

Health examinations of child migrants in Europe: screening or assessment of healthcare needs?

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ABSTRACT

Background More than 800 000 asylum-seeking children were registered in Europe during 2015–2017. Many of them arrived with accumulated needs of healthcare. In this study, we examined the legislation for health examinations on arrival for migrant children in the EU/EEA area.

Methods We did a survey to child health professionals within the EU-funded MOCHA project, supplemented by desktop research of official documents.

Results In all but three surveyed countries in the EU/EEA, there were systematic health examinations of newly settled migrant children. In most eastern European countries and Germany, this health examination was mandatory; while in the rest of western and northern Europe it was mostly voluntary. All countries that had a mandatory policy of health examinations screened for communicable diseases to protect the host population. Almost all countries with a voluntary policy also aimed to assess a child's individual healthcare needs, but this was rarely the case in countries with a mandatory policy.

Conclusion Systematic health examinations of migrant children are routinely performed in most countries in the EU/EEA; but in many countries, it could be improved considerably by extending the focus from screening for communicable diseases to assessing and addressing individual needs of healthcare.

In September 2016 Unicef estimated that 11 million children were living as refugees or asylum seekers outside their country of birth.¹ During 2015–2017, 2.5 million asylum seekers were reported in the 28 European Union (EU) member states alone, including more than 800 000 children below 18 years of age, of whom 180 000 arrived unaccompanied by a caretaker. Asylum-seeking and newly settled refugee children in northern Europe have considerable healthcare needs, primarily due to mental health problems,² especially prevalent among unaccompanied minors,³ and also due to infectious disorders, lack of immunisations,^{4–6} chronic disorders and poor dental health.⁷

According to Article 13 of the Reception Conditions Directive, EU member states may require health assessments for applicants for

Key messages

What is already known on this topic?

- ▶ During 2015–2017, more than 800 000 asylum-seeking children arrived in Europe. Many of them had accumulated needs of healthcare.

What this study hopes to add?

- ▶ Systematic health examinations of migrant children are routinely performed in most countries in the EU. In many countries, it could be improved considerably by extending the focus from screening for communicable diseases to assess and address individual needs of healthcare.

international protection on public health grounds. There is, however, no obligation to undertake such assessments.⁸ The United Nations Convention on the Rights of the Child states that all children, including all categories of migrant children, have the right to the highest attainable standard of healthcare (article 24). An assessment of healthcare needs can be an important part of the fulfilment of this obligation for migrant children.⁹ In this study, we wanted to investigate national policies of health examinations of newly settled migrant children in the EU/European Economic Area (EEA) countries, and in particular if these policies included assessments of healthcare needs.

METHODS

Data for the study was derived from a questionnaire distributed to 30 European national country agents/experts as part of the Models of Child Health Appraised (MOCHA) project (<http://www.childhealthservicemodels.eu/>) in December 2015 with response during the first half of 2016. The country agents were local partners who *were professional and skilled in research, able to assess and collate data, avoiding artificially showing their country in a falsely positive (or negative) light. Their tasks were to gather data for each country, identify expert informants,*

collate and synthesise data, seek clarification of the data and review project reports. The country agents all had extensive knowledge about the national situation and children's health issues, national health systems, and health determinant issues.

The respondents were asked the following questions: Does the legal framework for healthcare for children in your country include any health examination of newly arrived children from other countries? If yes, which categories of migrants are covered (eg, asylum seeking, undocumented)? Is the examination mandatory? And is the service delivery focused above all on the needs of the migrant child, or is it adapted primarily to protect the resident population against health conditions which might be brought into the country?

The survey was complimented by desktop research to identify reports, government information, law texts and guidelines, as well as relevant organisations working in the field. Google, Google scholar and Pubmed were used with the following search words: migrants, newly arrived, children, healthcare, health screenings, medical screenings, health examinations, European Union (EU) and policies. Publications from international and regional organisations specifically concerning migrants, entitlements to healthcare and children were identified. Publications from the following organisations were used as baseline studies and inspiration: WHO, International Organisation for Migration, Platform for International Cooperation on Undocumented Migrants (PICUM), Centre on Migration, Policy and Society, Health for Undocumented Migrants and Asylum seekers Network, Médecins du Monde, European Union Agency for Fundamental Rights (FRA), Unicef, Save the Children and United Nations High Commissioner for Refugees. Online platforms and EU projects regarding migrants, health and health policies were identified such as: MigHealthNet, NowHereland, Health Systems in Transition, (Migration Integration Policy Index) MIPEX, EquiHealth, AIDA and Pucafreu. Webpages from National Ministries related to health, migrants and social issues were scrutinised. Monthly newsletters and bulletins from PICUM and FRA were followed to keep track on any new developments regarding health examinations.

