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Taking care of minor migrants' health: the professionals' perception and training needs

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Abstract

Introduction. In Italy, minor migrants represent 21.8% of the non-EU citizens. The care of minor migrants might be challenging as this population is characterized by higher vulnerability and special needs. The study aim was to describe the perceptions on the provision of care, the bio-psycho-social needs of migrant children and the professional training needs.

Methods. The study is qualitative descriptive. In May 2019 three focus group, involving health and social professionals, cultural mediators and NGOs operators, were organized.

Results. The study explored different areas of the provision of care to minor migrants including bio-psycho-social needs, care provision, barriers to care and professionals' training needs.

Discussion and conclusions. The provision of care should consider the specific migration journey and narrative. In some cases healthcare is fragmented, generating obstacles to access especially in minors with lower levels of health literacy. Training plays a key role in the development of cultural competence.

Key words

- bio-psycho-social needs
- minor migrants
- training needs
- health literacy
- cultural competence

INTRODUCTION

In 2017, 2.4 million immigrants entered the European Union (EU) from non-EU countries [1]. Out of these, around 240,000 immigrated to Italy [1]. According to the Unicef [2], one in four of the 82,000 refugees and migrants arriving in Europe through Mediterranean migration routes (i.e., 19,800) is a child. Despite a significant reduction compared to 2017, the number of unaccompanied minors arriving in the EU remained high in 2018 [3].

In Italy, minor migrants represent 21.8% of the non-EU citizens [4]. The provision of care to minor migrants might be challenging for health and social professionals as this population group is characterized by high vulnerability and special needs.

The interaction of health professionals with persons with different migration backgrounds requires effective communication strategies (e.g. mediation and interpreting) as well as the knowledge of the migratory process and cultural background [5]. Health professionals recognize the need for special knowledge and skills when taking care of migrants, and that their training is often scarce or non-specific, making them inadequate in providing appropriate care [6]. Specific training in the field of cultural competence allows a greater understanding of the psychosocial context in the care of migrants [7]. Cultural competence means "a multidimensional learning process that integrates transcultural skills into cognitive, practical and affective dimensions that aim to achieve culturally congruent care" [8]. A study conducted with General Practitioners has shown that those who have received specific training for the development of intercultural competences seem to provide higher quality standards of care [9]. This cross-cultural knowledge and skills might also result from the continuous exposure to migrant patients [10]. There is

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evidence that training on cultural competence improves the knowledge, attitudes and skills of health professionals and positively affects patients' satisfaction [11]. Training in cultural competences has also proved effective for the professionals of rehabilitation facilities [12].

A controlled clinical trial, conducted to assess how a 3-day training affects the cultural skills of pediatric nurses, has shown improvements in cultural knowledge, skills, and desire to learn more about the topic of "culturally competent health services" [13]. When taking care of migrant populations, health professionals face several challenges: different expectations, difficulties in communication, and creating a trustful relationship, as well as a lack of specific training and inadequate organizational and management systems of care [14].

To our knowledge, there are no studies in the Italian context that have assessed the training needs of health and social professionals who are involved, at different levels, in the provision of care to migrant children.

Therefore, the objective of the present study was to describe the perceptions of health and social professionals on the provision of care, the bio-psycho-social needs of migrant children and the training needs and methodologies.

METHODS

The study design is qualitative descriptive. A series of focus group (FG) was organized within the European Union-Vocational Education and Training (EU-VET) care Project "Strengthening capacities for better health care to refugee and migrant children" [15], whose goal is to improve the training of professionals who are involved in the care of migrant/refugee children. The FGs aimed to explore the perception of key stakeholders regarding the care system addressing migrant/refugee children's health and wellbeing. Participants were recruited through a purposeful, theoretical built sampling and included physicians, psychologists, social workers, cultural mediators, child protection legal experts and administrative collaborators. All participants were contacted by telephone by an EU-VET project manager through the project stakeholders' network. The call has then been followed by an email invitation. All participants were actively involved in the care of migrant children in different settings at the moment of the study. The FGs were facilitated by experienced researchers of the Italian National Institute of Health in Rome, following a semi-structured set of questions. This questions guide was built by the contribution of all researchers, shared with EU-VET project managers, then tested during the first focus group, not requiring changes during data collection (*Table 1*). Each discussion lasted around 90 minutes. All the FGs were audio-recorded and transcribed, with the informed consent of the participants. Socio-demographic data were also collected in an anonymous form. The transcripts were independently read and coded by two authors who then discussed the categories for defining the tree-nodes. In case of disagreement, a third researcher was involved. Most categories were defined in advance according

