

Addressing migration and health inequity in Europe

Discriminatory, racist and xenophobic policies and practice against child refugees, asylum seekers and undocumented migrants in European health systems

Amy J. Stevens,^{a,*} Yamina Boukari,^b Sonora English,^c Ayesha Kadir,^d Bernadette N. Kumar,^e and Delan Devakumar^f

^aYorkshire and Humber School of Public Health, Leeds, UK

^bInstitute of Health Informatics, University College London, UK

^cInstitute for Global Health, University College London, London, UK

^dSave the Children International, St Vincent House, London, UK

^eNorwegian Institute of Public Health, Oslo, Norway

Summary

Child refugees, asylum seekers and undocumented migrants who have been forcibly displaced from their countries of origin have heightened health needs as a consequence of their migration experiences. Host countries have a duty to respond to these needs, yet across Europe we are seeing a rise in potentially harmful discriminative, hostile and restrictive migration policies and practices. Research exploring the role racism, xenophobia and discrimination in European health systems may play in child migrant health inequities is lacking. This Personal View seeks to highlight this knowledge gap and stimulate discourse on how discrimination in health information systems, data sharing practices, national health policy, healthcare entitlements, service access, quality of care, and healthcare workers attitudes and behaviours may infringe upon the rights of, and impact the health of child refugees, asylum-seekers and undocumented migrants. It calls for action to prevent and mitigate against potentially harmful policies and practices.

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Introduction

At the end of 2022 there were an estimated 43.3 million forcibly displaced children (0–18 years) worldwide; 60% were internally displaced, and a record 17.5 million were refugees or seeking asylum.¹ This paper focuses on refugee, asylum-seeking, and undocumented migrant children seeking sanctuary in Europe. These groups are a subset of child migrants within Europe, but they are amongst the children most in need and vulnerable to racism, xenophobia and discrimination. To clarify important differences between these groups, definitions are given in [Panel 1](#).

Children displaced by war and persecution have increased health needs compared to host populations because of their experiences pre-, during and post-

migration.² Health risks associated with psychological trauma, violence, environmental hazards and disease exposure are widely recognised. These children also face potential health harms from racism, xenophobia and discrimination during the journey and after arrival. Racism, xenophobia and discrimination, at interpersonal, institutional and structural levels, are profound determinants of health, and are associated with an increase in infectious and non-communicable diseases throughout the life course and intergenerationally.^{3–6}

Europe hosts 36% of the world's refugees; the exact number of children seeking sanctuary in Europe is uncertain, with many taking irregular routes.⁷ Eurostat data shows there were 222,100 child first-time asylum applicants (59% male; 19% unaccompanied) in 2022, accounting for 25% of applications.⁸ The main destination countries for children between 2012 and 22 were Germany (46%), France (11%) and Sweden (8%). The greatest number of children came from Syria (26%), Afghanistan (16%), and Iraq (8%).⁸ Additionally, many Ukrainian children have been granted temporary protection in European countries following Ukraine's invasion by Russia in February 2022.

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*Corresponding author.

E-mail address: a.stevens4@nhs.net (A.J. Stevens).



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Panel 1: Definitions of key terms.

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| Migrant | An umbrella term, not defined under international law, reflecting the common lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons. ¹¹ |
| Asylum seeker | An individual who is seeking international protection. In countries with individualised procedures, an asylum seeker is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it. ¹¹ |
| Refugee | A person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it. ¹² |
| Unaccompanied children | Children who have been separated from both parents and other relatives and are not being cared for by an adult who, by law or custom, is responsible for doing so. ¹¹ |
| Undocumented migrant | A non-national who enters or stays in a country without the appropriate documentation. ¹¹ This may include trafficked children and children born to undocumented migrant parents. |
| Discrimination | Differential treatments or outcomes that are unfavourable towards a group or an individual according to some aspect of their actual or perceived identity, such as race, religion, nationality, migratory status, physical ability, gender, sexual orientation, class, or social status. ¹³ |
| Racism | An organised system that affords power and privilege according to an established hierarchy based on racial categories. ¹³ Structural racism describes the socioecological macrolevel of social, economic and political systems in which people and institutions exist, which maintain and perpetuate racial inequity, including through facially race-neutral means. |
| Xenophobia | The fear or hatred of, or discrimination against, those who are considered to be foreigners. ¹³ |

Europe has seen a rise in right-wing populism, nativism and authoritarianism with anti-immigrant sentiment playing out in media and political commentaries. Such rhetoric risks normalising xenophobia and entrenching racism.⁹ This was highlighted in the European Network Against Racism's 2015–2016 Shadow Report on racism and discrimination against migrants, which reported that anti-migrant discourses and policies were increasingly being seen as acceptable across the political spectrum.¹⁰ Discriminatory, hostile and restrictive migration policies and practices implemented by countries across Europe may harm child health through negatively influencing the social determinants of health (e.g. housing, education, income, employment, integration), and restricting access to health services. Healthcare provider implicit and explicit bias may reduce access to and quality of care.

While migration status is recognised as a determinant of health and healthcare access, less attention is given to the impact of intersecting discrimination experienced by migrants based on factors including race, ethnicity, nationality, culture, religion, gender, sexuality and disability. Research exploring the effects of

racism, xenophobia and discrimination in European health systems on migrant health inequities is lacking, particularly for children. This paper seeks to highlight knowledge gaps and stimulate discourse about the impacts of discrimination in health systems, data practices, health policy and healthcare entitlements, healthcare worker attitudes, access to care, and quality of care on migrant children's health and rights.

