

Ensuring the Right of Migrant Children to Health Care: The Response of Hospitals and Health Services

International Organization for Migration (IOM)

Background Paper

*Developed within the framework of the IOM project
"Assisting Migrants and Communities (AMAC): Analysis of
Social Determinants of Health and Health Inequalities"
Co-funded by the European Commission DG Health and Consumers' Health Programme,
the Office of the Portuguese High Commissioner for Health and IOM*



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Executive Summary

In a context of migration of children, how do hospitals and health services respond to the needs and rights of children within the wider framework of child protection and healthcare provision? This paper deals with the response of hospitals and healthcare services to the right of migrant children to healthcare in relation to the provisions of the Convention on the Rights of the Child and the holistic concept of health. On the one hand, the Convention on the Rights of the Child provides a comprehensive and complex framework of protection for all children around the world in all their life settings. On the other hand, the concepts of health and healthcare have evolved in the last decades and hospitals and health services are called to include, not only preventive, curative and palliative care, but health promotion activities as well.

Moreover, hospitals and health services are called to empower patients and enable them to gain control of their own health and to address the social determinants of health. The paper presents the contribution of the Task Force on Health Promotion for Children and Adolescents in and by Hospitals and Health Services in ensuring the respect of children's rights in hospitals, and provides examples of good practices by hospitals and health services in Europe in relation to challenges posed to the community, hospital management and health professionals. Finally, four case-studies are presented to discuss in further detail what is being done and what can be learned from those experiences.



Conceptual and legal framework for the respect, protection and fulfilment of migrant children's right to healthcare

The first section of this paper aims to set the conceptual and legal framework upon which to present and understand the response of hospitals and health services in ensuring the right of migrant children to healthcare. The first sub-section provides a definition of migrant children; a second sub-section provides an interpretation of Article 24 of the Convention on the Rights of the Child (hereafter the Convention) and its general principles, which will be particularly important in order to understand what will be meant by 'healthcare' and to understand the framework of protection of children's rights in hospital; the final sub-section makes reference to some relevant international strategies and recommendations available to guide the work of hospitals and health services.

Definition of migrant children

For the purpose of this paper and as set out in Article 1 of the Convention, children will be considered from birth until aged 18.

The overall phenomenon of migration is complex and happens for various reasons. It may take place between the territory of a given State, between States or even across States and Continents. Because of this complexity, providing a definition of the different status of the groups that arrive and live in host countries is also challenging. It is the same for both adult and child migrants. Child migrants can travel with migrant workers; be either long or short-term migrants; be second generation migrants, having being born and raised in the host country; be asylum seekers or refugees; accompanied, unaccompanied or separated from their families or parents; and documented or undocumented.

Providing some detailed definitions is important. The Special Rapporteur of the United Nations (UN) Commission on Human Rights proposes the following definition of migrant persons:

- a) "Persons who are outside the territory of the State of which they are nationals or citizens, are not subject to its legal protection and are in the territory of another State;
- b) Persons who do not enjoy the general legal recognition of rights which is inherent in the granting by the host State of the status of refugee, naturalised person or similar status;
- c) Persons who do not enjoy either general legal protection of their fundamental rights by virtue of diplomatic agreements, visas or other agreements (Pizarro, 2002)."

Additionally, the Committee on the Rights of the Child defines unaccompanied children (also called unaccompanied minors), as children "as defined in Article 1 of the Convention, who have been separated from both parents and other relatives and are not being cared for by any adult who, by law or custom, is responsible for doing so (CRC, 2005)." And by separated children, it understands "children, as defined in Article 1 of the Convention, who have been separated from both parents, or from their previous legal or customary primary caregiver, but not necessarily from other relatives. These may, therefore, include children accompanied by other adult family members (*ibidem*)."

For the purpose of this paper, the term migrant children will include: unaccompanied and separated children; children 'who are outside the territory of the State of which they are nationals or citizens', and may or may not have legal status in the host/receiving State (also referred to as undocumented or irregular migrants); second generation migrant children, who were born in the host country, may or may not have the nationality of the host State and whose parents are migrant persons; refugee children and asylum seekers'. In some countries where there is centuries' long tradition of receiving migrants, i.e. the United Kingdom (UK), third and fourth generation migrants are referred to as 'Ethnic Minorities'. Although these population groups differ in status and features, they often share common challenges in relation to their right to healthcare. For this reason, where relevant, children belonging to Ethnic Minorities will be considered.

UN Convention on the Rights of the Child and migrant children's right to healthcare

Health is defined in the World Health Organisation (WHO) Constitution of 1948 as 'a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity', to which later was added the 'spiritual' component (*See Appendix 1 for the full definition of health according to WHO*). For the purpose of this paper, health will be understood as a component of the realisation of one's full human potential, as expressed in the Ottawa Charter on Health Promotion (WHO, 1986):

"Within the context of health promotion, health has been considered less as an abstract state and more as a means to an end which can be expressed in functional terms as a resource which permits people to lead an individually, socially and economically productive life. Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities (WHO, 1998)."

Healthcare, on the other hand, will be understood as the provision

of preventive, curative and palliative and health promotion services. For the purpose of this paper, healthcare will be considered as one element towards the realisation of migrant children's full human potential, which cannot be separated from empowerment for health, children's personal assets (Morgan and Ziglio, 2007) and the social determinants of health (CSDH, 2008). The Convention as a whole and, in particular, Article 24 and the general principles of the Convention, follow this reasoning.

In relation to the Convention, two concepts are fundamental in order to understand how and why it is the best framework for the protection of all children, and in particular of vulnerable children: the holistic nature of the Convention and the fact that children's rights are indivisible and interrelatedⁱⁱ. Indeed, the Convention does not categorise or provide a hierarchy of rights, meaning that it is not possible to fulfil one right, whilst neglecting other rights contemplated in the Convention; it calls upon States to take immediate actions for the realisation of *all* rights, as well as to maintain efforts that continue in time. Furthermore:

"The holistic approach of the Convention addresses human rights while placing the child at the centre of its considerations. This child-focused perspective guides its call for action and progress towards the realisation of all the rights of the child, and stresses that the best interests of the child should always be a guiding reference (Santos Pais, 1999)."

The holistic nature of the Convention also calls upon States to promote a multi-disciplinary and cross-sectoral perspective in the policies and actions implemented.

a) Article 24 - right to the highest attainable standard of health

(See Appendix 2 for the full text of Article 24 and the general principles of the Convention)

The right to the highest attainable standard of health draws from the provisions from the International Bill of Human Rightsⁱⁱⁱ, as well as the definitions and principles of organisations such as WHO and the United Nations Children's Fund (UNICEF). The holistic nature of the Convention and the interpretation of the Committee on the Rights of the Child, stress the connections between the right to health and the child's right to an adequate standard of living (Article 27); to education (Article 28); to protection from all forms of physical or mental violence (Article 19); the respect for the views of the child (Article 12); and respect for children's evolving capacities (Article 5) (Hodgkin and Newell, 2007). Components of the right to health include: accessibility, health education, preventive and primary healthcare, fam-

ily planning and education and abolition of traditional practices that are harmful to children's health. Finally, the right to health should be understood and implemented in light of the general principles of the Convention, as discussed below.

b) General principles (Articles 2, 3, 6 and 12)

Article 2 – right to non-discrimination

When interpreting the right to health in light of Article 2 of the Convention, it must be highlighted the obligation of States to, on one hand, respect the right to health by refraining from adopting measures that may prevent migrant children from exercising their right to health (i.e. laws obliging health professionals to report undocumented migrants to local authorities), as well as, by refraining from violating that right directly. On the other hand, the obligation to ensure implies an affirmative and immediate obligation to take up all necessary measures to enable children to enjoy and exercise their right to health. The fact that the Convention applies to all children *within the jurisdiction of the State* means that all migrant children, regardless of their status, have the right to exercise their rights on an equal basis as indigenous children. This Article also puts forward one of the main principles of the convention, that of non-discrimination:

"(...) it may be considered that non-discrimination means that no child should be injured, privileged, punished or deprived of any right on the ground of his or her race, colour, sex, religion, political or other opinion, national, social or ethnic origin, property, disability, birth or other status. This principle implies therefore that girls and boys, rich or poor children, living in urban or rural areas, belonging to a minority or indigenous group should be given the opportunity of enjoying the same fundamental rights as recognized by the Convention (UN, 1997)."

Hospitals and health services are, therefore, called to take positive actions, where necessary, to address the needs and rights of specific groups of children such as all migrant children, namely through public awareness campaigns and training of health staff. Indeed, the Committee on the Rights of the Child emphasises that:

"This principle, when properly understood, does not prevent, but may indeed call for, differentiation on the basis of different protection needs such as those deriving from age and/or gender (CRC, 2005)."

Article 3 – the best interests of the child

The second general principle of the Convention implies that within the hospital setting, the provision of healthcare for all migrant children should be done in the best possible and available manner to their benefit. The best interest of the child shall be considered in all actions affecting his or her well-being *and* as being different from child to



child, in accordance to their specific situation, including health and migration status, cultural background and particular individual needs, as well as, in light of the other provisions of the Convention.

Furthermore, this right entails that governments, through legislation and practice at hospital and health service level, must establish effective mechanisms to monitor children's well-being and the realisation of their rights. In the present case, hospitals and health services should attempt to ensure the implementation of guidelines coming from international organisations such as WHO and UNICEF; to set up monitoring and evaluation mechanisms to assess the respect, protection and fulfilment of migrant children's right to healthcare, including assessment of their health status and to take up appropriate response to their specific needs.

Finally, it is important to mention that in the provision of healthcare, at times it may be complex to define *the best interest of the child*. Health professionals should try to define it in a participatory way with the child and his or her parents and/or family.

Article 6 – right to life, survival and development

Under Article 6, States Parties recognise children's *inherent* right to life and are obliged to ensure their survival and development to the maximum extent of their resources. Within the hospital setting, it is crucial that systems are in place to ensure that there are no barriers in the access to healthcare, especially in the case of undocumented migrant children. Where necessary, hospitals and health services should promote affirmative actions that ensure that no child within the jurisdiction of the State is prevented from access and to provide the best possible and culturally-appropriate healthcare, meaning services that are "respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements (CESCR, 2000)." Furthermore, the right to life, as well as the right to health, is not only about ensuring the survival of children, but also to provide services that ensure the realisation of a child's physical, mental, cultural, social and spiritual well-being and their full human potential.

Article 12 – right to express views freely

Article 12 highlights the importance of enabling hospitalised children to express their opinion on all matters affecting treatment and hospitalisation, in accordance to their evolving capacities. This Article should be read together with Article 13 (right to freedom of expression), which implies that hospitals and health services have an obligation to provide health information, in a manner that is adequate to the child's developmental level, age and maturity, in order to enable children to have an informed view and to allow them to express their views freely. Marta Santos Pais further affirms that:

"It is not sufficient to allow children to express their views. The point of Article 12 is that these views to be duly taken into consid-

eration. (...) Children's views should not be simply ignored, nor automatically endorsed, but should genuinely be able to influence the decision to be taken. (...) Combining assistance, direction and guidance with respect for the views of the child, giving the child the opportunity and capacity to understand why a particular option, and not another, was followed, why a particular decision was taken and not another one the child might have preferred (UN, 1997)."

Ensuring migrant children's right to express their views freely in the hospital setting, may also call for the provision of a strong and supportive environment, child-friendly complaints' procedures, as well as, staff with appropriate cultural and language competence and /or family/patient councils. In relation to the attainment of the highest standard of health, the process of enabling children to express their views, to inform them appropriately and to involve them in all health matters affecting them is essential in the empowerment of the child in exercising control over his or her own health, well-being and personal realisation.

Other relevant international instruments and recommendations for the protection and promotion of migrant children's right to health

The Resolution of the Sixty-first Session of the World Health Assembly (WHA, 2008) and the Report of the WHA's Secretariat (WHA, 2008) on the 'Health of Migrants', together with the Resolution of the WHO Executive Board on 'Reducing health inequities through action on the social determinants of health' (WHO, 2009) put forward important implications for international agencies and national health systems in ensuring the respect of migrant children to healthcare. The following considerations are an interpretation of the three documents stated above:

- International agencies have the duty to assist national healthcare systems in ensuring the right of migrant children to healthcare, by providing strategies, models and tools to facilitate action at national and local level;
- WHO Member States have the duty to address the social determinants of health through declarations, information and awareness raising on the needs and rights of particularly vulnerable groups of the population, such as migrant children, children with disabilities and children experiencing poverty;
- WHO Member States have the duty to ensure that national and regional healthcare systems and, in particular, hospitals and health services, address migrant children's right to healthcare;
- WHO Member States have the duty to facilitate monitoring and evaluation mechanisms on the respect of migrant children's right to healthcare and the realisation of their rights in hospital by taking into account age, gender, ethnicity, education, employment and socio-economic status;

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- Healthcare systems are a social determinant of health, to acknowledge this implies an appropriate allocation and distribution of resources and services in an equitable manner.
- Hospitals and health services have the duty to empower migrant children and their families, by promoting knowledge and awareness on migrant children's rights;

The WHO Regional Office Strategy on Child and Adolescent Health and Development (WHO, 2005), in particular, through its tool kit, provides specific guidelines for actions by governments and sectors. Regarding migrant children's right to healthcare, the following are particularly relevant examples:

- To collect accurate, recent and disaggregated data for evidence-based planning and implementation in 'an equitable population-based approach', which should include collecting data for special groups of the population, namely 'asylum seeking, immigrant within the last 5 years, illegal immigrant, refugee, homeless (refugee and indigenous), ethnic group, etc';
- To provide mother and baby-friendly environment and practices;
- To adopt a life-cycle approach in planning and implementation of healthcare;
- To address key issues such as gender and culture-sensitive health services, inequality or equality of the involvement of partners in behavioural change, parenthood and the influence of mothers, parents and children's cultural background.

Summary

The concept and provision of healthcare goes beyond medical assistance in terms of preventive, curative and palliative services, to include health promotion activities, migrant children's personal assets, their empowerment and ability to exercise control over their own health and realisation of their full potential, as well as the social determinants of health. The Convention provides a useful protection framework to guide the work of hospitals and health services in respecting migrant children's rights and ensuring that such services are provided. Hospitals and health services must ensure that all children have access to healthcare services and that their rights are respected, protected and fulfilled in the hospital. In particular, hospitals and health services have the duty to ensure the realisation of children's rights in a holistic manner and not in a *right by right* approach. Finally, the international guidelines highlight the need for governments and national health systems to recognise and address the specific needs of vulnerable groups of the populations; to put in place implementation and monitoring systems that contribute to their empowerment; and to address the social determinants of health towards an equitable health for all migrant children.



