Children and migration: disease and illness

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Poverty, political turmoil, armed conflict, and human trafficking are but a few factors that lead to the significant migration of children. Researchers claim that the burden of ill health, infection, and emotional disturbance is much higher in child migrants than in other children (Hjern & Bouvier 2004). More than one-quarter of refugee children in the UK are believed to have significant psychological disturbances (Fazel & Stein 2003). Scandinavian studies of refugee children indicate that 40 to 50 percent of children in asylum-seeking families suffer from psychiatric and psychosomatic symptoms (Ekblad 1993; Almquist & Brandell 1997; Hjern et al. 1998). Almost all subjects (94%) among a group of internally displaced Bosnian children fulfilled the criteria for post-traumatic stress disorder (PTSD) (Goldstein et al. 1997). Similar findings were reported about Sudanese refugee children in Uganda (Paardekooper et al. 1999). Rates of PTSD varying from 11.5 to 28 percent were found in refugee children from Tibet and Bosnia (Weine et al. 1995; Servan-Schreiber et al. 1998). Children who experienced war in Cambodia and former Yugoslavia reportedly had PTSD prevalence rates of 40 to 50 percent upon resettlement in the US (Weine et al. 1995; Servan-Schreiber et al. 1998; Papageorgiou et al. 2000).

Forced migration, trauma, and health

Many health problems faced by migrant children are attributable to migration, particularly forced migration. However, entrenched poverty, hunger, and infectious diseases in many countries have significantly affected migrant children's health well before they left or were forced out of their homes. Post-migration experiences of insecure asylum status or undocumented immigration, continued poverty, and lack of access to health care can also adversely affect migrant children's mental and physical health (see Frates et al. 2003; Heiptinstall et al. 2004). For example, Sack et al. (1996) have argued that while war trauma is associated with PTSD, depression in children is strongly correlated with stressful events after resettlement.

The discourse about the health and illness of migrant children is dominated by discussions of trauma, pathology, and vulnerability (Hart 2006; Ensor & Gozdziak 2010). The prominence of the discourse of trauma as a major articulator of migrant children's suffering (Summerfield 2000) is based on the premise that ethnic cleansing, war, ethnic strife, and human trafficking constitute mental health emergencies and result in "post-traumatic stress." According to UNICEF, "10 million children have been psychologically traumatized by war in the past 10 years and . . . psycho-social trauma programs must be a cornerstone of their rehabilitation" (Bracken et al. 1997: 439).

Claims about mass psychological problems among war-affected children often stem from the use of screening instruments and diagnostic tools that have not been validated on populations living outside Europe or North America. Summerfield (2000) cites a striking example of a UNICEF (1996) survey of 3,030 Rwandan children aged 8–19 years using the Impact of Events Scale and a Grief Reaction Inventory, tools commonly used to assess bereaved children in the West. The survey concluded that there were high levels of post-traumatic stress requiring urgent treatment to "restore a sense of hopefulness about their future and to prevent long term sequelae such as depression and anxiety disorders." Summerfield points out that "this seems a poor empirical basis for a generalization which risks stigmatizing whole

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populations of children as sick or permanently damaged" (2000: 8).

Research on migration and mental health

Methodologically, research on migrant children's well-being is usually carried out by Western mental health experts in clinical settings far removed from the cultural and social contexts where children's lives take place (Hart 2006: 7; Ensor & Gozdziak 2010: 21). Not only do these studies focus almost exclusively on pathology rather than resiliency, but they also center on child migrants in particularly challenging circumstances – unaccompanied minors, child soldiers, refugee children, and trafficked children. Moreover, research favors children who have settled in Europe or North America to the detriment of studies of children who migrate within the global South (Leavey et al. 2004).

The emphasis on traumatic experiences of migrant children has led to the use of treatment modalities based on the Western biomedical model. In the mid-1990s, UNICEF established the National Trauma Program in Rwanda (UNICEF 1996). The National Trauma Center, with its headquarters in Kigali, provided intensive therapy for traumatized children and their families. By 1996, over 6,000 "trauma advisers" had been trained in basic trauma alleviation methods. They reportedly assisted 144,000 children. Similar efforts to train mental health staff were undertaken by UNHCR and WHO in Bosnia and Croatia (Summerfield 1999). A UNICEF-sponsored child trauma program in postwar Bosnia reportedly interpreted everything in the bearing and behavior of children and their parents in terms of post-traumatic stress, ignoring factors such as family poverty and domestic violence. A Western psychologist recommended that refugee children in a remote camp in Sudan lacking basic amenities use plasticine to work through their war traumas (Summerfield 2000).