Table 1
Aims and questions

Aim 1. Barriers and activators related to the care provision for migrant/refugee children
1a) In your opinion, what are the *main obstacles* in the provision of care for migrant/refugee children? Why? Can you give some examples? • What makes your job difficult? • Are you able to help them? If not why? • Does this age group have characteristics that make it difficult to help? • Are there skills/knowledge that would allow you to be more effective in helping? • What are these skills/knowledges? 1b) In your opinion, *what supports* the provision of care for migrant/refugee children? Why? Can you give some examples? • What would help your job? • What skills/knowledge would facilitate your work with these children?
Aim 2. Perceptions and attitudes about professional training on the provision of care for migrant/refugee children
2a) In your opinion, *how important is professional training* related to the provision of care for migrant/refugee children and why? *What impact* does professional training have on your care provision for migrant/refugee children in your practice? And what impact does the professional training have on the *interventions' outcomes* (health, biopsychosocial well-being)? 2b) What is your educational experience related to migrant/refugee children care? (search for knowledge, gaps and training needs of the participants) • Did you ever attend specific training on migrant/refugee children care? • If not, did you attend specific training on assistance to migrants/refugees in general? • How would you describe these learning experiences? Effective, engaging or not? Pros and cons and why. • What would you change in these training? Why? • What additional training do you consider necessary? • What has made you/would make you feel satisfied in this training? What makes training on these issues effective? • What instead makes it unsatisfactory?
Aim 3. Proposals to improve training on provision of care for migrant/refugee children
3a) Do you think that further training is needed for staff dealing with migrant/refugee children? 3b) Would you find further training useful for you? 3c) What content should training include, in order to cover needs and overcome the obstacles you have listed include? Why? • Who should be trained? • Should training be differentiated by profession or not? How would you structure it? • What content would you include related to the health and care provision of migrant/refugee children? • Which training methodologies? (e.g. case studies, role plays, other?) • What other issues should be included to promote motivation, involvement and active participation? (e.g. duration, certification, etc.)

to the main research questions (deductive approach) while additional categories were defined as emerging during the coding process (inductive approach). The software used for the qualitative analysis was NVivo 12 Plus. Data saturation was reached when no new information emerged. The tree-nodes has been applied to the whole of the transcripts and the most meaningful verbatim were identified.

The main themes addressed during the FGs were:

- the characteristics of care provision to migrant children (probe: barriers and activators of the care provision for migrant/refugee children);
- the bio-psycho-social needs and the ability, at system and at individual level, to address these needs;
- the training needs and methodologies.

RESULTS

In May 2019, 3 FGs were conducted at the Italian National Institute of Health (Istituto Superiore di Sanità) in Rome involving a total of 15 participants (93,3% response rate). *Table 2* summarizes the participants' characteristics. Among the physicians, three were pediatricians; the organizations were both public and private, with a representation of NGOs of national and international relevance (Medecins du monde, Save the Children, International Organization for Migration, InterSOS, Medecins sans Frontieres, Caritas, Red Cross, National Institute for Health, Migration and Poverty) and operators of the Reception Centers (RC). The majority of the involved physicians and psychologists worked in the Roman area within the Health System, in international institutions and reception centers.

