics, 2013):

- Immunization
- Developmental surveillance and screening at regular intervals
- Psychoeducational evaluation
- Recognition of migrant/refugee children's health barriers as well as the traditional medication and therapeutic practices applied in the origin country
- Emotional, behavioral, mental and physical problems most frequently faced by migrant/refugee children
- Prerequisites for sufficient medical history
- Provision of culturally competent care: knowledge, attitude, and skill development in culturally and linguistically effective practices as well as cross-cultural communication
- Recognition of migrant/refugee children's academic performance to advocate for the child and encourage and help parents to obtain appropriate evaluation and intervention from the school system.

- Screening and diagnostic protocols for evaluating foreign-born children for infectious diseases and other medical conditions when providing car for newly arrived immigrant children. Additional screenings, including lead, vision, and hearing screenings, should be considered whether required for school entry or not.

4.2 Overarching challenges on health care provision to migrant/refugee children

4.2.1 Language barriers

Language barrier comes on the top of the rank when it comes to paediatric care of migrant/refugee children. Health professionals usually report that this is the main reason for ineffective health care provision and difficulties in building a trustful relation with the child patient and his/her family. The use of cultural mediators or professional interpreters is not recognized as the best practice to deal with this barrier. For instance, several health professionals claim this may be time-saving yet without long-term effectiveness compared with translated tools and materials (Jaeger et al 2013).

4.2.2 Cultural competence and communication

Health care providers of migrant/refugee children and their families need being trained on cultural-competence related issues and on health conditions which normally they are not accustomed to encountering. Pediatricians usually feel inadequately skilled to communicate and provide care to families from different ethnic and cultural backgrounds since they have insufficient knowledge background on their cultural beliefs and interpretation of health-related issues (Jaeger et al 2013). The provision of culturally competent care to pediatric patients needs considering the triangular relationship between the child, family members or caregivers, and provider, attention to family structure, different levels of acculturation within the family, and the care of ill siblings (Jaeger et al 2013).

4.2.3 Human trafficking

Another major problem when it comes to migrant/refugee children is related with human trafficking. In 2013-2014, EU countries reported 15,846 victims of human trafficking. About eight out of ten were women and girls while more than half aged below 25 years old. Two out of three registered victims were trafficked for sexual exploitation while the rest, for various types of forced labor, begging, organs removal or domestic servitude. The phenomenon of human trafficking has reached the attention of health care professionals, especially those who provide care to migrant/refugee children in hospital, emergency departments, community health centers, migrant refugee care centers and adolescent health care centers. Indeed, health care providers' area among the few professionals with a high likelihood to encounter human trafficking victims. Migration crisis in Europe has fostered child trafficking, especially when it comes to unaccompanied migrant/refugee children who are particularly defenseless (Hadjipanayis et al 2018). In 2015, more than 400,000 children applied for asylum in Europe, of whom two thirds were younger than 14 years of age. In addition, a quarter of these children were unaccompanied at the time of registration. During the same year, 250,000 children were reported as missing; 2% of these were unaccompanied migrant children who had disappeared from institutional care. The recognition, assessment, care, legal considerations and referrals to appropriate services regarding child trafficking should be an important part of healthcare professionals' education and training, since trained health professionals are more likely to identify an refer such victims; for instance, in a recent study it was revealed that health care providers in emergency centers that attend a short-term training program were more skilled to identify such victims and ensure their access to sufficient care and support (Grace et al 2014). The important role of health care professionals, namely pediatricians, as regards migrant/refugee children that are victims of human trafficking has been recognized by the EU strategy for the eradication of this condition (European Commission, 2012). One of the five pillars of this strategy is presented as follows:

"Enhancing coordination and cooperation among key stakeholders, promoting multi-sectorial and multidisciplinary approaches, and addressing the training needs of professionals

responsible for children (in addition to paediatricians, psychologists, GPs, social workers, educators, etc.)" (United Nations General Assembly, 2015). In September 2015, the agenda with the Sustainable Development Goals for 2030 was adapted. Among others the end of trafficking and violence against children as well as to all forms of violence and exploitation has been underscored. To address this need, adequate training of health professionals, namely pediatricians is of high Importance; to this effect, health care professionals should be trained on how to address cultural barriers and biases, how to facilitate the integration of victims into their new environment and how to address mental health sequelae of exploitation.

