

Refugee and Migrant CRISIS IN EUROPE

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IS HEALTH CARE ACCESSIBLE?

General context

Poor physical health, as a result of persecution, torture, abuse and injuries, is common amongst all refugees¹ and health risks are particularly high for refugee and migrant pregnant women and very young children². Most refugee, asylum seeking and migrant children arriving in Europe in 2015-2016 are especially vulnerable, having been exposed³ to physical and psychological trauma, dehydration, nutrition disorders, hypothermia and infectious diseases on their journey. Some are affected by chronic illnesses and conditions; others may be children with disabilities; while others may have been 'married' as children, or exposed to sexual abuse and/or harassment. Health issues and inadequate health services are sometimes the reason why refugees and migrants move to Europe. But even when they reach Europe, some of them continue to experience barriers in accessing health care and a high level of stress due to, among others, uncertain legal and economic status, family separation and poor housing conditions.

The right to health is one of the core rights of children under the Convention on the Rights of the Child, and good health is essential to give all children the best start in life, develop their full potential and prevent problems in later life. On the other hand, poor physical or mental health can be a major obstacle to integration and can impact negatively on refugee and migrant children's ability to learn the host country's languages, engage with public institutions, or perform well in school. For this reason countries should integrate refugees and all migrants, regardless of their status into the public health system as soon as possible. Restricting access over long periods is likely to increase the long-term costs associated with late intervention⁴.



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Despite the evidence⁵ that ill health can be a fundamental and on-going obstacle to integration, many refugees still face significant barriers to accessing health care more than a year after living in their host country⁶. Barriers to access include lack of health coverage, the need for interpretation, and financial barriers.

UNICEF's own research indicates that migrants' and refugees' access to health care services is restricted in most European countries and is determined to a large extent by their legal status, rather than their health or development needs⁷.

1 See Making Integration Work: Refugees and others in need of protection, OECD (2016) Paris p42 available at <http://dx.doi.org/10.1787/9789264251236-en>

2 Lander T. (ed) Serbia: assessing health-system capacity to manage sudden large influxes of migrants Ministry of Health of Serbia/WHO (2015) Copenhagen

3 See Lander T. (ed) Serbia: assessing health-system capacity to manage sudden large influxes of migrants Ministry of Health of Serbia/WHO (2015) Copenhagen p4

4 See Making Integration Work: Refugees and others in need of protection, OECD (2016) Paris p41 available at <http://dx.doi.org/10.1787/9789264251236-en>

5 Action Plan on the integration of third country nationals EC (07 June 2016) Brussels p11

6 Médecins du Monde/International Network 2016 Observatory Report : Access to healthcare for people facing multiple vulnerabilities in health in 31 cities in 12 countries Medecines du Monde (November 2016). The survey was based on interviews with more than 30,000 patients and the social and medical data of 10,447 patients seen in 38,646 consultations in 12 countries. Among those surveyed, 94.2 per cent were foreign citizens, with 24.7 per cent migrant EU citizens and 69.5 per cent migrant citizens of non-EU countries. Half of the patients seen had permission to reside in the country where they were interviewed (50.6 per cent in Europe).

7 See Byrne K et al The Legal Entitlements of Refugee and Migrant Children in 33 European States UNICEF (April 2016) Geneva (unpublished)

Legal entitlements to healthcare

Under the Convention on the Rights of the Child (CRC), all children have the right to enjoy the highest attainable standard of health, and States are obliged to ensure that no child is deprived of the right to access health services. According to Article 23 of the 1951 Refugee Convention, refugees are entitled to the same treatment as nationals of their host State as regards public relief, which includes health care. This entitlement is interpreted to include asylum-seekers.



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Article 35 of the EU Charter of Fundamental Rights⁸ holds that everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. Although the Charter guarantees a right of access to healthcare, in practice children's legal status in country tends to determine the scope and extent of their access. Migrant children from another EU State are entitled to access health and welfare services on the same basis as citizens, following three months of residence in the host State⁹. However, the national laws regarding entitlements to primary and secondary health care services vary considerably and non-EU migrants may have to acquire permanent residence in a Member State, before they can access public, non-emergency health services. Even then, their entitlement may be restricted to so called 'core benefits'¹⁰ which are defined nationally and can differ considerably between States.

