Chapter

After Three Centuries of Migration, What Happened to the Children?

Tanya F.P. Herring and Victory Ezeofor

Abstract

Migration within the last three centuries centres on economics, shifts in government policies, and general concepts surrounding migrating children. However, this chapter asks a fundamental question, 'what happened to the children? Over the last three centuries, children have been born along the journey. Accompanied and unaccompanied children have been and continue to be the forgotten collateral damage. The chapter explores the critical role of protection, prevention, and harm to migrating children. It addresses gaps and noncompliance with the ratified treaty, the UN Convention on the Rights of the Child over the last three decades, international migration in countries of origin, transit, destination, and return, to include the lifetime of impact on their health.

Keywords: accompanied and unaccompanied children, forced migration, oral health, mental health, migration, UN convention on the rights of the child, vaccinations

1. Introduction

The chapter brings together discourse and information on: (a) the scale and nature of the forced migration, its adverse impact on children, and their likely fatalities during migration; (b) the role of the United Nations Convention on the Rights of the Child over the last three decades, the gaps in State responsibility for the migrating refugee and asylum-seeking child; (c) how children have been the migratory collateral damage, often overlooked in situations of forced migration, and the lifetime impact on health.

Structured to serve as the focal human rights instrument for children, the United Nations Convention on the Rights of the Child (CRC), its Optional Protocols, coupled with General Comments is the most widely ratified human rights treaties across the globe [1]. The CRC is ratified by all states with the exception of the United States and came into force on 2 September 1990. Subsequently, as of 5 September 2022, 196 countries are State Parties with two Optional Protocols adopted on 25 May 2000.

Three centuries ago, the CRC was a far-reaching hope in both the home, workplace, and communities with little to no legal standing for protection of their human rights. However, Article 22:

> *'State Parties shall take appropriate measures to ensure that a child who is seeking refuge status or who is considered a refugee in accordance with applicable international or domestic law and procedures shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection and humanitarian assistance in the enjoyment of appliable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties' [2].*

The CRC's tenets set out the general principles of children's rights and the law holding a position as a global universal instrument. Noting that deaths and atrocities usually occur far from public eye and any record keeping processes, gaps in prevention, protection measures are absent. Subsequently, the question remains 'what happened to the children?' This chapter investigates societies most vulnerable, children, from an international platform. Each section is guided by the three decades of children's rights law that dissects dangerous areas encountered during migration and the duty of States.

Much of what has been written about border matters centre on adult deaths, the volumes of numbers, border breaches, and gaps in border control – the "mathematics" of irregular arrivals [3]. Worldwide, children and adults caught up in poverty and conflict lack official identification. Consequently, in October 2013 when over 380 migrants drowned near the shores of Lampedusa while attempting to cross the Mediterranean, there is no true record of who were children and their names [4, 5]. This situation is used as an exemplar of what did not happen by the State Parties, their responsibility gaps, and sets an optical of what likely has occurred over the last three centuries during forced migrations.

2. Irregular migration

For centuries migrants have been making land and sea journeys across varying regions of the world. High migration occurs usually when people are escaping conflict, dire poverty situation. Until these extreme situations are addressed, there will continue to be little record of how many children are engaged in migration and the disposition of children. Migration across the Mediterranean, and perils of the Indian Ocean between Thailand, Malaysia, Indonesia and Australia, the rugged terrain at the United States-Mexico border, Central America, across the untamed weather conditions of the northern and sub-Saharan Africa is daunting and unconscionable to the layman.

The study of involuntary migration is often referenced as forced migration or involuntary placement under the international umbrella of the Office of the United Nations High Commissioner for Refugees (UNHCR), the International Organization for Migration (IOM), and a host of other organizations such as the Internal Displacement Monitoring Centre (IDMC). Research supports the premise that causation ranges from natural to manmade disasters of conflict, famine, extreme weather conditions that ravage regions where people depend upon crops, farm animals for their survival.

