

A HEALTHY START

A comparative analysis of
health reception policies for
asylum-seeking and refugee
children in the Nordic countries

Camilla Michaëlis, Allan Krasnik and Marie Nørredam

Camilla Michaëlis, Research Assistant
Danish Research Centre for Migration, Ethnicity and Health (MESU)
Department of Public Health
Faculty of Health and Medical Sciences,
University of Copenhagen, Denmark

Allan Krasnik, Professor
Danish Research Centre for Migration, Ethnicity and Health (MESU)
Department of Public Health
Faculty of Health and Medical Sciences,
University of Copenhagen, Denmark

Marie Nørredam, Professor
Danish Research Centre for Migration, Ethnicity and Health (MESU)
Department of Public Health
Faculty of Health and Medical Sciences,
University of Copenhagen, Denmark

A HEALTHY START

A comparative analysis of
health reception policies for
asylum-seeking and refugee
children in the Nordic countries

Camilla Michaëlis, Allan Krasnik and Marie Nørredam

Contents

Executive summary	6
Content of health reception	6
Organisation of health reception and healthcare services	6
Access to healthcare for asylum seekers	6
Acknowledgement	7
1. Introduction	8
Improving the Health Reception of Young Asylum Seekers and Refugees in the Nordic Countries	9
Aims	9
Definitions	9
Methods	10
2. Background	11
Immigration to the Nordic countries	12
The right to health for asylum-seeking and refugee children	13
3. Denmark	14
The health reception of asylum-seeking and refugee children in Denmark from 1980–2018	15
The establishment of a reception procedure for newly arrived asylum seekers	15
Health assessment with a strong focus on infectious diseases	16
Act on preventive health measures for children	17
Separate guidelines on healthcare for asylum-seeking children and preventive healthcare services	17
Implementation of mental health screening for asylum-seeking children	17
Reception of newly arrived refugees after receiving residence permit	18
A municipal health assessment of newly arrived refugees after receiving residence permit	18
Initial health assessment of asylum seekers upon arrival to Denmark	19
Health assessment of newly arrived refugees after receiving residence permit	20
4. Finland	22
The health reception of asylum-seeking and refugee children in Finland from 1980–2018	23
Historical context of immigration in Finland	23
The governance of immigrant reception and immigrants' health issues	23
The establishment of health reception procedure	24
Decentralised health reception and new screening recommendations	24
Changes in focus of reception of asylum seekers	25
New national screening guidelines	25
Asylum-seeking children became subject to the same legislation as Finnish children	25
Health services for asylum seekers and refugees	26
Health assessment upon arrival	26

5. Norway	29
The health reception of asylum-seeking and refugee children in Norway from 1980-2018	30
Historical context of immigration in Norway	30
The development of a reception system	30
Mental health of asylum seekers and refugees is put on the agenda	31
National guidelines on the provision of health services to asylum seekers and refugees is issued	31
Centralised reception unit.....	33
Insufficient mental health services for asylum seekers	33
A greater focus on the rights of the child	33
Introduction of mandatory tuberculosis screening for immigrants applying for residence permit.....	34
Tuberculosis guidelines issued	34
New TB recommendation and simplifications in the control of TB	34
Health reception in transit phase.....	35
Vaccination within three months in the ordinary asylum reception.....	36
Health assessment at three months.....	36
6. Sweden	38
The health reception of asylum-seeking and refugee children in Sweden from 1980–2018	39
Historical context of immigration in Sweden.....	39
The establishment of a reception structure for asylum seekers and refugees	39
Introduction of HIV testing and clarification of access to acute healthcare for asylum seekers and refugees ...	40
Implementation of a differentiated health assessment	40
From a centralised to a decentralised health reception structure.....	41
Revised guidelines due to changed reception conditions:	
Clarification of purpose and content and special attention to children	41
Sharpening health assessment obligations for county councils.....	42
A voluntary health assessment	43
The content of the assessment	43
Variations in the assessment across the country	44
7. Comparative analysis	46
Main differences and similarities between health reception policies and initiatives for asylum-seeking and refugee children in the four Nordic countries	47
Immigration to the Nordic countries in the 1980s.....	47
The historical purpose of health reception	47
Content of Healthcare reception.....	48
TB and infectious diseases screening	48
Mental health screening	48
Organisation of health reception and healthcare services.....	50
Access to healthcare for asylum seeking children.....	51
8. Conclusion	55
9. References	57

Executive summary

This report provides a comparative overview of policies and policy developments regarding the health reception of asylum-seeking and refugee children in the Nordic countries (Denmark, Finland, Norway and Sweden) during the period 1980 to 2018. Iceland has not been included in this project. It is the third of a series of policy reports produced as part of the Nordic project CAGE – Coming of Age in Exile financed by NordForsk focusing on the health and welfare of children and young refugees in the Nordic countries. Based on national laws, acts, regulations, policy documents, national guidelines, research papers, evaluation reports and central overviews, reception policies of Denmark, Finland, Sweden and Norway have been studied and compared in a historical perspective. The concept of health reception includes health examination/screening/assessment as well as provision of healthcare for immigrants when arriving in the destination country, and after having been granted asylum in the case of refugees.

Increased rates of asylum-based immigration in the 1980s led to the establishment of reception procedures for asylum seekers and newly arrived refugees in the Nordic countries. As part of the reception procedures, health reception initiatives were introduced throughout the 1980s and the early 1990s. The Nordic countries implemented different models for the health reception of asylum seekers and refugees, which were influenced by a wide range of economic, political, organisational and societal factors. Health reception has changed considerably over time – both within and across countries with respect to: the health issues addressed; the population groups targeted; the organisation of the initiatives; as well as there being overall variations in the organisation of healthcare provision and social services for these groups. Despite significant differences across the countries, a number of similarities came about in the course of the development of health reception.

Content of health reception

There seems to be an over-arching historical pattern in all four countries in that their health reception initiatives mainly focus on acute care and somatic health. All four countries established health reception initiatives for asylum seekers and refugees addressing infectious disease control and acute healthcare needs. Infectious disease control still seems to be a major component of today's health reception of asylum seekers, whereas

mental health has been a less frequent component in the health reception initiatives. Although in recent years the health assessments in all four countries have started to focus increasingly on the mental health of asylum seekers and refugees, yet this is not as often, nor to the same extent, as initiatives on acute and somatic health.

Organisation of health reception and healthcare services

The diversity in health reception initiatives across the countries also reflects differences in the organisation of the healthcare systems. In Norway and Sweden healthcare for asylum-seeking children, including the health assessment upon arrival, is arranged within the national healthcare system, whereas in Finland and in Denmark, the reception procedures and healthcare services are primarily centralised, located at the asylum centres or reception facilities, and arranged through an agreement between the immigration authority and the asylum centre operators.

Access to healthcare for asylum seekers

The access to healthcare for asylum-seeking children has changed over time with regard to content, entitlement and restrictions. According to the national legislations asylum-seeking children in Sweden, Finland and Norway respectively, have become legally entitled to the same healthcare rights as children legally residing in those countries – however, in Norway they are still not entitled to being registered with a regular general practitioner. In Denmark, asylum-seeking children's entitlement to healthcare on equal terms with resident children is not explicitly stipulated in any national legislation.

Acknowledgement

This report was written for the project “Coming of Age in Exile” (CAGE). The authors of this report would like to thank Nordic Research Council (NordForsk) for the opportunity to work on this topic. We also would like to thank all the CAGE project leaders and partners for their input to and feedback on the report. We would like especially to thank Ebbe Munk Andersern (Red Cross Denmark), Maili Malin (Migration Institute of Finland), Henry Ascher (University of Gothenburg) Robert Jonzon (Public Health Agency of Sweden/Umeå University) and Birgit Nanki Johanne Lie (Sørlandet Hospital Kristiansand) for their generous contribution to and assistance with the Danish, Finnish, Swedish and Norwegian country chapters, respectively.

June 2019

Camilla Michaélis
Allan Krasnik
Marie Nørredam

Introduction



Improving the Health Reception of Young Asylum Seekers and Refugees in the Nordic Countries

The reception of tens of thousands of asylum seekers and refugees each year during recent decades has made refugee reception policy, including health reception policies, a new and important part of welfare policy in the Nordic countries.

Asylum-based immigration places particular demands on health reception, stretching beyond core healthcare services, as some migrant groups may be more vulnerable regarding their health due to experiences of trauma, abuse and torture before and during migration; or they may originate from countries with limited access to healthcare or a high incidence of communicable diseases.

Health reception not only encompasses the assessment of newly arrived young asylum seekers' and refugees' somatic and psychosocial well-being, but also provides opportunities related to the term citizen shaping, e.g. introducing health systems, education and other health-promoting activities which will ultimately facilitate asylum seekers' and refugees' immediate and later integration into the healthcare system and society at large. Thus, offering asylum seekers and refugees health reception may not only benefit the health of the individual, but also the host countries,

based on the assumption that healthier individuals, in a socio-economic sense, are more likely to contribute to the host country.

Aims

At present little is written about either the historical development of health reception in the Nordic countries, nor about the similarities and differences in health reception between these countries.

The assumption is that the reception phase has important consequences for the children's future health and healthcare use. Addressing their health needs is instrumental in facilitating individual rehabilitation, integration, educational achievement and labour market participation, and positive social and economic development, which will benefit all of society.

Therefore, the aim of this report is to examine and compare national policies regarding the health reception of asylum-seeking and refugee children within the Nordic countries and to explore the development trends in the health reception of asylum seekers and refugees, with a particular focus on the children, within the Nordic countries from 1980 to 2018. The study includes

Definitions

In this report, a distinction between asylum seekers and refugees is made as there is a difference between the rights of these groups.

- **Asylum seeker** refers to individuals who have applied for refugee status and are awaiting a decision.
- **Asylum-seeking children** refers to individuals under 18 years who have applied for asylum and are awaiting a decision.
- **Refugee** refers to the beneficiaries of international protection according to the 1951 UN Refugee Convention for subsidiary protection.
- **Refugee children** refers to individuals below the age of 18 whose parents or who themselves are granted a residence permit either under international protection according to the 1951 law convention for subsidiary protection.
- **Health reception** has no formal definition and intersects with the terms screening, health assessments and health examinations in the literature. We define health reception as healthcare services and initiatives that safeguard the health of asylum seekers and refugees, irrespective of whether they are offered upon arrival, during the asylum-seeking process or upon obtainment of residency as refugees in the new country (1).

Denmark, Finland, Norway and Sweden, but not Iceland.

The research questions are as follows:

1. What are the national policies regarding health reception of asylum seeking and refugee children in the Nordic countries?
2. How has health reception developed over time from 1980–2018, and what similarities and differences exist between the Nordic countries?

Methods

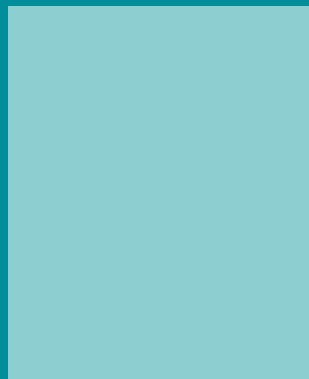
The material used in this report was obtained through desk research and combines textual data of various kinds to outline reception policies and policy development. Reception policies and development have been studied and compared between the Nordic countries based on national laws, acts, regulations, policy documents, national guidelines, research papers, evaluation reports and central overviews. The documents were identified through relevant authorities such as ministries and boards dealing with health, immigration, integration, social services or children. Additionally, some documents were identified through references in other policies. We have included documents with relevance to health reception of asylum-seeking and refugee children, including documents that addressed health reception of asylum seekers and refugees in general, as well as documents that focus specifically on asylum-seeking and refugee children. Undocumented migrant children, quota refugee children and other migrant groups have not been included as it is beyond the scope of this report.

The historical documents used in this report have been difficult to identify and access as many of the documents are no longer available or only available in (inaccessible) archives. Thus, information was collected in various ways and this might have led to unequal weight being given to different subjects. Consequently, the report is based on a non-exhaustive analysis of the health reception in the Nordic countries and the main changes from 1980 to 2018. The comparisons of health reception for asylum-seeking children in the Nordic countries are challenging, as both the healthcare systems and asylum policies are complex and constantly changing. To fill in potential gaps in the findings, individual interviews with and proofreading by key informants/experts were performed within the field from each country.

This study has been focusing on reception on a policy level, thus we cannot conclude as to whether and how health reception policies are implemented and play out in actual health reception practices, and to evaluate

the outcomes and to document the effect of policies in practice is beyond the scope of this report. Hence, further research is needed, to obtain a better understanding of the health reception and healthcare services in practice among asylum-seeking and refugee children. Furthermore, research is needed on the health reception of other migrant groups not included in the report, such as the health reception of quota refugees and undocumented migrant children.

Background



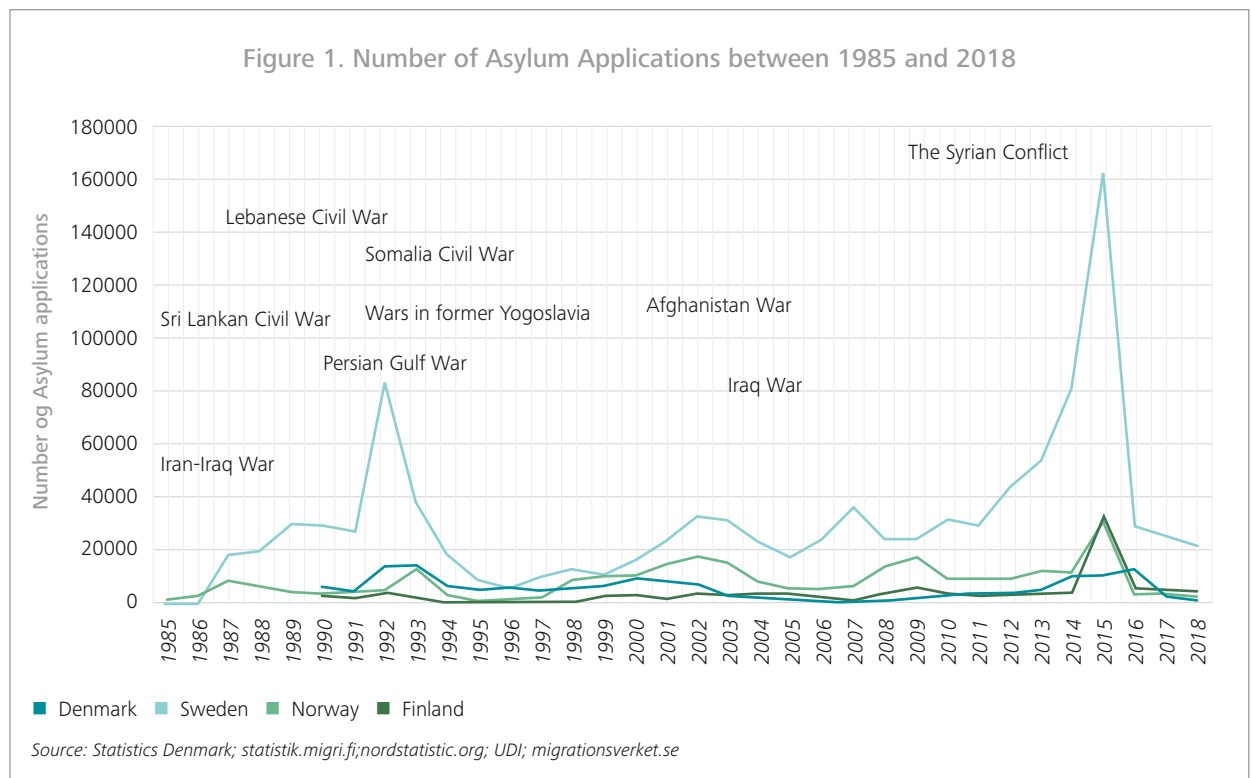
Immigration to the Nordic countries

Until the early 1970s, employment was the main reason for migration to the Nordic countries with a considerable proportion of the total migration taking place between Nordic countries, e.g. from Finland to Sweden. The Nordic countries have encountered the phenomenon of new immigration and asylum seekers at slightly different points in time – Sweden before Denmark and Norway and long before Finland. However, during the 1980s, the number of asylum seekers began to rise all over Western Europe and family reunification and humanitarian grounds constituted the main causes for immigration. Sweden received large numbers of asylum seekers and refugees as early as in 1970s and the scale of refugee immigration in the following years exceeded that of Denmark, Norway and Finland (see figure 1). While the immigration of the 1970s to a greater extent came via organised transfer such as quota refugees, those arriving in the 1980s came mainly spontaneously as asylum seekers. The number of asylum seekers increased rapidly and reflected the major wars that were taking place in or close to Europe. In Denmark, numbers increased from 300 in 1983 to 8700 in 1987. Norway experienced a corresponding increase from 830 in 1985 to 8600 in 1987. In Sweden, the numbers of asylum

seekers were already much higher, with approximately 14,500 in 1985 and more than 30,000 in 1989, peaking in 1992 with 84,000 asylum seekers (2). In this period, and in contrast, Finland received 15 refugees in 1980 and 547 in 1989 (3).

Asylum seekers and refugees already dominated the immigration policy debate in the Nordic countries in the early 1980s and major changes occurred in governments' perceptions of the importance of migration trends (3,4). Increased rates of asylum-based immigration in the 1980s led to great administrative and practical requirements within the Nordic countries, which resulted in the development of new institutional frameworks as well as a number of reforms (2). It furthermore led to the establishment of reception procedures for asylum seekers and newly arrived refugees, including health reception initiatives, in all four countries.

Recently, the Nordic countries have experienced their highest migration rates since the Second World War, and asylum-based immigration has dominated the immigration situation in the Nordic countries, with the largest groups of asylum seekers and refugees coming from Syria, Afghanistan, Iraq, Eritrea and Somalia. Accordingly,



this has led to changes and development in migration policies, including health reception policies (5).

The right to health for asylum-seeking and refugee children

As for all people, asylum seekers and refugees have the fundamental right to enjoy the highest attainable standard of health (6). In addition to national laws, a series of international human rights conventions include the right to the highest attainable physical and mental health (commonly called the right to health) (7,8) and having ratified these conventions, the Nordic countries are politically, morally and legally bound to follow them.

The right to health includes the provision that preventive, curative as well as palliative health services should be given to all persons within the jurisdiction of the country, based on clinical need alone and on equal basis and without discrimination (7,9). It is emphasised that this is especially important for vulnerable groups of people, hereunder children. Children constitute a vulnerable group, and migrating children can be regarded as even more vulnerable as migration in itself may have a negative impact on the health, development and well-being of children (10).

Children's right to healthcare is especially codified in the Convention on the Rights on the Child (CRC)(8). Article 24 of the CRC recognises "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". The CRC considers a child as a child first and foremost, which is underpinned by a principle of non-discrimination, and standards set out by the CRC should have primacy over any other aspect or policy involved. In the context of migration, this means that children's rights should not be subjected to migration goals defined by a state. Instead, children's rights should be explicitly included in any migration policies, legislation, and decisions that might impact them (10,11).

However, existing studies on health policies for asylum-seeking and refugee children have shown differences in how the Nordic countries regard the rights of the child, and show variations in entitlements to healthcare for migrant children according to their legal status (1,11–13). Furthermore, in recent years the increasing number of asylum seekers and refugees has resulted in numerous restrictions in Nordic immigration policies, some of which have been accused of violating the CRC and other human rights (13–15).

The professional medical ethics comply with the spirit of international human rights. Several of the conventions of the World Medical Association (WMA) underline that all patients should be treated in the same way, by independent doctors, and that physicians should always use their knowledge in the best interest of the patients (9,16). A special resolution on refugees and migrants underlines that physicians must be allowed adequate time and sufficient resources to assess the physical and psychological condition of refugees who are seeking asylum; and that national medical associations and physicians should actively support and promote the right of all people to receive medical care on the basis of clinical need alone, and speak out against legislation and practices that are in opposition to this fundamental right (17).

Denmark



The health reception of asylum-seeking and refugee children in Denmark from 1980–2018

Until 1983–4, the number of asylum seekers and refugees in Denmark was relatively limited. The refugees who came to the country were granted asylum on the basis of their “nationality” and not as a result of an individual assessment and case consideration – a system that was introduced when the first refugees of the Second World War arrived in Denmark (18). From the 1970s non-European asylum seekers and refugees were also being received in Denmark.

In 1972, Denmark accepted 158 refugees from Uganda due to the expelling of the Asian population from the country; and the following year, approximately 800 Chilean refugees were given residence permits in Denmark in consequence of Pinochet's military coup in Chile. In 1975, due to the Vietnam War, about 3500 Vietnamese refugees were picked up by the Danish ship Clara Maersk and subsequently brought to Denmark.

In 1979 the concept of “quota refugees” was introduced on the basis of a United Nations agreement and Denmark agreed to accept 500 refugees from the United Nations High Commissioner for Refugees (UNHCR) (18). It was not until 1984 and onwards that Denmark experienced an increase in the number of spontaneous asylum seekers, mainly from Iran, Lebanon, Sri Lanka

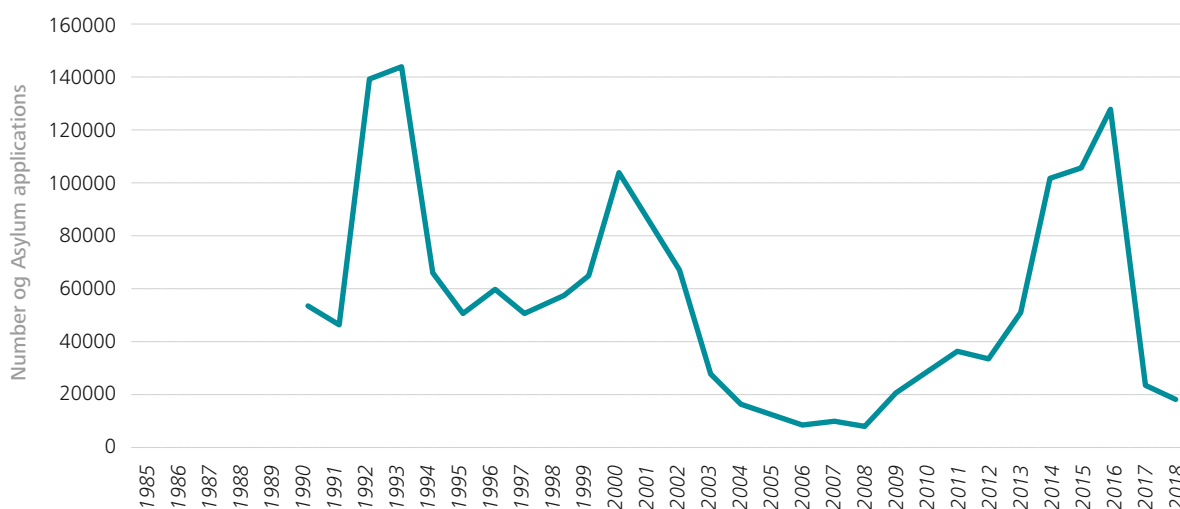
(Tamils) and Somalia, as well as from the Eastern Europe in the late 1980s (18,19).

