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Asylum seeking children in the European Union and their right to health care

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ABSTRACT

The necessity to recognize a right to health care for all migrants takes on particular importance for children. This is why in Article 24 of the Convention of the Rights of the Child, it is recognized that: 'the right of the child of the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health'. The exercise of this right is especially important for children who are especially vulnerable and therefore more subject to illnesses, like for example children seeking asylum.

In general in practice a distinction is made between those children whose status is consolidated (taken into care, obtaining a right to residence) and those children whose status is not consolidated (e.g. during the asylum procedure). For the first category, access to care is relatively easy and undisputed, for the second category, in some states access to healthcare only encompasses emergency, urgent medical care. When taking into account that sometimes asylum procedures may take several years, this could mean that during that period children are only entitled to urgent care.

To live up to the obligations under the Convention of the Rights of the Child, and also to the EU Charter of Fundamental Rights, the EU needs to put into place a framework of common standards designated to the specific needs and position of asylum seeking children.

KEYWORDS: asylum, health care, convention on the rights of the child, unaccompanied minors, EU Charter of Fundamental Rights

1. Introduction

Every asylum seeking child, be it accompanied or unaccompanied, has the right to have their application considered in a process where their needs are taken into account. The situation of asylum seeking children regarding health care does not seem that critical compared to the situation of undocumented children. Nevertheless, a study in 2006 showed that the legal situation in the twenty-five European Union (EU) countries found some restrictions on the access of asylum-seekers to health care in ten of them in spite of

their being 'documented' migrants.¹ The same study found that in five countries pregnant asylum-seekers were allowed access to emergency care only and that the entitlements of children were restricted in seven countries. Also the effective access to health care depends to a great extent on the legal entitlements recognized by the host country.

In general in practice a distinction is made between those children whose status is consolidated (taken into care, obtaining a right to residence) and those children whose status is not consolidated (e.g. during the asylum procedure). When taking into account that sometimes asylum procedures may take several years, this could mean that during that period children are only entitled to urgent care.

The second paragraph of this paper aims to set the conceptual and legal framework with regard to the right to health care for asylum seeking children, be it accompanied or unaccompanied. It will provide for some definitions (e.g. who is an asylum seekers, who is a child). The third paragraph will go into the reception of asylum seeking children, in the context of the Reception Conditions Directive. Fourthly, an overview will be given on the problem asylum seeking children face when it comes to the respect for their right to health care, based on the already existing reports that have been published on this topic. This paper will end with some concluding remarks and recommendations.

2. Conceptual and international legal framework with regard to the right to health care for asylum seeking children

2.1 Introduction

Children's rights form part of the human rights that the EU and the Member States are bound to respect under international and European Treaties. For the purpose of this paper, children will be considered from birth until the age of 18, in line with the definition given in Article 1 of the Convention on the Rights of the Child (hereinafter: CRC). The term 'asylum seeker' is usually reserved for those who have applied for asylum and are

¹ NORREDAM, M., MYGIND, A., AND KRASNIK, A., (2006), *Access to health care for asylum-seekers in the European Union: A comparative study of country policies*, European Journal of Public Health 16(3): 285–9.

awaiting a decision on their applications and those whose applications have been refused. According to the World Health Organization's Constitution of 1948 the term health is to be understood as 'a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. Within the context of health promotion, health has been considered less as an abstract state and more as a means to an end which can be expressed in functional terms as a resource which permits people to lead an individually, socially and economically productive life.

2.2 Children as asylum seekers and refugees

In the international law system of refugee protection, a key role is played by the 1951 Refugee Convention, and the 1967 Protocol relating to the Status of Refugees. There is no specific reference to children in the Convention.² This deficit means that when it comes to establishing the different rights of children seeking asylum, their rights have to be found in other instruments. This in turn may lead to having to take recourse in overlapping, European, national provision, that may perhaps be contradictory, and all having their own review system.³

The United Nations High Commissioner for Refugees (UNHCR) put the situation of asylum seeking children on its agenda. In 1987 the UNHCR Executive Committee (EXCOM) stated its intention to also protect and assist refugees, asylum seekers and displaced persons of concern to UNHCR up to the age of 18. Also in that year UNHCR EXCOM adopted a Conclusion on refugee children.⁴ UNHCR issued the first edition of the Guidelines on Refugee Children in 1988, and a revised version in 1994.⁵

In a study of the United Nations High Commissioner for Human Rights on challenges and best practices in the implementation of the international framework for the protection of the rights of the child in the context of migration one can read; 'Asylum-seeking and

² Only in Recommendation B (on family unity) to the Final Act of the Convention specific attention is paid to the position of children.