As one of the richest regions in the world, with nearly all countries party to the European Convention on Human Rights, Europe has a duty to recognise and address the health needs of all children residing within its borders irrespective of country of origin, immigration status, race or ethnicity.

Health information systems and data sharing

Lack of data and evidence related to child migrants is a recognised limitation of this paper and a knowledge gap that should be urgently addressed. This is particularly important given their diverse backgrounds and potential exposure to risk factors throughout migration journeys.¹⁴ Heterogeneity in the definition of a migrant child by existing studies reduces comparability of findings.^{15–17}

Robust data collection and reporting on child refugees', asylum seekers' and undocumented migrants' health is crucial to inform evidence-based responsive health policy and inclusive services.^{2,18} This is recognised in the Global Compact on Migration, which highlights the collection and utilisation of data disaggregated by migration status and age as a key objective.¹⁹ Less than half of the 53 WHO European region member states routinely report health data for migrants.²⁰ Current health information systems (HIS) for migrants are lacking in availability, scope, data quality, and ability to integrate into the general population's HIS.²⁰ Countries vary by the types of data collected, ranging from comprehensive population-based registries in Scandinavia and central Europe, to focused infectious disease surveillance in southern and western Europe.^{21,22} Even for notifiable infectious diseases, there is often a lack of stratification by migration status and age, and an absence of standardised data transfer both within and between countries.²³ Globally agreed definitions of categories of migration and standardised disaggregation would facilitate the pooling and comparability of data. Lack of standardised age disaggregation of health data on children is a global issue; this poses further challenges for children without documents proving their age, as no reliable methods to determine age exist.²⁴

While there is a recognisable need for data disaggregation and sharing, the Global Compact for Migration stresses that this should be done 'while upholding the right to privacy under international human rights law and protecting personal data'.¹⁹ A key concern is the sharing of health data for immigration purposes and the negative, discriminatory effects this has on health-seeking behaviour and health (Panel 2).^{2,19}

Panel 2: Case study: discriminatory health policy and efforts taken by health system stakeholders to address this.

England's discriminatory hostile environment policies, and their integration into the health system, including the sharing of health data for immigration enforcement purposes negatively impacts the health of child migrants.^{34,35} In England, refugee and asylum seeking children, unaccompanied children looked after by the local authority and detained migrant children are entitled to free healthcare at all levels of care.³⁶ However, with the exception of primary care and emergency department treatment, undocumented child migrants and dependents of refused asylum seekers who do not qualify for government support under section 4 or section 95 of the Immigration and Asylum Act 1999 are chargeable for many healthcare services, including inpatient care.^{36,37} In order to receive non-urgent care, these children must have user-fees paid upfront at 150% of the National Health Service (NHS) tariff.³⁶ They can receive urgent treatment without advance payment, but fees are subsequently sought. If children and their families cannot pay debts of over £500 then their details may be shared with the Home Office, with the potential consequence of detention and deportation.³⁶ There is concern that this complex NHS Overseas Visitor Charging policy has resulted in racial profiling and eligibility mistakes, with documented treatment delays and refusal of healthcare to entitled child migrants.³⁸ Migrant families and pregnant women are deterred from accessing healthcare due to confusion over entitlements, fears of unaffordable costs and the possibility of data sharing with the UK Home Office.³⁹ Inappropriate data sharing came to the forefront when a Memorandum of Understanding (MoU) between the Department of Health and Social Care, NHS Digital and the Home Office was agreed in 2017.⁴⁰ Its purpose was to formalise the sharing of non-clinical patient data between NHS England and the Home Office (which had been informally taking place since 2013), with the justification that it would support effective immigration enforcement. The MoU was withdrawn the following year after objections from advocacy groups and the public health community. Despite its withdrawal, it has created general distrust and fear, and has had a negative impact on health-seeking behaviour, relationships with healthcare providers and the quality of care.^{2,40}

In addition to healthcare barriers emerging from charging regulations, child refugees, asylum seekers and undocumented migrants also face challenges accessing primary care as they are wrongly refused registration with General Practice (GP) surgeries due to the inability to provide the identification documents demanded of them.⁴¹ This is contrary to NHS guidance which states GP registration must not be refused on the grounds of inability to provide proof of address, immigration status, or personal identification. Healthcare staff and patient ignorance of this NHS guidance perpetuates GP registration refusal of migrants. Studies reporting child refugee and asylum-seekers views on their experience with health-services in the UK describe dissatisfaction, citing difficulties and delays in registering with a GP and securing medical appointments, distrust in the health-service, and poor understanding of available health services and their right to access them.¹⁵ UK health system actors have taken actions to address discriminatory policies and practices and mitigate the health impact on child migrants:

Advocacy

UK medical colleges and the British Medical Association have issued statements outlining their concerns about the NHS Overseas Visitor Charges impact on health and health seeking behaviours, and called on the UK government to suspend the regulations;^{42,43}

Monitoring and reporting

To build an evidence base for policy change, the Royal College of Paediatrics and Child Health (RCPCH) hosts a reporting tool to facilitate data collection on the impacts of NHS charging, and wider immigration policy, on child health;⁴⁴

Training

The non-governmental organisation (NGO) Doctors of the World UK has developed a Safe Surgeries initiative providing free training and resources to clinical and non-clinical primary and secondary care NHS staff to increase understanding of migrant entitlements to NHS healthcare and enable them to better advocate for their patients;⁴⁵

Specialist health services

While limited in terms of geographic reach, there are examples of primary and secondary care specialist services delivering accessible, responsive and holistic integrated NHS healthcare and wellbeing services to child migrants and their families.^{46,47}

