Åbo Akademi University
Social Sciences, Business and Economics, and Law

Angelica Conti

EXTENT OF THE PROTECTION OF THE RIGHT TO HEALTH OF UNDOCUMENTED MINORS: LEGAL STANDARDS IN INTERNATIONAL HUMAN RIGHTS LAW AND PRACTICAL BARRIERS IN SELECTED EU MEMBER STATES

Master's Thesis
Supervisor: Stephen Phillips
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Åbo Akademi University 2023
E-mail: angelica.conti@abo.fi

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Abstract for Master's Thesis

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Writer: Angelica Conti	
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Supervisor: Stephen Phillips	Supervisor:

Abstract:

The right to health is a fundamental entitlement for all individuals, but certain groups, such as undocumented minors, face barriers that hinder their access to this right. Regrettably, there has been limited research dedicated to addressing this critical issue. Guided by this premise, this thesis explores the right to health of undocumented minors by employing a doctrinal and comparative method, examining international human rights law instruments and EU legislation. The need for a comprehensive rights framework is emphasized, considering the unique vulnerabilities of undocumented minors. The analysis reveals a gap in specific legal instruments for migrant children but highlights the significance of principles such as the best interest of the child and the non-discrimination. While states often prioritize sovereignty, non-binding instruments demonstrate a desire to expand protection for undocumented minors.

Practical barriers hinder access to healthcare for undocumented minors, with states offering limited services, mainly emergency care, and neglecting mental health support. Factors such as cost, communication challenges, fear of reporting to migration authorities, and social stigma further obstruct access. Following a comprehensive examination of the practical barriers faced by migrants in an irregular situation, the thesis adopts a comparative approach by examining the policies of selected EU member states. The comparison highlights the significant variations in healthcare policies among them, exacerbated by the EU's limited coordination powers in healthcare and migration. Notably, undocumented minors encounter healthcare access barriers in every EU member state, even those with more accommodating policies.

The thesis advocates for comprehensive measures to ensure healthcare access for undocumented minors, despite sovereignty concerns. Recommendations include augmenting the number of interpreters, establishing firewall systems, improving communication, reducing healthcare costs, and adopting a holistic approach to addressing undocumented minors' well-being. Moreover, the urgency of proactive measures is underscored, calling for further research to get more comprehensive and useful data.

Keywords: undocumented children, undocumented minors, undocumented migrants, irregular migrants, right to health, healthcare, vulnerability, EU member states

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Abbreviations

CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CESCR	Committee on Economic, Social and Cultural Rights
CFR	Covenant on Fundamental Rights
CJEU	Court of Justice of the European Union
CM	Committee of Ministers of the Council of Europe
CoE	Council of Europe
CRC	Convention on the Rights of the Child
CRC committee	Committee on the Rights of the Child
ECSR	European Committee of Social Rights
ESC	European Social Charter
ECRI	European Commission against Racism and Intolerance
ECHR	European Convention of Human Rights
ECtHR	European Court of Human Rights
EU	European Union
FRA	European Union Agency for Fundamental Rights
GC	General Comment
GDPR	General Data Protection Regulation
HRC	UN Human Rights Council
ICCPR	International Covenant on Civil and Political Rights
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labour Organization
IOM	International Organization for Migration
OHCR	Office of the United Nations High Commissioner for Human Rights
PACE	Parliamentary Assembly of the Council of Europe
RESC	Revised European Social Charter
TEU	Treaty on European Union
TFEU	Treaty on the Functioning of the European Union
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNGA	United Nations General Assembly

UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

1. Introduction

1.1. Introduction

Migration is a global phenomenon that impacts millions of individuals and has significant consequences for the protection of human rights.[1] Although obtaining precise data is challenging, it is estimated that approximately 15-20% of all migrants, or roughly 30-40 million individuals worldwide, are undocumented.[2] Estimations become even less precise when considering minors, but according to the United Nations International Children's Emergency Fund (UNICEF), in 2020 there were 36 million migrant children globally.[3] Furthermore, scholars highlight the fact that minors are typically hindered from accessing legal migration routes.[4] These considerations, despite being based on imprecise estimations, underscore the significant presence of undocumented children worldwide. Therefore, it is important to examine their access to fundamental rights, particularly the right to health.

The right to health is an essential pillar of human rights, one that should be accessible to all individuals, irrespective of their legal status, with special emphasis on safeguarding the well-being of children. However, notwithstanding the existence of binding international laws concerning the protection of the right to health, there are practical barriers that hinder undocumented minors from accessing healthcare. This not only affects their immediate well-being but has also long-term consequences on their development and the protection of their other health-related rights.[5]

This research is not aimed at merely providing a theoretical overview of legal standards. Instead, it wants to understand how these standards are applied in the real world, focusing on the practical obstacles that hinder undocumented minors from enjoying their right to health. To gain a deeper comprehension of these challenges, this study will examine the intersection of child rights, immigration policy, and public health, especially focusing on selected European Union (EU) member states.

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[1] OHCRC and WHO, 'The Right to Health. Fact Sheet No. 31' (Geneva 2008) 18.
[2] Estimation made in Sarah Spencer and Anna Triandafyllidou (ed), *Migrants with Irregular Status in Europe. Evolving Conceptual and Policy Challenges* (Springer Open 2020) 2, based on UN OHCHR and ILO figures.
[3] UNICEF, 'In 2020, the number of international migrants reached 281 million; 36 million of them were children', <https://data.unicef.org/topic/child-migration-and-displacement/migration/> accessed 15 September 2023.
[4] Fiona David, Katharine Bryant and Jacqueline Joudo Larsen, *Migrants and Their Vulnerability to Human Trafficking, Modern Slavery and Forced Labour.* (IOM 2019) 10.
[5] Carola Suárez-Orozco and Hirokazu Yoshikawa, 'Undocumented Status: Implications for Child Development, Policy, and Ethical Research' (2013) *New Directions for Child and Adolescent Development* 61.

To be able to examine the protection afforded to undocumented minors' right to health, it is necessary to provide a clear definition of the key terms involved. First, "minors" will be used interchangeably with "children," and according to the Convention on the Rights of the Child (CRC), "a child means every human being below the age of eighteen years",[6] unless otherwise stipulated by majority age norms. The importance of focusing on this group can be deduced by the existence of a whole convention on their rights. Moreover, the Universal Declaration of Human Rights (UDHR) states that children are entitled to "special care and assistance".[7]

The second part of the definition involves the term "undocumented". Undocumented or irregular migrants are individuals who migrate to another country without legal authorization or remain in a country beyond the expiration of their permits. Within the EU, every third-country national who is in the territory of a Schengen State without fulfilling or no longer fulfilling the entry conditions as prescribed by the Schengen Borders Code or specific regulations is considered to be in an irregular situation.[8] In this thesis, the terms "undocumented" and "irregular" will be used interchangeably, as the ones preferred by the international community to describe this category of migrants, as well as the most used in legal discourses in Europe.[9] The term "paperless" has not been chosen because it is more informal, while terms such as "illegal" and "unauthorized" have been excluded as they are considered against human dignity and carrying a criminal connotation.[10]

Children can find themselves in an undocumented status for various reasons, and their situations can differ greatly. A first distinction should be made between accompanied and unaccompanied minors. Unaccompanied minors arrive in a third country without a legal guardian and become undocumented if they fail to lodge an asylum claim, neglect to apply for a residence permit, or have their request rejected.[11] Accompanied minors, instead, usually have their residence status linked to that of their parents. For example, they may be born in the host country to undocumented parents or become undocumented due to their parents losing their residence or work permits.[12]

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[6] UNGA, 'UN General Assembly, 'Convention on the Rights of the Child' (adopted 20 November 1989, entry into force 2 September 1990) UNTS 1577, 3, Art. 1.
[7] UNGA, 'Universal Declaration of Human Rights' (10 December 1948) 217 A (III), Art. 25.
[8] See European Commission, 'Glossary: irregular migrant', <https://home-affairs.ec.europa.eu/pages/glossary/irregular-migrant_en> accessed 25 September 2022.
[9] See François Crépeau and Maja Vezmar, 'Words matter: 'illegal', 'irregular', 'unauthorized', 'undocumented' (Policy Note 15, KNOMAD 2021).
[10] IOM, 'Glossary on Migration, International Migration Law', No. 34, 2019 (IOM 2019) 102.
[11] PICUM, 'FAQ. Undocumented Children' (December 2020) 3.
[12] PICUM (n 11) 3.

Obtaining up-to-date statistics on undocumented minors in the EU is challenging due to their irregular status, which makes it difficult for states to accurately track their presence. Data collection mechanisms are not advanced, typically only capturing information about apprehensions or arrivals, therefore excluding a substantial portion of undocumented migrants.[13] However, as highlighted in the 2022 IOM World Migration Report, irregular migration remains a significant issue within EU countries, often central in political discourses that prioritize host country security.[14]

The lack of precise data on the extent of the phenomenon of undocumented minors should not dissuade from examining the issue; on the contrary, the importance of treating them primarily as children rather than mere irregular migrants must be underlined.[15] States have the responsibility to implement policies that ensure fundamental rights, such as the right to health, are accessible to all, eliminating the existing practical barriers and facilitating the integration of undocumented children into the host society.[16] This research will shed light on how these policies are implemented on the ground and the impact they have on the lives of undocumented minors.

To achieve its objectives, this thesis follows a structured approach, providing a logical progression of information. It begins by exploring the vulnerabilities faced by undocumented children and their *de facto* statelessness due to a lack of official documentation.[17] This analysis is needed to explain why undocumented minors were chosen as the main subject of this thesis, and it sets the stage for the following chapter, which underscores the importance of the right to health in human rights. This is done by studying the international law framework, both in general and with specific reference to children and undocumented migrants. The purpose of these two chapters is to build a strong foundation for the subsequent analysis of the extent to which the right to health of undocumented minors is protected. This analysis, focusing on availability and access to preventive healthcare and mental health services, is designed to evaluate the practical barriers faced by this vulnerable group.

[13] PICUM, 'Protecting undocumented children: Promising policies and practices from government' (January 2018) 7.
[14] Marie McAuliffe and Anna Triandafyllidou (ed), *World Migration Report 2022* (IOM 2022) 96.
[15] As stated by CRC Article 2.
[16] These responsibilities come from states' ratification of international human rights treaties, such as the CRC and ICESCR. By ratifying these treaties, states assume obligations and duties under international law to respect, protect and fulfill human rights.
[17] Luca Bicocchi, 'Undocumented Children in Europe: Ignored Victims of Immigration Restrictions', in Jacqueline Bhabha (ed), *Children Without a State: A Global Human Rights Challenge* (MIT Press 2011) 109.

In the final chapter, the thesis moves its focus towards the EU, examining EU laws and practical measures taken by selected member states, as well as the concrete barriers that undocumented minors face in those countries.[18] This comparative approach aims to connect international, regional, and local policies, providing a holistic view of the issue. Through concrete examples, the research intends to understand the complexities of ensuring the right to health for undocumented minors and contribute to broader discussions on human rights and immigration policy.

1.2. Research Question and Delimitations

This thesis thoroughly investigates the right to health of undocumented minors, with a focus on international human rights law and the EU. The main research questions are: 1. To what extent do international legal instruments protect the right to health of undocumented minors? 2. What practical barriers hinder undocumented minors' access to essential healthcare services, including mental health support? 3. How do selected EU member states address these practical barriers, and what lessons can be drawn from their practices? Concerning the latter, this research will identify both promising practices and areas that require improvement in safeguarding the right to health for undocumented minors.

To address the main research questions, other elements will be examined. Specifically, it will be explored whether undocumented children are considered a particularly vulnerable group and the potential implications of this categorization. Additionally, various levels of healthcare services that can be provided will be defined, which will lead to an examination of the delicate interplay between child rights, immigration policy, and public health.

As already stated, one of the primary challenges in this research revolves around the scarcity of comprehensive and readily accessible data concerning undocumented minors. In fact, this vulnerable and often marginalized category inherently presents difficulties in data collection and analysis. Consequently, the study relies on existing literature, reports, and studies, which may be limited in scope or subject to publication bias. Despite a thorough research and literature review, the lack of up-to-date data may impact the comprehensiveness of the analysis and the extent to which the findings can be generalized to the broader population of undocumented minors in the EU.

[18] See: PICUM (n 13); Anders Hjern and Liv Stubbe Østergaard, *Deliverable D3 (D7.1): Migrant children in Europe: Entitlements to healthcare* (MOCHA 2016).

Concerning the geographical scope, this thesis focuses on international law, while the selected examples are taken exclusively from EU member states. This decision was deliberate, aimed at highlighting variations in practices within a region that is, at least in theory, relatively homogenous. The choice of the states was made by examining both the states' policies and the relevant literature, including the 2018 PICUM study on promising government policies and practices towards undocumented children,[19] as well as the research conducted as part of the MOCHA (Models of Child Health Appraised) project.[20] The selection of these examples wants to offer an overview of a range of practices, showing both strengths and areas requiring improvement. It must be emphasized that this study does not aim to provide a comprehensive representation of the whole EU.

Considering the limited availability of research materials and sources in the specialized field of practical barriers related to undocumented minors, the specific practical barriers chosen for comparison among EU member states' practices are those for which more sources are available. Therefore, there is a need for additional comparative studies to explore a wider range of practical barriers.

Finally, the rapidly evolving landscape of migration policies makes it challenging to maintain up-to-date resources. For instance, at the time of writing, the Finnish government wants to limit undocumented individuals' access to non-urgent medical care,[21] which is mentioned in this thesis as a positive example.[22] Likewise, Sweden currently has a pending proposal aimed at abolishing the firewall system.[23] Hence, it is important to note that the examples and information considered in this study are accurate and up to date only until October 1, 2023. Any developments, policy changes, or events occurring after this date are not included in the scope of this analysis.

[19] PICUM (n 13).
[20] Hjern and Stubbe Østergaard (n 18).
[21] For further information: David Mac Dougall, 'Helsinki could become 'sanctuary city' as Finland's right-wing government targets paperless migrants' (*Euronews*, 14 August 2023) <https://www.euronews.com/2023/08/14/helsinki-could-become-sanctuary-city-as-finlands-right-wing-government-targets-paperless-m> accessed 30 August 2023.
[22] For further discussion, see Chapter 5.2.3.
[23] Charles Szumski, *'Sweden to crackdown on irregular migrants'* (*Euractiv*, 1 September 2023), <https://www.euractiv.com/section/politics/news/sweden-to-crackdown-on-irregular-migrants/> accessed 12 September 2023.
On the firewall system, see Chapter 4.4. and 5.2.4.

1.3. Material and Method

This research combines the use of the doctrinal method, which analyses existing legal material, and the comparative legal method. Moreover, the impact of the norms and the irregular status on undocumented minors are evaluated through the review of existing academic literature, mostly medical one.

The doctrinal method is the most traditional one with regard to the study of norms, as it is a type of research that focuses on the law and legal concepts.[24] It should be emphasized that the study is not limited to merely describing the norms as they are; interpreting them is one of the main objectives of the doctrinal method in legal research.[25] In this thesis, the adherence to the doctrinal method is reflected by the analysis of the studied human rights practices in the light of the existing international law framework. The research takes into account the fact that the interpretation of international human rights norms under examination is not always univocal due to internal conflicts among norms, variations between different treaty bodies, and changing perspectives over time. However, certain foundational principles serve as the basis for analysis.[26] Moreover, the existing law will be assessed to understand and analyze the basic beliefs and ideas that are used in the field of children's rights.[27]

First, in order to address the importance of the right to health for undocumented minors, the key international human rights law conventions will be examined, with a particular focus on the CRC. While it does not explicitly mention undocumented or irregular migrant children, their protection can be inferred from the convention's underlying principle of non-discrimination. The CRC has great importance, given its almost universal ratification, with the notable exception of the United States. In addition, the study will draw from the legal framework of the Council of Europe (CoE) and the EU, given that the EU is the geographic area under examination for practical examples.

[24] Terry Hutchinson and Nigel Duncan, 'Defining and Describing What We Do: Doctrinal Legal Research' (2012) 17 *Deakin Law Review* 83, 85.
[25] Mark Van Hoecke, 'Legal Doctrine: Which Method(s) for What Kind of Discipline?' in Mark Van Hoecke (ed. by), *Methodologies of Legal Research: Which Kind of Method for What Kind of Discipline?* (Hart Publishing 2011) 4.
[26] Milka Sormunen, 'The Best Interests of the Child in Human Rights Practice: An Analysis of Domestic, European and International Jurisprudence' (DPhil thesis, University of Helsinki 2021) 66.
[27] Didier Reynaert, Maria Bouverne-De Bie and Stijn Vandevelde, 'Between "believers" and "opponents": Critical discussions on children's rights' (2012) 20 *The International Journal of Children's Rights* 155, 156.

However, as mentioned above, this thesis wants to go beyond a mere description of the state of the international law, analyzing the practical implementation of these laws and the factors that limit their execution. Therefore, the sources used will include international law treaties, but also soft law, and state policies. Moreover, given the scarcity of both data and legal sources specifically concerning the right to health of undocumented minors, the research will resort to a diverse array of medical studies and social sciences sources, as well as reports and guidelines. This comprehensive approach highlights the necessity to investigate this particular issue, which undeniably needs further research and attention. This urgency stems from the importance of the right to health for all individuals and the particularly vulnerable situation faced by undocumented minors.

In the final chapter, a comparative approach is adopted to confront the actions of specific EU member states in addressing three distinct practical barriers. This approach helps bridge the gap between theoretical discussions and their real-world application, identifying best practices and areas that need improvement. By comparing the application of international norms in the national contexts, it is also possible to assess their content and effectiveness,[28] as well as to maintain a close link between international, regional and domestic level.[29] In fact, according to some scholars, multiple understandings of international human rights law are missed when the field is only studied through a doctrinal method.[30] Finally, comparing states' practices is useful to highlight the importance of international human rights law in promoting harmonized practices across different contexts to protect the right to health of undocumented minors.

[28] Andrea Carcano, 'Uses and possible misuses of a Comparative International Law approach' (2018) 54 *Questions of International Law* 21, 30.
[29] Carcano (n 28) 37.
[30] Damian Gonzalez-Salzberg and Loveday Hodson (ed), *Research Methods for International Human Rights Law. Beyond the traditional paradigm* (Routledge 2021).

2. Undocumented Minors as a Vulnerable Subject

2.1. Vulnerability in International Human Rights Law

It can be argued that the situation of undocumented minors and the protection of their rights, specifically the right to health, should be examined, despite the lack of data in this regard, because of their high grade of vulnerability that enhances their need for protection. To substantiate this statement, which is not without criticism, it is first of all necessary to understand what vulnerability means in international human rights law. Indeed, this concept and its implications are not as obvious as they may seem for those who are approaching it for the first time.

The concept of vulnerability has been examined by many scholars, and the topic has been thoroughly discussed. According to Martha Fineman,[31] one of the most prolific scholars on this issue, vulnerability is inherent to every human being, and what should be taken into consideration is the degree of resilience that specific groups or individuals have. The word "resilience" identifies the ability of individuals to overcome their vulnerability, which corresponds to the risk of harm.[32] Therefore, this perspective focuses on the resources available to individuals, and on the role of states and other institutions in providing these resources and reducing inequalities.[33] However, Fineman's theory is not universally embraced due to its association with the concepts of individualization and self-management.[34] Furthermore, it can be contested that her doctrine is closely linked to the U.S. society in which she resides, therefore having differences from the EU context that will be addressed in this thesis. Indeed, while European states tend to favor a welfare state system that is mindful of everyone's rights, US services mostly depend on private subjects.[35] Moreover, the concept of vulnerability has been mentioned multiple times in international human rights law. Considering that this thesis relies on legal sources, the emphasis will be on vulnerability rather than on resilience.

