Primary care for the migrant population in Switzerland: a paediatric focus

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Introduction

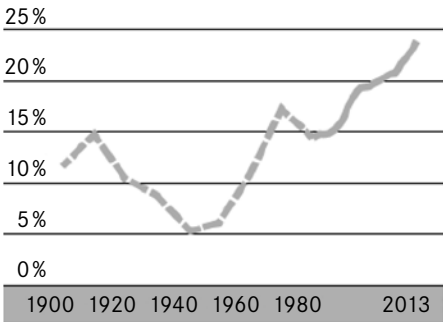
In 2014 the Swiss population was 8,2 million inhabitants (Federal Office of Statistics, (OFS)) comprising a high number of foreigners (2.1 million, 24,3 %). The tendency is the same for children (0–18 years old) who do not have Swiss nationality (20,2 %). Asylum seekers are about 80'000 (21'000 arrived in 2013 and 40'000 in 2015), the «undocumented» or illegal migrants between 100'000–300'000! The «migration issue» is important, notably from a public-health perspective, migrants being often considered as in less good health than the native population.

In this article, we attempt to propose a practical guide for the practitioners taking care of a migrant child and his/her family: this situation is far from being unusual and judged complicated by many caretakers who consider themselves lacking the requisite skills and feel sometimes «powerless»[1]. Indeed the medical paediatric literature on the subject is limited[2] and few guidelines are available.

Two recent Canadian publications should be mentioned in which a number of topics concern children (infectious disease, vaccination, child abuse, dental care)[3, 4]. Migrant children have health needs comparable to those of the local population; nonetheless, certain issues require a «specific» approach.

After addressing a few general notions, we will focus on a global healthcare (and family oriented) approach allowing taking care of complex situations, such as the first contacts with the Swiss health system (health evaluation at arrival, and where/how to begin?). The physicians have a tendency to over «medicalise» situations to which they are confronted, in particular at the beginning of the evaluation and often in an excessive way. It should be underlined, that despite their complicated personal history, especially at the psychological level, migrant children are generally in good health. A good social integration as well as access to «prevention measures» are two essential pillars that the paediatrician or general practitioner must be able to propose, after the first level of «screening», whether for somatic or psychosocial concerns. Finally, to be conscious that different barriers preventing access to healthcare exist is essential. These barriers can be linked to the patient, to the health professional, the health system, or a combination and need a professional approach.

Percentage of permanent resident with foreign nationality



Permanent and non permanent residents with foreign nationality, according to legal status in 2013. In thousand

Total	**2 020,1**
Residence permit (Permit B)	616,5
Settlement permit (Permit C)	1 227,9
International functionaries and Diplomats	28,9
Short-term residence permit (Permit L)	97,1
Permit for asylum seekers (Permit N)	21,3
Provisionally admitted foreigner (Permit F)	22,1
Not attributed	6,3

Permanent resident with foreign nationality, according to nationalities, in 2013 in %

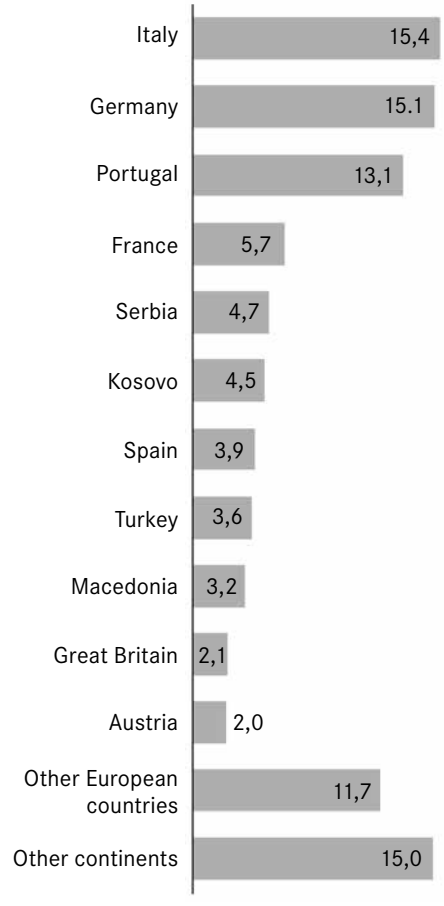


Table 1: Percentage of foreign resident in CH, 2013 (OFS – Federal office of statistic)

General information

Definitions, characteristics and legal status

The definitions used are from the UNESCO and IOM (International Organisation for Migration[5]):

- Migrant: foreign subject, born outside of the territory or the land where he/she resides, lives and works. The individual is supposed to develop important social relations (profession, school, etc) in that country.

