CHAPTER 8

HEALTH ISSUES OF IMMIGRANT CHILDREN AND THE HELPING ROLE OF SCHOOLS

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THE PICTURE AROUND THE WORLD

In 2020, at an international level, 36 million children were immigrants, according to the UNICEF international database of immigrant children. This number represents more than the total populations of the 20 largest cities in the US. Only 12 countries in the world reported to UNICEF that they had no child immigrants in 2020; most of these countries are small islands (UNICEF, 2021).

In 2020, one in every 66 children worldwide lived outside the country of his or her birth. 39 per cent of all international immigrant children live in Asia; 20 per cent in Europe; 18 per cent in Africa; 11 per cent in Northern America; 10 percent in Latin America and the Caribbean; and 2 percent in Australia, New Zealand, and Pacific islands (UNICEF, 2021). Some children are migrants within their own countries when their parents migrate for economic reasons, such as in China and India.

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In the US, according to the 2015 census, 23 percent of pupils in public schools are immigrants. In the US, immigrant families tend to cluster geographically, often in low-income neighborhoods. Immigrant pupils in US public schools account for 30 percent of public-school pupils living below the poverty line. This group of children creates stress on the resources available to schools that serve most low-income and minority pupils (Wicks, 2018).

THE CIRCUMSTANCES IMMIGRANT CHILDREN CAN FACE

The situations that immigrant children can face during and following migration include (UNICEF):

- exposure to conflicts, violence, and extreme poverty
- missing out on education
- lacking access to healthcare services
- lacking access to shelter, nutrition, water, and sanitation
- being separated from their families
- being placed in detention
- being preyed upon by smugglers and traffickers.

INTERNATIONAL AND NATIONAL POLICIES ON IMMIGRANT CHILDREN AND HEALTH

International Policies

The World Health Organization has acknowledged that "policy settings and national legal frameworks can exclude certain immigrant populations from accessing mainstream health services in their country of destination.... Further, policies that deny access to immigrant-friendly health and social services may also have a detrimental impact on the health of refugees and immigrants" (World Health Organization, Regional Office for Europe, 2018).

UNICEF has called for six actions to protect refugee and immigrant children (UNICEF, n.d.). These actions are:

1. Press for action on the causes that uproot children from their homes.
2. Help uprooted children to stay in school and stay healthy.
3. Keep families together and give children legal status.
4. End the detention of refugee and immigrant children by creating practical alternatives.
5. Combat xenophobia and discrimination.
6. Protect uprooted children from exploitation and violence.

Regional Policies

An example of a regional policy on health of refugee and immigrant children involves European countries. All Member States of the WHO European Region

support children's right to health care through the Convention on the Rights of the Child. The WHO Europe policy brief refers to five aspects of the provision of health care for immigrant children (World Health Organization, Regional Office for Europe, 2018):

- Provide equitable care and education. Schools are acknowledged as one of the main platforms through which health is delivered for young children.
- Provide comprehensive individualized health assessment by health professionals as soon as possible after arrival in the country of destination to determine healthcare needs, link immigrant children and their families with primary care services, and coordinate care across primary and specialist services, including providing preventive care.
- Promote mental health and well-being in refugee and immigrant children through a holistic public health strategy, early access to education for children, family reunification, avoiding multiple relocations, and child-friendly spaces in transit facilities and detention centers.
- Avoid detention for refugee and immigrant children and provide for access to health care and education, if detention is used.
- Adopt a holistic approach to age assessments, avoiding reliance on medical imaging to determine a person's age.

Individual Countries

Countries vary considerably in policies relating to the health of immigrant children. Following on from the European-adopted Convention on the Rights of the Child, the UK government provides extensive guidance and advice to healthcare organizations and professionals on the health needs of immigrants, including especially immigrant children (Public Health England, 2021). Immigrants are exempt from charges for healthcare services if they are refugees, asylum seekers, recognized victims of modern slavery and their children, unaccompanied minors, and immigration detainees. All other immigrants are charged for access to healthcare services.