Undocumented migrant children¹¹ are also legally entitled to emergency health care in all 28 EU Member States, although the services available under emergency health care differ between countries. Moreover, in majority of States, unaccompanied and separated children (UASC) have better access to health care compared to children accompanied by family or relatives. UASCs can access "emergency health treatment" in 24 EU States and Norway, although these terms are not defined and again, the services available to UASCs seem to vary from country to country¹². 22 EU Member States provide health care, in addition to emergency treatment to UASC even when they

are undocumented¹³. Only in eight Member States, children, whether with their parents or unaccompanied, have the same entitlements to health care as children who are nationals of that country: that is, in Estonia, France, Greece, Italy, Portugal, Romania, Spain and Sweden¹⁴. However, even in some of these eight States, undocumented children face restrictions. In Estonia, full entitlement is for children attending school only. In Greece, due to the large number of migrant and refugee arrivals, as well as extensive cuts to public health expenditure¹⁵, authorities are not always able to provide adequate medical assistance free of charge to all those seeking assistance¹⁶. Age limits can also restrict the entitlement - in Portugal for instance entitlement for children ends at 16 years of age.

UNICEF recommends that:

- refugee and migrant children access all the health services in the country, appropriate to their age, gender, capacity, medical status and stage of development, on the same basis as national children. This right needs to be clearly and explicitly recognised in legislation and any restriction removed.

Barriers to access

In addition to legal barriers, refugee and migrant children experience practical barriers to accessing healthcare. Responsibility for health care delivery in most countries has been delegated down to local or regional bodies and this can lead to varying interpretations of what care children are entitled to, particularly in countries where children's entitlements depend on whether the care is considered 'urgent' or 'essential'. If these terms are not adequately defined, or if there is not a clear and explicit message about entitlements at national level, then differing interpretations at local level, by administrative or medical staff, can lead to children being denied services that they are entitled to by law.

Barriers also arise from the different methods of financing for national health systems, and families face different restrictions depending on whether health services are funded through taxation, insurance or both. In some cases, while migrants have a legal entitlement to health care, access is regulated through patients' health insurance coverage, and access to public health insurance is restricted to certain categories of residents or to employed persons, while other groups are expected to take out private health insurance coverage. This is very expensive, offers limited access and may be unavailable to groups who are residing irregularly. Thus entitlement to healthcare

8 Charter of Fundamental Rights of the European Union EC (2000) Brussels p16

9 Free Movement Directive, Art. 24.

10 Article 29 of the Qualification Directive op cit; Council Directive 2003/109/EC of 25 November 2003 concerning the status of third country nationals who are long term residents, OJ L 16, 23.1.2004, Art. 11 (d)).

11 Spencer S. and Hughes V., *Outside and In: Legal Entitlements to health Care and Education for Migrants with Irregular Status in Europe*, COMPAS (July 2015) Oxford

12 *Policies, practices and data on unaccompanied minors in the EU Member States and Norway: Synthesis Report May 2015 Annexes*. EMN (2015) Brussels Table A3.4 pp50-53

13 See *Policies, practices and data on unaccompanied minors in the EU Member States and Norway: Synthesis Report May 2015 Annexes*. EMN (2015) Brussels Table A3.5 pp54-55. Five countries did not respond. However, the COMPAS study indicates that only in 11 countries do children who are unaccompanied and/or known to the authorities have additional entitlements beyond emergency care. The difference is likely to relate to different definitions of "full healthcare".

14 The eight are: Estonia, France, Greece, Italy, Portugal, Romania, Spain and Sweden. There are nine according to Keith L. and LeVoy M *Protecting undocumented children: Promising policies and practices from governments PICUM* (February 2015) Brussels. However, Spencer & Hughes hold that the Ministerial Circular issued in Cyprus does not constitute a legal entitlement. (See Spencer S. and Hughes V. *Outside and In: Legal Entitlements to Health Care and Education for Migrants with Irregular Status in Europe* COMPAS (July 2015) Oxford).