During the early 1990s Denmark experienced a particular increase in the numbers of asylum seekers due to the very large number of refugees fleeing the former Yugoslavia, especially Bosnia and Herzegovina. In the period 1992–94 a total of 34,882 asylum seekers were registered. In 2014–2016, Denmark again received relatively high numbers of asylum seekers. 33,386 asylum seekers were registered in that period, mainly explained by the Syrian conflict. However, the increased number of asylum seekers arriving in Denmark in 2014–2016 reached a level equal to, but no higher than, the number associated with the war in the former Yugoslavia in 1992–94 (see figure 2) (20).

The establishment of a reception procedure for newly arrived asylum seekers

Until August 1984 Denmark did not have a systematic organised healthcare reception process for asylum seekers. However, the sudden increase in the number of asylum seekers arriving led to the establishment of reception procedures including systematic organised healthcare reception. The care of asylum seekers was outsourced by con-

Figure 2. Number of Asylum Applications in Denmark between 1985 and 2018



Source: Statistics Denmark; statistik.migri.fi; nordstatistic.org; UDI; migrationsverket.se

tract between with the Ministry of Justice and the Danish Red Cross, who then became responsible for establishing and managing asylum centres and services across Denmark (21–23). Furthermore, it was decided that asylum seekers should reside at an accommodation centre while their claim was being processed (2,24).

In late October 1984 the National Serum Institute, the Danish Health Authority and selected experts implemented a health assessment of asylum seekers upon arrival, based on recommendations from the Danish Red Cross. At this time, no official objectives were formulated for the health assessment (25).

This health assessment was voluntary and consisted of a structured interview, including questions related to previous hospitalisation, imprisonment or experiences of torture, medication and current health issues, followed by a medical examination performed by a nurse. If deemed necessary, asylum seekers were referred to a doctor. Children and pregnant women were assessed by a doctor (19,25).

The assessment by Red Cross Denmark was based on a survey of 70 newly arrived asylum seekers, with the recommendation that the examination should be carried out by a nurse within 14 days of arrival. Red Cross Denmark did not recommend compulsory examinations but suggested a mandatory syphilis test. This test was, however, not incorporated into the assessment procedure finally agreed to.

In 1985, Red Cross Denmark employed its first coordinating nurse to guide the work in the asylum centres, and in 1986, a requirement of five years nursing experience was introduced for the healthcare professionals in the centres. Health clinics were later established in the asylum centres and Red Cross Denmark employed nurses, paediatricians and general practitioners. Consequently, a partly parallel healthcare system was established for asylum seekers where access to primary care and certain other healthcare services were outsourced from the mainstream healthcare system.

Also, in 1986, Centre Sandholm, former military barracks, opened as a reception centre for newly arrived asylum seekers, managed by the Danish Red Cross. With the establishment of Centre Sandholm, the reception of asylum seekers was centralised, several functions were brought together and services were standardised (26).

Subsequently, all newly arrived asylum seekers were accommodated in the reception centre, where they filed their application, underwent a health assessment and stayed for their first weeks after arrival before being referred to other asylum centres (26,27).

Health assessment with a strong focus on infectious diseases

Upon arrival in Centre Sandholm, all asylum seekers were offered a voluntary health assessment. Red Cross Denmark was responsible for the provision of healthcare in the centres and was “in charge of identifying and treating asylum seekers in need; obliged to safeguard against the spread of epidemic diseases; and initiate health education” (24). According to the Danish Red Cross, the purpose of the health assessment was to identify asylum seekers with health issues as soon as possible and to offer appropriate assessments and necessary treatment. Furthermore, the purpose was to protect other asylum seekers, staff at Red Cross Denmark and the police and other bodies, as well as the Danish population against the spread of diseases (24).

Special measures in relation to infectious diseases were introduced: from February 1986, all asylum seekers coming from the tropics or who had been imprisoned had to be screened with chest X-ray to identify cases of active TB; the screening being carried out by the Danish Red Cross. However, as there were no positive findings among 600 asylum seekers screened, the assessment procedure was changed the same year, in May 1986, to a symptom-based questionnaire among high risk groups (24,25). However, stool testing for pathogenic bacteria and parasites in the same group continued, and in January 1987, stool testing was introduced for all asylum seekers until September 1991 (25). Additionally, immunisation screenings and vaccines were offered to all children under the age of 18 years in accordance with national child vaccination programmes. Additionally, asylum seekers were offered a final health assessment when leaving the reception centre, which included an assessment of physical health, psychosocial issues and special needs due to torture or other severe trauma (19).

In 1992, a revised health assessment was issued due to inadequate assessment of the vulnerability of the asylum seekers and lack of systematic identification of vulnerable individuals (25). A social anamnesis and a care/action plan for the asylum seeker were added to the revised assessment, and according to the Danish Red Cross, the aim of the revision was to: gain knowledge about the physical and mental health state of the asylum seeker; refer the asylum seeker to treatment if needed; prevent disease and maintain health; provide the asylum seeker with information about Danish healthcare system; and provide the asylum seeker with information about specific infectious diseases, e.g. HIV/AIDS.

Throughout the 1990s there was still a special focus on infectious diseases among asylum seekers, and in 1994, human rights organisations paid particular attention to raising awareness of HIV testing and AIDS information in Centre Sandholm. Subsequently, a health education campaign on HIV/AIDS was carried out by Red Cross Denmark in 1995, in collaboration with Statens Serum Institut (25).

Act on preventive health measures for children

In 1995, an act on preventive health measures for children and adolescents came into force (28). The act introduced seven preventive health examinations by general practitioners and public health nurses/health visitors to children under school-age, including vaccinations according to age; and health examinations by a doctor or school nurse when starting school at the age of 6 and before leaving secondary school. Additionally, frequent examinations were provided to check vision, hearing, height and weight, and children with special needs were offered further examinations, guidance and assistance. Preventive dental care and treatment for children and adolescents under the age of 18 were also included (28–30). The act, however, only applied to Danish nationals and children resident in Denmark, hereunder refugees, but did not apply asylum-seeking children (28).

Two years later, in 1997, Red Cross Denmark and the Immigration Service came to an agreement whereby Red Cross Denmark could provide health measures to asylum-seeking children in accordance with the act (31). Subsequently, Red Cross Denmark employed health visitors in 1998 to carry out health examinations of asylum-seeking children in the asylum centres, previously carried out by nurses, and in 2001 municipal physicians were employed by Red Cross Denmark (28). Since 1984, asylum seeking children had been immunised in accordance with Danish national guidelines. However, in 2003, a hepatitis B vaccine was introduced as an additional part of the childhood immunization service for all asylum-seeking children aged 0–6 years (27,32).

Separate guidelines on healthcare for asylum-seeking children and preventive healthcare services

In 2006, the Danish Immigration Service published its first separate guidelines on healthcare for asylum-seeking children, which had previously been incorporated into the general guidelines on healthcare for asylum seekers (33). The guidelines stipulated that preventive

healthcare services for asylum-seeking children that matched the preventive health measures available to nationals, could be provided without prior approval from the Danish Immigration Service (33). Furthermore, the operators could, without prior approval, initiate access to general practitioners; three consultations with a child psychologist or psychiatrist; five consultations with a private practising specialist doctor (unless hospitalisation was required); X-ray, gastroscopy, urography, scans; and consultations with midwives in case of teenage pregnancies. However, prolonged contact with a specialist doctor and additional healthcare services required approval and guarantee of payment from the Danish Immigration Service (33). Asylum-seeking children were also entitled to preventive dental care and treatment but extensive treatments required prior approval from the Immigration Service, whereas cosmetic dental treatments were not to be covered by the Immigration Service (33).

Implementation of mental health screening for asylum-seeking children

In 2007, the reception and living conditions of asylum-seeking children became subject to public debate. The lack of mental health services for newly arrived asylum seekers and refugees was especially criticised. According to Bente Rich, former child psychiatrist in Centre Sandholm, asylum seekers were neither offered adequate trauma assessment nor provided with sufficient treatment upon arrival:

“Children from Chechnya, Iraq and other disaster areas do not get the same assistance as the children from Kolding received after the fireworks disaster. And the neglect happens, even though Denmark is obligated to provide equal treatment for asylum-seeking children as for all others.” (34).

Following the criticism, an agreement between Red Cross Denmark and the Danish Immigration Service was reached in August 2008, stating that newly arrived asylum-seeking children under the age of 16 should be offered a mental health screening upon arrival (35,36). Red Cross Denmark was granted six million DKK on an annual basis to carry out the screening, and established a psychological unit to carry out the psychological screening, assessment and treatment. In 2009, the unit started screening newly arrived children under the age of 16 years. The mental health

screening consisted of an interview with the parents followed by a screening of children under the age of 2; a structured educational playroom observation of children aged 2–3 years; and a Strengths and Difficulties Questionnaire (SDQ) for children aged 4–16 years.

The SDQ was carried out by both an educator/teacher and the parents of the children aged 4–10 years, whereas children aged 11–16 years completed a SDQ themselves (35). The aim of the screening was to identify asylum-seeking children who had developed or were at risk of developing psychological difficulties (21). The following year, the screening procedure was changed and the SDQ was replaced with a qualitative interview based on Alan Carr's case formulation model with a greater focus on resilience (37,38). Some preliminary results of screening, published by the Danish Red Cross, indicated that 34% of children between the age of 4–16 years were found to have a higher risk of emotional disturbances than Danish children and 25% of the screened children were considered to have a high risk of developing emotional problems (21,39).

In 2017, Red Cross Denmark introduced a new standardised reception procedure based on an electronic semi-structured interview, which included a revised TB screening and a screening for torture (25,40–42).

Reception of newly arrived refugees after receiving residence permit

Once granted refugees status, people move from the asylum centre to a municipality, are included in regional healthcare coverage and have the same rights as inhabitants registered with the Central National Register (43). The national health insurance scheme entitles insured persons to free hospitalisation and free consultations with general practitioners and specialists as subsidised medical supplies and dental care. However, until 2002, newly arrived refugees, including children, were subject to a six-week waiting period ("karensperiode") before they were able to access free healthcare services (44,45). According to the National Board of Health, the waiting period constituted a barrier to accessing healthcare service, which in particular created a problem in relation to the examination of newly arrived refugees coming from high-risk areas.

Children were, however, eligible for preventive healthcare – without waiting period – in accordance with the Act on preventive healthcare for children and adolescents once registered with the National Register (44).

A municipal health assessment of newly arrived refugees after receiving residence permit

In May 2013, the Parliament adopted an amendment to the Danish Integration Act with an overall goal to enhance the integration efforts towards newcomers (46). With the amendments, it became mandatory for the municipalities to offer a health assessment to all newly arrived refugees and their family members, including children of refugees, children reunited with families and unaccompanied minors as soon as possible and within three months after arrival in the municipality (46,47). Thereby, the act was intended to reform the current Danish health reception model, using a more systematic approach based on a close cooperation between social and health sectors.

The health assessment was introduced because

"a relatively large number of newly arrived refugees and their family members have severe health problems. Also there are indications that every third new refugee in Denmark shows signs of trauma,"

according to the Ministry of Immigration, Integration and Housing (46).

The health assessment should be carried out by a medical doctor (in most cases the individual's own general practitioner) and consist of two parts:

1. An interview and a health assessment of the physical and mental health status of the alien
2. An assessment of the need for further examination or treatment (48).

The purpose of the medical screening was to:

"[...] expose severe health problems at an early stage so adequate health treatment or social measures can be activated as early as possible preventing health problems from becoming a barrier for successful integration of the migrant and his family." (46).

In 2015, the first guidelines on the municipal health assessment, including content and organisation, was issued by the National Board of Social Services in collaboration with the National Board of Health (49). According to the guidelines, the health assessment of children should pay special attention to signs of traumatic experiences, including nightmares; other symptoms of anxiety, urinary and faecal incontinence,

psychosomatic well-being after arrival in the country; and aggressive behaviour. Furthermore, special attention should be paid to the immunisation status of the child (49).

Previous to the newly introduced municipal health assessment, there had been no national regulation concerning preventive examinations and vaccination programmes for newly arrived refugees after receiving residence permit or for family-reunified refugees. Previously, each municipality decided whether to implement screening services or preventive initiatives for newly arrived refugees and each general practitioner had to make sure that sufficient vaccinations were provided (43). Additionally, there were no previous national guidelines or instructions about children of refugee families and no formalised procedures for the municipality's services involved in healthcare or child welfare (21). However, with the new national guidelines on the health assessment, both adult and children refugees were targeted (49).

In 2016, amendments to the Integration Act changed the obligation to offer the health assessment and the municipalities were no longer required to offer the health assessment, unless it was deemed relevant (50,51). However, Copenhagen and Aarhus continued to offer a health assessment to all refugees – regardless of their needs – to identify possible health challenges (52).

Today's health reception in Denmark

Initial health assessment of asylum seekers upon arrival to Denmark

All newly arrived asylum seekers are accommodated in Reception Centre Sandholm, where they file their application and undergo a voluntary health assessment before being transferred to an accommodation centre. According to the Danish Immigration service, all newly arrived asylum seekers, including children, are to be offered a health assessment, preferably within ten days of arrival (32).

According to the contract signed between the Danish Immigration service and the Danish Red Cross, the health assessment for children includes (see table 1):

- An individual interview assessing the asylum seeker's physical and mental health status followed by relevant checks and tests, including provision of necessary medicine and vitamins. In addition, information about HIV and AIDS and contraceptives is provided.
- X-ray screening for active tuberculosis of asylum seekers >15 years of age from high risk areas

(>100/100,000) and the QuantiFERON-TB test for children aged <15 to test for both active and latent TB. An interview and guidance on tuberculosis and a voluntary medical examination is performed by a physician if deemed necessary.

- Pregnant women are referred to a physician and a midwife, including preparation of a pregnancy journal and an optional obstetric diagnosis/obstetrics, prenatal diagnosis
- Inquiries about torture with potential follow-up treatment by psychologist, psychiatrist, physiotherapist
- Hepatitis B vaccination of children aged 0–6 years and immunisation in accordance with Danish national guidelines

Following the initial health assessment, newly arrived asylum-seeking children under the age of 16 are offered a mental health screening if deemed necessary (36,53). Other healthcare services for children, including preventive healthcare, are likewise provided in the asylum centres by the operators. In practice, the following services should be carried out by public health nurses (32):

- Up to 7 consultations / home visits within the child's first year, the first visit no later than 5 days after the

Entitlements and access to healthcare for asylum-seeking and refugee children in Denmark

According to the Aliens Act §42 a. an alien who is staying in Denmark and submits an application for a residence permit will have the expenses for any necessary healthcare services defrayed by the Danish Immigration Service (56). The act, however, does not explicitly stipulate the healthcare entitlements of asylum-seeking children (56). The entitlement to healthcare for asylum-seeking children on equal terms with resident children is solely stated in non-legally binding guidelines by the Danish Immigration Service and explicitly related to the principle of non-discrimination in the CRC.

The access to healthcare for asylum seekers, including children, is arranged through an agreement between the immigration authority and the asylum centre operators. The contract between, however, carries a number of restrictions for additional healthcare services, for which approval and guarantee of payment by the Danish Immigration Service are needed (32, 53).

child and the mother have returned from the maternity ward

- An annual consultation/home visit for children aged 1–6 years
- An annual assessment by public health nurses/health visitor of vision, hearing, height and weight etc. Of school-aged children
- One consultation/home visit in the seventh month of pregnancy
- Preventive health examinations by general practitioner when starting school at the age of 6, through schoollyears and before leaving secondary school (a total of 7 health examinations)
- Information about the general healthcare system to all parents with children aged 0–17 years.

Health assessment of newly arrived refugees after receiving residence permit

Asylum seekers who receive residence permit, referred to as newly arrived refugees, are included in regional healthcare coverage and have the same rights as inhabitants registered with the Central National Register (43). Children with residence permit are enrolled in preventive health programmes just as children with Danish citizenship, and each municipality organises its child-welfare programmes according to its own policies and budgets.

According to the Integration Act, newly arrived refugees, must, when deemed necessary, be offered a medical assessment to detect physical and mental health problems (54). However, a recent study, by Rigsrevisionen, an independent institution placed under the

Table 1. National health reception services for asylum seekers and refugees in Denmark

Health assessment	Target population	Screening indication	Screening instrument	When
Pulmonary tuberculosis	Asylum seekers, children and adults, from high-risk areas	Tuberculosis (TB) incidence 100/100,000 or above in the country of origin; originating from conflict areas, or has stayed in a refugee camp, detention camp, prisons; HIV positive and/or hepatitis B; drug user; or close contacts with TB patients	Chest radiograph (CXR) for active pulmonary tuberculosis of asylum seekers >15 years (including pregnant from high risk countries) QuantiFERON test for active and latent pulmonary tuberculosis of children <15 years	Preferably <10 days or before leaving reception centre
Hepatitis B vaccine	All asylum-seeking children < 6 years of age	HBsAg prevalence >2% in the country of origin or transit	Hepatitis B surface antigen (HBsAg)	Preferably <10 days or before leaving reception centre
Immunisations	All asylum-seeking children	The programme may be accelerated or adjusted depending on previously administered vaccines. Arrangements should be made to vaccinate against disease in accordance with the National Vaccination Programme		Preferably <10 days or before leaving reception centre
Mental health screening	Asylum-seeking children aged <16 years		Qualitative interview based on Alan Carr's case formulation model	<3 months after arrival
Somatic and mental health status	All children and adults		Interview	Preferably <10 days or before leaving reception centre
Health assessment after arrival in a municipality	Newly arrived refugees, children and adults, if deemed necessary	If deemed necessary		<6 months after arrival in a municipality

Danish Parliament and which audits public spending on behalf of the Danish Parliament, showed that around 1/3 of the newly arrived refugees were not offered a health assessment despite indicated needs. For 1/3 of refugees and a slightly higher number of reunited family members, the need for a health assessment was not even considered, whereby the municipalities are not acting in accordance with the Integration Act. Furthermore, the study found that of the 1/3 of newly arrived refugees who were offered a health assessments, 29% of the assessments did not include a mental health assessment as stipulated in the Integration Act (55). Rigs-

revisionen concluded that the Ministry of Immigration and Integration and the regions have not ensured an adequate and coherent approach in tracking down and treating refugees with trauma (55).

Today's administrative arrangements for the reception of asylum seekers and refugees in Denmark

The asylum procedure and the competencies of asylum institutions are governed by the Aliens Act. The Danish Ministry of Refugees, Immigration and Integration holds the overall responsibility for immigration affairs in Denmark.

The Ministry of Refugees, Immigration and Integration prepares and implements laws and administrative regulations in the area of asylum, immigration, and integration. However, regarding asylum, competencies are divided between the Danish Immigration Service, which is a government agency under the Ministry of Refugees, Immigration and Integration, and the Danish Refugee Appeals Board.

The Danish Immigration Service is responsible for the overall reception of children (of asylum seekers, refugees and immigrants) and provision with either short- or long-term residence permit in Denmark. The Danish Immigra-

tion Service is responsible for providing accommodation for asylum seekers, while the daily operation of the reception, accommodation and deportation centres is contracted to public and private operators on behalf of the Immigration Service. These operators include municipalities, Red Cross Denmark and the Danish Prison and Probation Service.

All newly arrived asylum seekers are accommodated in the reception centre, Sandholm Centre, where they stay for their first weeks after arrival. The reception centre is operated by Red Cross Denmark, and the responsibilities and activities of Red Cross Denmark are decided in performance agreements with the Danish Immigration Service and are negotiated every year (32,57). Healthcare services for asylum seekers, including health reception upon arrival, is provided in the asylum centres by Red Cross Denmark (32).

Today's main legislative acts and regulations relevant to asylum procedures, reception conditions and healthcare services for asylum seekers and refugees in Denmark

Title in English	Original Title (DK)
Aliens (Consolidation) Act (Act No. 1127) of 11 Oct 2017	Udlændingeloven (LBK nr. 1127) af 11. oktober 2017 (56)
Act on Offer of Health-related Assessment of Newly Arrived Refugees and Family-reunited Refugees (Act No 979) of 28 June 2016	Bekendtgørelse om tilbud om helbredsmæssig vurdering af nyankomne flygtninge og familiesammenførte til flygtninge (BEK nr 979) af 28 juni 2016 (51)
The Integration Act (Act No. 1127) of 11 October 2017	Bekendtgørelse af lov om integration af udlændinge i Danmark/ (Integrationsloven) (LBK nr. 1127) af 11 oktober 2017] (54)
The Health Act (Act No. 191) of 28 February 2018	Sundhedsloven (LBK nr 191) af 28 februar 2018] (30)
Act on Preventive Healthcare Services to Children and Adolescents (Act No. 1344) of 3 December 2010	Bekendtgørelse om forebyggende sundhedsydelser for børn og unge (BEK nr 1344) af 3 december 2010] (28)

Finland



The health reception of asylum-seeking and refugee children in Finland from 1980–2018

Historical context of immigration in Finland

Finland does not have a long history of immigration. For much of its recent history, Finland has rather been characterised by large-scale, economically-motivated emigration. Finland began taking in quota refugees in the 1970s, initially from Chile and Vietnam (58). However, prior to the early 1990s, some 85% of the immigrants coming to Finland were largely made up of returning migrants and their families (3,59,60). Finland experienced its first spontaneous asylum seekers arriving in the early 1990s, mainly from Russia, Estonia, Somalia, Yugoslavia and more recently Afghanistan and Iraq (59,60). Furthermore, when the Soviet Union collapsed, Russians having Ingrian and thus Finnish ancestors, were allowed to move into Finland. Many of these people lived in Estonia and due to language and geographical proximity, many Estonians moved to work in Finland.