In the US, advocacy for meeting the health needs of immigrant children has come from healthcare professionals. The American Academy of Family Physicians, as one example, has stated (American Academy of Family Physicians, 2019): "The AAFP recognizes that immigration policies aimed at denying basic human rights to immigrant and refugee persons, documented or undocumented, can limit access to vital health care services, including comprehensive primary care. The AAFP recommends that health care systems should meet standards of care without compromising immigrant persons' rights. It also supports privacy protections for medical records of all immigrant persons, whether documented or undocumented, equal to those afforded to US citizens. The AAFP also recommends timely access to healthcare for immigrant persons in detention facilities and measures to reduce toxic stress associated with the threat of detention and

deportation. The AAFP also supports appropriate payment of physicians for care delivered to immigrant persons and their families."

Given the variation in national policies and access to healthcare services for immigrant children, the research on health issues related to immigrant children supports the need for these children to have advocates to identify and meet their health needs.

RESEARCH ON THE HEALTH OF IMMIGRANT CHILDREN

The Nature of the Research

Many research studies describing health issues related to immigrant children in several countries have been published. The published research includes systematic and scoping reviews and meta-analyses; randomized controlled trials; cross-sectional studies involving immigrant and native children; cohort studies; retrospective reviews; descriptive or observational studies; use of national survey data; cost studies; outbreak investigations; surveys of families of immigrant children; and case studies.

A summary of the subjects of the research and the countries in which data were collected since 2000 is in Table 8.1. Apart from research about access to healthcare services and other general subjects related to healthcare, the most frequent research subjects were: mental health (research in 18 countries); vaccinations and vaccine-preventable disease (14 countries); nutrition (14 countries); and oral health (8 countries).

Systematic Reviews

Sixteen systematic reviews, some with a meta-analysis, on a health issue related to immigrant children have been published since 2011, covering an array of health-related subjects including: health needs, health outcomes, and use of health services; health-related experiences of immigrant children in Europe; mental health and emotional and behavioral problems; immunization coverage; nutrition-related issues; and oral health use. Unfortunately, the reviews do not routinely identify the ages of the children involved in the research studies, although most studies include school-aged children because of the ease of access to these children through schools. A summary of the subjects and the key findings of published systematic reviews is in Table 8.2.

The array of research studies demonstrates the health-related disadvantages faced by immigrant children. The predominant health issues identified in the reviews are that immigrant children are:

- more likely to have:
  - infections and infectious diseases
  - mental health issues, including problem behavior
  - eating disorders, particularly being overweight

  - dental cavities, and
- less likely to have had the childhood immunizations recommended by the WHO.

A few qualitative studies about preschool immigrant children's health and wellbeing have been carried out in European countries. Two cross-sectional studies of children who were born in Switzerland but had immigrant parents found that children of immigrant parents had a significantly lower health-related quality of life (Pudar et al., 2013). However, health-related quality of life for preschool children in Switzerland was partly mediated by the children's place of birth, parental education, paternal occupational level, children's body mass index, screen time, and physical activity.

Another study of health-related quality of life among 350 kindergarten children in two German cities showed that overall quality of life for these children remained stable over a year (Villalonga-Olives et al., 2017). However, where there were differences in the children's quality of life, the variations were associated with kindergarten activities that the children were assigned to, such as music or art. Also, girls reported better quality of life than boys.

A study using five focus groups of parents of preschool children who had migrated to the UK from European, Asian, or African countries identified several barriers parents experienced in maintaining the health and wellbeing of their preschool children after arrival in the UK (Condon & McClean, 2017; Condon et al., 2020). Parents reported that there were profound differences in child health services in the UK and their countries of origin, with the extent of the difference varying by nationality and ethnic group. Parents expected that all healthcare services would be provided by doctors, whereas several health services are provided by nurses in the UK. The barriers that parents reported included ensuring family financial security and for children, barriers to children's exercise, play, and nutrition.

Gaps in Research on Health Issues of Immigrant Children

The reviews of research studies on the health of immigrant children point out that there are gaps in the designs of the studies. The gaps include:

- Many published studies are observational, including children who can be accessed conveniently through schools or participation in dedicated programs for immigrant children.
- Immigrant families in some countries have not been successful in achieving legal recognition in the country to which they have migrated, and therefore, are not easy for researchers to find.
- Immigrant children included in research tend to be of school age because of the difficulty researchers face in accessing younger children in immigrant families.