Under the provisions of General Comment (GC) 6, the CRC addresses the legal definition of a refugee by referring to the 1951 Refugee Convention,

> *'must be interpreted in an age and gender-sensitive manner, taking into account the particular motives for, and forms and manifestations of, persecution experienced by children [GC6]' [1].*

Subsequently, State Parties can refer to the refugee status as the basis of a child-specific manner of persecution which is inclusive of 'persecution of kind; under-age recruitment, trafficking of children for prostitution; and sexual exploitation or subjection to female genital mutilation [1]. Yet, there is extensive debate in the usage of terminology of migrant in lieu of refugee to separate and distinguish those deserving of international protection. Joint GC 4 of the CMW Committee and GC 23 of the CRC calls on State Parties to provide

> *'free, quality legal advice and representation for migrant, asylum-seeking and refugee children, including equal access for unaccompanied and separated children in local authority care and undocumented children' [6].*

The *Fatal Journeys Report* is published by the United Nations International Organization for Migration's (IOM) and is just one of very few UN agencies questioning the status of missing migrants. Since 2014, IOMs reports have focused on adult missing migrants [7]. Prior to 2014, statistics on missing migrants has been sporadic, difficult to compile, and validate. Deferring to reliable research from the IOM, the publication provides situational geographic snapshots that span across the Canaries and beyond, including the Central Mediterranean route to reach Europe, among others.

The Central Mediterranean route has been deemed by researchers to be the most fatal in the world where reports reflect that 17,900 lives have been lost between 2014 and 2018 [8]. The *Fatal Journey's* report further described that of the 32,000 deceased migrants during the same 2014 to 2018 period, 1600 were children under the age of 18 [8]. These figures likely pale in comparison to the three centuries of migratory global moments captured in this textbook. However, if just a portion of the IOM research suggests that over 60,000 migrants have lost their lives is an indicator for the past two decades, the volume for the last three centuries can reach the tens of thousands lost lives during efforts to reach migratory destinations [3].

3. Article 22. Asylum seeking and refugee child

Article 22 of the CRC sets out the responsibility for child refugees or asylum-seeking children to States Parties. When a child refugee seeks refugee status under international human rights and humanitarian law, States Parties are responsible for three elements under the provisions of Article 22:

1. adequate protection and humanitarian assistance,

2. cooperation with organisations linked to the UN when providing protection and assistance, and

3. the establishment of an adequate environment of care for children, either by reunification with their family or by finding alternative State protection.

Further GC 23 establishes a situation where all children, regardless of the race or gender in the context of international migration regardless of the distinction between refugee or asylum status. In the horrific events of the investigations following the highly publicized shipwrecks off Lampedusa in October 2013 [9], there is no record to reflect that the children received the State's responsible provisions of the CRC's Article 22.

The European Court of Human Rights (ECtHR) has multiple cases where it has addressed the issue of state obligations for accompanied and unaccompanied refugee and asylum-seeking children. Article 22 of the CRC was noted in the ECtHR's case of *Muskhadzhiyeva and others v Belgium* [10], and *Popov v France*, where the obligation for an asylum-seeking child 'enjoys protection and humanitarian assistance, whether the child is alone or accompanied by his or her parents'. In the case of *Muskhadzhiyeva and others v Belgium*, the four children were as young as 7 months and the oldest only 7 years, where the petition before the court was on behalf of a single mother living in a refugee camp seeking asylum. Similarly, in the case of the *Popov v France*, parents sought asylum based upon religious persecution [11].