National policy and healthcare entitlements in practice**National health policy and practice**

The United Nations Convention on the Rights of the Child (UNCRC), which all European countries have ratified and are thus bound to adhere to by international law, states all children have a right to 'the highest

attainable standard of health and to facilities for the treatment of illness and rehabilitation of health'.²⁵ Article 23 of the 1951 Refugee Convention holds that all refugees should receive the same treatment as nationals with respect to public relief, including healthcare.¹² Article 35 of the European Union Charter of Fundamental Human Rights states that 'everyone has the right of access to

preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices'.²⁶ In practice, the extent to which healthcare is accessible to children varies across Member States; often dependent on the child's legal status.²⁶ While this paper focuses on children, the rights of adults to healthcare is also important as caregiver health is a determinant of child health and wellbeing.^{27,28} Health policies and healthcare entitlements are complex and often discriminate by immigration status, leaving countries at risk of reneging on their commitments to human rights. A 2017 study of primary healthcare in 30 EU/EEA countries revealed 20 had policies entitling asylum-seeking children to healthcare equivalent to the host population in terms of coverage and cost, with delivery within the same healthcare system.²⁹ Eleven countries had comparable arrangements for undocumented children from non EU/EEA and eight countries had similar entitlements for children seeking asylum, but provided by a separate, parallel primary care organisation.²⁹ Only five countries—France, Norway, Portugal, Spain and Italy—explicitly entitled all migrant children, irrespective of legal status, to receive healthcare equal to that of nationals.²⁹ In many countries undocumented children only have free access to emergency care.²⁹

Systematic health examinations of newly settled migrant children are routinely performed in most EU countries.³⁰ These are mostly mandatory in eastern European countries and Germany and focused on communicable disease screening to protect the public health of the host population; in the rest of western and northern Europe, health examinations are predominantly voluntary and additionally endeavour to meet the individual child's needs.³⁰ However, there are reported discrepancies between health examination focus and the dominating needs of child migrants, with mental health assessment often neglected.³⁰

Leaving no one behind is at the core of the 2030 Agenda for Sustainable Development. Sustainable Development Goal Target 3.8 focuses on achieving universal health coverage, meaning everyone can access necessary health services of sufficient quality to be effective without experiencing financial hardship. We remain a long way from achieving these ambitions of equity, as migrant healthcare coverage and access to services responsive to their needs varies dramatically across Europe.³¹

Furthermore, there are inequities in the way European countries have responded to Ukrainians versus people seeking asylum from other countries. Following Russia's invasion of Ukraine, the EU activated the Temporary Protection Directive, giving Ukrainian citizens fleeing their country immediate access to healthcare. Many European countries quickly mobilised resources, issued guidance and translated health information to enable the health needs of Ukrainians seeking sanctuary

to be met.³² While this is of course welcome, the failure to include non-Ukrainians fleeing the same conflict or people fleeing other wars in the Directive or national response is potentially a racially-driven double standard.

Furthermore, healthcare entitlements are not always realised in practice due to misapplication of restrictive health policies, administrative barriers, and wrongful discrimination by healthcare gatekeepers.^{33–35} This is exemplified in the UK case study presented in [Panel 2](#).

Health policies can indirectly impact the health of child migrants through social mechanisms. Discriminative and restrictive policies impede integration and perpetuate racism, discrimination, and xenophobia within societies. They may drive creation of segregated residential, economic, social and psychological environments which adversely impact mental health.⁴⁸ Experiences of discrimination is a reported risk factor for depression in unaccompanied refugee children.⁴⁹ A cross-sectional study involving 131 young refugees (11–23 years) from the Middle East residing in Denmark reported that perceived discrimination was associated with mental problems and social adaptation.⁵⁰ Another study postulated that their findings of poorer health among young refugee men in Denmark compared with Danish men, and with young refugee men in Norway and Sweden, was due to Denmark's restrictive immigration policy.⁵¹

Healthcare access in immigration detention, refugee camps and reception centres

According to international law, migration detention should only be used as a last resort, and children should never be detained.⁵² All EU states have committed to ending detention of children and implementing community-based alternatives.⁵³ However, in practice, immigration-related detention of children is widespread across Europe, including explicit detention policies and de-facto detention in refugee camps and reception centres in 'hotspots'. Detention centres, refugee camps and reception centres are associated with health risks, and while most facilities provide access to basic primary healthcare, specialised care is often unavailable, and access to mental health professionals is critically lacking.^{54,55} In Europe, the quality of care provided in detention settings is not equitable to that delivered in community settings. Inadequate staffing reduces access to timely care as healthcare workers may only work specific hours/days.⁵⁵ There are reports of rudimentary medical screenings without follow up, inadequate consultation times, lack of interpreters, and low quality clinical protocols.^{55,56} The dire health and healthcare context of children in detention, camps, and reception centres has resulted in numerous cases brought to the European Court of Human Rights.^{57,58} [Panel 3](#) describes healthcare in camps on Aegean islands in Greece.

Panel 3: Case Study: access to healthcare in camps on Aegean Islands in Greece.