TABLE 8.1. Subjects of Research on Health Issues of Immigrant Children and Countries in Which Research Studies Have Been Published

Country or Countries or Region	Health (General and Chronic Disease)	Death in Custody/ Injury-Related Death/Intentional Injuries	Diarrhea	Dog Bites	Lead Exposure	Mental Health	Motor Impairment	Myopia/ Visual Impairment	Nutrition	Oral Health
International	✓					✓				
Africa									✓	✓
Australia									✓	
Austria			✓							
Bangladesh	✓					✓				
Canada	✓					✓				
Canada and USA	✓					✓			✓	
Chile	✓	✓		✓		✓	✓	✓	✓	✓
China*	✓									
China, India and Nigeria	✓									
Denmark	✓									
Denmark and Sweden	✓					✓				✓
Europe	✓									
Europe and Australia	✓					✓				
Finland	✓					✓			✓	✓
France	✓				✓					
Germany	✓					✓				
Greece	✓					✓			✓	
Hong Kong										
India*									✓	
Indonesia	✓									
Israel	✓									
Italy	✓					✓				✓
Italy and Switzerland									✓	
Malawi	✓									
Mexico						✓			✓	
New Zealand									✓	

Norway	✓									
Peru									✓	
Serbia	✓									
Spain										✓
Sweden	✓					✓				
Switzerland	✓					✓				
Thailand	✓					✓			✓	✓
The Netherlands	✓					✓			✓	
United Kingdom	✓								✓	
United States	✓					✓			✓	✓

Country Or Countries Or Region	Physical Activity	Rheumatic / Congenital Heart Disease	Sexual And Reproductive Health	Sleep Duration	Speech And Language Services Access	Surgery/ Hospital Admission Access	Trachoma	Tuberculosis Screening	Vaccination /Vaccine-Preventable Disease	Vitamin D Status
International										
Africa			✓ Sexual exploitation							
Australia										
Austria										
Bangladesh										
Canada										
Canada and USA										
Chile										
China		✓					✓		✓	
China, India and Nigeria									✓	
Denmark									✓	
Denmark and Sweden										
Europe									✓	
Europe and Australia										
Finland										
France										
Germany	✓				✓				✓	

(*continues*)

Country Or Countries Or Region	Physical Activity	Rheumatic / Congenital Heart Disease	Sexual And Reproductive Health	Sleep Duration	Speech And Language Services Access	Surgery/ Hospital Admission Access	Trachoma	Tuberculosis Screening	Vaccination /Vaccine-Preventable Disease	Vitamin D Status
Greece										
Hong Kong										
India									✓	
Indonesia										
Israel										
Italy		✓				✓			✓	✓
Italy and Switzerland									✓	
Malawi										
Mexico										
New Zealand									✓	
Norway										
Peru										
Serbia						✓				
Spain										
Sweden									✓	
Switzerland								✓	✓	
Thailand									✓	
The Netherlands	✓							✓	✓	
United Kingdom	✓								✓	
United States	✓				✓					

* Studies carried out in China and India involve children migrating within the country because their parents have migrated for economic purposes.

TABLE 8.2. Subjects and Key Conclusions of Systematic Reviews on Health Issues of Immigrant Children