The ship sailing from Libya to Italy sank off the Italian island of Lampedusa. Thought to include migrants from Eritrea, Somalia, and Ghana, there is no record that any of these States either carried out rescue missions, claimed or sought for

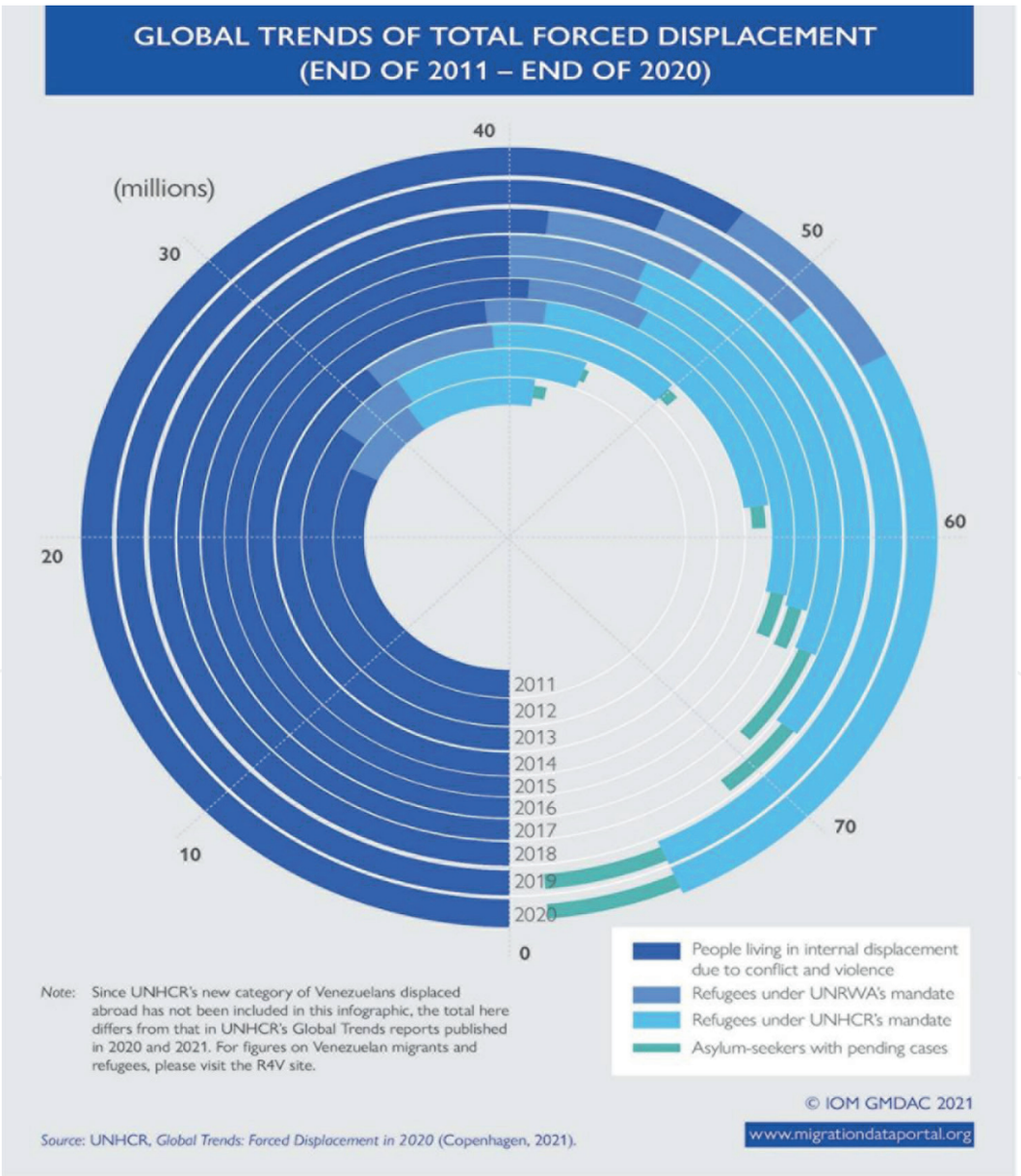

Figure 1.
Global trends of Total force displacement (end of 2011 – end of 2020).

family members after the incident. Italy ratified the CRC on 26 January 1990; Eritrea ratified on 3 August 1994; Ghana ratified on 5 February 1991; but Somalia did not ratify the CRC until 1 October 2015. No record can be referenced to show whether the passengers were seeking asylum, had made applications for asylum, or received any State assistance.