By the autumn of 2015 the number of asylum seekers in Finland had increased nearly tenfold since 2014, from 3,651 asylum applications made in 2014 to over 30,000 by the end of November 2015 (3, 58, 60-62). In 2017, a total of 5,059 persons applied for asylum in Finland (2016: 5,657). However, these numbers remain

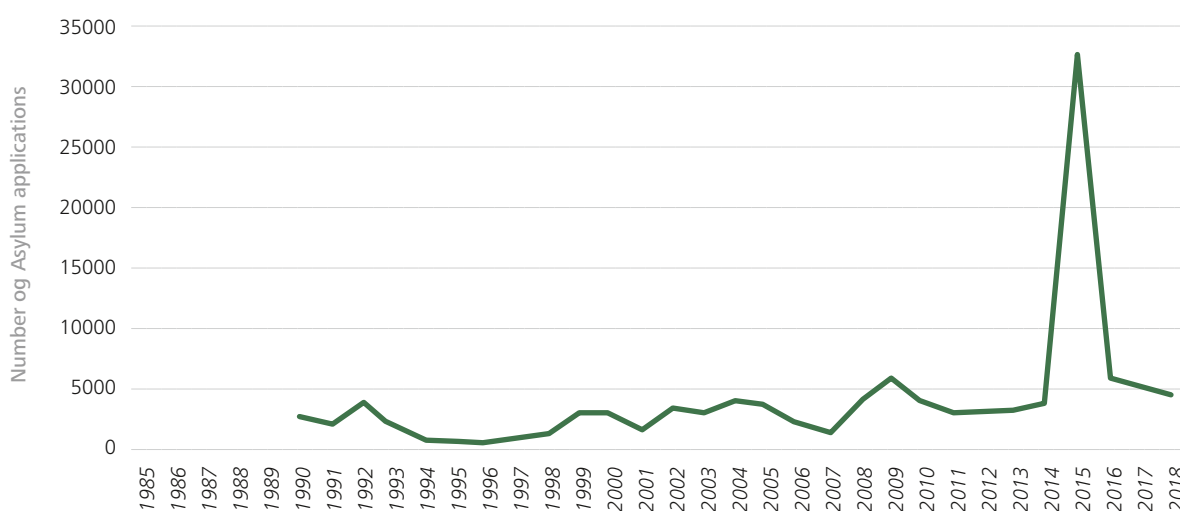
small – both by international standards, and when compared to the other Nordic and Scandinavian countries.

The governance of immigrant reception and immigrants' health issues

In recent years, the main governance of asylum seeker reception has been through the Ministry of the Interior. The overall control and governance of the immigrant population was under the jurisdiction of the Foreign Affairs Office in 1948 and continued until 1989. In 1989 the Foreign Centre (Ulkomaalaisvirasto) was established, and its main task was to grant residency permits to foreigners, receive asylum applications and decide citizenship issues (63). In 1995 the Foreign Centre became the Finnish Immigration Service (Migri), part of the Ministry of the Interior.

In general, the Ministry of the Interior is responsible for the preparation of immigration policy and legislation on immigration and citizenship. The Ministry directs and develops management of immigration and coordinates migration-related activities between different administrative sectors.

Figure 3. Number of Asylum Applications in Finland between 1985 and 2018



Source: www.nordstatistic.org/population and statistik.migri.fi

The specific health matters of asylum seekers and refugees have been the responsibility of the Ministry of Social Affairs and Health during its whole history. The Medical Board was responsible for developing health-care and monitoring the establishment of hospitals and health centres after the Public Health Act 1972. It was responsible for the legalisation of healthcare providers and the control of the production of pharmaceuticals. The Medical Board also guided reception centres for asylum seekers in health matters. In 1991 it was merged with the Social Board and became the National Research and Development Centre for Welfare and Health (STAKES) with the main functions of developing social- and healthcare at national level. The National Institute of Public Health (KTL) was established in 1982. KTL primarily carried out research in relation to improving the population's health, promoting health and preventing disease and disability. Its main research areas were infectious diseases, chronic diseases, mental health, substance abuse problems, vaccination programmes, environmental health and monitoring of the population's health. In 2009, KTL and STAKES merged to form a new agency of expertise and research, the National Institute for Health and Welfare (THL). The purpose of THL was to promote the welfare and health of the population, to develop social and health services and to prevent diseases (64). All these organisations worked under the surveillance of MSAH, who worked to promote the health and well-being of immigrants. The Medical Board, KTL and now THL have guided, developed and monitored the healthcare of the asylum seekers and refugees.

The establishment of health reception procedure

During the 1980s, when the first quota refugees were received in Finland, the Finnish Red Cross was appointed to be responsible for organising their reception. According to national guidelines issued by the Medical Board, quota refugees coming from "tropical or subtropical countries" should undergo an examination for tropical diseases at Aurora Hospital in Helsinki (65). The guidelines only addressed refugees but not asylum seekers. The first Vietnamese quota refugees, arriving in 1989, all underwent a health examination in the clinic for tropical diseases at Aurora hospital. Other parts of the health assessment were recommended to be conducted by a doctor in the municipal health centres since there was no need for specialised units due to the limited number of refugees (65).

The assessment for asymptomatic refugees included a blood count, serum biochemistry, urine analysis, and selected infectious diseases, including a thorax X-ray for tuberculosis, Shigella and Salmonella infections and intestinal parasites. In addition, children under the age of 15 should be examined by a specialised pediatrician in accordance with national recommendations for child-care with particular focus on the physical and mental development of the child. An asymptomatic child with suspected disease should have a follow-up appointment after 1–3 months (65).

Decentralised health reception and new screening recommendations

During the late 1980s, the practical responsibility of the reception of asylum seekers and refugees gradually shifted to the municipalities where reception centres were situated. Accordingly, health assessment as well as healthcare became decentralised and carried out in the health centres of the municipalities and in specialised healthcare units in hospitals in cooperation with the Finnish Red Cross (66).

In 1990, new national recommendations for infectious disease screening were developed, which included both refugees and asylum seekers. Three years later, in 1993, the National Institute of Public Health again issued new guidelines due to lack of implementation of the recommendations and great variation in the implementation across the country (67). The guidelines did not represent mandatory screening requirements but were intended as a guide to assist healthcare professionals in organising and performing health assessments, as well as in treating acute infectious diseases (67). The health assessment solely addressed somatic health and consisted of an initial interview with a nurse followed by an examination by a physician. According to the guidelines, recommended screening included HIV as well as hepatitis B for all, and lung X-ray for persons over the age of 7. Additional screenings would depend on region of departure and pre-departure and what was revealed during the interview (67). It was recommended that the WHO's (World Health Organization) Expanded Programme on Immunisation be carried out, including Bacillus Calmette-Guérin (BCG); pertussis, diphtheria and tetanus (PDT); oral polio vaccine (OPV), measles, hepatitis B (HBV). No health requirements were required for asylum seekers or refugees before entering the country and according to the guidelines only certain groups were to be assessed upon arrival – primarily to protect the individual in question and to a lesser degree

as a dimension of the public health response (67). These groups included among others children under the age of 7 and pregnant women. Since 1993, the guidelines have been amended, the latest amendment in 2009, as disease patterns have changed, and methods of diagnosis and treatment have developed (68).

Changes in focus of reception of asylum seekers

In 1991, Finland introduced its first act on the reception of asylum seekers (69). According to the act, “the state may establish reception centres” under the authority of the Ministry of Social Affairs and Health and the purpose of the reception centres was to offer asylum seekers temporary accommodation, provide income protection and other necessary services during the asylum process (69). The practical responsibility for the majority of the accommodation centres was still within the municipalities, the Finnish Red Cross and the Swedish-speaking NGO Folkhälsan. Responsibility for providing essential healthcare and health assessments lay with the accommodation centres (62).

Eight years later, in 1999, Finland introduced a new act on the reception of asylum seekers and integration of immigrants, which replaced the previous reception act from 1991(70). The new act stipulated that reception of asylum seekers should include “temporary accommodation, social assistance, interpretation services, work and training activities, and satisfaction of all other basic needs” (70), however with no reference to healthcare services.

In 2005, amendments to the act stipulated that reception of asylum seekers should include “essential healthcare services” (71). In addition, the best interests of children was incorporated in the act, stipulating that the best interests of children were to be taken into account in the asylum reception and that children in need of special support should be provided with the appropriate counselling, rehabilitation and mental health services (71). The act stipulated that beneficiaries of temporary protection were entitled to healthcare services just like any other person residing in a municipality in Finland. However, this did not apply to asylum seekers (71).

New national screening guidelines

In 2009, revised guidelines on prevention of infection problems with refugees and asylum seekers were issued, replacing the 1993 guidelines. The revised guidelines did not contain any new obligations but were mainly

Entitlements and access to healthcare for asylum-seeking children and refugees in Finland

Asylum-seeking children have the same access to healthcare as Finnish children resident in Finland, whereas asylum seekers who have reached the age of 18 have the right to acute and necessary medical treatment (72).

intended as an update of examination and treatment methods, matching them with the latest information and medical practices. The guidelines specified the arrangement procedure, cost liabilities and medical contents of health assessment (68). In addition, the guidelines provided information on TB screening, specifying that refugees and asylum seekers arriving from high TB incidence countries ($\geq 50/100,000$), should be screened for TB. Adult asylum seekers were screened with chest X-ray and an interview, whereas children under the age of 7 with no BCG scar had to have Interferon Gamma Release Assay (IGRA) or a tuberculin skin test. The TB screening was a mandatory offer, but participation was voluntary (68). The Ministry of Social Affairs and Health recommended providing health assessment for refugees, asylum seekers and for members of their family who arrive in Finland later. An assessment in these cases (i.e. subsequently arriving family members) involved a visit to a clinic nurse or, if necessary, to a physician; a lung X-ray to screen for tuberculosis; and laboratory tests to screen for HIV, hepatitis B and syphilis. Children were also screened for intestinal parasites. The person's vaccination history was also to be examined during the clinic visit.

Asylum-seeking children became subject to the same legislation as Finnish children

In 2011, a new act on the reception of asylum seekers came into force, repealing the former reception act from 1999 (72). The new act stipulated that asylum-seeking children, like beneficiaries of temporary protection, were entitled to healthcare services just like any other person residing in a municipality in Finland. Thereby, asylum-seeking children became subject to the same healthcare rights as Finnish children. Adult asylum seekers became entitled to acute medical care, including acute oral healthcare, mental healthcare, substance abuse care, and psychosocial support as well as other health services considered necessary by a healthcare

professional (72,73). In acute cases, municipalities were to have the same obligation regarding the specialised medical care of persons who have no domicile in Finland (72,74).

Today's health reception of asylum seekers and refugees in Finland

Health services for asylum seekers and refugees

Asylum-seeking children have the same access to healthcare as Finnish children resident in Finland, whereas asylum seekers who have reached the age of 18 have the right to acute and necessary medical treatment (72). According to the Act on the Reception of Persons Applying for International Protection, particular attention must be paid to children, their development and matters that affect their health (72). Asylum-seeking children are referred to a municipal child health clinic, pregnant women to a prenatal clinic and school-age children to school and school healthcare. Healthcare services are organised by the reception centre where the asylum seeker is registered, and within the centres healthcare services are provided by nurses and by other municipal and private healthcare providers (for more details, see the box below). They coordinate the asylum seekers' health services, carry out initial assessments, screening examinations for infectious diseases, vaccinations as well as acute and necessary medical care, and they provide health information.

According to a report published by the National Institute for Health and Welfare in 2016 (75), in practice there have been considerable shortcomings in securing adequate healthcare services for migrant children. Despite the situation improving during the period covered by the report, the variations in levels of care between municipalities remain considerable (75,76).

Health assessment upon arrival

The Ministry for Social Affairs and Health recommends the provision of health assessment for refugees, asylum seekers and for members of their family who arrive in Finland subsequently (77). Upon arrival in Finland, asylum seekers and refugees are offered a health assessment at the reception centres. Nurses initiate this assessment, and can provide primary level nursing. An initial interview should be done within two weeks of arrival and include an individual infectious disease risk assessment based on relevant disease epidemiology in

Today's administrative arrangements for the reception of asylum seekers and refugees in Finland

The Ministry of the Interior, through the Migration Department, is in charge of immigration issues. Its tasks include the formulation of the migration policy and the drafting of legislation on immigration and Finnish citizenship. The Ministry of the Interior is responsible for the performance guidance of the Finnish Immigration Service (71).

Migri is in charge of the asylum process in Finland. Migri also guides the operations of reception centres as well as maintaining the reception system (85). Migri directs, plans and supervises the implementation of asylum seekers' healthcare and monitors it together with the National Institute for Health and Welfare. Municipalities provide maternity clinic, child health clinic and school healthcare services as well as emergency care and oral healthcare. Municipalities are responsible for controlling infectious diseases in their areas (86).

The reception of asylum seekers is defined and regulated in the act on reception of persons seeking international protection and identification of and support to victims of human trafficking (72). The reception centres organise the necessary reception services and operate under the guidance of Migri. Reception centres are maintained by different operators, including the Finnish Immigration Service, Finnish municipalities, NGOs and private companies. The Government reimburses municipalities for all costs incurred in providing reception services in accordance with the Reception Act.

Healthcare services for asylum seekers are arranged by the reception centres maintained by the state, the municipalities and the Finnish Red Cross. The reception centres usually have a public health nurse and the reception centre also purchases healthcare services needed by asylum seekers from the private sector, the municipality or the joint municipal authority. Hospitals provide emergency care and specialised medical care. Some centres are also visited by volunteer physicians, dentists, psychologists, psychiatric nurses as well as dental nurses and hygienists (87). Asylum seekers may reside either in a reception centre with basic facilities or in private accommodation.

the countries of origin and transit, as well as individual medical history and risk behaviours (68,78).

Table 2. National health reception services for asylum seekers and refugees in Finland (68,77,88)

Infectious disease	Target population	Screening indication	Screening instruments	When
Somatic health status	Asylum seekers and refugees, children and adults		Interview performed by a nurse. Children <7 years are also assessed by a physician	< 2 weeks after arrival
Tuberculosis	Asylum seekers and refugees from high-risk countries, children and adults	Tuberculosis (TB) incidence > 50/100,000 in the country of origin, or originating from conflict areas, or has stayed in a refugee camp, or close contacts with TB patients, or symptoms of TB	Chest radiograph	Individuals with symptoms are to be referred for examination and treatment as soon as possible. Asymptomatic individuals are to be examined at the time of the initial interview or in group screening afterwards
	Children <7 years of age who do not have a BCG vaccination scar		Tuberculin skin test or Interferon Gamma Release Assay (IGRA)	< about 3 months of entering the country or at the time of a chest radiograph
Hepatitis B	Asylum seekers and refugees from high-incidence countries, children and adults	HBsAg prevalence above 2% in the country of origin or transit	Hepatitis B surface antigen (HBsAg)	For asymptomatic refugees < 1 month upon arrival For asymptomatic asylum seekers < 3 months upon arrival
HIV	Asylum seekers and refugees from high-incidence countries, children and adults	HIV prevalence above 1% in the country of origin or transit, or in the case of high-risk behaviour for HIV or if requested by the asylum seeker	Human Immunodeficiency Virus antigen and antibodies (HIVAgAb)	For asymptomatic refugees < 1 month upon arrival For asymptomatic asylum seekers <3 months upon arrival
Syphilis	Asylum seekers and refugees	If HBsAG or HIVAgAb screening is performed (No official incidence guidance of syphilis infection)	Treponema pallidum antibodies (Trpa-Ab)	For asymptomatic refugees <1 month upon arrival For asymptomatic asylum seekers < 3 months upon arrival
Intestinal parasites (F-para-O)	Children <16 years of age	Country of origin or transit in South-East Asia, peninsular India or Sub-Saharan Africa	Direct microscopy of faecal parasites	For asymptomatic refugee children < 1 month upon arrival For asymptomatic asylum-seeking children < 3 months upon arrival
Vaccinations	For asylum-seeking children	Immunisation in accordance with the National Vaccination Programme. The programme may be accelerated or adjusted depending on previously administered vaccines		

The initial interview covers:

- Places and circumstances of the migration e.g. country of origin, refugee camp
- Current symptoms, especially cough, expectoration, bloody sputum, pain, weight loss, fever, loss of appetite, diarrhoea, night sweats
- Vaccination history (have they received immunisations in line with the Finnish schedule) and examination of BCG vaccination scar in children under 7 years
- Prior diseases and treatments, e.g. measles, tuberculosis, HIV, syphilis
- Exposure to and risk of any infectious diseases e.g. close proximity to persons with TB, intravenous drug use, unprotected sex between men, imprisonment, prostitution
- Current medications
- Height and weight (of children).

A voluntary screening for tuberculosis is offered to asylum seekers and refugees arriving from countries with a high incidence of tuberculosis ($\geq 50/100,000$) and a lung X-ray should be initiated during the initial interview or as soon as possible (68). Children under the age of 7 who have not received a BCG vaccine are also screened for latent and extra-pulmonary tuberculosis. Moreover, children born to parents from high-incidence countries are given BCG vaccine at birth (79,80).

In addition, children under the age of 16 years are screened for intestinal protozoa and helminth eggs within three months of arrival in Finland and children under the age of 7 years receive a health and development screening at child health clinics (68,81). All children must be offered immunisations in accordance

with the National Vaccination Programme. An additional screening of hepatitis B, HIV infection and syphilis is arranged within one month for asymptomatic refugees and three months for asymptomatic asylum seekers (68,77,79). Participation is voluntary and a written informed consent is obtained from participants or their legal representatives.

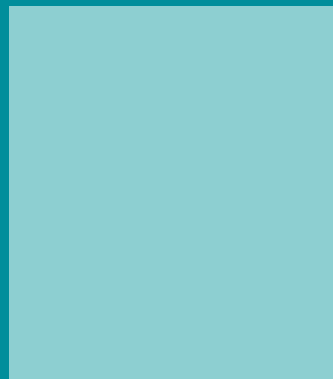
Current health assessment guidelines solely focus on somatic health and screening for infectious diseases, while mental healthcare is not systematically organised in Finland (82) (See table 2). There is, however, an increasing focus on mental health issues. According to the National Institute for Health and Welfare webpage on asylum seekers' health and services, special attention should be paid to certain factors concerning asylum seekers' health, including mental health. In addition, a national development project, the PALOMA project, aims at developing a national approach for effective mental health services for refugees in Finland and to ensure that mental health services improve and are equally organised throughout Finland (82,83).

Due to lack of information on the health status and service needs of asylum seekers arriving in Finland, the National Institute for Health and Welfare, in collaboration with the Finnish Immigration Service, launched a project in 2017, the TERTTU project, which is developing the national health assessment procedures towards a standardised protocol to be used in the reception of asylum seekers. Furthermore, the project aims at improving health monitoring for asylum seekers in Finland through systematic data collection on the health and service needs of newly arrived adults and children (83,84).

Today's main legislative acts and regulations relevant to asylum procedures, reception conditions and healthcare services for asylum seekers and refugees in Finland

Title in English	Original Title (FI)
Aliens Act	Utlänningslag 301/2004 (89)
Act on the Reception of Persons Applying for International Protection and on the Identification of and Assistance to Victims of Trafficking in Human Beings	Lag om mottagande av personer som söker internationellt skydd och om identifiering av och hjälp till offer för människohandel (746/2011) (72)
Act on the Promotion of Immigrant Integration	Lag om främjande av integration (1386/2010) (90)
The Healthcare Act	Hälsa- och sjukvårdslag (1326/2010) (73)

Norway



The health reception of asylum-seeking and refugee children in Norway from 1980-2018

The following section describes the development of the Norwegian health reception procedure for newly arrived asylum seekers and refugees from 1980–2018. The Norwegian health reception of asylum seekers and refugees consists of two separate and independent health reception initiatives: a voluntary health assessment upon arrival in Norway and a mandatory screening for tuberculosis. This section briefly outlines the context of immigration in Norway in a historical perspective and locates the development of the Norwegian health reception procedure within the wider context.

Historical context of immigration in Norway

While refugees in the 1970s came, to a great extent, via organised transfers such as quota refugees, Norway experienced a new migration pattern with a considerable increase in numbers of spontaneous asylum seekers arriving in the 1980s (91–94). In the early 1980s, asylum applications filed in Norway were in the hundreds per year. The numbers started to increase in 1986, reaching a first peak of 12,800 asylum seekers in 1993. Numbers decreased significantly from 1994 to 1997 and increased again in the late 1990s to reach a second peak of 17,500 in 2002. Asylum applications began to decline in 2003, reaching a low of some 5,300 in 2005 and 2006. In the

second half of 2007, the number started to increase, reaching more than 6,500 that year. In 2008 there were 14,431 applications (92,95) (See figure 4).

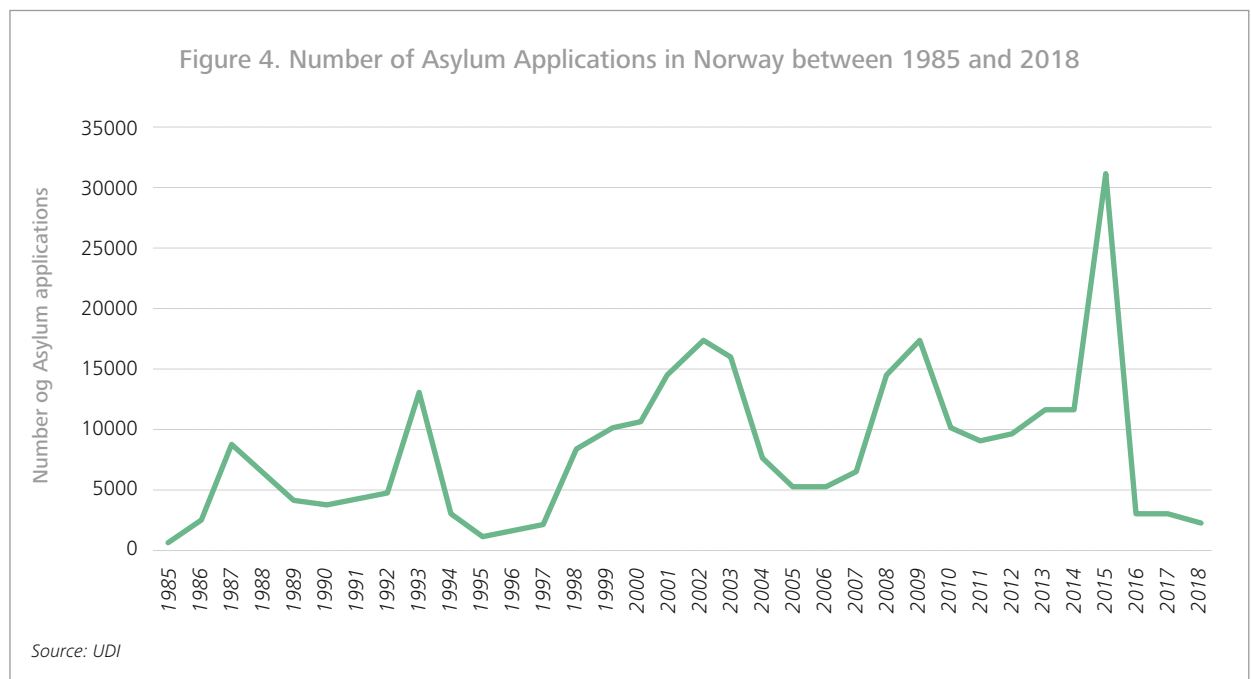
In 2017, there were 798,944 international migrants in Norway, constituting 15.1% of the total population. This number has increased at an annual rate of 3.4% since 2015. The largest groups of immigrants living in Norway are from Poland, Lithuania and Somalia. Of international migrants, 70,674 were refugees and asylum seekers (8.8%). Since 2007, work has been the most common reason for immigration, followed by family reunification (83).