Table 2
FGs participants' characteristics (N = 15)

Data of participants	N (%)
Country of origin	
Italy	15 (100)
Mean age in years	46.3
Women	12 (80)
Men	3 (20)
Education	
Bachelor's degree or higher	14 (93.3)
Some technical school	1 (6.7)
Professions	
Physician	6 (40)
Pediatricians (3)	
Psychologist	3 (20)
Cultural mediator	2 (13.3)
Child protection expert	2 (13.3)
Social operator	1 (6.7)
Administrative assistant	1 (6.7)
Mean working time in years	
Adult or any age	9.7
Migrant minor	7.7
Specific training	
Any migrant	8 (53.3)
Minor migrant	8 (53.3)
Development of training course	
Any migrant	10 (66.7)
Minor migrant	9 (60)

The average working experience with migrants was 10 years with regard to adults or any age and 8 years with regard to minors, respectively. In most cases, they did not have specific training on both migrants in general and on migrant children, but most of them had participated in the development of training courses related to social and health care.

Bio-psycho-social needs

One of the main emerged themes was the identification of minor migrants' health needs, framed in a bio-psycho-social holistic perspective (*Figure 1*). The achievement of unaccompanied migrant minors' (UMM) primary needs, like "give a supportive space... a shower, a family space", is part of the activities implemented and to be implemented, although often accompanied by linguistic and cross-cultural barriers and by unfamiliar care settings.

Migration has been described as a "fragmented" event that breaks down the child's needs on several levels of care. In this context, the professionals and the operators are requested to connect "these pieces" and, therefore, the minor's identity. This fragmentation causes a need for reassurance and trust, which is especially expressed on arrival and reflects the fear of "being sent away or not being accepted". Often their migration project does not comply with "our migration stereotype which often does not coincide with their history". Therefore, including their migration goal in the provision of care means responding to their need to achieve it. Although many experiences, in particular the "journey", require migrant minors to assume responsibility as adults, professionals recognize their need and right to be recognized and treated as children especially when they "have to manage their own health and the health of their parents".

Sometimes, the need for caring relationships in reception overcomes the health needs because it allows to "enhance all aspects beyond the more technical ones". About specific health needs, one of the main themes is the reduced vaccination coverage or the difficulty in reconstructing the child/adolescent's vaccination history, and the consequent lack of access to school. Another issue is the higher risk of obesity "because diets change". In addition, the implementation of an inclusion and integration process requires a guarantee for working autonomy. Thus, adolescents need appropriate training and/or gradual job placement.

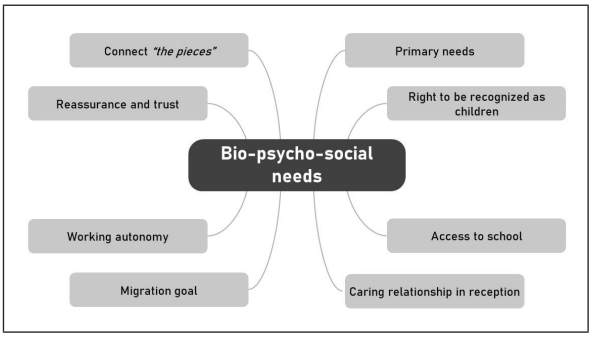

Figure 1
Bio-psycho-social needs.

Care provision

Professionals report an "infantilization" of minor migrants and the consequent tendency to not recognize their "edge over" that allows reaching a greater degree of autonomy.

Volunteer tutors are an important resource because they help to build a therapeutic relationship that is not only conveyed "by pieces of paper". The excess of bureaucracy is also due by the recognition of the minor age, which is not always univocal, generating difficulties and slowdowns. The recognition of minor frailties is challenging as it does not always occur in a multidisciplinary and holistic way. In the case of a psychic vulnerability, especially in adolescents and UMMs, "little work is being done towards prevention", but rather at an emergency level. Provision of care in the first 1000 days and childhood emerged as being complicated by several issues emerge. In Western Countries, pregnancy is considered as a potential risk condition, while migrant women deem it as a physiological process. Breastfeeding for 2 years and beyond is a well-received practice by migrant women who unwillingly accept early weaning (around 4-5 months), "they would like to start weaning later".