In a few cases, the information retrieved from documents did not match the information provided by the national experts. In these cases, the information was discussed between the country agents and the authors until a consensus was reached. In a final round, the preliminary tables were sent to the country agents for correction of misunderstandings.

Patient and Public Involvement (PPI)

No patients were involved in this study.

RESULTS

Of the 30 surveyed countries, 3 reported that no systematic health assessments are offered; Greece, Portugal and Spain. The reasons for this ranged from a lack of

resources, as in Greece, to more conscious public health considerations related to ethical issues and the doubts about the effectiveness of such examinations, as is the case of Spain. For three countries; France, Lichtenstein and Luxembourg, the information retrieved was insufficient for the purpose of this study.

Tables 1 and 2 display an overview of targeted health examinations of newly arrived migrant children of the remaining 24 countries in the EU/EEA area. Table 1 presents the 11 countries that provide a broad assessment of healthcare needs including a screening for communicable disorders. In eight of these countries, the health assessment is voluntary (Denmark, Finland, Ireland, Netherlands, Norway, Poland, Sweden and the UK), while it is mandatory in the remaining three countries (Austria, Iceland and Malta). In two of these countries, Norway and the Netherlands, screening for tuberculosis (TB) is mandatory but other parts of the health assessment are voluntary.

Table 2 presents the 14 countries that only screen migrant children for communicable disorders; all Eastern European countries, Belgium, Germany, Cyprus and Italy. In all of these countries, with the exception of Belgium, the assessment for communicable disorders is mandatory.

In most member states, health examinations target asylum seekers only; in a few member states they target all newly arrived migrants in need of protection or children of those applying for job/residence.

In the majority of the countries that have mandatory health examinations, the primary aim is protecting the *resident population* against communicable diseases, whereas in countries with a voluntary approach the examinations have the double aims of *both* assessing the healthcare needs of migrant children and protecting the resident population. In most Eastern European countries, health examinations are mandatory and primarily aimed at protecting the host population. In *Hungary*, the Chief Health Officer of the district orders the health examinations required by a given epidemiological situation. Such screenings usually cover a predefined scope of illnesses (for instance, TB, HIV infection, syphilis, typhoid fever, hepatitis B). In *Lithuania*, all newly arrived migrants are referred to the State Border Guard Service under the Ministry of the Interior where they have a mandatory health examination. The Foreigners Registration Centre has a primary healthcare centre, where one family physician works part-time (2 days a week), and three nurses are present.

The content of these mandatory examinations varies a great deal typically consisting of examinations of urine, blood, heart and lungs in order to detect communal diseases such as TB and hepatitis. Furthermore, vaccination status is established. In countries such as *Croatia*, *Czech Republic*, *Lithuania* and *Slovakia* newly arrived migrants are held in quarantine until the results from these tests are obtained. In *Slovakia*, migrants who test positive for certain diseases, such as TB or Sexually transmitted

Table 1 EU/EEA countries that provide health examinations for newly arrived asylum-seeking and refugee children with an aim to assess healthcare needs as well as to screen for communicable disorders

	Mandatory	Voluntary	Migrant groups covered
Austria	✓		All children without permanent residency.
Denmark		✓	Asylum seekers and people granted refugee status.
Finland		✓	Asylum seekers.
Iceland	✓		Everyone that is applying for permanent residency and comes from Central and South America, European countries that are not part of the EEA, Asia and Africa. If these individuals have a ratified health certificate that was issued less than 3 months ago, they are exempt from such assessment.
Ireland		✓	All migrants, including returning emigrants, those who come voluntarily to work, asylum seekers undocumented or irregular migrants.
Malta	✓		All migrants in need of international protection including migrants arriving by sea.
The Netherlands		✓*	Third-country citizens applying for residency and asylum seekers. Tuberculosis screening of the Municipal Public Health Service will be held for special groups, such as illegal immigrants and the homeless.
Norway		✓*	Asylum seekers.
Poland		✓*	Asylum seekers.
Sweden		✓	Asylum seekers, refugees and family relations to these groups.
UK		✓	Asylum seekers.

*Mandatory screening for tuberculosis.

disorders (STDs), are usually immediately sent back to country of origin.