The establishment of a voluntary health assessment

The development of a reception system

As a response to the increased numbers of asylum seekers arriving during the 1980s, institutions were established and new organisational structures took form.

In 1981, a decentralised reception structure was established where municipalities and local authorities were responsible for receiving asylum seekers directly in the municipalities. However, as the numbers of asylum seekers increased considerably in the mid-1980s munic-



ipalities faced great challenges regarding reception, and especially a shortage of housing. Thus, in the late 1980s reception directly in the municipalities was withdrawn and a governmental reception organisation was established. In 1988, the responsibility for accommodating asylum seekers was transferred from the municipalities to the government in collaboration with NGOs (93). During this period, hotels, closed-down nursing homes and ships were used as temporary accommodation until state-operated reception centres were established (93,94). The same year, the Norwegian Directorate of Immigration (UDI) was established (94,96). Initially, the authorities had decided not to copy the Swedish centralised model of an immigration board as immigrants should not be perceived as a separate group with such special needs that they required a separate administration (94). Instead the immigration-related activities were divided between a number of ministries and departments but lack of coordination between ministries and departments led to a need for a centralised coordination body. UDI took charge of immigration policy and immigration-related activities, including reception facilities for asylum seekers and refugees (94,96). A comprehensive reception structure was prepared by UDI, which introduced a transit reception where asylum seekers were accommodated upon arrival in order to be registered and undergo a brief health examination, primarily to detect tuberculosis, before being transferred to a permanent reception centre (93).

However, no uniform health assessment for asylum seekers existed at this time, nor any official guidelines on the provision of health services to asylum seekers and refugees (97). In 1989, UDI published an unofficial guide/paper on health problems and treatment among asylum seekers and refugees, prepared by a Norwegian doctor, Berit Austveg (91). The guide provided information on common health issues among asylum seekers and refugees and recommendations for health services. Although children were not specifically addressed, it was, however, mentioned that asylum-seeking and refugee children younger than school-age should be subject to more comprehensive examinations than Norwegian children who received regular health assessment (91).

Mental health of asylum seekers and refugees is put on the agenda

During the late 1980s, the mental health of asylum seekers and refugees was put on the agenda. A cohort study of Vietnamese refugees showed that among the 22% of the refugees who had a psychiatric disorder af-

ter three years in Norway, none were in contact with public mental health services, and 8 out of 10 had no contact with a primary care physician either. Consequently, a small national psychosocial team within the public mental health service was established in 1986 (98). In 1990 a more permanent psychosocial centre for refugees, the Psychosocial Centre for Refugees, was established in Oslo to function as a national resource centre and to conduct research and provide guidance and training to health professionals. Provision of psychological treatment was, to a limited extent, offered to traumatised refugees. As the need for services increased, a total of four regional psychosocial teams for refugees were established, covering the whole country (98,99).

Mental health was again put on the agenda in 1992–1993, when incidents involving casualties among traumatised refugees, drew attention to the reception of traumatised refugees and the lack of sufficient reception services and treatment routines (93,97). UDI's Director Arild Kjerschow agreed that there was a lack of a national strategy for a routine mental health programme for asylum seekers and refugees arriving in Norway (97). The same year the Ministry of Labour and Local Government established a working group to investigate the need for mental health services for asylum seekers and refugees, how to obtain better information about the health of newly arrived asylum seekers, and how to provide better training for health professionals working with traumatised asylum seekers and refugees (97). The results were presented in the report "Measures to improve refugees' mental health" [Tiltak for bedring av flyktningers psykiske helse], which among other things, recommended authorities to pay more attention to children in asylum reception centres, and give greater priority to considerations of the mental health of children (93,100).

National guidelines on the provision of health services to asylum seekers and refugees is issued

In 1993, the first official national guidelines on the provision of health services to asylum seekers and refugees was issued, which suggested an implementation of health assessments in asylum centres and several other health reception initiatives (99,101,102). The guidelines provided comprehensive information about health reception initiatives in different phases of the asylum-seeking process, including both somatic and mental health services with particular attention to children. See outline of the guidelines in textbox below.

In 1999, Norway agreed to receive some 6000 refugees

Guidelines for healthcare services for immigrants and asylum seekers IK-09/93

In the transit phase:

The Health Service must concentrate on the mandatory tuberculosis screening, as well as the necessary healthcare that cannot be postponed. Initial assessment can be done by a nurse. In the case of reduced well-being, signs of infectious diseases and poor mental function, the right to necessary healthcare will normally imply that the individual is offered an examination by a doctor. The same applies to those who claim to have chronic diseases that need control. Asylum seekers and refugees with signs of recent traumatising should also be offered an examination by a doctor.

There will be limited opportunity to provide health education/information during this phase. Foreign language brochures on important topics such as HIV/AIDS, hepatitis B and nutrition issues can be offered. At larger transit receptions, one can offer information groups.

In the asylum-seeking period:

Municipalities with asylum seekers should develop routines for cooperation between the health service and the reception centre, so that asylum seekers receive the necessary healthcare. The asylum seeker should be offered a medical examination and possibly treatment. Many people will need treatment for psychosocial problems due to migration, loss and traumatising and being an asylum seeker. Past experience indicates that the need for mental health treatment increases with time spent in Norway. In cases of clinical doubt, examination for infectious diseases such as syphilis, hepatitis B, HIV and bowel infections, along with information on infectious diseases, must be provided.

One must take into account the country of origin and previous living conditions when deciding what examinations to offer. The health service should map the asylum seekers' vaccination status and vaccination needs. The health service should offer children regular check-ups at a health centre. Special attention must be paid to the health status of children who have lived under poor conditions before coming to Norway. This often leads to anemia, symptomatic intestinal protozoa and inability to thrive. Clinical and laboratory examinations must be provided based on broad indications. Special attention must be paid to children's mental health. Many suffer mental health problems as a result of past experiences in, and through fleeing from, their home country, as well as a result of their current situation in the reception country.

After being granted a residence permit:

A full medical examination should be provided if not previously performed. Medical records should be obtained from any previous place of residence, and one should follow up on initiated or planned treatment.

When settling into the municipality:

It is important that the individual is quickly offered contact with the primary health service in the municipality. It is recommended that a complete medical examination is tailored to the individual's background and needs (living conditions, previously documented examinations and current health problems) (99).

from Kosovo, which led to a revision of the guidelines due to changes in disease patterns, a need to include issues related to torture and psychosocial care as well as a need for a standardised procedure for the health assessment upon arrival (97,103,104). New guidelines were issued by UDI in 2003 and later in 2010, providing updated and comprehensive information and guidance on health services for asylum seekers and refugees (102,105). The guidelines sought to clarify the administrative management as well as content of healthcare services for asylum seekers and refugees and to ensure that they were given the necessary somatic and mental healthcare. The new guideline included information about medical examina-

tions in the transit phase, in the ordinary reception centres, and after settlement in a municipality. In this regard, municipalities were expected to follow the guide as a basis for planning, organising and providing health services to asylum seekers and refugees. The guide was primarily intended for healthcare professionals, people in administrative positions in primary and specialised healthcare as well as employees in reception centres (102,105). The guidelines contained a range of issues regarding the healthcare provider's responsibility in providing qualified interpreters, obligatory tuberculosis examination in transit reception centres, transferring of health-related information and medical records from health services in

transit centres to the municipal health services where the ordinary reception centre was located. The guidelines further included prevention, examination and treatment of communicable disease, vaccination, the need for the assessment of psychosocial problems, dental healthcare, prenatal care, maternal and child health centres, school health services and environmental health safety in reception centres (105).

The guidelines, however, addressed health services for asylum seekers in general with no particular attention to children and adolescents. Issues related to the health of children and adolescents were briefly mentioned in subsections concerning psychosocial problems, prenatal care, maternal and child health centres and school health services.

Centralised reception unit

In the early 2000s Norway began the establishment of a centralised reception unit for asylum seekers, including a transit reception, facilities for asylum interviews and health examinations etc. The aim of the centralisation was to establish a more efficient asylum procedure (106).

Insufficient mental health services for asylum seekers

In 2004, Norwegian Health Services Research Centre carried out a study on the possibilities for a systematic identification of need for psychiatric help among asylum seekers, on behalf of the Norwegian Directorate of Social and Health Affairs. The Norwegian Health Services Research Centre concluded that sufficient help for asylum seekers with mental health problems was not available. However, a systematic identification of further unmet needs for mental healthcare would put greater pressure on the health services, thus a routine large-scale systematic identification of mental health problems among asylum seekers was not recommended by the Norwegian Health Services Research Centre as they considered it unethical to identify illness or disease by a screening procedure if no treatment could be offered (107). Following, several reports on mental health problems among asylum seekers, including the mental health in children, were published (108–112).

A greater focus on the rights of the child

The following year, in 2005, the UN Committee on the Rights of the Child raised concern about insufficient psychological and psychiatric services provided to children

living in reception centres in Norway as well as insufficient supervision of and care provided to unaccompanied asylum-seeking children (113). At this time, an instrument for the screening of traumas and post-stress syndromes among refugee children was being developed by the Centre for Crisis Psychology and had entered the phase of clinical testing. However, again in 2007, the Committee reiterated its concern about the insufficient psychological and psychiatric services provided to children living in reception centres, as well as the insufficient supervision of and care provided to unaccompanied asylum-seeking children (114). The Committee recommended that Norway should take measures to ensure that children living in reception centres were provided with adequate support and supervision as well as adequate psychological and psychiatric care. Furthermore, the Committee urged Norway to expedite its efforts to implement the instrument developed by the Centre for Crisis Psychology for the screening of traumas and post-stress syndromes among refugee children (114).

In 2009, in a consultation on a proposed revision of the guidelines on the provision of health services to asylum seekers and refugees, the Children's Ombudsman in Norway stated that children were not sufficiently addressed in the guidelines. The Ombudsman called for a clearer child perspective as well as a greater focus on the right of the child with reference to the CRC (102). Following the consultation, the revised guidelines from 2010 (IS-1022) introduced a subsection with the heading "Oppfølging av barn" [Following-up of children], stressing that children should receive special attention and care. However, the content of the subsection did not differ considerably from the previous guidelines. Reunited family members who were directly settled in Norwegian municipalities without staying in reception centres upon arrival were included in the revised guidelines (102,115,116).

In 2011, a committee appointed by the government reported on the organisation and the conditions of the accommodation for asylum seekers in Norway (93). The committee found that no routine physical examination was conducted, neither in transit nor in the regular reception, to identify signs of torture or other abuse, and they stressed a need to strengthen health-screening procedures to improve the identification of vulnerable asylum seekers (93,117). Similarly, Norway's fifth and sixth periodic reports to the UN Committee on the Rights of the Child found that there was no special procedure for identifying vulnerable asylum seekers in general, or children in need of rehabilitation due to experience of armed conflicts (118).

The guidelines for health services for asylum seekers and refugees has been updated and modified a number of times, the latest in 2018, but what has been constant is that the only required and legally defined form of assessment is a tuberculosis screening (see following section). Beyond this, all other assessments or screening have been included as recommended, though these recommendations have varied over time, from early assessments of health, till at a later point, health assessments within three months after arrival at the regular reception centres. The recent amendments to the guidelines from 2018 reflect greater focus on trauma and torture by including a brief self-assessment form on trauma items, based on internationally developed instruments for this (HTQ-25; H-10) and by referring to the Istanbul Protocol, a UN document outlining international legal standards and setting out specific guidelines on how to conduct effective legal and medical investigations into allegations of torture and ill-treatment (119,120).

Mandatory tuberculosis screening upon arrival

Introduction of mandatory tuberculosis screening for immigrants applying for residence permit

Tuberculosis screening had been in place before the general health assessment was introduced. Already in 1956, tuberculosis screening became by law compulsory for foreigners who applied for work in Norway (121), and in 1977 chest X-ray became mandatory for all immigrants >15 years of age who applied for residence permit. Additionally, tuberculosis testing and BCG vaccination, a vaccine primarily used against tuberculosis, became mandatory for immigrants who applied for residence permit. Tuberculosis testing and BCG vaccination were also mandatory for immigrants under 15 years of age (121).

Tuberculosis guidelines issued

In 1981, the Norwegian Institute of Public Health (NIPH) issued a guide on tuberculosis for health professionals, "Control of tuberculosis", which clarified the current policies and practices regarding tuberculosis management in Norway, including information on screening procedure for immigrants who applied for residence permit (122,123). In 1994, an act on communicable diseases control (124) came into force, which made the NIPH responsible for monitoring infectious diseases in Norway (124,125). In 1996, a revised edition of the tu-

berculosis guide from 1981 was prepared in accordance with the new act on communicable diseases control. According to the new guidelines, all asylum seekers and refugees should be examined for tuberculosis within 14 days after arrival, while persons arriving for family reunification should be examined as soon as possible and within four weeks after arrival. BCG vaccination remained mandatory until 1995 when it became a voluntary offer for all. From 2009 BCG vaccination was only offered to high-risk groups (126).

Ongoing amendments to the guidelines have been made, and in 2001, a new section about preventive treatment of latent tuberculosis and referral procedures for asylum seekers were added (123). The guidelines were further revised in 2002 when new governmental regulations for tuberculosis screening and treatment were issued (123,127). The regulations emphasised a continued need to screen all asylum seekers and refugees as well as individuals from high incidence countries after arrival (128,129). Furthermore, it became mandatory for the municipalities to have a tuberculosis coordinator to organise treatment plans and secure effective follow-up procedures (123,128). Accordingly, the revised guidelines promoted more vigorous treatment of latent tuberculosis by recommending increased use of preventive treatment for children and adolescents (129).

In 2004, the Mantoux test with Old Tuberculin was introduced in the tuberculosis control programme replacing the Pirquet method previous used. Additionally, IGRA was introduced as a screening/diagnostic tool in 2007 (126,130,131).

New TB recommendation and simplifications in the control of TB

Further recommendations for the procedure of tuberculosis screening of asylum seekers and refugees were introduced in 2015 (123,132). A National TB Committee agreed on some temporary simplifications in the TB control programme due to significant challenges with the implementation of routine tuberculosis examination of asylum seekers. From November 2015, the supplementary blood test (IGRA) was no longer required for asylum seekers who came from countries with a low incidence of tuberculosis, including Syria and Iran. Only adolescents and adults who came from a country with very high incidence (occurrence of over 200 cases per 100,000 inhabitants) would be given an IGRA in addition to the X-ray upon arrival, and the IGRA survey could now be postponed for up to three months (123,132).

According to the new recommendation infants (children <6 months) were no longer to be examined with IGRA but with personal consultation. All children aged 6 months – 15 years were to be examined with IGRA on arrival, whereas everyone >age 15 years were to be examined with X-ray. (132). In addition to the mandatory tuberculosis testing on arrival, NIPH recommended that newly arrived asylum seekers, and refugees, including family-reunified refugees, were offered a TB follow-up and a general health examination after three months in the municipalities (123).

In March 2017, a distinction between countries with high and very high occurrence of tuberculosis was introduced to target screening for latent tuberculosis. The change consisted of the IGRA test for latent tuberculosis among young adults (15-35 years of age) being limited to only include new arrivals from countries with very high occurrence. However, all refugees and asylum seekers were still required to undergo tuberculosis testing regardless of country of origin (133).

Today's health reception of asylum seekers and refugees in Norway

The health reception procedure, including a voluntary health assessment and a mandatory screening for tuberculosis, is generally divided into three phases: the transit phase, where asylum seekers undergo a mandatory tuberculosis screening and a brief medical exami-

nation; the ordinary asylum reception, where children are offered vaccinations within three months of arrival; and a voluntary health examination after three months of arrival in the country (see table 3) (93,134)

Health reception in transit phase

Upon arrival in Norway, asylum seekers are initially accommodated in a transit reception centre, where they stay for a limited time (116,142). While still in the transit reception centre, all asylum seekers and refugees are required to undergo mandatory tuberculosis screening and to be examined within 14 days of entry (105,143,144).

The tuberculosis screening method used differs by age group. Infants are examined with a personal consultation, children are IGRA-tested (blood tests), whereas adolescents and adults (>15 years of age) examined with lung X-rays. In addition to X-rays, adolescents and adults who come from a country with very high incidence (occurrence \geq 200 cases per 100,000 inhabitants) will also be IGRA-tested (144).

In the transit phase or as soon as possible afterwards, NIPH recommends a brief health assessment covering questions about somatic diseases, physiological issues, pregnancy, medication, functional disabilities, imprisonment/war/torture sexual assault etc. or recurring nightmares/flashbacks (105). However, health assessments and services in the transit phase primarily concentrate on acute matters that require

Today's administrative arrangements for the reception of asylum seekers and refugees in Norway

The Ministry of Justice and Public Security holds the overall responsibility for immigration and integration policy. UDI, an authority under the Ministry of Justice and Public Security, is responsible both for the processing of the asylum claims and the provision of accommodation for asylum seekers (117,135). The Norwegian reception system is not regulated by any primary or secondary legislation but governed by instructions from UDI (117). Norwegian authorities have recently legally defined the operation of reception centres as health and social services.

The daily operation of the reception centres is contracted to public and private operators on behalf of UDI. These operators include municipalities, commercial actors and NGOs. The same requirements apply to all operators of the reception centres and they are formally bound by

contracts with UDI including requirements specified in circulars issued by UDI (136,137).

The municipalities in Norway are autonomous and Municipal authorities are responsible for providing healthcare for their inhabitants – including asylum seekers and refugees in the ordinary reception centres. When the asylum seekers are transferred to ordinary reception centres, they are assigned to local medical health services in the respective municipality (116). Municipal healthcare services' responsibilities and obligations in relation to asylum seekers and refugees are clarified in the circular (IS-22/2004) "Healthcare services for asylum seekers and refugees – professional advice and a reminder of prevailing laws and regulations – with particular emphasis on mental health" (138).

Entitlements and access to healthcare for asylum-seeking and refugee children in Norway

Asylum-seeking and refugee children younger than 18 years have the same rights to healthcare as Norwegian children resident in Norway and shall be assisted by the ordinary services network with necessary adjustments (139,140). In addition, all children and adolescents aged 0–20 years have the right to health examinations, vaccinations, home visits and health information and guidance by child health clinics and school health services (105). However, children without authorised residence do not have the right to a general practitioner (141).

quick clarification and follow-up. According to NIPH, follow-up of asylum seekers with special health needs should generally not be initiated in the transit phase as the phase is rather short and transfer may cause discontinuation of treatment (105).

After the mandatory tuberculosis screening and asylum interview, asylum seekers are moved to ordinary reception centres (145). If the tuberculosis examination reveals symptoms or signs of tuberculosis, asylum seekers will be transferred to a reception centre, which will facilitate the necessary follow-up. Asylum seekers who need frequent medical assistance and examination should be transferred to specially adapted units that facilitate such follow-up. In case asylum seekers are not accommodated in an arrival transit reception centre or the ordinary referral centre, the municipal health services are responsible for performing the tuberculosis screening.

Vaccination within three months in the ordinary asylum reception

NIPH and the Directorate of Health recommend all children under the age of 15 years who are accommodated in large, crowded reception centres should be offered MMR vaccine against measles, mumps and rubella, if not previously immunised. In addition, it is recommended that children receive catch-up immunisation according to the National Immunisation Programme (105,146). NIPH recommends that all children are vaccinated within three months after arrival in Norway. For children under two years of age NIPH recommends vaccination on arrival (105).

Health assessment at three months

Furthermore, the Directorate of Health recommends municipalities should contact asylum seekers, refugees, and family-reunited refugees, three months after arrival in the country to establish contact and identify health problems that require treatment or follow-up, including a preliminary mental health assessment (105,118). Municipal authorities are responsible for providing healthcare for their inhabitants and each municipal health service can structure and organise the health assessments for newly arrived asylum seekers (139). However, the Directorate of Health has provided a comprehensive examination scheme for the assessments and urges municipalities to offer health assessment to all asylum seekers in order to examine the health status and needs for mental and /or somatic follow-up (147). The Directorate of Health recommends following to be considered when carrying out the health assessment (105):

- TB exposure and risk assessment
- Vaccinations if not previously vaccinated
- Optional HIV-, hepatitis B and C - and syphilis screening of certain high-risk groups
- General health, skin and oral health check
- Questions about self-perceived health
- Optionally, questions that can reveal experiences of traumatic events and potential mental health problems that require follow-up
- Questions about chronic or contagious disease
- Questions about medicine needs and use
- Questions about contraception, and information on how to access contraceptives.

Table 3. National health reception services for asylum seekers and refugees in Norway (147,148)

Disease	Target population	Screening indication	Screening instrument	When
Pulmonary tuberculosis (active and latent)	Children and adults from high incidence countries	Tuberculosis (TB) incidence >100/100,000 in the country of origin	Consultation, IGRA and/or lung X-rays	< 14 days after arrival (In transit phase)
Hepatitis B	Adults	Hepatitis B prevalence >2% in the country of origin	HBsAg, anti-HBs og anti-HBc,	Three months after arrival
Hepatitis C	All (children and adults)	Hepatitis C prevalence >3,5% in the country of origin	HCV antistofftest + evt HCV RNA	Three months after arrival
HIV	Immigrants from country of origin with adult (15–49 years) HIV prevalence > 0.5%	Adult (15–49 years) HIV prevalence > 0.5%		Three months after arrival
Syphilis	Adults > 15 years	Immigrants from country of origin with syphilis prevalence in pregnant women > 1.0%	TPPA, TPHA and EIA IgG/IgM)	Three months after arrival
Others	All	In case of signs /information about current symptoms, other tests e.g. intestinal parasites, intestinal pathogenic bacteria, MRSA, malaria, schistosomiasis etc. should be carried out		Three months after arrival
Somatic and mental health status	All (children and adults)		Interview	Three months after arrival

Today's main legislative acts and regulations relevant to asylum procedures, reception conditions and healthcare services for asylum seekers and refugees in Norway

Title in English	Original Title (NO)
Act concerning the entry of foreign nationals into the Kingdom and their presence in the realm (Immigration Act), Act 2008-06-15	Lov 2008-06-15 nr 64 Lov om utlendingers adgang til riket og deres opphold her (Utlendingsloven) (149)
Act on Communicable Disease Prevention, Act 1994-08-05-55	Lov 1994-08-05-55 om vern mot smittsomme sykdommer (smittevernloven) (150)
Regulations on Tuberculosis Control, Reg 2009-02-13-205	Forskrift om tuberkulosekontroll FOR-2009-02-13-205 (143)
Act on Patient- and User Rights, Act-1999-07-02-63	Lov om pasient- og brukerrettigheter (pasient- og brukerrettighetsloven) LOV-1999-07-02-63(151)
Act relating to municipal health and care services, etc. (Health and Care Services Act)	Lov om kommunale helse- og omsorgstjenester m.m. (helse- og omsorgstjenesteloven), LOV-2011-06-24-30 (139)
Act relating to the strengthening of the status of human rights in Norwegian law (the Human Rights Act)	Lov om styrking av menneskerettighetenes stilling i norsk rett (Menneskerettsloven) LOV-1999-05-21-30 (152)
Act of 17 July 1992 No. 100 relating to Child Welfare Services (the Child Welfare Act).	Lov om barneverntjenester (Barnevernloven) LOV 1992-17-100 (153)

Sweden



The health reception of asylum-seeking and refugee children in Sweden from 1980–2018

The following section describes the development of the Swedish health reception procedure for newly arrived asylum seekers and refugees in the period 1980–2018. The section outlines the main development trends of health reception in the light of some of the contextual factors, including political, economic, organisational and societal factors that have been central to, and have influenced, the Swedish health reception procedure.