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- Migrant child (from birth to 18 years of age): concerns all children accompanied or not by their parents, those undocumented, refugees or asylum-seekers.
- Unaccompanied Minor: youth under 18 years of age
  - Asylum-seekers
  - Not-accompanied by a parent or a legal representative
  - Forced into exile: because of war, child abuse, rape, forced or arranged marriage, death of the parents, even for economic reasons.

  450 arrived in Switzerland in 2012, and 2736 in 2015. 120 are under 12 years old, 80 % are boys and 85 % come from Africa (Eritrea, Ethiopia), Afghanistan and Syria. The unaccompanied minors essentially live in St. Gallen and Lausanne.

In the majority of cases, the migrant comes from a European Union country and generally neighbouring countries, mostly from Germany and Italy *(Table 1)*. The cultural factor expresses itself therefore more by the linguistic difference, than by a difference in attitude, and social behaviour.

In Switzerland, from a legal perspective, the term migrant does not have a clear meaning. It is thus necessary to define the different legal status to which the migrant is subject, all the more so that access to medical insurance depends directly on that status. The most important notions are indicated in *Table 2* (adapted to the type of permits most frequently given[6]); foreigners with authorization of residence or establishment are not mentioned (those having B and C permit). The permits N and F are characterized by their temporary nature; they have to be constantly renewed, which creates a climate of insecurity for the permit-holder.

Health condition of migrants in Switzerland with a focus on children

Considerable social and economic differences in the migrant population exist. Generally speaking, two groups can be distinguished (intermediary categories also exist):

- A first group **with low risk of health problems:** diplomats, intellectuals, students, managers, liberal professions or politicians and their children.
- A second group of **immigrants (including the family and children) with high risk for health problems:** workers, low-income professionals, asylum seekers, and undocumented migrants. Women and children constitute in themselves an «at risk group» requiring specific approaches. The Syrians and Eritreans recently arriving belong to this second group.

We will focus our discussion mostly on the second category, the most vulnerable.

The mental health condition of the migrant population, in comparison with the Swiss population is fragile[7, 8]. In families with children, there is evidenced of frequent consultation to the school psychologist. If one wishes to speak in terms of «pathologies», migrant children would be more susceptible to «functional» problems (chronic abdominal pain, enuresis, thoracic pain, feeling of breathing difficulties, even hyperventilation, sleep disorders, and nightmares) to depressive states and anxiety disorder. They are especially af-

Status	Every person …	Right to the health insurance and type of permit
Asylum seeker	Who formally requests protection from Switzerland, independently of the answer, which will be given to him; she or he hopes to be recognized as a refugee and benefit from the legal and material assistance linked to this status.	Benefits from a basic health insurance. But each canton is free to limit the choice of the health insurance (which is private in Switzerland) and the health provider. N Permit
Refugee	Is recognized as a refugee, any person who according to the Geneva Convention on Refugees who is outside their country of citizenship because they have well-founded grounds for fear of persecution because of their race, religion, nationality, membership of a particular social group or political opinion, and is unable to obtain sanctuary.	Has access to the same system and health insurances system as the Swiss population. Permit F, N, S, sometimes B.
Non entrée en matière (NEM) *no translation*	Are asylum seekers whose application the Swiss authorities have refused to consider.	Has the possibility of receiving a minimal «emergency assistance», including access to health care. No permit
Dublin cases	The asylum request is usually not examined. The Dublin Regulation aims to determine rapidly the Member State of the Schengen space, responsible for an asylum claim and provides for the transfer of an asylum seeker to that Member State.	Has the possibility for receiving a minimal «emergency assistance», including access to health care. No permit
Asylum not granted	A person whose request for asylum has been definitely refused after a request which has been formally examined by the Federal office of migration and after eventually the legal appeals	Has no automatic health insurance, but can affiliate himself to one and obtain partial financial help without being denounced to the police. No permit or permit F in case of temporary admission but non-recognition as refugee
Illegal migrants	Foreign people living illegally in Switzerland, thus longer than the time of a tourist visas or any other authorized stay, that she or he has arrived at the end of the asylum procedure with negative answer and has not requested or obtained or lost the legal status to stay in Switzerland.	Has no automatic health insurance, but can affiliate himself to one and obtain partial financial help without being denounced to the police. No permit

