



Input to OHCHR study on children's rights to health (Human Rights Council Resolution 19/37)

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The information compiled in this document is based on two FRA studies and focuses first, on health care for children in an irregular situation and second, on health care for children and young women facing multiple discrimination because of the interplay of age, gender, ethnic origin and disability.

1) Information on what your organisation considers to be the main health challenges related to children

At the end of 2011 the FRA published the report *Migrants in an irregular situation: access to healthcare in 10 European Union Member States*¹, which highlighted difficulties faced by irregular migrants when accessing health care. It also covered the access of specific groups to health care, such as children and women in need of maternal and reproductive care.

The study covers ten member States: Belgium, France, Germany, Greece, Hungary, Ireland, Italy, Poland, Spain, and Sweden. Despite the international commitments and the right to health services established in art. 24 of the CRC and art. 12 of the CEDAW the extent to which services are provided to irregular migrants in the different European countries varies widely.

Within maternal and reproductive health services, delivery is considered an emergency in all of the countries studied and thus medical staff may not refuse to treat migrant women in an irregular situation who are in labour. However, the need to pay for the care provided presents a major obstacle. For example, in Sweden the price for giving birth can cost up to EUR 2,684, and in Ireland billing of hospital costs depend upon the healthcare provider. In Hungary, delivery is included in the list of 31 situations, which are to be treated as emergencies. However, evidence collected from interviews with migrants suggested that women in an irregular situation are expected to pay the costs of delivery.

Full access to ante-and post-natal care is granted in only four of the 10 countries reviewed in this study, namely Belgium, France, Italy and Spain. In Greece, access to ambulatory care is possible, but hospitalisation is limited to emergencies. In Germany, because of reporting requirements linked to non-emergency healthcare reimbursement, the risk of being reported to immigration authorities restricts, in practice, cost-free healthcare services provided in principle to pregnant women and mothers to emergency care only. In Hungary, Ireland, Poland and Sweden migrant women in an irregular situation receive treatment during pregnancy only in emergency cases. "Emergency" is a vague term that must be assessed by a doctor on a case-by-case basis. In general, migrant women in an irregular situation only receive cost-free care if complications, such as bleeding, occur during pregnancy. Other forms of antenatal or post-natal care are not typically considered emergencies and are therefore only provided upon payment.

¹ FRA (2011). *Migrants in an irregular situation: access to healthcare in 10 European Union Member States*, Luxembourg, Publications office of the European Union. Accessible at:

The provision of health care services for irregular children also varies widely between the 10 studied member States. Only in two of the 10 countries surveyed, Spain and Greece, are migrant children in an irregular situation (at least up to a certain age) entitled by law to receive the same healthcare under the same conditions as national children. Three countries, France, Belgium, and Italy, make a distinction between unaccompanied migrant children in an irregular situation and those children living with their families, providing to the former a higher level of access, comparable with that of nationals.

Table 1: Cost-free healthcare entitlements for migrant children in an irregular situation in the 27 European Member States²

Country	Same access as nationals	Same access as nationals for some services	Similar to nationals for unaccompanied children	Access beyond emergency care for specific categories	Emergency care only
Austria					
Belgium			✓		
Bulgaria					✓
Cyprus			✓		
Czech Republic				Formally tolerated children	
Denmark		✓			
Estonia				Children in schools	
Finland					✓
France			✓		
Germany				Tolerated children*	
Greece	✓				
Hungary					✓
Ireland					✓
Italy			✓		
Latvia					✓
Lithuania			✓		
Luxembourg			✓	Failed asylum seekers	
Malta					✓
Netherlands		✓			
Poland				Children in schools	
Portugal	✓				
Romania	✓				
Slovakia					✓
Slovenia					✓
Spain	✓				
Sweden				Failed asylum seekers	
United Kingdom			✓		

Note: * Although legally entitled to healthcare, children not provided with a toleration to stay risk being reported to immigration law enforcement.

² FRA (2011) *Fundamental rights of migrants in an irregular situation in the European Union*. Luxembourg, Publications office of the European Union, pp. 80. Available at: http://fra.europa.eu/fraWebsite/research/publications/publications_per_year/pub-migrants-in-an-irregular-situation_en.htm

Early childhood immunisation is part of a basic healthcare package for children in many countries. FRA research showed that immunisations are provided cost-free in eight of the ten countries studied namely Belgium, France, Greece, Hungary, Ireland, Italy, Spain and Sweden. Germany covers cost-free immunisation under the Asylum seekers benefit act, but police reporting requirements put those children seeking immunisation at risk of being reported to immigration authorities. Immunisations are available in Poland only if parents pay for the vaccinations, although migrant children in an irregular situation also have access to mandatory vaccinations through provisions that generally target school children.

The right to health is also linked to the right of children to education. Some health services and medical checks are offered only to those children attending school, such as the case in Poland. The FRA's report *Fundamental rights of migrants in an irregular situation in the European Union*³ includes a comparative table of the right to education for undocumented children in the 27 European member States.