Regarding the utilization of the vulnerability concept in legal contexts, it must be clarified that it is frequently employed in discussions of rights, but at the same time, a specific categorization of

[31] Her most recent works include: Martha Albertson Fineman, 'Beyond Equality and Discrimination' (2020) 73 *SMU Law Review* 51; Martha Albertson Fineman, 'Vulnerability and Social Justice' (2019) 53 *Valparaiso Law Review* 341.
[32] Martha Albertson Fineman, 'The Vulnerable Subject and the Responsive State' (2010) 60 *Emory Law Journal* 251, 269.
[33] Martha Albertson Fineman, 'Vulnerability and Inevitable Inequality' (2017) 4 *Oslo Law Review* 133, 143.
[34] See e.g. Benjamin Davis and Eric Aldieri, 'Precarity and Resistance: A Critique of Martha Fineman's Vulnerability Theory' (2021) 36 *Hypatia* 1.
[35] On this, see e.g. Dennis C. Spies, *Immigration and Welfare State Retrenchment: Why the US Experience is not Reflected in Western Europe* (Oxford University Press 2018)

vulnerable groups in international legal texts is lacking. Indeed, although certain conventions (for example, the Convention of Belem do Para) and soft-law documents include lists of particularly vulnerable groups, they are never exhaustive, as demonstrated by the word "other" which usually ends those statements.[36] The identification of specific categories is usually connected to particularly limited scopes, i.e. to a specific right or issue that has currently been addressed by an international human rights body.[37] However, from the mentioned lists it is possible to extrapolate some recurring categories that prove valuable when referring to undocumented minors, such as age and status.[38]

The absence of clearly defined lists can be attributed to the consequences deriving from increased vulnerability: states would be required to provide a higher level of protection to more vulnerable groups. Furthermore, even if broader protection was explicitly demanded, it would still be impossible to determine the level of care required *a priori*. Instead, the appropriate level should be determined case by case, considering the concrete situation of a specific person, the risks faced by them, and the categories of vulnerability that can be applied.[39] In fact, the categories connected to vulnerability are often combined, creating sub-groups that can lead to different degrees of protection. It can be said that undocumented minors, besides being vulnerable as are all human beings, have a triple vulnerability: as children, as migrants, and as undocumented migrants.[40] The specific vulnerability of these three categories will be further analyzed in separate sections. The description will begin by addressing the most general category of vulnerability, encompassing all children, progress towards the more specific group of migrants, and finally to the sub-group of undocumented migrants.

As a last critical element before proceeding to a more specific discussion on the vulnerability of undocumented minors, it must be highlighted that the identification of specific groups as particularly vulnerable is not without its critics. Indeed, certain scholars have observed that discussing the vulnerability of a particular category can contribute to its stigmatization, with a paternalistic logic that prioritizes state assistance instead of building resilience.[41] Moreover, if the concept is overgeneralized, all those inside a group are thought to face the same kind of vulnerability, which is

[36] Alexander H. E. Morawa, 'Vulnerability as a Concept of International Human Rights Law' (2003) 6 *Journal of International Relations and Development* 139, 141.
[37] Morawa (n 36) 150.
[38] Morawa (n 36) 141.
[39] Morawa (n 36) 150.
[40] Bicocchi (n 17) 112.
[41] Ana Beduschi, 'Vulnerability on Trial: Protection of Migrant Children's Rights in the Jurisprudence of International Human Rights Courts' (2018) 36 *Boston University International Law Journal* 55, 58.

false.[42] Migrant children, for example, do not have the same necessities nor do they face the same issues as other children, and their level of vulnerability can also be influenced by their economic situation, gender, and possible disabilities.

However, children's specific rights can be given broader consideration if their vulnerability is judicially recognized, as has been done by the European Court of Human Rights (ECtHR) when handling certain cases that concerned migrant children.[43] Positive outcomes can be reached especially if the courts consider the particularities of each specific situation of the individuals, which avoids stigmatizing practices. Furthermore, identifying certain vulnerabilities as relative to a certain situation and not inherent to a group can lead to broader protection from harm.[44]

In conclusion, to avoid utilizing the concept of vulnerability in a way that reinforces paternalistic views, courts should adopt a multi-faceted analytical approach, which should consider both the groups to which an individual belongs and the specific circumstances that each individual is confronted with. By using this context-based approach, the courts can use the concept of vulnerability to expand the protection of the rights, but without widening stigmatization and fueling stereotypes.[45]

2.2. Vulnerability as Children

As previously mentioned, the vulnerability of undocumented minors can be delineated into distinct layers, each deserving separate consideration for a more comprehensive understanding of their situation. First, undocumented minors have a special vulnerability that is connected to their minor age and their non-completed development, as stated by the Committee on the Rights of the Child (CRC committee) in a General Comment (GC) of 2003.[46] The particular phase of life they are going through makes them vulnerable, even though the extent of the vulnerability can vary, increasing due to particular situations, such as being in a certain geographic dimension.[47] However, the fact that

[42] Beduschi (n 41) 68.
[43] E.g. in *Elmi and Abubakar v Malta* App Nos 25794/13 and 28151/13 (Judgment, Fourth Section) (European Court of Human Rights, 12 July 2016); *Popov v France* App Nos 39472/07 and 39474/07 (Judgment, Fifth Section) (European Court of Human Rights, 19 January 2012).
[44] *Elmi and Abubakar.*
[45] Beduschi (n 41) 68.
[46] Committee on the Rights of the Child, 'General comment No. 5 (2003) on general measures of implementation of the Convention on the Rights of the Child' (3 October 2003) CRC/GC/2003/5, para. 72 f.
[47] Kirsten Sandberg, 'The Convention on the Rights of the Child and the Vulnerability of Children' (2015) 84(2) *Nordic Journal of International Law* 221, 245.

they are not fully physically nor mentally developed always leads to the need of greater protection of their rights.[48]

In the wording of the CRC committee, the fact that children's vulnerability leads to broader protection of their rights looks clear and undeniable, and this has been confirmed even by the ECtHR in certain judgments, such as *Rahimi v. Greece*[49] and *Popov v. France*.[50] Both cases concern asylum-seeking minors, and the ECtHR states that children are an extremely vulnerable category, and that age consideration should prevail when making decisions concerning them. However, among scholars, there are contrasting views on children's vulnerability. Firstly, especially in the past, certain scholars supported the will theory of rights, according to which rights only pertain to those who have the capacity to choose to be right holders, and therefore to respect the duties connected to the rights they hold.[51] If children are considered more vulnerable than adults because they cannot autonomously render decisions regarding their rights, then, according to this theory, they may not be entitled to any rights.[52] However, this is not the theory that has been the basis of the CRC and other international law instruments, that instead consider the right holders as persons to whom other subjects have an obligation to grant certain rights.[53] When considering general international human rights treaties, all human beings are right holders, and children are included since they are regarded as human beings under international law.[54]

Moreover, other criticisms can be found against the application of the concept of vulnerability in addressing issues related to children. The perspective that all human beings are vulnerable and only their degree of resilience is different[55] can lead to the conclusion that children are not entitled to special rights, as they should be. This idea can be countered by examining studies on the physical and psychological development of children, as well as the practical observance of their behaviors, which show that minors do not always act in their best interests and that they should not be presumed

[48] Sandberg (n 41) 222.
[49] *Rahimi v Greece* App No 8687/08 (Judgment, First Section) (European Court of Human Rights, 5 April 2011).
[50] *Popov v France* para. 91.
[51] Joseph Bowen, 'Beyond Normative Control: Against the Will Theory of Rights' (2020) 50(4) *Canadian Journal of Philosophy* 427, 432.
[52] On this topic, see for example James Griffin, *On Human Rights* (Oxford University Press 2009); Harry Brighouse, 'What Rights (if any) Do Children Have?', in David Archard and Colin M. Macleod (ed), *The Moral and Political Status of Children* (Oxford University Press 2002) 31.
[53] For a broader discussion on rights' theories applied to children, see Robert E. Goodin and Diane Gibson, 'Rights, Young and Old' (1997) 17 *Oxford Journal of Legal Studies* 188.
[54] John Tobin, 'Understanding Children's Rights: A Vision beyond Vulnerability' (2015) 84 *Nordic Journal of International Law* 155, 160.
[55] As says for example Martha Fineman.

to have the capacity to understand the consequences of their actions, as it happens with adults.[56] Therefore, considering adults and children equally vulnerable fails to acknowledge the reality.

Conversely, acknowledging that children do not possess the same capacity as adults to exercise choices about their lives should not lead to a situation where their development is not taken into account and their opinions are disregarded. Indeed, the right of the child to be heard is one the of the basic principles of the CRC, and its application should be ensured in a way that is beneficial for the minors.[57] Excessive control over the rights and lives of children would not allow them to develop their capacity and resilience, and they would be treated as objects that must be protected but without listening to them. In this case, excessive attention toward vulnerability would actually increase the latter.[58]

In response to these criticisms and concerns, certain scholars have suggested the adoption of a rights-based approach, which wants to strike a balance between recognizing children's vulnerability and ensuring their right to be heard. According to this theory, children should be recognized as individuals entitled to specific rights, with their maturity and age assessed to determine their capacity to render decisions regarding their needs. This means that, while sometimes adults will be the only ones in charge of making decisions, at times they will have to collaborate with children, and sometimes the latter will possess the full capacity to evaluate their own vulnerability and the best way to address it.[59] Therefore, using a rights-based approach can help overcome the main concerns related to granting special rights to children based on their vulnerability, leading to their recognition as a particularly vulnerable group.

Following the determination that children should be regarded as subjects of rights, another question that arises is whether all children are vulnerable in the same way. As previously mentioned, the concept of vulnerability has been used in international human rights law to claim a higher level of protection towards certain groups, including children. While vulnerability varies depending on various factors, it is challenging to establish a hierarchy of vulnerability due to the absence of a comprehensive list that would lead to different levels of responsibilities to protect rights.

[56] Tobin (n 54) 165.
[57] For a more thorough analysis of the right of the child to be heard, see e.g., Aisling Parkes, *Children and International Human Rights Law: The Right of the Child to be Heard* (Abingdon 2013); Daniel O'Donnell, *The right of children to be heard: Children's right to have their views taken into Account and to participate in legal and administrative proceedings* (UNICEF Innocenti Working Paper, 2009).
[58] Tobin (n 54)169.
[59] Tobin (n 54) 180.

Nevertheless, the words used by human rights bodies for describing certain categories can be instrumental in determining a hierarchy. Indeed, the CRC committee uses certain words, such as "particularly", "extremely" or "especially", when referring to the vulnerability of certain groups of children, to underscore that they deserve extra care due to their special situation.[60] Sometimes even other particulars are added to the text, for example by using statistics concerning a specific condition or enumerating the risks that certain minors face.[61]

When the theory of vulnerability is employed to examine the CRC, it is also necessary to highlight the geography dimension of this theory, from which two sides can be identified. On the one hand, the geography dimension relates to all the places where children can build their resistance to vulnerability, such as their family, school, and community. On the other hand, it refers more specifically to the more traditional view of geography, and in this sense, it is strictly connected to migrant children. Indeed, the latter find themselves in an environment that is different from the one they were used to, and this increases their vulnerability and the possibility that their rights will be violated, especially if they do not have the support of their family anymore.[62] This aspect will be further elaborated upon in the following sections.

2.3. Vulnerability as Migrants

On the vulnerability of migrants, limited available material can be found, perhaps due to various factors. Firstly, the word "migrants" includes many different sub-groups, whose situation and vulnerability can be extremely different. For example, highly skilled labor migrants are attracted by states to use their qualifications and therefore bring a benefit, as exemplified in the case of Finland through the Talent Boost project, funded by the Finnish Government.[63] The situation of this migrant group notably differs from the one of refugees, asylum seekers, or irregular migrants, for their background, competencies, and for society's perception on their presence in the country. In fact, while highly skilled migrants are attracted, stereotypes and fear persist for other sub-groups of migrants, and states fight to maintain their sovereignty. Indeed, the sovereignty principle gives states the right to control entries inside their territories, and it is one of the reasons why enacting new hard

[60] E.g., the use of "particular" referring to street children in CRC committee, Concluding Observations: Mozambique, CRC/C/15/Add.172 (7 February 2002) para. 52 (d); children with disabilities in CRC committee, Concluding Observations: Sudan, CRC/C/15/Add.10 (18 October 1993) para. 13.
[61] Morawa (n 36) 142.
[62] Sandberg (n 47) 238.
[63] See <https://tem.fi/en/talent-boost-en>.

laws on migration is exceptionally challenging, and both courts and committees exercise caution in describing migrants as a vulnerable group.[64]

As previously mentioned, the geography of vulnerability leads to a deeper discussion concerning migration, which hinders children's rights because no state wants to take responsibility for their protection.[65] One of the main causes of vulnerability with regard to migrants is the fact that they are forced to use dangerous routes to migrate, due to the lack of legal and safe ones, therefore risking of being subject to abuse and exploitation.[66] The imperative to turn to irregular routes often arises from state policies based on securitization, which is connected to the desire to keep territorial sovereignty, often prioritizing security measures over the recognition of human rights.[67] Indeed, society tends to consider all migrants as unworthy of protection and often compares them to criminals, as demonstrated by the fact that many similarities can be found between immigration law and criminal law. Juliet Stumpf coined the term "crimmigration" to describe this phenomenon, highlighting the similitudes between the two kinds of law.[68]

Even after migrants have reached the host country, their situation does not become any easier: they live with constant uncertainty, and their vulnerability is elevated, whether they are irregular or asylum seekers. It can be stated that, although at a different level, vulnerability is inherent to all migrants, regardless of their affiliation with specific subgroups.[69] In fact, all of them are displaced from their support structures and usually even from their family, and they often resort to third party sources of help because they do lack access to adequate information, thereby exacerbating their vulnerability and risk of exploitation.[70] The mental well-being of migrants is also affected by the migration process, as can be easily understood by considering the experiences they live and the trauma they face. For example, a study conducted with a multidisciplinary approach showed that

[64] Tarvainen Laura, 'Embodied and Embedded Vulnerable Subject: Asylum Seekers and Vulnerability Theory' (2019) 17 *No Foundations* 183, 197.
[65] Tarvainen (n 64) 242.
[66] Majia Mustaniemi-Laakso, Mikaela Heikkilä, Eleonora Del Gaudio, Sotiris Konstantis, Maria Nagore Casas, Dolores Morondo, Venkatachala G. Hegde, Graham Finlay, 'The protection of vulnerable individuals in the context of EU policies on border checks, asylum and immigration' (2016) *FRAME (Deliverable 11.3)* 9.
[67] Gwendolyn Sasse, 'Securitization or Securing Rights? Exploring the Conceptual Foundations of Policies Towards Minorities and Migrants in Europe' (2005) 43 *Journal of Common Market Studies* 673.
[68] Juliet P. Stumpf, 'The Crimmigration Crisis: Immigrants, Crime, and Sovereign Power' (2006) 56 *American University Law Review* 367, 381.
[69] Mustaniemi-Laakso (n 66) 9.
[70] David, Bryant and Joudo Larsen (n 4) 10.

political refugees have greater difficulties in handling their emotions, which results in them suffering from PTSD, usually associated with personality or other mental disorders.[71]

While the specific vulnerability of irregular migrants will be specifically addressed in the next paragraph, the condition of asylum seekers will now be briefly mentioned. Indeed, although being undocumented may seem a more difficult situation, and to a certain extent it is, asylum seekers undergo a complete dependency on the host state, which presents an obstacle to the recognition and protection of their rights.[72] This particular vulnerability has also been acknowledged by the ECtHR in *M.S.S. v. Belgium and Greece*.[73] Moreover, when assessing the credibility of asylum seekers to determine their eligibility for refugee status, the concept of vulnerability is sometimes used as an exclusionary tool. This can result in the exclusion of young men from special protection measures due to their perceived ability to work.[74] Therefore, this instrument should always be used carefully, not to deny anyone the protection they require.

2.4. Vulnerability as Irregular Migrants

2.4.1. Irregular Migrants as a Vulnerable Subject

While asylum seekers need their credibility to be assessed in order to be considered worthy of protection, undocumented migrants are regarded as a group of lawbreakers, unworthy of possessing rights and protection, and therefore subject to detention or deportation.[75] The particular status of irregular migrants, which enhances their vulnerability, actually depends on states' policies and legal procedures, rather than on the willingness of migrants of breaking the law intentionally.[76] Many irregular migrants experience semi-legality, often due to common reasons such as overstaying in a country where they initially entered legally. Moreover, there is also a condition of semi-belonging, which embodies invisibility and alienation from society, and places undocumented migrants

[71] See Emanuele Caroppo, Giuseppina Del Basso, Patrizia Brogna, 'Trauma e vulnerabilità nei migranti richiedenti protezione internazionale' (2014) 43 *Revista Interdisciplinar da Mobilidade Humana* 99.
[72] Mustaniemi-Laakso (n 66) 10.
[73] *MSS v Belgium and Greece* App No 30696/09 (Judgment, Grand Chamber) (European Court of Human Rights, 21 January 2011) para. 232: "the Court must take into account that the applicant, being an asylum seeker, was particularly vulnerable because of everything he had been through during his migration and the traumatic experiences he was likely to have endured previously".
[74] Tarvainen (n 64) 191.
[75] Magdalena Kmak, 'The right to have rights of undocumented migrants: inadequacy and rigidity of legal categories of migrants and minorities in international law of human rights' (2020) 24 *The International Journal of Human Rights* 1201, 1202.
[76] Fabio Macioce, 'Undocumented migrants, vulnerability and strategies of inclusion: A philosophical perspective' (2018) 25 *Constellations* 87, 90.

between citizens and non-citizens, escaping from this traditional dualism. Both conditions are connected to irregular status and uncertainty, and they lead to a particularly high degree of vulnerability. The situation of irregular migrants is worsened by social misrecognition, which complicates their integration into society and the protection of their rights.[77]

Another element that should be taken into consideration when engaging with undocumented migrants is their fear of being discovered and therefore deported or detained because of their status. This leads to mistrust towards authorities and may hinder them from seeking assistance, diminishing the possibility of their rights being protected.[78] This situation is easily understandable, considering that undocumented immigrants, especially children, usually encounter state authorities only as agents of repression and control.[79] The main issue is that service providers, such as medical doctors and schools, sometimes have an obligation to report to legal authorities the irregular status of those who ask for the services. Furthermore, while in certain countries authorities are obliged not to disclose individuals' immigration status to ensure their access to essential services and protect their fundamental rights, undocumented migrants often lack awareness of these policies.[80] Due to their consequent fear, they tend to avoid using necessary services to prevent potential reports of their irregular status.[81]

From an international human rights law perspective, there should be a thorough study of the concrete situation when handling cases that involve undocumented persons. On the one hand, vulnerability applies to the whole group of irregular migrants, because of the elements mentioned above. On the other hand, vulnerability is also strictly connected to the historical, institutional, and social context, therefore varying depending on the individual who is considered. This means that the individual situation must be carefully taken into account to identify the degree of vulnerability of the migrant, but at the same time irregular status cannot be overlooked, because it makes every choice regarding that person more likely to cause harm to them.[82]

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[77] Macioce (n 76) 91.
[78] Jyothi Kanics, 'Realizing the Rights of Undocumented Children in Europe', in Jacqueline Bhabha (ed. by), *Children Without a State: A Global Human Rights Challenge* (MIT Press 2011) 131, 141.
[79] Elena Rozzi, 'Undocumented Migrant and Roma Children in Italy: Between Rights Protection and Control', in Jacqueline Bhabha (ed. by), *Children Without a State: A Global Human Rights Challenge* (MIT Press 2011) 177, 184.
[80] E.g. in Finland healthcare professionals do not have the right to report the irregular status of their patients to the authorities. See: <https://thl.fi/> More examples can be found in Chapter 5.2.4 of this thesis.
[81] OHCRC and WHO (n 1) 19.
[82] Macioce (n 76) 98.

Specifically referring to undocumented minors, their higher degree of vulnerability is connected to the fact that prejudice, stereotypes, and discrimination against them are still a tangible reality. A dual gap can be found in policies, since those related to children's rights often assume their citizenship within the involved state, while policies related to migration mostly focus on adults.[83] This situation, more than from a problem of invisibility in front of the law, comes from the society's desire to exclude those who are considered a threaten, notwithstanding the age.[84] In political discourses, irregularity is always underlined over minor age, and undocumented minors' situation makes them look like delinquents in the eyes of the authorities and the society.[85] Therefore, their vulnerability is enhanced due to this kind of hostile consideration and treatment, which decreases their possibility to be helped and to see their rights protected.[86] The consideration given to irregular migrants by the international community can be confirmed also considering the above-mentioned *Rahimi v. Greece* and *Popov v. France*. As previously mentioned, both cases involve minor asylum seekers, and the ECtHR emphasizes that children's vulnerability should always take precedence over their "status of illegal immigrant".[87] This shows that irregular status is not considered an element that increases vulnerability but is often treated as an element to blame.