The role of hospitals and health services in respecting migrant children’s right to healthcare

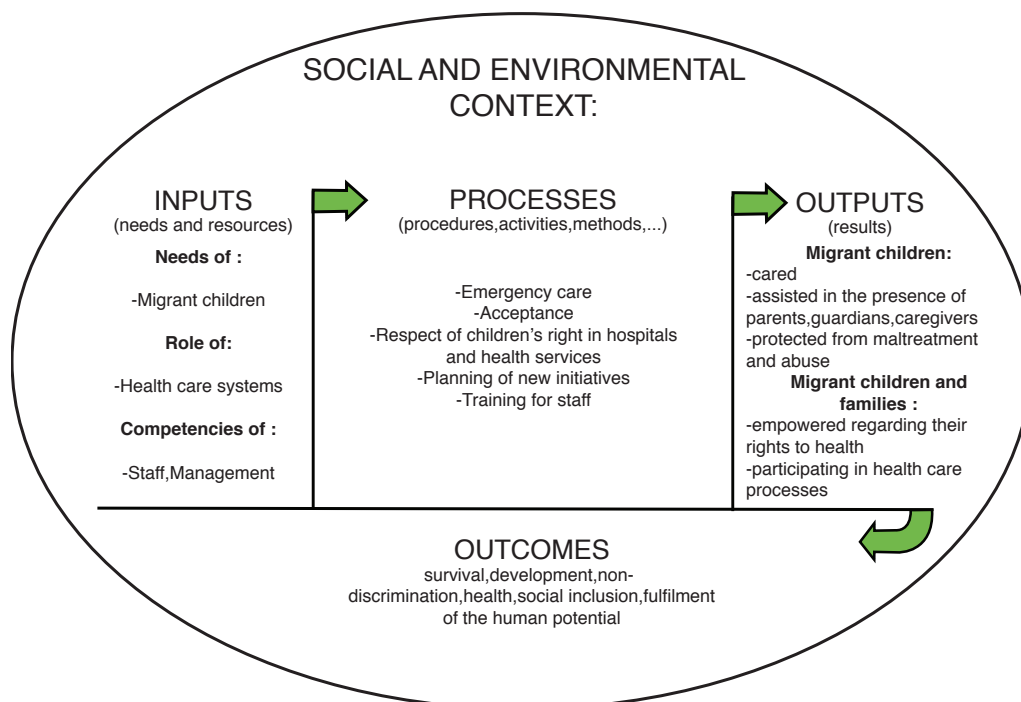
Hospitals and health services should provide *high quality* services of health promotion, prevention, treatment and care. In their programmes, they should also consider the different life settings of children and adopt partnerships and protocols with governmental and non-governmental actors at community/local level, as appropriate. The so-called youth-friendly clinics and adolescent-friendly health services and the baby-friendly hospital initiatives provide valuable examples of how this can be achieved. Child-friendly services bring together the qualities that young people demand and need, with the highest possible standard of service provision. Additionally, migrant-friendly hospitals provide services and a work culture that address the needs and rights of migrants.^v This section of the paper discusses what the role of hospitals and health services is in respecting migrant children’s right to healthcare, in two ways. Firstly, the general role of hospitals in health services in a social context of migration is presented. Secondly, this section highlights four different aspects of migrant children’s right to healthcare: the different health dimensions; children’s right to information and participation and children’s right to be protected from all forms of violence. Under each section, specific examples of what hospitals and health services could ensure are given.

The role of hospitals and health services in a context of child migration

The quality and standard of the healthcare provided by hospitals and health services is dependent upon the context where they are inserted and follows a logic of response to the context, with its needs and resources (input); implementing actions, procedures and activities to respond to those needs (processes); followed by immediate results (outputs); and long-term effects in the context (outputs). Figure 1 presents a representation of the response of hospitals and health services in a context of child migration.

As seen in Figure 1, responding to the right of migrant children to healthcare entails recognising and understanding the needs of migrant children, having health and management staff with the appropriate competencies and healthcare systems with the adequate resources allocated. The process of responding to these inputs involves activities of healthcare provision, respect of children’s rights in hospital, planning of activities and training for staff. The outputs include children’s immediate response to treatment, the realisation of their rights in hospital (i.e. the ability to have the presence of their parents at all times), empowerment for health and participation in healthcare

Figure 1. The role of hospitals and health services in a context of child migration^{iv}



processes. Outcomes include change at wider and long-term individual and social levels, namely survival and development of children, social inclusion and fulfilment of their human potential.

Ensuring migrant children's right to healthcare in hospitals and health services

a) Health dimensions

The concept of health as proposed by WHO and the health promotion strategies as proposed in the Ottawa Charter highlight that healthcare cannot respond solely to the physical needs of patients. Good health and, in particular, healthy development and the realisation of the human potential entail the realisation of all dimensions of health: physical, mental, cultural, social and spiritual. This sub-section draws considerations and examples of how hospitals and health services should take into account migrant children's dimensions of health when providing healthcare services.

Physical dimension

All children should have access to the best available healthcare without discrimination. This requires hospitals and health services to know of and understand the needs of different groups of the population, in particular those more at risk of communicable and non-communicable diseases, poor nutrition and those more exposed to other risks, which may influence their health negatively. To provide the best possible standard of healthcare, services must be informed about the health status of different groups of migrant children, to be aware of cultural habits that may influence treatment (i.e. fasting during Ramadan) and to be committed to reach out to children for screening and vaccination purposes in schools or other social settings.

Mental dimension

Hospitals and health services should provide counselling to all children. Accessibility of counselling to migrant children may mean having to provide language and culturally-competent staff and staff trained in dealing with post-traumatic disorders and that are sensitive about the experiences and mental health conditions that some children may have suffered. Children should also be involved in their treatment process in a way that they understand what their health condition is, what it means, how it will affect their life and how to manage it. This is both fundamental for the children to gain control in the management of their health, but also in contributing to their mental well-being.

Cultural dimension

For Webb and Sergison, cultural competence is:

"An evolving process that depends on self reflection, self awareness, and acceptance of differences, and is based on improved understanding as opposed to an increase in cultural knowledge (Webb and Sergison, 2003)."

To take into account the cultural dimension of health means to consider a patient's cultural background, beliefs and values, not to necessarily *know* the patient's cultural, but to *accept* that it is different and to respect it. For the hospital and health services this entails adopting proactive measures, such as providing different or ethnic menus and cultural mediators.

In addition to this, practitioners should be aware of cultural practices, such as Female Genital Mutilation (FGM), which may be relevant to all groups of migrant children, either newly arrived or children that were already born in the host country and may be submitted to the practice by their parents and families. Paediatricians should be both aware and sensitive about these practices and knowledgeable about the health implications, national legal framework and social dynamics (Levenson and Sharma, 1999). Gender aspects must also be dealt with, whilst accounting for the cultural dimension.

Social dimension

Social support networks and complementarity of services is a fundamental aspect of ensuring the realisation of migrant children's right to healthcare. These networks can be built both in the hospital, with the involvement of families and patients' associations and referral to other relevant health services; or at community level, with the promotion of, for example, programmes that build a social network between parents of migrant children of a specific and common background or with a specific disability.^{viii} Social support networks are also essential in the dissemination of information and the integration of migrant children and, consequently, or their access to and enjoyment of healthcare.

Spiritual dimension

Children have the right to practice their religion and enjoy their culture alone and with their families during hospitalisation. Health staff should respect and be sensitive to different beliefs, while hospitals and health services should provide appropriate spaces for worship for all religious groups.

b) Information and Participation

During hospitalisation, children have the right to be adequately in-



formed about their health condition in a manner that is appropriate to their age, developmental level and understanding, in order to participate actively in all decisions involving their healthcare. Moreover, health information provided to children should be done with a vision to empower them and enable them to become active players in the management of their own health, outside the hospitalisation experience.

Children should be informed by their paediatricians about their health condition and the different possibilities of treatment. Children should also be informed about general health aspects that are relevant to their age and about their rights in hospital. In order to reach out to migrant children, partnerships can be developed at community level and health information distributed in cultural centres, migrants' associations, schools and other places where children are likely to spend time. A Charter on Children's Rights in Hospital and/or the Convention should be available in a version understandable to children and displayed in every ward. Clinical records should also provide information on whether the Charter or Convention has been given and explained to the child. These documents should be translated into all migrant/minority languages and available in different formats.

The right to be informed is strictly related to the right to freely express their views and vice-versa. The following Articles of the Convention are particularly relevant to the right to freely express their opinions: Article 12 (respect for the views of the child); Article 13 (child's freedom of expression); Article 14 (child's right to freedom of thought, conscience and religion) and Article 17 (child's access to appropriate information).

Children should be able to feel that they are in a safe environment that respects them and where they can express their opinions without being judged. Adolescents should also be given the opportunity to be informed and to express their opinions separately from their parents, if it is in their best interest. The hospital should provide adequate resources for migrant children to fulfil this right, such as adequately trained interpreters. Children should also have access to effective independent complaints' procedures. For migrant children it may also be especially important that the hospital and health services promote their participatory rights within the family, by providing parenting education and preparation for parenthood services. The following research with young people sums up the above considerations:

"Beresford and Sloper's (1999) research with 63 young people affected by six chronic conditions identified their views on medical and psychosocial information needs which must be met to promote physical and emotional well-being. These included medical information on factors such as the condition, general human biology, treatments, tests and investigations, managing exacerbation, lifestyle factors, current research and health and other sources of

statutory support. Psychosocial information needs included dealing with negative emotions, living with physical symptoms, living with unanswered questions, dealing with parents and peers, managing at school and in other social settings, living with restrictions on lifestyle, maintaining a positive attitude and planning for the future. The young people also highlighted the important role of parents as information providers, indicating that parents' information needs must also be addressed (Franklin and Sloper, 2006)."

Finally, all children should have the right to express their views not only in relation to their health condition, but also in the planning and development of healthcare services. Lansdown gives an example of a group of architects in Derby (England) that consulted with children in the design of a new hospital. "One outcome was a reception desk with a lowered section in order that children could see who was speaking to them (Lansdown, 2000)".

c) Protection from all forms of violence

Hospitals and health services should have in place policies, multi-agency protocols and mechanisms to ensure the protection of all forms of violence against hospitalised children. These may include collaborative protocols with organisations at community level, referral mechanisms to social services and the local authorities and the provision of counselling and rehabilitation services. Moreover, policies of hospitals and health services must recognise this and provide health staff with the necessary resources to treat children in the most adequate way, such as through awareness raising and training activities.^{ix} Cardiff's Local Safeguarding Children Board has prepared a 'Multi-Agency Protocol for Safeguarding Children who have been Trafficked', which includes a section on the trafficking phenomenon; a second section on the role of specific groups and services; and finally a third section with other relevant information, such as referral processes (LSCB, 2008). These protocols should be easily accessible to practitioners, as they are a valuable resource especially in ensuring the continuity of care for children who have been a victim of any form of violence.

In order to facilitate recovery of children that have already undergone any form of violation, healthcare services should:

"Facilitate such recovery and integration, culturally appropriate and gender-sensitive mental healthcare should be developed and qualified psychosocial counselling provided (CRC, 2005)."

This right further requires hospitals and health services to fully respect children's equal human right for their dignity, physical and personal integrity.

Violence against children occurs all around the world, to children from

all social, cultural and economic backgrounds. The report of the United Nations Secretary-General's Study on Violence Against Children identifies some groups of children who may be particularly vulnerable to violence:

"These include children with disabilities, those from ethnic minorities and other marginalized groups, 'street children' and those in conflict with the law, and refugee and other displaced children (Hodkin and Newell, 2007)."

Hospitals and health services should guarantee that parents, guardians and caregivers are able to stay at all times with their child during hospitalisation, except when it is not in the best interests of the child. Insurance policies should also facilitate this stay, by providing free overnight stay and free or subsidised food.

Hospitals and health services should respect to the maximum extent possible children's right to privacy. This includes for children to have the option to stay in either single or double rooms and privacy during examinations. Gender respect is also crucial to respect children's right to privacy and healthcare services should provide, for instance, the possibility for children to be examined by a doctor of the same sex, if required.

Finally, culturally appropriate bereavement care should be provided by the hospital. Programmes for a dignified death should be done together with children and parents, taking into consideration children's cultural background.

Summary

The role of hospitals and health services in ensuring migrant children's right to health must be seen in a contextual logic. Migrant children have a specific social context and they have both needs and rights to which hospitals and health services must respond with adequate human and financial resources, including competent health and management professionals. Responding to migrant children's needs and rights entails the implementation of actions with consequent immediate and long-term results. It is important to understand this cycle in order to be able to ensure the realisation of migrant children's right to healthcare, as well as the realisation of all their rights at hospital level. The different dimensions of health, children's right to information and participation and their right for protection from all forms of violence provide examples of key issues to address in this cycle. Healthcare should be delivered in response to all dimensions of health, with the appropriate information and participation of children during that process. Finally, protection from all forms of violence is a key element to the right to life, survival and development and should be considered also in a holistic manner.



The Task Force on Health Promotion for Children and Adolescents in and by Hospitals and Health Services: contributing to the respect of children's rights in hospital

The Task Force on Health Promotion for Children and Adolescents in and by Hospitals and Health Services (hereafter Task Force) was set up in April 2004 within the International Network on Health Promoting Hospitals and Health Services (HPH) (Groene and Garcia-Barbero, 2005) and it is composed of representatives of several European and non-European Paediatric Hospitals, the European Association for Children in Hospital (EACH), the National Institute of Child Health (Hungary) and the European Society of Social Paediatrics (ESSOP). The main areas of work of the Task Force are: definition of a specific conceptual work background; promotion and safeguarding of children's rights in hospitals; mapping and evaluation of current practices of health promotion focusing on children and adolescents in hospitals and promotion of HPH-CA communities of practice. This section presents the work of the Task Force, which led to the recent elaboration of the self-evaluation model on the respect of children's rights in hospital. In 2005, the Task Force carried out an initial survey with the participation of 114 Paediatric Hospitals and Paediatric Departments of General Hospitals from 22 countries from the WHO European Region (See Appendix 3 for a complete list of participating countries) to assess the extent of health promotion practice and the respect of children rights in hospital (Simonelli et al., 2006). The main findings of this study and the follow-up recommendations are presented in this section. The last part of the section provides a brief overview of the abovementioned model and tool.