Regarding the UMMs, the organization should know, at various levels, their narratives, especially for those who have a greater vulnerability. Taking care of adolescents mainly concerned the psychic area, such as boredom and "suspended time". To cope with this discomfort, it is the care facilities' task to engage the adolescent in "a calendar of activities". The family custody of these adolescents seems to be a long and tiring journey, and this prevents the adolescents from completing their migration project, whether it is to reach the "country of hope" or to work in the host country. Furthermore, there seems to be a "difficulty of the system to take care of girls", especially in the case of victims of trafficking for whom "the offer of individual psychological support is not always the most suitable solution" and should be accompanied by support groups. These girls had experienced "missed adolescence and childhood" that could be aggravated during the stay in the reception centers: "... arrives the maman and they became victims three times, because they could no longer even talk to us". The UMMs, especially adolescents, are identified in the streets by the community services, within their "informal network".

With regard to accompanied migrant minors, the difficulties are bureaucratic, mainly related to the lack of access to services due to residence problems (e.g. the registration with the family pediatrician) and family problems "because the fragility of the family always affects the child". The new adults and minors approaching 18 years of age are particularly vulnerable "because they simply do not exist", as they become adults without the possibility of inclusion in institutional reception systems. This greater vulnerability leads to psychological problems without structured care pathways.

In the care relationship, the participants described two main types of minors: the translator or interpreter of the family unit and "adult minor". It has been a common opinion that children, by fulfilling these functions, are more fragile because they are invested with a "responsibility that they should absolutely not have". In some cases the figure of "translator" is a direct consequence of a system that does not provide the cultural mediator as a support in the provision of care to the migrant population. On the other hand, "adultization" allows to reach a level of autonomy that differentiates these boys/girls from the adolescents of the host country.

The participants provided indications to better respond to minors needs. Among these, briefing, mutual help, discussion and sharing within a multi-professional and multidisciplinary team emerged, "to always have focused everything on how to proceed". This would help to understand and overcome the critical points, and to improve care. Clinical protocols would allow all the actors involved in migrant children's care to work in a synergistic, clear and defined way. According to some of the participants, the wide reception centres (RCs) could represent a solution that allows them to welcome migrants in a multidisciplinary way in order to "feel part of this world". On the other hand, others have expressed favourable opinions for the widespread small centres, linked by networks with local services, because they could facilitate a real opportunity of integration and a "truly intercultural world".

The opportunistic provision of services, compared to a pro-active offer, leads to inappropriate access to services by migrants (minors and their families), such as greater use of emergency services. Moreover, cultural mediators, differentiated by gender, especially for girls, and ethnicity can facilitate the comprehension and the response to bio-psycho-social needs.

The participants also addressed the topic of the vicarious trauma experienced by operators in situations of emotional involvement, when coming into "contact with dramatic stories". The participants highlighted the need of listening, sharing and support services for operators, to guarantee them the possibility of unburdening any problems they may be facing before emotional distress occurs. There is also a need for "external supervision, both technical and psychological", to overcome the operators' feeling of loneliness and not recognition. Moreover, the participants raised the attention on the emergence of stereotypes, that could lead to attribute labels to the migrant person, and this "is very dangerous, because once it is given, all the other information is read in this key".

Barriers to care

The three FGs revealed obstacles to accessing health services (*Figure 2*). The scarce availability of orientation information and the reduced health literacy of migrants make it difficult to access and use health services properly. While the prevention services are underused, there is excessive and inappropriate use of emergency services. Health literacy is a key point for the adequate access to services, as well as other aspects like food safety (especially for the preservation of food) and the conscious use of drugs (e.g. over/misuse of antibiotics or vitamins in children).

The barriers to the provision of care resulted to be

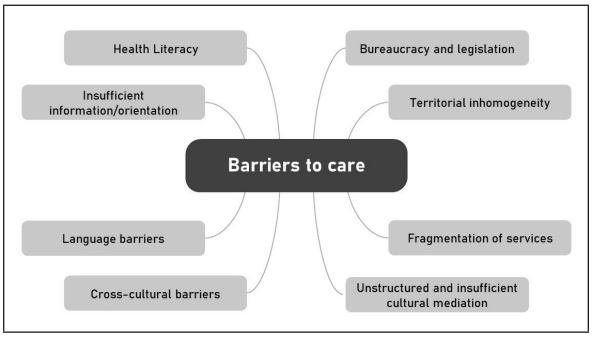

Figure 2
Barriers to care.

also bureaucratic and legislative, e.g. the difficulty in obtaining residence. A "bureaucratic delay" was found, and it appears to be opposed to the common representation that migrants have of "a structured, fast and efficient European world". The cultural mediator, however, is able to explain, especially to children, the rationale behind bureaucracy and the necessary administrative procedures, making them more comprehensible and acceptable. One of the main difficulties is the registration with the National or Regional Health Service, that is essential for the universal, free of charge care system.