15 Greece's public hospital budget was cut by 25 per cent between 2009 and 2011.

16 <http://www.independent.co.uk/news/world/europe/tough-austerity-measures-in-greece-leave-nearly-a-million-people-with-no-access-to-healthcare-9142274.html>

16 Health for Undocumented Migrants and Asylum seekers, *Are Undocumented Migrants and Asylum Seekers Entitled to Access Health Care in the EU?* HUMA, (2010), <http://www.epim.info/wp-content/uploads/2011/02/HUMA-Publication-Comparative-Overview-16-Countries-2010.pdf>

and to social protection need to be examined together¹⁷. While the expectation in all States is that patients and service users will have to contribute towards costs, the level of payment demanded can also effectively block access, especially to the most vulnerable. Cost is the principal barrier to health care most often cited by migrants in Cyprus and Poland, while in Germany, Ireland and the UK, migrants' entitlements to primary and secondary health care is seriously diluted by the requirement to pay the full cost of some or all of the service provided¹⁸. Other barriers to access to national health care systems include lack of awareness and unfamiliarity with local health care services, and issues related to stigma¹⁹.

Minimising administrative and financial barriers in France

Although unaccompanied children in France are entitled to mainstream health insurance, the children of undocumented migrants are not. However, they are entitled to State Medical Assistance (Aide Médicale État - AME) free of charge, which covers all kinds of health care. Unlike undocumented adult migrants, children have the right to AME immediately, without having to meet residence or income criteria or any administrative requirements except proof of their identity. They do not have to wait for their parents to prove that they are eligible, and can access AME even if their parents are not eligible. AME is granted for a year and families do not have to wait until their child is sick to register them. Health care of all kinds should also be available through the hospitals to all children, regardless of their legal status, thus ensuring health care for children outside the AME system.

Keith L, LeVoy M. et al *Protecting undocumented children: Promising policies and practices from governments* PICUM (February 2015) p18.

A further practical barrier arises for migrants with irregular status who fear of detection by authorities. The relationship between migration authorities and service providers is unclear in many countries, and the absence of a clear firewall between immigration authorities and health and social services may deter undocumented parents from seeking medical assistance for their children. Only Italy and the Czech Republic have put explicit policies in place to address this (through Ministerial regulations and a professional Code of Conduct respectively).

Lack of medical records is another practical barrier to children's ability to access health care. The European Commission, together with the European Centre of Disease Prevention and Control (ECDC) and the International Organisation for Migration (IOM) has developed a Personal Health Record²⁰, in order to help identify third country nationals' health needs and facilitate the provision of healthcare, and this may go some way to mitigate the absence of full medical records.

Most unaccompanied children interviewed in 2010 as part of an EU wide study²¹ confirmed that they were able to access healthcare services when needed and were generally satisfied both with the treatment received and with the behaviour of the medical staff. However, some of the barriers they encountered included failure to pick up medical conditions during their initial health screening; insufficient attention paid to their input or expressed health concerns; and insufficient information given to them about their entitlements and the services available. These would seem to indicate the absence of a consistent approach to unaccompanied children's health across EU States. The absence of documents and health records undoubtedly also acted as a practical barrier to health services, and the children also stressed the need for proper interpreters to be available to them. Children often had to rely on social workers, foster parents and other trusted adults for interpretation and mediation during interactions with medical and/or health staff. Some girls noted that their preference for female doctors could not always be accommodated. With the increased number of children reaching Europe in 2015-2016, it can be argued that some of these aspects may have further deteriorated.