Instead, families, such as the ones from the Lampedusa incident are left missing and unknown whether they are alive, dead, or whether they were buried. The Lampedusa situation may likely be an indicator of how many other assumptions that the protection of the CRC should have provided. The CMW and CRC Committee, Joint General Comment 4 and 23 on State obligations regarding the human rights of children in the context of international migration while in transit appear to remain unaddressed. As the children were in transit and as the textbook reflects back over the last three centuries, one could conclude that many other situations such as that of Lampedusa has occurred, the situation was not made public, or may simply be unknown. Reflecting on **Figure 1** and the global trends of total forced displacement for the periods of 2011 to 2022 provides an optic to align with the volume of migrations [12]. Again, no delineation of children to adults can said to provide an illusiveness that children's rights are collateral to situations where their parents are found to be in an irregular migration situation.

4. Health of the migrant child

With the many reasons for migration, continuous growth in the number of refugees and migrants are inevitable. This comes with various challenges for both the migrant, the country of migration and its citizens. In the UN Convention on the Rights of the Child, some of the challenges facing child migrants are addressed [13];

> "**Article 24** *(health and health services)*
>
> *Every child has the right to the best possible health. Governments must provide good quality health care, clean water, nutritious food, and a clean environment and education on health and well-being so that children can stay healthy. Richer countries must help poorer countries achieve this.*"

One of the most prominent challenges raised in Article 24 is the health of the migrant child and this has a huge impact on the health risk to the populace coming in contact with the migrant. New migrants to the EU/EEA, as well as other migrant groups in the region, might be under-immunized and lack documentation of previous vaccinations, putting them at increased risk of vaccine-preventable diseases circulating in that country [14]. There is an increased health risk when the migrant is particularly vulnerable such as a child. To enable decision-makers to make the right choice and develop the right system to tackle these child migrant health issues, health economic evaluation analyses are mandatory. In health economic evaluation, one of the major questions addressed is distributional cost-effectiveness analysis (DCEA). Distributional cost-effectiveness analysis is a general umbrella term that covers all economic evaluation studies that provide information about equity in the distribution of costs and effects as well as efficiency in terms of aggregate costs and effects. DCEA can provide distributional breakdowns of who gains most and who bears the largest

burdens by equity-relevant social variables (such as socioeconomic status, ethnicity, and location) and disease categories. DCEA can also use various forms of "equity weighting" to analyze trade-offs between equity and efficiency [15]. The health of the child is of intrinsic interest, both as a current measure of health and well-being and as a source of future human capital.

There is insufficient empirical evidence on the relation between migration and child health in most western countries, and this evidence is further reduced especially in comparison to the population size of the child migrants in terms of health economic evaluations that look at health interventions focused on child migrants or this population as a subgroup. In some longitudinal studies that investigate the health difference between migrant children and non-migrant children, the results do not align or have the same conclusions.

Children who migrate from less developed countries may face health issues such as incomplete immunization and poor nutrition. In a study by Cousins et al., one of the major causes of death due to the Syrian crisis was non-communicable diseases with half of the displaced populace being children [16]. The possibility that these communicable diseases are carried into the migrant's new country of residence is very high. There is an increased possibility of infectious disease outbreaks occurring due to the transmission of vaccine-preventable diseases (VPDs), such as polio and measles, across national borders. Other studies indicate that migrants and refugees experience higher rates of VPD-associated hospitalization, morbidity, and mortality compared to the host population [17–19]. While other studies suggest that contrary to lay misconceptions, epidemiological studies show that the majority of infectious diseases affect migrants after entry into the recipient country, as most refugees are young and previously healthy [20, 21]. The spread of such diseases is avoidable if treated appropriately in a suitably resourced shelter system with medicines, vaccines, and specialized medical personnel who can provide health services including counseling [22].