The FRA is currently finalising another research project which seeks to understand how multiple discrimination prevents access to healthcare services because of the interplay of age, gender, ethnic origin and disability⁴. Based on research in 5 EU Member States – Austria, Czech Republic, Italy, Sweden and the United Kingdom - it explores the barriers, the needs and the experiences of (multiple) discrimination faced by different groups of health users at the intersection of gender, age and ethnic origin when accessing the health system. Interviews have been conducted with more than 150 health users with migrant/ethnic background belonging to three different groups: women with reproductive health issues between the ages of 18 and 50 years, older people (over 50 years), and young adults between 18 and 35 years with intellectual disabilities. In addition, interviews were also conducted with 142 health providers, policy makers, advocacy groups, health ombudsmen, equality bodies and legal experts. A summary of the main obstacles encountered by these groups, as well as good practices are presented below.

2) Examples of good practices undertaken to protect and promote children's rights to health, particularly in relation to children in especially difficult circumstances⁵

- Italy, health centre caters to migrant women's health needs- The Centre for health and assistance for migrant women (Centro di salute e ascolto per le donne immigrate) offers medical support to all migrant women and girls, both regular and irregular, who are pregnant. A department of the San Carlo Borromeo hospital in Milan, the centre is the result of cooperation between the social cooperative Crinali and the public health sector and was initially funded by the Lombardy region. The centre has multilingual, exclusively female medical staff employed by the hospital and cultural mediators employed by Crinali. A similar centre also exists at the San Paolo hospital in Milan.
- Ireland, support to women victims of trafficking-A dedicated unit set up in 2010 in the Health Service Executive (HSE) develops individual care plans for all (male and female) potential and suspected victims of human trafficking, irrespective of their legal status. The care plans cover, depending on individual need, general health screening, sexual health services, mental/psychological health services and counselling intervention, relationship and family counselling, assistance with social and spiritual issues including voodoo and juju, assistance with financial management; assistance and

³ Idem, pp. 89.

⁴ FRA *Inequalities and multiple discrimination in access to and quality of healthcare* (working title, to be published).

⁵ FRA (2011) *Migrants in an irregular situation: access to healthcare in 10 European Union Member States*, and FRA *Inequalities and multiple discrimination in access to and quality of healthcare* (working title, to be published).

advice in relation to education/training and to immigration status as well as an explanation of the criminal investigation process and an escort to police interviews.

- Germany, local initiatives- Despite the legal limitations in the provision of services in Germany, as well as the “duty to report”, the health office in Bremen has organised healthcare to irregular women during pregnancy through a network of voluntary gynaecologists. Similarly, the city of Cologne, offers a “humanitarian consultation” during pregnancy, however, here women must cover a portion of the costs.
- Sweden, the ‘doula’ movement- A doula is a woman who has experience of childbirth and is trained in giving support and information to the birthing woman and her family during pregnancy, childbirth and the postnatal period. This practice is reported to have provided advocacy support to vulnerable women, specially migrant and disabled women, and to have led to a reduction in birth complications. The national organisation for doulas/childbirth pedagogues in Sweden provides a list of doulas, who are willing to assist women at a reduced price (www.doula.nu).
- UK, The Patient Experience Group (PEG) – The PEG is a decision making group created by the NHS that meets monthly to improve the service user experience, to ensure provision of choice in access and choice in treatment by providing a range of information accessible by the local population, to monitor environments that promote dignity and respect for patients’ needs, to review survey requests, the deployment of the patient experience tools and the feedback from the tools. The PEG is based on feedback to and from patients, carers and relatives on ‘what actually happened’ in the course of receiving care or treatment, both the objective facts and their subjective views of it. It consists of representatives from inpatient and outpatient healthcare services and service users.
- Austria, healthcare provisions for patients with intellectual disabilities- the Down Syndrome Outpatients Department at a Viennese public hospital (Rudolfsstiftung) supports children, adolescents, and adults with Down syndrome and their families. The ambulance is the only one in Austria and at the moment it provides services for about 400 patients. The service encompasses multi-professional clearing and medical, psychological, and social support. One third of the users have a migration background.

3) Please indicate what you consider to be the main barriers when trying to implement children’s right to health.

When access to health care for irregular children is granted by law, an additional obstacle that prevents access in practice is lack of awareness about entitlements. For example, in France young children up to the age of six years may access cost-free healthcare and immunisations at special motherhood and childhood protection health centres that target the general population. However, migrants in an irregular situation are often not sufficiently informed about the accessibility of these and similar services. In Sweden, migrant children who are in an irregular situation have a right to receive immunisations; however, health providers as well as migrants are often unaware of this.