The Background Survey on Health Promotion for Children and Adolescents in Hospitals

The Background Survey on Health Promotion for Children and Adolescents in Hospitals focused on four areas:

- The general situation of health promotion in hospitals throughout the WHO European Region;
- Children's rights in hospital;
- Adopted standards of health promotion in hospital; and
- Current practices of health promotion in hospital.

The following findings emerged from the collection of data through the questionnaires in question:

- a) Only 50 hospitals (43,9% of total sample) had adopted a 'Charter on the Rights of Children in Hospital'. It was found that even when a Charter had been adopted, there were no systems in place to assess the respect of children's rights in hospital. Furthermore, the formulation of Charters had seldom been done in collaboration with associations representing hospitalised children.
- b) 35 hospitals (30,7%) declared to have a written policy on health promotion and 33 hospitals (29%) declared to have defined standards for health promotion. Of these standards, none related to the assessment of programmes by patients and only 5 hospitals (7,3%) declared to have standards on patient information.
- c) In relation to the current practices of health promotion for children and adolescents, it was found that there is variety in both target groups and type of practice. Children and adolescents with chronic diseases and their parents where the first and main target group for health promotion practices and the most common type of practices were health information activities, therapeutic education and health education (*ibidem*).

Recommendations on Children's Rights in Hospital

Following the main findings that emerged from the Background Survey and in an attempt to contribute to a better understanding and definition of a role for hospitals and health services in relation to health promotion for children and adolescents in and by hospitals and health services and to contribute to the respect and fulfilment of children's rights in hospital, the Task Force identified and proposed the recommendations reported below:

- "All paediatric hospitals and paediatric departments of general hospitals are invited to:
 - Adopt and make widely known to both children and adults a Charter of the Rights of Children in Hospital in line with the principles and provisions of the Convention on the Rights of the Child;
 - Implement, compare and share tools to evaluate the respect, protection and fulfilment of the rights of children in hospital;
 - Include the issue of the respect of children's rights in hospital set-

tings, as well as child and developmental psychology and communication techniques in the continuous education activities for hospital staff.

- National and regional Ministries of Public Health, of Social Affairs and Education are invited to include the issue of the respect of children's rights in hospital settings, as well as child and developmental psychology and communication techniques in the compulsory courses for students in Medicine/Paediatrics/Nursing, in order to facilitate the relation among patients, their relatives and health-care providers.
- National and regional Ministries of Public Health and of Social Affairs, National Human Rights Institutions, Local Health Authorities, Non-Governmental Organisations and other bodies responsible for Convention monitoring are invited to promote, facilitate and verify the implementation of the above mentioned recommendations.
- International organisations committed to the promotion of children's health are invited to provide their support and co-operation to the national/local bodies mentioned above, in order to ensure the respect, protection and fulfilment of the rights of children in hospital (Task Force, 2007)."

The self-evaluation model and tool on the respect of children's rights in hospital: A human rights-based approach

After implementing the Background Survey and drawing the recommendations stated above, within the work area 'promotion and safeguarding of children's rights in hospital', the Task Force decided to develop a model and practical implementation tool for assessing the respect of children's rights in hospital. The first concern of the development of this model was to follow a human rights-based approach with the recognition that the fulfilment of human rights is a key in the process of full realisation of the human potential. The universality of human rights has been recognised by all agencies of the UN and in their work. The Convention as a whole, in particular, can be used as a legal, policy and operational framework to assess the realisation of children's rights and to plan actions (Santos Pais, 1999). The self-evaluation model on the respect of children's rights in hospital reflects the holistic interpretation of the Convention and its general principles and a recognition of the need to fill existing gaps in order to promote equal access of services to all children and the respect of all their rights, with the aim of realising children's rights in hospitals and of empowering them for the realisation of their human potential.

The overall aim of the model is to assess the gap between the full respect of children's rights and current hospital practice, as a basis to

improve the current situation and produce change. This process foresees four phases, namely:

- 1) Mapping the reality through the implementation of the proposed self-evaluation tool;
- 2) Planning the improvement, through the identification of a set of standards for the respect of children's rights in hospital;
- 3) Making improvement, through the implementation of specific actions;
- 4) Evaluating the change, by monitoring progress and gaps (Task Force, 2009). (See figure below)

The tool itself was designed as a practical instrument to assess the respect of children's rights in hospital. Three main rights' areas and relevant 'sub-rights' were identified as priority areas for hospitals and health services, which the Task Force considered priorities within the hospital setting. The final Self-evaluation Model and tool is the result of a review of the Convention, the EACH Charter^{xi} and the Charter of the International Children's Palliative Care Network^{xii} (Please see Appendix 3 for the complete list of areas and rights); and a consultation process with international partners at WHO Headquarter, UNICEF Innocenti Research Centre, the Greek Ombudsman, the former Healthcare Commission for England and the HPH Task Force on Migrant Friendly and Culturally Competent Hospitals and Health Services.

The self-evaluation model and tool on the respect of children's rights in hospital was designed to assess the respect of the rights of *all* hospitalised children, however the rights of children particularly at risk, such as migrant or disabled children, were taken into account and emphasised where it was found relevant. Moreover, as above-mentioned the HPH Task Force on Migrant Friendly and Culturally Competent Hospitals and Health Services was involved in the process to ensure that the needs and rights of migrant children were taken into consideration. In order to best implement this model and similar assessments and actions aimed at the improvement of migrant children's right to healthcare, hospitals and health services must ensure the respect of the previous considerations made under the role of hospitals and health services, namely children's health dimensions, information, participation and respect for their views. A previous version of the Self-evaluation tool was pilot-tested within the member hospitals of the Task Force, which led to a final revision of the document. The Self-evaluation Model and Tool is currently under dissemination and implementation. Its efficiency is still to be seen however, on a first instance it can be said that it has been well received by national partners and international organisations and experts working in hospitals or for children's rights.



Other European models and tools on the respect of children's rights in hospitals

Outside the Task Force few other experiences were found during the research for this paper. Only two European examples of assessing the respect of children's rights in hospital were found: one done by the Child Support Institute (Instituto de Apoio à Criança) and one by the Association Pour l'Amélioration des Conditions d'Hospitalisation des Enfants (APACHE), the Portuguese and French EACH members, respectively. The APACHE organisation developed a comprehensive questionnaire for hospitals (APACHE, 2000), which was also used by IAC to develop a nation-wide study.

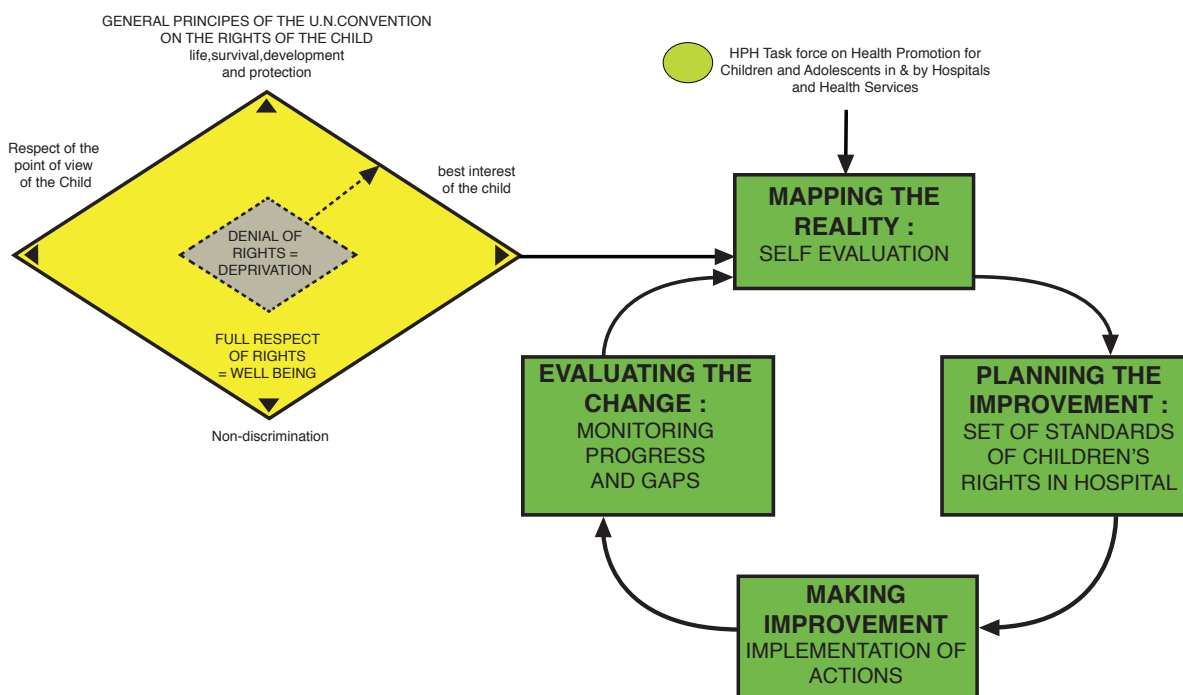
The IAC study was carried out in all Portuguese hospitals except two to assess to what extent the rights laid out in the EACH Charter were being fulfilled by Portuguese hospitals. The data collected shows that there are still hospitals that do not have procedures for communicating with children and families that do not speak Portuguese. Only 21.3% of the hospitals inquired have a qualified interpreter, with 93.4% calling upon occasional interpreters. As recommended in the Convention (Article 30), the Charter protects the right of children to enjoy their own culture, to practice their religion and use their mother tongue. Although people are aware of the need to adapt hospital care to the needs of migrant children, there is still some way to go so that their rights are fully respected (IAC, 2006).

In the UK, within the Department of Health, there is an established inspectorate body – the Social Services Inspectorate (SSI) – which carries out assessments and draws recommendations to guide the work of national and local governmental bodies, hospitals and health services. The SSI has four main functions:

- “To provide professional advice to Ministers and central government departments on all matters relating to the personal social services;
- To assist local government, voluntary organisations and private agencies in the planning and delivery of effective and efficient social care services;
- To run a national programme of inspection, evaluating the quality of services experienced by users and carers; and
- To monitor the implementation of Government policy for the personal social services (O’Neale, 2000).”

The SSI has also carried out assessments on services for ethnic minority children and families, which can also be useful to carry out assessment for migrant children.

Figure 2. The self-evaluation model on the respect of children's rights in hospitals and health services.



Summary

The European Background Survey carried out by the Task Force show evidence of the lack of awareness of children's rights in hospital settings, as well as the lack of monitoring and evaluation mechanisms to assess to what extent children's rights are respected, protected and fulfilled in hospitals and health services. The recommendations proposed by the Task Force following the survey call on Paediatric Hospitals and Departments to adopt a Charter on Children's Rights in hospital and to put in place appropriate assessment mechanisms. Children's rights should also be included in professional training and university degrees for health professionals and health management. The self-evaluation model and tool on the respect of children's rights in hospital aims to fill in the gap with regard to monitoring and evaluation mechanisms that was identified and to facilitate a model and tool for consideration and adoption by hospitals and health services throughout the world. This instrument should also enable hospitals and health services to pay particular attention to vulnerable groups.



Situation Analysis

Overview of programmes ensuring the rights of migrant children to healthcare

This section of the paper has been prepared with inputs from two separate processes: a) a desk-based review of literature and b) direct contact with stakeholders, namely representatives of hospitals and health services, non-governmental organisations (NGOs) and Ombudspersons for Children, amongst others. The overall objective of this analysis was to understand what types of programmes and specific services for different groups of migrant children exist in Europe and how their right to healthcare is being protected. The specific objective was to learn about good practices that manifest the holistic approach of the Convention and that respond to the following challenges identified throughout this research: cultural change at community level, cultural change in the hospital following a rights-based approach, organisational change of services provided to migrant children and professional change for the orientation of services towards health promotion. The first sub-section is divided in accordance to the above-mentioned challenges, whereby an explanation of the challenge is followed by a good practice at community, hospital or health service level. For the purpose of this paper, the term *good practice* follows the criteria set out by the Task Force in 2007, as set out in *Appendix 5*. The second sub-section presents four case-studies aiming at presenting detailed examples of the response of hospitals and health-services to ensuring the right of migrant children to healthcare. The case-studies followed criteria specifically developed for the purpose of this paper, as set out in *Appendix 6*.

Challenges and good practices

As it has been mentioned in the previous section of this paper, few examples were found in Europe of assessments of children's rights in hospitals at national level and no assessment was found at European level. For this reason, it is difficult to assess to what extent hospitals and health services are ensuring the *protection, respect and fulfilment* of children's rights throughout Europe and, in particular, the right of migrant children to healthcare. One of the aims of identifying the challenges and good practices presented below was to fill this gap, as much as possible in the context of a qualitative paper (See *Appendix 5 for full criteria of a good practice*).

a) Cultural change in the community for advocacy of migrant children's health and development

Cultural change at community level is possibly one of the most important enabling factors in promoting access to healthcare services; facilitating dialogue amongst sectors and between associations, patients and health services; empowering migrant children and their families and in addressing the social determinants of health. Moreover, it is a fundamental step in overcoming stigma and in enabling migrant children and their families to integrate fully into society and to become equal citizens. A European survey by Médecins du Monde on undocumented migrant's access to healthcare found that

"The most frequent obstacles to healthcare access and treatment continuity (voiced by the people surveyed) are lack of knowledge about their rights, lack of knowledge about where to go for treatment, treatment cost, administrative problems, fear of being reported to the authorities and of discrimination, and linguistic and cultural barriers (Médecins du Monde, 2007)."

The media, local civil society organisations and local governmental services are important vehicles in reverting this situation and in contributing to change, as they have the ability to reach out to migrant children and their families through information dissemination, awareness raising campaigns and the promotion of specific programmes in public spaces, such as libraries. National examples of these types of actions include the *Libraries as Gateways to the Integration of Immigrants in the EUⁱⁱⁱ* project in the Czech Republic and the programme *Nós (Us)*, a television transmission sponsored by the Portuguese High Commissioner for Immigration and Intercultural Dialogue (ACIDI) (See *Appendix 6* for more information). These two projects are not aimed at migrant children or their healthcare, however they provide valuable examples of the type of format that hospitals, health services, civil society organisations and local government structures could adopt to ensure the right of migrant children to healthcare.