The national repressive migration policies have generated insecurity and distrust among migrants, as the offer of the reception system has been downsized. Moreover, the territorial and national inhomogeneity contributes to create obstacles because "a guideline is missing, protocols are lacking, in short, more standardized directions are missing". This generates a fragmentation of the services that often do not communicate with each other, causing a "fragmentation" of the minor's needs and identity, and undermining continuity of care. In spite of this, "some realities have successfully developed a virtuous pathway" "…modelling their interventions taking into account some cultural peculiarities".

Language barriers represent one of the greater obstacles to the provision of care, from the perspective of migrants, professionals and administrative personnel (e.g. information desk). This adds up to the lack of cultural mediators to accompany the migrant throughout his/her reception pathway. This figure is often not recognized by the reception system, it is not structurally integrated within the Social-Health System and it is not part of the programming of the services. This leads to communication problems, reinforcing the idea that cultural mediation, beyond translation, implies a transcultural dialogue between the migrant person and the care system.

The cross-cultural barriers between operators and migrant minors were perceived as an obstacle that affects both the migrant and the operators. As an example, male circumcision, practiced during childhood in some cultures/religions, could be "made possible in public structures, hospitals, Local Health Authority" contributing to eliminate the undeclared and dangerous practice. Often the operators don't know the culturally different ways of caring for infants, because "we don't have the same cultural reference on caring". Among the barriers that emerged for migrants, there is poor adherence and compliance to long-term drug therapies, especially by minor migrants; the non-acceptance of diagnostic techniques (e.g. blood sampling); psychological disorders culturally interpreted in a different way by the caregiver. The gender difference also seems to be an obstacle, "in many cities the ability to take care of girls is very lacking", e.g. human trafficking and sexual victims.

Training

The target should include health professionals, educators, mediators, reception managers, technicians, administrators, and, "in general, all those who will take care of the child on a daily basis". Training should be planned according to the different professional specificities, with a special focus on those who interact with children. The tutors and families to whom the minors could possibly be entrusted were also identified as a target of the training. It should be a specific training, aimed to describe the process, the timing and the dynamics of welcoming and entrusting.

Training is considered as "a very individual thing" that requires different timing for everyone, because "starting from the same conditions, there are those who develop immediately [knowledge and abilities]… and others who do not" and help to be aware of one's attitudes. At the same time, it is evident that professionals attend these courses according to their individual predisposition, causing a selection bias.

The training contents include the development of counselling skills, the identification of the risk profile of the minor migrant, and the social health determinants. The latter, according to a "global health approach, therefore an approach that takes into account the effect of the social determinants of health on people's lives. We are talking about inequalities in health". This will support early identification of the situations of greatest vulnerability. Another content to address is the processing of sensitive data. Moreover, "training should be centred on how to make these skills talk to each other".

The training on the first 1000 days should involve infant care, in its cultural declinations, breastfeeding, complementary feeding, infant massage and job placement of mothers. In addition, it is useful to give directions to the professionals on culturally sensitive good practices related to child feeding, in order to not responding to a typical vision of our western societies but to the mothers' desire and cultural background. It is the case of weaning, which is often advised before 6 months and according to pre-set Italian dietary schemes. The need to have a cross-cultural food pyramid emerged. Another topic was infant feeding in emergencies and, therefore, training "on the importance of breastfeeding in war and emergency areas".

The training methodologies considered most effective were those that provide for a higher level of active participation of the learners (role-playing, discussion of cases, etc…). In this type of training, the young migrants can play the role of trainers, because the testimony of their experience would allow people to get in touch with each other ("Making stories speak"). The Community of Practice could be an adequate tool, to

promote collaboration among "police headquarters, prefecture, immigration office, Local Health Authority and reception centers". It should be "a long-term solution, which requires strong hierarchical coordination both at the micro-level in the management of the single center and at the macro-level in the management and taking care of the minor".