Authors	Year of Publication	Subject	Key Findings
Awoh & Pugge	2016	Immunization coverage in rural-urban migrant (RUM) children in low- and middle-income countries (LMICs) compared with coverage in non-migrant children	11 studies from three countries (China, India, and Nigeria) showed that the proportion of fully immunized rural-urban migrant (RUM) children was lower than the WHO benchmark of 90% at the national level. RUMs were also less likely to be fully immunized than the urban-non-migrants and general population. For the individual Expanded Program on Immunization (EPI) vaccines (diphtheria, pertussis, tetanus, poliomyelitis, measles, and tuberculosis), all but two studies showed lower immunization coverage in RUMs compared with the general population using national coverage estimates.
Baauw et al	2019	Health needs of refugee children on arrival in reception countries	From 53 population-based studies, refugee children exhibit high estimated prevalence rates for anemia (14%), haemoglobinopathies (4%), chronic hepatitis B (3%), latent tuberculosis infection (11%), and vitamin D deficiency (45%) on entry in reception countries. Approximately one-third of refugee children had intestinal infection. Nutritional problems ranged from wasting and stunting to obesity.
Bajo et al	2021	Antecedents of well-being in first-generation immigrant children	Of 38 eligible studies, the evidence is mostly descriptive and focused on involuntary immigrants settled in Western countries. There is fragmentation in the literature and a bias which overlooks younger immigrant children. There are important gaps in the literature on the key antecedents of well-being for voluntary and involuntary immigrant children.
Belhadj Kouider et al	2014	Current prevalence of emotional and behavioral problems of native children and adolescents in comparison with children with a migration background in European countries	36 studies analyzed showed that immigrant childhood in Europe could be declared a risk in increasing internalizing problem behavior. However, the prevalent rate in externalizing problem behavior was comparable between native and immigrant children. Migration status itself can often be postulated as a risk factor for children's mental condition, in particular migration in first generation. Furthermore, several major influences in immigrant children's mental health could be pointed out, such as a low socio-economic status; a non-European origin; an uncertain cultural identity of the parents; maternal harsh parenting or inadequate parental occupation; a minority status; the younger age; gender effects; or a specific culture declaration in diseases.
Belhadj Kouider et al	2015	Current mental health status in immigrant children and adolescents in the North American continent	In 35 studies, almost all carried out in the United States and Canada, comparing native and immigrant children, balanced results in problem behavior were reported. However, the Asian migrant group was at higher risk of developing mental disorders. Family-based risk factors were offered: high acculturation stress; low English language competence; language brokering; discrepancies in children's and parent's cultural orientation; the non-Western cultural orientation, e.g., collectivistic, acceptance feelings of parents, or harsh parenting. However, the importance of supporting immigrant families in the acculturation process is apparent.

(*continues*)

TABLE 8.2. Continued

Authors	Year of Publication	Subject	Key Findings
Clancy et al	2020	Palliative care experiences of forced immigrant children, families, and healthcare professionals	18 studies were included, with most focusing on challenges to care provision. Themes identified were: (a) divergence of beliefs and expectations; (b) communication; (c) navigating healthcare systems; (d) burdens and coping strategies; and (e) training and knowledge.
Curtis et al	2018	What is known about children's own perspectives on their health experiences, based on children and young people who migrated into, and within, Europe	46 articles reporting data on the health experiences of first-generation immigrant children, up to the age of 18 years, who had migrated across national borders into or within Europe were subject to thematic analysis, which identified research based on four broad areas: alcohol, smoking and substance use; diet, eating disorders and overweight; emotional, psychological, and mental health issues; and children's views and experiences of health and health services. Most studies were cross-sectional analytic or incidence or prevalence studies. There is a general lack of clarity in the literature regarding the reporting of children's own migration status. Children's voices are often subsumed within those of their adult parents or carers.
Deng et al	2021	How children exercise behavioral agency within families in the context of migration	65 studies with moderate and strong quality were reviewed. Children and adolescents with demographically and culturally diverse backgrounds were analyzed. Children have different levels of behavioral agency in the migration decision-making process; they also exercise agency in different aspects of family life. Immigrant children exercise agency in media and language brokering. Children's behavioral agency is place specific. Adults working with children need to pay more attention to children's behavioral agency to support children's healthy development and facilitate their adaptation in the context of migration.
Dondi et al	2020	Food insecurity and major diet-related morbidities in immigrant children	Most of 29 papers reviewed described a strong correlation between obesity and migration. A high prevalence of stunting, early childhood caries, and iron and vitamin D deficiency was also reported; however, the studies were few and heterogeneous. Food insecurity and acculturation were found important social factors influencing dietary habits and contributing to the development of morbidities such as obesity and other metabolic disorders.
Jaeger et al	2012	Health of immigrant children in Switzerland	Over 22 percent of children and adolescents living in Switzerland have an immigrant background. From 30 publications, compared to their Swiss peers, immigrant children had higher hospitalization and intensive care admission rates, more dental cavities, twice the odds of being obese and had a higher prevalence of infectious diseases such as tuberculosis, intestinal parasites, H. pylori infection, or hepatitis A.