The two good practices presented below provide examples of what action could be promoted at community level, in an innovative, multi-sectoral and multi-disciplinary way.

Good Practice - Cultural change at community level

*Red de Familias Hospitalarias para los Inmigrantes
(Cataluña, Spain)^{xiv}*

The *Asociación Salud y Familia* of Barcelona has developed a programme of host families for recently arrived or immigrants in the process of family reunification. Every family living in Spain can be a host family on a voluntary basis for a period of three months. The aim of the network is to enable citizens in the region of Cataluña to undergo experiences of direct understanding of cultural diversity. Host families receive a basic information guide on the main services that immigrant families will need. A cultural mediator is available to facilitate the language communication between the two families. Besides the families and cultural mediators, the project also involves local governmental structures and the media. This programme provides a very valuable example of not only how to overcome stigma but very importantly, how to foster the integration of new immigrants fully into society. 60 families are currently participating in this programme, migrant families have different cultural backgrounds and typology, from 'traditional' families (parents and children) to single people, sisters and friends.^{xv}

Outcomes

In the long-term, this programme can have multiple outcomes and to contribute to the right of migrant children to healthcare through: the establishment of a social support network (starting from the host family, the association and the health services involved), improved access to healthcare services and information and through the facilitation of integration of children and their families into the host society.

Good Practice - Intersectoral / Multidisciplinary action

Projecto Geração (Casal da Boba, Amadora, Portugal)

'Project Generation' is a very good example of a community-based, multi-sectoral and multi-disciplinary programme that highlights the interdependence of the various settings of children's lives and, therefore, of the need to address their needs and rights in a holistic manner. This project started in 2004 with a partnership between the Municipality of Amadora, the Calouste Gulbenkian Foundation and ACIDI. Furthermore, the delivery of the project included local schools, private and local health services, NGOs, international partners, the Parish Centre, local Prison Services and the Music School of the National Conservatory. The project focused on a neighbourhood of Amadora comprising of 700 houses and whose population is mostly of Cape Verdean origin and very young – half of the population is between 10 and 24 years old. Furthermore, the community is characterised by social exclusion factors, such as unemployment, low income, poor schooling, family instability and undocumented migrant status. The

aim of the project was:

"To change the options available for a generation living in this community, to tackle and to prevent the major factor of social exclusion that affects youngsters and instead, provide them with real opportunities (Municipality of Amadora, 2008)."

Activities and main deliverables included:

- Youth Workshop: aiming at preventing school dropouts by means of educational support, computer courses and promoting extra-curriculum activities. 80 youngsters benefited from this initiative;
- More Health: This initiative was promoted by the local administrative council of S. Brás, together with services from the private sector and the local health centres. The aim was to provide access to specialty consultations indicated by family doctors on previous occasion, which the children were not able to follow-up. From January to June 2007, 71 dental treatments, 4 ophthalmology and 7 speech therapy consultations were provided and 7 pairs of spectacles were acquired.
- You Can be Anything you Want: The Association Unidos de Cabo Verde promoted a programme for young mothers who received support during pregnancy and after birth. The initiative included support in defining and implementing a life project, parental training, education and professional training. Fathers were included, when they wished so. The 12 young mothers were aged between 16 and 19 and over half of them were undocumented.
- Generation Youth Orchestra: Following the model of the Venezuelan Simón Bolívar Youth Symphony Orchestra, with the support of the Music School of the National Conservatory, the Miguel Torga School promoted a 3 year pilot-project aimed at creating the first local youth orchestra, which involves 80 children. The Generation Youth Orchestra is expected to be the seed of a Metropolitan System of Youth Symphony Orchestras.

Outcomes

This programme is a good example of a comprehensive package tackling not only the right of migrant children to healthcare, but their empowerment, the social determinants of health, their right to education and leisure, amongst others. The programme created partnerships between local health centres, the local parish centre, school and an NGO. Moreover, human resources included anthropologists, sociologists, social assistants, psychologists, musicians, lawyers, economists, teachers and other professionals. Finally, it can be said that most probably this programme has not only had immediate results (outputs), but most probably will have an impact on children's lives in time (outcomes).



b) Cultural change in the hospital following the rights based approach

For a long-term and continuous effective delivery of quality health-care services for migrant children to take place and for hospitals and health services to respect their rights in a holistic manner; a rights based affirmative action and programmes must become a routine in daily hospital practice. And for a cultural change to happen at hospital and health services level, a comprehensive change must take place in that setting in the form of a 'package'. This means that policies must be adopted to ensure that monitoring and evaluation mechanisms are in place, as well as, research programmes; needs assessments of patients and health professionals; specific services related to cultural and linguistic competent staff; and training and awareness raising activities for health professionals, patients and their families. Policies should be put in place to ensure that on one hand, the services provided are culturally adequate and clinically of high quality and, on the other hand, that they are empowering patients and supporting them in developing their personal assets and managing their life settings and environment. Finally, hospitals and health services, together with other sectors of society should also take up action to overcome any existing barriers preventing accessibility and availability of healthcare provision.

Good practice – Equality and Diversity Strategy

Bradford Teaching Hospitals NHS Foundation Trust (England, UK)

The Bradford District has a unique social composition, approximately half of the population are migrant or belong to a minority ethnic community and it is estimated that 63 languages are spoken in the community. The Bradford District is also characterised by great economic poverty (ranking as the fourth most deprived area in England) and reported poor health status of the population. The Bradford Teaching Hospitals have a long standing tradition in providing services for ethnic minority communities: 40 years ago the first cultural mediator arrived in the hospital and today there is a dedicated equality and diversity department with appropriate human and financial resources.

Following the UK Human Rights Act (1998) and the Equality Act (2006), organisations providing services to the public, from hospitals to the police forces have been called to develop 'Equality and Diversity' strategies. Bradford Teaching Hospitals adopted their 'Equality and Diversity Strategy' for the period comprising 2008-2015. The strategy provides a valuable example of how a cultural change in the hospital setting following a human rights based approach can be developed. The Table below provides a summary of the Equality and Diversity Strategy.

As seen below, the Equality and Diversity Strategy adopted by the Bradford Teaching Hospitals provides a comprehensive set of policies and actions that aim at providing a culture of equality and diversity at all levels: embraced by all staff, patients and other key stakeholders, with a vision to empower patients and improve overall health status and living conditions of the community, an accountable and transparent system and, importantly, a policy that is long-term with adequate allocated resources and with space for continuous improvement through the various monitoring procedures.

Outcomes

The Equality and Diversity Strategy provides for Equality Schemes in relation to Race, Disability and Gender. Moreover, every department is obliged to undertake an Initial Equality Impact Assessment of their policies and functions. In addition to this, "Full Equality Impact Assessments of those policies and functions that have the highest impact on equality groups" are also carried out. These enable departments, staff and hospital management to identify the existing equality gaps within their services for all age groups and to plan improvement. Children and their parents are an integral part of this Strategy, which has the potential to contribute to the improvement of services and to a cultural change of services, staff and patient behaviour and the increase of the quality of healthcare.

Equality and Diversity Strategy 2008-2015 (Summary)

- A seven-year strategy with appropriate allocated human and financial resources.
- A **human rights based approach** inspired by national equality and human rights bills, such as:
 - *Framework for a Better Future – The Equality Bill (2008)*;
 - *NHS Draft Constitution (2008)*;
 - *Human Rights Act (1998)*;
 - *NHS Next Stage Review – High Quality Care for All (2008)*.
- **Core principles** of the human rights based approach:
 - Equality;
 - Dignity;
 - Respect;
 - Fairness;
 - Autonomy.
- Other **working principles**:
 - Empowering staff and patients;
 - Meaningful involvement and participation of all key stakeholders;
 - Accountability;
 - Non-discrimination and attention to vulnerable groups.
- **Awareness raising campaign** on the Strategy for staff, patients and other key stakeholders;
- **Staff training**: space for open discussion, patient-centred and a collaborative culture;
- Calling upon all levels of staff to ensure compliance, awareness of principles to follow and revision of policy;
- **Routine and regular consultancy with patients**: user feedback
- **Clear and accessible complaints procedure**;
- **Monitoring mechanisms**:
 - Equality Impact Assessment;
 - Equality teams (made up of clinicians, lead nurses, managers, staff and patient representatives);
 - Transparency: the results of monitoring information are published on the website;
 - 24 Equality and Diversity Pledges monitored every 6 months and 1 Annual Report.

Bradford Teaching Hospitals NHS Foundation Trust (2008); Equality and Diversity Strategy 2008-2015; available at <http://www.bradfordhospitals.nhs.uk/about-us/e/Equality%20and%20Diversity%20Strategy%202008%20-%202015.pdf/view>

c) Organisational change of services provided to migrant children

A European cross analysis needs assessment showed that the following areas are particularly problematic in migrants' right to healthcare:

- "Language and communication;
- Linguistically and culturally adequate patient information and education;
- Cultural barriers and lack of cultural competence;
- Family visits;
- Lack of culturally adequate food;
- Spirituality and social support (Chiarenza, 2007)."

Hospitals and health services should guarantee specific services that ensure the respect, protection and fulfilment of migrant children's right to healthcare; which include adequate cultural mediation and interpretation services, complaints' mechanisms, as well as, a system of monitoring and evaluation to ensure the identification of gaps and subsequent improvement. Hospitals and health services should also promote continuous research to assess health status of migrant children as this is a fundamental step in improving the response to their needs. In order to do this, the reorganisation of services must take place and specific services, projects and policies must be set up.



Good practice – Provision of interpretation and cultural mediation services

Bambino Gesù Hospital for Children (Rome, Italy)^{xvii}

From 2003, the Bambino Gesù Hospital in Rome has made a cultural-linguistic mediation service available to foreign patients that use the hospital, with the aim to:

- Improve the quality of healthcare and the acceptance of foreign patients;
- To ease the use of the services, in relation to the healthcare, administrative and accommodation needs;
- To facilitate the exchange and mutual knowledge of cultures, traditions and social systems;
- To gather essential information, which may be useful in anticipating patients' and parents' needs and to plan innovative programmes or activities as a response.

The current practice is applicable to the linguistic needs of all foreign patients who need it and it is available in every ward and service within the hospital, including in the accommodation for parents. The interpretation and cultural mediation service is provided by staff with adequate linguistic competences and it may be accessed by both the foreign patients and the health staff. The procedure for requesting this service entails that each ward or service sends out a form to the Public Relations' Office, which identifies the interpreter and guarantees the availability of the service within 24 hours of request. For emergencies the service is available within 2 hours of request.

The monitoring data related to the period between 2003 and 2008 shows a change in the patient population, both regarding the languages requested and the increase of the number of requests, which have increased from 169 requests in 2003 to 783 completed in 2008. In these years, there has been a significant increase of the request for Arab interpreters (from 46 requests in 2003 to 357 in 2008), followed by Romanian, Albanian, Iraqi/Kurd and Chinese. The other languages include: Bangladeshi, English, French, Russian, Spanish, Bulgarian, Senegalese, Swahili, Bosnian/Serbo-Croatian, Turkish, Polish, Pakistani, Portuguese, Slovenian and Ethiopian.

The hospital has carried out both quantitative evaluation reports, which are carried out every 3 months and made available to the health staff; and a qualitative survey with the aim of monitoring the activity of medical interpretation through the observation of the relation between the cultural mediators, health staff and patients.

The communication model used (lexicon, tone of the voice and the distribution of people in the room) varies according to the ethnic group and it is influenced by the behaviour and communication features of each culture. For this reason it is essential to assess the

different needs, in order to guarantee the best possible comprehension of health information by all of the actors involved. One of the most sensitive issues is the informed consent, meaning the effective understanding of invasive procedures, such as surgery. This is particularly important as many of the foreign patients arrive at the hospital because they are not able to receive the necessary treatment in their country of origin.

The cultural mediator is often joined by an officer of the Public Relations Office, with the aim to:

- Verify the effective understanding between the different actors (mediator, patient, health staff);
- Ensure an acceptance in the hospital, which takes into consideration the cultural needs of the patients from other countries;
- Assess other needs of a logistic, administrative and social nature, which may need to be solved during the medical appointment;
- Support the different needs of all actors and to organise, in the shortest period of time possible, further appointments between the mediator, health staff and the patient's family;
- Facilitate the work of the organisations or associations that assist the foreign patients in improving the quality of their stay in the hospital.

d) Professional change for a health promotion approach oriented to migrant children

Health professionals should be given the adequate resources and tools to provide the best possible healthcare delivery to migrant children. These resources and tools can include awareness raising and training activities on specific issues, such as cultural competency; communicable, non-communicable and tropical diseases; information on the availability of mediation and interpretation services; information on common cultural practices, such as FGM; and awareness of the referral mechanisms available to migrant children. Specific educational packages should also be developed in a comprehensive manner and made available to health professionals. The UK's Department of Health and the different Royal Colleges have developed a significant number of educational packages such as these (see for example *Female Genital Mutilation: An RCN educational resource for nursing and midwifery staff*, Royal College of Nursing, 2006; and *The Health of Refugee Children – Guidelines for Paediatricians*; Royal College of Paediatrics and Child Health, 1999). Including cultural diversity modules at under-graduate and post-graduate levels is also an important step to improve cultural awareness and contribute to culturally-sensitive services. Webb and Sergison argue that:

“Families from Black Ethnic Minority communities may have many assets, including strong and stable extended family networks, strong spiritual/faith environments, and a well developed sense of

cultural identity. Recognising and valuing these assets will lead to more effective support and empowerment of families to work in full partnership with professionals. But establishing asset based and family focused care, in line with the new assessment framework, requires practitioners who are culturally competent (Webb and Sergison, 2003)."

The Good Practice below describes a process of development and implementation of a training methodology for health professionals on Equality and Child Health.