Historical context of immigration in Sweden

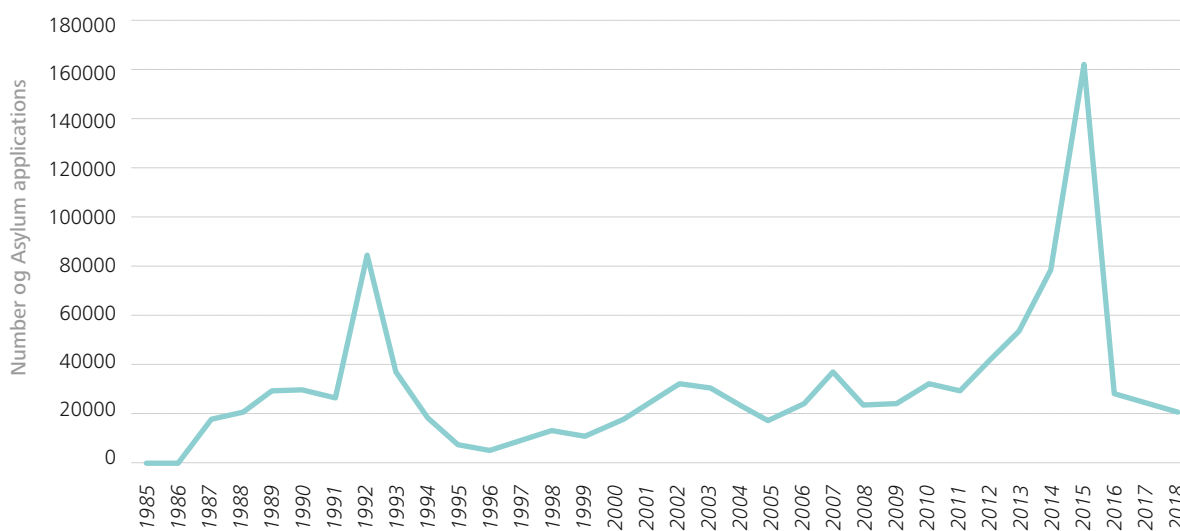
Sweden has a long history of migration and received large numbers of asylum seekers and refugees as early as in the 1970s when significant immigration took place from Southern Europe as well as from Chile, in connection with armed conflict or crises. In the mid-80s, the number of asylum seekers began to increase all over Western Europe, and Sweden accordingly experienced a rise in the number of people seeking asylum from countries like Iran, Iraq, Lebanon, Syria, Turkey, Eritrea and Somalia, as well as South American countries (154,155) (see figure 5). In 1985, Sweden received approximately 14,500 asylum seekers, and more than 30,000 in 1989 mainly from Iran, Iraq, Lebanon and Ethiopia as well as stateless individuals, peaking in 1992

with a total 84,000 people, mainly from former Yugoslavia, seeking asylum in Sweden (155). In this period, the scale of asylum-based immigration exceeded that of Denmark, Norway and Finland. Between 1995 and 1999, the number of asylum seekers was fairly low (155). However, in 2000, the numbers rose again, and the level of asylum-based immigration has continued to be high in comparison with other Nordic countries ever since, with the exception of 2004 and 2005, when a temporary decline was noted (156). Asylum seekers from war zones and armed conflicts continued to immigrate to Sweden, and this immigration peaked in 2015 with 162,877 people seeking asylum, the three largest groups being Syrians, Afghans and Iraqis. However, from 2016 onwards Sweden saw a drop in the number of asylum seekers after four years of increase, with a total of 25,666 seeking asylum in 2017 (156).

The establishment of a reception structure for asylum seekers and refugees

From the 1950s to the early 1980s the National Labour Market Authority [Arbetsmarknadsstyrelsen, AMS] was responsible for the reception of asylum seekers and refugees. The government bill 1983/84:124 on the reception

Figure 5. Number of Asylum Applications between 1985 and 2018



Source: migrationsverket.se

of refugees and asylum seekers, etc. proposed that asylum seekers and refugees “should normally get a basic health assessment as soon as possible after arrival” (157). However, only quota refugees should be offered a regular assessment to promote the well-being of refugees and their integration into Swedish society, whereas asylum seekers should only be offered an assessment in certain cases – e.g. if there were obvious health risks (157). The health assessment should be free of charge for the individual and financed by the government. It should be voluntary and carried out within the ordinary health system as soon as possible after arrival. The reason behind the suggestion of a health assessment was that:

“Asylum seekers as well as organised refugees, not unusually, come from conditions that have meant that many basic needs have been neglected for a long time. [...] Infectious diseases such as tuberculosis, bowel disease and hepatitis may occur but do not dominate in any way the health of the refugees” (157).

The content of the health assessment was, however, not explicitly stated. According to the bill, the assessment should be prepared by the National Board of Health and Welfare in consultation with the Swedish Immigration Board and adapted to meet individual health needs (157). As the number of asylum seekers began to rise during the mid-80s, a new organised system for the reception of asylum seekers was introduced. The responsibility was handed over from National Labour Market Authority to the Swedish Immigration Board [Statens invandrarverk] (the predecessor of the Swedish Migration Agency) (157). Alongside the establishment of the new reception procedure, the first guidelines on healthcare for asylum seekers and refugees (Socialstyrelsen Allmänna råd) were issued by the National Board of Health and Welfare in 1985. The guidelines were intended as non-obligatory recommendations rather than as mandates. However, frequent revisions took place in the following years. The National Board of Health and Welfare's guidelines on healthcare for asylum seekers and refugees were consolidated over the years and revised in 1988, 1995 and the latest revision being in 2011 (158–160). See more details below.

Introduction of HIV testing and clarification of access to acute healthcare for asylum seekers and refugees

Since the 1980s, Swedish authorities have stressed the importance of HIV testing as part of the health assessment of

newly arrived asylum seekers (158,161). Accordingly, optional HIV testing was introduced into the Swedish health assessment programme and a section on HIV/AIDS was added to the revised guidelines in 1988 (158). According to the revised guidelines, both refugees and asylum seekers were entitled to a health assessment upon arrival. The assessment should be carried out in the general healthcare system and include an interview as well as physical examination and testing, if deemed relevant. Furthermore, the guidelines clarified asylum seekers' right to acute healthcare and the procedures for acute and dental care as well as mental health efforts, and according to the guidelines, psychological symptoms and disorders such as anxiety and depression required acute care (158). During the 1980s, asylum-seeking children were not entitled to the same healthcare as children resident in Sweden. Asylum-seeking children were, like adults, granted access to acute healthcare, obstetric and abortion services as well as being entitled to a health assessment upon arrival (157,158). The need for care was assessed from the perspective that it may take several months before the opportunity to receive non-acute care was given. A narrow, restricted definition of acute care could therefore lead to harmful delays of treatment. Thus, the National Board of Health and Welfare emphasised that this perspective was of particular importance in relation to children – thereby supporting a broader and more inclusive definition of acute care in the case of children. It was further stated that asylum-seeking children should have the possibility of being assessed by a doctor as part of the health assessment (158,162).

Implementation of a differentiated health assessment

New regulations regarding the health assessment for asylum seekers were issued in the early 1990s. The starting point seemed to have been the financial crisis in Sweden starting in 1990 rather than health concerns (163). An increase in the number of asylum seekers and a corresponding increase in the costs of the health assessment led to “the need to consider the scope of health assessment” and a limitation of the assessment was introduced (163). The government bill 1992/93:50 on measures to stabilise the Swedish economy stated that:

“There are several reasons for limiting health assessment. The assessment shows that it is very rare to find any infectious or other serious diseases through the extensive screening programme currently being carried out” (163).

In the light of the economic crisis, a selective health assessment strategy was introduced in 1993, which was estimated to save around 205 million Swedish Crowns (SEK) the following year (163). The assessment was no longer to be offered on a regular basis to all asylum seekers, but targeted certain risk groups based on criteria such as country of origin, individual risk factors and other background factors. Asylum-seeking children, however, should always be included in the examinations forming part of regular child healthcare (163).

From a centralised to a decentralised health reception structure

In the early 1990s, asylum seekers were mostly accommodated in state-operated asylum centres in different parts of the country with health units staffed by full-time nurses who carried out the health assessment. In addition, the units were served by general practitioners once to twice a week, and occasionally by paediatricians (164,165). The procedures and content of the health assessments varied greatly across units, although the assessments were focused primarily around infectious disease, and most units had developed systematic ways of handling infectious disease. Yet in contrast, few units had systematic approaches to identifying and treating mental health needs (164,166). In accordance with national guidelines for Swedish childcare, child health programmes should be offered in the centres and provide health assessments and immunisations for pre-school children. However, only a few health units adapted and incorporated the programmes in accordance with the particular needs of asylum-seeking children (164).

In 1994, a new act on the reception of asylum seekers came into force, which allowed asylum seekers in Sweden to arrange their own accommodation (167). Consequently, the amount of widely dispersed accommodation, such as private housing, began to increase, which led to a decline in the number of health assessment being carried out as several asylum centres were closed (168,169). To adjust to the new conditions, the health assessment was again to be carried out mainly in primary healthcare, similar to the procedure in the 1980s. Accordingly, the responsibility for asylum seekers' healthcare was transferred from the State to the county councils in 1997 (170).

Revised guidelines due to changed reception conditions: Clarification of purpose and content and special attention to children

In 1995, new guidelines on healthcare for asylum seek-

ers and refugees were issued, replacing the guidelines from 1988 due to the changed reception conditions, and including changes in the healthcare provision and infection control (159). The new guidelines sought to clarify the level and content of the health and medical care that should be offered to asylum seekers and refugees, as well as clarifying measures to prevent the spread of infectious diseases (159). According to the National Board of Health and Welfare, the health assessment had two distinct purposes and consequently two different approaches: an individualised approach to identify persons with urgent health problems demanding immediate attention, and a community-oriented approach to identify the need for infection disease control in order to prevent the spread of diseases (159). According to the new guidelines, all asylum seekers and refugees should be offered an individual health interview as soon as possible after arrival. If deemed relevant, physical examination and testing could be initiated as part of the health assessment. Testing should include tuberculosis, hepatitis B and C, sexually transmitted infections including HIV, syphilis, chlamydia, gonorrhoea, as well as diphtheria, intestinal bacteria and parasites. Only asylum seekers and refugees coming from areas or social conditions associated with very low risk of infectious diseases should not routinely be offered testing. A physical examination should only be carried out if deemed necessary based on the interview and clinical findings, or if a serious disease was suspected. Asylum seekers should be informed that the assessment was voluntary, although it could be mandatory in case of suspected infectious diseases, in accordance with the Communicable Diseases Act §13 (159,171). Special attention should be paid to children in all parts of a health assessment, regardless of whether they were accompanied or unaccompanied. Children should always be included in the examinations forming part of regular child healthcare and be offered vaccinations in accordance with the national immunisation programme (159).

However, in the mid-1990s, there was an intense debate in Sweden, which questioned whether Sweden was fulfilling its obligations under the CRC (172). In 1996, after advocacy and political discussions, the healthcare services available to asylum seeking children in Sweden were, by law, expanded beyond the provision of emergency healthcare services, and asylum-seeking children became entitled to the same rights to health and medical care, including dental care, under the same conditions as children legally residing in the country (170,173,174). The following year, the principle

of the best interests of the child (Article 3 of CRC) was introduced in the Swedish Aliens Act.

Sharpening health assessment obligations for county councils

Due to an increased prevalence in HIV and other sexually-transmitted diseases in the early 2000s, a national strategy to combat HIV/AIDS and certain other communicable diseases was processed by the Swedish Parliament in 2006 (161). As part of the strategy, county councils were urged to identify asylum seekers and offer health assessments to a greater extent:

“It is important to follow up the health assessment offered by county councils to asylum seekers and close relative immigrants newly arrived in Sweden. The Government therefore wishes, by means of incentives to the county councils, to ensure that these groups are indeed offered health assessment in accordance with current statutory obligations” (175).

The strategy further introduced a time limit of two months to identify HIV infection in asylum seekers and newly arrived close relative immigrants (161,175).

In addition, a compulsory health assessment for asylum seekers and refugees, including HIV prevention, was proposed by the Swedish Integration Board and other authorities but the government did not find sufficient ground for introducing a compulsory assessment (161,176). Instead, the government proposed that county councils' should be obligated to offer a health assessment regulated by law, and in 2008 a new act (2008:344) on healthcare for asylum seekers and others came into force, which gave county councils a legal responsibility to offer a voluntary health assessment and to then carry it out, as well as to provide complementary treatment (177). Prior to this act, there was no legal obligation to offer the health assessment. However, the act implied a formalisation of the agreements already existing between the state and the Swedish municipalities and county councils, and did not change the scope of care (161,178). According to the act, the county councils where asylum seekers reside were obliged, unless it was clearly unnecessary, to offer asylum seekers a health assessment. Furthermore, the act stipulated asylum seekers' entitlement to medical and dental care that could not be deferred, antenatal

care, abortion care and contraceptive advice, while asylum seekers under the age of 18 were entitled to healthcare, medical care and dental care to the same extent as that offered children otherwise residing in the County Council's jurisdiction (177).

The latest guidelines on healthcare for asylum seekers and refugees were issued in 2011, replacing the guidelines from 1995 (160). The guidelines were changed from recommendations to obligatory requirements and non-binding recommendations, and stipulated the obligation to offer all asylum seekers, both children and adults, a voluntary and free-of-charge health assessment in accordance with the act (2008:344) on healthcare for asylum seekers and others (160).

Today's health reception of asylum seekers and refugees in Sweden

As described in the previous section, the health assessment of asylum seekers and refugees in Sweden has been consolidated over the years due to several factors, among them: changing policies, the right to healthcare, the spread of infectious diseases, country of origin, number of asylum seekers; as well as costs, and changes in the asylum reception procedure and accommodation opportunities. All this has led to the development of today's health reception procedures, which will be outlined in the following section.

Today's administrative arrangements for the reception of asylum seekers and refugees in Sweden

The Migration Agency, previously known as Migration Board, is the central administrative authority in the area of asylum, and is subordinate to the Government. The Migration Agency is responsible for the reception and registration of asylum seekers as well as processing of asylum applications and provision of accommodation. The Migration Agency has the financial responsibility for health screenings and for the reimbursement of the county councils for the health screenings of asylum seekers (179). County councils or Regions are the authorities responsible for primary healthcare centres (vårdcentraler), hospitals and the National Dental Service (Folktandvården) and are responsible for carrying out healthcare policy and for the provision of healthcare services for asylum seekers, including health assessment upon arrival (180,181).

A voluntary health assessment

Swedish law entitles all registered asylum seekers to a voluntary health assessment, free-of-charge, by the county councils or regions where they reside (186,187). The assessment must be offered when settled in a municipality (177). The Swedish Migration Agency is obliged to inform asylum seekers about their right to a health assessment when they submit their asylum application, which should be followed by an invitation to the health assessment from the healthcare organisation. This must include clarification on the purpose of the health assessment, that it is optional, and that an interpreter can assist if needed, and provide contact details for the caregiver (160,177,188).

The content of the assessment

According to the National Board of Health and Welfare, the purpose of a health assessment is to identify health problems and need for infection control measures, as well as to inform about the Swedish healthcare system and refugees' entitlement to medical and dental care. For children, this also includes information regarding their entitlement to preventive healthcare. The health assessment is regulated by the National Board of Health and Welfare guidelines in accordance with the act (2008:334) on healthcare for asylum seekers and others; the act (2013:407) on health services and healthcare for

certain foreigners who are staying in Sweden without the necessary permission, and the act (2004:168) on communicable diseases (160). According to the guidelines, which represent a minimum level of health initiatives, the assessment shall include an individual interview examining past and current physical and mental health status, vaccination status as well as providing information about Swedish healthcare. Special attention should be paid to children at the interview and adjusted to the age and maturity of the child (160,189). The National Board of Health and Welfare recommends certain questions to be considered when assessing a child, including whether and how current psychosocial circumstances of the child affect his or her physical or mental health, as well as how the child is affected by the state of health and well-being of guardians and other family members (190,191). The health assessment shall also include a health examination and tests, if deemed necessary (160,192). Besides individual needs, the National Board of Health and Welfare recommends a screening test for HIV and hepatitis B for all asylum seekers, including children, and tuberculosis screening for persons from high-incidence countries (TB incidence >100/100,000 in the country of origin). In addition, hepatitis C screening is recommended for all children, while giardia infection screening is recommended for all children under the age of 6 and phenylketonuria (PKU) screening for all children under the age of 8. All girls and women of childbearing age are recommended to be tested for rubella (193) (for more information see

Entitlements and access to healthcare for asylum-seeking and refugee children in Sweden

Children under 18 seeking asylum in Sweden are entitled to the same healthcare as all other children living in the county council jurisdiction where they are seeking treatment, including preventive and dental care. Care for asylum seekers 18 years old or more is regulated by the Act (2008:344) on Healthcare for Asylum Seekers and "others", which entitles them to medical and dental care ***"that could not be deferred"***; antenatal care, abortion care and contraceptive advice as well as care in accordance with the Swedish Communicable Diseases Act to prevent the spread of contagious diseases (177). The local county council decides on what kind of care is included and also has the right to decide about more generous rules. In addition, all registered asylum seekers, children and adults, are entitled to a health assessment upon arrival (182-184).

Healthcare is largely free of cost for children, but this can vary depending on the county council area.

Asylum seekers holding an LMA card pay 50 SEK (€4.80) to see a doctor at the district health centre or to receive medical care after obtaining a referral. Other medical care, such as with a nurse or physical therapist, costs 25 SEK (€2.30) per visit. Medical transportation costs €4.80. The fee for emergency care at a hospital varies from county to county. Visits after referral to other healthcare providers such as nurses, physiotherapists or counsellors cost 25 SEK (€2.30). Asylum seekers pay no more than 50 SEK (€4.80) for prescription drugs. That applies to children as well (184, 185).

Asylum seekers who are granted a residence permit, referred to as newly arrived refugees, are entitled to the same healthcare as other citizens living in Sweden.

table 4). In addition, each county council has medical officers – independent authorities who have the operational responsibility for communicable disease control within their county council – who provide screening guidelines on the regional level to prevent the spread of communicable diseases (194).

Variations in the assessment across the country

While following the above obligations and recommendations, each county council can structure and organise its own health assessment for newly arrived asylum seekers residing within the county, and this has led to variations across counties (169,183,195).

In a recent report, the Swedish Association of Local Authorities and Regions outlined some of the main variations of the assessment between county councils (183,196). In relation to the organisation of the assessment, some counties carried out the health assessment in ordinary health

centres without specialisation and coordination between the centres, while other counties had organised centralised and specialised health assessment facilities, outreach activities and mobile health teams (183,196). For example, Västra Götaland Region and Värmland county council have implemented mobile health screening clinics with specialised staff to carry out the health assessment in various parts of the region (196,197). Some county councils have developed their own guidelines for the health assessments of asylum seekers. For example, Västra Götaland county council has formulated a specific questionnaire with a specific focus on psychological health that is used during health assessment of children under the age of 18 (198). A few selected municipalities under Sörmland county council have invested in improved performance of health assessment of children who have not received it at a primary care facility (197).

Other variations in the assessment across Sweden relate to the duration of the health assessment, the

Table 4. National health reception services for asylum seekers and refugees in Sweden (160,192,193)

Disease	Target population	Screening indication	Screening instrument	When
Pulmonary tuberculosis (active and latent)	Children and adults from high incidence countries	Tuberculosis (TB) incidence >100/100,000 the country of origin	PPD and or IGRA	As soon as possible after filing asylum application and after being settled in a municipality
Hepatitis B	All, children and adults	HBsAg is recommended for all asylum seekers, while both HBsAg and anti-HBs are recommended for children	HBsAg, anti-HBs	As soon as possible
Hepatitis C	All children	Hepatitis C prevalence >3% in the country of origin	Anti-HCV	As soon as possible
HIV	All, children and adults		Combo test	As soon as possible
Syphilis	No longer recommended for all			
Rubella	Girls/women of child-bearing age (15-49 years)			As soon as possible
Giardiasis Parasite	Children < the age of 6			As soon as possible
Phenylketonuria (PKU)	Children < the age of 8			As soon as possible
Vaccinations	Children <6 years coming from war and conflict areas are prioritised	If not previously immunised, children are recommended to be vaccinated in accordance with national vaccination programme		As soon as possible
Somatic and mental health status	All, children and adults		Interview/questions	As soon as possible after filing asylum application and after being settled in a municipality

use of interpreters, invitation procedure, screening and tests procedures, as well as differences in administrative duties and responsibilities (169,196,199). Furthermore, Jonzon et al. (169) found that infectious disease control seemed to be prioritised during the health assessment across counties, whereas mental health issues were given insufficient attention; and provision of information about the Swedish healthcare system, although stipulated in national guidelines, was addressed to lesser extent (169). Accordingly, the Swedish Association of Local Authorities and Regions called for more interventions to improve mental healthcare and promote the mental health of asylum seekers as they found that less than half of all asylum seekers, who received a health assessment, were asked about their mental health status (197). Jonzon et al. argue that there seems to be a lack of a coherent national system for carrying out the health assessment on newly arrived asylum seekers

(169) and several county councils have requested clearer instructions for the assessment.

National statistics have shown that only approximately 50% of asylum seekers attend the assessment, though with significant national variations ranging from 20% to 90% among counties (169,197,200). The reasons behind the low rate are not clear, though explanations related to structural and organisational barriers have been suggested, such as difficulties in reaching individuals with the letter when living in diverse forms of accommodation (168,169). Mobile teams have been found to be a successful way of organising the health assessment and reaching newly-arrived asylum seekers (169,197,200). Additionally, studies have suggested that poor communication, inadequate information, mistrust and lack of clarity regarding the purpose of the health assessment could to some extent explain the poor attendance (195,201).