UNICEF calls upon States to:

- make sure that health sector managers, practitioners and staff are aware of health entitlements of refugee and migrant children;
- put mechanisms in place to ensure refugee and migrant children are able to access public health care on the same basis as nationals, including through provision of free services, removal of restrictions on access to health insurance, or subsidised insurance premiums;
- ensure that there is a clear, explicit and public firewall between health service providers and migration authorities;
- address obstacles that may prevent children from accessing health services, through involving community leaders, migrant groups and trained counsellors from countries of origin to help build trust, ease stigma and increase use of health services by refugee and migrant populations. More should be invested in making available qualified translators and cultural mediators, providing improved information on services in appropriate languages; and adopting innovative solutions to overcome the lack of medical records.

¹⁷ See Keith L. and LeVoy M. *Protecting undocumented children: Promising policies and practices from governments* PICUM (February 2015) Brussels' and Spencer S. and Hughes V. *Outside and In: Legal Entitlements to Health Care and Education for Migrants with Irregular Status in Europe* COMPAS (July 2015) Oxford

¹⁸ Ibid

¹⁹ OECD (2016) op cit

²⁰ See *Action Plan on the integration of third country nationals* EC (07 June 2016) Brussels p11

²¹ *Separated, asylum-seeking children in European Union Member States Comparative report* FRA (2010) Vienna

Maternal and Child Health

Because engagement with regular, on-going health care for children tends to be more effective for children and cost-effective for society than reactive medical interventions, most countries have developed specific Mother and Child Health (MCH) programmes within their national primary health care (PHC) system that combines on-going child-development monitoring, regular preventive interventions and services targeted at especially vulnerable groups. Throughout Europe and indeed most of the world, child birth and related health care needs are seen as a special case that justifies a higher level of care. States have also recognised the economic and social benefits of investing in mother and child health. Although the nature, scope and extent of national MCH services – including delivery, ante- and post-natal care and check-up – varies across European States, they all provide a minimum package of services and entitlements for pregnant women, mothers and infants who are nationals of the State.

However, across the EU refugees' and migrants' access to MCH services is restricted²²; and mothers and children whose residence status is irregular or uncertain are excluded from the full range of antenatal, postnatal and pediatric care services. Seven EU Member States make no specific provision for maternity care for migrants at all (Bulgaria, Cyprus, Finland, Lithuania, Luxembourg, Poland and the Slovak Republic) although it is assumed that all of them will include giving birth within the definition of emergency care²³. In other EU Member States, women are entitled to some level of maternity care, subject to varying conditions and criteria. In Austria, Greece and Slovenia entitlement relates to delivery only; in Estonia and Hungary it is only available after payment. A recent survey of refugee and migrant women's access to maternal health care in 31 cities across 12 European countries found that over forty percent of pregnant women interviewed had not been able to access antenatal care, and less than half of pregnant women were receiving care after the 12th week of pregnancy.²⁴

Easy, simple and automatic admission of all children into the country's child health and development system would not only safeguard the child's health and welfare, but would also provide immediate and long-term benefits for the host country in terms of improved public health and reduced costs in secondary care interventions over some years. Children generally benefit more from on-going, continuous care, combined with regular preventive interventions, than from erratic and reactive emergency treatments, and as a result most countries have a child health service within their PHC system that includes regular vaccinations, check-ups and targeted interventions to especially vulnerable groups.

UNICEF calls upon States to:

- ensure that all mothers and children, regardless of their legal or residence status, enjoy equal access to a basic package of health care that includes access to PHC, ante-natal care, early and new-born care, developmental monitoring and immunization services.

22 See Spencer S. and Hughes V. *Outside and In: Legal Entitlements to Health Care and Education for Migrants with Irregular Status in Europe* COMPAS (July 2015) Oxford pp23-33

23 See COMPAS op cit Table 2 for a full list of maternal care entitlements in EU28

24 Médecins du monde/International Network 2016 *Observatory Report : Access to healthcare for people facing multiple vulnerabilities in health in 31 cities in 12 countries* Medecins du monde (November 2016)