Good practice - Equal Rights, Equal Access – A training package

Equal Rights Equal Access – Cardiff Race Equality Council, Child Health and the University of Wales College of Medicine (Wales, UK)

The King's Fund, in recognition that minority ethnic communities in the UK do not enjoy equality of access to health services, financed a grant programme to improving access to Black Minority Ethnic Communities, in 1992. South Wales received one of the grants and the Race Equality Council together with the Community Child Health Services promoted a two-fold programme: a community based development programme^{xix} and a training package for professionals and their managers, who worked directly or indirectly with children and their care.

"The overall aim of this project was to improve the accessibility and the quality of health and social care for children from minority ethnic communities with chronic illness and/or disability, and to improve support services to their families (Webb, 1999)."

Regarding professional training, the Department of Child Health at the University of Wales (College of Medicine) developed a race and cultural awareness training pack, contextualised in the field of childhood illness and disability. The training was piloted in Cardiff, Bristol and Birmingham in 1995 and published in 1996. Following this, a local programme was set up in Cardiff and the training package was also included in the MSc in Child Health. A programme was also developed in Huddersfield in 2000, with the attendance of 92 staff from health, education and social services. The training pack deals with:

- "Exploring attitudes: allowing trainees to recognize that they are not culturally neutral but a product of their own cultural conditioning;
- Understanding how attitude to race, colour and religion interact with those to class, age, gender and disability;
- Understanding racism in all its subtle forms – stereotyping, victim blaming, colour blindness, marginalisation, ethnocentrism, discrimination and prejudice;
- Identifying how institutional racism affects services;

- Developing strategies for improvement (*ibidem*)."

The evaluation of the training programmes in Cardiff and Huddersfield has demonstrated the following:

- "Cultural competence and antiracism training has been neglected in child health in both generic undergraduate and postgraduate training across a range of disciplines;
- Such training is well received, although not always prioritised, by health professionals;
- It is a positive experience for trainees and perceived to be relevant to their practice, both during the training and subsequently;
- Effective training does not require cultural menus. Our work with this training programme emphasizes the need for the subtler and more difficult aspect of cultural awareness as opposed to the learning by role of, for example, dietary needs, naming systems. However, prior to training, many staff identify their training need to be for knowledge rather than understanding; a few trainees still want 'menus' after training;
- Appropriate and non-threatening training in cultural competence changes behaviours and practice, including promoting good practice in communication across linguistic and cultural differences (Webb and Sergison, 2003)."

Outcomes

Although the training package was designed within a framework to support access and quality of services delivered to Black Minority Ethnic Communities, it is obvious that it will affect positively migrant groups of children, as well. The most positive aspect of the training is possibly the open format and the fact that it deals with behaviour change, rather than the above mentioned set 'menus'. In the long-term, this training package can promote culture competency within a wide number of services, to increase awareness amongst health professionals and to contribute to a cultural change within their work settings.



Case-Studies

The aim of the case-studies is to present detailed examples of the response of hospitals and health services in Europe to the right of migrant children to healthcare, with the aim of learning how different hospitals and health services are and can respond to the right of migrant children to healthcare in a holistic way. For this purpose a case-study was prepared by a hospital (the Meyer University Children's Hospital in Italy) and by a health service (the Balsekin Refugee Centre in Ireland). To complement these case-studies, two additional case-studies were prepared: one on the response of the Regional Government of the Canary Islands and one on the situation in the Stockholm county. Though not a comprehensive picture of the situation in Europe, these four case-studies should enable to withdraw some conclusions on the role and potential of hospitals and health services in the respect of the right of migrant children to healthcare; and on the complementarity role between hospitals, health services and governmental policies and institutions. The criteria set out for the case-studies was inspired by the Task Force HPH-CA self-evaluation model and tool on the respect of children's rights in hospital (See Appendix 7 for Case-Study criteria).

The four case-studies presented are the following:

- **Case-study 1.** Migrant children's right to healthcare: the response of the Regional Government of the Canary Islands;
- **Case-study 2.** Healthcare for migrant children in a Nordic welfare state – the case of Stockholm;
- **Case-study 3.** *Progetto Intercultura*: re-organising services at hospital level to respond to the needs and rights of migrant children;
- **Case-study 4.** "Easing Transitions" – the case for child-centred interdisciplinary work with asylum seeking children in Ireland.

Introduction

During the last few years, there has been an exponential growth of the immigrant population in Spain, who is a very heterogeneous group of persons that must be respected and cared for according to their origin and cultural differences.

Migratory movements and the groups of population arriving in Spain, mostly from developing countries, highlight that multiculturalism is a reality in Spanish society and, in view of the dimension that immigration is reaching in the country and particularly in the Canary Islands, the provision of healthcare should reflect the new social needs of immigrants. Consequently, it is essential to know their social, cultural and sanitary characteristics and needs in order to provide a proper healthcare delivery.

Is a specific healthcare necessary for migrant children?

The immigrant population in Spain was 8,67% in 2005 out of the total population, in addition to the immigrants in an irregular situation. The Mediterranean area and the Region of Madrid attract the largest percentage of foreign population: Balearic Islands 15,9%, Madrid 13,1%, Valencia and Murcia, 12,4% each. In the Canary Islands, the foreign population was 11,3% in 2005 and it has increased to 13,67% in the last few years.

Table 1 below shows the foreign population according to geographic area of origin in 2005 and the graph that follows shows the incidence of the foreign population in the demographic structure of the Canary Islands in 2007.

Case-Study 1: Migrant children's right to healthcare: the response of the Regional Government of the Canary Islands

Rosa Gloria Suárez López de Vergara, Alberto Armas Navarro and Sara Darias Curvo

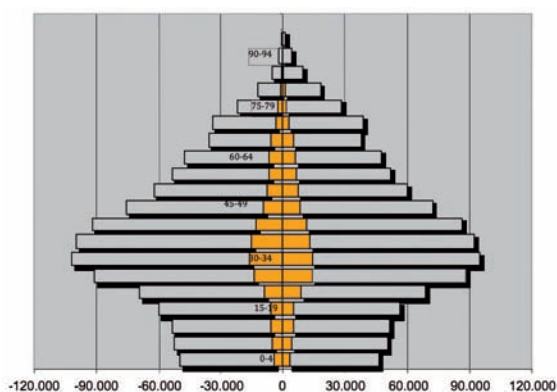
Table 1. Foreign population according to geographic area of origin in 2005.

POPULATION ACCORDING TO NATIONALITY	
CANARY ISLANDS	
TOTAL	1.968.280
From Spain	1.746.020
From abroad	222.260
E.U.(1)	93.422
Rest of Europe	9.087
Africa	26.732
America	80.201
Other	12.818

(1) Except Spain.

Source: National Institute of Statistics (INE): 'Update of the Resident's Census Records on 1/Jan/2005'

Graph 1. Incidence of the foreign population in the demographic structure of the Canary Islands in 2007.



There has been an increase in the number of births in the Canary Islands, in part due to the births from foreign mothers that represented 14,49% of the total number of births in 2005, against 13,8% in 2004 and 12,2% in 2003.

In relation to underage immigrants, the table below provides the distribution of children by islands, of the total of 36,750 underage migrants present in the Canary Islands.

Most children arriving here belong to families from countries outside the EU, who have migrated due to economic reasons and who are in a situation of vulnerability and precariousness (frequently in an irregular situation). They come from sanitarily deficient countries, where healthcare is limited to basic vaccination programs, and whose environmental, home and hygienic conditions are deficient, making them more vulnerable to certain pathological processes (nutritional problems, parasites, etc.).

In relation to unaccompanied underage immigrants, it is more and more frequent that they arrive in our islands in boats (*cayucos*). Until a few years ago, the largest contingent came from Morocco but, at present, the illegal immigration routes depart from African countries such as Senegal, Gambia, Mali, Morocco, Côte d'Ivoire, Guinea Conakry, Guinea Bissau, Ghana, Mauritania and Equatorial Guinea. Immigrants are usually males with an average age of 16 years.

At the beginning of 2006, the number of unaccompanied underage immigrants under the guardianship of the Regional Government of the Canary Islands amounted to 200; by November 2006, it had increased to 720. As opposed to the case of other regional governments, the Regional Government of the Canary Islands is the guardian of underage persons, even though it is the Government of each Island (*Cabildo Insular*) who is in charge of their custody.

Protocol of action and coordination for the healthcare of underage immigrants

For the abovementioned reasons, the Regional Government of the Canary Islands has prepared a Protocol of action and coordination for the healthcare of underage immigrants, whose main objectives are:

- To define the courses of action to follow in order to guarantee healthcare to all immigrants under 18 years of age living in Immediate Detention Centres and in Underage Foreigners Detention Centres;
- To provide an adequate and continuous healthcare to unaccompanied and accompanied underage immigrants, by including them in the Children Health Program of the Region.
- To have a document that defines the coordination channels between the different public administrative units.
- To create the information channels that ensure continuity of healthcare provision to underage immigrants.



Table 2. Underage immigrants according to census.

	CANARIAS	Lanzarote	Fuerteventura	Gran Canaria	Tenerife	La Gomera	La Palma	El Hierro
0-4	7.042	1.281	786	2.068	2.653	53	168	33
5-9	9.567	1.338	923	2.846	3.988	118	288	66
10-14	10.127	1.420	801	3.059	4.324	116	336	71
15-19	10.014	1.439	775	3.050	4.182	120	381	67

Source: ISTAC Census 1-1-2005. Canary Islands as a region and each island individually. Foreign population by age groups.

There is a normative frame that regulates assistance and care to immigrants; among them, the Organic Law 4/2000 of the 11th January, about foreigners' rights and freedoms in Spain and their social integration (*Ley Orgánica 4/2000 de 11 de Enero sobre derechos y libertades de los extranjeros en España y su integración social*) establishes, in Article 12, that (...) *Foreigners under 18 years of age who are in Spain have the right to receive healthcare in the same conditions as Spanish citizens.*

The protocol establishes a difference in the organisation of healthcare to underage immigrants according to their situation:

1. *Unaccompanied underage immigrants.*
2. *Accompanied underage immigrants.*

This difference is mainly due to the fact that the persons directly responsible for them are different: Unaccompanied underage immigrants are under the custody of the competent Public Institution (General Directorate of Underage Children and Family) and they live in a Centre with other underage children in the same situation and Accompanied underage immigrants are under the custody of their parents or legal guardians.

This structure was established in order to guarantee the healthcare of children, by allowing a better accessibility to the system.

Adequate training of health staff

For the proper implementation of the protocol, it is important to provide adequate training to health professionals, which should focus on them being able to integrate the attitudes, capabilities and knowledge that are necessary to provide effective, useful and care that is respectful of multiculturalism. To this purpose, the Spanish Paediatrics Society of Hospital and Primary Care prepares guides work manuals to facilitate the organisation of health actions focusing on immigrant children, both in and outside the hospital, by coordinating both levels of action. An example of this is the "Manual of attention to immigrant patients (Gancedo, 2007)", which provides information related to imported infectious diseases, non-infectious diseases, deficiency diseases,

vaccination coverage and other diseases that immigrant children may carry, and deals in a practical way with mechanisms to follow a patient of those characteristics, at the same time favouring integration of the immigrant population.

The Protocol of action of the Region of the Canary Islands also provides specific indications about the most prevailing pathology in different geographical areas, as well as indications of complementary tests depending on the details of the anamnesis and on examination.

The rights of migrant children in hospital

Accessibility to the health system: as mentioned before, any immigrant child has access to hospital, with no distinction from indigenous children and with the same health guarantees, which is regulated by a legal framework.

However, these regulations could be reinforced by a protocol of control of the observance of children's rights during the hospitalisation process, which could be at the same time a supervision and an evaluation for the hospital itself. Paediatrics patients would take part in the process of preparation of such protocol.

Language assistance: Language barriers are what creates most difficulties during assistance to immigrant children, because it is not possible to have interpreters in all wards and services and at all times of assistance, as would be recommendable. In view of the difficulties in this issue, tele-translation equipments are being introduced via mobile phones in hospitals and in some health centres, where a large number of immigrants are assisted. Training courses on health issues should also be provided to interpreters.

Attention to "migratory bereavement": there is a Program for the mental healthcare of children and adolescents in our community, which should be adapted to new pathologies within the recent Health Plan for the Canary Islands, which is being debated at present.

Health promotion in the hospital: health promotion programs must be updated and adapted to include a holistic healthcare provision to migrant children.

Background Paper

Assisting Migrants and Communities (AMAC) Project

Satisfaction questionnaires: At this moment, the number of underage immigrants assisted in the hospitals of the region cannot be determined, nor can the treatment carried out be specified, since the registration of data is codified in the same way both for indigenous and migrant patients, and therefore, immigrants' details cannot be separated from those of the rest of children assisted in the hospital, with the purpose of non-discrimination.

However, this fact means that, if we intend to provide specific assistance according to multiculturalism, we must look for a formula that allows doing a follow-up, especially in the case of unaccompanied underage children, by establishing a control network that includes the observance of the rights of immigrant children in hospital. This should be done by the persons in charge of the underage immigrants in Detention Centres, together with NGOs and the Immigration Observatories.

Self-analysis questionnaires: for health staff, which allows for hospital and health services management to learn about the difficulties they encounter when caring for migrant children.

Conclusion: immigrant population is included in the most disadvantaged social strata. And it is therefore necessary to take measures to provide social and healthcare to this population in order to favour a correct development of their children.



Case-Study 2: Health care for migrant children in a Nordic welfare state - the case of Stockholm

Anders Hjerm

Since the 1960s the population in Sweden has gradually developed from being a homogeneous population with one language, one religion and one culture to a multicultural population with a lot of diversity. In the 1960s and the early 1970s immigration was dominated by young men and their families from southern Europe and Turkey migrated to Sweden to work in the Swedish industry. From the 1970's onwards immigration to Sweden has consisted primarily of refugees. In the 1970s and 1980s many refugees from the dictatorships in Latin America and the Islamic revolution in Iran settled in Sweden. During the 1990s and the first years of the 2000s, refugees have come mainly from the disintegrating former Communist countries of Yugoslavia and the Soviet Union, as well as from civil war-plagued Iraq and Somalia.

Many refugees in Sweden have settled in the greater Stockholm area where 2 million inhabitants live. 36% in the registered population below 18 years of age have at least one foreign-born parent and 8% were born in another country than Sweden. To this we need to add a few thousands of asylum seeking children and some hundred undocumented migrant children that do not show up in statistics of residents.