In the group of countries where health examinations on arrival are optional, examinations typically consist of

a review of the child's health history; a physical examination aimed at assessing the health needs of the child in terms of acute or chronic conditions and to some extent screening for mental health problems. Identification

Table 2 EU/EEA countries that provide health examinations for newly arrived asylum-seeking and refugee children with an aim to screen for communicable disorders only

	Mandatory	Voluntary	Migrant groups covered
Belgium		✓	Asylum seekers.
Bulgaria	✓		Asylum seekers.
Croatia	✓		Asylum seekers.
Cyprus	✓		All newly arrived migrants.
Czech Republic	✓		Asylum seekers.
Estonia	✓		Asylum seekers.
Germany	✓		Asylum seekers in accommodation or reception centres.
Hungary	✓		All migrants in need of international protection.
Italy	✓		All migrants in need of international protection including migrants arriving by sea.
Latvia	✓		Third-country citizens applying for residency and asylum seekers.
Lithuania	✓		All migrants in need of international protection.
Romania	✓		All migrants in need of international protection.
Slovakia	✓		Asylum seekers and migrants requesting work permit with tolerated residency or regular residency. Undocumented children only when they are reclassified to another category.
Slovenia	✓		Asylum seekers.

of communicable diseases and immunisation status will also be included, and referral for treatment and complementary healthcare are provided according to need.

DISCUSSION

This survey shows that systematic health examinations of migrant children are routinely performed in most EU/EEA countries. In most eastern European countries and Germany, this health examination is mandatory, while in the rest of western and northern Europe it is mostly voluntary. All countries that have a policy of health examinations aim to identify communicable diseases, to protect the host population. Almost all countries with a voluntary policy also aim to assess a child's individual healthcare needs, but this is rarely the case in countries that have a mandatory policy.

Health assessments traditionally focus on physical health, mainly infectious disease, while evidence from studies of health in migrant children indicates that the main healthcare needs are in the mental health area.¹⁰ In this survey, there were few countries that mentioned having the ambition to assess needs of mental healthcare. One factor that impedes the inclusion of mental health in these assessments is lack of suitable methods.¹¹ The development of appropriate methods to this end should be a priority.

A comprehensive individualised health assessment by a paediatric nurse or doctor, preferably as soon as possible after the arrival in the country of destination, can pick up needs of healthcare that would otherwise go undetected. Untreated health problems and unidentified disabilities can have long-term consequences for well-being, learning and integration into the new country.¹² To ensure prioritisation and successful implementation, such health assessments should ideally be based on explicit national health reception policies and available guidelines for the healthcare professionals in charge. If health assessments are made with a clear structure and with the collaboration of a network of relevant specialists, it can increase the likelihood of detection of significant health conditions, link newly arrived migrant children and their families with primary healthcare and reduce costs by coordination of care across primary health and specialist services.¹³ Importantly, the organisational health reception structure has to ensure coherence and coordination implying that data from the individual assessments should always be forwarded to primary care specialists or other professionals who have to follow-up on the results of the assessments when resettling in the country, that is vaccination information. Since much of the economic investments involved in providing health assessment for newly settled migrant children are the same for all programmes, adding a broader paediatric assessment to the assessment of communicable disorders should be a quite limited economic investment, that may even lower the total costs of care for these children according to the before mentioned experiences in Australia.¹³

Most of the European countries in this survey provide a health assessment for asylum-seeking children only, leaving out many other categories of migrant children. The rationale for this targeted approach is somewhat unclear, but one may speculate that administrative reasons may be important since this specific group of migrant children is easily identifiable. This strategy, however, creates considerable gaps for some migrant children that can be expected to have a considerable burden of unmet healthcare needs, such as undocumented children and children of destitute European migrants without rights for healthcare in their country of origin.¹⁴ Iceland is an interesting exception here, providing health assessments for most migrant children with an origin in a middle-income or low-income country.

There is not much evidence to support mandatory screening for communicable disorders as a mean to protect the host population. The chronic infectious disorders that are identified in these screening programmes are primarily an issue for family relations, as has been shown in a large study of TB in the UK.¹⁵ Thus, there is a case for arguing that these programmes are primarily implemented for political reasons, based on xenophobic sentiments in the host population.¹⁶ Considering the low vaccination rates found in some populations of migrant children,¹⁵ vaccination programmes for migrant children would probably be a more effective way of protecting the host population for communicable disorders.

The main limitation of this study is that changes in national policies may have occurred since the data was collected during 2016. In conclusion, a health assessment of migrant children is currently in place in all but a few countries in the EU/EEA area, but in many countries consist only of a screening for communicable disorder thus leaving many migrant children with unidentified needs of healthcare including mental health problems. A closer collaboration on the European level, coordinated by an EU body such as the European Centre for Disease Prevention and Control, has a potential to improve the quality and cost effectiveness of health assessments of migrant children.

Considering the significant resources invested in health assessment programmes for migrants in many countries in Europe, the lack of evaluation of these programmes, in relation to the healthcare needs of the migrants and whether they fulfil their aim to protect host populations, is noteworthy. Further research based developmental work is needed to provide an evidence base for this practice and should be considered a priority issue in migrant healthcare policy on the EU/EAS level.

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Contributors AH came up with the idea to this study, interpreted the results, wrote the first draft and revised the manuscript. LSØ collected and analysed the data interpreted the results and revised the manuscript. MN interpreted the data and revised the manuscript.

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