Interpreting national policy in Spain

Before 2012, all undocumented migrants in Spain were entitled to access healthcare on an equal basis with nationals, but this has been restricted by Real Decreto-ley 16/2012 to emergency care and some services related to public health. Although undocumented migrant children in Spain are still entitled to access health care on an equal basis with national children, pregnant women's legal entitlement is now restricted to healthcare during pregnancy, delivery and post-partum only. These changes have been contested by many civil society actors and the Real Decreto was unsuccessfully challenged in the Spanish Supreme Court. The Regional authorities (who hold competence in health matters) do not interpret or implement the law consistently so that migrants' access to health services can vary across the country. Children's entitlement to health care is also enshrined in the national children's act (Ley Orgánica 1/1996, de 15 de enero, de protección jurídica del menor, de modificación del Código Civil y de la Ley de Enjuiciamiento Civil) and migrant children's access to health care is generally facilitated across Spain, But the confusion and uncertainty around legal entitlements can create unnecessary barriers to families' use of services. There have been reports of parents not claiming services that their child is entitled to, because of confusion between their entitlements and the child's; and of services being denied inappropriately because of providers' confusion about entitlements.

Collantes S. UNICEF Spain (2016)



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Infectious Diseases

Medical examination is a standard element of the asylum registration and application process all over Europe. However, only 17 EU Member States²⁵ allow migrants to access public screening services for infectious diseases such as tuberculosis (TB) and only 14 Member States allow them access to treatment. This still leaves at least 11 EU Member States where undocumented migrants are not entitled to access public screening or treatment services for infectious diseases – Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, Lithuania, Luxembourg, Romania, Slovakia and Slovenia.

Some refugee and migrant children come from countries where vaccination coverage is low or has been disrupted by conflict. Among refugee and migrant children reporting to Médecins du Monde clinics in 2016, there were unacceptably high levels of non-vaccination among children, with 30-40 per cent of them not vaccinated against tetanus, MMR, hepatitis B, and whooping cough²⁶. A health assessment²⁷ of refugees and migrants crossing into Serbia from the former Yugoslav Republic of Macedonia (fYROM) in August 2015 found that children's vaccination records were often absent or deficient. In the absence of proof of vaccination, public health institutes (PHI) in Serbia put in place a programme of vaccination for all children, but due to the haste with which many families moved through Serbia, it is unlikely that the vaccination programme was comprehensive enough and there is a need for all countries in Europe to initiate coordinated, large-scale programmes of vaccination and to ensure that all children on their territory are absorbed into their national child health and development programmes as soon as possible.