³ See also G.S. GOODWIN-GILL (1996), Protecting the human rights of refugee children: some Legal and institutional possibilities, in Doek, J., Van Loon, H., Vlaardingerbroek, P. (eds.), Children on the move : how to implement their right to family life, The Hague, Kluwer Law International, p. 97-111.

⁴ EXCOM Conclusion No. 47 ((XXXVIII) - 1987.

⁵ UNHCR, Refugee Children. Guidelines on Protection and Care, Geneva 1994, to be found at www.unhcr.org.

refugee children have particular international protection needs which must be identified and addressed. At the same time, it is necessary to bear in mind that children can have, and can acquire in the course of movement, a need for protection that is different from refugee status, but that is no less important. It is critical also to recognize and address in policy and practice the particular vulnerability of girl children to violence and discrimination within the context of migration.’⁶ In its Conclusion on Children at Risk, The UNHCR Executive Committee in 2007 adopted the Conclusion on Children at risk, which provides operational guidance for States, UNHCR and other relevant agencies and partners, including through identifying components that may form part of a comprehensive child protection system, with the aim of strengthening the protection of children at risk.⁷

2.3 UN Convention on the Rights of the Child

The 1989 CRC forms the main legal instrument on the protection of Children. It is the Convention that is ratified the most in the world, it currently has 193 States Parties.⁸ The CRC embodies four general principles: 1. Non- discrimination (Article 2).⁹; 2. The best interest of the child shall be a primary consideration in all actions affecting children (Article 3).¹⁰; 3. The obligation to protect the right to life and to the maximum extent

⁶ Study of the United Nations High Commissioner for Human Rights on challenges and best practices in the implementation of the international framework for the protection of the rights of the child in the context of migration, UNGA, A/hrc/15/29, see point number 6.

⁷ EXCOM Conclusion No. 107 (LVIII) – 2007.

⁸ Information retrieved from <http://treaties.un.org>.

⁹ Article 2 CRC: 1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.: 2.States Parties shall undertake all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions or beliefs of the child's parents, legal guardian's or family members.

¹⁰ Article 3 CRC: 1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration. : 2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures. : 3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards

possible the survival and development of the child (Article 6).¹¹; 4. The right to express their views freely in all matters affecting them, their views being given due weight in accordance with the child's age and level of maturity (Article 12).¹² Also the CRC supplements the other universal human rights treaties, because it enforces their general provisions, but also includes additional rights especially crafted for children.

States Parties to the CRC undertake to ensure and respect the rights proclaimed to each child within their jurisdiction. Specific reference is made to the right to the enjoyment of the highest attainable standard of health in Article 24 CRC.¹³ This Article reads as follows:

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such healthcare services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: a. To diminish infant and child mortality; b. To ensure the provision of necessary medical assistance and healthcare to all children with emphasis on the development of primary healthcare; c. To combat disease and malnutrition, including within the framework of primary healthcare, through, inter alia, the application of readily

established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

¹¹ Article 6 CRC: 1. States Parties recognize that every child has the inherent right to life.; 2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

¹² Article 9 CRC: 1. States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. Such determination may be necessary in a particular case such as one involving abuse or neglect of the child by the parents, or one where the parents are living separately and a decision must be made as to the child's place of residence. ; 2. In any proceedings pursuant to paragraph 1 of the present article, all interested parties shall be given an opportunity to participate in the proceedings and make their views known.; 3. States Parties shall respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests.; 4. Where such separation results from any action initiated by a State Party, such as the detention, imprisonment, exile, deportation or death (including death arising from any cause while the person is in the custody of the State) of one or both parents or of the child, that State Party shall, upon request, provide the parents, the child or, if appropriate, another member of the family with the essential information concerning the whereabouts of the absent member(s) of the family unless the provision of the information would be detrimental to the well-being of the child. States Parties shall further ensure that the submission of such a request shall of itself entail no adverse consequences for the person(s) concerned.