According to certain scholars, children who are in an undocumented situation can be defined as *de facto* stateless, which means that they are still nationals of their country of origin, but they cannot take advantage of it, because they have emigrated irregularly to the host country. Therefore, on the one hand, they cannot demand anything from the country they are nationals of, and on the other hand, the general protective measures provided by the host country do not apply to them.[88] This means that they are not granted access to basic services, and at the same time they do not receive protection from serious rights violations, such as exploitation.[89] In certain cases, undocumented children can even become *de jure* stateless, which hinders them from enjoying basic rights. For example, there can be a lack of birth registration of children due to their undocumented parents' fear of revealing their irregular status during the registration process or because the procedures are excessively bureaucratic and complex. If the children whose birth registration has never been done

[83] Jacqueline Bhabha (ed), *Children Without a State: A Global Human Rights Challenge* (MIT Press 2011), 19.
[84] Bhabha (n 83) 19.
[85] See e.g. the decision of the Italian region Lombardia about irregular minors' health: Salvatore Geraci, 'Politica, migrazioni e salute. A farne le spese sono i più piccoli' (*Salute Internazionale*, 11 July 2013), <saluteinternazionale.info> accessed 12 January 2023.
[86] Kanics (n 78) 143.
[87] *Popov v France* para. 91.
[88] Bicocchi (n 17) 110.
[89] Rozzi (n 79) 184.

are not entitled to the citizenship of their parents by descent, and they do not manage to regularize their status later on, they will become stateless.[90]

Finally, it should be noted that since vulnerability is a non-legal concept that can be interpreted in different ways, the perception of different sub-groups is an important element to consider, together with the objective differences that can be found among them. While a comprehensive discussion on this point is beyond the scope of this thesis, it is important to emphasize two key categorizations. Firstly, according to CRC Article 1, a "child" is any person under 18 years old. However, especially in the migration context, a child who is 3 years old may be seen as more vulnerable than a 17-years-old adolescent, who is almost an adult and is therefore identified as a threat. For older children, there are also many suspects around their age declaration, which states try to contrast by using different age-assessment techniques, often contested because of their scarce accuracy or high invasiveness.[91]

A second differentiation that is worth mentioning is the one between girls and boys. Being a girl, on the one hand, enhances the child's vulnerability because of a higher chance of becoming a victim of trafficking[92] and sexual violence.[93] On the other hand, the societal notion of women as more vulnerable often leads to the tendency to embrace stereotypes, portraying girls as vulnerable and boys as less vulnerable.[94] In conclusion, even though undocumented minors are always in a vulnerable position, the degree of vulnerability can vary depending on other characteristics. The next paragraph will show another clear example of these differences.

2.4.2. Differences Between Accompanied and Unaccompanied Children

In addition to the age and gender of the minors, a fundamental distinction to consider when dealing with undocumented children is whether they arrived in the host country accompanied or unaccompanied. To gain a clearer understanding of their distinct circumstances, a definition of those

[90] Kanics (n 78) 136.
[91] On these techniques, see e.g. Jill Benson, Jaklin A. Elliot, Ashish I. Vaska and Jan Williams, 'Age determination in refugee children: A narrative history tool for use in holistic age assessment' (2016) 52(5) *Journal of Paediatrics and Child Health* 523.
[92] Farhan Navid Yousaf, 'Forced migration, human trafficking, and human security' (2018) 66(2) *Current Sociology Monograph* 209, 210.
[93] See e.g. Ines Keygnaerta, Nicole Vettenburgband and Marleen Temmerman, 'Hidden violence is silent rape: sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands' (2012) 14(5) *Culture, Health & Sexuality* 505. See also OHCHR, 'Principles and Guidelines, supported by practical guidance, on the human rights protection of migrants in vulnerable situations' (February 2017) 45.
[94] Alexandra Timmer, 'Toward an Anti-Stereotyping Approach for the European Court of Human Rights' (2011) 11 *Human Rights Law Review* 707, 738.

categories is needed. According to the Inter-Agency Guiding Principles on Unaccompanied and Separated Children, are categorized as "unaccompanied" the minors "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". [95] Separated children, conversely, "are those separated from both parents, or from their previous legal or customary primary care-giver, but not necessarily from other relatives."[96] In either case, they are considered irregular migrants if they fail to lodge an asylum claim or do not ask for a residence permit in the host state, or if the request is rejected. [97]

According to Bicocchi, unaccompanied minors lack support from their parents and family in general, as well as from their community. Being in an irregular situation also implies that they cannot benefit from the support system that is usually granted by states to children, both citizens and non-citizens, who grow up without their families. [98] In fact, although they are entitled to state protection, in practice, they are frequently unaware of this opportunity, or they are too afraid of authorities to ask for help. The CRC committee has drafted a GC specifically on how the host countries should treat unaccompanied and separated children, highlighting the fact that they are in a "particularly vulnerable situation" and that gaps can be found in the law concerning their protection. [99] Building upon these premises, the CRC committee reaffirmed the obligations, both positive and negative ones, that states have towards this group. This shows the recognition by the international community that this category of children has a particular vulnerability and that it needs broader protection, but at the same time, being a non-binding document, it does not guarantee that those necessities will be respected by states.

While the circumstances of accompanied children might appear more advantageous due to family support, their rights are still at risk because they are closely linked to those of their parents. Firstly, bureaucratic practices impede them from benefiting from social services or only grant benefits under unacceptable conditions. For example, undocumented minors are granted access to shelters, but usually, their families are excluded from accessing them. Therefore, accompanied children have to choose whether they want to live in the shelter alone or stay with their family but have difficulties in finding accommodation. Moreover, irregular migrants face economic challenges, and their right

[95] Inter-Agency Working Group on Unaccompanied and Separated Children, 'Inter-Agency Guiding Principles on Unaccompanied and Separated Children' (January 2004) 13.
[96] Inter-Agency WG (n 95).
[97] PICUM (n 11) 3.
[98] Bicocchi (n 17) 109.
[99] CRC committee, 'General comment No. 6 (2005): Treatment of Unaccompanied and Separated Children Outside their Country of Origin' (1 September 2005) CRC/GC/2005/6, para. 1.

to housing is also compromised by the fact that in many cases documents are needed to get a housing contract.[100] Furthermore, recommendations and policies for accompanied minors are lacking, which enhances their vulnerability. Indeed, on the one hand, recommendations for unaccompanied children do not apply to them, even when the application would be feasible and beneficial. On the other hand, policies would be needed to respond to situations that are peculiar to accompanied children, such as the actions to take when their parents are detained or expelled, or a possible solution to avoid their separation from their family when they are granted the above-mentioned access to shelters.[101]

As evidenced by this concise analysis of the differences that characterize the situations of accompanied and unaccompanied irregular children, the peculiarities of these two groups should also be taken into account when defining their degree of vulnerability and deciding upon the level of protection they need according to it. However, the analysis also underlined that both categories have elements of particular vulnerability, requiring special protection.

2.4.3. Consequences of Irregularity on Children's Development

A significant aspect of children's vulnerability comes from their ongoing development and transition into adulthood. The importance of their development is recognized even by international human rights law: in particular, the CRC mentions it both in its preamble and Article 6, and according to the CRC committee it must be interpreted in a holistic sense, which embraces "the child's physical, mental, spiritual, moral, psychological and social development".[102] Since the focus tends to be on the short-term repercussions of laws and policies, it is evident that taking a broader perspective and examining long-term data is essential for ensuring positive development. Additionally, understanding the impacts of undocumented status on minors is valuable in demonstrating their vulnerability.

The situations in which children find themselves and the experiences they live have an impact on their development, especially the cognitive one.[103] The uncertainty that comes from their irregular status is reflected in undocumented minors' everyday life because of the constant fear of being deported or detained, or seeing one of their parents or relatives being deported or detained. This

[100] Bhabha 2011, 122.
[101] Rozzi (n 79) 201.
[102] CRC committee (n 46) para. 12.
[103] Concerning this topic, see e.g. Stephanie A. Guinosso, Sara B. Johnson and Anne W. Riley, 'Multiple adverse experiences and child cognitive development' (2016) 79 *Pediatric Research* 220.

hinders them from participating in normal activities in the host country and therefore makes their integration more difficult.[104] Regrettably, the effects of irregular status on children's development are not much researched, and they are usually not taken into account when making decisions concerning them.[105]

The biggest part of research that can be found on this topic describes the situation of minors with refugee status, and especially of the unaccompanied ones.[106] Moreover, the majority of these studies are cross-sectional and descriptive, focus only on specific groups of refugees and mostly on European host countries.[107] Nevertheless, even from this limited amount of data, results clearly show that minors with refugee status suffer from higher risk of psychiatric disorders, due to their trauma exposure.[108] According to follow-up studies, mental health issues persist at a substantial level in refugee children even after they have spent a certain amount of time in the host country, therefore continuing to have a strong influence on their development.[109] When evaluating the impact of migration on minors' development, it should always be taken into account that being a refugee means that the status of the person has been recognized, therefore granting her at least a degree of stability in the host country.[110] On the contrary, undocumented migrant children have first suffered from migration and every issue that comes from it, and then they continue suffering from uncertainty, without having a defined status and without the possibility of benefiting from certain services that are reserved for refugees.

Despite the limited available data on the psychological effects of being undocumented on children, certain studies show that the sense of not belonging to the host country can lead them to social isolation. Especially in the US context (but it applies to all Western countries where certain characteristics are considered to be "the norm"), often researchers mention the perpetual foreign

[104] Carola Suárez-Orozco and Hirokazu Yoshikawa, 'The Shadow of Undocumented Status', in Carola Suárez-Orozco, Mona M. Abo-Zena and Amy K. Marks ed. by), *Transitions. The Development of Children of Immigrants* (NYU Press 2015) 97, 104.
[105] One of the only studies, which considers the US context, can be found in the book Carola Suárez-Orozco, Mona M. Abo-Zena and Amy K. Marks (ed. by), *Transitions. The Development of Children of Immigrants* (NYU Press 2015).
[106] E.g., see Farah Khan, Noha Eskander, Therese Limbana, Zainab Salman, Parveez A. Siddiqui and Syed Hussaini, 'Refugee and Migrant Children's Mental Healthcare: Serving the Voiceless, Invisible, and the Vulnerable Global Citizens' (2020) 12(8) *Cureus*.
[107] Abigail H. Gewirtz, Lynn Muldrew, Margrét Sigmarsdóttir, 'Mental health, risk and resilience among refugee families in Europe' (2022) 47 *Current Opinion in Psychology* 1, 2.
[108] Gewirtz (n 107) 3.
[109] Marianne Vervliet, Jan Lammertyn, Eric Broekaert and Ilse Derluyn, 'Longitudinal follow-up of the mental health of unaccompanied refugee minors' (2014) 23 *European Child & Adolescent Psychiatry* 337, 340.
[110] UNGA, 'Convention Relating to the Status of Refugees' (adopted 28 July 1951, entry into force 22 April 1954) UNTS 189, 137, Art. 31.

syndrome, which is a microaggression and a form of discrimination. This syndrome is connected to the fact that the children of immigrants, especially if they are black or with traits that are not recognized as "the norm", are asked where they come from or are praised for their good local accent, although sometimes they have never lived in the origin country of their family. This can be related to undocumented children who were born in the host country to undocumented parents, and therefore cannot be considered citizens of that country, if the principle of *ius soli* is not applied in that country or their birth has never been registered.[111] A similar experience can also occur to those who have migrated when they were still babies or very young children.

Furthermore, childhood represents a critical phase for personal development, and experiencing it in a host country without documentation poses educational challenges for both unaccompanied and accompanied minor migrants. Indeed, although studies demonstrate that undocumented parents devote as much time as possible with their children and care about their education, they suffer from language barriers in communication with the school, lack of proper information, and fear of being caught if they have contacts with service providers. Moreover, the economic difficulties and psychological distress of the parents have an impact on the children's lives as well.[112]

Growing up and entering into adolescence, undocumented minors feel a growing sense of exclusion from society, and are left out of social rituals that define adulthood, such as getting a driving license.[113] Furthermore, the discrimination and the media representation of their situation, as well as the social and legal exclusion, create stress that can manifest itself through internalized or externalized symptoms, such as anxiety in the first case and substance abuse in the second one.[114] Differences can also be detected among undocumented minors depending on the age they migrate into the host country, but once again attention to this topic is still in its early stages and it needs further research, especially for making more attentive policies on family reunification.[115]

In fact, another element to consider is that many undocumented children suffer from long separations and difficult reunifications with their parents, given that the family reunification process is long and

[111] Seth J. Schwartz, Miguel Ángel Cano and Byron L. Zamboanga, 'Identity Development', in Carola Suárez-Orozco, Mona M. Abo-Zena and Amy K. Marks (ed. by), *Transitions. The Development of Children of Immigrants* (NYU Press 2015) 142, 144.
[112] Suárez-Orozco and Yoshikawa (n 104) 105.
[113] Daysi Ximena Diaz-Strong and Roberto G. Gonzales, 'The divergent adolescent and adult transitions of Latin American undocumented minors' (2023) 17(1) *Child Development Perspectives* 3, 7.
[114] Suárez-Orozco and Yoshikawa (n 104) 107.
[115] Diaz-Strong and Gonzales (n 113) 7.

complex. Certain individuals opt for irregular pathways since the legal ones appear impossible to go through. Even when they reunite with their biological parents, minors will experience difficulties, since they have spent much time apart from them.[116] In this context, being unaccompanied adds another layer of difficulty for children, who suffer the fact that they do not have any adult to support them in the foreign country, and they have to face post-migration social exclusion and discrimination.[117]

Further research into the impact of irregular status on children's development is crucial, as data are essential for addressing the existing challenges and initiating discussions that may result in more suitable and attentive policies. Current legal provisions aim to protect minors' rights in the present, rather than considering future needs. If undocumented children have issues integrating into the host society, they will be less likely to feel a sense of belonging, and this could lead to negative outcomes. If they have fewer possibilities of getting a good education, they will be less likely to express their full potential and to bring benefits to the host country. If they suffer from uncertainty, stress, anxiety, and even PTSD, they will grow up as more vulnerable adults, afraid of authorities and in need of mental healthcare services.

The analysis of the vulnerability of undocumented minors and its impact on children's development aimed to highlight the importance of studying their access to the right to health, taking into account their unique situation and the consequences of actions taken concerning them. After this necessary premise, the next chapter explores the core of this thesis, examining the legal aspects of the right to health and assessing the extent of protection afforded to undocumented children. It also investigates whether this protection considers the composite nature of vulnerability associated with their described situation.[118]

[116] Suárez-Orozco and Yoshikawa (n 104) 102.
[117] On this topic, see e.g. Jordan Bamford, Mark Fletcher and Gerard Leavey, 'Mental Health Outcomes of Unaccompanied Refugee Minors: a Rapid Review of Recent Research' (2021) 23 *Current Psychiatry Reports* 46; Laura Migliorini, Nadia Rania, Nicoletta Varani, and Joseph R. Ferrari, 'Unaccompanied migrant minors in Europe and U.S.: A review of psychological perspective and care challenges' (2022) 50 *Journal of Prevention & Intervention in the Community* 273.
[118] Beduschi (n 41) 63.

3. Right to Health of Undocumented Minors

3.1. Right to Health in International Human Rights Law

The right to health is undeniably one of the fundamental rights for all human beings, regardless of background, age, and conditions.[119] However, is important to note that different categories of individuals are granted broader protection, due to certain characteristics and, possibly, their perceived level of vulnerability. At the same time, the practical enjoyment of the right to health can be hindered for certain individuals. Therefore, once again, the situation of undocumented minors will be analyzed by dividing the discussion into different parts, beginning with the right to health to which all humans are entitled, followed by an examination of specific norms pertaining to children, migrants, and migrant children.

Although binding international conventions concerning the right to health were drafted only in the mid-1960s, already in the years immediately following World War II it is possible to find soft-law instruments that articulate its content.[120] In 1946, during the International Health Conference organized in New York by the Economic and Social Council of the United Nations, a Technical Preparatory Committee of Experts presented a constitution for a World Health Organization (WHO).[121] According to the preamble of the WHO Constitution, "[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[122] Moreover, it is stated that "[h]ealth is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", implying a positive obligation to provide for it rather than merely protect against its absence. From this, it is possible to understand the importance that was given to the right to health, seen as fundamental and inalienable.[123]

In 1948, the UN General Assembly (UNGA) drafted the Universal Declaration of Human Rights (UDHR),[124] which includes a whole article dedicated to the right to health. Indeed, Article 25 states that everyone is entitled to a "standard of living adequate for the health and well-being", and it

[119] OHCRC and WHO (n 1) 1.
[120] OHCRC and WHO (n 1) 3.
[121] Frank P. Grad, 'The Preamble of the Constitution of the World Health Organization' (2002) 80 *Bulletin of the World Health Organization* 981.
[122] WHO, 'Constitution of the World Health Organization' (New York, 22 July 1946), Preamble.
[123] Grad (n 121) 981.
[124] UNGA, 'Universal Declaration of Human Rights' (10 December 1948) 217 A (III).

further specifies that "medical care" is part of the essential services that should be provided to guarantee the already mentioned adequate standard. This confirms the WHO Constitution's view of the right to health. It should be mentioned the importance of the UDHR, despite its non-binding nature. Drafted by individuals from diverse backgrounds and based on universal human rights, the UDHR has inspired a series of international treaties with legal force, and it remains a foundational document of international human rights law.[125]

As mentioned above, the first international binding treaty that mentions the right to health was drafted in the mid-1960s, in particular in 1965, and it is the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD).[126] Explicitly addressing the prohibition of discrimination, the convention lays down an obligation for States Parties to guarantee everyone's right to "public health, medical care, social security and social services".[127]

The most important international treaty that deals with the right to health, however, is the International Covenant on Economic, Social and Cultural Rights (ICESCR),[128] which was drafted in 1966 by the UNGA. Article 12 recognizes the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health", and it lists a series of measures that states should undertake in order to guarantee it. According to the ICESCR, states are obligated to strive for "[t]he creation of conditions which would assure to all medical service and medical attention in the event of sickness".[129]

According to the GC drafted by the UN Committee on Economic, Social and Cultural Rights (CESCR), the right to health to which this article refers is broader than what it appears to be just reading the plain text: it includes a variety of socio-economic factors that help people to achieve a healthy life, in a more general term.[130] Moreover, the CESCR identifies two factors to take into consideration when establishing "the highest attainable standard" of health: the "individual's

[125] UN, 'Universal Declaration of Human Rights. The Foundation of International Human Rights Law', <https://www.un.org/en/about-us/udhr/foundation-of-international-human-rights-law> accessed 3 October 2022.
[126] UNGA, 'International Convention on the Elimination of All Forms of Racial Discrimination' (adopted 21 December 1965, entry into force 4 January 1969) UNTS 660, 195.
[127] UNGA (n 126) Art. 5 (e) (iv).
[128] UNGA, UN General Assembly, 'International Covenant on Economic, Social and Cultural Rights' (adopted 16 December 1966, entry into force 3 January 1976) UNTS 993, 3.
[129] UNGA (n 128) Art. 12.2 (d).
[130] UN Committee on Economic, Social and Cultural Rights (CESCR), 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)', 11 August 2000, E/C.12/2000/4, para. 4.

biological and socio-economic preconditions"[131] and the available resources for the single state involved. Although the GCs by CESCR and other treaty bodies are not binding on states, they are essential instruments that provide an authoritative interpretation of the treaty texts. States should use them as guidance when they incorporate treaty norms into their legislation.

The CESCR also mentions certain core obligations that states must respect when they act to ensure the right to health, and that can be inferred by reading the ICESCR together with other instruments, such as the Declaration of Alma-Ata,[132] adopted during the International Conference on Primary Healthcare in 1978. This declaration, although not binding, should be mentioned because it has been a milestone in the field of the right to health, and its principles are still at the base of the WHO work. Among the obligations outlined in the Declaration of Alma-Ata, the CESCR emphasizes the commitment to guaranteeing equitable access to healthcare services, goods, and facilities, with a particular focus on the most vulnerable populations. This includes the provision of essential elements such as adequate food, clean drinking water, basic shelter, sanitation, and essential medications, all of which are fundamental to the realization of their right to health.[133]

Article 2 of the ICESCR requires states to progressively realize the rights in the treaty, by taking steps forward and prioritizing international cooperation and assistance among states. This means that countries that cannot achieve the minimum standards of protection should receive help from others, so that they can also fulfill their obligations and enable everyone in their territory to enjoy their fundamental rights, such as the right to health.[134] Moreover, the same article encompasses two obligations that exert an immediate effect on states: the principle of non-discrimination when granting rights,[135] and the prohibition of taking retrogressive measures, unless the state demonstrates that it has made every effort to avoid diminishing the protection of the right in question.[136]

[131] CESCR (n 130) para. 9.
[132] WHO, 'Declaration of Alma-Ata' (Alma-Ata, USSR, 6-12 September 1978).
[133] CESCR (n 130) para. 43.
[134] OHCRC and WHO (n 1) 23.
[135] See 3.2.3.
[136] OHCRC and WHO (n 1) 24.