Table 2: Status, type of permit and social consequences (insurance), adapted from[6]
Comment: The Convention on the Rights of Child (CRC) state that unaccompanied minor benefit from special protection. The goal is to give the basis to allow them to grow up safely and to be able to develop perspectives for the future; either by returning to their native country if that is possible, or to find a long-lasting solution in Switzerland (or another country).

fected by traumatic experienced in their native lands or during their migration journey (one can think of recent examples in the populations coming from Syria or from the horn of Africa). The experience of violence, sometimes reproduced within the family, provokes serious psychological sufferings for both the children and their parents. A disturbed psychological state will often have repercussions on the «at risk behaviour» which can lead for example to all kind of accidents. The border with «child abuse» is often difficult to situate but requires particular attention. A Canadian systematic review of the literature (3) underlined that children of ethnic minorities and in particular asylum seekers are over-diagnosed (8.7x more than local children), and over-reported (4x) as «abused»; excessive denunciations to child protection authorities can be the cause of serious family and social disruption with serious consequences on the general health of the children and their families as emphasized in this review done in a context rather different than the Swiss one. Their recommendations conclude that there is a need for professionalism in this very sensitive field where an empathic clinical approach is needed. The need for an early psychological evaluation to detect significant problems (like post traumatic disorders) is debated[9]. The paediatrician should be particularly attentive to these problems during the first months.

The **«somatic pathologies»** discovered on arrival of the migrant child are mostly related to infectious diseases. The first one to be mentioned, even though it is not entirely infectious is the «bottle» dental caries, which one can find in nearly 50 % of migrant children under the age of 5 (while 20 % of Swiss children are concerned by this problem as proposed by *Madrid et all.* and confirmed by a study done in Lausanne[10]). This issue is not well known by health workers and insufficiently taken care of. From their country of origin or their migration route, diseases considered «exotic» can affect the children: hepatitis B (certain children have not been vaccinated and come from countries where it is highly endemic), HIV, schistosomiasis, malaria or tuberculosis (the risk being increased by the transit in prison or refugees camps, mostly in Africa). The vaccination history of some of these children is poor although overall the vaccination coverage – especially in the southern hemisphere – has much improved these last 10 years. One should also mention that females may have had genital mutilation, frequently practiced in some African countries (East Africa, Egypt, etc)[11]. It is thus important to practice a geographic and probabilistic medicine, which allows doing the most logical screening. For example, when confronted with anaemia (either clinical or discovered fortuitously), if one knows the origin of the family, one can search for sickle cell anaemia. Intestinal parasites are frequent in certain regions; some recommend systematic screening approach; others more pragmatically recommend treating any patient from theses regions. In addition, unexplained anomalies, among others hormonal have been observed in girls in the months following their arrival in Switzerland, being at the origin of a precocious puberty[12]. A regular follow-up of the growth; as well as informing the mother to consult if any sign of puberty appears is important. A specialised consultation is then mandatory in a short delay.

Nutrition is a central health concern. The different studies in this field have shown mostly iron and vitamins (D, A) deficiencies. There are different approaches: from universal blood screening, to screening reserved only in the presence of risk factors and clinical signs in the case of vitamin D[13]. Because of the lack of financial means, of knowledge of their new social environment or out of habit (over-fatty food habits in the South American population for example), many migrants do not have a proper diet. In this population, one observes a higher obesity rate than in the local population[14), 15), 16)], which is the combined result of an unhealthy diet and lack of physical activity. Raising awareness and educating on healthy diet is essential. A cultural mediator can play a role in helping them adapt to the local food and understand the local customs. Many institutions now include in their teams professionals certified cultural mediators-interpreters, who interact with the migrant patient by doing prevention and have a central role in the care of chronic diseases (asthma, diabetes, sickle cell anaemia) where therapeutic education of the family is essential.