The hotspot approach, brought into force by the 2015 EU Agenda on Migration, established facilities for initial reception and processing of people seeking asylum at the EU's external borders.^{59,60} The approach is in use on five Greek Aegean Islands (Lesvos, Chios, Samos, Leros, and Kos) where it has resulted in the containment of thousands of people for months to years at a time, in overcrowded facilities designed for short term accommodation and lacking key specialised services.^{59,61,62} People seeking asylum are prohibited from leaving the island on which their application was lodged and are required to reside at hotspot facilities isolated from urban areas.^{61,63} These have been likened by NGOs and asylum-seeking residents to open-air prisons.^{56,64} Children account for almost one in three (28%) of the population of the Greek Aegean hotspots, and most of these children are under 12 years old (70%).⁵⁹ Unaccompanied asylum-seeking minors also face confinement in substandard conditions, including within barbed-wired areas of camps and with unknown adults, for prolonged periods without adequate care.^{59,61,62,65} Hotspot facilities on the Aegean Islands have been characterised by a lack of access to timely and appropriate medical care. While Greek law guarantees access to free medical care for all refugees and people seeking asylum, including children, this is consistently curtailed in practice by limited resources and capacity.^{59,66} Medical services in hotspot facilities are severely understaffed, sometimes even lacking medical and psychosocial personnel necessary to treat emergency cases.^{59,67} In Samos, there was no doctor on staff one year after the hotspot facility was opened. Instead, a doctor from the public hospital would occasionally visit the facility.⁵⁶ Understaffing leads to severe delays in access to medical care, including months-long waits for secondary care and delays to vulnerability assessments, forcing extremely vulnerable people to stay in inappropriate facilities for weeks to months, aggravating existing health issues.^{68,69} Access to specialised services, especially mental healthcare, is critically limited. In 2019 and 2020, there were no psychiatrists working inside any of the island hotspots, and only one child psychiatrist working in the public hospital system of all the Aegean Islands with hotspot facilities.⁵⁹ The European Committee for Social Rights and the European Court for Human Rights affirms that the confinement and lack of access to appropriate care, including medical care, of children in Aegean Island hotspots violates their rights.⁶⁶ Beyond these rights violations, the limited access to healthcare faced by these children is of paramount clinical concern given the desperate need for medical care in these facilities.

The dire conditions, confinement, and lack of access to healthcare faced by child migrants in Aegean Island hotspots is not an inevitability; it is a “policy-made humanitarian crisis.”⁶⁹ This is particularly evident considering Greece's response to the influx of Ukrainian refugees, who are automatically granted one year of temporary protection and access to the labour market and medical care. Greece's migration minister's statement to parliament that Ukrainians are “real refugees” while those arriving from Syria or Afghanistan are “irregular migrants” must be seen for what it is, blatant discrimination.⁷⁰ Such discrimination underpins the perpetuation of the humanitarian crisis on Greece's Aegean Islands and the lack of political will to combat it.

Health system level racism, xenophobia and discrimination

Racism, discrimination and xenophobia of institutions or among people responsible for healthcare delivery influences the overall health system responsiveness to the needs of child migrant populations.

Failure of institutions to provide inclusive and accessible services that account for language needs discriminates against migrants and impedes delivery of equitable quality care. Medical interpretation services are not universally provided across Europe, and when available there may be a financial cost to patients. Language barriers were the most frequently identified obstacles to the provision of urgent and emergency care to refugee children in a cross-sectional survey of 110 healthcare professionals from 23 European countries (n = 66, 60%).⁷¹ Similarly, a survey of 492 European paediatricians identified cultural/linguistic factors as the most frequent barrier (90%) to accessing healthcare faced by child migrants, yet only 37% of responding providers had access to professional interpreters or cultural mediators.⁷² Lack of access to trained interpreters has been cited as a barrier to unaccompanied

children accessing mental health services.⁷³ Language barriers may impact quality of care through diagnostic challenges, patient safety risks, making patients feel unsafe, and discouraging care-seeking.^{74,75} Data from Doctors of the World UK clinics (2014–2017) showed that of the patients reporting healthcare barriers, 7% (n = 41) of refused asylum-seekers and 10% (n = 88) of asylum-seekers cited language as the access barrier.⁷⁶ In a 2019 Swiss cross-sectional study of 504 primary care professionals, 80% of primary care paediatricians and 75% of family doctors felt they had not been able to provide appropriate care for patients and families due to language barriers.⁷⁵ Sixty-two percent of respondents reported difficulties determining the right diagnoses; 62% forewent giving information on disease, therapy and care plans and 56% forewent giving preventative advice.⁷⁵ One fifth reported adverse events that could have been avoided through interpreter use.⁷⁵ Furthermore, there are concerns that language barriers in pharmacy settings may increase adverse drug events.⁷⁷

Quality of interpretation is influenced by the interpreter's education, experience and knowledge of the healthcare sector, medical terms and ethics, and also by

the healthcare professional's competence in working with interpreters.^{78,79} Use of untrained interpreters is more likely to result in medical errors, yet while there are examples of training programmes and certifications in medical interpretation, the employment of formally trained medical interpreters is not standard.^{79,80}

Culture-specific barriers are also risk factors for health inequities experienced by child migrants. Under-utilisation of mental health services by refugees and people seeking asylum in Europe has been explained by differences in symptom expression, fear of stigmatisation stemming from cultural beliefs, and disinclination to seek care due to personal beliefs associated with mental illness.⁸¹ Cultural factors have been identified as obstacles to accessing immunisation services in European host countries.⁸² Institutional provision of cultural mediators hold potential to address linguistic and cultural barriers in healthcare and improve quality of care, however intercultural mediators working in the WHO European Region have been found to lack sufficient training and formal certification in the absence of an accreditation process.⁸³