4.3 Adult vs. pediatric health care provision in migrant/refugee populations: special knowledge and skills demanded by health professionals

Considering the migration crisis in Europe within the last five years, various national and international initiatives have been performed towards the provision of training, educational resources and tools to address the health needs of migrant/refugee populations. However, it should be outlined that these are mostly adapted to adult health care provision. Nevertheless, the specialties of pediatric health care which discriminate the children from the adult migrant/refugee populations are inadequately covered. The most frequently reported –by health professionals– issues are presented as follows (Jaeger et al 2013):

- Different disease patterns (pediatric diseases)
- Different life stage
- Time constraints: admission often via emergency room, shorter hospitalizations, often immediate decisions required
- Health care planning by a multidisciplinary team
- Primary decision and responsibility by the family or care provider, yet not by the child
- Parents and care providers as the recipients of children's medical history
- The challenge of unaccompanied minors
- The challenge of human trafficking
- Different levels of language-related skills and acculturation in minors and parents: different resulting needs/views
- Communication skills to enhance empowerment of migrant/refugee children and their families
- Legislation matters

5. Validation and Accreditation Systems for trainings applied to health professionals

Table 1 Continuing Medical Education Validation/Accreditation					
	Target group	**Accreditation Institute**	**Institute Description**	**Useful link**	**Accreditation Criteria and Procedure link**
Europe	Medical professionals: physicians (with a special focus on pediatricians) and nurses	European Accreditation Council for Continuing Medical Education (EACCME)	The **European Union of Medical Specialists (Union Européenne des Médecins Spécialistes – UEMS)** is a non-governmental organization representing national associations of medical specialists in the European Union and in associated countries.	https://eaccme.uems.eu/ https://www.uems.eu	https://www.uems.eu/__data/assets/pdf_file/0016/40156/EACCME-2-0-CRITERIA-FOR-THE-ACCREDITATION-OF-LEE-Version-6-07-09-16.pdf
Greece	Medical professionals: physicians (with a special focus on pediatricians) and nurses	Panhellenic Medical Association		https://www.pis.gr/	https://www.pis.gr/images/site/100/1676_large/genikes_odhgies_gia_aithsh_ajiologhshs-moriodothshs_episthmonikvn_ekdhlvsevn_sie_new.pdf (in Greek)

Table 2 Vocational Education Training Validation/Accreditation					
	Target group	**Accreditation Institute**	**Institute Description**	**Institute link**	**Accreditation Criteria and Procedure link**
Europe	Medical professionals, psychologists, social workers, cultural mediators, aid workers	European Quality Assurance in Vocational Education and Training (EQAVET)	**EQAVET** develops and improves quality assurance in European VET systems within the context of the implementation of the European Quality Assurance Reference Framework.	eqavet.eu/	Link for each country's accreditation institution: eqavet.eu/What-We-Do/Implementing-the-Framework
Greece	Medical professionals, psychologists, social workers, cultural mediators, aid workers	National Organization for the Certification of Qualifications and Career Guidance, EOPPEP	**EOPPEP**, a legal entity under private law, supervised by the Greek Ministry of Education and Religious Affairs, acts as the National Euro guidance Centre of Greece, member of the Euro guidance Network (https://www.euroguidance.eu/ - European Network of National Resource and Information Centers for Guidance). Develops and implements the National Accreditation & Certification System for non-formal education, including initial and continuing vocational training and adult education, and provides scientific support to Vocational Guidance & Counseling services in Greece.	https://www.eoppep.gr/index.php/en/eoppep-en	https://www.eqavet.eu/Eqavet2017/media/Documents/2-EL_-final_Template-for-updating-info-on-the-EQAVET-website.pdf