There is a lack of access to preventive approaches within the migration population. Girls

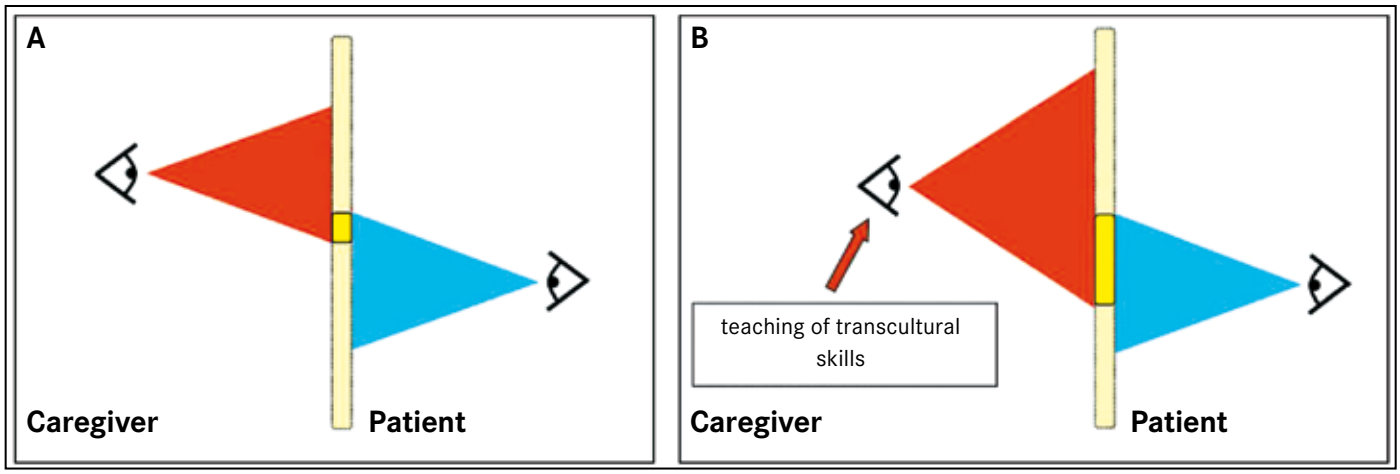

Figure 1: What to expect from the acquisition of transcultural clinical skills?[20]

A. Represents the perception of a clinical situation (medical knowledge, representation of the disease, linguistic competences, expectations, values). The shared assessment of caregiver and patient.
B. The common assessment is improved thanks to the caregiver's acquisition of transcultural clinical skills. (Better understanding of the medical knowledge, disease representation through the help of a cultural interpreter. Exploration of the expectations and better sharing of values.)

and boys may lack information and knowledge about sexual health[17]. The consequences of such a deficit is particularly visible during the puberty years where one encounters in this population a high rate of non-desired pregnancies, sexual transmitted diseases, as well as a non harmonious sexual life with its psychological consequences. Smoking and alcohol prevention require more attention. Adult migrants are more affected by these problems than the Swiss population. Appropriate information is required for the young generations. For example the Swiss Red Cross has edited a booklet specifically for migrants.

One should also underline that the health professional must be particularly attentive when a migrant family travels back to their country of origin and when they come back. The potential risk of being exposed to some infectious disease is high (e.g: malaria, typhoid fever, hepatitis, STI). Therefore, a special consultation before departure is required (e.g tropical medicine type of consultation) and special attention is needed as they return, in particular in the case of febrile conditions[18].

Generally, the transmission of «health information» is not done adequately with the migrant population. In Switzerland, the statistics highlight a higher number of hospitalisation, admissions to intensive care unit and mortality in migrant children[19]. The cases of sudden infant death (SIDS) also concern predominately migrant children.

In order to encourage a systemic approach, special attention should be given to the mothers; some of whom are ill, malnourished or psychologically fragile. Their level of education can be low or inexistent. Mostly in the foster home, the children may lack stimulation, which can lead to psychomotor delay. This topic has not been sufficiently studied, and ist thus largely unknown to the professionals and political authorities. When giving birth in Switzerland, the whole concept of childcare can be questioned: sleeping habits, food habits, care of a newborn. Specific approaches to prevention are again needed. As for the fathers, their migrant trajectory and their health is often precarious and has repercussion on the family's health.