Healthcare staff attitudes, beliefs and implicit bias (unconscious prejudice against a specific group) can negatively impact behaviours towards patients and clinical decision-making.⁸⁴ Healthcare discrimination towards migrants in Europe and its association with poor quality care is a concern.^{85,86} A 2023 scoping review comprising 38 studies conducted across 14 different European countries and inclusive of testimonies from health professionals and racialised migrants of different nationalities, reported anti-migration bias, Othering, and racist language and behaviour during health service provision.⁸⁷ Included studies reported health-related prejudices (e.g. linked to health behaviours, symptom expression and treatment compliance) and widespread negative perceptions amongst healthcare providers treating migrant populations.⁸⁷ Differential clinical care was perceived and witnessed, including reduced responsiveness to health needs, longer waiting times, fewer clinical investigations, higher risk of not receiving timely treatment, poorer quality of care, and reduced compassion.⁸⁷ While the review did not specifically focus on paediatric services, it included studies from prenatal, antenatal and maternity settings, which impact the health of the unborn child and birth outcomes. The UNCRC states Parties make prenatal and postnatal healthcare a human right.²⁵ A systematic review of systematic reviews examining perinatal outcomes and care amongst asylum seekers and refugees reported predominantly worse perinatal outcomes on a background of structural, organisational, social, personal and cultural barriers to access and use of care and experiences of racism, prejudice and stereotyping within perinatal healthcare.⁸⁸ In the UK, maternal mortality rates amongst Black women are nearly four times that of White women; rates in Asian women are almost double

their White counterparts.⁸⁹ It is difficult to prove causal pathways between discrimination and adverse health outcomes, but the growing body of research into racial/ethnic disparities in maternal mortality and birth outcomes suggests that institutional biases and structural racism may play a significant role.⁹⁰⁻⁹² Living in a European country with a welcoming integration policy is a protective factor for adverse pregnancy outcomes in migrant women.⁹³ It is hypothesised that living in a society that promotes participation and equity may reduce the psychological and physical effects of discrimination.⁹³

Most research exploring racial and ethnic disparities in the quality of children's healthcare has been carried out in the USA, where inequities in the quality of primary care, asthma care, cardiovascular surgery, mental healthcare, pneumonia hospitalisations, ophthalmologic care, orthopaedic conditions, and care of children with end-stage renal disease have been reported, alongside differences in prescribing practices for analgesia and antibiotics for children of different races.⁹⁴⁻⁹⁶ European studies on this topic are relatively scarce but published findings are consistent with those from the USA. Research in England identified Asian school-aged children to be half as likely to be diagnosed with Autism Spectrum Disorders as White British children.⁹⁷ In Sweden, child migrants were less likely than Swedish children to be diagnosed with certain psychiatric conditions, and less likely to receive recommended treatments when a diagnosis was made.⁹⁸ A large European study reported that Black and Asian children were less likely to receive a kidney transplant than White children even after adjustment for primary renal disease.⁹⁹

Perceptions of discrimination by healthcare workers have been reported by migrant parents accessing paediatric services as well as by child migrants themselves.^{100,101} Migrant populations report higher levels of healthcare discrimination in Greece, Italy, Cyprus, and Austria, but lower levels in Spain.⁸⁵ However, 92% of Spain's study participants were Spanish-speakers from South America, for whom language was not a barrier, thus contributing to the author's claim of a significant relationship between language barriers and feelings of being discriminated against during healthcare encounters.⁸⁵ Concerningly, one Turkish study reported that 34.3% of 140 surveyed physicians would not want to provide health services for refugees if they were given the choice, and believed that health services should not be free of charge for refugees and should be provided in separate places.¹⁰² Perception of racism, xenophobia, and/or discrimination in health services and by health workers influences health-seeking behaviour, leading to low trust, reduced use of the health services, and barriers to treatment compliance.¹⁰³ Negative experiences of health services may delay or alter the way in which a young person seeks care, or a parent seeks care for their child, with potentially adverse outcomes.^{3,104} There is

increasing evidence that personal experience of racism, xenophobia and discrimination can harm health over the life course and intergenerationally due to alteration of stress physiology.³

Despite the attention paid to quality assurance and patient safety, there are few measures or instruments to monitor discrimination in healthcare, particularly at the structural level. While guidance has been developed on health rights and intercultural care, without a system to monitor changes in practice, evidence for the impact of such guidance is lacking. Many institutions are under no obligation to critically review their policies and practices for evidence of racism, xenophobia or discrimination toward migrant populations and there is no accountability for inequities in health provision. Healthcare professionals lack knowledge about racism and discrimination as a phenomenon and are ill-equipped to support and treat migrant children and families who have experienced it.^{105,106} If Europe is to succeed in achieving health equity for child migrants, then addressing racism, xenophobia and discrimination must be a priority which is met with meaningful action at all levels.

Addressing racism, xenophobia and discrimination now and in the future

In addition to child rights obligations, countries have an ethical, moral and humanitarian duty to ensure the protection, health and wellbeing of all children living within its borders. Prevention and mitigation against racism, xenophobia and discrimination experienced by child refugees, asylum seekers and undocumented migrants is essential to achieve health equity. A vertical approach targeting identified issues at specific levels should be combined with a horizontal approach that involves action across and between governments, systems and institutions to tackle structural and intersecting forms of discrimination. Stakeholders in policy, healthcare, academia and civil society must integrate their efforts to promote the health of child migrants and identify areas for sustainable collaboration in order to break existing silos of operation. The Refugee and Migrant Child Health Initiative (Panel 4) is an example of inter-sectoral partnerships to address the health needs of child migrants.¹⁰⁷

Fig. 1 uses the Lancet Series on Racism, Xenophobia, Discrimination and Health conceptual model to map potential areas for actions to reduce child migrants' experience of racism, xenophobia and discrimination in healthcare at the structural and health system levels.⁶ These are discussed in detail below.