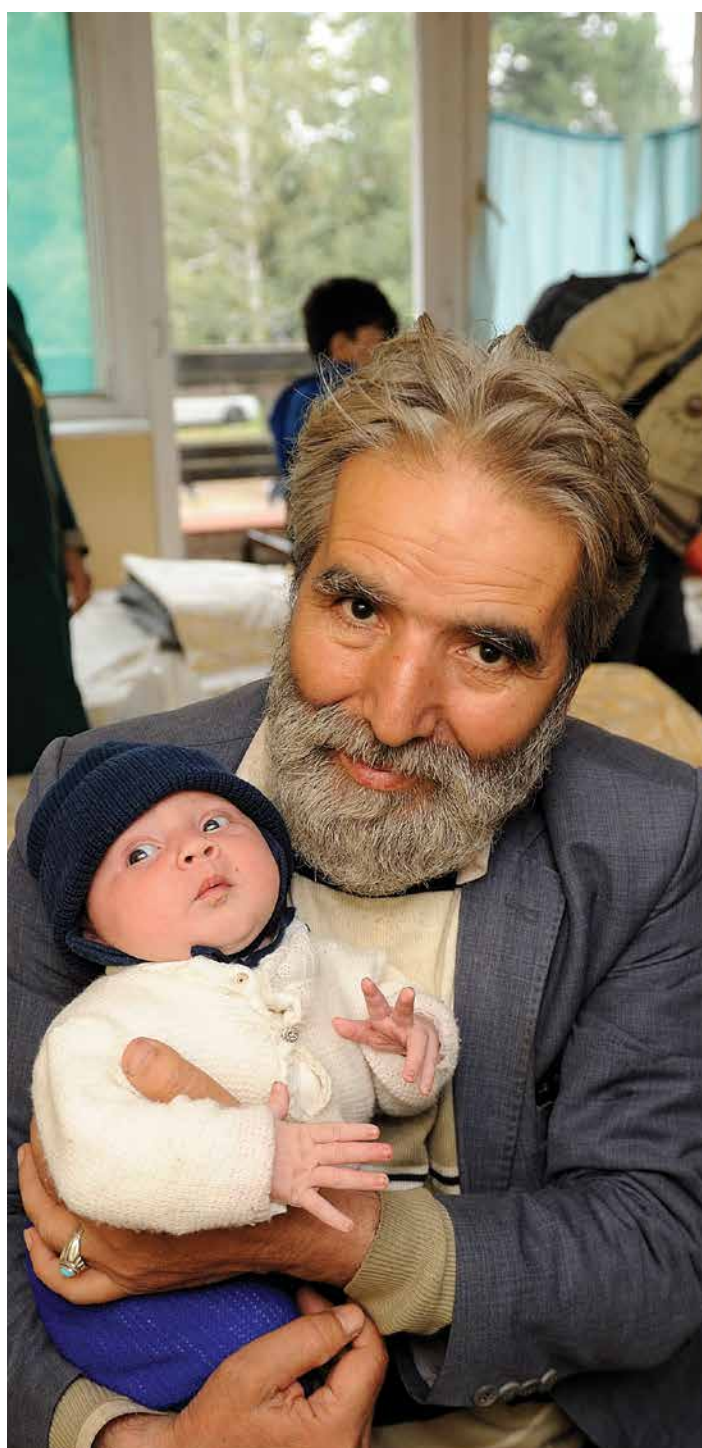
Vaccination campaign for refugee and migrant children in Greece

In 2016, UNICEF supported a campaign by the Greek Ministry of Health (MoH) for priority vaccination of refugee and migrant children in Greece. Following MoH's request, UNICEF procured the following vaccines: Pneumococcal Conjugate Vaccine: 11,000 doses; Measles Mumps Rubella Vaccine with Mumps Jeryl-Lynn Strain: 50,000 doses; and Bacille Calmette Guerin Vaccine: 1,200 doses.

In November 2016, UNICEF supported the provision of MMR vaccines, which were used in a nation-wide vaccination campaign, reaching 12,000 refugee and migrant children.

UNICEF calls upon States to:

- ensure that supplies, facilities and personnel are available at point of entry to vaccinate refugee and migrant children against highly-infectious vaccine-preventable disease;
- ensure that refugees and migrant children have access to testing and treatment for infectious and communicable diseases on the same basis as nationals;
- initiate catch-up vaccination campaigns for children in migrant and refugee communities;
- ensure that all processes guarantee full respect of the dignity of the children concerned and avoid that refugee and migrant children are portrayed as a public health risk.



25 See COMPAS op cit Table 2 for a full list

26 Médecins du monde (2016) op cit

27 Lander T/WHO. op cit

Mental health

EU legislation²⁸ requires Member States to provide vulnerable children, particularly those who have suffered violence or torture, with access to sufficient healthcare support to address their physical and mental needs. This has translated into a practical commitment by 24 EU Member States plus Norway to provide psychological care to unaccompanied and separated children (UASC) although Austria, Greece, Estonia and Latvia have entered reservations²⁹. Many countries rely on NGOs to meet their commitment without providing adequate support to them. In some countries the service available is limited. In Greece, for instance, psychological care is provided only to unaccompanied children in certain accommodation centres³⁰. Children have also identified the need for better information about psychological support. Many children claimed that they were not aware that it was available; others claimed that there were cultural barriers to its use. All stressed the need for proper interpreters to be available³¹.