«Barriers to health care access»

Difficulties encountered by health professionals when working with migrant population

The task is not easy for professionals working with migrant patients and new to the Swiss health system. A recent publication[20] has demonstrated that, and has highlighted three main challenges: **the linguistic context,** the **difference of reference system** between the doctor and the patient as well as the **patient's profile**. The health professional cannot alone tackle all these challenges.

Too many medical consultations take place with complete incomprehension between the patient and caregiver[21]. In order to address this issue, one can request the help of a cultural mediator-interpreter, however these are frequently not used by the doctors because of «lack of time», «too complicated», lack of funding of the service and at times refusal on the part of the patient. *«The patient refuses the interpreter by fear of having to deal with someone from the community, and because*

Examples of attitudes, of knowledge and know-how to be acquired during trans-cultural clinical competences training.
Knowing how to be
The clinician needs to accept his responsibility to identify and take into account social and cultural aspects while caring for a patient.
Knowledge
Knowledge of the importance of social-cultural factors in the beliefs and behaviour in the field of health.
Knowledge of the social, economic and cultural barriers preventing proper access to health care and compliance with treatment.
Awareness of the most frequent causes of misunderstanding between the patient and clinician.
Recognition of one's bias and prejudice concerning patients and their impact on their care.
Specific knowledge in the field of migration (demography, epidemiology, legal, type of permits, resources for migrants, etc.)
Know-How
Capacity to work with an interpreter
Capacity to identify and explore the socio-cultural factors that could influence the care of the patient.
Capacity to propose a treatment plan that takes into account the social cultural context of the patient and in case of disagreement with the proposed plan, the capacity to negotiate

Table 3: Essential trans-cultural clinical competences[20].

Social factors	Psychological factors	Medical factors
• No or poor social network • Non secure legal situation • Quality of integration of the parents in the country of immigration • Unaccompanied minor • Language barriers (communication)	• Exposure to violence, torture, environmental disaster before arrival • Importance of the cultural and language differences.	• Incubation of tropical disease • Having been through camps, prisons, hospitals • Difference in the feeding habits • Epidemics in the country of origin, malaria risk, … • Vaccination calendar in the country of origin

Table 4: «Red Flags» allowing to define the priorities in the care of the patient taking into account social, psychological and medical aspects during a first consultation

the illness is a taboo subject, he or she does not want someone of the community to be informed»[22]. A family member will often serve as interpreter, which complicates the discussion of some topics, such as family dynamics, questions linked to sexual health and the illness in general; in particular when it is psychological. Nevertheless, the positive role of a certified interpreter is well proven (quality, economy, relevance, etc)[23), 24)].

To the language dimension, the cultural dimension can be added. The disparity between the Swiss system and the one in the country of origin, whether at a political, social and health level is often striking. The acquisition of «transcultural clinical competences»[25)] (= set of attitudes, knowledge and know-how that allows a health professional to provide quality care to patients from different origins) is very useful. *Table 3* describes what a health professional should master and *Figure 1* shows the benefits one can expect; specific trainings are now available in that field.

Migrant patient profile in the Swiss health system

The 2010 survey done by the Swiss Confederation highlighted that migrants (migrant children were not specifically taken into account in this study) used the health system more often than the Swiss population, and favoured the emergency departments[26)]. This was explained by a lack of confidence and/or a lack of information on how the Swiss health system functioned, as well as the constant linguistic barrier they face with the family doctors who do not have easy access to the certified interpreters.

The migrant patient regularly shows a «defensive» attitude in certain medical situations: post-traumatic stress syndrome (PTSD), illnesses like HIV or STI, etc. The caregiver must learn to break the code. The therapeutic alliance between the patient and health professional will directly depend on it. The reasons are:

- Lack of knowledge and information on the health system of the host country
- Lack of trust in the health system, sometimes due to bad experiences
- Financial distress
- Professional pressure
- Fear of denunciation to the authorities
- Lack of health education
- Their own vision of the illness, different from the one recognized in Switzerland.