Structural level

Governments have a responsibility to ensure national policies align with their human rights commitments

and legislation. Recommendations and guidance is available to support countries to meet obligations under the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) regarding the right to health.¹¹⁹ To support delivery on the right to equality and non-discrimination based on race, colour, descent, or national or ethnic origin in the context of public policy, the Office of the United Nations High Commissioner for Human Rights (OHCHR) encourages States to develop national action plans against racism (NAPAR).¹²⁰ Migrants, refugees, asylum seekers, and children are identified as priority groups in need of protection against racial discrimination. OHCHR and the European Commission have produced guidance and tools to support the development of NAPAR. This may be one effective mechanism to address the health impacts of structural racism and discrimination experienced by child migrants.^{120,121}

Further, integrating migration, health and children in all policies could improve child migrant health and equity through cross-sector action on the wider determinants of health, including structural racism, xenophobia and discrimination.¹²² 'Health in All Policies' (HiAP) is already an established approach implemented in many European countries, and in 2021 WHO-UNICEF-Lancet launched the 'Children in All Policies 2030' Initiative.^{123,124} However, barriers to delivering and sustaining cross-sectoral partnerships persist for health, migration and children. Challenges include: securing long-term investment; ensuring alignment in incentives across sectors; navigating competing priorities; and maintaining an equity-oriented focus.¹²³ Cross-sector and cross-government participation and community involvement is critical for success, and careful framing around health, migration and children would be paramount for stakeholder buy-in.¹²³

Dismantling of healthcare segregation through provision of inclusive healthcare entitlements would reduce health inequities experienced by child migrants. Inclusive health and social policies can be affordable and effective.¹⁰⁸ European studies have shown that inclusive non-emergency healthcare provision to refugees, asylum-seekers and undocumented migrants can achieve significant savings in direct medical and non-medical costs, and reduce the risk of progression of disease to more complex and expensive-to-treat conditions requiring hospital-setting care.^{125,126} Delayed presentation to healthcare services because of fear of or past experience of discrimination, racism or xenophobia may result in worse health outcomes for child migrants and avoidable emergency presentations and inpatient admissions. Economic modelling of provision of regular prenatal care to undocumented migrant women instead of emergency-care only in Germany, Greece and Sweden was found to be cost-effective.¹²⁷ Inclusive, regular

Panel 4: Case studies of interventions to improve the health of child migrants.

The Refugee and Migrant Child Health Initiative

The EU funded Refugee and Migrant Child-Health Initiative was implemented by UNICEF with partners in Southern and South Eastern Europe between 2020 and 2022. Its aim was to strengthen national health systems to enable them to address the needs of forcibly displaced children. It adopted a multi-pronged approach with three key objectives: to strengthen the capacity of national authorities to deliver healthcare to migrant children; to increase health literacy through provision of health information and access to interpreters and cultural mediators; and to strengthen the implementation of health policies e.g. by increasing health workforce skills and knowledge capacity to support child migrants.¹⁰⁷ The initiative recognised the importance of integrated efforts to achieve these objectives. It sought to create links between healthcare, child protection and gender based violence services; promoted collaboration between health services, civil society, reception centre staff and other frontline workers; and endeavoured to strengthen referral pathways to specialist health services but also to services that support with addressing the wider determinants of health e.g. legal services.¹⁰⁸ The Initiative was evaluated and found to have helped build the capacity of national partners and frontline workers to address the childrens' needs.¹⁰⁹ Training of government officials and employees of implementing partners reportedly initiated noticeable behaviour change in health service providers and their approach to service delivery. The Initiative has resulted in the five participating countries -Bosnia and Herzegovina, Bulgaria, Greece, Italy and Serbia-engaging in service mapping, improving standard operating procedures and bettering referral services linking children with specialist services. Cultural mediators were found to be pivotal in bridging communication gaps and building trust between refugees and health services, and were able to utilise training and materials supported by the Initiative to uphold healthcare rights.¹⁰⁹

Norway's New Families Program

Integrated within the existing Maternal and Child Health Care Service, Norway's 'New Families Program', adopted a strengths-based salutogenic approach to supporting first time immigrant mothers and their infants, with a focus on equity and relationship building.¹¹⁰ Community participation in program development ensured that the service was responsive to needs and staff were encouraged to consider their own implicit bias before starting the program. Home visits by public health nurses in place of clinic site visits and longer and more frequent appointments enabled nursing staff to gain a greater understanding of a family's needs but also their capabilities and resources. The program fostered trust and allowed professionals and families to work together to overcome healthcare barriers and promote infant wellbeing. Mothers who engaged with the service reported a greater confidence in the Maternal and Child Health Care Service and a sense of increased inclusion.¹¹⁰

Taking a migration-aware response to delivering the national Healthy Child Program in England

Local authorities in England have shown innovative ways of delivering the national Healthy Child Program to refugee and asylum-seeking children.¹¹¹ Examples include: the development of a specialist health visiting service; local needs assessments of migrant children and young people to inform service development; and delivery of services for migrant parents that address child health promotion, development interventions, oral health and child safety alongside services that address the social determinants of health-e.g. English language courses, food banks, Citizens Advice services and immigration support.¹¹¹