Mental health services in Sweden

Sweden systematically screens asylum seekers for physical and mental health problems in routine check-ups performed in primary care units. Counsellors assess mental health in conversations with asylum seekers and seek to discern whether or not, and in what context, they may have undergone traumatic experiences, how they are coping with the memories of traumatic experiences and how such memories affect their current psycho-social situation. Based on the assessment and subject to regional availability, an asylum seeker in need of further treatment may be referred for psychological counselling or psychiatric treatment with an interpreter present if need be. Centres offering health care support specifically for refugees who have been injured during war or undergone torture are to be found in 13 municipalities. Half of them are managed by the Swedish Red Cross, while the rest are run by county and regional councils. Some of the centres use “health communicators” who meet with newly arrived asylum seekers at reception facilities and in schools where language training is provided. The health communicators describe the Swedish health care system, symptoms of post-traumatic stress syndrome and other health-related issues. Health communicators undergo six months of health care training and generally speak the same language and originate from the same countries as the refugees.

OECD Making Integration Work: Refugees and others in need of protection OECD Publishing (2016) Paris p44



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The commitment to provide psychological care to UASC is welcome, but does not go far enough to address the much more widespread incidence of psychological distress among refugee and migrant children. A significant percentage of all refugees, not just UASC, suffer from psychological complaints like anxiety and depression as a consequence of the events and experiences they have gone through in their country of origin and on the journey³². This seems to be borne out by assessments³³ in Greece, FYROM and Serbia that confirm the need for a significant extension and strengthening of psychological counselling and mental health services in all destination and transit countries. WHO³⁴ has also noted cases of psychological trauma, while the Director of the Center for Protection and Assistance to Asylum Seekers in Belgrade commented³⁵ that many of the children referred to the Center had experienced some kind of trauma either in their country of origin or on the way to Serbia. All the assessments quoted above noted the lack of mental health services at points of entry and registration but, because trauma can have long-term effects on women’s and children’s health, there is a need to strengthen and extend counselling and psychosocial services for refugees and migrants in all European countries.

28 Chapter IV Recast Reception Directive, Articles 21, 23 (4) and 25). The Qualification Directive contains similar provisions for vulnerable child migrants

29 See *Policies, practices and data on unaccompanied minors in the EU Member States and Norway: Synthesis Report May 2015 Annexes*. EMN (2015) Brussels Table A3.5 pp54-55. Five countries did not respond. However, the COMPAS study indicates that only in 11 countries do children who are unaccompanied and/or known to the authorities have additional entitlements beyond emergency care.

30 European Migration Network, *Policies, practices and data on unaccompanied minors in the EU Member States and Norway Annexes to the Synthesis Report* (Brussels: European Commission, 2015), http://ec.europa.eu/dgs/home-affairs/what-we-do/networks/european_migration_network/reports/docs/emn-studies/emn_study_policies_practices_and_data_on_unaccompanied_minors_in_the_eu_member_states_and_norway_annexes_to_the_synthesis_report_eu_2015.pdf.

31 *Separated, asylum-seeking children in European Union Member States Comparative report FRA* (2010) Vienna

32 *Making Integration Work: Refugees and others in need of protection*, OECD (2016) Paris p41 available at <http://dx.doi.org/10.1787/9789264251236-en>

33 See Lander T. (ed) Serbia: assessing health-system capacity to manage sudden large influxes of migrants Ministry of Health of Serbia/WHO (2015) Copenhagen and Eapen R. et al Initial Assessment Report: Protection Risks for Women and Girls in the European Refugee and Migrant Crisis UNHCR/UNFPA/WRC (December 2015)

34 Lander T/WHO op cit
35 B92 29 May 2015



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UNICEF calls upon States to:

- strengthen and extend mental health facilities and services and ensure they are culturally sensitive and that properly trained and qualified personnel are available to refugee and migrant children and their families, wherever they are living;
- ensure that interpreters and other support services are available to enable provision of a quality mental health services for refugee and migrant children;
- include access to counselling and mental health services in the core package available to newly arrived migrants and asylum-seekers;
- inform all newly arrived migrants and asylum seekers of their entitlement to mental health services and the mechanisms for referral and take-up.