Germany	Medical professionals, psychologists, social workers, cultural mediators, aid workers	1. Federal Institute of Vocational Education and Training (BIBB) 2. Accreditation and Certification in Further Training Ordinance (Akkreditierungs- und Zulassungsverordnung Arbeitsförderung, AZAV) 3. Weiterbildung Hessen	1. The national reference point of EQAVET in Germany, DEQA-VET, is hosted by the **Federal Institute for Vocational Education and Training (BIBB)**. A regular data collection undertaken by it. 2. Nationwide criteria for providers offering C-VET eligible for public funding are set out by **AZAV** and are underpinned by law. 3. Regional associations promoting transparency and issuing standards for quality assurance in C-VET (e.g. '**Weiterbildung Hessen**')	https://www.bibb.de/en/ https://azwv.de/ https://weiterbildungehessen.de/ *(available in German)*	https://www.eqavet.eu/Eqavet2017/media/Documents/2-DE_final_may-2016_updating-info-on-the-EQAVET-website.pdf
Spain	Medical professionals, psychologists, social workers, cultural mediators, aid workers	National Institute for Evaluation of Education (INEE)	EQAVET National Reference Point in Spain is established in the **Deputy Directorate General of Guidance and Vocational Education and Training in the Ministry of Education, Culture and Sport**. Departments of the Autonomous Communities are in charge of quality assurance and the certification processes. The **National Institute for Evaluation of Education (INEE)** carries out the general evaluation of the education system, based on the National System of Education Indicators. At regional level, each Autonomous Community has its own evaluation body responsible for the evaluation of the education	https://www.educacionyfp.gob.es/inee/portada.html	https://www.eqavet.eu/Eqavet2017/media/Documents/2-ES_final_Template-for-updating-info-on-the-EQAVET-website.pdf

			system in its territory, and also collaborates with the INEE.		
Italy	Medical professionals, psychologists, social workers, cultural mediators, aid workers	ISFOL (Istituto per lo sviluppo della formazione professionale dei lavoratori)	In Italy, the competent authorities for Quality Accreditation in Continuous VET are the Regions and Autonomous Provinces. The EQAVET national reference point **ISFOL**, informs national and regional stakeholders concerning quality assurance in vocational education and training systems and supports the implementation of the EQAVET work programmed for quality assurance.	http://www.isfol.it/en	https://www.eqavet.eu/Eqavet2017/media/Documents/2-IT-final_template-for-updating-info-on-the-EQAVET-website.pdf

Cyprus	Medical professionals, psychologists, social workers, cultural mediators, aid workers	1. Department of Secondary Technical and Vocational Education (STVE), based in the Ministry of Education and Culture (MoEC) 2. Human Resource Development Authority (HRDA) 3. Pancyprian Medical Association 4. Cyprus Nurses and Midwives Association.	The **Department of STVE** supervises and monitors providers and coordinates all relevant actions. It is responsible mainly for the quality assurance of IVET CVET is primarily managed by the **HRDA**. A harmonious collaboration that exists between them.	Human Resource Development Authority http://www.hrdauth.org.cy/ *(available in Greek)* Department of Secondary Technical and Vocational Education http://www.moec.gov.cy/mtee/en/	https://www.eqavet.eu/Eqavet2017/media/Documents/2-CY-_final_Template-for-updating-info-on-the-EQAVET-website.pdf

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Annex 1

Supplementary epidemiological data regarding migration in pediatric population, for Italy.

Italy represents an arrival country, especially by sea, through Central Mediterranean sea route. It's quite difficult to collect precise data: numbers are changing month by month and different sources sometimes adopt different method to count and list, or consider different periods. In addition, there are many countries of origin of accompanied and unaccompanied children, changing year by year (and month by month). Finally, there are more data available on unaccompanied children, who represent the largest percentage of children arriving and registered in Italy.
Data collected derived from different sources concerning last updates, also with comparison to last years, to have an idea of changes, with regard to number of arrivals by sea, number of children listed in Italy and hosted in reception facilities, ages and country of origin.

A. CHILDREN'S ARRIVAL BY SEA

Global data and comparison unaccompanied and accompanied children 2014-2016 (UNICEF, Rome, 2017)
2014: 26,122
2015: 16,478
2016: 28,223
% children in overall migrants
2013: > 19%
2014: 15%
2015: 11%
2016: 16%
% unaccompanied in overall migrant children
2011: 94%
2012: 88% (of 2,279 children)
2014: 50% (13,026 unaccompanied children and 13,096 accompanied children)
2015: 75% (12,360 unaccompanied children)
2016: 92% (25,846 unaccompanied children)
Number of migrant children arriving in 2017 (Save the Children, Rome, 2018)
17,337 children arrived by sea, almost 11,000 less than 2016. Unaccompanied children were 15,779, 91% of overall migrant children and 13,2% of overall migrants.
Country of origin unaccompanied children

	2016	**2017**	**Comparison**
Guinea	2,406	1,904	- 20.8%
Côte d'Ivoire	1,729	1,646	- 4.8%
Gambia	3,257	1,417	- 56.5%
Bangladesh	1,053	1,312	+ 24.6%
Nigeria	3,040	1,228	- 59.6%
Eritrea	3,832	1,219	- 68.2%