Schools as a setting for addressing mental health needs

There is increasing evidence that school-based psychosocial services may promote child migrant health and wellbeing by: overcoming barriers of institutional distrust and mental health stigma; facilitating positive relationships with teachers and peers thus potentially counteracting social isolation, discrimination, and exclusion; and bridging child migrants' family context and the host society.¹¹² Bennouna et al. (2019) evaluate twenty Mental Health and Psychosocial Support (MHPSS) school-based program structures targeting adolescent forced migrants in high income countries, including 10 in European settings.¹¹³ Mental health work in schools can both improve services access and provide opportunities to address challenging peer interactions and support integration and acceptance.¹¹⁴

Holistic multidisciplinary team health assessments of newly arrived asylum seeking children in the UK

In the UK unaccompanied asylum-seeking children are taken into the care of local authorities who have a statutory duty to provide accommodation and meet their health and wellbeing needs, which includes facilitating an Initial Health Assessment with a registered medical practitioner within a target time of twenty working days of being taken into care.¹¹⁵ The Initial Health Assessments (IHAs) are holistic and cover physical, mental, emotional, sexual and dental health, development and education, vision and hearing, safety and health promotion, screening and immunisations.¹¹⁶ While in theory this enables timely management of identified health needs, research has shown there are challenges associated with delayed IHAs and variation in practice.^{115,117} Health professional training on child migrant health; early nurse-led triage assessments prior to the IHA; and a comprehensive multidisciplinary team 'one-stop shop' model approach to facilitate care coordination and access could enhance IHA delivery and outcomes.^{46,115,117} The RESPOND service in London is an example of an integrated multidisciplinary joined-up approach to health assessments of newly arrived asylum-seeking families housed in contingency accommodation delivered by primary and secondary healthcare providers.¹¹⁸ After GP registration, families receive a holistic protocol-informed assessment by an infection and inclusion health practitioner. Children and their parents are signposted and referred to specialist services according to their needs. RESPOND partners with the local authority "early help" services and non-governmental organisations to ensure the family's wider needs, including housing, schooling, and access to welfare services, are met. Each family member receives an electronic integrated migrant health plan which stays with them as they are moved around the country subject to government dispersal policies to enable continuity of care following each short notice relocation.¹¹⁸

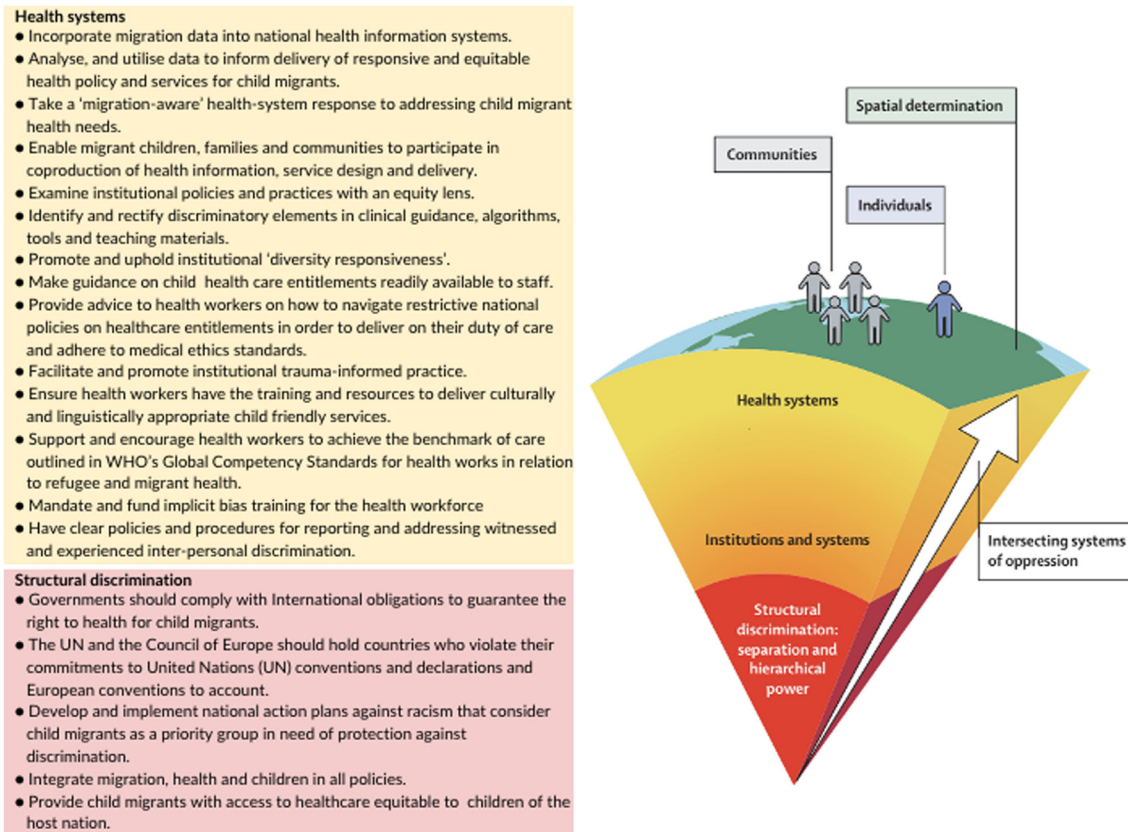


Fig. 1: Actions to reduce child migrants' experience of racism, xenophobia and discrimination in the context of healthcare, mapped within Devakumar and colleagues' conceptual model on racism, xenophobia, discrimination, and health.⁶

prenatal care is cheaper than managing avoidable cases of low-birth-weight associated with non-provision. Likewise, inclusive immunisation policies cost less than managing infectious disease outbreaks.¹²⁸ Furthermore, many child migrants will become part of the host nation's future workforce, therefore inclusive policies promoting health, integration, and social cohesion in this population can contribute to long-term economic growth.¹²⁹