In participants' experiences, the strengths of effective training were: multidisciplinarity and multi-professionalism; field training; a combination of theoretical and practical training methodologies. The weaknesses were, instead, pre-established training modules that do not allow the active involvement of participants in the construction of training objectives and needs and obsolete training programs that do not raise awareness on reception.

The proposals to improve training included the involvement of different professions, a training needs analysis and the activation of the participants on their own needs. Moreover, a follow up is required to monitor the results achieved and whether these are preserved over time. Pre-service and in-service training should be included both in university curricula and in continuous training, through Continuing Medical Education (CME) accreditation.

DISCUSSION

In our study, we explored the health needs of minor migrants and the barriers to care as a means to understand and improve the professionals' training and the provision of care. During our FG, the participants recursively addressed and showed greater interest in the theme of minor migrants' frailties and barriers to care. Among the other aspects, the FGs brought to light the professionals' need for listening and discussion as they experience a sense of isolation. As for the study results, although the scientific literature is not extensive, we found some consistency with other published studies.

The UMMs' emerging needs are often the expression of inadequate living conditions due to the migration route from the country of origin to the host country. Migrant minors in general, but in particular the UMMs, face risks related to the social and political situations of their countries of origin, and the modality, distance and duration of the journey, and the arrival in the host country; all elements that negatively impact on the psycho-physical health. These findings are consistent with the ISSOP position statement on minor migrant health, reporting that these children show high rates of depression and post-traumatic stress disorder (PTSD) in the first years after resettlement [16].

In our results, these aspects cause difficulties in taking care of minors. Language and cross-cultural barriers undermine communication between service providers and people, produce insecurity in migrants, make more difficult to build a therapeutic relationship based on mutual trust and this can also negatively affect the provision of primary care, the quality, and continuity of care, as showed also by Dauvrin *et al.* [17]. Moreover, the care practices can be misinterpreted and consequently not accepted by the migrant population. A metasynthesis [18] analysed migrants' views on obstacles to accessing services. They included linguistic and cross-cultural barriers related to belonging to an ethnic group, religion, or country of origin that produce distrust towards organizations and health professionals. As emerged from our focuses, a strategy that migrants put in place to deal with communications barriers is the use, within the family, of children as translators. This leads to problems related to greater fragility and responsibility of those children who are invested in carrying out this function. Additional problems that emerge from the literature concern the impairment of the parents' authority who rely on their child for interpretation; the lack of school attendance by children who must accompany a family member to a health visit; parents and children can experience emotional trauma, fear, embarrassment and shame [19]. Sometimes, the figure of the "minor-translator" is needed to overcome the lack of a system that does not include the structural integration of cultural mediation and interpretation. In scientific literature, the difference between cultural mediators and interpreters is not always clear. According to the Regional Office for Europe of the World Health Organization (WHO), mediators encourage and improve the use of services by explaining the health care provided and promoting the trust of migrants in the service and the staff [19]. Interpreters, on the other hand, translate spoken information from one language to another [19]. Our participants strongly support for active provision of cultural mediation in the context of standard health/social care, in a way that is efficient and sensitive to gender and ethnicity. The shortage of cultural/linguistic mediation is consistent with other authors' findings [20], causing the child to be used as interpreter and to become an "adultized child". "Adultization" also occurs in other circumstances, e.g. when migrant children try to improve the economic conditions of their families [21].

At the same time, there is often a tendency to infantilize children by not recognizing their degree of autonomy. Kanics *et al.* describe how this negatively impact on the ability to exploit integration opportunities [22]. According to our findings, an intercultural approach is necessary to address the difficulties to adapt to a new culture and country while maintaining the native culture, as described also by Nakeyar C. *et al.* [23].