Even when access to health care is provided, there are other obstacles in practice, mainly the fear of being detected and deported. The way immigration law is enforced has an impact on whether irregular migrants approach or not essential service providers. The research by the FRA found that fear of being detected is one of the main obstacles which prevent irregular migrants from seeking healthcare when in need.⁶ Such fear can be based on current or past practices of apprehending

⁶ FRA background report, (2012) *The Impact on Fundamental Rights of Certain Practices to Detect or Report Migrants in an Irregular Situation* (unpublished)

migrants at healthcare facilities, on the existence of a reporting duty by the healthcare provider or on the believe that healthcare providers would pass on information to the police.

The current health expenditure cuts in several of the EU member States are also affecting the provision of services to irregular migrants. This adds to the main barriers already mentioned above, faced by irregular migrants, the cost of accessing health services. For example, in Spain the recent expenditure cuts have limited the access to health care for irregular migrants to situations of emergency.⁷ Fortunately, the services of ante-and post-natal care for irregular women have been maintained, as well as full health coverage for irregular children in the same conditions as for national children.⁸ The economic crisis will also especially affect the funding of NGOs, weakening their important role as providers of additional services to irregular children and women in those countries where public health services are insufficient.

This is a summary of the main barriers faced by children and young women with disabilities in accessing health care, based on the FRA research on multiple discrimination⁹:

1) Children with disabilities

- Non availability of specific therapies: psychotherapy and specific therapies for persons with disabilities are sometimes not or only partially covered by health insurance funds.
- Accessibility was mentioned by many interviewees as a general barrier affecting people with disability when accessing healthcare. In terms of physical accessibility, hospitals and particularly local doctors' surgeries in Austria, Italy and the Czech Republic were often found to be not fully accessible for persons with certain impairments, such as wheelchair users and people with sensory impairments. Aside from physical accessibility, evidence from this research in the UK, Austria, Sweden and the Czech Republic revealed that unaccompanied people with intellectual disabilities often find information in hospitals inaccessible.
- Psychological barriers: the research found that persons with intellectual disabilities often have long histories of serious medical interventions and regular contact with health or care services dating back to early childhood. Together with a low awareness of preventative health, this may prompt them or their families to avoid contacts with the health system where possible.
- Informed consent: health users with intellectual disabilities in the Czech Republic, Sweden and the UK described not being given important information. Insufficient communication was described in relation to health providers not seeking their consent before medical interventions, about their healthcare or it being presented in an inaccessible form. For health users with intellectual disabilities, the patient's ability to give their informed consent can be undermined by attitudes that see healthcare professionals direct information to parents, relatives or carers rather than the patient themselves, even in situations where there is no formal loss of legal capacity.
- Interviewees recalled experiences of patients being forcibly restrained and anaesthetised for treatment. Some also experienced medical malpractice, including incorrect or insufficient medical examinations by healthcare professionals; medical errors or errors in treatment; and incorrect dosage.

⁷ Spain, Royal Decree 16/2012 of 20 April 2012 (Real Decreto-ley 16/2012, de 20 de abril, de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus prestaciones).

⁸ Idem. Art. 3 ter, Royal Decree 16/2012 of 20 April 2012.

⁹ FRA *Inequalities and multiple discrimination in access to and quality of healthcare* (working title, to be published).

2) Children with disabilities belonging to ethnic minorities

- Language barriers in access to healthcare: lack of translation and mediation services in healthcare is very problematic for all migrants, but especially for health users - including children - with intellectual and psycho-social problems. Among persons with intellectual disabilities, lack of available medical multilingual professionals/translation can also result in difficulties obtaining a confirmed diagnosis. This in turn can create barriers to receiving treatment.
- Financial barriers in access to healthcare as a result of legal status: third country nationals' ineligibility for certain benefits. These restrictions particularly affect migrants with a disability, who, in some countries, might not be eligible for specific allowance schemes unless they hold a permanent residency permit.
- Lack of awareness of healthcare services and social protection schemes: migrant families with children who had an intellectual disability appeared to be ill-informed about support schemes they were eligible for.
- Taboos regarding certain types of impairment among ethnic minorities may prevent persons with disabilities – including children – belonging to ethnic minorities from accessing healthcare. The stigma associated with mental health among certain national/ethnic groups can in turn lead them to 'hide' family members with a disability, reinforcing their exclusion from society, and ultimately leaving these children without a diagnosis and without treatment.
- Difficulties in making a diagnosis: interviews with healthcare professionals in Sweden and Italy pointed to the complexity of assessing the impairment of children with intellectual disabilities belonging to ethnic minorities. For example, learning difficulties amongst children of immigrant background might be assessed differently than a Swedish child with similar problems, with certain behaviours attributed to cultural differences rather than learning difficulties.

3) Young women with intellectual disabilities

- Several interviewees with intellectual disabilities described being asked intrusive questions, sometimes of a sexual nature, which were unconnected to their health complaint.
- Cases of forced sterilisation and abortion of young women with intellectual disability and psychosocial problems and lack of choice of the gynaecologist.