¹³ Comparable articles – not especially crafted for children – can be found in Article 12 International Covenant on Civil and Political Rights and Article 11 European Social Charter.

available technology and through the provision of adequate nutritious foods and clean drinking water, taking into consideration the dangers and risks of environmental pollution; d. To ensure appropriate prenatal and postnatal healthcare for mothers; e. To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents; f. To develop preventive healthcare, guidance for parents and family planning education and services.

The Committee on Economic, Social and Cultural Rights notes the State obligation to respect the right to health by, “inter alia, refraining from denying or limiting equal access for all persons, including ... asylum seekers and illegal immigrants, to preventive, curative and palliative health services.”¹⁴ In prohibiting discrimination based on nationality, the Committee notes, for example, that all children within a State, including those with an undocumented status, have the right to receive affordable health care.¹⁵

The CRC applies to every child, regardless of categorization, or of his or her nationality or immigration status. In its General Comment on Adolescent health and developments in the context of the CRC, the Committee on the Rights of the Child, explicitly refers to the nature of the States’ obligations under the CRC.¹⁶ States have to fulfil a number of obligations. With regard to adolescent asylum seeking children the following obligations are of importance. States have to: ensure that health facilities, goods and services, including counselling and health services for mental and sexual and reproductive health, of appropriate quality and sensitive to adolescents’ concerns are available to all adolescents;

The Committee further notes that to ensure that adolescents belonging to especially vulnerable groups are fully taken into account in the fulfilment of all aforementioned obligations. In accordance with articles 24, 39 and other related provisions of the CRC, States parties should provide health services that are sensitive to the particular needs and

¹⁴ Committee on Economic, Social and Cultural Rights, General Comment No. 14 on the right to the highest attainable standard of health (Article 12).

¹⁵ Committee on Economic, Social and Cultural Rights, General Comment No. 20

¹⁶ Committee on the Rights of the Child, GENERAL COMMENT NO. 4 (2003), Adolescent health and development in the context of the Convention on the Rights of the Child, CRC/GC/2003/4.

human rights of all adolescents, paying attention to the following characteristics:

- (a) Availability. Primary health care should include services sensitive to the needs of adolescents, with special attention given to sexual and reproductive health and mental health;
- (b) Accessibility. Health facilities, goods and services should be known and easily accessible (economically, physically and socially) to all adolescents, without discrimination. Confidentiality should be guaranteed, when necessary;
- (c) Acceptability. While fully respecting the provisions and principles of the Convention, all health facilities, goods and services should respect cultural values, be gender sensitive, be respectful of medical ethics and be acceptable to both adolescents and the communities in which they live;
- (d) Quality. Health services and goods should be scientifically and medically appropriate, which requires personnel trained to care for adolescents, adequate facilities and scientifically accepted methods.¹⁷

3. The EU and the and the right to health care for asylum seeking children

3.1 The Treaty on European Union, the Charter on Fundamental Rights, and other European Conventions

The respect, protection, promotion and fulfillment of the rights of the child are one of the European Union's main priorities.¹⁸ According to Article 3 of the Treaty on European Union, the Union shall promote the protection of the rights of the child. Article 6 of the Treaty establishes that the Union is founded on the respect of human rights and fundamental freedoms, on the rule of law and on principles which are common to the Member States. Article 24 of the Charter of Fundamental Rights of the European Union, which is devoted to the rights of the child, states that "children shall have the right to

¹⁷ Committee on the Rights of the Child, GENERAL COMMENT NO. 4 (2003), Adolescent health and development in the context of the Convention on the Rights of the Child, CRC/GC/2003/4, under 41.

¹⁸ Read also the 2009, so-called Stockholm programme, in which an integrated approach with regard to the rights of the child is advocated, THE STOCKHOLM PROGRAMME — AN OPEN AND SECURE EUROPE SERVING AND PROTECTING CITIZENS, OJ 2010, C 115/1.

such protection and care as is necessary for their well-being”, while requiring that “in all actions relating to children, whether taken by public authorities or private institutions, the child's best interests must be a primary consideration”. Upholding the common European Principles enshrined in the Treaty and the Charter, means taking full account of the CRC, and also of the provision of the European Convention on Human Rights and Fundamental Freedoms that affect children’s rights. According to the European Court of Human Rights, the RCD contains a positive obligation to provide decent material conditions to asylum seekers.¹⁹ Also there might be a remaining role to played by the European Social Charter.²⁰ Matrixes displaying the various measures the EU has taken for each right of the child can be consulted, and they show the interplay between EU actions concerning the rights of the child.²¹