3.2. Right to Health of Undocumented Minors as Children

3.2.1. IHRL Specific Norms on Children's Health

In addition to the international law norms that generally deal with the right to health, more specific norms related to children can also be identified. Starting from the non-binding but still highly important UDHR, it is possible to find an explicit reference to minors in the article that concerns the right to health, since it states that "childhood [is] entitled to special care and assistance"[137] and that children should receive the same level of social protection "whether born in or out of wedlock".[138] This is quite an old-fashioned definition but recalls the principle of non-discrimination that in other documents, such as the CRC, includes "birth" as a possible factor that causes discrimination in the enjoyment of rights.

In this context, certainly the most important international law convention is the CRC, which is a comprehensive treaty concerning children' rights. The fact that a whole convention was done on this topic shows the international community's recognition of minors as a vulnerable subject,[139] as discussed in the preceding chapter of this thesis. The right to health can be found in CRC article 24, which underlines states' obligation to provide children the "highest attainable standard of health",[140] therefore using the exact same wording as the ICESCR.

The CRC committee has issued specific GCs regarding this article, providing an authoritative and comprehensive explanation of its content. The GCs offer clear guidance to states on how to interpret the norms, although they are not binding. One of the GCs focuses on the "highest attainable standard of health", declaring that a holistic approach should be adopted and that the right to health for children also includes their "right to grow and develop to their full potential".[141] Moreover, it is mentioned that, similarly to the right to health for adults, the right to health for children is closely linked to other economic, social, and cultural rights. Therefore, the provision of healthcare is essential for minors to exercise their other rights. Simultaneously, as rights are interdependent, the fulfillment of children's right to health is hindered if they are denied other rights outlined in the CRC, such as the right to a shelter. The CRC committee reiterates what already said by the CESCR

[137] UDHR Art. 25.2.
[138] UDHR Art. 25.2.
[139] John Tobin and Judy Cashmore, 'Thirty years of the CRC: Child protection progress, challenges and opportunities' (2020) 110 *Child Abuse & Neglect* 1, 4.
[140] UNGA, 'Convention on the Rights of the Child' (20 November 1989) UNTS 1577, 3, Art. 24.
[141] CRC committee, 'General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (Art. 24)' (17 April 2013) CRC/C/GC/15, para. 2.

concerning the highest attainable standard of health, stating that this must be evaluated by looking both at the preconditions of the child concerned and the resources that are available for the state.[142] States are urged to act in order to achieve the minimum requirements and to fulfill the core obligations established by the CRC, by adopting a human-rights based approach and working for a progressive realization of the right to health. Among the topics touched by the CRC committee, there are both preventive care and mental health, that should both be granted to children to ensure the full enjoyment of their rights.[143]

The CRC committee also drafted a GC specifically referring to the right to health of adolescents, who are a particularly vulnerable category among minors, both because of the pressure they receive from society to adopt risky health behaviors and because they are in a crucial moment for the development of their identity and personality.[144] As said in the previous chapter, the vulnerability of adolescents is further heightened when they are migrants, because of the stigma and the climate of suspects against them. The CRC committee's approach adopted when dealing with the right to health of adolescent is once again holistic, therefore giving importance not merely to physical health but also to interrelated rights that should be granted to adolescents so that they can develop in the best way possible. In particular, the CRC committee highlights the importance of "creating a safe and supportive environment",[145] without which it would be impossible to grant the full enjoyment of the right to health: support must be given to adolescents by their families and the whole society, which includes school, peers, media, national and local policies.

3.2.2. The Best Interest of the Child

One of the most important principles concerning children's rights is certainly the best interest of the child, which is stated by CRC article 3 and that "[i]n all actions concerning children […] shall be at primary consideration".[146] The same article affirms that this principle applies to actions undertaken by any actor, ranging from a child's parent or legal guardian to public and private institutions. The CRC committee provided an in-depth explanation of this provision in a GC of 2013, which considers the history of the principle of the best interest of the child, its link with other general principles, and

[142] CRC committee (n 141) para. 23.
[143] A more extensive discussion on preventive care and mental health will be in Chapter 4.
[144] CRC committee, 'General comment No. 4 (2003): Adolescent Health and Development in the Context of the Convention on the Rights of the Child' (1 July 2003) CRC/GC/2003/4.
[145] CRC committee (n 144) para. 10.
[146] CRC Art. 3.

provides guidelines for its interpretation and practical implementation in states' legislations.[147] Specifically, the GC clarifies the threefold nature of the concept of the child's best interest. The best interest should be seen as a substantive and self-executing right, an interpretative legal principle for legal provisions that are open to more than one interpretation, and a rule of procedure that must be taken into account in every decision concerning minors.[148]

In the same GC, the CRC committee states that the best interest of the child principle is aimed at granting children the full enjoyment of their rights, as well as at ensuring their "holistic development".[149] Moreover, a rights-based approach is invoked in order to guarantee the application of this principle. Concerning its implementation, its aims should always be taken into account when doing the best-interest assessment.[150] The latter consists in weighing the different elements of a certain case to understand what decision will be better in the child's interest, and it is done on a case-by-case basis. Judges should always justify their choices based on the best interest, but they have great discretion in this context, which may lead to very different outcomes for two similar cases. Furthermore, this principle applies to all children, and it is closely related to the principle of non-discrimination. This means that undocumented minors are also covered and that their best interest should be the primary consideration. However, since a balancing must be done, the fact that those belonging to this group are irregular migrants may prevail over the fact that they are children, especially because of the "crimmigration" approach mentioned in the previous chapter.[151]

CRC Article 3 paragraph 3 contains the States' obligation to ensure that the standards outlined concerning the best interest of the child are respected, as well as the measures to deploy to check that. There, it is possible to find an explicit reference to healthcare, when stating that:

> "States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of […] health, in the number and suitability of their staff, as well as competent supervision."[152]

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[147] CRC committee, 'General Comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1)' (29 May 2013) CRC /C/GC/14.
[148] CRC committee (n 147) para. 6.
[149] CRC committee (n 147) para. 4.
[150] CRC committee (n 147) para. 80.
[151] See Chapter 2.3.
On the difficulties of taking into consideration children's individuality when applying the best interest of the child, and on the tension between the vagueness and flexibility of its definition, see e.g. Council of Europe, Milka Sormunen (ed), *The best interests of the child – A dialogue between theory and practice* (Strasbourg 2016); Wouter Vandenhole and Gamze Erdem Türkelli, 'The Best Interest of the Child, in (ed. by) Jonathan Todres and Shani M. King (ed) *The Oxford Handbook of Children's Rights Law* (Online edn, Oxford Academic 2020) 204.
[152] CRC Art. 3, para. 3.

Therefore, minors' right to health is a fundamental component in protecting the best interest of the child, and states are given an active role in realizing this right by checking the conformity of care providers with the established standards. Although the CRC committee focuses only on the first paragraph of Article 3 in the GC, it still refers to the right to health and its connection to the principle of the best interest of the child. In this case, the CRC committee states that the best interest should be granted by assessing the advantages of all possible treatments if more of them are available or their outcomes are uncertain. Moreover, information should be given to the concerned minor so that their view can also be kept into consideration when deciding regarding healthcare.[153] Indeed, the right to be heard is one of the general rights included in the CRC that should always be considered when making decisions about minors.[154] In fact, even though it is important to recognize minors' vulnerability, the latter should always be balanced with their right to be heard, on a case-by-case basis.[155]

3.2.3. The Principle of Non-Discrimination

Non-discrimination is another fundamental principle that must be considered when addressing the right to health of undocumented children, and it can be found in international law norms that concern both individuals in general and children specifically. When examining binding international law conventions, the principle of non-discrimination is embedded in the ICESCR, the International Covenant on Civil and Political Rights (ICCPR), and in conventions with a more specific topic such as the CRC, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the ICERD. For example, Article 24 of the ICCPR states that "[e]very child shall have […] the right to such measures of protection as are required by his status as a minor", reaffirming that this should occur without differentiation based on discriminatory grounds.[156]

However, as already mentioned, the most important convention to consider when the right to health is at stake is the ICESCR. Paragraph 2 of Article 2, in particular, states that the rights enunciated in the convention must "be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other

[153] CRC committee (n 147) para. 77.
[154] CRC Art. 12.
[155] See above, Chapter 2.2.
[156] UNGA, 'International Covenant on Civil and Political Rights' (adopted 16 December 1966, entry into force 23 March 1976) UNTS 999, 171, Art. 24.

status." [157] According to the interpretation given to this article by the GC of the CESCR, "[d]iscrimination undermines the fulfilment of economic, social and cultural rights for a significant proportion of the world's population".[158] This is true also for the right to health, which may be obstructed for certain groups due to discrimination against them. Among the grounds that are listed in the ICESCR as discriminatory, race, national origin, and birth are certainly to be considered when dealing with undocumented minors. Notably, the CESCR underlined that the grounds of nationality should not hinder children from being granted the right to affordable healthcare.

As previously mentioned, the ICERD specifically concerns racial discrimination, condemning behaviors and decisions that are based on this reason and impede the enjoyment of human rights for certain categories. However, even though this convention mentions an obligation for states to ensure non-discriminatory and equal treatments in granting the right to health, it loses its usefulness for the topic of this thesis when it states that it "shall not apply to distinctions, exclusions, restrictions or preferences made by a State Party to this Convention between citizens and non-citizens". [159] Therefore, distinctions and exclusions based on the differentiation between citizens and non-citizens in the realm of human rights recognition can still be enacted by states, although they must always be done according to the international law standards connected to those specific rights, and more generally to the non-discrimination principle. This illustrates the states' commitment to the sovereignty principle, which necessitates a differentiation between citizens and non-citizens.[160]

Referring specifically to minors, it must be noted that the same list present in the ICESCR and ICCPR is also included in CRC Article 2. This article prohibits discrimination as well, adding that "the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members".[161] Therefore, the fact that minors should not be treated differently because of certain characteristics of their parents is underlined. The CRC committee, in the Report of 2012 General Discussion, specifically addressed the context of international migration and stated that, by referring to every child, the CRC also includes migrant children, not discriminating among them by any

[157] ICESCR Art. 2, para. 2.
[158] CESCR, 'General comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights)' (2 July 2009) E/C.12/GC/20, para. 1.
[159] ICERD Art. 1 para. 2.
[160] See above, Chapter 2.3.
[161] CRC Art. 2, para. 2.

means, nor distinguishing between accompanied or unaccompanied, settled or in the move, documented or undocumented.[162]

According to this interpretation of the convention, the minor age should be taken as a primary consideration when engaging with children, and their status as irregular migrants should not lead to discrimination towards them when granting them their fundamental rights. Indeed, the CRC committee openly states that "a child is first and foremost a child, whatever the condition he or she may find himself or herself in", [163] and gives recommendations to states for them to comply with this view. Nevertheless, although the CRC committee is an authoritative source as for the interpretation of the CRC, it cannot oblige states to act in a certain way, as its recommendations are not binding. So, state practices may differ from these recommendations. Therefore, it is worth examining international law norms that specifically address the right to health of undocumented migrants, since their irregular status in a state's territory is often a key factor in their treatment, and in practice, it may override the principle of the best interest of the child.[164]

3.3. Right to Health of Undocumented Minors as Migrants

3.3.1. IHRL Norms Concerning Migrants

A comprehensive international instrument that deals with migration and migrants' rights is absent, therefore it is necessary to look at scattered norms that are included in different instruments in order to be able to have a normative framework concerning this particular situation. Notably, the existent international instruments that deal with migrants only pertain to specific categories, such as refugees or migrant workers, leaving out undocumented migrants. As previously mentioned,[165] according to the principle of non-discrimination, migrants should not be discriminated against solely because of their status, nor because they have irregularly entered a certain territory, and they should therefore be granted the fundamental rights that all human beings are entitled to, including the right to health.

[162] CRC committee, 'Report on the 2012 Day of General Discussion: The rights of all children in the context of international migration' (28 September 2012), para. 13.
[163] CRC committee (n 162) para. 56.
[164] PICUM, 'PICUM Submission to OHCHR Study on Children's Right to Health' (Brussels 2012) 1.
On the main issues to be considered when applying the principle of non-discrimination to children, such as the complexity and diversity of the grounds of discrimination they may face, as well as the interaction of this principle with other principle and rights, see e.g. Children's Rights Erasmus Academic Network, Dagmar Kutsar and Hanne Warming (ed. by), Children and Non-Discrimination. Interdisciplinary textbook (University Press of Estonia 2014).
[165] See Chapter 3.2.3.

Thus, human rights instruments should always be taken into consideration since they are applicable to non-nationals as well as to nationals.[166]

Although no international binding convention exists concerning migration in general, the UNGA drafted, in 2016, the New York Declaration for Refugees and Migrants, which wants to reaffirm and give protection to "the human rights of all refugees and migrants, regardless of status; all are rights holders".[167] The right to healthcare is mentioned as one of the fundamental ones to be afforded to migrants, with the aim of improving their integration and inclusion into the society. It is further stated that, in order to achieve the full enjoyment of this right, racism, discrimination, and xenophobia must be countered.[168] Although the New York Declaration is not binding, and therefore states are not formally obliged to follow the recommendations contained in it, it still holds significant value, since it was drafted by the UNGA, which gives it a political impact. It may serve as the first step towards new international human rights law instruments concerning migration and migrants' rights.

The New York Declaration called for the creation of two global compacts, one specifically on refugees and the other one regarding migration more in general, and therefore in 2018 the UNGA officially adopted with a resolution the Global Compact for Safe, Orderly and Regular Migration (Global Compact). The Global Compact is characterized as a "non-legally binding, cooperative framework",[169] which advocates cooperation among all migration-related actors and "upholds the sovereignty of States and their obligations under international law".[170] Therefore, states do not have binding obligations deriving from this document, and their sovereignty is reaffirmed, so the recommendations contained are useful only if there is cooperation among governments. However, it is still significant that there has been a dialogue and a consensus among international actors on the importance of addressing migration in a cooperative way, and that the Global Compact is the result of a member-state-driven process. States have been given policy options to choose from when they have to deal with migration-related issues, but at the same time, they enjoy flexibility in the implementation of policies according to their specific situation and capacity. Since the Global

[166] IOM, Paola Pace (ed. by), 'Migration and the Right to Health: A Review of International Law' (2012) 19 International Migration Law 22.
[167] UNGA, 'New York Declaration for Refugees and Migrants: resolution / adopted by the General Assembly on 19 September 2016' (3 October 2016) A/RES/71/1 para. 5.
[168] UNGA (n 167) 39.
[169] UNGA, 'Global Compact for Safe, Orderly and Regular Migration: resolution / adopted by the General Assembly on 19 December 2018' (11 January 2019) A/RES/73/195 para. 7.
[170] UNGA (n 169).

Compact aims to promote only regular migration, states are required to differentiate between regular and irregular migration when designing their policies,[171] and this implies that norms concerning the irregular one can be more restrictive.

Specific pertinent sections of the Global Compact when dealing with the right to health of undocumented migrants are the one referring to healthcare as one of the needed elements to ensure migrants' inclusion into society and social cohesion,[172] and the one that asks to "[i]ncorporate the health needs of migrants into national and local healthcare policies and plans",[173] including both physical and mental health. Furthermore, the Global Compact states that immigration authorities must cooperate with service providers so that the safe access to basic services of irregular migrants is not compromised because of an unlawful infringement upon the rights to liberty, privacy, and security of the person in the places where the services are delivered.[174] Therefore, even though the document urges states to find solutions for regular migration, irregular migrants are recognized as a vulnerable group and they are awarded the right to access basic services.

These non-binding soft law instruments reaffirm that migrants, like all human beings, possess fundamental rights, including the entitlement to basic healthcare. However, states have shown, through their national laws or before international human rights bodies, that they are unwilling or unable to grant non-citizens the same level of protection as citizens. Regarding the right to health, although the minimum standard must always be guaranteed, states have set a limit to the healthcare provided to migrants, mentioning "essential care".[175] As is apparent, this leads to a big differentiation between citizens and non-citizens right to health, as essential care is defined as an emergency measure that does not include preventive care or mental health. Hence, the extent of protection afforded to non-citizens is notably limited and significantly differs from that extended to citizens. Moreover, undocumented migrants also face many practical barriers to accessing health services and are therefore even more vulnerable.

[171] UNGA (n 169) para. 15(c).
[172] UNGA (n 169) para. 32(d).
[173] UNGA (n 169) para. 31(e).
[174] UNGA (n 169) 31(b).
[175] OHCRC and WHO (n 1) 19.

3.3.2. IHRL Norms Concerning Migrant Children

If specific norms on migrants, especially undocumented ones, are challenging to locate among binding international instruments, the scarcity is even more significant with regard to undocumented children. Indeed, there are no specific instruments on migrant children in general, although the norms contained in the Convention Relating to the Status of Refugees can be applied to minors with refugee status, while the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families protects those whose parents are workers. The CRC only refers to refugees, while it does not mention the category of undocumented minors. However, the CESCR GC No. 20[176] and the CRC committee 2012 Report[177] clarified that the same norms that apply to all children should also apply to those who migrate irregularly, without discrimination based on nationality or documentation status.

In the above-mentioned New York Declaration, the UNGA affirms that it will "protect the human rights and fundamental freedoms of all refugee and migrant children, regardless of their status, and giving primary consideration at all times to the best interests of the child".[178] It is explicitly stated that no difference should be made based on minors' status, therefore undocumented children are certainly included among those whose rights should be protected. The same paragraph also mentions basic health, which is one of the rights that children need to enjoy for their full development. In addition, the UNGA acknowledges the high vulnerability of migrant children, due to their background, which should always be considered when handling their cases.[179] Migrant minors are also mentioned in the Global Compact, which states that the best interest of the child must always be considered and guide the decision,[180] and that particular protection should be given to unaccompanied and separated children, for example providing them "access to health-care services, including mental health".[181] As previously mentioned,[182] the New York Declaration and the Global Compact are not binding for states, but they can still influence states' and international policies. It is significant that they specifically address migrant children and include the right to health as one of the essential ones.

[176] CESCR (n 158) para. 30.
[177] CRC committee (n 162) para. 13.
[178] New York Declaration, para. 32.
[179] New York Declaration, para. 59.
[180] Global Compact, para. 23(e).
[181] Global Compact, para. 23(f).
[182] See Chapter 3.3.1.

3.4. European Legal Standards

3.4.1. Right to Health in the CoE Legal System

In preparation for later analyzing the practice of selected EU states, after having studied the general standards that relate to the protection of the right to health of undocumented children, it is necessary to look at European regional standards as well. In particular, the regional standards set out by the CoE will be taken into consideration in this paragraph. EU-specific norms will instead be examined in Chapter 5.1. of this thesis, when selected EU states policies and practices will be analyzed.

The most important instrument in relation to the CoE is certainly the European Convention of Human Rights (ECHR), [183] which is powerful as it is binding for the member states and has a monitoring mechanism carried out by the ECtHR. Although the ECHR does not contain any specific provision on the right to health, the latter is strictly connected to certain rights mentioned in the articles, such as the right to life contained in Article 2, and the prohibition of torture, inhuman or degrading treatment or punishment in Article 3. This connection has been highlighted by the ECtHR in some of its judgments, both concerning migrants and different subjects. [184] Despite this interpretation by the court, due to the interdependence of rights, the threshold for establishing the severity of health conditions is set very high, as it can be inferred from *Paposhvili v. Belgium*.[185] At the same time, the ECtHR does not place any obligations on states to provide the highest standard of healthcare to irregular migrants, in order to respect their sovereign powers and not to place an excessive burden on them.[186]

Given the nature of the right to health, the primary instrument to consider with regard to Europe is certainly the European Social Charter (ESC), which was published in 1961 and then revised in 1996

[183] Council of Europe, 'Convention for the Protection of Human Rights and Fundamental Freedoms' (adopted 4 November 1950, entry into force 3 September 1953) ETS 005.
[184] E.g. *Kudła v Poland* App No 30210/96 (Judgment, Grand Chamber) (European Court of Human Rights, 26 October 2000).
[185] *Paposhvili v Belgium* App No 41738/10 (Judgment, Grand Chamber) (European Court of Human Rights, 13 December 2016) para. 183: "[…] seriously ill person in which substantial grounds have been shown for believing that he or she, although not at imminent risk of dying, would face a real risk, on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy."
[186] E.g. *AS v Switzerland* App No 39350/13 (Judgment, Second Section) (European Court of Human Rights, 30 June 2015) para. 31: "[…] Article 3 does not place an obligation on the Contracting State to alleviate such disparities through the provision of free and unlimited healthcare to all aliens without a right to stay within its jurisdiction. A finding to the contrary would place too great a burden on the Contracting States."