Stockholm is a very segregated city where immigrant families tend to settle in low status apartment areas in suburbs built in the 1970s and 1980s. Some of these housing areas have developed into just about "Swedish-free" areas, while other suburbs where native Swedish families live in residential housing area contain very few immigrant families.

The ethnic background of the non-Swedish child population is extremely heterogeneous. There is a fairly large population with roots in the Middle East, Christians as well as Moslem, from countries like Iraq, Iran, Lebanon, Syria and Turkey. Finnish is the largest Scandinavian minority, and there are also fairly large populations of Polish, Bosnian, Latin American and Somali families in the greater Stockholm area.

Health care for immigrant children who are residents in Sweden

Sweden has a strong welfare state where health and medical care on equal terms for all residents has been one of the guiding principles since 1940's. Hospitals and health care centres have traditionally been run by the society and funded by tax money. There have been some private health and medical care for children, within the tax-funded system, for many years and since 2008 the first insurance-based

health care centre for children opened in Stockholm. There are a several foreign-born paediatricians in Stockholm who work primarily with patients from their own ethnic group in private practice, but funded by tax money.

Interpreters

Anyone who needs an interpreter during a planned visit has a right to have one according to Swedish legislation. At Karolinska University Hospital at Huddinge, a hospital that serves the southern part of Stockholm where the proportion of immigrants is particularly high, there is a staff of interpreters in four major languages that can be used also in emergency cases and during child birth. Huddinge also has a multicultural staff in all wards, which means that interpreters can often be found among the personnel. In other hospitals, in primary care and for other languages interpreters from special agencies can be used. There is a medical course for interpreters in Stockholm, and in the major languages skilled interpreters with a basic medical education who have passed this course are available. For less common languages, however, interpreters less often are very qualified. In recent years the county has tried to save money by using less qualified interpreters, and there is currently a debate among health professionals about this.

Child health care

Health care for children is centred around the local child health care centres where nurses serve 4-700 children with the aid of consulting health professionals like physicians, psychologists and speech therapists. Each school has a nurse who is responsible for the school health program in collaboration with physicians who serve a number of schools.

Each family is registered with a general practitioner of their choice and there are also ambulatory paediatric clinics within primary care that take care of more complicated medical problems. Three hospitals in Stockholm have paediatric wards and emergency clinics. All health and medical care for children in Stockholm is free of charge. Prescribed drugs for the population are paid for by the society when they exceed approximately 150 euros a year.

When immigrants from Turkey and refugees from Latin America started settling in Stockholm in greater numbers in the early 1970s, child health professionals were very much in the forefront in the develop-

ment of a multicultural health care. Medical interpreters were trained and employed and used extensively in child health care centers. In areas where many immigrants settled, immigrants with a health education were employed and used as “cultural bridges” between the Swedish staff and their immigrant patients. Research projects described the needs of immigrant families in a child health care perspective and the meeting between Swedish health professionals and immigrant families in an anthropological perspective. Some special needs were identified, such as a higher rates of infectious disorders like hepatitis B and tuberculosis and prevention of caries and child injuries, two areas of child health where Sweden has been quite successful for many years. The larger picture, however, was better than most people had anticipated. Growth pattern were similar to the general Swedish population and mental health seemed to be at least as good as that of native Swedish children.

From early on immigrant families were attracted to the ambitious Swedish child health care in a similar manner as native Swedish families, and rates of immunizations and other routine procedures are as high, or even higher in immigrant families as in native Swedes. The number of visits to a physician in the child population in Stockholm is similar in children in immigrant families compared with the native Swedish population, but immigrant children tend to have more emergency visits in the hospital and fewer visits with primary care physicians. A reason for this pattern might be the language barrier which makes it difficult for some immigrant parents to make appointments in the primary care.

When refugees started settling in greater number in the greater Stockholm area in the 1980s greater needs for child psychiatric counseling and treatment were identified with previous labor migrants. Training programs and methodological developments focusing on the newly settled refugees were initiated and funded by the county and NGO's. and met by health care and child psychiatric clinics.

Health care for asylum-seekers and undocumented migrant children

Since the 1980s asylum-seekers have been settling in Stockholm in considerable numbers, often coming through Arlanda airport, which is the most important international airport in Sweden.

Asylum-seeking adults are entitled to receive subsidized health and medical care for treatment “which cannot wait,” i.e., treatment when a moderate delay can result in negative consequences for the patient's health. In the 1980s children had the same restricted rights for medical and health care. In the early 1990's, however, a campaign led by the Swedish Paediatric society and other child right NGO's reminded the Swedish government of the obligations made when the UN Convention on the Rights of the Child was signed. Article 2 was par-

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

This led to a new law that granted asylum-seeking children the same rights to health and medical care as other children in Swedish society in 1994, including preventive services and dental care.

In 1995 a special child health team for asylum seeking children was created in Stockholm. The team consisted of a nurse, two psychologist and two paediatricians who served asylum seeking families in the southern part of the city with basic child health care and to a certain extent also emergency care. The most important challenge for this team was to find ways of preventing the high prevalence of mental health problems observed in the children. A social support approach was used based on already existing resources such as child health care centres and the school system. Child health nurses offered individual support and information to refugee parents and in some areas organised parent groups for mutual support.

Much effort was put into trying to open up the nursery school system for asylum seeking children. After several failed efforts to establish special nursery schools for asylum seeking children, more and more places were eventually found within the already existing nursery school system in Stockholm. Finally, a state legislation that gave asylum seeking children equal rights to nursery school opened up the whole system for these children, which had a dramatic effect on the well-being of the preschool children.

The child health team for asylum seekers was closed in 2000 and since then the medical and health care for asylum seeking children has changed considerably to the worse. Recent reports have documented that the majority of asylum seeking children are not enlisted in child health care centres and that basic preventive measures like immunisations and screening programs are out of reach for many of these children.

Many children also show signs of significant mental illness during the asylum period. Asylum-seeking children are greatly overrepresented among the children being treated in in-patient child and youth psychiatric care. During 2002–2005 hundreds of asylum-seeking children in Sweden, the majority residing in Stockholm, developed severe and prolonged loss of functions, so-called severe withdrawal syndrome. Many of these children required energetic support interventions for long periods, including drip feeding and help with toileting. The number of children who have fallen ill in this way has diminished drastically following changes in refugee policy in 2005 and as a result



of improved support for families where asylum-seeking children are in poor mental health. With few exceptions, the children who became ill have also recovered, often after a long period of rehabilitation during which they regained their activities of daily life step by step.

Immigrants who are excluded from medical treatment

Sweden also has their share of migrants without a residence permit, who are not asylum seekers, the so called 'undocumented migrants'. Most of these are asylum seekers who have had their application for a residence permit rejected or labor immigrants without a work permit. For obvious reasons it is impossible to calculate precisely how many undocumented migrants are living in Sweden at a particular point in time, but it was estimated to be around 20,000 during the years 2003–2004.

Adult undocumented migrants are only entitled to 'immediate' health and medical care, which is a very narrow concept of emergency treatment. They are also liable to pay for the care they receive. When the number of undocumented children increased in the end of the 1990s there was again a lot of advocacy to change these rules based on Article 2 in the UN Convention of the Child. After having been reprimanded about this by the UN Committee in Geneva the government and county councils came in 2000 to an agreement whereby the children of families who have had their application for asylum rejected would have the same rights to health and medical care as other children in Sweden. Children in the remaining groups of undocumented migrants were, however, not included in this agreement and continue to have just as limited access to medical care as the adults.

The use of restricted access to medical care as a tool in immigrant policy, has stirred a lively discussion within the medical profession on the basis of medical ethics. In Stockholm, Gothenburg and Malmö special medical clinics for undocumented migrants have been opened, on a non-profit basis. Individual county councils have, on their own initiative, extended the rights of irregular immigrants to medical care but they receive no reimbursement from the government. But the greater Stockholm council has yet to join this initiative. The Swedish Paediatric Society has appealed to its members to offer undocumented children the same health and medical care as documented residents, and this appeal has in fact led to extensive disobedience to the state by the staff in the paediatric and child health clinics of Stockholm where care is indeed offered on more or less equal premises as for the rest of the population. A major problem in this effort to provide adequate care has been the fear that many undocumented migrants have, to be reported to police authorities if they are enlisted as patients in a clinic. In theory such reports are unlawful according to Swedish legislation that protects the secrecy of patients in care, but several cases of such reports have been documented in the media and caused great concern among the undocumented migrants.

Conclusion

In summary, the well-organised Swedish welfare state, within which care is provided to migrant children in Stockholm, has two very different faces of health care for migrants. The county seems to have been quite successful in integrating documented immigrant families into the health care system. Immunization rates and consumption patterns are quite similar to the general population and interpreters are available for patients that need them. But for those that are not accepted into the welfare state, asylum seekers and undocumented migrants, the situation is radically different. Although efforts have been made to protect children from the adverse consequences of restricting access to care as an integral part of a restrictive immigrant policy, there is no doubt that this limitation has in fact had an adverse effect on the health of the children in these families. For children in undocumented families the effects are great and is alleviated only by the widespread disobedience of the paediatric staff in hospitals and child health centres.

Case-Study 3: Progetto Intercultura: Re-organising services at hospital level to respond to the needs and rights of migrant children

Anna Zappulla

Facts, figures and trends

In a national and regional context of increasing immigration, the Meyer University Children's Hospital attempts to respond to the health needs of migrant children and their families not only in a treatment perspective, but also through the provision of health promotion services in a holistic perspective. The services provided aim to guarantee adequate information about the services, as well as guarantee access, appropriate use and participation in all services provided.

In 2008, 209 children of foreign national were hospitalised, out of 19,480 children. In addition, 385 accessed the out-patients' clinics and 115 access the emergency department, out of a total of 500 and 104,088, respectively. Most of these children were of Albanian, Romanian, Chinese, Moroccan, Peruvian, Iraqi and Algerian origin.

Background information and specific services for migrant children

The new Meyer University Children's Hospital has a capacity of 200 beds (including 50 beds for day hospital), 7 operating rooms, 9 diagnostic rooms and 5,000 square meters green areas.

One of the most important services focusing on migrant children's healthcare is the cultural and linguistic mediation. From the 2004, the hospital joined the Progetto Intercultura (Intercultural Project) of the Tuscany HPH Network with the aim to support migrant children and their families in order to:

- Facilitate the communication between service users and health staff;
- Guarantee as best as possible, access to all services provided by the hospital;
- Facilitate the work of hospital staff, which also due to different International Development Cooperation protocols, is increasingly in contact with patients from different backgrounds.

The hospital ensures cultural and language mediation in different languages, including Albanian, Arabic, Chinese, Romanian, Somali, French, English, Spanish, Polish, Czech, Slovak, Macedonian, Serbo-Croatian, German and Philippine. An interpretation service is also available via telephone, which is used especially in cases of emergency. This service is available from Monday to Saturday between 8 a.m. and 8 p.m.. Presently, this service is being mostly used in the

emergency service, in-patient departments and in the day-hospital. In 2008 the following languages were the most frequently used: Romanian, Arabic, Russian, Chinese, English, Iraqi and Macedonian.

Following the needs of the hospital and upon suggestion from the hospital staff, the SOS Intercultural Team was also activated. This group is composed of 22 professionals working in the hospital with language competence in 10 different languages: Albanian, Arabic, Bulgarian, French, English, Iranian, Romanian, Spanish, German and Hungarian. This team does not substitute the formal cultural and language mediation services, but provides an emergency substitute, face-to-face or by telephone.

The hospital has also provided other services for migrant children, which will be indicated in the achievements section below.

Description of practice

Timeframe and actors: The Progetto Intercultura started in April 2004 and is still operational; whilst it has been developed and improved throughout its existence. The main actors involved are health and administrative staff as an operative, motivated, trained and voluntary part of the project; the hospital management by being committed to contribute to a cultural change within the hospital; and civil society organisations (i.e. the agency for language and cultural mediation).

Aims and objectives: The project aims to re-orient the hospital services in a culturally-sensitive way; to receive and treat all children who arrive at the hospital appropriately through the respect of their cultural and religious and other social backgrounds; and to prevent and overcome discrimination against migrant children in accessing and understanding hospital services.

Target group: Migrant children and their families.

Precondition needed for export: a proactive hospital management and a motivated staff. All staff should be properly trained and have a high-level language competence, in order to be a real asset in cultural mediation.



Achievements and lessons learned

- To ensure the respect for the spiritual and cultural dimensions of health, the hospital undertook: the dissemination of the contacts of the religious entities present in the region in all departments and services; ratification of a protocol between the hospital and religious communities to ensure the necessary religious assistance to the patients of migrant background; and preparation of 'Intercultural' Calendars in 2006 and 2007, which were disseminated in every department and service to increase awareness of the main religious events. The hospital also provides 'free and flexible' menus, which are translated into different languages. The aim is to guarantee, as much as possible, the respect of the different cultural and social eating habits.
- Although one of the aims of the Progetto Intercultura was the increased access of migrant children to healthcare services, there has been no assessment to evaluate the extent to which improvement has been achieved.
- In 2005 and 2006 the hospital promoted a training course entitled 'At the Meyer Hospital we want them in one thousand colours', with the aim to increase cultural awareness amongst hospital staff. The two-day training (total of 16 hours) was attended by over sixty percent of both health and administrative staff.
- In 2008, 24 migrant children (out of 108) were provided home care services. The interesting fact is that all foreign children were of Albanian nationality. This may indicate that children and families of Albanian origin are more integrated into Italian society and therefore have more information of the services available and how to request them. If this is the case, the hospital should promote actions to ensure that other populations of migrant or ethnic minority background have more information and access to different healthcare services.
- The hospital has signed and approved a Charter of Children's Rights in Hospital. This demonstrates the hospital's commitment to ensure the respect, protection and realisation of children's rights in hospital. It is also possible to say that other hospital policies and characteristics of the hospital are contributing to the realisation of children's rights in hospital: the new and innovative hospital infrastructure has guaranteed a new arrangement of spaces, playgrounds, education spaces and common spaces adequate to children's needs and an upgrade of rooms, with the availability of single and double rooms with private bathrooms, as well as, the possibility for parents to stay in children's rooms during hospitalisation.
- Regarding hospital forms and information material, the hospital has produced: Frequently Asked Questions (FAQs) Guides to communication with foreign patients for both the administrative office that receives patients and the emergency department; information material about informed consent and the preparation of patients in the radiology department; and the publication of a booklet entitled 'What is Tuberculosis?', which has been translated into 8 languages and distributed in hospital departments, services and schools. At present, the hospital is also preparing for publication the production of an information leaflet to be translated into 8 languages on the Newborn Screening Programme undertaken by the hospital at regional level for the diagnosis of genetic and rare diseases. The leaflet will be distributed to parents at the time of birth.
- For the care of pain, the hospital has information in Italian, Albanian, Romanian, Arabic, Chinese, English, French and Spanish.
- With the aim to contribute to the protection from all forms of violence against children and the elimination of traditional practices harmful to the health of children, in collaboration with a local cinema school, the Health Promotion Programme designed and prepared a short-movie on FGM. On a first occasion, the movie was presented in the hospital to an audience of approximately 100 people, to whom the DVD was freely distributed. The DVD has also been sent to national and international partners, local libraries and, in partnership with the local government, distributed to all local educational institutions.
- The strongest point of the project is the motivation of health staff. On the other hand, one of the weakest points has been the lack of strong commitment by the hospital management.