To ensure the coherence of the strategy on the rights of the child, in 2006, the Commission adopted a communication, entitled “Towards an EU Strategy on the Rights of the Child.”²² In this communication, the Commission indicates that the EU’s obligation to respect fundamental rights, including children’s rights, implies not only a general duty to abstain from acts violating these rights, but also take them into account wherever relevant in the conduct of its own policies under the various legal basis of the Treaties (mainstreaming).²³ In the conclusion of this communication, the Commission states that it will develop a comprehensive strategy to ensure that the European Union contributes to promoting and safeguarding children’s rights in all its internal and external actions and supports the efforts of the Member States in this field.²⁴ In February 2011, a new Commission Communication, entitled “An EU Agenda for the Rights of the Child, was published.²⁵ According to the Commission, in view of the strong and reinforced

¹⁹ See e.g. ECtHR 21 January 2011, appl.nr. 30696/09, *M.S.S. v. Belgium and Greece*.

²⁰ See e.g. ESC 8 September 2004, appl.nr. 14/2003, *FIDH v. France*; ESC 20 October 2009, appl.nr. 47/2008, *DCI v The Netherlands*. See also resolution CM/ResChs (2010)6.

²¹ Matrixes can be found at ec.europa.eu.

²² COM(2006) 367 final.

²³ COM(2006) 367 final, p. 3.

²⁴ COM(2006) 367 final, p. 10.

²⁵ Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, entitled “An EU Agenda for the Rights of the Child, COM(2011) 60 final.

commitment to the rights of the child in the Treaty of Lisbon and in the Charter of Fundamental Rights, the Commission believes it is now the time to move up a gear on the rights of the child and to transform policy objectives into action.²⁶ Under 2.2 (Targeting EU action to protect children when they are vulnerable) explicit attention is paid to the situation of children seeking asylum.²⁷ However, no reference is made explicitly to the right to health care for children seeking asylum. In the Communication it is stated that: 'Steps taken by the Commission so far to consult children and listen to them are a starting point in providing possibilities for greater participation of children in the development and implementation of actions and policies that affect them, such as for example education, health or environment policies. To this end, the Commission will draw on the expertise of the European Forum on the Rights of the Child and will continue to work with this Forum and with Ombudspersons for children and other relevant partners in this area.'²⁸ Hopefully this means that when asylum seeking children face difficulties with regard to their right to health care, they are able to be heard.

3.2 The Reception Conditions Directive

Of course, within the EU, with regard to the reception of asylum seekers, including asylum seeking children, there are the provision of the Reception Conditions Directive (Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers, OJ 2003, L 31/18, hereinafter RCD). The purpose of the RCD is to lay down minimum standards for the reception of asylum seekers in Member States (Article 1 RCD). The RCD forms part of the so-called Common European Asylum System. Reception conditions constitute the material support offered to asylum seekers in the host country. Such support usually includes food, housing, education, health care, language training and access to employment.²⁹

²⁶ COM(2011) 60 final, p. 3.

²⁷ COM(2011) 60 final, p. 8.

²⁸ COM(2011) 60 final, p. 14.

²⁹ See for an in depth study on implementation: Odysseus Academic Network, Comparative overview of the implementation of the Directive 2003/9 of 27 January 2003 laying down minimum standards for the reception of asylum-seekers in the EU Member States, October 2006,

This Directive, besides other general provision on reception conditions, includes the right to minimum health care in Article 15.³⁰ In the RCD specific reference is made to the rights of children. It refers to the right to schooling and education (Article 10). It also states that Member States shall take into account to the position of persons with special needs, including minors and unaccompanied minors (Article 17), also when implementing Article 15. Also reference is made to the best interest of the child (Article 18), when implementing the provision of the RCD. Although specific reference is made to the best interest of the child, no specific rule is foreseen implementing their specific rights to health care. It does provide asylum seekers with certain minimum reception standards regarding access to health care, which the member states are obliged to fulfil. On the other hand the flexible and general character of the articles allow member states to maintain very different national policies that in some cases may fall short of an adequate standard of health care.