(RESC). The latter includes all the provisions included in the ESC and its protocols, enhancing rights' protection, but not all the states that ratified the ESC ratified the RESC as well. Nevertheless, for practical reasons, the RESC will be taken as a reference. The RESC contains certain useful provisions to define the right to health, but two significant drawbacks can be noted. On the one hand, it is an *à la carte* treaty, which means that states can decide to which provisions they want to adhere, making its application quite uneven; on the other hand, it does not specifically refer to undocumented minors, having a limitation *ratione personae*.

To underline that the personal scope of the RESC is limited, not referring to all human beings, is important. Indeed, the Appendix to the RESC (which contains a provision identical to that in the Appendix to the ESC), specifically mentions that "the persons covered […] include foreigners only in so far as they are nationals of other Parties lawfully resident or working regularly within the territory of the Party concerned",[187] and then broadens the scope to include also refugees and stateless persons, given that they fall within the definition given by the respective conventions and that they are lawfully residing in the territory of the state. Instead, irregular migrants are not included, as well as third-country nationals, and refugees and stateless persons not complying with the enounced conditions. Nonetheless, this does not affect "the extension of similar facilities to other persons by any of the Parties".[188] The European Committee of Social Rights (ECSR), which monitors and promotes social rights within the context of the (R)ESC, decided in some cases that certain basic rights must be granted also to those who are not covered by the personal scope of the RESC. It mentioned that human dignity should always be preserved, also because of the indivisibility of human rights and the complementarity of the RESC and the ECHR.[189]

Concerning the right to health, Part I of the RESC stipulates that "[e]veryone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable."[190] Furthermore, Article 11 is closely related to the right to protection of health, affirming that states must ensure the exercise of the right to health "either directly or in co-operation with public or private organisations",[191] also preventing illnesses as much as possible and raising awareness about them. The RESC refers to children in different contexts: Article 7 concerns the protection of their

[187] Council of Europe, 'European Social Charter (Revised)' (adopted 3 May 1996, entry into force 1 July 1999) ETS 163, Appendix to the Revised European Social Charter, 1 (RESC).
[188] RESC.
[189] See *International Federation of Human Rights League (FIDH) v. France*, Complaint No. 14/2003 (European Committee of Social Rights, 8 September 2004) paras. 26-32.
[190] RESC Part. I.11.
[191] RESC Art.11.

rights when working, while Article 17 addresses social, legal, and economic protection, encouraging states to take measures in order to ensure minors' full development, therefore giving a comprehensive perspective. No explicit reference is made to migrant children. Concerning migrants in general, Article 18 only refers to migrant workers and their families, specifically those who are lawfully residing in the state territory, and it therefore cannot be applied to those who lack documentation.

In addition to the RESC, other conventions drafted by the CoE are related to health. For example, the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Oviedo Convention) is the first international treaty that specifically concerns bioethics, and it entered into force in 1999. It examines a specific part of healthcare, and thus it does not mention migrants nor children, apart from referring to the CRC in its Preamble. However, the general norms that can be found in the first articles can still be useful for defining the right to health in the European context. Indeed, Article 2 of the Oviedo Convention highlights the prevalence of human beings' welfare over other needs of the society, and Article 3 asks parties to provide "equitable access to healthcare of appropriate quality",[192] while always "taking into account health needs and available resources".[193]

3.4.2. Right to Health of Migrants in the CoE System

As previously explained,[194] the RESC does not refer to undocumented migrants, due to its limited personal scope. Nevertheless, the necessity to grant the right to health to undocumented minors can be inferred from a decision of the ECSR, which monitors the compliance of member states with the ESC through state reports and complaint procedures. Although the decisions rendered by the ECSR are not directly enforceable in the domestic legal systems, they still have a significant political and moral weight, and can influence the behavior of state parties.[195] The ECSR decision to consider is *Defence for Children International (DCI) v. Belgium*, where the complainant denounced the fact that undocumented migrant children, both accompanied and unaccompanied, were excluded from social assistance by Belgium. The ECSR decided that there had been a violation of both Articles 11

[192] CoE, 'Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine' (4 April 1997) ETS 164, Art. 3.
[193] Convention on Human Rights and Biomedicine, Art. 3.
[194] See Chapter 3.4.1.
[195] On the monitoring system, see CoE, 'The Charter in four steps', <https://coe.int/en/web/european-social-charter/about-the-charter> Accessed 10 September 2023.

and 17 of the ESC, arguing that not granting undocumented minors their right to health would result in a deprivation of their human dignity and that their irregular presence in the territory of the state raises their vulnerability.[196] This shows that undocumented minors are covered by the ESC when it refers to children, and that their protection should be even stronger due to their especially high degree of vulnerability.

Moreover, it is possible to find reference to the right to health of migrants in certain documents drafted by other organs of the CoE, such as the Committee of Ministries (CM), which acts on behalf of the CoE itself. In particular, in the Action Plan on Protecting Vulnerable Persons in the Context of Migration and Asylum in Europe (Action Plan),[197] the CM highlights the importance of granting healthcare assistance to migrants, and especially to vulnerable individuals in the context of migration. Children are included in the definition of vulnerable subjects, in particular referring to unaccompanied ones. The Action Plan also explicitly refers to mental health support measures, that should be granted to vulnerable individuals in the migration process. While irregular migrants are not directly mentioned among the vulnerable groups, it can be argued that they should be included, as particularly vulnerable subjects. However, it is important to note that the documents issued by the CM, such as the Action Plan, are not legally binding for the member states of the CoE. They are rather recommendations or guidelines that express the political will and commitment of the states to adhere to certain standards and principles. Therefore, they do not create any legal obligation for the states to ensure the right to health of migrants, especially irregular ones, but rather a matter of moral and ethical obligation.

Soft-law instruments issued by the Parliamentary Assembly of the CoE (PACE) are also relevant for the right to health of undocumented minors. The PACE is the parliamentary organ of the CoE and, although it cannot make binding norms or decisions, it has an ongoing dialogue with the governments of the state parties. The first instrument is a resolution on equal access to healthcare,[198] urging states to ensure this right for everyone, placing both children and irregular migrants among the most vulnerable groups. The PACE has also issued a recommendation specifically on undocumented minors,[199] recognizing their triple vulnerability (as migrants, as undocumented

[196] *Defence for Children International (DCI) against Belgium*, Complaint No. 69/2011 (European Committee of Social Rights, 23 October 2012) para. 28.
[197] CoE, 'Council of Europe Action Plan on Protecting Vulnerable Persons in the Context of Migration and Asylum in Europe (2021-2025)' (CoE 2021).
[198] PACE, 'Equal access to healthcare', Resolution 1946 (2013).
[199] PACE, 'Undocumented migrant children in an irregular situation: a real cause for concern', Recommendation 1985 (2011).

persons, and as children) and asking for the strengthening of the protection of their rights, overcoming possible practical barriers. A paragraph is entirely dedicated to the right to healthcare and mentions the need to simplify access to it, provide financial assistance, and ensure that there is no report of the irregular situation of the children or their family. Concerning the extent of the protection, it is noteworthy that the right should be ensured through:

> "clarifying, through legislation, the entitlement, without discrimination, of undocumented migrant children to healthcare that goes beyond emergency care and which includes primary and secondary healthcare, as well as appropriate psychological assistance."[200]

The CoE protects undocumented minors' right to health through the ECSR decisions and the soft-law instruments of the MC and the PACE, and the protection is broad, including more than emergency care. However, the (R)ESC, which is the only binding standard, does not directly cover undocumented minors, so non-binding measures are essential to address their right to health's protection in the CoE context. Certainly, it is important to have a committee such as the ECSR that monitors the compliance with the CoE standards and reports to the CM, which can adopt resolutions and recommendations based on the ECSR decisions. On the one hand, these instruments carry substantial political weight and can influence new binding policies, but on the other hand, as previously mentioned, their non-binding nature allows states to disregard them.

After a comprehensive analysis of international human rights policies pertaining to the healthcare rights of undocumented minors, it becomes evident that universally binding guidelines on this matter are lacking. While the existing standards may theoretically offer sufficient protection, their application to non-citizens in irregular situations is often subject to the discretion of states, which maintain strong connections to the principle of sovereignty. Therefore, several limitations and practical barriers to realizing this fundamental right persist, which will be the focus of Chapter 4. It will provide general information on the barriers faced by undocumented migrants, with specific attention to minors when their situation differs from that of adults.

[200] PACE (n 199) para. 9.2.1.

4. Limitations to the Protection of the Right to Health of Undocumented Minors

4.1 Emergency and Primary Care

Although according to the ICESCR states should grant everyone the "highest attainable standard of physical and mental health",[201] the previous chapter has already shown that in practice the highest standard is not always granted, for example, when the right to health conflicts with the principle of sovereignty. UNICEF found out that

> "[i]n 2015, only eight European Union Member States granted undocumented migrant children the same level of healthcare as national children; six totally restricted their entitlements to emergency care only; and 12 allowed undocumented migrants limited access to specialist services."[202]

According to the same Thematic brief, migrants generally use healthcare services less frequently than citizens, and the immunization rate for undocumented children is lower than for their peers. This shows that, notwithstanding the existence of international human rights norms on the right to health as universal, the concrete situation is different. Because of this discrepancy, it is worth studying both the barriers that hinder undocumented migrants from accessing healthcare services in the host state, and the different levels of services that states offer to migrants. Therefore, emergency care, preventive care, and mental healthcare will be examined, drawing a picture of the existing policies that affect undocumented minors. Afterwards, the focus will shift to the practical barriers that operate for undocumented minors even in the contexts where policies would be more favorable.

As previously mentioned, with regard to the right to health of migrants who are in an irregular situation, the focus is on emergency care, which is often referred to as "urgent care" or "essential care".[203] For undocumented minors, in most countries the situation is the same: they only receive emergency care and lack access to a general practitioner who follows them during their development, with very limited access to specialized care.[204] In fact, half of the studies considered by a systematic literature review of 2018 confirmed that immigrant children use healthcare services

[201] ICESCR Art. 12.
[202] UNICEF, 'Health and Children on the Move' (Thematic Brief, February 2022).
[203] See Chapter 3.
[204] Bicocchi (n 17) 118.

way less than the local ones when it comes to preventive, primary and specialistic care, while the use is greater for emergency care.[205]

States are reticent to go beyond this minimum protection of the right to health, which applies only in emergencies, and international human rights norms do not explicitly hinder them from setting those limits. On the contrary, international law instruments, both binding and non-binding, contain similar phrasings. For example, the Declaration of Alma-Ata reaffirms the right to health as defined by the ICESCR, but at the same time it describes primary healthcare as

> "essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination."[206]

Defining primary healthcare is quite complex since it is made of different components, as explained by the WHO in a document written together with UNICEF. Indeed, primary healthcare is considered to be an approach to health that needs the cooperation of the whole society to work, in order to be able to ensure "the highest possible level of health and well-being and their equitable distribution".[207] The necessity to allow all human beings to fully enjoy the right to health, as established by the main international human rights law instruments is also reaffirmed. Unlike secondary and tertiary care, which respectively refer to services given by specialists and to highly complex medical and surgical treatments, primary healthcare services are the first ones that individuals encounter when they require treatments, and they have a strong focus on prevention.[208] This broad understanding of primary care is compatible with the idea of "essential care" only to a certain extent, since the first seeks wider protection than the latter, going beyond its limitations.

The CESCR also uses the words "essential primary healthcare" when it refers to the core obligations arising from the ICESCR.[209] Introducing the idea of core obligations, the CESCR has been able to

[205] Niina Markkula, Baltica Cabieses, Venla Lehti, Eleonora Uphoff, Sofia Astorga and Francisca Stutzin, 'Use of health services among international migrant children – a systematic review' (2018) 14(52) *Globalization and Health*.
[206] Declaration of Alma-Ata (n 132) IV.
[207] WHO and UNICEF, 'A Vision for Primary Healthcare in the 21st Century. Towards universal health coverage and the sustainable development goals' (2018), 2.
[208] Danielle da Costa Leite Borges and Caterina Francesca Guidi, 'Rights of access to healthcare for undocumented migrants: understanding the Italian and British national health systems' (2018) 11(4) *International Journal of Human Rights in Healthcare* 232, 233.
[209] See Chapter 3.1

give protection to individuals, such as irregular migrants, who are not part of the community, and who would therefore be more difficult to address. The CESCR does not provide an exact definition of "essential care." However, according to certain scholars, it can be inferred that essential care addresses the basic needs of the population, without requiring emergencies for the protection to be activated.[210]

In the context of the CoE, even though the ECtHR has given protection to the right to health by connecting it with other rights,[211] its interventions are still limited to emergency situations. It does not look like there is a trend towards expanding states' obligations in everyday situations, and the interventions remain exceptional.[212] The focus of the ECtHR, or at least what appears from its judgments, is not on granting the highest attainable standard of health, but on the maintenance of the person's physical integrity.[213] The same observation can be made when considering the decisions taken by the ECSR concerning the right to healthcare of irregular migrants, especially children, who should receive emergency care even though they are not included in the personal scope of the treaty.[214] Although a broader recognition of the right to health is desirable, it would be difficult to impose upon states positive obligations that go beyond providing emergency care. This is due to the limited material scope of the ECHR and personal scope of the RESC, and the continuous effort to respect the sovereignty principle.

With a sole focus on emergency care, undocumented migrants cannot fully enjoy their right to health. On the one hand, as will be explained further in the last paragraph of this chapter, formal and informal barriers can prevent access even to emergency care, completely depriving human beings of one of their fundamental rights. On the other hand, the fact that only emergency care is provided to undocumented migrants could raise the pressure on states' emergency healthcare system, and at the same time it still does not allow migrants to fully enjoy their right to health.[215] While it is important to underline that many states cannot afford to provide unlimited secondary and tertiary

[210] Stefano Angeleri, 'Healthcare of undocumented migrants framed as a right to emergency treatment? The state of the art in European and international law', in Giuseppe Nesi (ed), *Migrazioni e diritto internazionale: verso il superamento dell'emergenza? XXII Convegno, Trento 8-9 giugno 2017* (SIDI 2018) 467, 480.
[211] See above, Chapter 3.
[212] Angeleri (n 210) 472.
[213] Angeleri (n 210) 473.
[214] Angeleri (n 210) 474.
[215] Henriette Sinding Aasen, Alice Kjellevold and Paul Stephens, 'Undocumented' migrants' access to healthcare services in Europe: tensions between international human rights, national law and professional ethics' in Henriette Sinding Aasen, Siri Gloppen, Anne-Mette Magnussen and Even Nilssen (ed), *Juridification and Social Citizenship in the Welfare State* (Social And Political Science 2014) 178.

care to undocumented migrants, still the core of the right to health, which includes at least emergency and primary care, should always be protected.[216] Scholars often expand the discussion to preventive and mental healthcare, trying to understand whether undocumented migrants in general, and minors in particular, are entitled to them or not. Therefore, these two levels of healthcare will be considered in the following paragraphs.

4.2. Preventive Care

As previously said, emergency and primary healthcare must be provided to undocumented migrants for them to fully enjoy their right to health, and prevention is part of primary care. Nevertheless, preventive care is often denied to undocumented migrants. First of all, the ICESCR does not explicitly contain any binding right to preventive healthcare for undocumented migrants. However, the authoritative, though non-binding, interpretation of the convention made by the CESCR underlines that states have an "obligation to *respect* the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including […] illegal immigrants, to preventive, curative and palliative health services."[217] Moreover, the right to non-discrimination applies to preventive care as well as to the general right to health, therefore including undocumented migrants in the group of individuals who are granted this right.[218]

Unfortunately, even in the GCs of the CESCR the preventive healthcare is not clearly defined, so it is difficult to understand its limits and what it entails, even though it surely includes health education.[219] One of the issues is that health is strictly connected to other fundamental rights, such as the access to adequate safe food, potable water, and a basic shelter.[220] This means that to prevent illnesses, those connected rights must be tackled as well. However, the exact measures to be taken in this regard remain unspecified, and since states do not have any clear obligation, it is impossible to find any violation of this right.[221] A more comprehensive international legal instrument about preventive healthcare would be needed, in order to define this important part of the general right to health.[222]

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[216] Sinding Aasen et al. (n 215).
[217] UN Committee on Economic, Social and Cultural Rights (CESCR), 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)', 11 August 2000, E/C.12/2000/4, para. 34.
[218] Veronika Flegar, 'The Principle of Non-discrimination: An Empty Promise for the Preventive Healthcare of Asylum Seekers and Undocumented Migrants?' (2015) 3(2) *Groningen Journal of International Law* 80, 100.
[219] CESCR (n 217) para. 16.
[220] CESCR (n 217) paras. 44 (b) and (c).
[221] Flegar (n 218) 93.
[222] Sarah Conly, 'The right to preventive healthcare' (2016) 37 *Theoretical Medicine and Bioethics* 307, 320.

Another element to add to the discussion is that from a scientific point of view, and considering equity as well, preventive healthcare should be tailored to the specific needs of every individual, looking at their personal situation. Unfortunately, there is no academic literature concerning the tailoring of preventive healthcare to meet the needs of undocumented migrants, which would take into account their specific situation and level of vulnerability.[223] Gathering additional data on the healthcare needs of undocumented minors, and migrants in general, would be an important starting point in advocating for a more precise delineation of states' responsibilities in this regard.

The fact that preventive healthcare is not provided to undocumented migrants, since as said, the focus is on emergency care, can be said to be counter-intuitive: according to different scholars, preventive care is both effective and low cost.[224] On the one hand, it helps avoiding further issues when illnesses are detected early on, and on the other hand, it allows a more equal redistribution of benefits and burdens among the population, benefiting the healthcare system as a whole.[225] In fact, the costs for adequate preventive care is usually lower than the one that should be sustained to cure illnesses, and the standard of health provided is usually higher than when only reactive care is performed.[226] Even the CESCR recognizes the value of preventive care and its lower cost, by stating that "investments should not disproportionately favour expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive healthcare benefiting a far larger part of the population."[227]

The concept that treatment costs could be reduced through increased preventive measures has not been thoroughly examined, and it remains a subject of debate, as mentioned for example by the EU Fundamental Rights Agency (FRA) in a 2015 report.[228] This report is particularly interesting because it presents an economic model that compares the costs of providing regular access to healthcare for migrants in an irregular situation with the costs incurred when they are denied access and rely on expensive emergency healthcare. The model focuses on two medical conditions, hypertension and prenatal care, and applies to three EU Member States: Germany, Greece, and Sweden.

[223] Flegar (n 218) 91.
[224] Conly (n 222) 307; KCE, 'What Healthcare for Undocumented Migrants in Belgium?' (2015) KCE Report 257Cs 7.
[225] Conly (n 222) 312.
[226] Conly (n 222) 312.
[227] CESCR GC 14, para. 19.
[228] FRA, 'Cost of exclusion from healthcare. The case of migrants in an irregular situation.' (Luxemburg 2015).

The report emphasizes that excluding individuals from regular healthcare leads to delayed detection and treatment of preventable conditions, increasing reliance on emergency services. It mentions research showing that cost savings achieved through denying regular healthcare may be lost by transferring the costs to secondary or community healthcare providers. Late treatment of HIV-positive patients, for example, significantly increases healthcare costs.[229] The analysis suggests that providing regular preventive healthcare to migrants in an irregular situation would not only fulfill their right to health but also prove to be economically beneficial. In fact, while the model used may not capture all external benefits and costs, evidence suggests that governments could save money by providing access to primary healthcare for migrants in an irregular situation, specifically for hypertension and prenatal care.[230] While this study appears promising and could be a starting point for states to make changes in their policies, further research is still needed to explore the financial implications of early treatment for other conditions, consider a broader territory, and provide more conclusive data.