Health-systems level

National health information systems should include data from all its sub-populations to enable equitable data-driven decision-making on health policies, systems and services.^{2,130} Addressing the data gap on child migrant health is a fundamental first step to ensuring their needs are met. A human rights-based approach to data collection should be adopted with consideration for participation, disaggregation (e.g. age, sex, race, ethnicity, migratory status, disability and geographic location/setting), self-identification, transparency, privacy and accountability.^{131,132} WHO has developed a manual to support inequality monitoring in newborn,

child and adolescent health, which offers guidance on data collection, analysis, reporting, and translating knowledge into action.^{131,132} Guidance on relevant migration indicators in children can also be derived from international studies on child health, such as the WHO Health Behaviour in School-Aged Children (HBSC) study, in which participants were asked about whether they were born in their country of residence, their parents' country of birth and the language spoken at home.¹³³ A child's and their family's legal status may impact their health; however, this information is challenging to collect, particularly when people are fearful of data-sharing with immigration authorities.^{134,135}

A step towards health equity for child migrants could be achieved by taking a 'migration-aware response' to addressing their health needs.¹³⁶ This requires a multi-sector system-wide response whereby migration is a principal consideration in the design of service delivery, policy and research.¹³⁶ European examples of interventions designed to improve the health of refugee and asylum-seeking children are presented in Panel 4.

There must be leadership buy-in and commitment to identifying and addressing institutional level racism, xenophobia and discrimination, with dedicated funding for the time, staff, training, community participation and partnerships, and service developments necessary to achieve transformational change.¹³⁷ Institutions should examine their policies and practices with an equity lens. Consideration should be paid to the inappropriate use of race in clinical guidelines, algorithms, tools and teaching materials. Discriminative elements should be openly acknowledged and rectified. While institutional promotion of cultural sensitivity is essential in efforts to reduce barriers to care, health worker training in ‘cultural competence’ must avoid reliance on delivering ‘expert knowledge on minority populations’ as this has been reported in some settings to result in systematic teaching of stereotypes to health workers; which can reinforce racism and discrimination.^{138,139} Healthcare institutions should exhibit ‘diversity responsiveness’ through: organisational commitment; collecting and analysing data to provide empirical evidence on inequalities and needs; development of a competent and diverse workforce; ensuring access for all people; ensuring responsiveness in care provision; fostering patient and community participation; and actively promoting the ideal of responsiveness.¹³⁹

Staff guidance on healthcare entitlements and advice on how to navigate restrictive national policies on healthcare entitlements to enable healthcare delivery should be available. Institutions should dismantle barriers to health services and provide a welcoming environment where child migrants can access quality trauma-informed care.¹⁴⁰

While access to medical interpreters is not a universally recognised right, it could be argued that in order to deliver on the UNCRC right to healthcare, children and their caregivers must be able to communicate with healthcare professionals to express needs, and understand and participate in their healthcare.²⁵ The expense of interpreters has been shown to be balanced by a reduction in unnecessary investigations and treatments, and improvements in patient safety, service access, compliance and health outcomes.^{141,142} It is the responsibility of health institutions and its health workforce to ensure patient verbal and written communication needs are met. Failure to do so risks breaching their duty of care and results in poor service quality. Co-production of health information sources with migrant communities can ensure that messaging is relevant and culturally sensitive.

Health institutions and medical schools should provide the training and support necessary for health workers to achieve the benchmark of care outlined in WHO’s Global Competency Standards for health workers in relation to refugee and migrant health. The Standards focus on: people centredness; communication, collaboration; evidence informed practice and

personal conduct. The latter domain explicitly recognises the need for health workers to: maintain awareness of their own culture, beliefs, values and biases; demonstrate awareness of institutional discrimination and intersectionality and how this impacts on health; adapt personal practice to address individual and institutional discrimination; and respond to health needs in a culturally sensitive way.¹⁴³ Mandatory, funded implicit-bias training for health workers has been heralded as sending a clear message about the importance of equity.¹⁴⁴ Clear, mandatory reporting channels should exist for experienced or witnessed discrimination, and perpetrators should be held accountable. Behaviours are influenced by the culture and practice of institutions. Focus on inclusion, compassion and anti-racism by health institutions may reduce interpersonal discrimination against child migrants during care.¹³⁷

Further research is needed to better understand the pathways by which racism, xenophobia and discrimination in European health systems impact children’s health. High quality longitudinal studies, psychometrically validated exposure instruments and clarity of conceptualisation and definition of racism, xenophobia and discrimination are required.¹⁴⁵ Health policies and practices to address health needs and mitigate harm from of discrimination should be evaluated for impact and effectiveness.

Conclusion

Racism, xenophobia, and discriminatory health policies and practices exist across Europe. Such practices are potentially harmful to children’s health and contravene obligations under international law. European countries should and can do better. Efforts to identify, acknowledge, and address racism, xenophobia and discrimination should take an integrated approach that engages all levels of the health system and across institutions, sectors, and nations. Research to understand how racism, xenophobia and discrimination within European health systems impacts child migrant health, and how this can be prevented and mitigated, should be prioritised. Lessons learned, and the impacts of policy and practice changes on health equity and child public health outcomes should be shared, so we can collectively improve how we meet the needs of child refugees, asylum seekers and undocumented migrants in Europe.

Contributors

All authors conceived the work and wrote, reviewed and edited the draft.

Declaration of interests

DD is the director and co-founder of the Race & Health group in UCL. YB’s spouse is employed by Elsevier as a Software Engineer.

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