Recommendations for the first health visit

I. The following 4 points suggest the priorities

1. Take into account the most pertinent social, psychological and medical information *(table 4)*
2. Have a clear idea of the most frequent health problems found in migrant children *(table 5)*; one needs to know how to look for them (that it is by the history and/or the physical exam). An age related approach is useful *(table 6)*
3. Propose a pertinent health work-up on arrival *(table 7)*
4. Propose a coherent follow-up for the child and his family

II. At an appointment for one child, it happens that the family comes with several children. It is then necessary to detect rapidly if:

1. The child or a member of the family presents a health problem dangerous for the community (these are rare situations, but as there are no more systematic «border health check-up», one needs to think of tuberculosis, and certain epidemics existing in the country of origin – e.g Ebola in 2014–2015, cases of measles)
2. The child with an acute health problem, needing immediate attention, must receive the care as any other child **independently** of his legal status! One needs to have in mind imported illnesses with their incubation period[26)].
3. The child with evidence of mental health problems or at risk psychosocial problem must receive the necessary protection and support. We refer in particular to unaccompanied minors.

If these factors are present, they will influence the «timetable» proposed in *table 7*, as one will have to give priority to this child's needs (e.g

Infectious	Nutritional	Mental health, post traumatic stress disorder	General problems related to integration	Other health problems observed
Intestinal parasite Hepatitis B Malaria (in case of fever) Tuberculosis/HIV Dermatological • Scabies • Leishmaniasis • Mycosis	Iron deficiency anemia Malnutrition Obesity Rickets *	Humiliating life experience Exposure to war and violence Separation from the family	Prevention of drug abuse, alcohol abuse and tobacco Sexually transmitted infection (STI)	Difficulty in assessing the age of the child Dental problems Developmental delay Precocious puberty Hearing and visual problems Health problems explaining the arrival in Switzerland (congenital heart disease, cerebral palsy, …)

Table 5: Most frequent health problems in migrant children («to keep in mind»)
Note: * Clinical manifestation of vitamin D
• Infants: seizure, tetany, cardiomyopathies
• Children: pain, myopathies causing motor delay, rickets.
• Adolescents: pain, muscle weakness, clinical sign of rickets or osteomalacia, including Xray signs found in traumatological events (fractures in the emergency room)

hospitalisation, «isolation» of the child and/or his family, etc).

III. However, in the vast majority of cases, the migrant child, what ever his age, seems to be in good health. The goals of the first consultation are then:

1. To **create a climate of trust** by taking a thorough history and a full physical exam done in the presence of the family and a professional cultural mediator (mostly if communication is poor). A blood test is not needed immediately.
2. While doing the **complete physical examination**, one will be attentive to certain points *(table 2 and 4 should be in our mind at each consultation)*
3. Decide which **exams** need to be done on arrival and **explain them**! These examinations can be perceived as intrusive and stigmatizing (e.g. HIV, sickle cell disease, hepatitis, or just «drawing blood»).

4. Planning of the next consultations.

a. In case of a tuberculin skin test (TST); it needs to be read and interpreted within 48–72 hours.
b. A blood test will be done a few weeks later and the results will be explained
c. Detailed evaluation of the child's development and a regular follow-up of his growth.
d. Detailed evaluation of his vision and hearing (if indicated will be referred to a specialist).
e. **Dental examination** (referred to a dentist if any doubt).
f. Evaluation of the **psychological state** of the child and his family to decide if any specialized consultation and follow-up is needed. Functional symptoms are very frequent and should not be overly investi-

New born	Pre-school aged children	School age children and adolescents
• Looking for a maternal newborn transmission (hepatitis, HIV, syphilis) • Chagas disease if coming from Latin America (mostly Bolivia) • Growth evaluation	• Clinical signs of malnutrition and nutritional deficiencies (hair and nails, skin, eyes), rickets • Dentition examination (primary and secondary teeth) • Hepatomegaly and/or splenomegaly • Anemia (palm of the hand, conjunctiva) • Jaundice • BCG scar • Growth evaluation	• Looking for sequelae of rheumatic fever (heart murmur) • To look for signs of tuberculosis (chronic cough, weight loss) • Hepatomegaly and/or splenomegaly • To look for functional disease • To look for mental health problems • At risk behavior (street children, substance abuse, alcohol, …) • To clarify the school situation of the child in his country of origin • Growth evaluation • Puberty staging

Table 6: A few landmarks related to the clinical evaluation and age of the patient.