Article 15 RCD as such is too minimal to be seen as fulfilling Article 24 of the CRC, Article 3 and 24 of the EU Charter, and also Article 17 and 18 of the RCD itself.³¹ So this means, that Member States should uphold a higher level of health care with regard to children. As the RCD has to respect the fundamental rights and observes the principles of the Charter of Fundamental Rights,³² this means that asylum seeking children are entitled to more than just a right to 'necessary healthcare'. And because Article 6 of the CRC forbids discrimination on the ground of status, asylum seeking children are entitled to the same health rights, 'national' children in the Member States have.

4. Overview of the problems asylum seeking children face when it comes to respecting their right to health care

³⁰ Article 15 RCD: 1. Member States shall ensure that applicants receive the necessary health care which shall include, at least, emergency care and essential treatment of illness.; 2. Member States shall provide necessary medical or other assistance to applicants who have special needs.

³¹ It should also be noted that Article 19 of the Reception Conditions Directive recast proposal maintains that access to health care for persons with special needs, such as separated children, shall be granted under the same conditions as nationals.

³² As can be read in preamble 5 and 6 of the RCD.

A great number of reports have been published on the position of asylum seeking children. In these reports the problems asylum seeking children face when it comes to the respect for their right to health care, is also – sometimes briefly - dealt with.³³ Each EU Member State has in place its own system of regulating asylum seekers' access to health care, including asylum seeking children. From reports it shows that the rights and administrative conditions imposed greatly differ from country to country.³⁴

A study in 2006 found that in seven countries there were legal restrictions in access to health care for asylum seeking children at the time of their arrival compared with citizens in the host country.³⁵ The researchers also remarked that the absence of legal restrictions to access did not necessarily imply equity in access as practical barriers may hinder this. They identified a number of practical restrictions in access to care. Practical restrictions could overall be divided into (i) lack of awareness of available health care services, (ii) language barriers, (iii) cultural barriers, and (iv) structural barriers.³⁶

The Fundamental Rights Agency, in its report, noted with regard to the right to health care that children had mixed experiences of accessing health care.³⁷ This lead to the

³³ The following reports have been used for this paragraph, Fundamental Rights Agency, Separated, asylum seeking children in European Member States, Summary Report, April 2010; DELBOS, L., (2010)., The reception and care of unaccompanied minors in eight countries of the European Union. Comparative study and perspectives of harmonization, Synthesis, HUMA, October 2010; COLLANTES, S., Are undocumented migrants and asylum seekers entitled to access health care in the EU? A comparative overview in 16 countries, Health for Undocumented Asylum Seekers, November 2010; PEIRO, J.P., BENEDICT, R., 2009, Ensuring the right of migrant children to health care: the response of hospitals and health services, International Organization for Migration (IOM); NORREDAM, M., MYGIND, A., AND KRASNIK, A., (2006), *Access to health care for asylum-seekers in the European Union: A comparative study of country policies*, European Journal of Public Health 16(3): 285–9; GERRITSE, L., Jeugdzorg voor 'illegale' kinderen. De toegankelijkheid en de werkwijze van de Bureaus Jeugdzorg in de hulp aan en bescherming van 'illegale' kinderen, Defence for Children International 2006; HUMA Network, ACCESS TO HEALTH CARE FOR UNDOCUMENTED MIGRANTS AND ASYLUM SEEKERS in 10 EU Countries. Law and Practice, 2009; Dokters van de Wereld, Rapport van de European Observatory, De toegang tot de gezondheidszorg van personen zonder verblijfsvergunning in 11 Europese landen, September 2009.

³⁴ DELBOS, L., (2010)., *The reception and care of unaccompanied minors in eight countries of the European Union. Comparative study and perspectives of harmonization*, Synthesis, HUMA, October 2010.

³⁵ NORREDAM, M., MYGIND, A., AND KRASNIK, A., (2006), *Access to health care for asylum-seekers in the European Union: A comparative study of country policies*, European Journal of Public Health 16(3): 285–9.

³⁶ NORREDAM, M., MYGIND, A., AND KRASNIK, A., (2006), *Access to health care for asylum-seekers in the European Union: A comparative study of country policies*, European Journal of Public Health 16(3): 285–9.