Labree et al	2011	Prevalence regarding overweight and obesity among children and adolescents from immigrant and native origin within Europe	From 19 studies in six countries, mostly situated in Western and Central Europe, in most of the European countries for which data are available, especially non-European immigrant children are at higher risk for overweight and obesity than their native counterparts.
Markkula et al	2018	Patterns of use of health services of international immigrant children and differences with respective native populations	Of the 107 studies that reported comparable outcomes, half (50%) indicated less use of healthcare by immigrants compared with non-immigrants; 25% reported no difference, 18% reported greater use, and 7% did not report this outcome. There was variation by theme, so that the proportion of conclusions "less use" was most common in the categories "general access to care," "primary care" and "oral health," whereas in the use of emergency rooms or hospitalizations, the most common conclusion was "greater use."
Pabbla et al	2021	Oral health status among immigrant children in Europe	69 studies showed higher dental caries among immigrant children. Poor oral health behaviors were generally reported among the immigrants, and they frequently made use of emergency service utilization compared to the host population.
Riggs et al	2014	Cultural competence of oral health research conducted with immigrant children	4 cohort, 5 intervention, 37 quantitative cross-sectional, and 2 qualitative studies were included in the review. Overall, immigrant children had worse oral health outcomes in all studies compared with their host-country counterparts. However, the studies were poor in assessing cultural competence.
Sun et al	2016	Impacts of internal migration on child health outcomes in China	25 studies revealed that migrant children in public schools present significantly greater mental health problems and lower well-being than their urban counterparts, while migrant children in migrant schools do not present significantly different outcomes. In addition, migrant children were found to be more likely to be exposed to physical health risks due to limited utilization of health services. The disadvantageous health outcomes of migrant children were found to be related to a series of individual and social factors, including academic performance, social relationships, and discrimination.
Zhang et al	2019	Rural-urban migration and mental health of Chinese migrant children	11 studies involving 4621 migrant children and 5076 urban children report that the mental health of migrant children was worse than that of urban children, as evidence by a score on a standardized mental health test. Migrant children have more mental health problems with less public services to support them.

- Although there are published studies about health issues faced by immigrant children in many countries, substantial research is focused in a few countries, namely, the US, Canada, China, and western European countries.
- The motivation for migration of families with children varies considerably by country and area of the world. Studies of Chinese migrant children are most frequently involving children whose parents migrated to take advantage of economic opportunities. Immigrant children involved in research studies in the US similarly are in families where migration has been motivated by economic opportunity. On the other hand, children of immigrant families in western European countries have a variety of backgrounds ranging from professional parents moving to a European country for employment purposes to families escaping from war-torn home countries. Research studies don't tend to discriminate among the motivations of families for migration to other countries.

THE ROLE OF SCHOOLS IN SUPPORTING THE HEALTH OF IMMIGRANT CHILDREN

All immigrant children have one common experience, which is the opportunity to go to school. If school can provide the right support for an immigrant child, the child can become self-sufficient, academically successful, and have options for the future (Wicks, 2018).

Recognizing and Responding to Health Needs of Immigrant Children

Schools are also the place where an immigrant child's health needs can be recognized, and action taken to arrange for response to the child's health needs. Teachers and the other staff who work in schools are sensitive to a child's mental health issues, eating disorders, or if a child appears to be seriously ill, and they may become aware of dental and oral health problems through observation. Through referral to health support systems in the education system, teachers can be pivotal in contributing to enhanced health of the immigrant child.

In countries such as the US, where access to the healthcare system is not easy, schools can help by facilitating access to the healthcare system for the immigrant family with a child with a health issue. In countries in which access to primary care or family medicine or pediatric services requires confirmation of legal status, immigrant patients with a sick child tend to wait too long to access health care services, and then, to rely on hospital emergency departments for care. Emergency care may be the only route into the healthcare system; however, this route may not provide the most appropriate and effective care for the sick immigrant child.

THEORETICAL MODELS THAT CONTRIBUTE TO UNDERSTANDING THE NEEDS OF IMMIGRANT CHILDREN

Concepts that contribute to understanding the context in which immigrant children are functioning are acculturation and development (Juang & Syed, 2019). *Acculturation* refers to how an individual changes and adapts as a result of longer term, continuous contact with a new culture. Acculturation is influenced by the domains in which the individual is functioning. For example, the individual's private life with close family and friends, which maintains the individual's heritage culture, can contribute to positive psychological well-being. The individual's public life with interactions with school or at work can contribute to positive psychological well-being by helping the individual adapt to features of the new culture (Birman et al., 2014). Schwartz et al., (2010) added the dimensions of practices, values and identity to the domains, calling attention to the need to track how the dimensions change over time.