Mali	1,390	993	- 28.6%
Somalia	1,584	964	- 39.1%
Senegal	1,179	753	- 36.1%
Syria	220	568	+ 158.2%
Tunisia	51	544	+ 966.6%

Other countries of origin (2017)

Sudan	505
Iraq	389
Ghana	326
Morocco	325
Pakistan	250
Libya	216
Sierra Leone	191
Cameroon	188

January-November 2018 (UNHCR, 2018)

4,216 children (18% of overall arrival)

- 3,485 unaccompanied (15% of overall arrival)
- 731 accompanied (3% of overall arrival)

Unaccompanied children arriving in Italy (update 2 January 2019) (Ministero del Lavoro e delle Politiche Sociali, 2019)

Year 2016: 25,846 (UNICEF, Rome, 2017)

Year 2017: 15,779

Year 2018: 3,536

B. ASYLUM SEEKERS IN PEDIATRIC POPULATION

Asylum Data (2016-2017) (Ministero dell'interno, 2018)

Unaccompanied children

2016: 5,930

2017: 9,782

Accompanied children

2016: 5,201

2017: 6,527

Asylum seekers 2017 (AIDA, ECRE, 2017)

Children: 16,309 (12.5% total number of applicants)

Unaccompanied children: 9,782 (7,5% total number of applicants)

Asylum seekers unaccompanied children 2014: 2,500 (2017 versus 2016: + 73.5%). (ISMU, Milan, 2018)

Nationality unaccompanied asylum-seeking children 2017 (AIDA, ECRE, 2017)

Gambia	2,090
Nigeria	1,166
Bangladesh	1,113
Guinea	996
Senegal	841
Mali	774
Côte d'Ivoire	742

Eritrea	580
Ghana	388
Others	1,092
Total	9,782

1 January-30 June 2018 (Ministero del lavoro e delle politiche sociali, 2018 June)

2,857 unaccompanied children applied for asylum (International protection), 92% male (2,637).

Country of origin N (%) (Ministero del lavoro e delle politiche sociali, 2018 June)

Gambia	531 (18.6)
Nigeria	307 (10.7)
Mali	284 (9.9)
Guinea	282 (9.9)
Senegal	250 (8.8)
Bangladesh	237 (8.3)
Côte d'Ivoire	225 (7.9)
Eritrea	128 (4.5)
Pakistan	114 (4.0)
Others	499 (17.5)
Total	2,857 (100)

1 January-1 October 2018 (ISMU, Milan, 2018)

Asylum seekers unaccompanied children requests: 3,343, 7.6% overall asylum seekers requests.

C. CHILDREN LIVING IN ITALY

Unaccompanied children (31 December 2017) (Save the Children, Rome, 2018; Ministero del lavoro e delle politiche sociali, 2017)

18,303 unaccompanied children were present and listed in Italy (+ 5.3% compared to 2016, n=17,373; in 2012 n=5,821), of which 17,056 males (93.2%) and 1,247 females (6.8%).

Children living in reception facilities up to the attainment of 18 years of age:

- 90.8% were hosted in reception facilities
    - ° 5,605 children (30.6%) in first reception centres
    - ° 11,022 children (60.2%) in second reception centres

Only 3,1% living in private families.

Ages of unaccompanied children (present and listed in 2017) (Save the Children, Rome, 2018; Ministero del lavoro e delle politiche sociali, 2017)

0-6 years old: 116 (0.6%) (83 males; 33 females)

7-14 years old: 1,113 (6.1%) (955 males; 158 females)

15 years old: 1,760 (9.6%) (1,611 males; 149 females)

16 years old: 4,279 (23.4%) (4,016 males; 263 females)

17 years old: 11,035 (60.3%) (10,391 males; 644 females)

(15-17 years old: 17,074)

Unaccompanied children 0-14 years old 2012-2017 (% in the year) (Save the Children, Rome, 2018)

2012: 511 (6.8%)

2013: 619 (9.8%)

2014: 979 (9.3%)
2015: 939 (7.9%)
2016: 1,326 (7.7%)
2017: 1,229 (6.7%)

Country of origin of unaccompanied children present and listed 2017 (Ministero del lavoro e delle politiche sociali, 2017)