Conclusion

Within the framework of the Progetto Intercultural, the Meyer University Children's Hospital has promoted a number of initiatives aimed at improving both the access and the quality of healthcare given to migrant children. The project is seen by the responsible staff as of major importance, however there has been no systematic evaluation of the project. There have also been some organisational challenges, including the opening of the new hospital at the end of 2007 and the change of the Hospital's management structure. Despite this, the project is ongoing.

Case-Study 4: “Easing Transitions” – the case for child-centred interdisciplinary work with asylum seeking children in Ireland

Lynda Stokes and P.J. Boyle

This case study focuses on a primary healthcare project aimed specifically at newly arrived asylum seeking children in Ireland.

Historically Ireland has been a country of net emigration. However over the past decade Ireland’s demographics have changed significantly with over 10% of the population being of Non-Irish origin (CSO2007). Ireland has the fastest growing population in the European Union recording an 8% rise in population between 2002 and 2006. This shift from a monocultural to a more culturally diverse population continues to provide challenges and opportunities for Irish society. The earlier part of this decade in Ireland saw a significant growth in the number of asylum seeking and refugee applications, a large percentage of this group were children (ORAC, 2008).

In Ireland a system of ‘Direct Provision’ (accommodation and basic provisions) has operated since 2000 (www.orac.ie). This system is controlled by an agency of the State Department of Justice, known as the Reception & Integration Agency (www.justice.ie www.inis.gov.ie). When this system was first established little or no attention was given to the fact that a significant proportion of newly arrived asylum seekers were children or to accommodating their health, development and wellbeing rights as children within the asylum accommodation system i.e. spaces for play, health and safety issues, diet and nutrition, access to early education etc.

The healthcare needs of asylum seekers who live in accommodation centres are met by staff from the primary care services of the Health Service Executive (National Health Service). The project outlined here is a specific service offered to asylum seeking children living in the ‘Reception Stage’ of the asylum process in association with other primary healthcare services available to families and individuals such as voluntary health screening, maternity care, psychology and general practice (Boyle et al 2008). Since 2008 the HSE has begun to implement actions from its National Intercultural Health Strategy, of which is mentioned the needs of migrant children and asylum seekers (www.hse.ie). In Ireland the Asylum Seeker population have access to full health services i.e. emergency, generic and specialist medical services and follow-up. In undertaking a data search for this case study on specific reports for migrant children accessing health services in Ireland there was a demonstrable lack of published material on this topic.

The children’s service within the asylum accommodation system (reception) was established in 2002 following concerns raised by

paediatric nursing staff for the health and welfare of asylum seeking children living in accommodation centres. At the time accommodation centres were not conducive to meeting the needs of children as obliged under Ireland’s obligations to the UNCRC. Consequently a number of nursing staff and voluntary NGO members led a project proposal for sustainable funding to establish a specific interdisciplinary and primary healthcare focused children’s service within the Direct Provision accommodation system. We were successful in our proposal to establish a generic early childhood facility that later included a specialist play therapy service. The service is now a fully operational professional service catering for newly arrived children and has been used as an example of best practice for establishing similar services in other centres nationally and elsewhere in Europe.

The following narrative is based on research carried out as part of a Masters Programme in Play Therapy by Lynda Stokes (2008).

Counteracting the Problems Facing Children and Families within Direct Provision

In a refugee reception centre asylum seekers have left behind extended family, older siblings, possibly a primary caregiver and also friends that can leave the child feeling isolated and alone. The vulnerability of a child going through the asylum process is exposed and may require due care and consideration to encourage a continuation of healthy development.

Further obstacles experienced by asylum seekers in direct provision include potential language and cultural differences, which sometimes require the use of a translator. A secondary consideration is that some adults may be unwilling to impart their full case history. They can maintain natural suspicions of the mechanisms of the asylum process because their credentials are under scrutiny. A result of this can be misleading information or omission of past experiences. For example a parent may not divulge that they have already sought asylum in a different country before arriving in Ireland. This short stay in another country may have had a big impact on the child. To overcome these barriers, greater emphasis on confidentiality has proven effective. Sensitivity to such experiences serves to develop a stronger rapport with parent/s.

It can be the case that while parents of asylum seeking children want their children to benefit from the Children’s Service their full attention may not be present due to the external factors of the asylum process.



For this reason particular emphasis should be placed on the role of the parent. Linking with the interdisciplinary team that can provide supports to the parent is essential as they may also be experiencing their own difficulties based on their personal experiences.

“Minority ethnic parents are usually on their own and without traditional family supports so they have a great need for guidance and support as they negotiate family life in a new culture (Pillinger, 2008).”

As part of the government procedures for seeking asylum, various stages need to be traversed. Throughout this process children do not have a choice in these upheavals and are often not informed of the situation. It is this aspect of the transient nature that may be seen as negative in terms of the child’s development. Within the context of institutional care emphasis is continually placed on the persistent experiences of disruption and trauma.

“Whether or not the outcome of an asylum case result is positive, the months, or more frequently years that a child lives during the asylum process are foundation years in his/her development. For many children, it will be the first step of integration into Irish society. The resources and support that children and their families receive will either assist them to move to full participation in Irish communities or will be the first step to marginalisation and social exclusion (Fanning, Veale, O’Connor, 2001).”

Within the context of direct provision the point is raised that institutional living as part of the asylum process may have a negative impact on children.

“It is also suggested that the stresses of resettlement create an important context that surrounds and impacts on the mental health needs of refugee children and families as well as on any mental health interventions (The National Child Traumatic Stress Network, 2005).”

The dislocation experienced may serve to intensify any negative experiences retained by the child as a result of fleeing their country of origin. This service represents the position that intervention at the earliest point can help the child find resolutions that encourage normal stages of development to continue.

The Children’s Play Service

The Children’s Service is an essential part of the healthcare provision on premises. It serves to provide a safe and contained space for children who are experiencing the difficulties of the asylum process. In tandem with the children’s groups that are run daily a specialised play therapy service is provided. This allows referrals to be taken for one to one work with children who are in particular need of a therapeutic intervention.

“There are many experiences in childhood in which children feel they have little or no control. Play is children’s way of working out balance and control in their lives for, as children play, they are in control of the happenings in play, although it may not be possible to be in control of the life experience represented in the play (Landreth, 2002).”

The operation of these children’s services within the centre primarily focuses on meeting the developmental needs of the children. The aim is to provide a stimulating and happy environment from where the children can acclimatise to their new host country. There is an emphasis on freedom of expression and support derived from their peer group who are experiencing similar shifts in their home life. It provides a consistent routine and structure that serves to counteract the instabilities inherent in the asylum process.

Early intervention, such as interdisciplinary work and play therapy, can equip a child with increased resilience, positive identity formations and better coping mechanisms to overcome negative effects that may occur as a result of changing life circumstances.

In cases where children are coming from numerous social backgrounds and contexts, with less developed skills for social interaction, play is embraced as a common and safe ground. The significance of such an environment in a refugee reception centre is broad. Initially a space is provided for children to present themselves as individuals. Outside of the family, community and nation, the child is allocated a social space for their sense of self. A transition period is initiated between the outside disruptions that cause the child to depart from their home and a new environment with unfamiliar surroundings and different social orders.

Achievements and Lessons Learned

The children’s services and healthcare provision on premises attempts to take into account all aspects of migrant’s children’s health and development. The process of working with the interdisciplinary team facilitates broader access to specialised care such as psychologists, the GP service and nursing specialists. Open communication between the team makes each individual more aware of the client’s circumstances. For example if parents inform health screening staff of trauma experienced by their child, a referral will be made to the play therapy service.

There is a need to acknowledge that some children are presenting with behaviours that stem from trauma. This may be as a result of the cultural bereavement they have experienced and their current living conditions as a possibly temporary guest in Ireland. Simply because their citizenship is uncertain, it does not mean that they should not be afforded the same duty of care given to the indigenous population.

Background Paper

Assisting Migrants and Communities (AMAC) Project

“The multi-dimensional effects of trauma on children and their families are compounded by forced uprooting, multiple losses, and the myriad of changes brought about by migration. Children as a group have greater dependence on outside sources for their protection and care and have their own specific developmental and emotional needs. . . Refugee children are a silent group that are easily overlooked. Attention to the mental health needs of this vulnerable group by government and other policy makers is urgent (Fazel, & Stein, 2002).”

Early childhood interventions that recognise the value of play as a scientifically proven method already exist in paediatric healthcare settings. These are utilised in the acute care setting and in the primary health and social care context. Early intervention can alleviate broader challenges to a child’s developmental progress and improve integration into schools. It is a common characteristic of the asylum process that families are unsettled due to the number of transitions that they have experienced. The availability of more specialised services for chil-

dren would have the effect of neutralising disruptions within family dynamics to refocus care and attention back onto the child. Furthermore it would provide other services working on the frontline with asylum seekers (i.e. primary healthcare or acute care environments) recourse to refer cases for a specialised intervention that may otherwise remain unresolved.

The specialised service explained in this case study demonstrates that the HSE has been attentive to the needs of asylum seeking children and families. In recognising these unique needs the service achieves the aims of health promotion and prevention. A unique characteristic of this project is how it incorporates an interdisciplinary healthcare model of working with children in transition. In doing so it enables a better standard of health and well-being for this group by assisting with the integration process and thus allowing for healthier and socially harmonious communities.



Emerging findings

Cross-analysis of the different practices presented, according to the rights identified in the introduction of the paper

The case-studies presented above present a good picture of the complexity of the migration phenomenon and, in particular, of the role of hospitals, health services and governmental bodies in tackling the challenges inherent to it. Appendix 8 provides a quick comparison of the findings and results presented in each of the case-studies in relation to the outlined health dimensions, the right to information and participation, as well as the right to protection from all forms of violence, as presented in Chapter 2 of the paper. Overall, the case-studies show evidence that:

- There is a need to understand the complex needs of children and the dynamics that come with the migration phenomenon in order to provide services, which meet their developmental, health and integration needs;
- Health professionals must be given the resources to provide appropriate healthcare to migrant children, which include training and a legislation supportive of the provision of continuous and holistic healthcare to all groups of children;

Furthermore, these case-studies demonstrate the importance of ensuring the implementation, respect, promotion and fulfilment of the provisions of the Convention, especially its guiding principles; and the potential of the Convention as a framework of protection for all children.

Conclusions

The increase in immigration trends in Europe in the last decades has reflected in the growing attention of international organisations at large and services in particular of the human needs that come with that phenomenon. The Convention on the Rights of the Child, together with the Strategies, guidelines and initiatives of the International Organisation of Migration, UNICEF and WHO provide both knowledge and guidance to national health systems, hospitals and health services in ensuring the right of migrant children to healthcare.

The aim of this paper was to provide evidence of how hospitals and health services across Europe are ensuring the right of migrant children by taking into account those guidelines, including the provisions of the Convention and the holistic concept of health by WHO. Section 1 and 2 provided considerations for hospitals and health services on how to ensure the right of migrant children to healthcare in relation to these provisions. In addition to this, the good-practices and especially the case-studies demonstrate how hospitals and health services are called to respond to migrant children's right to healthcare and how they are doing it. The questions below provide a reflection on the main findings of the paper and present some suggestions on how to improve and support the response of hospitals and health services in ensuring the right of migrant children to healthcare.

How is migrant children's right to healthcare being met by hospitals and health services?

- There is a vast range of epidemiological data and literature reporting the health status of various groups of migrant children, but few that assess their right to healthcare and even fewer assessing the respect, protection and fulfilment of their rights in hospital;
- There is a lack of documentation on hospital and health services' practice, which makes it difficult to assess their effective performance and to improve it;
- Most documented programmes focusing on migrant persons either deal with adults in general or with maternity care (including pre and post-natal services). Migrant children are seldom addressed as a specific target group and 'migrant-child' services are hard to find, especially services dealing with children in a holistic manner;
- The good practices and case-studies demonstrate the range of activities available and their effectiveness in ensuring the right of migrant children to healthcare: international organisations and national health systems should provide the resources to implement them;
- Following the experience and findings of this paper, it is important to suggest that a European-wide research initiative to assess the delivery

of specific healthcare services for migrant children would be very useful in understanding effectively how hospitals and health services are ensuring the right of migrant children to healthcare and how it can be improved.

What type of assessment instruments may be adopted by hospitals and health services to evaluate the respect of migrant children to healthcare?

- Top-down approach: instruments from external agencies, such as Ministry, regional or local inspectorate services;
- Bottom-up approach: external evaluation from advocacy/civil society organisations, which independently, voluntarily or in partnership with hospitals and health services carry out the assessment;
- Self-evaluation: by hospitals and health services of how they are meeting migrant children's right to healthcare: the Self-evaluation model and tool on the respect of children's rights in hospitals could contribute to this.

Common responsibility, common action: Complementarity between the work of international agencies, governments, civil society organisations, hospitals and health services

- International agencies should assist governments and national health systems in developing instruments for monitoring migrant children's right to healthcare;
- Governments should ensure that national health systems, hospitals and health services protect, respect and fulfil migrant children's right to healthcare;
- Civil society organisations should provide advocacy for migrant children at community level and with hospitals and health services;
- Hospitals and health services have the duty to ensure the fulfilment of migrant children's right to healthcare, to empower them and their families and to contribute actively to the fulfilment of their human potential.
- This complementarity and the synergy between these levels of action could be done by setting up a reference structure for monitoring the respect, protection and fulfilment of migrant children's right to healthcare. This structure could possibly be part of a wider structure that monitors the respect of the rights of all hospitalised children, with particular attention being given to the more vulnerable groups of the population, such as migrant children, but also children with disabilities, experiencing poverty and other groups at risk.