Bornstein (2017) identified five factors of acculturation, which are (1) the setting condition, for example, reason for migration, place of migration, experience, or status, (2) the person, for example, gender, personality, and individual-difference characteristics, (3) time, for example, age, length of time in the country, and adjustment history, (4) process, for example, socialization, learning, or opportunity, (5) domain, for example, multidimensionality and dynamic adaptability. Ward and Geeraert's model of acculturation (2016) acknowledges Bronfenbrenner's work (Bronfenbrenner & Morris, 2006) on ecological contexts, but adds additional contexts beyond family and institutional, including societal and global cultures which influence the acculturation of the immigrant child.

Development refers to the achievement of tasks by an individual that represent age-appropriate milestones, such as relating to caregivers in infancy or developing friendships in childhood. Development and acculturation are intertwined in practice, with characteristics of the individual child, interactions with family and school contacts across heritage and majority cultures, and societal contexts all influencing the immigrant child's adaptation.

The integrative risk and resilience model for immigrant child adaptation recognizes all these perspectives—individual child, interactive microsystems with family and school, societal—and adds a global perspective (Suárez-Orozco et al., 2018). The model acknowledges that global forces such as climate change, poverty, and conflicts may affect the immigrant child's country and culture, and also require adjustment by the child.

Research on What Schools Can Do

A research study carried out in the UK aimed to identify ways in which schools were actively integrating pupils, focusing on practices that were contributing to achieving successful integration of the child across all areas of learning and school life (Manzoni & Rolfe, 2019). The study involved over 50 interviews with

teachers, school leaders, and parents, and 10 focus groups and five one-to-one interviews with a total of 92 children.

Four key themes emerged through this research (Manzoni & Rolfe, 2019):

1. **Identifying the needs of the immigrant child and his or her family**, including learning English, mental health issues, responses to trauma, adapting to a new education system, being aware of choices relating to schools, and coping with the isolation of the immigrant family
2. **Schools' integration approaches and practices**, including engaging families of immigrant children in the schools, capturing accurate data about the backgrounds and needs of immigrant children, using parent ambassadors to relate to the families of immigrant children, using interpreters for meetings with parents and parent evenings, and involving parents in school life, including having special projects such as pupil performances that are presented for parents
3. **Welcoming and settling immigrant pupils**, including a special orientation to the school and how it works, placing the immigrant child in the most appropriate year for the child's needs, mentoring programs and peer support such as playing a sport, and non-immigrant children serving as ambassadors for immigrant children. A novel approach is to include a dog that relates well to children in the teaching environment and encourage immigrant children, if culturally feasible, to talk to or read to the dog.
4. **The pupil experience**, including the difficulty for children who have little or no English on arrival at school, the importance of kind and helpful teachers and support and friendship from other pupils, and the importance of being able to talk and read in their own language.

The key findings of the study identified schools and characteristics of schools that were successful in integrating immigrant children. The key characteristics of successful schools included the following (Manzoni & Rolfe, 2019):

- Teachers and school leaders were very positive about the contribution that immigrant pupils and their families make to the life of their schools, including the motivation and attitude of many immigrant pupils and their families and the enrichment to other pupils through exposure to different languages and cultures.
- Immigrant children come from very diverse backgrounds. These children should not be regarded as a single group. As new entrants into the educational system, they should always be individually assessed and given tailored support where needed.
- When immigrant children speak no or very little English and also are unfamiliar with the teaching, learning, and cultural aspects of school life, the