³⁷ FUNDAMENTAL RIGHTS AGENCY (2010), *Separated, asylum seeking children in European Member States*, Summary Report, April 2010, p. 20

following consideration: “Member States should conduct a thorough health assessment of separated, asylum-seeking children to attend to their health needs as soon as possible upon their entering into contact with authorities, while ensuring their informed consent. The results of this assessment should in no way influence or affect negatively the outcome of the asylum claim. Access to adequate healthcare must be guaranteed to all children without discrimination and irrespective of their legal or other status, and incorporate mandatory professional interpretation and intercultural mediation support. Especially girls, and also boys, should, as far as possible be provided with doctors of the same sex when this is their preferred option. Specific attention should be devoted to the emotional problems and the mental health situation of separated, asylum-seeking children.”³⁸ The IOM report explicitly refers to the holistic approach that should be taken with regard to the concepts of health and healthcare. In their report, it can be read in the executive summary that: ‘On the one hand, the Convention on the Rights of the Child provides a comprehensive and complex framework of protection for all children around the world in all their life settings. On the other hand, the concepts of health and healthcare have evolved in the last decades and hospitals and health services are called to include, not only preventive, curative and palliative care, but health promotion activities as well.’³⁹ In the IOM report four case studies are presented: The four case-studies presented are the following: - Case-study 1. Migrant children’s right to healthcare: the response of the Regional Government of the Canary Islands; - Case-study 2. Healthcare for migrant children in a Nordic welfare state – the case of Stockholm; - Case-study 3. Progetto Intercultura: reorganising services at hospital level to respond to the needs and rights of migrant children; - Case-study 4. “Easing Transitions” – the case for child-centred interdisciplinary work with asylum seeking children in Ireland. Especially the case studies 2 (by A. Hjern)⁴⁰ and 4 (by L. Stokes and P.J. Boyle)⁴¹ are of importance to describe the problems encountered by asylum seeking children with regard

³⁸ FUNDAMENTAL RIGHTS AGENCY (2010), *Separated, asylum seeking children in European Member States*, Summary Report, April 2010, p. 21.

³⁹ PEIRO, J.P., BENEDICT, R., 2009, *Ensuring the right of migrant children to health care: the response of hospitals and health services*, *International Organization for Migration (IOM)*, p. 6

⁴⁰ PEIRO, J.P., BENEDICT, R., 2009, *Ensuring the right of migrant children to health care: the response of hospitals and health services*, *International Organization for Migration (IOM)*, p. 29-31.

⁴¹ PEIRO, J.P., BENEDICT, R., 2009, *Ensuring the right of migrant children to health care: the response of hospitals and health services*, *International Organization for Migration (IOM)*, p. 34-36..

to access to health care. The following is derived from these two case studies. In case study 2, with regard to Sweden, there is a short description of the evolving law with regard to access to health care for asylum seeking children. At first, in the 1980s, asylum-seeking children were entitled to receive subsidized health and medical care for treatment "which cannot wait," i.e., treatment when a moderate delay can result in negative consequences for the patient's health. In the early 1990's, however, a campaign led by the Swedish Pediatric society and other child right NGO's reminded the Swedish government of the obligations made when the UN Convention on the Rights of the Child was signed. Article 2 CRC proved to be particularly useful: "States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status."

This led to a new law that granted asylum-seeking children the same rights to health and medical care as other children in Swedish society in 1994, including preventive services and dental care. Recent reports have documented that the majority of asylum seeking children are not enlisted in child health care centres and that basic preventive measures like immunisations and screening programs are out of reach for many of these children.

According to the statistics, in Sweden, asylum-seeking children are greatly overrepresented among the children being treated in in-patient child and youth psychiatric care. The conclusion of case-study 2 is quite alarming. It reads: 'In summary, the well-organised Swedish welfare state, within which care is provided to migrant children in Stockholm, has two very different faces of health care for migrants. The county seems to have been quite successful in integrating documented immigrant families into the health care system. Immunization rates and consumption patterns are quite similar to the general population and interpreters are available for patients that need them. But for those that are not accepted into the welfare state, asylum seekers and undocumented migrants, the situation is radically different. Although efforts have been made to protect children from the adverse consequences of restricting access to care as an integral part of a restrictive immigrant policy, there is no doubt that this limitation has in fact had an adverse effect on the health of the children in these families. For children in

undocumented families the effects are great and is alleviated only by the widespread disobedience of the pediatric staff in hospitals and child health centres.'