When referring to preventive care as an effective and low-cost solution, it must be underlined that it should not be intended as a means to replace any other kind of care, as certain injuries and illnesses are unpreventable.[231] Nevertheless, a holistic approach to healthcare, which goes beyond the mere "reparative" function, is seen as more compliant with the idea of adopting an ethical justice.[232] Moreover, when focusing on undocumented children, providing comprehensive healthcare from the very beginning is the best way to address their right to development and help them integrate into the host society, especially with regard to mental health.

4.3. Mental Health

As mentioned in the previous chapter, ICESCR Article 12 mentions mental health, together with the physical one, by stating everyone's right to obtain the "highest attainable standard". Furthermore, states have been urged by the UN Human Rights Council (HRC) to "fully integrate a human rights perspective into mental health",[233] in particular refraining from discriminative practices. However, concerning migrants, mental health is still quite unexplored and most studies regarding it are related

[229] FRA (n 228) 7.
[230] FRA (n 228) 34.
[231] Conly (n 222) 312.
[232] da Costa Leite Borges and Guidi (n 208) 233.
[233] UNGA, 'Resolution adopted by the Human Rights Council on 28 September 2017' (9 October 2017) A/HRC/RES/36/13 para. 5.

to refugees, therefore not providing enough data on undocumented minors, as mentioned in Chapter 2.[234] On the contrary, there should be ever higher focus on this aspect since uncertainty connected to irregularity, and migration during a particular stage of a person's life, such as adolescence, are elements that negatively affect mental health.[235] According to a study conducted in Australia, higher rates of probable PTSD, suicidal intent and depression can be identified among those who do not hold a secure visa, even controlling other key factors that notably affect migrant mental's health, such as gender or level of education. The identification of insecurity as an important stressor is supported by the finding that, once the status changes to a secure one, mental health improves as a result.[236] According to the same study, the higher tendency to mental disorders among those who have an insecure status may be connected to the fact that their insecurity leads to isolation, which is exacerbated by this group of migrants being less likely to reside in the host country with their family.[237]

Concerning minors, the ISSOP Migration Working Group in 2018 prepared a position statement where it reaffirms that migrant children have higher risk of suffering from psychosocial and mental issues, due to different reasons connected both to the travel and the marginalization they suffer once they arrive in the host country.[238] Therefore, according to the same statement, states should provide to migrant children sufficient mental healthcare services, at least at the same level as the ones provided to the local population, and the service providers should be trained in order to take into consideration cultural and linguistic differences.[239] In fact, one of the most experienced issues related to mental healthcare is the lack of trust between the migrants and the service providers, which is connected to the different cultural expectations and beliefs systems, as well as the language barriers.[240] It appears quite clear that providing a service is not enough: the service must be

[234] Adele Lebano, Sarah Hamed, Hannah Bradby, Alejandro Gil-Salmerón, Estrella Durá-Ferrandis, Jorge Garcés-Ferrer, Fabienne Azzedine, Elena Riza, Pania Karnaki, Dina Zota and Athena Linos, 'Migrants' and refugees' health status and healthcare in Europe: a scoping literature review' (2020) 20:1039 *BMC Public Health,* 8.
235 Cécile Rousseau and Rochelle L. Frounfelker, 'Mental health needs and services for migrants: an overview for primary care providers' (2019) 26(2) Journal of Travel Medicine, 2.
[236] Rosanna Pajaka, Susan Lia, Amber Hamiltona, Savannah Minihana, Candy Liua, Richard A. Bryanta, David Berlee and Belinda J. Liddell, 'The association between visa insecurity and mental health, disability and social engagement in refugees living in Australia' (2019) 10 *European Journal of Psychotraumatology,* 10.
[237] Pajaka et al. (n 236) 11.
[238] ISSOP Migration Working Group, 'ISSOP position statement on migrant child health' (2018) 44 *Child: Care, Health and Development* 1, 4.
[239] ISSOP Migration Working Group (n 238) 9.
[240] Sima Sandhu, Neele V. Bjerre, Marie Dauvrin, Sónia Dias, Andrea Gaddini, Tim Greacen, Elisabeth Ioannidis, Ulrike Kluge, Natasja K. Jensen, Majda Lamkaddem, Rosa Puigpinós i Riera, Zsigmond Kósa, Ulla Wihlman, Mindaugas Stankunas, Christa Straßmayr, Kristian Wahlbeck, Marta Welbel and Stefan Priebe, 'Experiences with treating immigrants: a qualitative study in mental health services across 16 European countries' (2013) 48 *Social Psychiatry and Psychiatric Epidemiology* 105, 112.

accessible and take into consideration the real needs of the those who resort to it, because otherwise it will not be really helpful.

Taking into consideration the actual situation, mental healthcare is one of the areas where the capacity is limited the most, meaning that undocumented migrants hardly ever have access to it, even though they suffer both from their migration experience and from the status of uncertainty that they experience in the host country, as mentioned above.[241] The multi-faceted nature of mental health complicates the possibility for states to provide adequate care since socioeconomic determinants such as housing, education, work, and integration into the host community should be tackled for mental healthcare to be effective.[242]

Certain scholars claim that interventions to help immigrants' resettlement, as well as to support undocumented immigrants in their regularization process, are a first fundamental step to protect their mental health, although they are non-specific to mental healthcare. Moreover, for children, the school should be a place to elaborate trauma and improve the feeling of acceptance and integration into the host society.[243] Instead, in many cases they have difficulties in accessing school because of practical barriers such as the request of documents for enrolling, the parents' fear of being identified, and the expenses not related to tuition fees.[244] In general, multi-directional support for the health of undocumented migrants is rarely offered, and European policies lack a focus on assessing the influence of community support and family factors on the health and development of migrant children.[245]

Granting mental health services to young migrants is extremely important, considering the higher rates of self-harm and suicidal attempts of this group compared to non-migrant minors.[246] It is important to provide services that are specifically designed for children, taking into consideration

[241] Karen Hacker, Maria Anies, Barbara L. Folb, and Leah Zallman, 'Barriers to healthcare for undocumented immigrants: a literature review' (2015) 8 *Risk Management and Healthcare Policy* 175, 178.
[242] Mina Fazel and Theresa S. Betancourt, 'Preventive mental health interventions for refugee children and adolescents in high-income settings' (2018) 2(2) *The Lancet Child & Adolescent Health* 121, 128.
[243] Rousseau and Frounfelker (n 235) 5.
[244] Bicocchi (n 17) 115.
[245] Ayesha Kadir, Anna Battersby, Nick Spencer and Anders Hjern, 'Children on the move in Europe: a narrative review of the evidence on the health risks, health needs and health policy for asylum seeking, refugee and undocumented children' (2019) 3(1) *BMJ Paediatrics Open*, 13.
[246] Aditya Basu, Alexandra Boland, Katrina Witt and Jo Robinson, 'Suicidal Behaviour, including Ideation and Self-Harm, in Young Migrants: A Systematic Review' (2022) 19 *International Journal of Environmental Research and Public Health* 8329.

the differences in mental health perception and treatment among the different age groups.[247] Finally, education on the importance of mental health should also be implemented, as certain studies showed that specific migrant groups may not acknowledge mental health issues due to a negative perception of mental illnesses and concerns about the associated social consequences.[248] The cultural aspect should be further analyzed to properly address migrant children's access to mental health services.

4.4. Practical Barriers

A final aspect to consider when addressing the effective access to the right to health of undocumented minors is certainly the existence of practical barriers, both formal and informal, that hinder this category of subjects from accessing this right, or from being entitled to it. Although this leads to further issues, such as higher costs to heal illnesses and more difficulties in integration, policies that try to overcome those barriers are still hard to find.[249] On the contrary, barriers to accessing healthcare services are often used as a deterrent to entering the country, even though seeking improved health treatments is not a primary motivation for migration, and that therefore, it does not attract undocumented migrants.[250]

States can have quite different approaches on granting healthcare services to undocumented migrants, and if sometimes the barriers correspond to only granting emergency care, in other cases the access to care is denied in all its aspects.[251] Moreover, even when policies exist to award full access to healthcare, providers are often not able to deliver the needed services to undocumented migrants in a professional and effective way because clear administrative or financial guidelines are lacking, or too bureaucratic.[252] In certain cases, extensive and costly paperwork is required to access medical assistance, which turns to be an issue both for the migrants and the providers.[253] Furthermore, there is often a lack of knowledge of the healthcare system on the migrants' part, which

[247] On this, see for example, Miriam K. Forbes, Erica Crome, Matthew Sunderland and Viviana M. Wuthrich, 'Perceived needs for mental healthcare and barriers to treatment across age groups' (2017) 21 *Aging & Mental Health* 1072.
[248] Pallab Majumder, 'Exploring Stigma and Its Effect on Access to Mental Health Services in Unaccompanied Refugee Children' (2019) 43 *BJPsych Bulletin* 275.
[249] Elisabetta De Vito, Chiara de Waure, Maria Lucia Specchia, Paolo Parente, Elena Azzolini, Emanuela Maria Frisicale, Marcella Favale, Adele Anna Teleman and Walter Ricciardi, 'Are undocumented migrants' entitlements and barriers to healthcare a public health challenge for the European Union?' (2016) 37(13) *Public Health Reviews* 1.
[250] Hacker et al. (n 241) 180.
[251] Hacker et al. (n 241) 176.
[252] Sinding Aasen et al. (n 215) 178.
[253] Hacker et al. (n 241) 178.

means that they are unaware of the available services and their requirements, and of their right to access healthcare.[254]

One of the biggest barriers, which hinders irregular migrants from accessing healthcare services, is the fear of being identified, reported to the authorities, and deported. In certain countries, such as Italy, France, and Denmark, this fear is due to the lack of knowledge of the system by the migrant. In fact, although each of these countries has different policies concerning access to healthcare, it is prohibited for service providers to report undocumented immigrants. The separation of immigration enforcement activities from public service provision is usually referred to as "firewalls", and it helps protect fundamental human rights of migrants, such as the right to health, without them risking being identified.[255] However, in countries such as Germany, Sweden, and Slovenia, reports are mandatory to be done, and therefore the fear of migrants to be deported is completely justified.[256] For undocumented children the fear barrier becomes double: on the one hand, they are themselves scared of asking for help because of the possibility to be detected and either expelled or detained; on the other hand, if they are accompanied, they depend on their parents' decisions, that may be affected by the same fear.[257] Fear leads to a situation in which irregular migrants wait until their own or their children's health issues become critical before resorting to healthcare services, often opting for self-treatment otherwise.[258]

Lack of financial resources is, as expected, another barrier affecting migrants' healthcare, especially in countries where undocumented migrants have no access to insurance or other protection schemes, such as Denmark.[259] This can harm undocumented minors' access to immunization and post-natal care, for example.[260] In general, healthcare services costs are considerably high, and in many countries, regulations regarding the treatment of undocumented migrants are absent. Consequently, service providers often face uncertainty about reimbursement for treatments. Even when such regulations exist, there can still be problems: for example, in Germany, someone must guarantee to pay for the cost of any treatment, except for emergency ones, while in France reimbursement procedures are in place, but they are time-consuming and "the payment system is so complicated

[254] Hacker et al. (n 241) 178.
[255] François Crépeau and Bethany Hastie, 'The Case for 'Firewall' Protections for Irregular Migrants' (2015) 17 *European Journal of Migration and Law* 157.
[256] De Vito et al. (n 249) 4.
For a more thorough discussion on the firewall systems in the different EU member states, see Chapter 5.2.4.
[257] Bicocchi (n 17) 117.
[258] Hacker et al. (n 241) 178.
[259] Hacker et al. (n 241) 178.
[260] UNICEF (n 202).

that even many doctors cannot understand it".[261] Furthermore, notwithstanding undocumented children's higher degree of vulnerability, which has already been discussed in Chapter 2, many countries reserve them the same treatment as adults, therefore not offering services free of charge.[262]

Another significant problem that frequently hinders migrants' access to healthcare is communication, encompassing language proficiency and communication styles, which may differ between the migrant and a service provider who belongs to the dominant culture of the host country. Therefore, the migrant may be unable to communicate what is the issue, or there may be misunderstandings.[263] The latter can also stem from cultural differences, which include religious practices and customs.[264] Miscommunication can be expected to be even higher than usual when individuals seek out health service providers, as they might be in pain and scared, especially when children are involved. However, it is rare in the hospitals to find interpreters, who could facilitate the communication and make the treatment process smoother, potentially reducing readmissions and, consequently, treatment costs.[265] Furthermore, service providers often lack specific training or guidelines regarding cultural and communication differences.[266]

The language barrier becomes even more problematic when mental health is addressed, as limited language skills are insufficient to provide individuals the support they need or to properly assess their situation. Often, friends or family members are asked to help as interpreters, not respecting the patient's confidentiality and endangering delicate family relations.[267] Even in the countries where there are interpreters, other issues may make their work less effective. First, many times they are involved only if the person does not speak the language at all, assuming that limited language proficiency is sufficient for effective communication. Moreover, professional interpreters are often not trained to work with children, nor they have enough knowledge on psychiatric symptoms, which would require meetings with the clinicians before the interview. This is not always possible, both

[261] Sinding Aasen et al. (n 215) 176.
[262] Sinding Aasen et al. (n 215) 177.
For a more comprehensive discussion of costs in the EU countries, see Chapter 5.2.2.
[263] Sinding Aasen et al. (n 215) 177.
[264] De Vito et al. (n 249) 6.
[265] Leah S. Karliner, Eliseo J. Pérez-Stable and Steven E. Gregorich, 'Convenient Access to Professional Interpreters in the Hospital Decreases Readmission Rates and Estimated Hospital Expenditures for Patients With Limited English Proficiency' (2017) 55(3) *Med Care* 199.
[266] De Vito et al. (n 249) 4.
[267] Rousseau and Frounfelker (n 235) 3.

because of the lack of resources devolved to this area, and because the interpreter may be required to help only through a phone call, which complicates the situation even further.[268]

Finally, according to certain articles, shame and stigma are also hindering undocumented migrants from accessing healthcare services. In fact, undocumented migrants fear stigmatization, due to past experiences across various aspects of society, and at the same time they want to avoid becoming a burden on the host country.[269] In many states, undocumented children, as well as migrants in general, are perceived to be stealing opportunities and resources from the citizens. This perception can escalate, especially when service providers are already struggling to provide high-quality healthcare to the host country's residents.[270] For example, the COVID-19 pandemic highlighted general difficulties of the healthcare systems worldwide, also leading to additional restrictions on the use of healthcare services by migrants and worsening the perceptions of host populations toward people on the move, including children.[271]

Despite being aware of these barriers and their impact on irregular migrants, there is still a lack of data on undocumented minors, especially when they live in particularly vulnerable contexts. The limited studies involving children are usually restricted to specific illnesses and country-specific, thus not contributing to a comprehensive understanding of the overall situation.[272] Therefore, there is a pressing need for more accurate data collection to gain a deeper understanding of the specific limitations and to take effective actions to overcome them. At the same time, it is necessary to establish or maintain privacy measures, such as firewall systems, to protect migrants from potential identification, expulsion, or detention.[273] Even if data is not accurate enough, it can still reflect a real-life situation that does not comply with the international human rights norms due to the specific impediments to accessing healthcare services. Examining the practical barriers that may hinder undocumented minors' access to healthcare is noteworthy for evaluating the effectiveness of existing laws, and particularly for identifying and addressing any shortcomings. In Chapter 5, selected EU countries will be analyzed and compared as examples of both inadequate and effective practices concerning the protection of the right to health of undocumented minors. This analysis will also demonstrate the practical functioning of barriers to healthcare services.

[268] Rousseau and Frounfelker (n 235) 4.
[269] Hacker et al. (n 241) 178.
[270] UNICEF (n 202).
[271] UNICEF, 'COVID-19 has led to dramatic reduction in essential services and protection for migrant and displaced children in countries around the world' (Press release, 18 December 2020).
[272] Lebano et al. (n 234) 5.
[273] UNICEF (n 202).

5. EU Law and Selected Member States' Practices

5.1. Specific EU Policies

5.1.1. The Right to Health in the EU Law

After providing a general description of the factors that limit, in practice, undocumented minors' attainment of the highest standard of health, those factors will be further analyzed by placing them in the EU context and comparing the concrete situation of different EU states. However, before proceeding with this type of comparison, it is necessary to address the EU norms concerning the right to health of undocumented minors, because of the principle of supremacy of the EU law. In fact, according to this principle, proclaimed by a series of relevant judgments of the Court of Justice of the European Union (CJEU), EU law takes precedence over conflicting national law, which ensures uniform interpretation and application of EU law in all member states.[274] First, the main treaties will be taken into consideration, as they are binding for all EU member states.

Regarding the right to health in the EU, the Charter of Fundamental Rights of the European Union (CFR)[275] must be addressed, as it is a binding document that sets the fundamental rights and freedoms of individuals within the EU. According to the Consolidated version of the Treaty on European Union (TEU), which is one of the two primary treaties governing the EU,

> "[t]he Union recognises the rights, freedoms and principles set out in the Charter of Fundamental Rights of the European Union of 7 December 2000, as adapted at Strasbourg, on 12 December 2007, which shall have the same legal value as the Treaties."[276]

Most of the rights of the CFR, except for the ones connected to the election of representatives in the European Parliament, are applicable both to EU citizens and to non-citizens who are in the territory of an EU state and subject to its jurisdiction. However, it must be underlined that the CFR applies to all EU states only when the latter are implementing the EU law, and therefore acting within its scope, which means that it does not automatically extend to matters that fall within the exclusive competence of the member states.

[274] See e.g. *Flaminio Costa v ENEL* (Case 6/64), EU:C:1964:66, [1964] ECR 585 (Judgment, Full Court) (Court of Justice of the European Union, 15 July 1964).
[275] European Union, 'Charter of Fundamental Rights of the European Union' (adopted 7 December 2000, entry into force 1 December 2009) 2012/C 326/02.
[276] European Union, 'Consolidated version of the Treaty on European Union' (adopted 13 December 2007, entry into force 1 December 2009) 2008/C 115/01, Art. 6.1 (ex Article 6 TEU).

The CFR does not explicitly mention the right to health as a separate right, but Article 35 can be considered as an expression of this right since it refers to healthcare. This article states that "[e]veryone 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." It is noteworthy to observe that the importance of granting preventive healthcare is stressed by the CFR given that, as observed in the previous Chapter, usually states neglect it to focus more on emergency care, even though the latter is in practice more expensive. Conversely, "national laws and practices" are mentioned regarding medical treatment, and this might lead to huge differences among different states. This is connected to the fact that the EU does not have extensive powers in the area of health, which mostly falls into the jurisdiction of the single member states. In fact, concerning the "protection and improvement of human health",[277] the EU primarily has the role to "support, coordinate or supplement the actions of the Member States",[278] as established by Article 6 of the Treaty on the Functioning of the European Union (TFEU).

The TFEU, which holds significant value as a foundational document that outlines the legal framework and principles for the functioning of the EU, should also be taken into account when addressing the right to health. TFEU Article 168 (ex Article 152 TEC) focuses on public health. It outlines the objectives and principles that guide the EU's actions in promoting and safeguarding public health within its member states, with the aim to improve the overall health of EU citizens, prevent diseases, and reduce health disparities across the region. One significant aspect emphasized by Article 168 is the importance of reliable health information. The EU encourages the collection, analysis, and dissemination of health data and statistics to enable effective monitoring of health trends, healthcare delivery, and outcomes across member states. These measures can benefit all individuals residing in EU member states, not being limited to EU citizens. Indeed, even though the TFEU does not specifically state that migrants are included in the provisions of Article 168, the EU has taken measures to ensure the protection of public health for all individuals within its jurisdiction, regardless of their nationality or immigration status.[279] Therefore, the provisions should apply to undocumented minors as well. However, as already mentioned, single member states have great

[277] European Union, 'Consolidated version of the Treaty on the Functioning of the European Union' (adopted 13 December 2007, entry into force 1 December 2009) 2008/C 115/01 Art. 6 (a).
[278] TFEU Art. 6.
[279] One example is the communication: European Commission, 'Preparedness for COVID-19 vaccination strategies and vaccine deployment' (Brussels, 15.10.2020) COM(2020) 680 final, 12. This document mentioned among the most vulnerable groups, which should be prioritized to receive the Covid-19 vaccine, the "[c]ommunities unable to physically distance", which include "refugee camps" in the examples.

power in this field, and therefore the treatment of migrants may vary greatly depending on the national policies.