4.1 Vaccination

A 2006 to 2015 retrospective cohort study that linked de-identified data was conducted from government sources using Statistic NZ's Integrated Data Infrastructure. The VPD-related hospitalisations were compared between three cohorts of children below the ages of five (5) years old: foreign-born children who migrated to NZ, children born in NZ of recent migrant mothers, and a comparator group of children born in NZ without a recent migration background [23]. The VPD-related hospitalization rates were higher among NZ-born non-migrant children compared to NZ-born migrant and foreign-born children for all of the diseases of interest [23]. In a study by Cebotari et al., the migration and child health in Moldova and Georgia two post-Soviet countries with large out-migration flows in the region showed that, regardless of the transnational family setting, children of migrants have overall positive or no differing health compared to children in non-migrant households. However, significant gender differences are found in both countries. More often than not, Moldovan and Georgian girls are more at risk of having poorer health when living transnationally [24].

One of the most infectious diseases is tuberculosis, in a study by Kamper-Jørgensen et al., an evaluation of tuberculosis transmission between the Danish national population and migrants in Demark was conducted. The study population consisted of 904 Danes and 785 migrants, which consisted of 183 children and adolescence aged below 20 years of age and 60 children below 10 years. The result showed

that up to 7.9% (95% CI 7.0–8.9) of migrants were infected by Danes. The corresponding figure was 5.8% (95% CI 4.8–7.0) for Danes. Thus, transmission from Danes to migrants occurred up to 2.5 (95% CI 1.8–3.5) times more frequently than vice versa (OR = 1). A dominant strain, Cluster-2, was almost exclusively found in Danes, particularly younger-middle-aged males. The study also showed that TB-control efforts should focus on continuous micro-epidemics, for example with Cluster-2 in Danes, prevention of reactivation of TB in high-risk migrants, and outbreaks in socially marginalized migrants, such as Somalis and Greenlanders [25].

It is very important that some type of screening is carried out to prevent progression to active tuberculosis. A study by Usemann et al. conducted a school-based TB screening programme targeting migrant children and showed that it was cost-effective if populations with a relatively increased Latent Tuberculosis Infection (LTBI) prevalence and/or high progression rates are included [26]. It was also suggested that diagnostic and treatment strategies for migrants be focused on young subjects from high-incidence countries [27].

Another VPD is Hepatitis B which spreads through blood, saliva, or other bodily fluids. The most common way children become infected with hepatitis B is if they are born to a mother with the virus. Older children can become infected through injection drug use or unprotected sex. Many children are able to rid their bodies of HBV and do not have long-term infections. However, some children never get rid of HBV. This is called chronic hepatitis B infection. Younger children are more prone to chronic hepatitis B. These children do not feel sick and live a relatively healthy life. However, over time, they may develop symptoms of long-term (chronic) liver damage. Globally, there has been a recent increase in children who have hepatitis. While still rare, hepatitis cases have been reported in 35 countries and nearly 200 children have now been admitted to hospitals in the UK. Several of these children have required emergency liver transplants for rapid liver deterioration [28]. Migrants from hepatitis B virus (HBV) endemic countries to the European Union/European Economic Area (EU/EEA) comprise 5.1% of the total EU/EEA population but account for 25% of total chronic Hepatitis B (CHB) infection. Migrants from high HBV prevalence regions are at the highest risk for CHB morbidity. Screening of high-risk children and vaccination of susceptible children, combined with treatment of Hepatitis infection in migrants, are promising and cost-effective interventions, but the linkage to treatment requires more attention [29, 30].

4.2 Education

Voluntary migrants moving from a developing to a developed country generally experience different types of challenges. Economic migrants experience large gains in income and increased access to health care and clean water, thus they are potentially introduced unhealthy lifestyle patterns, such as increases in fat and refined sugar-rich diets and decreases in regular physical activity [31–33]. This can lead to obesity in young migrants or children of migrants. Thus, migration may potentially have negative impacts on health, particularly for still-growing children who are most affected by environmental and dietary changes. The best way to tackle this type of health-related quality of life is through better education of the child migrant or parent/carer of the child.