TABLE 8.3. Practical Suggestions to Help Schools Support the Immigrant Child

- Ask the immigrant child to talk about his or her own lives and share his or her knowledge of the homeland and culture.
- Provide a tour of the school for the immigrant child and family.
- Explain basic school rules and customs such as timetables, breaks, uniforms, registers, etc.
- Assign a buddy pupil to each immigrant pupil. Buddies can be other immigrant children who speak the same or a different language.
- Minimize the number of moves from one class to another or from one teacher to another.
- Be creative in applying the curriculum, choosing topics to teach that reflect the range of immigrant children's cultural identities and experiences.
- For immigrant children who do not speak English, use picture books that tell complex stories that require little or no proficiency in the English language to enjoy. Examples are books by Shaun Tan, Armin Greder, David Weisner, and Anthony Browne.
- Make sure immigrant pupils know about upcoming events so they feel included.
- Engage immigrant pupils in sports activities and teams in the school.
- Help pupils and their families access appropriate services and support to reduce risk factors that might undermine an immigrant child's mental health.
- Provide school newsletters and other information in appropriate languages where possible.
- Don't underestimate immigrant children. They may have been high achievers in their home countries.
- Be aware that some immigrant children have experienced serious trauma in their home countries or en route to their current country.

school needs to carefully assess the immigrant child for additional support and special needs.

- Schools can help families to access services they are entitled to but don't know how to access, such as health and welfare services. The informal role that a school can play in assisting an immigrant family should be recognized and appropriate referrals to support provided.
- Parents of immigrant children need to be informed about the school system their children will be attending, and how the school system functions. For example, where parents have choice among schools, parents should be informed about how to make choices that will benefit their children.
- A steady stream of funding to help immigrant children, especially those who don't speak English, is needed to ensure that immigrant children reach their potential quickly and require less support in the longer term.
- An initial meeting with an immigrant child and the child's parents is helpful because it is a chance for the school to welcome families, to ensure they have information about health and welfare supports, and to start a collaborative relationship. Priorities for the child's education can be identified, for example, to learn English.

Practical Suggestions

Several practical suggestions are available to help schools support the immigrant child. The suggestions in Table 8.3 are intended to facilitate integration of the immigrant child into the school, and therefore, contribute to the mental health of the child (Anna Freud National Centre for Children and Families, n.d.; Hanna & Kucharczyk, 2016).

Regarding the health needs of the immigrant child, teachers and other staff in a school who interact with children can be aware of the health conditions identified by research studies as being associated with immigrant children, such as infections, mental health issues, obesity or eating disorders, and dental cavities. Help the child's family arrange for support for the child and family to deal with these health issues, to enable the child to progress to his or her abilities in school.

Depending on the health-related systems in schools, schools also can check on the vaccination status of immigrant children and arrange or recommend arrangements for immigrant children to receive vaccinations they have not had.

CONCLUSION

Immigrant children can face extreme circumstances during and following migration, such as exposure to conflicts, violence, and extreme poverty; being separated from their families; lacking access to shelter, nutrition, water, and sanitation; being placed in detention; or being preyed upon by smugglers and traffickers. All these circumstances affect the health of these children.

Individual research studies carried out on immigrant children of all ages have identified a full range of health problems experienced by these children, from death in custody and sexual exploitation to dog bites, mental health problems, visual impairment, obesity, dental cavities, and vaccine-preventable diseases. Some children have undetected and unmanaged serious health problems such as motor impairment, congenital heart disease, or tuberculosis.

The most common health problems reported in individual research studies and systematic reviews are mental health problems, nutrition problems especially obesity, and dental health problems especially dental cavities. Immigrant children also can have undetected and unmanaged infections.

Countries around the world vary considerably in how they respond to immigrant children and families, particularly if they have policies that refer to the provision of health screening services and the treatment of health problems. The World Health Organization, particularly the European Regional Office of WHO, has explicit policy relating to five aspects of provision of health care for immigrant children, including providing equitable care and comprehensive individual health assessment by health professions and linking immigrant children and their families to primary care services.

Some countries such as the UK have explicit national policies directing the nation's healthcare services to respond to the health needs of immigrant children, including that they are exempt from charges for healthcare services.

Schools are the natural focus for looking after the health needs of immigrant children. Teachers, teaching assistants, and other staff working in schools and interacting with children observe children and can detect health problems and refer children with health problems to appropriate healthcare professionals for advice and support.

In addition, the way schools act to integrate the immigrant child itself has the potential to affect the health of the immigrant child. Faster integration of the immigrant child into the school and its activities could act to reduce at least the mental health issues some immigrant children might otherwise develop in response to a feeling of isolation. In addition, through engagement in school sports and other activities, immigrant children could benefit even further through the possibility of avoiding obesity and dental health problems. Several strategies for integrating immigrant children into school are available from research as well as from practical experience.

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