In Ireland (case study 4), the asylum seeker population have access to full health services i.e. emergency, generic and specialist medical services and follow-up. In Ireland a so-called children's service within the asylum accommodation system (reception) was established in 2002 following concerns raised by paediatric nursing staff for the health and welfare of asylum seeking children living in accommodation centres. The service is now a fully operational professional service catering for newly arrived children and has been used as an example of best practice for establishing similar services in other centres nationally and elsewhere in Europe. In the case study the problems facing asylum seeking children are highlighted. It is written that: 'In a refugee reception centre asylum seekers have left behind extended family, older siblings, possibly a primary caregiver and also friends that can leave the child feeling isolated and alone. The vulnerability of a child going through the asylum process is exposed and may require due care and consideration to encourage a continuation of healthy development.'" A warm plea is held for the Children's service: 'The specialised service explained in this case study demonstrates that the HSE (this is the Health Service Executive of the National Health Service) has been attentive to the needs of asylum seeking children and families. In recognising these unique needs the service achieves the aims of health promotion and prevention. A unique characteristic of this project is how it incorporates an interdisciplinary healthcare model of working with children in transition. In doing so it enables a better standard of health and well-being for this group by assisting with the integration process and thus allowing for healthier and socially harmonious communities."

A report by the Equality and Human Rights Commission⁴² (chapter 3) documents the areas of disadvantage experienced by asylum seekers and refugees in accessing health and social care services and considers disparities in health and social care outcomes. It looks firstly at issues around provision and access of health and care services, and then goes on to explore health issues and needs that impact upon particular groups of refugees and asylum seekers a number of key human rights and equality issues, and the areas

⁴² EQUALITY AND HUMAN RIGHTS COMMISSION (2010), Research report 52, *Refugees and asylum seekers. A review from an equality and human rights perspective*, Peter Aspinall and Charles Watters.

that these fall into are: • Asylum seekers' access to and use of primary care. • Asylum seekers' access to and use of secondary care. • Gender specific needs. • Age specific needs. • Disability related needs. • Mental health needs. • The health needs of asylum seekers in detention. • The needs of those with communicable diseases. • The needs of those with HIV/AIDS. • Death registration.⁴³ With regard to asylum seeking children and refugee children it is concluded that the vulnerability and ill health of these children is an area of particular concern, and the prevalence of post traumatic stress disorder among these groups needs more attention. Older refugees and asylum seekers have particular health needs and barriers to accessing services which should be taken into consideration.⁴⁴

From these reports it can be drawn that there are indeed problems when it comes to the guaranteed right to health care for asylum seeking children, be it legal or practical problems. These problems need to be addressed.

5. Concluding remarks and recommendations

The situation as it stands with regard to the right to health (care) for asylum seeking children, does not conform with the CRC's requirement that States parties recognise the right of the child to enjoy the highest attainable standard of health and health care services (Article 24 (1) CRC), regardless of legal status (Article 2 CRC). Also there is a tension between the obligations under the EU Charter of Fundamental Rights, the ECHR and the law and practice in a number of Member States of the EU. The strange situation seems to emerge that in some cases the position of unaccompanied minors with regard to their right to health care is better guaranteed than the right to healthcare of accompanied children seeking asylum. When it comes to ensuring the right to health care for asylum seeking children, the international, European and national law and its implementation, seems to break when moving principles into practice.

⁴³EQUALITY AND HUMAN RIGHTS COMMISSION (2010), Research report 52, *Refugees and asylum seekers. A review from an equality and human rights perspective*, Peter Aspinall and Charles Watters. p. 19.

⁴⁴EQUALITY AND HUMAN RIGHTS COMMISSION (2010), Research report 52, *Refugees and asylum seekers. A review from an equality and human rights perspective*, Peter Aspinall and Charles Watters., p. 36.

To live up to the obligations under the Convention of the Rights of the Child, and also to the EU Charter of Fundamental Rights, the ECHR, the Reception Conditions Directive and other prevailing principles, the EU (and its Member States) need to put into place a framework of common standards designated to the specific needs and position of asylum seeking children.

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