Finally, it is noteworthy to mention the Return Directive[280], which establishes common rules and procedures for the return of irregularly staying third-country nationals (non-EU citizens) from the EU member states. As a directive, it sets out specific objectives that EU member states are required to achieve through their national legislation. Member states are expected to transpose the provisions of the directive into their national laws, ensuring its implementation and enforcement within their respective jurisdictions. Since the Return Directive is aimed at facilitating effective and humane return processes while also respecting fundamental rights, it also mentions the right to healthcare. In particular, Article 14 asks states to provide "emergency healthcare and essential treatment of illness" to undocumented migrants "during the period for voluntary departure […] and during periods for which removal has been postponed".[281] Therefore, this provision applies only to a small portion of migrants who are in an irregular situation, since it does not work for those, whose departure has not been stipulated nor postponed.

5.1.2. Children's Right to Health in the EU

Children's rights are particularly important in the EU legal and policy framework, reflecting the EU's commitment to ensuring the well-being, protection, and development of all children within its member states. To begin with, in connection with international norms and principles, the EU actively cooperates with international organizations, such as UNICEF, and promotes the implementation of international conventions concerning children's rights, such as the CRC.[282] Moreover, the EU has also adopted specific directives and regulations that address various aspects of children's rights. These include directives on combating sexual abuse and exploitation of minors, promoting procedural safeguards for child suspects or accused persons in criminal proceedings, and establishing standards for the reception conditions of asylum-seeking individuals, including minors, among others.

[280] Council of the European Union, 'Directive 2008/115/EC of the European Parliament and of the Council of 16 December 2008 on common standards and procedures in Member States for returning illegally staying third-country nationals' (16 December 2008) OJ L. 348/98-348/107; 16.12.2008, 2008/115/EC.
[281] CoE (n 280) Art. 14(1).
[282] Some examples in this sense are the publication of certain instruments such as the EU Strategy on the Rights of the Child and the EU Guidelines for the Promotion and Protection of the Rights of the Child, and the creation of the EU Children's Participation Platform, which wants to promote children's right to participation, and the EU Network for Children's Rights, which promotes the exchange of good practices and information among the Commission, the EU member states, and relevant stakeholders concerning children rights.

Regarding the right to health of undocumented minors, the CFR should once again be taken into account as the first source. In particular, CFR Article 35 should be read together with Article 24, which addresses the rights of the child. Although the latter does not explicitly mention the right to health, it states that "[c]hildren shall have the right to such protection and care as is necessary for their well-being", and it reiterates the principle of the best interests of the child. This implies that access to healthcare should be granted to minors, since ensuring their physical and mental well-being is fundamental for acting in their best interest. As in the case of health, migration policies usually fall into member states' jurisdiction, while the EU only has coordinating functions, and therefore the application of this article to undocumented minors depends on each state's regulatory framework. Nevertheless, the fact that the best interest of the child is an internationally recognized principle should suffice for states to apply it to immigrants as well.[283]

In the context of non-binding policy initiatives, the EU Commission has recently adopted the "EU Strategy on the Rights of the Child"[284] (EU Strategy), which is a strategic framework to guide and coordinate actions and policies related to children's rights within the EU. As stated in the document, "[b]y adopting this first comprehensive strategy on the rights of the child, the EU Commission is committing to putting children and their best interests at the heart of EU policies, through its internal and external actions",[285] though always "in line with the principle of subsidiarity"[286]. While it is not legally binding, the EU Strategy is still an important policy document that provides a framework for EU institutions and member states to collectively promote and protect children's rights.[287] It should be used as a basis to guide legislation, policies, and funding priorities related to minors' rights at the EU level, as well as to facilitate coordination and cooperation among member states in implementing and monitoring actions. Therefore, on the one hand, the content of the EU Strategy can be useful for coordination purposes, and as a reference point when it comes to take decisions regarding children's rights.[288] On the other hand, the implementation of specific measures and policies in this area

[283] Unfortunately, states often act in a way that is against the principle of the best interests of the child as shown, e.g., by the practice of detaining migrant children. On this, see e.g., Ravinder Barn, Roberta Teresa Di Rosa and Theano Kallinikaki, 'Unaccompanied Minors in Greece and Italy: An Exploration of the Challenges for Social Work within Tighter Immigration and Resource Constraints in Pandemic Times' (2029) 10 *Social Sciences* 134.
[284] European Commission, 'EU Strategy on the Rights of the Child (2021-2024)' (Brussels, 24.3.2021) COM(2021) 142 final.
[285] EU Strategy (n 284) 2.
[286] EU Strategy (n 284) 2.
[287] The importance of this document, as well as the necessity of keeping the rights of all children at the heart of EU policies, have been reaffirmed by different stakeholders (including e.g. PICUM, Save the Children, and Plan International) in the Joint Statement "On the first anniversary of EU Strategy on the Rights of the Child, effective implementation is needed more than ever", published on 24 March 2022.
[288] Juan Antonio Ureña Salcedo and Pablo Miguel Argudo, *European framework of the best interests of the child* (SeBI 2021), 19.

primarily falls within the competence of individual member states, which play a significant role in ensuring the realization of the right to health for children.

Specifically concerning the right to health, the EU Strategy acknowledges the importance for minors and their development to have access to quality services, emphasizing the need for member states to prioritize children's health and well-being and to ensure that healthcare systems are child-friendly and responsive to their needs.[289] Moreover, great attention is given to mental healthcare, and member states are invited to place minors as a priority target group in this matter.[290] The EU Commission highlights that migrant children's previous experiences during the migration route, as well as the conditions in the host country, may lead to an increase in mental health problems. Although undocumented minors are not specifically mentioned, "uncertainty" is included among the possible issues that migrant children may face, and this can be easily associated with irregular status.[291] Furthermore, nutrition is emphasized as a fundamental factor to consider in order to ensure the protection of the right to health, and in particular minors' development, both physical and mental. Migrant children residing in overcrowded facilities are indicated, together with homeless, Roma, and Traveller children, as one of the groups that are more likely to suffer from hunger.[292] Finally, the EU Commission specifically mentions children who are stateless, both since birth and because of migration. Not having a nationality is underlined as a factor that hinders minors from accessing healthcare or other basic services and may lead to exploitation and further issues.[293]

Another document of the EU Commission that tackles this topic is "The protection of children in migration", which is a communication to the EU Parliament and the Council.[294] It stresses the importance of ensuring timely access to healthcare, including preventive care, and psychosocial support for all children, regardless of their, or one of their parents', migration status. The EU Commission and EU agencies encourage Member States to prioritize the provision of healthcare services and inclusive formal education to all children. Moreover, timely access to medical assistance and an adequate standard of living are considered crucial for the integration of migrant children into their host countries. Therefore, the importance of improving living conditions, addressing child poverty, and ensuring the provision of healthcare, including mental care, is

[289] EU Strategy (n 284) 5.
[290] EU Strategy (n 284) 7.
[291] EU Strategy (n 284) 7.
[292] EU Strategy (n 284) 8.
[293] EU Strategy (n 284) 14.
[294] European Commission, 'The protection of children in migration' (Brussels, 12.4.2017) COM(2017) 211 final.

stated.[295] Finally, the communication emphasizes the challenges faced by unaccompanied children who migrate irregularly to the EU, who are vulnerable to risks such as child trafficking, exploitation, and serious threats to their health and well-being.[296] This policy document does not have a legally binding value in itself but it offers guidance, recommendations, and best practices to EU member states on how to ensure the protection of children in the context of migration. Therefore, it serves as a reference for member states to align their national legislation, policies, and practices with the EU's commitment to safeguarding the rights and well-being of children in migration, encouraging cooperation and coordination among them. However, as is often the case with non-binding provisions, states still play the most important role in taking decisions regarding the protection of migrant children, which frequently leads to quite different practices.[297]

5.2. EU Member States' Practices

5.2.1. General Considerations on EU Member States' Practices

As mentioned above, in the context of healthcare, regulations and directives are typically determined at the national level within each EU member state. Therefore, there is no specific legislation or directive that addresses healthcare in the EU as a whole. However, when considering migrants, the EU Reception Conditions Directive establishes minimum standards for the reception of asylum seekers, and it includes provisions regarding their access to healthcare, both physical and mental.[298] Nevertheless, that this directive exclusively refers to the healthcare rights of asylum seekers, and it cannot apply to undocumented individuals. Over the years, the focus of EU policies related to the latter has primarily been on combatting irregular migration through measures such as external border control.[299] In fact, as mentioned in Chapter 2, the tension between the protection of rights and maintenance of security in Europe has mostly resulted in the predominance of the latter, in a "securitization" perspective.[300] Another aspect to consider is that national norms may vary significantly among the different EU member states, leading to variations in the level of rights protection, and the same variation is often observed in actual practices.

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[295] European Commission (n 294) 13.
[296] European Commission (n 294) 4.
[297] As said, for example, by Ramses A. Wessel, 'Normative transformations in EU external relations: the phenomenon of 'soft' international agreements' (2021) 44 *West European Politics* 72.
[298] Council of the European Union, 'Directive 2013/33/EU of the European Parliament and Council of 26 June 2013 laying down standards for the reception of applicants for international protection (recast)' (29 June 2013) OJ L. 180/96 -105/32; 29.6.2013, 2013/33/EU.
[299] As said, e.g., by Andrew Geddes, 'The Politics of European Union Migration Governance' (2018) 56 *Journal of Common Market Studies* 120.
[300] Sasse (n 67).

The protection of the right to health of undocumented minors suffers the same fate as the rest of the immigration regulations, which means that there are noticeable differences among EU member states. Therefore, a comparison must be made between states by using concrete examples, in order to find out whether more favorable norms towards undocumented children exist, and what practices can be considered to be the most positive and negative ones. As a premise, when analyzing states' norms, it is nearly impossible to find a set of regulations and practices that are entirely positive towards undocumented children and their right to health. Hence, instead of focusing on specific states, considerations and comparisons will be made by reviewing selected aspects connected to providing healthcare services, with the aim to highlight the most positive and negative practices. Comparing states allows for a comprehensive analysis of the existing regulatory frameworks and practices, shedding light on the main issues and providing insights into areas where improvements can be made. As explained more broadly in the introduction, comparative law in the international context can be useful both to see how existing norms are interpreted in different states and to find good practices that could be an inspiration to other countries.[301]

The aspects on which the following analysis will focus have been selected from the practical barriers that were examined in the previous chapter, choosing these specific ones mainly because of the greater amount of information that it is possible to find concerning the states' practices. Indeed, as mentioned several times in this thesis, obtaining reliable and updated information on the right to health of undocumented individuals is quite challenging.

5.2.2. Cost of Healthcare in EU Member States

The cost of healthcare significantly affects individuals' access to it, and this applies particularly to irregular immigrants since they usually have very limited resources. Indeed, UNICEF mentioned in one advocacy brief that the cost is the most frequently raised issue among migrants living in states like Poland and Cyprus.[302] One of the main differences between the states is whether their healthcare services are funded by taxation or social insurance: the services funded by taxation are way more connected to the state, which can pose a problem to those in an irregular situation because of the fear of being reported to authorities, especially if a firewall system is not in place; if healthcare

[301] Andrea Carcano, 'Uses and possible misuses of a Comparative International Law approach' (2018) 54 Questions of International Law 21, 30.
[302] UNICEF, 'Advocacy Brief. Refugee and Migrants Crisis in Europe. Is Healthcare Accessible?' (January 2017).

services are insurance-based, instead, irregular migrants can often buy insurance without proving their identity, but affordability remains a significant challenge for them.[303] Moreover, it is important to note that the cost of healthcare treatments is affected also by the so-called out of pocket payments, which typically refer to the portion of healthcare costs that individuals are responsible for paying themselves after deductibles, co-pays, or co-insurance amounts.[304]

In Austria, the healthcare system depends on statutory insurance that covers most of the population, excluding however certain individuals, who are usually either unemployed or immigrants.[305] Undocumented migrants cannot access the insurance system, nor the state-funded scheme for uninsured persons, which makes it mandatory for them to pay the full cost of healthcare treatments. Considering their precarious situation in the host country, as well as the high cost of treatments, irregular migrants often lack the means to pay for the healthcare services they need, resorting to the hospital only when no other option is available.[306] In this context, NGOs play a fundamental role both as service providers and in assisting undocumented migrants in accessing healthcare services.[307] In Hungary, the situation is similar: both citizens and non-citizens working in the country must join the national social health insurance system, without a possibility for opting out.[308] Therefore, undocumented migrants will be able to access primary care only by paying the full price for the healthcare services, which can hinder their opportunities of getting the treatment they need.[309]

One positive example with regard to payment of healthcare services is Italy, where the right to health is constitutionally protected for all individuals, regardless of their citizenship status. Notably, according to the Italian Constitution, free healthcare services must be granted to the indigent, which can include undocumented migrants.[310] To access healthcare services, individuals are required to register, but this registration process can be completed anonymously, and the only key requirement

[303] Sarah Spencer and Vanessa Hughes, *Outside and in: Legal Entitlements to Healthcare and Education for Migrants with Irregular Status in Europe* (Oxford: COMPAS 2015) 9.
[304] Spencer and Huges (n 303).
[305] PICUM, 'Access to Healthcare for Undocumented Migrants in Europe: The Key Role of Local and Regional Authorities' (2007), 13.
[306] PICUM (n 305) 14.
[307] Monika Potkanski, 'Undocumented Immigrants: Health Needs in Sweden and Austria' (2015) 5 SIAK-Journal – Journal for Police Science and Practice 68, 71.
[308] OECD/European Observatory on Health Systems and Policies, *Hungary: Country Health Profile 2021, State of Health in the EU* (Paris 2021), 10.
[309] Sandro Cattacin, Carin Björngren-Cuadra, 'Policies on Healthcare for Undocumented Migrants in the EU27: Towards a Comparative Framework. Summary Report' (Nowhereland Project 2010) 15.
[310] Costituzione della Repubblica Italiana (22 December 1947) (Constitution of the Italian Republic) Art. 32(1): "La Repubblica tutela la salute come fondamentale diritto dell'individuo e interesse della collettività, e garantisce cure gratuite agli indigenti".

is to provide evidence of limited financial resources. This approach effectively ensures access to healthcare for undocumented individuals. However, the choice of healthcare providers for the latter is limited, since they can only seek medical assistance from doctors affiliated with hospitals or organizations, and they are unable to register with a permanent primary care physician. In fact, the latter can only be assigned to Italian citizens, legal residents, and individuals with proper documentation.[311] Moreover, even though the State-Regions Permanent Conference approved, in 2012, the "Guidelines for the correct application of legislation on healthcare to the foreign population by the Italian Regions and Autonomous Provinces", healthcare is still delegated to regions, that may therefore give a different interpretation to the national law.[312]

In Finland, while Kela, which is the Social Insurance Institution of Finland, reimburses the public healthcare providers for most of the costs of the treatments if they cannot be paid by the undocumented person, the latter always has to pay the client fee. One positive practice in this sense is the existence of Global Clinic, which is run by volunteers and provides primary healthcare services free of charge to undocumented individuals.[313] Of course, even though this can benefit migrants in ai irregular situation, and it compensates for the deficiencies of the state, it is not an ideal solution, especially because it is based on voluntary work, being unable to provide high-quality services to everyone who turns to them.

One interesting case is the existence, in France, of the State Medical Assistance (AME), which allows irregular migrants who have low income and can prove to have lived for at least three months in the country to have access to free healthcare. One important point to note is that for undocumented children these requirements do not apply, which means that 100% of their treatments' costs are reimbursed from the moment they enter France, and even if their parents do not meet the conditions to receive AME.[314] Although AME is a social benefit created to overcome exclusion, and it deserves recognition for its objectives, it is not without criticism.[315] In fact, on the one hand experts are favorable towards the measures and they say that even if the costs to be incurred are high, they would be even higher if health problems were not treated on time.[316] On the other hand, a low take-up from

[311] Sinding Aasen et al. (n 215) 175.
[312] Spencer and Hughes (n 303) 18.
[313] See 'Health services for undocumented migrants' at thl.fi.
[314] Jean-Marie André and Fabienne Azzedine, 'Access to healthcare for undocumented migrants in France: a critical examination of State Medical Assistance' (2016) 37 *Public Health Reviews* 4.
[315] André and Azzedine (n 314).
[316] Caroline Izambert, 'The State Medical Assistance: Inaudible expertise, inevitable politicisation', in Betty Rouland (ed.), *Issue State Medical Assistance and the making of a fake problem* (31 February 2022) 31 *De facto*.

migrants shows the weaknesses of the system that according to certain scholars are related to lack of information and migrants' vulnerabilities, which in the family context has an impact on children as well.[317] However, as it often happens when migration is involved, the main discussion on AME is political, revolving around the fear of attracting more irregular individuals because of the good healthcare services provided to them, a thesis which seems to have been disproved by the data and the scientific evidence.[318]

Comparing EU states practices on healthcare costs for undocumented migrants, it is clear that the practical situations faced by these individuals can be very different. Certainly, it should be mentioned that also citizens of each EU country experience differences in healthcare treatment, and that the states spend different percentages of their public money on healthcare services financing, which affects irregular migrants' treatment as well.[319] Moreover, even in the states, such as Italy, where healthcare is free of charge for everyone, practical barriers, misinformation, and discrimination may still affect the effective usage of the services.

5.2.3. Level of Healthcare Services Granted to Undocumented Minors

The level of healthcare awarded to undocumented minors varies among different states, depending on the specific category of individuals they are associated with. The worst-case scenario is that they are granted the same level of service as adult irregular migrants: if adult irregular migrants receive only emergency care, minors will receive the same. This situation occurs in certain states, such as Slovakia, Luxemburg, and Bulgaria, which means that the protection of minors' right to health is quite weak.[320]

As a general consideration, irregular migrants are entitled to emergency care in all EU member states but while in some of them this kind of care is the only one provided, in other ones, they have access to specialist services, or to primary and even secondary care, to a certain extent.[321] However, it must be noted that even in the latter countries the scope of the healthcare provided can vary greatly,

[317] Paul Dourgnon, Florence Jusot, Antoine Marsaudon, Jawar Sarhiri, Jawar and Jérôme Wittwer, 'Just a question of time? Explaining non-take-up of a public health insurance program designed for undocumented immigrants living in France' (2022) 18 *Health Economics*.
[318] Izambert (n 316).
[319] One example in this sense is Greece, as shown by Amnesty International, 'Greece: Resuscitation required – The Greek health system after a decade of austerity' (28 April 2020).
[320] Spencer and Huges (n 303) 11.
[321] Spencer and Hughes (n 303) 11.

depending on the definitions found in the legislations and on external factors that function as practical barriers. One example is the case of Germany, which in theory provides primary and secondary care next to emergency one. However, Germany operates on a system where this kind of hospital treatment necessitates upfront or subsequent payment, leaving no room for free medical care. Moreover, irregular migrants seeking the state's coverage for their healthcare expenses, excluding emergencies, must seek assistance from the Sozialamt (social security) office, which has the duty to report any irregular migrants who approach them. Therefore, access to non-emergency care is in practice hindered.[322]

Costs of primary and secondary care and reimbursement procedures also pose issues in other countries, such as France, and other barriers can occur, such as the 90 days' residence that Portugal requires before being able to access secondary care. Notwithstanding these barriers, the states that provide access to non-emergency care, at least according to their policies, should be considered positive examples.[323] As explained in the previous chapter, in fact, providing preventive care is an effective way of granting better treatment and reducing costs. A good example of a country that recently changed its policies in this sense, also due to the insistence of the volunteers of the Global Clinic mentioned above, is Finland: according to a new law, undocumented immigrants are no more entitled only to "urgent" care (that was restrictively interpreted as the emergency one), but also to "necessary" care. The latter includes the treatments that professionals consider to be necessary because connected to conditions that, if left untreated, would put the patient's life at risk, or would require emergency care in the future.[324] Moreover, it should be noted that, as stated on the website of the Finnish Ministry of Social Affairs and Health, "[u]ndocumented children have the right to healthcare services on the same grounds as those underage children who have a municipality of residence in Finland."[325]

Finland is not the only EU state where undocumented children are granted more extensive healthcare services than adults who are in the same situation. For example, Sweden grants full care, including dental care, to all undocumented immigrants who are under the age of 18.[326] Although states do not make explicit the reason why this happens, it is likely that it depends on the willingness to comply with international standards, such as the best interest of the child, and on the idea that minors are