Health care in cases of gender based violence (GBV)

Many refugee and migrant children have experienced various forms of gender based violence on the way to and within Europe,³⁶ which can have severe immediate and long-term physical, mental and psychosocial consequences. Unfortunately the identification of such cases remains a challenge and therefore many of the children who have experienced GBV do not receive the assistance and support needed. The children themselves might not want to, or know how to, report the violence they have suffered, and the health providers with whom they come in contact are generally not trained in identification and clinical care of sexual assault. Specialised

care services for cases of sexual assault are not always available and health practitioners are not provided with specific protocols on examination and care. HIV-PEP and emergency contraception (as basic components of clinical management of rape) are legal but rarely available.

UNICEF calls upon States to:

- invest in prevention of GBV by ensuring adequate accommodation conditions for refugee and migrant children, implementation of safeguarding rules, and child protection training, monitoring and support for staff, volunteers and others in contact with children³⁷;
- build the capacity of local agencies to identify and respond to GBV among migrant and refugee children. Capacity building should enable local agencies to proactively lead on the issue, and facilitate early disclosure and immediate and appropriate response, including clinical care of sexual assault;
- procure age-appropriate post exposure prophylaxis (PEP) as well as other needed supplies for medical and forensic services;
- support referral to psychosocial support and legal counselling, including training on GBV specific frameworks or sensitisation to working with GBV child survivors;
- expand the number and range of GBV services and facilities available in country and build linkages to existing centres and service providers in contact with refugee and migrant children.

³⁶ Fry H. *A Gender Sensitive Response to the Migrant and Refugee Influx in Europe is Needed* OSCE PA (June 2016) quoting European Women's Lobby, "Asylum is not gender neutral: the refugee crisis in Europe from a feminist perspective," EWL News, 21 September 2015

³⁷ UNICEF, *Refugee and Migrant Crisis in Europe, A home away from home for refugee and migrant children*, 2016

HIV and reproductive health

The incidence of GBV in mixed migrant flows constitutes another reason for expanding existing reproductive health services and developing programmes to promote HIV testing and treatment among refugee and migrant populations. The UN Committee on the Rights of the Child (CRC) emphasises the importance of access for adolescents to sexual and reproductive information³⁸ and it has clarified that children's right to health entails *"the right to control one's health and body, including sexual and reproductive freedom to make responsible choices"*³⁹. It encourages States to *"consider allowing children to consent to certain medical treatments and interventions without the permission of a parent, caregiver, or guardian, such as HIV testing and sexual and reproductive health services, including education and guidance on sexual health..."*.

15 EU Member States allow undocumented migrants access to screening for HIV and ten of them allow access to treatment - Belgium, France, Greece, Italy, Malta, Netherlands, Portugal, Spain, Sweden and the UK⁴⁰. Payment is required in some countries and patients can face the same obstacles to access as noted for primary and secondary care.

38 UN Committee on the Rights of the Child (2003), *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, UN Doc. CRC/GC/2003/4, para.28.

39 UN, Committee on the Rights of the Child (2013), *General Comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health* (art. 24), UN Doc. CRC/C/GC/15, para.24.

40 See COMPAS op cit p29

Moreover, although most of the unaccompanied and separated children in Europe are adolescents, little efforts is made to reach out to them with information and counselling on reproductive health care. While the services do probably exist in most of the countries of destination in Europe, refugee and migrant children will not be aware of them or might face cultural and/or other forms of barriers in asking for information and advice.

UNICEF calls upon States to:

- strengthen and expand reproductive health care services to make sure that they are culturally sensitive and accessible to refugee and migrant populations
- ensure that children and young people are provided with information, appropriate to their age and gender, and that they are supported and enabled to make responsible decisions in terms of reproductive health
- ensure age and culturally sensitive access to contraceptive supplies;
- include HIV testing in the basic package of services available to refugees and migrants including children and ensure confidentiality and access to counselling and ARVs in the event of testing positive for HIV.