Gambia	2,202 (12%)
Egypt	1,807 (9.9%)
Guinea	1,752 (9.6%)
Albania	1,677 (9.2%)
Eritrea	1,459 (8.0%)
Côte d'Ivoire	1,388 (7.6%)
Nigeria	1,274 (7.0%)
Mali	1,071 (5.9%)
Senegal	1,006 (5.5%)
Bangladesh	860 (4.7%)
Somalia	837 (4.6%)
Pakistan	392 (2.1%)
Afghanistan	353 (1.9%)
Ghana	314 (1.7%)
Kosovo	296 (1.6%)
Morocco	256 (1.4%)
Tunisia	251 (1.4%)
Sudan	169 (0.9%)
Sierra Leone	108 (0.6%)
Cameroun	99 (0.5%)
Etiopia	92 (0.5%)
Burkina Faso	90 (0.5%)
Guinea Bissau	73 (0.4%)
Benin	62 (0.3%)
Algeria	52 (0.3%)
Syria	40 (0.2%)
Togo	33 (0.2%)
Niger	30 (0.2%)
Iraq	29 (0.2%)
Ciad	26 (0.1%)
Liberia	25 (0.1%)
Libya	22 (0.1%)
Congo	21 (0.1%)
Ucraina	15 (0.1%)
Brasile	15 (0.1%)
Moldova	11 (0.1%)
Iran	10 (0.1%)
Others	86 (0.5%)

Unaccompanied children (30 June 2018) (Ministero del lavoro e delle politiche sociali, 2018 June)

According to the Ministry of Labour Report (update at 30 June 2018), data concerning presence of unaccompanied children in Italy are slightly different, but analysis has been done considering a time frame of the year.

Unaccompanied children (30 June 2018): 13,151

Males: 12,169 (92.5%)

Females: 982 (7.5%)

34.0% in first reception centre (4,476), 54,7% in second reception centre (7,190), 3,9% with private (compatriots, relatives, families; 517) and 7,4% no information (968).

Comparison unaccompanied children 30 June 2016-2017-2018 (Ministero del lavoro e delle politiche sociali, 2018 June)

- unaccompanied children (30 June 2016): 12,241
- unaccompanied children (30 June 2017): 17,864
- unaccompanied children (30 June 2018): 13,151 (- 26.4% versus 30 June 2017; + 7.4% versus 30 June 2016)

Age of unaccompanied children living in Italy in different years (Ministero del lavoro e delle politiche sociali, 2018 June)

	30 June 2016	30 June 2017	30 June 2018
0-6 years old	17 (0.1%)	92 (0.5%)	104 (0.8%)
7-14 years old	945 (7.7%)	1,157 (6.5%)	845 (6.4%)
15 years old	1,222 (10%)	1,687 (9.4%)	1,172 (8.9%)
16 years old	3,414 (27.9%)	4,227 (23.7%)	3,315 (25.2%)
17 years old	6,643 (54.3%)	10.701 (59.9%)	7,715 (58.7%)
Total	12,241 (100%)	17,864 (100%)	13,151 (100%)

Principal countries of origin 30 June 2018 (Ministero del lavoro e delle politiche sociali, 2018 June)

Albania	1,517
Gambia	1,353
Egypt	1,225
Guinea	1,153
Côte d'Ivoire	1,081
Eritrea	953
Nigeria	879
Mali	748
Senegal	624
Somalia	542
Tunisia	441

Comparison countries of origin 30 June 2016-2017-2018 (Ministero del lavoro e delle politiche sociali, 2018 June)

	30 June 2016	30 June 2017	30 June 2018
Albania	1,396 (11.4%)	1,639 (9.2%)	1,517 (11.5%)
Gambia	1,511 (12.3%)	2,474 (13.8%)	1,353 (10.3%)
Egypt	2,572 (21.0%)	2,093 (11.7%)	1,225 (9.3%)
Guinea	535 (4.4%)	1,656 (9.3%)	1,153 (8.8%)

Côte d'Ivoire	539 (4.4%)	1,284 (7.2%)	1,081 (8.2%)
Eritrea	872 (7.1%)	1,106 (6.2%)	953 (7.2%)
Nigeria	757 (6.2%)	1,429 (8.0%)	879 (6.7%)
Mali	517 (4.2%)	928 (5.2%)	748 (5.7%)
Senegal	582 (4.8%)	949 (5.3%)	624 (4.7%)
Somalia	634 (5.2%)	700 (3.9%)	542 (4.1%)
Tunisia	65 (0.5%)	82 (0.5%)	441 (3.4%)
Total	9,980 (81.5%)	14,340 (80.3%)	10,516 (80%)