4.3 Oral health

Untreated tooth decay (dental caries) in children is the tenth most prevalent disease worldwide, affecting 621 million children globally [34]. Decayed, missing

teeth due to cavities, and Filled Teeth in the permanent teeth (DMFT) values, caries prevalence, and unmet restorative treatment needs index among migrant children is higher than that of not migrant children. In order to reduce inequalities in dental caries experience, there is a need to design policies aimed at primary prevention through health promotion programmes [35, 36]. In a dental study by Ezeofor et al., the result showed that an educative goal-setting proactive talking intervention provided better health-related quality-of-life gains in dental care. The low-cost intervention was cost savings with a dominant incremental cost-effectiveness ratio (ICER) even with a 200% increase in the cost of intervention. The NHS will be providing better oral health for children at a better net monetary benefit-to-risk ratio by adopting proactive intervention in preventing the reoccurrence of caries [37].

For some diseases or illnesses, the educative and informative approach will provide a more effective and cost-effective result in migrant children. Thus, the importance of more economic evaluations of different types of healthcare interventions to compare the costs and outcomes. This will provide a measurement of economic efficiency and health-related quality of life (HRQoL).

4.4 Mental health

There is no doubt that in addition to these health risks, children migrating from an unstable environment may also have to endure violence and trauma that may predispose them to mental health problems including depression and posttraumatic stress symptoms (PTSD) [38, 39]. Heptinstall et al. found that premigration trauma such as the violent death of a family member correlated significantly with the children's current scores for PTSD [38]. Such children may experience physical violence or sexual exploitation, such children may be particularly vulnerable to self-inflicted harm and depression postmigration [40]. These experiences may be substantial barriers (fear, withdrawal syndrome, etc) for refugee children or migrant children with mental health problems to access healthcare. This why consistent screening, check-ups and affordable healthcare systems must be put in place by the government as stipulated in Article 39 of the UNICEF United Kingdom, A summary of the UN Convention on the Rights of the Child [13].

> "**Article 39** *(recovery from trauma and reintegration)*
>
> *Children who have experienced neglect, abuse, exploitation, torture or who are victims of war must receive special support to help them recover their health, dignity, self-respect and social life.*"

4.5 Funding and policies

Migration is a complex social process that often subjects individuals and families to social factors and stressors that can result in mental health problems. There are many types of migration, and each type of migration is associated with different health risks. The health experiences of migrating individuals and subgroups vary tremendously among transnational and internal migration, legal and illegal migration, and voluntary and involuntary migration [41]. Children, as a population subgroup, are vulnerable in the migration process. Children in many countries due to their lack of legal, socioeconomic and financial status, as well as cultural and language barriers are often neglected within the healthcare system [42].

> "**Article 4** *(implementation of the Convention)*
>
> *Governments must do all they can to make sure every child can enjoy their rights by creating systems and passing laws that promote and protect children's rights."*

In Canada, the USA, and Australia, pediatricians are guided by national recommendations for the care of migrant children [43–45]. In Europe, the European Commission has issued a handbook for health professionals on the health assessment of refugees and migrants in the EU/EAA [46]. This protocol has been tailored for the early health assessment at reception centres or organized hotspots to identify significant medical conditions that impact on placement in hosting institutions and fitness for travel. Only a few European countries have national guidelines for primary care for migrant children. The United Kingdom provides guidelines that help to protect and promote the health and well-being of migrant children [47]. Though the UK has prescribed suitable systems to support the healthcare of migrant children, Charges for NHS services in the UK prevent and deter migrant children and their families from accessing healthcare. This has adverse effects on child health and the wider public health of the population [48]. It is estimated that around 200,000 children currently live in the UK who lack formal immigration status and most likely have to be charged for NHS secondary care [49].