Today's main legislative acts and regulations relevant to asylum procedures, reception conditions and healthcare services for asylum seekers and refugees in Sweden

Title in English	Original Title (SE)
Aliens Act	Utlänningslagen (2005:716) (202)
Aliens Act Ordinance	Utlänningsförordningen (2006:97) (203)
Law on Reception of Asylum Seekers and Others	Lagen om mottagande av asylsökande m.fl. (1994:137) (167)
Ordinance on the Act on Reception of Asylum Seekers	Förordning om lagen om mottagande av asylsökande (1994:361) (188)
Act on Health Services and Healthcare to Asylum seekers etc.	Lagen om hälso- och sjukvård åt asylsökande m.fl. (2008:344) (177)
Ordinance on the Act on Health Services and Healthcare to Asylum seekers etc	Förordning om hälso- och sjukvård åt asylsökande m.fl. (2008:347) (177)
Act on health services and healthcare for certain foreigners who are staying in Sweden without the necessary permission	Lag om hälso- och sjukvård till vissa utlänningar som vistas i Sverige utan nödvändiga tillstånd (2013:407) (204)
Ordinance on state compensation for healthcare for asylum seekers	Förordning om statlig ersättning för hälso- och sjukvård till asylsökande (1996:1357) (179)
Ordinance on state compensation for certain immigrants	Förordning om statlig ersättning för insatser för vissa utlänningar (2010:1122)
Ordinance on state compensation for refugee reception etc.	Förordning om statlig ersättning för flyktingmottagande m.m. SFS 1990:92
The National Board of Health and Welfare regulations on healthcare for asylum seekers	Socialstyrelsens föreskrifter och allmänna råd om hälsoundersökning av asylsökande m.fl. (SOSFS 2011:11) (160)
	Proposition 2005/06:46 om mottagande av ensamkommande barn
	Lag om god man för ensamkommande barnlänk till annan webbplats, öppnas i nytt fönster SFS 2005:429

Comparative analysis



Main differences and similarities between health reception policies and initiatives for asylum-seeking and refugee children in the four Nordic countries

The aim of this report is to examine and compare national health reception policies within the Nordic countries, and to explore the trends in the development of health reception policies within the countries from 1980 to 2018. The following section will provide an overview of the findings, including an analysis of the most significant similarities and differences across the Nordic countries.

Immigration to the Nordic countries in the 1980s

During the 1980s, the number of asylum seekers began to rise all over Western Europe. Ongoing wars and conflicts in the Middle East and the Horn of Africa since the 1980s caused a steady and high immigration from these regions to the Nordic countries, whereas immigrations from Chile and other South American countries in the 1970s and the Balkan region in the 1990s were temporary phenomena. Asylum seekers and refugees already dominated the immigration policy debate in the early 1980s and 1990s in the Nordic countries, and major changes occurred in governments' perceptions of the significance of migration trends (3,4). Increased rates of asylum seekers in the 1980s led to pronounced administrative and practical problems within the Nordic countries, which resulted in the development of new of institutional frameworks as well as a number of reforms so the 1980s were characterised by the development of institutions (2).

The historical purpose of health reception

Systematic health reception initiatives for newly arrived asylum seekers were introduced in Denmark, Sweden and Norway in the early 1980s, whereas Finland implemented a systematic health reception programme in the early 1990s. Healthcare reception initiatives differed between the Nordic countries and have changed considerably over time in relation to several factors, among them, the perceived risk of infectious diseases, the number of asylum seekers, as well as economic, political, organisational and societal factors. There have been significant differences across the countries both with respect to coverage and type of health examinations.

However, over many years in all four Nordic countries and within each of their respective health reception initiatives, there seems to have been a fairly constant pattern of a focus on infectious disease control. Historically, the health reception procedures in many European countries aimed at protecting the local population against imported infectious diseases, and have therefore focused on screening for these diseases, and not least tuberculosis. Foreign-born migrants, returning traders, explorers, and military forces were perceived as potential public health threats and port-of-entry authorities met ships on arrival and conducted screening and quarantine programmes (5). Recurring epidemics of leprosy, syphilis, cholera, smallpox, plague and typhus shaped European history, and consequently regional foreign policy in relation to trade and health protection also (205). However, diseases of great interest in the early twentieth century, such as trachoma and smallpox, are no longer public health issues of concern. Current types of disease to which screening is organised, tend to reflect illnesses of public health importance of the mid- to late-twentieth century, such as tuberculosis, sexually transmitted diseases, and other infections (205). Furthermore, the more recent number of migrants and diverse modes of travel have reduced the effectiveness of former public health approaches (5).

Migration to and within the European Union and European Economic Area (EU/EEA) in recent years has led to changes in, and development of, migration policy, including health policy (5).

Nevertheless, health reception initiatives in many European countries still aim at protecting the general population against the risk of spreading communicable diseases; hence upon-entry screenings of infectious diseases among asylum seekers are widely implemented across the European countries, although these vary in terms of content, whether they are voluntarily, and how they are organised (169,206–212).

Infection control still seems to be a primary component of today's health reception of asylum seekers in the Nordic countries. Infection control is mentioned as a primary element of the health reception in the current policies of all four countries, and all the four have specific initiatives for acute healthcare of newly arrived asylum seekers, including vaccinations and infectious disease control, which clearly reflects the rationales of

protecting the population against infections as well as supporting acute health needs (32,68,119,160).

Main similarities and differences of today's health examination

Content of Healthcare reception

The healthcare reception of asylum seekers and refugees is carried out according to the varying national and local policies of the receiving country, and diversity in initiatives were identified across all four countries.

National legislation and guidelines on health reception, as well as organisation and timing of health reception initiatives, not only vary across but also within countries. Health reception initiatives also differ in focus, target population, content and aim, with some focusing on infectious disease control, prevention of disease spread and the protection of public health, and other initiatives focusing on the early identification of health needs of asylum seekers (206,207).

TB and infectious diseases screening

In all four countries, most health examinations are voluntary and target specific risk groups based on country of origin, individual risk factors etc. Only in Norway a compulsory, extensive screening for TB exists, including screening for both active and latent TB. This also included mandatory BCG vaccine until 1995.

In Denmark, Sweden and Norway TB screening was introduced in the 1980s, whereas this screening was introduced in Finland in 2009. Despite all four countries having policies in place regarding TB-screening of asylum seekers and refugees, the procedure, organisation as well as screening criteria differ considerably across the countries. While obligatory TB screening is an independent health reception initiative in Norway, it continues to be a secondary and voluntary element of a general health examination in Denmark, Sweden and Finland. In Denmark and Sweden, all asylum seekers with symptoms or from high risk areas, defined by TB incidence > 100/100,000 in country of origin, are offered a TB screening, whereas the screening criteria in Finland is TB incidence > 50/100,000 in the country of origin. In Norway, all asylum seekers and refugees, regardless of their country of origin and other risk factors, are required to undergo the TB screening.

The timing of the TB screening also varies across countries. For example, in Norway, the screening is intended to be carried out within two weeks of refugees'

arrival in the country; whereas in Finland, individuals without symptoms are examined at the time of the initial assessment, within two weeks of arrival, or as soon as possible afterwards. Individuals with symptoms are assessed as soon as possible.

This implies that the same asylum-seeking population from a certain country, therefore, can be offered varying health assessments in their respective resettlement countries, as these depend on the policy of the receiving country and not necessarily on the needs of the individual (169,213,214).

In addition, health assessments were offered to family-reunified refugees, ordinary refugees and quota refugees in Sweden, Norway and Finland. In Denmark, health assessments were offered to these groups in the whole country 2015-17, but from 2017 and onwards only in specific municipalities due to a change in the law. Focusing screening efforts solely on asylum seekers and selected groups of refugees may imply that some groups, such as quota refugees or children with other migration backgrounds (e.g. children of a refugee parent but who are family-reunified to a Nordic citizen) are overlooked, although they may face an equally high risk of infectious diseases or mental health problems.

Mental health screening

A relatively high proportion of asylum seekers and refugees suffer from mental health problems, though mental health has been a less frequent component in the health reception initiatives compared to infectious disease control (1,212). In recent years the health assessments in all four countries are moving towards a more holistic approach by taking into account mental health as well, though there are still significant differences in the detail to which mental health is subject within today's health reception. In Denmark, a mental health screening procedure was established in 2009 and offered to all newly arrived asylum-seeking children, but only to children under the age of 16. In Norway, a guideline incorporates mental health and the municipalities are urged to offer an initial health examination three months after arrival in Norway, which addresses both screening for trauma and general mental health services, however not specifically in relation to asylum-seeking children (105). Current guidelines in Sweden briefly mention that in the initial health examinations health professionals should be aware of children who had been exposed to traumatic events, (160,215), whereas only somatic health is included in the health reception initiatives in Finland (68,86,88). General mental health initiatives during the

Health services for asylum seeking and refugee children in the Nordic countries								
	Denmark			Finland		Norway		Sweden
Health reception service	Initial health examination	Psychological screening	Health assessment after being granted asylum	Initial health interview (incl. chest X-ray)	Health examination	Mandatory TB screening (active + latent TB)	Initial health examination	Health examination
Target group	Asylum seeking children 0–17 years of age	Asylum seeking children aged <16 years	Newly arrived refugees, based on needs	Asylum-seeking children		Asylum-seeking children		Asylum-seeking children
Focus	Somatic and mental health status			Somatic health status		Somatic health status	Somatic and mental health status	Somatic and mental health status
Participation	Voluntary	Voluntary	Voluntary	Voluntary*		Mandatory	Voluntary	Voluntary*
When	Preferably <10 days or before leaving reception centre	<3 months after arrival	<6 months after arrival in municipality	<2 weeks after arrival	Individuals with symptoms as soon as possible. Asymptomatic refugees <1 month Asymptomatic asylum seekers <3 months	Immediately and absolutely <14 days after arrival	<3 months after arrival	When accommodated in a country or as soon as possible
Where	Asylum centres	Asylum centres	National health system	Asylum centres/ National health system	Asylum centres/ National health system	National health system	National health system	National health system

* Certain examinations can be mandatory in accordance with national Communicable Disease Act

asylum-seeking period were mentioned in Finnish policies but without reference to children. In accordance with this information, a recent study by Barghadouch et al. (not yet published) found that health reception policies supporting mental health initiatives were less present and less detailed than policies supporting acute and somatic health initiatives in the four Nordic countries. Similarly, a review of 53 studies on the health screening of resettled refugees in Europe, North America and Australia/New Zealand showed that most screenings focused on infectious diseases identification, whereas screening for mental health and non-communicable

diseases like diabetes and hypertension were addressed to a lesser extent (213).

Furthermore, two Swedish studies, both examining the health assessment procedures from the perspective of the asylum seekers, found that asylum seekers considered the health assessment that they had undergone was primarily an infectious disease control rather than an opportunity to express their health concerns and identify actual health needs (168,216).

Policies on screening are not exclusively dependent on the health needs of the asylum seekers or the relative risk of infection, but also on non-medical grounds, such

as economic, political and societal factors. Thus, the implementation of various health reception initiatives and screening programmes and the variation in national guidelines raise questions about the reasoning behind the different health reception initiatives (206).

Migrants are a diverse group and heterogeneous in their health, which makes it hard to generalise about their health needs. It is therefore challenging to identify approaches that optimally improve health outcomes in immigrant populations across Europe and decide what should be assessed, who to be targeted as well as where and when assessments should be delivered. Furthermore, it is not clear what constitutes an effective and cost-effective screening approach and what factors hinder or facilitate the screening process (169,207,208).

The European Centre for Disease Prevention and Control (ECDC) has recently developed evidence-based guidance on the prevention of infectious diseases among newly arrived migrants in the EU/EEA to strengthen infectious disease prevention and control among migrants and meet the health needs of these populations (5). According to the ECDC, asylum seekers and refugee populations are a priority group for communicable disease prevention and control efforts, as they are disproportionately affected by, or vulnerable to, certain infectious diseases, including active and latent TB, HIV, hepatitis B and C, and have low levels of vaccination (5). This increased vulnerability is related to pre- and during-migration risk factors, including demographic profile, patterns of disease and weak health systems in countries of origin, high-risk behaviour, exposure to unsafe migration journeys that increase the risk of infectious diseases, lack of access to healthcare services and interruption of care, living conditions in host countries such as reception centres, overcrowding or shared accommodation. Furthermore, social, economic, cultural and legal barriers in host countries can hinder or limit access to and uptake of healthcare services. Additionally, post-migration risk factors such as poor living conditions and other determinants of health in the host country can also exacerbate the vulnerability of asylum-seeking and refugee populations (5).

However, the ECDC stresses that asylum-seeking and refugee populations do not generally pose a health threat to the host population. In spite of the common perception of an association between migration and the importation of infectious diseases, there is no systematic association, according to the WHO (217). The most frequent health problems of asylum seekers and newly arrived refugees include accidental injuries, hypo-

thermia, burns, gastrointestinal illnesses, cardiovascular events, pregnancy- and delivery-related complications, diabetes and hypertension (217).

According to the WHO, the safest way to ensure that the resident population is not unnecessarily exposed to imported infectious agents is to ensure that asylum seekers and refugees have full access to a hospitable environment, prevention and, when needed, to high-quality healthcare, without discrimination on the basis of gender, age, religion, nationality or race or legal status (217). Accordingly, the ECDC stresses that the failure to address asylum seekers' and refugees' rights to healthcare and access to health services, and to consider their unique needs, risks undermining regional and global efforts to combat the spread of communicable diseases (5).

The WHO does not recommend obligatory screening of asylum seekers, refugee or other migrant populations for diseases, because there is no clear evidence of benefits or cost-effectiveness. Furthermore, it can cause anxiety in individual refugees and the wider community. Instead, the WHO recommends offering and providing health assessments, including both communicable diseases and non-communicable diseases, to ensure access to healthcare for all asylum seekers and refugees requiring health protection (217).

Most health initiatives focus on the asylum-seeking phase by providing a front-line health initiative at arrival. However, in Denmark some municipalities also provide a health assessment related to resettlement after asylum has been granted. The assessment after asylum has been granted covers both somatic and mental health aspects and includes newly arrived refugees, children and adults. It is governed through the Danish Integration Act aiming at promoting labour market participation among newly arrived refugees (51).

Organisation of health reception and healthcare services

The organisation of health reception procedures and healthcare services for asylum seekers differ across and within the countries, and the organisation of the initiatives will naturally depend on existing structures of the healthcare system and programmes for health-reception.

In Norway and Sweden healthcare for asylum-seeking children, including the health assessment, is arranged within the national healthcare system, whereas in Finland and in Denmark the reception procedures and healthcare services are primarily centralised and located at the asylum centres or reception facilities, arranged

Table 5. Organisation of healthcare for asylum-seeking children in the Nordic countries

	Denmark	Finland	Norway	Sweden
Integrated into the National health system	-	-	Yes	Yes
Contracted with asylum centre operators / parallel healthcare system	Yes	Yes	-	-

through an agreement between the immigration authority and the asylum centre operators.

In Sweden, each of the 21 county councils/regions are responsible for providing healthcare, including the health assessment for newly arrived asylum seekers. Thus, the structures, organisations, processes, and outcomes vary between the counties (169). In Norway, the TB-screening is centralised, and managed by nationwide procedures, while the TB-follow-up and the general health assessment are assigned to local medical health services at the municipal level. In Finland, the initial health examinations are performed at the asylum centres, while other healthcare services, including the TB-screening, are purchased from public or private health services. In Denmark they are provided in a parallel healthcare system in the asylum centres by Red Cross Denmark (22).

An advantage of healthcare being provided within the asylum centres – as in Denmark and partly in Finland – is the high numbers of asylum seekers reached by a systematic health examination programme and the potential for detailed reports of physical and mental health problems, which could help document the need for the health examination. Furthermore, specialists with competencies in migrant-related topics, e.g. specific disease patterns, health determinants, cultural competencies, the use of interpreters etc. in the specific centres or in the secondary sector, might facilitate a more focused and hence shorter contact path to the healthcare system (218).

Providing healthcare services within the asylum centres, however, can contribute to isolating and marginalising – instead of the desired normalising and integrating into society and into the national healthcare system. Because asylum-seeking children in Finland – as in Denmark – are placed outside the community, in terms of housing as well as healthcare, their status as non-members of society is emphasised (22). This organisation may also be vulnerable because of limited funding and reliance on a small staff (11). Furthermore, Sandahl et al. argue that providing healthcare services within the asy-

lum centres positions children primarily as asylum seekers, rather than children, meaning that asylum-seeking children's political and juridical rights, opportunities, obligations, and limitations differ from those of other children (22). Building health reception into the primary sector may facilitate detection, follow-up and routine handling of general public health issues. Furthermore, it can facilitate future navigation in, and access to, the national healthcare system as well as normalising and integrating the refugees into society. In a recent analysis of the Nordic country responses to asylum-seeking children by UNICEF, these countries are urged to integrate asylum seekers into mainstream national health systems and avoid exclusion from mainstream services (13). On the other hand, decentralising the governance of the health assessment to the municipality level may lead to considerable heterogeneity of assessment content and procedure. The absence of nationwide binding standards may result in a substantial heterogeneity with varying content of the health assessment across the country (169,207). Furthermore, when healthcare is provided outside the centres, difficulties in reaching individuals as well as structural and organisational barriers/ informal and formal barriers to healthcare services may complicate the access to and use of healthcare services (169).

Access to healthcare for asylum seeking children

The right to healthcare is governed through differing legislation across the four countries. In Denmark, entitlement to healthcare for asylum seekers is governed through legislation on both health and immigration (30) (56). In Finland, the right to healthcare is included in the law on general reception of refugees (72) whereas Norway and Sweden have specific laws on asylum seekers' rights to general healthcare (140,204).

Finland and Norway have integrated CRC into national law, and in Norway, CRC takes precedence over any other legislative provision, including asylum law (13). In Sweden, the parliament has adopted a bill on

making the CRC Swedish law by 2020 (219). Denmark, on the other hand, has not incorporated the CRC into national law.

Today, in all four countries, asylum seekers under the age of 18 are entitled to healthcare on equal terms to the host population in the respective country. All countries but Denmark explicitly address asylum-seeking children's right to healthcare services in the respective legislation. In Denmark, asylum-seeking children are not explicitly addressed in the law and their entitlement to the same healthcare services as resident children is not explicitly stated or mandated in any legislation. Asylum-seeking children's rights to healthcare services compared to that of the host population is solely mentioned in the Danish Immigration Service's guidelines for allocation of health services to asylum seekers, which state that asylum-seeking children – in principle – are given the same rights as resident children (53), while other guidelines state that asylum-seeking children have the same rights as Danish children resident in Denmark (220). This assumes that asylum-seeking children have the same entitlements to healthcare as native-born and resident children, and there is no evidence that asylum-seeking children living in Danish asylum centres do not receive the necessary treatment, although it remains undocumented what the children are offered and whether they receive relevant and equal treatment compared to resident children (22). According to the Danish Immigration

Service and Danish Red Cross, asylum-seeking children in Denmark in practice have access to healthcare that is equal to that of resident children, as healthcare services would be granted, and the costs would be met, if such treatment were likely to be offered to resident children. However, there are categorical – although possibly not applied – restrictions in access to hospital care and specialised treatment for asylum-seeking children, and this conflicts with CRC stipulations (22).

In a recent study on healthcare entitlements for migrant children in Europe, Hjern et al. argue that policies that do not explicitly entitle all migrant children, irrespective of legal status, to receive equal healthcare to that of its nationals, is a breach of the non-discrimination principle in article 2 of CRC, signed by all four countries in the study (11). Hjern et al. stress the importance of putting pressure on governments to honour the obligations of the CRC and to explicitly entitle all children to equal rights to health, and to advocate for better access to primary and preventive care for migrant children (11,12). Accordingly, in the afore-mentioned analysis, UNICEF urges Denmark to stipulate the healthcare entitlements of asylum-seeking children in law, and to enable their access to healthcare through the national health services, just as for all other children. Furthermore, UNICEF recommends Denmark should incorporate the CRC fully into domestic legislation, ensuring its primacy over national migration law, and should sub-

Entitlements and access to healthcare for asylum-seeking children and refugees in the Nordic countries

Denmark	<p>All asylum seekers, children and adults, are entitled to necessary healthcare and emergency treatment (56) (30). However, Danish legislation does not explicitly stipulate the healthcare entitlements of asylum-seeking children and does not distinguish between children and adults but refers to “an alien who is staying in Denmark and submits an application for a residence permit”. According to the Danish Immigration Service asylum-seeking and refugee children are entitled to the same healthcare treatment as Danish citizen children living in Denmark. This entitlement is, however, solely stated in non-legally binding guidelines for allocation of health services to asylum-seeking children by the Danish Immigration Service (220) and is not explicated or mandated in any legislation.</p> <p>The access to healthcare for asylum seekers, including children, is arranged through an agreement between the immigration authority and the asylum centre operators and carries a number of restrictions for additional healthcare services including restriction on hospital care and specialised treatment, for which approval and guarantee of payment by the Danish Immigration Service are needed (32,53).</p>
Finland	Asylum seeking children and refugees under the age of 18 have the same right to healthcare as Finnish children residing within the same municipality (72).
Norway	As authorised residents, children younger than 18 have the same rights to healthcare as Norwegian citizen children living in Norway. However, children who do not have authorised residence do not have the right to a general practitioner (140,141).
Sweden	Asylum-seeking children and refugees under the age of 18 years have the same right to healthcare, medical care and dental care as Swedish citizen children residing within the same county council jurisdiction (204).

scribe to the CRC view of children as children first and foremost instead of migrants with different legal status (13). In addition, Hjern et al. argue that unclear entitlements in combination with decentralised economic responsibility can create incentives for limiting access to care, particularly when the inflow of migrants increases rapidly in small communities with limited resources (12).

The merit of screening is closely linked to the access to healthcare services and the availability of treatment. Screening may therefore create an ethical dilemma if the screening is done at a time when treatment cannot be provided (213). In many countries, asylum seekers, except children, only have limited access to healthcare until receiving legal status as a refugee and obtaining a residence permit. Thus, screening after receiving legal status as refugee may create a better opportunity for screening and for starting treatment (213).

Conclusion



Conclusion

This report has provided a comparative overview of policies and development trends regarding the health reception of asylum-seeking and refugee children in the Nordic countries from 1980 to 2018.

The Nordic countries share similarities and differences in their implementation and development of health reception policies and health assessment of asylum seekers and refugees. The increased rates of asylum-based immigration in the 1980s led to the establishment of health reception procedures for asylum seekers and newly arrived refugees in all four countries. However, migrant health policies in the four countries diverged and different models for health reception were implemented across countries with respect to the health issues targeted; the population groups targeted; the organisation of the initiatives; as well as overall differences in the organisation of healthcare systems and social services. Furthermore, economic, political, organisational and societal factors influenced the development of the different health reception policies in each country.