Unaccompanied children (30 November 2018) (Ministero del lavoro e delle politiche sociali, 2018 November)

Unaccompanied children: 11,339

Males: 10,506 (92.7%)

Females: 833 (7.3%)

Ages of unaccompanied children living in Italy 30 November 2018 (Ministero del lavoro e delle politiche sociali, 2018 November)

0-6 years old: 87 (0.8%)

7-14 years old: 707 (6.2%)

15 years old: 922 (8.1%)

16 years old: 2,833 (25.0%)

17 years old: 6,790 (59.9%)

Total: 11,339 (100%)

(15-17 years old: 10,545)

Countries of origin unaccompanied children present and listed 30 November 2018 (Ministero del lavoro e delle politiche sociali, 2018 November)

Albania	1,550 (13.7%)
Gambia	994 (8.8%)
Egypt	959 (8.5%)
Guinea	865 (7.6%)
Côte d'Ivoire	848 (7.5%)
Eritrea	792 (7.0%)
Mali	635 (5.6%)
Nigeria	632 (5.6%)
Pakistan	566 (5.0%)
Senegal	548 (4.8%)
Somalia	479 (4.2%)
Tunisia	379 (3.3%)
Kosovo	333 (2.9%)
Bangladesh	324 (2.9%)
Afghanistan	309 (2.7%)
Morocco	213 (1.9%)
Ghana	149 (1.3%)
Sudan	105 (0.9%)
Sierra Leone	88 (0.8%)
Burkina Faso	54 (0.5%)
Cameroon	54 (0.5%)

Etiopia	41 (0.4%)
Guinea Bissau	37 (0.3%)
Iraq	37 (0.3%)
Benin	34 (0.3%)
Syria	30 (0.3%)
Algeria	24 (0.2%)
Liberia	18 (0.2%)
Ucraina	17 (0.1%)
Tchad	17 (0.1%)
Niger	17 (0.1%)
Bosnia-Erzegovina	16 (0.1%)
Congo	16 (0.1%)
Brasile	14 (0.1%)
Moldova	13 (0.1%)
Libya	13 (0.1%)
Turchia	12 (0.1%)
Others	107 (0.9%)
Total	11,339 (100%)

D. CHILDREN LOST

Unaccompanied children lost (nowhere to be found)

31 December 2017 (Save the Children, Rome, 2018)

5,828 children (6,561 at 31 December 2016), 5,223 males (89.6%) and 605 females (10.4%).

0-6 years old: 12 (0.2%)

7-14 years old: 1,168 (20%)

15 years old: 1,329 (22.8%)

16 years old: 3,021 (51.8%)

17 years old: 298 (5.1%)

(15-17 years old: 4,648)

Considering only the year 2017, 2,440 children were nowhere to be found.

30 June 2018 (Ministero del lavoro e delle politiche sociali, 2018 June)

4,677 children

Data for **Annex 1** were obtained from the following resources:

AIDA (Asylo Information Database), ECRE, European Council on Refugees and Exiles (2017). Country report Italy. Update 2017.

Ministero del Lavoro e delle Politiche Sociali (2019, January 2). Report statistici mensili - Minori Stranieri Non Accompagnati (02 January 2019). From Ministero del Lavoro e delle Politiche Sociali website: http://www.lavoro.gov.it/temi-e-priorita/immigrazione/focus-on/minori-stranieri/Pagine/Dati-minori-stranieri-non-accompagnati.asp;

http://www.interno.gov.it/sites/default/files/cruscotto_giornaliero_02-01-2019.pdf

Ministero dell'interno, Dipartimento per le libertà civili e l'immigrazione (2018, November). I numeri dell'asilo. From Ministero dell'interno website:

http://www.libertaciviliimmigrazione.dlci.interno.gov.it/it/documentazione/statistica/i-numeri-dellasilo

Save the Children (2018). Atlante minori stranieri non accompagnati Italia. Rome, Italy. (https://www.savethechildren.it/press/giornata-del-migrante-save-children-effetto-del-dl-sicurezza-forte-rischio-i-minori-stranieri)

UNHCR (2018, December 30). Italy weekly snapshot - 30 Dec 2018. From Reliefweb website: https://reliefweb.int/sites/reliefweb.int/files/resources/67444.pdf

UNICEF Italia, CNR-Irpps (2017). Sperduti. Storie di minorenni arrivati in Italia. Rome, Italy.