Clinically healthy Child	Clinically sick child

1st consultation
• Detailed history and physical exam
• Exclude any health problems which implies immediate isolation or protection measure of the child
• Conclusion, explanation and propose a calendar for the following consultations
 	
A few days later (J1):
• Tuberculosis screening (tuberculin skin test or immunodiagnostic testing) if indicated
• Complete the vaccination according to age, country of origin, etc.
• Presumptive treatment against intestinal parasite or stool examination if indicated
 	
J 3:
• Reading and interpretation of the tuberculin skin test
 	
After 4–6 weeks
• CBC, ferritin, serology (tetanus, hepatitis B and others in function of the geographical origin of the child and his history (HIV, hepatitis, hemoglobinopathies)
 	
After 8 weeks
• Complete the developmental evaluation, hearing, vision, etc.
• Discuss blood test results
• Complete the vaccinations in regard to the results of the vaccination serology
	• Investigate with great attention for possible serious and relatively frequent imported pathologies, taking into account the geographical origin of the migrant child. Examples:
	  • 1) If the child comes from an endemic malaria region and has a history or documented fever (microscopy and rapid diagnostic test)
	  • 2) In case of a febrile illness, taking into account the clinical context and geographical origin, one should exclude the following by appropriate tests:
	  • Thyphoïde fever
	  • Dengue
	  • Meningococcal meningitis
	  • Amibiase,
	  • Hepatitis
	
	• In case of chronic cough and poor general condition exclude pulmonary tuberculosis.
	
	• Propose a calendar for the follow-up (see -healthy child)

Table 7: Proposition of which approach to adopt towards a child (healthy or ill) at the first health visit on arrival: indicative calendar. For screening of infectious disease refer to the following article: «Guidance for testing and preventing infections and updating immunisations in asymptomatic refugee children and adolescents in Switzerland» by S. Bernhard et al. in Paediatrica 2016, special issue on migrants.

gated (mainly chronic abdominal pain and enuresis).

g. After a few months, evaluate the quality of the child's **school integration** and the quality of the family's **social integration**
h. Follow-up consultations can be grouped together in order to facilitate care. Examples are
   i. Development, vision and hearing evaluation
   ii. Dentist consultation
   iii. Social resources, prevention and health education – sexual education
5. Ensure that all the necessary **information on the health system** has been delivered (if useful written and translated documents). What approach to adopt in case of any health concern (telephone numbers, emergency resources etc) including common health problems (fever, accidents, trauma etc). This list of information is encouraged to be completed by the nursing staff, the social or cultural mediators etc. The role of each professional need to be complementary and harmoniously distributed. Every region has its own specific resources that need to be known and be proposed in a proactive way. Internet resources are immense, but need a careful selection.
6. Carefully fill the health book, in particular concerning anthropometric facts (weight, height, BMI, pubertal stages, teeth).

Even though specialists are frequently required, the family doctor needs to coordinate and keep the leadership of his patient. For example, unaccompanied minors followed by a paediatrician or a general practitioner, the resource of a specialised adolescent consultation is frequently useful but not exclusive.

There is a need for a good transmission of the medical information, shared decisions between primary care physician and specialists, as well as with all other actors. All professionals concerned need to be present at the meetings of the network, including the cultural mediator. When medical information needs to be transmitted to political authorities, the family doctor should coordinate what is transmitted in respect to the professional confidentiality

Conclusion

We have attempted to give an overview of the health situation of migrant children in Switzerland and have proposed guidelines concerning the medical care of these children and their families. Two aspects should be underlined. Firstly, the health condition of these children has a tendency to deteriorate once the child and his family have arrived in Switzerland. It is thus essential to improve the integration of this population in the Swiss health system through an improved «health education» and promotion of good health in line with the Swiss health system. Secondly, to reach this objective one needs to reinforce the training and qualification of all the health staff[22]. The physician cannot respond alone to issues which he is confronted with the migrant population. It is essentially a public heath problem. Today the globalisation of our world gives us the opportunity to live in contact with other cultures. However, that does not mean that we know or understand them. This implies the need to refer to transcultural specialists and progressively put into place training programs and a research program in that field. An empathic, kind and mindful welcome is the responsibility of each of us.

Useful links

www.elearning-iq.ch
Formation continue online, proposé par OFSP.
www.migesplus.ch/migesexpert

Informations pour médecins centré sur les questions en lien avec la Migration, par la Croix- Rouge suisse.

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