Failure to recognize the minors' psycho-physical frailties, the lack of multidisciplinary and multi-professional management, and no specific cross-cultural skills, represents an obstacle to treatment. In our results, among the frailties, emerged an increased risk of obesity and overweight due to changes in eating habits. These data are also confirmed by the Italian surveillance system, which shows how the family context can influence the lifestyles [24]. With regard to mental health, migrant children are at high risk of mental and psychosocial problems, including depression and PTSD [16]. These frailties are reported in our study and result in difficulties of integration, provision of holistic care, and access to services that can harm the migrants' health and increase vulnerability. The inhomogeneity and, in some cases, the lack of integration of health services, not always oriented to continuous and tailored care, reduces

the possibility of adequate use of services, in particular those relating to ordinary care. This leads to greater use of emergency services. Several studies showed that the probability of using emergency services is higher among migrants than the local population [25] [26]. Another reason that could explain this increased access is the use, in the countries of origin, of emergency services as first-line access to healthcare; this is especially evident in countries where primary and community health care is not widespread. Many migrant children may not have access to adequate community preventive care and, therefore, may not have adequate vaccination coverage resulting in limited access to school. The poor vaccination coverage is mainly due to poor implementation of primary prevention programs in the countries of origin [26], but, as emerged from our study, it may also be due to a difficulty in tracking and certifying the vaccination pathways.

Our study highlights some areas that need to be considered when planning training aimed at operators involved in the provision of care for minor migrants. These areas include context analysis and the capacity to identify and address the main children's needs and barriers to care, comprising specific frailties and conditions related to the migration process (e.g. PTSD, depression). Another area to be addressed is the professionals' cultural competence and appropriate communication and counselling skills. The professionals should also improve their capacity to work according to a trans-disciplinary, trans-sectoral, and trans-cultural approach. Therefore, the training should promote a transformative (trans-formative) process and the co-construction of a new/different way of provision of care, both on individual and organizational level. Some specific topics regard self-medication and therapeutic appropriateness, abuse screening and prevention, sexual health, health promotion, lifestyles and health literacy; maternal and child health should be treated in the training according to the WHO/UNICEF recommendations. The training should also be aimed to improve awareness on bias and prejudices of health professionals, that can contribute to the vulnerability and impact health outcomes. On the other hand, the operators are more likely to develop a vicarious trauma, which exposes them to a greater risk of "short circuit". Aside from peer professional support, specific training can help in developing awareness and coping strategies, in order to prevent, recognize and seek help in case of vicarious trauma and burnout.

A trans-cultural training on minor migrant health is intended for a broad target. Indeed, there is a "selection bias" that leads professionals with higher motivation to be more frequently involved in social and healthcare pathways for minor migrants, compared to those who are less interested in the migration issue. For this reason, a transcultural approach falls within the core competencies addressed by pre-service and in-service (CME) education for all the health, educational, and social personnel.

Our participants expressed a preference for training methodologies that allow greater involvement and active participation of learners. Among these, role-playing, case-studies, and the activation of a Community of Practice were mentioned. Berlin *et al.* (2010) described the effectiveness of an educational method that combines theory, practice, seminars, activities, and discussion [13]. Previous studies on cultural competence among health professionals have used various methods, such as didactic presentations, discussions, role-playing, videos, and exercises [27]. A 2017 study, which used and assessed the participatory approach of the Community of Practice, showed how this could be able to improve knowledge, attitudes, perceived skills, and involvement of members belonging to the Community, in order to optimize resources and skills by generating new knowledge [28].

Continuous discussion and comparison through audit and feedback strategies would help to make a critical analysis of successful and unsuccessful strategies and find shared solutions to improve the provision of care. In general, clinical experiences have shown how these moments of sharing and discussion between professionals lead to small but important changes in professional practice [29].

This study has some limitations: the purpose sampling and its small size may not allow considering all the possible experiences in this field. Further research involving the UMMs would provide a broader comprehension of the phenomena from their own perspective.

CONCLUSIONS

In our study, multiple organizational and individual challenges have been reported in both care provision to minor migrants and professionals' training needs. In light of these results, a guidance is given to trainers, lecturers, health/social/educational professionals, reception systems, associations, NGOs, decision and policy makers, and other stakeholders to orient training planning, content and methodologies. A broad, a trans-cultural approach is needed to promote the core competencies during pre-service and in-service education. Further studies are needed to develop and evaluate the effectiveness of training programs in improving the cultural competence of the operators and the consequent improvement in migrants' health and care.

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