The prominence of mental health programs in refugee camps, resettlement sites, and detention centers is directly related to what Kleinman (1995) calls the "medicalization of human suffering" and Hughes (1994) labels a "culture of victimhood." Medicalization is a widespread tendency to expand the meaning of medical diagnosis and the relevance of medical care. As a result of medicalization, migrant children's suffering is transformed into a psychiatric condition (a disease). An existential experience of tragedy, human rights abuses, and loss is converted into technical problems that transmogrify its existential roots (Kleinman 1995: 34). Furthermore, medicalization not only reconstructs human experiences, but also, as Illich (1976), Pupavac (2002), and Summerfield (1999) have argued, the exultation of biomedicine may actually diminish the capacity of migrant children to deal with anxiety and suffering, deny their resiliency, render them incapacitated by their dramatic experiences and indefinitely dependent on external actors for their psychosocial survival.

Despite finding rather high rates of poor psychological outcomes such as PTSD, depression, and anxiety, several groups of researchers concluded that refugee children are a highly functioning group, and that their school performance and academic achievement are often unaffected by their traumatic experiences (Fox et al. 2004; Geltman et al. 2005). Refugee children are enormously resilient (Crowley 2009). The disposition of the child, family support, and a positive relationship with parents as well as environmental support from teachers, peers, and service providers have been identified as protective factors during various phases of the refugee experience (Berman 2001; Lustig et al. 2004).

Pediatric health care and poverty

Many migrant children have been raised in societies where living conditions and pediatric health care differ from those of industrialized countries. As a result, migrant children have important health-care needs. Many migrant children have not been immunized against vaccine-preventable diseases such as tetanus, diphtheria, pneumococcal disease, and pertus-

sis. A study of Kosovar and Kurdish refugees in Italy indicated that only 46 to 74 percent of children up to the age of 10 were fully protected against diphtheria, while 12 to 24 percent were sero-negative to diphtheria (Chironna et al. 2003). Low rates of breastfeeding in migrant infants (Koctürk & Zetterström 1989) and the increased prevalence of iron deficiency and rickets in toddlers who settled in Europe in the late 1980s and early 1990s created a particular need for nutritional counseling and, when needed, prescriptions of iron and vitamin D supplements (Pelto 1991; Pedersen et al. 2003). Tuberculosis (TB) is endemic in many less-developed countries (Romanus 1995; Chemtob et al. 2003) and can be particularly devastating to populations in areas with high prevalence of HIV infection and AIDS.

For example, East Timorese refugees who resettled in Australia in 1999 had very high rates of smear-positive and culture-positive TB (Kelly et al. 2002). Many children have been raised in environments where certain infectious diseases are quite common. Epidemiological studies have shown that migrant children in Europe have higher levels of dental problems and dental caries compared with the majority population (Mejare & Mijones 1989; Wang 1996; Hjern & Grinderfjord 2000).

Undocumented migration and health

Although undocumented or irregular migration has become an issue of high international relevance, it has been strikingly understudied, especially with respect to its impact on health. Emerging research on this issue focuses mainly on access to care (Frates et al. 2003; Rousseau et al. 2008; Weathers et al. 2008; Magalhaes et al. 2010) and less on the effects of undocumented status and associated lack of access to health care on the prevalence of particular diseases. Many studies have focused on economically disadvantaged groups of migrant children, either because poor status was linked to worse infant health or because it had no effect (Landale et al. 2000). Despite their low socioeconomic status, Mexican children in the United States have better health outcomes than other ethnic groups who are wealthier, better educated, and have greater access to health care (Guendelman 2000). Interestingly, some studies indicate the possibility that migration benefits girls' health more than boys' (Donato et al. 2003).

Despite their resilience and relatively good health outcomes, migrant children have important health needs. Health-care providers and child advocates can play an important role in ensuring migrant children's access to affordable and culturally appropriate quality care.

SEE ALSO: Armed conflict and refugees; Children of migrants; Children, migration, and human rights; Political economy of refugees; Public health and migration; Refugee families and children

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