5. Conclusion

Most studies that have examined the cost-effectiveness of vaccination uptake among migrants conclude that the data suggest social mobilization, vaccine programs, and education campaigns are promising strategies for migrants, but more research is needed.

To be a health economic evaluation study one must have two essential features: Both costs and outcomes must be analyzed, and measures such as the CHU-9D, EQ-5D-Y, and PedsQL which are specifically targeted at children will be very helpful [50–52] as outcome measures. Health economics is used to promote healthy lifestyles and positive health outcomes through the study of health care providers, hospitals and clinics, managed care, and public health promotion activities. There are generally four types of economic evaluation: Cost-Benefit Analysis (CBA), Cost-Minimization Analysis (CMA), Cost-Effectiveness Analysis (CEA), and Cost-Utility Analysis (CUA) [53]. Economic evaluation contributes to evidence-based decision-making by helping the public health community identify, measure, and compare activities with the necessary impact, scalability, and sustainability to optimize population health [54]. Research should also study the cost-effectiveness of strategies. Vaccination of migrants should continue to be a public health priority in the EU/EEA.

Between 2015 and 2017, an estimated 200,000 to 400,000 children were seeking asylum each year in EU/EEA countries, and in 2019, 6% (896,000) of children under age 18 were born abroad, and 8% (1,082,000) were non-UK/Irish citizens; Access to high-quality health care is important [55, 56]. We do suggest the Policy, Preventive, and Treatment (PPT) strategy be implemented. It is very important that the right *policies* which comprise of adequate funding and appropriate guidelines and documentation are put in place to help navigate through this complexity of healthcare for migrant children. The *preventive* phase encompasses giving the necessary education

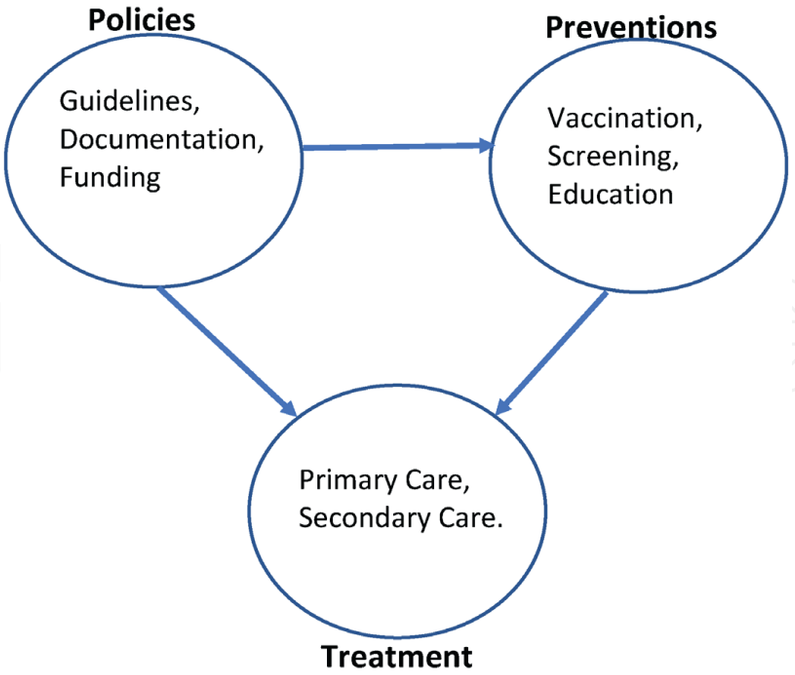

Figure 2.
Pictorial representation of steps involved to tackle Children's migration health challenges.

and information, regular screening exercises, and vaccinations are carried out, and third of all adequate and timely *treatment* should be put in place to tackle cases that need to be addressed (**Figure 2**).

Conflict of interest

The authors declare no conflict of interest.

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