Despite the diversity in health reception initiatives across the countries, similarities in the course of development of health reception have been shown in this report. All countries introduced policies aiming at preventing asylum seekers and refugees from importing communicable diseases, such as TB, and throughout the 1980s all countries implemented health reception procedures to identify communicable disease among asylum seekers and provide adequate healthcare for the more pressing healthcare needs. Infectious disease control still seems to be a primary component of today's health reception of asylum seekers, whereas mental health has been a less frequent component in the health reception initiatives. However, in recent years, the health assessments in all four countries have moved towards a more holistic approach by taking into account the mental health of asylum seekers and refugees, yet not as often, nor to the same extent, as initiatives on acute and somatic health.

Healthcare services for asylum-seeking children have changed over time with regard to entitlement, restrictions and content. Today, national legislation in all countries but Denmark explicitly stipulates asylum-seeking children's right to health on an equal basis as resident children.

The general decentralised organisation of health services in the Nordic countries is also reflected in the organisation of the health reception programmes. This may lead to considerable differences in assessment con-

tent and procedure as well as in service provision. The absence of nationwide binding standards may result in a substantial heterogeneity with varying content of the health assessment across the country. Furthermore, when healthcare is provided outside the reception and asylum centres, difficulties in reaching individuals as well as structural and organisational barriers/ informal and formal barriers to healthcare services may complicate the access and use of healthcare services.

As a next step, the analysis would benefit from further extension with more information from the four countries considered and from other countries in Europe.

This study has only focused on asylum-seeking and refugee children. However, a child who is legally categorised as asylum seeker or refugee is more likely to be entitled to healthcare on equal terms with a resident child than other migrant children who are not applying for asylum or without residence permit, such as undocumented children. Therefore, to investigate how legal rights might be bound to migrant status rather than to the child and his/her rights as a child, there is a need to compare the levels of equality regarding entitlements to healthcare across different groups of migrant children, including undocumented/irregular migrant children, compared to native-born children/child citizens.

We have little knowledge as to whether and how the health reception policies play out in practice and how differences across countries play out in actual health reception practices. To document the effects of health reception policies in practice, and to explore the relative benefits and disadvantages of the different organisations of healthcare services for asylum-seeking children – which is an important starting point for any health reception policy – a comparative study at policy level needs to be supplemented with empirical follow-up studies of access to healthcare services in practice among asylum-seeking children, as well as follow-up studies of their health status.

There is a need for further research to obtain a better understanding of the importance and effects of recognising asylum-seeking and refugee children specifically in national policies.

The comparison of four countries' policies may facilitate opportunities for learning across countries and may particularly benefit countries currently designing health reception policies; however, it is beyond the scope of this report to draw conclusions on the best policy practices within the Nordic countries.

References



References

- Barghadouch A, Skovdal M, Norredam M. Do health reception policies in the Nordic region recognize the rights of refugee children? [in press].
- Brochmann G, Hagelund A. Comparison: A Model with Three Exceptions? In: *Immigration Policy and the Scandinavian Welfare State 1945-2010*. 1st ed. Palgrave Macmillan UK; 2012. p. 225–76.
- Elli Heikkilä, Peltonen S. Immigrants and integration in Finland. Surv About Situat Immigrants Refug Six Balt Sea States Dev within Framew Eur Community Action, SOCRATES [Internet]. 2002; Available from: http://denver.utu.fi/files/pdf/artikkelit/immigrants_and_integration_in_finland.pdf
- Reginald Appleyard. *International Migration Policies 1950-2000*. Vol. 39, International Migration. 2001.
- European Centre for Disease Prevention and Control. Public health guidance on screening and vaccination for infectious diseases in newly arrived migrants within the EU/EEA. 2018.
- World Health Organization. Health promotion for improved refugee and migrant health: policy brief. 2018;1–2.
- OHCHR. International Covenant on Economic, Social and Cultural Rights [Internet]. 1976. Available from: <https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx>
- United Nations General Assembly. Convention on the Rights of the Child Convention on the Rights. 1989;(September). Available from: <https://www.refworld.org/docid/3ae6b38f0.html>
- UN Economic and Social Council. CESCR General Comment No. 14: The Nature of States Parties' Obligations (Art. 12) P. UN Comm Econ Soc Cult Rights [Internet]. 2000; Available from: http://www.nesri.org/sites/default/files/Right_to_health_Comment_14.pdf
- Kalverboer M, Beltman D, Van Os C, Zijlstra E. The Best Interests of the Child in Cases of Migration: Assessing and Determining the Best Interests of the Child in Migration Procedures. *Int J Child Rights*. 2017;25(1):114–39.
- Stubbe Østergaard L, Norredam M, Mock-Munoz De Luna C, Blair M, Goldfeld S, Hjern A. Restricted health care entitlements for child migrants in Europe and Australia. *Eur J Public Health*. 2017;27(5):869–73.
- Hjern A, Østergaard LS. Migrant children in Europe: Entitlements to health care. 2016.
- UNICEF. Protected on Paper? An analysis of Nordic country responses to asylum-seeking children [Internet]. 2018. Available from: https://www.unicef-irc.org/publications/pdf/NORDIC_28_LOWRES.pdf
- Søren Elkrog Friis. Asylpolitik kan bringe Danmark på kant med FN's børnekonvention. *Altinget*. 2016;
- Bech EC, Borevi K, Mouritsen P. A “civic turn” in Scandinavian family migration policies? Comparing Denmark, Norway and Sweden. *Comp Migr Stud* [Internet]. 2017;5(1):7. Available from: <http://comparativemigrationstudies.springeropen.com/articles/10.1186/s40878-016-0046-7>
- General Assembly of the World Medical Association. WMA Declaration of Geneva [Internet]. 1948. Available from: <https://www.wma.net/policies-post/wma-declaration-of-geneva/>
- World Medical Association. WMA Resolution on Refugees and Migrants [Internet]. 2016. Available from: <https://www.wma.net/policies-post/wma-resolution-on-refugees-and-migrants/>
- Jønsson HV, Petersen K. Denmark: A National Welfare State Meets the World. In: *Immigration Policy and the Scandinavian Welfare State 1945-2010*. 1st ed. Palgrave Macmillan; 2012. p. 97–148.
- Kjersem HJ. *Migrationsmedicin i Danmark: vurdering af nogle migrationsmedicinske problemstillinger blandt asylansøgere og flygtninge*. 1996.
- Camilla Hvidtfeldt, Schultz-Nielsen ML. *Flygtninge og asylansøgere i Danmark 1992-2016*. Antal, ventetid, bosætning og lovgivning. 2017.
- Jessen T, Montgomery E. Reception of asylum seeking and refugee children in the Nordic countries: The Danish report. 2010.
- Sandahl H, Norredam M, Hjern A, Asher H, Nielsen SS. Policies of access to healthcare services for accompanied asylum-seeking children in the Nordic countries. *Scand J Public Health*. 2013;41(6):630–6.
- The Red Cross Denmark. Fakta om asylarbejdet i Dansk Røde Kors. 2010.
- Jepsen S. The General Health of Asylum Seekers - the Danish Experience. In: *Refugees- The Trauma of Exile: The Humanitarian Role of Red Cross and Red Crescent*. Martinus Nijhoff Publishers; 1988. p. 80–7.
- The Red Cross Denmark. Sundhedssektionen 1984-2006. 2017.
- Kreihau R. From forced migration to forced arrival: the campization of refugee accommodation in European cities. *Comp Migr Stud* [Internet]. 2018;6(1):7. Available from: <https://comparativemigrationstudies.springeropen.com/articles/10.1186/s40878-017-0069-8>
- Nakken CS, Skovdal M, Nellums LB, Friedland JS, Hargreaves S, Norredam M. Vaccination status and needs of asylum-seeking children in Denmark: a retrospective data analysis. *Public Health* [Internet]. 2018;158:110–6. Available from: <https://doi.org/10.1016/j.puhe.2018.02.018>
- The Ministry of Health. Bekendtgørelse om forebyggende sundhedsydelse for børn og unge. BEK nr 1344 af 03/12/2010 [Internet]. 2010. Available from: <https://www.retsinformation.dk/forms/r0710.aspx?id=133870>
- Ministry of Health and Prevention. Health care in Denmark [Internet]. 2008. Available from: <http://www.issa.int/library/read/56728>
- The Ministry of Health. Bekendtgørelse af Sundhedsloven. LBK nr 191 af 28/02/2018. 2018;(sagsnr. 1705918). Available from: <https://www.retsinformation.dk/Forms/r0710.aspx?id=152710>
- Red Cross Denmark. Når en flygtning banker på - scener fra 25 års asylarbejde i Dansk Røde Kors. 2009.
- The Danish Immigration Service. Indkvartering og underhold af asylansøgere m.f. 2018.
- The Danish Immigration Service. Retningslinier for sundhedsbehandling af asylansøgerbørn mv. 2006;(december):1–31.
- Politiken. Børnepsykiater: Psykisk syge asylbørn bliver svigtet. 2004; Available from: <https://politiken.dk/indland/art4886325/Børnepsykiater-Psykisk-syge-asylbørn-bliver-svigtet>
- Shapiro DK, Christiansen KL, Nielsen MV. Børn i risikozonen - Psykologisk Screening i Dansk Røde Kors Asylafdeling. 2010.
- The Red Cross Denmark. Standard for psykologiske screeninger af mindreårige asylansøgere. 2015.

37. The Danish Psychological Association. Faglig vejledning - Psykologisk udredning af børn og unge med flygtningebaggrund. 2017.
38. Trillingsgaard A, Wejdemann A, Stenderup E, Alsinger B. Case-formulering i praksis. *Psykolog Nyt*. 2007;17.
39. Christiansen KL, Obel C, Nielsen SS, Hilden J, Norredam M, Krasnik A. Mental health among children seeking asylum in Denmark – the effect of length of stay and number of relocations: a cross-sectional study. *BMC Public Health*. 2008;8(1):1–9.
40. The Danish Health Authority. Vejledning om forebyggende sundhedsydelse til børn og unge 2011 [Internet]. Sundhedsstyrelsen.dk. 2011. 177 p. Available from: <http://sundhedsstyrelsen.dk/publ/publ2011/cff/sundhedsydelse/sundhedsydelse.pdf>
41. State Serum Institute. EPI-NEWS - About diseases and vaccines: Tuberculosis 2017. 2018.
42. The Red Cross Denmark. Instruks til sygeplejersker og læger - Screening for lungetuberkulose hos nyankomne asylansøgere. 2018.
43. Olejaz M, Nielsen AJ, Rudkjøbing A, Birk HO, Krasnik A, Hernández-Quevedo C. Health Systems in Transition. Denmark - Health system review. in: *Health Systems in Transition*. Vol. 14. 2012.
44. The Danish Health Authority. Redegørelse for sundhedsbetjeningen af flygtninge og indvandrere, der kommer til Danmark, hvad angår smitsomme sygdomme. 2002.
45. Sundhedsudvalget. Betænkning over Forslag til Sundhedsloven. 2005.
46. The Ministry of Immigration Integration and Housing. International Migration - Denmark. 2015.
47. The Danish Parliament. Betænkning: Forslag til lov om ændring af integrationsloven og lov om ansvaret for og styringen af den aktive beskæftigelsesindsats. 2013 p. 1–4.
48. Folketinget. 2012/1 LSV 190 (Gældende) Forslag Lov om ændring af integrationsloven og lov om ansvaret for og styringen af den aktive beskæftigelsesindsats. 2013.
49. The National Board of Social Services. Faglige anvisninger til praktiserende læger og andre læger, som gennemfører helbreds-mæssige vurderinger af nyankomne flygtninge og familiesammenførte til flygtninge. 2015.
50. The Ministry of Immigration and Integration. International migration - Denmark. 2016.
51. The Ministry of Immigration and Integration. Bekendtgørelse om tilbud om helbreds-mæssig vurdering af nyankomne flygtninge og familiesammenførte til flygtninge. 2016;(j.nr. 2016-6734).
52. Municipality of Copenhagen. The City of Copenhagen's integration Initiative [Internet]. Available from: https://www.kk.dk/sites/default/files/uploaded-files/the_city_of_copenhagens_integration_initiative_for_refugees.pdf
53. The Danish Immigration Service. Retningslinjer for bevilling af sundhedsmæssige ydelser til asylansøgerbørn og børn med ulovligt ophold i Danmark. 2015;1–32.
54. The Ministry of Immigration and Integration. Bekendtgørelse af lov om integration af udlændinge i Danmark (integration-sloven). LBK nr 1127 af 11/10/2017. 2017;(j.nr. 2017-14169). Available from: <https://www.retsinformation.dk/forms/r0710.aspx?id=163323#Kap4a>
55. Rigsrevisionen. Rigsrevisionens beretning om forløbet for flygtninge med traumer. 2018.
56. The Ministry of Immigration and Integration. Bekendtgørelse af udlændingeloven. LBK nr 1117 af 02/10/2017. 2017;(j.nr. 2017-12470).
57. The Danish Immigration Service. New to Denmark - Asylum centres [Internet]. 2018 [cited 2018 Oct 17]. Available from: <https://www.nyidanmark.dk/en-GB/You-are-waiting-for-an-answer/Asylum/Where-can-asylum-seekers-live/-Asylum-centres>
58. European Migration Network. Resettlement and Humanitarian Admission Programmes in Europe: what works? – National Report of Finland. *Forced Migration Review*. 2016.
59. Korkiasaari J, Söderling I. Finnish Emigration and Immigration after World War II [Internet]. 2003. Available from: http://www.migrationinstitute.fi/files/pdf/artikkelit/finnish_emigration_and_immigration_after_world_war_ii.pdf
60. OECD. Finding the way: A discussion of the Finnish migrant integration system [Internet]. 2017. Available from: http://www.oecd.org/els/mig/Finding_the_Way_Finland.pdf
61. The Law Library of Congress Global Legal Research Center. Refugee Law and Policy in Selected Countries. *Law Libr Congr* [Internet]. 2016;6462(March):1–310. Available from: <https://www.loc.gov/law/help/refugee-law/refugee-law-and-policy.pdf>
62. European Commission. Country Profile: Finland [Internet]. 2001. Available from: https://ec.europa.eu/home-affairs/sites/homeaffairs/files/e-library/docs/pdf/finland_final_en_en.pdf
63. Finish Immigration Service. Ulkomaalaisvirasto 10 vuotta [Internet]. 2005 [cited 2019 Apr 2]. Available from: https://migri.fi/artikkeli/-asset_publisher/ulkomaalaisvirasto-10-vuotta
64. National Institute for Health and Welfare. THL History [Internet]. 2019 [cited 2019 May 1]. Available from: <https://thl.fi/en/web/thlfi-en/about-us/what-is-thl/history>
65. National Board of Health. Lääkintöhallituksen Työryhmän Mietintö: Ulkomaalaisten terveystarkastukset [Report of the Medical Board Working Group: Health Check of Aliens]. 1980.
66. Socialstyrelsen, Skolstyrelsen, Medicinstyrelsen, Bostadstyrelsen. Uudet Naapurimme: Uudet Naapurimme: johtajien kirje kuntien päättöksentekijöille pakolaisten vastaanotosta [Our new neighbors: Directors-General to municipal decision-makers on the reception of refugees]. 1990.
67. National Institute of Public Health. Pakolaisten Ja Turvapaikanhakijoiden Infektio-ongelmien Ehkäisy [Prevention of infection problems among refugees and asylum seekers]. 1993.
68. National Institute for Health and Welfare. Förebyggandet av infektionsproblem hos flyktingar och asylsökanden [Prevention of infection problems among refugees and asylum seekers]. Vol. 22. 2009.
69. Social- och hälsovårdsministeriet. Lag 1465/1991 om mottagningsstationer och förläggningar för asylsökande [Act on Reception Points and Centres for Asylum Seekers]. 1991.
70. Ministry of the Interior. Act on the Integration of Immigrants and Reception of Asylum Seekers (493/1999). 1999;(493):1–14.
71. Ministry of the Interior. Act on the Integration of Immigrants and Reception of Asylum Seekers [Internet]. 2009 p. 1–34. Available from: <https://www.finlex.fi/en/laki/kaannokset/2004/en20040301.pdf>
72. Ministry of the Interior. 746/2011 Lag om mottagande av personer som söker internationellt skydd och om identifiering av och hjälp till offer för människohandel. 2011.
73. Ministry of Social Affairs and Health Finland. Health Care Act (1326/2010). 2010;(1326). Available from: http://www.finlex.fi/en/laki/kaannokset/2010/en20101326_20131293.pdf

74. Ministry of Social Affairs and Health (Finland). Act on Specialized Medical Care (1062/1989). 2010 p. 210.
75. Helve O, Tuomisto K, T PT, Puumalainen T. Turvapaikanhakijoiden terveydenhuollon toteutuminen 2015–2016. 2016.
76. The White and Case team. Reception of Children on the Move in Finland. 2017.
77. Ministry of Social Affairs and Health. Screenings in Finland 2014: The present state of health care screenings and future prospects. 2015. 71 p.
78. National Institute for Health and Welfare. Notable symptoms and infectious diseases in asylum seekers [Internet]. 2018 [cited 2018 Oct 16]. Available from: <https://thl.fi/en/web/infectious-diseases/what-s-new/information-to-special-groups/infection-prevention-and-vaccinations-for-asylum-seekers/notable-symptoms-and-infectious-diseases-in-asylum-seekers>
79. Tiittala P, Tuomisto K, Puumalainen T, Lyytikäinen O, Ollgren J, Snellman O, et al. Public health response to large influx of asylum seekers: implementation and timing of infectious disease screening. BMC Public Health [Internet]. 2018;18(1):1139. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/30249224><https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-018-6038-9>
80. Räsänen PE, Soini H, Turtiainen P, Vasankari T, Ruutu P, Nuorti JP, et al. Enhanced surveillance for tuberculosis among foreign-born persons, Finland, 2014–2016. BMC Public Health. 2018;18(1):1–6.
81. The Ministry of Social Affairs and Health. Social security and services of asylum seekers in Finland [Internet]. [cited 2018 Nov 12]. Available from: <https://stm.fi/en/social-security-and-services-of-asylum-seekers-in-finland>
82. Jokela S, Mäki-Opas J. PALOMA project – developing National mental health policies for refugees. Eur Psychiatry [Internet]. 2017;41(2017):S337–8. Available from: <http://linkinghub.elsevier.com/retrieve/pii/S0924933817325634>
83. WHO European Region. Health of refugees and migrants - Practices in addressing the health needs of refugees and migrants. 2018;1–19.
84. National Institute for Health and Welfare. Developing the health examination protocol for asylum seekers in Finland: A national development project (TERTTU). 2018.
85. Finnish Immigration Service. About the Finnish Immigration Service [Internet]. 2018 [cited 2018 Oct 16]. Available from: <https://migri.fi/en/about-the-finnish-immigration-service>
86. National Institute for Health and Welfare. Asylum seekers' health and services [Internet]. 2018 [cited 2019 Jan 21]. Available from: <https://thl.fi/en/web/immigrants-and-multiculturalism/services-for-immigrants/asylum-seekers-health-and-services>
87. The Ministry of Social Affairs and Health, the National Institute for Health and Welfare, the Social Insurance Institution, Contact Point for Cross-Border Healthcare. Healthcare in Finland: Refugees and asylum-seekers [Internet]. 2017 [cited 2019 Jan 21]. Available from: <https://www.choosehealthcare.fi/healthcare-in-finland/your-right-to-treatment-in-finland/refugees-and-asylum-seekers/>
88. National Institute for Health and Welfare. Infection prevention and vaccinations for asylum seekers [Internet]. 2018 [cited 2018 Oct 16]. Available from: <https://thl.fi/en/web/infectious-diseases/what-s-new/information-to-special-groups/infection-prevention-and-vaccinations-for-asylum-seekers>
89. Ministry of Interior Finland. Aliens Act 301/2004. 2004; Available from: <https://www.finlex.fi/en/laki/kaannokset/2004/en20040301.pdf>
90. Ministry of Employment and the Economy. Act on the Promotion of Immigrant Integration (1386/2010). 2010.
91. Austveg B. IK 2277 Flyktninger og asylsøkere- helseproblemer og medisinsk behandling. 1989.
92. Brochmann G, Kjeldstadli K. A history of immigration - The case of Norway 900-2000. Universitetsforlaget; 2008.
93. Norwegian Government Security and Service Organisation. I velferdsstatens venterom - Mottakstilbudet for asylsøkere. 10th ed. Norges offentlige utredninger; 2011.
94. Brochmann G, Hagelund A. Norway: The Land of the Golden Mean. In: Immigration Policy and the Scandinavian Welfare State 1945-2010. 2012. p. 149–225.
95. Inter-governmental Consultations on Migration Asylum and Refugees. Asylum Procedures - Report on policies and practices in IGC participating states. 2009.
96. The Norwegian Directorate of Immigration. Årsrapport 2008 [Internet]. 2008. Available from: https://www.udi.no/globalassets/global/aarsrapporter_i/aarsrapport-2008.pdf
97. Lie B. The Triple Burden of Trauma , Uprooting and Settlement. 2003.
98. Bemak F, Chung RC-Y, Paul B. Pedersen. Global Perspectives on Refugees - Norway. In: Counseling Refugees: A Psychosocial Approach to Innovative Multicultural Interventions. 2003. p. 165–77.
99. The Norwegian Directorate of Health. Retningslinjer (IK-09/93) for helsetjenestetilbud til innvandrere og asylsøkere. 1993.
100. Barbro Bakken/ Kommunal- og arbeidsdepartementet. Tiltak for bedring av flyktningers psykiske helse:rapport fra arbeidsgruppe. 1993;50.
101. Norwegian Board of Health Supervision. Tilsyn med helsetjenester til asylsøkere, flyktninger og familiegjenforente. 2004.
102. Pastoor L de W, Eide K, Mekonen L. Reception of asylum seeking and refugee children in the Nordic countries: The Norwegian report. 2010;1–40.
103. The Journal of the Norwegian Medical Association. Retningslinjer for attester og helseerklæringer i asylsaker. 2003;8(123):1124–5.
104. Lie B. Tanker og erfaringer etter et doktorgradsarbeid. Mennekerettigheter – helsetjenester til flyktninger og asylsøkere – migrasjonsmedisin. Utposten. 2005;
105. The Norwegian Directorate of Health. Veileder for helsetjenestetilbudet til asylsøkere, flyktninger og familiegjenforente. 2018.
106. Kommunalkomiteen om asyl- og flyktningpolitikken i Norge. Innst. S. nr. 197 (2000-2001). Innstilling fra kommunalkomiteen om asyl- og flyktningpolitikken i Norge og om forslag fra stortingsrepresentant Odd Einar Dørum om å gjennomgå lover, forskrifter og praksis for å sikre forfulgte kvinner bedre beskyttelse. 2001.
107. Norwegian Research Centre for Health Services. Identifisering av personer med behov for psykiatrisk hjelp blant asylsøkere. 2004.
108. Ministry of Local Government and Regional Development. Psykisk helse for barn i asylmottak - Anbefalinger fra en interdepartemental. 2005;1–58.
109. Dahl S, Sveaass N, Varvin S. Psykiatrisk og psykososialt arbeid med flyktninger: veileder. 2006; Available from: <https://www.nkvts.no/rapport/psykiatrisk-og-psykososialt-arbeid-med-flyktninger-veileder/>