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Background Paper

Assisting Migrants and Communities (AMAC) Project

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Footnote

- i According to the 1951 Convention Relating to the Status of Refugees, a refugee is a person who flees to a foreign country to escape danger "Owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of their nationality, and is unable to or, owing to such fear, is unwilling to avail him/herself of the protection of that country." A person who is seeking to be recognized as a refugee is an asylum seeker.
- ii This notion was put forward by the World Conference on Human Rights (1993) and reaffirmed by the Committee on the Rights of the Child in its General Comment N°. 4 on Adolescent health and development in the context of the Convention on the Rights of the Child.
- iii The International Bill of Human Rights comprises the Universal Declaration of Human Rights (UDHR) and the two International Covenants on Civil and Political Rights and on Economic, Social and Cultural Rights
- iv The interpretation of the general principles follows the guidelines for reporting within the context of the Convention on the Rights of the Child, as set out in the UN Manual on Human Rights Reporting under six major human rights instruments (1997)
- v For more information see the Amsterdam Declaration on Migrant-Friendly Hospitals available at: http://ec.europa.eu/health/ph_projects/2002/promotion/fp_promotion_2002_Appendix7_14_en.pdf
- vi The design of this figure was inspired in the work done by Donabedian, A. (1980); The definition of quality and approaches to its assessment, (Explorations in Quality Assessment and Monitoring , Vol 1), Health Administration Press and Lawrence, P. and Lorsch, J. (1967) Organization and Environment; Boston: Harvard University Press
- vii These considerations draw from the TF HPH-CA Self-evaluation model and tool on the respect of children's rights in hospital, referred to in section 4 of this paper.
- viii For example of a community based project of this nature see the ABCD project at <http://www.abcdcymru.org.uk/>
- ix For more information visit the United Nations Secretary-General's Study on Violence Against Children at <http://www.violencestudy.org/r25>
- x For more information visit: <http://who.collaboratingcentre.meyer.it>
- xi To access the EACH Charter, please go to: <http://www.each-for-sick-children.org/each-charter>
- xii To access the ICPCN Charter, please go to: <http://www.icpcn.org.uk/page.asp?section=000100010014§ionTitle=Charter>
- xiii For more information see the full report available at: www.mkc.cz/uploaded/download/Libraries_as_Gateways.pdf
- xiv Personal communication with the Asociación Salud y Familia in March 2009
- xv For further information please visit <http://www.saludyfamilia.es/eng/projectes/familieshosp.htm>
- xvi *Ibidem*
- xvii Personal communication with the Bamibino Gesù Children's Hospital in May 2009
- xviii For further information please contact Lucia Celesti at lucia.celesti@opbg.net
- xix For more information on the ABCD project, visit <http://www.abcdcymru.org.uk/>

Appendixes

Appendix 1: Definition of Health, World Health Organisation

Health is defined in the WHO constitution of 1948 as:

A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. Within the context of health promotion, health has been considered less as an abstract state and more as a means to an end which can be expressed in functional terms as a resource which permits people to lead an individually, socially and economically productive life.

Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities.

(Reference: *Ottawa Charter for Health Promotion*. WHO, Geneva, 1986)

In keeping with the concept of health as a fundamental human right, the Ottawa Charter emphasises certain pre-requisites for health which include peace, adequate economic resources, food and shelter, and a stable eco-system and sustainable resource use. Recognition of these pre-requisites highlights the inextricable links between social and economic conditions, the physical environment, individual lifestyles and health. These links provide the key to an holistic understanding of health which is central to the definition of health promotion.

Today the spiritual dimension of health is increasingly recognised. Health is regarded by WHO as a fundamental human right, and correspondingly, all people should have access to basic resources for health.

A comprehensive understanding of health implies that all systems and structures which govern social and economic conditions and the physical environment should take account of the implications of their activities in relation to their impact on individual and collective health and well-being. WHO (1998); *Health Promotion Glossary*; Geneva; WHO/HPR/HEP/98.1

Appendix 2: Article 24 and General Principles of the Convention on the Rights of the Child

Article 24.1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such healthcare services.

Article 24.2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

- a. To diminish infant and child mortality;*
- b. To ensure the provision of necessary medical assistance and healthcare to all children with emphasis on the development of primary healthcare;*
- c. To combat disease and malnutrition, including within the framework of primary healthcare, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking water, taking into consideration the dangers and risks of environmental pollution;*
- d. To ensure appropriate prenatal and postnatal healthcare for mothers;*
- e. To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;*
- f. To develop preventive healthcare, guidance for parents and family planning education and services.*

Article 24.3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

Article 24.4. States Parties undertake to promote and encourage international cooperation with a view to achieving progressively the full realisation of the right recognised in the present Article. In this regard, particular account shall be taken of the needs of developing countries.
OHCHR (1989); *Convention on the Rights of the Child*

Article 2. 1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

Article 2. 2. States Parties shall undertake all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions or beliefs of the child's parents, legal guardian's or family members.

Article 3.2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her and, to this end, shall take all appropriate legislative and administrative measures.



Article 3.3. States Parties shall ensure that the institutions, services and facilities responsible for the care and protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

Article 6.1. States Parties recognise that every child has the inherent right to life.

Article 6.2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

Article 12.1. States shall assure to the child who is capable of forming his or her own view the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

Article 12.2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

Appendix 3:

Health Promotion for Children and Adolescents in Hospitals – Background Survey: participating countries

Country & Number of participating hospitals

Austria	16
Belgium	1
Estonia	2
France	14
Finland	1
Germany	4
Greece	2
Hungary	1
Ireland	13
Israel	2
Italy	12
Kazakhstan	1
Lithuania	1
Netherlands	26
Poland	1
Russia	1
Slovakia	1
Spain	1
Sweden	5
Switzerland	1
United Kingdom	7

Total number of participating hospitals 114

Appendix 4:
Self-evaluation model and tool on children's rights in hospital and health services: Summary of areas and rights

Self evaluation tool: Children's rights in hospital and health service

Area 1: Right to the highest attainable standard of healthcare

Right 1.1 Children's healthcare provision should take into consideration all dimensions of health, including physical, mental, social, cultural and spiritual.

Right 1.2 Children have the right to access health services without ethnic, racial, class, religious, gender, age, sexual orientation, disability, language, cultural and social discrimination.

Right 1.3 Children shall be admitted to hospital only if the care they require cannot be equally well provided and effective at home or on a day basis.

Right 1.4 Children have the right to have full opportunity for play, rest, leisure, recreation and education suited to their age and condition and to be in an environment designed, furnished, staffed and equipped to meet their needs.

Area 2: Right to information and participation in all decisions involving their healthcare

Right 2.1 Children have the right to be informed in a manner appropriate to their age, developmental level and understanding.

Right 2.2 Children have the right to express freely their opinions on any issue that involves them and the right to be heard and to be taken into consideration in a way consistent with their age and maturity.

Area 3: right to protection from all forms of violence

Right 3.1 Children have the right to be protected from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse.

Right 3.2 Children have the right not to be separated from their parents/guardians/caregivers against their will during their stay in hospital.

Right 3.3 Children have the right to privacy.

Right 3.4 Children have the right to a dignified death.

Right 3.5 Children have the right not to feel pain.

Right 3.6 Children have the right not to be submitted to clinical research or experimentation projects and to have the possibility to withdraw during the process of research.

Appendix 5: Criteria for a Good Practice

The following set of criteria were identified by the TF HPH-CA after a literature review and discussion within the group with the aim to identify good practices for health promotion, following the work done Irving Rootman *et al* (2001) and Kahan and Goodstadt (2001).

Criteria for "good practice" in health promotion include:

- 1) Empowering: enabling individuals/communities to assume more power over their personal, socio-economic and environmental factors that affect their health;
- 2) Participatory: involving all concerned at all stages of the process;
- 3) Holistic: physical, mental, social and spiritual health;
- 4) Equitable: explicit and implicit aims at equity and social justice;
- 5) Integrated / inter-sectoral / multi-strategic:
 - include improvement(s) for individuals and settings;
 - be multi-professional (staff);
 - involve all relevant sectors.
- 6) Sustainable: incremental quality improvement over time.

"Good practice" should also fulfil managerial and scientific criteria:

- 7) Accepted: acceptance of the practice by all main stakeholders groups (e.g. patients, involved professionals, hospital management);
- 8) Documented / evaluated: that can demonstrate what results are achieved;
- 9) Effective and efficient: practice has positive outcomes and a good cost-benefit relationship;

Finally there are two additional criteria from the perspective of dissemination:

- 10) Innovative: it is not standard or well known routine at the time of publishing;
- 11) Transferable: be repeatable or replicable for other practitioners with limited modifications.

Task Force on Health Promotion for Children and Adolescents (2007); Template for Description of Good Practices; available at: <http://who.collaboratingcentre.meyer.it/>



Appendix 6:

Programme *Nós* – Portuguese High Commissioner for Immigration and Intercultural Dialogue

The Portuguese High Commissioner for Immigration and Intercultural Dialogue (ACIDI) and CAIS (a non-profit organisation, whose mission is to help homeless, vulnerable and people at risk of social exclusion) joined together to promote the programme *Nós*, whose first emission went on air on the 11th of January 2004.

Nós is a weekly one-hour magazine showed on public television. The programme is dynamic and joyful and is committed to the integration and welcome of the communities that chose Portugal as a host country. It privileges the cultural and social richness that the distinct communities bring to the country through the presentation of life stories, gastronomy, sports, culture, etc.

The aim of the programme is to create a bridge of information with the civil society, through the presentation of interviews; debates about current issues; informative coverage on the rights and duties of the immigrant citizens; connection with immigrant associations and the various services provided by the civil society and the State.

For more information visit: <http://www.acidi.gov.pt/>

Appendix 7: Case-Study Criteria

Facts, figures and trends on migrant children's right to health-care within each 'case-study hospital' (i.e. access, treatment, etc)

This section should provide statistical information on the number of migrant children that have access to the hospital services, type of treatment received and other relevant information.

Background information on the hospital and specific services for migrant children

This section should provide general information on the hospital and specific services that are promoted both in and by the hospital in respect to migrant children and their right to healthcare (i.e. health promotion programmes and programmes on the respect of children's rights in hospital).

Description of practice

- Aims and objectives;
- Timeframe;
- Main actors involved (i.e. hospital management, health professionals, voluntary staff and civil society organisations);
- Target group (i.e. migrant children 0-5, 5-10, 10-15/18; children and

- parents/mothers/family) and number of beneficiaries, if relevant;
- Preconditions needed for export: funding, training, human resources.

Achievements and lessons learned

This section should provide information on how the programme/intervention has ensured the fulfilment of migrant children's right to health-care, by responding to:

- Has the programme taken into account all dimensions of migrant children's health, including the physical, mental, social and spiritual elements?
- Has the programme improved the access of migrant children to health services, including through positive action?
- Has the programme used staff with appropriate language and cultural competences?
- Has the programme provided for care of migrant children within their home setting?
- Has the programme considered migrant children's right to play, rest, leisure, recreation and education according to their language and cultural background?
- Has health information regarding the programme, been translated in the mother tongue of the target population?
- Has the programme ensured migrant children's right to express freely their opinions, decisions and complaints?
- Has the programme taken into account any form of violence suffered by the child prior to hospitalisation, in the home-setting or during migration (in case of newly settled migrant children)?
- Has the programme ensured the respect for the right of migrant children not to be separated from their parents during hospitalisation?
- Has the programme provided for specific interventions regarding the dignified death of migrant children in a culturally-appropriate way?
- Has the programme provided for specific interventions regarding the right of migrant children not to feel pain?
- Has the programme ensured the respect of migrant children's right to privacy during hospitalisation?
- Has the programme ensured the respect of migrant children's right not to be submitted to clinical research or experimentation projects?
- Has the programme improved the quality of the services provided by the hospital to migrant children?
- Have migrant children and their families participated in programme design and implementation?
- Has the programme contributed to build a social support network for migrant children?

Appendix 8: Summary of case-study results and findings

Rights Health dimensions Information and Participation Protection from all forms of violence

Case-study 1

Comprehensive Training Manual on immigrant patients by the Spanish Paediatric Society of Hospital and Primary Care;

- Detailed information of specific pathologies in different geographical areas;
- 'Migratory bereavement' healthcare provision;
- Importance of interpretation services;
- The Protocol of Action and Coordination defines: Provision of adequate and continuous healthcare to unaccompanied and accompanied minors under 18;
- Referral channels to ensure the continuity of care.

Case-study 2

Respect for the cultural and spiritual dimensions;

- Charter on Children's Rights in Hospital;
- Social communication and cultural awareness raising activities;
- Training session on how to work within a multicultural health setting and with foreign patients. Importance of interpretation services;
- Charter on Children's Rights in Hospital;
- Translation of health information into a variety of languages.

Charter on Children's Rights in Hospital

Case-study 3

Training sessions on methodological and developments focusing on newly settled refugees;

- Positive impact of multidisciplinary healthcare team for asylum seeking children;
- Legislation ensures the right to interpretation services;
- Skilled interpreters with basic medical education are available for the major foreign languages;
- For the less common languages, less qualified interpretation personnel is available;
- Individual support and information provided to refugee parents by nurses;
- Legislation guarantees the right of asylum-seeking children to the same healthcare as native children;

Positive impact of Legislation guaranteeing the right of asylum seeking children to national nursery school;

Case-study 4

National Intercultural Health Strategy

- Positive impact of multidisciplinary healthcare team for asylum seeking children;
- Understanding the complexity of children enables to provide the adequate response and meet the developmental needs of children;
- Positive impact of play therapy;
- Importance of the involvement of parents;
- Provision of a safe and contained space for refugee children;
- Increased resilience in children;
- Ease of the integration process.
- Emphasis on freedom of expression/recognition of its importance;
- Positive impact of play therapy;
- Referral of children in need of therapeutic interventions.



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