[322] Spencer and Hughes (n 303) 12.
[323] Spencer and Hughes (n 303) 13.
[324] PICUM, 'Finland: New Law Expands Healthcare for Undocumented Migrants' (24 January 2023, picum.org).
[325] See 'Healthcare and social welfare for undocumented persons' on stm.fi.
[326] Potkanski 2015, 68.

generally more vulnerable, and therefore in need of broader protection.[327] This hypothesis about the vulnerability seems to be confirmed by the fact that in certain states, such as Belgium and Croatia, only children who are unaccompanied, and therefore more vulnerable, are granted the same level of healthcare as the nationals of the state.[328] As discussed in Chapter 2.4.2., while distinguishing between accompanied and unaccompanied minors is beneficial for a particularly vulnerable category of children, this can lead to disadvantages for those who migrate irregularly with their families, since they are placed in a less favorable position.[329] In fact, accompanied children can encounter more access barriers due to their parents' fear of being caught.[330]

In certain EU member states, however, all undocumented minors, whether unaccompanied or arriving with their parents, are treated in the same way, being entitled to the same level of healthcare as the children who are nationals of that country. Some examples in this sense are Portugal, France, Spain, and Italy, where this assimilation is made explicit in the law.[331] In other states, such as Romania and Estonia, the assimilation is instead implicit, since the law states that all children are covered by insurance, and there is no exception as regards the undocumented status.[332] In Greece, according to the law, undocumented children should have the same access to healthcare as nationals, but the level of care is not explicitly mentioned. Because of the uncertainty of the legislation, the implementation depends on the interpretation at the local level, and it is mostly interpreted as needing only to provide urgent care.[333]

A further element that should be taken into consideration is the age until which the minors receive the same treatment as nationals: while in Spain, for instance, it is up to 18 years old, in Portugal, it is only up to 16.[334] While this age difference can disadvantage some undocumented minors, it must be recognized that Portugal has one of the most positive policies towards the right to health of minors who are in an irregular situation, especially considering the extent of services that are provided to them.[335] In fact, in Portugal, all children up to the age of 16, regardless of their legal status, are

[327] European Commission, 'Fact Sheet. Questions & Answers: Protecting of children in migration' (Brussels, 12 April 2017).
[328] Spencer and Hughes (n 303) 30.
[329] Hjern and Stubbe Østergaard (n 18) 5.
[330] Bicocchi (n 17) 115.
[331] Spencer and Hughes (n 303) 29.
[332] Spencer and Hughes (n 303) 29.
[333] PICUM, 'Protecting undocumented children: Promising policies and practices from government' (Reprint January 2018), 17.
[334] Spencer and Hughes (n 303) 19.
[335] Hjern and Stubbe Østergaard (n 18) 66.

entitled to receive comprehensive healthcare services through the National Health Service (NHS).[336] This includes access to primary care, secondary care, emergency care, immunization, screening, and prevention programs, all free of charge. As mentioned above, the Portuguese law specifically addresses the healthcare needs of irregular migrant children and has established a register managed by the High Commission for Migration to ensure their access to healthcare, as well as preschool and school education. Making explicit through the law the equality of children in an irregular situation to citizens is very important, as it can help avoid issues connected to unclear policies and the consequent fear of being identified and detained or deported. Nevertheless, practical barriers such as lack of knowledge of the system, or communication problems, can still affect, or even impede, undocumented children's access to healthcare services.[337]

As it can easily be deduced from the different examples made, in the EU states the level of healthcare granted to undocumented children highly depends on the category of rules that are applied to them, i.e., whether they possess the same rights as adult irregular migrants, regular migrants, or citizens. Furthermore, other elements such as age limits, costs, and state definitions, can have an impact on the level of services provided. Finally, it should be mentioned that if undocumented adults are hindered from accessing healthcare services, they are more likely to wait longer before seeking help for their children as they are unaware of their rights and fearful of turning to the service providers or the authorities.[338]

5.2.4. Firewall Systems in EU Member States

As discussed in the preceding chapter, the fear of being reported is one of the main practical barriers that *de facto* hinder undocumented migrants from accessing the healthcare services they would be entitled to. While sometimes this apprehension is only connected to the unfamiliarity with the established system, certain EU member states lack firewall systems to protect undocumented migrants' data. It can even happen that either the care providers or those responsible for processing payments for the treatments are obliged to report the information on the irregular situation to the immigration authorities. This compromises their access to specific healthcare services.[339] Germany has been previously cited as a negative example in this matter, especially in non-emergency care

[336] Direcção-Geral da Saúde, Circular Informativa nº 65/DSPCS de 26/11/2004 (Directorate-General for Health, Information Circular)
[337] PICUM (n 13) 17.
[338] PICUM (n 13) 18.
[339] Spencer and Hughes (n 303) 10.

situations: while doctors do not have to report irregular migrants who approach them, therefore granting them emergency care, with regard to secondary care the access is *de facto* hindered by the fact that the Sozialamt must report those who are in an irregular situation.[340] Other states where a legal obligation occurs for healthcare service providers to report irregular migrants to authorities are, e.g., Austria, Belgium, and Hungary.[341]

Examples like these exist, even though the importance of firewalls has been mentioned multiple times in the European context, for instance, by the European Commission against Racism and Intolerance (ECRI)[342] and by the WHO[343]. Moreover, it is important to refer to the General Data Protection Regulation (GDPR)[344]. In fact, the GDPR strengthens the right to privacy and data protection by limiting the reasons for which data can be processed and applying stricter limitations to sensitive data, which includes racial or ethnic origin. According to certain sources, such as PICUM, the GDPR might become a powerful tool for enhancing the firewall system when it comes to irregular migrants' right to health.[345] This approach can be especially beneficial because the GDPR is a regulation, which implies its binding nature as a legislative act for all EU member states.

When firewall systems are in place, they protect irregular migrants from being reported by prohibiting service providers from notifying the police or the immigration authorities. For example, this occurs in Sweden, where the handling of patient data is regulated by the Patient Data Act (Patientdatalagen) and other relevant regulations. A key element is the principle of patient confidentiality, which prohibits healthcare professionals from sharing patient information, including immigration status, without proper authorization or legal requirements. This principle applies to all patients, including irregular migrants, and serves as a safeguard against the disclosure of sensitive information. Since healthcare professionals in Sweden are not expected to proactively inquire about or report patients' immigration status, they can concentrate on providing medical care to patients

[340] Spencer and Hughes (n 303) 12.
[341] Clare Fox-Ruhs, Martin Ruhs, Policy Department for Citizens' Rights and Constitutional Affairs Directorate-General for Internal Policies, 'The Fundamental Rights of Irregular Migrant Workers in the EU: Understanding and Reducing Protection Gaps' (Brussels 2022) PE 702.670 50.
[342] European Commission against Racism and Intolerance, 'ECRI General Policy Recommendation N°16 on safeguarding irregularly present migrants from discrimination' (adopted on 16 March 2016).
[343] WHO, 'Collection and integration of data on refugee and migrant health in the WHO European Region. Technical guidance' (2020).
[344] European Union, 'Directive 95/46/EC of the European Parliament and of the Council on the Protection of Individuals with Regard to the Processing of Personal Data and on the Free Movement of Such Data (General Data Protection Regulation)' (24 October 1995)
[345] PICUM, 'Data Protection and the "Firewall": Advancing the Right to Health for People in an Irregular Situation' (2020).

instead of enforcing immigration laws. Additionally, they are guided by ethical codes and professional guidelines that prioritize patient well-being and respect for privacy. These codes emphasize the importance of maintaining patient confidentiality and avoiding actions that may compromise patient trust.[346]

In certain countries, such as Italy, the Netherlands, and Finland, the healthcare service providers are explicitly prohibited from reporting irregular migrants to authorities, even when irregular entry or staying constitutes a crime.[347] In all the states where similar firewalls apply, the aim is to encourage individuals, regardless of their immigration status, to seek necessary healthcare without fear of their information being used against them for immigration enforcement purposes, prioritizing health and well-being over immigration status. Such an approach should be encouraged, additionally, because it clarifies the relationship between service providers and state authorities. As previously mentioned, the nature of this relationship remains unclear in many states, which may discourage parents from seeking medical assistance for their children. Therefore, greater clarity regarding the existing firewall systems is necessary in order to eliminate this barrier.[348]

The focus on single EU states and their standards was done to show how, in practice, the right to health of undocumented minors, as extensively discussed in Chapter 3, is hindered by the practical barriers mentioned in Chapter 4 that exist, albeit to varying degrees, in all the states under examination. In fact, even with regard to a particularly vulnerable category like undocumented children, regulations often lack clarity, and the migrants' fear of being recognized plays a role in the scarcity of services provided to them, especially if firewall systems are not in place. Although all the mentioned states belong to the EU, which would suggest greater harmonization, the impossibility of the EU to directly intervene in certain subjects and the unwillingness of the states to lose power over immigration control, leads to significant disparities in the actual practices. A final element to highlight in this analysis is the fact that, as certain sources point out, the wealth of states does not directly correlate with either the level or the cost of healthcare services provided to undocumented minors.[349] As an illustrative case, Denmark, despite being a Scandinavian country with an advanced

[346] Hjern and Stubbe Østergaard (n 18) 67.
Note that the firewall system in Sweden is currently endangered by a policy proposal. For further discussion on this, see the Chapter 1.2. (n 23) and Chapter 6 (n. 366).
[347] FRA, 'Fundamental rights of migrants in an irregular situation in the European Union' (2011) 44.
[348] UNICEF (n 302).
[349] E.g., Fox-Ruhs and Ruhs (n 341) 49; Spencer and Huges (n 303) 51.

healthcare system, limits access to free healthcare for undocumented migrants, including children.[350] Hence, the restrictive behavior of states depends more on their securitization attitude than on their financial capabilities.[351]

[350] CESCR, 'Concluding observations on sixth periodic report of Denmark' (12 November 2019) E/C.12/DNK/CO/6, para. 63.
[351] Spencer and Huges (n 303) 51.

6. Conclusions

The analysis conducted in this study examined the extent to which international human rights instruments and EU legislation protect the right to health of undocumented minors. It also went beyond theoretical considerations, identifying practical barriers impacting the overall well-being of undocumented children. As explained in the introduction, this dual approach involved a doctrinal method, which analyzed the legal framework provided by international human rights instruments and EU legislation, and a comparative legal method that confronted the practices of selected EU member states.

In particular, the doctrinal method provided a comprehensive understanding of the legal framework in place, identifying potential gaps and areas where the protection of the right to health for undocumented minors could be strengthened. The comparative legal method underlined the variations among EU member states' practices, showing the real-world implications and enforcement of these legal standards. This combined approach highlighted the complexities of the subject matter, emphasizing the primary challenges requiring attention. Furthermore, the utilization of existing academic literature not only helped define the context of the analysis but also compensated for the limited availability of data encountered during the research.

Chapter 2 expanded the contextual background to provide a more solid foundation for the research and to demonstrate why studying this topic is valuable. Specifically, the necessity for broader protection of the rights of undocumented minors was highlighted by referring to their triple vulnerability, which arises from the combination of their status as children, migrants, and undocumented individuals.[352] Recognizing the unique circumstances of each child and their different level of vulnerability is fundamental, and it should guide courts to address their issues in a way that prioritizes their best interests, without stigmatizing them.[353] Moreover, the analysis done in Chapter 2.4.3 showed that irregularity has several negative effects on children's development, including their integration into the host society and their mental and physical health. This forms the basis for understanding why providing healthcare services to them is essential and what the consequences could be if their right to health is not adequately protected.

[352] Bicocchi (n 17) 112.
[353] Beduschi (n 41) 68.

The examination of the legal framework in Chapter 3 answered to the first research question of this thesis, which wanted to investigate the extent of protection granted by international law instruments to the right to health of undocumented minors. This analysis has revealed the scarcity of specific legal instruments on migrant children, with references to undocumented migrants mostly limited to non-binding soft law instruments such as the New York Declaration and the Global Compact.[354] Conversely, children's rights have a position of importance in the international framework, being mainly protected by the CRC. In addition to the provisions that explicitly address the right to health, other principles such as the best interest of the child and non-discrimination postulate the need for undocumented minors to enjoy the same rights to healthcare as the citizens of their host states. This necessity is also connected to their higher level of vulnerability. Moreover, the existing norms on the right to health are broad and comprehensive, entailing further obligations that holistically address the well-being of individuals.

Shifting the focus to the CoE legal framework and ECtHR judgments, it becomes evident that the states' sovereign powers often supersede other considerations, even health-related ones. This is demonstrated, for example, by the limitation *ratione personae* of the RESC, which excludes individuals in an irregular situation. However, instruments such as the ECSR decisions and the non-binding documents issued by CM and PACE are important as they show an aspiration to broaden the protection for undocumented minors and, subsequently, all migrants.[355]

Notwithstanding the presence of international human rights law instruments safeguarding the right to health and children's rights, theoretically protecting their well-being, the research highlighted the existence of practical barriers that hinder access to these rights. The second research question was answered by listing and describing the different existing barriers, also showing how they impact undocumented minors' well-being, especially focusing on the consequences on their mental health. Firstly, the "highest attainable standard of physical and mental health"[356] articulated by the ICESCR is often not provided by states due to their desire to maintain their sovereignty, resulting in services primarily limited to emergency care. Preventive care is considered too expensive by states, even though it has been proved that consistently resorting to it would actually reduce the general healthcare costs.[357] Moreover, mental health is rarely provided to undocumented minors, despite the

[354] See Chapter 3.3.1.
[355] See Chapter 3.4.2.
[356] ICESCR Art. 12.
[357] FRA (n 228).

great impact of irregularity on their well-being. This is due to the states' tendency to only provide migrants with minimal care, and to the stigma that dissuades migrants from seeking mental health support. In addition to the different levels of care provided to undocumented minors, other barriers include the cost of services, communication difficulties, irregular migrants' fear of being reported to migration authorities, and the shame and stigma faced in the host communities.[358]

Chapter 5 focused on the EU context, answering the third research question by analyzing the practices of selected EU member states and underlining the main problems and flaws, as well as the most positive policies. The analysis on the states was conducted after an assessment of the EU legal framework. An examination of the CFR revealed that, on the one hand, preventive healthcare is mentioned as necessary for migrants; on the other hand, significant power is left to states through their "national laws and practices".[359] Indeed, the fact that the EU only has support and coordination powers both in the area of healthcare and migration, renders member states' approaches highly different. While soft-law instruments such as the EU Strategy and communications from the EU Commission signal a desire to encourage states to broaden protection for the right to health of migrants, the non-binding nature of these documents lowers their efficacy.[360]

Due to these limitations of the EU powers, member states' policies regarding the right to health of undocumented minors present significant differences, as shown by the comparative analysis of three main different aspects. The first barrier examined was the cost of health services, with states such as Italy providing free healthcare to the indigent, regardless of their irregular status, while others, such as Hungary, requiring everyone to join the national social health insurance system, having to bear the costs for healthcare services. In some cases, voluntary services, such as the Global Clinic in Finland, try to compensate for state deficiencies by providing free healthcare to migrants in irregular situations.[361] It was pointed out that this kind of initiative, although welcome, cannot be comparable to states' efforts to solve the existing problems.

The second aspect taken into consideration related to the level of healthcare provided, which varies highly across the EU, as it depends on the classification of undocumented children.[362] In some states, such as Slovakia and Bulgaria, the protection is minimal because undocumented minors are provided

[358] See Chapter 4.4.
[359] CFR Art. 35.
[360] See Chapter 5.1.2.
[361] See Chapter 5.2.2.
[362] See Chapter 5.2.3.

the same services as adults in an irregular situation. Conversely, other states, such as Portugal, Spain, and France, grant the maximum protection, comparable to the one granted to children who are citizens. However, there can still be practical differences due to other factors such as the maximum age, which is 16 years in Portugal and 18 in Spain, as well as the implicit or explicit recognition of the assimilation of undocumented and citizen minors in the law.[363] Moreover, some countries, such as Belgium and Croatia, grant broader protection only to unaccompanied minors, disadvantaging accompanied ones. Finally, the situation of adults in an irregular situation should also be considered, as their awareness of minors' sets of rights or fear of apprehension may discourage them from seeking services for their children.[364]

Finally, the firewall systems in different EU states were compared, since the lack of such a system constitutes one of the biggest barriers for irregular migrants to benefiting from medical assistance.[365] In fact, fear of apprehension hinders undocumented minors and their parents from seeking healthcare services until their situation becomes an emergency. Conversely, the existence of firewall systems, together with the migrants' awareness of their existence, facilitates the provision of necessary care without reporting the irregular situation to authorities. Even in this case, the differences between states are quite significant. Some countries, such as Italy and Finland, prohibit service providers from reporting the irregular status of patients, while others, such as Austria and Hungary, permit such reporting. At the time of this study, as mentioned in the introduction, the Swedish right-wing coalition has proposed to introduce the mandatory report of individuals in an irregular situation.[366] However, the professionals in Sweden have been protesting against this proposal, arguing that it is "antithetical to professional ethics and obligations to care for and serve all."[367]

This research shed light on the complexities of ensuring the right to health for undocumented minors. This comes from the interconnection between fundamental rights and migration law, which is strictly linked to states' sovereignty. The recognition of these complexities is not an ending point, but it should serve as an impetus for a broader discussion on human rights and immigration policy, as well as for further research in this area. Furthermore, it calls for studies that go beyond the geographical

[363] Spencer and Hughes (n 303) 29.
[364] PICUM (n 13) 18.
[365] See Chapter 5.2.4.
[366] Szumski (n 23).
[367] Claudia Lorenzo Rubiera, 'Professionals in Sweden are pushing back hard against a rightwing plan to make them snitch on undocumented migrants' (The Conversation, 21 September 2023), <https://theconversation.com/professionals-in-sweden-are-pushing-back-hard-against-a-rightwing-plan-to-make-them-snitch-on-undocumented-migrants-213124> accessed 28 September 2023.

scope of this thesis, utilizing a global perspective. The limitations in available data emphasize the need for further statistical and medical research. This should address both the consequences of irregularity and lack of proper levels of care for undocumented children and the impact of practical barriers such as communication and language proficiency, as well as the role of stigma. In fact, possessing more comprehensive data about an issue is useful to emphasize the urge for proactive measures to solve it.

Regularization emerges as the first and most pragmatic solution to facilitate access to healthcare for undocumented minors, but the principle of sovereignty often leads to states' reticence in moving in this direction. However, states still have the obligation to protect children's rights, and therefore they should, at a minimum, act to remove the barriers that limit access to healthcare services, refraining from discrimination based on irregular status. Drawing from the analysis done in this thesis, and being inspired by the most positive EU states' practices examined in Chapter 5, a set of recommendations is offered. To diminish the fear of undocumented migrants towards service providers, firewall systems should be established, accompanied by clear communication regarding rights and available opportunities. Healthcare should be made more affordable, and preventive care should be more extensively utilized to mitigate treatment costs. Undocumented minors should be granted the same level of healthcare as the children who are citizens of the host state, guided by the best interest of the child and the principle of non-discrimination. To address communication issues, a higher number of qualified interpreters should be deployed, taking into account cultural differences and the particular vulnerability and needs of undocumented children. Finally, a holistic approach should be applied when considering their well-being, since it depends on multiple factors such as access to food, housing, and education.

In addition to states, all stakeholders should act to solve the lack of access to healthcare of undocumented minors. In cases where their rights are at stake, courts should always consider their higher level of vulnerability and the specific challenges they face due to their status. Moreover, treaty bodies such as the CRC committee and the CESCR should closely monitor states' compliance with international human rights treaties related to the right to health of undocumented minors, and the UN agencies should advocate for the rights of undocumented children and promote awareness among member states. The EU, even though it only has a coordinating role in health and migration, should raise awareness regarding this issue through soft-law instruments. In addition, it could

enforce the GDPR to enhance states' firewall systems, as suggested by organizations such as PICUM.[368]

In conclusion, undocumented minors must be treated primarily as children deserving of protection and care, regardless of their legal status, and their right to health should not be affected by migration policies designed to expel individuals. As children, they deserve the opportunity to live healthy lives and access healthcare services whenever they are in need. Cooperation among all stakeholders is necessary to safeguard undocumented minors' rights and ensure their well-being, building a more equitable and humane world. The example of the Swedish professionals who have been protesting against the proposal to eliminate the firewall system in Sweden should inspire all members of society to challenge discriminating policies and advocate for the fundamental rights of all human beings, especially when children's rights are in danger.

[368] PICUM (n 11).

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