110. Ministry of Local Government and Regional Development. Psykisk helse for asylsøkere og flyktninger i asylmottak - Anbefalinger fra en interdepartemental arbeidsgruppe. 2003.
111. Norwegian Centre for Violence and Traumatic Stress Studies. Psykososialt arbeid med flyktningbarn - Introduksjon og fagveileder. 2006.
112. Ministry of Labour and Social Inclusion. Medfølgende barn i mottak. Rapport fra tverrdepartemental arbeidsgruppe. 2006.
113. UN General Assembly. Convention on the Rights of the Child [Internet]. Vol. CRC/C/15/A. 2005. Available from: <http://www.unhcr.org/refworld/docid/3ae6b38f0.html> [accessed 25 May 2012]
114. UN General Assembly. Convention on the Rights of the Child. 2007;CRC/C/OPAC. Available from: <http://www.unhcr.org/refworld/docid/3ae6b38f0.html> [accessed 25 May 2012]
115. The Norwegian Directorate of Health. Revidering av veileder IS-1022 - Helsetjenestens tilbud til asylsøkere og flyktninger. 2009.
116. The Norwegian Directorate of Health. Veileder - Helsetjenestetilbudet til asylsøkere, flyktninger og familiegjenforente. 2010.
117. Norwegian Directorate of Immigration. The Organisation of Reception Facilities for Asylum Seekers in Norway. 2013.
118. Ministry of Children and Equality. The Rights of the Child in Norway - Norway's fifth and sixth periodic reports to the UN Committee on the Rights of the Child. 2016.
119. The Norwegian Directorate of Health. Veileder for helsetjenestetilbudet til asylsøkere, flyktninger og familiegjenforente - Traumatiserte, torturerte og krigsskadde [Internet]. 2018 [cited 2018 Dec 1]. Available from: <https://helsedirektoratet.no/retningslinjer/asylsokere-flyktninger-og-familiegjenforente/seksjon?Tittel=traumatiserte-torturerte-og-krigsskadde-10723>
120. OHCHR. Istanbul Protocol - Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. 2004.
121. The National Board of Social Services. Rundskriv I-1003/77 Tuberkulosekontroll ved røntgen-undersøkelse av lungene. 1977.
122. Bjartveit K. Kontroll af Tuberkulose – Vejledning for helserådspersonell. 1981.
123. Norwegian Institute of Public Health. Tuberkuloseveilederen [Internet]. 2015 [cited 2018 Sep 7]. Available from: <https://www.fhi.no/nettpub/tuberkuloseveilederen/>
124. The Ministry of Health and Care Services. Lov om vern mot smittsomme sykdommer [smittevernloven] LOV-1994-08-05-55. 1995.
125. Norwegian Institute of Public Health. History of the Norwegian Institute of Public Health [Internet]. 2017 [cited 2018 Oct 20]. Available from: <https://www.fhi.no/en/about/about-niph/this-is-the-norwegian-institute-of-public-health/history-of-the-norwegian-institute-/#historical-overview>
126. Norwegian Institute of Public Health. Utredning om bruk av BCG-vaksine i Norge [Investigation about BCG vaccination in Norway]. 2008.
127. Norwegian Institute of Public Health. Anbefaling om innhold i tuberkuloseundersøkelse for ulike grupper med plikt til undersøkelse, jf. forskrift om tuberkulosekontroll. 2009;2012(07/27):3–4.
128. The Norwegian Directorate of Health. Forskrift om tuberkulosekontroll FOR-2002-06-21-567. 2003;
129. Harstad I. Tuberculosis infection and disease among asylum seekers in Norway. 2011.
130. Norwegian Institute of Public Health. Erstatning for Kapittel 8.3 i Smittevern 7 Forebygging og kontroll av tuberkulose.
131. Norwegian Institute of Public Health. Tuberkulose. 2015.
132. Norwegian Institute of Public Health. Midlertidig forenkling av tuberkulosescreening av asylsøkere. 2015;1–2.
133. Norwegian Institute of Public Health. Land med høy og særlig høy forekomst av tuberkulose [Countries with high occurrence of tuberculosis] [Internet]. 2018 [cited 2018 Oct 20]. Available from: <https://www.fhi.no/sv/smittsomme-sykdommer/tuberkulose/land-med-hoy-forekomst-av-tuberkulo/>
134. The Norwegian Directorate of Health. Veileder - Helsetjenestetilbudet til asylsøkere, flyktninger og familiegjenforente [Internet]. 2018. Available from: <https://helsedirektoratet.no/retningslinjer/asylsokere-flyktninger-og-familiegjenforente/seksjon?Tittel=helseundersokelser-av-asylsokere-flyktninger-10776>
135. The Norwegian Directorate of Immigration. About the UDI - Who does what in the immigration administration ? [Internet]. [cited 2018 Oct 23]. Available from: <https://www.udi.no/en/about-the-udi/about-the-udi-and-the-immigration-administration/who-does-what-in-the-immigration-administration/>
136. The Directorate of Immigration. RS 2008-032 Krav til etiske retningslinjer for statlige mottak. 2008.
137. The Directorate of Immigration. RS 2011-003 Reglement for drift av statlige mottak. 2011.
138. The Ministry of Children and Equality. The Rights of the Child - Norway's fourth periodic report to the UN Committee on the Rights of the Child 2008. 2008.
139. The Ministry of Health and Care Services. LOV-2011-06-24-30 Lov om kommunale helse- og omsorgstjenester m.m. (helse- og omsorgstjenesteloven). 2018.
140. The Ministry of Health and Care Services. Forskrift om rett til helse- og omsorgstjenester til personer uten fast opphold i riket (FOR-2011-12-16-1255). 2012.
141. The Norwegian Directorate of Health. Your rights to healthcare as a refugee or an asylum seeker [Internet]. 2016 [cited 2018 Dec 10]. Available from: <https://helsenorge.no/other-languages/english/rights/asylum-seekers#Children's-rights-to-health-care>
142. The Norwegian Directorate of Immigration. Asylum reception centres (different types) [Internet]. 2018 [cited 2018 Oct 18]. Available from: <https://www.udi.no/en/word-definitions/asylmottak-ulike-typer/>
143. The Ministry of Health and Care Services. Forskrift om tuberkulosekontroll FOR-2009-02-13-205 [Internet]. 2009. Available from: https://lovdata.no/dokument/SF/forskrift/2009-02-13-205/KAPITTEL_3#§3-1
144. Norwegian Institute of Public Health. Routine screening for tuberculosis. 2017; Available from: <https://www.fhi.no/en/id/infectious-diseases/TB/routine-screening-tb/>
145. The Norwegian Directorate of Immigration. RS 2011-003 Reglement for drift av statlige mottak. 2017 p. 10/3501-1 (17/02805-2).
146. The Norwegian Institute of Public Health. Vaksinasjon av asylsøkere [Internet]. 2018 [cited 2018 Oct 23]. Available from: <https://www.fhi.no/sv/asylsokeres-helse/vaksinasjon-av-asylsokere/>
147. The Norwegian Directorate of Health. Helseundersøkelse for asylsøkere, flyktninger og familiegjenforente Helseundersøkelsen (IS-1022) [Internet]. Available from: <https://helsedirektoratet.no/Documents/NFR/Asylsokere%2C%20flyktninger/Skjema-Helseundersokelse-flyktninger-asylsokere.pdf>

148. The Norwegian Institute of Public Health. Oversikt over land med høy forekomst av hivinfeksjon , hepatitt B , hepatitt C og syfilis. 2016; Available from: https://www.fhi.no/globalassets/dokumenterfiler/veiledere/landliste-asylsokere_151216.pdf
149. The Ministry of Justice and Public Security. Lov om utlendingers adgang til riket og deres opphold her (utlendingsloven) LOV-2008-05-15-35. 2008.
150. The Ministry of Health and Care Services. LOV-1994-08-05-55 om vern mot smittsomme sykdommer. 1995.
151. The Ministry of Health and Care Services. LOV-1999-07-02-63 Lov om pasient- og brukerrettigheter (pasient- og brukerrettighetsloven). 1999.
152. Ministry of Justice and Public Security. Lov om styrking av menneskerettighetenes stilling i norsk rett (menneskerettsloven). 1999.
153. Ministry of Children Equality and Social Inclusion. Lov om barneverntjenester (Barnevernloven). 2018.
154. The Swedish Migration Agency. Migration to Sweden: History [Internet]. 2019 [cited 2019 Jan 2]. Available from: <https://www.migrationsverket.se/English/About-the-Migration-Agency/Migration-to-Sweden/History.html>
155. Swedish Migration Agency. Applications for asylum received 1984-1999 [Internet]. 2019. Available from: [https://www.migrationsverket.se/download/18.2d998ffc151ac3871598175/1485556079477/Application for asylum received 1984-1999.pdf](https://www.migrationsverket.se/download/18.2d998ffc151ac3871598175/1485556079477/Application+for+asylum+received+1984-1999.pdf)
156. Swedish Migration Agency. Applications for asylum received 2000-2017 [Internet]. 2019. Available from: [https://www.migrationsverket.se/download/18.4a5a58d-51602d141cf41038/1515076827649/Application for asylum received 2000-2017.pdf](https://www.migrationsverket.se/download/18.4a5a58d-51602d141cf41038/1515076827649/Application+for+asylum+received+2000-2017.pdf)
157. The Swedish Parliament. Regeringens proposition 1983/84:124 Om Mottagandet Av Flyktingar Och Asylsökande M.M. [Internet]. 1984. Available from: <https://data.riksdagen.se/fil/FF970B37-D1E5-4398-87CA-DCF7682C7BB3>
158. The National Board of Social Services. Allmänna råd 1988-8: Häslövård för flyktingar och asylsökande. 1988.
159. The National Board of Social Services. Allmänna råd från Socialstyrelsen 1995:4 Hälsa- och sjukvård för asylsökande och flyktingar. 1995;
160. The National Board of Social Services. Socialstyrelsens föreskrifter och allmänna råd om hälsoundersökning av asylsökande m.fl. 2011; Available from: <http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/18488/2011-11-15.pdf>
161. The Swedish Parliament. Prop. 2005/06:60 Nationell strategi mot hiv/aids och vissa andra smittsamma sjukdomar. 2005.
162. The Swedish Parliament. Regeringens proposition 1988/89:86 med förslag till utlänningslag m.m. 1988.
163. The Swedish Parliament. Regeringens proposition 1992/93:50 om åtgärder för att stabilisera den svenska ekonomin. 1992.
164. Hjern A, Allebeck P. Health examinations and health services for asylum seekers in Sweden. 1997;25(3):3–5.
165. European Migration Network. The changing influx of asylum seekers in 2014-2016: Member States' responses - Country Report Sweden. 2017; Available from: https://ec.europa.eu/home-affairs/sites/homeaffairs/files/27a_sweden_changing_influx_final_en.pdf%0A
166. Brendler-Lindquist M, Hjern A. Reception of asylum seeking and refugee children in the Nordic countries – the Swedish report. 2010;1–40.
167. The Ministry of Justice. Lag (1994:137) om mottagande av asylsökande m.fl. [Internet]. 1994. Available from: http://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/lag-1994137-om-mottagande-av-asylsokande-mfl_sfs-1994-137
168. Pacheco LL, Jonzon R, Hurtig A-K. Health Assessment and the Right to Health in Sweden: Asylum Seekers' Perspectives. PLoS One [Internet]. 2016;11(9):e0161842. Available from: <http://dx.plos.org/10.1371/journal.pone.0161842>
169. Jonzon R, Lindkvist P, Hurtig AK. Structural and procedural barriers to health assessment for asylum seekers and other migrants - An explorative survey in Sweden. BMC Health Serv Res. 2018;18(1).
170. Swedish Association of Local Authorities and Regions. Sjukvård åt asylsökande , omfattning och kostnader år 2007 Sammanfattning. 2008.
171. The National Board of Social Services. Smittskyddslag (2004:168) [Communicable Diseases Act]. 2004.
172. Ascher H, Gustafsson LH, Hjern A, Köhler M, Lindberg T. Barnläkarföreningens arbetsgrupp för flyktingbarn 25 år. Barnläkaren. 2017.
173. The Ministry of Justice and Public Security. Förordning (1996:1357) om statlig ersättning för hälso- och sjukvård till asylsökande. 1996.
174. UN. The Convention on the Rights of the Child, Concluding Observations: Sweden, UN Doc. No. CRC/C/15/Add101. Health Hum Rights [Internet]. 1999; Available from: <https://www.refworld.org/docid/3ae6aefd24.html>
175. Ministry of Health and Social Affairs. National Strategy to Combat HIV / AIDS and Certain Other Communicable Diseases. 2007.
176. The Ministry of Justice. SOU 2003:89 EG-rätten och mottagande av asylsökande. 2003.
177. The Ministry of Justice. Lag (2008:344) om hälso- och sjukvård åt asylsökande m.fl. [Health and medical care for asylum seekers and others act] [Internet]. 2008. Available from: https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/lag-2008344-om-halso--och-sjukvard-at_sfs-2008-344
178. The Ministry of Justice. Prop. 2007/08:105 Regeringens Lag om hälso- och sjukvård åt asylsökande m.fl. 2008.
179. The Ministry of Justice. Förordning (1996:1357) om statlig ersättning för hälso- och sjukvård till asylsökande. 1996 p. 11–2.
180. AIDA. Country Report - Sweden. 2017;(February).
181. European Commission. Country Profile: Sweden. 2001.
182. Migrationsverket. Asyl [Internet]. 2018 [cited 2018 Oct 24]. Available from: <https://www.migrationsverket.se/Om-Migrationsverket/Statistik/Asyl.html%0A%0A>
183. The Public Health Agency of Sweden. Möten om hälsa.Vägledning inför Hälsoundersökningar för migranter. Solna; 2014.
184. 1177 Healthcare Guide. Healthcare in Sweden for asylum-seekers, people with no papers and people in hiding [Internet]. 2018 [cited 2018 Dec 12]. Available from: <https://www.1177.se/Stockholm/Other-languages/Engelska/Regler-och-rattigheter/Vard-i-Sverige-om-man-ar-asylsokande-gomd-eller-papperslos/?ar=True>
185. The Asylum Information Database. Country Report: Sweden. 2017; Available from: <https://search-proquest-com.proxy.library.carleton.ca/docview/1951288253?pq-origsite=summon>

186. The Swedish Migration Agency. Ersättning för hälsoundersökning av asylsökande. 2018.
187. The Ministry of Justice. Förordning (1996:1357) om statlig ersättning för hälso- och sjukvård till asylsökande. 2018.
188. The Ministry of Justice. Förordning (1994:361) om mottagande av asylsökande m.fl. 1994; Available from: http://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/forordning-1994361-om-mottagande-av_sfs-1994-361
189. The National Board of Social Services. Vård och omsorg för asylsökande och andra flyktingar: Hälsoundersökning av asylsökande [Internet]. [cited 2019 Feb 1]. Available from: <https://www.socialstyrelsen.se/vardochomsorgforasylsokandemedflera/halsundersokning>
190. The National Board of Health and Welfare. Senaste version av SOSFS 2011 : 11. 2015. p. 2011–2.
191. The National Board of Social Services. Vägledning för barnhälsovården. Falun; 2014.
192. The Swedish Migration Agency. Människor på flykt – vägledning om smittskydd till hälso- och sjukvården. 2015;
193. The National Board of Social Services. Vård och omsorg för asylsökande och andra flyktingar: Provtagnin [Internet]. 2019 [cited 2019 Jan 25]. Available from: <https://www.socialstyrelsen.se/vardochomsorgforasylsokandemedflera/halsundersokning/provtagnin>
194. The Public Health Agency of Sweden. Responsibility for communicable disease control [Internet]. 2018 [cited 2019 Jan 12]. Available from: <https://www.folkhalsomyndigheten.se/the-public-health-agency-of-sweden/communicable-disease-control/responsibility-for-communicable-disease-control/>
195. Delilovic S, Kulane A, Åsbring N, Marttila A, Lönnroth K. What value for whom? - Provider perspectives on health examinations for asylum seekers in Stockholm, Sweden. *BMC Health Serv Res*. 2018;18(1):1–9.
196. The National Board of Social Services. Hälso- och sjukvård och tandvård till asylsökande och nyanlända. Slutrapport oktober 2016. 2016.
197. Swedish Association of Local Authorities and Regions. Positiv hälsoutveckling för asylsökande och nyanlända Förord. Stockholm; 2016.
198. Berndes M, Cavefors AS, Dotevall L. Hälsoundersökning barn och unga under 18 år. Göteborg; 2018.
199. Delilovic S, Åsbring N, Hergens M, Kulane A, Marttila A, Norderby-Öhd J, et al. Hälsoundersökningar för asylsökande och nyanlända – vägen fram. 2017.
200. Swedish Association of Local Authorities and Regions. Framgångsrik satsning för asylsökande och nyanländas hälsa. 2017.
201. Jonzon R, Lindkvist P, Johansson E. A state of limbo – in transition between two contexts: Health assessments upon arrival in Sweden as perceived by former Eritrean asylum seekers. *Scand J Public Health*. 2015;43(5):548–58.
202. The Ministry of Justice and Public Security. Utlänningslag (2005:716). 2005; Available from: https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/utlanningslag-2005716_sfs-2005-716
203. The Ministry of Justice. Utlänningsförordning (2006:97). 2006.
204. The National Board of Social Services. Lag (2013:407) om hälso- och sjukvård till vissa utlänningar som vistas i Sverige utan nödvändiga tillstånd [Internet]. 2013. Available from: http://www.riksdagen.se/sv/Dokument-Lagar/Lagar/Svensk-forfattningssamling/Lag-2013407-om-halso--och-s_sfs-2013-407/?bet=2013:407
205. WHO. Health and foreign policy: influences of migration and population mobility. 2018;1–11.
206. Beeres DT, Cornish D, Vonk M, Ravensbergen SJ, Maeckelberghe ELM, Boele Van Hensbroek P, et al. Screening for infectious diseases of asylum seekers upon arrival: The necessity of the moral principle of reciprocity. *BMC Med Ethics*. 2018;19(1):1–7.
207. Bozorgmehr K, Wahedi K, Noest S, Szecsenyi J, Razum O. Infectious disease screening in asylum seekers: Range, coverage and economic evaluation in Germany, 2015. *Eurosurveillance*. 2017;22(40).
208. Seedat F, Hargreaves S, Nellums LB, Ouyang J, Brown M, Friedland JS. How effective are approaches to migrant screening for infectious diseases in Europe? A systematic review. *Lancet Infect Dis* [Internet]. 2018;18(9):e259–71. Available from: [http://dx.doi.org/10.1016/S1473-3099\(18\)30117-8](http://dx.doi.org/10.1016/S1473-3099(18)30117-8)
209. Kärki T, Napoli C, Riccardo F, Fabiani M, Grazia Dente M, Carballo M, et al. Screening for Infectious Diseases among Newly Arrived Migrants in EU/EEA Countries—Varying Practices but Consensus on the Utility of Screening. *Int J Environ Res Public Health*. 2014;11(10):11004–14.
210. European Migration Network. Ad-Hoc Query on Ad-hoc query on infectious diseases during the international protection procedure. 2017;(April).
211. European Migration Network. Ad-Hoc Query on Health Screening. 2010;(November):1–13.
212. Hjern A, Stubbe Østergaard L, Nørredam M-L. Health examinations of child migrants in Europe: screening or assessment of healthcare needs? *BMJ Paediatr Open*. 2019;3(1):e000411.
213. Hvass AMF, Wejse C. Systematic health screening of refugees after resettlement in recipient countries: a scoping review. *Ann Hum Biol*. 2017;44(5):475–83.
214. Kalengayi FKN, Hurtig AK, Nordstrand A, Ahlm C, Ahlberg BM. “It is a dilemma”: Perspectives of nurse practitioners on health screening of newly arrived migrants. *Glob Health Action*. 2015;8(1).
215. Rikshandboken i barnhälsovård. Migration och barns hälsa. 2017; Available from: <https://www.rikshandboken-bhv.se/ivsvillkor/migration/migration-och-barns-halsa/>
216. Kalengayi FKN, Hurtig AK, Nordstrand A, Ahlm C, Ahlberg BM. Perspectives and experiences of new migrants on health screening in Sweden. *BMC Health Serv Res* [Internet]. 2016;16(1):1–13. Available from: <http://dx.doi.org/10.1186/s12913-015-1218-0>
217. World Health Organization. Migration and health: key issues. 2016; Available from: <http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/migrant-health-in-the-european-region/migration-and-health-key-issues#292115>
218. Frederiksen HW, Kamper-Jørgensen Z, Agyemang C, Krasnik A, Nørredam M. Health-reception of newly arrived documented migrants in Europe - Why, whom, what and how? *Eur J Public Health*. 2013;23(5):725–6.
219. Government and Government Offices. Convention on the Rights of the Child will become Swedish law. 2018.
220. The Danish Immigration Service. Asylansøgeres vilkår - Sundhedsbehandling [Conditions for asylum seekers - Healthcare] [Internet]. 2018 [cited 2018 Dec 12]. Available from: <https://nyidanmark.dk/da/Du-venter-svar/Asyl/Asylansogernes-vilkar?anchor=9791A15AE95F439085E3E53B50339E3D>

About the project Coming of Age in Exile (CAGE)

CAGE is a research project based on collaboration between five leading research institutions in the Nordic countries; the Danish Research Centre for Migration, Ethnicity and Health, University of Copenhagen, Denmark; Migration Institute of Finland, Finland; Norwegian Centre for Violence and Traumatic Stress Studies and University College of Southeast Norway, Norway; and Centre for Health Equity Studies, Stockholm University and University of Gothenburg, Sweden.

CAGE brings together a pan-Nordic, multidisciplinary team of leading scholars and research students to shed light on some of our time's most pressing social challenges related to the societal integration of young refugees. CAGE will provide analyses and insights to inform policy and practice related to health, education and employment among young refugees arriving in the Nordic countries and beyond. CAGE is funded by the Nordic Research Council (NordForsk).

CAGE was developed within the Nordic Network for Research Cooperation on Unaccompanied Refugee minors and its sister network Nordic Network for Research on Refugee Children.

This report is the third in a series of 3 CAGE policy reports. The first report is focusing on labour market policies and the second report on education policies.

You can read more about CAGE at:
www.cage.ku.dk



DANISH RESEARCH CENTRE FOR
MIGRATION, ETHNICITY AND HEALTH

**NORWEGIAN CENTRE FOR VIOLENCE
AND TRAUMATIC STRESS STUDIES**



Centre for Health
Equity Studies



MIGRATION INSTITUTE
OF FINLAND



NordForsk